



# NAMI

# Virginia

## National Alliance on Mental Illness

*The Official Newsletter of NAMI Virginia*

*July 2009*

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### Message from the Director

During times like these I am reminded, as many of you probably are, of the things in life that are truly important – family, friends, health, and simple pleasures. I'm grateful to the volunteers and staff who work hard to help make NAMI Virginia what it is – a grassroots organization committed to providing education and support and engaging in advocacy to raise the bar on critical mental health issues. From our *Family-to-Family* and *MESA* teachers to *Peer-to-Peer* mentors to Support Group facilitators and *In Our Own Voice* presenters, the organization – and the "movement" — relies very heavily on those who put their experiences into action for the greater good. *Thank you.*

Now more than ever each of us must do our part—whatever is possible for us—to ensure that NAMI Virginia remains strong and active and to help our communities become more caring and responsive to those in need. Here's what you can do:

1. **Become a member of NAMI Virginia.** Or if you are certain that you are a member (Is your membership current?), talk to a family member or friend about the merits of membership. Joining online is quick and easy!
2. **Participate in the 2009 NAMIWalk.** See pg. 4 for more information.
3. **Learn** about the many education, support, and recovery programs that NAMI has to offer.
4. **Talk to a friend** about mental illness. Share your story.
5. **Educate** yourself about NAMI's positions and principles on healthcare reform. Visit the Health Care Reform section at [www.nami.org](http://www.nami.org)

In return, NAMI Virginia will be here for you. We will do our best to continue offering quality programs that provide support and education for people affected by mental illness and their loved ones, to advocate for improved policies and better funding for mental health services, to use our resources to address and stamp out the stigma associated with mental illness, to provide you with up-to-date science-based information from NIMH (see our NIMH section on our Web site) – and much more.

NAMI Virginia is busy as ever. We are rolling out a new program (*Basics* — See pg. 2 for more information); participating in task forces and advocacy meetings related to children's mental health issues, parity, housing, criminal justice, and other critical areas; getting ready for what we hope will be our most successful NAMIWalk yet, and supporting affiliates as they grow and develop. And of course MUCH more. Wow!

Your support is needed to help keep us strong. If you can make a contribution, please do so today (A contribution form can be found on pg. 12 or you can do so online via our Web site). All contributions are tax-deductible to the fullest extent of the law. If you are not a member, please join today. Help make our voice as strong as possible!

Sincerely,  
Mira Signer  
Executive Director

### CONTACT US!

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NAMI Virginia is the state office of NAMI (the National Alliance on Mental Illness). NAMI Virginia was created in 1985 to provide support, education, and advocacy for people with mental illness and family members affected by mental illness. Our mission is to promote recovery and improve the quality of life of Virginians with serious mental illness through support, education, and advocacy. NAMI Virginia's 27 local affiliates play an active role providing support, education, and advocacy at the community level.



**What is NAMI *Basics*?** It is NAMI's new signature education program for parents and other caregivers of children and adolescents living with mental illnesses.

**What are the goals of the NAMI *Basics* program?**

- To give the parent/caregiver the fundamental information necessary to be an effective caregiver
- To help the parent/caregiver cope with the traumatic impact that mental illness has on the child living with the illness and the entire family
- To provide tools for the parent/caregiver to use even after completing the program that will assist in making the best decisions possible for the care of the child
- To help the parent/caregiver take the best care possible of the entire family – especially themselves

**What does the course include?**

- Introduction to the normative stages of emotional reactions of the family to the trauma of mental illness
- Insights into an empathic understanding of the subjective, lived experience of the child living with the mental illness
- Current information about Attention Deficit Disorder, Major Depression, Bipolar Disorder, Conduct Disorder, Oppositional Defiant Disorder, Anxiety Disorders, Obsessive Compulsive Disorder, Childhood Schizophrenia and Substance Abuse Disorders
- Information about the systems that are major players in the lives of children and adolescents with mental illness – the school system and the mental health system
- Exposure to personal record keeping systems that have proven to be effective for parents/caregivers in their interactions with the school and healthcare systems
- Information on planning for crisis management and relapse
- And many more topics

**How to get involved?**

NAMI Virginia plans to hold a State Teacher Training in the fall of 2009, tentatively November, to train qualified individuals to teach the *Basics* curriculum. *Basics* teachers will attend the weekend training to learn how to effectively teach this course in their community to parents and other caregivers of children and adolescents living with mental illnesses. It is ideal for two people from the same NAMI affiliate to be trained together since the curriculum is taught by a team of two people. We hope to train 12-16 people — at no cost to the participants thanks to a grant from the Department of Behavioral Health and Development Services (DBHDS) and NAMI.

Currently we are collecting names of people who may be interested in participating in the State Training. An application to become a State Teacher can be found at <http://www.namivirginia.org/> under Programs. Click on the *Basics* link and scroll to the bottom of the page.

Individuals who are interested in being trained to teach the *Basics* curriculum **must** meet the following criteria:

- Be the parent or other primary caregiver of an individual who began experiencing symptoms prior to the age of 13 (it is not necessary that the child have been formally diagnosed prior to 13). It is important that all individuals trained in this curriculum have lived through the experiences of having a young child with a mental illness
- Be at a point in their life where they are familiar and comfortable with the emotional issues families face and can self-disclose about their own feelings of guilt, anger, shame, ambivalence and grief regarding their life situation.
- Be willing to participate in the intensive weekend training (date to be announced) on how to teach the curriculum
- Be willing to make the commitment to teach the *Basics* program once a year for two years

*If you are interested in learning more about the State Teacher Training for NAMI Basics please contact Sarah at [seisenman@nami.org](mailto:seisenman@nami.org) or (804) 285-8264 ext. 203, and we will add you to the list of people to notify as more information becomes available. If you would like more information about the NAMI Basics program including flyers and brochures to give to NAMI members please visit [www.nami.org/Basics](http://www.nami.org/Basics) or contact Sarah.*

## 2009-2010 Training Schedule for NAMI Virginia Education and Support Programs

<b>Sept. 2009:</b> Family Support Group State Facilitator Training	For more information about the training schedule, please contact Sarah Eisenman, Program Coordinator, at (804) 285-8264 ext. 203 or seisenman@nami.org, or visit our Web site: <a href="http://www.namivirginia.org">www.namivirginia.org</a>
<b>Oct. 2009:</b> <i>Family-to-Family</i> Teacher Training (mid-month)	
<b>Nov. 2009:</b> <i>Basics</i> Teacher Training	
<b>Dec. 2009:</b> <i>Peer-to-Peer</i> Mentor Training (early)	
<b>Feb. 2010:</b> <i>Connection</i> Support Group Facilitator Training	
<b>March 2010:</b> <i>MESA</i> Teacher Training	For information about LOCAL classes and support groups, please contact your local NAMI affiliate. Visit the Affiliate Section on our Web site or call our office for contact information.
<b>April 2010:</b> <i>Family-to-Family</i> Teacher Training	
<b>May 2010:</b> <i>Peer-to-Peer</i> Mentor Training	

## National Institute of Mental Health (NIMH) Updates From the Outreach Partnership Program

### NIMH: Schizophrenia and Bipolar Disorder Share Genetic Roots: Chromosomal Hotspot of Immunity/Gene Expression Regulation Implicated

A trio of genome-wide studies – collectively the largest to date – has pinpointed a vast array of genetic variation that cumulatively may account for at least one third of the genetic risk for schizophrenia. One of the studies traced schizophrenia and bipolar disorder, in part, to the same chromosomal neighborhoods. "These new results recommend a fresh look at our diagnostic categories," said Thomas R. Insel, M.D., director of the National Institute of Mental Health (NIMH), part of the National Institutes of Health. "If some of the same genetic risks underlie schizophrenia and bipolar disorder, perhaps these disorders originate from some common vulnerability in brain development." Three schizophrenia genetics research consortia, each funded in part by NIMH, report separately on their genome-wide association studies online July 1, 2009, in the journal *Nature*. However, the SGENE, International Schizophrenia, and Molecular Genetics of Schizophrenia consortia shared their results - making possible meta-analyses of a combined sample totaling 8,014 cases and 19,090 controls.

Press Release: <http://www.nimh.nih.gov/science-news/2009/schizophrenia-and-bipolar-disorder-share-genetic-roots.shtml>

### Suicide Prevention Resource Center: Suicide Prevention Toolkit for Rural Primary Care

This new product contains the information and tools needed to implement state-of-the-art suicide prevention practices in primary care settings. Although the tools are designed with the rural practice in mind, most are quite suitable for use in non-rural settings as well. By taking a systems approach, the kit offers the support necessary to establish the primary care provider as one member of a team, fully equipped to reduce suicide risk among their patients. The toolkit is available free through a web-based portal and was developed collaboratively by the Suicide Prevention Resource Center and the Western Interstate Commission for Higher Education Mental Health Program, with funding from the Health Resources Services Administration and SAMHSA. <http://www.sprc.org/pctoolkit/index.asp>

### NIH Research Matters: Common Gene Variants Implicated in Schizophrenia

Three international research teams have detected many tiny and common gene variations that together could account for at least one-third of the genetic risk for schizophrenia. Although none of these variants alone significantly boosts the chances of developing schizophrenia, in combination they seem to exert a powerful effect on disease risk. [http://www.nih.gov/news/research\\_matters/july2009/07132009schizophrenia.htm](http://www.nih.gov/news/research_matters/july2009/07132009schizophrenia.htm)

### SAMHSA: New Treatment Improvement Protocols from the Center for Substance Abuse Treatment: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

This Treatment Improvement Protocol (TIP) is designed to assist substance abuse counselors in working with adult clients who may be suicidal, and will help clinical supervisors and administrators support the work of substance abuse counselors. <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=18118>



# NAMI Walks



## National Alliance on Mental Illness

"The best way to raise awareness about mental illness and to educate the public about the hope that NAMI represents."

*"One of the most powerful and effective ways to fight the stigma that surrounds serious mental illness and to educate the public about the prevalence, cause and treatment of the illness is telling your personal story of why you are involved with NAMI. Many of the misconceptions disappear when people talk about how a mental illness has affected themselves, their family and their friends.*

*The foundation for the NAMI Walks for the Mind of America is the process that encourages NAMI members and supporters to write letters and send e-mails to everyone in their personal and professional networks to educate them on mental illness and NAMI. It is through this letter and e-mail campaign that we can begin to have a meaningful impact on the stigma associated with this issue and successfully reach out to the segment of the community that could benefit from knowing about NAMI programs."*



-Blair Young

NAMI Walks National Walk Manager



## We Need YOU to Get Involved with NAMI Walks Virginia 2009!

**Would you like to be a Team Captain or find out more about NAMI Walks?**

Join us for our **Kick-Off Luncheon** on Thursday August 13 at 11:30 a.m. at **Lewis Ginter Botanical Garden**. Please call 804-285-8264 ext. 202 for more information or to RSVP.

This year's Walk is on Saturday, October 3 at Innsbrook Picnic Area in Richmond. Join hundreds of others from across the state to help raise awareness for mental illness.

For more information, please contact Farleigh Fitzgerald at 804-285-8264 ext. 202 or [ffitzgerald@nami.org](mailto:ffitzgerald@nami.org)

To register for NAMI Walks Virginia, please visit [www.nami.org/namiwalks/VA](http://www.nami.org/namiwalks/VA)

## In Our Own Words

We issued a call for poetry for the newsletter by consumers and received MANY inspiring and creative poems. **Thank you** to all who submitted their work. Since we received such a great response we were only able to select a couple of poems and we will try to include others in future newsletters.

*“Poetry is the chiseled marble of language; it’s a paint-spattered canvas - but the poet uses words instead of paint, and the canvas is you.” -Mark Flanagan*

### Seasonal Smothering

For a fruitless summer  
Watched carbon rich water  
Recede below rotten timber tops.  
Seethed in dank thick air  
While waiting for another loveless winter.

The color leaves first  
In shades of summer’s dying flame.  
Leather brown hands litter the ground,  
A breath blows in a gray season,  
The cold sows seeds of shame.

An emotion that sheepishly arrives  
With whispers of reborn futility.  
The frigid white blanket keeps it snug  
To our chest, rattling with sickness,  
We endure what is within our ability.

Monthly celebrations, keep us up,  
Bolster weakened almost absent stimuli.  
Gives the gray shades not noticed before,  
Returns hues of nature’s spring mood  
Feeds a growing warmth to the eye.

By Reed Bass  
NAMI Western Tidewater  
October 7, 2007

### fairy within my heart

within my heart  
dances a fairy  
displayed in leaves and dew drops  
light as a feather  
bright as a star

childhood sings still within my fairy heart  
always keeping tune  
to the song of springtime in the air  
always ringing with laughter  
from love's soft spot.

by Dolores A. Treadway  
NAMI Central Virginia



## 2009 NAMI Virginia State Convention: *All In One Voice* Highlights

The 2009 NAMI Annual Convention was an excellent opportunity for NAMI Virginia members to learn from one another, learn from specialists, network, develop camaraderie, and unite for advocacy actions. Several NAMI Virginia members received an Award of Excellence for their hard work, dedication and advocacy for those affected by mental illness.

### 2009 NAMI Virginia Award Recipients

**Outstanding Consumer Achievement Award**

Cheryl DeHaven

**Exemplary Psychiatrist Award (issued by NAMI National)**

Dr. Ramakrishnan Shenoy and Dr. Audrey Moss

**Outstanding Affiliate Award**  
NAMI Hampton-Newport News

**Outstanding Family Member/Caregiver Achievement Award**  
June Hagee

**Joshua Steven Collins Award of Excellence**  
Bill Farrington



Award recipients: (left to right) Brian Sanderson, Booker Bullock, Cheryl DeHaven, Elyse Hunt, Jim Payne, Barbara Harling, Linda Gurley, Dr. Ramakrishnan Shenoy, Bob Williams, and Bill Farrington.



Kathy Harkey presents the Joshua Steven Collins Award of Excellence to Bill Farrington



Commissioner James Reinhard, M.D gives an update on *Transformation in the Mental Health System*.



Dr. Paul Aravich entertains and educates Convention attendees with his presentation "The Universe Between Our Ears and Mental Illness."

Dear NAMI Virginia,

I would like to thank you for selecting me as the recipient of the NAMI Virginia - Award of Excellence "Outstanding Consumer Achievement Award." I must admit that when I received this award, it happened so fast that before I realized it I was sitting down, and I did not take the opportunity to thank you and the many others that made this award possible. First, I want to thank June Hagee and NAMI Williamsburg Area affiliate for the opportunity to become involved in NAMI through the "In Our Own Voice" program and as affiliate board member. These early opportunities propelled me into a life of recovery that has given me endless opportunities to work at the NAMI local, state, and national level. Next, I would like to thank the leaders of NAMI Virginia. It is your guidance and support that provides consumers the opportunity to learn and grow within the organization. Finally, I would like to thank the people that have supported me personally in my journey, including my employer and coworkers at the Hampton-Newport News CSB and all of the people living with mental illness that have chosen to become dedicated members of NAMI. It is your hard work that is moving NAMI Virginia into becoming a state organization that helps recover the lives of those living with mental illness and the people who love them. We are all in this together and every voice counts.

Sincerely,  
Cheryl DeHaven  
NAMI Hampton-Newport News  
Recipient of the "Outstanding Consumer Achievement Award"

## NAMI's Principles for Health Care Reform

*Visit the NAMI National Legislative Action Center for more information and action alerts!*

### **1. Require that all health plans made available to uninsured individuals and families through a "Health Insurance Exchange" or other means both offer coverage for mental illness treatment and comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.**

Health reform proposals moving forward in the House and Senate envision a Health Insurance Exchange that would make coverage more available and affordable to uninsured individuals and families and small businesses, with the goal of moving toward universal coverage. These proposals are expected to include a requirement for everyone to have coverage – including tax credits and subsidies for low-income families and incentives for small businesses that are unable to offer coverage. A number of proposals also call for a “public plan option” whereby a federally sponsored plan would be available as a market alternative.

As part of any Health Insurance Exchange or public plan offering, NAMI is seeking a minimum requirement that all plans both include coverage for mental illness treatment and meet the requirements Paul Wellstone and Pete Domenici Mental Health Parity and Equity Addiction Act for equitable coverage with respect to treatment limits and financial limitations

### **2. Integrate mental and physical health care and promote wellness.**

Mental and physical healthcare should be integrated and easily accessible. A 2007 NASMHPD report found that adults with serious mental illness have a life expectancy on average 25 years lower than the general population -- largely resulting from medical co-morbidities such as obesity, heart disease and chronic obstructive pulmonary disease (COPD). These in turn result from a multitude of factors such as poor access to primary care, the debilitating side effects of some psychiatric medications, sedentary lifestyle, high smoking rates, poor diet, and infrequent physical exercise. Health reform is a historic opportunity to address this public health crisis and expand access to patient-centered primary care and chronic disease management. Health plans should cover smoking cessation, exercise, nutrition and wellness education, and related services designed to improve overall healthcare and reduce premature deaths.

### **3. Do not discriminate in the coverage of inpatient psychiatric treatment.**

Currently, federal Medicaid law does not permit payment for inpatient treatment in facilities that primarily serve people with mental illnesses. This discriminatory policy must be eliminated.

### **4. Address serious workforce shortages and increase the qualified mental health workforce.**

Strong incentives are needed to attract and retain qualified mental health professionals, including higher payment rates, loan forgiveness programs, funding for fellowship programs, and the utilization of peers and families as mental health service providers.

### **5. Make early identification and early intervention priorities in healthcare reform.**

Research shows that 50% of serious mental illnesses begin by age 14 and 75% begin by age 24. On average, it is 8 to 10 years from the onset of symptoms to diagnosis and treatment. In the life of a child, those represent critical developmental years that simply cannot be recaptured. Research also shows that delays in services and supports results in more severe and difficult to treat mental illness. The early identification of mental illnesses in primary care and other child-serving systems through early screening and evaluation must be included in health care reform to allow children and youth with mental illnesses to receive the services and supports they need to ultimately lead independent and productive lives. Early identification and intervention also promises to help control overall health care costs.

### **6. Enhance information sharing, while protecting privacy.**

Improved information technology can significantly improve coordination of care and prevent adverse outcomes. Health care reform should include improvements in storing and disseminating information among healthcare providers, while not compromising the privacy of sensitive medical and mental health information.

### **7. Improve data collection, outcomes measurement, and accountability.**

Without good data, it is virtually impossible to design or implement quality mental health services and supports. Urgent action is needed to improve data collection and outcomes measurement both at the local and state levels. Federal leadership is needed to develop uniformity in the collection and measurement of this information. At a time of economic turmoil -- policy makers, consumers, and family members have the right to know whether scarce resources are being spent wisely and producing positive outcomes.

### **8. Improve cultural and language competence.**

Medical and mental health services in the U.S. have not kept pace with the increasing diversity of the American populace. Health care reform must include incentives to increase the diversity and cultural sensitivity of healthcare systems and the healthcare workforce.

### **9. Protect access to psychiatric medications.**

Clinical judgment of treating physicians, in partnership with consumers, must be protected. A "one-size fits all" approach to prescribing psychiatric medications must be avoided. Also, funding should be provided to support effective psychosocial and therapeutic interventions that, when combined with medication treatment, often lead to improved outcomes.

## Law Revised to Enhance Health Care Decision-Making Rights

By Nathan A. Kottkamp, Stephen D. Rosenthal and Susan C. Ward (June 1, 2009)

For nearly two decades, all adults in Virginia have had the right to make their health care wishes known in documents called advance directives, in which they explain the health care they do or do not want in case they later cannot make their own health care decisions. These documents have taken two key forms:

- The designation of an agent to make health care decisions for you if you cannot speak for yourself.
- Written instructions – in what is often called a “living will” – about life-prolonging procedures if you have a terminal condition. “Life-prolonging procedures” are those that will not cure the condition and only prolong the dying process.

On July 1, 2009, Virginia’s law will change to expand the types of decisions an individual can make with an advance directive. The changes also address the following: assessment of decision-making capacity; authority of health care agents; situations where a patient who lacks decision-making capacity protests care recommendations; revocation of documents expressing care decisions; and protection of decision-makers and providers who act in good faith to carry out patient directions.

The revisions were recommended by the Supreme Court of Virginia’s Commission on Mental Health Law Reform to create additional legal authority for individuals to give instructions about their health care, especially if they anticipate losing their decision-making capacity due to dementia or other mental health conditions and wish to give advance instructions about their future health care, including mental health care.

### New options and rights

Under the expanded law, an individual can give instructions in his advance directive about all forms of health care (not just end-of-life care as is currently the case) even if he has not named an agent to make decisions for him when he cannot make them for himself. This means that, with an advance directive, a person can now express his choices about mental health care, health care facility admission, maintenance treatments such as dialysis and insulin treatment, or any other health care. (§§ 54.1-2983 and 54.1-2984)

In the interest of both public and patient safety, the revised law makes it clear that an advance directive cannot override laws authorizing immediate custody of individuals who may be at risk of harming themselves or others or judicial orders authorizing certain aspects of mental health care and treatment. (§54.1-2983.3)

It has always been the case in Virginia that advance directives take effect only when a patient is determined to be incapable of making informed decisions as determined by his own physician

and a second physician upon personal examination of the patient. The law now specifically requires that the second physician be one who is not involved in the patient’s care, unless such independent physician is not reasonably available. Also, to ensure that the decisions of those patients who regain their ability to make informed decisions for themselves are honored, the revised law provides that a determination of a patient’s regained capacity for decision-making requires only one physician to document the finding in writing. (§ 54.1-2983.2)

Generally, Virginia’s law does not authorize any treatment under an advance directive that the patient’s provider and decision-maker know the patient does not want. However, in recognition of the fact that a patient’s condition may cause him to say things he either does not mean or that are inconsistent with his previous statements, the expanded law creates two limited exceptions to this policy, allowing the patient’s previously expressed wishes to be carried out in the event the patient protests after having been determined to be incapable of making an informed decision. Both of these exceptions contain several safeguards to protect the interests of the patient. (§ 54.1-2986.2)

First, an individual may make certain choices in his advance directive that are binding, even if he objects to those choices later during a time that he has lost his capacity to make decisions for himself. This provides an opportunity for an individual with recurring mental illness or dementia – or any other condition that intermittently affects his awareness, judgment or ability to understand his circumstances – to direct that he wants his advance directive followed even if he later, while incapacitated, objects to the instructions in his advance directive. For an individual to make directions expressed in the advance directive binding over his later objection, his physician also must sign those particular instructions in the advance directive, verifying that the individual understands this decision. Even then, the treatment must be medically appropriate and cannot involve withholding or withdrawing life-prolonging procedures.

The second exception prevents decision-making stalemates. Specifically, before the revisions, there was no mechanism for situations in which a patient who is incapable of making informed decisions protests a physician’s treatment recommendation made during the patient’s incapacity, even if the decision would be consistent with the patient’s previously stated wishes or the recognized best interest of the patient as determined by his health care agent or other legally designated decision-maker. Experience has shown the need for a change in the law because providers have been reluctant to proceed in these situations without a court order, which delays care, may not result in the patient receiving the care he originally requested, and adds considerable cost.

(continued on next page)

(continued from page 8)

The revised law allows the patient's agent or other decision-maker to authorize the recommended treatment even if a patient who has been determined to be incapable of making an informed decision protests it. In a second scenario, if the patient objects to a treatment recommendation otherwise allowed in his advance directive, the agent whom he has named in his advance directive (but no other decision-maker) can authorize the recommended treatment over his protest. In either case, the treatment recommendation must be one that does not involve withholding or withdrawing life-prolonging procedures, and the treatment must be found to be ethically acceptable by either an ethics committee or two physicians who are not involved with the patient's care. Ultimately, these provisions allow decision-making by someone who knows the patient personally, while providing safeguards appropriately limiting the decision-maker's authority in light of the patient's protest.

Regardless of these exceptions, if a patient without decision-making capacity protests the general authority of his agent or other decision-maker, then under most circumstances those decision-makers no longer will have authority to make decisions. Decisions in such an event then must be made under other provisions of the advance directive or other laws, including seeking authority from a court.

Revoking an advance directive continues to be a simple process: an individual can revoke an advance directive in writing; orally, by destroying the document, or by directing someone else to destroy it in his presence. The revised law makes it clear, however, that only intentional purposeful actions will revoke an advance directive. For example, if an angry patient tears up his advance directive and does not understand the nature and consequences of his actions, the physical destruction of the advance directive is not a revocation. The directions stated in the advance directive would continue to apply unless and until it is clear that the patient is capable of understanding the significance of his actions as constituting a revocation of the document. (§ 54.1-2985) The revised law also clarifies the rules on the revocation of Durable Do Not Resuscitate (DDNR) Orders, which are issued by physicians to ensure that a patient's desire to forego cardiopulmonary resuscitation is honored by emergency medical personnel and other licensed providers outside of a hospital or nursing home. The change clarifies that only the individual who consented to the DDNR Order may revoke it and that an authorized decision-maker cannot revoke a DDNR Order issued with the consent of the patient himself. With this change, a family member cannot demand resuscitation against a patient's wishes when the patient suffers a heart attack, for example. The law now also clarifies that physicians cannot revoke DDNR Orders,

but they may rescind them in accordance with accepted medical practice, as is the case with any physician order. (§ 54.1-2987.1)

Virginia's health care decision-making law has always protected providers and decision-makers from liability if they follow the law in good faith in seeking patient consent and carrying out treatment decisions. However, the revised law has filled gaps that have existed in that protection to provide assurance uniformly to providers and decision-makers who are acting in good faith. (§ 54.1-2988)

Finally, while any individual who has an advance directive may want to create a new document to take advantage of these new decision-making opportunities, if he chooses not to do so, his legally valid advance directive created under any previous law continues to be valid. For individuals creating new advance directives, it is helpful to know that advance directives in Virginia need not be on a specific form, written by an attorney or notarized. They simply must be signed by the individual and two adult witnesses. Nevertheless, to assist all Virginians in creating an advance directive, a free form, based on the model suggested under Virginia's law (§ 54.1-2984), is available at <http://www.vsb.org/site/public/healthcare-decisions-day>.

### Implementation resources

Ultimately, advance directives serve as a powerful tool to accomplish many important health care goals. They serve as a way to ensure that a patient's wishes are honored; they provide guidance and relieve the burden on family members who might otherwise be left to guess about a patient's health care wishes; and they serve as an opportunity to provide improved care to patients because health care providers are better informed about patients' wishes. Unfortunately, for several reasons, including a very common reluctance to talk about our own mortality as well as confusion about the legal requirements and ways to obtain these documents, it is estimated that no more than one-third of all Americans have empowered themselves through advance directives. In an effort to demystify this topic and the process for creating advance directives, free resources are available at <http://www.vsb.org/site/public/healthcare-decisions-day>.

**Nathan A. Kottkamp is a partner with McGuireWoods LLP. Stephen D. Rosenthal, a former Virginia attorney general, is a partner with Troutman Sanders LLP. Susan C. Ward is vice president and general counsel with the Virginia Hospital & Healthcare Association.**

*This article was reprinted with permission of the Virginia Lawyers Weekly*

# Answers

Wouldn't it be wonderful if you always had the best information to help you take care of yourself?

If you could count on having reliable answers for those times when your health is a concern?

If you could be assured breakthrough medicines would continue to be sought?

We think that would be wonderful, too. And we're working to make it happen. Your good health is our passion.



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[lilly.com](http://lilly.com)

*Lilly*  
Answers That Matter.

# CONVENTION NAMI COVERAGE 09

2009 SAN FRANCISCO • 2009 SAN FRANCISCO • 2009 SAN FRANCISCO • 2009 SAN FRANCISCO • 2009 SAN FRANCISCO • 2009 SAN FRANCISCO

It was a week of remembrance, celebration, friendship, sharing and -- above all -- hope. Perhaps the biggest thrill came on Wednesday evening when Nathaniel Ayers, the title character in *The Soloist*, enchanted attendees with a virtuoso performance on cello and violin. Several NAMI Virginia members were able to attend this wonderful event. Here is what they had to say about their experience!

The highlight of the convention was sitting with hundreds of respectful and empathic families listening to Mr. Ayers play his violin--you could quite literally hear the proverbial pin drop. I took the opportunity at the convention to advocate with three people associated with Mental Health Courts across the country including two judges. I still can't believe I walked up to judges to introduce myself and speak about my own experience where my diagnosis and my behavior intersected the legal system. It was the behind the scenes networking that I enjoyed the most by finally putting faces behind the names from e-mails and the Web site. I got a chance to meet other NAMI members from across my state and nation. It was completely empowering listening to individuals speak on their own advocacy experiences.

**Christopher Yanez (Norfolk)**



Musician and person on which *The Soloist* was based, Nathaniel Ayers, Jr. receives the Rona and Ken Purdy Award at the 2009 NAMI Convention in San Francisco.

I felt the convention this year was great! I went to one session entitled *Parity: Pathway to a Healthy Future*. This topic interested me because I wrote my thesis on parity and my belief that persons will flock into the system and the costs will soar. While my thesis was inconclusive, it was supported by the things said at the convention. Those things are that mental illness is now on an equal playing field with all other illnesses, and they don't know what that means as far as cost and the number of people utilizing this benefit will be. It was said that much is still unknown about how this new law will work, but it is a plus for the many people that have a mental illness and seek treatment for it. The impact on the medical/mental health system will not be known until parity is actually in place all over the country.

**Constance Hollands (Virginia Beach)**

I had a blast at the convention! The workshops and breakout sessions were outstanding. I especially enjoyed the Dallas Crisis Intervention Team (CIT) session and am looking forward to hearing what Henrico County is doing along those lines. Also, the *Connection* and *Peer-to-Peer* sessions were timely and helpful. It was good to hear other's perspectives on the programs. I'm glad that *Peer-to-Peer* is making some changes. The "Results Worth Striving For" session was interesting -- I didn't agree with a lot of Wootton's tips for wellness and recovery but respected his opinion and thought he was a dynamic speaker. He was quite enthusiastic and full of himself. I wish I'd gotten his book. My favorite session was "Arts and Recovery." I love to write and it was great to hear other writers share their work. There's no disputing the healing effects art can have on recovery, and I'm glad NAMI felt it was important enough to include in the convention's program. Along those lines, I was incredibly touched by Nathaniel Ayers' performance. It was astounding and beautiful.

**Debbie Collins (Richmond)**



NAMI Virginia members celebrate together at the Closing Banquet at the NAMI National Convention in San Francisco.

*NAMI Virginia is very grateful to DBHDS for providing scholarship funding to enable four consumers to attend the NAMI National Convention.*



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