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From the campus of Harvard Medical School, this is *ThinkResearch,* a podcast devoted to the stories behind clinical research. I'm Oby.

And I'm Brendan, and we're your hosts. *ThinkResearch* is brought to you by Harvard Catalyst, Harvard University's clinical and translational science center.

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Throughout history, systematic and institutional barriers have blocked access to basic human rights for people of color, LGBTQ communities, and more. As years go by and the discourse changes, some barriers are taken down, but replaced by others. However, racism, prejudice, and discrimination are still woven throughout our laws and policies today.

On this episode of our community engaged series, Dr. Bryn Austin of Boston Children's Hospital is joined by civil rights advocates Rahsaan Hall and Janson Wu to discuss the discriminatory laws that harm gender and racial minorities. Dr. Austin, thank you for joining us. Welcome.

Thank you. It's a pleasure to be here.

So we're here to talk about a pilot grant that you were recently awarded. And we're also joined by two of your collaborators on the grant. So I was going to ask, Rahsaan and Janson, if you could both introduce yourselves.

My name is Rahsaan Hall. I'm the Director of the Racial Justice Program for the American Civil Liberties Union of Massachusetts.

Hi I'm Janson Wu. I'm the Executive Director of GLAD, which stands for a GLBTQ Legal Advocates and Defenders here in Boston.

So, Dr. Austin, as I mentioned, you received a pilot grant to look at state laws in the US and how they impact health outcomes across LGBTQ and racial minority populations. Can you tell us how you aim to do this?

We've known a long time that there are health disparities, widespread health disparities, affecting the LGBTQ community and racial ethnic minority communities. But what we haven't had is how does this larger climate, in many areas of the country, of stigma and discrimination affecting the health of sexual and gender minorities. And how are positive changes perhaps improving the health? And that's the question that we set out to answer with this study.

What are the specific outcomes that you're looking at?

We're looking at outcomes having to do with physical health and mental health in a whole range of areas that could have to do with depression, anxiety. It could include HIV infection, asthma, eating disorders. All of these areas, we have a sense, may be affected by the kinds of stressors that LGBTQ populations and racial ethnic minorities-- and particularly when you bring those together, sexual and gender minorities who are people of color.

We want to look at a variety of health outcomes and look back at what folks' experience was in the larger community around discrimination and perhaps protective laws and how that might be affecting their health.

So, Rahsaan and Janson, could you tell us what are some examples of discriminatory laws that exist in this country that would affect the population that you're looking at, that, Dr. Austin, you're looking at in the study?

Part of it is understanding what we're talking about when we say discriminatory laws. Because a lot of the laws, as a constitutional matter, are not racially discriminatory on their face. It's the outcomes of the laws. And so when people are talking about structural and institutional racism, it is these race-neutral laws that have disparate impacts on communities of color.

And so looking at stand-your-ground laws that enable the person to defend themselves in their home or sometimes in the street with a weapon when they feel threatened. Or mandatory minimum sentences for any number of offenses, but particularly for drug offenses. So those are some of the things that we look at when we're thinking about the discriminatory outcomes of racially neutral laws that disproportionately impact communities of color.

And for the LGBTQ community, we've been working decades to overturn the last of the targeted anti-LGBTQ laws that do exist on the books, such as laws criminalizing same-sex sexual intimacy and laws prohibiting openly gay teachers from teaching in schools. I mean, these are the laws we've been working for decades to overcome and overturn.

One of the clearest examples I can think of this is the laws that prohibited LGBTQ people from becoming adoptive parents or foster care parents. And only up until very recently, these laws were on the books. But then, as Rahsaan was saying, then there's also just laws that have a disparate impact on LGBTQ people, such as laws that only recognize families based upon genetics or biology and don't take into account how LGBTQ families are formed.

And then there's also just an absence of affirmative protections for LGBTQ people, such as basic non-discrimination protections in jobs, in housing, and in public spaces that we're still fighting for across the country.

So, Rahsaan, you mentioned stand-your-ground laws as an example of a law that's not discriminatory on its face but has discriminatory effects. How does that work?

Sure. I think a perfect example is the situation of Trayvon Martin, the young black child who was murdered by a community watchman claiming that he was standing his ground, that he felt that he was under attack. Or the young man who was killed in Florida because he was playing music too loudly in his vehicle, and the person who killed him felt that the young man and his friends-- thought he saw a weapon. And so he was entitled, under the law in Florida, to use deadly force.

And those are problematic in that they are disproportionately applied when the defendant is white, less likely applied when the defendant or the person accused of the violent crime is a person of color, particularly a black person. It starts from when the police make charging decisions to what the prosecutors decide to do. And then, also, it creates an opportunity for race to influence not only the police and the prosecutors, but also the jury pool in determining whether or not the stand-your-ground law is applicable.

How exactly do these laws impact health outcomes, whoever wants to chime in? And maybe, Dr. Austin, if you could give us some information about any-- is there any literature linking these laws to health outcomes? Or either of you, if you have any.

Yeah. There's a growing literature looking at specific laws. Where there's the most research are laws around marriage equality, where there have been studies that have looked at how has mental health of LGBTQ people changed before and after either a positive change in the law-- looking back, for instance, in Massachusetts some years ago, when same-sex marriage was made legal. Or looking at how the impact may be negative in many states over the last decades, where there was major discriminatory organizing to ban marriage equality.

And with that research, we've seen a strong signal of negative impacts on mental health of LGBTQ people in states where there was a lot of organizing to push through discriminatory laws. And we see some protective effect-- when Massachusetts was the first state to go forward with marriage equality, we saw protective effects. But that's just one type of law.

What there has never been before is a comprehensive study that looks at the whole universe of laws, the whole climate. Because states will have many, many laws that can affect LGBTQ people and laws with at the intersection that affect racial and ethnic minority communities and then people of color in LGBTQ communities.

Nothing comprehensive has been done. So sounded like a big challenge to take on, so Rahsaan and Janson, we're up for it, and our other colleagues. And we decided we're going to be the ones to do that. And we set out to create the most comprehensive databases on LGBTQ state-related state laws, whether discriminatory or protective, and then also racial justice laws at the state level, covering two decades period every year, updated across the whole United States in every state.

That's our goal, is putting together the most comprehensive databases. What there has been available is one law documented in every state over a couple of years or some databases that will cover part of this around racist laws and capturing some of that. But no databases we could find were comprehensive enough for us to be able to fully explore and understand the experiences, particularly of sexual and gender minorities of color. And that's what we set out to do and have made great progress on that. Thank you to Harvard Catalyst, to be able to begin that work.

Was there anything, Rahsaan or Janson, you wanted to add in terms of the health outcomes?

I think particularly when we're talking about policing and the criminal legal system, in general, the physical and psychic impact that involvement in these systems have on people who are overwhelmingly poor compounds some of the existing environmental issues that people are dealing with, the already existing health issues that folks may have. And so, for instance, with mandatory minimum sentences for drug offenses, that takes all the discretion away from a judge.

And so a judge could look at a situation and see, like, here's someone who was suffering from substance use disorder. And the prosecutor, because they have the leverage of a mandatory minimum sentence, is saying, I'm not going to break this down. And this person is going to be forced to either take it to trial and serve a mandatory minimum sentence or accept a bargain that I offer, which many times includes some form of incarceration. There are studies that show, here in Massachusetts, that people who suffer from opioid use disorder are 120 times more likely to die of an opioid-related overdose death after being released from incarceration.

And so when you think about the racial disparities and who is incarcerated, who's charged with and convicted of mandatory minimum offenses, it skews heavily towards people of color. Black and Latinos make up roughly 25% of the state's population. We make up 75% of the people who are serving sentences on mandatory minimum drug offenses. And so to think within that population, there are people who are struggling with substance use disorder, disproportionately, they're going to have worse health outcomes when they're released.

That's separate and apart from whatever kind of conditions, communicable diseases, trauma that people experience inside of these facilities and incarceration. And then the stress of just living in a community that is over-policed, where people are randomly subjected to being stopped and frisked by the police, in many instances for no reason at all.

You know, I think Rahsaan made a really good point in kind of talking both about the physical harms as well as the stress that impacts vulnerable communities. You know, I think about that in terms of tangible harms and kind of dignitary harms. And for LGBTQ people, that's really true. So if we're thinking about tangible harms, if you aren't protected from being evicted because of your sexual orientation or your gender identity, then that's a health issue, if you're housing insecure.

If you can't find employment because of your gender identity-- we know that transgender people are four times more likely to make less than $10,000 a year. That's a health issue, right? But we also know that there is harm from just the stigma, the dignitary harm of being targeted by your own government. And so when you think about recent and current policies and laws that exclude public insurance coverage for transition-related care, including hormones and surgery for transgender people-- and it's a very targeted exclusion of a vulnerable population for necessary health care that is then deemed either elective or cosmetic.

And to have your own government say that your identity is somehow cosmetic has its own stress that impacts transgender people, as well, too. And so we see the outcomes. We see the disparities when it comes to mental health-- depression, suicidality, drug use-- as a result of the dignitary harm.

And you mentioned that-- so you're building this database, comprehensive database, looking at all the laws across the country that fit into this category of discriminatory-- or how would you describe the category of laws that you're looking at? Is there like a term for-- is it just discriminatory laws, or it's just you're evaluating laws based on how they operate?

Well, I can tell you a little bit about our process for creating the databases. We sat down with experts, like Janson and Rahsaan, and also pored over legal textbooks of how is racial justice law or civil rights taught in law schools, and how is LGBTQ rights taught in law schools, to see what domains they identified. And the domains, some are overlapping, and some are very different.

So we put together these databases by reviewing what is known in the civil rights literature and the LGBTQ rights literature and the racial justice literature, what domains. And we have about 10 domains in each database. And then the specific laws are listed under there. We worked with legal specialists at Northeastern University and at Columbia University and at Harvard and then, of course, with the ACLU and with GLAD to put together the most comprehensive and rigorously designed databases that we could get on these types of laws.

We were restricted to state level. We made that choice. Certainly, there are laws happening at the city level, the federal level, and then administrative type rulings that could be important, also. Our database is focused on the state level as a starting place. If we have the opportunity to expand our databases further, we would include a lot more. Because we know that there's many different ways that laws and policies at multiple levels affect the conditions of people's lives.

Right. So you needed that legal expertise to sit down and kind of comb through and read the literature and get that perspective on how to sort these laws into different domains.

Yeah, to put together databases like this, we absolutely needed a legal expertise. Public health experts, medical experts wouldn't have the right expertise to be able to read the legal literature. We hired folks at Northeastern University, at Columbia and Harvard to work with us and spend the hours, days, weeks, months combing through the legal databases of laws all over the country and going back 20 years to be able to create this database for us. So it's a very interdisciplinary team was required to be able to do the work that we're doing now.

Can you talk about why it's important to collect this kind of data and how you use it as advocates in your work at GLAD, Janson, and your work with the ACLU, Rahsaan?

I think there is this-- particularly when we're talking about racial justice, there is this desire of people in positions of power to deny that there are issues with race. I'd like to say that, for example, we here in Massachusetts struggle with liberal exceptionalism. We think that because we are the first state to pass same-sex marriage or that we were one of the early abolitionist states or that because we overwhelmingly vote for the Democratic candidate in presidential elections that we don't have these other issues.

But when you look at the gross racial disparities in educational outcomes, in wealth, in incarceration rates and policing, it's hard to say that there are not issues around race here. And so in doing the advocacy to really get policy change-- it's one thing, for me, as an advocate, to say, here is a law that needs to be changed, or here's a law that needs to be implemented, because it will have beneficial outcomes for people in communities of color, people who are living in poverty or on the cusp of poverty.

But it's another thing to have the data that supports that. I recall, as an advocate, pushing for legislative reform to some of the criminal laws. And legislative session after legislative session, we were told that it really couldn't move forward, because the legislators wanted to be sure that the proposals that were being implemented would actually work. And so they wanted to see some sort of analysis. And the way that you conduct this analysis is through research and through data.

And so it's beneficial to have a database like this, where the data is available to make the arguments as to why health outcomes are impacted by these discriminatory laws and why some of these laws need to be changed, eliminated, or protective laws need to be enacted.

And I'll maybe even be blunter than Rahsaan was. In terms of the really tough social justice issues of our time, LGBTQ rights, on racial justice, legislators would like nothing more than to not have to do something, right? They have to be forced to see that there is a problem, that there is harm to our communities first before they will act. And so one of the reasons why collecting just the datas on disparities is to show there is something wrong happening. This isn't happening by accident, and you legislators have a role in fixing that.

But just showing those negative disparities is not enough. And let's just be clear, these negative disparities in the LGBTQ populations and communities of colors, and especially if you combine them together, are profound. And so I'll speak specifically about LGBTQ youth for a second in terms of the high suicidality rates, levels of depression and anxiety that we see, which we believe is not an accident, but is a result of a whole cycle of challenges that they face from family rejection to being targeted by both their peers, as well as administrators in the schools, leading to involvement with different state institutions that are inadequate and ill equipped to support those identities.

We believe all that together is leading to these negative disparities for LGBTQ youth. But if we don't do the work that Dr. Austin is doing to connect that to the discriminatory laws-- and our opponents will do the exact opposite. And so one example that I've been noticing more and more recently is that our opponents of LGBTQ rights are actually using this data on negative disparities against us. And they're actually saying, you know, actually, the reason why there's high levels of suicidality amongst LGBTQ youth is because these identities are disordered, and they are unhealthy. And the last thing that government should be doing is supporting the creation of these identities.

I was in a hearing recently in New Hampshire on a bill that would have banned the discredited use of so-called conversion therapy on young people. This is abusive practices that have been denounced by all the major medical associations who try to change a person's sexual orientation and gender identity. And one of the things I pointed to was the suicidality rates of LGBTQ youth, particularly when they are subjected to conversion therapy. And the other side's argument was, actually, we're trying to save them.

So their argument is that suicidality, depression is a result of these identities. We're trying to change their identity to eliminate these negative outcomes.

Exactly.

And that's quite a pernicious argument on their side to do that, but it also points to a limit of prior research that just looked in the very small bubble around sexual minority youth as an example of what's happening with them maybe with peers, with family, and in their own mental health. What we are doing is expanding out the vision, the scope of what's happening in the larger environment with discrimination and harassment stigma. And how with these larger forces-- that government should take responsibility for what's happening in the law and policy, absolutely.

What's happening with them and connecting the dots all the way to the higher suicide rates or the mental health struggles of sexual minority youth, particularly in discriminatory environments. Now, Janson had mentioned the idea that one type of injustice relates to what he called dignitary, or the dignity-- being disrespected, treated as second-class citizens-- and how that affects LGBTQ people, how it affects racial and ethnic minorities and communities of color, sexual and gender minority communities of color.

Now, we can't direct connect the dots now, in a larger sense, through the medical physiological research, too. So there's the stressor of being treated as a second-class citizen, the stressor of being deliberately isolated and shunned from your family and your community. There's a loss of dignity there, but we can trace the effects of that all the way through the physiological impacts of that kind of discrimination and stress so that we know from other research that this kind of mistreatment against different groups can lead to higher risk of heart disease, higher risk of diabetes, higher risk of unhealthy weight gain, other kinds of mental health responses.

What it does, physiologically, is puts the stress response, our fight or flight response, it puts it into overdrive in a constant basis when people are living in such a stigmatized and harassing environment, discriminatory environment. When your stress response, the physiological stress response, is put into overdrive on a long-term basis, that just wreaks havoc on all systems of the body.

So we know, from other literature, that these are likely to be very connected. We haven't connected all of the dots for sexual and gender minorities, but we have collected connected a lot of them. And through this additional research with these very comprehensive databases, we're looking to see what are all the pathways that are leading to these really abhorrent health differences and disadvantages in these communities so that we can come up with leverage points, develop leverage points, whether it's advocates like Rahsaan and Janson and the teams they work with, or it's people designing health care systems or other ways.

We want all of that kind of programs and interventions and changes in law to be evidence based. And we're producing the evidence to do that.

Was there anything you wanted to add, Rahsaan?

I did, just about the importance of this work, especially in the public health space. Dr. Nancy Krieger, who's over at the School of Public Health, her and some colleagues issued a paper of structural racism and health inequities in the US. And one of the things that they looked at was a web science search that looked at the term race in conjunction with health or disease or medicine or public health. And there were 47,855 articles that were retrieved. But when race was replaced by racial discrimination, there were only roughly 2,000 articles that were located, and only 1,996 were found when the term racism was used.

And so that goes to this notion of this reluctance to really get to the root causes of what is a source of some of the health disparities that we're looking at, especially when we're talking about people of color. And then, from an intersectional lens, of LGBTQ people of color. And so I think this database and this research is a very significant and very important, because it begins to shift the narrative. It's not that people are just unhealthy or live high-risk lifestyles, and therefore, they have these adverse outcomes. But there are these structural and institutional barriers to people's health that also contribute to actual physical as well as mental health decline.

What have some of the challenges been that you faced putting this database together, with trying to get all this collaboration moving forward? Have you run into any roadblocks or issues that you didn't anticipate?

Well, finding funders to support the work is challenging when you're doing something that's in a new area, but thank you to Harvard Catalyst. We were able to get a lot of work done, and we will certainly continue to expand the work with more funding. I would say one of the really interesting ways, when you're bringing disciplines together and trying to do a joint project together-- one question that came up when we were working with the legal researchers-- in law school, they are trained to get at every nuance of the law. All kinds of detail, writing paragraphs and paragraphs, might describe a single law and how it's administered.

And then in the health research, when we're doing work with big databases and using the methods that we have in the health research, we want that boiled down to zeros and ones, down to a very concrete and limited and finite set of ways of characterizing a law-- not in paragraphs, not with all of the nuance, so much. But something that we would be able to then do analyses with tens of thousands, hundreds of thousands or more records in big database type research.

So that was actually kind of like speaking different languages and bringing the teams together of how do we make sure we're capturing everything we need to know about each of these laws. Because none of them are really simple yes or no, on or off, implemented in the same way everywhere or not. All of them are more complex than that. But we needed to be able to link them in all of the methods that we use for the health research.

But we did. We sat down, and we talked it through. We talked it through how to code this law or that law and whether to capture a nuance, or was that going to be maybe too much of the fine grain that we would need for the health research. But in general, I'd say everybody was so on board. Every single person on this project was 100% committed.

We talked through where there was differences in the kinds of language or ways we approach defining questions in law and in public health, in medicine. We talked it through and came up with this really solid, comprehensive-- really the most comprehensive databases there are to date. So I'd say those were easy problems to work through.

Dr. Austin, what work still needs to be done to kind of finish out this first part of the project? I know that you want to expand to capturing more laws, but what do you still have to do in this phase?

Well, the work to be done is along a couple of different lines. One of them is to continue and expand how we're linking the databases to major national databases that have years and years of health experience already captured in a cross-section of American society-- some with data from youth, some with data from nationally representative databases across communities of color. And linking that with health services utilization or delays in care with diagnoses and other aspects of life experience, including employment, income, a lot of different kinds of issues that have come up in this conversation.

So we've had many years of work to do that, and we're well on our way to do that work. We also want to expand the databases to continue to update them as laws change progressively in the country and to also expand them going back in time, also. We've got 20 years, but we could go back further. And we have all the methods worked out on how to do that. It's just a matter of implementing it that way.

And then a third line is connecting with community organizations and other research groups to make our databases available widely. We will make them freely available once we're done putting them together. At Temple University, they have the premier outfit for legal epidemiology, which is where this study fits into that realm, there in that field, legal epidemiology. They have a publicly available database called LawAtlas, where they will put legal databases that are used in health research up for anyone to use.

And that's the direction that we will take with these. So it could be used by advocates, who would not be doing the kinds of health analysis we would do. But it could also be used by peers of ours in the scientific community to look at some different health questions. All of that we have mapped out and plans to move forward on that, and we're doing the work as fast as we can. And we will continue, as laws change and as new databases become available, to connect with the health outcomes, the health experience, and also economic outcomes with what's happening at the state level across the country.

So you mentioned that you hope the scientific community will use these databases, as well. Are there any other ways that you hope the databases will be used? And Rahsaan and Janson, feel free to chime in, too. Once this project is completed and as it continues to evolve, how do you hope these databases will be used?

Well, I hope that as legislators and policymakers understand that discriminatory laws hurt people's health and laws that affirm and protect communities improve those outcomes, that we'll see our laws and policies moving in a more positive direction. One area that I think would be great to-- as we think 10 years later from now-- see what the impact has been is around school curricula with LGBTQ identities.

So it's interesting. Tomorrow, actually, we're having an organization coming to GLAD's office to talk about their work creating LGBTQ-inclusive curriculum modules for teachers to use. And there is now a growing demand from schools and teachers to actually be able to incorporate LGBTQ history, not as a separate topic. But of course, yes, people should understand about the LGBTQ rights movement. But just incorporating it into the classes on literature and history and civics.

And we're starting to see some states-- not many, but some states-- start to encourage inclusive curricula. I'd love to see, 10 years from now, what impact that makes on the healthy development of self-esteem for LGBTQ young people. I think that positive impact could be really profound, for them to just know from the start from their families, from their schools, from their teachers that their identities are included as a healthy component of our civic society.

You know, I think it's valuable to have this data and this research to go along with the anecdote. I've got anecdotes for days about racial profiling. I've been racially profiled myself. I can tell legislators about that. But it's another thing to say, it's not just a one-off. It's not just my own personal experience. Here is a data set that shows it.

And then to take it a step further, if we begin to examine the health outcomes of racial profiling and what that has done to people and to communities. And particularly when you look at the significant health disparities that exist, as well as other disparities in community. It creates a significant shift, at least in my mind. And my hope is that it will create a significant shift in the conversation about race and racism in this country, that it's not just interpersonal racism. It's not somebody calling me the n-word and that's the racist, right?

But it's these systems and these structures that perpetuate this oppression and these negative health outcomes and financial outcomes and educational outcomes in communities of color. And to get to the root of it, that it's not just this maniacal madman or group of maniacal madmen sitting in a room planning to let's disenfranchise black folks. It's not that. It's about structures, institutions, and infrastructure that is built up around these notions of racial superiority or white supremacy that have perpetuated throughout society.

And I think this research is another layer on the narrative about how the things that seem relatively innocuous are part of the problem, and they have these deep roots in some of this nation's original sins, but are masked because of their facial neutrality.

And I would say, from my perspective as a scientist, we need scientists doing this kind of research. Because if we want evidence-based policy and law, we have to be at the table. We have to be contributing to designing the studies and evaluating what laws and policies are already out there, which is what this study is designed to do. To evaluate where are they having harm, maybe where they are not, or where they're being protective and actually benefiting health.

And then, also, to be doing the research to help inform new laws and policy. To have evidence-based policy that affects health, scientists have to be involved. And that's absolutely a top priority for this study. And I hope that many other scientists will want to do studies like this or expand the research they're doing so that we can know that the process of making law and policies or revising them when they need to be changed is done based on evidence of what ultimately is going to help society improve health and give everyone a fair chance to succeed in our society.

One other thing I wanted to commend Dr. Austin on doing is that by pulling in folks like Rahsaan and myself, she's really showing that she wants to be intentional about how this research is used. Not to impact the neutrality or the unbiased nature of the research itself. I mean, the data is what it is. But rather, to make sure that there aren't unintended consequences of the research.

And so often, I see well-intentioned research by academics being used by opposite sides for opposite purposes and twisted in ways that folks never intended. I think what Dr. Austin's really doing here is to make sure that the data speaks for itself and is used for its intended purposes.

Thank you all for coming in. It was great to have this conversation with you.

Thank you.

Thank you.

Next time, on *ThinkResearch.*

We still have, in South Africa, about 40% of the population living with HIV not in care. And really, that's where we have to focus. This 40% may just face additional barriers that we need to be addressing more creatively. Dr. Ingrid Katz returns to discuss her research on HIV/AIDS treatment in South Africa.

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