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Digital Object Identifier: https://doi.org/10.13023/ETD.2017.355

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AN EXPLORATORY STUDY OF INCAPACITATED PERSONS WITH CRIMINAL BEHAVIORS SERVED BY
KENTUCKY'S PUBLIC GUARDIANSHIP PROGRAM

DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Social Work at the University of Kentucky

By
Karen E. Martin

Lexington, Kentucky

Director: Dr. David D. Royse

Lexington, Kentucky

2017

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ABSTRACT OF DISSERTATION

AN EXPLORATORY STUDY OF INCAPACITATED PERSONS WITH CRIMINAL BEHAVIORS SERVED BY KENTUCKY'S PUBLIC GUARDIANSHIP PROGRAM

State run public guardianship programs are legally mandated to provide custodial care for persons deemed incapacitated by the courts. Historically, the majority of state wards were elderly women residing in skilled nursing facilities. Today, those demographics are rapidly changing. This new incapacitated cohort has become less institutionalized, with a rising number of persons who have entered the program with criminal records and who continue to commit crimes. This exploratory study focuses on incapacitated persons (IP) with criminal behaviors in order to seek what intervention(s) might reduce their criminal activity. Relying on routine activity theory, differing levels of supervision were compared to those persons institutionalized 24 hours per day. The results of the study indicated that as levels of residential supervision decrease, criminal activities significantly increase. This study can assist administrators of public guardianship programs better understanding the supervisory needs of their incapacitated citizens as well as improve safety precautions for their respective communities.

KEYWORDS: Kentucky, Public Guardianship, Incapacitated Persons, Criminal

Behaviors, Supervision

Karen E. Martin

June 30th, 2017

AN EXPLORATORY STUDY OF INCAPACITATED PERSONS WITH CRIMINAL BEHAVIORS SERVED BY
KENTUCKY'S PUBLIC GUARDIANSHIP PROGRAM

By

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June 30th, 2017
Date

Some paradox of our nature leads us, when once we have made our fellow men the objects of our enlightened interest, to go on to make them objects of our pity, then of our wisdom, ultimately of our coercion.

-Lionel Trilling

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Chapter 1: Introduction

Guardianship is a legal process designed to assist persons, who for a variety of reasons, have lost or never possessed the mental capacity to properly care for themselves. The determination of mental capacity is a judicial decision based on the perception of a person's skillsets involving memory, reason, and rationality; all necessary components to properly manage one's day-to-day self-care and financial transactions (Gavisk & Greene, 2007). The belief that persons with diminished mental capacity deserve a safe and secure future can be traced back to the ancient civilizations of Greece and Rome when the control of an "insane" person's property was given over to a "curator" by a local magistrate to protect said property (Milns, 1986). In Medieval England, feudal courts began to appoint legal custodians for "two major medicolegal categories known as 'idiots' and 'lunatics' " (Neugebauer, 1989 p. 1580). Current terminology would now replace the label of *idiot* as someone with an intellectual disability while the term *lunatic* would more closely characterize a person with a psychiatric disability or end-stage dementia. Although a gentler description for this population has evolved, issues related to the termination of an individual's civil liberties in conjunction with the need for skilled custodial care remain a societal challenge that has yet to be satisfactorily met.

A succinct definition of guardianship is "a relationship created by state law in which a court gives one person or entity (the guardian) the duty and power to make personal and/or property decisions for another person (the ward or incapacitated person)" (Teaster, P. B., Wood, E. F., Schmidt, W. C., & Lawrence, S. A., & Mendiondo , 2007, p. 5).

Guardianship has been described as a “two-headed creature; half Santa and half ogre” (Regan, & Springer, 1977, p.27) as its design authorizes the delivering of aid and support while simultaneously eliminating fundamental rights through its forceful restrictions on self-determination. Within the relationship between the ward and the appointed guardian is a relentless tension between the respect for the ward’s autonomy and the paternalistic actions by the guardian. The value laden guardianship process in conjunction with the ethical conflicts creates numerous concerns within the guardianship arrangement. Over the course of the last several decades, long identified problems have been discussed with subsequent recommendations offered to improve the process to protect the stereotypical elderly vulnerable adult.

Unfortunately, in recent years state guardianship workers have observed what appears to be a new problem. It is an influx of a different type of incapacitated person (IP) from years past; a younger more mobile subgroup (Teaster, Wood, Lawrence, & Schmidt, 2007). This new cohort exhibits noncompliant behaviors, which oftentimes results in criminal actions. Their non-compliance threatens their own safety as well as their guardians and the public at large. It is this recently identified subset of the guardianship population that is the area of investigation for this study. The goal of this research project will be to identify who comprises this group, what types of crimes they commit and what factors may contribute to the commission of their crimes.

Legal Process of Guardianship

Today in the United States, the legal doctrine of *parens patriae* remains the underpinning upon which the legal process of guardianship rests. This legal principle affirms it is the duty of the sovereign to care for persons who lack the capacity to make appropriate decisions about themselves and their property (Teaster, 2003). A modern translation of this principle has resulted in the state court system being the entity responsible for determining if a person's mental competency meets the criteria necessary for placing them into a guardianship arrangement. The guardianship process occurs in three stages; pre-adjudication, adjudication and post-adjudication (Crampton, 2004).

The pre-adjudication phase involves the request for guardianship based on observations of a person's unmet needs and/or concerns about behavior. Requests for guardianship typically follow a significant event such as a health crisis, substantiated abuse/neglect or fiscal mismanagement. Other potential initiating circumstances include an unexpected change in a will deemed a threat by potential heirs, institutional concerns regarding payment and liability and conflicts of interest among states agencies (Dore, 2008).

The request for guardianship begins by filing a petition with the properly designated court. In almost every state, any person is allowed to file a petition for private or public guardianship. Within the domain of private guardianship, the petition by "any interested party" may create conflicts of interests as potential heirs position themselves to gain control over future inheritance. With respect to privately owned guardianship agencies, there can exist intent to select individuals with no family yet in possession of

extraordinary financial assets, as a way to exploit the vulnerable for professional and personal financial gain. Within the domain of public guardianship, Adult Protection Services (APS) is the primary referral source and guardians are state employees, typically social workers, who are assigned clients that are often living in poverty with few resources (Teaster, 2003).

The adjudication stage involves the actual court proceedings. The process for the courts to grant guardianship is based upon the Uniform Probate Code (UPC) Article V and the Uniform Guardianship and Protective Proceedings Act (UGPPA) of 1997. The UPC has been fully adopted by 18 states and partially in several others. Article V of the UPC provides for the "protection of persons under disability and their property" which outlines the legal process for guardianship and conservatorships. Guardians are appointed by the courts to care for incapacitated adults that cannot take care of themselves. Those under the care of a guardian are deemed a ward, according to the UGPPA. Conservators are also court appointed and they are responsible for receiving, investing, managing, and disbursing property held for an incapacitated person (Uniform Law Commission, 2013).

In every state the court must serve notice to the respondent of the guardianship petition thereby assuring due process protections through the action of a judicial hearing. The right to counsel is required in 25 states, which typically provide free counsel for indigent clients. However, some states require counsel appointment only if requested by the respondent or if the judge determines it to be necessary (Teaster, et al., 2010).

Concerns surrounding the judicial review for determining mental capacity abound. Current guardianship statutes rely on "functional determination of capacity" rather than

clinical conditions to determine guardianship appointments (Teaster, et al., 2010; p. 17). However, when medical records are submitted to the court, the person's medical diagnosis may be used as the primary rationale for an incompetency determination despite the fact that diagnosis alone is not an accurate indicator of a person's decision-making abilities (Kjervik, Miller, Jezek & Weisenee, 1994). Decisions of incapacity or disability are not always left to an individual judge's discretion. Twenty-seven states provide for a jury trial if requested by the respondent; however Kentucky mandates a jury trial for all adult guardianship cases (Teaster, et al., 2010).

A review of the standards of proof criteria among differing states reveals a range in regulatory language standards. Evidentiary specifications include terms such as "clear and convincing", "if court satisfied", "preponderance of evidence" and "beyond reasonable doubt". Unfortunately, this regulatory ambiguity complicates the intent for any national standardization of capacity. Also, uniformity within a single state cannot be guaranteed as judges and juries are left to their own unique interpretations of the legal language. Furthermore, eight states do not define any standard of proof within their regulations or statutes (Teaster et al., 2010).

Beyond the standard of proof requirements are terminological variations related to mental impairment and guardianship status. In the past guardianship language referenced the person's status as *competent* or *incompetent*. This is a distortion of reality as the word "competence is task specific" (Gert, 2006, p. 220). No one person is competent in all areas at all times and such a dichotomous determination ignores the continuum of understanding everyone experiences. Informed and rational decision-making vary as they are dependent upon circumstance; thus a broader range of determinations is more

prudent. Fortunately, these two terms have been gradually replaced in the literature and statutes by the words *capacity* and *incapacity* (Gibson, 2007).

According to the UPC "an 'incapacitated person' is defined as any person impaired by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause, excluding minority to the extent he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person" (Langen, 1978, p. 268). This definition acknowledges the range of potential reasons for mental impairment and allows for a broader interpretation of an individual's deficits and capabilities.

As example, the Kentucky General Assembly acknowledged the varied degrees of disabilities when they enacted KRS 387.500 in 1982. This statutory revision redefined individuals as *legally disabled* as opposed to the previous term of incompetent. Moreover, the disability could be deemed a full or partial disability. As a result, the inquest as to the disability of a Respondent provides seven potential outcomes; 1) not disabled to manage personal affairs and financial resources; 2) partially disabled in managing financial resources only; 3) wholly disabled in managing financial resources only; 4) partially disabled in managing personal affairs only; 5) wholly disabled in managing personal affairs only; 6) partially disabled in managing bother personal affairs and financial resources; and 7) wholly disabled in managing both personal affairs and financial resources (Kentucky Administrative Regulations, 2002). Regrettably, despite the varying degrees of guardian oversight available to a respondent, Kentucky's public guardianship program reports that approximately 79% of the state wards are delegated to the appointment type of Full Guardianship/Full Conservator. Previous research is

consistent with this finding, as former studies conclude that despite alternatives Full Guardianship is the most prevalent determination (Frolick, 2002).

Gavisk & Greene (2007) reported that there is little information available on how judges, attorneys and professional guardians actually determine capacity or assess for appropriate levels of care needs. Previous analysis (Bulcroft, Kielkopf & Tripp, 1991) revealed reliable assessments of competency were often absent in court proceedings and petitions for guardianship were seldom challenged.

In summary, guardianship is a convoluted judicial process complicated by its state-to-state variations. Although designed to protect a defenseless population from potential exploitation, its numerous ambiguities with poorly defined procedures is one of the few consistencies in both private and public guardianship programs (Teaster, et al, 2010).

Public Guardianship

The post-adjudication phase occurs after the assignment of a guardian and concerns the care and support supplied to the IP. Private guardians are individuals willing to assume the responsibility of making informed decisions to ensure the health, welfare and safety of the incapacitated person. Private guardians are often family members, attorneys (Teaster, 2003) or in some cases friends or neighbors. In instances when no family or friends are willing to become a guardian the state will provide guardianship services through a public guardian program (Teaster, Wood, Lawrence, & Schmidt, 2007). All states have some type of general code for public guardianship. In a 2005 national study it was determined 44 states had "specific statutory provisions on public guardianship"

(Teaster, et al., 2010, p.16) with the state being named the guardian in approximately 25% of cases (Crampton, 2004).

Although the term guardian brings forth a benevolent image of a sympathetic caretaker, in reality it is an invasive action by the State (Teaster & Roberto, 2002) which results in a severe loss of fundamental rights and freedoms for the individual deemed "incapacitated" (Dore, 2008). Once adjudicated by the court, the individual loses the right to marry, vote, transfer property, choose their place of residence and make health care decisions (Teaster & Roberto, 2002). Depending on the level of intrusiveness of the appointed guardian, the IP may be deprived of who he/she spends time with, the food they are offered, and the ability to travel throughout their community (Dore, 2008).

Organization and implementation of state public guardianship programs vary by state. Originally suggested by Regan and Springer (1977), utilized in early guardianship research by Schmidt (1981), and more recently confirmed by Teaster et al. (2010) there are four distinct models of public state guardianship programs. The first, known as the *court model* places the public guardianship offices within the state court system. In 1981, six states were identified under this model. By 2007, that number had dwindled to five.

Following the court model is the *independent agency model* which positions guardianship within the executive branch of state government. It is an independent model in that no direct services are provided to the IPs. The latest study finds four such models located in Alaska, Illinois, Kansas and New Mexico (Teaster et al., 2010).

The third type is the *social agency model*. This is the most prolific and problematic model. Schmidt (1981) and Teaster et al. (2010) agree that this particular model

possesses an inherent conflict of interest between guardians serving simultaneously as decision-makers/advocates and also as service providers. Also, when guardianship programs are located within the same state Cabinets or agencies, ethical challenges can occur due to the temptation by departments to transfer problematic cases or cherry pick the least troublesome IPs to serve (Teaster, et al., 2010). Nonetheless, 34 states have implemented this type of model including Kentucky.

The fourth guardianship model is the *county model* where each individual county has an established public guardianship office. Eleven states have selected this design and Teaster et al. (2007) recommend this design over the previous three as it is believed local officials are more acutely aware of the needs of the IPs.

Beyond the differing models, some similarities can be identified. Public guardianship is an area of public administration often overlooked. Citizens with a range of intellectual and psychiatric disabilities including end-stage dementia and individuals living with HIV/AIDS garner little attention among policymakers or the public. As a result, public guardianship programs are not adequately funded. Caseloads among guardianship workers are high. Accountability for guardian's actions and decisions are for all practical purposes nonexistent (Teaster, 2003).

Criticisms of public guardianship programs are multifaceted and have been documented by academics within the literature as well as in news reports aimed to create public awareness. Injustices within the guardianship system were brought to the public's attention by a series of articles published by the Associated Press (AP). Reporters Bayes and McCartney (1987) declared the guardianship systems as an ailing one, which was

“failing many of those it is designed to protect.” Based on a yearlong investigation the series of articles described individual cases where wards were subjected to abuse, neglect and theft.

Almost two decades later, *The Los Angeles Times* (Leonard, Fields & Larrubia, 2005) published an extensive article on the unethical behavior of professional guardians/conservators who used their immense power over their clients to pocket large sums of money for themselves. The article explained how their criminal activities were conducted with judicial oversight that consistently and frequently “overlooked incompetence, neglect and outright theft” (A1).

In the academic literature, guardianship problems discussed include: 1) the primary intent of the program is to preserve the estate and third-party interests rather than the actual care for vulnerable adults (Crampton, 2004); 2) inconsistent judicial standards for determining capacity (Gavisk & Greene, 2007; Kjervik, et al., 1994; Meynen, 2009; Roof, 2012); 3) loss of autonomy and civil rights (Dore, 2008; Kjerviket al., 1994; Teaster & Roberto, 2002); 4) insufficient funding and personnel to assist an ever growing state guardianship population (Teaster, 2003; Teaster, Schmidt, Wood, Lawrence & Mendiondo, 2010); 5) a lack of court oversight and/or genuine concern for the IP (Fields, Larrubia, Leonard, & Moore, 2005; United State Government Accountability Office, 2004); and 6) insufficient data and research available on guardianship issues (Teaster, 2010; Uekert & Schauffler, 2008).

Beyond the above-mentioned criticisms is an impending concern involving public guardianship’s anticipated increase in persons likely to become candidates for

guardianship. The United States is fast approaching a period of unprecedented growth among older adults. In 2000, those ages 65 and over numbered 35 million. By 2030, this population will have more than doubled reaching a total of 71.5 million persons. As the number of seniors increase, so will the number of persons diagnosed with age-related cognitive disabilities (U.S. Senate Special Committee on Aging, 2007). Aging baby boomers are expected to have a higher risk of depression, anxiety disorders and substance abuse than those of previous generations. Estimates on the number of psychiatrically ill elderly patients will increase from 4 million in 1970 to 15 million by 2030. For those ages 30 to 44, the population increase is less dramatic but will rise to 65.8 million with an expected 67% increase in mental disorders (Jeste, Alexopoulos, Bartels, Cummings, Gallo, Gottlieb, Halpain, Palmer, Patterson, Reynolds, & Lebowitz, 1999).

A state specific example of this trend can be confirmed by Kentucky's public guardianship program's recent statistics. Kentucky's adult state guardianship program is located in the Department for Aging and Independent Living (DAIL), a social service agency within the Cabinet for Health and Family Services (CHFS). In 2006, Kentuckians under public guardianship numbered 1,760 persons. By 2011, the number had increased to 3094 and as of November 2013, the active number of IPs in the program was 3659. Future expectations estimate that the Kentucky's guardianship program will increase on average 20 additional appointments per month beyond those who have been removed from the program due to deaths or resignations (Anderson, 2013).

There are other contributing factors offered for this increase in guardianship beyond the aging Baby Boomer population with their extended life span and related mental decline (Teaster, et al., 2010). Of equal concern is the declining mortality rate in

conjunction with declining fertility rates which has resulted in an increase in "dependence care ratio", meaning there are fewer adult children to share in the caregiving duties for their parent(s) (Kapp, 1999). An added family dynamic in modern America is a mobile society where family networks are more geographically challenged (Teaster, et al., 2010). This has resulted in long distance caregiving which often includes a greater reliance on others outside the family to care for their loved ones. Lastly, the spectacle of deinstitutionalization has resulted in persons with severe mental illness living in their community but without the necessary community-based supports to do so successfully (Crampton, 2004).

Relevant to the growing guardianship population is the impact on guardianship caseloads. General duties for state guardians in Kentucky include a 24/7 on-call rotation schedule, handling real estate/personal property issues, attending all court hearings regarding IPs, face-to-face visits on at least a quarterly basis, completing annual reports to the court for each IP, attending care plan meetings at facilities, signing all consents for treatment forms, making medical appointments, arranging transportation, requesting payments for bills and establishing pre-paid burials. In 2010, there were 41 Kentucky state guardians with an average caseload of 71. In 2013, the average caseload has dropped to 69; however at the current rate of new assignments the program will need approximately six more staff per year to maintain caseloads at their current levels. If approved, the new staff will result in an additional cost of approximately $275,000. This is at a time when DAIL has experienced nine budget reductions over the past five years culminating in a total loss of over 8 million dollars (Anderson, 2013). A previous study by Teaster, Schmidt, Abramson, & Almeida (1999) recommended "a ratio of 1:20"

(Teaster, 2002, p. 344) to ensure quality care and oversight. Given the limited financial resources provided through the legislative budget allocations, a recommendation for drastically lowered caseloads appears unattainable.

It is for the above-mentioned concerns, in addition to still other unnamed realities among public guardianship programs, that further research is needed. There exists a plethora of issues surrounding public guardianship involving ethical dilemmas, lack of resources and supports, and unintended consequences from current policy decisions. However, this paper will address an area previously unexplored in previous studies; criminality among incapacitated persons in Kentucky's state guardianship program.

Statement of the Problem

The case notes, which follow, were current cases within Kentucky's state guardianship program. They are indicative of actions within Kentucky's criminal justice system that have contributed to the rising number of IPs with criminal behaviors being placed under state guardianship.

A District Judge contacted Kentucky State Guardianship and stated G. G. has been incarcerated since August 27, 2012. He stated this inmate had been found incompetent to stand trial for an assault charge related to his shooting a former police officer in the back. This person has been diagnosed with dementia, depression, personality disorder and Diabetes Type II. He refuses to take all medication and also refusing to allow jail personnel to check his blood sugar. The Judge is requesting State Guardianship to take over the care of this individual so he can be released from jail. The inmate has no immediate family and the judge is requesting he be placed where he is not a danger to himself.

L.P. was appointed to guardianship while in jail. He had taken his mother to Wal-Mart and forced her to buy a tarp. He then forced her at gunpoint to drive to a local cemetery where he held her in front of a grave. A passerby saw what was happening and called Kentucky State Police (KSP). When they arrived, L.P. ran and forced people who were

visiting the cemetery out of their vehicle and stole the vehicle. He led KSP through two counties before crashing the vehicle into a tree. He was then transferred to UK hospital with police guards and handcuffed to the bed. He was released back to jail and then to guardianship. At the time of appointment, guardianship was told by the Judge to pick him up and take him someplace and he didn't care where. Last month, L.P. threatened to kill the guardianship worker and threatened to blow up the state building where she worked. The building was evacuated. The county attorney refused to press charges stating L.P. would be found incompetent to stand trial. He is still in the community.

C.B. has a history of violence and sexual aggression toward women. Last year he attacked a nurse at Appalachian Regional Health Care and nearly choked her to death. He was appointed to state guardianship while in jail. When two female guardianship workers met face to face with him, the jailer advised they could not meet alone with him due to safety concerns. When the workers spoke with him through a glass window he became very aggressive and out of control. Staff at the jail stated he is very violent but that the guardianship workers had to "take custody" of him because he could not stay at the jail (Anderson, 2013).

Anecdotal reports such as those above reveal a growing frequency among this diverse cohort of IPs with histories of criminal behaviors. Particularly problematic for the state guardian is when an IP commits a crime; county prosecutors terminate all judicial proceedings once their incapacitated status becomes known. Since the courts previously deemed the person incompetent, criminal proceedings are halted and they are subsequently released from jail with all criminal charges dropped (D. Anderson, personal communication, October 12, 2012).

Such actions by the criminal justice system require the guardian to find placement and adequate oversight for IP. Residential placements are limited by availability, provider permission and limited funds. Consequently, those categorized as community-based placements (which are the least expensive for the state) might be expected as the guardians' most common residential placement decision. However, the consequences of placing incompetent persons with criminal behaviors back into the community with little

support or oversight is a danger to the general public, family members, fellow residents, state guardianship workers and the IPs themselves.

Purpose of the Study

This study will focus on a recently identified subset of 746 IPs among the 3491 Kentuckians under State Guardianship as of June 2013. Previous academic literature encompasses many distinctive aspects of guardianship including assessments concerning competency criteria (Meynen, 2009), ethical dilemmas associated with guardianship cases (Tomossy & Weisstub, 1997) and concerns with program implementation (Teaster & Roberto, 2002). Related fields of research associated with this study include disability groups linked with specific criminal behaviors (Repo & Virkkunen, 1997), mental health law (Morse, 1999) and the trans-institutionalization of the mentally ill from psychiatric hospital to prison (Steadman & Naples, 2005). Nevertheless, public guardianship involvement with IPs with known criminal behaviors appears absent from the literature. This dearth of knowledge and insight is significant for the IPs, state guardianship programs and the public.

Given the study’s exploratory nature the research questions will examine fundamental questions surrounding this unique cohort. Descriptive and inferential statistical analyses will be used to investigate IPs with and without criminal behaviors. The types of criminal behaviors tracked by State Guardians employed by DAIL during a 2013 survey will also be compared. At the time of the survey, State Guardians were asked to report on known criminal behaviors for the IPs on their respective caseloads for the following categories; 1) murder; 2) physical assault; 3) verbal assault; 4) fire setting;

5) drug/alcohol violations; 6) property destruction; 7) sex crimes; 8) stalking; 9) theft; and 10) trespassing.

Not only will this study gather descriptive statistics on the 746 IPs who have exhibited criminal behavior, but also an inferential statistical analysis will investigate predictor variables concerning which IPs are more likely to engage in criminal activities. No known study has explored this unique cohort of individuals utilizing predictor variables for criminality but hopefully this initial analysis will begin a new area of research for this vulnerable population.

Significance to Social Work Profession

Social workers' involvement in guardianship cases occurs in all phases of the guardianship process. Social workers are employed in a variety of settings and are often times interacting with persons who lack the mental or physical capabilities to properly care for themselves. Institutions concerned with patient liability as well as reimbursement may involve their social work personnel to intervene on their behalf to secure informed consent and/or payment.

Social workers have many of roles and may serve as advocates for the disabled or elderly in which case their understanding of the guardianship process is of paramount importance. In some states, social workers serve as "court visitors" in which they not only assess potential wards for capacity, the appropriateness of guardian selection, but also provide vital information necessary to secure services to ensure the health, welfare, and safety of their clients. Other states, including Kentucky, deem social workers as qualified mental health professionals who in turn serve as interdisciplinary team members

charged with conducting competency assessments (Crampton, 2004). They may also be subpoenaed to testify on the respondent's mental and functional status. Testimonies and professional documentation are essential components to judicious capacity determinations. Social workers should be at least provided the opportunity to acquire guardianship-specific knowledge currently absent from standard social work curriculums and textbooks.

Since few guardianship petitions are voluntary social workers need to be aware of the not only the guardianship process but also the potential for ethical dilemmas that can so easily occur during the process. The essential conflict between respect for one's autonomy versus the paternalistic action of the State is pervasive. Self-awareness regarding whose best interests are actually being served is vital to the ethical requirements of the profession. Expertise on recognizing signs of depression, alcoholism and medication side effects is also necessary tools for the social worker professional. Equally important is the ability to complete advance care directives that may prevent the future need for guardianship and assist clients and families in planning for the future (Crampton, 2004).

Explicit knowledge to be gained from this study is an understanding of mental health law and the unintended consequences of judicial decisions concerning capacity, especially for persons with criminal behaviors. In addition, state social service residential options for persons with behavioral issues should prove to be extremely helpful for the social work professional and student. Given the lack of information available on this unique subset of the guardianship population, in conjunction with the relatively scarce quantitative data available concerning IPs in general, this study will contribute to the

professional literature and provided knowledge for policymakers planning for the future needs of public guardianship.

Lastly, with regard to social welfare policy, the results from this study can better inform policy makers on what residential living conditions are best for persons who are mentally challenged and participate in criminal activities. This study will seek to better understand how to best serve the guardianship client and the community at large.

Chapter 2: Literature Review

This exploratory study on criminality within the guardianship system involves a variety of different but related subject matters and research findings. The most explicit area of examination is guardianship literature since this research topic is directly related to the Kentucky's public guardianship program. However, interconnected themes within this review will include information on mental health policy, healthcare policy, law and criminal behaviors among those deemed incapacitated. This literature review provides facts, figures and noted commentaries on these multiple topics in order to impart the contextual knowledge necessary to understand the rationale for the study and its ultimate findings.

Literature on Guardianship

Historical Foundation of Guardianship

Guardianship can be traced back to the early civilizations of both Greece and Rome. The sons of the famous playwright Sophocles initiated one of the oldest documented cases concerning the request for guardianship. The evidence offered to prove their father's incompetence was his preoccupation with writing the play *Oedipus*. In his own defense, Sophocles read the play aloud to the jury, who reacted with cheers and the case, was immediately dismissed (Quinn, 2005).

The Twelve Tablets of Rome promulgated in 449 BC, stated "If a person is a fool, let this person and his goods be under the protection of his family or his paternal relatives if he is not of under the care of anyone" (Quinn, 2005, p.18). As Roman law further

developed, “an insane” person’s property was given over to a “curator” by a local magistrate to protect said property (Milns, 1986).

During the Middle Ages, common law provided for a “tutorship” of property by feudal lords to help protect those under their domain. In 14th century England the statute “De Praerogativa Regis” proclaimed it was a King’s benevolent duty to care for those unable to manage their affairs which resulted in the fundamental doctrine known as *parens patriae* (Curtis, 1975-1976; Quinn, 2005; Teaster, 2003). Colonial America adopted similar laws based on this European judicial tradition. Today *parens patriae* remains the basis for guardianship laws which instruct the state to intervene when a person is at risk of physical or financial harm due to their own mental incapacitation (Arias, 2013; Curtis, 1975-1976; Moye, et al., 2007; Teaster, 2002; Quinn, 2005).

Guardianship Issues

Early works on guardianship originated almost exclusively from various university law reviews rather than journals from social science disciplines. These judicial writings focused primarily on the history of guardianship arrangements and/or state specific statutory instructions (Woerner, 1897; Sherman, 1913-1914; Clark, 1936; Haskins, 1949). Social science research on guardianship remained relatively rare until the 1960’s. The gap between legal and social science literature may well be attributable to the era’s newfound appreciation for civil rights protections which spurred social justice advocates for the elderly and mentally disabled to begin the examination of guardianship proceedings through the lens of social science research (Quinn, 2005). It was during the civil rights era that social science and legal publications began to examine how a process

designed to protect the vulnerable continuously failed to achieve its intended goals. Recognition of the increasing need for reform is a common theme throughout guardianship studies. However, improvements in the process vary according to what the individual author identifies as guardianship's most pressing problem.

Given the multifaceted issues discussed in guardianship literature, procedural reform is recommended in numerous areas and is categorized as follows; 1) guardianship as it related to the social work profession; 2) third-party interests rather than the actual care for vulnerable adults; 3) inconsistent judicial standards for determining capacity; 4) loss of autonomy and civil rights; 5) insufficient funding and personnel; 6) a lack of oversight and/or genuine concern for the IP; and 7) insufficient data and research available on guardianship issues.

Guardianship and the Social Work Professional

Early research focused on the importance of social workers' knowledge concerning guardianship. In a study sponsored by the National Council on the Aging (NCOA), project directors Lehmann & Mathiasen (1963) placed the responsibility for caring for the incompetent older adult squarely on the social work profession due to its direct involvement in both guardianship and protective service case work.

Zborowsky (1985) expressed concerns about the social workers' effectiveness in initiating appropriate interventions for the elderly. She advised social work professionals to acquire legal knowledge pertaining to protective services for the elderly. Her conclusion was an important one as regulatory authority directs the social work practitioner's conduct and instructs the permissible interventions available. Social work

practitioners unaware of these legal protocols may inadvertently act beyond their scope of practice resulting in illegal and/or harmful actions towards their client.

Crampton (2008) discusses the importance of adult guardianship and social work practice as addressing potential social injustices, pointing out that social workers are becoming more involved in all phases of guardianship proceedings. In recent years, changes in state law are allowing social workers to submit evidence as mental health professionals in competency hearings. Acting alone or as part of a multidisciplinary team, social workers are being asked to either assess for competency for the court or provide testimony on current physical and mental status of the respondent. Additional responsibility may include assignment as a court visitor to assess the potential guardian's abilities to serve as an effective guardian or in other cases become a state guardian in a public guardianship program.

Guardianship is paternalism in action. Autonomy, a cornerstone within the social work profession's National Association of Social Workers' (NASW) Code of Ethics mandates a respect for a person's right to self-determination (Workers, 2008). Social workers involved with the protection of vulnerable clients especially in regard to guardianship issues need to recognize the ethical challenges and tensions between autonomy and paternalism.

Bauman (2007) incorporated the NASW Code of Ethics in her macro level study, when she advocated for incapacitated persons under corporate guardianship in Wisconsin. Through focus groups comprised of adjudicated persons, comments on: 1) experiences under guardianship; 2) participation in decision-making; 3) complaint and

grievance process; and 4) contact with guardians were elicited, recorded and shared with state policy makers involved in revising Wisconsin's rules for non-profit guardianship agencies (Wisconsin Administrative Code HFS85). The study found that wards' experiences were overall satisfactory but could be improved. Most notable areas for improvement were identified as greater participation in residential placement decisions, education on the complaint and grievance process, and more frequent contact with their guardian.

Additional research and education on guardianship law, social work interventions and ethical responsibilities throughout all levels of social work practice will advance the legal expertise and ethical judgment for the practitioner and overall enhance the social work profession.

Third-Party Interests

It is true that in some cases the desire to provide benevolent care to those with diminished mental capacity initiatives guardianship proceedings. However, more often, it is the pressing needs of a treatment facility to obtain informed consent or financial payment that propels people into a guardianship arrangement. Third party interest has been found as a consistent motivation for guardianship referrals. The studies of Lehmann & Mathiasen (1963) and Zborowsky (1985) focused on social work's importance in the guardianship as a way to defend against the multifaceted injustices inherent within the guardianship process. In their respective studies, it was revealed that the primary intent of guardianship referrals was to preserve a person's estate or serve some other third-party interest.

Focusing on the specialized population of "mentally retarded and epileptic" persons which was a unique population under Minnesota public guardianship program, Levy (1964-1965) reviewed the standards and procedures utilized by the courts and welfare departments of the day. The author surveyed the Minnesota program and concluded that reform was needed in order to improve collaborative efforts between the courts and third parties in order to help ensure the protection of the rights of those under their control. Levy concluded with the Program for National Action when he wrote "In short, the law must…protect the rights of the retarded; it cannot rely exclusively on the good intentions of those who manage institutions and other programs." (p. 824).

Fratcher (1965-1966) provides an historical account of guardianship law based on the 1946 Model Probate Code which was in revision at the time of his writing. The author cited examples of rural farm children, veterans and disabled adults who ultimately lost part of their financial assets to third-party entities due to gaps in statutory language and/or the courts misinterpretations of the law.

The financial reward of self-interested individuals is reiterated by law professor and students Alexander, Brubaker, Deutsch, Kovner & Levine (1969-1970). Protection from neglect and financial exploitation among the aged is the motivation for their work as evidenced by conclusions drawn from their state-by-state review of guardianship administrative regulations and statutes. Troubled by the lack of checks and balances within the court system, they concluded that the utilization of incompetency proceedings was a legal mechanism chosen by the guardians as a way to deceptively increase their own financial worth.

Although the first public guardianship program began in Minnesota in 1917 (Teaster, 1997), by the end of the 1960's state public guardianship programs were becoming more prolific, in large part to address third-party interests. Regan (1971-1972) reported on California, Kentucky and North Carolina's public guardianship programs. He referenced the publication of the *Handbook of Model State Laws* by the Legal Research and Services for the Elderly, which contained information, designed to assist states in implementing public guardianship. For example, in 1970, Kentucky authorized the Department of Mental Health to serve as the state's public guardians. In explaining Kentucky's limited guardianship program Regan wrote, "The effect is to permit the release from state hospitals and placements in a nursing home or boardinghouse of many patients who might otherwise continue to be confined because they had no one to help them" (p. 610).

Regan's (1971-1972) statement verifies that third-party interests played a significant role in the initiation of Kentucky's public guardianship program. Moreover, the observable outcomes are distinguished by the residential placements chosen by the public guardian. However, this article written in 1971 predates the impact of the American Disabilities Act and the Supreme Court's Olmstead decision. Prior to those legal actions, trans-institutional placements were the most convenient remedies for emptying state psychiatric hospitals during the early years of deinstitutionalization.

Alexander and Lewin's (1972) study reviewed over 400 guardianship cases. They agreed with previous legal scholars that guardianship appeared to be designed to serve third-party interests. Through casework and law review in conjunction with personal interviews, they determined that "in almost every case examined, the aged incompetent

was in a worse position after he was adjudicated than before. The study could identify no particular benefit which flowed to the incompetent that he could not have received with a finding of incompetency" (as cited in Teaster, 1997).

Horstman (1975) described the guardianship system as one designed to protect the elderly from "themselves and from unscrupulous third parties" (p. 215) yet concedes little protection is offered to the adjudicated person. Horstman (1975) provided clarification between the differing functions between *police power* and the doctrine of *parens patriae*. Police power, being the more adversarial authority, instills formal due process. Unfortunately, the rationale for the court acting as a sovereign benefactor results in a loss of judicial formality, which in turn allows for the absence of the individual's right to due process. Guardianship and conservators proceedings are deemed as non-adversarial and categorized as components of adult protective services. Horstman (1975) found that, while guardianship programs may implore benevolent intentions, the reality is their actions are more punitive than helpful while simultaneously concealing the adverse interests of third parties. The author concluded that benefits to the ward mirrored those of Alexander and Lewin (1972).

Mitchell (1978-1979) reports similar findings when she wrote; "Regardless of who petitions for guardianship, the actual impetus for a guardianship may stem from a demand by an outside third-party, whose existence and interests are not apparent on the face of the petition" (p. 1439). She also theoretically agrees that guardianship is a protective service for the elderly but warns that in actual practice it is coercive tool for social supervision as evidenced by its ability "to move the poor from one residential facility to another" (p. 1444). Mitchell's recommendations for reform are not mere

cosmetic changes to regulations or additions to a strained work force; rather she advocates for radical changes within our educational, economic and social welfare systems as the simple solutions currently in play only serve to punish and stigmatize the less fortunate.

Seeking guardianship placements by third parties generally serves as a mechanism for securing payment, obtaining consent for care or assistance with discharge planning. Over time, these measures have not abated. Although, more recent studies specific to third-party incentives have waned, it is commonly referenced in books (Schmidt, 1996; Teaster et al., 2010) national reports (Teaster, et al., 2007; U.S. Senate Special Committee on Aging, United States Senate, 2007) and academic literature (Schmidt, 1984; Moye, et al., 2007; Teaster, 2003) as a primary motivation for the filing of guardianship petitions.

Determinations of Incompetency/Incapacity

The inconsistency of judicial standards for determining capacity is a distinct area of discussion within guardianship literature. Early writing clearly identified this issue as a major national concern which would have to be resolved through individual state reform (Alexander & Lewin, 1972; Horstman, 1975; Mitchell, 1978-1979).

The National Law Center of George Washington University found statutory definitions for incompetence lacked any meaningful instruction for physicians and attorneys involved in competency determinations. Participants in their study rated the incompetency definition as one that “has no psychiatric meaning” or “ambiguous as hell” (Allen, Ferster & Weihofen, 1968 as cited by Schmidt, 1984, p. 354).

As late as the early 1980's state statutory language contained outdated terminology for incapacity thereby allowing guardianship appointments for 'idiots', 'lunatics', 'persons of unsound mind' and 'spendthrifts'. Today, many states continue to reference mental conditions as mental disability, impairment or deficiency (Quinn, 2005). Teaster, et al., (2010)

The vague criteria standards are problematic for all professionals involved in the adjudication proceedings. Kjervik, et al., (1994) conducted focus group interviews with healthcare professionals, legal professionals and family caregivers involved in the guardianship process. The purpose of their study was to explore what differing professionals and layperson believed regarding the most important factors to consider when making capacity determinations. Content analysis from the transcribed focus group discussions showed four broad categories relevant to assessing competency; 1) awareness; 2) cognition; 3) decision-making; and 4) communications. Laypersons placed a greater emphasis on decision-making and interpersonal problems, while healthcare professionals stressed the importance of potential underlying physical disorders that may be affecting cognition. Legal professions mentioned specific functional abilities more than the other two groups. The person's ability to control impulses, which can result in violence to others, was a concern expressed by the judges and attorneys. Although, the criterion chosen was remarkably similar across the groups, their unique emphasis on specific factors lead to disagreement in their assessment findings. This difference in interpretation of criteria makes an impartial assessment process an elusive one.

Beyond the differences in capacity determinations by unrelated disciplines is that similar disagreements may occur within a single professional group. Marson, McInturff,

Hawkins, Bartolucci & Harrell (1997) investigated the amount of agreement between physicians on judgments of capacity to consent to treatment for normal adults (control group) and for those adults diagnosed with Alzheimer's disease (AD). Competency judgments of physicians showed high agreement among the control group (98%) but low agreement (56%) for those diagnosed with dementia. In a subsequent study (Marson, Earnst, Jamil, Bartolucci & Harrell, 2000) physicians were provided a standardized instrument for competency assessments in conjunction with education on legal standards for competency. This intervention resulted in higher levels of agreement among physicians. For the AD group, agreement ranged from a high of 84% (evidencing a treatment choice) to a low of 67% (appreciating consequences of treatment choice). Mean percentage agreement for personal competency was a judgment of 76%.

The use of standardized national assessment instruments is ineffectual given that each states defines its own standards for the burden of proof criteria (Teaster, et al., 2010). However, the American Bar Association (ABA) (2006) provides resources for legal professionals, which recommend the use of a comprehensive assessment, based on their self-described *Six Pillars of Capacity*. The first "pillar' is consideration for any medical condition that could be the organic cause for diminished capacity. Contemplation should also be given as to whether this is a permanent condition or rather one that is temporary or reversible. Second, is the a person's cognitive functioning ability; a standard in many states. This aspect of deliberation involves a person's level of alertness, memory, language and reasoning. The third important factor for consideration is the "everyday functioning component." Attention to this component is an attempt to counter the vague and subjective language often found in state statutes. For example, criteria

language such as “incapable of taking care of oneself” could be revised to “inability to meet personal needs for medical care, nutrition, clothing, shelter or safety” (p. 4). The fourth capacity factor is based on evidence supporting a consistency of choices with values, preferences and patterns. Autonomous decisions associated with a lifetime of values are rational to the individual even if those values are outside the norm of society. The fifth pillar of consideration is “risk of harm and level of supervision needed” and should be considered when determining not only capacity but also the need for environmental supports. Low risk can be addresses through less restrictive measures than full guardianship. Lastly, the means to enhance capacity should also be included in the determination of capacity and potential interventions to increase a person’s level of self-determination. Consideration of all six components would improve the capacity determination process, however despite this the *Six Pillars of Capacity* document being freely available from the ABA (2006) there is “a very wide range of practices in determining capacity with no consensus.” (Helmes, Lewis & Allan, 2004, p. 823).

Recent literature on guardianship assessments continues the trend of noting inadequacies within the determination process. Roof (2012) reported a review of 298 adult guardianship cases in three states that revealed that capacity evaluations were found to be illegible, lacked comment on functional deficiencies and made only general conclusions about decision-making.

Arias (2013) reports similar findings on the deficiencies within capacity assessments process and describe the current situation as one that does not allow for a “balance between autonomy and safety” (p.159). The author recommends inclusion of the ABA (2006) *Six Pillars of Capacity* in his revised model for capacity determinations.

This new model will reflect both a medical model (domain and risk specific) but also account for the realities of every individual's potential for progressive decline. He advocates for interim measures that provide for legal protections designed for those that fall between full determinations of competent to incompetent. Given the impending growth of the U.S.'s elderly population, his advice for more limited and thereby less restrictive interventions appears to be a prudent realistic measure long overdue for serious consideration and discussion.

Loss of Autonomy and Civil Rights

Early guardianship studies cited a plethora of concerns involving the loss of rights for those placed under the control of a guardian (Fratcher, 1965-1966; Alexander, Brubaker, Deutsch, Kovner & Levine, 1969-1970; Alexander & Lewin, 1972). Horstman (1975) compared the adult ward as being someone reduced to the "status of a child in the eyes of the law" (p. 231). So significant is the impact of guardianship that it was described as being more restrictive than incarceration (Heap v. Roulet, 1979 as cited by Schmidt, 1996). Dr. Dennis Koson, a forensic psychiatrist stated "Guardianship is a process that uproots people, literally 'unpersons' them, declares them legally dead" (Bayles & McCartney, 1987). Undeniably to be placed under the *protection* of guardianship commonly leads to the confiscation of a person's previously intrinsic human rights.

The loss of these rights include the right to make contracts, to marry or divorce, to vote, to choose where one lives, to travel, to lend or borrow money, to defend against lawsuits, to engage in certain professions, to serve on jury, to keep or care for children, to

appoint representatives, and to refuse or consent to medical treatment (Horstman, 1975, Teaster 2003, Schmidt, 1996). Any such curtailment would be disastrous to one's self esteem, but the combination of all these restrictions leads to what Horstman (1975) referenced and which was later characterized as "legal infantilization" (Schmidt, 1996, p. 6).

Bell, Schmidt & Miller (1981) were critical of guardianship's ability to provide protection to its wards. Their study focused a review of public guardian statutes in 34 states including visits to six selected states (Delaware, Minnesota, North Carolina, Ohio, Washington and Wisconsin). They endorsed less restrictive alternatives to guardianship and while also strengthening adult protective services to prevent abuse, neglect and financial exploitation.

The exploitation of incapacitated persons was portrayed in two different newspaper exposés 18 years apart. In 1987 the Associated Press (AP) published a five-part series on guardianship programs in all 50 states and the District of Columbia. Their investigation revealed the system was failing many in need of support and protection. They examined over 2,200 randomly selected guardianship court files to determine the quality of services wards received. They found those facing criminal convictions were afforded more stringent due process protections than someone experiencing the likelihood of guardianship appointment. In 44% of the cases reviewed, no legal representation was provided to the respondent. Thirty percent of the files contained no medical evidence and 49% of the respondents were not even present at their court hearing. Additionally 25% of the files contained no documentation to prove that a judicial hearing was ever held. Anecdotal examples of persons unaware of their guardianship status included a woman in

Florida who first learned of her status when she was turned away at her voting precinct. A Vermont woman was informed by the nursing home she could no longer spend any of her discretionary funds without her guardian's permission.

Beyond the issue of notification and due process, the AP report provided multiple examples of wards being exploited or neglected. A 92-year-old woman was found living in filthy condition in an adult congregate facility owned by her guardian. Payments to car dealers were found in files in both South Carolina and Texas even though driving privileges are revoked for those under guardianship. In Montana, an elderly man was found ill and alone in a cabin yet the self-described "friends" that served as his guardian could not produce any record of what happened to his previous bank balance of $131,000.

In 2005, the *Los Angeles Times* reported on the actions of privately owned professional guardians and conservators appointed by the courts to act in the best interest of the incapacitated person. They examined over 2,400 conservatorship cases. *Times* staff discovered numerous cases where conservators steered business to friends and relatives while others took cash and jewelry while simultaneously deducting their monthly fees from their clients' bank accounts. One particular case illustrated how the system can take advantage of a respondent, as he was required to pay for all attorney's fees; prosecutorial and defense. In 1996, Harry Cassel, 80 arrived in the Los Angeles' Probate Court to fight against his family's wishes to have a professional conservator appointed for him. Despite his attempts to maintain his autonomy, an appointment was made, however Cassel appealed the decision. The higher court dismissed the lower court's decision and ultimately Cassel won his case. He died shortly thereafter. Attorney

fees for both sides amounted to $400,000, which devoured his entire estate (Leonard, et al., 2005).

Teaster (2002) conducted the first known study on the ward's perception of their guardians and the system that had placed them under their control. Wards were selected from six sites in four states. The sample included six public guardians and 13 wards living in a variety of settings. The wards were selected based on their cognitive and communication capabilities. They ranged in age from 28 to 109 years old. Twelve of the 13 wards lived in some type of residential facility and their wish to return home and live independently was their most frequent request. One ward, age 83, stated he would most like to "get up and go out when I can. I feel like a prisoner." (p. 347). Another ward asked to be reminded of what day it was so she could attend church. Two others requested more contact with their family. Other requests included a desire for more privacy, owning a pet, and permission to go shopping.

While some wards could not remember who their guardian was or understand that they were wards, three felt their guardians did not care about them as individuals while two others expressed resentment about the intrusive nature of guardianship. Teaster (2002) offered several recommendations to improve relationships between wards and guardians. First guardians should take greater care in assuring the needs of the wards are met. Documentation should be improved to include the ward's value history to assist in future decisions that would more closely align with their true desires. Equally important to the documentation standards would include a psychosocial component. Guardianship workers should have more training in the area of "gerontology, nursing, mental health, ethics, law, social work and public administration" (p. 349). She concludes with a call for

further research to improve guardianship interventions, as the preservation of the ward's sense of autonomy is imperative for this arrangement between ward and guardians to be based truly on beneficence.

Two phases of research conducted in 2004 and 2007 culminated in the findings of Teaster, et al. (2010) in their *book Public Guardianship: In the Best Interests of Incapacitated People?* By first utilizing the findings from the seminal work conducted by Winsor Schmidt and colleagues (Bell, Schmidt, & Miller, 1981 as cited by Teaster et al., 2010) they sought to compare current data to the 1981 study. The earlier study's purpose was described as one "to assess the extent to which public guardianship assists or hinders older persons in securing access to their rights, benefits and entitlements" (p.2). In addition, they updated statutory information, created a model statute and developed state profiles on their respective public guardianship programs. Information and assessments of nine public guardianship programs in six states provided the case studies analyzed in their report. Further investigation included review of public guardianship statutes in 50 jurisdictions (49 states and the District of Columbia). Absent from the study was Nebraska as it is the only state without a public guardianship program. The study produced 25 conclusions with corresponding recommendations for improvement.

Relevant to this discussion on autonomy and civil rights restrictions, the researchers discovered the population served by public guardianship is rapidly changing. This newer cohort under guardianship now includes younger individuals with a range of disabilities including mental illness, intellectual and developmental disabilities, traumatic brain injuries and chronic substance abuse (Teaster et al., 2007; Teaster et al., 2010). This differing population with its fluctuating needs and more mobile capabilities changes

guardianship responsibilities significantly. Rights and liberties taken from an elderly person with dementia in a nursing home bed may have fewer consequences than when interacting with a 45-year-old alcoholic with a brain injury living in the community. Issues for this group can include elopement, criminal behaviors, sexual misconduct and physical aggression, all of which a public guardian has little control over and the awareness of their behaviors is most always after the fact.

Eleven states contract with private vendors for public guardianship services. Teaster et al, (2010) warns that outsourcing such a complex program as guardianship may produce a potentially perilous situation for the incapacitated. Although the authors recommend public guardianship be provided by a governmental entity, of equal concern is when a social service agencies is selected as the authority over guardianship. Although this model is utilized in 32 states and may appear to be a logical placement due to staff expertise in services and resources, potential conflicts of interests are pervasive. The ability to fervently advocate for the incapacitated person and to assess needs in an unbiased manner is greatly diminished in this model. They concluded, “the person’s physical and mental outcomes may be adversely affected” (p. 125).

People in guardianship become powerless and remain at the mercy of their guardian’s decision making. Public guardians should seek to know and understand their clients not as a collective caseload but as unique individuals. Although the responsibility can be immense, people deserve individualized attention as they rely on others to provide protection of their physical safety and financial security (Teaster, 2007a).

Insufficient Funding and Personnel

The accelerated growth of America's aging population coupled with advances in medical technology designed to prolong life (but not necessarily avoid mental decline) has moved from a futuristic concern to an imminent crisis. Today's healthcare system does not properly serve individuals with a psychiatric disability and is not prepared to meet the looming geriatric mental health crisis certain to come. The number of older adults with significant psychological disorders is anticipated to quadruple from 1970 to 2020 (Jeste, 1999). These population predictions impact all areas of social services for both the elderly and incapacitated including guardianship. The need for reforms and for a greater number of public guardians could not be more apparent. Unfortunately, this is not new information or a new predicament for public guardianship programs.

Over thirty years ago, a study was conducted to determine the need for guardians in Florida. Seventy-four public facilities, community mental health centers and clinics, 30 private facilities, 11 Aging and Adult Service districts and six state mental hospitals were surveyed. The results reported 2,842 persons who had been found legally incompetent had no guardian. An additional 6,054 persons were assessed by social workers and deemed in need of guardianship but since no guardians were available adjudication never occurred. The service workers reported another 2,251 clients they thought would be eligible for guardianship services if they were available (Schmidt, 1984).

Teaster et al., (2007) reported the predominant weakness of the public guardianship programs is the lack of funding. In the seminal study conducted by Schmidt et al., (1981) states did not disclose their funding sources. However today it appears public

guardianship funding comes from a variety of different sources including general funds from the federal, state and county levels, Medicaid reimbursement, estate recovery, grants, private donations and collection of fees from client assets. Costs per case are estimated at an average of $1,850 per year per client (Teaster, et al., 2010). This lack of funding is also a barrier to the courts systems that may attempt to implement guardianship reform initiatives, but also lack the funding to do so (Quinn, 2005).

The lack of consistent and appropriate funds results in a lower number of guardianship personnel being hired and consequently inappropriately high caseloads for those that are employed. The lack of funding was identified in much earlier studies (Siemon, Hurme, & Sabatino, 1993; Schmidt, 1995) with acknowledgment that public guardians were “typically overworked and inadequately compensated” (Teaster, 2003, p. 398).

Caseloads for public guardians vary greatly across states. “Schmidt’s et al. 1981 study (as cited by Quinn, 2005) found states to have very high caseloads. Year later Schmidt (1995) recommended no office be responsible for over 500 wards and each professional in the office be not assigned more than 30 clients. Teaster et al., (2010) reported on a 2004 study that illustrated the range of caseloads among state guardians. The lowest was 1:2 for a new program in Florida to a high of 1:173 in New Mexico. The average was 1:36. The amount of time guardians spent with their clients ranged from one hour twice a year to some over 20 hours per week. The Council on Accreditation (COA) recommends a ratio of 1:20 to help ensure improved outcomes for clients (COA, 2013).

Lack of Oversight

Once the adjudication process is complete, incapacitated persons typically live out their lives under the control of their guardians since revocation of guardianship is exceptional. As previously, discussed public guardians are typically state employees with large caseloads who are over burdened by the multiple and complex tasks their position requires. Funding for guardianship is not sufficient to provide adequate staffing as well as personnel assigned to provide compliance oversight or program evaluation (Johns, 1997; Teaster, 2003).

Accountability of public guardians is rarely discussed until litigation and/or media coverage brings a specific case to light. Schmidt, et al., (1981) noted needed reforms for public guardianship, which included increased oversight. Later research reaffirmed Schmidt's proposed solutions for national standards and minimum requirements for monitoring services and financial accountability (Siemon, et al., 1993).

An example of media attention, which brought the court's lack of oversight to the public's attention, can be illustrated by the 2002 District of Columbia Court of Appeals case concerning Mollie Orshansky. Ms. Orshansky was well known for her seminal work in developing the federal poverty threshold during President Lyndon Johnson's Administration's War on Poverty (Fisher, 1992). In a lower court ruling, Ms. Orshansky's advance care directives and desire to live near family was ignored by her guardian. The Appeals Court ruled the lower court had acted in an abusive manner as they had disregarded her wishes. This court case triggered a *Washington Post* article that concluded there had been "chaotic record-keeping, lax oversight and low expectations

in….” the D. C. Superior Court, which fostered a culture that rarely held guardians accountable for neglect, abuse or exploitation of their wards.” This investigation spawned similar reports by other newspapers across the country (United States Senate Special Committee on Aging, 2007, p. 14)

Teaster (2003) concluded from her qualitative study with public guardians in Delaware, Maryland, Tennessee and Virginia that given the tremendous power public guardians have over their clients, intensive scrutiny of their actions should be well established. Sadly, her results indicate only mechanical accountability currently exists; meaning statutory language exists as guidance but meaningful checks and balances continues to be absent. She advocates for a more meaningful examination of surrogate decision making practices and financial oversight. Her recommendations are based the concepts of normative values and democratic governance in order to improve the process through internal and external audits designed to expose exploitation and regulatory noncompliance. Teaster (2003) argues that the "[I]ncapacitated citizen deserves rigorous accountability for decision making that curtails inappropriate abuses of power and enables public administrators to fulfill multiple and complex roles."(p. 402).

Teaster (2003) acknowledgement of automatic accountability aligns with the findings by the United States General Accounting Office (GOA, 2004). In their report to the U. S. Senate Special Committee on Aging, they find states have laws that require the courts to oversee guardianship; however the implementations of these programs vary significantly. Nearly all the states require two types of reports; personal status and financial. Personal status reports may require a physician's statement or details on mental status, living conditions, or number of guardian visits. Financial accounting reports may list assets,

bank balances, property holdings or detailed expenses. The timeliness of reporting varies from annually to once every three years. However, fewer than half the states require the courts to review the reports. Court discretion as to who reviews is often a common practice.

Although guardianship is a state responsibility, persons found incompetent by the state are often times receiving federal benefits. The GAO's (2004) study confirmed a lack of coordination among state and federal agencies. As an example, the Department of Veteran Affairs (DVA) and the Social Security Administration (SSA) do not necessarily notify other agencies or the court when they identify someone as incapacitated or when they discover representative payee exploitation.

The GAO (2004) sent surveys to 58 superior courts in California, 67 superior courts in Florida and 12 judicial districts in New York. The survey response rate was tabulated as the following: 42 (72%) for California, 55 (82%) for Florida and 9 (75%) from New York. When asked if annual financial statements were required to be submitted to the court, 13 of the 42 responding California's courts stated they did require court submissions. In Florida, 50 out of 55 responded in kind. Only in New York did 100% of the respondents report they required annual financial reports to be submitted. The number was lower for reporting requirements concerning personal status with California, Florida and New York reporting a compliance rate of 21%, 46% and 77% respectively.

Although guardianship reform discussions have continued through the literature and resulted in efforts to revise guardianship statutes, training, and court practices, in 2005 the American Association of Retired Persons (AARP) and the American Bar Association

(ABA) Commission on Law and Aging conducted a national internet-based survey on how courts monitor guardianship cases. Approximately 1,200 surveys were sent to guardians, probate judges, court managers, elder law attorneys and legal representatives for individuals with disabilities. Three hundred and eighty seven responses were received (32%) from 43 states and the District of Columbia. Survey results indicated 74.2% of respondents reported their state requires annual filings on personal status and 87.2% for financial accounting. Only 19.9 % of the respondents reported the court routinely sends forms to be filed and more than 40% claimed no samples of reports or accounting was available to them to utilize. Clearly, report submissions differ in format and quality to such an extent that standardized reporting is unachievable (Karp & Wood, 2007).

More than half the respondents (50.6%) indicated financial accounting was reviewed by a court auditor. Other financial reviewers included court staff, judges and other assigned parties. Survey respondents that reported no one had such responsibility on a regular basis were 8.5%. Regular review of personal status was the responsibility of court staff as reported by 36.7% of respondents followed by judges (30.5%). Verification of these reports was confirmed by only 16% of the respondents. In cases when reports may indicate an issue of the incapacitated person’s well-being, only 38% reported the courts initiated further investigation. This lax of oversight was highly correlated to lack of funding. Only 10.9% of the respondents claimed funding was available, with over two-fifths (43.4%) of the respondents stating that funding for monitoring was unavailable or insufficient (Karp & Wood, 2007).

Insufficient Data and Research

In order to provide oversight to any guardianship program, funding is imperative, but equally important is access to accurate and comprehensive data. The GAO (2005) and Karp & Wood (2007) reports concluded there is little state level data on guardianship and a comprehensive national database is non-existent. The U. S. Senate (2007) concurred with the previous findings and agreed that the lack of accurate data remains a barrier to understanding the extent of the problem and prevents reliable predictions for coming trends to be determined with any sense of realism or validity.

The Court Statistic Project (CSP) called guardianship data "woefully deficient" (Uekert & Schauffler, 2008, p. 1) and pressed for solutions and appealed that a concerted effort be made to rectify the current state of data collection. Using the incomplete data provided to the CSP initial observations included 1) few states report complete statewide data; 2) adult guardianship and conservatorships are often not reported as distinct case types; 3) the rate which states file guardianships cases is highly divergent; and 4) any trends to interpret are suspect due to the lack of data.

The National Center on Elder Abuse (NCEA) requested the ABA's Commission on Law and Aging to conduct an exploratory study on adult guardianship data collection. The NCEA recognized that with the demographic trend of an increasing elderly population in conjunction with an increasing number of younger adults with intellectual disabilities, developmental disabilities and mental illness, the need for a comprehensive uniform data collection is becoming of paramount importance. The Commission sent electronic surveys to all 56 state and territorial count administrations which resulted in a

total of 47 responses. Their findings indicated that 66% of state court offices do not receive trial court reports on filings and dispositions for adult guardianship for either person or property as a distinct case type. The information received only provides the number of filings and dispositions. Only five states report elder abuse as a distinct case type. Less than half of the responding states (44.7%) indicated they were interested in compiling data but named substantial barriers. Obstacles cited by the responding court offices included these findings: 1) statewide data is unavailable, 2) data elements are not standardized, 3) procurement of data is cost prohibitive, 4) the lack of technology and training and outdated computer systems makes the task impossible and 5) the sheer volume of cases makes the task too labor intensive for an already understaffed agency (Woods, 2006).

A subsequent online survey was conducted in 2009 by the National Centers for Elder and Courts (CEC) on the behalf of the Conference of Chief Justices (CCJ) and Conference of State Court Administrators (COSC). Results were not nationally representative as the findings were based on a convenience sample from key association list serves. However, the findings were similar to the previous surveys. Quality of data on guardianship cases were generally lacking in accuracy as only 13 states and the District of Columbia could report complete statewide data. However, upon closer inspection the inconsistencies within the states suggested that what had been reported was either incomplete or inaccurate. Difficulties in collecting data included the lack of statewide case management systems and official notification procedures consistently followed between court jurisdictions. What data is available appears to have been collected through a random patchwork process (Uekert, 2010). This lack of meaningful data is

problematic for guardianship evaluation, recommendations for reform and appreciation for future needs as the current state of guardianship remains relatively unknown.

Guardianship Recommendations for Reform

Despite the multifaceted concerns that continue debate within the guardianship literature, recommendations for improving the process have endured as a significant area of the discussion since the late 1970's. In 1979, the Commission on the Mentally Disabled began their analysis of issues related to limited guardianship, public guardianship and adult protective services. Their efforts resulted in a model guardianship statute as part of its Developmental Disabilities State Legislative Project to provide direction for state legislative guardianship reform (American Bar Association (ABA), 1989).

A decade later the ABA sponsored a symposium to address continuing concerns and offer potential solutions to problems found with particular guardianship arrangements. In the summer of 1988, thirty-eight guardianship experts met at the Johnson Foundation's Wingspread Conference Center for two days to participate in this national guardianship summit. Experts included probate judges, attorneys, service providers, physicians, mental health experts, governmental officials, law professors, aging network representatives and a bioethicist. This conference later known as the *Wingspread Symposium* provided 31 recommendations with which all but two were subsequently adopted by the ABA House of Delegates.

The first recommendation was to encourage other alternative actions before any consideration of guardianship become necessary. As example, the execution of a Durable

Power Of Attorney (DPA) could assist the person with healthcare payments and healthcare decisions thereby reducing the number of petitions fueled by third party interests.

Months later this highly agreed upon recommendation to utilize a DPA to circumvent the need for guardianship was tested in the 1989 Kentucky Supreme Court Case *Rice v. Floyd*. The court refused to uphold a lower court's ruling that a DPA precluded the trial court from establishing a need for guardianship. The Supreme Court found a DPA does not make a guardianship appointment automatically unwarranted and the intent of the DPA was to "validate the acts of the attorney-in-fact during a period of actual disability prior to a finding of legal disability" (p. 578). No other court has agreed with Kentucky's Supreme Court. Conversely, Pennsylvania courts concluded in a case similar to *Rice v. Floyd*, that the needs of the incapacitated are met under the DPA provision. The Kentucky case is inconsistent to the legislative objective of both the Uniform Probate Code (UPC) and the Uniform Durable Power of Attorney Act (UDPA) (Stiegel, Mason, Morris, Gottlich & Rave, 1993).

Additional *Wingspread* recommendations called for a standardized performance evaluation and comprehensive data collection as well as improvement for each phase in the guardianship process including proper procedures for petitioning of the court to quality standards for adjudication orders as well as the inclusion of rights restoration (ABA, 1989).

In 2001, a second national guardianship conference was held to examine the progress made in the 13-year interim. Known as the *Wingspan Conference*, attendees

came from several national discipline-specific associations. National organizations in attendance included the National Academy of Elder Law Attorneys, the National College of Probate Judges, the National Guardianship Association, the Centers for Medicare Advocacy and the American Association of Retired Persons. Three distinct areas of current reforms were identified; 1) procedural; 2) operational; and 3) avoidance. The conference attendees concluded that legislative reforms had been significant but actual practice and outcomes for the wards were barely perceptible as the lack of data available on guardianship was "scant" (p. 593). The expectation expressed by conference members encouraged support for a national guardianship network throughout all 50 states with the intent that such action would produce improvements in the quality of life among guardianship wards while also creating a mechanism for data collection to assist with evaluation and research (Johns & Sabatino, 2002).

Teaster, Wood, Schmidt & Lawrence (2007b) issued the recommendation to adopt the Model Public Guardianship Act based on the findings of the multi-state study. Their focus was to create a public program that was independent from interagency conflicts and provided for the least restrictive environments with respect for the incapacitated person's autonomy. Quality assurance measures and public accountability were also important facets of the model. In order to provide the highest quality, guardians should work from a county level office, have professional credentials in law, social work or psychology and possess a caseload no higher than 20 clients.

Teaster et al (2010) further examined the multiple state models and provided 29 distinct recommendations. Again, the Model Public Guardianship Act was promoted as the best solution to address problems related to public guardianship's structure and

implementation. Although the majority of states possess a social service agency model, Teaster et al (2010) warn such a model should be avoided due to its inherent conflicts of interests. Standardized forms and reporting instruments were recommended as a way to improve data collection and program evaluation. Public guardianship should also be subject to external audits and evaluations from an outside agency. Lastly, future areas of research were also provided as a priority recommendation. Research initiatives needed include longitudinal studies, incapacitated persons with a mental health diagnosis, fiscal accountability, exploration of other types of external funding including Medicaid and the roles of professionals involved in the guardianship process.

The enhancement of guardianship accountability has been a continuing theme throughout the years of guardianship reform recommendations. Woods (2012) provided "Five Systemic Solutions" to reduce the need for guardianship petitions and increase accountability. The "Five System Solutions" are 1) to work collaboratively with other agencies to consider alternatives to guardianship; 2) provide guardianship training to better understand issues of abuse, neglect and exploitation; 3) criminal background checks on potential guardians; 4) increase court monitoring for guardians reporting and physical welfare of the incapacitated; and 5) courts and community stakeholders improve guardianship accountability through collaboration and discussion.

Throughout decades numerous recommendations have continued to be offered. However, the problems from yesterday continue on into today, unfortunately, as the need increases and the diversity of the cohorts intensify; implementing reforms becomes more complex.

Summation of National Guardianship Trends

Guardianship is a legal mechanism that has existed for centuries. Throughout this expanse of time the conflict between a person's right to self-determination and the beneficent yet paternalistic actions of the state has remained. Today social work professionals are involved with guardianship proceedings and outcomes in a vast array of roles and responsibilities, yet because of a lack of education about in conjunction with the lack of clarity within the law; generalist social workers are often challenged when working with this unique population.

Despite numerous calls for reform the excessive number of issues involved with guardianship remains. Third-party interests often initiate guardianship proceedings based on a pursuit self-interest that may disregard the needs of the respondent. Incapacity determinations are inconsistent due to variation among court proceedings, ambiguous statutory language and differing assessment criteria. The loss of autonomy and civil rights for the incapacitated is significant which can result in harm to self-esteem and the individual's quality of life. Guardianship programs are hampered in their own ability to provide competent care for the incapacitated as insufficient funding has remained a constant obstacle when implementing and operating public guardianship programs. This lack of funding is not simply confined to public guardianship as the offices of the state court systems also suffer from insufficient state allocations. The strain on court personnel consumed with high caseloads has resulted in a lack of oversight and inability to address the quality of care for persons under guardianship. Lastly, empirical knowledge concerning guardianship is difficult to ascertain, as the data submitted may not be valid and comprehensive data among all states is non-existent. The lack of quality

measures has subsequently led to a limited availability of quantitative guardianship research. All the above concerns have initiated reforms and recommendations for additional improvements from multiple sources. Although some of these recommendations have been implemented, many remain elusive due to fiscal and personnel restraints. The lack of meaningful data continues to present as a barrier to understanding the nature and outcomes of guardianship from the perspective of all parties involved.

This study's unique subset population of incapacitated persons with criminal behaviors will be limited by the above-mentioned factors. Although data are available, it involves only the reported experiences within one state and therefore may not be representative of the issue on a national level. However, research in this field is important. Public guardianship is a product of multiple disciplines including social work, law, medicine and psychology. Additional research is necessary in order to improve public guardianship's performance. Without evaluation and improvements, it remains a program that can easily result in creating more harm than good (Teaster, et al., 2010). This overview of national guardianship explains many of the vexing issues facing Kentucky's public guardianship program, however, the following state specific information will provide more precise contextual knowledge as to better understand the uniqueness of issues upon which this study is based.

Kentucky's Public Guardianship Program

Susceptible Populations in Kentucky

In 1970, Kentucky authorized the Department of Mental Health to serve as the state's public guardians (Regan, 1971-1972). From 1970 to 2010, Kentucky's aging population increased by 35 percent, a significant change from the preceding decades (U. S. Administration on Aging, 2012). In the last ten years, persons aged 65 and above increased by 73,434 or 14.5 percent (Bowling, Hoyt, Blackwell & Childress, 2013). Not only have the number of elderly Kentuckians increased but other unique populations subject to guardianship have grown within the state. In Kentucky there are an estimated 181,000 persons living with a serious mental illness (National Alliance of Mental Illness, 2010). Prevalence rates for intellectual disabilities (ID), ranks Kentucky as the second highest state in the nation (16.2 persons per 1,000) (Centers for Disease Control, 1996). The latest census data for Kentucky indicates the estimated 2010 state population to be 4,339,367 (US Census Bureau, 2010). Utilizing the CDC prevalence rate we can project there are approximately 70,000 Kentuckians with an intellectually disability. Furthermore, research informs that persons with an intellectual disability have a significantly higher rate of schizophrenic illness and phobic disorders (0.4% and 1.1%, respectively) than the general population. Equally disconcerting is the finding that with increasing age and physical disability, psychiatric illness also increased (Deb, Thomas & Bright, 2001).

Those persons with a traumatic brain injury may also be forced to experience the difficulties of an incompetency determination. Approximately one-fifth (19.4%) of

Kentucky households report that at least one family member has a history of a head injury resulting in an estimated 202,488 to 214,031 Kentucky residents with an acquired brain injury. The outcomes from brain injuries include increased memory problems (24.2%), increased depression (20.5%), increased anxiety (23.3%) and need for professional services following the injury (31.6%). Persons with traumatic brain injury show a high prevalence of substance abuse both prior to and after the injury. This finding suggests that drug and alcohol abuse might be a risk factor for a brain injury and vice versa (Walker, Logan, Leukefeld & Stevenson, 2004).

The culmination of all these distinctive population types in Kentucky indicates the need for guardianship will continue to grow. Schmidt (1984) warned that as deinstitutionalization intensified, civil commitments would become more restrictive and guardianship proceedings would increase. By all indications his prediction was accurate and Kentucky is facing an impending crisis due to its lack of preparedness for this impending and substantially increased need for public guardianship.

Organization

Kentucky's adult guardianship program has always been designed as a social service agency model. It began in 1970 as a program to be administered by Kentucky's Department of Mental Health (DMH) (Regan, 1971-1972). A 1984 court case *Commonwealth v. Cabinet for Human Resources* established legal precedent that the state's public guardianship program was the guardian of last resort, and therefore mandating that if no other individual or entity was willing to serve, the public guardianship program must accept all court appointments (Teaster et al., 2007). During

the 1990’s, the Office of the Public Guardian was placed within the Department of Social Services, which has since been renamed the Department for Community Based Services (DCBS). Although this change did not increase the number of guardians, there was a substantial increase in wards which has not abated. Consideration was given to the potential conflict of interest due to Adult Protection Services (APS) and Public Guardianship being housed within DCBS (Teaster et al., 2007). Under a Cabinet reorganization in 2008, the adult public guardianship program was transferred to the Department for Aging and Independent Living (DAIL). All of the departments have been within the same cabinet now known as the Cabinet for Health & Family Services (CHFS) (Anderson, 2013).

The current organization of Kentucky’s public guardianship program is based on county assignments to specified geographic regions. DAIL maintains a central office in Frankfort, Kentucky and manages seven regional offices. Based on the number of incapacitated persons for which they are the responsible the regions are as follows: Bluegrass (637 cases); Jefferson (594); Midwestern (534); Cumberland (498); Western (457); Northeastern Mountain (422); and North Central (354). As of May 2013, the totality of the regional caseloads resulted in a statewide census of 3,496, which serves as the model for which this study’s statistical analysis will be based. Within each region are guardianship personnel who consist of a Field Supervisor and public guardians; with the majority being certified social workers. Currently, there are 50 state guardians with an average caseload of 69 wards per guardian (Anderson, 2013).

Statutes and Administrative Regulations on Guardianship

Kentucky Revised Statutes (KRS) Chapter 387 provides the statutory authority for establishing Kentucky's guardianship program. The majority of these statutes became effective July 1, 1982. KRS 387.500 declares it was the General Assembly's intent and purpose to promote all disabled persons' well-being by providing protection from neglect, exploitation and abuse. Furthermore it states that if the court determines a disability it can be in varying degrees and partial guardianship is preferred over full guardianship. However, research on this outcome indicates that partial or limited guardianship occurs in only approximately 5% of the petitions (Teaster, et al., 2010).

KRS 387.510 provides the definitions for all the guardianship statutes and regulations. Terms legally operationalized include the following: conservator, limited conservator, guardian, limited guardian, standby guardian or conservator, testamentary guardian or conservator, developmental disability, disabled, partially disabled, mentally ill person, interdisciplinary evaluation report, interested person or entity, petitioner, respondent, ward and committee. KRS 387.530 through 387.590 provides guidance on the pre-adjudication process. This includes information on the evaluation report, notification of hearing, burden of proof and types of appointments. KRS 387.600 through 387.690 speaks to court appointment types, the guardian duties and annual report requirements. KRS 387.700 through 397.800 references powers and duties of conservators, emergency powers, court costs, and notices. KRS 387.810 through 387.854 is under the subheading of Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act. Issues involved with petition filings, appointments, court jurisdictions and transfers of guardianship or conservators between states are covered in this

subchapter of Chapter 387. KRS 387.580 mandates a jury trial for guardianship determinations. The six-person jury requirement is unique to Kentucky and over the last few years has been subject to legislative initiatives to overturn. To date such efforts have been unsuccessful (Teaster et al, 2007).

Explicit program implementation directives can be located in the Kentucky Administrative Regulations (KAR) Title 910 Chapter 2**:** Cabinet for Health and Family Services: Office of Aging Services. This title contains four administrative regulations instructing legal expectations on how the public guardianship program is to be implemented. The referral process for adult guardianship is described in 910 KAR 2:020. The regulation aligns with the statutes concerning definitions and provides detailed instructions on eligibility, referrals, applications, responsibilities for opening a case, and confidentiality. 910 KAR 2:930 provides requirements for accounting provisions, including a list of allowable expenses, steps for financial transactions and reporting criteria for the courts. The services provided through adult guardianship are covered in 910 KAR 2:040. It contains 27 distinct section topics, which include sale of real estate, decision making on behalf of the ward, guardianship visits, changing residential placements, health care decisions, involuntary treatment, deaths and cremations. Lastly, 910 KAR 2:050 concerns compensation for the guardianship program, which is performed by the Fiduciary Services Branch. With the exception of wards residing in family care or personal care homes, the Cabinet assesses a monthly compensation fee of 6% but cannot exceed $200 per month from a ward's excess financial resources. A ward's balance cannot be reduced to below $500 due to securing the compensation fee.

Other methodology rules for calculating any guardianship fees are also included in the regulation.

Policies and Procedures

Beyond the statutes and regulations, state guardians must follow the Guardianship Field Services Standards of Operation (SOP). Listed within the SOP are 57 unique policy statements created to advise workers on best practices for varying scenarios they may encounter. The most relevant Kentucky legislative statutes and administrative regulations support each policy statement. Also included are procedural steps the guardian must follow (Kentucky Guardianship Field Services, 2013).

As example, in the SOP's first policy statement (DAIL GField 1), the directive informs that CHFS may serve as guardians of last resort for a partially or wholly disabled person if there is a previous guardian that can no longer serve, or when no other suitable person is available. Legal statutory authority is based on KRS 387.500 Declaration of Legislative Purpose; KRS 387.600 Appointment-Consideration of Preference of Respondent; and KRS 311.631 Responsible parties Authorized to Make Health Care Decisions. Administrative regulative authority for this policy is based on 910 KAR 2:020 Section 2 Eligibility; 910 KAR 2:020 Section 3 Referral, Petition and Application for Individuals who are Not Adjudicated; and 922 KAR 5:070 Adult Protective Services. The procedure section provides instructions dependent upon varying scenarios such as if Adult Protective Services is involved with the case (Kentucky Guardianship Field Services, 2013).

Other policy statements involve topics such as annual court reporting, 24/7 responsibilities, emergency health consent, visiting the ward, pet ownership and hospice care. Based on the methodology design of this study, the policy on ward placement and movement is of upmost importance and is discussed below (Kentucky Guardianship Field Services, 2013).

DAIL Policy 36 instructs the guardian on ward placement and movement. The policy statement declares, "The Division of Guardianship strives to make provisions for the ward to receive the least restrictive and highest quality services from the most appropriate provider" (p.1). Kentucky Administration Regulation 910 KAR 2:040 Section 12 addresses this policy. State guardians are advised to develop and maintain a working knowledge of the "resources, services, providers and facilities" located in their region. The guardians should consider ancillary support services to best meet the needs of the individual in the least restrictive setting. Furthermore, the guardian should ensure that the living arrangements are "the most appropriate, least restrictive, environment taking into consideration the ward's wishes and needs" (Kentucky Guardianship Field Services, 2013, p. 1).

Should the ward be moved to a new location that includes "an acute care facility, nursing facility, psychiatric hospital, and other placements for persons diagnosed with mental illness and mental retardation may only be made after the Guardianship Field Office Supervisor (GFSOS) or designee: a) evaluates the physical and mental health needs of the ward by reviewing the recommendations of treating professionals; and b) determines the best care options". To approve any move, the guardian must make a request for a courtesy visit to the new location, attend the first plan of care meeting, and

visit the ward within 30 days of the move. For any voluntary or long-term care placement the guardian should consider how best to minimize substantial harm to the ward and "obtain the most appropriate care". Other duties related to a residential move include notification to the provider if the ward is listed on the Sex Offender Registry (as mandated by KRS 17.500 through KRS 17:540) and to update the new address in the state guardianship database within twenty-four hours of the move (Kentucky Guardianship Field Services, 2013).

The above review on guardianship at both the national and state level has provided an overview of the problems and potential reforms for a legal arrangement created to protect the vulnerable but implemented in a manner that insufficiently cares for the mentally incapacitated. Persons with psychiatric diagnoses, regardless of guardianship status must also deal with numerous other federal and state policies that have a dramatic impact on the quality of their lives, opportunities for treatment and barriers to care. The following will provide a historical overview of how such policies evolved and the current state of American mental health policy comprised of federal and state executive decisions, Supreme Court decisions and subsequent legislative actions.

Literature on U. S. Mental Health Public Policy, Legislation & Court Decisions

The following sections will review and discuss notable areas of development and implementation of U. S. mental health policies, Supreme Court decisions and Congressional legislative actions that have affected the legal status and treatment for persons diagnosed with a psychiatric disability. This specialized area of legal requirements is commonly referenced as mental health law.

For centuries and in almost every area of civil and criminal law, special rules have been designed to provide separate consideration for those proven to have a significant mental disorder. Although the legal system and mental health science are both concerned with the causes of human behavior, the court first assumes a person's actions are based on untethered free will and requires accountability for those actions based on its institutional values and morals. However, cases involving mental incapacity are viewed in an empirical and deterministic view, thus removing legal responsibility for deviant behavior if so deemed by the courts (Morse, 1977-1978).

Guardianship's judicial procedures are typically relegated to probate and eldercare law with its foundation based on the doctrine of *parens patriae* (Arias, 2013; Curtis, 1975-1976; Moye, et al., 2007; Teaster, 2002; Quinn, 2005). *Parens patriae* is also the foundational basis for a related area of legal study known as mental health law. This collection of statutes and regulations are designed to justify specific judicial interventions based on a person's varying degree of mental competency. For example, the term, "insanity" is generally used to refer to the degree of mental illness, which excuses a person from any criminal responsibility (Ross, 1959). Society believes that it should protect the public from dangerous people and protect certain persons from themselves. When cases involve an aspect of mental incompetency, then such circumstances necessitate exceptional legal provisions (Morse 1977-1978).

Topics within the realm of mental health law include involuntary commitment, the right treatment, incompetency to stand trial and the insanity defense (Appelbaum, 1994).

Development of U. S. Mental Health Policy

In colonial America the care of those described as "lunatics and persons furiously mad" was either provided through family custodial care or local almshouses. If a person's behavior was beyond control, they would typically be housed in a jail-especially if the person was poor (Grob, 1994, p. 44). During 1840-1850's Dorothea Dix traveled the country documenting the horrific conditions of these county jails and almshouses. She called the Massachusetts General Court's attention to the plight of the insane as being kept "in cages, closets, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience!" (Dix, 2011, p. 4). Dix advocated for specialized hospitals for the mentally ill based on a British model of care known as "moral treatment" which was a gentle restorative approach to care for persons deemed mentally disordered. Since such institutions offered a shelter from the stresses of the outside world they were named asylums. Dix was successful in her advocacy efforts as numerous state operated asylums were constructed across the country (Appelbaum, 1994).

Unfortunately, this organization of care for the mentally ill was vulnerable to economic and technological challenges brought on by increased urbanization. New sociological demands on the family and individuals resulted in a decreased tolerance for deviant behavior evolving away from moral treatment and into non-therapeutic custodial care. As the patient census in mental hospitals increased, societal support for care of the mentally ill declined (Mechanic, 2008). The 1908 publication of Clifford Beers' *A Mind that Found Itself*, advocated for improved institutional conditions and better treatment for psychiatric illness with efforts towards prevention. His writings sparked the 'Mental Hygiene Movement' and the focus on state hospitals began to shift. This became

markedly more apparent after the collapse of public funding during the Great Depression (Reid & Silver, 2003).

Psychiatry became more involved in making public policy making upon America's entrance into World War II. This was due in large part to their participation in the selective service screenings as millions of young men entered the military. During the years of 1942-1945, 1.9 million young men were deemed ineligible to serve in the armed forces due to psychiatric disorders. After the war, returning soldiers suffered from personal battlefield experiences brought mental health prevention and treatment to the attention of a patriotic America (Mechanic & Rochefort, 1992). Numerous newspaper articles expanded the public's awareness on the horrendous conditions within state mental hospitals as evidenced by the work of Albert Deutsch (Weiss, 2011). As a result, in 1946, Congress passed the Mental Health Act, which created the National Institute on Mental Health (NIMH). The intent was to "have a traditional public health approach applied to the mental health field" (Mechanic, 2008, p.102) through the provision of state grants designed to support or create outpatient mental health facilities (Grob, 1992).

In the mid 1950's the emergence of antipsychotic drugs created a new era in treatment for mental illnesses. These drugs help control bizarre behaviors and hence administrative changes occurred within state psychiatric hospitals. Security measures were lowered and hospital physicians became more receptive to hospital discharges. Lobbying efforts for more community-based services lead Congress to pass the Mental Health Study Act of 1955. This resulted in the creation of the Joint Commission on Mental Illness and Health which released a 1961 report titled *Action for Mental Health*

that set in motion the passage of the Community Mental Health Centers Act of 1963 (Mechanic & Rochefort, 1992).

The Community Mental Health Centers Act of 1963 federally mandated the construction of regional centers known as Community Mental Health Centers (CMHC) to provide inpatient and outpatient mental health services, 24-hour emergency services, partial hospitalizations, consultations and education. By 1969, there were 205 CMHCs established in the country, which later increased to 789 by 1980 (Watkins & Callicutt, 1997).

Deinstitutionalization

Beginning in 1963, concurrent with the establishment of CMHCs, deinstitutionalization became the official policy of the Federal government for the purposes of two distinct goals; 1) reduce the hospitalized mental health population and 2) provide mental health services in the community (Gronfein, 1985). There were many factors that led to deinstitutionalization. Mental hospital populations were growing but changing in demographics. State mental institutions served as a last resort for the disabled elderly, late stage syphilis patients, others with debilitating chronic diseases and disadvantaged immigrants. This increase in inpatient care created a heavy burden on state budgets and persuaded states to look for a cost shifting solution (Mechanic & Rochefort, 1992).

One of the most significant policy changes affecting U. S. mental health policy was the enactment of the Amendments to the Social Security Act in 1965. This federal action created two programs designed to assist the elderly, aged and disabled. Medicare, a

program for the elderly and disabled, paid for facility based care (Part A) and physician services (Part B). Since its beginnings, Medicare has allowed only a 190-day lifetime limit in public and private psychiatric hospitals as an intentional policy maneuver to limit long-term custodial care in state mental hospitals (Frank, 2000).

The second program to come from the amended Social Security Act was Medicaid, a joint state and federal system designed to provide healthcare to the poor. As a shared program between these two entities, numerous state and federal regulations are involved in its implementation and operation with each state Medicaid being unique in eligibility requirements and service options.

Eligibility for the program is determined by varying state requirements tied to the Federal Poverty Level (FPL), Social Security Insurance (SSI) or Social Security Disability Insurance (SSDI) payments. The federal government typically pays 50% to 70% of the costs incurred by the state operated program. Federal assistance is referred to as Federal Medical Assistance Percentages (FMAP) and is based on state per capita income. For example, from fiscal years 1965-2011, the federal government provided Kentucky with 65%-73% federal matching dollars to supplement their Medicaid expenditures (U. S. Department of Health and Family Services, 2013).

Medicaid provides payment for long term care in nursing homes and some other types of residential settings. However, from its inception the federal government has prohibited any payment to 'institutions for mental disease' (IMDs). Medicaid's IMD Rule states that reimbursement cannot be provided for patients age 22-64 who are being treated for a psychiatric disability in a facility of 16 beds or greater (Frank, Goldman &

Hogan, 2003; Zuvekas, 2010). The IMD rule incentivized state governments to move mental hospital patients to either community-based outpatient treatment (deinstitutionalization) or transfer them to nursing homes (trans-institutionalization) in order to receive federal financial assistance for treatment settings outside the restrictive IMD requirements (Frank, 2000).

The mere creation of CMHCs did not dramatically decrease the inpatient hospital population as anticipated. Gronfein (1985) examined mental hospital data against CMHC utilization records and determined higher CMHC activity was significantly associated with less deinstitutionalization. The clientele of the CMHC were not the seriously mentally ill. Data analysis indicated that nursing homes admissions that were much more highly correlated (.82) with public mental health decline. As mentioned previously, the IMD rule in conjunction with Medicaid reimbursements for long-term nursing home care resulted in a large number of transfers from mental institutions to skilled nursing facilities. Gronfein (1985) concluded, "Medicaid has a much stronger effect than the CMHC program, and suggest that the structure of reimbursement schedules, rather than the philosophy of community care was decisive in promoting deinstitutionalization" (p. 192). As states increasingly designed public mental health programs to maximize the influx of federal dollars, the number of mental hospital residents over the age of 65 fell from a 1962 census of 153,309 to 78,479 in 1972. During this same period persons diagnosed with mental disorders living in nursing homes rose from 187,675 to 367,586 (Frank, 2000).

Medicaid expanded the utilization of mental health services for the lower income population, but not necessarily those who were candidates for state hospital admission.

By the 1980's CMHCs were treating as many as 3.3 million patients, a six-fold increase from 1955 when mental health institutions reached their peak census of 558,922 (Mechanic & Rochefort, 2002). In 1965, mental institution population was reduced to 475,202 (15%). It was the increase of social welfare programs in the mid-1960s to 1970s such as Medicare, Medicaid, SSI, SSDI and housing vouchers that created the greatest impact in reducing state mental hospital census by almost 60% during the years 1965-1975 (Mechanic & Rochefort, 2002).

Varying Federal Administration Initiatives on U. S. Mental Health Policy

As the focus of mental health policy shifted from custodial care to community treatment, the needs of the most severe and chronically mentally ill were frequently overlooked. Inadequacies in a continuum of care were apparent as mass deinstitutionalization revealed a lack of planning for the previous mental hospital patients that would not meet nursing home level of care. Chu & Trotter (1974) conducted a study evaluating the National Institute of Mental Health (NIMH) and its CMHC program. The researchers found the CMHC program was "vastly oversold, the original goals quickly perverted" (p. 195). Factors involved with this poor performance were related to the Nixon's administrations unsympathetic view towards mental health care. In 1971, no federal dollars were budgeted for new CMHC construction (Chu & Trotter, 1974) and mental health research and professional training was equally inadequately funded (Mechanic, 2008).

The Carter administration attempted to change the previous direction of mental health policy. In 1977 President Carter established the Presidential Commission on

Mental Health to review the mental health system and make recommendations. The following year, the Commission made its report, which advocated for a more robust investment to improve services, increased research, added personnel and public education on mental health. Unfortunately, the report offered no clear plan on how best to meet these goals. However, the Department of Health and Human Services (HHS) developed a federal strategy to ensure an effective array of services and supports for dealing with the complexity of issues involved with chronic and severely mentally ill population. HHS's efforts resulted in the Mental Health Systems Act signed into law by President Carter in October 1980. However, Ronald Reagan was elected President a month later, and his administration chose not to implement the act and once again federal interest in the chronically mentally ill waned (Mechanic, 2008).

During the Reagan and Bush administrations (1981-1993) mental health treatment and support for the mentally ill was dramatically decreased. The Omnibus Budget Reconciliation Act (OMBRA) of 1981 allowed the Reagan administration to reduce CMHC support by repealing Carter's Mental Health Systems Act and replaced direct federal funding with smaller block grants to the individual states. Federal interest shifted away from treatment for mental illness to treatment for substance abuse. Federal dollars for programs devoted to treatment and prevention of drug abuse increased by 679% from 1981-1991 (Humphreys & Rappaport, 1993).

Presidential changes from the previous Republican administrations to the newly elected Democratic President Bill Clinton once again altered the political focus on mental health treatment. The Clinton administration was sympathetic to the plight of those suffering from mental illness (Mechanic, 2008). David Satcher, the Surgeon General of

the United States delivered a detailed 494-page report on the status of the then current mental health system. The report acknowledged that the U. S. mental health system was fractured and complex due to the involvement of many sectors including public and private health care providers, social welfare, criminal justice, housing and education. Furthermore, the report informed that the 1996 direct cost for treatment of mental disorders totaled $69 billion. Recommendations were made for mental health parity (equal treatment between physical and mental health) and legislation intended to provide a partial solution to the financial barriers for the millions seeking mental health services (Satcher, 2000). The report, as well as the Vice-President Gore's wife publically discussing her personal experience with depression, encouraged mental health care advocates. There was great anticipation by the mental health community that a potential Gore administration would bring forth significant improvements in the mental health system. However, it was George W. Bush who took the reign of office in 2001(Mechanic, 2008).

Expectations by the mental health community were low when another President Bush took office, as the previous Republican administrations had historically showed little support for the severely mentally ill (SMI) population. However, within the George W. Bush administration were powerful advocates for treatment options due to their own personal experiences with the challenges of the mental health system (Mechanic, 2008). In 2002, Bush announced the President's New Freedom Commission on Mental Health and affirmed his support for parity legislation (Executive Order 13263, 2002). An interim report noted barriers to treatment including fragmented service delivery, gaps in care for adults with serious mental illness, suicide prevention and the lack of mental health being

viewed as a national priority. The final report proposed six goals to transform the mental health system: 1) Americans understand that mental health is essential to overall health; 2) Mental health care is consumer and family driven; 3) Disparities in mental health care are eliminated; 4) Early mental health screening, assessment, and referral to services are common practice; 5) Excellent mental health care is delivered, and research is accelerated; and 6) Technology is used to access mental health care and information (Hogan, 2003). The commission also endorsed the concept of "recovery" described by others as a vague idea that varies in interpretation among mental health stakeholders (Davidson, O'Connell, Tondora, Styron & Kangas, 2006, p.640). It was the intention of the administration to implement the commission's recommendations but sadly with a large federal deficit, concerns about the Iraq and Afghanistan wars and fears of additional terrorist attacks, the initial attention to mental health improvements diminished and the goals became a much lower priority for the Bush administration (Mechanic, 2008).

Beginning in 2009, the Obama administration's efforts to expand healthcare access through the implementation of the Affordable Care Act (ACA) was perhaps the most significant changes for the future of mental health systems of care. The passage of the legislation in 2010 specifically mandated services referred as the *Ten Essential Health Benefits*. Treatment for mental health and substance use disorder services, including behavioral health treatment and prescription drugs were covered as part of the essential benefit package. These required services in conjunction with the expansion of Medicaid, a mandate for employers to offer insurance, the creation of healthcare insurance exchanges with subsidies for low income persons were expected to culminate into healthcare coverage for "at least 3.7 million currently uninsured people with severe

mental illnesses and many more with less severe needs for mental health and addiction treatment" (Barry, & Huskamp, 2011, p.973).

Mechanic (2012) offered multiple reasons why the ACA could reinvent mental health and substance abuse treatment in the United States. He anticipated improvements would come from the availability of enhanced financial and organization tools thereby reducing the current fragmentation of care. Additionally, the creation of *Health Homes* were to provide opportunities for providers to be more responsive to clients as their physical and mental health needs could be treated within a solitary practice setting. The legislation also allowed for better interaction between social programs and behavioral health services. Another pivotal action was the support of preventive care through education and screenings with the intent to provide more holistic treatment plans including non-medical services such as supported employment and subsidized housing.

A vast number of stakeholders involved with mental health treatment were encouraged by the opportunities potentially available once the ACA was fully implemented. However, with the recent election of President-elect Trump in conjunction with the state elections that resulted in Republican majorities in both the Senate and House, it appears a repeal of ACA may be imminent. Discussions about a replacement legislation to date have lacked depth and details pertaining to mental health treatment are absent. As U. S. mental health policy takes another dramatic turn, the hope and change once promised by President Obama may never become a reality for the historically underserved population of the mentally ill. Time and again promises have been made, but support has waxed and waned as differing federal administrations have come and gone. One particularly strong advocate for mental health treatment in the current administration

is Surgeon General Vivek Murthy. Maintaining that mental and emotional well-being are essential components to overall health, his recent report on national healthcare priorities recommends the federal government must improve access to mental health treatment in both clinical and community settings (Surgeon General, 2016). However, it is unclear if the Surgeon General's declaration will impact the federal monetary allocations necessary to make this goal a reality. Consequently mental health policy advocates working in 2017, no longer have the promising futures previously offered by the Obama administration and the essential health benefits mandated in the Affordable Care Act.

Legal Opinions on Mental Health Law

There have been numerous legal cases related to civil rights issues for those mentally impaired. The following are significant legal decisions that have impacted mental health law and policy. Although the following are not the only court decisions that have dealt with issues related to mental competency, individual rights and due process, collectively they well represent the important legal decisions that resulted in dramatic changes in procedures and policies. The following court cases are categorized and discussed by topic and presented in chronological order as to provide the context of judicial precedents and their previous implications.

Competency to Stand Trial and the Insanity Defense

The judicial system is based on the concept of fairness. To treat persons with mental disabilities in the same manner as those who are rational and possess normal intelligence would be considered unjust. Therefore, the courts have made allowances for the actions of individuals whose mental state is deemed inadequate to meet the criteria

necessary for judicial accountability and punishment. Much of the involvement by the courts is based on the state's obligations as required by the 14th Amendment to the U. S. Constitution which states "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws" (U.S. Const. amend. XIX). In addition, the failure to hold a competency hearing also violates the 6th Amendment right to a fair trial (U.S. Const. amend. VI)

In order to ensure due process and a fair trial, two distinct legal determinations may be rendered when a person is suspected of being mentally ill, intellectually disabled or having an organic brain disorder. The first determination the court must rule on is whether the individual is competent to stand trial. Should that requirement be met, then a second determination by the court is whether the person can be found not guilty by reason of insanity. The distinction between the two is often confusing to the general public and the media especially when discussed with regard to high profile cases (Gutheil, 1999). Both determinations are legal terms utilized during specific times throughout the criminal proceedings and have been reviewed and revised in subsequent court cases.

Competency to Stand Trial

Competency to stand trial is a legal determination heavily based on clinical opinion. A request for a psychiatric evaluation of competency can occur at any time

during a trial prior to the conviction (Erickson & Erickson, 2008). This legal standard has four goals; 1) to ensure the accuracy of criminal verdicts; 2) to guarantee a fair trial; 3) to preserve the integrity of the courts; and 4) if the defendant is found guilty he or she understands why they are being punished (Felthous, 2003).

Dusky v. United States was a Supreme Court ruling issued in 1960 which is often cited as one of the Court's earliest decisions related to improving competency standards. Milton Dusky was a 33-year-old man, charged with assisting in the kidnapping and rape of a female minor. Although he was diagnosed with schizophrenia, he had previously been found competent to stand trial and was later convicted and sentenced to 45 years in prison. The Supreme Court determined the previous competency criterion was insufficient. In their final order the Court held: [I]t is not enough for the district judge to find that "the defendant [is] oriented to time and place and [has] some recollection of events" (Dusky v. United States, 1960). Rather competency determinations must include findings that the defendant possesses a rational understanding of the charges against him, subsequent potential penalties and the mental capacity to work collaboratively with his defense attorney (Gutheil, 1999; Perlin, 2000; Brakel, 2003).

On those occasions when a person was found incompetent to stand trial they were then committed to a psychiatric facility until their level of competency had been restored. This restoration period of time was unspecified and unlimited (Miller, 2003). Studies conducted in the mid to late 1960's revealed that an incompetent defendant's time served in a facility could be equivalent to a lifetime prison sentence as many waited for trial for decades or died during their institutionalization. Lipp (1968) reported on mentally ill

prisoners kept in hospitals long after their sentences have expired. Anecdotal reports from his study include a 19-year-old male accused of burglary confined in a New York mental institution for 64 years awaiting trial. Lipp (1968) reached the conclusion that the consequences of incompetency commitment "indicates serious injustice exists, that this injustice serves no useful purpose to medicine or the law and that such conditions must be remedied' (p.315).

It was not until 1972, when Supreme Court considered the issue of indefinite commitments during the *Jackson v. Indiana* case. Theon Jackson was a 27-year-old man with developmental and intellectual disabilities who was also deaf. He had been charged with two separate acts of robbery with a total value of $9.00 for the items taken. Due to his lack of communication skills and mental incapacity he was found incompetent to stand trial and committed to the Indiana Department of Mental Health until his competency could be restored. In 1972, three and one-half years after his confinement the Supreme Court reversed the Indiana court's decision stating their actions were unconstitutional. The Court ruled that Indiana deprived him of equal protection under the law and due process (Morris & Meloy, 1993). The Court issued their opinion unanimously and clarified their position in the following statement:

> Indiana's indefinite commitment of a criminal defendant solely on account of his lack of capacity to stand trial violates due process. Such a defendant cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain competency in the foreseeable future. If it is determined that he will not, the State must either institute civil proceedings applicable to indefinite

commitment of those not charged with crime, or release the defendant (*Jackson v. Indiana*, 1972)

This federal judicial ruling put forth limits on the length of time an incompetent person may be confined. However impact of the Supreme Court decision on individual states has been inconsistent. Morris & Meloy (1993) surveyed all 50 states and found many had ignored or circumvented the ruling with 15 imposing lengthy treatment periods and another 14 still permitting indefinite commitment on permanently incompetent defendants.

Additional and subsequent landmark Supreme Court decisions related to incompetency to stand trial include *Drope v. Missouri*, in which it was ruled that due process is denied when an incompetency exam is not requested (*Drope v. Missouri*, 1975). Competency exams do not provide confidentiality as between a doctor and patient or client and attorney. This warning had not been given to Ernest Benjamin Smith during his competency exam. The findings from that examination were used in court and Smith was found guilty and sentenced to death. The resulting Supreme Court case resulted in the death sentence to be vacated as the defendant was not informed about potential self-incrimination (*Estelle v. Smith*, 1981).

In *Godinez v. Moran* (1993) the Court ruled that if a defendant is found competent to stand trial he is equally competent to plead guilty and waive right to counsel even if his self-representation is inadequate. In *Cooper v. Oklahoma* (1996) the court ruled against the state court system that required clear and convincing evidence as a higher standard for incompetency. In 2008, a new Supreme Court case revisited the issues of self-representation per the *Godinez v. Moran* case. In this debate the court ruled that a

criminal defendant can be competent to stand trial but not necessarily competent to represent themselves as the later requires a high level of thinking and education (*Indiana v. Edwards, 2008*).

Studies on competency issues are similar to guardianship research in that multiple concerns are raised with accompanying recommendations for reform. Evaluations for competency to stand trial are estimated to be 25,000 annually and are the most often requested forensic assessment (Hoge, Bonnie, Poythress, Monahan, Eisenberg & Feucht-Haviar, 1997). Agreement between the court and mental health professionals has been determined to be 91% (Freckelton, 1996). However; scholars argue that variation in state statutes, judge's interpretations, differences among evaluation instruments and the range of mental health professional types allowed to testify create inconsistent judicial rulings (Roesch & Golding, 1978; Zapf & Roesch, 2000; Pinal, Tillbrook & Mumley, 2006; Siegel, 2008).

In Kentucky, instructions on how to deal with incompetency issues in criminal court are found in Kentucky Revised Statute (KRS) 504.100-504.130. These state regulations mandate the appointment by court of psychologist or psychiatrist during the proceedings. KRS 504.110 informs the court that if it finds the defendant incompetent to stand trial but there is probability he will attain competency in the foreseeable future the defendant will be committed to a treatment facility or forensic psychiatric facility for sixty (60) days or until the psychiatrist or psychologist providing treatment finds him/her competent. If the court finds substantial probability that competency cannot be restored then an involuntary hospitalization procedure will be conducted. For those cases when

the defendant's competency can be restored the criminal proceeding move forward to trial (Kentucky Penal Code, 2005).

The courts' determination on competency to stand trial is only the first step in criminal proceedings for those with psychiatric diagnosis. Should the defendant pass the competency criteria and go to trial, the next legal determination to be met is whether the person was insane at the time the crime occurred. The following provides a more detailed discussion of the legal standards and considerations for an insanity defense.

Not Guilty by Reason of Insanity

Aristotle was one of the first to publically argue that a person's mental state was an important factor in considering the morality of a person's actions, especially in regard to the causation of harm. The moral significance related to a person's underlying delusional beliefs was vastly ignored by his contemporaries and for several centuries afterwards. It was not until the 13th century writings of British jurists Henry of Bracton when he further asserted this Aristotelian view by professing a "crime is not committed unless the will to harm is present" (Appelbaum, 1994, p.165). Defined in legal language as *acrus reus* (wrongful acts) and *mens rea* (guilty mind) the judicial system demands both to be present for a criminal charge should to become a punishable offense (Erickson & Erickson, 2008).

However, over time, varying court rulings and subsequent public sentiment have changed the decisive factors pertaining to an insanity defense. The British M'Naghten case of 1843 is most significant due to its extensive historical foundation which has continued to influence American law to this day. Daniel M'Naghten was accused of

murdering Edward Drummond. In actuality it was a case of mistaken identity as his intended victim was the British Prime Minister. M'Naghten's explanation for his actions was based on his conviction that the government's relentless persecution had caused him numerous personal and financial hardships. During the trial several medical witnesses testified to his delusional thinking and paranoia which resulted in a verdict of not guilty by reason of insanity. However, Queen Victoria, the House of Lords and the public at large decidedly disagreed with the verdict and demanded the courts to respond to a series of questions related to the insanity verdict (Erickson & Erickson, 2008). The result of the inquiry produced what is known as the M'Naghten rules, which narrowed the concept of insanity. The opinion from the Queen v. M'Naghten trial stated that those accused of a crime but found insane would be those who:

> [W]ere laboring under such a defect of reason, from disease of the mind as not to know the nature and quality of the act he was doing; or if he did know it, that he did not how what he was doing was wrong" (Fredrick, Mrad & DeMier, 2007, p. 39).

Despite criticism as early as 1887, the rulings failed to reflect advances in the field of behavioral science (Robinson, 2013). The criterion for legal insanity was accepted by American federal courts by 1851 and remained the legal standard for insanity in the majority of U. S. jurisdictions until the mid-twentieth century (Cetti, 1962-1963; Appelbaum, 1994; Erickson & Erickson, 2008).

Due to the failure to consider recent discoveries in the cognitive neuroscience arena attorneys and psychiatrists continued to challenge the narrow definitions in the M'Naghten rules. These discoveries indicated there are separate mental capacities responsible for one's power of self-control (Bennett, 2009). Various states including Kentucky began to include the concept of "irresistible impulse" as a legitimate claim against criminal culpability. This extension of the M'Naghten rules allowed an individual with mental illness who did not possess the ability to control their behavior as no longer responsible for the actions and could therefore plead not guilty by reason of insanity (Erickson & Erickson, 2008).

In 1954, the case *Durham v. United States* provided an expanded standard for an insanity defense, which became known as the Durham rule or the *product test*. The case was presided over by Judge David Bazelon, an advocate for those with mental illness. His ruling stated, "an accused is not criminally responsible if his unlawful act was the product of a mental disease or defect" (Appelbaum, 1994, p. 167). This expansion was well received by mental health advocates but not by the legal community. Attorneys and judges expressed concern that this new rule gave too much power to psychiatrists whose expert testimony could be paid for by the more affluent defendants and therefore was inherently unfair. Their concerns were legitimized in the finding that in the four years following the Durham rule, the number of acquittals in the District of Columbia alone increased to 150. Of equal concern were the conditions of mental hospitals where those found insane would be placed. Criticism on both sides evolved into a debate on whether mental hospitals were merely prisons in disguise or conversely they were improper temporary placements for those acquitted on the grounds of insanity. Oftentimes those

found insane and placed in mental hospitals were quickly released to the community creating public concerns for safety (Erickson & Erickson, 2008).

By 1972, the product test was abandoned based on a subsequent insanity case; *United States v. Brawner.* The judicial ruling for this case resulted in the replacement of the Durham rule through the adoption of the American Law Institute (ALI) test. Their recommendation created Model Penal Code § 4.01 (1) which states:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he *lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law"(Robinson, 2013, p.4).*

This revised standard was popular among the legal community however the implementation of the ALI standard was relatively short lived. Less than ten years later, on March 30, 1981, an assassination attempt on the life of President Ronald Reagan by John Hinckley served as the catalyst that again changed the legal requirements for an insanity defense. The assassination attempt was caught on film and televised across the country assuring that it was indeed John Hinckley that committed the crime. His defense rested on his mental state at the time of the act. During the trial, evidence was introduced that showed Hinckley was obsessed with actress Jodie Foster. He believed that a violent act committed on her behalf would eventually result in her falling in love with him. At the time John Hinckley shot Reagan, the ALI rule was in effect in the District of

Columbia. Hinckley's defense team successfully argued on his behalf that he did not possess the mental capacity to appreciate the consequences of his actions. Consequently, the jury found Hinckley not guilty by reason of insanity (NGRI) (Erickson & Erickson, 2008).

Similar to the M'Naghten case, government leaders and the public vehemently disagreed with the verdict and reform for changes in the NGRI criteria ensued. Proposals for change came from a variety of sources including the American Medical Association (AMA), American Psychiatric Association (APA) and the American Bar Association (ABA). Task forces were assembled to review and comment on the current NGRI standards; reform recommendations also came from advocacy groups, Congress, and state legislatures. Prior to the Hinckley trial, Montano and Idaho had abolished the more modern ALI insanity defense and replaced it with the more strict *mens rea* requirements. After the Hinckley verdict, calls for abolishing the insanity defense on a federal level produced legislation introduced by Republican Senator Orrin Hatch of Utah. Ultimately the Hatch bill failed but Utah became the third state to revert back to the narrow *mens rea* standard. Other states responded independently but one of the most widely accepted reform was to shift the burden of proof from the prosecution to the defense. Other reforms included modifying the ALI standard, reversion to the M'Naghten rule and excluding the volitional standard that focused on the defendant's ability to control his behavior (Appelbaum, 1994).

Public and political dissatisfaction with the Hinckley verdict also created a new judicial finding in cases where the defendant sought an insanity defense. Juries

sympathetic to the defendant's psychiatric problems could issue the verdict of guilty but mentally ill (GBMI); however, in reality it was the same as being found guilty since the defendant was sentenced to prison with a possibility of receiving some form of mental health treatment (Appelbaum, 2004).

This new judicial finding was incorporated into Kentucky's Penal Code in 1982, as evidenced by KRS 504.120 which provides instruction to the jury that should a defendant provide evidence at the trial that he has mental illness he/she may offer the following verdicts; 1) guilty; 2) not guilty; 3) not guilty by reason of insanity at the time of the offense; and 4) guilty but mentally ill at the time of the offense (Kentucky Penal Code, 2005).

In the prevailing years with some states having abolished the ALI law and others initiating reforms which narrowed the insanity defense, researchers Steadman, Callahan, Robbins, and Morrissey (1989) studied the effects of these state statutory changes in Montana that had returned to the strict standards of *mens rea*. They found insanity defense acquittals significantly declined, but the incompetence to stand trial pleas increased. They concluded defense attorney utilized the incompetence to stand trial as a "substitute" for the *mens rea* based insanity defense. Although it appeared that the reform had decreased the number of defendants found not guilty by reason of insanity (NGRI), in actuality roughly the same number of defendants were found incompetent to stand trial and once their treatment was deemed successful they were released without further criminal charges (Appelbaum, 1994).

The above court cases have significantly impacted the criminal judicial process afforded persons who have been judged mentally incompetent. These are important issues given the association to this dissertation topic of criminal behaviors committed by people previously deemed mentally incapacitated by the courts. The following court cases are also central to mental health policy development especially for those persons with a psychiatric and/ and intellectual disabilities. However since the criminal component is not involved in these later cases only a brief overview will be provided.

Additional Landmark Cases Impacting Mental Health Policy

Lessard v. Schmidt (1972)

Lessard v Schmidt was a lawsuit filed by Alberta Lessard, a schoolteacher from West Allis, Wisconsin. Ms. Lessard had been involuntarily committed to the Milwaukee County Mental Institution. Her case was a class action lawsuit brought forth on the behalf of herself and all persons 18 years of age and older who had been involuntary committed to a mental institution on the basis of a mental illness diagnosis. Setting aside traditional *parens patriae* grounds for commitment (Zander, 1976), the three-judge court ruled the state's civil commitment laws were unconstitutional and had a worse impact on a person's life than for those associated with being convicted of a crime (Petrila & Levin, 2010). Failures in the commitment proceedings were based on the lack to provide adequate notice concerning the commitment proceedings, detentions that lasted longer than 48 hours, the absence of legal counsel for the accused and a commitment made without evidence of mental illness and dangerousness beyond a reasonable doubt

(Zander, 1976). The revised standard mandated that involuntary commitment was only permissible when "there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others" (Perlin, 2000, p. 274).

The Lessard ruling had a profound effect on civil commitment proceedings and within a few years all states had revised their laws to conform to this new standard (Petrila & Levin, 2010). In Kentucky these civil commitment proceedings are referenced as 202A hearings and are based on the enacted *Kentucky Mental Health Hospital Act* which states:

> Criteria for involuntary hospitalization: No person shall be involuntarily hospitalized unless such person is a mentally ill person: (1) Who presents a danger or threat of danger to self, family or others as a result of the mental illness; (2) Who can reasonably benefit from treatment; and (3) For whom hospitalization is the least restrictive alternative mode of treatment presently available (Kentucky Mental Health Hospitalization Act, 1982)

This case utilized a therapeutic jurisprudence perspective as it examined the therapeutic and equally important antitherapeutic consequences that may arise from their court decision (Madden & Wayne, 2003). This perspective allowed the court to simultaneously create a standard that protected a person's civil rights while ensuring public safety (Perlin, 2000). The issue of dangerousness and curtailment of liberty was further examined by the Supreme Court in the 1975 decision of *O'Connor v. Donaldson.*

***O'Connor v. Donaldson* (1975)**

Kenneth Donaldson was civilly committed to the Florida State Hospital of Chattahoochee on January 3, 1957. Despite numerous attempts to convince state and federal courts that his detention was illegal, he remained confined to that institution for almost 15 years. The evidence at trial showed that Donaldson was not a danger to himself or others and the enforcement of custodial care with no treatment was unconstitutional. In 1971 a jury awarded him $28,500 as compensatory damages and an additional $10,000 in punitive damages. This judgment was upheld in the appeals; however, the defendant petitioned the Supreme Court for certiorari due the "important questions seemingly presented" (Fields, 1975-1976, p.512).

The Supreme Court did not address the issue of right to treatment but did rule that a state cannot constitutionally confine a non-dangerous individual who is capable of caring for himself through community and family supports. They agreed with the lower courts finding that the defendant's right to liberty had been curtailed. Based on this ruling, states have no legal standing to maintain indefinite commitments unless they continue to meet commitment criteria (Watkins & Callicutt, 1997).

Referencing back to the *Kentucky Mental Health Hospital Act* (1982) the petitioner for commitment must request in court that involuntary hospitalization will not to exceed 60 or up to 360 consecutive days from the date of the court order. Once again, court decisions and judicial verdicts resulted in reforms in state legislations. The following case is unique from the previous cases in that in this circumstance, federal

legislation created the legal environment from which the Supreme Court case of *Olmstead v. L. C*. was the result.

***Olmstead v. L. C*. (1999)**

In 1990, The U. S. Congress passed federal legislation titled *The Americans with Disabilities Act* (ADA) that addressed the pervasive discrimination against persons with physical and mental disabilities. Within the five separate titles of the ADA were measures intended to end discrimination in the areas of employment, public service, public accommodations, telecommunications and the prevention of retaliation against persons with disabilities or their advocates in asserting their rights (Mechanic, 2008). This legislation allowed persons with disabilities the autonomy to make individual decisions about their own life and strongly encouraged full community integration for the physically and mentally disabled (Perlin, 2000).

The ADA was the basis for a lawsuit brought forth by the Atlanta Legal Society on the behalf of Lois Curtis (L.C.) and Elaine Wilson (E.W.) in 1995. One woman was diagnosed with a severe mental illness while the other had been identified as having a significant intellectual disability. Both had been confined in a Georgia state psychiatric hospital for several years and the plaintiffs argued that Title II of the ADA authorized them to move to "the most integrated setting appropriate to their needs" (Perlin, 2000, p. 191).

By 1999, the case was eventually brought before the U. S. Supreme Court which ruled that their confinement was discriminatory as defined by the ADA. The court's

decision was based on two important factors. First, institutionalization "perpetrates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Secondly, institutionalization "severely diminishes" the opportunity to fully engage in daily activities within a community (as cited by Levin, et al., 2010, p. 52).

Although the Court's decision was met enthusiastically by mental health advocates, states were allowed to rely on the judgments of their own professionals with regard to the decision making for the most appropriate level of care setting and creating their own state plans for placing persons with disabilities into less restrictive environments (Levin et al., 2010.

These state controlled measures have blunted the impact of the landmark Olmstead decision more than originally anticipated. Barriers to implementing state Olmstead plans include a shortage of qualified community-based professionals, financial barriers due to concerns involving underfunded state programs in conjunction with the ever-increasing Medicaid expenditures as well as the difficulties involved with locating appropriate housing (DiPolito, 2006). Other post-Olmstead studies reveal the psychiatric hospital census after the 1999 Olmstead decision actually slowed when compared to the previous years which included the initial deinstitutionalization era (Salzer, Kaplan & Atay, 2006).

Summary of Mental Health Case Law

Time and again, court decisions have had significant impact on the lives of those with psychiatric or intellectual disabilities. Much like the description afforded guardianship as "half Santa and half ogre" (Regan, & Springer, 1977, p.27) the outcomes from these protective judicial actions can also create their own unique set of unintended consequences. Numerous times, therapeutic jurisprudence has intervened on the behalf of this vulnerable population only to later discover that politicized legislation in conjunction with the undue hardship of administrative burdens has yielded not rewards but penalties to those deemed incapacitated.

Special Populations and Criminality

In May 2013, DAIL requested their state public guardians to provide information on the known criminal behaviors of persons on their respective caseloads. The types of behaviors reported by the guardians included trespassing, substance abuse, verbal and physical assaults, fire setting, property destruction, sexual offenses, stalking, theft, and homicide. The following studies discuss the significant findings associated with these types of behaviors within the specialized populations that frequently enter into public guardianship.

Substance Use and Abuse

Available research on substance use and abuse by individuals with intellectual disabilities (ID) has been understudied and is located across a diverse number of disciplines. Chapman & Wu (2012) conducted a meta-analysis comprised of 37 journal articles and two dissertations on substance abuse among the ID population. Many of

those studies were limited in sample size, total reliance on self-reported measures and concerns about the completeness of data. However, the identified trends and information gleaned from their work concludes that persons with borderline to mild ID were at greater risk for substance use and related problems than those with lower cognitive function. In the event an individual with ID begins to use illegal substances this typically occurs in early to late adolescence. Compared to the general population, people with ID have higher rates of mental health problems and the association between mental illness and substance abuse is well established. Criminal activity and substance use were also found to be highly correlated. The research concludes that substance use within the ID population often evolves to substance abuse primarily because too few prevention programs or treatment options have been designed to meet the needs for individuals with ID.

Violence

The ADA and Olmstead decision strongly supported community integration for persons with ID. Expectations for community inclusion included the right to receive appropriate residential placement and equal opportunities for employment, education and recreational opportunities (Perlin, 2000).

However one major barrier to successfully integration has been a concern regarding the aggressive behaviors sometimes exhibited by the ID population. In a study conducted in 2006, research findings revealed a linear relationship between the severities of the intellectual disability and the types of behaviors exhibited. Individuals with mild to moderate ID were more likely to exhibit verbal aggression while those with more

profound ID exhibited physical aggression. Younger men were more likely to be aggressive than older men, while among women with ID, age showed no significant difference. Findings relative to residential settings found that the highest level of aggressive behaviors were among those living in group homes. Those living independently displayed the lowest level of behavior problems involving property destruction (Crocker, Mercier, Lachapelle, Brunet, Morin & Roy, 2006).

Police intervention was sought in 4.4% of cases when aggressive behavior was identified and occurred most often with individuals' diagnoses with mild ID. Persons with a criminal history of arrests were 5 times more likely to have displayed verbal aggression and sexually aggressive behaviors, 3 times more likely to have been charged with property destruction and 2.5 times to have been reported as physically aggressive. Researchers concluded a wide range of variation in behaviors for the men and women with ID and offered that these challenging behaviors can be linked to undiagnosed medical conditions, co-occurring psychiatric issues, stress of victimization and circumstances dependent upon their unique home environments (Crocker, et al., 2006).

The relationship between severe mental illness and violence is complex and research findings fluctuate regarding prevalence and the epidemiology of mental health disorders due the research design issues such as the interpretation of relevant terminology, adequate evaluations and the delay between that actual criminal behavior and subsequent research initiatives (Teixeira & Dalgalarrondo, 2009). Serious acts of violence perpetrated by the severely mentally ill appear to be a rare event (Monahan, 1992) despite high profile cases in the news which inaccurately influence public perception. Elbogen & Johnson (2009) researched the link between violence and mental

disorder and found that violence was significantly higher for persons with severe mental illness only when factors of co-occurring substance abuse or dependence were included. Their analysis indicated that severe mental illness alone was not a significant factor in predicting violence. More specifically, factors of past violence, juvenile detention, physical abuse, parental arrest records, substance abuse and an unstable home life were found to be more reliable predictors for violent behavior. A review of similar literature on schizophrenia and violence confirmed an association between violence for this specific diagnosis, but as mentioned in the previous study, it was the comorbidity of substance abuse which considerably increased the risk for violence (Walsh, Buchanan & Fahy, 2002).

Fire Setting

In 2012, law enforcement agencies reported 52,766 cases of arson (Federal Bureaus of Investigations, 2013). Fire setting is a sub-classification of arson. It is a relatively easy crime to commit as no weapon is needed and can be an impulsive action with little if any premeditation required (as cited in Burton, McNeil & Binder, 2012). The prevalence of lifetime fire setting in the US is 1.13%. Risk factors most strongly associated with fire setting behaviors include being male, Caucasian, unmarried, over age 30 and an annual income above $70,000. In terms of mental disorders associated with fire setting are a lack of impulse control, drug dependence, bipolar disorder, and pathological gambling. Associations between fire setting and all antisocial behaviors were positive and significant. A lifetime history of fire setting, “was strongly associated with substantial rates of axis I comorbidity, history of antisocial behavior, family history of other antisocial behaviors, decreased functioning and higher treatment seeking rates” (Blancos,

Alegria, Petry, Grant, Simpson, Liu, Grant, & Hasin, 2010, p. 1218). The proportion of schizophrenic fire setters has been reported to range from 10-30 percent. Among schizophrenic fire setters, a review of family history revealed alcoholic fathers (68%) and mothers who had been diagnosed with psychiatric disorders (23%) increased the likelihood for fire setting. Beyond family background, fire-setting schizophrenics suffered from higher levels of alcohol abuse (56.8%), as well as difficulties in school, early substance use and hyperactivity. Researchers also noted that alcohol dependence among fire setters had increased when compared to data from the 1970's (Repo & Virkkunen, 1997). Psychotic disorders are highly associated with arson and also have the strongest correlation to diminished capacity (Vinkers, De Beurs, Barendregt, Rinne & Hoek, 2011).

Studies about fire setting by persons with ID are almost absent from the literature. A single British study indicated ID individuals with known fire setting behaviors may have experienced disrupted attachments during their early years of development. However, the study noted the surprising finding that despite this probable attachment disorder, these individuals scored significantly higher on two separate self-esteem assessments. Explanations for the unexpected findings proposed that persons exhibiting aggression do so from "threatened egotism" and therefore aggressive actions may occur when "grandiose self-image is questioned" (Johnson, 2011, p.323).

Sexual Offenses

Studies indicate that sexual offenders have the highest rate of recidivism than any other criminal behavior. Sexual offenders were also most likely to minimize their actions

and felt little need for treatment (Craig, Browne, Beech & Stringer, 2006). Research focusing on schizophrenia reveals this population is four times more likely to have been convicted of a serious sexual crime than the non-mentally ill population. There is complex association between sexual offending behaviors and drug and alcohol use, personality disorders, mental illness and social circumstances. Researchers report a limitation in the literature on sexual offenders per mental diagnosis and propose increased empirical research in order to design assessments and treatment that is specific to the person's mental diagnosis (Drake & Pathé, 2004).

Studies on sexual offenses perpetrated by males with intellectual disabilities suggest that this population is capable of committing rape, sexual abuse of children, sexual abuse among their peers, public exposure and voyeurism. However, researchers Thompson & Brown (1997) caution against labeling males with ID as overly sexually aggressive as some research findings may suggest. In reviewing their study conclusions it was observed the ID population lacks privacy, possesses a level of sexual naivety and report their sexual behaviors with honesty--which can lead to a distorted view of what is their normal sexual behavior. Complicating this area of research is a lack of reliable data as police, custodial staff and family members tend to minimize sexual actions among the ID population that results in inconsistent reporting and subsequent faulty data. Despite concerns with data collection, it is estimated that approximately 3% of the ID population has severe sexual aggression issues (as cited in Thomson & Brown, 1997).

There is a dearth of literature on women with ID who have are sexual offenders. One study reported they knew of no single report on this topic. However, their study findings noted female offenders comprised only 9% of referrals for treatment. Among

those women, 61% reported having experienced prior sexual abuse. This is significantly higher than their male counterparts (38.5%). A noteworthy characteristic among the female offenders included a high level of co-occurring mental illness (67%) with a recidivism rate of 22% over the following 5 year period. Female recidivism rates were markedly lower than males and female sexual offenses were considered less violent than the male sex offenders (Lindsay, Smith, Quinn, Anderson, Smith, Allan & Law, 2004).

Stalking

Stalking can be defined as a "constellation of behaviors involving repeated and persistent attempts to impose on another person unwanted communication and/or contact" (Mullen, Pathé, Purcell & Stuart, 1999, p. 1244). Most stalkers are not violent and serious violence is rare. James & Farnham (2003) reported that serious violence showed no association with substance abuse, previous violent convictions or a diagnosis of personality disorder. Rather, serious violence was associated with previous visits to the victim's home, shorter durations of stalking episodes and violence committed against previous stalking targets.

A previous study indicated stalking durations varied from 4 weeks to 20 years (median = 12 months). In this earlier study, 59 stalkers (41%) were diagnosed with delusional disorders, schizophrenia and bipolar disorders. Twenty-two were classified as "incompetent" stalkers who were diagnosed as ID and predominately came from isolated and disadvantaged social backgrounds They acknowledged that their victim had not ever reciprocated any affection towards them, yet they still regarded them as potential romantic partners. These ID stalkers had previously stalked others, yet despite previous

failed attempts for attention, they continued to hope their explicit behavior would eventually lead to intimacy (Mullen, et al., 1999). Logan, Leukefeld & Walker (2000) found a significant association with alcohol use and stalking by males. Their study contributed to the hypothesis that stalking is a variation of intimate violence.

Thefts

Review of the literature related to theft by those deemed mentally ill or intellectually disabled is problematic for a number of reasons. Many studies examine both populations in terms of violent or non-violent behaviors but do not classify criminal activity into sub-categories such as theft. Further review of the literature finds methodological problems relating to varying IQ-based concepts making generalizations concerning the ID population indeterminable. A meta-analysis of offending patterns of the ID population is provided with citations to specific studies included. However these researchers agree that the level of rigor among the studies make any valid assumptions suspect (Simpson & Hogg, 2001).

Hodgin (1992) examined the relationship between crimes committed by those with a mental disorder and crimes committed by the intellectually disabled in a Swedish study. Hodgin found that men with major mental disorders were 2.5 times more likely than men with no disorder to have a criminal conviction and 4 times more likely to be registered for a violent offense. Women with major mental disorders were 5 times more likely than women with no disorder to be registered for an offense and 27 times more likely to be registered for a violent offense. The ID population was 3 times more likely to be convicted of a crime and 5 times more likely to commit a violent offense than those

with no cognitive disabilities. This study did include the specific types of crimes committed and findings indicated that among the ID male population sample one-third had been convicted of theft (as cited by Simpson & Hogg, 2001).

A later study within the meta-analysis investigated the criminal convictions of the intellectually disabled in terms of types of criminal charges in conjunction with the offender's race. Finding based on the 288 criminal offenders with ID culminated into 452 separate criminal charges in which 91 were identified as theft. Among the 91 charges 19.8% were against Caucasians and 80.2% were held against African Americans. Although the focus of the study was on whether the IQ assessments retained a racial bias, the theft charges comprised 20% of the total crimes (Ho, 1996).

Summary of Crime and Special Populations

Understanding the criminal behavior among those diagnosed with mental illness or intellectual disability is a complex undertaking. Numerous aspects of individual circumstance and environments complicate the research, limit generalizations and lead to little in terms of policy solutions. What is evident is the consistent tension between the law and science similar to the debate between the concepts of free will and determinism. The confusing and ever changing laws for competency and insanity pleas mirrors the public's uncertainty as to when blame and accountability are just actions deserving of punishment. Until collaborative policy making among legal scholars and mental health experts emerges, the cycle of marginalizing the mentally impaired will likely continue regardless of what significant correlations we may uncover in this unique area of research.

Kentucky's Residential Facilities

State Psychiatric Hospitals

In Kentucky, there are three psychiatric hospitals administered by the Cabinet for Health and Family Services (CHFS). Additionally, the Department for Behavioral Health, Developmental and Intellectual Disabilities contracts with the private provider Appalachian Regional Healthcare (ARH) to supplement an additional 100 beds to provide inpatient psychiatric care. These four facilities provide Kentuckians with severe mental illness inpatient psychiatric care. The facilities are 1) ARH Psychiatric Center in Hazard; 2) Eastern State Hospital in Lexington; 3) Central State Hospital in Louisville; and 4) Western State Hospital in Hopkinsville The care provide in these facilities for adults ages 22-64 is provided strictly through state general fund dollars due to the IMD rule restrictions that prevent psychiatric care for this age group in any other setting that has over 16 beds (Kentucky Cabinet for Health and Family Services, 2013a).

Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID)

ICF/ID is a level of care considered to be institutionalized care much like psychiatric hospitals; the IMD rule does not affect this setting. Although persons with ID may have co-occurring mental illness, their primary diagnosis of ID allows for federal dollars to supplement their daily care. In Kentucky, there are seven state run ICF/ID facilities which provide intensive care to those with severe intellectual disabilities through training programs, recreational activities and health care designed to meet the extensive needs of this population. The facilities are 1-3) Bingham Gardens, Hazelwood, and Del Maria, which are located in Louisville; 4) Meadows located in Mt. Washington;

5) Windsong located in Crestwood; 6) Oakwood located in Somerset; and 7) Outwood located in Dawson Springs (Kentucky Cabinet for Health and Family Services, 2013a).

Additional Long-Term Care Facilities

Skilled nursing facilities, nursing facilities, nursing homes and specialized Alzheimer units comprise another category of long term care (LTC) residential units in Kentucky. Kentucky's Office of Inspector General conducts the licensing and subsequent monitoring of these facilities. In their most recent report, Kentucky has 26,881 certified long-term care beds in 295 facilities across the state (Kentucky Cabinet for Health and Family Services, 2013b). Although research indicates mental health and behavior problems are common in long-term care facilities, a survey of Kentucky nursing home administrators revealed use of psychiatric services in some instances but overall there remained an underutilization of mental health services for LTC residents. Barriers to mental health care were attributed to financial and logistical barriers (Meeks, Jones, Tikhtman & La Tourette, 2000).

Medicaid 1915 (c) Waiver Residential Treatment Programs

The Kentucky Medicaid program offers six different 1915(c) waivers to their Medicaid members in order to provide unique community based care for special populations. They are called waivers because certain federally mandated requirements are waived by the Centers for Medicare and Medicaid (CMS). This would include the combination of traditional medical care with non-medical services such as case management, personal care attendant care and respite. These six waivers in Kentucky have been designed for persons with ID or developmental disabilities (DD), persons who have an acquired brain injury, the physically disabled and the elderly. Among these

waivers, the Supports for Community Living waiver (SCL) and the Acquired Brain Injury Waivers (ABI acute and long term care) offer residential placement by privately owned providers. Although Kentucky Medicaid pays for residential treatment, reimbursement by the federal government is approximately 70%, so state costs are significantly lowered by the FMAP contribution. There are no waivers in Kentucky designed to serve the mentally ill. CMS waivers are required to be budget neutral meaning that the average cost per recipient is no greater than the average cost of an institution serving that unique population. Due to the IMD rule, there are no federal costs associated with psychiatric hospital stays, therefore from CMS's perspective there are no federal expenditures available to demonstrate the state's budget neutrality efforts.

Personal Care Homes

There are 81 Personal Care Homes (PCH) in Kentucky of which there are two types; those that serve the elderly through private resources (31) and those that typically serve low income groups that receive state supplementation payments (50). The primary population for the State Supplementation PCH is for persons with severe mental illness and intellectual disabilities. The poor accommodations and low levels of services provided in the Supplement PCHs are well documented in reports by the Kentucky Legislative Research Commission (LRC) and the Kentucky Protection and Advocacy (KPA). Low reimbursement is often cited as the cause for the substandard care provided to PCH residents. According to many PCH administrators and ombudsmen, the only alternate to PCH placement is homelessness (Kentucky Legislative Research Commission, 2012; Kentucky Protection and Advocacy, 2012).

Homelessness

On a given night in 2010 there were over 400,000 homeless individuals in shelters, transitional housing or on the streets. Over the course of a year (October 2009-September 2010) 1,593,150 persons experienced homelessness of which 26.2% had severe mental illness and 34.7% had chronic substance use issues. Over 60% of the chronically homeless have experienced lifetime mental health problems (SAMHSA, 2011). During this same time period of 2010, 6,623 individuals were homeless in Kentucky. An additional 9,833 persons were 'precariously' housed meaning they were living with another family, facing imminent eviction or lacked utilities (Institute for Children, Poverty and Homelessness, 2011). Unfortunately, data on the total number of Kentuckians homeless with mental illness and or substance abuse issues was not obtainable. However a University of Louisville study by the Kent School of Social Work, revealed that over $25 million dollars was spent on mental health costs for the homeless during the years of 2004-2005 (The Coalition for the Homeless, n.d.).

Incarceration

The current incarcerated population in the United States is 2,220,300 (U. S. Department of Justice) with over 50% of federal prisoners in prison for drug offenses (Federal Bureau of Prisons, 2013). In Kentucky, the most recent statistics indicated the total number of incarcerated persons in the state is 20,554 (Kentucky Department of Corrections, 2013). Research on prison recidivism reveals approximately two-thirds will be incarcerated within the following three years from their release. In a recent study on factors related to recidivism, findings indicated that mental illness alone was not a significant factor however, when combined with co-occurring substance abuse, the risk of

re-incarceration was 40% higher than that of individuals with no mental health diagnosis (Wilson, Draine, Barrenger, Hadley & Evans, 2013). State correction departments are the primary source for paying prison costs although other state agencies may share some of the burden. In fiscal year 2010, Kentucky's state costs totaled $311.7 million. This calculates to approximately $14, 603 average annual costs per inmate (VERA Institute for Justice, 2012).

Summary of Kentucky's Residential Facilities

The vast array of residential types provides some insight in the variation in IPs day-to-day living arrangements. Some facilities provide institutionalized care where actions are monitored continuously. Other settings offer little if any oversight. It is this range in supervision that will be examined in detail as it may prove to be a predictor in criminal activity among its resident population.

Chapter 3: Theoretical Foundation for the Study

This exploratory study on criminal activity within Kentucky's public guardianship program will rely on the theoretical perspective of Cohen & Felson's (1979) Routine Activity Theory. Previous criminological theories focused strictly on individual characteristics of criminals (Penrose, 1955; Waldo & Dinitz, 1967). However, Cohen and Felson (1979) elected not to examine individuals or groups traits but rather study how criminal actions occurred as a result of changes in daily activities. Their perspective serves as more of a complementary than conflictual approach in that offenders may be motivated to commit a crime but without a reasonable opportunity to act on these motivations the crime will not occur (Eck & Weisburd, 1995).

Routine Activity Theory postulates that three distinct elements are required for a criminal action to transpire; 1) a motivated offender; 2) a suitable target; and 3) the absence of a capable guardian. In their original study, a capable guardian was conceptualized as anyone intentionally or unintentionally present who might witness or intercede during the commission of a crime (Cohen & Felson, 1979). However, over the last almost forty years the definition of *guardian* has evolved beyond an incidental bystander to what numerous researchers have now redefined in a vast array of roles and responsibilities (Brunet, 2002; Hollis-Peel, Reynald, Bavel, Elffers & Welsh, 2011).

As an example, Garofalo & Clark (1992) measured guardianship to include the household members in the home, as well as the presence of a dog or an alarm system. Their findings indicated that these combined guardianship elements did reduce the number of residential burglaries and that previous studies had underestimated their effect.

Lynch & Cantor (1992) found a significant effect on burglary risk when measuring guardianship in terms of time spent at home and neighborhood watch groups. Expanding the concept of guardianship further, self-protective behaviors of homeowners including weapons possession showed a significant reduction in crime in studies by Mustaine & Tewksbury (1998) and Tseloni et al (2004). A meta-analysis of Routine Activity Theory's guardianship element found it remained an under-researched component of the theory with varying and continuously expanding definitions (Hollis-Peel et al., 2011). It is in consideration of these expanding definitions and the continuation of research grounded on this theory that the current study has been based.

In reviewing guardianship roles three subtypes are detected. All three guardianship related roles can be considered *controllers* because they exercise control over environmental conditions (Brunet, 2002; Felson, 1995; Sampson, Eck & Dunham, 2010). *Guardians* remain as those who keep watch over potential victims as originally discussed by Cohen & Felson (1979). However, two expanded roles beyond the original concept of guardianship now include *handlers* and *managers*.

*Handler*s are persons that share an emotional attachment with potential offenders (Felson, 1986). This concept of *handler* originally was originally based on Hirschi's (1969) control theory that stated social bonds created "handles" on potential offenders that could be grasped by a caring individual to exert control (Brunet, 2002, p.70). Typical *handler* relationships include parents, siblings, friends, religious leaders and coaches. Due to their personal concern for the potential offender, they attempt to do what is necessary to keep them out of trouble (Sampson, Eck & Dunham, 2010). The *handler*

closely resembles the relationship many IPs have with family members and roommates they live with as well as community leaders with whom they interact.

The second role documented is *managers*. *Managers* are individuals who monitor specific places as part of their employment responsibilities. Since crime is costly and disruptive, *managers* work towards maintaining efficiency and productivity through oversight and intervention to prevent crimes from occurring (Felson, 1995; Sampson, Eck & Dunham, 2010). Incapacitated persons (IP) who reside in institutions and community-based healthcare facilities are monitored by persons in this role of manager. In this study, managers may be required to supervise IPs from 24 hours a day to no less than 12 hours per day. All three subtypes are considered *controllers* because they exercise control over environmental conditions and potential offenders (Brunet, 2002, Felson, 1995; Sampson, Eck & Dunham, 2010).

Beyond the previously discussed subtypes of *controllers* is a higher level of supervision identified as *super controllers.* Samson, Eck and Dunham (2010) describe how *super controllers* are able to alter the behavior of the controllers (guardians, handlers and managers) and ultimately the motivated offender. Although researchers identified ten types of super controllers, they classified them into three major categories; formal, diffuse and personal. *Formal super controllers* are defined as those that rely on organizational, contractual, financial, regulatory or court appointed authority (Sampson, Eck and Dunham, 2010). State public guardians are in this *formal super controller* group as they are given power as a state agency via regulatory powers and power over persons deemed incapacitated through judicial court decisions.

The second category, known as *diffuse super controllers* can influence the actions

of formal super controllers through power gleaned from politics, financial markets and the media. They are not institutions or individuals but rather a collection of members. Samson, Eck and Dunham (2010) provide an example as when "media reports can influence political behavior" (p. 43).

This concept is easily demonstrated by an event in Kentucky that involved a person under state guardianship along with various state agencies, the media and Kentucky legislators. In August 2011, an IP voluntarily left a facility identified as a Personal Care Home (PCH) and then disappeared into a nearby wooded area. Four weeks later, local hunters found his remains near a small creek. Media reports concerning this young man's disappearance and death resulted in a state investigation of the PCH by the Office of Inspector General (OIG), Department of Aging and Independent Living (DAIL) and Kentucky Protection and Advocacy (KYPA). The OIG concluded, "the facility failed to establish effective policies to ensure continuous supervision of residents" (Lexington Herald-Leader, 2011, p. A1). A continuation of effort by super controllers (based on the results of state agency investigations) resulted in two bills being filed during the 2012 Kentucky Legislative Session. The bills were written to address concerns about the mental state of persons admitted into PCHs. Senate Bill 115 was passed by the Kentucky Legislature and signed by then Governor Steve Beshear in April 2012. The statute requires a mental and physical exam to be administered prior to admission to a PCH. It was the intent of the bill to prevent persons with serious mental problems from being admitted into PCHs, however, the legislation did not address the supervision requirements that were documented as a deficiencies in the OIG report (Kentucky Legislative Research Commission (LRC), 2016).

The final and third category of super controllers is *personal super controllers*. They are individuals who rely on personal connections within a social network. Personal super controllers would include peer groups and families. Their social connections would allow them the ability to impact the actions of the handler subtype. Samson, Eck and Dunham (2010) determined it was the *super controllers* that can most efficiently provide proper incentives to controllers and therefore positively influence the behavior of the offenders and/or targets. The precepts of Routine Activity Theory are utilized within the context of this study as explained further in the variable description section.

Routine Activity Theory was selected as the underpinning of the study because of the mounting concerns about the unsustainable growth within the public guardian program. State guardians, administrators and policymakers hold this view as the Kentucky guardianship census consistently increases by approximately 20 people per month. Awareness and planning for this increase is important. However, of equal importance is the understanding that as guardianship programs are increasing in size, diversity is also escalating. Historically, the majority of state wards were elderly Caucasian women residing in skilled nursing facilities. Today, those demographics are rapidly changing (Teaster, et al., 2007). This new IP cohort has become less institutionalized, more ethnically dissimilar, more varied in age and tend to have cognitive deficiencies which include psychiatric and intellectual disabilities, acquired brain injuries and dementia caused by chronic substance abuse (Anderson, 2013).

It is with this new and more diverse group of IPs that complaints are lodged regarding inappropriate guardianship appointments. State guardians report that persons are declared incompetent and placed under emergency guardianship because they have no

financial resources or residential placement. Judges frequently order guardianship staff to control behaviors and will threaten to hold staff in contempt of court when the IP acts out or disappears. Judges acknowledge the appointments are inappropriate but state they have no other alternatives (Anderson, 2013).

Despite such concerns among guardians, administrators, IPs, their families and the courts, literature concerning this new reality is inaccessible. Interested parties looking for theoretical insights, potential solutions or basic information concerning population demographics or size have no recourse. To date, the only published approximation of persons in guardianship comes from Schmidt's 1996 study when he estimated that 1.5 million people were under private and public guardianship (Teaster, 2003). The lack of reliable data within state guardianship programs has been discussed and recommendations offered (Uekert & Schauffler, 2008); however, no studies specific to IPs with criminal behavior could be located. Consequently, this study may well be the first to review criminal activity within a state guardianship program. Furthermore, this informal policy of admitting criminals into a program ill-designed for their specific issues has not been mandated by law or sanctioned by any department policy. Rather this change in judicial review and subsequent recommendations are being conducted in a more informal case-by-case manner.

It is the intent of this study to examine placements made with regard to levels of supervision for those IPs who have committed crimes and those who have not in this unique population. In an ideal world, IPs who have committed predatory crimes and multiple crimes should receive greater supervision. The study will explore the

demographics of the IPs and examine questions (stated in the next chapter) that can be answered by the limited database.

Chapter 4: Methodology

Data Sources

This study is a secondary data analysis based on two distinct data sources. Demographic information was obtained from Kentucky State Guardianship's electronic database known as KYGFIS and created by Panoramic Software. This database also contains case notes, incident reports and financial holdings for the 3,491 persons under the Kentucky's public guardianship program as of May 2013. Public state guardians submit basic demographic information via the software program. However, in some cases, certain variables may be missing due to the varying degrees of data fields completed per individual guardian. Regardless, the number of individuals included in the database provides a sample size sufficient to meet statistical analytical assumptions (n=3,491).

The second dataset is based on a survey conducted by the Department for Aging and Independent Living (DAIL) in May 2013. At that time there were 58 state guardians employed by the state of Kentucky and each guardian completed a spreadsheet created by DAIL administrators. Guardians were instructed to enter general information on age, sex, type of residence also known as Level of Care (LOC), county of residence and guardianship region. It should be noted that the type of residential facility where the IP resides determines the ordinal variable related to level of daily supervision. Additional information was requested concerning types of criminal behaviors and the number of criminal occurrences per criminal category. These two primary data sources were merged

to create a complete dataset that was imported in the statistical analysis software program Statistical Package for the Social Sciences (SPSS) version 24.

Although anecdotal reports concerning various criminal actions committed by IPs within Kentucky's public guardianship program are frequently discussed among the Cabinet for Health and Family Services (CHFS) personnel, the 2013 survey was the first attempt to gather quantifiable data on the disturbing trend of criminality among persons who are under the authority of Kentucky's State Guardianship Program. This exploratory study analyzes the data to discover currently unknown information on the demographics and crime frequencies for this unique group. Additionally the logistic regression analysis determines whether the tenets of Routine Activity Theory explain fundamental aspects of the criminal behaviors exhibited by IPs.

Variable Descriptions and Rationales

The following information identifies the variables utilized in the study and provides a rationale for why each was chosen and how they are operationalized.

Criminal Activity

An additional concept found in Routine Activity Theory is the classification of criminal activity. Felson (1987) creates a typology with four categories.

> The exploitative (or predatory) offense requires that at least one person wrongly take or damage the person or property of another. (2) The mutualistic offense (such as gambling or prostitution) links two or more illegal parties acting in complementary roles. (3) Competitive violations (such as fights) involve two

illegal parties acting in the same role, usually a physical struggle against one another. (4) An individualistic offense is a lonely illegal act (such as solo drug use or suicide)" (p. 912).

For the purposes of this study, the dichotomous dependent variable will be based on whether the IP has committed a predatory crime (coded as 1) or has not committed a predatory crime (coded as 0). Although data are available that includes information regarding 1) drug and alcohol offenses, 2) trespassing and 3) verbal assault, those charges will be excluded when classifying predatory criminals. Physical assaults will remain in the predatory crime category despite Felson's (1987) language on "fights" because details of the altercations are not available and a physical assault meets the threshold of "damage to a person or property" (p. 912). This is the same benchmark that was used to include the remaining predatory charges of fire setting, murder, property destruction, sex crimes, stalking and theft in the current study.

Supervision Hours of Care

According to the principles of Routine Activity Theory, the amount of daily supervision an IP receives can have a significant impact on behaviors. Thus this study will examine the direct supervision provided by the *controllers* identified as *handlers* and *managers*. For this study, regulatory supervision levels are determined according to the IP's respective residential placement. Persons living in residential healthcare facilities are supervised by the employees of the facility and are classified as *managers* while the family members or roommates sharing a private residence with IPs are categorized as

handlers. IPs who live alone, are homeless or have an unknown address are considered as having no supervision.

In the KYGFIS database this variable is referenced as Level of Care and includes numerous categories that will be collapsed into four ordinal variables based on the regulatory requirements for hourly supervision per day. The supervision levels are based on the level of care per the residential setting category chosen by the IPs guardian and approved by the residential healthcare administrators. On occasion, guardians may request a specific level of care for their IPs but should facility management not accept the IP (typically due to known behavior problems) an admission request is denied. The mandatory supervision levels were based upon the criteria for which the residential settings are categorized and collapsed. Collapsed groupings are necessary since the data collected from the DAIL survey recorded 25 different types of residences despite that fact that many were simply different names for the same type of residential setting. For example, one location type, typically termed as a nursing home was also listed as convalescent care, rehab center, skilled nursing facility and intermediate care facility. Therefore, similar settings with identical supervision levels were grouped together into the four categories described below:

Institutional setting with 24-hour supervision

This group includes all institutions that provide in-patient care 24 hours per day seven days a week. Examples include the above mention nursing homes as well as the Intensive Care Facility for Mental Disease (ICF-MD), Intensive Care for Mentally Retarded (ICF-MR), acute care hospitals, private and state-operated psychiatric hospitals

and jails. This group would be similar to Felson's (1995) concept of "managers" who serve as guardians employed to protect a specific place where crimes may occur. In this study they are identified as Institutional Managers.

Community Setting with 12-24 hours of daily supervision

This group is comprised of residential Medicaid waiver providers who care for persons diagnosed with traumatic brain injuries, intellectual disabilities or mental illness. Additional community settings with this level of supervision include group homes, personal care homes (PCH) and licensed family care providers. These residential providers are required by regulation to provide 12-24 hours of daily supervision as well as room and board to their residents (Acquired brain injury waiver, 2016; Supports for community living waiver, 2013; Personal care homes, 1999; Boarding homes, 1996; Intermediate care facilities for the mentally retarded and developmentally disabled, 1990).

Community Settings with informal supervision

This group is similar to Felson's (1995) description of *controllers* known as *handlers*. *Handlers* have an emotional connection to and watch out for the potential offenders. This group is comprised of IPs living with family members or other persons for whom they have an emotional attachment. Supervision is more informal than the two previous groups and varies in duration and intensity.

Community Setting with No Supervision

Lastly, this group is comprised of those individuals who have no one that serves in a supervisory capacity on a daily basis. They are either living alone, homeless or designated by the state guardian as absent without leave (AWOL) meaning their physical whereabouts are unknown.

Based on the conceptualizations discussed in studies using Routine Activity Theory it is expected that those with the least supervision will be more likely to participate in predatory criminal activities and those with the most supervision will not. Succinctly, as the IP's hours of residential supervision decreases, their criminal activity will increase. The null hypothesis for the study states that regardless of residential placement, criminal activity among the residents will not significantly vary.

Guardianship Region

The State Guardianship program is divided into seven regional offices. Based on the number of incapacitated persons for whom they are the responsible, the regions contain the following number of cases: Bluegrass (637 cases); Jefferson (594); Midwestern (534); Cumberland (498); Western (457); Northeastern Mountain (422); and North Central (354).

State public guardians, identified in this study as *formal super controllers*, are only required to have face-to-face visits every 90 days (Service provisions for guardianship, 2014). State guardians do not provide routine daily supervision in the same way as handlers or managers. However, the number of IPs on the state guardians' individual caseloads impacts the time they have available to inspect the type of

environment in which the IP resides and the quality of care they are receiving. Therefore, the average caseload per region is an ordinal variable that will be employed in the statistical analysis.

Sex

This dichotomous variable is coded as female (0) or male (1). A recent review of U. S. crime statistics revealed that over 1.6 million adult males were arrested for violent crimes in 2014. In that same year, a little over 780,000 women were arrested for violent crimes, revealing that males were arrested at over twice the rate as females. In 2005, the rate was 2.7 times (Federal Bureau of Investigation, 2016). This male/female arrest ratio is not surprising as researchers for decades have confirmed that crime is much more likely to be committed by a male regardless of nationality or culture (Berman & Dar, 2013).

One theory offered as to why this phenomenon is so consistent throughout time and culture is based on evolutionary psychology. Succinctly, the theory explains that male self-interest in acquiring a mate became a psychological rationale for aggression towards their rivals. Such antagonistic actions were necessary in order to acquire the status and resources needed to secure a mate as stipulated by early polygamous cultures (Daly & Wilson, 1988). Despite the stark differences in courtship and marriage in our present-day world, this deep-seated behavior plays out as males fulfill their unconscious motivations to obtain power and influence in order to thwart any potential adversaries. Theorists cite the increase in criminal activity beginning soon after puberty as evidence of the male's subliminal desire to insure future progeny despite the risk of injury,

incarceration or even death. The decline in criminal activity after marriage and children may further confirm the validity of this evolutionary theory (Kanazawa & Still, 2000). Regardless of the validity of these theoretical underpinnings, males commit crimes at a significantly higher rate than females, and therefore sex serves as a reliable predictor for criminal behavior.

Age

The subjects in this study range in age from 18-103. No one may be younger than 18 since by state regulations they would be enrolled into the Foster Care Program instead of State Guardianship. The ages will be collapsed into 4 ordinal variables; 1) Age 18-29; 2) Age 30-42; 3) Age 43-60; and 4) Age 61 and older. Criminological research repeatedly indicates a strong association between age and criminal behavior with numerous studies confirming that criminal actions begin in adolescence (Hirschi & Gottfredson, 1983; Levitt, 1999; Sampson, 1992; Snyder, 2012). According to data from various industrialized countries, including the United States, property and violent crimes peak at ages 16 and 18 respectively and then decline as individuals mature into the later stages of adulthood (Sampson & Laub, 1992). Snyder (2012) confirms the peak age for theft, burglary and robbery as age 18, followed by the peak age for murder and rape as age 19. For physical assaults the peak age is 21. Upon their internal review of U. S. crime statistics, the Bureau of Justice Statistics operationalizes "older juveniles and young adults as persons between 17 and 29 years old" (Snyder, 2012, p.3). Utilizing this rationale for defining the youngest age group, the preliminary analysis reveals there are 461 (13.2%) persons in this category.

The second and third collapsed groups are categories of older IPs based on research conducted by Blumstein, Cohen and Hsieh (1982), which noted a variability of crime rates among certain groups. Researchers found that those between the ages of 30 and 42, who previously participated in criminal activity through their 20's, had a fairly low drop out rate, meaning their criminal careers were more likely to continue. However, once they reached age 43 to 60 their criminal behavior began to recede. "The physical wear and tear, it seems, forces people to retire" (Blumstein, Cohen and Hsieh, 1982, p. 38). For those over the age of 60 the impact of health issues also impedes their ability to commit predatory crimes. In this study, the collapsed age groups mirror Blumstein, Cohen and Hsieh's (1982) research.

Race

Among the responses available in the KYGFIS dataset for race are White, Black or African American, Hispanic, Asian, Native Americans, Other and Unknown. These six categories will comprise the race variable. Unfortunately, initial analysis indicates that due to the inconsistency in reporting this demographic information, over 1,100 persons will be eliminated from the study's population due to missing data.

With respect to how race may be a predictor for criminal activity, the literature indicates consistent findings over time. Pettit and Western (2004) concluded "between 1965 and 1969, three percent of whites and 20 percent of blacks had served time in prison by their early thirties. The risks of incarceration are highly stratified by education. Among black men born during this period, 30 percent of those without college education and nearly 60 percent of high school dropouts went to prison by 1999" (p. 151).

As early as 1990, approximately 23 percent of African American males (age 20-29) were under the control of the criminal justice system by means of incarceration, probation or parole. A mere five years later, the rate of Black male participation in the criminal justice system increased to 32.2 percent or approximately one in three (Mauer, Marc, and Huling, 1995). By 2000, African Americans comprised 47 percent of the prison population even though they only encompass 12 percent of the total U. S. population (Donahue and Levitt, 2001).

More recent studies that included the examination of other races provided further insight. The noted differences between Black and White males remained consistent. However, there was no significant difference between Hispanics and other race groups or any race differences found among females (Brame, Bushway, Paternoster, & Turner, 2014). Native Americans experience a 26.3 % higher incarceration rate than Whites but oftentimes they are not in federal or state prisons. They are incarcerated on reservations leading to skewed prison demographics. Asians have consistently been incarcerated at lower rates and with less punitive sentences (Bowman, 2014). The combination of Hispanics, Asians and Native Americans defines the “Other” group but they account for only 25 IPs in this study. Consequently, race may not show any significant contribution to the statistical analysis.

Research Questions

The following questions will provide descriptive information regarding the variables available from the database.

I. Univariate Research Questions:

1. How many incapacitated persons under Kentucky's Public Guardianship Program have committed a crime?
2. What types of crimes (predatory and non-predatory) have been committed by IPs in Kentucky's Public Guardianship Program?
3. How are the IPs distributed by age group?
4. Are there more male IPs than female?
5. How are the IPs distributed by race?
6. How are the IPs distributed by region?
7. How are IPs distributed by level of care and supervision?

Results of Univariate Analysis

Descriptive statistics are provided below in an accompanying table to an answer to each research question. The questions have been restated for the reader.

1. How many incapacitated person under Kentucky's Public Guardianship Program have committed a crime?

Approximately 17% of IPs (n=578) committed a predatory crime and 168 IPs (5% of all IPs) committed a non-predatory crime. Slightly more than three-quarters (≈ 79%) of the remaining IPs did not possess a criminal record.

Table 4.1

Frequency of Criminal Behaviors

Variable Name	IPs with Criminal Charges	%	N
Crime Categories			
No Crimes Committed	2745	78.6	3491
Non-Predatory Crimes Committed	168	4.8	3491
Predatory Crimes Committed	578	16.6	3491
Total	3491	100	

2. What types of crimes (predatory and non-predatory) have been committed by IPs in Kentucky's Public Guardianship Program?

Table Two provides the descriptive statistics for the criminal activity committed by persons under state guardianship. In totality there were 1,466 criminal charges. On closer inspection of the data, 34 individuals have committed five different types of crimes. Among the 746 criminals, there were 258 (39.9%) alcohol and/or drug offenses; 234 (36.2%) verbal assault charges and 155 (20.78%) trespassing charges.

The predatory crime with the highest incidence of arrests is physical assault, which accounts for 354 (43.5%) charges. This is followed by theft (183; 22.3%), property destruction (101; 12.3%) and sex crimes (97; 11.8%). The lowest arrest records are for fire setting (36) and stalking (28), with murder being the least committed crime (15; 2.6%).

Table 4.2 Criminal Charges by Specific Offense: Non-Predatory and Predatory Crimes

Non-Predatory Criminals N=168 IPs with 647 criminal charges							
Crime Type	1st Offense	2nd Offense	3rd Offense	4th Offense	5th Offense	Total	%
Alcohol/Drug Charges	174	49	21	12	2	258	39.9
Verbal Assault	87	87	40	14	6	234	36.2
Trespassing	48	45	31	24	7	155	24
Total	309	181	92	50	15	647	100
Predatory Criminals N=578 IPs with 814 criminal charges							
Crime Type	1st Offense	2nd Offense	3rd Offense	4th Offense	5th Offense	Total	%
Physical Assault	210	91	39	13	1	354	43.5
Fire Setting	22	4	8	2	0	36	4.4
Murder	13	2	0	0	0	15	1.8
Property Destruction	50	33	14	4	0	101	12.4
Sex Crimes	64	12	11	6	4	97	11.9
Stalking	7	13	2	4	2	28	3.4
Theft	71	42	39	24	12	188	22.5
Total	437	197	113	53	19	819	100
Grand Total	746	378	205	103	34	1466	100

3. How are the IPs distributed by age group?

The age range for persons in Kentucky's Public Guardianship program was 18-103 with a mean of 55.5 years. IPs four categories were created based on those used in previous criminal justice studies. When grouped this way, Table Three reveals that incapacitated persons (IPs) who were 18-29 years of age accounted for 461 or (13.2%) of the total caseload, followed by a similar size group of 491 (14.1%) for those 30-42 years of age. The IPs are distributed in greater numbers in the latter two categories. For the age group 43-60, 1,139 (32.6%) of the IPs fall into this category. The oldest group, those over the age of 61, account for 40.1 % (1,399) of the population. (One person in the population did not have a recorded age in the database, therefore the N for this variable is 3,490.)

Table 4.3

Age Categories for Incapacitated Persons in Study

Age Categories	**N**	**%**
18-29	461	13.20
30-42	491	14.1
43-60	1139	32.6
61and older	1399	40.1
Totals	3490	100%

4. How are the IPs distributed by sex?

The cases in the database were almost evenly split between male and females (50.4% male; 49.6% female). According to the U. S. Census Bureau (2010),

Kentucky's population has slightly more females than males, (50.8% and 49.2%, respectively) so the guardianship population is a close fit to the general population of the state.

Table 4.4

Incapacitated Persons by Sex

Sex Categories	**N**	**%**
Female	1730	49.56
Male	1761	50.44
Totals	3491	100%

5. How are the IPs distributed by race?

The race of the individual IPs were recorded in the KYGFIS database, however, a review of the data indicated that due to the inconsistency in reporting this demographic information, over 1,100 persons in the study's population did not have any information on file concerning race. Based on the available data, this reduced population of 2,319 is predominately White (81%) with 17% Black and about one percent represented as "Other" races, which included Asian, Hispanic and Native American.

Table 4.5

Incapacitated Persons by Race

Variable Name	N	%
Race Categories		
White	1883	81.19
Black	411	17.72
Other Race	25	1.07
Totals	2319	99.98

6. How are the IPs distributed by region?

The data collected especially for this study revealed that in 2013 there were 3,491 persons being supervised by public guardians in Kentucky. The number of IPs by region along with the number of guardians can be seen in Table 2. Breaking this down by the seven regions, Kentucky employed 48 public guardians in 2013. The Bluegrass Region had the highest number of IPs (637) followed by the only region comprised of a single county, (Jefferson), with 594 IPs. The smallest number of IPs in a single region is North Central with 354.

With regard to caseload ratio per guardians, the Northeast Mountain region had the highest caseload at 84 IPs per guardian. The lowest level for guardian caseload ratio was North Central (354) at 59:1. For the whole state, guardians averaged 73 cases.

Table 4.6

Caseloads and Number of IPs per Supervisory Region

Regional Office	Guardians Per Region	Census	Mean Caseload
Bluegrass	8	637	80
Cumberland	7	498	71
Jefferson	8	593	74
Midwestern	7	531	76
Northeast Mountain	5	422	84
North Central	6	354	59
Western	7	456	65

7. How are IPs distributed by supervisory Level of Care (LOC)?

Residential facilities were collapsed into four categories based on the amount of daily supervision IPs received. Twenty-four (24) hour institutional care is where 1,246 (35.7%) of IPs were residing. The largest supervision group was composed of those supervised from 12-24 hours with 1,860 (53.3%) of the state caseload. The two remaining groups with the least supervision were informal supervision with 155 IPs (4.4%) and those with no supervision at all who numbered 230 (6.6%).

Table 4.7

Level of Supervision Associated with the Incapacitated Persons in Guardianship

Care Categories	Cases	Percentage
24 Hours Institutional Supervision	1246	35.69
12-24 Hour Institutional Supervision	1860	53.28
Informal Supervision	155	4.44
No Supervision	230	6.59
Totals	3491	100%

II. Bivariate Research Questions

The bivariate statistical analysis for following research questions will begin with an analysis of variance (ANOVA) since age is the only continuous variable within this data set. The remaining statistical analyses will be based on the chi-square test of independence since all other variables are either ordinal or nominal and questions pertain to association between categorical variables.

1. Is there a difference in average age for IPs associated with predatory crimes, non-predatory crimes or no criminal behavior?
2. Is there a difference in in predatory crimes, non-predatory crimes and no criminal behavior by sex?
3. Is there a difference in in predatory crimes, non-predatory crimes and no criminal behavior by race?

4. Is there a difference in in predatory crimes, non-predatory crimes and no criminal behavior by region?
5. Is there a difference in in predatory crimes, non-predatory crimes and no criminal behavior by level of care (LOC) categories?

Results of Bivariate Analysis

Bivariate statistics for each research question are provided below. In some cases, an accompanying table has been provided.

1. Is there a difference in average age for IPs associated with predatory crimes, non-predatory crimes or no criminal behavior?

A one-way between groups analysis of variance (ANOVA) was conducted to explore the effect of age on predatory, non-predatory and no criminal behaviors. IPs were divided into three groups according to their criminal history (Group 1: No Criminal History; Group 2: Committed Non-predatory Crimes; Group 3: Committed Predatory Crimes). The Levene statistic was reviewed for the test of homogeneity of variances and it was discovered the assumption of homogeneity had been violated. Consequently, the Welch and Brown-Forsythe statistic are reported respectively (157.579, 171.250, $p = .000$). There was a statistically significant difference at $p < .05$ level in age and the three criminal history groups: ($F(2,3488) = 134.72$, $p = .000$). The effect size, calculated using eta squared, was .071, which was interpreted as a medium effect size. Post-hoc comparisons using the Tukey HSD test indicated that that all groups were significantly different from one another: Group 1 ($M = 57.62$, $SD = 19.13$); Group 2 ($M = 50.77$, $SD = 15.65$); and Group 3 ($M = 43.89$, SD 19.29).

2. Is there a difference in in predatory crimes, non-predatory crimes and no criminal behavior by sex?

In this analysis, crosstabulation found that 85.8% of female IPs have never committed any crime compared to 71.6% of males. Females who committed non-predatory crimes comprised 3.2 % of the IP population; males committing non-predatory crimes were double that percentage (6.4%). Eleven percent of females have committed a predatory crime while males committed twice as many predatory crimes as their female counterparts (22%). A Chi-square test for independence indicated a significant association between sex and criminal behavior, X^2 (2, 3491) = 106.02, p = .000, *phi* = .174. The significant association between criminality and sex indicates males are more likely than females to have engaged in criminal behavior.

3. Is there a difference in in predatory crimes, non-predatory crimes and no criminal behavior by race?

Due to missing data on race and the exceptionally low count of IPs in the Other category (n=25), the total number of IPs in this analysis decreased to 2,294. There were too few of IPs classified as "Other" to enter them into the crosstabulation. The Chi Square table indicates that 83.1% of White IPs have no criminal history, compared to 77.1% of Black IPs. Approximately 17% of Whites were charged with a predatory crime, compared to 22.9% for Blacks. The Chi-square test for independence (with Yates Continuity Correlation) indicated a significant association between race and criminal behavior, X^2 (1, n = 2294) = 8.2, p = .004, *phi* = .060, indicating that Blacks are charged with predatory crimes more often than Whites.

Is there a difference in in predatory crimes, non-predatory crimes and no criminal behavior by region?

A Chi-square test for independence indicated a significant association between regions and criminal behavior, X^2 (22, 3491) = 86.8, p = .000, *phi* = .158. Table 8 provides the number of IPs and percentages per crime category and region. The Jefferson region has the highest number of predatory crimes (134) and the highest percentage (23.2). The Midwestern and Northeast Mountain region are tied for the highest percentage of non-predatory crimes (18.5). The region with the lowest percentage of predatory crimes is North Central (6.9). The significant association between criminality and region indicates IPs living in the Jefferson region are more likely to have engaged in criminal behavior than other regions in the state.

Table 4.8

Crosstabulation of Incapacitated Persons by Crime Categories by Region

Regional Office		No Crime	Non-Predatory Crime	Predatory Crime	Total
Bluegrass	Count	565	25	47	637
% within category		20.6	14.9	8.1	18.2
Cumberland	Count	382	24	92	498
% within category		13.9	14.3	15.9	14.3
Jefferson	Count	431	28	134	593
% within category		15.7	16.7	23.2	17
Midwestern	Count	413	31	87	531
% within category		15%	18.5	15.1	15.2
NE Mountain	Count	309	31	82	422
% within category		11.3	18.5	14.2	12.1
North Central	Count	297	17	40	354
% within category		10.8	10.1	6.9	10.1
Western	Count	348	12	96	456
% within category		12.7	7.1	21.1	13.1
Total	Count	2745	168	578	3491
% within all regions		78.6	4.8	16.6	100

Is there a difference in predatory crimes, non-predatory crimes and no crimes by level of care (LOC) categories?

A Chi-square test for independence indicated a significant association between LOC and criminal behavior, X^2 (6, 3491) = 99.2, p = .000, *phi* = .169. Table 9 provides the number of IPs and the percentages per crime category and per Level of Care. The LOC category that offers 12-24 hours of supervision is the most populated LOC category

with 1,860 IPs. Fifty-three percent of all IPs lived in this supervision level and residents were responsible for 56.1% of the predatory crimes. Persons living with no supervision comprised only 6.6% of the IP population but committed 12.3% of the predatory crimes. For IPs who committed a predatory crime, the smallest percentage were living with a roommate or family member with informal supervision (6.2%). However, IPs with no criminal record and those with non-predatory crime were also the least represented in the Community Informal level of care category.

Table 4.9

Crosstabulation of Crime Categories Per Level of Care (LOC)

Level of Care Based on Hours of Daily Supervision		No Crime	Non-Predatory Crime	Predatory Crime	Total
24 Hours LOC	Count	1056	43	147	1246
	% within category	38.5	25.6	25.4	35.7
12-24 Hours	Count	1450	86	324	1860
	% within category	52.8	51.2	56.1	53.3
Com. Informal LOC	Count	105	14	36	155
	% within category	3.8	8.3	6.2	4.4
Unsupervised	Count	134	25	71	230
	% within category	4.9	14.9	12.3	6.6
Total	Count	2745	168	578	3491
	% within LOC	78.6	4.8	16.6	100

III. Logistic Regression Question

Based on the tenets of Routine Activity Theory, logistic regression analysis will be conducted to investigate the following question:

1. Given the assumption that IPs placed in facilities with greater supervision should commit fewer crimes, will those (IPs) placed in situations without 24 hours of daily supervision be more likely to commit (or have committed) predatory crimes compared to the other levels of care?

The following model was examined using binomial logistic regression. The dependent variable is based on the presence or absence of predatory criminal behavior by IPs under the authority of Kentucky's State Guardianship Program. The independent variable selected, Level of Care, was chosen based on Routine Activity Theory. Even though, it is not known when the crimes associated with IPs occurred (e.g., prior to placement in a higher level of supervision or while in their current level of care), this analysis provides a glimpse of what *might be* or *could be* the situation. It serves to suggest the potential dangerousness of a group of incapacitated persons under the care of state guardians and also the need for better data regarding the criminal activity of those under guardianship.

The model examines four levels of daily supervision as predictors of the commission of predatory criminal behavior. A preliminary review of the data indicates the four groups differ significantly in size. Among the entire sample of 3,491 persons under the authority of public guardianship, *institutional managers* supervised 1,246 people. This group is the reference group and receives 24 hours of daily supervision.

They can be considered as institutionalized or as receiving in-patient care. The second level of supervision is comprised of those living in community-based residential settings (controlled by *community managers*) who are under 12-24 hours of supervision per day. This group contains 1,860 people. The third level of supervision is for those living with family, roommates, caretakers, or friends (also known as *handlers)* and they number 155 people. Lastly, 230 people live alone and have no daily supervision.

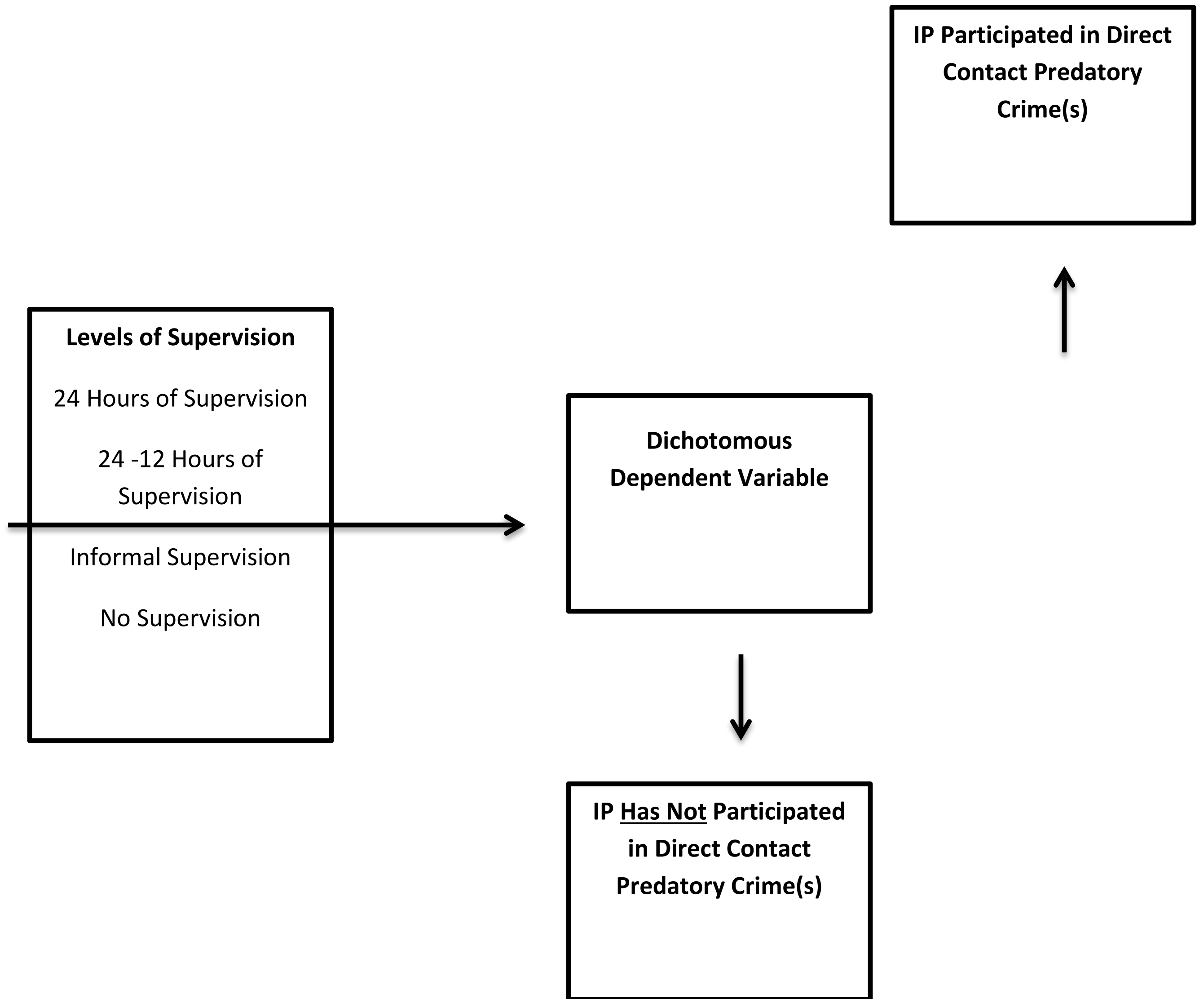
Regression Assumption Testing

Prior to testing any of the models previously described, the variables were examined to determine if certain assumptions for logistic regression had been met. The first assumption is for the dependent variable to be dichotomous (Pallant, 2010) and the commission of a predatory crime or not has been coded as 1 and 0 respectively. The second assumption for a sufficient sample size (Pallant, 2010) was also met since for this study (n = 3,491).

The third important assumption concerns multicollinearity. This refers to independent variables having a highly correlated relationship to one another. The existence of multicollinearity can cause regression statistics to be incorrect and therefore variables should be examined to ensure this is not an issue (Pallant, 2010). For this study, the variables were tested for multicollinearity using the linear regression collinearity statistic (Field, 2005). The coefficient table providing the collinearity statistics of *tolerance* and *VIF* was reviewed. Menard (1995) reports that a tolerance value of less than .2 may signify a collinearity concern and certainly a .1 statistic indicates a "serious" collinearity problem (p.76). Additionally, Myers (1990) advises that a VIF value greater

than 10 indicates a collinearity problem. With respect to this dataset analysis, the lowest tolerance statistic generated was .544 and the highest VIF statistic reported was 1.839. Both statistics were from the guardianship region variable, specifically the Jefferson region. Since none of the independent variables meet the two collinearity statistics benchmarks, multicollinearity for the independent variables in this study is not a concern. Knowing that the assumptions for binomial logistic regression have been met, the following diagram illustrates the conceptual model tested in the statistical analysis.

Figure 4.1 Conceptual Model 1



Logistic Regression Results

This initial inquiry examines the relationship between level of supervision and predatory crimes. Twenty-four hour supervision is the reference category for the analysis. In this model, all predictors are significantly significant (X^2 =56.439, p < .001). The Hosmer and Lemeshow test confirms the model has a goodness of fit (X^2 =0.00, p = 1.00) The model correctly identified 83.4% of cases. The strongest predictor of who commits a predatory crime is Level 4 recorded by the odds ratio of 3.338. This indicates that persons who have no daily supervision are over 3 times more likely to commit a predatory crime than those who have 24-hour supervision. Informal handlers recorded an odds ratio of 2.26, which reveals persons living with family or roommates are twice as likely to commit a predatory crime than those that have 24 hours supervision. Community managers who provide 12-24 hours of supervision record an odds ratio of 1.57, indicating a slight increase in crime commission when daily supervision moves from an institutional to a community setting.

Table 4.10

Logistic Regression Analysis Results Predicting Predatory Criminality (N = 3491)

	Model 1		
Variable	*B*	*SE B*	*B*
Daily Supervision			
24 Hours	*ref*	*ref*	*ref*
12-24 Hours	.456	.107	1.577**
Informal Supervision	.816	.210	2.262**
Unsupervised	1.205	.168	3.338**

Chapter 5: Discussion

Crime Prevalence and Typology

A review of the descriptive statistics demonstrates that almost 17% of the IPs within Kentucky's State Guardianship Program committed a predatory crime at some point. Out of the 746 individuals in the public guardianship that have some type of criminal record, 578 have committed predatory crimes with the highest percentage belonging to those who have committed physical assault. Predatory criminal charges were 3.5 times more prevalent than non-predatory crimes. In terms of public safety, this is a major concern due to the possible implication that the majority of perpetrators are not confined in a 24-hour supervised institutional setting, but rather are living in the community.

Among those who committed a non-predatory offense, alcohol and drug charges are prevalent with nearly 40% of the IPs involved—despite alcohol and drugs being prohibited on-site at all residential healthcare settings. If these offense occurred in their current level of care setting, which is actually unknown, then this behavior can only be occurring during times of non-supervision. Clearly, non-supervised individuals high on drugs or alcohol in conjunction with their mental incapacities are a concern for both their own safety as well as the public.

Again considering that physical assaults are the most frequent predatory crime and likely involve a range of situations that include aggression towards others living in the same facility, conflicts with mangers and handlers, state guardians and community members, there is a suggestion that needed supervision and interventions are lacking. Persons found incompetent by the courts may not be capable of self-regulating their

behavior. Given their multiple limitations on personal freedom, internalized frustration may easily transform into externalized aggression towards others. The combination of these factors again places this vulnerable population at personal risk of harm in addition to the public's risk of victimization.

A more in-depth review of the murder charges shows that within Kentucky's guardianship program there are 13 murderers, including two individuals who convicted of two separate murders each. Among the 13 convicted murderers, seven were reported living in the highest supervision level (24 hours a day) with the remaining six individuals living in various community settings that require 12-24 hours of daily supervision. The age range among the 12 males and one female is 47-83 years old.

Age

The largest age group within the guardianship population is persons over the age of 60. This is not surprising given that the historical context for creating a public guardianship program was to secure payments to nursing homes for caring for their elderly patients with dementia (Teaster, et al., 2007). However, the population is now much more diverse with 27% of them under the age of 42. This more physically active group of IPs can increase the difficulties for guardians to keep up with their whereabouts as well as complicating the location of appropriate residential placements designed to meet their younger needs. The bivariate analysis also confirms previous findings concerning age and criminality. For those IPs that have not committed a crime, the mean age was 57.6 and 50.7 years for non-predatory crimes. Predatory crime commission indicates an average age of 43.8 years; 14 years younger than the non-criminal group.

Sex

Males were more likely to have committed a crime than females. This aligns with previous research and remained consistent with the findings of Blumstein, Cohen and Hsieh (1982). In this study, males were twice as likely to commit non-predatory and predatory crimes than females. Due to males being more aggressive and oftentimes combative, locating appropriate residential placements can become extremely difficult for male IPs with a criminal record. Healthcare facilities are not mandated to take in every individual. If a provider fears the potential resident may cause harm to others residents or staff, they will not allow the person to be admitted to their facility. Guardians must continue to seek out a willing provider, which can take an extensive amount of time and may also require the IP to move to a different region of the state.

Race

The data revealed a higher criminal rate for Blacks than for Whites. Utilizing an additional crosstab statistical analysis on race and predatory crime it was determined that among the 578 predatory criminals, it was possible to only identify 318 as “White,” 94 as “Black” and 7 as “Other.” This totals 419 racially identifiable criminals--meaning 159 persons known to have committed a predatory crime cannot be identified. This calculates to a loss of information on 27.5% of IPs that committed predatory crimes. Consequently, it is ill advised to make any general assumptions in the study based on race and criminality.

Guardianship Regions and Caseloads

Super controllers (state public guardians) are expected to remedy these types of concerns but the data reveals regional offices are not equal in their allotment of responsibility as there is significant variation in caseloads. A previous study by Teaster, Schmidt, Abramson, & Almeida (1999) recommended "a ratio of 1:20" (Teaster, 2002, p. 344) to ensure quality care and oversight. The North Central region has the lowest average caseload of 59, which is almost 3 times over the Teaster, et al. (1999) recommendation. The two highest average caseloads are Northeast Mountain (84) and Bluegrass (80), which are over 4 times the recommended ratio. These excessive high caseloads for often-overworked public guardians can help us better understand how it happens that clients end up in inappropriate residential settings.

Level of Care

The level of supervision variable indicates 74.5% of predatory criminals live in the community. The vastly different types of facilities monitored by community managers are known to vary—supervisory hours can range from 24 down to 12 hours per day. Informal supervision by family or roommates can also vary significantly as it is dependent upon the relationship and involvement of the other people the IPs live with. Clearly, living alone indicates the IP has no supervision and is free to make autonomous decisions concerning his or hers day-to-day activities. As previously noted, persons living with no supervision comprised only 6.6% of the IP population but they committed 12.3% of the predatory crimes. A chi-square test for independence indicated LOC supervision levels and criminality are significant across all levels.

Results from the binomial logistic regression provide some support for the Routine Activity Theory. For persons living in the community with 24-12 hours of supervision the odds ratio was 1.57 for committing a predatory crime. For informal supervision, it rose to 2.26—meaning those IPs were twice as likely to commit a predatory crime than those supervised more tightly. Persons living alone were 3 times more likely to commit a predatory crime than those under 24-hour supervision. These results should confirm to state governments that appropriate residential placement and supervision are key to reducing the criminal activity of IPs—especially for younger males. If, these crimes are being committed in the level of care associated with them in the database. Unfortunately, the database does not indicate when the crimes occurred or where the IP was living at the time.

Study Limitations

The primary limitation of this study is the data available on Kentucky's State Guardianship Program. Despite the convergence of two separate data sources, the final database had missing and incomplete data leaving certain fields of inquiry impossible to answer. Due to the demands of exceptionally high caseloads (three to four times the recommended ratio) state guardians do not have the time to enter all the data elements available in the KYGFIS software. While the 2013 survey provided information related to criminal activity for the 3491 IPs, the dates of arrests were not provided. Consequently, it is not clear if the IPs were criminally charged while under the supervision level where they were currently residing. Equally unfortunate is that the survey relied on the knowledge and recall of state guardians which was not necessarily

substantiated by official documentation arrest records from Kentucky's Office of the Courts.

For the variable pertaining to hours of supervision, the categories were collapsed into four major groups. The managers for 12-24 hours of supervision most assuredly vary significantly from facility to facility. For example, Personal Care Homes (PCH) are required by regulation to provide room, board and supervision for up to 24 hours. However, in reality, some PCH's are rather lax in their enforcement of said regulations resulting in some residents not being closely supervised. Equally true is the range in hours among handlers' supervision as family relationships may vary in levels of family involvement/supervision. This wide variation in supervision within each category is another limitation to the study.

Lastly, this study was based on a snapshot of the guardianship population at the time the survey was administered. This population is constantly in flux with changes in guardian assignment, residential placement and the admission and removal of persons who are deemed incompetent. Due to the shifting census and demographics, a complete understanding of this complex program is difficult to operationalize and study. However, research initiatives should be encouraged as there is so little data concerning this vulnerable population.

Recommendations

Through a single judicial decision this unique group of citizens has lost countless freedoms including the right to vote. Consequently, this often poor, mentally unstable population lacks the ability to create change for themselves and advocates can offer few

facts to support their cause. It is for these reasons I strongly encourage social work educators to include public guardianship programs, policies and research within their respective aging, policy and/or research courses. Although the majority of state guardians have social work degrees, they have received little if any education on the plight of the IPs within their charge. They face a steep learning curve as they attempt to learn more about this population, effectively deal with ethical dilemmas involving paternalism and self-determination as well as the policy driven bureaucratic paperwork for which they are responsible.

The results from this study can be useful to state legislators and administrators who desire to protect the vulnerable and the public at large. Clearly, the need to hire additional social workers to serve as state guardians is evident in the findings. All of the guardianship regions in Kentucky have caseloads 3-4 times the recommended ratio of 1:20. This will only become more problematic as the demographics of persons over 65 continues to increase. The state guardianship program budget has been reduced at a time when personnel should be increased significantly. Social workers who are constantly being asked to do more and more will eventually suffer from burnout and compassion fatigue which in turn creates employee turnover. A similar situation has already occurred in Jefferson Country's Child Protection agency (Louisville Courier-Journal, 2016). It is strongly advisable that state administrators request additional funding in order to increase staffing in all seven of Kentucky's State Guardianship regions. Legislators informed of the individual and public safety issues discussed in this study, should approve a significant increase in the State Guardianship program's budgetary allocations in order to ensure a more closely monitored program that places persons in appropriately supervised

residential settings. A reasonably staffed state agency in conjunction with the proper residential placement of public guardianship IPs should reduce the number of criminal actions that will be committed in the future.

The political will to provide research funding or initiate policy changes is practically nonexistent. During the 2017 Regular Legislative Session, House Bill 63 was introduced and has remained in the Judiciary Committee since January 3, 2017. The purpose of this bill is to remove the jury requirement from the judicial process for guardianship, thereby allowing judges to make the sole determination of one's competency (Kentucky Legislative Research Commission, 2017). This legislative effort to streamline the guardianship adjudication process may improve efficiency among the courts but does little to protect the civil rights of the person before the court or assist public guardians in meeting their multiple and paradoxical obligations to their client and the state.

Guardianship has been described as a "two-headed creature; half Santa and half ogre" and the relentless tension between the respect for the ward's self-determination and the sometimes necessary paternalistic job requirements by public guardians, undoubtedly explains the nature of this mythical creature described by Regan and Springer (1977, p. 27). Public guardians have no power over a residential provider's decision to admit their client to their facility. Additionally, they also have little sway over managed-care companies' management decisions on who meets the level of care requirements for institutional or community residential placements. However, what this study strongly suggests is that the amount of supervision received may be a key factor in reducing

recidivism rates for those clients who have previously exhibited criminal behaviors and/or been incarcerated.

Public guardians, who are assigned the responsibility to find appropriate housing, should be allowed to have input into judicial and healthcare decisions prior to their final judgments instead of the current procedure that only allows them to become after-the fact miracle workers. Public guardians have many responsibilities to their clients and to their communities and when given the time and resources necessary to properly perform their job, the lives of their clients could be improved while also helping to maintain a community's public safety.

It is notable that during this legislative session, State Legislators enacted a budget increase of 5% for 2017 and 1% for 2018 (Kentucky State Office of Budget Director, 2017). However, it remains to be seen of this nominal increase (after previous years of budget cuts) will make up for the losses Public Guardianship has experienced. As a largely forgotten segment of our society, those served by public guardianship deserve to be better understood and their dilemma acknowledged and improved upon. Future research in this area can provide newfound knowledge to assist a currently uninformed public of the plight of IPs throughout this state. Awareness is at least the first step in solving a problem that is silently and rapidly growing throughout Kentucky.

Future Research

For guardianship research to successfully contribute to the literature and serve as a foundation for evidence-based practices for this population, consistent data collection is imperative. Every state should submit data to a centralized federal location in order to create a comprehensive national database. This is the only way for valid empirically

based research to begin. Specific future research endeavors tied to this study could include an examination of other state guardianship programs to determine if criminality is an issue in other areas of the country. Kentucky state guardians discuss the existence of criminality within guardianship regularly but it is not yet understood if this problem is only occurring in Kentucky’s court system or rather is it a national or regional trend.

Adding variables for IQ, mental, and physical diagnoses may prove to be significant predictors for crime but these options were not available from this data set. Criminality and IQ are empirically correlated but there are mixed opinions as to whether this indicates causality. Future research in this area could focus on the mechanisms as to how lower IQ can impact numerous other factors that may also lead to crime including the loss of self-determination as mandated by the guardianship program (Raine, 2013). Persons under the control of public guardianship have a variety of diagnoses including intellectual disability, mental illness, dementia and traumatic brain injuries. Many times they have more than one diagnosis. Future research could examine how these factors contribute to criminal behavior in scope and specificity.

In addition to the quantitative research, potentially available from state and national data sets, more qualitative data collection such as interviews with IPs and their families could provide a clearer picture in understanding this phenomenon. Since the related areas of study within guardianship could include criminal justice, aging, mental health law, healthcare decision-making and palliative care, future research has a rich potential for numerous disciplines of study and interdisciplinary collaborations. Unfortunately, the lack of data continuously serves as a considerable barrier in allowing

research to serve a more informed public, a better-educated workforce and a government that truly serves all of its citizenry.

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Vita

NAME: Karen E. Martin, PhD, MSW.

EDUCATION

PhD University of Kentucky Lexington, KY 2017
Major: Social Work
Dissertation Title: An Exploratory Study of Incapacitated Persons with Criminal Behaviors Served by Kentucky's Public Guardianship Program

M.S.W. University of Kentucky Lexington, KY 2006
Major: Social Work

B.S.W. University of Kentucky Lexington, KY 2004
Major: Social Work

PROFESSIONAL POSITIONS

Director, Division of Community Alternatives, Department for Medicaid Services, 2008 - 2014

TEACHING

Course Number	Title
SWK 210	Human Behavior/Social Environ II
SWK 335	Human Behavior/Social Environ II
SWK 410	Social Welfare Policy Practice
SWK 455	Social Justice in Media and Film

Courses Taught at Other Institutions

University of Kentucky, Lexington, KY, "Social Welfare Policy: Theory & Implementation", SW, 430. (Spring 2014).

University of Kentucky, Lexington, KY, "Foundations of Professional Ethics in Social Work", SW, 435. (Fall 2013).

University of Kentucky, Lexington, KY, "Foundations of Professional Ethics in Social Work", SW, 435. (Spring 2013).

PUBLISHED WORKS

Martin, K. *Martin, K. (2013). Three teaching modules on 1) Healthcare Reform; 2) The Corporation and 3) Social Work Resources.* Teaching Human Rights: Curriculum Resources for Social Workers, A Resource Manual.

PRESENTATIONS

Martin, K. *Kentucky Department of Public Advocacy's (DPA) Annual Public Defender Educational Conference*. June 2014.

Martin, K. An Exploratory Study of Incapacitated Persons with Criminal Behaviors Served by Kentucky's Public Guardianship Program. *Presentation for EKU Junior Faculty Research Grant,* November, 2015.

OTHER MEETINGS/WORKSHOPS/PROFESSIONAL DEVELOPMENT

Legal and Ethical Training, Service, College of Arts and Sciences, Richmond, KY. (November 14, 2014).
Legal Issues for Faculty were presented by EKU's Chief Ethics and Compliance Officer, Dr. Judy Spain. Dr. Spain presented on compliance policies and procedures and The Family Educational Rights and Privacy Act (FERPA).

College of Arts and Sciences Junior Faculty Mentoring Program, Service, College of Arts and Sciences, Richmond, KY. (October 7, 2014).
Structure of CAS Junior Faculty Mentoring Program, Best Practices on Faculty Mentoring and Expectations for Mentors and Mentees. (Mentors also required to attend)

Assurance of Learning Day, Teaching, College of Arts and Sciences, Richmond, KY. (September 19, 2014).
Social Work faculty meet for the day to discuss and create documentation for upcoming Council on Social Work Education (CSWE) accreditation requirements.

College of Arts and Sciences New Faculty Orientation and Reception, Service, College of Arts and Sciences, Richmond, KY. (September 12, 2014).
1. New Faculty Orientation (Friday, September 12, 2014; 3-5 pm)
2. New Faculty Orientation Reception (Friday, September 12, 2014; 6.30-9 pm; Arlington)

Orientation for EKU students in the BSW program, Service, Social Work Program, Richmond, KY. (September 9, 2014).
Assisted students with understanding the EKU Social Work program requirements for admission

GRANTS & CONTRACTS

Technology Grant *(PI)*: Martin, K., Student Government Association, Funded $1,596.00. (January 20, 2015 - Present).

Junior Faculty Summer Research Award, (PI): Martin, K., College of Arts and Sciences, Eastern Kentucky University, Funded $1500.00 (June-August, 2015).

INSTITUTIONAL SERVICE

Department

ANSW Awards Committee, **Committee, Member**, Appointed. (August 14, 2014 - Present).
The Department's Awards Committee oversees the nomination and selection process for all student awards.

EKU Social Work Program, **Workgroup, Member**, Volunteered. (September 25, 2014).
The Eastern Kentucky University Social Work Program hosted its annual Student Social Work Day on Thursday, September 25, 2014. The theme for the event is Political Empowerment within the Feminist Perspective. The documentary film Raising of Ms. President, produced by Kiley Parker, was shown in the morning. The film examines reasons for women's lack of political involvement.

College

EKU Spotlight Day, Faculty Administrative Assignment - Department, College, University. (November 15, 2014).

EKU Faculty Senate, Senator. (August 2016-May 2018).

PROFESSIONAL MEMBERSHIPS

National Center on Substance Abuse and Child Welfare. (2010 - 2014).

HONORS AND AWARDS

Personal Awards

2013 Teacher that Makes A Difference award University of Kentucky, College of Education. (2013).

OTHER ACTIVITIES/ACCOMPLISHMENTS

Licensures and Certifications

"Certified Social Worker", Kentucky Board of Social Work. (May 25, 2012 - May 25, 2015).