



ARTICLES

THE BUDDING HEMP INDUSTRY: THE EFFECT OF TEXAS HOUSE BILL 1325 ON
EMPLOYMENT DRUG POLICIES
Meina Heydari..... 1

INTERNATIONAL HUMAN RIGHTS LAW AND THE HEALTH OF PERSONS WITH
INTELLECTUAL DISABILITIES
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This issue is dedicated to individuals facing inequity due to their health needs and the systems that fail them.

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LETTERS FROM THE EDITORS

Dear Reader:

On behalf of the Editorial Board and Staff, we proudly present Volume 15, Issue 1 of the *Health Law & Policy Brief* (HLPB). As we began working on the articles below, a theme emerged of systems lagging behind the reality of health needs of our communities. Science and medicine develop quickly and without regard to the systems that control the delivery to individual patients. When updates to the criminal justice system, employment policies, and the health care systems no longer match the current state of medicine, communities face forgoing their medical needs because of the risk of drug enforcement actions or the care they need simply is not made available to them.

Our first article explores the current landscape of cannibidol (CBD) legalization in Texas, a state that has historically taken a harsh stance on marijuana use. With Texas having legalized hemp and hemp-derived products, the author, Meina Heydari, argues that employment drug policies that prohibit the use of marijuana must rectify their old policies in favor of policies that demonstrate their understanding of the important distinctions between hemp and marijuana and the vital medical uses of CBD products.

The second article discusses the inequalities and discrimination that persons with intellectual disabilities face in mainstream health systems. The author, Javier Vasquez, uses the human rights law framework to establish the human rights of individuals with intellectual disabilities and how current systems are not made to care for these individuals or meet their needs. Mr. Vasquez concludes by arguing that the Special Olympics and its athletes have come to represent the ideal system for the promotion of inclusive health care for this community.

We would like to thank the authors for their hard work and cooperation in writing, researching, and editing their work. We would also like to thank HLPB's article editors and staff members who worked diligently on this issue. Their efforts are greatly appreciated, and we are proud of their work.

To all our readers, we hope you enjoy this issue and it encourages you to think broadly and critically about how systems that influence health care can be improved and to be creative in how we can improve society to reach equity for every community.

Sincerely,
Cale & Elizabeth

Cale H. Coppage
Editor-in-Chief

Elizabeth Raterman
Executive Editor

* * *

The Budding Hemp Industry: The Effect of Texas House Bill 1325 on Employment Drug Policies

Meina Heydari*

Contemporary attitudes toward cannabis use in the United States have shifted from War on Drugs-era prohibition toward decriminalization over the past two decades. As states that do not seek to decriminalize marijuana nonetheless enact legislation legalizing CBD, policy tensions arise. In 2019, Texas joined the ranks of states that legalized hemp and hemp-derived products with the passage of House Bill 1325. In light of this legislation, this Article discusses the implications of legalized cannabidiol (CBD) on employment drug policies in Texas. The benefits of CBD legalization must be weighed against the practical implications to effectively balance policies that aim to protect employees and employers with potentially divergent interests. This Article examines the various sources of employment protection in Texas and advocates for an amendment to H.B. 1325 that raises the threshold of delta-9 tetrahydrocannabinidiol (THC) content permitted in hemp, an adoption of administrative rules modeled after those established by the Utah Department of Agriculture and Food, and an amendment to the Texas Labor Code. This approach places the burden on CBD sellers to verify that their products are consistent with claimed CBD content, ensures that the products produce no psychoactive effects, allows room for error in the event of inconsistent THC content, and protects individuals who are mistakenly deemed as using illegal drugs.

* Meina Heydari is a third-year law student at Texas A&M University School of Law. She would like to thank Professor Aaron Retteen for his thoughtful feedback in advising her, Brian Kent for his invaluable help, and her parents for their support and encouragement.

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I. Introduction

Seventy-two-year-old Lena Bartula takes cannabidiol (CBD) to treat pain caused by her sciatica.¹ On September 16, 2018, she passed through Texas during her trip from Mexico to Portland, Oregon to visit her granddaughter.² At DFW Airport, however, police arrested her when a bag check at the customs checkpoint yielded the discovery of her CBD oil.³ Testing instruments could not differentiate between CBD and tetrahydrocannabinidiol (THC), and she was charged with possession of a controlled substance.⁴ Bartula was booked, fingerprinted, given a tuberculosis vaccine shot without her consent, and jailed for two days at the Tarrant County Jail.⁵ Although she was released, Bartula's case was not dismissed until two months later, when a grand jury declined to indict her.⁶

As CBD use skyrockets,⁷ consumers like Bartula must contend with possible criminal implications. However, Bartula's case highlights another aspect of life that may be affected: employment. While CBD is now legal at both the federal and state levels, consumers face occupational ramifications if they test positive for THC, even if they have never used marijuana.⁸ Due to CBD's relatively new presence in the market, the Federal Drug Administration (FDA) has yet to develop standards and regulations governing the content of CBD products.⁹ The Texas government lacks the requisite testing equipment to ascertain whether CBD products satisfy the statutorily required THC threshold.¹⁰ Remedies under the Americans with Disabilities Act (ADA) and Texas Labor Code are unavailable due to the alleged use of illegal drugs.¹¹ The recent legalization of CBD, therefore, allowed consumers access to a whole new market, but failed to implement policies to ensure their safety. Instead, Texas consumers face onerous consequences without ever breaking the law.

¹ Carlos Miller, *Stop Arresting Grandmothers for CBD*, MIAMI NEW TIMES (May 28, 2019), <https://www.miaminewtimes.com/marijuana/stop-cbd-cannabidiol-marijuana-arrests-of-grandmothers-hester-burkhalter-and-lena-bartula-11181105>.

² *Id.*; Mitch Mitchell, *Still Illegal: Texas Law on CBD Oil Lands Grandmother in Jail After DFW Airport Search*, FORT WORTH STAR-TELEGRAM (May 22, 2019), <https://www.star-telegram.com/news/local/article230704704.html>.

³ Mitchell, *supra* note 2.

⁴ Miller, *supra* note 1.

⁵ Mitchell, *supra* note 2.

⁶ *Id.*

⁷ Matej Mikulic, *Total U.S. Cannabidiol (CBD) Consumer Sales from 2014 to 2022*, STATISTA (Sept. 2018), <https://www.statista.com/statistics/760498/total-us-cbd-sales/> (last updated Sept. 23, 2020).

⁸ See *Horn v. Medical Marijuana, Inc.*, 383 F. Supp. 3d 114, 121–22 (W.D.N.Y. 2019).

⁹ See generally Press Release, U.S. Food & Drug Admin., FDA Approves First Drug Comprised of an Active Ingredient Derived from Marijuana to Treat Rare, Severe Forms of Epilepsy, (June 25, 2018), <https://www.fda.gov/news-events/press-announcements/fda-approves-first-drug-comprised-active-ingredient-derived-marijuana-treat-rare-severe-forms>.

¹⁰ See Nicholas Bogel-Burroughs, *Texas Legalized Hemp, Not Marijuana, Governor Insists as Prosecutors Drop Pot Charges*, N.Y. TIMES (July 19, 2019), <https://www.nytimes.com/2019/07/19/us/texas-hemp-marijuana-legalization.html>.

¹¹ See 42 U.S.C.A. § 12114(a)–(b) (West 2009); TEX. LAB. CODE ANN. § 21.051 (West 2019).

The goal of this Article is to analyze the scientific differences between marijuana and hemp, examine the formation of the legal definition of the substances, apply the existing employment protection structures to the recent legislation, and ultimately suggest a change in policy for state governments that have not legalized marijuana to implement in the future. Part II of this Article will clarify the differences between marijuana, hemp, and CBD and will provide context for lawmakers' decision to legalize hemp and CBD. Part III will provide a historical background of the cannabis decriminalization processes in the United States to highlight how many states are further ahead of the curve regarding cannabis regulation.

Then, Part IV of this Article will examine the current difficulty differentiating between marijuana and hemp from the perspectives of law enforcement and employers. Part V will analyze the interaction between cannabis use and employment discrimination protection and the effect of CBD legalization on the existing structure. A brief discussion of the ADA and the Texas Labor Code is necessary to understand the effect of marijuana use on the ability to implicate the statutory protections. This section will also assess the lack of regulation of CBD products, the FDA's current regulatory position regarding the presence of CBD products in interstate commerce, and possible protections under federal and state employment discrimination laws for users of CBD who may test positive for THC.

Lastly, Part VI will propose a three-pronged amendment to Texas House Bill 1325: an increase of the THC threshold, the enactment of administrative rules by the Texas Department of Health mandating third-party verification of CBD products and state-allocated funding for enforcement, and an exception to the Texas Labor Code protecting individuals who disprove allegations of illegal drug use. The proposed amendment provides a balance of interests that benefits both the economic and individual well-being of Texas citizens following the passage of H.B. 1325.

II. Definitions of Marijuana, Hemp, & CBD

There is confusion regarding the difference between hemp and marijuana, and how CBD factors into the equation.¹² However, understanding those differences is the key to forming a practical employment policy regarding the use of CBD.

Marijuana and hemp are two members of the *cannabis* genus.¹³ This species of plant produces a variety of chemical compounds known as cannabinoids.¹⁴ While the plant produces many different cannabinoids, the two relevant to this discussion are delta-9 tetrahydrocannabinol and cannabidiol.¹⁵ Delta-9 tetrahydrocannabinol, more commonly known as THC, is the cannabinoid

¹² See generally Peter Grinspoon, *Cannabidiol (CBD) – What We Know and What We Don't*, HARV. HEALTH PUBL'G: HARV. HEALTH BLOG (Aug. 24, 2018, 6:30 AM), <https://www.health.harvard.edu/blog/cannabidiol-cbd-what-we-know-and-what-we-dont-2018082414476>.

¹³ DAVID P. WEST, N. AM. INDUS. HEMP COUNCIL, *HEMP & MARIJUANA: MYTHS & REALITIES* 3 (1998).

¹⁴ See *id.* at 7.

¹⁵ See *id.* See generally Ernest Small, *Evolution and Classification of Cannabis Sativa (Marijuana, Hemp) in Relation to Human Utilization*, 81 BOTANICAL REV. 3, 189, 240–41 (Aug. 2015).

responsible for inducing the psychoactive effect, or the notorious “high.”¹⁶ The *cannabis* plant must contain at least one percent THC in order to produce the psychoactive effect.¹⁷ Cannabidiol, commonly referred to as CBD, is a non-intoxicating cannabinoid that has been shown to reduce the effects of THC.¹⁸ A substance containing a high amount of CBD will thus be incapable of producing the “high” that marijuana is known for.¹⁹ Instead, scientific studies indicate that CBD produces anti-inflammatory and neuroprotective effects.²⁰

Marijuana is depicted frequently in the media and is likely the most recognizable recreational drug to the public.²¹ There are various stages of cultivation and an abundance of concentrated products.²² The typical method of consumption involves combustion or vaporization of a cured flower end product that generally contains anywhere from 3.4% to 20% THC, and cannabis oils can contain as much as eighty percent THC.²³ Hemp itself, referred to as “industrial hemp,” is the *cannabis* plant that has been cultivated to contain low amounts of THC and high amounts of CBD.²⁴

Put simply, marijuana and hemp are cousins in the *cannabis* genus and contain varying amounts of CBD and THC, with hemp containing more CBD than THC.²⁵ Congress has defined “hemp” as the *cannabis sativa* plant that contains less than 0.3% THC on a dry-weight basis.²⁶ A plant that contains 0.31% THC on a dry-weight basis, therefore, is legally classified as a marijuana plant, regardless of the fact that it does not produce marijuana’s psychoactive effect.²⁷ In other words, Congress imposed definitions on naturally occurring plant products—a decision that seems somewhat laughable in light of the current tensions with respect to the differences between the two plants. Hemp may be used in a multitude of products, such as fertilizer, cosmetics, cooking oils, paints, and automotive fuel.²⁸ Its pervasiveness in the market, therefore, sets consumers up to face the issue of testing due to the heightened risk of inadvertently ingesting THC.

¹⁶ WEST, *supra* note 13, at 7–8.

¹⁷ Small, *supra* note 15, at 242.

¹⁸ WEST, *supra* note 13, at 7–8.

¹⁹ *See id.* at 8.

²⁰ Lawrence Leung, *Cannabis and Its Derivatives: Review of Medical Use*, 24 J. AM. BD. FAM. MED. 452, 458–59 (July 2011).

²¹ *See* Steve P. Calandrillo & Katelyn Fulton, “High” Standards: The Wave of Marijuana Legalization Sweeping America Ignores the Hidden Risks of Edibles, 80 OHIO ST. L.J. 201, 203 (2019).

²² *See* Paul J. Larkin, Jr., *Marijuana Edibles and “Gummy Bears”*, 66 BUFF. L. REV. 313, 318 (Apr. 2018).

²³ *See id.* at 318, 338.

²⁴ *See* WEST, *supra* note 13, at 8.

²⁵ *See id.*; Grinspoon, *supra* note 12.

²⁶ 7 U.S.C.A. § 1639o(1) (West 2018).

²⁷ *See* Nicole Gleichmann, *Hemp vs. Marijuana: Is There a Difference?*, ANALYTICAL CANNABIS (Sept. 2, 2019), <https://www.analyticalcannabis.com/articles/hemp-vs-marijuana-is-there-a-difference-311880>.

²⁸ *See* DAVID G. KRAENZEL ET AL., INDUSTRIAL HEMP AS AN ALTERNATIVE CROP IN NORTH DAKOTA 7 fig.2 (Agric. Econs. Report No. 402, 1998).

The Texas Legislature has designated CBD products marketed for individual use as consumable hemp products.²⁹ CBD products may be labeled as one of three types: full-spectrum CBD, broad-spectrum CBD, or CBD isolate.³⁰ In full-spectrum CBD, all of the naturally occurring compounds in the *cannabis* plant are present, including terpenes, flavonoids, and THC.³¹ Such extracts are required to contain less than 0.3% THC, but compliance is difficult to ascertain due to the lack of available testing.³² Full-spectrum CBD is widely available.³³ The second type of product is broad-spectrum CBD, which is essentially full-spectrum CBD without THC.³⁴ This type of CBD extract is less available than full-spectrum CBD.³⁵ The third type of CBD product is CBD isolate, or pure CBD.³⁶ It does not contain THC or any other compounds and is generally derived from the hemp plant itself.³⁷ CBD isolate is typically sold as an oil, tincture, edible slab, or crystalline powder.³⁸ CBD and marijuana both take a variety of similar forms, and uninformed consumers may be unable to distinguish between them in order to comply with the law.

III. History of Cannabis Decriminalization

Having established the substantive differences between marijuana, hemp, and CBD, this Article next describes the historical background of the cannabis decriminalization processes in the United States, beginning with marijuana. Had the legislative bodies considered this history, they may have been able to foresee, and thus prevent, the issues that have arisen.

It is important to note, however, the difference between the terms “decriminalization” and “legalization.” Decriminalization refers to “policies that do not define possession for personal use or casual distribution as criminal offenses.”³⁹ For example, marijuana is decriminalized in Mississippi because a first-time offense of possession of fewer than thirty grams of marijuana is punishable by a \$250 fine.⁴⁰ Legalization, on the other hand, “removes the criminal and monetary

²⁹ See H.R. 1325, 86th Leg., Reg. Sess. (Tex. 2019).

³⁰ Alan Carter & Carly Vandergriendt, *Does CBD Show Up on a Drug Test?*, HEALTHLINE (Apr. 24, 2019), <https://www.healthline.com/health/does-cbd-show-up-on-a-drug-test>.

³¹ *Id.* Terpenes are naturally occurring compounds that provide cannabis with its distinct scent. Flavonoids are metabolites that affect UV filtration, pigmentation, and nitrogen fixation. Sean M. O’Connor & Erika Lietzan, *The Surprising Reach of FDA Regulation of Cannabis, Even After Descheduling*, 68 Am. U. L. Rev. 823, 848 (2019).

³² Carter & Vandergriendt, *supra* note 30.

³³ *Id.* See also Jessica Timmons, *Best-Full-Spectrum CBD Oils*, HEALTHLINE (Oct. 27, 2020), <https://www.healthline.com/health/best-full-spectrum-cbd-oil>; *10 Best Full Spectrum CBD Oil*, BEST CBD, <https://www.bestcbdoils.org/best-full-spectrum-cbd-oil/> (last visited Nov. 11, 2020). As the most widely available form of CBD, full-spectrum CBD implicates a higher likelihood that consumers will inadvertently ingest more THC than they believe.

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ Rosalie Liccardo Pacula & Rosanna Smart, *Medical Marijuana and Marijuana Legalization*, 13 ANN. REV. CLINICAL PSYCHOL. 397, 400 (2017).

⁴⁰ *Mississippi*, MARIJUANA POL’Y PROJECT, <https://www.mpp.org/states/mississippi/> (last updated Oct. 4, 2020).

penalties for the possession, use, and supply of marijuana for recreational purposes.”⁴¹ For example, marijuana is legalized in fifteen states and the District of Columbia, wherein citizens may freely purchase and consume marijuana.⁴² In other words, legalization and decriminalization may be viewed as a hierarchy in which legalization renders decriminalization unnecessary.

A. Marijuana

Congress significantly acted upon the issue of marijuana for the first time in 1937 when it passed the Marihuana Tax Act.⁴³ While the Act did not declare the drug illegal, it implemented various requirements and taxes that paralyzed the marijuana industry.⁴⁴ In 1970, Congress acted again by repealing the Marihuana Tax Act and replacing it with the Comprehensive Drug Prevention and Control Act, which effectively declared all cannabis illegal—regardless of whether it was marijuana or hemp.⁴⁵ Title II of the Act, known as the Controlled Substances Act (CSA), contains five categories, or schedules, in which substances may be placed.⁴⁶ Congress categorized substances based on possibility of abuse, accepted medical use in treatment, and degree of dependence.⁴⁷ Upon its enactment, the CSA classified marijuana as a Schedule I drug.⁴⁸ A drug or substance placed in Schedule I has a high possibility for abuse and lacks both any “currently accepted medical use in treatment in the United States” and “accepted safety for use under medical supervision.”⁴⁹ This framework relies on legislative action; it lacks a self-updating mechanism to reschedule drugs, resulting in laws that lag behind accepted medical uses, particularly in light of severe restrictions on marijuana research.⁵⁰

In the same year that Congress enacted the CSA, President Richard Nixon announced a national “war on drugs.”⁵¹ In 1972, he appointed the National Commission on Marihuana and Drug Abuse, known colloquially as the Shafer Commission, to study the health and psychological effects of marijuana.⁵² After analyzing the interrelationships between marijuana use, marijuana itself, and

⁴¹ Pacula & Smart, *supra* note 39, at 401.

⁴² Darla Mercado, *These 4 States are Voting to Legalize and Tax Marijuana Sales*, CNBC, (Oct. 7, 2020), <https://www.cnbc.com/2020/10/07/f04-states-voting-to-puff-puff-pass-pot-legalization.html>. See also Kyle Jaeger, *Every Single Marijuana and Drug Policy Ballot Measure Passing on Election Day Bolsters Federal Reform*, MARIJUANA MOMENT (Nov. 4, 2020), <https://www.marijuanamoment.net/every-single-marijuana-and-drug-policy-ballot-measure-passing-on-election-day-bolsters-federal-reform-push/>.

⁴³ See generally WEST, *supra* note 13, at 9–10 (discussing the history of the Marihuana Tax Act).

⁴⁴ See *Gonzales v. Raich*, 545 U.S. 1, 11 (2005) (“the onerous administrative requirements, the prohibitively expensive taxes, and the risks attendant on compliance practically curtailed the marijuana trade.”).

⁴⁵ WEST, *supra* note 13, at 10–11.

⁴⁶ 21 U.S.C.A. § 812(b) (West 2018).

⁴⁷ See *id.*

⁴⁸ *Id.* § 812(c).

⁴⁹ *Id.* § 812(b).

⁵⁰ See generally 21 C.F.R. § 1301.18 (2010) (stating protocols for research with Schedule I substances).

⁵¹ *Raich*, 545 U.S. at 10.

⁵² See NAT. COMM’N ON MARIJUANA AND DRUG ABUSE, MARIJUANA: A SIGNAL OF MISUNDERSTANDING (1972), <http://www.druglibrary.org/schaffer/library/studies/nc/ncmenu.htm>.

marijuana as a social problem, the Commission recommended decriminalization of marijuana, finding that criminalization of possession for personal use [was] socially self-defeating.⁵³ However, President Nixon rejected the findings.⁵⁴

Marijuana is still today prohibited as a Schedule I controlled substance pursuant to federal law.⁵⁵ However, fifteen states and the District of Columbia have legalized recreational marijuana use,⁵⁶ and thirty-six have enacted some form of compassionate use legislation.⁵⁷ The conflict between federal and state legality—or lack thereof—has led to confusion as to whether states that have legalized or decriminalized marijuana must enforce the federal policy prohibiting it.⁵⁸ A widely accepted concept of voluntary cooperation has formed in the wake of such uncertainty; states may choose whether to accept the federal invitation, created through the CSA, to authorize their own officers to arrest for a violation of the federal marijuana policy.⁵⁹

However, the Trump administration has radically affected the concept of voluntary cooperation.⁶⁰ In 2009, then-Deputy Attorney General David Ogden issued a memorandum informing federal prosecutors that prosecution of individuals lawfully using marijuana for serious illnesses was an inefficient use of resources.⁶¹ Former Deputy Attorney General James M. Cole followed up with a memorandum in 2013, allowing states to enforce their own decriminalization structures and advising law enforcement to enforce the CSA only when the use, possession, or distribution of marijuana threatened to cause harm specified in the memorandum.⁶² However, under the Trump administration, Attorney General Jeff Sessions rescinded all previous guidance and effectively mandated federal law enforcement to enforce the CSA against all marijuana use, regardless of whether a state has adopted the decriminalization structure.⁶³

In 2019, House and Senate members in the 116th Congress introduced a number of bills proposing changes in marijuana policy.⁶⁴ H.R. 2093, also known as the Strengthening the Tenth Amendment

⁵³ *Id.* at ch. 5; see Michael Vitiello, *Legalizing Marijuana and Abating Environmental Harm: An Overblown Promise?*, 50 U.C. DAVIS L. REV. 773, 784 (Dec. 2016).

⁵⁴ EMILY DUFTON, GRASS ROOTS: THE RISE AND FALL AND RISE OF MARIJUANA IN AMERICA, 54 (2017).

⁵⁵ 21 U.S.C.A. § 812(c)(1) (West 2018).

⁵⁶ Mercado, *supra* note 42.

⁵⁷ Katherine Berger, *ABCs and CBD: Why Children with Treatment-Resistant Conditions Should Be Able to Take Physician-Recommended Medical Marijuana at School*, 80 OHIO ST. L.J. 309, 324 (2019). See also *State Medical Marijuana Laws*, NAT. CON. STATE LEGS., <https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx> (last visited Nov. 11, 2020).

⁵⁸ See generally *Callaghan v. Darlington Fabrics Corp.*, No. PC-2014-5680, 2017 WL 2321181, at *13–*15 (R.I. Super. May 23, 2017) (discussing preemption).

⁵⁹ See Todd Grabarsky, *Conflicting Federal and State Medical Marijuana Policies: A Threat to Cooperative Federal*, 116 W. VA. L. REV. 1, 18 (2013).

⁶⁰ See Memorandum from Att’y Gen. Jefferson B. Sessions to U.S. Att’ys (Jan. 4, 2018), <https://www.justice.gov/opa/press-release/file/1022196/download>.

⁶¹ Memorandum from Deputy Att’y Gen. David W. Ogden to Selected U.S. Att’ys (Oct. 19, 2009), <https://www.justice.gov/opa/press-release/file/1022196/download>.

⁶² Memorandum from Deputy Att’y Gen. James M. Cole to U.S. Att’ys (Aug. 29, 2013), <https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>.

⁶³ Memorandum from Att’y Gen. Jefferson B. Sessions to U.S. Att’ys, *supra* note 60.

⁶⁴ See H.R. 2093, 116th Cong. (2019); H.R. 127, 116th Cong. (2019).

Through Entrusting States (STATES) Act, proposes an amendment to the CSA that protects states' ability to enact marijuana policies.⁶⁵ Similarly, the House has introduced H.R. 127.⁶⁶ This bipartisan act, known as the Compassionate Access, Research Expansion, and Respect States (CARERS) Act of 2019, proposes "[t]o extend the principle of federalism to state drug policy, provide access to medical marijuana, and enable research into the medicinal properties of marijuana."⁶⁷ While the current federal policy regarding marijuana is a clear prohibition, the matter is becoming a nationally recognized issue with support from both major parties.⁶⁸ Therefore, it remains to be seen as to whether that policy will change.

Prior to 1996, all fifty states prohibited marijuana.⁶⁹ In 1996, however, California became the first state to decriminalize marijuana for medical use.⁷⁰ Alaska, Oregon, and Washington did the same in 1998.⁷¹ Over the next ten years, ten states decriminalized medical marijuana.⁷² In 2012, Colorado made history as the first state to legalize recreational marijuana.⁷³ As of 2020, thirty-four states have decriminalized marijuana for medicinal use.⁷⁴ Alaska, Arizona, California, Colorado, Illinois, Maine, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Jersey, Oregon, South Dakota, Washington, Vermont, and the District of Columbia have legalized marijuana for both medical and recreational use.⁷⁵

Texas is one state that has yet to decriminalize marijuana.⁷⁶ However, the Texas Legislature implemented the Compassionate Use Act in 2015.⁷⁷ This bill allows registered physicians to

⁶⁵ H.R. 2093.

⁶⁶ H.R. 127.

⁶⁷ *Id.*; accord Press Release, Cong. Steve Cohen, Lawmakers Introduce Bipartisan Med. Marijuana Bill (Jan. 3, 2019), <https://cohen.house.gov/media-center/press-releases/lawmakers-introduce-bipartisan-medical-marijuana-bill>.

⁶⁸ Andrew Daniller, *Two-Thirds of Americans Support Marijuana Legalization*, PEW RESEARCH CTR. (Nov. 14, 2019), <https://www.pewresearch.org/fact-tank/2019/11/14/americans-support-marijuana-legalization/>.

⁶⁹ Alex Kreit, *Marijuana Legalization and Nosy Neighbor States*, 58 B.C. L. REV. 1059, 1059 (2017).

⁷⁰ Calandrillo & Fulton, *supra* note 21, at 210.

⁷¹ *Id.* at 211–13 tbl. 1.

⁷² *Id.*

⁷³ See *id.* (showing that Washington also legalized recreational marijuana in the same year).

⁷⁴ *Id.* at 210; Jaeger, *supra* note 42.

⁷⁵ *Id.* at 210; CBS NEWS & ASSOC. PRESS, *Illinois Becomes 11th State to Legalize Recreational Marijuana*, CBS NEWS (June 25, 2019, 2:05 PM), <https://www.cbsnews.com/news/illinois-recreational-marijuana-governor-legalizes-governor-j-b-pritzker-signs-bill-today-2019-06-25/>. See also Kyle Jaeger, *Every Single Marijuana And Drug Policy Ballot Measure Passing On Election Day Bolsters Federal Reform*, MARIJUANA MOMENT (Nov. 4, 2020), <https://www.marijuanamoment.net/every-single-marijuana-and-drug-policy-ballot-measure-passing-on-election-day-bolsters-federal-reform-push/>.

⁷⁶ See Mercado, *supra* note 42. As of November 10, 2020, Texas legislators have pre-filed fifteen bills related to the decriminalization and legalization of marijuana. *Tracking: Texas Marijuana Policy, 87th Legislative Session*, TEXANS FOR RESPONSIBLE MARIJUANA POLICY, <http://www.texasmarijuanapolicy.org/txmj21/?fbclid=IwAR2R3tXTHELUwbTVxZb7Dyy-307KsHn15mJHuEP2Sc-J68nGwib7HjqgZsQ> (last visited Nov. 11, 2020).

⁷⁷ See Texas Compassionate Use Act of 2015 § 4, TEX. OCC. CODE ANN. §§ 169.001–169.005 (West 2019).

prescribe cannabis containing low percentages of THC to patients suffering from epilepsy.⁷⁸ The Act defines low-THC cannabis as containing less than 0.5% THC on a dry-weight basis.⁷⁹ House Bill 3703, enacted in 2019, expands the application of the Compassionate Use Act to additional medical disorders.⁸⁰ “Incurable neurodegenerative disease, terminal cancer, a seizure disorder, multiple sclerosis, spasticity, amyotrophic lateral sclerosis, and autism” now qualify as covered medical disorders.⁸¹ Thus, Texas allows the use of low-THC marijuana in specified circumstances.⁸²

B. Hemp

Along with marijuana, the 1937 Marihuana Tax Act banned hemp from the United States markets.⁸³ In 1970, the CSA included hemp as an illegal substance and was subsequently reinforced by the Drug Enforcement Agency’s (DEA) interpretation of its language.⁸⁴ The CSA classified “any material, compound, mixture, or preparation, which contains . . . THC” as a Schedule I controlled substance.⁸⁵ However, it simultaneously excluded “mature stalks of [*Cannabis sativa*] plant” from its definition of marijuana.⁸⁶ The DEA, utilizing its regulatory authority, interpreted the former language to include hemp as a Schedule I substance.⁸⁷ Therefore, the government had prohibited all forms of cannabis pursuant to the CSA until the passage of the 2018 Farm Bill.⁸⁸

Before the 2018 Farm Bill, the 2014 Farm Bill served as the first move away from hemp prohibition pursuant to federal law.⁸⁹ The bill instituted an exception for hemp production by allowing farmers to grow hemp under specified conditions.⁹⁰ It established a definition of hemp and narrowly allowed its production; however, hemp was still categorized as a Schedule I drug, along with all other forms of cannabis.⁹¹ The bill enacted a form of protection for hemp growers in the Hemp Pilot Programs, which allowed those who registered under a state’s hemp research program to cultivate the plant.⁹² Nevertheless, hemp remained illegal if produced in violation of the Farm Bill’s requirements.⁹³

⁷⁸ TEX. OCC. CODE ANN. § 169.003(3)(A)(i).

⁷⁹ *Id.* § 169.001(3).

⁸⁰ *Id.* § 169.003.

⁸¹ *Id.*

⁸² *See id.*

⁸³ Shannon Smith, *Hemp on the Horizon: The 2018 Farm Bill and the Future of CBD*, 98 N.C.L. REV. ADDENDUM 35, 40 (2020).

⁸⁴ *Id.* at 41.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *See id.*

⁸⁸ *See id.* at 41–42.

⁸⁹ *Id.* at 42.

⁹⁰ Agricultural Act of 2014, Pub. L. No. 133-79, § 7606, 128 Stat. 649, 912-13 (codified as amended at 7 U.S.C. § 5940 (2018)).

⁹¹ *Id.*; Smith, *supra* note 83, at 42.

⁹² *Id.*

⁹³ *Id.*

The 2018 Farm Bill expanded the realm of hemp cultivation established by the 2014 Farm Bill.⁹⁴ It defined industrial hemp as cannabis containing 0.3% THC on a dry-weight basis,⁹⁵ adopted from a Canadian scientific study that sought to differentiate between two strains of marijuana.⁹⁶ The researchers themselves had “arbitrarily adopt[ed] a concentration of 0.3% THC . . . as a guide to discriminating [between hemp and marijuana]” during the study.⁹⁷ Additionally, the bill legalized hemp production across the board and declassified it as a Schedule I drug.⁹⁸ It established a federal framework for hemp regulation and enforcement by transferring the regulatory authority to the U.S. Department of Agriculture.⁹⁹ However, while the 2018 Farm Bill removed hemp from Schedule I status, it did not federally legalize CBD.¹⁰⁰ Instead, CBD is legal if, and only if, the hemp from which it is derived complies with federal and state regulations and is produced by a licensed cultivator.¹⁰¹ If the hemp in question does not comply with such requirements, the CBD product is deemed a Schedule I drug.¹⁰²

In 2019, the Texas Legislature approved the passage of House Bill 1325.¹⁰³ The bill legalized the use and production of hemp and hemp-derived products, such as CBD oil, and mirrored the federal statute in defining hemp.¹⁰⁴ The Texas Legislature had previously emphasized that it had no intention of decriminalizing marijuana;¹⁰⁵ H.B. 1325 pertains exclusively to hemp and hemp-derived products.¹⁰⁶

IV. Lack of Proper Testing

When H.B. 1325 legalized hemp and its derivatives, it created challenges in differentiating between hemp and marijuana. Such challenges carry implications in both criminal and employment contexts. This Part explores how law enforcement and employers must contend with these difficulties following the bill’s enactment.

⁹⁴ *See id.*

⁹⁵ Agricultural Improvement Act of 2018 § 297A, 7 U.S.C. § 1639o (2018).

⁹⁶ *See* Ernest Small & Arthur Cronquist, *A Practical and Natural Taxonomy for Cannabis*, 25 TAXON 4, 405, 408 (Aug. 1976).

⁹⁷ *Id.*

⁹⁸ Agricultural Improvement Act § 12619.

⁹⁹ *See* Smith, *supra* note 83, at 42.

¹⁰⁰ Berger, *supra* note 57, at 324.

¹⁰¹ John Hudak, *The Farm Bill, Hemp Legalization and the Status of CBD: An Explainer*, BROOKINGS INST. (Dec. 14, 2018), <https://www.brookings.edu/blog/fixgov/2018/12/14/the-farm-bill-hemp-and-cbd-explainer/>.

¹⁰² *Id.*

¹⁰³ *See generally* H.R. 1325, 86th Leg., Reg. Sess. (Tex. 2019).

¹⁰⁴ *See id.*; 7 U.S.C. § 1639o(1) (2018).

¹⁰⁵ On November 10, 2020, Texas legislators pre-filed three proposals to legalize marijuana. *See* HJR 13, 87th Leg. Reg., Reg. Sess. (Tex. 2020); S.B. 14087th Leg. Reg., Reg. Sess. (Tex. 2020); H.B. 447, 87th Leg., Reg. Sess. (Tex. 2020).

¹⁰⁶ *See* Letter from Greg Abbott, Governor of Tex., et al., to Tex. Dist. And Cty. Att’ys, (July 18, 2019).

A. Law Enforcement

While advocates have lauded H.B. 1325 as a step forward for both agricultural and legalization interests, it has simultaneously created confusion with respect to enforcement.¹⁰⁷ Prior to the passage of the bill, the marijuana testing process simply consisted of identifying hairs on marijuana flowers and using a cannabinoid-detecting test strip.¹⁰⁸ However, crime laboratories must now establish the precise percentage of THC in the suspected substance to determine whether it is marijuana or hemp.¹⁰⁹ Prosecutors and forensic experts have raised concerns that public laboratories lack the proper testing equipment while well-equipped laboratories impose high costs.¹¹⁰ In fact, the president of the Houston Forensic Science Center has identified only two laboratories in the nation with such capabilities, and both are privately owned.¹¹¹

Texas law enforcement now faces both financial and practical implications of the bill. Prosecutors must contend with the possibility that they may be required to compensate the aforementioned private labs to run the tests and testify to the results at trial.¹¹² Given that marijuana offenses made up twenty-four percent of the Texas criminal docket in 2018, the potential financial impact on the state is staggering.¹¹³ Practically, there is a potential for tremendous backlogging of marijuana cases.¹¹⁴ In 2018, marijuana-related arrests in the United States totaled 663,367.¹¹⁵ In Texas specifically, the criminal docket contained 113,452 active marijuana possession cases.¹¹⁶ Considering these numbers, it is unrealistic to expect two crime labs to handle marijuana testing for the entire state of Texas, particularly when accounting for other states that have not decriminalized marijuana.¹¹⁷

Prosecutors across Texas have voiced such concerns, with many having dropped misdemeanor and even felony possession charges.¹¹⁸ Prosecutors fear that the bill has eliminated the possibility of using circumstantial evidence: law enforcement can no longer rely on using the smell and

¹⁰⁷ See Bogel-Burroughs, *supra* note 10.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ Off. Of Court Admin., *Annual Statistical Report for the Texas Judiciary: Fiscal Year 2018*, TEX. JUD. COUNCIL, 1, 31 <https://www.txcourts.gov/media/1443455/2018-ar-statistical-final.pdf> (last visited Oct. 26, 2020).

¹¹⁴ Bogel-Burroughs, *supra* note 10.

¹¹⁵ See Uniform Crime Reporting, *2018 Crime in the United States*, FBI, <https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018/topic-pages/persons-arrested> (last visited Oct. 26, 2020) (stating that, of 1,654,282 drug-related arrests, 3.3% were related to sale/manufacturing of marijuana and 36.8% were related to marijuana possession).

¹¹⁶ Off. Of Court Admin., *supra* note 113, at 18.

¹¹⁷ See generally Bogel-Burroughs, *supra* note 10 (stating that there are only two accredited labs in Texas that can appropriately distinguish between marijuana and hemp).

¹¹⁸ *Id.*

appearance of marijuana as evidence because hemp has similar characteristics.¹¹⁹ The primary distinction between marijuana and hemp lies in the THC concentration; an inability to test this difference may hinder the conclusion that a suspected substance is marijuana “beyond a reasonable doubt.”¹²⁰

In response to such dismissals and concerns, Texas Governor Greg Abbott, Lieutenant Governor Dan Patrick, Speaker of the Texas House of Representatives Dennis Bonnen, and Texas Attorney General Ken Paxton issued a letter to Texas district and county attorneys.¹²¹ It stated that attorneys have misunderstood H.B. 1325 and advised them that lab tests are not the exclusive method of proving marijuana possession cases.¹²² It went on to emphasize the acceptability of circumstantial evidence.¹²³ Additionally, the letter stated that companies and labs were developing THC concentration tests prior to the passage of H.B. 1325, and that costs of THC tests would decline as companies enter the market for testing.¹²⁴ The letter reminded attorneys that marijuana remained illegal and that they were responsible for carrying out the law.¹²⁵

Some Texas counties have proceeded to charge and prosecute marijuana cases as they had done prior to the adoption of the bill.¹²⁶ However, district attorneys in Travis and Harris counties have reaffirmed their plans to require lab testing for low-level marijuana cases in order to prove guilt beyond a reasonable doubt.¹²⁷ Until labs possess the requisite testing equipment to determine THC concentration levels, many prosecutors are postponing prosecution of marijuana offenses as advised by the Texas District and County Attorneys Association.¹²⁸ Until Texas can establish a consistent method of discerning THC concentration levels, such confusion will likely continue.¹²⁹

¹¹⁹ See *id.* See generally *Big Sky Scientific LLC v. Idaho State Police*, No. 1:19-cv-00040-REB, 2019 WL 438336 at *3 (D. Idaho Feb. 2, 2019) (describing a defendant who was arrested while transporting 7,000 pounds of industrial hemp and charged with marijuana trafficking).

¹²⁰ See generally Bogel-Burroughs, *supra* note 10 (stating that labs are now required to determine the concentration of THC in seized substances due to the new legal distinction between marijuana and hemp).

¹²¹ Letter from Greg Abbott, Governor of Tex., et al., to Tex. Dist. And Cty. Att’ys, *supra* note 106.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ Jolie McCullough & Alex Samuels, *This Year, Texas Passed a Law Legalizing Hemp. It Also Has Prosecutors Dropping Hundreds of Marijuana Cases*, TEX. TRIBUNE (July 3, 2019), <https://www.texastribune.org/2019/07/03/texas-marijuana-hemp-testing-prosecution/>.

¹²⁷ *Id.*

¹²⁸ *Interim Update: Hemp*, TEX. DIST. & CTY. ATT’YS ASS’N (June 24, 2019), <https://www.tdcaa.com/legislative/interim-update-hemp/>.

¹²⁹ See generally Boulette Golden & Marin LLP, *Changing Laws, Attitudes Pushing Employers to Explore Alternatives to Drug Tests*, 30 NO. 11 TEX. EMP. L. LETTER 4 (Nov. 2019).

B. Employers

A 2018 study found that Dallas and Houston were among the top ten cities in the nation with the highest amount of jobs that require drug testing.¹³⁰ Texas employers are likely to encounter comparable levels of difficulty in determining whether employees are using marijuana or CBD solely on the basis of drug test results.¹³¹ The current inability to test CBD creates tension between permitted state use and employers' ability to regulate the conduct of their employees inside and outside the workplace.

Urinalysis testing is one of the most common methods used in the workplace.¹³² However, such tests merely establish drug use and cannot indicate levels of intoxication.¹³³ In fact, research indicates that unintentional inhalation of marijuana smoke may be sufficient to trigger a positive urinalysis test result.¹³⁴ The existing unreliability of drug testing methods faces compounded uncertainty in light of H.B. 1325.¹³⁵ In addition, employers have given no indication that they intend to change their existing testing procedures.¹³⁶

Therefore, employers now must contend with drug testing employees and establishing whether positive test results are due to marijuana or CBD use.¹³⁷ For example, a former federal agent in Texas failed a drug test that returned a positive result for marijuana despite the fact that he had used CBD oil, not recreational marijuana, to alleviate back pain.¹³⁸ Conventional drug testing methods are able to detect the presence of THC but cannot differentiate between marijuana and CBD.¹³⁹ Accordingly, Texas law enforcement and employers are currently experiencing the same heightened burden for drug testing.

¹³⁰ *An Analysis of Employer Drug Testing in the United States*, AM. ADDICTION CTRS., <https://americanaddictioncenters.org/learn/analysis-employer-drug-testing/> (last visited on Oct. 26, 2020).

¹³¹ See Establishment of a New Drug Code for Marijuana Extract, 81 Fed. Reg. 90,194, 90,195 (Dec. 14, 2016) (codified at 21 C.F.R. § 1308.11(d)) (in the comments to the proposed rule, the DEA states, "Although it might be theoretically possible to produce a CBD extract that contains absolutely no amounts of other cannabinoids, the DEA is not aware of any industrially-utilized methods that have achieved this result.").

¹³² Kathleen Harvey, *Protecting Medical Marijuana Users in the Workplace*, 66 CASE W. RES. L. REV. 209, 215 (2015).

¹³³ Anne M. Rector, *Use and Abuse of Urinalysis Testing in the Workplace: A Proposal for Federal Legislation Limiting Drug Screening*, 35 EMORY L.J. 1011, 1019–20 (1986).

¹³⁴ *Id.* at 1020.

¹³⁵ See Scott Friedman & Jack Douglas Jr., *His Back Hurt So He Tried CBD – It Cost Him His Job*, NBC DALLAS-FORT WORTH (Sept. 23, 2019), <https://www.nbcdfw.com/investigations/His-Back-Hurt-So-He-Tried-CBD---It-Cost-Him-His-Job-561139041.html>.

¹³⁶ See generally Mitch Mitchell, *Don't Get Lost in the Weeds. Using Legal CBD Products in Texas Could Cost You a Job*, FORT WORTH STAR-TELEGRAM (Sept. 19, 2019), <https://www.star-telegram.com/news/business/article234972167.html>.

¹³⁷ *Id.*; see Friedman & Douglas, *supra* note 135.

¹³⁸ See *id.*

¹³⁹ *Id.*

V. Employment Protection

This Part highlights relevant provisions of the ADA and its state counterpart, the Texas Labor Code, to fully illustrate the requirements that employees and applicants must meet in order to ensure employment protection, in addition to the type of drug policies employers may impose on their employees. This Part describes the tension between cannabis use and the ADA—specifically, the effect of marijuana usage on an employee’s ability to implicate protection under either the ADA or Texas state employment laws. However, the primary focus of this Part is the current lack of CBD regulation, the FDA’s position regarding CBD products, and possible employment protection for users of CBD who inadvertently test positive for THC. By evaluating these factors in totality, this Part emphasizes the current precariousness of employee protection and employer prohibitions in the wake of H.B. 1325.

A. Federal

The Americans with Disabilities Act (ADA) provides protection against employment discrimination at the federal level.¹⁴⁰ Congress enacted the ADA to establish and enforce standards that eliminated employment-based discrimination against individuals with disabilities.¹⁴¹ The Act defines “disability” as “a physical or mental impairment that substantially limits one or more major life activities of an individual, a record of such impairment, or an individual who is regarded as having such an impairment.”¹⁴² The statute provides examples of such major life activities, such as “hearing, seeing, sitting, standing, eating, thinking, and communicating.”¹⁴³

A person claiming that they have such an impairment must demonstrate that they have been subject to an action prohibited under the ADA because of an actual or perceived impairment, regardless of whether the impairment limits or is perceived to limit a major life activity.¹⁴⁴ The claimed impairment must last or be expected to last at least six months.¹⁴⁵ An impairment that is “episodic or in remission” must “substantially limit a major life activity when active” in order to qualify under the ADA.¹⁴⁶

The ADA prohibits employment-based discrimination against a qualified individual by a covered entity with respect to job application procedures, the hiring, advancement, or termination of

¹⁴⁰ Elisa Y. Lee, *An American Way of Life: Prescription Drug Use in the Modern ADA Workplace*, 45 COLUM. J.L. & SOC. PROBS. 303, 304 (2011) (“Congress passed the Americans with Disabilities Act . . . which expanded the scope of civil rights protections for individuals with disabilities . . .”).

¹⁴¹ See 42 U.S.C. § 12101 (2012).

¹⁴² 42 U.S.C.A § 12102(1) (2009).

¹⁴³ *Id.* § 12102(2).

¹⁴⁴ *Id.* § 12102(3)(A).

¹⁴⁵ *Id.* § 12102(3)(B).

¹⁴⁶ *Id.* § 12102(4)(D).

employees, compensation, job training, and other terms of employment.¹⁴⁷ Such “qualified individuals” are those who, with or without reasonable accommodation, can perform the essential job functions of the position at issue.¹⁴⁸ A “covered entity” is defined as an “employer, employment agency, labor organization, or joint-labor management committee.”¹⁴⁹

The statute defines an “employer” as a person who participates in an industry that affects commerce and has at least fifteen employees, excluding “United States government-owned corporations and bona fide private membership clubs.”¹⁵⁰ A covered entity is not obligated to accommodate disabilities without an employee’s request or if doing so would pose an undue hardship upon the employer.¹⁵¹ If an employee requests a reasonable accommodation, the covered entity may require documentation before granting it.¹⁵² Additionally, a covered entity may not ask job applicants about the “existence, nature or severity of a disability.”¹⁵³

The ADA defines the “illegal use of drugs” as the “use of drugs considered unlawful under the Controlled Substances Act,” but excludes the use of a drug “taken under supervision by a licensed health care professional or other uses authorized by the Controlled Substances Act.”¹⁵⁴ The ADA allows covered entities to entirely prohibit the use of illegal drugs and alcohol at the workplace or prohibit employees from being under the influence of drugs and alcohol at the workplace.¹⁵⁵ Covered entities are required to provide notice of policies to applicants and employees.¹⁵⁶

The ADA does not protect an otherwise qualified individual with a disability who currently uses illegal drugs, “when the covered entity acts on the basis of such use.”¹⁵⁷ Therefore, if an employer discriminates against a qualified individual with a disability, the ADA will not protect that individual if the discriminatory act is based on the individual’s use of illegal drugs pursuant to the CSA.¹⁵⁸ However, the ADA does protect individuals who are mistakenly regarded as using drugs but are not in fact doing so.¹⁵⁹ Interestingly, this language indicates that the ADA formulated an exception for individuals who could disprove allegations of illegal drug use, long before the enactment of the Farm Bill. Theoretically, if an individual can prove that his alleged marijuana use was in fact CBD, the ADA’s exception would apply—particularly because the ADA’s scope is limited to the CSA, not the Farm Bill or state-approved uses.¹⁶⁰

¹⁴⁷ *Id.* § 12112(a).

¹⁴⁸ *Id.* § 12111(8).

¹⁴⁹ *Id.* § 12111(2).

¹⁵⁰ *Id.* § 12111(5).

¹⁵¹ *Facts about the Americans with Disabilities Act*, EEOC, <https://www.eeoc.gov/eeoc/publications/fs-ada.cfm> (last visited on Oct. 26, 2020) [hereinafter *Facts*].

¹⁵² See *Templeton v. Neodata Servs., Inc.*, 162 F.3d 617, 619 (10th Cir. 1998) (holding that employee’s failure to provide medical information about her condition precluded her claim that her employer violated the ADA).

¹⁵³ See *Facts*, supra note 151.

¹⁵⁴ § 12111(6)(A).

¹⁵⁵ *Id.* § 12114(c)(1)–(2).

¹⁵⁶ *Id.* § 12115.

¹⁵⁷ *Id.* § 12114(a).

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* § 12114(b)(3).

¹⁶⁰ *Id.*

B. Texas

Texas state law prohibits disability-based employment discrimination pursuant to Chapter 21 of the Texas Labor Code.¹⁶¹ Chapter 21 is consistent with many ADA provisions and contains similar language.¹⁶² However, there are differences between Chapter 21 and the aforementioned ADA provisions.¹⁶³

Chapter 21 follows the ADA standard by withholding protection against employment-based discrimination for an individual who “currently uses or possesses a controlled substance as defined in Schedules I and II of . . . the Controlled Substances Act.”¹⁶⁴ It similarly carves out an exception for authorized use of a prohibited Schedule I drug.¹⁶⁵ However, it also inadvertently broadens the scope of protection to include Schedule II drugs authorized by a health care professional “or otherwise authorized by the [CSA] or any other federal or state law.”¹⁶⁶

While the Texas statute deviates from the ADA by permitting the authorized use of a wider scope of drugs and allowing laws other than the CSA to define illegal drugs, it mirrors the ADA in its lack of protection for individuals who test positive for THC because Texas has not decriminalized marijuana.¹⁶⁷ Therefore, for purposes of CBD use, Chapter 21 reflects the requirements of the ADA in order for a CBD user to invoke its protection.¹⁶⁸ So long as an individual can prove the substance in question does not contain THC, they may invoke protection against discrimination pursuant to Chapter 21.

C. Cannabis Use

As marijuana is currently prohibited as a Schedule I controlled substance under the CSA, the ADA will not protect an individual who uses marijuana.¹⁶⁹ Therefore, an otherwise qualified individual may not bring a claim under the ADA for discrimination based on medical marijuana use, even in a state that has decriminalized such use.¹⁷⁰ While the ADA offers marijuana users no protection,

¹⁶¹ TEX. LAB. CODE ANN. § 21.001(4) (West 2019).

¹⁶² *El Paso v. Vasquez*, 508 S.W.3d 626, 637 (Tex. App. 2016).

¹⁶³ See generally *id.* at 641 (“We cannot conclude that Chapter 21 [of the Texas Labor Code] and the ADA are analogous for purposes of creating a disclosure of confidential health information cause of action.”).

¹⁶⁴ TEX. LAB. CODE ANN. § 21.120(a).

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ Compare 42 U.S.C.A. § 12114(a)–(b), with TEX. LAB. CODE ANN. § 21.120(a).

¹⁶⁸ Compare 42 U.S.C.A. § 12114(a)–(b), with TEX. LAB. CODE ANN. § 21.120(a).

¹⁶⁹ 21 U.S.C. § 812(c) (1970); 42 U.S.C.A. § 12111(6)(a).

¹⁷⁰ See generally 21 U.S.C. § 812(c); 42 U.S.C.A. § 12111(6)(a).

employees may find relief through enforcement of state laws.¹⁷¹ Courts have generally held that while marijuana is federally prohibited, state laws authorizing the use of marijuana are not federally preempted.¹⁷²

Questions regarding employment rights and CBD-based products surfaced following the passage of the 2018 Farm Bill.¹⁷³ Many employers are now uncertain whether the legalization of hemp-derived products will affect their ability to enforce drug policies; employees are unsure what their rights will be regarding CBD use and whether the ADA will protect such rights.¹⁷⁴ In Texas, H.B. 1325 amplifies these questions.¹⁷⁵

Following the 2018 Farm Bill's declassification of hemp as a controlled substance, the ADA exception for individuals who engage in illegal drug use does not apply to those using CBD.¹⁷⁶ Therefore, the ADA would presumably protect an otherwise qualified individual who uses CBD to ameliorate a disability.¹⁷⁷ At the same time, a caveat remains: the substance may not contain more than 0.3% THC.¹⁷⁸ This poses further complications due to the lack of regulation regarding CBD products, coupled with stringent FDA restrictions on current products.¹⁷⁹

1. Unregulated CBD Concentrations

As hemp-derived CBD is not yet regulated, CBD concentrations in consumer products lack standardization.¹⁸⁰ For purposes of federal and Texas state law, hemp-derived products are merely required to contain less than 0.3% THC.¹⁸¹ There is no standard for CBD concentration.¹⁸² Consumers and regulators alike have no method of discerning just how much CBD a product contains. Companies face legal challenges both with the FDA and in courts due to inconsistency between claimed and actual levels of CBD.¹⁸³ Therefore, consumers lack both actual knowledge

¹⁷¹ See *Wild v. Carriage Funeral Holdings, Inc.*, 205 A.3d 1144, 1147 (N.J. Super. Ct. App. Div. 2019) (holding that although the New Jersey Compassionate Use Act refused to require employment accommodations for users of medical marijuana, employers were not immunized from such requirements imposed elsewhere).

¹⁷² See *Barbuto v. Advantage Sales & Mktg., LLC*, 78 N.E.3d 37, 45 (Mass. 2017); *In re D.M.*, 444 P.3d 834, 837 (Colo. App. 2019).

¹⁷³ See generally Lisa L. Gill, *Can You Take CBD and Pass a Drug Test?*, CONSUMER REPORTS (May 15, 2019), <https://www.consumerreports.org/cbd/can-you-take-cbd-and-pass-a-drug-test/>.

¹⁷⁴ See *id.*

¹⁷⁵ See Friedman & Douglas Jr. *supra* note 135.

¹⁷⁶ U.S.C.A. 42 § 12114(a) (West 2009); see *id.* § 12111(6)(a); *supra* text accompanying notes 99–101.

¹⁷⁷ See § 12114(a).

¹⁷⁸ Agricultural Improvement Act of 2018 § 297A, 7 U.S.C. § 1639o(1) (2018).

¹⁷⁹ See generally Cindy Krischer Goodman, *Buyer Beware: CBD Products Could Be This Century's Snake Oil*, S. FLA. SUN SENTINEL (Jun. 07, 2019), <https://www.sun-sentinel.com/health/fl-ne-cbd-regulation-20190607-4upiw7zacfgt5k24glrvxqiswu-story.html> (discussing the CBD industry's lack of regulations and resulting concerns).

¹⁸⁰ Grinspoon, *supra* note 12.

¹⁸¹ Agricultural Improvement Act § 297A; H.R. 1325, 86th Leg., Reg. Sess. (Tex. 2019).

¹⁸² Grinspoon, *supra* note 12.

¹⁸³ See *Warning Letters and Test Results for Cannabidiol-Related Products*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/news-events/public-health-focus/warning-letters-and-test-results-cannabidiol-related-products> (last updated Aug. 20, 2020). See generally *Horn v. Med. Marijuana, Inc.*, 383 F. Supp. 3d 114, 122 (W.D.N.Y.

of what they are consuming and clarity regarding drug-testing results. Although CBD products are required to contain less than 0.3% THC, there is no guarantee of compliance.¹⁸⁴

The inability to discern CBD content has led to inconsistency in labeled dosages of CBD products.¹⁸⁵ A 2017 scientific study found that about seventy percent of CBD products sold online were incorrectly labeled, with twenty-six percent of the products containing a lower CBD concentration than the labeled dosage indicated.¹⁸⁶ In addition to the mislabeling of CBD concentration, a number of the tested products contained a mean of 1.18% THC—a concentration high enough to produce psychoactive effects, and that exceeds the federal- and state-mandated limit.¹⁸⁷ For consumers, this entails the possibility that lawful purchase and use of a CBD product could result in a positive drug test, in addition to potentially severe health effects, such as adverse reactions with other drugs or abnormalities in the liver.¹⁸⁸

The lack of CBD regulation implicates consumers' inability to ensure safety even if they adhere to the stipulations of the law. The uncertainty of CBD concentration in products means that there is currently no consistent answer for drug testing: will a person test positive for THC, even if he purchases a CBD product under the assumption that it does not contain THC? If such a product is CBD isolate, then the answer is likely no.¹⁸⁹ On the other hand, full-spectrum CBD is generally regarded as more effective than CBD isolate because of the “entourage effect” in which the different cannabinoids work together to increase effectiveness of the substance.¹⁹⁰

Thus, consumers are likely to opt for full-spectrum CBD and run the risk of ingesting more THC than they had expected, based on the information on the product label.¹⁹¹ Such risk is compounded when considered in combination with how THC may appear in a urinalysis test up to thirty days after initial use and in a hair analysis test for up to ninety days after initial use.¹⁹² While some authorities have stated that any THC present in CBD products would be minimal and unlikely to

2019) (plaintiff employees relied on a CBD product's claim of zero percent THC concentration and subsequently failed drug tests, resulting in termination).

¹⁸⁴ See *Horn*, 383 F. Supp. 3d at 129 (“Defendant's own testing revealed that the product contained detectible amounts of THC.”).

¹⁸⁵ Marcel O. Bonn-Miller et al., *Labeling Accuracy of Cannabidiol Extracts Sold Online*, 318 JAMA 1708, 1708 (Nov. 7, 2017), <https://jamanetwork.com/journals/jama/fullarticle/2661569>.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ Marilyn A. Huestis et. Al., *Cannabidiol Adverse Effects and Toxicity*, 17 CURRENT NEUROPHARMACOLOGY 974, 975, 977, 981 (2019) (stating that CBD pharmacology has the potential for adverse effects and drug-drug interactions, including toxicity and increased liver function). See generally Bonn-Miller et al., *supra* note 185.

¹⁸⁹ See generally Carter & Vandergriendt, *supra* note 32 (stating that CBD isolate does not contain additional compounds and therefore should not contain THC).

¹⁹⁰ *What Does Full Spectrum Mean?*, EXTRACT LABS (July 31, 2019), <https://www.extractlabs.com/cbd-guides/what-does-full-spectrum-mean/>.

¹⁹¹ See generally *id.*

¹⁹² Scott E. Hadland and Sharon Levy, *Objective Testing – Urine and Other Drug Tests*, 25 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM. 549 tbl.1 (July 2016).

cause a positive drug test, the current lack of regulation breeds uncertainty regarding actual THC content, and thus implicates the possibility of positive drug test results.¹⁹³ In light of H.B. 1325, Texas employers now must contend with such uncertainty as CBD products enter the state market without regulation.

2. FDA Restrictions

Congress explicitly reserved the authority to regulate products containing cannabis and cannabis-derived substances (cannabis-derived products) to the Food and Drug Administration in the 2018 Farm Bill.¹⁹⁴ The FDA therefore is responsible for enforcing the law as well as establishing regulations for cannabis-derived products.¹⁹⁵ The FDA holds cannabis-derived products to the same requirements as other FDA-regulated products.¹⁹⁶ The agency requires cannabis-derived products that are marketed with a therapeutic benefit claim or disease claim¹⁹⁷ to obtain FDA approval for their intended use before entering interstate commerce.¹⁹⁸

The FDA defines a “dietary supplement” as a “product . . . intended to supplement the diet that bears or contains one or more” of a specified list of dietary ingredients.”¹⁹⁹ In contrast, a “drug” is defined as an “articles intended for use in the diagnosis, cure, mitigation, or prevention of disease,” and “articles . . . intended to affect the structure or function of the body.”²⁰⁰ However, the FDA has explicitly excluded THC and CBD products from the definition of “dietary supplements.”²⁰¹ Cannabis-derived products intended for disease-related use are instead considered new drugs,²⁰² and may not be marketed in the United States without undergoing the FDA drug approval process for human use.²⁰³ Currently, the FDA prohibits the introduction of food containing added CBD or THC into the market, as well as the marketing of CBD or THC products as, or as component part of, dietary supplements.²⁰⁴

¹⁹³ See generally Gill, *supra* note 173.

¹⁹⁴ Scott Gottlieb, *Statement from FDA Commissioner Scott Gottlieb, M.D., on Signing of the Agricultural Improvement Act and the Agency’s Regulation of Products Containing Cannabis and Cannabis-Derived Compounds*, U.S. FOOD & DRUG ADMIN. (Dec. 20, 2018), <https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-signing-agriculture-improvement-act-and-agencys>.

¹⁹⁵ *Id.*.

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ 21 U.S.C.A. § 321(ff)(1) (West 2016).

²⁰⁰ See *id.* § 321(g)(1) (2016).

²⁰¹ *FDA Regulation of Cannabis and Cannabis-Derived Products, Including Cannabidiol (CBD)*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd#dietarysupplements> (last visited Oct. 28, 2020).

²⁰² Gottlieb, *supra* note 194; see § 321(p) (defining “new drug” as one whose composition is not generally recognized or has been investigated and deemed safe for use but has not been used to a material extent).

²⁰³ Gottlieb, *supra* note 194.

²⁰⁴ *Id.*

In June 2018, the FDA “approved [the drug] Epidiolex . . . for the treatment of seizures associated with two rare and severe forms of epilepsy.”²⁰⁵ Epidiolex is the first, and currently the sole, FDA-approved drug containing a cannabis-derived substance.²⁰⁶ Presently, the presence of any other drug, food product, or dietary supplement containing CBD in interstate commerce violates the Food, Drug, and Cosmetic Act.²⁰⁷ The FDA’s focus, nevertheless, is on the “marketing of CBD products that make unsubstantiated therapeutic claims” without new drug approval.²⁰⁸ Thus, the FDA’s main enforcement efforts have primarily constituted the issuance of warning letters to non-compliant sellers of CBD products.²⁰⁹ Although the presence of food and dietary drugs containing CBD in interstate commerce is currently unlawful, the FDA’s focus is on CBD products that are marketed with unsubstantiated therapeutic claims.²¹⁰ As Epidiolex is presently the only FDA-approved cannabis-derived medical treatment on the market, no other drugs containing CBD may be sold legally.²¹¹ The FDA’s demonstrated and enumerated lack of focus on CBD products without such marketing, however, contributes to the current uncertainty surrounding the actual benefits and contents of such products.²¹²

3. Effect of Cannabis Use

While the ADA does not protect marijuana users from employment discrimination on the basis of disability, it may protect CBD users so long as the CBD product does not contain THC.²¹³ A qualified individual must have a disability, use CBD to ameliorate such a disability, and be able to provide documentation to that effect.²¹⁴ The ADA does not specifically require the accommodation to be a medication.²¹⁵ Thus, the lack of FDA-approved CBD drugs is unlikely to bar ADA protection because a qualified individual would presumably be able to use a dietary supplement or food containing CBD as an accommodation.²¹⁶ While such products are presently illegal at the federal level and will likely remain so until the FDA deems otherwise, the ADA only

²⁰⁵ Press Release, U.S. FOOD & DRUG ADMIN., *supra* note 9.

²⁰⁶ *Id.*

²⁰⁷ *Hemp Production and the 2018 Farm Bill: Hearing Before the Senate Comm. On Agriculture, Nutrition, & Forestry*, 116th Cong. 11 (2018) (statement of Amy Abernethy, Principal Deputy Comm’r of the Office of the Comm’r, Food & Drug Admin., U.S. Dep’t of Health & Human Servs.).

²⁰⁸ *Id.* at 51.

²⁰⁹ *Warning Letters and Test Results for Cannabidiol-Related Products*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/news-events/public-health-focus/warning-letters-and-test-results-cannabidiol-related-products> (last updated Oct. 9, 2019).

²¹⁰ *See generally Hemp Production and the 2018 Farm Bill: Hearing Before the Senate Comm. On Agriculture, Nutrition, & Forestry*, *supra* note 207.

²¹¹ *Id.* at 49.

²¹² *Id.* at 54.

²¹³ *See generally* 42 U.S.C.A. § 12114(a) (West 2009).

²¹⁴ *See id.* § 12102(1); *Templeton*, 162 F.3d at 619 (granting summary judgement to defendant-employer for Templeton’s failure to produce medical information).

²¹⁵ § 12111(9).

²¹⁶ *See generally id.*

excludes illegal drug use as defined by the CSA.²¹⁷ An employee therefore would likely be able to implicate the ADA in an employment discrimination dispute.

Conversely, if the CBD contains THC, the issue becomes whether an employee who lawfully uses a substance to ameliorate his disability but tests positive for a substance that is illegal at both the state and federal levels, may access employment discrimination protections. The ADA does not protect medical marijuana users due to the Schedule I classification, even though such use is permitted in some states.²¹⁸ Therefore, employees have no federal protection against employment discrimination if they test positive for THC, regardless of whether they used marijuana or CBD.

Similarly, Texas state laws provide no protection against employment discrimination based on positive results of a drug test.²¹⁹ Chapter 21 of the Texas Labor Code allows employers to “[adopt] a policy prohibiting the employment of an individual who currently uses or possesses a controlled substance as defined in . . . the Controlled Substances Act . . . other than the use or possession of a drug taken under the supervision of a licensed health care professional or any other use or possession authorized by the Controlled Substances Act or any other federal or state law.”²²⁰ The provision may protect CBD users so long as they do not test positive for THC.

As described above, the broadened scope encompassing “any other federal or state law” fails to provide additional protection because Texas has yet to decriminalize marijuana.²²¹ Additionally, the Compassionate Use Act does not furnish employment protection for qualifying patients.²²² Therefore, Texas state laws mirror federal laws in that they do not provide protection against employment discrimination for an employee who tests positive for THC.²²³

In light of the current state of employment discrimination laws, employers may form policies prohibiting the use of CBD until drug testing equipment advances. Meanwhile, employees should abstain from using CBD at the risk of testing positive for THC due to the risk that employment discrimination laws may not apply to them.

²¹⁷ Gottlieb, *supra* note 194.

²¹⁸ See *James v. City of Costa Mesa*, 700 F.3d 394, 397, 401 (9th Cir. 2012) (concluding that the plaintiff’s medical marijuana use is not protected by the ADA despite the relief she experiences and the state of California’s recognition of medical marijuana as an effective treatment for debilitating pain).

²¹⁹ See TEX. LAB. CODE. ANN. § 21.120 (West 2019).

²²⁰ *Id.*

²²¹ See generally Calandrillo & Fulton, *supra* note 21, at 211–13 tbl.1 (showing that Texas has not decriminalized marijuana).

²²² See generally Texas Compassionate Use Act of 2015 § 4, TEX. OCC. CODE ANN. §§ 169.001–169.005 (West 2019).

²²³ TEX. LAB. CODE. ANN. § 21.120.

VI. Proposal for Legislative Amendment of H.B. 1325 and Regulatory Rules

The vague languages of the ADA and Chapter 21 of the Texas Labor Code exacerbate the confusion surrounding protection of CBD use in the workplace.²²⁴ Employers and employees alike require a clear rule regarding permitted CBD use, particularly in light of the absence of reliable testing methods and rigorous FDA restrictions.²²⁵ This issue will likely increase with time as the remaining states that have not legalized CBD choose to do so.

Ideally, drug testing equipment will advance such that both law enforcement and employers will be able to accurately differentiate between marijuana and CBD, thereby eliminating the need to alter employment protection policies. Employees would then have access to protection under the ADA and the corresponding Texas Labor Code in the event of a dispute over CBD use.²²⁶ Employers would be provided clarification regarding their ability to prohibit CBD use entirely.²²⁷

However, such technological advances require extensive funding and time,²²⁸ which leaves Texas civilians and law enforcement without guidance in the interim.²²⁹ The best method to ameliorate the uncertainty that has followed CBD legalization is likely a combination of an amendment to H.B. 1325 raising the THC threshold, administrative rules requiring third-party verification on CBD content and state-allocated funding for enforcement, and an exception to the Texas Labor Code for employees who successfully prove lawful use.²³⁰

The 0.3% THC threshold was established on the basis of Dr. Ernest Small's research study, in which the researchers "arbitrarily adopt[ed] a concentration of 0.3% THC . . . as a guide to discriminating" between hemp and marijuana.²³¹ There is a weak basis for the 0.3% THC threshold, as it falls quite short from the amount required to produce the psychoactive effects. In fact, the present definition of hemp was adopted "because [THC] is the only one of at least 113 different biochemical compounds produced in . . . [cannabis] that can have an intoxicating effect on humans."²³² Thus, the government's primary concern is preventing THC intoxication.²³³ While

²²⁴ See generally 42 U.S.C.A. § 12111(6)(A) (West 2009); TEX. LAB. CODE ANN. § 21.001(4).

²²⁵ See Friedman & Douglas, *supra* note 135.

²²⁶ See generally 42 U.S.C.A. § 12111(6)(A); TEX. LAB. CODE ANN. § 21.001(4).

²²⁷ See generally 42 U.S.C.A. § 12111(6)(A); TEX. LAB. CODE ANN. § 21.001(4).

²²⁸ See Ryan Poppe, *Bexar County Approves Purchase of Crime Lab Equipment to Test Marijuana, Hemp*, TEX. PUB. RADIO (Sep. 4, 2019), <https://www.tpr.org/post/bexar-county-approves-purchase-crime-lab-equipment-test-marijuana-hemp>.

²²⁹ See Bogel-Burroughs, *supra* note 10.

²³⁰ See generally UTAH ADMIN. CODE r. 68-26-3.3 (West 2020) (requiring third-party certification that an industrial hemp product's composition is in compliance with state law).

²³¹ Small & Cronquist, *supra* note 96, at 408.

²³² *Hemp Production and the 2018 Farm Bill: Hearing Before the Senate Comm. On Agriculture, Nutrition, & Forestry*, 116th Congress 61 (2019) (statement of Erica Stark, Exec. Dir., Nat'l Hemp Ass'n).

²³³ See *id.*

raising the THC threshold may cause conflict with the federal statute, states are not federally preempted with respect to authorizing marijuana use.²³⁴ Therefore, an amendment to H.B. 1325, in which the Texas Legislature redefines hemp by raising the THC threshold, would both alleviate concerns regarding employees working while under the influence as well as preserve the right to access legal treatment for disabilities.

As cannabis requires a concentration of at least one percent THC to produce a psychoactive effect,²³⁵ raising the permitted concentration from 0.3% to 0.5% would promote flexibility for law-abiding consumers while also accommodating safety interests.²³⁶ Due to seasonal fluctuations and environmental influences, cannabis plants may contain “more or less THC than 0.3% at different times.”²³⁷ Additionally, the Texas Compassionate Use Act allows qualifying patients who suffer from specified illnesses to use cannabis containing 0.5% THC.²³⁸ While the Texas Legislature has explicitly stated that it will not decriminalize marijuana,²³⁹ it may be receptive to increasing the THC threshold by 0.2%, particularly after evaluating the benefits of doing so. Raising the THC threshold for CBD would result in more flexibility for lawful users, and a continued absence of psychoactive effects. However, while the increased threshold provides more flexibility, it does not in itself solve the issue of the State’s inability to test CBD.

Between 2017 and 2018, fifty-two cases of CBD-related poisoning were reported in Utah.²⁴⁰ In 2018, the Utah Department of Agriculture and Food responded by imposing administrative rules requiring registration of all hemp products.²⁴¹ The rules require both manufacturers and distributors of CBD products to obtain a certificate of analysis of each CBD product from a third-party lab.²⁴² The product is then accompanied with a QR code or bar code that links to the certificate and appears similar to labels for dietary supplements.²⁴³ This policy ensures that label information is verified, and alleviates consumer concerns regarding CBD purity.²⁴⁴ The Utah

²³⁴ See *Barbuto v. Advantage Sales & Mktg., LLC*, 78 N.E.3d 37, 45–46 (Mass. 2017).

²³⁵ Small, *supra* note 15, at 252.

²³⁶ See generally Steven B. Perlmutter, *High Times Ahead: Products Liability in Medical Marijuana*, 29 HEALTH MATRIX 225, 247-55 (2019). As high levels of THC can cause adverse health effects such as anxiety or dizziness, a THC concentration well below the accepted minimum to induce psychoactive effects benefits public safety interests.

²³⁷ Robert C. Clark, *Interview, Dr. Ernest Small*, 6 INT’L HEMP ASS’N (Dec. 1999), <http://www.internationalhempassociation.org/jiha/jiha6208.html>.

²³⁸ TEX. OCC. CODE ANN. §§ 169.001(3), 169.003 (West 2019).

²³⁹ See Letter from Greg Abbott, Governor of Tex., et al., to Tex. Dist. and Cty. Att’ys, *supra* note 106.

²⁴⁰ Roberta Z. Horth et al., *Notes from the Field: Acute Poisonings from a Synthetic Cannabinoid Sold as Cannabidiol – Utah, 2017-2018*, CDC (May 25, 2018), https://www.cdc.gov/mmwr/volumes/67/wr/mm6720a5.htm?s_cid=mm6720a5_w#T1_down.

²⁴¹ Taylor Hartman, *Utah Department of Agriculture and Food Announces New Rules for Sale of CBD Oils*, FOX 13 SALT LAKE CITY (Nov. 16, 2018), <https://fox13now.com/2018/11/16/utah-department-of-agriculture-and-food-to-register-hemp-based-products-like-cbd-oil-for-legal-purchase/>.

²⁴² UTAH ADMIN. CODE r. 68-26-3.3 (West 2020).

²⁴³ Hunter Geisel, *UDAF Registering Hemp-Based Products, CBD Oil, for Sale in Utah*, KUTV (Nov. 17, 2018), <https://kutv.com/news/local/udaf-registering-hemp-based-products-cbd-oil-for-sale-in-utah>.

²⁴⁴ *Id.*

Department of Agriculture and Food has begun working with retail stores to ensure that only compliant products are available for sale.²⁴⁵

In Texas, the Department of State Health Services oversees CBD regulation.²⁴⁶ By adopting administrative rules modeled after those in Utah, the Department would transfer the burden of verifying CBD contents from the State to CBD manufacturers and distributors who seek participation in the Texas CBD market. The possible bar on participation in the Texas CBD market would likely incentivize manufacturers, distributors, and private companies to establish labs in compliance with the administrative rules. The U.S. Census Bureau estimates the Texas population as of July 2019 at nearly twenty-nine million people,²⁴⁷ making up almost nine percent of the total United States population.²⁴⁸ In 2019, Texas contributed over eight percent of the total United States gross domestic product.²⁴⁹ Therefore, CBD manufacturers and distributors face a substantial incentive to comply with any certificate analysis stipulations mandated by the Department of Health.

The administrative rules should include a provision requiring Texas legislators to allocate funding for enforcement. For example, Travis County legislators are currently debating whether to allocate funding for lab testing due to concerns that arrests for low-level marijuana possessions would “derail people’s lives.”²⁵⁰ In contrast, Bexar County recently allocated over \$100,000 in city funds to obtain drug testing equipment.²⁵¹ While such a provision would impose costs on the state, such costs would likely be mitigated by the burden-shifting mechanism of the verification rules. In addition, it would likely motivate Texas legislators to allocate funding for lab testing, considering that CBD sales are projected to surpass twenty billion dollars in the United States by 2024.²⁵² Thus, the adoption of administrative rules modeled after those in Utah, including a provision requiring funding for enforcement, would likely provide a solution to the current lack of available testing equipment.

Finally, Chapter 21 of the Texas Labor Code should be amended to include a provision granting protection for employees who successfully prove that any alleged use of marijuana was actually

²⁴⁵ *Id.*

²⁴⁶ Sid Miller, *Hemp Regulations*, TEX. DEP’T AGRIC., <https://www.texasagriculture.gov/RegulatoryPrograms/Hemp.aspx> (last visited Oct. 29, 2020).

²⁴⁷ *Quick Facts: Texas*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/TX> (last visited Oct. 29, 2020).

²⁴⁸ See *National Population Totals and Components of Change: 2010-2019*, U.S. CENSUS BUREAU, https://www.census.gov/data/tables/time-series/demo/popest/2010s-national-total.html#par_textimage_2011805803 (last visited Oct. 29, 2020).

²⁴⁹ Bureau of Econ. Analysis, *Gross Domestic Product by State, Third Quarter 2019*, U.S. DEP’T COM. tbl.3 (Jan. 10, 2020), https://www.bea.gov/system/files/2020-01/qgdpsstate0120_2.pdf.

²⁵⁰ Joy Diaz, *Austin Considers Not Buying Marijuana Testing Equipment*, TEX. STANDARD (Jan. 13, 2020), <https://www.texasstandard.org/stories/austin-considers-not-buying-marijuana-testing-equipment/>.

²⁵¹ Poppe, *supra* note 228.

²⁵² Eamon Levesque, *U.S. CBD Market Anticipated to Reach \$20 Billion in Sales by 2024*, BDS ANALYTICS (May 9, 2019), <https://bdsanalytics.com/u-s-cbd-market-anticipated-to-reach-20-billion-in-sales-by-2024/>.

use of CBD. Unlike the ADA, Chapter 21 lacks a specific remedy for individuals who were wrongfully discriminated against on the basis of illegal drug use.²⁵³ A specific exception, modeled after that of the ADA,²⁵⁴ would provide individuals who lawfully used CBD with a procedure by which to appeal a decision or to combat an allegation of illegal drug use. Therefore, if an individual uses CBD that has been verified in accordance with the proposed administrative rules but is found to have contained greater than 0.5% THC, they will nevertheless have an avenue by which to pursue relief.

VII. Conclusion

CBD use has rapidly risen over the past twenty years, specifically in the wake of the 2018 Farm Bill.²⁵⁵ At the same time, practical issues such as reliable drug testing equipment and FDA regulations have yet to be solved, resulting in confusion about what exactly consumers are ingesting when they purchase CBD products. While CBD currently poses uncertainty at the federal level, it simultaneously does so at the state level.

By passing H.B. 1325, the Texas Legislature took a step forward in the realm of cannabis decriminalization while repeatedly emphasizing its disinterest in decriminalizing marijuana,²⁵⁶ forcing its citizens to choose between treating impairments with CBD and ensuring that they test negative for the presence of drugs.

The government should amend H.B. 1325 to increase the THC threshold to 0.5%, implement rules requiring third-party verification of CBD purity, allocate state funding for enforcement, and amend the Labor Code to provide people wrongfully deemed as using illegal drugs with procedure to appeal such findings. By implementing these policies, the Texas government may balance employers' safety concerns with employees' rights to access treatment without fear of discrimination.

²⁵³ Compare 42 U.S.C.A. § 12114(b) (West 2009) (providing an exception for individuals who are incorrectly regarded as using drugs) with TEX. LAB. CODE. ANN. § 21.051 (West 2019).

²⁵⁴ See 42 U.S.C.A. § 12114(b).

²⁵⁵ See Mikulic, *supra* note 7.

²⁵⁶ Jolie McCullough, *Texas Leaders: Hemp Law Did Not Decriminalize Marijuana*, TEX. TRIBUNE (July 18, 2019), <https://www.texastribune.org/2019/07/18/greg-abbott-texas-leaders-hemp-marijuana-law/>.

International Human Rights Law & The Health of Persons with Intellectual Disabilities

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I. Introduction

As of Monday April 6, 2020, 1,100 of the 140,000 developmentally disabled people (“persons with developmental disabilities”) monitored by the state of New York had tested positive for the COVID-19, state officials said. One hundred five had died—a rate far higher than in the general population that echoes the toll in some nursing homes. Separately, a study by a large consortium of private service providers found that residents of group homes and similar facilities in New York City and surrounding areas were 5.34 times more likely than the general population to develop COVID-19 and 4.86 times more likely to die from it. What’s more, nearly ten percent of the homes’ residents were displaying COVID-like symptoms but had not yet been tested, according to the consortium, New York Disability Advocates.¹

This sad situation, reported by the *New York Times* at the beginning of the coronavirus pandemic, is not an isolated event that is only occurring in the United States. Despite having severe needs and higher health risks, persons with intellectual disabilities around the world often lack access to health services and are frequently among the most vulnerable populations in any country, regardless of its economic status.² This Article will examine how, on many occasions, persons with intellectual disabilities are exposed to gross human rights violations, stigma, and social isolation, which has a negative impact on their dignity, emotional well-being, and fundamental freedoms. Further, this Article will discuss the research that has shown that inequalities are in fact a consequence of not having timely, effective, or appropriate health care—including health prevention and promotion activities. As a result, persons with intellectual disabilities are excluded from mainstream health systems and, in some countries, even die earlier than other populations.³

As I will discuss in this Article, exclusion of persons with intellectual disabilities from health systems also contributes to other inequalities and discrimination related to the social and economic determinants of health such as low incomes, unemployment, poor housing, social isolation, loneliness, bullying, and abuse, among others.⁴ Indeed, the vast majority of these social and economic determinants are also human rights, which are enshrined in international human rights

¹ See Danny Hakim, *‘It’s Hit Our Front Door’: Homes for the Disabled See a Surge of COVID-19*, N.Y. TIMES (Apr. 8, 2020), The New York Times refers to persons with “developmental disabilities” which is an umbrella term that includes “intellectual disabilities.” The present Article focuses on “intellectual disabilities.”

² See Nygren-Krug, *infra* note 6, at 18 (defining “vulnerable” groups).

³ Wendy Rickard & Angela Donkin, *A Fair Supportive Society*, INSTITUTE HEALTH EQUITY 6–9 (2016), <http://www.instituteofhealthequity.org/resources-reports/a-fair-supportive-society-summary-report/a-fair-supportive-society-summary-report.pdf> (analyzing in the executive summary the socioeconomic inequalities in health and the drivers of health for persons with learning disabilities in England. The report includes data and information on “intellectual disabilities.”).

⁴ *Id.* (concluding that in England, compared to the general population, persons with learning disabilities die fifteen to twenty years sooner, are more likely to live in poverty, less likely to be in work, more likely to be in poor environments, more likely to be discriminated against and more likely to be socially isolated).

law instruments: food, access to water and sanitation, education, safe health conditions, employment, and housing.

One of the objectives of this Article is to highlight and review the systemic health barriers that, according to public health practitioners and international and regional human rights organs, treaty bodies, and independent experts, persons with intellectual disabilities face globally. This Article also analyzes how these health barriers, as they exist in national health policies, plans, and legislation, negatively impact the most fundamental human rights and freedoms of these persons. The proposal that international human rights law, like many other public health strategies and technologies, is a powerful tool to remove obstacles relating to health, and to more effectively promote and protect the health of persons with intellectual disabilities, is mainstreamed throughout this document.

Human rights and fundamental freedoms are universal legal guarantees which are inherent to all human beings, regardless of race, nationality, place of residence, sex, gender identity, sexual orientation, national or ethnic origin, color, religion, language, political belief, or any other status such as “intellectual disability.”⁵ International human rights law protects the human values, entitlements, and human dignity of all persons with intellectual disabilities in many areas: civil, political, economic, social, and cultural.⁶

Human rights are universal, interrelated, interdependent, indivisible, and inherent to all persons—including those with intellectual disabilities—precisely because they are “members of the human family.”⁷ Universal human rights are legally guaranteed by treaties, customary international laws, general principles, and other sources of international law.⁸

⁵ G.A. RES. 217 (III) A, UNIVERSAL DECLARATION OF HUMAN RIGHTS (Dec. 10, 1948), <http://www.ohchr.org/EN/UDHR/Pages/UDHRIndex.aspx> (recognizing that “everyone is entitled to all the human rights and freedoms . . . without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”).

⁶ See Helena Nygren-Krug, 25 *Questions & Answers on Health & Human Rights* 1 WORLD HEALTH ORG. 1, 9 (2002), <https://www.who.int/hhr/information/25%20Questions%20and%20Answers%20on%20Health%20and%20Human%20Rights.pdf> (describing the different areas and rights that international human rights law encompasses, such as civil, political, economic, social, and cultural rights).

⁷ See *id.* (citing the Vienna Declaration and Programme of Action, U.N. Doc. A/CONF. 137/23 adopted at the World Conference on Human Rights in Vienna, 25 June 1993 ¶ 5, <https://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx>).

⁸ See United Nations Office of the High Commissioner for Human Rights (OHCHR) and the United Nations Staff College Project, *Human Rights: A Basic Handbook for U.N. Staff* 1, 3 (1999), <https://www.ohchr.org/documents/publications/hrhandbooken.pdf> [hereinafter Human Rights Handbook]. See also *What Are Human Rights?*, U.N. HUM. RTS. OFFICE HIGH COMM’R, <http://www.ohchr.org/EN/Issues/Pages/WhatAreHumanRights.aspx> (explaining how human rights are enshrined in international law).

International human rights law establishes obligations of governments to act in certain ways or to refrain from certain acts in order to promote, respect, protect, and fulfill⁹ all human rights of individuals or groups, especially those most excluded and discriminated against, such as persons with intellectual disabilities.¹⁰ Governments must guarantee that non-state actors, such as those in the private sector, corporations, and non-governmental organizations (NGOs), comply with international human rights law.¹¹

With regard to effective strategies to promote health gains for groups in situations of vulnerability, such as persons with intellectual disabilities, some international health agencies consider that “human rights law, as enshrined in international and regional human rights conventions and standards, offers a unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders....”¹²

International human rights law provides individuals with intellectual disabilities a set of national and international norms, standards, and mechanisms of protection that guarantee their effective participation in civil, political, economic, social, and cultural affairs.¹³ Biomedical and scientific

⁹ See Comm. on Economic, Social and Cultural Rights, *General Comment No. 14, art. 12, The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4, ¶ 33 [hereinafter General Comment 14] (explaining the levels of obligations that human rights impose on States Parties to international treaties).

¹⁰ According to WHO, the term “intellectual disability” is designed to cover persons who have received a diagnosis specifically related to their cognitive or intellectual functioning including, but not limited to, dementia and autism. See *Human Rights: WHO QualityRights Core Training for All Services & All People*, WHO i, xxv (2019), <https://apps.who.int/iris/bitstream/handle/10665/329538/9789241516693-eng.pdf>. Estimates suggest that more than 200 million people worldwide have an intellectual disability. Persons with intellectual disabilities have certain limitations in cognitive functioning and skills, including communication, social, and self-care skills. Intellectual disability can be caused by injury, disease, or problems in the brain. Other causes of intellectual disability do not occur until a child is older and these might include severe injury, infections, or stroke. The most common causes of intellectual disabilities are genetic conditions (e.g., Down Syndrome), complications during pregnancy, problems during birth, and diseases or toxic exposure. See also *What is Intellectual Disability?*, SPECIAL OLYMPICS, <https://www.specialolympics.org/about/intellectual-disabilities/what-is-intellectual-disability> (explaining what intellectual disabilities are).

¹¹ See Nygren-Krug *supra* note 6, at 15 (describing what are the obligations of governments under international human rights law with regard to respecting, protecting, and fulfilling human rights and governmental human rights obligations in relation to other actors in society, such as the private sector).

¹² See Pan American Health Organization [hereinafter PAHO] Strategic Plan 2008–2012 (Official Document 328) presented at the 48th Directing Council of PAHO, 60th Session of the Regional Committee of WHO for the Americas, Washington, D.C. 70–71 (Oct. 3, 2008), <https://www.paho.org/english/gov/cd/cd48-od328-e.pdf>. See also generally Steven R. Keener & Javier Vasquez, *A Life Worth Living: Enforcement of the Right to Health Through the Right to Life in the Inter-American Court of Human Rights*, 40 COLUM. HUM. RTS. L. REV. 595 (2009) (arguing that international human rights law as interpreted by the Inter-American Court of Human Rights’ jurisprudence has become a vehicle for reviewing and formulating public health policies, laws and programs in areas such as access to potable water, food, sanitation, medicines, and health facilities).

¹³ Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, art. 3, U.N. Doc. A/Res/61/106 (Jan. 24, 2007) <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx> [hereinafter CRPD] (recognizing that one of the general principles of CRPD is the “full and effective participation and inclusion in society” of all persons with disabilities).

approaches often consider persons with intellectual disabilities as “patients.”¹⁴ On the contrary, human rights instruments can support health policies, programs, and laws to protect persons with intellectual disabilities as “subjects with rights and freedoms” who contribute to “human, social and economic development.”¹⁵

Some contributions from international human rights law to health programming for persons with intellectual disabilities—and other persons in situations of vulnerability—that could be beneficial to governments, multilateral organizations, and NGOs, include:¹⁶

- (1) Human rights law provides an internationally accepted legal framework for formulating national health policies with regard to persons with intellectual disabilities and other groups in situations of vulnerability;
- (2) Human rights norms and standards can strengthen health systems, prioritizing the health needs of persons with intellectual disabilities in health services, including primary health care centers and community-based services;¹⁷
- (3) Human rights provide an internationally accepted legal framework to facilitate the access, by all persons with intellectual disabilities, to the underlying determinants of health that are essential for inclusive communities/cities: food,

¹⁴ See, e.g., Teresa Iacono et al., *A Systematic Review of Hospital Experiences of People with Intellectual Disabilities*, 14 BMC HEALTH SERVS. RES. 505 (Oct. 25, 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4210514/>.

¹⁵ See CRPD, *supra* note 13, at Preamble (recognizing that the “full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty”); *Id.* at art. 4 (establishing, as a general obligation of States Parties, “to take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes”).

¹⁶ See Nygren-Krug, *supra* note 6, at 18–20 (discussing what is the value-added of human rights in public health, including health systems).

¹⁷ Health needs of persons with intellectual disabilities have not been a priority in most health systems and these persons have been left out. This is one of the major themes of this article. Human rights treaties—such as the U.N. and Inter American Conventions on Disability Rights and the U.N. Convention on the Rights of the Child—contain specific norms that can strengthen health systems with regard to the health needs, including more specialized health workers and de-institutionalization of health care in primary health centers for persons with intellectual disabilities. In addition to the observations of WHO, I have observed this in several countries where I have supported the implementation of recommendations issued by Human Rights Bodies. See PAHO Health and Human Rights *infra*, note 19. For example, it was through specific provisions of the U.N. Convention on the Rights of the Child and the American Convention on Human Rights that some countries (e.g., Paraguay and Brazil) reformed and strengthened the health system for persons with intellectual and psychosocial disabilities, thus making them a priority. See *Paraguay WHO Special Initiative for Mental Health Situational Assessment*, WHO (2020), https://www.who.int/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---paraguay---2020.pdf?sfvrsn=e1a4fad0_2. The process in Paraguay involved “precautionary measures” requested by NGO “Disability Rights International” that were issued by the Inter-American Commission on Human Rights with regard to persons with intellectual and psychosocial disabilities. *Id.* See also Inter-American Commission on Human Rights, Precautionary Measures 2003, *Patients of the Neuro-psychiatric Hospital*, <https://www.cidh.oas.org/Ninez/m edcaute2eng.htm>.

access to water and sanitation, transportation, accessibility, education, employment, safe and healthy working conditions, and housing, among others; and

(4) Human rights norms and standards lay down obligations of governments with regard to the inclusion and participation of persons with intellectual disabilities in the negotiation and formulation of national policies, plans, and laws that affect their health and other related rights.

Part I of this Article analyzes the three basic relationships between the human rights of persons with intellectual disabilities and the enjoyment of health by examining the research of Jonathan Mann, et al., and more recent research of international health agencies. Parts II and III of the Article provide some examples of international human rights law instruments and internationally recognized human rights and fundamental freedoms that can be used to design and deliver health services for persons with intellectual disabilities. These sections also present the human rights law framework that can support stakeholders in their efforts to create healthy communities and inclusive cities for persons with intellectual disabilities. The argument behind Parts II and III of this Article is that international human rights law provides health systems and communities with a robust framework of specific legal obligations, which is different from those offered by public health strategies, plans of action, and policies. In other words, international human rights law clarifies the responsibilities and accountability of governments and other stakeholders regarding persons with intellectual disabilities and other groups in situations of vulnerability.

Part V of the Article explores the connections between sports and health. This section explores the three basic relationships between human rights and health of persons with intellectual disabilities, focusing on the right to practice sport. The right to practice sport, as recognized by international human rights instruments and the Olympic Charter, is presented in this Article as an “enabler” for the health and well-being of persons with intellectual disabilities. In line with the right to practice sports and its relationship with health, Part VI of the Article recognizes the contributions of Special Olympics as a sports organization for persons with intellectual disabilities. The Article contends that the Special Olympics movement and its athletes are role models contributing to the promotion of all internationally recognized human rights, using the right to practice sport and the Special Olympics Games as a catalyst for health, physical and mental well-being, and inclusion of all persons with intellectual disabilities.

Finally, Part VII proposes ten recommendations that can help governments, NGOs, health agencies, human rights treaty bodies, and others to more effectively promote and protect the health of persons with intellectual disabilities. It is important to mention that the focus of this Article is not health and human rights of persons with intellectual disabilities solely in the context of COVID-19, in part because international health agencies and international human rights organs,¹⁸

¹⁸ Human rights organs are institutions created to promote the observance and protection of human rights, such as the Inter-American Commission on Human Rights and Inter-American Court of Human Rights. Some human rights organs monitor the compliance of State Parties to human rights treaties. See *Human Rights Bodies*, U.N. HUM. RTS

treaty bodies, independent experts, and envoys do not yet have sufficient data and analysis on the health and human rights of persons with intellectual disabilities in the context of this pandemic. Nevertheless, the hope is the analysis, conclusions, and recommendations of this Article can contribute to the removal of health barriers and eradication of gross violations of human rights that persons with intellectual disabilities have been experiencing for generations, even before the outbreak of pandemics such as the human immunodeficiency virus (HIV) and COVID-19. Ideally, these conclusions and recommendations will be studied and, as appropriate, applied in the context of epidemics, pandemics, and health emergencies such as COVID-19 to protect the health of persons with intellectual disabilities.

II. Relationships Between the Human Rights of Persons with Intellectual Disabilities & the Enjoyment of Health¹⁹

Human-rights violations have negative effects on the physical and mental health of persons with intellectual disabilities.²⁰ Violations of human rights that negatively impact the health and well-being of persons with intellectual disabilities can occur in different settings.²¹ For example, often, in some of these settings, persons with intellectual disabilities cannot decide through clear protocols and procedures whether they want to receive medical treatment or surgical procedures (right to informed consent) or where they want to live (right to live independently and to be included in the community).²² In other instances, persons with intellectual disabilities cannot legally marry or have children (right to have a family) or are excluded by service providers from sporting and recreational activities (right to practice sports).²³

OFFICE HIGH COMM’R, <https://www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx> (providing examples of human rights bodies, organs and monitoring mechanisms).

¹⁹ See PAHO Health and Human Rights (concept paper, Document CD50/12) presented at the 50th Directing Council of PAHO, 62nd Session of the Regional Committee of WHO for the Americas, Washington, D.C. 3–4 (Oct. 1, 2010), <https://www.paho.org/hq/dmdocuments/2010/CD50-12-e.pdf> (analyzing the three relationships between health of persons in situations of vulnerability—such as persons with disabilities, persons with mental health conditions, young people, indigenous peoples, persons with HIV, and women/girls in connection with complications of pregnancy and birth—and the human rights recognized in international law as identified and researched by Jonathan Mann et al.). See also Nygren-Krug, *supra* note 6 at 10–12 (explaining the complex links between human rights and health (citing to Jonathan Mann et al., *Health and Human Rights*, 1 HEALTH & HUM. RIGHTS: INT’L J. (1994))).

²⁰ See, *Persons with Disabilities, Technical Document of the Secretariat, Human Rights & Health*, PAHO at 2 (2008) (discussing health impacts resulting from violations of human rights).

²¹ These violations can occur in general hospitals, private clinics, community-based services, specialized group residences, group homes, family homes, mental health institutions, long-term care facilities for older persons, or schools. *Id.*

²² *Id.*

²³ See Committee on the Rights of Persons with Disabilities, *General Comment 1, art. 12, Equal Recognition Before the Law*, U.N. Doc. CRPD/C/GC/1, ¶¶ 8–9 (May 19, 2014), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement> (follow the “Official Document System” hyperlink; then search “Equal Recognition Before the Law, U.N. Doc. CRPD/C/GC/1” in the “Word(s) in the title” search bar) [hereinafter General Comment 1] (explaining that the denial of legal capacity to persons with disabilities lead to violations of human rights and that persons with cognitive and intellectual disabilities have been disproportionately affected by the denial of legal capacity).

Health and disability policies, plans, and legislation can have a positive impact on the human rights of persons with intellectual disabilities.²⁴ However, national policies, plans, and legislation can also restrict the exercise of health-related human rights of persons with intellectual disabilities. For example, there are still national laws and policies in certain countries that permit coercive medical interventions, such as forced sterilizations of women with intellectual disabilities or involuntary admissions of persons with intellectual disabilities to psychiatric institutions.²⁵

In other cases, these policies or laws also allow or perpetrate the excessive use of medications on persons with intellectual disabilities who remain “chemical[ly] restrain[ed]” for a long period of time.²⁶ These policies, plans, and laws are intrinsically related to the enjoyment of health and other related human rights of persons with intellectual disabilities, such as the right to physical and mental integrity, the right to equal protection, the right to security of the person, the right to personal liberty, the right to freedom of movement, the right to inclusive education, and the right to work.²⁷

The human rights of persons with intellectual disabilities and their health act in synergy.²⁸ According to Jonathan Mann, et al., “promoting and protecting health requires explicit and concrete efforts to promote and protect human rights and dignity, and greater fulfillment of human rights necessitates sound attention to health and to its social determinants.”²⁹

When persons with intellectual disabilities are healthy, they are in a better position to exercise their human rights to practice sports, to inclusive education, to work, and to freedom of movement.

²⁴ See Nygren-Krug, *supra* note 6, at 8 (explaining that the public functions, including implementing health policies, can potentially benefit human rights (citing to Jonathan Mann et al., *Health and Human Rights*, 1 HEALTH & HUM. RTS.: INT’L J. (1994)).

²⁵ See Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. E/CN.4/2005/51, ¶¶ 77–80 (Feb. 11, 2005) (explaining human rights abuses that persons with intellectual disabilities face in health systems and in the community at large). See also Juan E. Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/HRC/22/53, ¶¶ 57–70, 80 (Feb. 1, 2013) (analyzing abuses to persons with intellectual disabilities in health care settings such as compulsory detention for medical conditions and reproductive rights violations).

²⁶ Manfred Nowak, *Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment*, U.N. Doc. A/63/175, ¶¶ 52, 55 (July 28, 2008).

²⁷ See Dainius Pūras, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/HRC/35/21, ¶ 62 (March 28, 2017) (explaining the excessive use of medications as a practice that affects persons with intellectual disabilities, particularly those with autism); see CRPD, *supra* note 13, at arts. 5, 14, 17, 18, 24, 27.

²⁸ See Jonathan Mann et al., *Health and Human Rights*, 1 HEALTH & HUM. RTS. 6, 16–18 (1994) (discussing the importance of health in areas such as HIV as a precondition to enjoy human rights).

²⁹ See PAHO *Health and Human Rights*, *supra* note 19, at 3.

However, according to some public health and human rights experts, more research and evaluation on the “inextricabl[e] link” between health and human rights is still necessary.³⁰

III. International Human Rights Instruments in the Context of the Health of Persons with Intellectual Disabilities

The Member States of the United Nations (UN) and regional organizations have adopted human rights instruments that are part of international law and can be used to protect the health and other related human rights of persons with intellectual disabilities. International human rights treaties, covenants, conventions, protocols, and charters are binding on the governments that ratify them.³¹ International human rights law utilizes non-binding authority such as declarations, standards, and programs of action.³² They are generally issued by the U.N. General Assembly;³³ the U.N. Office of the High Commissioner for Human Rights;³⁴ the U.N. Human Rights Council; regional organizations and bodies such as the Organization of American States (OAS), the European Union, the Council of Europe, or the African Union;³⁵ regional human rights organs such as the Inter-American Commission on Human Rights;³⁶ and international health agencies.³⁷ There are very few “standards” or “recommendations” in current international law that specifically promote and protect the health and other related human rights of persons with intellectual disabilities.

³⁰ See Mann, *supra* note 28, at 21 (proposing further analysis and rigorous evaluation of the human rights dimensions of health problems such as cancer, cardiovascular diseases, injuries, and nutrition). See also Lawrence O. Gostin & Zita Lazzarini, PUB. HEALTH & HUM. RTS HIV PANDEMIC 46 (1997) (discussing that promoting human rights is critical to improving health and may contribute to lower mortality and morbidity and proposing further research on the links between poverty and good health).

³¹ See Nygren-Krug, *supra* note 6, at 7, 30 (explaining treaties, declarations, standards, and programs of action as sources of international human rights law).

³² *Id.* The list of non-binding instruments in international human rights law is longer and includes guidelines, recommendations, and principles. See Human Rights Handbook, *supra* note 8. However, for the purpose of this Article, non-binding sources include declarations, standards, and programs of action.

³³ See, e.g., Standard Rules on the Equalization of Opportunities for Persons with Disabilities, G.A. Res. 48/96, U.N. GAOR, 48th Sess., Supp. No. 49, at 202, U.N. Doc. A/RES/48/96 (Dec. 20, 1993).

³⁴ See, e.g., *COVID-19 and the Rights of Persons with Disabilities: Guidance*, U.N. OFFICE HIGH COMM’R HUM. RTS. (Apr. 29, 2020), https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf.

³⁵ See, e.g., Eur. Union Agency for Fundamental Rts., Legal capacity of persons with intellectual disabilities and persons with mental health problems (2013); Recommendation No. R (99) 4 of the Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults, Council of Eur. Comm. of Ministers (Feb. 23, 1999), [https://www.coe.int/t/dg3/healthbioethic/texts_and_documents/Rec\(99\)4E.pdf](https://www.coe.int/t/dg3/healthbioethic/texts_and_documents/Rec(99)4E.pdf).

³⁶ See, e.g., Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of Persons with Mental Disability, Inter-Am. Comm’n H.R., ANN. REP. INTER-AM. COMM’N H.R. 2000, OAS/Ser./L/V/II.111/, doc. 20 rev. (2001), <http://www.cidh.org/annualrep/2000eng/chap.6e.htm> (recommending several actions, *inter alia*, to amend existing disability laws and support the establishment of organs that supervise compliance with human rights norms in mental health institutions and services).

³⁷ See, e.g., Montreal Declaration on Intellectual Disabilities, PAHO/WHO (Oct. 6, 2004), http://www.jaid.org/jm/membersdocs/declaration_eng.pdf; e.g. *Atlas: Global Resources for Persons with Intellectual Disabilities*, WHO (2007), https://apps.who.int/iris/bitstream/handle/10665/96353/9789241563505_eng.pdf;jsessionid=F9C5CB83A98EB75D6E1FA4DC1EEE7691?sequence=1.

According to international health agencies, such as the Pan American Health Organization (PAHO), non-binding instruments can play a significant role in the protection of the human rights and health of persons with intellectual disabilities and other populations in situations of vulnerability:

Unlike the binding instruments ratified by the PAHO Member States, these standards or guidelines are not binding. However, they do articulate important recommendations that can be integrated into plans, policies, legislation and national practices to protect the health of people in situations of vulnerability. Furthermore, they provide very important guidance for interpreting the provisions of international human rights treaties relating to the health of groups in situations of vulnerability. The value of these standards lies principally in the general consensus among the United Nations Member States, General Assembly, and other organs on the need to promote and protect the human rights of people in situation of vulnerability. The effectiveness of these standards depends on their implementation by the aforementioned States and organizations.³⁸

In addition, more recently, international human rights tribunals have also used international human rights standards and recommendations to interpret general human rights norms in the context of persons with intellectual, cognitive, and psychosocial disabilities. For example, the Bulgarian Government reformed its guardianship system for adults with intellectual disabilities, based on the 2012 decision in *Stanev v. Bulgaria*.³⁹ In this judgment, the European Court of Human Rights interpreted the norms of the European Convention for the Protection of Human Rights and Fundamental Freedoms, in light of principles and standards recommended by the Council of Europe concerning the legal protection and legal capacity of persons with disabilities.

Some of the most important human rights instruments applicable to health, physical activity, and other key areas pertaining to persons with intellectual disabilities—which are binding only on the governments that have ratified them—include:

- (1) CRPD;⁴⁰
- (2) International Covenant on Civil and Political Rights;⁴¹

³⁸ See PAHO Health and Human Rights, *supra* note 19, at 7 (citing M. W. Janis, AN INTRODUCTION TO INTERNATIONAL LAW (1988); J. A. Carillo Salcedo, EL DERECHO INTERNACIONAL EN UN MUNDO EN CAMBIO [*International Law in a Changing World*] (1984)).

³⁹ See *Stanev v. Bulgaria* (No. 36760/06), 2012-I Eur. Ct. H.R. 81, 147 (2012) (noting the growing importance which international human rights instruments give to the protection of legal autonomy of persons with disabilities and citing the CRPD and the Recommendation No. R (99) of the Committee of Ministers of the Council of Europe on legal capacity).

⁴⁰ See CRPD, *supra* note 13.

⁴¹ International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171.

- (3) International Covenant on Economic, Social and Cultural Rights;⁴²
- (4) International Convention on the Elimination of All Forms of Racial Discrimination;⁴³
- (5) Convention on the Rights of the Child;⁴⁴
- (6) Convention on the Elimination of All Forms of Discrimination Against Women;⁴⁵
- (7) European Convention for the Protection of Human Rights and Fundamental Freedoms, Supplemented by Protocols Nos. 1, 4, 6, 7, 12, 13 and 16;⁴⁶
- (8) American Convention on Human Rights;⁴⁷
- (9) Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights;⁴⁸
- (10) Inter-American Convention on the Elimination of all Forms of Discrimination Against Persons with Disabilities;⁴⁹
- (11) Inter-American Convention on Protecting the Human Rights of Older persons;⁵⁰ and
- (12) African Charter on Human and Peoples' Rights.⁵¹

IV. Human Rights & Fundamental Freedoms Related to the Health & Well-Being of Persons with Intellectual Disabilities

International human rights law offers a framework that can significantly contribute to the promotion and protection of the health and well-being of persons with intellectual disabilities in health services through its emphasis on civil and political rights and in the communities at large—specifically in the context of the determinants of health through a focus on economic, social, and cultural rights.

⁴² International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3.

⁴³ International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195.

⁴⁴ Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3, 52.

⁴⁵ Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13, 19.

⁴⁶ European Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, Europ.T.S. No. 5; U.N.T.S. 221.

⁴⁷ American Convention on Human Rights, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123.

⁴⁸ Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, Nov. 17, 1988, O.A.S.T.S. No. 69, 28 I.L.M. 161.

⁴⁹ Inter-American Convention on the Elimination of all Forms of Discrimination Against Persons with Disabilities, June 7, 1999, AG/RES. 1608.

⁵⁰ Inter-American Convention on Protecting the Human Rights of Older Persons, O.A.S.T.S., June 15, 2015, T.S. No. A-70.

⁵¹ African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), *entered into force* Oct. 21, 1986.

The human rights framework that can contribute to the delivery of health services for persons with intellectual disabilities includes the:

- (1) Right to the enjoyment of the highest attainable standard of health (“right to health”);
- (2) Right to equal protection and non-discrimination;
- (3) Right to life;
- (4) Right to equal recognition;
- (5) Right to personal integrity and to be treated with humanity;
- (6) Freedom from torture or cruel, inhuman or degrading treatment;
- (7) Freedom from violence—including sexual violence;
- (8) Right to personal liberty and security of person;
- (9) Right to privacy;
- (10) Freedom of expression—including access to health information;
- (11) Right to a name;
- (12) Right to informed consent; and
- (13) Right to enjoy benefits of scientific progress—research and data collection.⁵²

The human rights framework that can contribute to inclusive and healthy communities and accessible cities for persons with intellectual disabilities includes the:

- (1) Right to enjoyment of the highest attainable standard of health (“right to health”);
- (2) Right to recreation and sports;
- (3) Right to accessibility;
- (4) Right to personal mobility;
- (5) Freedom of movement;
- (6) Right to work;
- (7) Right to habilitation and rehabilitation;
- (8) Right to live independently and be included in the community;
- (9) Right to education;
- (10) Right to social security;
- (11) Right to food and nutrition; and
- (12) Right to a family.⁵³

It is important to mention that the application of these rights and the measures to be implemented in countries, health systems, rural communities, and municipalities require, according to the CRPD, data collection, international cooperation with organizations of persons with disabilities, governments, universities, and others and monitoring at the local, national, regional, and international level.⁵⁴

⁵² See CRPD, *supra* note 13.

⁵³ *Id.*

⁵⁴ See CRPD, *supra* note 13, at art. 31, 32, 33 (establishing obligations of States Parties regarding data collection, international cooperation and national implementation/monitoring).

V. Examples of Health Barriers that Negatively Impact the Rights of Persons with Intellectual Disabilities

International human rights law provides health workers, policymakers, NGOs, and organizations of persons with disabilities and families with a valuable framework and legal obligations for identifying and removing barriers to the enjoyment of health by persons with intellectual disabilities. It is important that health care providers become familiar with the human rights framework that applies to persons with intellectual disabilities used in their localities and countries. It is equally important that international health agencies include human rights-based indicators for persons with intellectual disabilities in their technical cooperation on “universal health,” “health promotion and health in all policies,” “disabilities,” and “mental health.”

Particularly, the right to health for persons with intellectual disabilities can be summarized as follows: health services, goods, facilities, and the underlying determinants of health shall be available, accessible, acceptable, and of good quality for all persons with intellectual disabilities without discrimination.⁵⁵

There are several barriers identified in national health policies, plans, laws, or services.⁵⁶ One of the most common barriers is the involuntary admission of persons with intellectual disabilities to isolated mental health institutions that can restrict the rights to enjoy personal liberty, equal protection, life in the community, and recreation or sports.⁵⁷ Another barrier is the lack of protocols and procedures to make decisions on medical treatment or surgical procedures, appointment of a personal representative who provides decision-making support, or decisions

⁵⁵ See General Comment 14, *supra* note 9, at ¶¶ 12–17 (explaining the normative content of art. 12 of the International Covenant on Economic, Social and Cultural Rights in the context of persons in situation of vulnerability).

⁵⁶ Rebecca Jarvest et al., *Special Olympics, WHO, and Partners Commit to Ending Unjust Health Disparities for People with Intellectual Disabilities*, SPECIAL OLYMPICS (Mar. 2019), <https://www.specialolympics.org/about/press-releases/special-olympics-who-and-partners-commit-to-ending-unjust-health-disparities-for-people-with-intellectual-disabilities>; see also United Nations (UN) News, Interview by Antonio LaFuente with Mr. Javier Vasquez, (Nov. 29, 2018), <https://news.un.org/en/audio/2018/11/1027071> (discussing health barriers and human rights of persons with intellectual disabilities).

⁵⁷ See Committee on the Rights of Persons with Disabilities, *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, The right to liberty and security of persons with disabilities*, Adopted during the Committee’s 14th session, ¶¶ 13–15 (2015), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=A/72/55&Lang=en (providing further clarification on why and how persons with intellectual disabilities are frequently denied of liberty in contradiction to their right to liberty and security of persons). See also Special Envoy of the United Nations Secretary-General on Disability and Accessibility and Special Envoy on COVID-19 for Latin America and the Caribbean of WHO, *Joint Statement: Mental Health of Persons with Disabilities during the COVID-19 Pandemic*, ¶ 18 (2020), <https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2020/04/Salud-Mental-Covid19-y-personas-con-discapacidad-ENGapril15.pdf> (recommending a review of involuntary hospitalizations of persons with disabilities to facilitate the discharge and release).

about their own lives such as on employment or education.⁵⁸ This can hinder the rights to equal recognition, informed consent, access to health care, education, and to work.

With regard to the health systems, there is a lack of health and service workers who have the knowledge, training, and experience on intellectual disability, speech pathology, occupational therapy, and physiotherapy, which can hinder the rights of access to health information, access to health care, rehabilitation, mobility, and accessibility.⁵⁹ Long waiting lists to obtain medical services is another obstacle that persons with intellectual disabilities face; this can hinder the rights to equal protection, non-discrimination, health, recreation and sports, education, and work.⁶⁰ Routine screening measures, such as mammograms, blood pressure measurements, or prostate examinations, are performed less often than needed for persons with intellectual disabilities, which hinders the right to equal protection, non-discrimination, life, personal integrity, and health.⁶¹

Regarding communications, health providers often have problems communicating with persons with intellectual disabilities, due to inexperience or lack of alternative modes and formats of communication, interpreters, accommodations, communication technology, and other forms of non-spoken language.⁶² This can hinder the rights to access health information, health care, and to personal integrity.

In the area of sexual and reproductive health, there are restrictive policies and laws that impose invasive practices on women and adolescent girls with intellectual disabilities such as sterilization—hindering the rights to health, non-discrimination, personal integrity, privacy, and to have a family. The exclusion of persons with intellectual disabilities from scientific research can impede the right to benefit from scientific progress.⁶³

Finally, cruel, inhuman, or degrading punishment or treatment, such as chaining of children with intellectual disabilities in prayer camps, Electroconvulsive Therapy (ECT), and surgical procedures without informed consent, are still practiced in some countries, hindering the rights to

⁵⁸ See General Comment 1, *supra* note 23, ¶¶ 40–42 (confirming that forced treatment is a particular problem for persons with intellectual disabilities and explaining the legal obligations of medical professionals on obtaining free and informed consent prior to any treatment).

⁵⁹ See Hunt, *supra* note 25, at ¶¶ 55–56, 81 (arguing that services must support the rights of persons with intellectual disabilities; however, many countries are faced with a scarcity of human resources with appropriate skills).

⁶⁰ See Brown, I., Percy, M., A COMPREHENSIVE GUIDE TO INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 630–31 (Baltimore, Paul H. Brookes Publishing Co., 2007) (explaining the key considerations in primary care and understanding the health needs and barriers to high-quality care for persons with intellectual disabilities).

⁶¹ *Id.*

⁶² *Id.* at 398–99, 631 (explaining the approaches and alternative communication services for overcoming health barriers and the improvement of health providers' performance for treating persons with intellectual disabilities). See Pūras, *supra* note 27, at ¶ 81 (referring to the support and care needs of persons with intellectual disabilities and their families which are unmet in many countries).

⁶³ *Id.*

health care, life, equal protection, and the freedom from torture, cruel, inhumane, or degrading treatment.⁶⁴

The Special Olympics have identified some health barriers.⁶⁵ Thus, the “Healthy Athletes Program” of Special Olympics has the world's largest dataset on the health of persons with intellectual disabilities, including the only health data on this population in many countries.⁶⁶ This information is now available to ministries of health, clinicians, universities, international agencies, NGOs, families, and organizations of persons with disabilities.⁶⁷

Since 1997, more than two million free health screenings have been conducted in more than 130 countries, and the program has identified certain health barriers that can prevent athletes from exercising certain human rights. Typically, on a team of ten athletes, problems with dentistry, physical therapy, health promotion, audiology, and ophthalmology exist.⁶⁸ Of ten athletes, four athletes have untreated tooth decay, and one to two needs an urgent referral to a dentist, which can hinder the rights of athletes to recreation and sports, equal protection and non-discrimination, health, and personal integrity.⁶⁹ Six athletes have significant problems with flexibility, and five athletes will struggle with strength, placing them at high risk for injuries, impeding the rights of athletes to recreation and sports, health, personal mobility, freedom of movement, and personal

⁶⁴ See Juan E. Mendez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶¶ 68–81, 91–93 U.N. Doc. A/HRC/25/60/Add. 1 (Mar. 5, 2014), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/118/18/PDF/G1411818.pdf?OpenElement> (explaining inhumane practices against persons with intellectual disabilities in prayer camps and mental health care facilities).

⁶⁵ Special Olympics is the world's largest sports organization for children and adults with intellectual disabilities and provides year-round training and activities to 5.5 million athletes and Unified partners and 1,100,000 coaches and volunteers in 193 countries. *Frequently Asked Questions*, SPECIAL OLYMPICS, <https://www.specialolympics.org/about/faq> (last visited Oct. 24, 2020) [hereinafter *FAQs*]. The “Special Olympics Movement” was founded in 1968 by Eunice Kennedy Shriver, aiming to foster the inclusion and participation of all persons with intellectual disabilities in all areas of life. *Id.* Special Olympics uses the “power of sports” to help persons with intellectual disabilities discover—on the playing field and in life—new abilities, skills, success, and purpose in life. *Our Mission*, SPECIAL OLYMPICS, <https://www.specialolympics.org/about/our-mission> (last visited, Oct. 24, 2020). Since signing the Protocol Agreement in 1988, the International Olympic Committee has granted Special Olympics International official recognition subject to Special Olympics International's compliance with the provisions of the Protocol Agreement, which includes human rights provisions and principles. Protocol of Agreement Between the International Olympic Committee and Special Olympics International, IOC-SOI, Feb 15, 1988; *International Olympic Committee*, SPECIAL OLYMPICS, <https://www.specialolympics.org/about/sports-federation-partnerships/international-olympic-committee>. See also Sanderson & Badam, *infra* note 82. For information on Special Olympics and its “Inclusion Revolution,” see *Inclusive Health*, SPECIAL OLYMPICS, <https://www.specialolympics.org/our-work/inclusive-health> (last visited Nov. 26, 2020).

⁶⁶ *Healthy Athletes 2018 Prevalence Report*, SPECIAL OLYMPICS 4 (2018), <https://media.specialolympics.org/resources/research/health/2018-Healthy-Athletes-Prevalence-Report.pdf>.

⁶⁷ *Id.* at 3. The Special Olympics Healthy Athletes program offers health screenings and information to athletes in dire need. *Id.* at 4. Healthy Athletes has become the largest global health program dedicated to serving persons with intellectual disabilities. The program offers screenings on podiatric, physical therapy, health education, hearing, and oral health, in addition to a sports physical, a vision and eye health assessment, and an interactive learning activity focused on developing coping and stress management skills. *Id.*

⁶⁸ *Id.* at 8.

⁶⁹ *Id.*

integrity.⁷⁰ Six athletes are overweight or obese and at risk for chronic health conditions, and two to three have low bone density hindering the rights of athletes to recreation and sports, health, life, personal mobility, education, work, and adequate nutrition.⁷¹ Two athletes fail a hearing test, preventing the athletes' rights to education, work, health, recreation and sports, and equal protection.⁷² Finally, four athletes need a new prescription for eyeglasses, and two have never had an eye exam; this can hinder the rights of athletes to education, work, health, recreation and sports, personal mobility, and personal integrity.⁷³

VI. The Human Right to Practice Sport as an Enabler for the Health of Persons with Intellectual Disabilities

According to the Olympic Charter, “[t]he practice of sport is a human right. Every individual must have the possibility of practicing sport, without discrimination of any kind and in the Olympic spirit, which requires mutual understanding with a spirit of friendship, solidarity and fair play.”⁷⁴

In addition, CRPD also establishes the following measures that States Parties shall implement in order to enable persons with intellectual disabilities to participate on an equal basis with others in sporting activities:

- (1) To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
- (2) To ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;
- (3) To ensure that persons with disabilities have access to sporting, recreational and tourism venues;
- (4) To ensure that children with disabilities have equal access with other children to participate in play, recreation and leisure and sporting activities, including those activities in the school system;
- (5) To ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities.⁷⁵

Thus, the three basic relationships between the human rights of persons with intellectual disabilities and the enjoyment of health are also particularly important in the context of the

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ INT’L OLYMPIC COMM., OLYMPIC CHARTER: FUNDAMENTAL PRINCIPLES OLYMPISM ¶ 4 (July 17, 2020), https://stillmed.olympic.org/Documents/olympic_charter_en.pdf.

⁷⁵ CRPD, *supra* note 13, at art. 30.

Olympic Charter and CRPD. Violations of the human right to practice sport have negative effects on the physical and mental health of individuals with intellectual disabilities.⁷⁶ Health and disability policies, plans, and legislation can promote and protect the human right of persons with intellectual disabilities to practice sport.⁷⁷ Health and the human right to practice sport are synergistic. Promoting and protecting physical and mental health requires specific actions that nurture the right to practice sport. At the same time, the enjoyment of the right to practice sport requires specific actions in relation to physical and mental health; preliminary findings indicate that the enjoyment of the right to practice sport in teams is related to health benefits and positive psychological outcomes, such as reduction of stress.⁷⁸

Therefore, treaties, conventions, and charters that protect the human right to play sports and other related civil, political, economic, social, and cultural rights become an important conceptual, legal, clinical, and public health framework. As stated above, the human rights norms and standards are helpful to evaluate success and measure the accountability and responsibilities of stakeholders such as health authorities, ministries of education, ministries of social inclusion/sport, National Olympic Committees, health workers, universities, NGOs, families, organizations of persons with disabilities, and athletes⁷⁹ with regard to different technical areas and measures that are necessary to guarantee the participation and inclusion of persons with disabilities.

In addition, the human right to practice sport and sports competitions and activities can facilitate the implementation of the following inter-programmatic areas established by CRPD and other international human rights instruments, benefitting the physical and mental well-being of all persons with intellectual disabilities:⁸⁰

- (1) Full and effective participation and inclusion in society of persons with intellectual disabilities;
- (2) To combat stereotypes, prejudices, and harmful practices relating to persons with intellectual disabilities;
- (3) To promote and protect the enjoyment of the highest attainable standard of health of persons with intellectual disabilities;
- (4) To promote and protect the right of persons with intellectual disabilities to receive and impart information on health (e.g. during sports activities) and express their own opinions;

⁷⁶ See U.N. Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶¶ 10, 78–84, A/HRC/32/33, (Apr. 4, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/067/39/PDF/G1606739.pdf?OpenElement> (discussing the health benefits of team sports in the context of the right to health and other related human rights and the relationships between sport and the right to health of persons with disabilities).

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ See PAHO, *supra* note 12 and accompanying text.

⁸⁰ See CRPD, *supra* note 13 (establishing general principles and legal obligations relating to participation, non-discrimination, acceptance, accessibility, access to information, legislation, and policy reform, among others).

- (5) To promote inclusive education (e.g., joining students with and without intellectual disabilities on the same sport teams and adopting the “Unified Sports approach”);⁸¹
- (6) To collect appropriate information (e.g. during sports activities), including statistical and research data (as appropriate and respecting human rights) on persons with intellectual disabilities to enable governments and other stakeholders to formulate and implement policies, programs, and laws which protect persons with intellectual disabilities; and
- (7) To ensure that persons with intellectual disabilities have an opportunity to organize, develop, and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision on an equal basis with others, of appropriate instruction, training, and resources.

VII. The Contributions to Human Rights of Organizations of Persons with Intellectual Disabilities: The Special Olympics Movement

There are many athletes’ stories that show the contributions of the Special Olympics movement to the health and other related human rights of persons with intellectual disabilities. For example, during the 2019 Special Olympics World Games in Abu Dhabi, a clinical doctor checked an athlete’s hearing for the first time, and the athlete was able to hear for the first time after being fitted with free hearing aids.⁸² Medical personnel have also detected fatal infections in athletes’ feet during Special Olympics Games that have been treated, preserving the right of athletes to physical integrity and health.⁸³ In one case, dentists referred an athlete for follow-up care, which revealed gum cancer, for which the athlete then received treatment and survived.⁸⁴

The Special Olympics Games have saved lives. Volunteer doctors with the Healthy Athletes Program discover life-threatening conditions in many countries. On one occasion, an athlete with

⁸¹ About 1.4 million persons worldwide take part in Special Olympics Unified Sports. *Unified Sports*, SPECIAL OLYMPICS, <https://www.specialolympics.org/our-work/sports/unified-sports> (last visited Oct. 24, 2020). Unified Sports joins persons with and without intellectual disabilities on the same team under the principle that “training together and playing together is a quick path to friendship and understanding.” *Id.* Unified Sports is part of *Special Olympics Unified Champion Schools* which was founded in 2008 and is funded through the U.S. Office of Special Education Programs at the U.S. Department of Education. *Id.* The main purpose is to make inclusion and tolerance a reality in schools. *Id.* See also *supra* note 66.

⁸² See D. Sanderson & R. Talwar Badam, *Healthy Athletes Screenings Give Some the Chance to Hear for the First Time*, THE NATIONAL (Mar. 21, 2019, 10:23 PM), <https://www.thenational.ae/uae/special-olympics/healthy-athletes-screenings-give-some-the-chance-to-hear-for-the-first-time-1.840003> (narrating the story of Sanatou Diarra and Mame Ndiagne Ndiaye).

⁸³ See Devon O’Neil, *Special Olympics Makes Health a Global Priority*, ESPN (Apr. 15, 2015), https://www.espn.com/specialolympics/story/_/id/12698644/special-olympics-healthy-athletes-program-saving-lives-world (narrating the story of Vedrana Novic).

⁸⁴ *Id.* (narrating the story of Dustin Plunkett).

Down syndrome was referred to a cardiologist and underwent life-saving surgery.⁸⁵ Given that she had visited medical doctors and her congenital heart condition was quite common in children with Down syndrome, the national health system clearly failed to protect her health.⁸⁶ The surgery added an estimated twenty to thirty years to the athlete's life.⁸⁷

The Special Olympics serve as a catalyst for promoting and protecting the human rights of persons with intellectual disabilities. When these persons have access to health exams and care, they are given referrals for surgery, such as tooth removal to alleviate constant pain, or other remedies, such as glasses or hearing aids. When athletes and other persons with intellectual disabilities have access to health care, they can better exercise the fundamental human rights and freedoms that have been explained in this Article.

Referrals of Special Olympics' athletes during Special Olympics Games to health services in national health systems represent a good practice that can influence health authorities and providers in many countries to make their health systems inclusive of all persons with intellectual disabilities. As explained above, these persons are often excluded from the health systems due to health barriers that exist in policies, plans, laws, and services, including the lack of health workers trained on intellectual disabilities.

Special Olympics Games and programs already provide year-round training and activities to six million athletes and Unified partners, and to 1,100,000 coaches and volunteers in 193 countries.⁸⁸ As such, this Article proposes that these programs are the ideal 'healthy settings'⁸⁹ to promote and protect the human rights of persons with intellectual disabilities.

VIII. Inter-Disciplinary Recommendations

This Article proposes specific recommendations to governments; NGOs, including sports organizations; international organizations and health agencies; human rights treaty bodies, organs, and commissions; U.N. Special Rapporteurs and Envoys; and organizations of persons with intellectual disabilities. These recommendations are in line with CRPD and aim at resolving or addressing specific issues, such as the lack of standards, educational materials, or a workforce trained to address the health and related human rights of persons with intellectual disabilities; the review of health-related protocols on intellectual disabilities; the lack of systems and procedures

⁸⁵ See *Global Health Challenges*, CTR. GLOB. HEALTH & DEV., <https://cghd.org/index.php/global-health-challenges/feature/56-left-behind-health-care-and-people-with-intellectual-disabilities> (narrating the story of Zuebeyde Horus).

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *FAQs*, *supra* note 65.

⁸⁹ According to WHO, a healthy setting is the place or social context in which people engage in daily activities in which environmental, organizational, and personal factors interact to affect health and wellbeing (e.g., municipalities, schools, workplaces, prisons, and islands, among others). See *2019 Global Reach Report*, SPECIAL OLYMPICS (2019), <https://media.specialolympics.org/resources/reports/reach-reports/2019-Reach-Report-Global-Version-English.pdf?ga=2.258300751.435060156.1601349644-1964580061.1425666792>.

to monitor health-related rights of persons with intellectual disabilities in services and in the community; outdated policies and laws that negatively affect the health and related human rights of persons with intellectual disabilities; the limited information among key stakeholders on intellectual disabilities; and the need of re-imagining sports events and social media campaigns as tools to empower persons with intellectual disabilities and their families with international human rights instruments.

In addition, these recommendations, leverage Special Olympics' experience in areas such as data collection, health screenings, sports games/competitions, and empowerment of athlete leaders:

- (1) To issue specific international human rights standards, guidelines, principles, or recommendations to promote and protect the right to health and other related human rights of persons with intellectual disabilities, addressing their health barriers and solutions;
- (2) To train health professionals, in collaboration with ministries of health and the private sector, on the human rights instruments that protect persons with intellectual disabilities with the purpose of strengthening national health systems;
- (3) To include human rights instruments in video training modules and online courses dedicated to sports and the health of persons with intellectual disabilities;
- (4) To include human rights instruments and indicators during visits to communities for monitoring and evaluations in line with obligations and measures of CRPD and the concluding observations and recommendations of the U.N. Committee on the Rights of Persons with Disabilities⁹⁰ regarding persons with intellectual disabilities;
- (5) To include human rights norms and standards in protocols used to conduct health screenings (e.g., during Special Olympics Games), medical treatments, or surgical procedures in national health services and in new health strategies that could be brought to scale on intellectual disabilities (e.g. on protection of persons with intellectual disabilities during pandemics);
- (6) To include human rights instruments and approaches when stakeholders are advocating for the adoption of national policies and laws aiming at benefiting persons with intellectual disabilities and eradicating the systemic barriers mentioned above;

⁹⁰ The U.N. Committee on the Rights of Persons with Disabilities is a treaty body comprised of eighteen independent experts who monitor the implementation of CRPD in States Parties. *Questions and Answers*, COMM. RTS. PERS. DISABILITIES, <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/QuestionsAnswers.aspx> (last visited Oct. 24, 2020). All States Parties to CRPD have to present reports to the Committee on the implementation of the obligations of CRPD. *Id.* After reviewing these reports, the Committee issues their concluding observations which are forwarded to the State Party. *Id.* The concluding observations of the Committee can be a powerful tool to promote and protect the right of persons with intellectual disabilities to health and other related human rights. The Committee meets biannually in Geneva. *Id.*

- (7) To share existing Special Olympics global data and available information on intellectual disabilities (e.g. through hearings, technical opinions, and reports) with international and regional human rights bodies and special procedures and national parliaments to catalyze policy, programs, and legislation reform (e.g., with U.N. Committee on the Rights of Persons with Disability, U.N. Committee on the Rights of the Child,⁹¹ U.N. Special Rapporteur on the Right to Health,⁹² Special Envoy of the U.N. Secretary General on Disability and Accessibility,⁹³ African Commission on Human and Peoples' Rights,⁹⁴ and Inter-American Commission on Human Rights,⁹⁵ and any other organization with an interest in the data);

⁹¹ *Monitoring Children's Rights*, COMM. RTS. CHILD, <https://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIntro.aspx> (last visited Oct. 24, 2020) ("The U.N. Committee on the Rights of the Child is a treaty body comprised of eighteen independent experts who monitors the implementation of the Convention on the Rights of the Child in States Parties. It also monitors the Optional Protocols related to involvement of children in armed conflicts . . . and on sale of children, child prostitution, child pornography" and communications procedures to present complaints on violations to the Convention and the Optional Protocols). All States Parties have to present reports to the Committee on the implementation of the obligations of the Convention on the Rights of the Child. *Id.* After reviewing these reports, the Committee issues the "concluding observations" which are forwarded to the State Party. *Id.* The individual complaints and the concluding observations can be powerful tools to promote and protect the right to health and other related human rights of children with intellectual disabilities.

⁹² *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. OFF. HIGH COMM'R, <https://www.ohchr.org/en/issues/health/pages/srrihealthindex.aspx> (last visited Oct. 24, 2020). The Special Rapporteur expresses his or her views in a personal capacity. *Id.* He or she takes on his or her functions out of a commitment to human rights and a conviction that the UN's work in this field could make a difference. *See id.* The U.N. Special Rapporteur on the Right to Health can be very effective in promoting and protecting the right of persons with intellectual disabilities to health via individual complaints, country visits, thematic reports, statements, and open letters.

⁹³ The U.N. Secretary-General António Guterres appointed in 2017 Maria Soledad Cisternas Reyes as his Special Envoy on Disability and Accessibility. *Special Envoy of the Secretary-General on Disability and Accessibility*, U.N. DEP'T OF ECON. & SOC. AFF.'S, <https://www.un.org/development/desa/disabilities/resources/special-envoy-of-the-secretary-general-on-disability-and-accessibility.html> (last visited Oct. 24, 2020). *Senior Leadership Posts, United Nations Global Call*, <https://www.un.org/globalcall/content/senior-leadership-posts> (last visited Nov. 9, 2020) ("A Special Envoy of the Secretary-General are usually assigned at the USG [Under Secretary General] or ASG [Assistant Secretary General] to undertake a special mission relating to matters of which the Security Council or the General Assembly are seized..."). The U.N. Special Envoy on Disability and Accessibility expresses her views in a personal capacity and helps promote the human rights of persons with disabilities, including accessibility for all in line with CRPD and other international human rights instruments. *See* internal communications of the office of the U.N. Special Envoy on Disability and Accessibility, to author (Nov. 9, 2020, 10:21 AM EST) (on file with author). The U.N. Special Envoy is an effective mandate to promote the rights of persons with intellectual disabilities to health and other related human rights via statements and principles, presentations in seminars and meetings of governmental bodies, and country visits to meet organizations of persons with disabilities, universities, and other stakeholders, as appropriate.

⁹⁴ The African Commission on Human and People's Rights is a quasi-judicial body that interprets the African Charter on Human and People's Rights. AFR. N. COMM'N HUM & PEOPLE'S RTS., <https://www.achpr.org/home> (last visited Oct. 24, 2020). It reviews individual complaints of violations to the Charter and investigates human rights violations, which can be powerful mechanisms to promote and protect health-related rights of persons with intellectual disabilities. *Id.* The Commission reports to the Assembly of Heads of States of the African Union. *Id.*

⁹⁵ The Inter-American Commission on Human Rights (IACHR) is an autonomous organ of the Organization of American States. *What is the IACHR*, ORG. AM. STATES, <https://www.oas.org/en/iachr/mandate/what.asp> (last

- (8) To convene national, regional, and global sports events, seminars and workshops on the human rights of persons with intellectual disabilities that involve governments, corporations, multilateral organizations, international agencies, Special Olympics athlete leaders, sport coaches, and NGOs;
- (9) To include human rights instruments in toolkits and training modules to provide staff of organizations of persons with disabilities, sport coaches, Special Olympics athlete leaders, and families of persons with intellectual disabilities with leadership skills to self-advocate for their rights and non-discrimination in their communities and engage other community leaders and organizations of persons with intellectual disabilities; and
- (10) To include human rights instruments and Special Olympics athletes' stories from a human rights perspective in the local, regional, and global social media campaigns aiming at activating self-advocates, families, and other persons with intellectual disabilities and preventing violations of human rights and non-discriminatory practices in their communities.

IX. Conclusion

This Article has discussed international human rights law not only as a legal tool, but also as a powerful public health tool, which, like other health strategies and technologies, is very useful to protect the health of persons in situations of vulnerability. Similarly, the Article presents international human rights law as a framework of legal obligations to guarantee access to the social determinants of health.

This Article could have addressed other vulnerable groups. However, the existing barriers to health for persons with intellectual disabilities are very worrying. These barriers affect the access of persons with intellectual disabilities to health systems and social determinants and represent gross and systematic violations of their fundamental human rights and dignity. As analyzed in the Article, human rights violations have serious consequences on the physical and mental health of persons with intellectual disabilities. These health-related human rights violations have been recently documented by international human rights bodies and independent experts from the United Nations. It is imperative to make these persons and their health more visible.

visited Oct. 24, 2020). Along with the Inter-American Court of Human Rights, it is one of the bodies that comprise the Inter-American human rights system. *Id.* It is a permanent body, with Headquarters in Washington D.C. and it meets in regular and extraordinary sessions several times a year to review allegations of human rights violations in the Western Hemisphere. *See id.* The IACHR can promote and protect health-related human rights of persons with intellectual disabilities via: reviewing individual complaints; issuing country specific human rights reports; issuing thematic reports; conducting on-site visits to countries; organizing conferences and training workshops; issuing precautionary measures to prevent irreparable harm to persons with intellectual disabilities; referring cases to the Inter-American Court of Human Rights and asking the Inter-American Court to provide advisory opinions on issues relating to the interpretation of the American Convention on Human Rights and other Inter-American human rights instruments. *See id.*

The Article reveals that persons with intellectual disabilities have not been a priority in the policies or strategies of international organizations, health agencies, or in the information systems of the ministries of health. On the contrary, most of the health data and analysis related to these persons come from international and regional human rights bodies, special procedures, and the organizations of persons with intellectual disabilities themselves. International human rights law has served to make persons with intellectual disabilities more visible in health systems.

The links between human rights and health studied by Jonathan Mann, et al., and documented in this Article are, at this time, more valuable than thirty years ago. These links are very instrumental in the context of pandemics such as COVID-19 or discriminatory practices and policies based on race, ethnicity, gender identities, or disability—just to mention a few—that can significantly affect the health and life of certain groups. Health crises are allowing us to re-evaluate and further value the relationships between human rights and health in the context of persons with intellectual disabilities and other vulnerable persons. The recommendations of Jonathan Mann and others, and the implementation of the United Nations Convention on the Human Rights of Persons with Disabilities, are useful strategies for reforming policies, plans, services, and legislation related to health that can remove the barriers that persons with intellectual disabilities and other vulnerable groups still face in health systems.

International human rights instruments provide health systems and communities with new approaches, strategies, and frameworks, such as legal obligations on the right to practice sport to promote health—the Special Olympics’ work, and its ‘inclusion revolution,’ are proof of this. Perhaps more progress will be seen as health systems incorporate measures, plans, and policies on the right to practice sport and physical activity as a strategy to prevent disease and disability. More research is needed on how sports games and competitions, such as the Olympics, Paralympics and Special Olympics can serve as “healthy settings” and be used to promote and protect health and human rights, particularly in the area of non-communicable diseases.

This Article calls for a systematic application of international human rights norms and standards and for the inclusion of persons with intellectual disabilities in the strategies, action plans, and policies of international health agencies and ministries of health. Likewise, it recommends strengthening the work of the regional and international treaty bodies in charge of monitoring international human rights obligations, analyzing with greater detail the particular health situation of persons with intellectual disabilities and all related human rights. This Article makes specific recommendations regarding the need to reform health policies and legislation that, until now, in most countries have remained silent regarding persons with intellectual disabilities. These outdated policies and laws should, as soon as possible, incorporate current international human rights norms and standards, as discussed in this Article. This will require training health personnel and legislators with international human rights instruments, such as the CRPD.

Finally, this Article seeks to elevate the role of organizations of persons with intellectual disabilities. The challenge will be for these organizations to use the CRPD and all the international human rights instruments analyzed in this article to train and empower all persons with intellectual

disabilities as true “subjects of human rights,” as well as their board members, staff, and volunteers. Persons with intellectual disabilities now have in their own hands a conceptual and legal framework to promote and protect their health and prevent serious and systematic violations of their most fundamental human rights.