



OUT OF THE FOG

The monthly newsletter of NAMI San Francisco

Advocacy Booklet Available

"Advocating for Someone with a Mental Illness" is a booklet by a mother who started coping with her daughter's diagnosis with a severe mental illness 25 years ago. Sonya Nesch joined NAMI in 1986 and later became president of the Mendocino County chapter. Her booklet summarizes the best of NAMI's advocacy lessons interwoven with the personal experiences of Nesch and her daughter, Cathleen.



Cathleen was diagnosed with schizophrenia at age 15, bipolar disorder at age 20, and later with schizoaffective disorder and panic and anxiety disorders. Her first psychotic break was preceded by a dose of LSD. Sonya Nesch has written the booklet as a resource for family members, friends, and consumers who advocate for themselves. It will also be of value to anyone trying to gain insight into the lifelong struggle to manage a severe mental illness.

It offers advice such as preparing a one-page summary of medical and symptom history (sample included), developing a crisis intervention plan for symptom breakthrough or relapse, and the use of complementary practices (acupuncture, nutrition, herbalists, etc.) as an adjunct to medication. Topics such as suicidality, psychosis and violent behavior are addressed in a straightforward manner, cutting through the natural responses of shock and sadness that make them difficult to talk about.

The booklet is for sale for \$15 at NAMI-SF's monthly General Meeting or by calling our office at 905-6264. You can also mail a check to NAMI San Francisco, 1010 Gough Street, San Francisco, CA, 94109 and a copy will be mailed to you.

Study Shows Behavioral Health Courts Work

San Francisco's Behavioral Health Court reduces recidivism and violence by people with mental illnesses who are involved in the criminal justice system. That's the conclusion of a just completed three and a half-year University of California, San Francisco study.

The study was funded in recognition of the fact that too many people with mental illnesses are winding up in jails. An article about the summary is published in September's American Journal of Psychiatry or online at www.ajp.psychiatryonline.org.

The study shows that mental health courts reduce the involvement of persons with mental illnesses in the criminal justice system. The likelihood of Behavioral Health Court participants being charged with any new crimes was about 26% lower than that of comparable individuals in the criminal justice system. The likelihood of Behavioral Health Court participants being charged with new violent crimes was 55% lower than that of comparable individuals in the criminal justice system.

The proportion of people entering U.S. jails who have severe mental disorders has been estimated to be between 6% and 15%. The number of jail admissions involving people who have severe mental illnesses has been estimated at 804,000 annually. People with mental illnesses who are incarcerated tend to stay longer in jail than others charged with similar crimes and to cycle through the criminal justice system, the mental health

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

The Monthly Meeting

October 17

Dr. Rona Hu will be speaking on "**Antipsychotic Medications: Weight gain and other side effects.**" She is Assistant Professor of Psychiatry at Stanford University School of Medicine, and Medical Director of the Acute Psychiatric Inpatient Unit at Stanford Hospital.

November 21

Consumer Forum

NIMH Perspective on Diagnosing and Treating Bipolar Disorder in Children

Reprinted from the NIMH website, Sept. 3, 2007
Director's Update

A recently published research paper (September 2007, Archives of General Psychiatry) reported a 40-fold increase in the rate of diagnosing bipolar disorder in youth over the past decade. This paper raises several important questions:

- Were physicians under-diagnosing bipolar disorder in the past?
- Are they over-diagnosing currently?
- Are more children developing behavioral disorders than in the past?

It is unclear exactly what is causing this increase, but current evidence suggests a combination of each of these and possibly other factors. The following is intended to discuss the paper's findings within the broader context of what we know about the diagnosis and treatment of bipolar disorder in children and adolescents.

It is important to note that the paper's findings were based on data from a survey conducted annually by the National Center for Health Statistics. The survey comprises a one-page form that asks a nationally representative sample of private practice doctors to describe certain characteristics of each patient visit, including children and adults, over a one-week period. Neither the survey nor the paper provides information regarding:

- how common bipolar disorder is (prevalence) within the community;
- the annual rate at which new cases are reported (incidence).
- practices of other mental health providers, such as psychologists, clinical social workers, and mental health counselors;

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New Schizophrenia Drug Shows Promise in Trials

By Alex Berenson, September 3, 2007

Correction Appended

In a clinical trial of about 200 patients, an experimental drug from Eli Lilly reduced schizophrenia symptoms without the serious side effects of current treatments, according to a paper published yesterday in the journal Nature Medicine.

The drug must still be evaluated on many more patients to test for the possibility of side effects that have not yet emerged, and it is at least three to four years from completing regulatory review.

But schizophrenia researchers said the trial's results were surprising and impressive, especially since the drug works in a different way from existing antipsychotic medicines, all of which have serious side effects, including substantial weight gain and tremors.

Lilly will begin a larger clinical trial for the drug this month. If that trial confirms the results seen so far, the new drug could mark a breakthrough in the treatment of schizophrenia - and open the way to a broad new class of treatments for the disease. Schizophrenia, a devastating mental illness that affects 1% of adults, or about 2.5 million in the United States, usually begins in the late teens or 20s and is marked by psychotic delusions as well as social withdrawal and cognitive impairment.

"This is potentially one giant step forward for patients," said Dr. Jeffrey Lieberman, chairman of the psychiatry department at Columbia and the lead investigator on a federally sponsored clinical trial of schizophrenia medicines. "This drug may turn out to be not just a comparably good antipsychotic agent, but a better antipsychotic agent."

Dr. Lieberman has not been involved with the development of the medicine and does not receive any payments or consulting fees from Lilly.

The new drug also has the potential to be a blockbuster for Lilly. Medicines for schizophrenia and bipolar disorder are the fourth-best selling class of medicines in the United States, with sales of \$12 billion in the United States and \$18 billion worldwide last year.

The troubled history of Zyprexa, another antipsychotic medicine from Lilly, will lead regulators and psychiatrists to scrutinize the new medicine closely for hidden dangers, Dr. Lieberman said. When it introduced Zyprexa in 1996, Lilly hailed it as a breakthrough with fewer side effects than older drugs. But Zyprexa causes severe weight gain, and the American Diabetes Association has linked it to diabetes. Internal Lilly documents

County Mental Health

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

The Mobile Crisis Unit is
415-355-8300

show that the company played down Zyprexa's side effects, worrying they would hurt sales.

Despite that history, psychiatrists will be eager to see whether the new Lilly medicine works, since the existing drugs are of limited help for many patients. Existing schizophrenia medicines, whether older drugs such as Thorazine or newer medicines like Zyprexa, all work by blocking the brain's dopamine receptors.

But the new Lilly drug does not directly affect dopamine. Instead, it modulates brain activity through a different set of receptors. As a result, it has the potential to be the first truly novel treatment for schizophrenia since Thorazine was introduced 1954, Dr. Lieberman and other researchers said.

Lilly's new drug - which does not have a name yet and is referred to as LY2140023 - emerged from almost two decades of research by Dr. Darryle D. Schoepp, a toxicologist and pharmacologist who joined Lilly in 1988.

For decades, psychiatrists have known that users of PCP, a street drug sometimes called angel dust, have symptoms nearly identical to those of people with schizophrenia. By the 1980s, scientists had discovered that PCP blocked brain receptors that are triggered by an amino acid called glutamate. This led some companies and scientists to study ways to stimulate glutamate receptors as a treatment for schizophrenia.

But the brain has many different kinds of glutamate receptors, and figuring out how to stimulate or block them in medically beneficial ways has proved complicated. Instead of focusing on the receptors blocked by PCP, Dr. Schoepp concentrated on modulating the action of glutamate receptors in the brain's prefrontal cortex, an area responsible for personality and learning.

"This is a system that is so fundamental to the function of your brain that it is quite powerful," said Dr. Schoepp.

But because drugs that blocked dopamine had been the only successful schizophrenia treatments, many researchers viewed the glutamate pathway as unlikely to produce useful medicines, said Dr. P. Jeffrey Conn, director of the Vanderbilt University drug discovery program and an expert on glutamate research.

Dr. Schoepp deserved praise for persuading Lilly to invest in a field that appeared to be a long shot, Dr. Conn said, adding, "He locked in very early."

As a result, Lilly appears to have a multiyear lead over its competitors in glutamate drugs, Dr. Conn said. Dr. Schoepp left Lilly in March to become the head of neuroscience research for Merck. Dr. Schoepp and Dr. Steven Paul, the president of Lilly Research Laboratories, both said that his departure would not hurt the

development of Lilly's new medicine

Dr. Joseph T. Coyle, a professor of psychiatry and neuroscience at Harvard Medical School, said the Lilly trial validated the theory that modulating glutamate receptors might control the symptoms of schizophrenia.

Even if this drug fails in later trials, companies and scientists are likely to pursue glutamate research more aggressively, he said.

"When you see a company that comes up with something that's completely different, completely out of the box, that attracts attention," Dr. Coyle said.

Existing drugs are reasonably good at treating the hallucinations and delusions of schizophrenia.

But they are far less effective at treating the so-called negative symptoms of the disease - the lack of motivation and emotion that leave many patients unable to work or have normal social relationships. The side effects of existing medicines, which affect nearly all patients, are also severe. Older drugs like Thorazine often cause tics and movement disorders, while newer medicines typically have fewer effects on movement but can cause weight gain and other metabolic changes.

In the clinical trial whose results were reported yesterday, LY2140023 had none of those side effects and appeared to work about as well as Zyprexa at reducing symptoms. In the trial, which was conducted in Russia from August 2005 to June 2006, patients were given the experimental drug, Zyprexa or a placebo. About 100 patients received the experimental medicine.

For the drug to be approved, Lilly will need to replicate the results in larger trials. This month, Lilly will begin a trial with 870 patients to determine the most effective dose of the drug. That trial is expected to be complete in January 2009, and if it is successful Lilly will probably start a large Phase III trial that could cover at least 2,000 patients.

"We have to confirm safety and efficacy with multiple studies," Dr. Paul of Lilly said. He said he did not want to offer a prediction of when Lilly might ask the Food and Drug Administration for approval. But he said Lilly intended to develop the drug aggressively.

"We are very actively working on this target and related targets because we believe that this mechanism is now validated," he said.

Correction: September 6, 2007

An article on Monday about an experimental drug from Eli Lilly for the treatment of schizophrenia symptoms misidentified the journal that published a paper on the effectiveness of the drug. It was Nature Medicine, not Nature.



- practices of physicians who work for the Federal government (such as the Veterans Administration); or
- practices of non-office based health settings where people with bipolar disorder may receive mental health care, such as community mental health centers and hospital clinics.

The survey recorded the number of office visits instead of the number of individual patients, so some people may have been counted more than once. Because the survey was conducted only over one week, it was not possible to study the length and progress of treatment. In addition, information on the doses of some medications was not available. Finally, while a 40-fold increase seems large, the base rate (25 bipolar diagnoses per 100,000 people) suggests that the diagnosis was rarely used in 1994-1995. The recent rate of 1,003 bipolar diagnoses per 100,000 people is indeed much higher than the 1994-1995 rate, but still well below the rate of bipolar disorder for adults (1,679 bipolar diagnoses per 100,000 people).

How do physicians currently diagnose bipolar disorder in children? The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) lists criteria to define bipolar disorder in children. These criteria are based on how the disorder typically appears in adults and have not changed over the past decade.¹ Research indicates that there are children whose symptoms clearly meet these criteria, as well as a much larger group of children who show some but not all symptoms. It is in this latter group, who frequently show excessive irritability and impulsivity, where there is disagreement as to whether these are symptoms of bipolar disorder or of a broader spectrum of mood disturbances. Such mood disturbances may have been diagnosed differently or may not have come to a physician's attention a decade ago.

Co-occurring disorders can also make diagnosis more difficult. As many as 60 percent of children diagnosed with bipolar disorder in most studies also have attention deficit hyperactivity disorder (ADHD),^{2,3} raising questions about whether the current diagnostic criteria are specific enough to distinguish symptoms of bipolar disorder from symptoms of other related illnesses in children.

Recent research has demonstrated that many adult mental disorders begin in childhood. The NIMH-funded Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) trial found that about 65 percent of adults with bipolar disorder describe the onset of symptoms before age 19,⁴ suggesting that the disorder

may have been insufficiently recognized in the past. It is not yet clear, however, that all of the children currently diagnosed with bipolar disorder will grow up to be adults with bipolar disorder.

A current NIMH supported study is following a group of children and adolescents diagnosed with bipolar disorder to determine the course of their symptoms over time. In this and other research studies for which having bipolar disorder is a requirement, only a small fraction of children referred for participation actually meet criteria for the disorder. It seems likely therefore, that many of the children and adolescents in the community diagnosed as having bipolar disorder do not have the same illness as adults with bipolar disorder. In this sense, the diagnosis may be over-used or mis-used in children. This is not to say that these children and their families are not in distress. While these children may not all have bipolar disorder, it appears that physicians are reporting a true increase in the number of children and adolescents presenting with severe behavioral problems, including irritability, aggression, and erratic moods.

NIMH is committed to the development of biological tests that can help validate the diagnosis of bipolar disorder in children. Recent research advances showed that electroencephalograms (EEGs) and magnetic resonance imaging (MRI) studies of the brain can reveal differences between bipolar disorder and related behavioral syndromes which cause some of the same symptoms in children as bipolar disorder causes. In addition, recent studies have identified novel candidate genes that may increase risk for adults with bipolar disorder.^{5,6} NIMH researchers also recently found that parents of children diagnosed with bipolar disorder appear more likely to themselves have bipolar disorder, compared with the parents of children with severe irritability but without the classic mood episodes of bipolar disorder. This suggests that genetics should ultimately prove helpful for validating bipolar diagnoses in children.

Whatever the issues are in diagnosis, the Archives paper also described widespread prescribing of medications not FDA-approved for children diagnosed with bipolar disorder. Currently, there are no antidepressants approved by the FDA for treating bipolar disorder in children and adolescents, and only one approved atypical antipsychotic, risperidone (Risperdal).

More research is needed to determine the safety and effectiveness of the many medications currently used to treat bipolar disorder in youth, as well as to identify other types of appropriate treatment. Several NIMH-funded clinical trials seek to accomplish this goal, including the Treatment of Early Age Mania study, involving children (ages 6-15) who have mania, which is comparing the

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effectiveness of three medications commonly used to treat bipolar disorder in adults. An additional study is focusing on teens (ages 13-17) diagnosed with bipolar disorder to examine the effectiveness of family-focused therapy (FFT) in conjunction with medication treatment. Another promising area of study lies in the ongoing trials of early diagnosis and interventions for children at risk for developing bipolar disorder because of a strong family history.

The apparent inaccurate use of the bipolar diagnosis and questions about the safety and effectiveness of medications being prescribed to young children raise real concerns. These concerns need to be balanced by recognizing that psychiatric illnesses can cause disabling and sometimes dangerous symptoms during a critical period of physical and cognitive development, with many potential long-term effects for a child's future. Parents and physicians concerned about the risk of treatment need to consider the risks of not treating children who may have impulsive behaviors that can threaten themselves or others and make it difficult or impossible for the child to function well at home, at school or with peers. Children currently in treatment should not discontinue medication without consulting a physician.

Information on current trends in mental health care can help to highlight specific areas for further research and to assess ongoing efforts. Clearly, more studies are needed to determine the best ways to define, diagnose, treat, and perhaps someday even prevent, the range of mood disorders that affect children and adolescents. By supporting a broad range of rigorous research in this area, NIMH seeks to ensure that concerns about under-diagnosis or over-diagnosis can be resolved with valid diagnostic methods and safe, effective treatments.

Behavioral Health Courts Work from page 4

system, and substance abuse treatment programs. The President's New Freedom Commission on Mental Health identified reducing unnecessary criminalization of people with mental disorders as a priority.

San Francisco's mental health court was established in early 2003. Representatives of the court have spoken at NAMI-SF meetings twice since that time. The mission of San Francisco's Behavioral Health Court is to connect criminal defendants who have serious mental illnesses to treatment services, to solutions to criminal charges that the mental illness into consideration, and to decrease their chances of returning to the criminal justice system.

Remember to donate to the



Community Thrift Store

This is our *best source* of income
for the NAMI SF Chapter!!

625 Valencia Street at 17th Street
415-861-4910

Making a Commitment to Help the Mentally Ill

By C.W. Nevius, San Francisco Chronicle, Oct. 2, 2007

Last January, Dale Milfay's 32-year-old son, Andre, told her he wanted to talk about his feelings. She immediately called the police. Milfay, who says Andre is "manic, psychotic, paranoid and (often) homicidal," knew what would follow when he wanted to discuss feelings - an uncontrollable outburst.

"He threw me down on the floor in front of the fireplace and broke my glasses," Milfay says. "When my husband rushed downstairs, he karate-kicked him. Then he got in his car and left before the police arrived."

Clearly, Andre Milfay needs help. He's a danger to himself, to others, and his mother is genuinely afraid that he will kill her. And there's nothing she can do about it.

"It is an issue of civil liberty," says Dr. Mitch Katz, director of the San Francisco Department of Public Health. "We (in this country) have decided that the benefit of the doubt belongs with the individual. The rules are very strict about locking someone up against their will."

This comes up because next Wednesday there will be a hearing before the budget and finance committee of the Board of Supervisors to discuss the cutting of some 20 acute care beds at San Francisco General Hospital. Those beds are used for severely mentally ill patients who are picked up by police and determined to need involuntary confinement.

There are two points of view on this. Katz, although extremely sympathetic to the families of what he says is an estimated "37,000 persons with a severe mental illness," says the cuts won't make much difference. Another facility, the highly regarded Progress Foundation, will open its doors next year. The hope is that the center, which specializes in acclimating mentally ill to everyday life, will make up the difference for the beds eliminated at S.F. General.

But Milfay, vice president of the local National Alliance on Mental Illness (NAMI), disagrees. So does Officer Kevin Martin, vice president of the Police Officers Association. "I think it is a big deal," Martin says, "because any time someone is being turned away, their only refuge is on the street."

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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 (meets at California Pacific in SF)

Consumers with Schizophrenia

3rd Wednesday 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 encouraged to join and support the organization.

To be fair, the Progressive Foundation will have beds. However, it is voluntary, meaning that if the patient doesn't want to stay, he or she can leave. That's entirely different from the confinement at S.F. General, where patients are supposed to spend at least 72 hours under psychiatric care.

"My son cannot be voluntary," says Milfay, who says Andre has been hospitalized over 35 times. "He won't take his medications, he gets homicidal. Where does someone like my kid go? To be honest, he got better treatment in jail."

While the issue of the beds at S.F. General is important, there is a much larger issue. Across the country, and particularly in California, we need to take an honest look at the consequences of letting mentally ill people decide whether they want to accept treatment. Remember, in these cases their own parents are begging to have them confined to a safe, secure facility where they will have to take their medication and hopefully begin to find themselves. Leaving the choice up to them, as a consequence of patient rights movement, is a recipe for failure. "Think about it," says Katz. "This is the only illness where the illness causes you not to take the treatment. It is the nature of the illness to say, 'There is nothing wrong with me.'"

So, under the current system, Milfay and her good friend Pamela Fischer, who is pres. of San Francisco's NAMI chapter, must spend their lives dreading the next phone call as their children careen out of control. Fischer's son, once a top student at the rigorous Phillips Academy in Andover, Mass., has lived on the streets in the Tenderloin, is addicted to crack cocaine, and cannot function in everyday life.

"It's taken over our lives," says Fischer, who says NAMI's San Francisco chapter has over 100 members, almost all of whom have family members with several mental

issues. "It's just ghastly."

The sad and upsetting part of this story is that everyone agrees that this is a terrible problem - one that not only puts families at risk, but the rest of us as well.

Officer Martin, who walks a beat in downtown San Francisco, estimates that "six to seven out of 10 of our contacts have mental health issues." The police have limited recourse, even in the most extreme cases. One thing they can do is file a 5150 under the California welfare and institution penal code, which is a "72-hour psychiatric hold." But Martin says even that confinement is often "a pipe dream."

"There's been times when I've 5150'd somebody," he says, "and they'd be walking out when I was getting back into my patrol car."

The only certainty is that no one seems able to agree on what should be done. Suggestions range from community centers like Progressive Foundation to "tough love" facilities where patients have to toe the line or lose their bed. "They've taken the idea of tough love and hitting bottom and placed it on mental illness," Milfay says. "My son has no bottom. The bottom is death."

There is one proposal that seems to make sense, but good luck getting support for it. Katz says "Laura's Law allows forced outpatient treatment if someone has a repeated history of going off their meds."

The state law passed, but it was such a political hot button that counties were left on their own to come up with money to carry it out.

So far, only one, Los Angeles, has funded Laura's Law. Milfay and her fellow NAMI members are strong supporters of statewide funding legislation, even if they think it might take something dramatic to get the public's attention.

"If my son kills me," she says. "I hope that law is passed."

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.

NAMI San Francisco

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San Francisco, CA 94109
415-905-NAMI (6264)

www.namif.org

Contact us at namif@fsasf.org

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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)

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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 Benefactor 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

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