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Heather A. Walter-McCabe

Killian M. Kinney

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AN ARGUMENT FOR EXPLICIT PUBLIC HEALTH RATIONALE IN LGBTQ ANTIDISCRIMINATION LAW AS A TOOL FOR STIGMA REDUCTION

HEATHER A. WALTER-McCABE* AND M. KILLIAN KINNEY**

ABSTRACT

The lesbian, gay, bisexual, transgender (inclusive of nonbinary), and queer (collectively, LGBTQ) community is experiencing health inequities at alarming rates. From behavioral health issues, to violence issues, to increased rates of homelessness, structural stigma impacts LGBTQ communities at a disproportionate rate. Suicide numbers are particularly concerning. The LGB community rate of suicide is two to three times that of the general population. For the transgender and nonbinary community, that number soars to nearly nine times that of the general population. In this article, we examine the social determinates of health impacting the LGBTQ community and the ways structural stigma supports health inequity. Given the health data, the article analyzes how policymakers could include an explicit rationale in antidiscrimination laws to shift social norms and lower stigma in pursuit of improving population health. Even when a policy is anti-discriminatory on its face, naming the intent of shifting norms and lowering stigma matter. When the explicit rationale is named, it can serve two purposes: 1) articulating a clear public health purpose of the antidiscrimination law and 2) educating the public on the need for norm change and its public health impact. Making it clear that the goal of social norm change is to protect and improve the population's health may make the state's compelling state interest case stronger, particularly in the face of Religious Freedom Restoration Acts, in challenges to antidiscrimination laws.

* Heather A. Walter-McCabe, JD, MSW. Associate Professor, Indiana University School of Social Work. Assistant Professor of Social Work and Law, Indiana University Robert H. McKinney School of Law.

** M. Killian Kinney, MSW, LSW. Doctoral Candidate & Associate Faculty, Indiana University School of Social Work.

I. INTRODUCTION

The lesbian, gay, bisexual, transgender (inclusive of nonbinary), and queer (collectively, LGBTQ¹) community is experiencing suicide at alarming rates.² The LGB community rate of suicide is two to three times that of the general population.³ For the transgender and nonbinary community, that number soars to nearly nine times that of the general population.⁴ Research supports that stigma is a structural determinant of health that contributes to harmful mental and physical health outcomes, especially among LGBTQ communities.⁵

The public health community is increasingly examining and seeking to impact not only the social determinants of health, but also the structural determinants of health—those health disparities at the institutional and policy levels impacting communities.⁶ This is an important shift in conceptualizing the issues that may assist in making broad improvements to health inequities. Given what we know about stigma, built on a strong foundation of research from public health, mental health, and stigma scholars, it time for public health to move one step further.⁷ Generally, antidiscrimination laws move the public's behaviors

1. In this article, the term LGBTQ will be used as inclusive of Lesbian, Gay, Bisexual, Transgender (inclusive of those who are nonbinary), and Queer or Questioning (inclusive of those who self-identify as queer or others who are generally included in this community but not well covered by the other categories such as asexual, pansexual, genderqueer, or others). If other letters are used, it is based on the scope of the work referenced or is an intentional discussion of only one portion of the overall community.

2. See NAT'L LGBT HEALTH EDUC. CTR., FENWAY INST., SUICIDE RISK AND PREVENTION FOR LGBTQ PEOPLE 2 (2018).

3. See *id.* See generally Ann P. Haas et al., *Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations*, 58 J. HOMOSEXUALITY 10, 17, 21 (2011) (discussing how reported suicide attempts are two to seven times higher in high school students who identify as LGB as compared to heterosexual high school students and two to three times higher among all age groups generally).

4. SANDY E. JAMES ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY 3 (2016).

5. NAT'L LGBT HEALTH EDUC. CTR., *supra* note 2, at 2. See generally Mark L. Hatzenbuehler & John E. Pachankis, *Stigma and Minority Stress as Social Determinants of Health Among Lesbian, Gay, Bisexual, and Transgender Youth*, 63 PEDIATRIC CLINICS NORTH AM. 985 (2016); Mark L. Hatzenbuehler et al., *Structural Stigma and All-Cause Mortality in Sexual Minority Populations*, 244 SOC. SCI. & MED. (forthcoming 2020).

6. See Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. 2–8 (May 2018), <http://files.kff.org/attachment/issue-brief-beyond-health-care> (defining social determinants of health and examining some current initiatives targeting the social determinants); ORIELLE SOLAR & ALEC IRWIN, WORLD HEALTH ORG., A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 30, 36 (2010).

7. See e.g., Daniel S. Goldberg, *On Stigma and Health*, 45 J.L. MED. & ETHICS 475, 475–77 (2018); Mark L. Hatzenbuehler, *Structural Stigma: Research Evidence and Implications for Psychological Science*, 71 AM. PSYCHOLOGIST 742, 743 (2016); ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY (2009); Scott Burris, *Disease Stigma in U.S.*

positively toward communities over the years.⁸ It is time to explicitly name changing norms towards marginalized groups as a goal of antidiscrimination laws to improve population health.

This article will be divided into four sections. First, we will examine the wealth of knowledge on LGBTQ health inequities, with a particular examination of suicide. Second, we will discuss stigma and its role in the population health of the LGBTQ community. Third, we will discuss the rationale for a call to increase the inclusion of a public health purpose in LGBTQ antidiscrimination laws. Lastly, we will examine current research projects that will assist in understanding the impact of law and policy on structural stigma in the LGBTQ community.

II. BACKGROUND ON LGBTQ HEALTH INEQUITIES

A. LGBTQ Demographics

LGBTQ individuals have long experienced health inequities in a variety of areas.⁹ In the 2020 Healthy People agenda, the Office of Disease Prevention and Health Promotion (ODPHP), for the first time, included a goal for improving the health, safety, and wellbeing of LGBT individuals.¹⁰ The agenda recognizes areas of need for promoting the public's health.¹¹ In 2011, the Institute of Medicine released a report entitled *The Health of Lesbian, Gay, Bisexual, and*

Public Health Law, 30 J.L. MED. & ETHICS 179, 186 (2002); Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 ANN. REV. SOC. 363, 367 (2001).

8. See Burris, *supra* note 7, at 186.

9. See Brian Mustanski et al., *The Effects of Cumulative Victimization on Mental Health Among Lesbian, Gay, Bisexual, and Transgender Adolescents and Young Adults*, 106 AM. J. PUB. HEALTH 527, 527–28 (2016) (discussing that LGBTQ individuals experience greater stressors, such as child abuse, unstable housing, internalized homophobia, and identity concealment, all of which can lead to exacerbated health disparities like anxiety, depression, suicide attempts, and cardiovascular disease, than their heterosexual and cisgender counterparts); THE HEALTH OF SEXUAL MINORITIES: PUBLIC HEALTH PERSPECTIVES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER POPULATION 456–57 (Ilan H. Meyer & Mary E. Northridge eds., 2007); Hudaisa Hafeez et al., *Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review*, 9 CUREUS 1, 1–5 (2017); Michael King et al., *A Systematic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Bisexual People*, 8 BMC PSYCHIATRY 1, 2, 4–13 (2008).

10. See *Lesbian, Gay, Bisexual, and Transgender Health*, OFF. DISEASE PREVENTION & HEALTH PROMOTION, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last updated Apr. 25, 2020). See also Mitchell R. Lunn et al., *Sociodemographic Characteristics and Health Outcomes Among Lesbian, Gay, and Bisexual U.S. Adults Using Healthy People 2020 Leading Health Indicators*, 4 LGBT HEALTH 283, 284 (2017).

11. See *About Healthy People*, OFF. DISEASE PREVENTION & HEALTH PROMOTION, <https://www.healthypeople.gov/2020/About-Healthy-People> (last visited May 19, 2020).

Transgender People: Building a Foundation for Better Understanding.¹² This report provided much-needed information on and attention to health inequities for the LGBTQ community.

While this article focuses on suicide in the LGBTQ community, it is crucial to understand the context within which these suicides are occurring. Below is a broad description of the overall health inequities experienced by this community that provides an understanding of the environment within which these suicides occur.

Despite increased protection for LGBTQ individuals ensured by the Affordable Care Act,¹³ one study suggests that over half of LGBTQ people in America have experienced discrimination in health care, from harsh interactions, to abusive language, to the refusal of care.¹⁴ In that study, seventy percent of transgender and gender-nonconforming individuals experienced discrimination, including physical roughness, harsh language, refused care, and ignorance of their health care needs.¹⁵ Further, ninety percent of individuals who identified as transgender reported experiencing barriers to care due to concerns about lack of adequately trained professions, eighty-six percent reported fear of different treatment, and over fifty percent expressed concerns about refusal of services.¹⁶

1. Behavioral Health

LGBTQ persons are at enormous risk for behavioral health issues.¹⁷ Depression, anxiety, panic disorder, PTSD, and substance use disorder have all been found to be experienced at higher rates in the LGBTQ community.¹⁸ Of particular concern are LGBTQ youth, who are at higher risk for mental health concerns, substance abuse disorders, and poor overall health than youth than their heterosexual and cisgender peers.¹⁹ In a 2008 study, depression, anxiety, alcohol and substance misuse were found to be experienced by the LGBTQ

12. See INST. OF MED., *THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING* i-ii (2011).

13. Lindsey Dawson et al., *The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation*, KAISER FAM. FOUND. 1 (2018), <https://www.kff.org/disparities-policy/issue-brief/the-affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/>.

14. LAMBDA LEGAL, *WHEN HEALTHCARE ISN'T CARING: LAMBDA LEGAL'S SURVEY ON DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE LIVING WITH HIV* 5 (2010).

15. *Id.*

16. *Id.* at 13.

17. ABBI COURSOLE & RACHEL HOLTZMAN, NAT'L HEALTH LAW PROGRAM, *PROTECTIONS FOR LGBTQ PEOPLE WITH BEHAVIORAL HEALTH NEEDS* 1–8 (2019).

18. *Id.* at 8, 9; Susan D. Cochran et al., *Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use Among Lesbian, Gay, and Bisexual Adults in the United States*, 71 J. CONSULTING & CLINICAL PSYCHOL. 53, 58 (2003).

19. Tumaini R. Coker et al., *The Health and Health Care of Lesbian, Gay, and Bisexual Adolescents*, 31 ANN. REV. PUB. HEALTH 457, 458 (2010).

community at one and a half times the rate of the heterosexual community.²⁰ The transgender and nonbinary community are also disparately impacted, often at higher rates than the LGB community at large.²¹ For example, in the largest national survey of persons who are transgender, thirty-nine percent of respondents reported experiencing significant psychological distress in the month before the survey, compared to five percent reported in the general population.²²

Numerous studies have confirmed these findings, but nearly all mention the difficulty of studying these differences given the paucity of data collected on gender identity and sexual orientation.²³ Healthy People 2020 objectives seek to address this issue by recommending increased data collection efforts specifically to collect sexual orientation and gender identity information routinely in standard data collection efforts, such as the American Community Survey (ACS), Behavioral Risk Factor Surveillance Survey (BRFSS), Youth Risk Behavior Survey (YRBS), and others.²⁴

2. Disease Disparities

The ODPHP lists multiple health disparities in the LGBTQ population.²⁵ As with other areas, there are differences within the community itself.²⁶ The LGBTQ community is at an increased risk for tobacco, alcohol, and other substance use.²⁷ Lesbian and bisexual women are at increased risk for breast and ovarian cancer due to avoidance of preventative care (i.e., mammograms and

20. King et al., *supra* note 9, at 13.

21. G. Tyler Levefor et al., *Health Disparities Between Genderqueer, Transgender, and Cisgender Individuals: An Extension of Minority Stress Theory*, 66 J. COUNSELING PSYCHOL. 385, 391 (2019).

22. JAMES ET AL., *supra* note 4, at 105.

23. See, e.g., NAT'L LGBT HEALTH EDUC. CTR., *supra* note 2, at 2; *Lesbian, Gay, Bisexual, and Transgender Health*, *supra* note 10; GAY & LESBIAN MED. ASS'N, HEALTHY PEOPLE 2010: COMPANION DOCUMENT FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) HEALTH 14 (2001), <http://www.nalgap.org/PDF/Resources/HP2010CDLGBTHealth.pdf>.

24. *Lesbian, Gay, Bisexual, and Transgender Health*, *supra* note 10.

25. *Id.*

26. See, e.g., GAY & LESBIAN MED. ASS'N, HEALTHY PEOPLE 2010: COMPANION DOCUMENT FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) HEALTH 12 (2001), <http://www.nalgap.org/PDF/Resources/HP2010CDLGBTHealth.pdf>.

27. *Lesbian, Gay, Bisexual, and Transgender Health*, *supra* note 10.

pap smears).²⁸ Gay men are at higher risk of sexually transmitted infections, particularly among communities of color.²⁹

One contributing factor of disease disparities in the LGBTQ community is the lack of inclusive sex education in schools.³⁰ In 2015, the Real Education for Healthy Youth Act was introduced to ensure federal funding was allocated only to the sexual health programs that include inclusive language about LGBTQ issues.³¹ The bill was not signed into law and was introduced again (the latest attempt in May 2019) but remains unpassed.³² There is accordingly a lack of LGBTQ-affirming sex education.³³ Only thirty-nine states and D.C. mandate sex education, and only seventeen states require medically accurate curricula.³⁴ Youth across America thus receive false information about birth control, STD prevention, and HIV transmission.³⁵ Even when sexual health information is included in schools, it may promote a negative frame to LGBTQ-related content.³⁶ LGBTQ youth are thus more likely to use internet-based resources for

28. *Cancer Facts for Lesbian and Bisexual Women*, AM. CANCER SOC'Y (Sept. 23, 2019), <https://www.cancer.org/healthy/find-cancer-early/womens-health/cancer-facts-for-lesbians-and-bisexual-women.html>; Thomas Buchmueller & Christopher S. Carpenter, *Disparities in Health Insurance Coverage, Access, and Outcomes for Individuals in Same-Sex Versus Different-Sex Relationships, 2000-2007*, 100 AM. J. PUB. HEALTH 489, 494 (2010); Julia A. Dilley et al., *Demonstrating the Importance and Feasibility of Including Sexual Orientation in Public Health Surveys: Health Disparities in the Pacific Northwest*, 100 AM. J. PUB. HEALTH 460, 460, 463–65 (2010).

29. GAY & LESBIAN MED. ASS'N, *supra* note 26.

30. JOSEPH G. KOSCIW ET AL., GAY LESBIAN STRAIGHT EDUC. NETWORK (GLSEN), THE 2017 NATIONAL SCHOOL CLIMATE SURVEY 57 (2018) (finding that of the 77.6% of surveyed LGBTQ students who received some form of sex education in school, the majority reported that the sex education did not include LGB or trans/gender non-conforming topics).

31. *See* Real Education for Healthy Youth Act of 2015, H.R. 1706, 114th Cong. (2015).

32. *H.R. 1706 – Real Education for Healthy Youth Act of 2015: Actions*, CONGRESS.GOV, <https://www.congress.gov/bill/114th-congress/house-bill/1706/actions?KWICView=false> (last visited Apr. 27, 2020); *H.R. 2720 – Real Education for Healthy Youth Act of 2019: Actions*, CONGRESS.GOV, <https://www.congress.gov/bill/116th-congress/house-bill/2720/actions?KWICView=false> (last visited Apr. 27, 2020).

33. *See Sex and HIV Education*, GUTTMACHER INST. (Apr. 1, 2020), <https://www.guttmacher.org/print/state-policy/explore/sex-and-hiv-education> (providing an overview of state requirements surrounding sexual education). *See also* KOSCIW ET AL., *supra* note 30.

34. *Sex and HIV Education*, *supra* note 33.

35. SPECIAL INVESTIGATIONS DIV., U.S. HOUSE OF REPRESENTATIVES COMM. ON GOV'T REFORM – MINORITY STAFF, THE CONTENT OF FEDERALLY FUNDED ABSTINENCE-ONLY EDUCATION PROGRAMS i–ii, 9–11 (2004).

36. *See* KOSCIW ET AL., *supra* note 30 (finding that only 6.7% of surveyed students received LGBTQ-inclusive sex education that included positive representations of LGBTQ topics, while 8.8% of LGBTQ students were taught sex education that included negative representations of such topics).

sexual health information.³⁷ The accessibility and range of sexual content on the internet makes for an attractive private (i.e., not having to ask) source for sexual health information.³⁸ However, the internet, including pornography, does not necessarily provide science-based information that is accurate or real-life, which cause increase the risk for STI and HIV transmission.³⁹ Research has also indicated that many primary care providers do not feel prepared to address sexual health matters with LGBTQ youth.⁴⁰ As a result, approximately two-thirds of new syphilis cases are among young men who have sex with men (MSM),⁴¹ and over ninety percent of new HIV cases among youth ages thirteen to twenty-four are among MSM.⁴²

Older LGBT adults⁴³ may experience adverse health effects from chronic stress,⁴⁴ including higher risks of poor mental health, smoking, excessive drinking, cardiovascular disease, diabetes, and obesity.⁴⁵ In particular, individuals who lived through the HIV/AIDS crisis may be hesitant to engage with medical/service providers,⁴⁶ which is only further exacerbated when older

37. Kimberly J. Mitchell et al., *Accessing Sexual Health Information Online: Use, Motivations and Consequences for Youth with Different Sexual Orientations*, 29 HEALTH EDUC. RES. 147, 148 (2014).

38. *Id.* at 147–48.

39. *See id.* at 155.

40. R.E. Knight et al., *Examining Clinicians' Experiences Providing Sexual Health Services for LGBTQ Youth: Considering Social and Structural Determinants of Health in Clinical Practice*, 29 HEALTH EDUC. RES. 662, 665 (2014).

41. Div. of HIV/AIDS Prevention, Nat'l Ctr. for HIV/AIDS, Viral Hepatitis, STD, & TB Prevention, *Syphilis & MSM (Men Who Have Sex With Men) – CDC Fact Sheet*, CTRS. DISEASE CONTROL & PREVENTION (Jan. 2017), <https://www.cdc.gov/std/syphilis/syphilism-2019.pdf>.

42. Div. of HIV/AIDS Prevention, Nat'l Ctr. for HIV/AIDS, Viral Hepatitis, STD, & TB Prevention, *HIV Surveillance – Adolescents and Young Adults*, CTRS. DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2017.pdf> (last visited Apr. 27, 2020).

43. Due to the historical use of the word “queer” as a derogatory term, some older LGBTQ folk do not use it. Others do. While many within the LGBTQ community have reclaimed “queer” as an empowering label, we have dropped the “Q” out of recognition that some older generations do not self-identify as “queer” in light of historical discrimination. Because use of the term “queer” has since shifted toward empowerment, it is thus used throughout the rest of the article.

44. LGBT MOVEMENT ADVANCEMENT PROJECT (MAP) & SERVS. & ADVOCACY FOR GAY, LESBIAN, BISEXUAL, & TRANSGENDER ELDERS (SAGE), *IMPROVING THE LIVES OF LGBT OLDER ADULTS 5* (2010).

45. *Id.* at 32; Erin Fitzgerald, *No Golden Years at the End of the Rainbow: How a Lifetime of Discrimination Compounds Economic and Health Disparities for LGBT Older Adults*, NAT'L GAY & LESBIAN TASK FORCE, 12–14 (2013); Leah Eskenazi, *How to Find Care for LGBT Seniors*, PBS NEWSHOUR (June 11, 2015), www.pbs.org/newshour/health/lgbt-older-adults-emerging-community.

46. *See generally* Michael Adams, *LGBT Advocate Sees Hurdles Ahead*, AARP PRIDE: THE BIGGEST ISSUES FACING OLDER LGBT AMERICANS (Apr. 20, 2011), <https://www.aarp.org/relationships/family/info-04-2011/biggest-issues-facing-older-lgbt-americans>.

LGBT adults face additional barriers to health because of isolation, lack of social services, and lack of culturally competent providers.⁴⁷

3. Violent Injury

Violence is another area that disproportionately impacts the LGBTQ community, with differences between groups within the LGBTQ community.⁴⁸ For example, higher rates of verbal and physical abuse have been found for LGBTQ youth compared to their heterosexual, cisgender peers.⁴⁹ Taken together, LGBTQ school-aged youth, from elementary school to high school, report regular bullying within the school environment perpetrated by other students, staff, and administrators.⁵⁰

A 2013 survey of LGBTQ students found that seventy-four percent were verbally harassed due to their sexual orientation, and fifty-five percent were verbally harassed due to their gender expression.⁵¹ Also, nearly fifty-six percent of LGBTQ students felt unsafe due to their sexual orientation, while thirty-eight percent felt unsafe due to their gender expression.⁵²

These findings have been confirmed by another study that also found high rates of verbal and physical abuse experienced by LGBTQ youth.⁵³ For youth, school environments can have a significant impact on safety.⁵⁴ “It is not sufficient to simply address the presence or lack of homophobia in these systems, it is also imperative that heterosexism be examined.”⁵⁵ Notably, in-school victimization experiences have been associated with adverse psychosocial outcomes through young adulthood.⁵⁶

47. Michael Adams, *LGBT Advocate Sees Hurdles Ahead*, AARP (Apr. 20, 2011), <https://www.aarp.org/relationships/family/info-04-2011/biggest-issues-facing-older-lgbt-americans>.

48. Kenta Asakura, *Paving Pathways Through the Pain: A Grounded Theory of Resilience Among Lesbian, Gay, Bisexual, Trans, and Queer Youth*, 27 J. RES. ADOLESCENCE 521, 521 (2017).

49. *Id.*

50. JOSEPH G. KOSCIW ET AL., GAY LESBIAN STRAIGHT EDUC. NETWORK (GLSEN), THE 2013 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH IN OUR NATION’S SCHOOLS (2014); GLSEN & HARRIS INTERACTIVE, INC., PLAYGROUNDS AND PREJUDICE: ELEMENTARY SCHOOL CLIMATE IN THE UNITED STATES (2012).

51. KOSCIW ET AL., *supra* note 50, at xvii.

52. *Id.* at xvi.

53. Asakura, *supra* note 48, at 521.

54. See Linda L. Morrison & Jeff L’Heureux, *Suicide and Gay/Lesbian/Bisexual Youth: Implications for Clinicians*, 24 J. ADOLESCENCE 39, 40, 43 (2001).

55. *Id.* at 42–43.

56. Stephen T. Russell et al., *Lesbian, Gay, Bisexual, and Transgender Adolescent School Victimization: Implications for Young Adult Health and Adjustment*, 81 J. SCH. HEALTH 223–230 (2011).

Even though intimate partner violence (IPV) has been homogenized as occurring among heterosexual men and women, LGBTQ individuals are more likely to experience psychological, physical, and sexual IPV in sexual and romantic relationships at a higher rate than their cisgender, heterosexual counterparts.⁵⁷ The bisexual community has also seen a disproportionate risk of sexual assault and IPV.⁵⁸ The transgender community experiences violent injury and death, particularly among Black transgender women, at alarming rates.⁵⁹ Media reports, for example, have described the violent deaths of Black transgender women as an epidemic.⁶⁰ The numbers appear to support this conclusion.⁶¹ Furthermore, the concealment of violence is further hidden by stigma towards LGBTQ individuals that can render their relationship invisible.⁶²

4. Hate Crimes

According to the Federal Bureau of Investigation (FBI), the number of anti-LGBTQ hate crimes has been rising over the past several years.⁶³ The 2018 FBI Uniform Crime Reporting (UCR) showed 16.9% of hate crimes were motivated by anti-sexual orientation bias, while an additional 2.2% were motivated by anti-

57. ADAM M. MESSINGER, LGBTQ INTIMATE PARTNER VIOLENCE: LESSONS FOR POLICY, PRACTICE, AND RESEARCH 5 (2017). Judy Porter, LaVerne McQuiller Williams, *Intimate Violence Among Underrepresented Groups on a College Campus*, 26 J. INTERPERSONAL VIOLENCE 3210, 3217–18 (2011). Mikel L. Walters et al., NAT'L CTR. FOR INJURY PREVENTION & CONTROL & CTRS FOR DISEASE CONTROL & PREVENTION, NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY (NISVS): 2010 FINDINGS ON VICTIMIZATION BY SEXUAL ORIENTATION 1–2, 18–27 (2013).

58. *Id.* at 6, 9.

59. See, e.g., *Violence Against the Transgender Community in 2019*, HUM. RTS. CAMPAIGN, <https://www.hrc.org/resources/violence-against-the-transgender-community-in-2019> (last visited Apr. 29, 2020). See also *A National Epidemic: Fatal Anti-Transgender Violence in America in 2018*, HUM. RTS. CAMPAIGN, <https://www.hrc.org/resources/a-national-epidemic-fatal-anti-transgender-violence-in-america-in-2018> (last visited May 17, 2020).

60. See, e.g., Gina Martinez & Tara Law, *Two Recent Murders of Black Trans Women in Texas Reveal a Nationwide Crisis, Advocates Say*, TIME (June 12, 2019), <https://time.com/5601227/two-black-trans-women-murders-in-dallas-anti-trans-violence/>; Petula Dvorak, *The Murder of Black Transgender Women is Becoming a Crisis*, WASH. POST (June 17, 2019), https://www.washingtonpost.com/local/the-murder-of-black-transgender-women-is-becoming-a-crisis/2019/06/17/28f8db-a6-912b-11e9-b570-6416efdc0803_story.html.

61. Dvorak, *supra* note 60.

62. MESSINGER, *supra* note 57, at 19.

63. Grace Hauck, *Anti-LGBT Hate Crimes Are Rising, the FBI Says. But It Gets Worse*, USA TODAY (July 1, 2019), <https://www.usatoday.com/story/news/2019/06/28/anti-gay-hate-crimes-rise-fbi-says-and-they-likely-undercount/1582614001/>. See also Rhissa Briones-Robinson et al., *Sexual Orientation Bias Crimes: Examination of Reporting, Perception of Police Bias, and Differential Police Response*, 43 CRIM. JUST. & BEHAV. 1688, 1690 (2016).

gender identity bias.⁶⁴ This is disproportionate to the 4.5% of the general population who report identifying as LGBTQ.⁶⁵

The UCR hate crime data collected by the FBI have been critiqued for underestimating the frequency of hate crimes against LGBTQ individuals.⁶⁶ According to Schwencke, the reasons for the lack of accurate hate crime reporting include misclassification, missed reporting, uncertainty about classification, misconceptions about hate crimes, discomfort with hate crimes, and lack of training on hate crimes.⁶⁷ The UCR reports hate crimes by the frequency of incidents, offenses, victims, known offenders, location type, and hate crime by jurisdiction.⁶⁸ When considering the impact of hate crimes on the LGBTQ community, reporting by victims is arguably the most appropriate factor, as one incident or one offender does not capture the negative impact with multiple victims (see Figure 2).⁶⁹ For example, the shooting at the Pulse nightclub in Orlando, Florida resulted in the deaths of forty-nine individuals and the injuries of another fifty-three—which demonstrates the degree of damage that one individual can inflict upon the LGBTQ community.⁷⁰ Additionally, these limited statistics on the Pulse shooting fail to show the emotional impact that the shooting had on the LGBTQ community in Florida, the U.S., and around the world.

Underreporting of hate crimes in the LGBTQ community unfortunately exists at even the most comprehensive national sources for data reporting. Considering the challenges of UCR, the National Crime Victimization Survey (NCVS), the U.S. Census Bureau's household-based survey of perceived crimes by victims, has been recommended for more accurate and detailed reporting.⁷¹

64. DEP'T OF JUSTICE, *Uniform Crime Report: Hate Crime Statistics, 2018*, FED. BUREAU INVESTIGATION 2 (2019), <https://ucr.fbi.gov/hate-crime/2018/topic-pages/incidents-and-offenses.pdf>.

65. *Adult LGBT Population in the United States*, UCLA SCH. L. WILLIAMS INST. 1 (2019), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Adult-US-Pop-Mar-2019.pdf>.

66. Ken Schwencke, *Why America Fails at Gathering Hate Crime Statistics*, PROPUBLICA (Dec. 4, 2017), <https://www.propublica.org/article/why-america-fails-at-gathering-hate-crime-statistics>.

67. *See id.*

68. *Hate Crime Statistics*, FED. BUREAU INVESTIGATION, <https://www.fbi.gov/services/cjis/ucr/hate-crime> (last visited Mar. 22, 2020). The term “victim” may refer to a person, business, institution, or society as a whole. The term “known offender” does not imply that the identity of the suspect is known, but only that an attribute of the suspect has been identified, which distinguishes him/her from an unknown offender.

69. *See* fig. 2, located after this subsection.

70. Ralph Ellis et al., *Orlando Shooting: 49 Killed, Shooter Pledged ISIS Allegiance*, CNN (June 13, 2016), <https://www.cnn.com/2016/06/12/us/orlando-nightclub-shooting/index.html>.

71. *See Data Collection: National Crime Victimization Survey (NCVS)*, BUREAU JUST. STAT., <https://www.bjs.gov/index.cfm?ty=dcdetail&iid=245> (last visited Apr. 29, 2020). *National Crime Victimization Survey: Technical Documentation*, NCJ 247252 (Sept. 2014), <https://www.bjs.gov/content/pub/pdf/ncvstd13.pdf>. The NCVS data is collected through individual interviews,

For example, a comparison of hate crime statistics from 2013-2017 shows a substantial difference in average annual hate crime victimization reports between the UCR (7,500 victimizations) and the NCVS (204,600 victimizations).⁷² Similarly, percentage of hate crime victimization specific to bias against sexual orientation was also lower for UCR (17.7%) compared to NCVS (25.7%) for the same period.⁷³ Evidence required for the NCVS to classify a crime as motivated by hate, or a hate crime, are (a) hate language used by the offender, (b) hate symbol(s) left by the offender, or (c) hate crime confirmation by police investigators.⁷⁴ A considerable limitation of the NCVS, however, is the exclusion of gender identity from the questions, which does not capture hate crimes based on gender identity for transgender and nonbinary folk.⁷⁵ Conversely, the FBI has been recording hate crimes related to gender identity since 2013.⁷⁶

The following figures and tables show hate crime statistics from 2013-2018. Data in Figures 1 and 2 and Table 1 are pulled from the UCR.⁷⁷ Data in Table 2 are pulled from the Centers for Disease Control and Prevention (CDC).⁷⁸

providing detailed data on crimes that are unreported and unrecorded—also known as the “dark figure of crime.” *Id.*

72. Barbara Oudekerk, *Hate Crime Statistics – Briefing Prepared for the Virginia Advisory Committee, U.S. Commission on Civil Rights*, BUREAU JUST. STAT. 5 (Mar. 29, 2019), <https://www.bjs.gov/content/pub/pdf/hcs1317pp.pdf>.

73. *Id.* at tbl.2 app.

74. *Hate Crime*, BUREAU JUST. STAT., <https://www.bjs.gov/index.cfm?ty=tp&tid=37> (last visited Apr. 29, 2020).

75. See *Data Collection: National Crime Victimization Survey (NCVS)*, *supra* note 71.

76. *2013 Hate Crime Statistics Methodology*, FED. BUREAU INVESTIGATION, https://ucr.fbi.gov/hate-crime/2013/resource-pages/methodology/methodology_final (last visited Mar. 22, 2020).

77. *2013 Hate Crime Statistics Table 1 – Incidents, Offenses, Victims, and Known Offenders by Bias Motivation, 2013*, FED. BUREAU INVESTIGATION, https://ucr.fbi.gov/hate-crime/2013/tables/1tabledataecpdf/table_1_incidents_offenses_victims_and_known_offenders_by_bias_motivation_2013.xls (last visited May 30, 2020); *2014 Hate Crime Statistics Table 1 – Incidents, Offenses, Victims, and Known Offenders by Bias Motivation, 2014*, FED. BUREAU INVESTIGATION, <https://ucr.fbi.gov/hate-crime/2014/tables/table-1> (last visited May 30, 2020); *2015 Hate Crime Statistics Table 1 – Incidents, Offenses, Victims, and Known Offenders by Bias Motivation, 2015*, FED. BUREAU INVESTIGATION, <https://ucr.fbi.gov/hate-crime/2015/tables-and-data-declarations/1tabledataecpdf> (last visited May 30, 2020); *2016 Hate Crime Statistics Table 1 – Incidents, Offenses, Victims, and Known Offenders by Bias Motivation, 2016*, FED. BUREAU INVESTIGATION, <https://ucr.fbi.gov/hate-crime/2016/tables/table-1> (last visited May 30, 2020); *2017 Hate Crime Statistics Table 1 – Incidents, Offenses, Victims, and Known Offenders by Bias Motivation, 2017*, FED. BUREAU INVESTIGATION, <https://ucr.fbi.gov/hate-crime/2017/tables/table-1.xls> (last visited May 30, 2020); *2018 Hate Crime Statistics Table 1 – Incidents, Offenses, Victims, and Known Offenders by Bias Motivation, 2018*, FED. BUREAU INVESTIGATION, <https://ucr.fbi.gov/hate-crime/2018/topic-pages/tables/table-1.xls> (last visited May 30, 2020).

78. SHARON G. SMITH ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION & NAT’L CTR. FOR INJURY PREVENTION & CONTROL, *THE NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY: 2015 DATA BRIEF – UPDATED RELEASE* (2018).

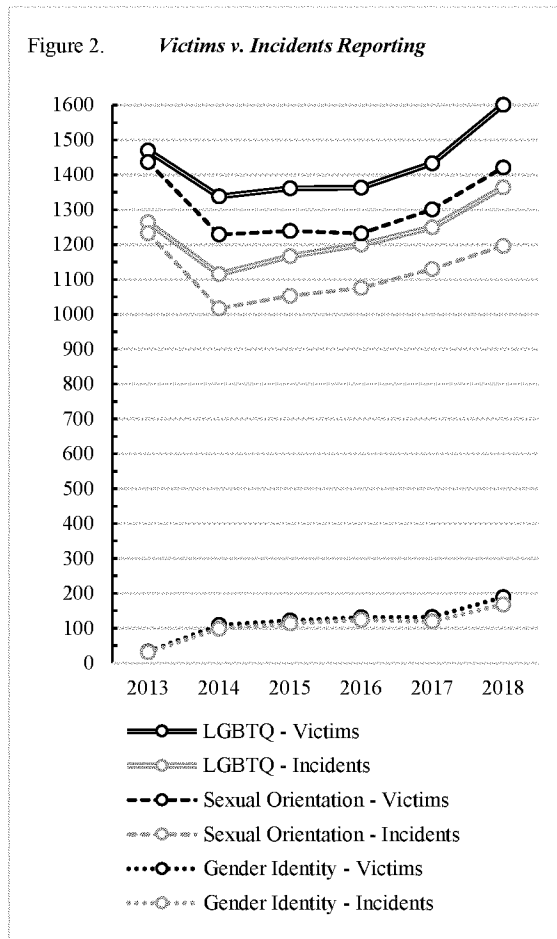
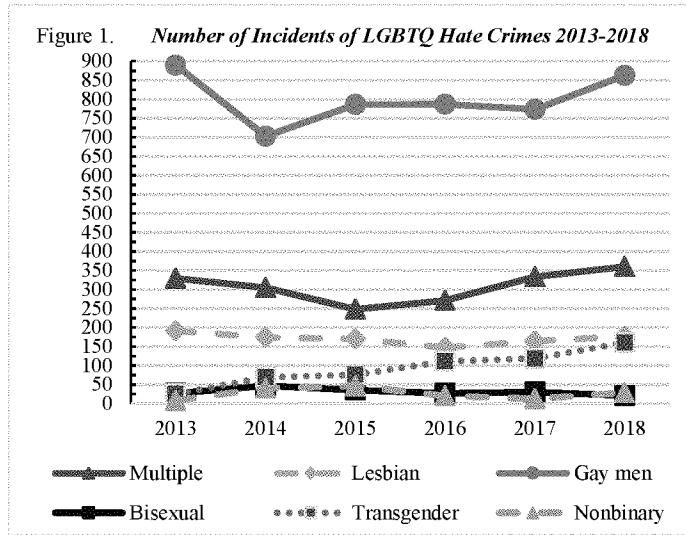


Table 1. <i>FBI Hate Crimes Statistics from 2013-2018*: Victimization by Year</i>							
	2013	2014	2015	2016	2017	2018	Mean
2018 Total	7,242	6,727	7,173	7,615	8,828	8,819	7,734
LGBTQ-related victimization	1,470	1,338	1,361	1,363	1,433	1,601	1,428
LGBTQ-related % of total	20.3%	19.9%	19.0%	17.9%	16.2%	18.2%	18.6%
Sexual Orientation*:							
Anti-Gay (Male)	1,461	1,248	1,263	1,255	1,338	1,445	1,335
Anti-Lesbian	890	703	786	787	774	683	771
Anti-Lesbian, Gay, Bisexual, or Transgender (Mixed Group)	191	174	170	147	164	177	171
Anti-Bisexual	329	305	248	271	333	360	308
Anti-Transgender	27	47	35	27	30	21	31
Gender Identity:	33	109	122	131	132	189	119
Anti-Gender Non-Conforming	25	69	76	111	119	160	93
Anti-Transgender	8	40	46	20	13	29	26
<i>Notes.</i> * Sexual orientation originally included an anti-heterosexual count, which has been excluded from this report.							

Table 2. <i>IPV Victimization by LGB Populations Compared to Heterosexuals (N=16,507)</i>					
LGBTQ sub population	<i>n</i>	Percentage**			
		Psychological Aggression ^{HBW, BL}	Rape ^{HBW, BL}	Other sexual Violence ^{HBW, HBM, HG, BL}	Any Severe Physical Violence ^{HBW, BL}
Gay men	149	59.6%	*	40.2%	16.4%
Bisexual men	89	53.0%	*	47.4%	*
Heterosexual men	7,183	49.3%	0.7%	20.8%	13.9%
Lesbian	118	63.0%	31.1%	46.4%	29.4%
Bisexual women	200	76.2%	46.1%	74.9%	49.3%
Heterosexual women	8,768	47.5%	17.4%	43.3%	23.6%
<p>* not reported by authors due to relative standard error > 30% or small cell size < 20. **Weighted response rates ranging from 27.5% to 33.6%. ^{HBM} Statistically significant differences ($p \leq .05$) between heterosexual and bisexual men. ^{HBW} Statistically significant differences ($p \leq .05$) between heterosexual and bisexual women. ^{HG} Statistically significant differences ($p \leq .05$) between heterosexual and gay groups. ^{BL} Statistically significant differences ($p \leq .05$) between bisexual and lesbian groups.</p>					

B. Description of Suicide in the LGBTQ Community

There has been growing concern around suicide in the LGBTQ community. Though behavioral health outcomes overall are disproportionate to the general population, suicide is an exponential risk for this population.⁷⁹ The LGBTQ population has seen the suicide attempt rate climb to two to three times that of the general population,⁸⁰ with particular concern about these rates among LGBTQ youth.⁸¹ The average rate of suicidal attempts among LGBTQ-

79. *Suicide Risk and Prevention for LGBTQ People*, NAT'L LGBT HEALTH EDUC. CTR. (Sept. 2018), <https://www.lgbthealtheducation.org/wp-content/uploads/2018/10/Suicide-Risk-and-Prevention-for-LGBTQ-Patients-Brief.pdf>.

80. Haas et al., *supra* note 3, at 21.

81. *Lesbian, Gay, Bisexual, and Transgender Health: LGBT Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/lgbthealth/youth.htm> (last updated June 21, 2017). *LGBT Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/lgbthealth/youth.htm> (last visited Mar. 22, 2020).

identified youth is approximately thirty percent.⁸² In addition to the microsystem factors (e.g., social support, access to affirming healthcare providers), macrosystem risk factors for suicidality among LGBTQ youth include mass media, antidiscrimination policies, and other social systems that pressure LGBTQ individuals to stay closeted.⁸³ In particular, media coverage of LGBTQ topics can contribute to intra-psychic stress.⁸⁴ Bathroom bills,⁸⁵ for example, have not been passed in any state, yet the proposed bills have created a flurry of public discourse of whether or not transgender and nonbinary identities are valid and whether or not gender identity and expression should be protected.⁸⁶

The suicide numbers are even more concerning for the transgender and nonbinary communities.⁸⁷ Research studies report the rate of suicide attempts in the transgender community to be nearly nine times that of the general population, and for Black transgender individuals, the suicide rate is nearly fifteen times that of the general population.⁸⁸ Among gender minority youth, studies suggest that as many as forty-seven percent attempt suicide at some point

82. Arnold H. Grossman et al., *Transgender Youth and Suicidal Behaviors: Applying the Interpersonal Psychological Theory of Suicide*, 20 J. GAY & LESBIAN MENTAL HEALTH 329, 329 (2016).

83. Morrison, *supra* note 54, at 44.

84. *Id.* at 44–45.

85. The collective bathroom bills began in March 2016, when North Carolina passed House Bill 2 (NC HB2). 2016 N.C. Sess. Laws 3 (repealed by 2017 N.C. Sess. Laws 4). NC HB2 was reportedly a response to several trans-affirming bathroom bills that allowed transgender individuals to use the bathroom according to their gender. Kevin Drum, *A Very Brief Timeline of the Bathroom Wars*, MOTHER JONES (May 14, 2016), <https://www.motherjones.com/kevin-drum/2016/05/time-line-bathroom-wars/>. Conversely, NC HB2 legally required transgender and nonbinary people to use the bathroom that aligned with their assigned sex at birth. Joellen Kralik, “Bathroom Bill” *Legislative Tracking*, NAT’L CONF. ST. LEGIS. (Oct. 24, 2019), <https://www.ncsl.org/research/education/-bathroom-bill-legislative-tracking635951130.aspx>. The implications of such requirements placed transgender and nonbinary people at risk of physical and mental health risks as a result of facing daily suspicion, harassment, and hostility. Bathroom bills have turned bathrooms into hostile places where transgender and nonbinary individuals face harassment, attacks, and forced removal. JAMES ET AL., *supra* note 4, at 134, 151, 228–29. At worst, being denied access to bathrooms has been linked to suicide among transgender individuals. Max Kutner, *Denying Transgender People Bathroom Access Is Linked to Suicide*, NEWSWEEK (May 1, 2016), <http://www.newsweek.com/transgender-bathroom-law-study-suicide-454185>. Though no bathroom bills have yet passed, several states have proposed such legislation. Kralik, *supra* note 85. This perpetuates an unsafe climate for transgender and nonbinary individuals.

86. Diana Ali, *The Rise and Fall of the Bathroom Bill: State Legislation Affecting Trans & Gender Non-Binary People*, NASPA (Apr. 2, 2019), <https://naspa.org/blog/the-rise-and-fall-of-the-bathroom-bill-state-legislation-affecting-trans-and-gender-non-binary-people>.

87. JAMES ET AL., *supra* note 4, at 1, 5.

88. *Id.* SANDY E. JAMES ET AL., 2015 U.S. TRANSGENDER SURVEY: REPORT ON EXPERIENCES OF BLACK RESPONDENTS 19 (2016).

in their lives,⁸⁹ and fifty-one percent experience suicidal ideation.⁹⁰ Within-group differences in suicide rates have been found among transgender and nonbinary communities.⁹¹ Transmen reported higher rates of suicide (32.1%) than transwomen (26.5%), as well as higher rates among multi-racial (57.1%) and “other” racial minorities (60%).⁹² Notably, rates of suicidal ideation were highest among younger transgender youth.⁹³ A study of transgender and gender nonconforming youth found the highest rates for suicidal ideation (73.9%) and suicide attempts (46.4%) among gender nonconforming youth who were assigned female at birth.⁹⁴

These high rates of suicidality are not surprising, given that these individuals are frequently stigmatized, marginalized, and discriminated against due to their gender identity and expression, and these individuals face opposition with the very gender role norms and expectations associated with their assigned birth sex.⁹⁵ Transgender and nonbinary individuals accordingly face unique challenges due to navigating society as their gender identity.⁹⁶

The interpersonal-psychological theory of suicide (IPTS), a desire-capability framework that provides help to understand suicidality through multiple explanations for suicidal ideation and capability to act, posits two concepts of suicidality.⁹⁷ First, suicidal ideation is created when an individual consistently and unchanged feels *thwarted belongingness* and *perceived burdensomeness*.⁹⁸ Second, long-term exposure to harmful and disturbing life

89. Asakura, *supra* note 48 at 521; Kristen Clements-Nolle et al., *HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention*, 91 AM. J. PUB. HEALTH 915, 915 (2001); Jack Harrison et al., *A Gender Not Listed Here: Genderqueers, Gender Rebels, and Otherwise in the National Transgender Discrimination Survey*, 2 LGBTQ POL’Y J. HARV. KENNEDY SCH. 13, 13 (2011–2012).

90. Johanna Olson et al., *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. ADOLESCENT HEALTH 374, 378 (2015).

91. See Peter Goldblum et al., *The Relationship Between Gender-Based Victimization and Suicide Attempts in Transgender People.*, 43 PROF. PSYCHOL. RES. & PRAC. 468, 471 (2012).

92. *Id.*

93. *Id.* at 470.

94. Grossman, *supra* note 82, at 339.

95. See generally Arnold H. Grossman & Anthony R. D’Augelli, *Transgender Youth: Invisible and Vulnerable*, 51 J. HOMOSEXUALITY 111, 111–13, 123 (2006); Emilia Lombardi, *Varieties of Transgender/Transsexual Lives and Their Relationship with Transphobia*, 56 J. HOMOSEXUALITY 977, 979–80 (2009); Audra K. Nuru, *Between Layers: Understanding the Communicative Negotiation of Conflicting Identities by Transgender Individuals*, 65 COMM. STUD. 281, 281–83 (2014).

96. Nuru, *supra* note 95.

97. Jessica D. Ribeiro & Thomas E. Joiner, *The Interpersonal-Psychological Theory of Suicidal Behavior*, 65 J. CLINICAL PSYCHOL. 1291, 1291–92 (2009); Kimberly A. Van Orden et al., *The Interpersonal Theory of Suicide*, 117 PSYCHOL. REV. 575, 575 (2010).

98. Van Orden et al., *supra* note 97, at 575.

events can contribute to higher pain tolerance and the capability to perform self-harm.⁹⁹ The stigma experienced directly and indirectly by LGBTQ individuals could arguably be described as daily exposure to discrimination and marginalization from harmful interpersonal exchanges, systemic exclusion, and erasure.¹⁰⁰

As an example, the high rates of homelessness and unemployment among transgender and nonbinary communities can contribute to negative self-perceptions, and particularly, in internalized transphobia.¹⁰¹ Though approximately seven percent of the general youth population identify as LGBTQ, a disproportionate twenty to forty percent or more of homeless youth identify as LGBTQ, indicating factors outside of their gender identity contributing to these disparities.¹⁰² By far, the primary reason for homelessness among LGBTQ youth is parental rejection.¹⁰³ Parents may doubt the validity of their child's gender identity and lack the information and resources to improve their ability to understand.¹⁰⁴ Faith-based beliefs and negative views toward LGBTQ individuals can also increase the degree of parental rejection.¹⁰⁵ Environments with a general lack of affirming information, unaddressed biases, and daily minority stressors contribute to hostile surroundings for LGBTQ individuals with deleterious effects.¹⁰⁶ This raises the question, "Who is responsible for changing social norms?"

99. *Id.* at 585.

100. Michael L. Hendricks & Rylan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 *PROF. PSYCHOL.: RES. & PRAC.* 460, 464 (2012).

101. *Id.* at 462.

102. SOON KYU CHOI ET AL., WILLIAMS INST. & THE TRUE COLORS FUND, *SERVING OUR YOUTH 2015: THE NEEDS AND EXPERIENCES OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUESTIONING YOUTH EXPERIENCING HOMELESSNESS* 9–10 (2015); NICHOLAS RAY, NAT'L GAY & LESBIAN TASK FORCE POLICY INST. & THE NAT'L COAL. FOR THE HOMELESS, LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH: AN EPIDEMIC OF HOMELESSNESS 153 (2006).

103. CHOI ET AL., *supra* note 102, at 9–10 figs.4 & 5.

104. See generally Darryl B. Hill & Edgardo Menvielle, "You Have to Give Them a Place Where They Feel Protected and Safe and Loved": The Views of Parents Who Have Gender-Variant Children and Adolescents, 6 *J. LGBT YOUTH* 243, 251–264 (2009); Caitlin Ryan et al., *Family Acceptance in Adolescence and the Health of LGBT Young Adults*, 23 *J. CHILD & ADOLESCENT PSYCHIATRIC NURSING* 205, 212 (2010); Lisa Simons et al., *Parental Support and Mental Health Among Transgender Adolescents*, 53 *J. ADOLESCENT HEALTH* 791, 793 (2013).

105. See generally Hill & Menvielle, *supra* note 104, at 244–64.

106. See generally Hendricks & Testa, *supra* note 100, at 460–67.

II. STIGMA THEORY AND PUBLIC HEALTH IMPACT

A. *An Overview of Stigma Theory*

If stigma is contributing to poor public health outcomes, including death, then understanding and eliminating stigma is a necessary public health aim. In 1963, Ervin Goffman wrote a seminal study on stigma.¹⁰⁷ He describes stigma as having an attribute that is “deeply discrediting.”¹⁰⁸ His work described how stigma created conditions for both the person and others to view the person experiencing stigma.¹⁰⁹ The work laid the groundwork for discussions of groups Goffman referred to as “normal” and those with a “spoiled identity.”¹¹⁰ The concept of a spoiled identity follows a person through all aspects of their life, from the social to the private, and ultimately takes a toll on the day-to-day lived experience of the person who experiences stigma.¹¹¹

Following Goffman’s study, other theorists provided additional detail on how stigma worked in communities. Phelan and Link conceptualized stigma as a five-part phenomenon: labeling, stereotyping, separation, loss of power, and stigmatization or discrimination.¹¹² The addition of the power component to Goffman’s work has proved compelling when considering the ways that laws are a part of, and sometimes even exacerbate, structural stigma against targeted populations.¹¹³

Stigma in public health law specifically is a growing area of research. A 2006 article by Bayer examines the use of stigma as a tool of public health.¹¹⁴ He uses smoking as an example of how stigma toward unhealthy behaviors can work to decrease the behavior in the population.¹¹⁵ Though he acknowledges the harm stigma can cause, here using the example of the gay population and HIV, he also posits that some forms may serve a public health goal even while creating ethical issues.¹¹⁶ Following Bayer’s article, Burris wrote a nuanced and thoughtful response to Bayer, reviewing the history of stigma research and its

107. *See generally* GOFFMAN, *supra* note 7.

108. *Id.* at 3.

109. *See generally id.* at 4.

110. *See generally* Brian K. Ahmedani, *Mental Health Stigma: Society, Individuals, and the Profession*, J. SOC. WORK VALUES & ETHICS, Fall 2011, at 4-1, 4-2.

111. *See* GOFFMAN, *supra* note 7, at 7-9.

112. Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 ANN. REV. SOCIOLOGY 363, 367 (2001).

113. Hatzenbuehler, *supra* note 7, at 743.

114. *See generally* Ronald Bayer & Jennifer Stuber, *Tobacco Control, Stigma, and Public Health: Rethinking the Relations*, 96 AM. J. PUB. HEALTH 47, 47-50 (2006).

115. *Id.*

116. *Id.* at 48.

use.¹¹⁷ His conclusion is clear: "...[S]tigma is a barbaric form of social control that relies upon the most primitive and destructive of emotions. And chances are that it won't work anyway."¹¹⁸

Goldberg has also been a prolific writer on stigma and public health law.¹¹⁹ After synthesizing reviews of stigma research, he concludes, "Stigma is corrosive. It is capable of inducing intense psychosocial harm. It is a risk factor for suicide. Even when controlling for every conceivable confounder, members of groups subjected to persistent stigma get sicker and die quicker than comparators. It is therefore important both as a social problem and as a health problem."¹²⁰ He also discusses the ways that social policies may serve to impact stigma but cautions that more research is needed on how these policies do or do not change attitudes and behaviors, and he advocates for additional research in this area.¹²¹

B. Stigma Theory and LGBTQ Population Health

The impacts of stigma specifically on LGBTQ populations is an important component of health inequity for the population. Meyer first discussed this concern in his work on Minority Stress Theory (MST).¹²² MST, as described by Meyer, considers the "excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position."¹²³ Meyer cites the work of Durkheim and the need for social norms versus a sense of normlessness as he discussed how minority stress can lead to the harms of suicide.¹²⁴ Meyer labels three specific processes which are important to the LGBTQ community: "(a) external, objective stressful events and conditions (chronic and acute), (b) expectations of such events and the vigilance this expectation requires, and (c) the internalization of negative societal attitudes."¹²⁵ He goes on to discuss the harm that concealing one's sexual orientation can cause.¹²⁶

117. See generally Scott Burris, *Stigma, Ethics and Policy: A Commentary on Bayer's "Stigma and the Ethics of Public Health: Not Can We but Should We,"* 67 SOC. SCI. & MED. 473, 473–75 (2008).

118. *Id.* at 475.

119. See, e.g., Goldberg, *supra* note 7, at 475–483; Daniel S. Goldberg, *What Kind of People: Obesity Stigma and Inequities*, 124 AM. J. MEDICINE 788, 788 (2011).

120. Daniel S. Goldberg, *Pain, Objectivity and History: Understanding Pain Stigma*, 43 MED. HUMAN. 238–243 (2017).

121. See Goldberg, *supra* note 7 at 476–79.

122. See generally Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 1 PSYCHOL. SEXUAL ORIENTATION & GENDER DIVERSITY. 3, 20–21 (2013).

123. *Id.* at 4.

124. *Id.*

125. *Id.* at 5.

126. *Id.*

Other scholars have built on Meyer's work, working to understand how structural stigma is impacting the LGBTQ community. Mark Hatzenbuehler is a leading researcher on this subject. His work has provided importing information on differences in suicide rates of LGBTQ youth that examines local level ecological factors,¹²⁷ the impact of anti-bullying policy on the risk of suicide attempts in gay and lesbian youth,¹²⁸ the impact of state-level policy on LGBTQ psychiatric morbidity,¹²⁹ and other important measurements of how policy and other structural level mechanisms impact LGBTQ health.¹³⁰ Additional research is needed to have a full understanding of the link between structural stigma, policy, and health outcomes.

Blake and Hatzenbuehler published a 2019 call for additional research and research tools on this topic in an article entitled *Legal Remedies to Address Stigma-Based Health Inequities in the United States: Challenges and Opportunities*.¹³¹ The article reviews the studies which have implicated antidiscrimination laws as a driver of stigma or stigma alleviation.¹³² Further, they discuss the need to better understand the enforcement of such laws and the ways that courts are interpreting the laws and the impact that can have on health inequities.¹³³ Lastly, they call for the creation of a new surveillance system of antidiscrimination laws to be used in such research.¹³⁴ Below, we will present opportunities to address some of these needs.

127. See generally Dustin T. Duncan & Mark L. Hatzenbuehler, *Lesbian, Gay, Bisexual, and Transgender Hate Crimes and Suicidality Among a Population-Based Sample of Sexual-Minority Adolescents in Boston*, 104 AM. J. PUB. HEALTH 272 (2014).

128. See generally Mark L. Hatzenbuehler & Katherine M. Keyes, *Inclusive Anti-Bullying Policies and Reduced Risk of Suicide Attempts in Lesbian and Gay Youth*, 53 J. ADOLESCENT HEALTH S21 (2013).

129. See generally Mark L. Hatzenbuehler et al., *State-Level Policies and Psychiatric Morbidity in Lesbian, Gay, and Bisexual Populations*, 99 AM. J. PUB. HEALTH 2275 (2009).

130. See generally Mark L. Hatzenbuehler, *Advancing Research on Structural Stigma and Sexual Orientation Disparities in Mental Health Among Youth*, 46 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 463 (2017); Hatzenbuehler & Pachankis, *supra* note 5, at 985–97; Mark L. Hatzenbuehler, *How Does Sexual Minority Stigma “Get Under the Skin”? A Psychological Mediation Framework*, 135 PSYCHOL. BULL. 707 (2009).

131. See generally Valarie K. Blake & Mark L. Hatzenbuehler, *Legal Remedies to Address Stigma-Based Health Inequalities in the United States: Challenges and Opportunities*, 97 MILBANK Q. 480 (2019).

132. *Id.* at 480–81.

133. *Id.* at 480–81, 492–94.

134. *Id.* at 494–96.

III. A CALL FOR INCREASED PUBLIC HEALTH RATIONALE FOR STIGMA REDUCTION IN LGBTQ ANTIDISCRIMINATION LAWS

A. *Say Its Name – An Argument for Inclusion of Anti-Stigma and Social Norm Change as a Public Health Rationale for Antidiscrimination Laws*

*“Words have power in two kinds of ways: They have power when you speak them and power when you don’t.”*¹³⁵

We assert that it is time for policymakers to include an explicit rationale for antidiscrimination law to shift social norms and lower stigma for specific populations. Even when a policy is anti-discriminatory on its face, naming the intent of shifting norms and lowering stigma matters. When the explicit rationale is named, it can serve two purposes: 1) articulating a clear public health purpose of the antidiscrimination law and 2) educating the public on the need for norm change and its public health impact.

1. Expressive Function of Law

Much has been written about an expressive theory of law, a theory that examines the “statement” made by the law, not necessarily the consequences given through enforcement of the law.¹³⁶ For example, Sunstein, in his work *On the Expressive Function of Law*, examines the ways that laws serve to change social norms.¹³⁷ He purports that antidiscrimination laws may be passed even when the specific impact on the targeted population may be unknown, writing, “The norm can do what the law would do at possibly much greater cost.”¹³⁸ He asserts that the laws “signal” what behaviors are appropriate with or without enforcement activity attached.¹³⁹

This type of signaling has been used in civil rights laws historically. The Civil Rights Law of 1964 both required enforceable behavior and acted as a signal that race-based discrimination would not be tolerated.¹⁴⁰ In *Brown v. Board of Education*, the Supreme Court appeared to endorse an expressive view of the law.¹⁴¹ In the case, the Court expressly discussed the psychological impact of a “separate but equal” approach, writing, “[t]o separate them from others of similar age and qualifications solely because of their race generates a feeling of

135. Schwencke, *supra* note 66 (quoting James Robinson, CEO of Free2Be, an LGBTQ advocacy group in Alabama).

136. See Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2021–27 (1996). See also Elizabeth S. Anderson & Richard H. Pildes, *Expressive Theories of Law: A General Restatement*, 148 U. PA. L. REV. 1503, 1506, 1532 (2000).

137. Sunstein, *supra* note 136, at 2024–25.

138. *Id.* at 2030.

139. *Id.* at 2032.

140. See *id.* at 2043–44.

141. See Sunstein, *supra* note 136, at 2022. See generally *Brown v. Bd. of Educ. of Topeka*, 347 U.S. 483, 483–96 (1954).

inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone.”¹⁴² Interpreting the law in a way that did not acknowledge the impact of stigma or social norms would not meet the aims of equal protection.¹⁴³ Adler, in his work expressing some skepticism of the idea of the expressive theory of law, writes, “There appears to be widespread agreement among constitutional scholars that race discrimination is both meaningful and wrongful in virtue of what it means—in short, that an expressive theory is at least one component of a complete theory of the Equal Protection Clause.”¹⁴⁴

While we propose the expressive intent has meaning, here the inclusion of the intent to change social norms as a public health intervention goes beyond the mere expressive intent and includes a compelling state interest in lowering the public health harms documented to be caused by the stigma and discriminatory norms themselves. As courts examine a state’s ability to enact public health legislation under the state’s police powers, the court will look at what type of interest the state has in enacting the measure and proposed response.¹⁴⁵ We suggest that naming the goal of changing social norms and directly linking it to increasing positive health outcomes for the impacted population may strengthen the state’s ability to show a compelling state interest where necessary. This concept is discussed in more detail below.

2. Public Health Purpose and Communication Function

Since *Jacobson v. Massachusetts*,¹⁴⁶ the courts have consistently held that the states can legitimately exercise their police powers to protect the health and welfare of their citizens.¹⁴⁷ Antidiscrimination laws are not new, though their rationale has neither explicitly included a public health rationale nor been framed as an exercise of police powers in this manner. The evidence of the negative impacts of discrimination and stigma on LGBTQ population health is well-documented.¹⁴⁸ An Institute of Medicine report on the health of gay, lesbian, bisexual, and transgender people acknowledged the impact of discrimination on health as it examined MST.¹⁴⁹ In Healthy People 2020, the

142. *Brown*, 347 U.S. at 494.

143. *Id.* at 492–93, 495.

144. Matthew D. Adler, *Expressive Theories of Law: A Skeptical Overview*, 148 U. PA. L. REV. 1363, 1371 (2000).

145. See generally Jorge E. Galva et al., *Public Health Strategy and the Police Powers of the State*, 120 PUB. HEALTH REP. 20, 21–22 (Supp. 2005).

146. *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25 (1905).

147. *Id.*

148. See generally INST. OF MED., *supra* note 12; Hatzenbuehler, *supra* note 130; Hatzenbuehler & Pachankis, *supra* note 5; Meyer, *supra* note 122; *Lesbian, Gay, Bisexual, and Transgender Health*, *supra* note 10.

149. See INST. OF MED., *supra* note 12, at 221–22.

CDC, for the first time, included goals for improving LGBTQ health, acknowledging the health inequities experienced by this community.¹⁵⁰ Yet states have not added language regarding the potential health impact as they have chosen to enact antidiscrimination laws for the LGBTQ community.¹⁵¹

The states' reasoning for enacting laws has an impact on their ability to withstand a challenge in court.¹⁵² Laws that provide protection to LGBTQ populations are not mandated by the federal government.¹⁵³ As states have begun to provide these protections over the last few decades, they are increasingly being challenged as an infringement of religious rights under the Free Exercise Clause of the First Amendment by persons who do not wish to provide services to the LGBTQ community.¹⁵⁴ In order to survive these challenges, a state must show it has a compelling state interest in enacting antidiscrimination protections.¹⁵⁵ As stated above, public health interest may strengthen the state's case.¹⁵⁶

The Free Exercise Clause post-1963, the year *Sherbert v. Verner*¹⁵⁷ was decided, has generally been interpreted to require a compelling state interest applied in the least restrictive means in order for a state to substantially burden a person's religious liberty. In 1990, the Supreme Court, in *Employment Division v. Smith*, ruled that when the law is one of general applicability, the courts will rule in favor of the state as long as there is a rational relationship between the policy and the state's interest.¹⁵⁸ Given what the legislature saw as a change in course for the Court, though the Court sought to distinguish this case from *Sherbert* and other earlier rulings, Congress passed the 1993 Religious Freedom Restoration Act (RFRA).¹⁵⁹ RFRA codified the requirements of a compelling state interest applied in the least restrictive means for any state action

150. *Lesbian, Gay, Bisexual, and Transgender Health*, *supra* note 10.

151. See generally HUMAN RIGHTS WATCH, "ALL WE WANT IS EQUALITY": RELIGIOUS EXEMPTIONS AND DISCRIMINATION AGAINST LGBT PEOPLE IN THE UNITED STATES 1-4 (2018).

152. See generally *Sherbert v. Verner*, 374 U.S. 398, 403, 406-07 (1963).

153. See HUMAN RIGHTS WATCH, *supra* note 151, at 1.

154. See generally Ian Millhiser, *The Fight Over Whether Religion is a License to Discriminate is Back Before the Supreme Court: Fulton v. City of Philadelphia is Likely to Deal a Severe Blow to LGBTQ Rights*, VOX (Feb. 25, 2020), <https://www.vox.com/2020/2/25/21150692/supreme-court-religion-discrimination-lgbtq-foster-fulton-philadelphia-first-amendment>. See also HUMAN RIGHTS WATCH, *supra* note 151, at 9-10.

155. See *Sherbert*, 374 U.S. at 406-07.

156. See *Emp't. Div., Dept. Human Res. of Or. v. Smith*, 494 U.S. 872, 895-96 (1990).

157. See generally *Sherbert*, 374 U.S. at 398-410. See also *Thomas v. Review Bd. of Ind. Emp't. Sec. Div.*, 450 U.S. 707, 708 (1981).

158. *Emp't. Div.*, 494 U.S. at 879-82.

159. Jeff Guo, *How Religious Freedom Law Were Praised, Hated, Then Forgotten, Then, Finally, Resurrected*, WASH. POST (Apr. 3, 2015), <https://www.washingtonpost.com/blogs/govbeat/wp/2015/04/03/how-religious-freedom-laws-were-praised-then-hated-then-forgotten-then-finally-resurrected/>.

substantially burdening a person's religious liberty.¹⁶⁰ This Act created specific protections for religious freedoms, which are designed to protect persons from state action infringing on their deeply held religious beliefs.¹⁶¹ Though originally used to challenge state-level laws, the Court held in *City of Boerne v. Flores* that RFRA is only applicable to the federal government.¹⁶²

Since *Boerne*, twenty-one states have passed their own version of RFRA.¹⁶³ Initial states passed state RFRAs reflective of the federal version.¹⁶⁴ Importantly, later states began drafting their RFRAs specifically to allow persons to refuse to provide services to the LGBTQ community if they invoked a religious objection to providing such services.¹⁶⁵ Following *Elane Photography, LLC v. Vanessa Wilcox*, a 2013 case where the New Mexico Supreme Court found that a photographer could not use her religious beliefs to deny services to a same-sex couple because the photographer's actions were in violation of the state of New Mexico's antidiscrimination law,¹⁶⁶ states pointed to this case and the need to protect persons' ability to practice their religious liberties in the way they felt necessary.

Notably, in 2015, Indiana worked to pass a broad religious freedom act that received nationwide attention.¹⁶⁷ The law, signed by Governor Mike Pence in March 2015, was viewed by some as a license to discriminate.¹⁶⁸ Boycotts by

160. See generally Religious Freedom Restoration Act of 1993, 42 U.S.C. §§ 2000bb–2000bb-4 (2018).

161. See *id.* §§ 2000bb-1, 2000bb-3.

162. *City of Boerne v. Flores*, 521 U.S. 507, 531–532, 536 (1997).

163. *State Religious Freedom Restoration Acts*, NAT'L CONF. ST. LEGISLATURES (May 4, 2017), <https://www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx>.

164. See, e.g., Mississippi Religious Freedom Restoration Act, MISS. CODE ANN. § 11-61-1 (2020); Alabama Religious Freedom Amendment, ALA. CONST. art. I, § 3.01 (2018); Virginia Religious Freedom Restoration Act, VA. CODE ANN. § 57-2.02 (2020).

165. See, e.g., TEX. CODE ANN. § 110.009 (2020) (explaining that the protection of religious freedom is “in addition to” those protections provided under federal and state law). See also EMILY LONDON & MAGGIE SIDDIQI, CTR. FOR AM. PROGRESS, RELIGIOUS LIBERTY SHOULD DO NO HARM 13 (2019), <https://cdn.americanprogress.org/content/uploads/2019/03/29073132/Religious-Liberty-report-6.pdf> (explaining that the RFRA is not intended as a tool to discriminate, and states should add language in their RFRAs such as that included in Texas's statute).

166. *Elane Photography, LLC v. Willock*, 309 P.3d 53, 62–63 (N.M. 2013).

167. See generally Tierney Sneed, *5 Lessons from the Indiana 'Religious Freedom' Law Debate*, U.S. NEWS (Apr. 2, 2015), <https://www.usnews.com/news/articles/2015/04/02/5-lessons-from-the-indiana-religious-freedom-law-debate>; Jack Linshi, *What You Need to Know About Indiana's Controversial Religious Objections Law*, TIME (Mar. 30, 2015), <https://time.com/3762656/indiana-religious-objections-law/>.

168. See generally Campbell Robertson & Richard Pérez-Peña, *Bills on 'Religious Freedom' Upset Capitols in Arkansas and Indiana*, N.Y. TIMES (Mar. 31, 2015), <https://www.nytimes.com/2015/04/01/us/religious-freedom-restoration-act-arkansas-indiana.html> (highlighting Mike Pence addressing concerns that the law was “never intended to give a ‘license to discriminate’ against gay and lesbian couples.”).

artists and sports teams were immediate.¹⁶⁹ Business leaders made their concerns known.¹⁷⁰ Within a month, the governor signed an amendment clarifying that the bill was not to be used to discriminate on the basis of sexual orientation or sexual identity.¹⁷¹ Following the amendment, some religious leaders expressed concern that the bill had been watered down, while others supported the changes.¹⁷² Regardless of an individual's feelings about the laws, it is clear that for some, these bills are of specific concern to the LGBTQ community. Given the concern that state and federal RFRA laws may be used in a way that will harm the LGBTQ community, any laws meant to protect the LGBTQ community would be well advised to do everything possible to protect against possible RFRA challenges.¹⁷³

Would the Court view a state goal of changing social norms as infringing on the free expression of a person's religious beliefs if their beliefs go against the norm that the state expressed? Alternatively, would it strengthen the state's case, making the change of stigma and discriminatory beliefs a more compelling interest, if the state specifically linked the change to increase health and safety for the impacted group?

As Sunstein reasons, constraints on government action are applicable in antidiscrimination policy as with other laws.¹⁷⁴ He writes, "If government tried to change social norms so as to ensure that everyone is a Christian, it would violate the right to religious liberty; if government tried to change social norms so as to ensure that women occupy domestic roles, and men do not, it would

169. See Mary Ann Georgantopoulos, *Boycott Against Indiana's Religious Freedom Law Grows Across U.S.*, BUZZFEED NEWS (Apr. 1, 2015), <https://www.buzzfeednews.com/article/maryanngeorgantopoulos/here-are-the-celebrities-businesses-and-governments-boycotti>; German Lopez, *How Indiana's Religious Freedom Law Sparked a Battle over LGBT Rights*, VOX (Apr. 2, 2015), <https://www.vox.com/2015/3/31/8319493/indiana-rfra-lgbt>.

170. *Id.*

171. See Lopez, *supra* note 169.

172. See generally Tony Cook & Tom LoBianco, *Indiana Governor Signs Amended 'Religious Freedom' Law*, USA TODAY (Apr. 2, 2015), <https://www.usatoday.com/story/news/nation/2015/04/02/indiana-religious-freedom-law-deal-gay-discrimination/70819106/>.

173. It is important to note that there are legitimate uses of state RFRA claims that have nothing to do with the LGBTQ population. Lund discusses the concern of "throwing out the baby with the bathwater" writing, "In the last five years, six more states have adopted state RFRA claims, and in each case the *Elane Photography* issue was part of the debate. But Indiana was different. Now the debate seems to have nothing else left in it. One side sees *Elane Photography* as the *raison d'être* for state RFRA claims; the other side sees it as the *bête noire*. But on both sides, *Elane Photography* is all that matters. An unfortunate consequence is that all the other kinds of state RFRA claims—including the sympathetic ones mentioned here—have gotten completely lost in the shuffle. For those interested in protecting free exercise without protecting the claim in *Elane Photography*, there are several options going forward. The first is the simplest and probably the best—one can, by statute, simply exclude for-profits. There is nothing path-breaking about this suggestion." Christopher C. Lund, *RFRA, State RFRA Claims, and Religious Minorities* 53 SAN DIEGO L. REV. 163, 182 (2016).

174. See Sunstein, *supra* note 136, at 2048–50.

violate the Equal Protection Clause.”¹⁷⁵ Making it clear that the goal of social norm change is to protect and improve the population’s health may make the state’s case stronger in enforcing antidiscrimination laws. There is reason to believe that changes in policy specifically to support changes in behavior and beliefs can impact population health. For example, in a 2013 study, Krieger et al. examined Black infant mortality rates in relation to the abolition of Jim Crow laws.¹⁷⁶ The study compared Black infant mortality rates in states with and without Jim Crow laws before and after the laws were abolished. In the longitudinal examination of infant mortality rates, rates for Black infants improved in states with previous Jim Crow laws with “no comparable temporal patterns in Jim Crow birth cohort effects occur[ing] among White infants or... evident in Black versus White comparisons within these policies.”¹⁷⁷ More studies of this kind will help to answer the question of correlation versus causation in structural stigma.

More research regarding the public health impact of antidiscrimination laws on the LGBTQ community will strengthen any assertion of a public health imperative. The work of Hatzenbeuhler and other public health law scholars examining stigma will be an important component of ensuring meaningful inclusion of effective public health aims in these laws.

IV. POTENTIAL IMPLICATIONS FOR LGBTQ PUBLIC HEALTH RESEARCH

A. *LGBTQ Legal Epidemiology Project*

Given the relatively recent research on measuring the health impacts of anti-stigma law in general, and on the LGBTQ community in particular, more work is left to be done. To that end, data on laws and policies impacting the LGBTQ at the state and local levels will be needed. Currently, the public health community is working to increase the data collected regarding the sexual orientation and gender identity of persons on whom health outcomes data are collected.¹⁷⁸ The CDC is driving this work with Healthy People 2020.¹⁷⁹ In order to be able to examine these data in comparison with the laws and policies, more information is needed.

We are working to fill this need. Often, legal data collection contains information on where laws do and do not exist with some comparison between those jurisdictions. In order to consider the impact of laws on health outcomes data at the population level, information regarding enforcement mechanisms,

175. *Id.* at 2049.

176. See generally Nancy Krieger et al., *The Unique Impact of Abolition of Jim Crow Laws on Reducing Inequities in Infant Death Rates and Implications for Choice of Comparison Groups in Analyzing Societal Determinants of Health*, 103 AM. J. PUB. HEALTH 2234, 2234–2244 (2013).

177. *Id.* at 2237.

178. See generally *Lesbian, Gay, Bisexual, and Transgender Health*, *supra* note 10.

179. *Id.*

implementation dates, preemption, and other granular data must exist, and in a way that researchers can access it and use it in their work. In conjunction with the CDC Public Health Law Program, we are working to collect information on state-level laws and regulations covering sexual orientation and gender identity using legal epidemiology methods.¹⁸⁰ We will also collect information on state-level RFRAs. This information will be important for researchers who seek to examine the impact of laws on health outcomes for the LGBTQ community. Currently, some excellent programs disseminate information on LGBTQ laws.¹⁸¹ None, however, provide the level of detail needed to do the kinds of comparisons that will allow for a thorough analysis of the impact of laws, including which provisions of the laws appear to be most useful to improving LGBTQ health.

B. *Additional Considerations for Research*

As research moves forward, it will be important to consider the limitations to what we currently know and how we can improve knowledge on this topic. As stated above, researchers like Hatzenbuehler, Burris, and Goldberg are doing groundbreaking work in the area of structural stigma in the field of public health. There is a substantial collection of research that shows that stigma has a negative and pervasive impact on health. Furthermore, there is an increasing body of work that suggests structural stigma is a part of this process. The measurement of and research on structural stigma remain in their early stages. It will be important to distinguish between places where the policies are more favorable to the LGBTQ population, because in these places, societal attitudes are already generally supportive toward this population. Thus, in these places, policies can serve as tools to further favorably impact the beliefs and behaviors of the states' populations.

V. CONCLUSION

A call for action toward collective consciousness of daily discrimination and public health disparities faced by marginalized populations cannot be ignored. As described above, the cultural climate is influenced by the policies that are proposed and passed. These policies provide guidance for what is socially and legally acceptable and what is not, as reflected in evolving antidiscrimination laws. Given both the political reality embodied in discussion around RFRA laws

180. For more information on the legal epidemiology method, see *Theory & Methods*, TEMPLE U. CTR. FOR PUB. HEALTH L. RES., <http://publichealthlawresearch.org/theory-methods> (last visited May 30, 2020). See also *Legal Epidemiology*, CHANGE LAB SOLUTIONS, <https://www.changelab solutions.org/good-governance/phla/legal-epidemiology> (last visited May 30, 2020).

181. See, e.g., UCLA SCH. L. WILLIAMS INST., <https://williamsinstitute.law.ucla.edu> (last visited May 22, 2020); MOVEMENT ADVANCEMENT PROJECT, <https://www.lgbtmap.org> (last visited May 22, 2020).

and the data regarding alarming LGBTQ health inequity, we assert that innovation in how laws are designed to ensure protection is essential. Public health imperatives are a reasonable use of the state's police powers and may serve as one way to help states provide the antidiscrimination policies needed to make positive changes for the states.