Incarceration as a Health Determinant for Sexual Orientation and Gender Minority Persons

Incarceration is considerably more prevalent among sexual and gender minority persons (SGM) than among the general population. Once behind bars, they are at the greatest risk for health-related harms.

Although a growing number of studies have assessed health disparities produced by mass incarceration, scholars are yet to systematically assess the health consequences of incarceration on the basis of sexual orientation and gender identity.

We invite public health scholars to study the effects of incarceration on health in the SGM population and provide a roadmap to aid these research efforts. First, we document the disproportionate presence of SGM persons in jails and prisons. Second, we note health-related risks that are the most salient for this population. Third, we recommend examining heterogeneity in the effects of incarceration by teasing out distinct risks for groups defined by sexual orientation, gender identity, and race/ethnicity. Fourth, we note methodological challenges with respect to measurement and assessing causality. Finally, we discuss the importance of health care access and quality and the need to study health during incarceration and afterward. (*Am J Public Health*. 2018;108:994–999. doi:10.2105/AJPH.2018.304500)

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See also Kosenko and Nelson, p. 970.

It is now widely known that the United States has the highest incarceration rate in the world—a phenomenon that public health scholars have described as the epidemic of incarceration.[1] A growing body of research indicates incarceration as a powerful social determinant of health.[2] In correctional facilities, rates of infectious diseases—especially HIV, hepatitis, and tuberculosis—and noncommunicable diseases—such as cardiovascular problems—are much greater than in the general population.[1] A majority of incarcerated persons suffer from psychological or substance use disorders and for many of them incarceration is often a recurring experience. According to the latest nationally representative estimates, close to half of those confined in jails and state and federal prisons reported ever having a chronic condition or infectious disease compared with about a third in the general population.[3]

Even though many incarcerated persons have likely acquired poor health in the community, there is increasing evidence that incarceration may cause higher rates of infectious diseases and stress-induced health conditions.[4] As a result, public health scholars have begun responding to calls for research on health disparities generated by the criminal justice system.[1] Yet little attention has been paid to a population that is disproportionately incarcerated and exposed to the greatest risk of harm behind bars—sexual and gender minority (SGM) persons. We issue a call to scholars to examine how incarceration affects the health of SGM persons in jails and prisons during and after serving their sentence. To facilitate these efforts, we review the research and take an interdisciplinary perspective in discussing why incarcerated SGM persons may be especially vulnerable to health-related risks. We also note specific areas that need future research. Our review focuses on adults incarcerated in jails and prisons even though many of the issues are relevant for other institutions, such as juvenile detention facilities and immigrant detention centers.

Our effort to identify key issues facing incarcerated SGM populations is framed by the notion that stigma and hostile behavior toward stigmatized groups operate as a multilevel phenomenon.[5] At the individual level, we build on the minority stress perspective[6] and identify social psychological processes, such as internalized homophobia, as responses to the largely heterosexist penal environments. At the interpersonal level, we note the extremely high victimization rates of incarcerated SGM persons. Finally, at the structural level, we consider the institutional practices that expose incarcerated SGM persons to an increased risk of poor physical and mental health. These practices include assigning transgender inmates to gender-specific facilities on the basis of birth-assigned sex or genitalia rather than gender identity. Although public health studies tend to focus on risks associated with same-sex sexual behavior—engaging in sexual activity with someone of the same sex—our emphasis is on those who self-identify as SGM (e.g., gay, lesbian, bisexual, or transgender) as a population with unique health risks in correctional settings.

DISPROPORTIONATE INCARCERATION

Until recently, it was difficult to provide a meaningful estimate

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of how many SGM persons are incarcerated because national-level surveys in jails and prisons did not collect information on sexual orientation, gender identity, and same-sex behaviors. This information became available with the National Inmate Survey (NIS), which was mandated by the 2003 Prison Rape Elimination Act. According to the latest estimates from the NIS, collected in 2011 and 2012, approximately 238 000 sexual minorities were incarcerated in the United States.[7] In relative terms, 9.3% of men in prison, 6.2% of men in jail, 42.1% of women in prison, and 35.7% of women in jail self-identified as lesbian, gay, or bisexual or reported a same-sex sexual experience before incarceration. Estimates suggest an incarceration rate of 1882 per 100 000 lesbian, gay, or bisexual (LGB)–identified persons.[7] By comparison, the general incarceration rate is 612 per 100 000 adults. Such a disproportionate rate of incarceration is especially troubling considering that LGB persons make up only between, by some estimates, about 2% to 6% of the population.[8] Once incarcerated, SGM persons are exposed to severe health-related risks.

INCARCERATION AND HEALTH

There has been little research on incarceration and health among SGM populations. The most comprehensive study to date was performed on the basis of the 2011 to 2012 NIS data.[7] Men who identified as gay or bisexual or who had same-sex sexual experiences before incarceration reported higher prevalence of nonspecific psychological distress. Furthermore, incarcerated gay and lesbian persons were more frequently exposed to sexual victimization and solitary segregation than were inmates who identified as straight. Because the study was on the basis of cross-sectional data, questions remain of whether the mental health problems among SGM persons preceded incarceration or were a result of incarceration. The inability to determine temporal ordering is problematic because of the higher prevalence of mental health problems among SGM persons in the community.[9]

WHY INCARCERATION MAY HARM HEALTH

Estimating the effects of incarceration is closely tied to understanding the mechanisms that lead to poor health. In the general prison population, explanations for the incarceration–health link have often emphasized social isolation and separation from significant others.[4,10] These mechanisms are important, but we focus on those that may be especially salient for the SGM population: victimization and social psychological aspects of incarceration related to the stigma of minority status. As an assignment of negative beliefs to attributes perceived as non-normal, deviant, and discrediting, stigmatization is a means of indicating, and enforcing, socially accepted boundaries of expected behavior and often takes the form of oppression, rejection, and victimization. This process is especially powerful in correctional settings because of rigid heterosexist norms and hierarchies.[11,12] Whereas victimization has a direct effect on physical health through injuries and infectious diseases, it indirectly affects stress-induced physical problems such as high blood pressure and obesity. The psychological trauma of victimization can affect depression and anxiety.

Victimization

Victimization characterizes the lives of SGM populations at a rate higher than the general population throughout the life span, especially in childhood. Meyer et al.[7] found that incarcerated LGB persons, men who had sex with men (MSM), and women who had sex with women had substantially higher odds of sexual victimization in childhood than did their heterosexual counterparts. Another study reported that among Black and Latino MSM the experience of childhood neglect, or physical and sexual abuse as children, were associated with increased likelihood of arrest.[13] Others have also documented increased likelihood of arrest among gay and bisexual men who had experienced childhood abuse and violence.[14] Studies that examine the effect of incarceration on health among SGM populations need to carefully attend to the experiences of victimization during and before incarceration.

Sexual orientation and gender identity are among the greatest risk factors for victimization inside correctional facilities. The latest national data showed that the prevalence of sexual victimization in prison among men who identified as gay or bisexual was 17.5% compared with 2.7% among straight-identified men.[7] At the same time, victimization has been linked to a range of poor health outcomes through several mechanisms, including emotion dysregulation[15] and lower self-esteem.[16] Victimization is therefore a key mechanism through which incarceration may translate to poor health for incarcerated SGM persons. Furthermore, research suggests that multiple experiences of victimization may lead to especially deleterious health outcomes.[17] To the extent that SGM persons are at an increased risk for victimization outside prison, revictimization while incarcerated may carry added risk and have a prolonged health effect following their release into the community.

Social Psychological Processes

The minority stress model can help explain how social psychological processes may lead to poor health among incarcerated SGM populations. In particular, the model places an emphasis on understanding how heterosexist contexts produce chronic stress attributable to prejudice, stigma, and discrimination.[6] Although there is a dearth of empirical research on minority stress in correctional settings, related work provides indirect support. Gay men in contexts that trigger a concern about confirming their group's stereotypes experience acute poor mental health in the stereotyped performance domain.[18] Also, women who strongly identify as bisexual are more likely than are those who identify weakly to perceive discrimination across multiple social contexts which, in turn, is linked to increased drug abuse.[19] Furthermore, justice-involved individuals in employment contexts in which they must reveal their criminal records feel like the target of discrimination. As a result, they experience a strong emotional state of felt stigma and rejection sensitivity, which are risk factors for poor mental health among SGM persons.[20]

In addition, concealment of identity in SGM persons has been implicated in poor health.[21] Because SGM status is associated with an increased risk of violence during incarceration,

concealment may be a strategy that incarcerated SGM persons begin (or continue) to use in jail or prison, making them especially vulnerable to associated health problems. Even for persons who concealed their identity or orientation in the community, concealment during incarceration may be more complete because of the amplified risks they are exposed to behind bars in the form of violence and discrimination. Internalized homophobia has also been associated with negative health outcomes[6] and can be exacerbated during periods of exposure to nonaffirming institutions.[22] To the extent that jails and prisons enforce traditional sexuality and gender norms,[11,12] internalized homo- and transphobia may become a more challenging issue during confinement, leading to especially poor health outcomes for current and formerly incarcerated SGM persons.

HETEROGENEOUS HEALTH EFFECTS OF INCARCERATION

Studying the health of incarcerated SGM persons requires carefully considering possible heterogeneous effects because the type of health risks they are exposed to may vary on the basis of group membership. There might be important differences, for instance, between gay and lesbian persons in correctional settings. The most recent estimates indicate that 33.3% of women in prisons identified as lesbian or bisexual, whereas 8.8% reported same-sex behavior before incarceration—proportions much greater than those of nonstraight men.[7] The relative group size of sexual minority incarcerated women may therefore act as a buffer against health risks such as social isolation. However, such speculation is complicated by the gendered nature of prisons that reinforce heteronormative patterns and subordinate feminine women in favor of women that exhibit hypermasculine traits.[12] It is also important to consider that incarcerated women, in general, are subject to harsher disciplinary treatment than men by staff who play an important role in enforcing gender norms and penalizing those who violate them. In addition, being out for bisexual women is a risk factor for poor health behaviors in the community, and the same might be the case in jails and prisons.[19]

Gender Identity

Transgender persons are at high risk for incarceration, and they are at extraordinary risk for victimization once incarcerated. A study carried out in a male prison found that 59% of incarcerated transgender persons have reportedly been a victim of assault.[23] In the 2011 to 2012 NIS, about 1 in 3 transgender persons have reported being victimized, which is much higher than victimization rates for incarcerated LGB populations.[24] The vulnerability of transgender incarcerated persons may be further amplified if they also self-identify as a sexual minority. An issue that is salient for incarcerated transgender persons in particular is the assignment to gender-specific facilities on the basis of birth-assigned sex or genitalia instead of gender identity.[25] A transgender woman, for instance, incarcerated in a male prison may be exposed to an especially high risk of victimization. As part of the Prison Rape Elimination Act, in 2012 the Department of Justice has issued detailed standards that require correctional staff to consider gender identity as well as personal safety when deciding where to place transgender inmates, but the guidelines are not legally binding and many prisons follow state and local rules that do not carry the same requirements.[26]

Race and Ethnicity

Although Black persons constituted about 13% of the US population in 2017, they constituted 37.7% of the incarcerated population.[7] Among incarcerated sexual minority men, 27.0% are Black gay or bisexual persons whereas 34.0% are MSM.[7] The rate of HIV infection in the community is multiple times higher among Black MSM than among White MSM—despite lower levels of sexual risk behaviors. Race and SGM status interact in a synergistic fashion.[27] Black MSM are less likely to identify as gay or to disclose their sexual identity to others than are White MSM.[28] In extremely heteronormative environments such as prisons, Black SGM persons might feel even more compelled to conceal their sexual orientation and identity. They may also be more reluctant to seek medical help if victimized because of race-conscious medical distrust.[29] Furthermore, incarcerated Black SGM persons might be at an especially high risk for poor health as a result of greater levels of enacted and internalized homophobia compared with other racial groups—both of which are related to sexual risk behaviors.[29] Researchers should pay special attention to young Black men, who experience an exceptionally high risk of HIV/AIDS in the community. These research efforts can be usefully informed by the life course perspective and its emphasis on the timing of critical life events and early interventions because exposure to both incarceration and HIV are structured by age.

RESEARCH CHALLENGES

Reliably measuring sexual orientation and sexual behavior may be especially challenging in jails and prisons because of a distinct sexual culture.[11,12] Although same-sex sexual attraction or a gay, lesbian, bisexual, or transgender identification might not always be truthfully reported in correctional surveys, inmates may feel less stigmatized when reporting engaging in same-sex sexual intercourse because such behavior can be considered an expression of dominance and power, especially among male inmates.[11] Researchers have only recently started to attend to these differences in the general population, and results reveal different health outcomes with respect to SGM identity compared with same-sex behavior that deserve further attention.[30] For example, whereas the prevalence of psychological distress among incarcerated women who have sex with women and straight women is almost the same, the difference in prevalence between sexual minority men and their straight counterparts is considerable.[7] It is therefore essential to separately measure self-identified sexual orientation and same-sex sexual behaviors. Furthermore, because the health consequences of forced sex are likely different from the consequences of consensual sex, studies should distinguish between them.

That there are few studies examining how incarceration

affects the health of incarcerated SGM persons might be attributable to the limitations of data sets typically used in research on the consequences of incarceration. In national surveys, the proportions of participants who can be classified as SGM tend to be small, especially in combination with having served time in jail or prison. For that reason, scholars using national surveys sometimes use romantic attraction as a proxy for sexual orientation, combine both-sex and same-sex only attracted participants, or blend same-sex behavior with same-sex sexual orientation to augment the sample size. Another issue is reliability of SGM measures. In the often-used National Longitudinal Study of Adolescent to Adult Health, the measurement of LGB status in the first round of data collection has been described as dubious because a substantial number of participants either falsely reported same-sex attraction or did not understand what counts as romantic attraction.[31] Studies in correctional settings should follow current best practices in identifying SGM status and same-sex sexual behavior and ensure that behaviors and identities are not lumped together. At the same time, to the extent possible, sample sizes should be large enough to capture the diversity in the SGM population.

Estimating Causal Effects

The issue of causality deserves special attention. Because of the many health-related risks identified in the literature on incarceration and health, it may appear that estimating a credible causal effect of incarceration on health should be straightforward. This, however, is not the case. Incarcerated persons are disproportionately selected from socioeconomically disadvantaged groups that experience a much higher burden of disease than does the general population.[1] What appears to be an effect of incarceration might instead be a reflection of the overrepresentation of people from poor socioeconomic and health backgrounds in jails and prisons. Because of amplified and often overlapping socioeconomic and health problems, these issues may be even more salient for incarcerated SGM populations.[32] To advance our understanding of whether and how incarceration affects the health of SGM populations, future research needs to collect longitudinal data covering periods both during and after incarceration.[32] However, because of how little we know about incarcerated SGM persons, qualitative research can help elucidate the mechanisms involved in producing poor health and guide the design of quantitative studies.

HEALTH CARE ACCESS AND QUALITY

Studies that found lower mortality rates among incarcerated Black men compared with their nonincarcerated counterparts suggest that correctional institutions may have health benefits attributable to access to medical care.[33] The latest round of NIS showed that a majority of inmates have received medical assessments or examinations since admission. But the difference between jails and prisons is alarming.[3] For example, whereas 71% and 54% of prison inmates reported being tested for HIV and hepatitis C, respectively, the comparable numbers for jail inmates are 11% and 6%. Furthermore, there are no data about the ease of access or the content and the quality of health care that incarcerated persons receive. Interestingly, about half of prisoners and jail inmates report being either very satisfied or somewhat satisfied with the health care services received since they were incarcerated possibly because many did not have access to health care before incarceration.[3] Future studies should consider the availability and ease of access to health-related services for incarcerated SGM persons in jails and prisons.

Medical assistance may be especially important for incarcerated transgender persons, yet they experience direct obstacles in obtaining care. Both litigation and surveys suggest that many prisons and jails refuse to provide various forms of medically indicated transition-related care, sometimes explicitly adopting policies prohibiting providing hormone treatment or other appropriate transition care to transgender inmates.[34] Although courts have generally agreed with litigants that gender dysphoria is a serious medical need that cannot go untreated without violating the Eighth Amendment, lack of access to transition-related care remains common. Respondents in the 2015 National Transgender Survey indicated that a full 37% of those taking hormones before incarceration were "prohibited from taking their hormones in the past year whereas in jail, prison or juvenile detention."[34(p193)] These accounts strongly suggest the need for further systematic research into the extent and effects of direct discrimination against the provision of transition-related health care, which often constitutes one of the major health care needs of transgender individuals. Although providing appropriate medical care during incarceration is critical, care should not stop when formerly incarcerated persons reenter the community.

REENTRY

In addition to assessing experiences of SGM persons behind bars, public health scholars should also consider the period following incarceration. In a recent review of the available research on opportunities to improve the health of people involved with the criminal justice system, Freudenberg and Heller explicitly identified the need for "studies of interventions that meet the distinct reentry needs of lesbian, gay, bisexual, and transgender inmates, at high risk for trauma before and after incarceration."[35(p325)] Relationships between social support and SGM communities merit special attention. The reentry experiences may be distinct depending on the role that social networks in the form of "families of choice," as opposed to biological or legal "families of origin"[36] play in incarcerated SGM persons' lives and by varying levels of acceptance they may receive from their families of origin. Research that examines the health of recently released incarcerated SGM persons will need to carefully consider the role of social support in general and families in particular.

The most important period during reentry is immediately following release from confinement, when the risk of mortality is extremely high.[37] Continuity of health care between correctional settings and the community, as others have noted, is particularly important.[38] Because of the high rates of HIV and other infectious diseases among SGM populations in jails and prisons,[4,14] addressing these health conditions immediately

following release—and in preparation for release—is critical. Interruption of access to HIV antiretroviral therapy in correctional settings and during the first few weeks upon release is widespread.[39] Studies should examine the obstacles that SGM persons face in continuing access to medical care they need after they have been released into the community.[1] Nonprofit organizations working with the SGM population in the community may be a valuable resource for establishing the connection between correctional health care and postincarceration health care.

Because of the discrimination in the labor market and in other institutional settings, a great deal of research on the effects of incarceration on health upon reentry has focused on the stigma of a criminal record.[10] The intersection, or intersectionality, of overlapping and interdependent stigmatized identities—SGM status and a criminal record—can compound discrimination and experiences of negative treatment.[40] Therefore, it is important to attend to the variety of ways formerly incarcerated SGM persons are marginalized and how this can increase the risks of developing physical and mental health problems.

CONCLUSIONS

We have identified some of the key conceptual and methodological issues that need to be considered in research on the effects of incarceration on the health of SGM persons. Future studies should pay close attention to measuring and understanding how victimization and social psychological processes of adaptation to prison life are implicated in the mental and physical health of SGM persons. Measurement of SGM status needs to be precise and reflect current best practices that allow researchers to make nuanced distinctions between groups and examine possible heterogeneous effects. Yet studies will fail to satisfy the high standards for what counts as evidence in observational research without longitudinal designs that include both subjective and objective measures of health outcomes. Health research among SGM populations requires the same quality of approach and resources that are used in best public health studies in the general population. We urge researchers to be mindful of the vulnerable position of incarcerated SGM persons and to ensure that they are safe and fully protected from potential repercussions of their study participation.

Although time served behind bars should be the focus of research on incarcerated SGM persons, researchers should not stop at considering the health risks and health conditions that develop during incarceration. We should also study the experiences of formerly incarcerated SGM persons during reentry into the community. This is when the stigma of a criminal record and the stigma of SGM status may compound the difficulties of socioeconomic and legal reintegration into life outside prison. As many studies have found, the first few weeks of reentry are the riskiest for returning inmates—and this is especially the case for persons living with HIV, many of whom belong to the SGM population. Furthermore, although many inmates gain access to comprehensive health care for the first time when they become incarcerated, we know little about its accessibility and quality. Prisons are an opportunity to identify and treat the health needs of the SGM population but mainly if the medical resources are tailored to their specific needs and the risks experienced during incarceration. AJPH

CONTRIBUTORS

V. Baćak conceptualized and led the writing of the essay. All authors contributed to the writing of the essay and assisted with revisions.

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REFERENCES

1. Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public health and the epidemic of incarceration. *Annu Rev Public Health*. 2012;33:325–339.

2. Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. *Lancet*. 2017; 389(10077):1464–1474.

3. Maruschak LM, Berzofsky M. Medical problems of state and federal prisoners and jail inmates, 2011–12. 2015. Available at: https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf. Accessed February 1, 2018.

4. Massoglia M. Incarceration as exposure: the prison, infectious disease, and other stress-related illnesses. *J Health Soc Behav*. 2008;49(1):56–71.

5. Hatzenbuehler ML, Bellatorre A, Lee Y, Finch BK, Muennig P, Fiscella K. Structural stigma and all-cause mortality in sexual minority populations. *Soc Sci Med*. 2014;103:33–41. [Erratum Corrigendum to "Structural stigma and all-cause mortality in sexual minority populations" in *Soc. Sci. Med*. 2014;103:33–41]

6. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull*. 2003;129(5): 674–697.

7. Meyer IH, Flores AR, Stemple L, Romero AP, Wilson BDM, Herman JL. Incarceration rates and traits of sexual minorities in the United States: National Inmate Survey, 2011–2012. *Am J Public Health*. 2017;107(2):267–273.

8. Gates GJ. How many people are lesbian, gay, bisexual, and transgender? 2011. Available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf. Accessed February 1, 2018.

9. Gonzales G, Przedworski J, Henning-Smith C. Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States. *JAMA Intern Med*. 2016; 176(9):1344.

10. Schnittker J, John A. Enduring stigma: the long-term effects of incarceration on health. *J Health Soc Behav*. 2007;48(2): 115–130.

11. Hensley C, Wright J, Tewksbury R, Castle T. The evolving nature of prison argot and sexual hierarchies. *Prison J*. 2003; 83(3):289–300.

12. Gorga A. "Kinda like a man and a woman thing": the construction and reification of gender hegemony in a women's prison. *Soc Currents*. 2017;4(5): 413–428.

13. Ompad DC, Kapadia F, Bates FC, Blachman-Forshay J, Halkitis PN. Racial/ethnic differences in the association between arrest and unprotected anal sex among young men who have sex with men: the P18 Cohort Study. *J Urban Health*. 2015;92(4):717–732.

14. Vagenas P, Zelenev A, Altice FL, et al. HIV-infected men who have sex with men, before and after release from jail: the impact of age and race, results from a multi-site study. *AIDS Care*. 2016;28(1): 22–31.

15. McLaughlin KA, Hatzenbuehler ML, Hilt LM. Emotion dysregulation as a mechanism linking peer victimization to internalizing symptoms in adolescents. *J Consult Clin Psychol*. 2009;77(5):894–904.

16. Hill TD, Kaplan LM, French MT, Johnson RJ. Victimization in early life and mental health in adulthood. *J Health Soc Behav*. 2010;51(1):48–63.

17. Finkelhor D, Ormrod RK, Turner HA, et al. Polyvictimization and trauma in a national longitudinal cohort. *Dev Psychopathol*. 2007;19(1):149–166.

18. Bosson JK, Haymovitz EL, Pinel EC. When saying and doing diverge: the effects of stereotype threat on self-reported versus non-verbal anxiety. *J Exp Soc Psychol*. 2004;40(2):247–255.

19. Feinstein BA, Dyar C, London B. Are outness and community involvement risk or protective factors for alcohol and drug abuse among sexual minority women? *Arch Sex Behav*. 2017;46(5):1411–1423.

20. Feinstein BA, Goldfried MR, Davila J. The relationship between experiences of discrimination and mental health among lesbians and gay men: an examination of internalized homonegativity and rejection sensitivity as potential mechanisms. *J Consult Clin Psychol*. 2012;80(5):917–927.

21. Frost DM, Parsons JT, Nanín JE. Stigma, concealment and symptoms of depression as explanations for sexually transmitted infections among gay men. *J Health Psychol*. 2007;12(4):636–640.

22. Newcomb ME, Mustanski B. Internalized homophobia and internalizing mental health problems: a meta-analytic review. *Clin Psychol Rev*. 2010;30(8): 1019–1029.

23. Jenness V, Maxson CL, Matsuda KN, Sumner JM. *Violence in California Correctional Facilities: An Empirical Examination of Sexual Assault*. Irvine, CA: Center for Evidence-Based Corrections; 2007.

24. Beck AJ, Berzofsky M, Rachel C, Krebs C. *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*. Washington, DC: Department of Justice; 2013.

25. Sumner JM, Jenness V. Gender integration in sex-segregated U.S. prisons: the paradox of transgender correctional policy. In: Peterson D, Panfil VR, eds. *The Handbook of LGBT Communities, Crime, and Justice*. New York, NY: Springer; 2014:229–259.

26. US Department of Justice Final Rule. National standards to prevent, detect, and respond to prison rape under the Prison Rape Elimination Act (PREA). 2012. Available at: https://www.prearesourcecenter.org/sites/default/files/content/prisonsandjailsfinalstandards_0.pdf. Accessed February 1, 2018.

27. Wilson PA, Nanin J, Amesty S, Wallace S, Cherenack EM, Fullilove R. Using syndemic theory to understand vulnerability to HIV infection among Black and Latino men in New York City. *J Urban Health*. 2014;91(5):983–998.

28. Millett GA, Flores SA, Peterson JL, Bakeman R. Explaining disparities in HIV infection among Black and White men who have sex with men: a meta-analysis of HIV risk behaviors. *AIDS*. 2007;21(15): 2083–2091.

29. Vincent W, Pollack LM, Huebner DM, et al. HIV risk and multiple sources of heterosexism among young Black men who have sex with men. *J Consult Clin Psychol*. 2017;85(12):1122–1130.

30. Bostwick WB, Boyd CJ, Hughes TL, McCabe SE. Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *Am J Public Health*. 2010;100(3):468–475.

31. Savin-Williams RC, Joyner K. The dubious assessment of gay, lesbian, and bisexual adolescents of Add Health. *Arch Sex Behav*. 2014;43(3):413–422.

32. Caceres BA, Brody A, Luscombe RE, et al. A systematic review of cardiovascular disease in sexual minorities. *Am J Public Health*. 2017;107(4):e13–e21.

33. Patterson EJ. Incarcerating death: mortality in US state correctional facilities, 1985–1998. *Demography*. 2010;47(3): 587–607.

34. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Ana M. The Report of the 2015 U.S. Transgender Survey. 2016. Available at: http://www.ustranssurvey.org/report. Accessed August 17, 2017.

35. Freudenberg N, Heller D. A review of opportunities to improve the health of people involved in the criminal justice system in the United States. *Annu Rev Public Health*. 2016;37:313–333.

36. Weeks J, Heaphy B, Donovan C. *Same Sex Intimacies: Families of Choice and Other Life Experiments*. New York, NY: Routledge; 2001.

37. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157–165.

38. Wang EA, White MC, Jamison R, Goldenson J, Estes M, Tulsky JP. Discharge planning and continuity of health care: findings from the San Francisco County Jail. *Am J Public Health*. 2008; 98(12):2182–2184.

39. Baillargeon J, Giordano TP, Rich JD, et al. Accessing antiretroviral therapy following release from prison. *JAMA*. 2009;301(8):848–857.

40. Grollman EA. Multiple disadvantaged statuses and health. *J Health Soc Behav*. 2014;55(1):3–19.

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