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## Mental Health and Voter Turnout: A Study of Georgia Counties

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### Abstract

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*Despite the tacit belief that health and well-being are a necessary element of politics, there is little understanding of how mental health relates to political participation. The present paper focuses specifically on patterns of mental illness and voter turnout within the state of Georgia. Using county-level data, I argue that a greater and more widespread prevalence of mental illness has a dampening effect on political engagement. Although empirical results from this study are mixed, its theoretical contribution clearly highlights the role of psychological and emotional factors in maintaining an energetic and politically connected society. Implications for mental health policy and its integral role in the democratic process are discussed.*

Inflammatory rhetoric and passionate declarations of beliefs by political candidates, television pundits, and social media activists constitute business as usual within today's polarized political climate. But to infer from these highly-invested individuals the level of political involvement among the general public would be misguided. In reality, political participation is often far removed from the everyday lives of the average American. In day to day life, citizens struggle to pay their bills, appease their boss, obtain childcare, and provide meals for their family. These individuals live outside of the political realm, either by choice or necessity. As of July 2014, nearly 10% of Americans could be labeled "political bystanders", meaning they seldom or never voted and did not follow government and public affairs (Gao 2014). As Georgia officials continue to push restrictive legislation, such as strict voter identification laws and the reduction of early voting days (Doner, Schneer and Amsterdam 2014), we might speculate that costs of political involvement may come to outweigh the benefits. For those consumed by the management of daily life, staying abreast of political issues are luxuries only afforded to those who can pay the information costs and put forth the cognitive effort.

Yet the possession of a healthy mental and emotional state, a necessary component to individual political engagement, is rarely considered among scholars of political behavior. To the extent that mental health is influential in fueling or suppressing functionality among citizens, it must be regarded as a necessary component of the calculus of political participation. The purpose of this study is to shed light on the relationship between mental health and political participation. The first section of this paper develops a theoretical rationale as to why individual-level mental health relates to political engagement. My initial analyses explore predictors of mental illness at the county level. Secondary analyses determine whether higher incidents of mental illness at the

county-level depresses voter turnout. Finally, I consider issues regarding self-reported health measures and state-level mental health policies.

## **Background**

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Stigmatization of mental illness, often guided by misinformation (Henderson and Thornicroft 2009), is prevalent in many modern societies. Yet recent headlines regarding mental health, mass shootings, and gun control have thrust the issue into the national spotlight (Metzl and MacLeish 2015). It is estimated that 61.5 million Americans experience mental illness within a given year (National Alliance on Mental Illness 2013), and 349,000 of these individuals reside in Georgia (National Alliance on Mental Illness 2010). Among Georgia residents, approximately 19% experience anxiety disorders, such as post-traumatic stress, obsessive-compulsive disorder, and/or phobias (Reeves, Lin and Nater 2013). Another 18.5% of residents experience mood disorders, such as depression and/or schizophrenia (2013). While stigmatization that often comes with mental illness makes it difficult for individuals to seek treatment (Clement et al. 2015), the State of Georgia spends roughly \$565 million each year on community mental health services and hospital care (National Alliance on Mental Illness 2010). These services include the creation of educational outreach programs, access to individual and/or family counseling and maintaining crisis hotlines. Many of these services come from support centers like Mental Health America of Georgia<sup>1</sup>, the Georgia Chapter of the National Alliance on Mental Illness<sup>2</sup> and the Georgia Council on Substance Abuse<sup>3</sup>.

Clearly, mental illness is common among Georgia residents and is well-acknowledged in the policy initiatives and budgetary proposals put forth by Georgia's political leaders. With mental illness carving out a considerable portion of public policy, should it not be the case that researchers, political representatives, and - most importantly- constituents themselves take interest in what impact mental health has on the political process? The subsequent section of this paper provides a theoretical rationale as to why mental health, at the individual level, is expected to motivate (or demotivate) individual political involvement.

## **Mental Health as a Resource**

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Mental illness has generally been defined in terms of its outcomes. To experience mental illness means to suffer from impaired functioning of one's mental, emotional, or behavioral abilities (Centers of Disease Control and Prevention 2013) such that symptoms of psychological distress, like depression or anxiety, become evident (Kawachi and Berkman 2001). There are theoretical and empirical reasons to believe mental health<sup>4</sup> affects political participation. Much of the work in political behavior looks to the individual's psychological attributes in determining whether one expresses interest in politics, watches politically-oriented news, engages in protests, donates to campaigns, casts a vote and so on and so forth (Sears, Huddy, and Jervis 2003; Lewis-Beck et al. 2008). Political efficacy, the belief that one is well-qualified to participate in the political process and affect it, has been shown to be a motivator of voter turnout across a variety of electoral contexts (Blais 2000). Ambivalence, the psychological state of holding a set of mixed

or even conflicting beliefs, has been found to increase individual participation in politics (Yoo 2010). Similarly, one's sense of citizen duty (Riker and Ordeshook 1968) and personality traits like extraversion and conscientiousness (Gerber et al. 2011) have also surfaced as psychological factors that predict political engagement.

In the present paper I liken one's mental state to a political resource. Like other resource models (Verba and Nie 1972; Brady, Verba and Schlozman 1995), I view one's mental state as a possession. Just as individuals possess time, money, and cognitive capacity which allow them to invest in politics, individuals also possess (or fail to possess) psychological attributes that allow for involvement in political life<sup>v</sup>. Although this idea might be relatively new to the field of political science, the psychological literature on ego depletion (Baumeister, Bratslavsky, Muraven, and Tice 1998) and the organizational literature on psychological capital (Luthans, Avolio, Avey, and Norman 2007) also liken the mental state to a motivational source. To the extent that mental health varies, we should expect political behavior to vary as well.

Unlike other resource models, however, mental health can be an abstract or perhaps even taboo concept to apply to political engagement. Whereas money and leisure time can be easily quantified, 'mental well-being' remains nebulous. The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association certainly provides clinicians with standardized criteria used to identify mental illnesses. This is perhaps useful for psychologists, social workers and individuals who seek treatment. But in terms of analyzing the relationship between participation and self-reported 'mental health' on a wider, more nationally-representative scale, it is obvious that survey instruments will need to be precise in their measurement. Still, there is no reason to think that quantifying self-reported mental health should be any less subject to survey error than quantifying self-reported levels of partisanship.

The conceptualization of mental health as an empirical, measurable construct also warrants two additional words of caution. Despite previous mention of personality traits, mental health should in no way be understood as an enduring characteristic. Persons can experience relatively short bouts of mental illnesses, either clinically defined or otherwise. While my theory does not necessarily speak to the transitory nature of mental illness or its intensity, one might speculate that suffering with a chronic mental illness may indeed have an exacerbating effect on participation.

To date there remains little scholarly research directly connecting mental health and participation within the American political context. Of the literature that does exist, some has attempted to show a relationship in the opposite direction, hypothesizing that political participation has a positive effect on well-being (Sanders 2001; Pacheco and Lange 2010). I argue that this methodological approach is based upon flawed theoretical reasoning. Although it is certain that some degree of benefit can be derived from voting, an individual must feel healthy and mentally equipped to participate in the first place. The causal arrow must emanate *from* the individual.

Within the extant literature, a general relationship between *physical* health and political participation has been established. Mattila and Papageorgiou (2016) present evidence that Finnish individuals living with physical disabilities are less likely to vote, either because they feel discriminated against or are simply not able to reach the voting booth. Similar patterns have

emerged within the British (Denny and Doyle 2007) and American contexts, as chronic ailments have been shown to have a depressing impact on individual-level voter turnout (Pacheco and Fletcher 2015). It is perhaps easy to see how poor physical health might serve as a barrier to participation. Poor physical health may limit one's ability to get to a polling location, to participate in political rallies, or to canvass neighborhoods. Yet poor physical health need not condemn one to a life of political inactivity. Interestingly, and in line with other empirical research (Söderlund and Rapeli 2015; Couture and Breux 2016), Mattila and Papageorgiou (2016) demonstrate that those with disabilities do engage in other forms of political activism such as contacting their representative and attending protests or demonstrations.

Mental conditions such as anxiety, depression and post-traumatic stress, on the other hand, affect political engagement at its very foundation: motivation. Whether this motivation is due to intrinsic factors (e.g., a genuine personal desire to express oneself) or extrinsic factors (e.g., social pressures to express oneself), motivation to engage in any sort of behavior originates within the psychology of the individual. In other words, those experiencing poor mental health may simply lack the psychological resources or energy to devote to political involvement. With regard to this body of literature, Ojeda (2015) uses a similar motivational framework to explore the effects of individual feelings of depression on participation. His work concludes that depression does in fact have a deflating effect on voter turnout, though it does not significantly impact any other forms of political engagement (2015).

Examinations of additional mental health variables, such as stress and anxiety, on voter turnout have likewise displayed a complicated relationship. In contrast with Marcus, Neuman and MacKuen's Affective Intelligence theory (2000), replications by Ladd and Lenz (2011) show that anxiety in and of itself does not affect vote intention. Instead, anxiety is either diluted or bolstered by the strength of one's party identification. Similarly, day to day life stressors have the ability to undermine vote intentions of those without a strong history of political involvement but has little effect among habitual voters (Hassell and Settle 2016).

Mental health is a critical component to political engagement. Mental wellness predicts increased political involvement, perhaps via social connectedness (Mattila, Söderlund, Wass and Rapeli 2013) or internal motivational mechanisms (Ojeda 2015). To the extent that researchers are interested in examining the dynamics of civic engagement we should logically, and perhaps primarily, be concerned with the physical, mental, and emotional functioning of those actors who form the very foundation of civic involvement: voters. That is to say, political scholars must not simply model the machinery but the mechanisms by which it runs.

## **Hypotheses**

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The aim of the statistical analysis that follows is to 1) identify those county-level factors which influence the prevalence of mental illness and 2) determine whether mental illness has any significant bearing on voter turnout. To this effect, I put forth the following three expectations:

**Hypothesis 1 Density Hypothesis:** Higher rates of mental illness will be concentrated in more rural counties.

According to Probst et al. (2006), residents living in rural areas, as opposed to urban or suburban areas, tend to experience a greater number of depressive symptoms. Those living in rural areas may feel isolated, thus exacerbating mental illnesses, or they may simply not have access to proper treatment facilities. In either case, the effect of one's contextual environment should play a role in determining well-being.

**Hypothesis 2 Education Hypothesis:** Rates of mental illness will be more prevalent in counties where fewer residents have obtained some form of college education.

In their examination of major psychiatric disorders amongst Georgia residents, Reeves, Lin, and Nater (2013) found education level, specifically the lack of a high school diploma, to be the most important predictor of mental health. Based on previous findings, I expect education to play a significant role in determining mental well-being within this study as well.

**Hypothesis 3 Engagement Hypothesis:** Georgia counties with higher rates of mental illness will experience lower levels of voter turnout.

In line with Denny and Doyle (2007), I anticipate mental illness to suppress political participation. If voter turnout is the product of individual-level 'mental resources', any strain on mental functioning should prove taxing on one's overall level of political engagement. While I lay out no official expectation about the *degree* to which mental illness dampens political engagement, it is not unreasonable to expect this effect to vary according to election type (e.g., General Election, midterm election, primary election). General Elections, as opposed to primaries or midterm elections, are much more highly attended to by the American public. As a result, we may find the effect of mental health on turnout to be 'washed out' in General Elections.

## Data and Methodology

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Mental illness was operationalized in this study as a county's average number of poor mental health days reported per month. This data was made available for 2012 and 2014 by County Health Rankings & Roadmaps<sup>6</sup> (see <http://www.countyhealthrankings.org/> for more information). Note that while the author of this paper uses the terms 'mental illness' and 'poor mental health' interchangeably, these may represent two separate constructs with varying degrees of permanence and/or intensity. While the data at hand do not allow us to untangle these differences, this consideration is duly noted.

The dependent variable, political participation, was operationalized in terms of county-level voter turnout percentages. Turnout was calculated by dividing the number of individuals in a

county who submitted a vote by the number of individuals in a county who are registered to vote. These measures were provided by the Georgia Secretary of State.

Not all elections are optimal for this analysis. For example, voter turnout rates from U.S. House elections cannot be used because the independent variable is measured at the county level. In many cases across Georgia, Congressional districts do not match up with county boundaries. Using statewide elections circumvents this problem and ensures that motivation to turn out should be relatively equal across counties. We should also consider potential differential effects in how mental health relates to voter turnout across different types of statewide elections (e.g., primaries, midterm elections). For this reason I chose to examine Georgia voter turnout rates from the 2012 General Presidential Election, Georgia turnout rates from the 2014 midterm election (which includes a gubernatorial election and one statewide Senate election), and Georgia turnout rates from the (combined) 2016 Democratic and Republican primary elections held March 1, 2016.

Additionally, for the purposes of this paper I have only chosen to examine voter turnout, not other forms of participatory behaviors. While I do expect mental health to have a widespread influence on many forms of political engagement, such as discussing politics, donating to campaigns, and promoting candidates or issues online, the data within this study cannot speak to these effects.

Control variables in my models include county-level estimates of: total population, average days of poor physical health per month, percent aged 65 and older, percent of non-Hispanic whites, median household income, percent unemployed (among those 16 years of age and older), percent of adults aged 25-44 with at least some college education, percent of the county designated as rural<sup>7</sup>, percent female, percent violent crime rate, percent of adults who are uninsured, percent of residents who report not seeing a doctor due to cost, and the ratio of mental health providers (calculated as the raw number of providers divided by the total population).

All control measures were provided by County Health Rankings & Roadmaps for the years of 2012 and 2014. For 2012, County Health Rankings & Roadmaps did not include the percentage of non-Hispanic whites at the county-level. This data was supplemented from the U.S. Census American Fact Finder. For ease of interpretation, population has been rescaled per 100,000 residents and median household income has been rescaled per 10,000 dollars.

## **Results**

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In order to better understand the construct of mental health, I first explore those variables which factor into its existence. Are there existing patterns that may indicate which counties are more susceptible to higher or lower levels of mental well-being? Figure 1 presents the most recent mental health data for each of Georgia's counties<sup>8</sup>.







Chatham, tend to report fewer poor mental health days. One might also speculate that more affluent counties tend to have lower rates of mental illness, though the evidence here is mixed. Because Figure 1 does not produce a clear pattern of results and does not account for confounding factors, I turn to the ordinary least squares regression to examine which county-level variables were predictive of mental illness rates in 2012 and 2014. The results are listed in Table 1.

**Table 1. Predictors of Poor Mental Health**

	<b>Avg. Days Poor Mental Health, 2012</b>	<b>Avg. Days Poor Mental Health, 2014</b>
	<b><i>B</i> (S.E.)</b>	<b><i>B</i> (S.E.)</b>
Avg. Days Poor Physical Health	0.478*** (0.103)	0.239 (0.128)
% aged 65+	-0.051 (0.031)	-0.019 (0.032)
% Non-Hispanic White	0.022** (0.007)	0.028*** (0.007)
Median Household Income	-0.166 (0.143)	-0.185 (0.140)
% Unemployed	0.000 (0.058)	-0.041 (0.069)
% Some College	-0.013 (0.013)	-0.011 (0.015)
% Rural	-0.006 (0.005)	-0.010 (0.006)
% Female	-0.001 (0.038)	-0.110* (0.045)
% Violent Crime	-0.000 (0.000)	0.001* (0.001)
% Uninsured	0.011 (0.031)	-0.037 (0.027)
% Doctors Too Costly	0.028 (0.017)	0.061** (0.021)
Ratio Mental Health Providers	0.006 (0.005)	0.001 (0.002)
Constant	1.918 (2.962)	8.455** (3.158)
R <sup>2</sup>	0.516	0.557
N	95	84

Note: Models for 2012 include county-level statistics from 2012. Models for 2014 include county-level statistics from 2014. \*p<.05, \*\*p<.01, \*\*\*p<.001

Table 1 reveals that in both 2012 and 2014, poor mental health and poor physical health go hand in hand. The effect of poor physical health on poor mental health in 2014 is marginally significant ( $p = 0.066$ ), indicating that for every extra day of poor physical health residents of the county could expect to see 0.239 more poor mental health days per month. Consistent across years, the proportion of non-Hispanic whites in a county has a significant and positive effect on mental illness. I return to this finding in Figure 2. Interestingly, higher concentrations of elderly individuals, the urbanicity of a county, level of college education, and household income have no bearing on mental health rates for these years. The Density Hypothesis and Education Hypothesis are not supported by this data. In the case of population density, the relationships for both years are signed in the negative direction, suggesting that residents of more rural areas tend to experience fewer poor mental health days on average.

Unsurprisingly, perhaps, counties in which residents had a harder time accessing doctor's care (medical or otherwise) due to costs were much more likely to experience poor mental health. This effect is independent of uninsured rates, indicating that even those who have physical and mental health coverage may not be able to afford the out of pocket cost of seeking treatment. Likewise, we observe in Table 1 that insurance coverage has no relationship with a county's collective mental well-being. In terms of mental health policy, poor mental health is just as prevalent in counties with fewer mental health providers as it is in counties with many providers.

The next set of analyses, presented in Table 2, uses three separate ordinary least squares regressions to predict voter turnout in 2012, 2014, and 2016. Examining the results from Table 2, no statistically significant effect of mental health on turnout in 2012 is apparent. While the relationship is signed in the negative direction, suggesting a depressing effect of mental illness on turnout, a  $p$ -value of 0.258 indicates that this could be due to random chance. This finding might, however, be expected given that Presidential Election years tend to garner much higher levels of voter turnout than midterm or primary elections. In other words, because the 'threshold' for voting is particularly low in General Elections (Gerber, Huber, Biggers, and Hendry 2015) one might expect many of the individual differences among voters to wash out.

In 2014, a midterm election year, we do observe a statistically significant effect of mental health on voter turnout. A one unit increase in poor mental health days equates to a 1.062-unit increase in a county's level of voter turnout. Meaning, we expect Georgia counties with an average of 5 poor mental health days per month to experience 5.31% higher turnout rates compared to counties with an average of 1 poor mental health day per month.

**Table 2. Effect of Mental Health on Voter Turnout Across Georgia Counties**

	<b>Turnout 2012</b>	<b>Turnout 2014</b>	<b>Turnout 2016</b>
	<b>B (S.E.)</b>	<b>B (S.E.)</b>	<b>B (S.E.)</b>
Avg. Days Poor Mental Health	-0.421 (0.446)	1.062* (0.445)	0.263 (0.412)
Avg. Days Poor Physical Health	0.446 (0.383)	-0.954* (0.420)	-0.084 (0.388)
Total Population	0.315 (0.006)	-0.056 (0.333)	-0.020 (0.308)
% aged 65+	0.712*** (0.120)	1.013*** (0.135)	0.672*** (0.125)
% Non-Hispanic White	-0.088** (0.028)	-0.176*** (0.034)	0.088** (0.031)
Median Household Income	2.256** (0.637)	3.855*** (0.657)	2.877*** (0.608)
% Unemployed	0.278 (0.180)	0.418 (0.263)	0.391 (0.243)
% Some College	-0.016 (0.052)	-0.016 (0.058)	0.077 (0.054)
% Uninsured	-0.273* (0.135)	0.025 (0.134)	0.363** (0.124)
% Rural	0.059** (0.017)	0.031 (0.021)	-0.007 (0.020)
Constant	61.637*** (7.710)	24.716** (8.674)	-2.595 (8.022)
R <sup>2</sup>	0.436	0.5123	0.531
N	142	113	113

Note: Turnout models for 2012 include county-level statistics from 2012. Turnout models for 2014 and 2016 include county-level statistics from 2014. \*p<.05, \*\*p<.01, \*\*\*p<.001

Finally, in my 2016 model mental health has no bearing on turnout rates (see Table 2). These results should be interpreted with caution, as the dependent variable represents combined turnout in both the Democratic and Republican 2016 Presidential primary election (held March 1, 2016) and it is well-known that the characteristics of voters in primary elections are quite different from those in general elections (File 2015). Nevertheless, across all three models predicting county-level voter turnout, my Engagement Hypothesis was not supported. In fact, in 2014 the hypothesized relationship between mental health and political participation was shown to have functioned in the opposite direction, with higher levels of mental illness actually *increasing* turnout. Though this result is examined in more detail within the next section, one should note that the correlation between reported number of poor mental health days in 2012 and in 2014 is 0.80, suggesting that mental illness is in fact a chronic condition that continues to remain relatively stable within Georgia counties.

Among all three models, age and income performed as expected. Counties with higher proportions of those aged 65 years or older and counties with greater median household incomes

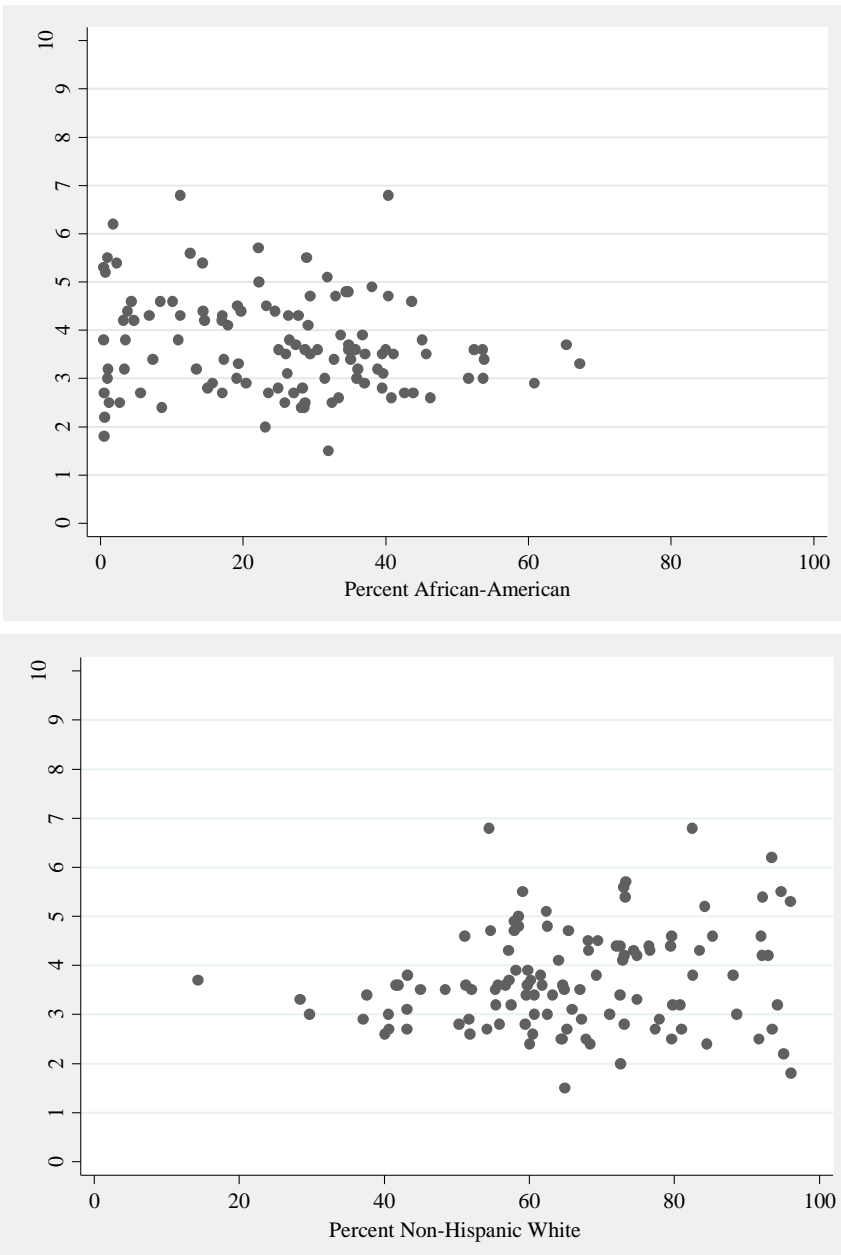
saw higher levels of voter turnout. Variables capturing education and race, however, produced conflicting and somewhat surprising results. In both the 2012 General Election and the 2014 midterm election counties with higher proportions of non-Hispanic whites were significantly *less* likely to turnout. Likewise, Georgia counties with higher proportions of college-educated individuals saw *lower* levels of voter turnout in 2012 and 2014, though this difference was not statistically significant ( $p = 0.752$  and  $p = 0.777$ , respectively).

Discrepancies also arise when comparing predictors of voter turnout across years. In 2012 and in 2016, the percentage of individuals living without health insurance at the county level is statistically significant, however these two relationships are signed in opposite directions. In 2012, Georgia counties with fewer uninsured residents saw higher levels of turnout. For every 1% increase in county residents who were uninsured in 2012, the county observed a 0.273% *decrease* in turnout rates. In 2016, however, counties with *higher* levels of uninsured residents tended to have higher turnout. This is a curious finding and may in fact be an artifact of the data itself (primaries) or may signal that dissatisfaction with the state of the healthcare system currently.

Although care has been taken in controlling for a variety of county-level factors that could affect voter turnout above and beyond rates of poor mental health, the analyses may be biased by social norms and/or stigma related to mental illness. Prior literature has shown that race or ethnicity plays a role in determining how forthcoming individuals are in acknowledging issues of mental health (Rao, Feinglass, and Corrigan 2007; Cheon and Chiao 2012). Specifically, African-Americans and Asians tend to be more disapproving of mental illness than Caucasians (Rao, Feinglass, and Corrigan 2007). This could obviously bias the present results if counties with higher populations of African-Americans and Asians are inclined to underreport rates of poor mental health. Examining the results from Table 2, it does indeed appear that counties with higher proportions of non-Hispanic whites tend to report higher levels of mental illness.

To obtain a more precise understanding of racial differences I next examined mental health rates among those Georgia counties with the highest percentage of African-American and non-Hispanic white populations. The ten counties with the highest percentage of African-American residents<sup>9</sup> reported, on average, 3.26 poor mental health days per month in 2014. In contrast, the ten counties with the highest percentage of non-Hispanic white residents reported, on average, 3.98 poor mental health days per month in 2014. Figure 2 provides a breakdown of reported mental illness by race among all Georgia counties for which data exist.

**Figure 2. County-Level Estimates of Mental Health by Race, 2014**



While the ten counties with the highest percentage of non-Hispanic white residents reported relatively higher levels of mental illness, Figure 2 shows that this average is an oversimplification. Whereas counties with higher African-American populations all report similar levels of mental illness, counties with higher non-Hispanic white populations tend to report widely varying levels mental illness. Towns County, which consisted of 96.1% non-Hispanic whites in 2014, reported an average of only 1.8 poor mental health days per month, while White County, composed of 93.1% non-Hispanic whites, reported 6.2 poor mental health days on average. Clayton and Gilmer Counties, on the other hand, have one of the highest and lowest African-American populations at 65.3% and 0.04%, respectively. In 2014 Clayton County

reported an average of 3.7 poor mental health days per month while Gilmer County reported an average of 3.8 days.

That communities with higher concentrations of African-American or non-Hispanic white residents may *systematically* report higher or lower incidents of mental illness is beyond the scope of this paper. What is important to note is that if self-reported measures of mental health are biased by race, and race has by all accounts been shown as an important predictor of political behavior (File 2015), my estimates of the relationship between mental health and political engagement may be tainted.

## Conclusion

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Contrary to my original Engagement Hypothesis, voter turnout was not significantly suppressed by higher rates of poor mental health. Variables that were shown to consistently predict turnout rates across all years and types of elections are income, age, and race. While these relationships should come as no surprise to scholars of political behavior, it is worthwhile to note that these same variables, particularly race, affected incidents of poor mental health itself. In this vein, it might be useful to look to individual differences in mental functioning in explaining *why* disparities in turnout exist amongst these demographic groups.

It is important to note that the data modeled within this study represent individual-level responses that were aggregated (by the Behavioral Risk Factor Surveillance System) at the county-level. Earlier in this paper a theoretical argument was developed to explain how individual, rather than collective, psychological states relate to political behavior. In order to identify the individual-level effects of mental health on participation more broadly, more intimate data is needed.

Another limitation of the data is that the independent variable is a rather subjective proxy measure of mental health. First, it aims to measure mental health in terms of frequency rather than intensity of poor mental health days. As a result, the present analysis may prove deficient in that it treats mental health as a count variable rather than a quality or characteristic measure that varies in strength. Future research in this area might improve upon the present design by constructing a measure which taps the qualitative dimensions of mental health. Along these same lines, the independent variable within this study does not specify which *type* of mental illness Georgia residents may be experiencing. Survey respondents are only directed to indicate how many days of poor mental health they experienced within the last 30 days. Unquestionably, survey error exists within this measure, as the definition and conceptual understanding of ‘poor’ and ‘mental health’ varies greatly across individuals. Beyond this measurement issue, it is likely that various mental conditions impart differential effects on political behavior. For instance, we might speculate that depressive disorders lead an individual to become less engaged in politics whereas anxiety disorders may actually facilitate political engagement. To the extent that individual mental illnesses are not fully disclosed, the examination of mental health and turnout remains opaque.



## Policy Implications

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In Table 1 it was observed that the ratio of mental health providers to county residents had no statistical relationship with mental health. The correlation between poor mental health days and the number of mental health providers in a county is relatively low as well (-0.14 in 2012 and -0.20 in 2014). This may be for a number of reasons. First, it could be that having more mental health providers means that residents are able to access care and get necessary treatment. This is perhaps the normative ideal. Still, in this case we would expect to see a significant negative relationship whereby mental health providers are systematically *reducing* levels of poor mental well-being. Second, there could simply be measurement error in calculating the number of providers in each county. The County Health Rankings & Roadmaps data comes from the National Provider Identification data file. Providers who do not have an identification number are not included on the list and those who had an identification number at some point in time, but are no longer practicing, may still be listed. To the extent that these estimates are flawed, it is rather unclear as to whether the number of mental health providers are in fact having an impact on rates of mental illness.

Another potentially troubling finding is that health insurance appears to have no effect on curbing mental illness. My results suggest that residents who have health insurance are no better off than those who do not in terms of experiencing undesirable mental conditions. This may be a product of the data itself, as it does not reflect new policy changes implemented with the passage of the Affordable Care Act. Nevertheless, it seems plausible that stigmatization of mental illness and/or unfamiliarity with one's insurance coverage may play a role in deterring individuals from getting the help they are rightfully afforded. A more thorough investigation of private and public health insurance plan coverage is necessary in order to draw conclusions about its relationship with mental health.

## Future Directions

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The goal of this research has been to disentangle the dynamics of mental illness across Georgia and to model its impact on political life. Although my analysis was able to shed some light on these matters, it appears that more questions were raised than were answered. Future work in this area should aim to parse out the data for a more comprehensive snapshot. It might be useful, perhaps, to separate the data into counties with the highest and lowest mental health expenditures and then compare the effects of mental health on participation. By exposing the systematic ways in which mental well-being relates to political behavior, Georgia representatives will be able to craft policy initiatives that are responsive to the needs of their constituents. After all, it is not only individuals who suffer from mental illness, it is the democratic process that also feels its effects.

## Endnotes

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1. [www.mhageorgia.org](http://www.mhageorgia.org)
2. [www.namiga.org](http://www.namiga.org)
3. [www.gasubstanceabuse.org](http://www.gasubstanceabuse.org)
4. Whereas mental illness is characterized by impaired functioning, 'mental health' is characterized by optimal functioning. In this paper I use mental health and mental illness interchangeably in the sense that both psychological states can have a (differential) effect on political behavior.
5. At present 14 states, including Georgia, have laws barring the "mentally incompetent" from voting. While it is outside the scope of this paper to discuss such issues, it should be noted that the mentally ill are in some instances formally disenfranchised from the political system by these laws.
6. County Health Rankings & Roadmaps obtains their data from the Behavioral Risk Factor Surveillance System (BRFSS), an annual survey conducted by the Centers for Disease Control and Prevention. Although it might be preferable to obtain survey data directly from BRFSS, public-use BRFSS data is coded only at the state-level.
7. County Health Rankings & Roadmaps calculates this variable using data from the U.S. Census. Refer to Census codebooks (<http://www.census.gov/>) for more on its measurement.
8. Map created using <http://diymaps.net/ga.htm>
9. These averages included only the counties for which mental health data were provided. For example, while Hancock County has the highest proportion of African-American residents in 2014 (73.4%), mental health data from this location was not reported within the County Health Rankings dataset.

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