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Sexual Minority Youth and the Juvenile Justice System: A Poignant Need Group

Dembo R[1*], Faber J[2], Wareham J[3], Krupa JM[4], DiClemente RJ[5] and Schmeidler J[6]

[1]*Department of Criminology, University of South Florida, USA*

[2]*Agency for Community Treatment Services, Tampa, USA*

[3]*Department of Criminal Justice, Wayne State University, USA*

[4]*School of Criminal Justice, Michigan State University, USA*

[5]*Department of Social and Behavioral Sciences, New York University, USA*

[6]*Department of Psychiatry and Bio mathematical Sciences, Mt. Sinai School of Medicine, USA*

[*]**Corresponding author:** Dembo R, Department of Criminology, University of South Florida, 4202 East Fowler Avenue, SOC 107, Tampa, FL, 33620, USA, Tel: 813-943-7116; Fax: 813-354-0740; E-mail: rdembo@usf.edu

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Abstract

Lesbian, gay, bisexual, transgender, and queer or questions (LGBTQ) youth are overrepresented in the U.S. juvenile justice system. These youth experience a variety of personal, social and systemic harms and difficulties that place them at greater risk of involvement in the juvenile justice system. Understanding the prevalence of risk factors experienced by LGBTQ youth can lead to improved intervention efforts. Using data from a Health Coach Service project implemented at a juvenile intake facility, n=1.619 newly arrested youth were included in the current study (8.3% self-identified as sexual minority). The current study sought to determine prevalence rates of minority sexual orientation, whether LBGTQ youth differed in regard to key demographic and risk factors, and whether these differences varied by gender. Findings revealed sexual minority, justice-involved adolescents suffered disproportionate juvenile justice placement, family problems, risky sexual behavior (including STD positivity), depression, and victimization. Gender differences among sexual minority youth were reported for family problems, sexual risk behavior, depression, sexual assault, bullying, and drug use severity. The results suggest a need to advocate for LGBTQ youth to ensure policies and procedures are sensitive to the rights of LGBTQ youth.

Keywords: Sexual orientation; Sexual minority; Gender; Delinquents; Arrested youth; STD; Depression; Drug problems; Family problems

Introduction

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth represent approximately 6%-9% of youth nationwide [1], with higher proportions among girls than boys. For example, a 2015 nationwide survey of high school students found LGB youth represent approximately 12% of girls and less than 5% of boys [1]. LGBTQ youth are overrepresented in the U.S. juvenile justice system (JJS), including the courts [2], probation and supervised diversion [3], juvenile detention and correctional facilities [4,5], and in other JJS facilities (e.g., residential commitment programs) [6]. For example, in a study of six juvenile detention facilities across the U.S., LGB youth represented 11% of juvenile detainees, with sexual minority girls and boys comprising 23% and 8% of detainees, respectively [7]. Irvine and Canfield [8] reported 32% of detained girls and 6% of detained boys identified as sexual minorities (i.e., gay, lesbian, bisexual, or queer/questioning), while a nationally representative survey of juveniles held in correctional facilities reported 39% of girls and 3% of boys identified as sexual minority [5]. The overrepresentation of LGBTQ youth in the JJS suggests sexual minority and gender non-conforming adolescents are among the most troubled youth in society. These youth experience a variety of personal, social, and systemic harms and difficulties that place them at greater risk of finding their way into the JJS.

At home, LGBTQ youth are more likely to experience childhood sexual and physical abuse, than sexual majority (i.e., heterosexual) youth [9]. LGBTQ youth are also likely to experience hostility and verbal abuse from their families, who reject their sexual orientation or non-conforming gender behavior [10]. LGBTQ youths who experience family rejection may suffer deleterious health effects (e.g., elevated levels of depression, illegal drug use, suicide attempts), and as many as 40% may be kicked out of the home by their family or run away from home as a result of family rejection [11,12]. Family rejection, and the abuse that may accompany it, place sexual minority youth at greater risk of foster care placement or homelessness, which may serve as a pathway to the JJS [7]. Further, placement in foster care often exposes LGBTQ youth to stigma, discrimination, abuse, and victimization from their sexual majority peers [8].

In addition to challenges at home, LGBTQ youth face challenges at school. The school environment can be difficult for many LGBTQ youth, who report elevated levels of bullying and victimization from classmates, as well as administrators and/or teachers [1,13]. A hostile school environment increases the risk of truancy, dropping out, lower grades, harassment and assault victimization, suspension/expulsion, and psychological stress among LGBTQ youth [1,9,13,14]. As well, LGBT youth often face hasher disciplinary actions from administrators [1,14,15].

For too many LGBTQ youth, bad experiences at home, school, and foster care leads to them becoming homeless. A recent study indicates 50% of youth homelessness seems to be directly preceded by family

conflict ending with the youth running away or being kicked out of the house [16]. A recent national study found LGBTQ youth were 120% more likely to experience homelessness, compared to non-LGBTQ identified youth [17]. Homeless youth may experience more maltreatment prior to leaving home, compared to the general population [18]. Homelessness can lead to victimization [16], involvement in survival crimes, such as shoplifting, trading sex, and drug sales, and experiences with police strategies and discrimination targeting of LGBTQ youth [6,14]. For many, the net result of these experiences is entry into the JJS [19]. Once LGBTQ youth enter the JJS, they are at risk of experiencing additional forms of discrimination and harm.

Under the due process clause of the Constitution, juveniles who are in the custody of the state, either JJS or foster care, have an affirmative right to safety [20]. However, as Estrada and Marksamer [20] demonstrate, LGBTQ youth under state custody were and in some cases are often subject to harsher and inequitable conditions. Discriminatory practices by the state have led to several noteworthy litigation efforts to protect the rights of LGBTQ youth in foster care (e.g., DeShaney *vs.* Winnebago County Department of Social Services) and in the JJS (e.g., Jackson *vs.* Johnson). These legal efforts, among others, have established the following important principles regarding LGBTQ youth in the JJS: (1) need for protection from emotional and physical harm; (2) appropriate placement in settings, rather than isolation or inequitable restriction; (3) a right to receive appropriate mental and physical health care; (4) constitutional right to equal protection, free speech, and freedom of religion; and (5) avoidance of participation in religious activities that condemn LGBTQ people. These rights, as well as requirements that state and local jurisdictions establish non-discrimination protections for LGBTQ youth in the JJS, have established a legal framework for protecting such vulnerable youth. The above noted legal efforts have been complemented by grass roots efforts to train JJS providers on sexual orientation and gender identity, to help them better understand LGBTQ youth and their needs, provide guidelines for staff [20], and recommend JJS reform [2,6,10,21-25].

LGBTQ youth in the JJS face additional challenges. They are more likely to be placed in secure detention [25] and other residential secure facilities [2]. While in secure placement, LGBTQ youth, especially girls, are at heightened risk of assault and discrimination by other incarcerated youth [25,26], often experience inappropriate placement [6], stigma, discrimination, and abuse by facility staff [26], and lack access to quality health care and other support services [27]. Further, although the state licenses and regulates youth facilities, both public and private, the quality of oversight varies. In fact, some private facilities operate without licenses [28].

The overrepresentation of LGBTQ youth in the JJS, and their unique needs and experiences warrants greater focus on these issues, particularly at the front-end of the JJS where their needs can be identified and met earlier. Unfortunately, there is scant systematic research on LGBTQ youth entering JJS, since most youth are released back to the community following arrest [29]. Such research could identify needs for support services for LGBTQ youth involved in JJS. Thus, our objectives are to estimate the prevalence of minority sexual orientation among female and male adolescents entering the JJS; examine differences from sexual majority (i.e., heterosexual) youth on socio-demographics, family problems, sexual risk behavior, mental health, and substance use issues; and identify whether such differences vary by gender.

Methods

Data source

The current study includes data from a Health Coach Service [30] for recently arrested youth entering a central intake facility, the Juvenile Assessment Center (JAC), serving a county in a southeastern U.S. state. Every juvenile arrested or charged in the county is taken to the JAC for intake processing, which must take no longer than six hours according to the State. During intake, youths were approached by trained Health Coach Staff; participation in the service was voluntary, with written informed youth consent prior to initiating service. Screening and assessment data were collected in face-to-face interviews by female Health Coaches in private booths at the JAC. As Health Coach Services, youth received evidence-based and culturally-appropriate information about HIV and other sexually transmitted diseases (STDs), and a urine assay for STDs and drug use. Youth identified with HIV/STDs, positive drug screens, or high depression scores were promptly linked to appropriate treatment services in collaboration with the state Department of Health [30]. Data were provided in electronic, de-identified form, and did not involve any interaction with the youth, so the present study was deemed exempt by the Institutional Review Board (IRB).

Participants in the current study received Health Coach Services from January 1, 2017 through December 31, 2017 at the JAC. To avoid multiple counting of youth, only the initial JAC entry data were used in analyses; over 80% had one entry. A total of 423 females and 1,196 males were included in the analyses, which excluded 14 youth who were "Not Sure" about their sexual orientation. Participation in the service exceeded 96%, precluding comparisons between youth participating and declining.

Sexual orientation

Sexual orientation was assessed with a single item: "Which of the following best describes you?" with answer options "Bisexual," "Gay or Lesbian," "Heterosexual (straight)," or "Not Sure." The question captured sexual orientation, not gender identity, including transgender. Youth who responded as bisexual, gay, or lesbian were coded as sexual minority (1), while those who responded as heterosexual were coded as sexual non-minority (0).

Socio-demographic characteristics

Age was a continuous variable. Biological sex (referred to as gender, though this term is restrictive here) was a dichotomy: male (0) and female (1). Race/ethnicity was a categorical variable for Hispanic (1), African American (2), white (3), or other (4). Youth were also asked about the adults in their living situation. Relatively few male (13%) and female (12%) youth reported living with both biological parents, but 34% of male youth and 34% of female youth lived with their birth mother alone. The analyses dichotomized birth mother alone (1) or all others (0).

Post JAC placement

During JAC intake, risk assessment is based on (a) the youth's most serious current offense, (b) other current offenses and pending charges, and (c) offense history, current legal status, and aggravating or mitigating circumstances. Each youth is given a risk score, ranging from 0-12 or more points, and placement depends on the risk score:

0-6 points=released to the community without supervision, awaiting placement in a diversion program (coded as 1); 7-11 points=placed on non-secure home detention (i.e., home arrest) (2); and 12 or more points=placed in secure detention (3).

Family problems

Dichotomous variables were created to capture affirmative (1) and negative (0) responses to three questions about the youth's family members. These three questions were: "Has any member of your family had problems with alcohol;" "Has any member of your family had problems with drug abuse;" and "Have either biological parent spent time in jail or prison?"

Youth sexual risk behavior

Three measures of risky sexual behavior were included. The number of sexual partners is widely used as a sexual risk behavior measure [31]. Number of sexual partners was measured as a single item appropriated from the Youth Risk Behavior Survey [32]: "During the past three months, with how many people have you had sexual intercourse?" Response choices were "I have never had sexual intercourse," "1 person," "2 people," "3 people," "4 people," "5 people," and "6 or more people." The sexual partners variable was coded as 0 for "never had sexual intercourse" to 6 for "6 or more people" in the analyses. The second sexual risk variable was substance use and sex. Alcohol and drug use before having sex is frequently used as a risk factor for acquiring HIV [33]. Each youth was asked: "Did you ever drink alcohol or use drugs before having sex?" Responses for this single item were no (0) and yes (1). Finally, STD status was also measured. A non-invasive, FDA-approved, urine-based nucleic acid test, GenProbe Aptima® Combo 2 Assay, was used to test for chlamydia and gonorrhea in the youth's urine specimen. The sensitivity of GenProbe's test has been shown to be superior to culture and direct specimen tests. For chlamydia, the sensitivity and specificity of the GenProbe urine-based test are 95.9% and 98.2%, respectively; and for gonorrhea, they are 97.8% and 98.9%, respectively [34]. The STD status measure was a dichotomous variable for positive (1) for any STD (i.e., chlamydia, gonorrhea, or both) and negative (0) for all STD tests.

Mental health, substance use, and victimization

Depressive symptoms were measured using the 8-item, shortened version of the widely used 20-item Center for Epidemiological Studies Depression Scale (CES-D) [35]. The eight items asked of participants were: "I felt I could not shake off the blues even with the help from my family and friends;" "I felt sad;" "I felt depressed;" "I thought my life had been a failure;" "I felt fearful;" "My sleep was restless;" "I felt lonely;" and "I had crying spells." The items were asked regarding the past week and response options were "less than one day" (0), "1-2 days" (1), "3-4 days" (2), and "5-7 days" (3).

An additive index for depressive symptoms was created from the items with total scores ranging from 0 to 24. Previous research has found a score of 7 or higher is a threshold indicative of potentially needing clinical intervention [36,37]. Therefore, the depression index was dichotomized for subsequent analysis as scores 7-24 indicative of potentially needing clinical intervention (1) or scores 0-6 not indicative (0).

Two measures of substance use were included. Drug assay results were obtained from urine analyses (UA) conducted at the DOH lab facility. At the DOH testing lab, urine specimens were tested for seven drugs using the EMIT procedure: methamphetamines, cocaine, opiates, marijuana, spice (UR144 metabolite), alcohol, and benzodiazepines. Very few youths tested positive for any drug other than marijuana (range 0% to 3%); hence, only UA results for marijuana were included here. The cutoff level for a positive marijuana test is 50 ng/ml of urine.

The marijuana UA results were dichotomized (0=negative, 1=positive). The second measure of substance use reflected the severity of youths' perceptions of problems associated with their drug use. Drug problems were measured using the Texas Christian University (TCU) Drug Screen V instrument [38], which is a self-report instrument probing use of various drugs and consequences of use based on DSM-V criteria during the past 12 months. Responses to this instrument are additively combined for total scores ranging from 0 to 11, which is then converted to three severity categories corresponding to DSM-V criteria: 1=mild disorder (score of 2-3 points, or symptoms), 2=moderate disorder (score of 4-5 points), and 3=severe disorder (score of 6 or more points). Another "severity" category was created corresponding to the presence of fewer than 2 points: 0=no disorder.

Finally, two indicators of victimization were included. Youths were asked to self-report their experience of being sexually assaulted. Specifically, they were asked: "Have you ever been sexually assaulted?" The sexual assault victimization variable was dichotomous based on responses of yes (1) and no (0). Youths were also asked to self-report experiences with bullying. Specifically, they were asked the following: "Have you ever been involved in bullying?" Responses to this dichotomous question were no (0) and yes (1). Bullying did not distinguish among perpetrators, victims, and perpetrators/victims, so this variable reflects victimization and/or perpetration.

Statistical analyses

Bivariate relationships sexual between minority and sexual majority youths and variables of interest were examined using Pearson χ^2 for contingency tables analyses and analysis of variance for tests of means. Differences were examined within gender group and the combined sample. SPSS version 25 for Windows was used for all analyses.

Results

Distribution of sexual minority

Most youths in the sample identified their sexual orientation as heterosexual, gay or lesbian, or bisexual; very few female (n=12) and male (n=2) youths reported they were "not sure" about their sexual orientation. Youths who were uncertain, or unwilling to share, about their sexual orientation were excluded from the study. The distribution of sexual orientation across gender was 1% of males and 18% of females bisexual, 1% of males and 8% of females gay or lesbian, and 98% of males and 71% of females heterosexual (straight). Thus, only 2% of males self-identified as sexual minority compared to 29% of females.

The proportion for females is comparable to other studies of sexual minority status in justice-involved youth, but low for males. Discussion with the Health Coach Program manager indicated male youth were more embarrassed or reluctant to report their sexual orientation, whereas female youth were more willing to share this information.

Socio-demographic comparisons between sexual minority and non-minority youth

As Table 1 shows, the average age for sexual minority youth was 15.73, almost identical to 15.76 for heterosexual youth. Comparable proportions of heterosexual youths (54%) and sexual minority youth (44%) self-identified as African American or Hispanic (about 15% in each sexual orientation group). Approximately one-quarter of heterosexual and one-third of sexual minority youth were white. About one-third of the youths in each sexual orientation group were living with their birth mother only at the time of arrest intake. Approximately half of the youths in each sexual orientation group were released to their homes without monitoring after arrest and 31% of each group was placed in secure detention after arrest. Generally, there were few differences in the distribution of sexual minority status across the socio-demographic characteristics of age, race/ethnicity, and living situation.

The only significant difference was that there were more placements in non-secure or secure detention for sexual minority than sexual non-minority females. These placement differences reflect sexual minority females being arrested on more serious charges and consequently receiving higher risk scores at intake, compared to their sexual non-minority counterparts.

Variable	Females		Males		Total	
	Sexual minority (n=114)	Sexual non-minority (n=309)	Sexual minority (n=21)	Sexual non-minority (n=1.175)	Sexual minority (n=135)	Sexual non-minority (n=1.484)
Mean age (SD) Significance	15.66 (1.46)	15.62 (1.47)	16.14 (1.15)	15.80 (1.42)	15.73 (1.42)	15.76 (1.43)
Significance	N.S.		N.S.		N.S.	
Race/ethnicity						
Hispanic	16.70%	13.30%	14.30%	15.10%	16.30%	14.70%
African American	45.60%	50.80%	38.10%	54.90%	44.50%	54.00%
White	30.70%	32.70%	47.60%	24.30%	33.30%	26.00%
Other	7.00%	3.20%	0.00%	5.70%	5.90%	5.30%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Significance	N.S.		N.S.		N.S.	
Living with birth mother only	38.60%	31.70%	38.10%	33.80%	38.50%	33.40%
Significance	N.S.		N.S.		N.S.	
Post JAC placement						
Home	48.20%	65.00%	66.70%	44.40%	51.10%	48.70%
Non-secure/home detention	17.60%	11.70%	19.00%	21.40%	17.80%	19.40%
Secure detention	34.20%	23.30%	14.30%	34.20%	31.10%	31.90%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Significance	$\chi^2(2)=9.85^{**}$		N.S.		N.S.	
Note: Two-tailed p-values: *p<0.05; **p<0.01; ***p<0.001						

Table 1: Socio-demographic comparison by gender and sexual orientation.

Family problems comparisons

Overall, as Table 2 shows, sexual minority youth reported significantly higher rates of family problems than sexual non-minority youth. For sexual minority youths, approximately one-third reported family member alcohol and other drug abuse and two-thirds reported parental incarceration.

For heterosexual youths, only 14% reported family member alcohol and drug abuse and 58% reported parental incarceration. Among female youths, sexual minority youths reported significantly greater frequencies of family member alcohol abuse and other drug abuse than sexual non-minority youths.

Variable	Females		Males		Total	
	Sexual minority (n=114)	Sexual non-minority (n=309)	Sexual minority (n=21)	Sexual non-minority (n=1.175)	Sexual minority (n=135)	Sexual non-minority (n=1.484)
Family member alcohol abuse	37.70%	20.70%	19.00%	12.00%	34.80%	13.80%
Significance	$\chi^2(1)=12.75$***		N.S.		$\chi^2(1)=41.53$***	
Family member other drug abuse	37.70%	22.30%	19.00%	12.30%	34.80%	14.40%
Significance	$\chi^2(1)=10.13$***		N.S.		$\chi^2(1)=38.06$***	
Biological parent spent time in jail/prison	70.20%	61.80%	47.60%	57.20%	66.70%	58.20%
Significance	N.S.		N.S.		$\chi^2(1)=3.70$†	
Note: Two-tailed p-values: †p<0.10; *p<0.05; **p<0.01; ***p<0.001						

Table 2: Family problems by gender and sexual orientation.

Sexual risk comparisons

As shown in Table 3, a larger proportion of sexual minority youth reported drinking alcohol or using drugs prior to sex, 33% compared to 20% for sexual non-minority youth. Further, the STD positive rate for sexual minority youths was nearly double (13%) that of sexual non-minority youth (7%); although the average number of sexual partners in the past three months was similar, approximately 0.8 partners for each group. Within-gender analyses identified several significant differences. Female, sexual minority youths reported significantly more sexual partners and a larger proportion reported alcohol or drug use prior to sex, compared to sexual non-minority girls. In contrast, male sexual minority youths, relative to sexual non-minority males, reported significantly fewer sexual partners in the past three months.

Variable	Females		Males		Total	
	Sexual minority	Sexual non-minority	Sexual minority	Sexual non-minority	Sexual minority	Sexual non-minority
Number of sexual partners in past 3 months (mean)	0.93	0.58	0.19	0.9	0.81	0.83
N	114	309	21	1,175	135	1,484
Significance	F(1,1,421)=9.73**		F(1,1,194)=6.14*		N.S.	
Ever drink alcohol or use drugs before having sex (yes)a	36.00%	19.10%	19.00%	20.30%	33.30%	20.00%
N	114	309	21	1,175	135	1,484
Significance	$\chi^2(2)=13.70$***		N.S.		$\chi^2(2)=13.62$***	
STD positive	14.60%	11.20%	5.60%	6.40%	13.10%	7.40%
N	89	250	18	907	107	1,157
Significance	N.S.		N.S.		$\chi^2(1)=4.29$*	
Note: STD=sexually transmitted disease. A affirmative (yes) and negative (no) responses for this question were compared to the affirmative and negative responses to the question "I have never had sexual intercourse." Two-tailed p-values: *p<0.05; **p<0.01; ***p<0.001						

Table 3: Sexual risk behavior by gender and sexual orientation.

Mental health, substance use, and victimization comparisons

Table 4 shows that sexual minority youth, overall, have significantly more mental health and drug use problems (except for UA positive marijuana use) than sexual non-minority youth: high depression scores, sexual assault, involvement in bullying (as victim and/or perpetrator), and severity of problems associated with drug use. All of these differences were significant for females, and all except problems associated with drug use for males.

Variable	Females		Males		Total	
	Sexual minority	Sexual non-minority	Sexual minority	Sexual non-minority	Sexual minority	Sexual non-minority
Elevated depression	27.30%	17.20%	28.60%	5.50%	27.40%	8.00%
N	114	309	21	1,173	135	1.482
Significance	$\chi^2(1)=5.28$*		$\chi^2(1)=19.56$***		$\chi^2(1)=53.98$***	
Been sexually assaulted	34.20%	14.60%	14.30%	2.20%	31.10%	4.80%
N	114	309	21	1.175	135	1.484
Significance	$\chi^2(1)=20.20$***		$\chi^2(1)=12.71$***		$\chi^2(1)=132.10$***	
Involvement in bullying	50.00%	30.10%	57.10%	15.70%	51.10%	18.70%
N	114	309	12	1,175	135	1,484
Significance	$\chi^2(1)=14.41$***		$\chi^2(1)=25.91$***		$\chi^2(1)=77.52$***	
Urine test positive for marijuana	49.50%	42.00%	33.30%	54.90%	46.80%	52.20%
N	93	269	18	1.022	111	1.291
Significance	N.S.		$\chi^2(1)=3.32$†		N.S.	
Drug severity						
None	87.70%	93.40%	95.20%	93.70%	88.90%	93.70%
Mild	5.30%	5.20%	0.00%	3.70%	4.40%	4.00%
Moderate	2.60%	0.30%	0.00%	1.30%	2.30%	1.10%
Severe	4.40%	1.00%	4.80%	1.30%	4.40%	1.20%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
N	114	309	21	1,175	135	1,484
Significance	$\chi^2(3)=10.13$*		N.S.		$\chi^2(3)=10.45$*	
Note: Two-tailed p-values: *p<0.05; **p<0.01; ***p<0.001						

Table 4: Mental health and substance use issues by gender and sexual orientation.

Discussion

The results contribute to the emerging empirical characterization of sexual minority youth involved in the JJS. Prevalence of sexual minority orientation was 27.0% for girls and 1.8% for boys; with most indicating they were bisexual. The markedly higher prevalence of sexual minority orientation in JJS females than in the general high school population is consistent with other studies involving JJS youth, although their rates differ [2-3,7-8]. In contrast, the present study found a lower prevalence of sexual minority males than other JJS studies. Based on discussion with Health Coach staff, it is likely the low prevalence rate for male sexual minority orientation was, to some extent, due to the their reluctance to disclose this information. Social stigma associated with being male and gay or bisexual may have led to discomfort of the male youths reporting their sexual orientation to Health Coach staff.

The results, summarized in Table 5, suggest that sexual minority adolescents, particularly girls, involved in the JJS experience greater risk factors associated with JJS involvement and STD infection, than their heterosexual counterparts. Within gender, sexual minority youths were similar to their heterosexual counterparts in their socio-demographic characteristics of age, race/ethnicity, and living situation. Sexual minority girls were more likely to be placed in non-secure or secure detention after determining their risk scores, based on arrest charge(s), arrest history, and mitigating or aggravating factors, during JJS intake. Generally, these girls received higher risk scores because they were arrested on more severe charges. Similarly, a general population of youth [14] found female sexual minority adolescents were significantly more likely to be stopped by the police and receive a juvenile conviction. Poteat and associates [15] found similar results of harsher punishment for sexual minority youth in schools and the JJS. Other researchers [5,20] have stated LGBTQ youth tend to receive harsher and inequitable treatment from school and JJS authority figures. While the present data do not permit exploration of the reasons for arrests, patriarchal ideologies may have, in part, led to greater conflict and discriminatory practices in identifying and sanctioning behavior among these girls. Research is needed to elucidate the gendered pathways to criminal justice involvement for LGBTQ youth.

Variable	Finding
Age	Similar across sexual orientation and gender
Race/ethnicity	Similar across sexual orientation and gender
Living with birth mother only	Similar across sexual orientation and gender
Post-arrest placement	1.5 times more sexual minority girls placed on either non-secure home detention or secure detention than heterosexual girls
Family member alcohol abuse	1.8 times more sexual minority girls report this problem than heterosexual girls
	2.5 times more sexual minority youths overall report this than heterosexual youth
Family member drug abuse	1.7 times more sexual minority girls report this problem than heterosexual girls
	2.4 times more sexual minority youths overall report this than heterosexual youth
Parent incarceration	Marginally more sexual minority youths overall report this than heterosexual youth
Number of sexual partners	Sexual minority girls reported 1.6 times the number than heterosexual girls
	Heterosexual boys reported 4.7 times than sexual minority boys
Alcohol or drugs before sex	1.9 times more sexual minority girls report doing this than heterosexual girls
	1.7 times more sexual minority youths overall report doing this than heterosexual youths
STD positive	1.8 times more sexual minority youths overall tested STD positive than heterosexual youths
Elevated depression	1.6 times more sexual minority girls reported than heterosexual girls
	5.2 times more sexual minority boys reported than heterosexual boys
	3.4 times more sexual minority youths reported than heterosexual youths
Sexual assault	2.3 times more sexual minority girls reported than heterosexual girls
	6.5 times more sexual minority boys reported than heterosexual boys
	6.5 times more sexual minority youths reported than heterosexual youths
Bullying	1.7 times more sexual minority girls reported than heterosexual girls
	3.6 times more sexual minority boys reported than heterosexual boys
	2.7 times more sexual minority youths reported than heterosexual youths
Marijuana use	1.6 times more heterosexual boys tested positive than sexual minority boys
Drug severity	5.4 times more sexual minority girls reported moderate to severe problems than heterosexual girls
	5.2 times more sexual minority youths overall reported moderate to severe problems than heterosexual youths

Table 5: Summary of findings.

There was a clear trend in the data indicating sexual minority youth, particularly girls, reported more family member alcohol abuse and other drug abuse than sexual non-minority youth. In addition, sexual minority youth reported more sexual assault and bullying. These findings are consistent with other research observing LGBTQ youth are at greater risk of sexual victimization [9] and other forms of victimization and bullying by school peers, teachers, and administrators [1,13,39]. Similarly, there were marked differences in risky sexual behaviors across sexual orientation status by gender. Sexual minority girls reported more sexual partners and substance use before having sex. Sexual non-minority boys, however, reported more sexual partners than their sexual minority counterparts. Overall, STD infection rates were higher among sexual minority youths than heterosexual youths. Research has rarely examined risky sexual behaviors and STDs among sexual minority, justice-involved youths. A small sample (n=63) study of girls involved in JJS rehabilitation facilities noted similar rates of condom use for heterosexual and LGBQ justice-involved youth, but did not examine number of sexual partners, substance use before sex, laboratory-confirmed STD status, or study males [40]. Hence, the present study contributes to our limited understanding of sexual risk behaviors among LGB justice-involved youth and suggests that sexual minority girls may be engaged in higher risk sexual networks or using condoms less frequently. Programs to address these differences in sexual health risk are needed for sexual minority youth.

Further, sexual minority youth, especially boys, reported higher rates of elevated depression, relative to sexual non-minority youth. Sexual minority girls also reported more problems associated with drug use. Though studies with similar measures are scant, these findings are consistent with research on other at-risk populations of girls. For example, Marshal and associates [41] found sexual minority girls in the Pittsburgh Girls Study reported higher levels of depression compared to their heterosexual counterparts, but no significant differences in marijuana use. Future epidemiological research is needed to more precisely quantify the prevalence, chronicity, and severity of substance use and mental health problems among justice-involved, sexual minority youth and programs are needed to reduce the adverse consequences of depression and substance use.

Our results have clear policy and service delivery implications in four areas: (1) advocacy for LGBTQ youth; (2) referral services; (3) intervention services; and, where possible, (4) family preservation services. First, regarding advocacy for LGBTQ justice-involved youth, there is a need to ensure JJS and JJS-funded agencies and their respective staff create and implement policies and procedures that are sensitive to, and respectful of, the rights of LGBTQ youth, and permit their access to and use of services to address their emotional/psychological, substance use and mental health service needs. An assessment of these policies and procedures should be incorporated into the periodic reviews of these agencies/programs. Second, referral service linkages should be established with community-based agencies providing sexual orientation-sensitive peer support groups, counseling services, anti-bullying support services, and STD/HIV testing and prevention services to LGBTQ youth. Third, where indicated, LGBTQ youth should receive coping skills, group counseling, including developing mindfulness skills, relationship skills, help in managing negative emotions and feelings, and confronting stressful situations. Procedures for skill development informed by dialectical behavioral therapy-an evidence-based modification of standard cognitive-behavioral therapy treatment-may be most beneficial [42-44]. Additional referral to more specialized and intensive one-on-one or group-based counseling services to address sexual risk behavior, mental health, and substance abuse issues should be provided. Finally, where possible, efforts should be made to work with family members to preserve the youth's residency and involvement with her/his family life. Family interventions should address stigma, bias, and discrimination based on sexual orientation and gender non-conformity, and promote acceptance of diverse sexual orientation and gender identity.

Limitations

There are also some limitations to this study. First, the data were collected at one site. There is a need to determine if the findings can be replicated in centralized intake centers in other settings, serving different populations of LGBTQ juvenile arrestees. Second, other than the biological test data for drug use and STDs, much of the data was self-report. In particular, the male sexual minority responses may underestimate this orientation. This highlights the need to develop procedures to obtain more truthful responses to questions probing sexual orientation so that special needs groups can be properly identified and linked to appropriate services. Third, since data analyses included both male and female youth, any underestimation of the proportion of sexual minority males also affected estimation of overall rates for sexual minority youths. Fourth, the small sample size of minority sexual males makes their comparisons with sexual non-minority males have low statistical power. Finally, the data were cross-sectional; hence, no causal statements about individual-level relationships can be made.

There are several strengths to this study. First, it includes biological data to measure recent drug use and STDs. Second, the sample is relatively large and permits subgroup analyses specifically comparisons of sexual minority and sexual non-minority separately in females and males. Third, to the best of our knowledge, this is amongst the first study assessing LGBTQ youth at the front door of the JJS.

Conclusion

Our findings indicate sexual minority, justice-involved adolescents suffer disproportionate juvenile justice placement, family problems, risky sexual behaviors and adverse biological sequelae (STDs), depression, and victimization. Our results highlight the need for criminal justice professionals and child advocates to reflect on strategies to protect LGBTQ youth by attempting to prevent social, familial, peer, and personal factors that may lead to and exacerbate criminal involvement, and by treating their consequences. The "front door" of the JJS is a relatively low cost, logistically efficient, and effective opportunity to improve these youths' quality of life.

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