November 2007

OUT OF THE FOG

The monthly newsletter of NAMI San Francisco

Lilly Adds Strong Warning Label to Zyprexa, a Schizophrenia Drug

By Alex Berenson, Reprinted from The New York Times, 10/6/07

Eli Lilly yesterday added strong warnings to the label of Zyprexa, its best-selling medicine for schizophrenia, citing the drug's tendency to cause weight gain, high blood sugar, high cholesterol and other metabolic problems.

For the first time, Zyprexa's label now acknowledges that the drug causes high blood sugar more than some other medicines for schizophrenia and bipolar disorder, called atypical antipsychotics.

Lilly previously argued that Zyprexa had not been proved to cause high blood sugar at a more frequent rate than its competitors.

Concern about Zyprexa's side effects has been increasing since at least 2004, and Zyprexa's prescriptions and market share have fallen sharply over the period. As a result, the new warnings may have only a moderate impact among doctors and patients, said S. Nassir Ghaemi, director of the Bipolar Disorder Research Program at Emory University. "The knowledge has been out there, and it's already impacted prescribing patterns a great deal," Dr. Ghaemi said.

The new label will also indicate that patients who take Zyprexa may keep gaining weight for as long as two years after starting therapy. That contradicts earlier public statements by Lilly that weight gain on Zyprexa tends to

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NAMI StigmaBuster Alert

October 4, 2007

By Stella March, NAMI

Help CANVAS Fight Stigma

During Mental Illness Awareness Week (Oct 7-13), the movie CANVAS [was] released in five cities: Chicago, New York, Ft. Lauderdale, Los Angeles, and Phoenix.

Starring award-winning actors Marcia Gay Harden and Joe Pantoliano, CANVAS is the story of a family's struggle with schizophrenia. The film educates as well as entertains. It will strike a blow against stigma, but only if enough people see it.

The NAMI Advocate has suggested ways to help. You don't even have to live in one of the five cities. Here are the key ones:
- Email family and friends in the five cities about the film this week!
- Buy tickets on-line early during the week before each opening. Donate tickets to others.

***** See movie review “Illness Rends” on page 3*****

Modeling Straitjackets

On October 3, "America's Next Top Model" featured contestants "perfecting their runway walk" while wearing straitjackets, as part of a competition to prove they can make it in "the high-stress, high-stakes world of supermodeling." The set was a mock, abandoned psychiatric ward and the modeling coach, dressed as a nurse, scolded them not to walk "like the former patients of this hospital."

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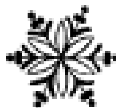
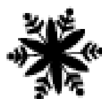
3rd Wednesday of each month
6:30 - 8:00 pm
1010 Gough St.
(between Eddy & Ellis)

The Monthly Meeting

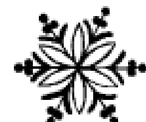
November 21
In Our Own Voice: Living with Mental Illness -- a consumer recovery education presentation

December
No meeting - see you in January!





Happy Holidays!



My Officemate Is Crazy! Can I Send Him to an Insane Asylum?

By Juliet Lapidos, The Explainer, Reprinted from Slate, Oct. 9, 2007

In the new legal thriller Michael Clayton, Michael must silence his colleague Arthur Edens, who plans to sabotage a big case. At wit's end, Michael wonders if he can send Arthur to an insane asylum against his will. Last Thursday, TV shrink Dr. Phil said that Britney Spears may be a suicide risk who needs "to be involuntarily committed." Under what circumstances can you force a loved one, suspicious officemate, or eccentric celebrity into the nuthouse?

Imminent danger. Laws vary somewhat from state to state, but all commitment statutes uphold a basic principle: If an individual is mentally ill and he poses an immediate, substantial threat of physical harm to himself or to others, then it's permissible to detain him for involuntary psychiatric care. New York, where Michael Clayton takes place, condones the forced hospitalization of any person with a mental illness who "attempts at suicide or serious bodily harm" or who manifests "homicidal or other violent behavior."

Many states also permit involuntary commitment in cases of grave disability. In California-where Britney Spears resides-this applies to those whose mental illness limits their access to food and shelter. Arizona's standards are somewhat lower. In that state, lawmakers have deemed that forced hospitalization is appropriate if an individual's condition is deteriorating, and he can't make an informed decision as to whether treatment is desirable.

To prevent wrongful detainment, all states require some sort of multistep review process. Here's how it works: Generally, either a family member or a health-care professional must petition a local judge. In some states, anyone-a co-worker, neighbor, or just a concerned observer-can serve as petitioner. If the judge finds reasonable grounds for a psychiatric examination, he'll order local law enforcement to haul the alleged loon to a mental ward. Next, at least two physicians evaluate the subject's condition and decide whether to proceed with a request for extended commitment. In the event of such a request, there's a full hearing.

How did these laws come about? Commitment statutes were once lax and arbitrary; essentially, anyone suffering from a mental illness could be forced into treatment, regardless of imminent danger. As a result, in 1955 there were more than 500,000 people in state mental wards-or 339 for every 100,000 Americans. (By way of contrast, there were only 59,400 psychiatric inmates as of December 2000-or 22 per 100,000.) This state of affairs led both liberals and libertarians to call for reform. Liberals argued that the civil rights of the mentally ill were being curtailed, and libertarians wanted to downsize state-owned hospitals by shifting the burden of responsibility onto community centers. Luckily, the deinstitutionalization movement coincided with the development of anti-psychotic medication, which can help schizophrenics and manic depressives lead independent lives. By the early 1970s, state legislatures began enacting more stringent commitment laws based on a "danger" standard.

Explainer thanks Richard Bonnie of the University of Virginia and Jon Stanley of the Treatment Advocacy Center.

At Therapy's End

As depression eases, patients often want to stop treatment. But are they better? Will they relapse?

Reprinted from The Los Angeles Times by Josh Fischman, 10/8/07

People come into Andrew Leuchter's office, saying they're better, saying they want to stop. "Oh, gosh, it happens all the time," says Leuchter, a psychiatrist at UCLA's Semel Institute for Neuroscience and Human Behavior. "They say they feel OK, that they don't need drugs or any other help, and that they've recovered. On one hand that's very encouraging, but on the other hand we have to be very careful, because the cost of being wrong -- if they are not ready -- can be very high."

These are not drug addicts saying they want to go cold turkey. They are not alcoholics. These are people with depression who want to stop treatment.

Nearly 20 million Americans suffer from some form of depression, according to the National Institute of Mental Health. About 14% of adults now take antidepressants -- triple the percentage during the late 1980s -- and most stay on them for at least six months.

A study published in this month's issue of the Archives of General Psychiatry estimated that mental disorders, largely depression, cost Americans 1.3 billion days of normal activity each year. Many people with such illnesses say they feel hopeless, helpless, unable to face life, unable to find solutions to their problems, and at times think of killing themselves. Some of them do.

Depression treatment, such as antidepressant drugs Prozac or some version of talk therapy, can help about two-thirds of sufferers. But as it does, patients start to ask: Am I better? Am I cured? Can I stop my therapy? The answers are not simple. Measuring depression is hampered because there's no physical marker that indicates whether a patient has it or does not. Information

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Illness Rends One Mind, Three Hearts

By Stephen Holden, Reprinted from The New York Times, 10/1207

"Canvas," Joseph Greco's drama about schizophrenia, is obviously a labor of love. In his director's note Mr. Greco writes, "I grew up watching my mother battle schizophrenia, and those harrowing memories had a profound impact on me." He adds that a screenwriting professor once told him, "Write what you know." That advice has resulted in a movie that rings emotionally true, despite structural contrivances and dim, washed-out color.

Because Mary Marino, the afflicted mother, is portrayed by the gifted Marcia Gay Harden, "Canvas" never threatens to become the kind of quasi-horror film that movies about the mentally ill tend to be. Cast in a role that would tempt many actresses to indulge in award-seeking histrionics, Ms. Harden underplays Mary's recurrent symptoms until the last moment. When the voices that periodically torment her return, her ears prick up, and her eyes dart, as expectancy mingles with fear that rapidly escalates to panic. Even when she erupts, you sense the human being in pain huddled inside the uncontrollably raving creature.

The story begins as Chris (Devon Gearhart), the 10-year-old son of Mary and her husband, John (Joe Pantoliano), returns to his family's home in Hollywood, Fla. Chris had been staying with relatives while his mother was hospitalized, and almost immediately it becomes clear that her mental stability is hanging by a thread. As she becomes delusional, then paranoid, you share her husband's sinking feeling that it's always going to be this way and his frustration at finding that his love is powerless against demons with whom there is no reasoning.

Mr. Pantoliano's John emerges as a working-class saint who, through some combination of devotion and inner resilience, almost never rises to the bait when Mary becomes shrill and irrational. But even he has his limits. Chris, being younger, isn't so patient. When his mother embarrasses him in front of his peers, he half blames her and wants to escape. In her more lucid moments Mary is mortified by her behavior.

The Marinos are devastated in countless ways. Mary's hospital bills drive John, who works in construction, into debt. The movie gives only a taste of the stress he undergoes dealing with insurance companies. His patience is tested when Mary, like so many schizophrenics, refuses to take her medication. Chris has nightmares that reflect his fear of having inherited his mother's illness.

When the police are called to the house one too many times, the neighbors' tolerance evaporates. How does life go on? Well, somehow it does.

The movie's title refers both to Mary's therapeutic painting, which, she explains, quiets the voices inside her head, and to John's construction of a sailboat in the backyard as a present for her. Chris also develops a profitable sideline sewing custom-made patched shirts for his classmates and experiences puppy love for the first time.

If "Canvas" tries much too hard to soften the Marinos' anguish by emphasizing the father and son's creativity and resilience, a tougher, more realistic movie would probably be close to unbearably painful. Below the film's sugar coating is an inner core of integrity and goodness. All three Marinos are noble everyday people visited by horror. Think of "Canvas" as a Lifetime movie: a likable one.

"Canvas" is rated PG-13 (Parents strongly cautioned) for mature thematic elements.

County Mental Health

The County mental health access line for all consumers is
415-255-3737

The Mobile Crisis Unit is
415-355-8300

Stigma Busters from page 1

The CW Television Network needs to know:

The episode was outrageous-mocking people with mental illnesses. Would the show ever use a cancer ward as the setting for a modeling test?

Straitjackets represent extremely painful, traumatic experiences. Their image is hurtful to individuals and families who struggle with mental illness. Using straitjackets for entertainment demeans individual dignity and trivializes mental illness. Straitjackets are often associated with violence. Their image reinforces the kind of stigma that the U.S. Surgeon General has found to be a major barrier to people seeking help when they need it.

Rick Mater
Senior Vice-President for Broadcast Standards
The CW Television Network
220 East 42nd Street
New York, NY 10017
feedback@CWTV.com

At Therapy's End from page 2

about that comes from behavior, thoughts and feelings, which can't be assessed as easily as, say, blood pressure.

Rating scales can show how far symptoms, such as trouble sleeping, have receded, but psychiatrists say they put even more stock in a patient's overall mood: whether he or she takes joy from life again and whether the person thinks he or she is back to a pre-depression emotional state. That too can be difficult to determine.

Now results from large, long-term studies are beginning to paint a clearer picture of the course of depression and are sharpening decisions about stopping treatment. If a person has had just one episode of depression, the chances of a long-lasting recovery are fairly good. But those chances go down with every subsequent episode.

Once people reach their third episode, Leuchter says, "then we need to discuss ongoing maintenance therapy, even if they are feeling better. I don't like to use the phrase 'lifetime treatment' with patients. But, essentially, that's what we're talking about."

A lingering battle

One woman, a 41-year-old professional pet sitter who lives in Los Angeles, has been battling depression since she was a child. (She prefers to remain anonymous because, she says, depression is still a taboo subject.)

"I lost my dad when I was 10, and I never seemed to be able to get over it," she says. She remembers crying on the school bus, crying a lot. At home, she didn't want to get out of bed. Her body ached with a vague pain. She says at times she had to push herself to go to the bathroom. She had trouble seeing herself growing older. There didn't seem to be any point. But it wasn't until she was 22 that she got some help.

"I was working as an aide in a pediatrician's office, and I was just crying all the time. It was over nothing, but it was uncontrollable," she says. "One day the doctor took me aside. He said, 'Look, we can't help you here with something like this. But you can get help.' And it was the first time somebody used the word 'depression' with me. It was the first time somebody took me seriously."

The pediatrician referred her to a psychotherapist and to other doctors who prescribed antidepressants. She saw the therapist for a year and a half, "and I learned coping skills. I learned not to internalize things completely all the time."

Medications were a rockier road. "I went through Paxil, and then Wellbutrin," she says. "I would be fine for a time. Then I would go back to being depressed."

It's not unusual for patients to try multiple antidepressants and multiple dosages. There's a lot of tinkering, because doctors still don't understand precisely how these medications work. They have theories. The dominant one involves maintaining a balance in the brain of chemicals that seem to be involved in mood and emotions.

When Prozac, the granddaddy of modern antidepressants, was approved by the Food and Drug Administration in 1987, it was because taking the drug improved the moods of depressed patients. Doctors then knew the drug made more of the chemical neurotransmitter serotonin available in the brain. They assumed -- and still think -- the two things are connected.

Serotonin flows across tiny gaps from one brain cell to the next. Then the cell that originally released the chemical absorbs it again. The process is called reuptake. What Prozac appears to do is block that reuptake, so more serotonin lingers in the gap, ready to be taken up by other brain cells. If depression is indeed caused by low serotonin levels, this method -- while not increasing the absolute amounts of the chemical in the brain -- should leave more serotonin out in the open for more brain cells to use. Some antidepressants, such as Effexor, do the same thing with another mood-regulating brain chemical, norepinephrine.

Still, because no one really knows what a low, normal or high level of these neurotransmitters is, there's a lot of trial and error involved in taking the drugs.

"We use many different doses and many different drugs because people seem to respond to them differently," says Ellen Frank, a clinical psychologist at the Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center. She has spent 25 years studying depression treatments. "Once we find something that works for a patient, we tend to stick with it," she says. "The dose that gets you well keeps you well."

That view is supported by results of a major study that followed 3,600 patients across the country for several years. One-third of them responded to the initial antidepressant treatment. People who did not respond were given a different drug, and some also got talk therapy. After that, non-responders got another combination. By the time the fourth combination was reached, 67% of the patients were no longer depressed.

That's good news and not-so-good news, says A. John Rush, a psychiatrist at the University of Texas Southwestern Medical Center who led the study, which is known as STAR*D. The good news is that there's hope for patients who can hang in there for multiple attempts at treatment. The not-great news, he admits, is that people who went through three or four treatment combos -- those with the toughest depressions to treat -- had the lowest chances of feeling better.

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At therapy's End from page 4

The wellness factor

How, then, do patients know if they are well enough to stop therapy?

"That idea of 'well' is something patient and doctor have to agree upon," says Leuchter, a specialist in the effectiveness of depression treatments. "They have to have a meeting of the minds on the definition. One real problem is that depressed patients often have a very low bar for what they would call feeling better. They've probably been depressed for years before they come to me for treatment. During this time they've lowered the bar: This, they tell themselves, is as good as it's ever going to get."

So a slight improvement in mood seems enormous, even if a depressed patient's overall emotional state is one of apathy and general listlessness and little hope for the future, a condition few non-depressed people would describe as normal. Though it may seem good to the patient, most can do better.

There are scales of symptom severity, such as the Beck Depression Inventory or the Hamilton Depression Rating Scale, that Leuchter uses to rate individual symptoms, such as irritability or loss of appetite. "A 50% improvement on these scales is good," he says. "But I don't know anyone who would stop there. The acid test is getting back to full function. Are you able to work as you did before? Do you get enjoyment from life as you did before?"

Adds Frank: "If you are a schoolteacher, for example, how many papers could you grade in a week before you felt depressed, and how many can you grade now? How often do you get in a fight with your wife? If it was once a month before, and it's once a month now, then you are probably back."

Since "before" may be clouded in patients' minds, Frank and Leuchter like to also get opinions from spouses or other people close to patients. After the end of a depressive episode, Leuchter says, it's good to continue therapy for four to nine months. "It's like the cast on a broken leg," he says. "You need the continued support to be able to heal." Coping skills need to be honed or a stressful incident might trigger another depression.

Then the patient begins to taper, whether it is drugs or psychotherapy or both, cutting the drug dose in half, or seeing a therapist every two weeks instead of every week. Then it's wait and see. "If it goes well, then cut it in half again," Frank says.

With drugs, if someone tries to taper too quickly or even go cold turkey, he or she often experiences a range of physical and emotional reactions. Some people complain of sleeplessness, dizziness, muscle aches or fatigue. Mentally, many feel anxious, nervous or, not surprisingly, depressed. Often, raising the drug back to the last effective dose alleviates the symptoms.

As with so many things regarding antidepressants, psychiatrists do not have hard-and-fast explanations for these effects. But it's possible that the brain might reduce its ability to produce chemicals such as serotonin while the drugs enhance the supply. When the drugs are stopped, a lack of serotonin might cause side effects until the brain regains its balance.

Sometimes it doesn't go well. For patients who have three episodes of major depression during their lives, particularly if the first one hit at a young age, chances of another relapse are high, about 90%.

Long-term management

The woman who lost her father at age 10 fits that profile. After her initial treatment she got better and then worse. She changed drugs and doses, but the cycle continued for 18 years. She thought about killing herself; she also thought about killing others. At one point she committed herself to a hospital.

The last time she tried to wean herself off medication was a year ago. "I couldn't do it," she says. She felt herself falling back into a scary, dark place. So she went back on medication. "That's frightening to me, a little. But I also know that there are meds that help. It's a lot better knowing that I don't have to go through life feeling like crap."

She also credits psychotherapy with helping her identify situations that trigger depressive and anxious thoughts. It's often periods of inactivity. So she keeps herself fully booked.

"I'm in L.A., I'm with dogs all day, and I'm walking them out in the sunshine, and all that feels good," she says. "I like my life. I'm able to be depressed and crack jokes. As long as I keep going in this direction, I'll be just fine."

Soiurce: Los Angeles Times

Support Groups

Family Members' Groups
African American Family Support
1st Thursdays, 5:30-7:30 pm at
1380 Howard St., Rm 537. Call Wanda at 255-3694

San Francisco Family Support Group
Tuesdays, 5:15-6:45 p.m. at SF General Hospital, 1001 Potrero St., Room 7M30. Info: Susanne at 415-558-5900

Sibling & Adult Children Network
Call Mary Gullekson at 474-7010 for information

Berkeley Sibling Support Group
Call Carolyn Defay at (510) 644-8579

Bilingual & Monolingual Support Groups
Chinese Families Mental Health Alliance. Ed Koo 352-2047

Consumer Self-Help Groups
Depression & Bipolar Support All. (formerly DMDA)
Saturday afternoons at 1:30-3:00 and
1st Mondays at 6:45-8:00 pm in the Saint Francis Hospital, 900 Hyde St., 2nd Floor Conf. Room. Call 519-0171

SPIRITMENDERS Community Drop-in Center
2940 – 16th Street #B2 (415) 552-8565

OASIS (Office of Self Help)
1095 Market Street at 7th, Suite 202 (415) 575-1400

RECOVERY, Inc. for nervous ailments
(415) 333-6454 Community Miracles Center,
2269 Market Street (between Noe and Sanchez

Consumers with Schizophrenia
3rd Wednesay of each month, 5:30 pm
1380 Howard St., 5th floor. Info: Susanne at 558-5900

Hoarding & Cluttering Support
2nd Monday and 4th Wednesday of each month.
Antonio (415) 421-2926 x306

Health and Wellness Action Advocacy
1st Thursday of each month, 1-3pm. Antonio at (415) 421-2926, x306

Anxiety&Panic Self Help Group: John (650) 755-0883

Alcoholics Anonymous: San Fran: (415) 621-1326
Marin: (415) 499-0400 San Mateo: (650) 573-6811

Narcotics Anonymous SF Helpline: (415) 621-8600

NAMI-San Francisco is a self-help organization of family members, mental health consumers, friends, professionals and other interested citizens, united to provide support, education and advocacy for persons with severe mental illness. NAMI-San Francisco is a private, non-profit organization.

NAMI-SF Support Groups

1) **For Caregivers and Friends Only**
   1010 Gough
   2nd Wednesday at 6:30
   Contact Vickie at 661-5208

2) San Francisco General Hospital
   7th Floor, Room 7 M 30
   Tuesdays, 5:15 – 6:45 p.m.
   Call Susanne Killing at 558-5900

DBSA meeting location change:
The latest word from Jo Beth Welsh, Director of Volunteer Services at St Francis Hospital, is that we will holding our DBSA SF Support Meetings at our old location (2nd Floor, Conference Rooms B&C) until July 21st and then move to the Lower Level, Conference Rooms A, B and C.

DBSA

Depression and Bipolar Support Alliance of San Francisco

(formerly San Francisco Depressive and Manic Depressive Association)

Regular Support Group:
every Monday at 6:45-8:15pm and
every Saturday at 1:30-3:00pm.

Young Adults Support Group:
1st and 3rd Monday of each month at 6:45-8:15pm for 18 to 25+ year old people.
Contact Harry at 650-430-2909 for information.

Friends And Family Support Group:
1st and 3rd Monday of each month at 6:45-8:15pm. Contact Jane at 415-519-0171 or Harry at 650-430-2909 for information.

Location:
2nd floor of St. Francis Hospital
900 Hyde St.
between Pine and Bush in San Francisco
Conference rooms B, C, and D

Meetings are on a drop in basis and are open to peers, please note we do not allow observers. You do not need to be a member to attend, however memberships are $20.00 a year and you are encourged to join and support the organization.

Zyprexa Warning from page 1

plateau after a few months of use. One in six patients who take Zyprexa will gain more than 33 pounds after two years of use, the label says.

Weight gain and high blood sugar are risk factors for diabetes, although Lilly says there has been no proof that Zyprexa causes diabetes more than its competitors do. "Obviously, we know that weight gain is a known risk factor for diabetes," said Marni Lemons, a Lilly spokeswoman. "However, not all patients who gain weight develop diabetes." Ms. Lemons also noted that older antipsychotic medicines also have severe side effects, including a tendency to cause facial tics. The new warnings may add to the controversy surrounding Zyprexa, which is by far Lilly's best-selling drug.

Zyprexa had global sales of more than $2.3 billion in the first half of this year and nearly 3 million prescriptions in the United States alone. Lilly said it had made the label changes as a part of continuing discussions with the Food and Drug Administration.

Lilly has asked the F.D.A. to allow it to begin marketing Zyprexa for adolescents, despite clinical trial data showing that Zyprexa causes weight gain and metabolic problems in teenagers that can be even more severe than in adults.

Heavily marketed by drug companies, atypical antipsychotic medicines have become one of the biggest and fastest-growing drug classes.

Overall sales for the category are projected at close to $13B this year, despite little evidence that the new drugs work better than older generics that cost just pennies a pill.

The label changes come 11 years after Lilly began selling Zyprexa and more than 12 years after a large Lilly clinical trial first showed that Zyprexa might have negative effects on weight and blood sugar.

Internal Lilly documents disclosed by The New York Times last December indicated that Lilly was aware of Zyprexa's tendency to cause weight gain and blood sugar changes by the late 1990s but played down the risks.

Lilly said at the time of those disclosures that the drug's risks were already reflected in the label. Ms. Lemons said the company had not delayed releasing information about Zyprexa's side effects, and had made yesterday's label change after a new review of clinical trials showed the drug's potential risks. "It's not like this is information that we have had since 1995," Ms. Lemons said.

The documents disclosed by The Times in December also indicated that Lilly had told its sales representatives to encourage doctors to prescribe Zyprexa to people who do not have schizophrenia or bipolar disorder, Zyprexa's only approved uses.

Federal laws prohibit drug companies from so-called off-label marketing, although doctors may prescribe drugs for whatever use they see fit. Lilly has spent $1.2 billion since 2004 to settle lawsuits from 28,500 people who claimed they developed diabetes or heart problems after taking the drug. At least 1,200 more lawsuits are still pending.

In 2004, the American Diabetes Association said that Zyprexa was more likely to cause diabetes than other commonly prescribed antipsychotic medicines, although the F.D.A. has never made a distinction between Zyprexa and other drugs. Even now, Zyprexa's label does not say it causes diabetes more than the other medicines, only high blood sugar.

In the United States, Zyprexa's prescriptions and market share have slid for three years. But the revenue it produces for Lilly has not fallen because Lilly has pushed through price increases on the medicine, which can cost $8,000 for a year's supply of a standard 20-milligram dose.

Out of the Fog is published 10 times a year by NAMI-San Francisco, a non-profit organization affiliated with the National Alliance on Mental Illness, which goes by the acronym NAMI, and NAMI-California, the statewide affiliate.

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Please Join NAMI SF

NAMI-San Francisco is moving to a system where members renew in their anniversary months, but many of you are on the calendar-year system. Please let us count you. There is power in numbers. We need the support of families, friends, consumers, professionals and others who share our goals. Your dues help us pay for the printing of the newsletter, educational materials and mailings and the Family-to-Family Education Course, an invaluable resource for people who love someone with a mental illness.

Checks may be made out to "NAMI San Francisco"

Please mail to:
NAMI-San Francisco Treasurer
PMB 426
1010 Gough St.
San Francisco, CA 94109

NAME________________________________
(Please Print)
ADDRESS______________________________

CITY______________________ZIP__________

PHONE_______________________________

This is a: •New Membership •Renewal •Address change

What is your relationship to a person with a mental illness?
•self • parent • sibling • spouse• health care/professional
Other_______________________________

Please Check One:
• $10 Consumer
• $45 Individual or Family Membership
• $100 Organization or Benefator Membership
• $250 or more for Patron Membership
• $500 or more for Sustaining Membership

• I cannot join NAMI-San Francisco at this time but I would like to receive ***Out of the Fog*** **or I am enclosing a donation of $______ to help cover the cost of *Out of the Fog.***

NAMI SAN FRANCISCO
1010 Gough St.
San Francisco, CA 94109

Return Service Requested

PRESORTED
STANDARD MAIL
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