

REPORT OF THE

**Select Committee to Study the
Statewide System of Providing
Substitute Consent for People
with Mental Disabilities**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



HOUSE DOCUMENT NO. 37

**COMMONWEALTH OF VIRGINIA
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**Report of the
Select Committee to Study the Statewide
System of Providing Substitute Consent for
People with Mental Disabilities
(HJR 614)**

to

**The Governor and General Assembly of Virginia
Richmond, Virginia**

Introduction

House Joint Resolution 614, patroned by Delegate DeBoer, agreed to during the 2001 General Assembly Session, established a select committee to study the system of providing substitute consent to persons with mental disabilities (Appendix A). The study resolution was introduced at the request of the Virginia Association of Community Services Boards (VACSB).

Background

After the General Assembly enacted legislation in 1999 (SB 1224) to strengthen the human rights' protections for consumers of mental health and mental retardation services, a limited population of consumers in the community with mental illness or mental retardation who are unable to make decisions for themselves and who have no guardian, authorized representative or available family member, were left with no one to make decisions for them.

Very often, these consumers need medical and dental care that may not be of an emergency nature, but that significantly affects their comfort, health and safety. Prior to 1999, the director of a community services board could serve as a legally authorized representative and consent to treatment. Although it is possible to obtain judicial authorization for treatment (§ 37.1-134.21) the process is expensive, time-consuming and cumbersome. The time that it takes to get a hearing, especially in rural areas, can be detrimental to the consumer's health and well-being. Recent regulations promulgated by the Board of Mental Health, Mental Retardation and Substance Abuse Services allow for a "next friend" to serve as a substitute consent maker. However, in order to be a "next friend" there must have been a pre-existing relationship between the parties. A method is needed to authorize urgent and emergent medical and dental services in a timely manner so that the needs of consumers are met with regard to and respect for their human rights.

Committee Activities

The committee heard from the VACSB, the Virginia Guardianship Association, the Department for the Aging, and the Department of Mental Health, Mental Retardation and Substance Abuse Services. A number of other state agencies and advocacy groups followed the work of the committee.

The committee asked that information be collected on (i) the number of people in facilities without a legally authorized representative, (ii) the number of persons with mental disabilities who are unable to give consent served by community services boards and are without a guardian or legal authorized representative, (iii) the number of times that community services boards have faced situations where consumers have needed urgent or emergent medical or dental treatment and there was no one to authorize treatment and (iv) descriptions of those situations.

The VACSB conducted a survey to respond to this request and to determine the extent of the problem. Twenty-seven of the 40 community services boards responded. The survey results indicated that 916 people fell in the category of being unable to give informed consent themselves and had no guardian or family member able to give consent for them. Three hundred forty-seven of those people needed urgent or emergent medical care within the last year. For 165 persons there was no problem, often because the provider was willing to treat without obtaining informed consent. For the remaining 182, the lack of substitute consent presented a problem.

It was noted that those consumers who have no one to give consent are often persons who have been recently released from state mental health and mental retardation facilities. As more persons with serious disabilities are released from institutions into the community, the lack of a mechanism for substitute consent will be an increasing problem.

A representative of the Virginia Guardianship Association advocated for the expansion of the Public Guardian and Conservator Program (VPGCP), stating that the most direct and expedient method to address the need for more substitute decision makers for this portion of the population would be to expand the VPGCP throughout the Commonwealth, with special emphasis on regions where public mental hospitals and residential facilities are located. The VPGCP was established in 1994 when the General Assembly appropriated funding to explore the feasibility of a publicly funded program. The cost of providing public guardianship services is approximately \$2,500 per person, annually. The protection provided to the individual by appointment of an accountable public entity governed by statute and regulations far exceeds other stopgap measures. It is estimated that a high

percentage of public guardianship costs are recovered by a reduction in the cost of medical and social services for persons receiving public guardianship services.

The Department for the Aging's administrator of the VPGCP stated that Virginia's nine programs were selected from 17 good proposals. The programs are administered by a variety of agencies and are rigorously monitored by the Department for the Aging. Because state funds are not sufficient, many of the nine entities subsidize the program. The VPGCP serves 212 persons and it is estimated that statewide there are 2,288 additional persons who are in need of public guardianship services. These numbers include persons who are elderly as well as persons with mental disabilities.

An evaluation of the program by the Center for Gerontology at Virginia Tech, which was completed subsequent to the committee's deliberations, is attached as Appendix B.

Committee Deliberations and Recommendations

The committee determined that the ideal solution is to expand the existing VPGCP. The guardianship programs perform many services for the people in their programs; service is not limited to obtaining consent when a medical or dental need becomes apparent. Many guardians are proactive in securing medical care, appropriate housing, placement in a day program or residential facility if needed and other services. It can be an advantage to have a corporate guardian because there will always be a guardian, even if a particular individual can no longer serve as a guardian. Since general funds are used in the VPGCP, full funding is not likely to occur in the immediate future and the committee concluded that there is a need for an interim solution.

The committee extensively discussed alternative solutions, including the feasibility of establishing alternative and speedier court procedures, allowing a "next friend" to give consent, utilizing special justices and having a physician at the local health department review and approve the need for treatment. Adequate protection of the rights of this vulnerable population was of paramount concern to the committee. The committee determined that using a "next friend" is not feasible because the Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services state that there has to be a pre-existing relationship in order to qualify as a "next friend." In order to qualify as a "next friend" the proposed "next friend" must have shared a residence with or provided support and assistance to the individual for a period of at least six months prior to being designated as a "next friend."

The committee considered a suggestion that the local human rights committees (LHRC), which every community services board has, and which already regularly approve treatment and medication plans for consumers, authorize specific urgent and emergent medical or dental treatment. One of the duties of an LHRC is to engage in fact-finding in complaints filed on behalf of consumers receiving services. Committee members noted that there could be a conflict of interest for the members of the human rights committees. The committee also noted that in many areas of the Commonwealth LHRCs are already overworked. After considerable discussion of this proposal the committee determined that this is not an appropriate responsibility for the LHRCs and rejected this as a solution.

The committee decided to recommend that § 54.1-2970 of the Code of Virginia be expanded to include incapacitated community services board consumers and to include dental treatment. Currently the statute applies to patients and residents of state mental health and mental retardation facilities who are incapable of giving informed consent by reason of mental illness or mental retardation and provides that a licensed health professional or licensed hospital will not be subject to liability arising from a claim based on lack of informed consent when a delay in treatment might adversely affect the recovery of an individual who has no guardian or committee; nor shall such professional or hospital be prohibited from treating the person. The statute also contains the following conditions: (i) no legally authorized guardian or committee was available to give consent, (ii) a reasonable effort was made to advise a parent or other next of kin of the need for medical treatment, (iii) no reasonable objection was raised by the incapacitated person, and (iv) two physicians document in writing that they have made a good faith effort to explain the treatment to the individual and they have probable cause to believe that the individual is incapacitated and unable to consent to treatment because the individual is mentally ill or mentally retarded and delay in treatment might adversely affect recovery. The statute applies only to physical injury or illness and not to treatment for mental, emotional or psychological conditions.

The committee recommended expanding the statute so that it will apply to community services board consumers and include dental treatment. In the case of dental care the written documentation must be obtained from two dentists or one dentist and one physician. The committee also recommended a change so that treatment will not be authorized if a reasonable objection to the treatment is made on behalf of the individual. Under current law only the individual can raise the objection.

This recommendation resulted in Senate Bill 483, which was passed by the 2002 General Assembly and will become effective July 1, 2002 (Appendix C).

The committee recognized that SB 483 addresses a limited portion of the problem of persons with mental illness or mentally retardation who need a guardian and made a number of other recommendations.

A complete list of the recommendations follows:

1. The existing public guardianship program should be expanded.
2. The Secretary of Health and Human Resources should look for alternative funding sources for the public guardianship program, possibly federal or foundation grants.
3. The community services boards should be proactive in identifying consumers who are without a guardian and in working with families to identify guardians for persons with mental illness or mentally retardation.
4. The community services boards should inform families of the importance of arranging for a guardian to serve in the event of the death, incapacity or unwillingness of the family member currently serving as guardian.
5. The community services boards should arrange for the necessary legal assistance in the appointment of a guardian if the potential guardian is not able to obtain his own legal services. Pro bono assistance should be explored.
6. The Association of Retarded Citizens should be asked to inform families of the importance of arranging for a guardian and an alternative guardian for their incapacitated family member and to encourage families to make arrangements.
7. Section 54.1-2970 of the Code of Virginia should be amended to include consumers receiving case management service from a community services board or behavioral health authority and to include dental care.

Respectfully submitted,

Delegate Jay W. DeBoer, Chairman
Senator Janet D. Howell, Vice-Chairman
Delegate Robert D. Orrock, Sr.
Delegate Anne G. Rhodes
Delegate John M. O'Bannon, III
Senator William C. Mims
Senator Frederick M. Quayle

GENERAL ASSEMBLY OF VIRGINIA -- 2001 SESSION

HOUSE JOINT RESOLUTION NO. 614

Establishing a select committee to study the statewide system of providing substitute consent for people with mental disabilities.

Agreed to by the House of Delegates, February 22, 2001

Agreed to by the Senate, February 21, 2001

WHEREAS, whenever possible, mentally disabled citizens should be provided the greatest amount of independence to make their own decisions; and

WHEREAS, in certain circumstances, there is a need for legal intervention in the decision-making of certain persons with mental disabilities, usually through the appointment of a guardian under current law; and

WHEREAS, it is essential to have a feasible and workable process in place to make medical treatment and other service decisions for certain mentally disabled citizens in Virginia to ensure their particular needs are met in a timely fashion; and

WHEREAS, there are some instances in which the lack of a guardian results in individuals with mental disabilities being unable to obtain medical care or participate in certain services and programs; and

WHEREAS, mentally disabled citizens with no family members who are active in their care must resort to having strangers serve as their guardians; and

WHEREAS, pilot programs to train public guardians are available in some localities, but other localities have few training opportunities for guardians; and

WHEREAS, the legal cost associated with obtaining a guardian is approximately \$2,000 and the Department of Social Services can only provide this service to a limited number of customers, and only to those who are deemed indigent; and

WHEREAS, because of lack of training opportunities and lack of funding, substitute decision makers with little or no experience in working with disabled people are often appointed; and

WHEREAS, additional tools and resources are needed to provide consistent and ongoing assistance to individuals with mental disabilities identified as needing someone to assist with decision making; and

WHEREAS, there may be other alternatives for assisting in decision making for citizens with mental disabilities in order to allow the person to retain as much autonomy as possible, receive treatment and services in a timely fashion, ensure that they are protected, and to minimize the cost; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a select committee be established to study the statewide system of providing substitute consent for people with mental disabilities. The select committee shall consist of seven members as follows: four members of the House Committee on Health, Welfare and Institutions, upon the recommendation of the co-chairmen, to be appointed by the Speaker of the House, in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; two members of the Senate Committee on Education and Health, upon the recommendation of the chairman, to be appointed by the Senate Committee on Privileges; and one member of the Senate Committee on Rehabilitation and Social Services, upon recommendation of the chairman, to be appointed by the Senate Committee on Privileges and Elections. The select committee shall seek the input and participation of consumers, family members of consumers, and advocacy organizations, including the Virginia Association of Community Services Boards.

In conducting its study, the select committee shall study the statewide system of providing substitute consent for people with mental disabilities, including guardianship, and identify solutions regarding the best means for providing substitute consent that will allow people with mental disabilities the most access to care, services, and personal autonomy.

The direct costs of this study shall not exceed \$7,000.

The Division of Legislative Services shall provide staff support for the study. Technical assistance shall be provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Supreme Court of Virginia. All agencies of the Commonwealth shall provide

assistance to the select committee, upon request.

The select committee shall complete its work in time to submit its findings and recommendations by November 30, 2001, to the Governor and the 2002 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

**VIRGINIA PUBLIC GUARDIAN AND CONSERVATOR PROGRAMS:
SUMMARY OF THE FIRST YEAR EVALUATION**

February 2002

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Authors' Note

The cooperation and assistance of the Virginia Department for the Aging and the ten Public Guardian and Conservator Programs in the Commonwealth of Virginia are gratefully acknowledged.

Virginia Public Guardian and Conservator Programs: Summary of the First Year Evaluation

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Public guardianship refers to the appointment and responsibility of a public official or publicly funded entity who serves as a legal guardian in the absence of willing and responsible family members and friends to serve, or without resources to employ, a private guardian. In response to a documented need for guardians of last resort (Teaster & Roberto, 1997), the Virginia Public Guardian and Conservator Programs were established by law in 1997 in § 2.1-373.10 - § 2.1-373.14 of the Virginia Code. The local programs, chosen through an RFP process, are administered by the Virginia Department for the Aging. Three of the 10 programs were originally Guardian of Last Resort demonstration projects.

This document provides information from the first year evaluation of the 10 Virginia Public Guardian and Conservator Programs. The evaluation is mandated in § 2.1-373.12 "the Department shall enter into a contract with an appropriate research entity with expertise in gerontology, disabilities and public administration to conduct an evaluation of local public guardian and conservator programs from funds specifically allocated for this purpose, and the evaluator shall provide a report with recommendations to the Department and to the Public Guardian and Conservator Advisory Board by December 1, 2003."

This evaluation includes both quantitative and qualitative information. Data sources included information from agency profiles, client assessments using information from the Uniform Assessment Instrument (UAI), care plans, and time logs. Data were gathered from the local or regional programs using a password protected, web-based collection site developed by researchers at Virginia Tech especially for this project.

Agency Profile

Ten local or regional guardianship programs serve incapacitated persons needing public guardians. During the evaluation period (August 2001-October 2001), the programs reported serving a total of 193 incapacitated citizens.¹ Table 1 shows program characteristics as reported by the programs. During FY 2001, guardianship programs contracted to serve 212 citizens and served a total of 208 incapacitated persons. Five programs reported incapacitated persons on a waiting list, and for those programs reporting no clients on a waiting list, two reported that their waiting list had dwindled because there had been no movement on their enrollment for so long that agencies stopped referring clients (i.e., could not add new clients to their programs).

The programs serve incapacitated citizens using a mixture of full-time, part-time, and volunteer staff. The programs, a mix of non-profit and governmental entities, reported utilizing a total of 9 full time staff, 24 part-time staff, and 205 trained, active volunteers. The Virginia Department for the Aging (VDA) contracted with the local programs for a maximum staff to client ratio of 1:20.

Client Assessment

Client Profile

The guardianship programs supplied client assessment information from the UAI on 191 incapacitated persons who became part of their client enrollment as of August, 2001. Of that number, there were 109 females (57.1%) and 82 (42.9%) males. The clients ranged in age from 19 to 96, with an average age of 63.8 years. Table 2 reveals that the incapacitated persons included 132 (69.1%) Whites, 55 (28.8%) Blacks/African Americans, and 3 (1.6%) Asians. Nearly half of the incapacitated persons (N=87/45.5%) had less than a high school education. The persons the programs serve are very poor, with more than half (N=131/68.6%) having annual incomes less than \$7,000.00. The majority of persons are disoriented in some spheres (e.g., person, time, and place), with 58 (30.4%) disoriented, some spheres, some of the time; 46 (24.1%) disoriented, some spheres, all of the time; and 47 (24.6%) disoriented, all spheres, all of the time.

¹ The total number of incapacitated persons served (193) is the number indicated on client roles as of 08/15/01.

Table 1. Agency Profiles of Individual Guardianship Programs

Program Catchment Area Clients Contracted to Serve Clients

Served ^a Client Enrollment ^b	Clients on Waiting List	Full-Time Staff	Part-Time Staff ^c	Trained, Active Volunteers	Bridges
Senior Care Solutions (Fredericksburg)					
BSCS Stafford, Spotsylvania, King George, Fauquier, Culpepper, Madison, Greene, Orange Co., & Fredericksburg	20	17	14	6	1 1 2
Catholic Charities of Hampton Rhodes (Hampton Roads)					
CCHR Suffolk, Franklin, James City, York Co., & Norfolk, Newport News, Williamsburg, Virginia Beach, Hampton	18	21	18	3	1 6
109 Chesapeake Guardianship Program (Chesapeake)					
CGP Chesapeake	20	24	21	0	1 2 8
District Three Governmental Cooperative (Marion)					
D3GC Washington, Smyth, Bland, Carroll, Wythe Cos., & Bristol	35	35	35	11	11NA
Family Services of the Roanoke Valley (Roanoke)					
FSRV Franklin, Roanoke Cos., Roanoke	20	11	11	0	1 1 NA
Guardian of Life's Dreams (Tazewell)					
GOLD Tazewell & Buchanan Cos. (Norfolk)	30	32	32	9	2 2 2
Jewish Family Service of Tidewater, Inc.					
JFS Suffolk, Franklin, James City, York Co., & Norfolk, Newport News, Williamsburg, Virginia Beach, Hampton	19	19	18	4	1 5 80
Mountain Empire Older Citizens, Inc. (Big Stone Gap)					
MEOC Scott, Wise Co., & Norton	20	21	178	02	2
Personal Support Network (Falls Church)					
PSN Fairfax, Arlington, & Falls Church	10	10	10	0	0 4 NA
Southwest Virginia Legal Aid Society (Christiansburg)					
SVLA Montgomery, Pulaski, Floyd, Giles Co., & Radford	20	18	16	0	1 0 2
TOTAL	212	208	1924	19	24 205

^aClient served by the program from July 1, 2000 though June 30, 2001.

^bClients enrolled in the program as of September, 2001.

^cSome programs are part of a larger organization and dedicate a percentage of staff time to the guardianship program.

Guardianship programs reported spending an average of 12.1 (S.D. = 14.3) hours prior to accepting a client into their programs. The programs reported serving as guardian for 183 (95.8%) individuals and serving as conservator for 94 (49.2%) individuals. The programs serve as both guardian and conservator for 93 individuals. The majority of clients 98 (51.3%) lived in a nursing home or in an assisted living facility (N=39/20.4%).

Table 2. Client Demographic Characteristics

Category	Number	%
White	132	69.1
Black/African American	55	28.8
Asian	3	1.6
Less Than HS Education ^a	87	45.5
Income Level (\$5,500-6,999)	60	31.4
Income Level (\$5,499 or less)	71	37.2
Disoriented, some spheres, some of the time	58	30.4
Disoriented, some spheres, all of the time	46	24.1
Disoriented, all spheres, some of the time	47	24.6
Persons Served as Guardian	183	95.8
Persons Served as Conservator	94	49.2

^aThe educational level of 53 clients was unknown.

Overall Client Needs

Shown in Table 3, the local or regional programs provided client information from the client assessment and care plans for 192 incapacitated persons. Over 80% of clients had needs in the areas of ADLs, IADLs, medical/physical health, and nutrition. Over 70% of clients had needs in the areas of financial assistance and mental health/emotional issues. Employment needs were present in 11.5% of clients. In addition to the need areas, the programs reported effort per client. In aggregate, 76 (39.6%) clients were regarded as low maintenance, 80 (41.7%), required moderate maintenance, and 36 (18.8%) required high maintenance.

Table 3. Client Needs Across All Areas

Need Area	Number	%
Medical/ Physical Health	185	96.4
Activities of Daily Living	163	84.9
Instrumental Activities of Daily Living	160	83.3
Nutrition	157	81.8
Financial Assistance	152	79.2
Mental Health/Emotional	135	70.3
Home/Physical Environment	121	63.0
Assistive Devices/Medical Equipment	80	41.7
Caregiver Support	40	20.8
Employment	22	11.5

Clients' Functional Needs—Activities of Daily Living

Table 4 illustrates that the incapacitated persons whom the programs serve have a number of activities of daily living (ADL) needs (e.g., bathing, dressing, toileting, transferring, and eating/feeding), with nearly half needing human physical assistance (i.e., individual in a proximal relationship with the client) with bathing (45%) and dressing (46.1%). One third of clients needed human physical assistance with toileting (33.5%), and over a fourth (29.3%) needed human physical assistance in eating/feeding.

Table 4. Activities of Daily Living Needs

Level of Assistance
 Bathing
 (n=191) % Dressing
 (n=191) % Toileting
 (n=191) % Transferring
 (n=191) % Eating/
 Feeding

(n=191) % None 33 17.3 46 24.1 69 36.1 73 38.2 87 45.5 Mechanical Assistance 0 0 0 3 1.6 5 2.6 7 3.7 Human
 Prompting/Supervision 38 19.9 38 19.9 22 11.5 16 8.4 25 13.1 Human Physical Assistance 86 45.0 88 46.1 64 33.5 42 22.0 56 29.3
 Mechanical & Human Prompting/Supervision 1 0.5 1 .5 2 1.0 4 2.1 3 1.6 Mechanical & Human Physical Assistance 23 12.0 8 4.2 13
 6.8 30 15.7 6 3.1 Mechanical, Human Prompting/Supervision, & Human Physical Assistance 6 3.1 6 3.1 6 3.1 7 3.7 3 1.6 Is Not
 Performed 4 2.1 4 2.1 8 4.2 10 5.2 0 0

Clients' Functional Needs--Instrumental Activities of Daily Living

Table 5 reveals specific information regarding clients' self-administration needs. Greater than 90% of clients had instrumental activities of daily living (IADL) needs (e.g., meal preparation, housekeeping, laundry, money management, transportation, shopping, using the telephone, home maintenance) in 6 need areas (meal preparation, housekeeping, laundry, money management, transportation, shopping). Clients also had great ambulation needs, with one fourth (24.1%) unable to walk, over half (49.7%) unable to climb stairs, and nearly one fifth (17.8%) requiring mechanical and human assistance in the area of mobility.

Table 5. Instrumental Activities of Daily Living Needs

Need Area	Number	%
Money Management	187	97.9
Transportation	182	95.3
Shopping	181	94.8
Meal Preparation	179	93.7
Housekeeping	177	92.7
Laundry	176	92.1
Home Maintenance	158	82.7
Using Phone	146	76.4
Other IADL Limitations	43	22.5

Client Care Planning

Tables 6A-C shows the extent to which client needs in the top 6 need areas are addressed in care planning, and as such, reveals outcome measures of guardians' response to identified client needs. All programs planned for needs in all areas, with the exception of employment, in which some programs had no clients with that need. Programs supplied care plans for 192 incapacitated persons. Care plans reveal planning for 178 clients in the areas of general physical health, followed by medication (N=160). In planning for mental health/emotional needs, agencies planned for medications for mental health problems for 100 clients, followed by mental health assessment (e.g., depression screening) (N=87). In ADL planning, 150 clients had planning for eating a healthy diet, followed by basic hygiene (N=129). In the IADL planning, agencies planned for 138 clients in the area of shopping, followed by meal preparation (N=84). In the area of financial assistance, agencies planned for expending funds for client needs and wishes (N=136) followed by conserving funds (N=110). Finally, regarding nutrition, agencies planned for the diet of 150 clients, followed by basic hygiene.

Tables 6 A-C. Extent of Care Planning Across Six Highest Need Areas

Table 6A.

Medical/Physical Health Planning	Number	%	Mental Health/Emotional Planning	Number	%
General Physical Health Care	178	92.7	Medications for Mental Health Problems	100	52.1
Medication for Physical Health	160	83.3	Mental Health Assessment	87	45.3
Dental Care	92	47.9	Client Counseling	72	37.5
Vision Care	71	37.0	Other Mental Health/Emotional Needs	73	38.0
Foot Care	58	30.2			
Other Medical/Physical Health Needs	94	49.0			

Table 6B.

ADL Planning	Number	%	IADL Planning	Number	%
Healthy Diet	150	78.1	Shopping	138	71.9
Basic Hygiene	129	67.2	Meal Preparation	84	43.8
Continence Care	87	45.3	Transportation	57	29.7
Other ADL Needs	99	51.6	Other IADL Needs	89	46.4

Table 6C.

Financial Assistance Planning	Number	%	Nutrition Planning	Number	%
Expend Funds	136	70.8	Diet	142	74.0
Conserve Funds	110	79.2	Nutrition Services	104	54.2
Pay Bills	95	49.5	Other Nutrition Needs	48	25.0
Locate/Identify Sources of Income	92	47.9			
Other Financial Needs	62	32.3			

Work Activity/Time Logs

Program Hours Per Client Need Area

For 20 working days, the programs provided information on client-specific time and time related to program administration.² Table 7 shows that, over a month's time, 175 out of 193 clients received client-specific attention and thus, the extent to which planned activities were accomplished. On average, programs spent the greatest amount of time in financial assistance areas (M=0.9 hrs.), with medical/physical health (M=8.3 hrs.) ranking second in time, followed by caregiver support (M=0.6 hrs.) and home/physical environment (M=0.5 hrs.) needs. Across all programs, clients received 779.1 hours of program time in 10 need areas, for an average of 4.5 hours per month.

Table 7. Time Spent Across Need Areas

Need Area	Total Hours	Mean Hours Per Client	S.D.
Financial Assistance	159.0	0.9	1.5
Medical/ Physical Health	145.5	0.8	1.3
Caregiver Support	107.8	0.6	2.4
Home/Physical Environment	92.3	0.5	1.7
Mental Health/Emotional	86.8	0.5	1.0
Instrumental Activities of Daily Living	74.3	0.4	1.3
Nutrition	46.0	0.3	0.5
Activities of Daily Living	42.3	0.2	4.5
Employment	13.8	.08	0.5

Assistive Devices/Medical Equipment	11.3	.06	0.2
TOTAL	779.1	4.5	50.7

Program Hours on Client Specific Tasks in Addition to Need Areas

Table 8 shows that 175 out of 193 clients received client-specific attention on areas in addition to the 10 need areas identified above. On average, programs spent the greatest amount of time in client-related travel (M=1.8 hrs.), with

² All Time Logs were recorded in 15 minute intervals for 20 working days between 09/17/01-10/14/01. other client-specific tasks (e.g., completing survey, working on client's funeral, calls to professionals regarding clients, arranging services, typing client notes), (M=1.8 hrs.) ranking second in time, followed by agency face-to-face contact (M=1.4 hrs.). Across all programs, clients received 1158.1 hours of client specific tasks in addition to the 10 need areas indicated below, for an average of 6.6 hours per month. Programs were also asked to report their typical amount of weekly face to face client contact: most clients were seen several times a month, (103/53.6%), with 71 (37%) seen once a month or less, and 17 (8.9%) seen once a week or more.

Table 8. Additional Activities/Time Spent in Client Related Tasks

Task	Total Hours	Mean Hours Per Client	S.D.
Travel	322.5	1.8	1.9
Client Evaluation	112.0	0.6	1.4
Client Care Planning	102.5	0.6	0.8
Agency Face to Face Contact	249.5	1.4	2.8
Volunteer Face to Face Contact	46.3	0.3	1.2
Other Volunteer Tasks	5.3	.03	0.2
Other Client Specific Tasks	320.0	1.8	4.2
TOTAL	1158.1	6.6	130.6

Program Administration Tasks

Over the 20 day evaluation period time, all programs reported their estimated time spent in program administration tasks (Table 9). On average, programs spent the greatest amount of time in other areas of program administration (e.g., telephone calls, mail, straightening office and files) (M=39.0 hrs.), with agency-related travel (M=15.8 hrs.) ranking second, followed by meetings (M=12.3 hrs). Across all programs, programs worked 1222 administrative hours for an average of 122 hours per month.

Table 9. Hours Spent on Program Administration

Task	Total Hours	Mean Hours	S.D.
Agency Related Travel	158.3	15.8	9.8
Meetings	122.8	12.3	7.4
Program Evaluation	119	11.9	9.6
Training	99.3	9.9	10.4
Responding to Pager	60.0	6	8.8
Human Resource Activities	55.2	5.5	8.8
Screening New Clients	39.8	4.0	3.7
Multidisciplinary Board Activities	51.0	5.1	9.6
Working on Weekend	35.0	3.5	4.6
Meeting with Volunteers	34.5	3.5	8.9
Promotional/Development Tasks	31.6	3.2	4.6
Grant Work	26.3	2.6	3.8
Other Program Admin.	389.5	39.0	31.7
TOTAL	1222	122.0	98.3

Costs of Operating Programs

Table 10 shows the total hours of service reported for a month's (20 days) time, or 3158.2 hours. The weekly average of time required for all programs is 789.55, and the average number of hours per week per program is 79 hours. The programs reported a state allotment of \$501,186 for FY 2001 to operate 10 programs. Three programs supplemented their expenses with \$8075 in grants and \$68,236 in in-kind contributions, for a total of \$577,497 (Table 11). The estimated evaluation period (monthly cost) for the programs is \$48,124.75. Agencies reported \$3,132,442.00 in yearly cost savings (e.g., discharge from a state hospital to an assisted living facility, discharge from a state hospital to a nursing home, recovering assets from clients who were being exploited, and arranging for a pre-paid funeral). Two clients were restored to competency. In addition, intangible costs savings were realized in improving incapacitated persons' quality of life, with all 10 agencies reporting providing emotional support to clients, and 9 agencies reporting securing medical care/equipment, securing community-based services, and enhancing clients' socialization (e.g., visits, shopping).

Table 10. Client Specific and Administrative Hours of Service

Category	Monthly Hours of Service
Client Specific Need Areas	779.1
Other Client Specific Tasks	1158.1
Program Administration	1221
TOTAL	3158.2

Table 11. Costs of Program Operations

All Funding Sources (FY 2001)	Evaluation Period Cost (Monthly Cost)	Estimated Monthly Cost Per Client (N=193)	Yearly Cost Per Client	Reported Cost Savings ^a
\$577,497	\$48,124.75	\$249.35	\$2992.21	

^aInformation on the calculation of cost-savings are available from the authors upon request.

Conclusions and Recommendations

On average, agencies have served the number of clients for whom they contracted. Agencies not serving the number of clients for whom they contracted experienced shifts in clientele due to the closing of an assisted living facility in the catchment area, start-up issues, and client attrition during the evaluation period.

The average age of clients served is consistent with that of earlier evaluations of the demonstration projects (63.4 years of age versus 69.9 years of age). Due to increased state coverage by the local or regional programs, there is greater diversity in client mix than exhibited by the demonstration projects (69.1% White versus 75.4% White). All programs addressed all need areas, with the exception of employment, which was not a need area for clients in some programs. In some agencies, the use of volunteers increased face to face time with clients and added to time spent on the overall functioning of the agency. Volunteers contributed 46.3 hours of time during the 20 day evaluation time, but the agencies spent 34.5 hours meeting with volunteers.

All programs were not equipped with modern computers and internet access. Problems with conducting the evaluation ranged from computers that were unable to guard against viruses and handle the requirements of conducting the evaluation online to public guardians having to use their home computers because agency computers were outdated or disabled. Because funding was inadequate for program personnel to physically attend training on the evaluation, training had to be conducted via telephone and online. Though the researchers acknowledge that much work can be accomplished via distance technologies, face-to-face meetings are nonetheless necessary and require funds for travel, lodging, and per diem.

Preliminary findings suggest the following:

1. Agencies are using program funds wisely in order to meet client needs.
2. The majority of clients (N= 175) received client specific attention by the programs during the 20-day time log period.
3. On average, programs have maintained a client to staff ratio of 20:1 as recommended in an earlier evaluation of the model programs.
4. Annual costs per client have risen slightly from earlier evaluations of the demonstration projects (\$2,734.57) versus (\$2,992.21).
5. Public guardianship programs provide costs savings for the state.
6. Program activities should more closely relate to the clients' need areas, particularly regarding time allotment on ADL and IADL needs.
7. Waiting lists and no movement on client rolls of programs indicate a greater need for public guardians than is currently being met. Thus, the Public Guardian and Conservator Program should expand to areas of the Commonwealth not now served. Future funding of programs should be predicated on demographic realities, which indicate increasing numbers of older persons and persons with disabilities who will require the services of a public guardian.
8. Annual evaluations of the programs should continue in order to provide efficient, economic, and effective services, to ensure both protection and autonomy, and to enhance the quality of life of Virginia's

incapacitated citizens. There are limitations to self-reported data; however, to collect and record data exclusively by the evaluators would cost significantly more in confidentiality, dedicated time, and real dollars. Conducting a periodic evaluation online insures greater program continuity, and enhances confidentiality and accuracy while decreasing costs.

VIRGINIA ACTS OF ASSEMBLY -- 2002 SESSION

CHAPTER 80

An Act to amend and reenact § 54.1-2970 of the Code of Virginia, relating to medical treatment for persons incapable of giving informed consent.

[S 483]

Approved March 4, 2002

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2970 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2970. Medical treatment for certain persons incapable of giving informed consent.

When a delay in treatment might adversely affect recovery, a licensed health professional or licensed hospital shall not be subject to liability arising out of a claim based on lack of informed consent or be prohibited from providing surgical ~~or~~, medical *or dental* treatment to an individual who is a patient or resident of a hospital or facility operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services *or to a consumer who is receiving case management services from a community services board or behavioral health authority* and who is incapable of giving informed consent to the treatment by reason of mental illness or mental retardation under the following conditions:

1. No legally authorized guardian or committee was available to give consent;
2. A reasonable effort is made to advise a parent or other next of kin of the need for the surgical ~~or~~, medical *or dental* treatment;
3. No reasonable objection is raised by *or on behalf of* the alleged incapacitated person; and
4. Two physicians, *or in the case of dental treatment, two dentists or one dentist and one physician*, state in writing that they have made a good faith effort to explain the necessary treatment to the individual, and they have probable cause to believe that the individual is incapacitated and unable to consent to the treatment by reason of mental illness or mental retardation and that delay in treatment might adversely affect recovery.

The provisions of this section shall apply only to the treatment of physical injury or illness and not to any treatment for mental, emotional or psychological condition.

Treatment *pursuant to this section* of an individual's mental, emotional or psychological condition when the ~~resident~~ *individual* is unable to make an informed decision and when no legally authorized guardian or committee is available to provide consent shall be governed by regulations promulgated by the State Mental Health, Mental Retardation and Substance Abuse Services Board under § 37.1-84.1 of this Code.

