

**PLACEMENT OF THE MENTALLY ILL IN AMERICA'S
STATE PRISON SYSTEMS: A COMPARATIVE CASE
STUDY OF NEW YORK AND SOUTH CAROLINA'S
STATE PRISONS**

MIRIAM KAVALERCHIK

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College of Charleston

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Primary Advisor: Claire Wofford, Ph.D.

Secondary Reader: Heath Hoffmann, Ph.D.

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Introduction

A mentally ill person is more than four times as likely to be put into jail or prison rather than a mental hospital in South Carolina than in New York. That such a disparity exists for the treatment of the mentally ill is disturbing to say the least. The mentally ill population in the United States is a very stigmatized group, and has been the target of isolation from American society for a substantial amount of time. In addition, the mentally ill population in the United States has continually come into contact with the criminal justice system since the 1950's, decreasing the chance that they will receive adequate assistant care (Torrey, et al: 1-4).

The study of the treatment of the mentally ill in society, and especially how the mentally ill population has become a substantial population in prisons across the United States, is important for many reasons. Studying the displacement of the mentally ill population in different facets of the criminal justice system helps one to understand how the criminal justice system works in some ways, how certain groups are cared for (or not), and how the system can be improved. I researched how the criminal justice system functions, and what are some of the best tactics for dealing with the mentally ill in prisons, by studying this phenomenon regionally in the United States. By studying how the North and the South differ in their approaches to this phenomenon, I will help explain the large disparity in the imprisonment rates of the mentally ill in Northern and Southern states.

In the end, I hope to devise a recommendation plan for states wishing to remedy their current situation in terms of the imprisonment rate of mentally ill persons. Unfortunately, because jails and prisons have become the replacement for mental

hospitals and asylums since the 1950's, facilities in the criminal justice system were not originally intended to function as houses for the mentally ill (Shenson, et al: 656-656). Jails and prisons have been built to incarcerate and rehabilitate the poor on the street, and because of this transformation, the mentally ill have become a target of incarceration, while the number of available psychiatric beds have simultaneously decreased. The shift of the burden of dealing with the mentally ill population in the United States from the hospitals to the criminal justice system has caused much tension between the healthcare and criminal justice systems.

Moreover, since the development of various programs such as Medicare and Medicaid in the 1960's, the federal government has placed the burden of the populations in need of help more on the taxpayers, rather than the private burden it was. The enactment of these programs made the transition of the mentally ill population from the mental hospitals and asylums easier because there were many cases in which the hospitals and asylums clearly proved to be both ineffective at helping the mentally ill and corrupt in many ways (Shenson, et al: 655-656). The community then became the outlet for the rejected mentally ill population, and as a result of negative interactions with the community at large, the mentally ill soon came into contact with the criminal justice system (Lamb and Weinberger: 529-534, James and Glaze, 2006: 1-12, and Simon, 2007: 153-155). Thus, a tension was created between the health care system in the United States, which controlled the hospitals and new programs, and the criminal justice system, which now had the mentally ill population as a significant population in jails and prisons across the country. The disparity in imprisonment rates of the mentally ill among

different states is a direct result of how the states dealt with the many facets of the emerging healthcare system and expanding prison population during the 1970's.

The disparity in the imprisonment rates of the mentally ill among different states cannot be understood properly without understanding the phenomenon of the deinstitutionalization of mental hospitals in more detail. "Deinstitutionalization is the name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of those institutions; it has been a major contributing factor to the mental illness crisis" (Torrey, 1997: 11-12). This phenomenon has had many stages to it, with the most significant markers in the 1950's, in the 1970's, and in the 1990's. The current situation of the mentally ill in hospitals and other outlets nationwide is a result of the various changes that have developed with deinstitutionalization. "Deinstitutionalization began in 1955 with the widespread introduction of chlorpromazine, commonly known as Thorazine, the first effective antipsychotic medication, and received a major impetus 10 years later with the enactment of federal Medicaid and Medicare" (Torrey, 1997: 25-42). The underlying argument that I will suggest, emphasizing this deinstitutionalization phenomenon, is that due to the lack of federal regulation regarding the placement of the mentally ill in our state prison system, states in different areas of the country are able to deal with this issue as they wish. Although the issue is not solely the lack of federal governance, this lack of governance has allowed the approaches of each state to be influenced by state-specific factors and therefore resulted in serious disparities in how mentally ill persons are treated in different states. More precisely, I will focus on political factors and be answering the question of "How have the political ideologies in American states since the de-

institutionalization of mental hospitals since the 1970's affected how the mentally ill are displaced to state prisons?"

Literature Review

The literature relevant to this project can be categorized into different groups: 1) the history and study of political ideology; 2) the definitions and explanations of mental illness; 3) the history of the deinstitutionalization of mental hospitals; 4) the nationwide developments involving the interaction of the mentally ill with the criminal justice system over time; 5) the treatment and placement of the mentally ill in New York; 6) the treatment and placement of the mentally ill in South Carolina; and 7) the current outlets available for the mentally ill to seek treatment and assistance.

As far as the history and study of political ideology, several books explained typical developments of both Democratic and Republican states. For example, southern states, which are typically attributed with voting Republican for presidential elections (uselectionatlas.org), have historically been tough on crime and supportive of the multitude of legislative measures and laws that have advanced crime control in the United States (Simon, 2007: 13-258; Alexander, 2010: 1-262; Clear, 2007: 3-208). The southern states have been known to exhibit this type of behavior all the way leading back to slavery continuing through the civil rights movement and today (Alexander, 2010: 1-262).

And this tendency for these conservative states to be tough on crime and those accused of a variety of crimes applies to the mentally ill population that interacts with the criminal justice system as well. The overall mentality of implementing "tough on crime"

provisions in conservative states is no more lenient for populations that may need extra assistance such as the mentally ill.

As for the opposite side of the political spectrum, northern states have more commonly been associated with the Democratic/liberal ideology (uselectionatlas.org). Northern states have historically been more progressive with provisions that assist stigmatized groups, and the mentally ill population is no exception. Many liberal presidents have passed several laws in the past promoting the inclusion of oppressed groups into society, making the northern states that are usually associated with supporting liberal provisions passed by the federal government more inclined to provide those in need with a variety of treatment and assistance options (Simon, 2007: 13-258, Clear, 2007: 3-208).

Before I began research, I needed to determine exactly what group of mentally ill people I was going to discuss. After finding research that explained the treatment and imprisonment of several different groups of mentally ill people, I decided to focus on those diagnosed with specific illnesses, namely those according to the DMS-IV-TR who are diagnosed with schizophrenia, delusional disorder, psychotic disorder, major depression and bipolar disorder (Lamb and Weinberger: 529-534; James and Glaze, 2006: 1-12). It was important to make this distinction of clarifying exactly what group I was going to study because many similar studies discuss the prevalence of those with drug and alcohol dependency issues (Lamb and Weinberger: 529-534; James and Glaze, 2006: 1-12). I did not want to include those suffering from drug and alcohol dependency in my research because there was a multitude of research on this topic already and it would have broadened my research too much.

Third, the history of the deinstitutionalization of mental hospitals is a major area of interest for my research. It is clear from the research that mental hospitals were shut down beginning in the 1950's/1960's because of mistreatment of the mentally ill and hospitals not being able to continue to provide adequate care for the mentally ill population (Lamb and Weinberger: 529-534; Shenson, Dubler, and Michaels: 655-656). Some of the mistreatments included corruption within the doctoral staffs, neglect of the patients, and an overall mentality that those being treated in the mental hospitals were already outcasts so they could be treated in unethical and illegal ways without consequences for the perpetrators.

The research already available clearly defined this phenomenon and emphasized the different areas of interest that are crucial to research when looking into this topic. This research gave me the majority of my numbers and data about how the availability of hospital beds, the number of mentally ill patients in the country, and how many mentally ill patients have sought out assistance has changed over time (United States Psychiatric Hospitals Database: 1-4; Torrey, 1997: 205-208; National Institute of Corrections). In accordance with the shutting down of the mental hospitals, and as a result of laws made at the federal level, there were many different developments that affected how the mentally ill population was to be treated. With these developments happening simultaneously, the mentally ill were to receive treatment without the existence of many mental hospitals or hospital beds devoted specifically to the treatment of the mentally ill.

The research that discusses the nationwide developments involving the interaction of the mentally ill with the criminal justice system over time helps to explain how the mentally ill population became a steady population in prison systems across the country.

The different nationwide developments that propelled this transition of the mentally ill to prisons include the closing of mental hospitals beginning in the 1960's/1970's, the expanding of the prison system since the 1970's (Simon, 2007: 13-258), and the new laws and expansion of crime control for many different groups of accused criminals as a result of a more strict criminal system since the 1970's (Simon, 2007: 13-258; Alexander, 2010: 1-262; Clear, 2007: 3-208). All of these nationwide developments set the stage for the United States' prison population to increase by an incredible number, now placing the United States on the map as the country that imprisons more people than nearly every other country in the world (Simon, 2007: 13-258). Of the multitude of people imprisoned in America's prisons every year, about 6-7% of that population are found to be diagnosed with a serious mental illness (Torrey, 1997: chapter 3).

After placing all of the background and historical pieces together, I turned to research specifically relating to the treatment and placement of the mentally ill in New York and South Carolina for my comparative case study. For this, there was a lot of research available tracking the history of New York in terms of the amount of hospitals, prisons and treatment options available for assistance with the mentally ill. Some of this research came from the deinstitutionalization literature, but the majority of the research came from state resources about the different laws and organizations New York has created since the 1970's to assist the mentally ill population (NY State Office of Mental Health; Hoffman: 75-85; Torrey, et al.: 1-5). The current research also includes the likelihood of a mentally ill person to end up in a hospital versus a prison and the different probabilities available to analyze how effectively New York has been in assisting the stigmatized mentally ill population (Torrey, et al.: 1-7). New York has made vast

improvements in the coordination of their health care and criminal justice systems in order to help the mentally ill, and the state is known to be an example of how other states should model their systems to help the mentally ill (NY State Office of Mental Health).

Existing research also discusses the treatment and placement of the mentally ill in South Carolina, including state databases and historical timelines. The general hospitalization versus imprisonment rates for the mentally ill (Torrey, et al.: 1-7), availability of hospital spaces for the mentally ill (Lamb and Weinberger: 529-534), and the number of mentally ill in South Carolina in total are easily accessible (Torrey, 1997: 205-208). There was not, however, a large amount of research pertaining to the specific legislative measures or additional agencies and organizations that South Carolina has put in place since the 1970's specifically relating to the treatment and assistance of the mentally ill within the state. The specific information for how South Carolina has contributed to the deinstitutionalization of mental hospitals phenomenon is how South Carolina has responded to the provisions passed on a national basis; not much is available for the state's specific actions (Craft, SC Dept. of Mental Health).

Finally, the research that focuses on the current interaction of the mentally ill with the health care and prison systems discusses the outlets available for the mentally ill to seek treatment and assistance. This includes a relatively new development with the usage of mental health courts (U.S. Psychiatric Hospitals Database: 1-4), organizations devoted specifically to the mental health field, and a variety of treatment options available in jails and prisons today that are accounted for in government-sponsored research and statistical data (Beck and Maruschak, 2000: 1-8). With the absence of mental hospitals and the movement of mentally ill people into jails and prisons, these institutions are developing

ways in which to help those who need extra assistance while incarcerated (Lamb and Weinberger: 529-534). The most interesting piece of research I read is that the many ways of dealing with prisoners would be more effective in terms of recidivism and building personal morale by using fairness instead of toughness to prompt compliance with the law (Clear, 2007: 40-60). More “fair” measures includes moving towards more therapeutic methods of assisting inmates by focusing on the psychological ramifications of an inmate’s actions and the influence of these psychological factors on the inmate’s crime (Clear, 2007: 40-60). Conversely, more “tough” measures include focusing on physical methods of changing an inmate’s behavior like creating a work ethic through manual labor while incarcerated (Clear, 2007: 40-60). This principle of focusing on fairness rather than toughness to correct harmful behaviors can be applied to mentally ill prisoners as well as prisoners in general, and our society has progressively been moving into supporting psychological studies as time goes on. This development also helps to expand upon treatment options for those needing psychological and mental assistance when involved with the criminal justice system, as effective states seem to combine the healthcare system with the criminal justice system (NY State Office of Mental Health).

Theory and Hypotheses

A common way of measuring the political divide among states is by studying the ways in which states adhere to the particular political culture in which they fall. Daniel Elazar is often known as the father of measuring political culture. According to one of Elazar’s major works, one can define political culture by dividing states into one of three categories: a state can be moralistic, individualistic or traditionalistic (Mead: 279-281).

By defining a state as falling into one of these three categories, certain characteristics of the state are assumed.

However, for my research I am not focusing on the political cultures of New York and South Carolina, but am studying how the different political ideologies of these two states can help to explain the different rates of imprisonment of mentally ill persons in state prisons. A state's political ideology is a specific component of what would comprise of a state's political culture. By studying political ideology over political culture I am able to more easily specify a correlation and possible causation relationship between a state's political ideology and how they treat the mentally ill within that state.

I define the political ideology of a state as whether it is Democratic/liberal-leaning or Republican/conservative-leaning. Historically, southern states have always adopted a more conservative view on how to deal with the state's economic, social and political ventures (Simon, 2007: 108-115). Crime and the detaining of suspected criminals have historically been known to be more firmly rooted in southern politics, especially since the resistance of the southern states during the civil rights movement in the second half of the twentieth century (Simon, 2007: 100-115). Southern politics and southern states are often associated with incarcerating the most people in jails and prisons, with executing the most criminals by usage of the death penalty, with encouraging harsher punishments, and with being less lenient to work with suspects (Mead: 271-274) Because of these generalizations, southern politics is seen as a strong influence on the criminal justice system in southern states. And in addition, prosecutors are often known to run the political scheme in a state along with the court and politicians (Simon, 2007: 163-165).

Ironically, the development of “tough-on-crime” platforms originated with Democratic President Franklin D. Roosevelt’s development of the Department of Justice in the 1930’s, making the criminal justice system more of its own entity since that development. Additionally, California, a historically recognized Democratic state, was actually the frontrunner in legislation and policies that influenced the implementation of the deinstitutionalization movement in the United States in the 1970’s (Torrey, 1997: 25-42). Although southern conservative politics is typically associated with a more strict interaction with the criminal justice system than northern liberal politics, the move to deinstitutionalize mental hospitals throughout the United States and create the expansive criminal justice system we have today began with Democratic leaders.

On the opposite side of the political spectrum are the northern liberal politics and ideology. The (typically northern) liberal ideology as it relates to the criminal justice system consists of enacting policies and provisions to combat crime while also advancing the usage of therapeutic rehabilitative strategies over increased imprisonment (Simon, 2007: 105-111). A big proponent of the move to support democratic policies concerning crime control (or limiting crime control) was President Lyndon B. Johnson. President Johnson was so skeptical of the Safe Streets Act of 1968 that emphasized the prevention of crime through a more advanced coordination of law enforcement efforts, that he proposed a Commission on Crime in 1967 that combined focusing efforts on raising the technological level of policing, rather than the subjective aspects, as well as advancing therapeutic rehabilitative strategies with certain groups who did not necessarily need to end up in jail or prison (Simon, 2007: 105-111). Around the same time the Democratic Party had the majority vote in both the House of Representatives and the Senate and

enacted several provisions to combat the Republican-passed crime control measures, including President Nixon's initial steps he took while in office toward crime control and an increase in the jurisdiction for police officers and correctional officers across the country (Simon, 2007: 110-113).

Following the nationwide movements that propelled the deinstitutionalization of mental hospitals -- the development of the United States Department of Justice in the 1930's, the emptying of mental health systems across the country in the 1970's, the development of Medicare and Medicaid in the 1960's, and the expansive building of prisons in the 1980's -- each state developed its own perspective on how to deal with the repercussions of all of these new policies (Simon, 2007: 153-156; Hoffman: 75-85). First, the expansion of the U.S. Department of Justice under President Franklin Delano Roosevelt in the 1930's had a substantial effect on how the criminal justice system was to be handled in the United States. From his massive expansion movements, in which law enforcement officials were instructed directly by the federal government to crack down on criminals across the country, the "war on crime" was created (Simon, 2007: 46-85). The "war on crime" became a nationwide phenomenon in which crime and catching criminals was a model problem for federal solution to be a part of. This mentality led the United States straight through to the 1960's with a proactive strategy to control crime (Simon, 2007: 45-85).

The next step in deinstitutionalization was the actual emptying of mental hospitals across the United States. During the 1970's, a large-scale push to empty the mental hospitals across the country, while simultaneously reducing the number of low-income housing, led to a surplus of disturbed and mentally ill persons roaming streets nationwide

(Shenson, Dublen, and Michaels: 656-656). “California was the first state to aggressively undertake deinstitutionalization, implementing the Lanterman-Petris-Short (LPS) Act in 1969, which made it much more difficult to involuntarily hospitalize, or keep in the hospital, persons who are mentally ill” (Torrey, 1997: 25-42). Other states began to follow suit, especially with the emerging Republican victories nationally with the 1971, 1980, and 1984 presidential elections, causing the country as a whole to recognize the emphasis placed on crime control and other popular Republican policies.

The implementation of the Medicare and Medicaid programs in the 1960’s also had a very significant effect on how the mentally ill were treated in different states and different state prison systems. The introduction of Medicare and Medicaid in the social welfare system switched the obligation of those to help with patients requiring these services more from the communities to government agencies (Craft, SC Dept. of Mental Health). There was a confusing dynamic of the federal government first closing mental hospitals and having a large proportion of the mentally ill patients having to fend for themselves in the community, followed by the development of new systems that tried to put the mentally ill and those in need of assistance back in the hands of the federal government. The disparity between the actions by the federal government of closing hospital doors to the mentally ill and then pushing them away from community assistance between the 1950’s through the 1960’s steered the mentally ill population toward one outlet the government had not anticipated: the criminal justice system.

And finally, along with this reallocation of this stigmatized group in the United States came the expansion of prisons across the country. “Building prisons served to remove troubled and troublesome individuals from the community while supporting

investment in construction contracts, in the production of a docile labor force, and in new forms of psychiatric and psychological expertise (Simon, 2007: 153).

The expansion of the prison system was a process that happened as a result of many things, with the population of the mentally ill moving into the criminal justice system being just one piece of the puzzle. The building of the many new prisons correlated with an increase in the prison population nationwide, most notably because of the sentencing policy changes that were occurring and the expanding “War on Drugs” phenomenon in the 1970’s and 1980’s in the United States (Simon, 2007: 85-115). A change in sentencing policy also occurred, including the growth of sentences without a possibility of parole, expansion of the usage of the death penalty, expansion of the bail system used at local jails, enactment of the Safe Streets Act of 1968, enactment of mandatory arrests, usage of 1-strike policies, and a 5-fold increase of arrests for drug crimes between 1970 and 2000 (Simon, 2007: 50-200; Alexander, 2010: 100-110).

The southern states took a different approach in responding to these developments and the mentally ill population than did the northern states. The northern states adopted a more freedom-preserving manner of dealing with the mentally ill population and were more willing to work with the federal programs passed such as Medicare and Medicaid (Hoffman: 75-85). This manner included focusing on the rights and freedoms of the accused and convicted primarily, in accordance of course with the law but with priorities set into place to first and foremost tend to the needs and concerns of the accused. Conversely, the southern states adopted a more traditional approach to dealing with the mentally ill population, following in typical southern ways of being tough on crime

regardless of the group accused. Because of this approach, the southern states were less willing to work with the Medicare and Medicaid programs (Hoffman: 75-85).

In short, the liberal state legislatures seemed to be developing in a more progressive manner in dealing with the mentally ill populations more so than the conservative southern states (Clear, 2007: 10-30). And since there was, and still is, a lack, of grassroots campaigns for prisoner advocacy, the only way in which the mentally ill population is subject to interaction with the criminal justice system is through the ways in which the *state* regulates this interaction (Clear, 2007: 35-45).

Combining this with the influence of political ideology on state-local politics, I hypothesize:

Hypothesis 1: *The varying political ideologies of the North versus the South have contributed to different patterns regarding the imprisonment rates of the mentally ill in the Northern and Southern states.*

Hypothesis 2: *The more Democratic-leaning Northern states have a more developed and proactive method of dealing with the mentally ill in their prison systems than the Republican-leaning Southern states.*

The first hypothesis, if accepted, will be used to explain 1) why a difference in imprisonment rates of the mentally ill exists between the Northern versus the South states and 2) how the difference can be partially explained by the political ideologies of the two states. However, it is necessary to note that I am studying just one factor, the political ideology of the states. As discussed below, there are certainly many other factors that can affect why the states treat their populations differently. The second hypothesis is used as the second observation in my research, working off of the results that come from the

confirmation or rejection of the first hypothesis. My second hypothesis cannot be assessed without adequate information to confirm or reject my first hypothesis.

Methods and Data

In order to answer my question, I conducted a comparative case study of two states that are representative of two different regions in the United States. In order to compare the South-Eastern United States and North-Eastern United States, I picked two states that varied significantly in the chances that a mentally ill person would be put into a prison or jail rather than a hospital. Additionally, every action that reflects a specific state's ideology, such as legislation and policies passed in the state, are governed by the state government, so one can assume as a result of the state's policies, its state government leans one way or the other on the political spectrum. Although some states in different areas of the country such as Arizona and Nevada have the top two worst ratios concerning the chances that a mentally ill person has of being put into a prison or jail compared to a hospital, I want to compare the traditionally conservative South-Eastern region and traditionally-liberal North-Eastern region. To do so I have picked the states of South Carolina and New York, who have a 5.1 to 1 odds of a seriously mentally ill person being in jail or prison compared to odds of being in a hospital and 1.2 to 1 ratio respectively (Torrey, et al: 1-7).

Dependent, Independent and Control Variables

The above ratio of South Carolina's mentally ill population having a 5.1 to 1 chance and New York's mentally ill population having a 1.2 to 1 chance of ending up interacting the criminal justice system is the primary dependent variable (Torrey, et al: 1-7). However, along with this ratio, many other figures will be studied, including South

Carolina having 21 psychiatric units and New York having 17 psychiatric units as of 2012 (U.S. Psychiatric Hospitals Database: 1-4); South Carolina having 4 mental health courts and New York having 28 mental health courts (U.S. Psychiatric Hospitals Database: 1-4); and how South Carolina's state expenditures on corrections have significantly increased recently with their increasing population while New York's state expenditures on corrections have increased with their recently decreasing population (Kyckelhahn, 2012: 1-13). These will be my additional dependent variables.

The primary independent variable is the varying political ideology of South Carolina and New York. The way in which I will measure the political ideology of the two states is by studying the Presidential vote share patterns in both New York and South Carolina for the elections of 1972, 1976, 1980, 1984, 1988, 1992, 1996, 2000, 2004, 2008 and 2012. A vote for a Democratic Presidential candidate means the state is liberal; a vote for a Republican Presidential candidate means the state is conservative. The year 1972 is a significant marker because the 1970's is when the research about the deinstitutionalization of mental hospitals across the country begins. Additionally to track what actions each state took, I will study the legislations and policies that are passed by each state since the 1970's. The legislation and policies that will be focused on are ones in regard to the criminal justice and health care systems as they relate to the incarceration of the mentally ill.

For New York's vote share information, with the states currently having 29 electoral votes allocated, its presidential voting pattern from 1972 through 2012 is as follows (270twin.com):

Table 1: Vote Shares for New York's Presidential Elections, 1972-2012

(uselectionatlas.org)

1972	41.21% Democrat
1976	51.95% Democrat
1980	43.99% Democrat
1984	45.83% Democrat
1988	51.62% Democrat
1992	49.73% Democrat
1996	59.47% Democrat
2000	60.21% Democrat
2004	58.37% Democrat
2008	62.88% Democrat
2012	63.32% Democrat

With the chart marked with the highlighted years that New York's election went Republican as red and the years that New York's election went Democrat as blue, there are three election years that stand out as different than the norm (the norm being New York voting Democrat and the years in question being 1972, 1980 and 1984). The term "norm" is used as describing the typical behavior of New York's voting pattern, or which way the state voted for over half of the elections studied. Between 1972 and 2012 there were 11 presidential elections, and New York voted Democrat 8/11 of those elections, which is well over half, so New York's "norm" is to vote Democrat. In 1972, New York followed suit with the rest of the nation in contributing to the sweeping Republican

victory of nominating Richard Nixon. “Emphasizing a good economy and his successes in foreign affairs...Nixon won the election in a massive landslide...with a 23.2% margin of victory in the popular vote, the fourth largest margin in presidential election history” (270towin.com). Continuing to 1980, following an unsuccessful Democratic term served by President Jimmy Carter, New York again voted similarly to the rest of the country in nominating President Ronald Reagan, the Republican nominee who won by a landslide. Finally, New York’s pattern of voting Republican ended with the election in 1984 with the re-election of popular Republican President Ronald Reagan. New York again voted in accordance with the majority of the nation for the 1984 election where “Reagan was helped by a strong economic recovery from the deep recession of 1981–1982. Reagan carried 49 of the 50 states, becoming only the second presidential candidate to do so after Richard Nixon's victory in the 1972 presidential election” (270towin.com).

In addition to the vote share patterns that existed for New York state from the 1972-2012 elections, a number of organizations and legislation have been an integral part of the state of New York’s plan in working with the mentally ill population and the presence of this population in New York’s healthcare and criminal justice systems. The New York State Office of Mental Health, or OMH, is responsible for the treatment of the mentally ill persons who become involved with the criminal justice system in New York. The OMH provides these individuals with various inpatient and corrections-based mental health services, of which other ordinary persons in the criminal justice system do not necessarily need (NY OMH, 2005: chapter 7). The OMH and Department of Correctional Services in New York, or DOCS, “jointly provide mental health services and treatment to individuals incarcerated in DOCS facilities. Over the past three decades, this service

delivery system has grown to become a nationally respected model” (NY OMH, 2005: chapter 7). The collaboration of these organizations is the only system that is accredited by both the American Correctional Association and the Joint Commission on Accreditation of Healthcare Organizations. This accomplishment speaks volumes about the success of these organizations in aiding New York’s state government treatment of the mentally ill persons involved in the criminal justice system.

Starting in 1976, legislation was passed in New York to transfer the responsibility to provide extra mental health services to people in New York state correctional facilities from just the DOCS to the OMH as well. To fulfill the mandate’s requirements, the OMH opened the Central New York Psychiatric Center, or CNYPC, to provide “triage, crisis services referral and clinic services” (NY OMH, 2005: chapter 7). With the development of this new center and the many satellite centers that were subsequently created, a new range of services to inmates needing extra mental health services became available to those in New York’s correctional facilities.

Since 1995, there have been three large grants from the state government, specifically in FY 1997-1998, FY 1999-2000 and FY 2005-2006 that have provided a significant amount of funds and services to the collaboration of the OMH, DOCS AND CNYPC. Currently, New York State’s correctional facilities include “Residential Crisis Treatment Programs, Intermediate Care Programs, Clinic Treatment Services, Screening and Evaluations, Forensic Telepsychiatry Consultations, Special Housing Unit Services, Behavioral Health Units, Bedford Therapeutic Behavioral Units, Special Treatment Programs, and Inpatient Services” to name just some of the available services (NY OMH, 2005: chapter 7).

South Carolina's vote share information, with the state currently having 9 electoral votes, its presidential voting pattern from 1972 through 2012 is as follows (270towin.com):

Table 2: Vote Shares for South Carolina's Presidential Elections, 1972-2012

(uselectionatlas.org)

1972	27.92% Democrat
1976	56.17% Democrat
1980	48.04% Democrat
1984	35.57% Democrat
1988	37.58% Democrat
1992	39.88% Democrat
1996	43.85% Democrat
2000	40.91% Democrat
2004	40.90% Democrat
2008	44.90% Democrat
2012	44.09% Democrat

With the chart marked with the highlighted years that South Carolina's election went Republican as red and the years that South Carolina's election went Democrat as blue, there is one election year that stands out as different than the norm of South Carolina voting Republican: 1976. In 1976, South Carolina's vote shares showed that the state as a whole voted Democrat, siding with the nationwide election of Democratic nominee Jimmy Carter. "The United States presidential election of 1976 followed the resignation

of President Richard Nixon in the wake of the Watergate scandal. It pitted incumbent President Gerald Ford, the Republican candidate, against the relatively unknown former governor of Georgia, Jimmy Carter, the Democratic candidate” (270towin.com). South Carolina followed suit with the rest of the country in turning a new leaf and going with the Washington newcomer from an adjacent state to start anew from the disappointment that followed President Nixon’s political legacy.

The availability of legislation and significant policies to aid the mentally ill people who have been involved with the criminal justice system in South Carolina varies greatly from that of New York. More specifically, there have been just a few significant points in time when the state expanded the services for the mentally ill involved with the criminal justice system. Going back to 1946, South Carolina passed Public Law 487 and later the Mental Health Act in 1952. “Public Law 487 provided federal funds from the Surgeon General, U.S. Public Health Service, for adequate mental hygiene clinics. The Mental Health Act provided for a Mental Health Commission to be in charge of all mental health facilities” (Craft, SC Dept. of Mental Health). Even with these improvements, however, South Carolina’s clinics were delayed in reopening until late 1947 because of a lack of adequately trained personnel (Craft, SC Dept. of Mental Health).

The next significant step in South Carolina’s treatment of the mentally ill population was the introduction of Medicaid in the 1960s and the passing of the Federal Community Mental Health Centers Act in 1963. These nationwide events allocated more funds to every state, including South Carolina, where the state was about to relocate patients with chronic mental illness to communities instead of mental institutions (Craft,

SC Dept. of Mental Health). Federal resources, in the form of block grants in the 1980's, shrank dramatically for South Carolina, so not much advancement for the mentally ill occurred then. Today, South Carolina has 21 psychiatric units total, 27 state prisons, with the mentally ill population consisting of about 13% of the state prison population (SC Dept. of Corrections). South Carolina has not passed other major legislative bills, created organizations or been proactive in other ways in terms of assisting the mentally ill population in limiting or assisting with their interactions with the criminal justice system.

However, there are certain variables that exist in both New York and South Carolina that provide for clear comparisons of the states. "Mental health courts have been created in numerous jurisdictions across the United States, largely as a response to the increasing number of defendants with serious mental conditions who are caught up in the criminal justice system" (Mental Health America: statement 53). The mental health courts are used as one of the many various outlets for the mentally ill population to help receive adequate treatment while involved with the criminal justice system. Mental health courts are used in a variety of ways depending on the state in which the courts are analyzed. According to the National Center for State Courts and the United States Psychiatric Hospitals National Database, the state of New York has a total of 28 mental health courts and 17 total psychiatric units in hospitals statewide, while the state of South Carolina has a total of 4 mental health courts and 21 psychiatric units in hospitals statewide (see Table 3 below). The total number of mental health courts across the country is 175.

Mental Health America, the leading organization involved with analyzing the effectiveness of mental health courts across the country, reportedly supports and opposes

the usage of mental health courts in various situations. Mental Health America, or MHA, “supports the use of mental health courts...that...reduce the number of persons with mental illnesses in the criminal justice system, reduce the number of persons with mental illnesses who are further stigmatized by a criminal conviction and reduce the number of persons with mental illnesses in prisons and jails” (Mental Health America Position Statement 53: Mental Health Courts). On the other hand, the MHA opposes mental health courts “...which are intended or result in bringing more people with mental illnesses into the criminal justice system...” (Mental Health America Position Statement 53: Mental Health Courts). Mental health courts generally function somewhat outside of the normal criminal justice system in that judges tend to be more sympathetic and accept testimonies such as psychiatric evaluations as the most significant pieces in each case, which is not typical of an ordinary civil or criminal court proceeding.

It is important to also recognize the number of mentally ill patients in mental hospitals both New York and South Carolina over time, to paint a large-scale picture of the effects of the deinstitutionalization phenomenon. As Torrey’s book *Out of the Shadows: Confronting America’s Mental Illness Crisis* illustrates (see the variety of charts in the appendix, pages 205-208) there was a sharp decline in the number of mentally ill patients in public hospitals in New York, South Carolina, and nationwide from 1955 to 1994 (see Table 4 below). In 1955, there were about 558,000 total mentally ill patients across the country, with this same population dropping to about 71,000 by 1994; this decline is a loss of about 487,000 mentally ill patients from mental hospitals in a span of nearly 40 years. Similar patterns occurred in both New York and South Carolina. New York’s mental hospitals population went from 96,000 in 1955 to 11,000 in

1994; these populations out of the total number of patients in mental hospitals come out to New York having about 16% of the country's mental hospital population in that state. For South Carolina, that state had about 6,000 mentally ill patients in mental hospitals in 1955 and less than 900 in 1994; these populations out of the total number of patients in mental hospitals come out to South Carolina having about 1% of the country's mental hospital population in that state. There is a large disparity between the numbers of mental hospital inhabitants in New York and South Carolina, with New York having 15% more of the country's mental hospital population than South Carolina.

The drastic decline of mentally ill persons in mental hospitals nationwide and in New York and South Carolina in particular illustrates that a large number of the mentally ill population were moved out of mental hospitals sometime between 1955 and 1994. It is highly unlikely that the United States' mentally ill population would diminish that much as to explain the absence of this population in the mental hospitals, so the only logical conclusion would be that the mentally ill went somewhere besides the hospitals. This supports my observation that the mentally ill population is one of the populations that began to flood state prisons beginning in the 1970s.

Additionally, it is important to note the amount of institutional spending that the state government awards to correctional facilities across the country. By studying this, it is clear how much effort the state and federal governments put toward the correctional facilities in America, and this monetary allocation directly effects the types of treatment options available to assist the mentally ill in prison. Tracey Kyckelhahn's compilation of this information from the Bureau of Justice Statistic's information on State Corrections Expenditures proves to be very interesting. From 1982 through 2010, the institutional

operations spending on correctional facilities went from \$9.7 billion for the 1982 FY to \$37.3 billion for the 2010 FY, the state and private prison population nationwide went from about 370,000 in 1982 to over 1.3 million in 2010, and the mean per capita expenditures remained relatively constant as it was about \$26,000 in 1982 and over \$28,000 in 2010 (see Table 5 for details below). Historically, "...corrections spending is the lowest category of state expenditures, below education, public welfare, highways, and health and hospitals" (Kyckelhahn, 2012). In New York, the Department of Corrections allocates \$2.7 billion for their prison budget, but they actually spend \$3.6 billion on prisons every year, with the average annual cost per inmate amounting to \$60,076 a year (Vera Institute of Justice, 2012). Conversely, the South Carolina Department of Corrections (SCDC) expended \$348.8 million in state appropriated funds for their state prisons, with a per inmate cost of \$15,316 per year (South Carolina Department of Corrections: FAQs). This lack of spending that goes toward state correctional facilities affects all employees, employers, inmates, and all others that are involved with the criminal justice system in the different states, including the mentally ill population who become involved with the criminal justice system. However, South Carolina has fewer people and therefore fewer people in their jails and prisons and fewer diagnosed with mental illness both in society and in prisons than New York. But even though this difference in population exists between the states, the disparity in New York and South Carolina's institutional spending for corrections is still very significant.

A final piece of data that is important to be able to view the phenomenon of deinstitutionalization in its entirety is the availability of hospital beds for the mentally ill. By understanding the trends of how the number of hospital beds are available for the

mentally ill over time, it helps to explain whether or not the majority of the mentally ill population resides in hospital beds or not. And because the number of hospital beds for the mentally ill have declined over the past several decades, it is reasonable to conclude that the mentally ill have turned to other outlets to seek assistance, whether that transition was intentional or not. Generally, from 1955 when the number of severely mentally ill patients in the United States' public psychiatric hospitals was over 550,000 patients, there was a general trend nationwide that about 339 out of every 100,000 patients could have easy access to hospital beds in state hospitals (Lamb and Weinberger: 529-534).

Alternatively, the number of severely mentally ill patients in the United States' public psychiatric hospitals dropped to less than 72,000 after 1994 and by 2000 only 22 out of every 100,000 mentally ill patients could have easy access to hospital beds in state hospitals (Lamb and Weinberger: 529-534). This decline in both mentally ill patients being in public psychiatric hospitals and the availability of hospital beds in state hospitals from 1955 to the present is a transition that happened across the country in every state (Lamb and Weinberger: 529-534). Table 6 illustrates this nationwide phenomenon, which happened along with the variety of provisions including the deinstitutionalization of mental hospitals, removal of mental hospitals nationwide and expansion of state prisons nationwide.

This data raises the question of where the mentally ill people who needed the hospital beds went. If 339 out of every 100,000 mentally ill patients had access to hospital beds in 1955 and 22 out of every 100,000 did in 2000, an extra 317 out of every 100,000 mentally ill patients did not have any hospital bed. If they had no hospital to turn to, then those who would have sought that treatment would have to be cared for in other

places. One of the other places in which the mentally ill can seek shelter and some basic care is in the criminal justice system, as every jail and prison is responsible for providing care for the inmates. I am not saying that mentally ill patients now choose to go to jail or prison because there is a lack of available hospital beds, but that is just one place that has served as a replacement default because of the deinstitutionalization phenomenon and expansion of the criminal justice system.

Table 3: Number of Mental Health Courts and Psychiatric Units in
New York and South Carolina

State	Number of Mental Health Courts/Total	Number of Psychiatric Units
NY	28/175	17
SC	4/175	21

Table 4: Mental Patient Statistics for New York and South Carolina Over Time

Year/State	Number of Patients in Public Mental Hospitals	Patients in Public Mental Hospitals/Total in Mental Hospitals
1955/NY	96,000	$96,000/558,000 = 17.20\%$
1955/SC	6,000	$6,000/558,000 = 1.08\%$
1994+/NY	11,000	$11,000/71,000 = 15.49\%$
1994+/SC	830	$830/71,000 = 1.17\%$

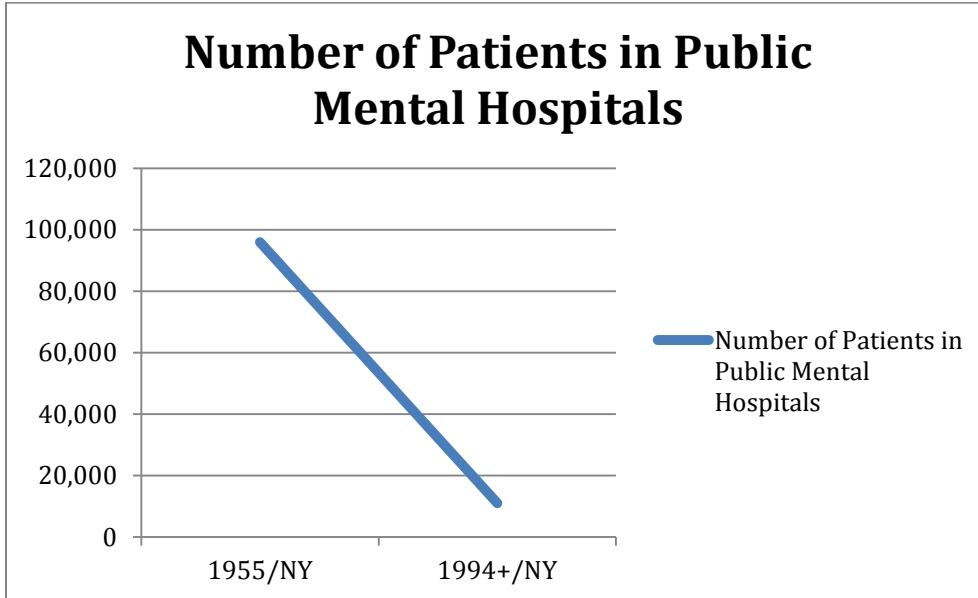
Table 5: Institutional Spending on State Prisons Nationally from 1982-2010

Year	Institutional Spending	Total Prison Population (U.S.)	Mean per capita expenditures (U.S.)
1982	\$9.7	371,522	\$26,036
1990	\$21 billion	675,907	\$31,123
1995	\$29.2 billion	979,727	\$29,783
2000	\$35.6 billion	1,170,350	\$30,449
2005	\$35.7 billion	1,261,578	\$28,263
2010	\$37.3 billion	1,316,858	\$28,323

Table 6: Overview of Available Hospitals Beds for Mentally ill in U.S. Over Time

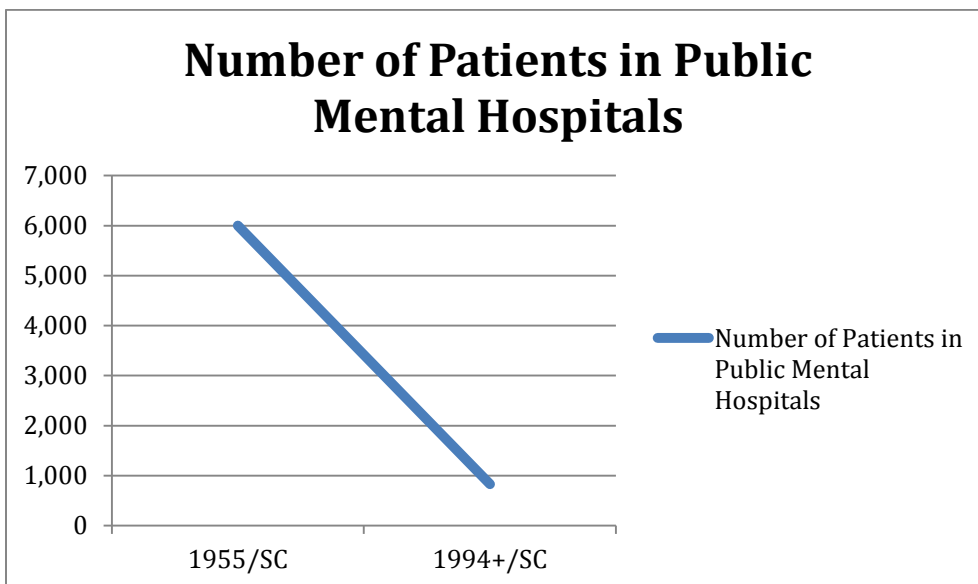
Year	Number of State Hospital Beds Available for Mentally ill
1955	339/100,000 people get a bed
2000	22/100,000 people get a bed

Graph 1: Number of Patients in Public Mental Hospitals in New York Over Time



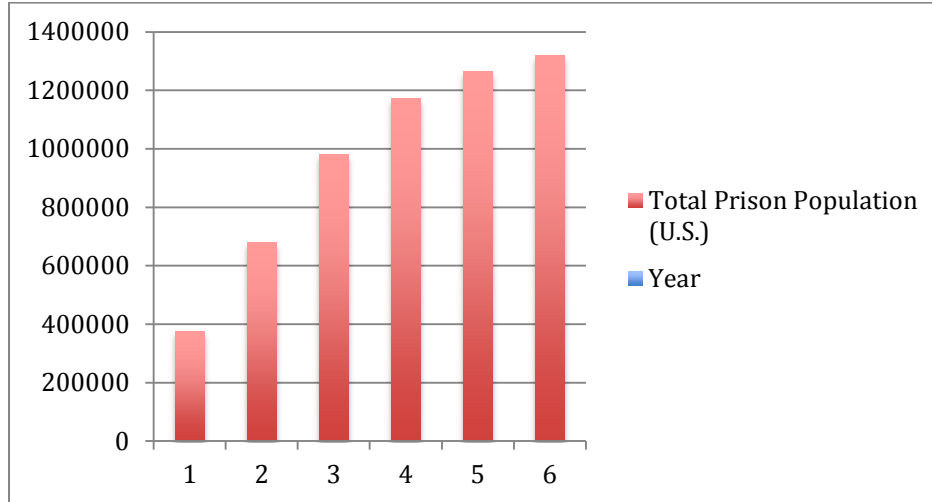
Rate of Decline: 1.11%

Graph 2: Number of Patients in Public Mental Hospitals in South Carolina Over Time



Rate of Decline: 0.92%

Graph 3: Total Prison Population in the United States Over Time



Key: Year 1 = 1982; Year 2 = 1990; Year 3 = 1995; Year 4 = 2000; Year 5 = 2005; Year 6 = 2010

Findings and Discussion

The findings on each of my dependent variables support my hypotheses that the varying political ideologies of the North versus the South have contributed to different patterns regarding the imprisonment rates of the mentally ill in the Northern and Southern states and that the more Democratic-leaning Northern states have a more developed and beneficial method of dealing with the mentally ill in their prison systems than the Republican-leaning Southern states.

For New York, the state's presidential election vote shares illustrate that from 1972 through 2012, New York voted Democratically for eight out of those eleven presidential elections. The elections that the state of New York had a majority of its vote shares side with the Republican candidate was in accordance with the popular Republican nationwide elections at the time. In regards specifically to the involvement of the

mentally ill population's involvement with the criminal justice system following the deinstitutionalization of mental hospitals phenomenon since the 1970's, New York:

- 1) has had a relatively consistent amount of mentally ill patients in public mental hospitals;
- 2) has 28 well-established mental health courts throughout the state;
- 3) has 17 fully-functioning psychiatric units in state hospitals across the state;
- 4) has established the New York State Office of Mental Health;
- 5) has created a stable relationship with the New York State Office of Mental Health and the Department of Correctional Services in New York that is accredited by both the American Correctional Association and the Joint Commission on Accreditation of Healthcare Organizations;
- 6) has opened the Central New York Psychiatric Center;
- 7) and has had three large enhancements from the state government since 1995, specifically in FY 1997-1998, FY 1999-2000 and FY 2005-2006.

New York has become a state that is nationally known to be one of the most active and progressive states that others look to model their own coordination of the criminal justice and healthcare systems (New York State Office of Mental Health). Of course it is also important to recognize that New York has a substantial amount of mentally ill patients in its state hospitals, comprising of about 17% of the country's mental hospital population.

However, while throughout the state of New York there is a significant amount of mentally ill patients in state hospitals, mentally ill people are still nearly just as likely to end up in a mental hospital than in a jail or prison. As noted above, a mentally ill person

in New York has a 1.2 to 1 chance that he/she will end up in a jail or prison in New York over a hospital, making New York one of the states with the best rates for this comparison.

On the other hand, South Carolina's vote share pattern showed that from 1972 through the 2012 election, South Carolina had voted Republican ten out of those eleven elections, siding with the Democratic candidate only once in the 1976 presidential election. In regards to the mentally ill population's involvement with the criminal justice system, South Carolina's provisions include that South Carolina:

- 1) has had a relatively consistent amount of mentally ill patients in public mental hospitals;
- 2) has 4 established mental health courts across the state;
- 3) has 21 functioning psychiatric unit in state hospitals across the state;
- 4) has passed outdated legislation such as in 1946 South Carolina passed Public Law 487 and later the Mental Health Act in 1952;
- 5) and has followed the necessary provisions asked by the federal government with the introduction of Medicaid in the 1960s and the passing of the Federal Community Mental Health Centers Act in 1963.

South Carolina, being a strong southern state since colonial days, falls true to its heritage of being a southern state, with a tendency of being harsher on crime and, because of that mentality, arguably less sympathetic to the needs of the accused. Not surprisingly, South Carolina is not a state that has been nationally recognized as being a hallmark state that others should necessarily follow in terms of the treatment of their mentally ill population in the criminal justice system. South Carolina's state prisons do

not provide many more healthcare programs for those with mental illness, and it has fewer mental health courts and organizations devoted to the improvement of the living situation of the mentally ill population than other states. South Carolina's allocation of professionals and funding to the betterment of the treatment of the mentally ill in their state prisons comes from the extra finances as a result of the nationwide provisions such as the implementation of Medicare and Medicaid programs from the 1960's rather than any state commitment. Typically, a seriously mentally ill person has about a 5.1 to 1 chance of ending up in a jail or prison rather than a hospital. This statistic places South Carolina in a category with other states that have one of the worst rates of adequate care for the mentally ill in a state hospital over a jail or prison.

Discussion

With the data above, I can conclude that it is probably not a coincidence that the mentally ill population fares better in New York than in South Carolina due at least partially to the state's Democratic/liberal ideology. In New York, the mentally ill in prison have better access to extra-care treatment centers and a variety of provisions and organizations dedicated to the betterment of the mentally ill across the state. South Carolina, with its Republican/conservative ideology, has very few measures in place that have helped the mentally ill population since the deinstitutionalization. Because of this, the mentally ill in South Carolina are far more likely to end up in a prison than a hospital, and the outlets in which these patients can seek treatment and assistance is very limited.

It seems, therefore, that the political ideology of a state can be a key factor in determining how mentally ill people are treated in liberal and conservative states. If a mentally ill person is brought into contact with the criminal justice system in a politically

liberal state, that person probably will be exposed to more therapeutic opportunities and outlets for assistance more so than a mentally ill person brought into contact with the criminal justice system in a conservative state. A mentally ill person will also be more likely to be imprisoned rather than sent to a treatment facility in a conservative rather than in a liberal state. My research can be applied to more general situations and be of use as a predictor for what mentally ill people will deal with depending on the type of state they are in.

With the above information known, I refer back to my hypotheses to reflect on whether I can reject or accept each hypothesis. My hypotheses are as follows: Hypothesis 1: The varying political ideologies of the North versus the South have contributed to different patterns regarding the imprisonment rates of the mentally ill in the Northern and Southern states; and Hypothesis 2: The more Democratic-leaning Northern states have a more developed and proactive method of dealing with the mentally ill in their prison systems than the Republican-leaning Southern states. I am confident with the findings analyzed above that I cannot reject either of my hypotheses.

There are several variables that I did not account for in the research that affect how confident I can be in my claims. Some of these control variables includes the different amount of state funding allocated by the federal government and the fact that every state has a different number of mentally ill people. Each state is allocated a different amount of money that goes toward financial support for its correctional facilities, and the money differs depending on the amount the federal government sees fit to give to each state. Since jails and prisons are run by the government, there is no private funding allowed to help finance the costs needed for the functioning of the jails and

prisons. Additionally, the different amount of mentally ill people in each state would affect the number of resources necessary and available to help treat the mentally ill in each state. If a state has less of a prison population and therefore less of a mentally ill population within its prison population, it would make sense that that state would not allocate as many human and monetary resources to assist the population like a state with a larger prison and mentally ill population. Many other variables would need to be accounted for to continue research on this topic to be able to conclusively decide what would affect the placement and treatment of the mentally ill in states across the United States.

Conclusion

A mentally ill person is more than four times as likely to be put into jail or prison rather than a mental hospital in South Carolina than in New York. My research focused on isolating the political ideology of those states as the independent variable that led to this finding. By studying the political ideology of the states and the treatment and placement measures of the mentally ill into these states' prisons, I was able to conclude that a state that is identified as being a Democratic state is more helpful to the mentally ill population than are Republican states. Although the political ideology cannot be the only variable that would cause this drastic of a discrepancy, it is definitely one variable.

Historically, southern states are more associated with identifying with a Republican political stance and northern states are more associated with identifying with a Democratic political stance. This information alone gives many clues as to the possibilities of the different measures that southern/Republican states would take in approaching the same issues as northern/Democratic states. Southern states have had a

tendency to implement more “tough on crime” provisions in their crime control and prevention, leading to harsher punishments, more of a disregard for the accused’s rights, and a variety of other factors that affect how those involved with the criminal justice system are treated, as compared to northern states.

My research illustrated the exact differences that exist when comparing a traditionally Republican southern state (South Carolina) versus a traditionally Democratic northern state (New York) in terms of the placement of the mentally ill in their prison system and the available programs and laws in place in each state. It became clear that South Carolina did not have much of a history of assisting the mentally ill in their interaction with the criminal justice system, following outdated provisions from the 1960’s and not having even a portion of the funding available that New York allocated to their correctional facilities as well as programs and departments available devoted to the assistance of the mentally ill in the prison system. New York is a state that is known to be a model example of how a state focuses on the betterment of the mentally ill population when trying to aid them in their interaction with both the health care and prison systems in New York.

Through my analysis and research highlighting the ability a state has to assist the mentally ill population in a state which is willing to work with this stigmatized group, I can conclude that more Democratic-leaning states are more helpful in aiding the placement and treatment of the mentally ill than are Republican-leaning states. However, it should be pointed out that in my research I discovered that South Carolina had a lower population, and therefore lower prison and mentally ill populations, which may explain some of the discrepancies in the placement and treatment of the mentally ill but cannot

account for the extent of the differences with New York since the rate of decline for mental hospital patients from 1955 to 1994 for New York was 1.11% and for South Carolina it was 0.92%, a mere 0.19% difference.

Because of the applicability of identifying a state as Democratic/liberal or Republican/conservative can be utilized with every state in the United States, my findings can be applied beyond just New York and South Carolina. The identification process of defining a state as one political ideology or another is commonly done just as my research proved with the vote share patterns of Presidential elections within a state, so the result of those studies would likely identify states that are similar to New York and South Carolina in many ways simply because of their political association. One of the many factors in which states of similar political ideology will match up certainly includes the treatment and placement of the mentally ill in each state.

Future research about the placement and treatment of the mentally ill in prisons across the United States should begin to focus on the states that are more developed in that they provide more resources for the mentally ill such as New York. By analyzing what states are the best in this regard, and essentially have the best ratios of the chances of a mentally ill person ending up in a mental hospital and prison being close to equal, you can see which states are the most developed. Once the most advanced states are pinpointed, other states can begin to use some of the recommendations and provisions that the best states provide to improve the treatment and placement of the mentally ill in those states that are currently lagging behind.

Bibliography

1. 270towin.com. "New York Voting History." And "South Carolina Voting History." http://www.270towin.com/states/New_York ;
http://www.270towin.com/states/South_Carolina
2. Alexander, Michelle. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. The New Press, NY. 2010. Pp. 1-262.
3. Beck, Allen J. and Maruschak, Laura M. "United States Department of Justice Bureau of Justice Statistics Special Report: Mental Health Treatment in State Prisons, 2000." July 2001. Pp. 1-8.
4. Clear, Todd R. *Imprisoning Communities: How Mass Incarceration Makes Disadvantaged Neighborhoods Worse*. Oxford University Press, Inc., NY. 2007. Pp. 3-208.
5. Council of State Governments. "Criminal Justice/Mental Health Consensus Project (2002)." Council of State Governments, Lexington, Kentucky. Pp. xii-432.
6. Craft, Susan. "History of the South Carolina Department of Mental Health." Department of Mental Health, South Carolina Department of Mental Health. <http://www.state.sc.us/dmh/history.htm>
7. Esch, Mary. "NY Prison System Opens Unit for Mentally Ill." *Adirondack Daily Enterprise*. 2009.
<http://adirondackdailyenterprise.com/page/content.detail/id/510244.html?nav=5008>

8. Hoffman, Beatrix. "Health Care Reform and Social Movements in the United States." *American Journal of Public Health*, Vol. 93, No. 1. Pp. 75-85.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447696/>
9. James, Doris J. and Glaze, Lauren E. "United States Department of Justice Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates." September 2006. Pp. 1-12.
10. Kyckelhahn, Tracey. "State Corrections Expenditures, FY 1982-2010." U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics, December 2012. Pp. 1-13.
<http://bjs.ojp.usdoj.gov/content/pub/pdf/scefy8210.pdf>
11. Lamb, H. Richard, and Weinberger, Linda E. "The Shift of Psychiatric Inpatient Care From Hospitals to Jails and Prisons." *Journal of the American Academy of Psychiatry and the Law Online*, Vol. 33, No. 4. Pp. 529-534.
12. Mead, Lawrence M. "State Political Culture and Welfare Reform." *The Policy Studies Journal*, Vol. 32, No. 2. Pp. 271-296.
13. Mental Health America. "Position Statement 53: Mental Health Courts."
<http://www.mentalhealthamerica.net/go/position-statements/53>
14. Morrissey, Joseph P. and Goldman, Howard H. "Care and Treatment of the Mentally Ill in the United States: Historical Developments and Reforms." *The Annals of the American Academy of Political and Social Science*, Vol. 484, No. 1. Pp. 12-27.
<http://ann.sagepub.com/content/484/1/12.short?r44b=no>

15. National Alliance on Mental Illness; State Advocacy 2010. "State Statistics: South Carolina."
<http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93519>
16. National Institute of Corrections. "Mentally Ill Persons in Corrections." U.S. Department of Justice. <http://nicic.gov/MentalIllness>
17. National Institute of Justice, United States Department of Justice, Office of Justice Programs. "Mental Health Screens for Corrections." May 2005.
<http://www.nij.gov/pubs-sum/216152.htm>
18. New York State Office of Mental Health. "2005-2009 Statewide Comprehensive Plan for Mental Health Service Services □ Chapter 7: Forensic Services."
<http://www.omh.ny.gov/omhweb/statewideplan/2005/chapter7.htm>
19. Rossman, Shell B.; Willison, Janeen Buck; Malik-Kane, Kamala; Kim, KiDeuk; Debus-Sherrill, Sara; and Downey, P. Mitchell. "Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York." Mental Health Courts Resource Guide, Final Report, February 2012.
<http://www.urban.org/UploadedPDF/412603-Criminal-Justice-Interventions-for-Offenders-With-Mental-Illness.pdf>
20. Shenson, Douglas; Dublin, Nancy; and Michaels, David. "Jails and Prisons: The New Asylums?" American Journal of Public Health, Vol. 80, No. 6. Pp. 655-656.
21. Simon, Jonathon. Governing Through Crime: How the War on Crime

Transformed American Democracy and Created a Culture of Fear.

Oxford University Press, Inc., NY. 2007. Pp. 13-258.

22. South Carolina Department of Corrections. "South Carolina Department of Corrections: Frequently Asked Questions (FAQs)."
<http://www.doc.sc.gov/faqs.jsp>
23. South Carolina Department of Corrections. "South Carolina Department of Corrections: Institutions."
<http://www.doc.sc.gov/institutions/institutions.jsp>
24. Southern State Psychiatric Hospital Association. "Southern States Hospital Links." <http://sspha.com/Hospital%20Links.htm>
25. Steadman, Henry J.; Monahan, John; Duffee, Barbara; Hartstone, Eliot; and Robbins, Pamela Clark. "The Impact of State Mental Hospital Deinstitutionalization of United States Prison Populations, 1968-1978." *The Journal of Criminal Law & Criminology*, Vol. 75, No. 2. Pp. 474-490.
26. The Gale Group, Inc. "Psychiatric Hospitals: SIC 8063." *Highbeam Business*.
<http://business.highbeam.com/industry-reports/business/psychiatric-hospitals>
27. Torrey, E. Fuller. *Out of the Shadows: Confronting America's Mental Illness Crisis* (New York: John Wiley & Sons, 1997). Pp. 1-12, 25-42, 205-208.
28. Torrey, E. Fuller; Kennard, Sherriff Aaron D.; Eslinger, Sherriff Don; Lamb, Richard; and Paule, James. "More Mentally Ill Persons in Jails and Prisons than Hospitals: A Survey of the States."

29. USHospital.info. "Psychiatric Hospitals."

<http://www.ushospital.info/Psychiatric.htm>

30. uselectionatlas.org. "Presidential General Election Results Comparison – New York." <http://uselectionatlas.org/RESULTS/> and "Presidential General Election Results Comparison – South Carolina."

<http://uselectionatlas.org/RESULTS/>

31. Vera Institute of Justice. "The Price of Prisons New York." January 2012.

<http://www.vera.org/files/price-of-prisons-new-york-fact-sheet.pdf>