

Slipping Through the Cracks:

Is Mental Illness Appropriately Identified Among Latino Offenders?

Elijah P. Ricks and Jennifer Eno Louden

The University of Texas at El Paso

Published in Criminal Justice and Behavior

©International Association for Correctional and Forensic Psychology, 2015. This paper is not the copy of record and may not exactly replicate the authoritative document published in the journal. Please do not copy or cite without author's permission. The final article is available, upon publication, at: doi: 10.1177/0093854815605525

Author Note

Elijah P. Ricks, Department of Psychology, The University of Texas at El Paso; Jennifer Eno Louden, Department of Psychology, The University of Texas at El Paso.

Elijah P. Ricks is now at Roosevelt University, Chicago, Illinois.

Acknowledgments: This research was supported in part by a grant from The University of California, Irvine, Center for Evidence Based Corrections. Jennifer Skeem was instrumental in obtaining the California data. Nothing in this manuscript is intended to reflect the opinions or findings of either the Arizona Department of Corrections or the California Department of Corrections and Rehabilitation.

Correspondence concerning this article should be addressed to Elijah P. Ricks, Department of Psychology, Roosevelt University, Chicago, IL 60605.

E-mail: elijah.ricks@gmail.com

Abstract

Among U.S. offenders, both ethnic minorities and persons with mental illness are overrepresented. In communities, ethnic minorities are less likely than European Americans to receive mental health treatment, despite having similar need. Many barriers to treatment (e.g., financial, transportation) are removed in prisons; therefore we sought to understand whether and how ethnicity relates to identification of mental illness (a proxy for treatment receipt) among prisoners. Due to the growth of the Latino population, we focused on Latino offenders. We examined records from 2 states with high proportions of Latino offenders to determine whether the likelihood of being identified with a mental illness differed by ethnicity. Offenders who had a mental disorder were disproportionately likely to be European American or African American, and less likely to be Latino. We offer suggestions for future research on ethnic disparities in correctional mental health to promote best practices with vulnerable offenders.

Slipping Through the Cracks:

Is Mental Illness Appropriately Identified Among Latino Offenders?

The United States incarcerates more people per capita than any other country in the world. A recent estimate (Glaze & Herberman, 2013) is that one in every 35 people in the United States is under correctional supervision in some form, with one in every 108 adults behind bars. Among those incarcerated, disadvantaged groups are often over-represented. Two such groups have separately received increasing attention from researchers in recent years: offenders with mental illness (e.g., Fazel & Seewald, 2012), and ethnic minority offenders (e.g., Carson & Sabol, 2012; Morrissey, Meyer, & Cuddeback, 2007). Both groups have unique needs that must be addressed via correctional practices.

Offenders have rates of mental illness 2 to 3 times higher than the general community (American Psychiatric Association, 2000; Fazel & Danesh, 2002; Kessler et al., 2005; Steadman, Osher, Robbins, Case, & Samuels, 2009; U.S. Department of Justice, 2006). Therefore, jails and prisons have become the primary care facilities for a large portion of people with mental illness (Council of State Governments, 2002; Diamond, Wang, Holzer, Thomas, & Crusier, 2001). This issue appears to be worldwide, as a review of 62 surveys from across the globe suggests that prisoners are several times more likely to have a psychotic disorder or major depression than are persons in the community (Fazel & Danesh, 2002).

Ethnic minorities are also overrepresented in the prison population. African Americans and Latinos¹ are incarcerated at more than double the rate of European Americans (Bonczar, 2003; Carson & Sabol, 2012; Morrissey, Meyer, & Cuddeback, 2007; U.S. Department of Justice, 2014). Latinos are also the fastest growing minority population in the United States (Pew Research Center, 2011; U.S. Department of Commerce, 2011). Thus, it is likely that they will be even more prevalent in prisons in the coming decades (National Council of La Raza,

2011; Schuck, Lersch, & Verrill, 2004). Ethnic diversity in highly controlled environments introduces many challenges to prison practices, including maintaining order (e.g., Berg & DeLisi, 2006; Steiner & Woodredge, 2009) and providing access to services. Latinos have a unique culture and often face language barriers that other ethnic groups do not. Therefore, it is important to understand how Latinos may differ from other ethnicities in corrections environments (Schuck et al., 2004).

Both offenders with mental illness and Latino offenders possess unique characteristics that prisons must understand in order to appropriately supervise them and deliver services. These groups are typically approached separately in prison policies and research. However, there is interplay between mental illness and ethnicity in many ways, as is discussed below. Due to the high proportions of both Latinos and persons with mental illness in prisons, there is pressing need to understand more about people who fit into both of these groups simultaneously—Latino offenders who have a mental illness.

To date, scant research has examined the overlap between ethnicity and mental illness among offenders (e.g., the U.S. Department of Justice, 1999). This is somewhat surprising, because the interaction of ethnicity and mental illness has received increasing attention within community populations (e.g., Riolo, Nguyen, Greden, & King, 2005). Community-based research often finds differences between ethnicities in the prevalence rates of disorders, but the results tend to be mixed, especially according to the disorder. For example, one large study found that Latinos were less likely to be diagnosed with anxiety disorders than were European Americans (Asnaani, Richey, Dimaitre, Hinton, & Hofmann, 2010). Conversely, another study found that Latinos were more likely to report comorbid depressive disorders than were European

Americans (Blazer, Kessler, McGonagle, & Swartz, 1994), and more likely to report symptoms consistent with dysthymia (Riolo et al., 2005).

The differences in prevalence of certain disorders among ethnicities are important to examine, as they suggest that ethnicities may manifest symptoms differently and/or have different risk factors associated with mental illness. However, these differences often disappear when controlling for factors such as socioeconomic status (e.g., Bromberger, Harlow, Avis, Kravitz, & Cordal, 2004; also see Alegría et al., 2008). Furthermore, the prevalence of mental health symptoms in general suggests that Latinos' mental health rates are at least as high as European Americans' (Kessler et al., 1994; also see Burnam et al., 1987; and Kessler et al., 2005), although not all research is consistent (e.g., Alegría et al., 2008).

Whereas prevalence of mental illness among ethnic minorities appears to be at least as high as European Americans', members of ethnic minorities differ from European Americans in treatment-seeking and in treatment-receiving (e.g., Alegría et al., 2008; Kessler et al., 2005; Mojtabai, 2007; Mojtabai et al., 2012). Latinos are more likely than other ethnicities to report impediments to treatment, and are less likely to receive treatment when they believe there is a need (Mojtabai et al., 2012). The common reasons cited for why Latinos receive treatment less often in communities are related to accessibility, such as financial and transportation obstacles (Woodward, Dwinell, & Arons, 1992). Additionally, Latinos often face language barriers that other ethnic minorities do not, which may further hinder treatment-seeking (Fiscella, Franks, Doescher, & Saver, 2002; Kim et al., 2011).

Whereas barriers to care may explain some of the ethnic disparity in treatment within communities, these variables are naturally controlled for within prisons—by law, correctional facilities are responsible for providing access to medical and mental health services (Americans

with Disabilities Act of 1990; *Estelle v. Gamble*, 1976). Thus, socio-economic status and other access-related barriers to treatment are virtually moot within prison; payment, transportation and interpreters (if needed) are provided by the correctional institution. Furthermore, many of the social and environmental risk or protective factors of mental illness, such as poverty (Patel et al., 2010; Draine, Salzer, Culhane, & Hadley, 2002) social support (e.g., Kawachi & Berkman, 2001), and acculturation (Organista, Organista, & Kurasaki, 2003) may differ far less among ethnicities in prison than they do in communities. Therefore, any differences in ethnicities' mental health identification and treatment must be due to other factors that uniquely affect an ethnic group. Latinos, for example, may have idiosyncratic views of mental illness and its treatment (Alvidrez, 1999, Kleinman, 1988; Gonzalez, 1997; Vega & Alegria, 2001), which affect their care-seeking. Furthermore, they may express symptoms differently from other ethnicities (Cuellar & Paniagua, 2000; Ruiz, 1985), in turn affecting identification of mental illness. Given that Latinos in the community are at risk of not receiving needed mental health treatment (Kessler et al., 2005), it is important to determine if this is also the case in prisons, where equal access to mental health treatment is mandated.

Prisons are a unique environment in which to examine where mental illness and ethnicity overlap, in part because they control naturally for many obstacles to identification and treatment of mental illness. However, the prison environment is also unique in its system for identification of mental health issues and provision of treatment. Typically, all offenders are screened for mental health needs upon arrival to a prison facility, and periodically thereafter (Arizona Department of Corrections, 2014; State of California, 2013; U.S. Department of Justice, 2001). Possible reasons for mental health referrals include past or present use of psychotropic medications, inmates' self-reports of symptoms, and staff observations of behaviors that may be

related to mental health (e.g., changes in aggression, repetitive behaviors, etc.; Arizona Department of Corrections, 2014; State of California, 2013). The frequency of mental health screenings within prisons may partially explain the increased rates of offenders identified as having a mental illness (see U.S. Department of Justice, 2006). Those who may have gone unnoticed in the community are more likely to be identified during required screenings.

Additionally, once an offender is designated to a mental health needs level, treatment is likely to continue throughout incarceration, barring substantial changes in symptoms. Prisons' policy-driven screening practices (U.S. Department of Justice, 2001) contrast with the largely patient-driven screening and treatment practices in the community (e.g., Mojtabai, 2007), and may help to explain why so many offenders are identified as having mental health needs.

We sought to explore whether the overrepresentation of mentally ill offenders is found equally among ethnicities, or if there are discrepancies in identification of mental illness by ethnicity. Although identification is not a clear indicator of receiving treatment, it is a necessary step toward treatment; as such, discrepancies in identification would suggest discrepancies in treatment. Because our interest was specifically with Latino offenders, we addressed this research question using aggregate-level data from departments of corrections in states where Latinos comprise more than 15% of the population: Arizona, California, Colorado, Florida, Illinois, Nevada, New Jersey, New Mexico, New York, and Texas (U.S. Department of Commerce, 2011). Of the corrections departments in each of these states, two delivered data that would allow us to examine ethnic disparities in mental health classification: Arizona and California. The remaining states' corrections departments were either unable or unwilling to provide this information.

The relatively large prevalence of Latinos in Arizona's and California's populations suggests that they are appropriate locations to examine our research questions. According to the 2010 United States Census (U.S. Department of Commerce, 2011), Latinos in Arizona made up 29.6% of the state's population in 2010. California has among the highest Latino populations in the nation, making up more than 37% of the state's total population. California and Arizona rank first and third (respectively) in states with the highest proportion of Latinos of Mexican origin in the U.S. (U.S. Department of Commerce, 2011). Because the two states have different criteria for mental health needs designation, and because each sample comes from different populations, we chose to analyze them separately. After describing the methods and results, we discuss the findings jointly.

Study 1 – Arizona

Method

Arizona's Department of Corrections regularly publishes records of many of its offender population demographics (i.e., ethnicity, age, gender, etc.). However, like other states we contacted, it does not regularly publish a breakdown of inmates with mental health needs by their ethnicity. In response to our inquiry, the Department delivered a table with aggregate information (R. Wilkins, personal communication, April 8, 2014) from which we were able to analyze expected and observed frequencies of offenders from ethnic minorities within the offenders who have an identified mental health need.

Arizona policies regarding mental health follow a needs-based level system. All offenders' medical and mental health records are reviewed upon arrival to a new complex. Offenders who have no history of mental health issues, and those with only past treatment are not regularly monitored by mental health staff, but are entitled to mental health services if

requested or if clinical staff deem them necessary. Offenders who have current mental health needs must meet with a psychiatrist at least once every 90 days. Other mental health staff members who make diagnostic decisions are masters- or doctoral-level professionals with degrees in mental health-related fields, and all staff in a supervisory role must conduct periodic peer reviews of supervisees' decisions and documentation. They are either licensed to practice in the State of Arizona, or are supervised by licensed professionals (Arizona Department of Corrections, 2014).

Sample. The data Arizona delivered comprise all adult offenders incarcerated in prison (not parolees or probationers) who were identified as having mental health needs as of March 31, 2014 ($N = 10,664$). Inmates were defined as having mental health needs if they were designated into one of four categories by mental health or medical staff: (a) "inmates in acute distress who may require substantial intervention in order to remain stable," (b) "inmates who may need regular intervention but are generally stable and participate with psychiatric and psychological interventions," (c) "inmates who need infrequent intervention and have adequate coping skills to manage their mental illness effectively and independently," and (d) "inmates who have been recently taken off of psychotropic medications and require follow up to ensure stability over time" (Arizona Department of Corrections, 2014, pp. 17-18).

Results

Arizona's records indicate that its prison population ($N = 41,363$) was 13.2% African American, 40.5% Latino, 39.5% European American, and 5.0% Native American in early 2014 (Arizona Department of Corrections, 2014, February). With all else being equal, we would expect to find these same proportions of ethnicities among the offenders who have mental health needs. In other words, assuming no disparity related to ethnicity, approximately 13% of Arizona

offenders with mental health needs should be African American, 40% should be Latino, and so on. After calculating the expected frequencies of each ethnicity within the offenders with mental health needs (Table 1), a chi-square analysis concluded that the expected frequencies were significantly different from the observed frequencies, $\chi^2(4) = 513.46, p < .001$. In sum, European Americans were found with greater frequency than expected among the inmates with mental health needs (standardized residual = 14.0) but Latino offenders were found with lower frequency than expected (standardized residual = -15.5). African Americans were found with somewhat higher frequency (standardized residual = 6.7), and Native Americans were found with less frequency among inmates with mental health needs as they are within the general prisoner population (standardized residual = -5.3). These findings will be discussed with those from the California data, following their analysis.

[Insert Table 1 about here.]

Study 2—California

Method

The California data were obtained as part of a larger study of parolees (Eno Loudon & Skeem, 2011), which obtained and integrated three databases from California's Department of Corrections and Rehabilitation. These databases included general demographic descriptors of each inmate and the facility records of any mental health evaluations or treatment contacts with mental health providers. Although our focus in the present studies was to examine ethnic differences, we also examined differences in age and gender between parolees with and without a mental disorder because these data were available.

Sample. Participants were all 44,987 persons released to a new term of adult parole within 1 calendar year: from January 1, 2004 to December 31, 2004. Since 1979, it has been the

practice of California's Department of Corrections and Rehabilitation to require a term of parole for every prisoner released, so we believe that these parolees are representative of the prison population, except for those with life and death sentences. These parolees were mostly male (87.5%), with a mean age of 33.7 ($SD = 10.0$) years at the time they were released to parole. The largest ethnic group among them was Latino (42.2%), followed by European American (31.3%), and African-American (21.6%).

Parolees with a mental disorder were defined based on diagnoses and designations issued by California's Department of Corrections and Rehabilitation clinicians, as they were entered into the Department's database (see Farabee, 2006, for more detail). California policies require all mental health diagnostic and treatment services to be supervised by a licensed psychiatrist or psychologist (State of California, 2013).

The vast majority of parolees with a mental illness were identified in prison because they received mental health services and/or were evaluated as mentally ill during a face-to-face assessment prior to release. In a few instances, the supervising parole agent noticed signs of potential mental disorder and referred the parolee for further evaluation. For the present study, we categorized a prisoner as having a mental illness if he or she (a) was designated to supervision including mental health treatment or (b) was clinically diagnosed (i.e., an Axis I mood, psychotic, or anxiety disorder as defined by the DSM-IV) but had no treatment designation.

Results

Regarding age and gender, we found that parolees with a mental disorder were slightly older than parolees without a mental disorder, $t(44,985) = 19.74, p < .001, d = .23, 95\% CI$

[17.78, 22.38] and were significantly more likely to be female, $\chi^2(1) = 339.2, p < .001, \phi = .09$ (Table 2).

Examining mental health showed that, overall, 20.4% ($n = 9,177$; Table 2) of California prisoners were identified as having a mental illness; the majority of whom were given a mental health designation by the State's Department of Corrections and Rehabilitation (20.2% of the total sample). Parolees with a mental disorder were more likely to be European American or African American, and less likely to be Latino than non-disordered parolees, $\chi^2(3) = 1389.3, p < .001$, Cramér's $V = .18$. That is, whereas 42.2% ($n = 18,985$) of the entire California parolee population was Latino, only 25.9% of those identified as having a mental disorder were Latino. On the other hand, 41.0% of parolees with mental disorder were European American, even though European Americans made up only 31.3% ($n = 14,081$) of the entire sample.

[Insert Table 2 about here.]

Discussion

Offenders with mental illness and ethnic minority offenders are overrepresented in the prison population, but treatment is legally mandated to be free of discrimination; as such, it is important to determine whether offenders with mental health needs are identified without regard to ethnicity while in prison. Given that Latinos' mental illness prevalence rates are at least equal to those of European Americans (Kessler et al., 1994), with all else being equal we would expect to find a similar pattern in the ethnic makeup of offenders with mental illness. According to the data we obtained from two states, European Americans and African Americans were overrepresented among offenders with mental illness, whereas Latinos were underrepresented (also see U.S. Department of Justice, 1999). This indicates that all else is not equal regarding ethnicity and mental illness for incarcerated offenders.

Differences Between Offenders With and Without Mental Illness

The data available suggest that there are ethnicity-based differences in the proportions of offenders who are identified as having mental health needs. These differences are concerning, and have several implications for corrections and future research. The challenge now is to determine where the inequity originates. There are several potential explanations for our findings, none of which can be answered with the current state of the literature or these data. We offer these possibilities to encourage future research on this important issue.

Before incarceration. It is possible that elements taking place before incarceration explain the fact that we found fewer Latino offenders with mental illness than expected. There are numerous factors that influence the likelihood of an individual to be arrested and incarcerated, and these affect ethnic minorities disproportionately. For example, poverty has been linked with increased crime (see Hipp & Yates, 2011, for a review) and may also lead to inadequate legal representation (e.g., Bright, 2010). Meager legal representation, in turn, may lead to a higher proportion of Latino persons without mental illness being incarcerated than is found in other ethnicities, thus explaining the mental illness underrepresentation that we found. However, this is an unlikely explanation for at least two reasons. First, Latinos face rates of poverty that are similar to African Americans' (e.g., DeNavas-Walt, Proctor, & Smith, 2013; Macartney, Bishaw, & Fontenot, 2013). Therefore, if poverty were the sole cause of the Latino underrepresentation in our samples, we should have found similar underrepresentation among African Americans. Instead, we found African Americans *over*represented among offenders with mental health needs. The second reason poverty is an unlikely reason for our findings is that it has been cited as a risk factor for mental illness (Patel et al., 2010) and vice versa (Draine et al., 2002). Thus, the higher rates of poverty among ethnic minorities should be associated

with higher rates of mental illness among Latino offenders, but we did not find this in our analyses. Although the poverty argument may help to explain the overrepresentation of other ethnicities with mental illness in prisons, it does not explain the underrepresentation of Latinos with mental health needs that we found.

Another possible explanation for our results that cannot be addressed with these data is the possibility of differences in the gender ratios among ethnicities. As we found in our California sample, women tend to have higher rates of mental illness (see also Diamond et al., 2001; Fazel & Danesh, 2002; Steadman et al., 2009; and U.S. Department of Justice, 2006). If our samples consist of relatively fewer Latina women, then this may help to also explain the relatively lower prevalence of mental illness among Latino offenders. It is difficult to estimate gender and ethnicity representation, as almost no literature exists to provide a reference (Schuck et al., 2004). Our data are not equipped to examine this possibility, but it should be addressed by future research.

Immigration status is a factor relevant to many Latino offenders that may also be related to mental illness. Alegria and colleagues (2008) found that mental illness rates were lower within immigrant Latinos than in those born in the U.S. (see also Burnam et al., 1987; Vega et al., 1998), but Gonzalez, Haan, and Hinton (2001) found that the risk of depressive disorders may increase when the individual is also an immigrant, bicultural, or less acculturated. Our data do not include a way to explore the differences in whether Latino offenders immigrated to or were born in the U.S., but other researchers have argued that Latino immigrants are actually less likely to commit crimes than are U.S.-born Latinos and citizens in general (Butcher & Piehl, 2007; Hagan & Palloni, 1999; Reid, Weiss, Adelman, & Jaret, 2005). Thus, we would not expect that those Latinos who are incarcerated would also have lower rates of mental illness.

Future research should consider these and other ethnicity- and mental illness-related factors that may lead a person to be incarcerated or not. For example, perhaps Latinos have more familial support to prevent members from being detained in a jail in the first place, and that perceived family support influences one's ability to cope with a mental illness (e.g., Mulvaney-Day, Alegría, & Sribney, 2007).

During incarceration. A plausible explanation for our findings is that Latino offenders are less likely to be identified as having mental health needs while in prison. Many of the explanations for why Latinos with mental illness may go unidentified in prison are comparable to the reasons they do not receive treatment in the community. We may sort these explanations into two categories: offenders' lack of treatment-seeking, and facility limitations in identification.

Lack of treatment-seeking. There are several reasons that Latinos may be less likely to seek mental health treatment than offenders of other ethnicities. Latino offenders may be particularly sensitive to the stigma of receiving psychiatric services (Gonzalez, 1997). Indeed, Alvidrez (1999) found that, compared to other ethnic groups, Latinos in the community attached more stigmatization to mental disorders. Such stigma could be exacerbated in the prison environment, where any sign of vulnerability can be dangerous (Edgar & O'Donnell, 1998). It is also possible that Latino offenders seek help for mental illness symptoms that do not include mental health treatment providers, such as through prayer or other spiritual methods (Ruiz, 1985; also see Larkey, Hecht, Miller, & Alatorre, 2001, for an examination of faith's role in medical care seeking). If it is the case that Latino offenders are less likely to seek care, or that they express symptoms differently, then it is important for treatment providers to take steps to reduce stigma, and use culturally-sensitive methods of assessment.

Facility limitations to identification. The prison environment makes ethnicities equal in regards to many socioeconomic factors and, thus, it cannot be that transportation or financial barriers prevent Latino offenders from seeking mental health treatment while incarcerated. There may be cultural considerations that prevent prisons from accurately identifying Latinos who have mental health needs. It is possible that Latinos express mental health symptoms differently from other groups. Kleinman (1988) argues that psychiatric diagnoses, and arguably their expression, are dependent upon the individual's cultural context. Other evidence suggests that expressing symptoms of a mental illness may be culturally inhibited among Latinos (Alvidrez, 1999), or limited by language barriers (see Timmins, 2002, for a review). If current assessment methods are not culturally sensitive for Latino offenders, this may partially explain their underrepresentation among offenders with mental health needs.

Another possible explanation is that Latinos may tend to express mental health symptoms in ways that are overlooked within the prison environment. Cultural inhibitions to expressing symptoms may lead clinicians to group Latino offenders' behaviors into what appears to be normal for the prison environment, even though it may be abnormal for the individuals (see Snowden, 2003, for discussion). This possibility does not appear to be answered in the literature, but future research may shed light on the issue.

An additional challenge to prisons' ability to identify Latinos with mental health needs may be bilingualism. Although the ideal scenario is to have a clinician who is fluent in the patient's primary language, there are few Spanish-speaking mental health professionals in prisons (Williams, 1985; see also Bischoff & Hudelson, 2010; and Drissel, 2003), and even bilingual clinicians lack training and often struggle to use both languages in their work (Verdinelli & Biever, 2009). The lack of Spanish-speaking clinicians makes it difficult to

accurately assess some offenders' needs, and perhaps discourages some from seeking help for their symptoms (e.g., Fiscella et al., 2002; Kim et al., 2011). Per department policy, interpreters are provided when there is a need (Arizona Department of Corrections, 2013; State of California, 2014), but facilities cannot control whether an offender with limited English fluency requests an interpreter during assessments or thereafter chooses to receive treatment through an interpreter. Offenders are likely hesitant to invite a third party to discuss sensitive mental health-related information, and even so, clinicians face many challenges to appropriately integrate interpreters into their interactions with clients (Tribe, 2009). Further compounding the language differences is that self-report assessment tools may be used to screen for mental illness, but may not be available in Spanish (see Eno Louden, Skeem, & Blevins, 2013).

Limitations

We acknowledge that these data are not equipped to comprehensively assess ethnic disparities in mental illness identification. First, there are some limitations in generalizability. Latinos are a heterogeneous group, and these aggregate data could not differentiate among subgroups (i.e., of Cuban, Mexican, Puerto Rican, South or Central American descent). We are encouraged by the fact that the majority of U.S. Latinos identify as being of Mexican origin, and the two states from which we sampled rank among the top five with the highest number of Latinos of Mexican origin (U.S. Department of Commerce, 2011), but accounting for origin may be important to address in future studies as there may be a cultural element to the expression of mental illness (López & Guarnaccia, 2000).

California's data included only prisoners who had been paroled, and thus do not represent any inmates sentenced to life or death. There may be different prevalence rates in mental illness among offenders with life or death sentences from those who are eventually released (e.g.,

Taylor, 1986). Although this issue does not appear to be addressed in the current literature, it may be an important area for future research. Additionally, mental disorder and needs classifications differ between state agencies, so it may be inappropriate to compare our samples to others in this respect. Likewise, the two states included in this research involved offenders who had “mental health needs” which, although includes, does not equate mental illness. It is promising that the proportion of California parolees who were designated as having a mental illness matches estimates in other corrections populations (approximately 20%; American Psychiatric Association, 2000; Steadman et al., 2009; see also Torrey et al., 2010), and that Arizona’s was near that as well (25.8%). Therefore, we believe that the number offenders designated as having mental health needs but not having a diagnosable disorder was minimal in our samples.

The second type of limitation is in the control we can exercise in our analyses. The data from Arizona were delivered to us in aggregate form, and we could not account for differences being due to variables other than ethnicity (e.g., age, gender, etc.). Additionally, California’s data classification reflects the parolee’s mental health designation at the time our database was captured (2006), rather than at the time of actual release to parole (2004). Although our California sample was comprised of new releases, it is likely that some parolees’ designations changed by the time our database was captured (e.g., 2004 parolees who recidivated and were re-released could have a new designation by 2006). On the other hand, the benefit of our data is that they allowed us to examine the proportion of offenders with mental disorder who were actually identified by the corrections agencies—given that the responsibilities of identification and treatment of mental illness are the agency’s, these data provide a glimpse into what proportion of these offenders are likely receiving treatment, which was our question of interest.

With the limitations to these data, we recommend cautious interpretation of our findings, but emphasize the importance of such research and its replication.

Implications

Whatever the source of the discrepancy we found, it is most important that the research into the discrepancy continue. Although this study has clear limitations in its control over other variables, our findings draw attention to a much-neglected area of mental health and criminal justice research, and these results have implications that go far beyond the individual mental health needs of Latino offenders. If Latinos as a group are differentially affected by elements that take place before incarceration (so that fewer Latinos with mental illness are incarcerated), it is important to determine why this occurs.

The possibility of the systematic (albeit unintentional) neglect of an already disadvantaged group will hopefully pique corrections agencies and lawmakers to action. Not only is there legal precedent for nondiscrimination based on ethnicity, but there may also be opportunity to increase the safety and effectiveness of correctional interventions. For example, Latino prisoners are much more likely to commit suicide than African Americans (Fazel, Cartwright, Norman-Nott, & Hawton, 2008; Way, Miraglia, Sawyer, Beer, & Eddy, 2005). Because a psychiatric diagnosis is also a risk factor for prison suicide (Fazel et al., 2008; Way et al., 2005) it is vital that Latino offenders with mental illness be identified correctly so that they may receive treatment. Mental health treatment and other interventions cannot happen without identification, thus improper identification may have grave consequences.

Additionally, offenders with a mental illness are at much higher risk of reincarceration after release than are those without mental illness (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). Although their incarceration may not be directly due to mental illness (Peterson,

Skeem, Hart, Vidal, & Keith, 2010), steps to reduce the likelihood of criminal behavior are effective only if mental health needs are also adequately addressed (Skeem, Manchak, & Peterson, 2011). Thus, improving continuity of care in an unbiased manner is an important intervention that could help to reduce recidivism (Baillargeon et al., 2009).

As the Latino population continues to grow in the United States (Pew Research Center, 2011; U.S. Department of Commerce, 2011), we should also expect more Latinos to come in contact with corrections agencies. As such, facilities must be prepared to identify and treat those with mental health needs. Further research in this area will help determine areas of mental health assessment and treatment in prisons that need improvement, such as decreasing language barriers, establishing more culturally sensitive assessment tools, and educating offenders on the benefits of treatment. These steps will help ensure that Latinos have the same opportunities for treatment as other ethnicities.

References

- Alegria, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D.,...Meng, X. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry*, 165, 359-369. doi:10.1176/appi.ajp.2007.07040704
- Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Health Journal*, 35, 515-530. doi:10.1023/A:1018759201290
- American Psychiatric Association. (2000). *Psychiatric services in jails and prisons* (2nd ed.). Washington, DC: American Psychiatric Association.
- Americans with Disabilities Act of 1990, 42 U.S.C.A. § 12101 *et seq.* (West 1993).
- Arizona Department of Corrections (2013). *Department order 704: Inmate regulations*. Retrieved from <http://www.azcorrections.gov/Policies/700/0704.pdf>
- Arizona Department of Corrections (2014). Levels of mental health services delivery (Chapter 2, Section 1.0). *ADC Mental Health Technical Manual*. Phoenix, AZ: Arizona Department of Corrections.
- Arizona Department of Corrections (2014, February). *Inmate ethnic distribution by unit*. Retrieved from Arizona Department of Corrections website: http://www.azcorrections.gov/adc/reports/stats_ethnic.aspx
- Arizona Department of Corrections; Budget, Planning and Research (2014, March). *Corrections at a glance*. Retrieved from Arizona Department of Corrections website: <http://www.azcorrections.gov/adc/reports/glance.aspx>

- Asnaani, A., Richey, J. A., Dimaite, R., Hinton, D. E., & Hofmann, S. G. (2010). A cross-ethnic comparison of lifetime prevalence rates of anxiety disorders. *Journal of Nervous and Mental Disease, 198*, 551-555. doi:10.1097/NMD.0b013e3181ea169f
- Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry, 166*, 103-109. doi:10.1176/appi.ajp.2008.08030416
- Berg, M. T., & DeLisi, M. (2006). The correctional melting pot: Race, ethnicity, citizenship, and prison violence. *Journal of Criminal Justice, 34*, 631-642. doi:10.1016/j.jcrimjus.2006.09.016
- Bischoff, A., & Hudelson, P. (2010). Access to healthcare interpreter services: Where are we and where do we need to go? *International Journal of Environmental Research and Public Health, 7*, 2838-2844. doi:10.3390/ijerph7072838
- Blazer, D. G., Kessler, R. C., McGonagle, K. A., & Swartz, M. S. (1994). The prevalence and distribution of major depression in a national community sample: The National Comorbidity Survey. *American Journal of Psychiatry, 51*, 979-986. Retrieved from <http://journals.psychiatryonline.org/data/Journals/AJP/3624/979.pdf>
- Bonczar, T. P. (2003). *Prevalence of imprisonment in the U.S. population, 1974-2001* (NCJ Publication No. 197976). U.S. Department of Justice Programs, Bureau of Justice Statistics Special Report. Retrieved from <http://www.cbsnews.com/htdocs/pdf/prisonetime.pdf>
- Bright, S. B. (2010). Legal representation for the poor: Can society afford this much injustice? *Missouri Law Review, 75*, 683-714. Available at: <http://scholarship.law.missouri.edu/mlr/vol75/iss3/3>

- Bromberger, J. T., Harlow, S., Avis, N., Kravitz, H. M. & Cordal, A. (2004). Racial/ethnic differences in the prevalence of depressive symptoms among middle-aged women: The Study of Women's Health Across the Nation (SWAN). *American Journal of Public Health, 94*, 1378-1385.
- Burnam, M. A., Hough, R. L., Escobar, J. I., Karno, M., Timbers, D. M., Telles, C. A., & Locke, B. Z. (1987). Six-month prevalence of specific psychiatric disorders among Mexican-Americans and Non-Hispanic Whites in Los Angeles. *Archives of General Psychiatry, 44*, 687-694, doi:10.1001/archpsyc.1987.01800200013003.
- Butcher, K. F., & Piehl, A. M. (2007). *Why are immigrants' incarceration rates so low? Evidence on selective immigration, deterrence, and deportation* (Working paper No. 13229). Retrieved June 9, 2014 from the National Bureau of Economic Research website: <http://www.nber.org/papers/w13229>
- Carson, E. A., & Sabol, W. J. (2012). *Prisoners in 2011*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Retrieved from: <http://www.bjs.gov/content/pub/pdf/p11.pdf>
- Civil Rights Act, 42 U.S.C. § 1971 (1964).
- Council of State Governments. (2002, June). *Criminal Justice/Mental Health Consensus Project*. Retrieved from: <http://csgjusticecenter.org/mental-health-projects/report-of-the-consensus-project/>
- Cuellar, I., & Paniagua, F. A. (2000). *Multicultural mental health*. San Diego, CA: Academic Press.
- DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2013). *Income, poverty, and health insurance coverage in the United States: 2012* (Current Population Reports, P60-245). Washington,

- DC: U.S. Government Printing Office. Retrieved from U.S. Census Bureau website:
<http://www.census.gov/hhes/www/poverty/data/>
- Diamond, P. W., Wang, E. W., Holzer, C. E., III, Thomas, C., & Crusier, d. A., (2001). The prevalence of mental illness in prison. *Administration and Policy in Mental Health, 29*, 21-40. doi:10.1023/A:1013164814732
- Draine, J., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services, 53*, 565-573. doi:10.1176/appi.ps.53.5.565
- Drissel, D. (2003). Massachusetts prison mental health services: History, policy and recommendations. *Massachusetts Law Review, 87*(3). Retrieved from <https://www.massbar.org/publications/massachusetts-law-review/2003/v87-n3/massachusetts-prison-mental-health-services>
- Edgar, K. & O'Donell, I. (1998). Assault in prison: The victim's contribution. *The British Journal of Criminology, 38*, 635-650. doi:10.1093/bjc/38.4.635
- Eno Louden, J., Skeem, J. L. (2011). Parolees with mental disorder: Toward evidence-based practice. *Bulletin of the Center for Evidence-Based Corrections, 7*, 1-9.
- Eno Louden, J., Skeem, J. L., & Blevins, A. (2013). Comparing the predictive utility of two screening tools for mental disorder among probationers. *Psychological Assessment, 25*, 405-415. doi:10.1037/a0031213
- Estelle v. Gamble, 429 U.S. 97, 103 (1976).
- Farabee, D. (2006). An evaluation of California's mental health services continuum program for parolees. *Corrections Today, 68*, 38-41.

- Fazel, S., Cartwright, J., Norman-Nott, A., & Hawton, K. (2008). Suicide in prisoners: A systematic review of risk factors. *Journal of Clinical Psychiatry, 69*, 1721-1731.
doi:10.4088/jcp.v69n1107
23490177_Suicide_in_prisoners_a_systematic_review_of_risk_factors/file/5046351ffd0aea53bc.pdf
- Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. *Lancet, 359*, 545-50. doi:10.1016/S0140-6737(02)07740-1
- Fazel, S., & Seewald, K. (2012). Severe mental illness in 33588 prisoners worldwide: Systematic review and meta-regression analysis. *The British Journal of Psychiatry, 200*, 364-373.
doi:10.1192/bjp.bp.111.096370
- Fiscella, K., Franks, P., Doescher, M. P., & Saver, B. G. (2002). Disparities in health care by race, ethnicity, and language among the insured: Findings from a national sample. *Medical Care, 40*(1), 52-59. Available at <http://www.jstor.org/stable/3767958>
- Glaze, L. E., & Herberman, E. J. (2013). *Correctional populations in the United States, 2012* (NCJ Publication No. 243936). Retrieved from U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics website:
<http://www.bjs.gov/content/pub/pdf/cpus12.pdf>
- Gonzalez, G. M. (1997). The emergence of Chicanos in the twenty-first century: Implications for counseling, research, and policy. *Journal of Multicultural Counseling & Development, 25*, 94-106. doi:10.1002/j2161-1912.1997.tb00320.x
- Gonzalez, H. M., Haan, M. N., & Hinton, L. (2001). Acculturation and the prevalence of depression in older Mexican Americans: Baseline results of the Sacramento area Latino

- study on aging. *Journal of the American Geriatrics Society*, 49, 948-953.
doi:10.1046/j.1532-5415.2001.49186.x
- Hagan, J., & Palloni, A. (1999). Sociological criminology and the mythology of Hispanic immigration and crime. *Social Problems*, 46, 617-632. doi:10.2307/3097078
- Hipp, J. R., & Yates, D. K. (2011). Ghettos, thresholds, and crime: Does concentrated poverty really have an accelerating increasing effect on crime? *Criminology*, 49, 955-990.
doi:10.1111/j.1745-9125.2011.00249.x
- Kawachi, I. & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 78, 458-467. doi:10.1093/jurban/78.3.458
- Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., ...Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *The New England Journal of Medicine*, 352, 2515-1523. doi:10.1056/NEJMsa043266
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., ...Kendler, K. S. (1994). Lifetime and 12-month prevalence of *DSM-III-R* psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51, 8-19. doi:10.1001/archpsyc.1994.03950010008002
- Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research*, 45, 104-110. doi:10.1016/j.jpsychires.2010.04.031
- Kleinman, A. (1988). *Rethinking psychiatry*. New York, NY: The Free Press.

- Larkey, L. K., Hecht, M. L., Miller, K., & Alatorre, C. (2001). Hispanic cultural norms for health-seeking behaviors in the face of symptoms. *Health Education & Behavior, 28*, 65-80. doi:10.1177/109019810102800107
- Lewis-Fernández, R., Das, A. K., Alfonso, C., Weissman, M. M., & Olfson, M. (2005). Depression in US Hispanics: Diagnostic and management considerations in family practice. *Journal of the American Board of Family Medicine, 18*, 282-296. doi:10.3122/jabfm.18.4.282
- López, S. R., & Guarnaccia, P. J. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology, 51*, 571-598. doi:10.1146/annurev.psych.51.1.571
- Macartney, S., Bishaw, A., & Fontenot, K. (2013). *Poverty rates for selected detailed race and Hispanic groups by state and place: 2007-2011*. (Report No. ACSBR/11-17). Retrieved from the United States Census Bureau website: <http://www.census.gov/prod/2013pubs/acsbr11-17.pdf>
- Mojtabai, R. (2007). Americans' attitudes toward mental health treatment seeking: 1990-2003. *Psychiatric Services, 58*, 642-651. doi:10.1176/appi.ps.58.5.642
- Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., ... Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey replication (NCS-R). *Psychological Medicine, 41*, 1751-1761. doi:10.1017/S0033291710002291
- Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal, 43*, 527-544. doi:10.1007/s10597-007-9092-9

- Mulvaney-Day, N. E., Alegría, M., & Sribney, W. (2007). Social cohesion, social support, and health among Latinos in the United States. *Social Science & Medicine*, *64*, 477-495.
doi:10.1016/j.socscimed.2006.08.030
- National Council of La Raza. (2011). *Toward a more vibrant and youthful nation: Latino children in the 2010 census*. Retrieved from: http://issuu.com/nclr.docs/latino_children_in_the_2010_census
- Organista, P. B., Organista, K. C., & Kurasaki, K. (2003). The relationship between acculturation and ethnic minority mental health. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 139-161). Washington, DC: American Psychological Association.
- Patel, V., Lund, C., Hatherill, S., Plagerson, S., Corrigan, J., Funk, M., & Flisher, A. J. (2010). Mental disorders: Equity and social determinants. In E. Blas & A. S. Kurup (Eds.), *Equity, social determinants and public health programmes* (pp. 115-134). Retrieved from http://www.who.int/entity/social_determinants/tools/EquitySDandPH_eng.pdf
- Peterson, J., Skeem, J. L., Hart, E., Vidal, S., & Keith, F. (2010). Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis. *Psychiatric Services*, *61*, 1217-1222. doi:10.1176/appi.ps.61.12.1217
- Pew Research Center, Pew Hispanic Center. (2011). *Hispanics account for more than half of nation's growth in past decade*. Retrieved from Pew Hispanic Center website: <http://www.pewhispanic.org/files/reports/140.pdf>
- Powell, T. A., Holt, J. C., & Fondacaro, K. M. (1997). The prevalence of mental illness among inmates in a rural state. *Law and Human Behavior*, *21*, 427-438.
doi:10.1023/A:1024811303834

- Reid, L. W., Weiss, H. E., Adelman, R. M., & Jaret, C. (2005). The immigration-crime relationship: Evidence across US metropolitan areas. *Social Science Research, 34*, 757-780. doi:10.1016/j.ssresearch.2005.01.001
- Riolo, S. A., Nguyen, T. A., Greden, J. F., & King, C. A. (2005). Prevalence of depression by race/ethnicity: Findings from the National Health and Nutrition Examinations Survey III. *American Journal of Public Health, 95*, 998-1000. doi:10.2105/AJPH.2004.047225
- Ruiz, P. (1985). Cultural barriers to effective medical care among Hispanic-American patients. *Annual Review of Medicine, 36*, 63-71. Retrieved from <http://www.annualreviews.org/doi/pdf/10.1146/annurev.me.36.020185.000431>
- Schuck, A. M., Lersch, K. M., & Verrill, S. W. (2004). The “invisible” Hispanic? The representation of Hispanics in criminal justice research. *Journal of Ethnicity in Criminal Justice, 2*(3), 5-22. doi:10.1300/J222v02n03_02
- Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior, 35*, 110-126. doi:10.1007/s10979-010-9223-7
- Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93*, 239-243. doi:10.2105/AJPH.93.2.239
- State of California. (2014). *California code of regulations: Title 15. Crime prevention and corrections*. Retrieved from the California Department of Corrections and Rehabilitation website: http://www.cdcr.ca.gov/Regulations/Adult_Operations/docs/Title15-2014.pdf
- Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*, 761-765. doi:10.1176/appi.ps.60.6.671

- Steiner, B. & Wooldredge, J. (2009). The relevance of inmate race/ethnicity versus population composition for understanding prison rule violation. *Punishment & Society*, *11*, 459-489. doi:10.1177/1462474509341143
- Taylor, P., Lopez, M. H., Hamar Martínez, J., & Velasco, G. (2012). *When labels don't fit: Hispanics and their views of identity*. Washington, DC: Pew Hispanic Center.
- Taylor, P. J. (1986). Psychiatric disorder in London's life-sentenced offenders. *British Journal of Criminology*, *26*(1), 63-78.
- Timmins, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. *Journal of Midwifery & Women's Health*, *47*(2), 80-96. doi:10.1016/S1526-9523(02)00218-0
- Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states*. Treatment Advocacy Center. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf
- Torres, L., & Rollock, D., (2007). Acculturation and depression among Hispanics: The moderating effect of intercultural competence. *Cultural Diversity and Ethnic Minority Psychology*, *13*, 10-17. doi:10.1023/A:1022994510944
- Tribe, R. (2009). Working with interpreters in mental health. *International Journal of Culture and Mental Health*, *2*, 92-101. doi:10.1080/17542860903115976
- U.S. Department of Commerce, U.S. Census Bureau (2011). *The Hispanic population: 2010* (Publication No. C2010BR-04). Available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf>

- U.S. Department of Justice. (1999). *Mental health and treatment of inmates and probationers* (NCJ Report No. 174463). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- U.S. Department of Justice. (2001). *Mental health treatment in state prisons, 2000* (NCJ Report No. 188215). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- U.S. Department of Justice. (2006). *Mental health problems of prison and jail inmates* (NCJ Report No. 213600). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- U.S. Department of Justice. (2014). *Prisoners in 2013* (NCJ Report No. 247282). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Vega, W. A., & Alegría, M. (2001). Latino mental health and treatment in the United States. In M. Aguirre-Molina, C. W. Molina, & R. E. Zambrana (Eds.), *Health issues in the Latino community* (pp. 179-210). San Francisco, CA: Wiley.
- Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., Caraveo-Anduaga, J. (1998). Disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, *55*, 771-778. doi:10.1001/archpsyc.55.9.771
- Verdinelli, S., & Biever, J. (2009). Spanish-English bilingual psychotherapists: Personal and professional language development and use. *Cultural Diversity and Ethnic Minority Psychology*, *15*, 230-242. doi:10.1037/a0015111
- Way, B. B., Miraglia, R., Sawyer, D. A., Beer, R., & Eddy, J. (2005). Factors related to suicide in New York state prisons. *International Journal of Law and Psychiatry*, *28*, 207-221. doi:10.1016/j.ijlp.2004.09.003

Williams, S. D. (1985). No comprendo: The language barrier in the Criminal Justice System.

Corrections Compendium, 10(4), 6-9.

Woodward, A. M., Dwinell, A. D., & Aarons, B. S. (1992). Barriers to mental health care for

Hispanic Americans: A literature review and discussion. *The Journal of Mental Health*

Administration, 9, 224-236. doi:10.1007/BF02518988

Endnote

¹ We use “Latino” to refer to persons who were categorized as “Hispanic” in some studies. See Taylor, Lopez, Hamar Martínez, and Velasco (2012), for discussion of the different terms.

Table 1

Arizona's Frequencies of Inmates With Mental Health Needs by Ethnicity

Ethnicity	% Observed Proportion of Prison Population	Expected Frequency Within Inmates With Mental Health Needs	Observed Frequency Within Inmates With Mental Health Needs (%)
European American	39.5	4212.3	5122 (48.0)
African American	13.2	1407.7	1660 (15.6)
Latino	40.5	4318.9	3297 (30.9)
Native American	5.0	533.2	410 (5.5)
Other	1.8	192.0	175 (1.6)

Table 2

California's Differences Between Parolees With or Without Mental Health Needs

Characteristic	Parolees With Mental Disorder	Parolees Without Mental Disorder
<i>n</i>	9,177	35,810
Mean Age (<i>SD</i>)*	35.5 (10.3)	33.2 (9.8)
% Female*	18.2	11.0
Ethnicity*		
%European	41.0	28.9
%American		
%African American	29.0	19.7
%Latino	25.9	46.4
%Other	4.1	5.1

* $p < .001$.