# 13 Institutionalization and Incarceration of LGBT Individuals

Erin McCauley and Lauren Brinkley-Rubinstein

Lesbian, gay, bisexual, and transgender (LGBT) populations are highly diverse; however, they share a common history of marginalization, stigma and discrimination, and violence [1], and some groups—particularly LGBT youth—also experience disproportionate rates of institutionalization and incarceration [2]. Experiences of social exclusion, stigma, and discrimination have had a sizable impact on both the unique mental health issues that members of the LGBT community face and their health-seeking behavior and access to care [1]. Additional injustices experienced by LGBT people who are institutionalized and/or incarcerated further contribute to the burden of trauma accumulated across the life course and must be appropriately addressed during the recovery process. An understanding of the prevalence, impact, and forces leading to increased rates of institutionalization and incarceration in LGBT communities is therefore crucial to providing competent healthcare to these groups.

## Drivers of Incarceration/Institutionalization

LGBT and gender nonconforming (GNC) individuals experience elevated rates of incarceration and institutionalization; both a history of and current experience of incarceration and institutionalization have profound influences on everyday health needs. While the drivers of incarceration and institutionalization within and across diverse and often multifaceted LGBT and GNC communities can be difficult to tease apart, Fig. 13.1 offers a pictorial representation to organize our discussion.

## Pathologization of LGBT and GNC Status

Both historical and the modern pathologization of LGB sexualities and transgender and GNC gender expressions lie at root of much of the discrimination and oppression of LGBT and GNC people and expose them to ongoing inhumane and immoral treatment. Categorization of nontraditional sexual orientations and gender expressions as illnesses established a seemingly rational pathway whereby discrimination in mental healthcare was sanctioned, with lasting societal implications. Pathologization of LGBT and GNC identities and expressions contributed to the creation of negative archetypes (which have often been used in the criminalization process as well), exposed LGBT and GNC people to traumatizing "treatments" such as conversion therapy, and acted as a barrier to access appropriate healthcare (either through LGBT and GNC people avoiding medical and psychiatric care or not disclosing their status to medical care providers) [3].

### Effect of Pathologization

The pathologization of LGBT and GNC sexuality and gender expression has had many negative consequences, including increased incarceration and institutionalization. Mogul, Ritchie, and Whitlock argued that one of the initial and core functions of imprisonment in the USA has been the regulation and punishment of sexualities and gender expressions considered "deviant" [4]. Using archetypes of criminality, predation, disease, and sexuality imprisonment, the criminal justice system in the USA has focused on punishing "deviance" through forced sex/gender segregation, violence, isolation, and the denial of sexuality and gender expression in

E. McCauley, MEd
Department of Policy Analysis and Management, College of Human Ecology, Cornell University, Ithaca, NY, USA

L. Brinkley-Rubinstein, PhD (✉)
Department of Social Medicine, University of North Carolina-Chapel Hill, 333 S. Columbia Street, Chapel Hill, NC 27514, USA

Center for Health Equity Research, University of North Carolina-Chapel Hill, Chapel Hill, NC, USA
e-mail: Lauren_Brinkley@med.unc.edu

© Springer International Publishing AG 2017
K.L. Eckstrand, J. Potter (eds.), *Trauma, Resilience, and Health Promotion in LGBT Patients*,
DOI 10.1007/978-3-319-54509-7_13

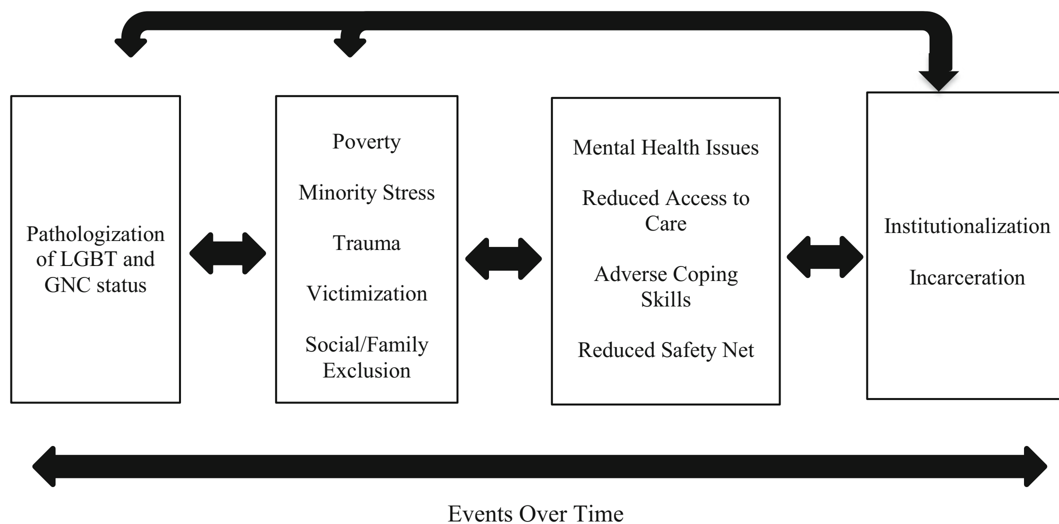


**Fig. 13.1** Drivers of institutionalization and incarceration for LGBT people

prisons and jails [4]. Laws that unjustly targeted LGB people, such as the sodomy laws (which were struck down in 2003), contributed to the criminalization of homosexuality [4]. Mogul, Ritchie, and Whitlock argued that sodomy laws gave "renewed legal weight to the message that queer people are immoral, sinful, and deserving of criminal punishment" [4, p. 72]. They also point to the sumptuary laws—laws limiting expenditures on food, clothing, and personal items—which ended in the 1980s and required people to wear three or more articles of clothing associated with their birth gender, as another form of gender and sexuality policing that contributed to the criminalization of sexuality and gender expression [4].

The pathologization of sexuality and gender expression also led indirectly to increased criminalization and institutionalization through several other mechanisms including poverty, minority stress, victimization, trauma, and social/familial exclusion. By conceptualizing some sexuality and gender identities and expressions as illnesses, these characteristics became "othered," exposing LGBT and GNC people to a plethora of risks. In turn, increased risks of poverty, minority stress, victimization, trauma, and exclusion led both directly and indirectly to increased incarceration and institutionalization. Because of these risks, LGBT and GNC people were and are more likely to experience reduced access to care and mental health issues, develop maladaptive coping skills, and have a diminished safety net which leaves them more vulnerable to incarceration and institutionalization. Poverty is linked to access to care among LGBT and GNC populations. Fredriksen-Goldsen found that 22% of older transgender and GNC people were unable to access medical care due to cost, and 15% of LGBT people fear seeking medical care by a provider outside of the LGBT community [3]. Lack of access to care is associated with increased self-medication through maladaptive coping behaviors, such as drug and alcohol use. Older adult LGB people are more likely to drink heavily and smoke cigarettes than their heterosexual counterparts [3]. Fredriksen-Goldsen also found that older LGBT adults have a high prevalence of depression and mental distress (31%) and 82% of LGBT people had experienced victimization [3]. People with mental health issues are overrepresented in the criminal justice system and mental health issues can lead to institutionalization, particularly for those who experience social rejection and therefore have a reduced safety net of people to provide care. Research has found that LGBT people are more likely to rely on the support of a friend than a family member [3, 5]. The reduced safety net experienced by many LGBT people can be even more significant for youth. Hunt and Moodie-Mills found that LGBT youth face higher risks of incarceration due to homelessness because of family rejection [6]. The many risks and barriers that LGBT and GNC people face which put them at increased likelihood of incarceration and institutionalization frequently overlap and intersect, leading to a complex web of risks with no simple solution or intervention. Furthermore, the experience of incarceration then exposes LGBT and GNC people to further traumatization and victimization which can lead to persistence of or development of more adverse coping mechanisms, with further social exclusion and a further decreased safety net and an increase in survival crimes. This vicious cycle of traumatization, institutionalization, and incarceration is also affected by events over time.

## Events Over Time

Several events over time have influenced the incarceration and institutionalization of LGBT people. Two highlighted here—transinstitutionalization and the War on Drugs—have

| Phase | Decade | Information |
|---|---|---|
| Institutionalization | 1840s | Dorothea Dix, after witnessing incarcerated people with mental illnesses chained naked to beds, left without heat, bathrooms, and in some cases, lights, started a campaign to improve conditions (7). She succeeded in advocating for the development of mental health hospitals run by state governments in the U.S.and Europe (7). |
| | 1870s | A study of sexual behavior defines a "third sex"—homosexuality-- to describe same-sex relations and transgender/gender non-conforming behavior. Homosexuality was considered morally neutral and the result of "inversion"—changes in the brain while in the womb (8). |
| | 1930s | Throughout the early 1900's, Freud developed the theory that homosexuality is a result of early childhood experiences (8). Shock therapy and lobotomy became popular treatments for "curing" mental illness. |
| | 1940s | The National Institutes of Mental Health (NIMH) was established 1949, aimed at preventing, curing, or aiding in the recovery of mental illnesses (10). Homosexuality was conceptualized as an "illness" that needed treatment in institutions and via psychoanalysis, a belief which continued through the 1970s (8). |
| | 1950s | The first effective anti-psychotic drugs were introduced, behavioral therapy was implemented on a broad scale, and the number of people in mental health institutions reached its peak (560,000 in 1955) (11). The first Statistical Manual of Mental Disorders (DSM) was published, which classified homosexuality alongside other sexual "disorders" (8). |
| Deinstitutionalization | 1960s | The Mental Retardation Facilities and Community Mental Health Centers Construction Act provided federal money to develop community-based mental health services (7) . Public opinion of institutionalization suffered (11). The gay rights movement garnered more publicity and public attention (8). |
| | 1970s | Due to increased symptom management by drugs and therapy, newly prevalent community-based mental health services, and the changing cultural perception of mental health institutions, the number of people institutionalized started to decline (11). Many people who left institutions were met with inadequate housing and follow-up care. |
| | 1980s | LGBT and GNC people became disproportionately represented among the homeless. Rates of mental illnesses among homeless populations increased. An estimated 1/3 of all people experiencing homelessness were found to suffer from a serious mental illness (11). Homosexuality was no longer classified as a mental disorder in the DSM-III; however, Gender Identity Disorder was added (63). |
| Incarceration | 1990s | Many people suffering from serious mental illnesses were unable to find adequate housing or mental health care, and ended up incarcerated (11). Series of policies criminalized substance abuse, leading to an increase in the number of people incarcerated for nonviolent drug law violations from 50,000 in 1980 to 400,000 in 1997 (12). Conversion therapies aimed at changing homosexual orientation continued despite criticism (8). |
| | 2000s | High rates of mental illness among incarcerated populations continued. By midyear in 2005, more than half of the incarcerated population in the U.S. suffered from a mental illness (11). According to Bureau of Justice Statistics, between 2002 and 2004 56% of people incarcerated in State prisons, 45% of people incarcerated in Federal prisons, and 64% of people incarcerated in jails suffered from a mental illness (13). |
| | Current | In 2012, one in every 35 adults in the U.S. was on probation, parole, or incarcerated in prison or jail, with 6,937,600 adults under the supervision of the correctional system (14). Currently, half of males and 75% of females who are incarcerated in state prisons and 63% of males and 75% of females incarcerated in jails experience mental health problems that merit services each year (13). LGBT and GNC people (particularly youth) have a higher likelihood of having mental health issues and being incarcerated (2). While we have seen a slight decrease in incarceration, rates remain high. |

**Fig. 13.2** A brief history of mental healthcare

had particularly adverse effects on the lives of LGBT and GNC people. The history of mental healthcare in the USA can be considered in three distinct phases: institutionalization, deinstitutionalization, and incarceration; the term transinstitutionalization refers to the transition from treating mental health issues via institutionalization to incarceration. Figure 13.2 provides a brief history of mental healthcare in the USA, highlighting the three stages of transinstitutionalization.

## The Shift from Mental Health Hospitals to Incarceration

The stated goal of deinstitutionalization was to allow people suffering from mental illnesses the ability to live more independent and full lives; the reality of deinstitutionalization, however, has been far different. The closure of mental health hospitals overwhelmed communities and families with individuals who had complex psychosocial and healthcare needs and eventually contributed to high rates of incarceration through a process often referred to as transinstitutionalization. Several factors contributed to transinstitutionalization, including the cost of healthcare for families and communities and high rates of dual diagnoses of substance use disorder and mental illness. These general trends were exacerbated among LGBT and GNC people, coinciding with a period of zero tolerance, as well as increased criminalization of LGB sexuality and transgender and GNC gender expression. Furthermore, the pathologization of LGBT and GNC individuals that contributed to high rates of institutionalization had far-reaching consequences that contributed to their later incarceration—such as the archetypes of "deviant" sexuality in need of treatment which were repurposed as "deviant" sexuality in need of punishment [4] through the process of transinstitutionalization.

## Cost for Families and Communities

When institutions for people suffering from mental health diagnoses were closed, families often took on the burden of paying for and providing care [11]. The expectation that families could or would take on the financial and interpersonal burdens of mental healthcare was particularly unrealistic for LGBT and GNC people. For example, Hunt and Moodie-Mills have found that LGBT youth are far more likely to have experienced family rejection and are forced to fend for themselves financially [6]. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the estimated total costs associated with treating people with serious mental illnesses in 2014 were $239 billion [15]. The process of deinstitutionalization caused a shift of the financial burden of care from the government to the families and communities to which individuals were released [11, 16]. This burden was particularly difficult for lower-income families or families from historically marginalized populations, such as genderqueer individuals who already faced barriers to access for healthcare [17]. The end result was that some families were unable to afford or did not have suitable access to adequate mental healthcare services. Furthermore, families who were unable to attain adequate care were more likely to be from low-income communities in which there were insufficient resources for community healthcare provision. This resulted in a disproportionate number of people suffering from mental illnesses in low-income areas, or from historically marginalized populations, to go untreated or to self-medicate with substances. This in turn contributed to increased criminalization of these communities and subsequent incarceration rates.

## Dual Diagnosis with Substance Use Disorders

Many people who suffer from a mental illness have a dual diagnosis with substance use disorder. According to the National Alliance on Mental Illness (NAMI), approximately one third of people experiencing mental illness and half of people experiencing severe mental illness also struggle with substance misuse issues [18]. Additionally, approximately one third of people who abuse alcohol and half of people who misuse drugs suffer from a mental illness [18]. In 2005, the Bureau of Justice Statistics reported that over one third (37%) of individuals with mental health diagnoses in state prisons were using drugs at the time of offense, compared to around a quarter (26%) of individuals without mental health problems [13]. One study looking at "postbooking" jail diversion programs for adults with dual diagnoses of mental health illness and substance misuse in Hawaii found that substance misuse was a more significant causal factor for criminal offenses [19]. This indicates that substance use increases the likelihood of incarceration, meaning that someone with a mental health issue who has lower access to healthcare, such as an LGBT or GNC-identified individual, is at increased risk of being incarcerated for misusing illicit substances. Another study comparing offending and violence rates between patients with dual diagnoses and patients with mental illness alone found that those in the group with dual diagnoses were more likely to have a criminal history, although there were no significant group differences as far as history of violence specifically [20].

## The Current State of Mental Healthcare

Simultaneous with the closure of mental health institutions and the increasing criminalization of mental health disorders, access to quality mental healthcare was difficult to attain. A recent study found that between 2012 and 2013, 57.2% of adults suffering from a mental illness received no treatment, with Vermont reporting the lowest prevalence of untreated adults with serious mental illnesses (41.7%) and Nevada reporting the highest (70.7%) [21]. In addition, more than 20% of adults in the USA with a mental illness reported that they were unable to access necessary treatment [21].

LGB individuals report experiencing discrimination at a higher rate than their heterosexual counterparts and, additionally, perceived discrimination is positively correlated with indicators of psychiatric morbidity, meaning that LGB individuals are more likely to experience mental health issues as a result of discrimination [22]. These findings have been confirmed in several other studies; for example, Meyer found that experiences of stigma, prejudice, and discrimination contribute to a stressful social environment and subsequent high rates of mental health problems [23]. LGBT individuals are at even higher risk than heterosexual, cisgender individuals of experiencing mental health issues. LGBT youth are more than twice as likely to take drugs or alcohol, and only 37% of LGBT youth report being happy (compared to 67% of non-LGBT youth) [24]. In addition, LGB youth are four times more likely to attempt suicide than their heterosexual peers [25].

Unfortunately, currently available options for provision of mental healthcare may be particularly inaccessible to or problematic for LGBT and GNC individuals. We will consider three loci in which mental healthcare is rendered in the USA today: (1) community-based mental health services, (2) institutions for the mentally ill, and (3) the criminal justice system.

## Community-Based Mental Health Services

The current trend in mental healthcare favors community-based services over institutional care, such that community-based mental health services are considered the standard of care in the USA [26]. Unfortunately, however, cost is often a barrier to accessing care in community-based settings. A recent study reported that 8 million adults with mental illnesses (18.5%) were uninsured between 2012 and 2013 [21]. In 2014, 27% of uninsured Americans did not seek needed treatment due to cost [27]. Furthermore, having insurance does not necessarily grant access to mental healthcare. People with mental health issues in certain regions, like Massachusetts or Washington, DC, reported being unable to access care due to the inadequacy of their health insurance [21]. Of adults with a disability in the USA, 25.5% (1.2 million) were unable to see a healthcare provider due to cost [21]. The rates of access to mental healthcare are even lower for youth. Nearly 65% of youth with major depression do not receive any mental health treatment, and of those who do, many do not receive the level of care they need [21]. In fact, Mental Health America found that only 21.7% of youth with severe depression received "consistent treatment" (defined as 7–25+ visits per year) [21]. While the treatment of mental illnesses may ideally be delivered in community-based settings, several factors prohibit access and lead individuals to seek care in less desirable venues.

LGBT populations are also likely to find cost a barrier to community mental health treatment. Four in ten of LGBT people who had an income under 400% of the federal poverty level delayed engagement in care because of cost [28]. In addition, those who identify as LGB more often report unmet medical needs and less often report having a usual source of care [29]. Transgender individuals specifically are much less likely to be covered by health insurance, have access to care, and, even if insured, to have coverage for transgender-specific health services such as surgical treatment for gender transition and hormone therapy [28].

## Institutions for the Mentally Ill

While most institutions that provide mental healthcare were closed during deinstitutionalization, around 200 state hospitals remain open and operational today. Despite the small number of state-run psychiatric hospitals, they accounted for nearly one third of state mental health agency (SMHA) budgets in 2006, totaling $7.7 billion [26]. A recent study found that the current role of state psychiatric hospitals is to house "populations deemed inappropriate for other settings" (p. 679), targeting three primary populations: forensic patients (people deemed incompetent to stand trial or not guilty by reason of insanity), sexually dangerous persons, and difficult-to-discharge patients [26]. This same study argued that the diminishing economic climate at the turn of the twenty-first century complicates efforts to close the last psychiatric hospitals. Community-based healthcare services do not have enough funding to accommodate mentally ill patients with extremely high needs [26]. Additionally, psychiatric hospitals do not have enough staff to prepare patients for successful discharge [26]. A study in Washington State found that 44% of people discharged from mental health hospitals were readmitted within 540 days [30]. While information on currently institutionalized LGBT and GNC people is difficult to come by, a study by Orel found that middle- to older-aged LGBT participants expressed the legality of their relationships as a primary concern, fearing that their living wills and power of attorney would not be sufficient to guarantee them in-home care as opposed to institutionalization [31]. Institutionalization remains a pressing concern for LGBT and GNC communities.

## Criminal Justice System

While the criminal justice system was not intended or designed to serve as a method of healthcare provision, it currently does provide healthcare for the growing

population of people who are currently incarcerated, including disproportionate numbers of LGBT and GNC people. Incarceration is associated with a variety of negative outcomes, such as higher occurrences of mental and physical health concerns [32], economic immobility [33], high rates of discrimination [34], and high rates of future or lifetime incarceration [35]. Beginning in the late 1970s, the USA began to experience an unprecedented era of incarceration. While due in part to changes in mental healthcare (as noted previously), this was largely due to the "War on Drugs."

Policies related to mass incarceration, including the War on Drugs, have had dramatic implications for people who suffer from mental illness, including those who are LGBT and/or GNC. The strict policies associated with the War on Drugs have been credited, in part, for the criminalization of mental illness in the USA. Criminologists continue to debate the roles of these various policies in the process of increasing incarceration rates, and have been unable to provide robust evidence as to the root cause [36] because these policies are highly embedded within a complex context that makes it difficult to tease apart cause and effect. However, there is an agreement in the literature that several key policies, including the War on Drugs, influenced both the criminalization of mental illness and sentencing policies and that these policies also influenced the disproportionate incarceration of LGBT and GNC people. Drug and alcohol use rates are higher among LGBT people than the general population. A review of the existing literature on drug and alcohol rates for LGBT people by SAMHSA found that 30% of lesbians struggle with alcohol abuse, that 20–25% of LG people are heavy alcohol users (as opposed to 3–10% of heterosexual people), that gay men are more likely to use drugs (including marijuana, psychedelics, hallucinogens, stimulants, and cocaine), and that LGBT people are more likely to use so-called party drugs, such as ecstasy and ketamine [37]. A meta-analysis of studies looking at sexual minority drug use found that LGB youth were nearly twice as likely to use substances [38]. A study that sought to explore the relationship between sexual and gender minority stress, substance use, and suicidality found that LGBT substance use was an insidious coping response to victimization on the basis of LGBT identity and had deleterious effects on suicidality [39]. Russel, Driscoll, and Truong found that LGB youth were more likely to use substances, and had different trajectories of substance use [40]. Additionally, SAMHSA found that LGBT people who are struggling with substance use disorders may be less likely to seek treatment for fear of discrimination from treatment providers or compounding discrimination if their sexual orientation, gender identity, and substance use disorders were to be discovered [37].

## Incarceration and Mental Health

In 2015, the Los Angeles County Jail was reported to be the largest provider of mental healthcare in the USA [41]. People suffering from mental illnesses are three times more likely to be in jail or prison than in mental health facilities and 40% of people with a diagnosis of severe mental illness are under the supervision of the criminal justice system [42]. Some people with mental illnesses also end up in diversion programs, such as drug court, or referral out to community-based mental health courts [16]. Others are not as fortunate. According to a 2003 report by Human Rights Watch, which may still have some applicability in the current criminal justice system, "in the most extreme cases, conditions [in jail/prison] are truly horrific: mentally ill prisoners locked in segregation with no treatment at all; confined in filthy and beastly hot cells; left for days covered in feces they have smeared over their bodies; taunted, abused, or ignored by prison staff" [43, p. 2]. The current state of healthcare provision relies disproportionately upon the criminal justice system as a provider of care, especially for LGBT people who experience disproportionately high levels of trauma, victimization, and mental health illness. Furthermore, LGBT adults and youth experience social isolation and family exclusion, and this diminished safety net increases the risk of incarceration. Unfortunately, the health care received in justice settings can be inadequate [43], and the disadvantage associated with incarceration can have deleterious effects on long-term health [44] and economic mobility and gain [33]. These issues will be discussed at length later in the chapter.

## Prevalence and Impact of Incarceration on LGBT People

Mass incarceration, coupled with transinstitutionalization, has had adverse effects on the health and well-being of LGBT people. Mass incarceration is a term that describes the rise in incarceration rates in the USA by more than 300% over the past 30 years [45]. Mass incarceration disproportionately impacts marginalized populations, such as people who identify as African American [46], Latino or Hispanic [47], or those who identify as LGBT [48]. Mogul, Ritchie, and Whitlock argue that the regulation of sexualities and gender expressions that are considered "deviant" by the dominant cultural narrative has always been a paramount feature of the justice system in the USA, making incarceration a highly dangerous proposition for LGBT people in particular [4]. To illustrate, these authors state, "prisons are places where deviance from gender and sexual norms is punished through sexual systemic violence, forced segregation, and denial of sexual and gender expression and failure

to provide medically necessary treatment for the conditions deemed queer" [4, p. 95–96].

## Prevalence of Incarceration Among LGBT Individuals

Identifying the number of LGBT individuals involved in the criminal justice system is challenging [49]. When gender identity or sexual orientation is queried (some data collection systems do not include LGBT or GNC status), data collection often relies on self-report, which can be highly unreliable, especially in coercive and controlled settings. Justice-involved individuals may hide their LGBT status for fear of punishment or discrimination by other inmates or correctional staff.

### Arrest and Incarceration of LGBT Adults

Adults who identify as LGBT are more likely to be questioned by the police, engage in what is often referred to as "survival crime" such as sex work, and be incarcerated. The National Center for Transgender Equality [50] found that one in six transgender people has been incarcerated (16%), whereas the Bureau of Justice Statistics estimates that only 5.1% of all persons in the USA will be incarcerated during their life [51]. In addition, 21% of transgender women and 47% of Black transgender people have been incarcerated in their lifetime [50]. Another recent study found that 19.3% of transgender women reported being incarcerated during their lifetime [52]. This same study also reported that transgender women who were Black and Native American/Alaskan Native were more likely than their White (non-Hispanic) counterparts to report a history of incarceration [52]. Mandatory minimum sentencing (which disproportionately affects racial minorities and the poor, both of which have high representation among transgender people), the federalization of crimes, and the abolishment of parole for people reentering the community from prison are factors that have influenced the disproportionately high representation of transgender people in the criminal justice system [50].

### Juveniles

LGBT youth are significantly overrepresented in the juvenile justice system, with an estimated 300,000 LGBT youth having contact with the juvenile justice system each year. While LGBT youth comprise 13–15% of justice-involved youth, they only represent five to seven percent (5–7%) of the youth population [6]. In addition, LGBT youth are disproportionately arrested and/or detained for nonviolent crimes [49]. Research has found that youth who identify as LGBT are twice as likely to be arrested and detained for nonviolent crimes than their heterosexual peers [48, 53]. One study identified detainment for truancy, warrants, probation violations, running away, and prostitution as key areas of disproportion [48]. There were no differences in detention rates for LGBT youth for serious violent crimes, however, indicating that the overrepresentation of LGBT youth in the criminal justice system centers around nonviolent offenses.

Several possible reasons for the disproportionate rate of incarceration among LGBT youth have been proposed. For instance, a study by Majd, Marksamer, and Reyes identified several factors that may be associated with the increased risk of detention among LGBT youth [54]. They found that disproportionate detention centered around juvenile justice professionals (including judges and court personnel) perceiving that LGBT youth lack family support, misperceptions that LGBT youth are "aggressive," and misconceptions that LGBT youth are more likely to reoffend [54]. Hunt and Moodie-Mills argue that family rejection, homelessness, and failed safety nets put LGBT youth at a higher risk of incarceration and that family rejection specifically can lead to homelessness and being pushed into the justice system [6]. Furthermore, youth who are experiencing homelessness and can no longer depend on their families to provide for them may be emotionally and physically vulnerable to abuse, coercion, and engaging in and becoming victims of survival crimes [6]. Stanley and Smith also illuminate survival crimes as a key contributor to the criminalization of LGBT youth. Survival crimes are nonviolent crimes that are committed out of desperation to survive, such as shoplifting food or prostitution in order to pay for food and shelter. Twenty-six percent (26%) of LGBT youth leave their homes at some point during their adolescence, and LGBT youth account for 40% of the youth population experiencing homelessness, despite being only 5–7% of the overall youth population [6]. These data are particularly significant because homelessness is one of the strongest predictors of contact with the juvenile justice system among LGBT youth [6]. Heightened levels of police contact can also have a disproportionate impact on LGBT youth. Police are often able to arrest and detain youth for violations that would not be considered crimes if committed by adults, such as running away or breaking curfew, leading to increased contact between the police and LGBT youth [48]. The increased risk of incarceration observed among LGBT youth is enormously troubling, as youth detention has been found to dramatically reduce educational attainment and increase long-term adult incarceration rates [55].

## Specific Health-Related Concerns Relevant to LGBT Inmates

People who identify as LGBT face numerous difficulties in the carceral environment, including emotional abuse and harassment, physical abuse, sexual assault, and prolonged

periods of isolation. In addition, research has shown that LGBT individuals in correctional facilities often also have issues related to the provision of medication, housing policies, discrimination and abuse by correctional staff and other inmates, and access to support systems.

## Provision of Medication

While those who are incarcerated represent one of the only groups in the USA with a constitutional guarantee of medical care, gaining access to necessary medical care and medication is still a persistent issue for LGBT people [50].

### Hormone Therapies

Most prisons and jails in the USA deny transgender people access to hormone therapies, despite the medical necessity of these medications for this population [4]. For example, some states have ruled that hormone therapies are "cosmetic," despite the DSM-V classification of "gender dysphoria" that categorizes hormone therapies as medically necessary. Even in states where transgender people can access their hormone therapies from prison health facilities, such prescription is under a strict regulation. Typically, a transgender person must prove that they had a legal prescription for hormones and were taking them prior to being incarcerated, which can be exceedingly difficult given the poor access to healthcare that transgender people face overall [4]. Also, hormone therapies for express purpose of gender affirmation are often not covered by medical insurance, making a prescription for hormone therapies economically unfeasible [4]. Therefore, many transgender people obtain their hormone therapies through unregulated markets, and therefore lack the documentation necessary to continue receiving treatment while incarcerated [4]. Denying hormone therapies to transgender people is associated with "extreme mental distress and anguish, leading to an increased likelihood of suicide attempt, as well as depression, heart problems, and irregular blood pressure" [4, p. 112]. In some cases, even when a transgender person is approved to receive hormone therapy while incarcerated, it is provided sporadically, inconsistently, at inappropriate doses, and without psychological support [4]. Furthermore, the irregular administration of hormone therapies, created by the denial or mismanagement of hormone therapies while incarcerated, and the inconsistent supply of hormones that incarcerated transgender people sometimes access from the black market, may lead to adverse health effects such as an elevated risk of cancer, liver damage, depression, hypertension, and diabetes [4].

### Treatment of HIV/AIDS

HIV and AIDS disproportionately affect transgender people, and men who have sex with men [56]. Although data are not comprehensive, it is believed that transgender people have the highest rate of HIV/AIDS in the world [56]. In 2010, transgender people had the highest rate of newly identified HIV-positive test results in the USA (2.1%), compared to females (0.4%) and males (1.2%) [57]. From 2007 to 2011, there were 191 new diagnoses of HIV among transgender people in New York City, and 99% of those infections were among transgender women [57]. Additionally, 51% of those transgender women had a documented history of substance misuse or incarceration [57]. The testing for and treatment of HIV/AIDS for incarcerated transgender people or men who have sex with men is important for the health and well-being of these populations. Some LGBT people have been denied treatment or testing while incarcerated [4]. Historically, people who are HIV positive have suffered discrimination, and HIV-positive people have also died at higher rates by preventable diseases [4]. Mogul, Ritchie, and Whitlock describe circumstances at the Limestone Correctional Facility in Alabama between the late 1980s and early 2000s in which HIV-positive people were housed in a segregated unit which was crowded and vermin infested [4]. Many of the people in this separated unit were suffering from chronic health conditions and an outbreak of staphylococcus infections, and were essentially abandoned in this segregated unit until the Southern Center for Human Rights sued the Alabama Department of Corrections and the private prison healthcare service company [4]. An infectious disease specialist reviewed the case and found that nearly all of the 43 people who died in this unit between 1999 and 2003 died of preventable illnesses because of the failure to provide proper medical care [4]. Lastly treatment and testing for HIV and AIDS often comes with a violation of confidentiality for LGBT people [4]. Because LGBT people often already face elevated rates of discrimination and inadequate healthcare, added stigmatization resulting from prison employees and other inmates knowing that an LGBT person has HIV or AIDS can be particularly dangerous.

## Housing Policies

The evaluation of LGBT status during jail or prison intake can be used in housing decisions to separate individuals who are LGBT from the general population [58]. Depending on the circumstance and the individual, separate housing may be either beneficial (i.e., afford protection) or punitive (i.e., result in further stigma and isolation). Unfortunately, such housing decisions, made at the sole discretion of prison officials, are frequently used to punish and regulate what is considered by dominant cultural narratives to be "deviant" sexuality or gender expression. Housing incarcerated adults who identify as LGBT in separate units can increase the risk of abuse depending on what other individuals are also housed in these separate units [4]. On the other hand, many LGBT people suffer extremely high rates of abuse (physical

and sexual) in general population housing. Mogul, Ritchie, and Whitlock describe the story of one Black gay man, Roderick Johnson, who was incarcerated in 1999 [4]. Originally placed in safe housing, he was eventually transferred to a maximum-security prison where he was housed in the general population, where he experienced repeated rapes which were not investigated and was traded as a commodity, masturbated on, and physically assaulted when he refused to perform sexual acts. At one point, he was even punished by loss of recreation and commissary privileges after being forced into performing a sexual act with another inmate. Despite experiencing horrific violence and abuse, Johnson's requests for safe and separate housing were repeatedly denied [4].

In other circumstances, the placement of LGBT people in special "protection" units can be harmful. Some jails and prisons have administrative segregation units for vulnerable or at-risk individuals where people have less access to social interaction with their peers and severely limited access to programs; LGBT people are also subjected to solitary confinement at higher rates than their heterosexual and gender binary counterparts [4]. Tellingly, Mogul, Ritchie, and Whitlock also describe the story of one inmate who explained that the psychological toll of solitary confinement was worse than the experience of rape and abuse that he suffered in the general population [4].

Housing placement is even more influential for transgender and gender nonconforming people. Typically, transgender people are placed in sex-segregated facilities based on their genitalia [4]. This can be particularly dangerous for transgender women, who are often targets of abuse and harassment in male prisons [4]. The primary justification for placing transgender women in male prisons is due to fear that transgender women pose a threat to other women [4]. This fear is underwritten by the dangerous and untrue archetype of transgender women as sexually degraded predators [4]. Transgender people are also more likely to be placed inappropriately in medical wings, as a consequence of untrue archetypes of transgender and gender nonconforming people as mentally ill [4].

## Treatment by Correction Staff and Fellow Inmates

The Bureau of Justice Statistics found that of incarcerated adults in federal prisons who identified as bisexual, homosexual, gay or lesbian, or other sexual orientation minority, 11.2% reported being sexually victimized by another inmate (compared to 1.3% of incarcerated adults who identified as being heterosexual) and 6.6% reported being sexually victimized by a staff member (compared to 2.5% of incarcerated adults who identified as heterosexual) [59]. Similarly, among incarcerated adults who identified as bisexual, homosexual, gay or lesbian, or other sexual orientation minority in jails, 7.2% reported being sexually victimized by another inmate (compared to 1.1% for their heterosexual peers) and 3.5% reported being sexually victimized by staff members (compared to 1.9% of their heterosexual peers) [59]. The Bureau of Justice Statistics found that after controlling for variables, "an inmate's sexual orientation remained an important predictor of (sexual) victimization" [59, p. 15].

Transgender and gender nonconforming people also face high rates of physical abuse and sexual abuse. The Justice Department emphasized in a 2012 report that GNC individuals face particularly high levels of sexual victimization [58]. Mogul, Ritchie, and Whitlock argue that transgender men and women who are perceived as gay or effeminate are at particularly high risk for sexual abuse, as they occupy the bottom rung of the prison hierarchy [4]. These investigators also emphasized that transgender women, in addition to the abuse and discrimination they face as a result of identifying as transgender women, are also exposed to added sexual degradation and harassment that women experience, such as, "excessive, abusive, and invasive searches, groping their breasts, buttocks, or genitalia, repeatedly leering at the while they shower, disrobe, or use the bathroom" [4, p. 101].

Majd, Marksamer, and Reyes found that LGBT youth experienced physical and emotional abuse, sexual assault, harassment by guards and peers, and prolonged periods of isolation [54]. Wesley Ware wrote, "nowhere in the literature regulation and policing of gender and sexuality, particularly of low-income queer and trans youth of color, so apparent than in the juvenile courts and in the juvenile justice system" [48]. The Bureau of Justice Statistics found that youth who identified as nonheterosexual reported disproportionate rates of youth-on-youth sexual victimization compared to their heterosexual counterparts (10.3% versus 1.5%, respectively); however, rates of reported staff-on-youth sexual victimization were similar for both heterosexual and nonheterosexual youth [60].

In response to the high rates of sexual assault and victimization of incarcerated individuals, the Prison Rape Elimination Act (PREA) was signed into law in 2003, and a comprehensive set of regulations was implemented in 2012 [58]. In the final summary of the PREA regulations, the Department of Justice emphasized the particular vulnerability of LGBT individuals in justice settings, especially those whose "appearance and manner does not conform to traditional gender expectations" [58]. Among the protections afforded to transgender people by the PREA is the right to request private showers; such rights are outlined for prison staff in an LGBT training guide [50]. The PREA Resource Center revised the protocol for screening and searching transgender prisoners in 2013 [50]. Although the PREA regulations can be leveraged to reduce the violence that LGBT people face while incarcerated, the ACLU warns

that some facilities or systems may not be updated [58]. Furthermore, the PREA regulations require adults to be screened within 72 h of intake to assess their risk of sexual victimization and abuse, which includes an evaluation of the likelihood that an individual may be perceived as LGBT [58].

### Access to Support Systems

Prisons and jails in the USA enforce strict rules against any sexual contact—inmate on inmate or staff on inmate. Some argue that while in theory these policies are meant to protect incarcerated people from unwanted sexual contact or attention, in reality the idea of situational homosexuality (sex among same-sex inmates who identify as heterosexual when outside of carceral settings) is considered a threat to the presumption of normalcy and heteronormativity [4]. This "threat" of homosexuality can lead to increased monitoring of LGB nonsexual relationships and forced isolation of LGB people from their peers [4]. Furthermore, LGB people can be cut off from their outside support systems. While heterosexual couples are allowed to embrace during visitation times, homosexual couples are often not permitted to do so and even cited an instance where a homosexual couple embraced and were threatened with loss of future visitation [4]. Furthermore, before the legalization of same-sex marriage, conjugal visits for homosexual partners were not allowed in four out of the five states in which such visits were permissible for other inmates [4].

## Specific Mental Health Issues Among Justice-Involved LGBT Individuals

Incarceration has far-reaching effects on both health and health-seeking behaviors [61]. In particular, justice-involved LGBT individuals face specific mental health issues, including increased levels of anxiety and stress, issues of self-esteem, and post-traumatic stress disorder (PTSD).

### Increased Levels of Anxiety and Stress

The carceral environment can lead to increased levels of anxiety and stress through stereotype threat—the fear or risk of confirming stereotypes related to a minority group one identifies with, the constant threat of violence, and the strict regulation of gender expression and sexuality. Increased anxiety and stress may also lead to clinical depression [62]. Incarcerated LGBT people may develop psychological adaptations in response to the high levels of stress and anxiety, including distrust, hypervigilance, and isolation [62]. While these adaptations might seem dysfunctional or even pathological in a community context, these psychological processes and coping mechanisms represent normal responses to the pathological context of prison or jail [62].

### Issues of Self-Esteem

Transgender people who are denied access to necessary hormone therapies may suffer from issues of self-esteem upon release. The physical and psychological effects of hormone deprivation can leave transgender people trapped in a space between womanhood and manhood, unable to express their true gender identity [4]. The repression of identity is correlated with issues of self-esteem that can lead to social isolation, depression, self-harm, and suicidal ideation. A study by Nuttbrock, Rosenblum, and Bluminstein found that identity affirmation was crucial for the emotional well-being of transgender people [63]. Transgender identity affirmation was conceptualized as the extent to which transgender identity is disclosed and recognized by others, preformed and supported by others, and incorporated successfully in social roles and relationships [63]. The carceral environment for most transgender people limits the ability of identity affirmation through social isolation, regulation of identity, and the denial of hormone therapies.

### Post-traumatic Stress Disorder

LGBT people are at an increased risk of being raped or sexually assaulted during incarceration. Additionally, more than two third of people who are raped in prison are raped multiple times, making the negative effects on their health and likelihood of PTSD even higher [64]. Neal and Clements found that people who were sexually assaulted by other prisoners were physically injured 70% of the time, whereas people who were sexually assaulted by correctional staff were physically injured 50% of the time, indicating that prisoner-on-prisoner rape can be particularly traumatic [64]. Furthermore, rape, particularly brutal or repeated rape, has been found to be associated with PTSD [65], meaning that LGBT people who have been sexually assaulted or raped while incarcerated are at risk for PTSD. Moreover, researchers have found a link between PTSD manifestations among people who have been raped and negative social reactions such as coping avoidance [66]. LGBT people who have been raped during incarceration may exhibit additional symptoms beyond PTSD, such as depression, anger, guilt, disruption of belief systems, and sexual dysfunction [64].

### Mental Deterioration

Transgender and gender nonconforming people who have been incarcerated in solitary confinement for prolonged periods of time may suffer from mental deterioration due to sensory deprivation [4]. Mogul, Ritchie, and Whitlock described punitive segregation units in which transgender and gender nonconforming people were caged 23 h a day for 7 days a week without television, radio, or personal contact [4]. This extreme level of sensory deprivation, over a prolonged period of time can cause people to lose the

ability to concentrate, to hallucinate, and in some cases to lose their aptitude for social interaction [4].

## The Future of LGBT Justice-Involved Individuals: Returning to a Public Health Paradigm

Incarceration rates have seen a slight decline over the last few years, but rates remain at historically high levels [67] and LGBT individuals are still disproportionately represented in correctional facilities. However, there is a swelling national movement to identify and understand the harms that incarceration is causing among the most disproportionately impacted populations and to return to a public health paradigm for mental health and substance use disorder treatment. For LGBT populations specifically, numerous policy and legal shifts have facilitated improved access to medical care and health insurance coverage, including passage of the Affordable Care Act and the recent Supreme Court overturning of the Defense of Marriage Act. However, much work remains to be done.

## Decriminalization of Substance Use and Mental Illness

Recent initiatives have devoted time and energy to developing programs such as "prebooking" diversion, which gives police officers the discretion to take a person with a substance use or mental health issue to a treatment facility rather than to jail. In addition, drug court and mental health courts have been established in states across the nation and research shows that they work. Findings from Virginia recently showed that on average drug courts cost taxpayers less money and that participants recidivated less often. Other alternatives to incarceration that deploy therapeutic techniques should be used more often as more and more advocates (see decarceration.org) are calling for an expanded era of decarceration. Criminal justice-involved LGBT populations, who often experience worse outcomes while incarcerated, would benefit exponentially from continued progression away from mass incarceration. However, given that correctional facilities are one of the largest "providers" of mental health services in the USA, and that structural change often happens gradually, there is also a need to consider the current context of incarceration and its impact on LGBT individuals specifically. Jails and prisons should engage in training for correctional workers in an attempt to lessen the prevalence of LGBT-related stigma and discrimination. Additionally, housing policies should be thoughtfully considered with an eye toward the collateral consequences of solitary confinement and policies that house people solely according to their biological sex. Research exploring the specific impact of incarceration on the physical and mental health of LGBT individuals is still nascent and much remains to be learned. Future studies must endeavor to elucidate how best to identify LGBT individuals in carceral settings, effective policies to protect LGBT people, and the impact of incarceration on LGBT populations over the life course. While mental healthcare has evolved for the better over the years, further improvement is still needed. For LGBT persons who suffer from both mental illness and co-occurring substance use, incarceration is a very real possibility, and stigma related to each problem can compound the challenges and result in destabilization. Research and advocacy efforts must continue so that, in the future, mental health and substance use can be addressed concurrently and without inflicting further harm on the lives of already vulnerable populations.

## References

1. Ard K, Makadon H. Improving the healthcare of lesbian, gay, bisexual, and transgender (LGBT) people: understanding and eliminating health disparities. Boston: The Fenway Institute, Fenway Health; 2012.
2. National Center for Transgender Equality. Standing with LGBT prisoners: an advocate's guide to ending abuse and combating imprisonment. 2014. Retrieved 6 Mar 2016 from http://www.transequality.org/issues/resources/standing-lgbt-prisoners-advocate-s-guide-ending-abuse-and-combating-imprisonment.
3. Fredriksen-Goldsen KI. Resilience and disparities among lesbian, gay, bisexual, and transgender older adults. Public Policy Aging Rep. 2011;21(3):3–7.
4. Mogul JL, Ritchie AJ, Whitlock K. Queer injustice: the criminalization of LGBT people in the U.S. Boston: Beacon Press; 2011.
5. Muraco A, Fredriksen-Goldsen K. "That's what friends do": informal caregiving for chronically ill midlife and older lesbian, gay, and bisexual adults. J Soc Pers Relat. 2011;28(8):1073–92.
6. Hunt J, Moodie-Mills AC. The unfair criminalization of gay and transgender youth: and overview of the experiences of LGBT youth in the juvenile justice system. Washington, DC: Center for American Progress; 2012.
7. Parry MS. Dorothea Dix (1802–1887). Am J Public Health. 2006;96(4):624–5.
8. Holler J. Pathologizing sexuality and gender: a brief history. Ment Health Addict J. 2010;6(2):7–9.
9. Freeman W, Watts JW, Hunt T. Psychosurgery: intelligence, emotion, and social behavior following prefrontal lobotomy for mental disorders. London: Bailliére, Tindal & Cox; 1942.
10. National Institutes of Health. National Institute of Mental Health (NIMH) mission. 2016. Retrieved 6 Mar 2016 from http://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh.
11. PBS Online. Timeline: treatments for mental illnesses. Retrieved 4 Feb 2016 from PBS Online: http://www.pbs.org/wgbh/amex/nash/timeline/index.html.
12. Drug Policy Alliance. A brief history of the Drug War. 2016. Retrieved 6 Mar 2016 from http://www.drugpolicy.org/new-solutions-drug-policy/brief-history-drug-war.

13. James DJ, Glaze LE. Mental health problems of prison and jail inmates. Washington, DC: Bureau of Justice Statistics; 2006.
14. Glaze LE, Herberman EJ. Correctional populations in the U.S., 2012. Washington, DC: Bureau of Justice Statistics; 2013.
15. Levit KR, Kassed CA, Coffrey RM, Mark TL, McKusick DR, King E, Vandivort R, Buck J, Ryan K, Strangers E. Projections of national expenditures for mental health services and substance abuse treatment. Rockville: Substance Abuse and Mental Health Services Administration; 2008.
16. Peternelj-Taylor C. Criminalization of the mentally ill. J Forensic Nurs. 2008;4(4):185–7.
17. Richards C, Bouman WP, Seal L, Barker MJ, Nieder TO, T'Sjoen G. Non-binary or genderqueer genders. Int Rev Psyc. 2016;28 (1):95–102.
18. National Alliance on Mental Illness. Public Policy Platform. 2016. Retrieved from http://www.nami.org/getattachment/Learn-More/Mental-Health-Public-Policy/Public-Policy-Platform-up-to-12-09-16.pdf.
19. Junginger J, Claypoole K, Laygo R, Crisanti A. Effect of serious mental illness and substance abuse on criminal offenses. Psychiatr Serv. 2006;57(6):879–82.
20. Wright S, Gournay K, Glorney E, Thornifcroft G. Mental illness, substance abuse, demographics and offending: dual diagnosis in the suburbs. J Forensic Psyc. 2002;13(1):35–52.
21. Nguyen T, Davis K, Counts N, Fritze D. The state of mental health in America: Mental Health America; 2016.
22. Mays VM, Cochran SD. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the U.S. Am J Public Health. 2001;91(11):1869–76.
23. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129(5):674–97.
24. Human Rights Campaign. Growing up LGBT in America: HRC youth survey report key findings. Washington, DC: Human Rights Campaign; 2013.
25. Center for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12: youth risk behavior surveillance. Atlanta: Department of Health and Human Services; 2011.
26. Fisher WH, Geller JL, Pandiani JA. The changing role of the state psychiatric hospital. Health Aff. 2009;28(3):676–84.
27. Kaiser Family Foundation. Key facts about the uninsured population. 2015. Retrieved from http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.
28. Center for American Progress. LGBT communities and the Affordable Care Act: findings from a national survey. 2013. Retrieved from https://www.americanprogress.org/wp-content/uploads/2013/10/LGBT-ACAsurvey-brief1.pdf.
29. Clift J, Kirby J. Healthcare access and perceptions of provider care among individuals in same-sex couples: findings from the Medical Expenditure Panel Survey (MEPS). J Homosex. 2012;59 (6):839–50.
30. Mancuso D. Quality indicators and outcomes for persons discharged from state psychiatric hospitals. Depart Soc Health Sci Res Data Anal Divi. 2015;3(41):1–10.
31. Orel NA. Investigating the needs and concerns of lesbian, gay, bisexual, transgender older adults: the use of qualitative and quantitative methodology. J Homosex. 2014;61(1):53–78.
32. Brinkley-Rubinstein L. Incarceration as a catalyst for worsening health. Health Justice. 2013;1(3):2–17.
33. Western B. The impact of incarceration on wage mobility and inequality. Am Sociol Rev. 2002;67(4):526–46.
34. LeBel TP. If one doesn't get you another one will: formerly incarcerated persons' perception of discrimination. Prison J. 2011;92(1):63–87.
35. Durose MR, Cooper AD. Recidivism of prisoners released in 30 states in 2005: patterns from 2005 to 2010. Washington, DC: Bureau of Justice Statistics; 2014.
36. Eckholm E. Prison rate was rising years before 1994 law. New York Times. 10 Apr 2016. Retrieved from http://www.nytimes.com/2016/04/11/us/prison-rate-was-rising-years-before-1994-law.html?_r=0.
37. Substance Abuse and Mental Health Services Administration. A providers introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals. U.S. Rockville: Department of Health and Human Services; 2012.
38. Marshal MP, Friedman MS, Stall R, King KM, Miles J, Gold MA, Bukstein OG, Morse JQ. Sexual orientation and adolescent substance use: a meta-analysis and methodological review. Addiction. 2008;103(4):546–56.
39. Mereish EH, O'Cleirigh C, Bradford JB. Interrelationships between LGBT-based victimization, suicide, and substance use problems in a diverse sample of sexual and gender minorities. Psychol Health Med. 2014;19(1):1–13.
40. Russell ST, Driscoll AK, Truong N. Adolescent same-sex romantic attractions and relationships: implications for substance use and abuse. Am J Public Health. 2002;92:198–202.
41. Steinberg, D, Mills, D, Romano, M. When did prisons become acceptable mental healthcare facilities? Stanford Law School—Three Strikes Project. 2012. Retrieved from http://law.stanford.edu/wp-content/uploads/sites/default/files/child-page/632655/doc/slspublic/Report_v12.pdf.
42. Aufderheid, D. Mental illness in America's jails and prisons: toward a public safety/public health model. Health Affairs Blog. 2014.
43. Human Rights Watch. Ill-equipped: U.S. prisons and offenders with mental illness. Washington, DC: Human Rights Watch; 2003.
44. Massoglia M. Incarceration, health, and racial disparities in health. Law Soc Rev. 2008;42(2):275–306.
45. Defina R, Hannon L. The impact of mass incarceration and poverty. Crime Delinq. 2013;59(4):562–86.
46. Alexander M. The new Jim crow: mass incarceration and the age of colorblindness. New York: New Press; 2012.
47. Lopez, H, Light, MT. A raising share: hispanics and federal crime. Pew Research Center; 2009. Retrieved from http://www.pewhispanic.org/2009/02/18/a-rising-share-hispanics-and-federal-crime/.
48. Stanley EA, Smith N, editors. Captive genders: trans embodiment and the prison industrial complex. Oakland: AK Press; 2015.
49. Department of Justice Statistics. LGBTQ youths in the juvenile justice system. Washington, DC: Office of Juvenile Justice and Delinquency Prevention; 2014.
50. National Center for Transgender Equity. Reducing incarceration and ending abuse in prisons. A blueprint for equality: federal agenda for transgender people. Washington, DC: National Center for Transgender Equality; 2015. p. 41–3. It was retrieved from: http://www.transequality.org/sites/default/files/docs/resources/NCTE_Blueprint_June2015.pdf?quot%3B=
51. Bonczar TP, Beck AJ. Special report: lifetime likelihood of going to state or federal prison. Washington, DC: Bureau of Justice Statistics; 1997.
52. Reisner SL, Bailey Z, Sevelius J. Racial/ethnic disparities in the history of incarceration, experiences of victimization, and associated health indicators among transgender women in the U.S. Women Health. 2014;54(8):750–67.
53. Heck NC, Livingston NA, Flentje A, Oost K, Stewart BT. Reducing risk for illicit drug use and prescription drug misuse: high school gray-straight alliances and lesbian, gay, bisexual, and transgender youth. Addict Behav. 2014;39(4):824–8.
54. Majd K, Marksamder J, Reyes C. Hidden injustice: lesbian, gay, bisexual, and transgender youth in the juvenile courts. San

Francisco: Legal Services for Children and National Center for Lesbian Rights; 2009.
55. Aizer A, Doyle JJ. Juvenile incarceration, human capital and future crime: evidence from randomly-assigned judges. Cambridge, MA: The National Bureau of Economic Research; 2013.
56. The Global Fund. The global fund strategy in relation to sexual orientation and gender identities. 2016. Retrieved from http://www.theglobalfund.org/documents/core/strategies/Core_SexualOrientationAndGenderIdentities_Strategy_en/.
57. Centers for Disease Control and Prevention. HIV among transgender people. 2016. Retrieved 6 Mar 2016 from http://www.cdc.gov/hiv/group/gender/transgender/.
58. ACLU. End the abuse: protecting LGBTI prisoners from sexual assault. Prison Rape Elimination Act (PREA) toolkit. 2014. Retrieved from https://www.aclu.org/sites/default/files/assets/012714-prea-combined.pdf.
59. Beck AJ, Harrison PM, Berzofsky M, Caspar R, Krebs C. Sexual victimization in prisons and jails reported by inmates, 2009–09. Washington, DC: Bureau of Justice Statistics; 2010.
60. Beck AJ, Canton D, Hartage J, Smith T. Sexual victimization in juvenile facilities reported by youth, 2012: national survey of youth in custody, 2012. Washington, DC: Bureau of Justice Statistics; 2013.
61. Bailey ZD, Williams DR, Kawachi I, Okechukwu CA. Incarceration and adult weight gain in the National Survey of American Life. Prev Med Int J. 2015;81:380–6.
62. Haney C. From prison to home: the effect of incarceration and reentry on children, families, and communities. Washington, DC: U.S. Department of Health and Human Services; 2001.
63. Nuttbrock L, Rosenblum A, Blumenstein R. Transgender identity affirmation and mental health. Int J Transgenderism. 2002;6(4). Retrieved from: http://www.symposion.com/ijt/ijtvo06no04_3.htm
64. Neal TMS, Clements CB. Prison rape and psychological sequelae: a call for research. Psychol Public Policy Law. 2010;16(3):284–99.
65. Boeschen LE, Sales BD, Koss MP. Rape trauma experts in the courtroom. Psychol Public Policy Law. 1998;4:414–32.
66. Ullman SE, Townsend SM, Filipas HH, Starzynki LL. Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD among sexual assault survivors. Psychol Women Q. 2007;31:23–38.
67. Kaeble D, Glaze LE, Tsoutis A, Minton TD. Correctional populations in the United States, 2014. Washington, DC: Bureau of Justice Statistics; 2015.