Appendix

Origins and Structure of the Virginia Advance Directive Project

The Chief Justice of the Virginia Supreme Court convened the Commission on Mental Health Law Reform (Commission) in 2006 to examine existing laws, policies and services and propose necessary reforms. The Commission's guiding principles included recovery-oriented services and consumer choice (1-2). The Commission established five task forces, including the Task Force on Empowerment and Self-Determination (Task Force). The promise of providing a legal foundation for a recovery-oriented public mental health services system led the Commission to include PADs as one of the core components of its blueprint for reform in the wake of the tragic shootings at Virginia Tech in April, 2007. The Task Force reviewed the growing body of research on recovery and PADs, as well as the commentary on laws in other jurisdictions, and issued its report and recommendations in 2008 (3), which were then adopted by the Commission (2). An overhauled and expanded Health Care Decisions Act (HCDA;4) was adopted in 2009 and then modified further at the Commission's request in 2010.

Based on the Task Force's recommendation, the Commission decided not to propose a stand-alone PAD statute but instead decided to integrate instructions

for mental health care within the basic legal framework of health care decision-making that formerly covered only end-of-life care. This integrated approach expresses a focus on a holistic conceptualization of personal health and well-being—an approach in which mental health is as integral a domain of health care as medical and end-of-life care. Only six other states had woven language about mental health decision making into their existing health care decision laws. Arguably, Virginia's statutory changes are the most comprehensive, however, even including mental health alongside all other treatments in the model advance directive form included in the statute (5).

The revised HCDA strengthened the presumption of decisional capacity and clarified the procedure for assessing a patient's capacity and activating the AD (or, in its absence, triggering the procedure for designating a surrogate decision-maker). The Act also established a non-judicial procedure for medically and ethically appropriate treatment over protest of a person with dementia who has not executed an AD. Among the provisions in the HCDA with specific relevance to ADs are those that specifically allow the person executing such a document to:

- authorize a designated health care agent to authorize psychiatric hospitalization for up to 10 days. (In the absence of an advance directive, neither the decisionally impaired patient, nor the patient's next of kin, would

have legal authority to admit the patient to a psychiatric hospital under Virginia law, and an involuntary commitment order would be necessary.)

- give specific instructions regarding his/her mental health care, including consent to or refusal of medication or ECT. (These instructions are binding in the absence of an emergency.)
- authorize the agent to consent to treatment, including hospitalization, over his/her later objection. (A "Ulysses clause" is legally effective only if it is accompanied by a clinical certification that the person understands the consequences of conferring this authority.)
- empower the agent to determine who may and may not visit the incapacitated person during inpatient treatment.
- authorize disclosure of information during a crisis in advance even when the health care privacy laws would otherwise forbid it.
- authorize his or her agent to enroll him or her in IRB-approved research. (This provision is particularly important in connection with studies involving subjects with dementia.)

These provisions are designed not only to facilitate use of ADs in empowering persons with serious mental illness to have greater control over the services they receive, but also to facilitate advance planning by persons with concerns about the loss of decisional capacity as a result of dementia.

Implementation efforts thus far have largely focused on integrating PADs into routine mental health services in the public outpatient sector. Public mental health services are provided in Virginia through collaboration between the central office of the Department of Behavioral Health and Developmental Services (DBHDS), the state hospitals operated by DBHDS, and Community Services Boards (CSBs), which are local government entities and the operational partners for providing services. DBHDS also licenses more than 750 private providers, however, CSBs are the leading provider of services with which DBHDS contracts each year. There are 40 CSBs across Virginia, each with its own infrastructure, culture, resource strengths and weaknesses, etc.

The implementation project was initiated immediately after enactment of the HCDA revisions, when the stakeholder leadership undertook a joint commitment to embed PADs into routine care and to take the necessary steps to implement the policy on a statewide basis. These efforts initially were conducted under the auspices of the Commission on Mental Health Law Reform. However, recognizing that the Commission was scheduled to expire in 2011, the stakeholder leadership group created a Coordinating Committee for Promoting Use of Advance Directives by People with Mental Illness—a collaborative oversight body composed of many of the same stakeholders that had participated in the development of the revised HCDA. Under the auspice of this Committee, the first 3 years of implementation efforts unfolded through several education, training,

and research initiatives conducted by workgroups comprised of relevant stakeholders (e.g., the workgroup that drafted a standardized form was comprised of legal counsel from a statewide healthcare association, legal scholars, and health law practitioners).

Activities undertaken include:

- Organization of a series of conferences in 2009/2010 to begin the process of educating the key constituencies, as well as garnering advice about implementation strategies.
- Creation of standardized AD forms developed in collaboration with the Virginia Hospital and Healthcare Association and available at www.virginiaadvancedirectives.org/option-1--integrated-ad.html.
- Incorporation of PADs at five pilot CSB sites, including coordination with relevant departments, identification and training of staff as facilitators, and creation of methods for tracking efforts and outcomes. In addition, pilot sites meet monthly by phone to discuss implementation barriers and strategies.
- Outreach and education of providers and consumers at relevant events, such as annual provider-focused conferences and consumer-led conferences.
- Outreach, education and consultation to non-pilot CSBs to promote awareness of the state's commitment to PADs and encourage their adoption.

- Efforts by a workgroup composed of health law experts to clarify the legal aspects of executing and enforcing PADs.
- Proactive pursuit of collaborations with area agencies (e.g., peer-run agencies) that also serve the consumers served by the pilot CSBs in order to increase consumer awareness of PADs.
- Recruitment and training a network of attorneys throughout the state to provide any necessary legal assistance pro bono, such as for consumers who prefer to meet with an attorney to complete a PAD or for more complex cases. Parallel efforts to develop a law school clinic model, in which law schools with (mental) health law clinics can train students on PADs and cooperate with area providers to assist consumers interested in PADs.
- Creation of an Implementation Manual, based upon knowledge of Virginia's health care system, insights from dissemination and implementation literature, and experiences of pilot sites, as well as a Facilitator Certification Training program, based upon the expertise of consumers, attorneys, and clinicians integrally involved with the PAD project. [ADD link to manual]
- Creation of a website and posting of Virginia-specific information and resources for consumers, families, and providers (www.VirginiaAdvanceDirectives.org).

References

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3. Report of the Task Force on Empowerment and Self-Determination. Richmond, Va, Commission on Mental Health Law Reform, Task Force on Empowerment and Self-Determination, March 2008. Available at www.courts.state.va.us/programs/concluded/cmh/taskforce_workinggroup/2008_0919_tf_empower_slfdtrmntn_rpt.pdf

4. Health Care Decisions Act of 1992, Va. Code Ann. § 54.1-2981 et seq., 2010

5. Suggested form of written advance directives, Va. Code Ann. § 54.1-2984, 2010