



# OUT OF THE FOG

The monthly newsletter of NAMI San Francisco

## January Meeting Notes

By Suzanne Brady

San Francisco Bay Area Walk Director Laurie Williams was the featured speaker at our January General Meeting that also included the introduction of our new Affiliate President. After four years as President of NAMI-San Francisco, Pamela Fischer handed off the baton to Dr. Gifford Boyce-Smith.

Giff has served on the NAMI-SF Board of Directors for two years. He said that in that time he has seen a maturing of our affiliate. He thanked each board member for their contributions to that maturation. However, he gave a lion's share of the credit to Pam.

"I'm thankful that Pam is still with us as a resource," Giff said. "It's thanks to her contacts in the mental health community that this organization is so well respected and well known."

Both Pam and Giff credited the funds raised at previous NAMI Walks with allowing the San Francisco affiliate to reach new heights. In 2007, the San Francisco Bay Area NAMI Walk brought \$35,000 to NAMI-SF. Recent accomplishments have included hiring a part-time office manager; launching a new website; and co-hosting two trainings for In Our Own Voice - a program that helps consumers to become public speakers and tell their stories of struggle and recovery.

San Francisco will be one of seven Bay Area affiliates sponsoring the 2008 NAMI Walk. This will be the first year for NAMI Solano County. The six returning affiliates are Alameda, Contra Costa, Marin, San Francisco, San Mateo and Santa Clara. The Walk is the major

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## The Body Electric's New Look

**Why shock therapy deserves its mini-revival**

By Barron H. Lerner, Reprinted from *Slate*, Jan. 3, 2008

The history of electric shock therapy would seem to lend itself to a rather straightforward tale of last-ditch, gruesome treatment of mental illness. After all, we've all seen *One Flew Over the Cuckoo's Nest*.

But in their new book *Shock Therapy*, Edward Shorter and David Healy say this version is almost entirely inaccurate. Shorter is a historian who has written extensively on psychiatry, and Healy is a psychiatrist who has been highly critical of the marketing of psychopharmacological drugs. They believe that electroconvulsive therapy is incredibly effective. And yet for decades, a severely depressed patient—even one on the brink of suicide—might not have been offered the therapy, or if her doctors had proposed it, she or her family might well have declined it. In explaining why, the authors demonstrate that though we may assume medical treatments get adopted or rejected based on objective statistics, in fact data are often misinterpreted and manipulated by outside influences that end up overpowering them.

The history of ECT began in 1938, when Italian psychiatrist Ugo Cerletti connected a pair of electrodes to the head of a schizophrenic mechanic and shocked him until he seized. Cerletti was building on earlier work showing that seizures caused by injecting insulin seemed to help certain mentally ill patients. After several ECT treatments, Cerletti reported, the man's confusion and mutterings had resolved. Doctors did not know *how*

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

## The Monthly Meeting

### February 20

Alisa Kriegel, Ph.D. will speak on Understanding Dialectical Behavior Therapy and Borderline Personality Disorder. She has been working in community mental health settings for the past 20 years in New York and the Bay Area. Currently she is the Training Director for San Mateo County Behavioral Health and Recovery Services.

### March 19

Dr Firestone,  
Forensic psychiatrist and  
attorney about HIPPA laws.

# Pregnancy Stress, Schizophrenia Linked?

Reprinted from CBS.com, Feb 4, 2008

(WebMD) Children born to women who suffer the death of a loved one during their first trimester of pregnancy may be at increased risk for developing schizophrenia, new research shows.

The study is not the first to suggest that a mother's psychological state can influence her unborn child's brain development, but it is the largest, involving nearly 1.4 million Danish children followed for decades.

The schizophrenia risk was still quite small in the children of women who experienced the death of a family member early in pregnancy, and the findings need to be confirmed.

But researchers say the study adds to the evidence that severe stress early in pregnancy -- in this case the death of a parent, sibling, spouse, or child -- may negatively impact fetal brain development. "We did not see this association in the months before pregnancy, or after the first trimester," says study co-author Kathryn M. Abel, PhD, of the University of Manchester.

## Stress and Schizophrenia

Abel and colleagues from the University's Center for Women's Mental Health Research examined data from a comprehensive, nationwide Danish health registry, which recorded about 1.38 million births in the country between 1973 and 1995.

The same registry was used to determine if mothers who gave birth during this time had first-degree relatives who died, received a diagnosis of cancer, or had a heart attack or stroke during their pregnancies.

Roughly 22,000 women experienced the death of a close relative during pregnancy, and about 14,000 had a relative treated for a life-threatening illness.

A total of 7,331 schizophrenia cases were identified among Danes born between 1973 and 1995 over at least two decades of follow-up. Being born to a mother who had a close relative die during her first trimester was found to be associated with a 67% increased risk for schizophrenia.

But a similar death up to six months before conception or at any other time during pregnancy did not appear to elevate risk, nor did having a seriously ill relative during pregnancy.

Abel tells WebMD that the research team plans to repeat the study using the Swedish health registry, which is more than twice the size of the Danish one.

The newly published study appears in the February issue of the journal Archives of General Psychiatry. "We also want to expand the research to look for other mental

health outcomes," Abel says. "I think it is highly likely that if we look at a broader spectrum of psychiatric disorders we will find that those are increased as well."

## Some Stress May Be Good

Developmental psychologist Janet DiPietro, PhD, who also studies the impact of maternal stress on fetal brain development, says even if major traumatic events such as the death of a loved one do influence schizophrenia risk, the risk is still very small.

Having a family history of schizophrenia or another mental illness was associated with a much larger risk, in this study and in others.

DiPietro says much of the research linking pregnancy stress to negative outcomes has focused on early child development and relied on mothers' perceptions of their children's behavior. "The problem is that mothers who are more anxious and stressed are more likely to view their child as having behavioral problems," she says.

In her own 2006 study, in which child behavior was independently assessed, moderate stress during pregnancy was actually associated with a good outcome -- advanced development at age 2.

One possible reason for this is that the chemicals the body produces in response to stress also play a role in fetal maturation, she tells WebMD.

DiPietro is associate dean for research and a professor at Baltimore's Johns Hopkins School of Public Health. "The knee-jerk reaction is to think that all stress is bad, but this may not be so in pregnancy, she says. "The fetus is not as vulnerable as we may think to the day-to-day stresses women deal with, like working and meeting deadlines."

## Volunteer at SF General

San Francisco General Hospital's Department of Psychiatry and Program in Prevocational Rehabilitation are looking for dedicated volunteers looking for a rewarding, hands on experience helping people with chronic and persistent mental illness learn useful life and social skills. The program currently serves 30-40 clients, and runs a clothing cart, coffee cart, and quilting program in the hospital, with plans to open a hot dog stand this spring. Volunteers are needed to help with supervision and support of clients. No experience is necessary, as volunteers will be supported by Amelia Truman, head of the Prevocational Rehabilitation program, and various members of the inpatient Psychiatry staff.

Volunteers are asked to make a 6 month commitment to the program and volunteer at least 3 hours per week. Please contact Sarah Altman MD, MPH at 415-206-5158 or sarah.altman@ucsf.edu or Amelia Truman at 415-206-5962 or amelia.truman@sfdph.org.

# Insomnia Patients with Anxiety, Depression Often Denied Sleep Meds

Source: Ohio State University, Feb. 4, 2008

Patients with insomnia who are diagnosed with accompanying mental health ailments often are not prescribed medication that will help them sleep - which could then make related anxiety or depression worse, new research suggests.

Newswise - Patients with insomnia who are diagnosed with accompanying mental health ailments often are not prescribed medication that will help them sleep - which could then make related anxiety or depression worse, new research suggests.

Scientists examining treatment patterns for insomniacs say that their findings suggest that many doctors appear to be reluctant to prescribe sleep aids, even those that pose no risk of dependence, if patients also have depression, anxiety or mood disorders. An exception is psychiatrists, who were found to be twice as likely as primary care physicians to prescribe medication for insomnia.

"Insomnia can cause you to have anxiety and depression, and depression and anxiety can cause you to have insomnia. It's a chicken-and-egg type of story. But research has shown that if one of the conditions is left untreated it can exacerbate the other condition," said senior study author Rajesh Balkrishnan, the Merrell Dow professor of pharmacy at Ohio State University.

"What this calls for is specific guidelines related to the treatment of insomnia that takes into consideration these different types of patients, because insomnia has become such a big public health problem."

An estimated 20 percent of Americans have occasional sleep problems, with about one in 10 suffering from chronic insomnia.

Balkrishnan acknowledges concerns that physicians might have about prescribing certain medications that can cause dependence, especially to patients with mental health disorders. Older sleep aids, a class of drugs called benzodiazepines, are muscle relaxants with addictive properties and high potential for abuse. However, since the early 1990s, a new class of drugs for insomnia called non-benzodiazepines has been on the market. They are effective sleep aids that don't carry the risk of addiction, Balkrishnan said, and for that reason, patients should have ready access to these medications.

"This research highlights the need to take into account that many patients who see their doctors with complaints of insomnia also have a psychiatric condition. But the presence of those mental conditions should not

preclude them from being appropriately treated for their insomnia," he said.

The study is published in the January issue of the Journal of Medical Economics. Balkrishnan and colleagues collected data from the National Ambulatory Medical Care Survey, which tracks Americans' annual outpatient medical visits. The researchers identified 5,487 physician visits by patients with insomnia between 1995 and 2004, which was calculated to represent about 161 million U.S. patients over that 10-year period.

According to the analysis, an estimated 6.5 million Americans who saw a doctor for insomnia also were diagnosed with a mental health disorder. Of the visits examined, 38 percent of patients with insomnia were diagnosed with at least one other condition, and at least four of every 10 of those accompanying conditions related to mental health. The most common additional condition was anxiety (15.6 percent), followed by episodic mood disorders (14.9 percent), high blood pressure (10.1 percent), depression (7 percent) and diabetes (3.5 percent).

The study showed that insomnia patients with mental health disorders were 36 percent less likely to receive medication for their sleeping problems than were patients without the mental health diagnosis. Those with anxiety were the least likely to receive a sleep aid, with a 45 percent decreased likelihood of receiving medication for insomnia compared to patients without anxiety.

Balkrishnan said that with generic forms of nonaddictive insomnia medication available by prescription, even patients taking antidepressants and anti-anxiety drugs can safely - and affordably - add a sleep aid to their regimen. The most common forms of antidepressants prescribed in the United States are a class of drugs called selective serotonin reuptake inhibitors (SSRIs).

"Physicians might perceive that drowsiness is induced by medications such as SSRIs so there might be a general fear about combining them with insomnia medications," Balkrishnan said. "But I think those fears are somewhat unfounded because we found that psychiatrists don't have any problems prescribing sleep medications in patients who have accompanying mental conditions; they know there is no danger of a drug-to-drug interaction."

According to the analysis, patients visiting psychiatrists had two times higher odds of receiving medication for insomnia than patients visiting family practice or internal medicine physicians. The study showed that 33 percent of patients with insomnia saw family practice or internal medicine physicians, 30 percent visited psychiatrists and 9 percent went to neurologists.

The study identified other factors associated with insomnia medication prescribing patterns - for example,

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# Lilly Considers \$1 Billion Fine To Settle Case

By Alex Berenson, Reprinted from *The New York Times*, 1/31/08

Eli Lilly and federal prosecutors are discussing a settlement of a civil and criminal investigation into the company's marketing of the antipsychotic drug Zyprexa that could result in Lilly's paying more than \$1 billion to federal and state governments.

If a deal is reached, the fine would be the largest ever paid by a drug company for breaking the federal laws that govern how drug makers can promote their medicines.

Several people involved in the investigation confirmed the settlement discussions, which began last year and took on new urgency this month. The people insisted on anonymity because they have not been authorized to talk about the negotiations.

Zyprexa has serious side effects and is approved only to treat people with schizophrenia and severe bipolar disorder. But documents from Eli Lilly show that from 2000 to 2003 the company encouraged doctors to prescribe Zyprexa to people with age-related dementia, as well as people with mild bipolar disorder who had previously had a diagnosis of depression.

Although doctors can prescribe drugs for any use once they are on the market, it is illegal for drug makers to promote their medicines for any uses not formally approved by the Food and Drug Administration.

Lilly may also plead guilty to a misdemeanor criminal charge as part of the agreement, the people involved with the investigation said. But the company would be allowed to keep selling Zyprexa to Medicare and Medicaid, the government programs that are the biggest customers of the drug.

Zyprexa is Lilly's most profitable product and among the world's best-selling medicines, with 2007 sales of \$4.8 billion, about half in the United States.

Lilly would neither confirm nor deny the settlement talks.

"We have been and are continuing to cooperate in state and federal investigations related to Zyprexa, including providing a broad range of documents and information," Lilly said in a statement Wednesday afternoon. "As part of that cooperation we regularly have discussions with the government. However, we have no intention of sharing those discussions with the news media and it would be speculative and irresponsible for anyone to do so."

Lilly also said that it had always followed state and federal laws when promoting Zyprexa.

The Lilly fine would be distributed among federal

*Insomnia Patients from page 3*

older and established patients were more likely to receive insomnia medications than were younger patients or those seeing the doctor for the first time. But Balkrishnan said a clear theme emerged from the analysis.

"There is a divide in who gets appropriate medication and who is not appropriately medicated," he said. "It might not be happening willfully, but it points to a knowledge gap between different types of physicians and the need to develop widely accepted treatment guidelines. And the guidelines should be ratified by essentially all physicians treating the condition."

This research was funded by a grant from Sanofi-Aventis, a sleep-aid manufacturer based in Bridgewater, N.J. The study does not discuss any specific products of the sponsor company. Balkrishnan is a paid consultant for the company. Co-authors on the study were Manjiri Pawaskar of Ohio State's College of Pharmacy, Vijay Joish of Sanofi-Aventis, Fabian Camacho of Wake Forest University School of Medicine, and Rafia Rasu of the University of Missouri-Kansas City.

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**415-861-4910**



*The Body Electric's New Look from page 1*

ECT worked, although it was assumed that the seizure relieved symptoms by somehow "resetting" the nerve cells in the brain. But they were quite sure that it *did* work, not only for certain forms of schizophrenia but also for severe depression, a discovery made when Cerletti and others tried the technique on a broad range of patients. As one psychiatrist wrote about treating depressed patients with ECT: "It was like a miracle. I always related it to Lazarus risen from the grave." This was the professional response, moreover, even though early ECT was primitive, causing uncontrolled seizures and fractured bones even as it treated disease.

By the 1940s, Shorter and Healy write, ECT "had become part of the therapeutic apparatus of nearly every mental hospital" across the globe. In 1959, Group Health

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Insurance, a company that insured New York City employees, proudly announced that it would cover "ten electroshock treatments, in or out of the hospital," for all of its subscribers.

But within a decade, ECT would become stigmatized as dangerous and even sadistic, "a fearsome last-ditch remedy to be used only under extraordinary conditions and under the most elaborate legal safeguards," as the authors put it. This is the best-known part of the story. ECT fell out of favor for several reasons. When phenothiazines, the first pills that could treat schizophrenia, became available in the early 1950s, pharmaceutical companies marketed them as better and safer than shock therapy even though they did not always work and often caused jerking movements and other side effects. This marketing dovetailed with the social upheaval of the 1960s, which led to the formation of the so-called anti-psychiatry movement, a loosely based coalition of activists, disenchanted mental health professionals, and patients. They charged that psychiatric hospitals, through procedures such as ECT and lobotomy, were punitive as opposed to therapeutic—a la the 1962 novel *One Flew Over the Cuckoo's Nest*, which was made into a film in 1975. When the hero, Randle P. McMurphy, receives damaging ECT and a lobotomy, it is essentially to prevent him from saving the other patients. And this link between shock therapy and the second, much more dubious procedure made it seem all the more frightening.

Also influential was a 1974 *New Yorker* article by renowned medical writer Berton Roueche, who claimed that ECT caused permanent memory loss. Because the woman featured in Roueche's essay was not a representative case, her story exaggerated the importance of a real, but limited, side effect. The anti-ECT sentiment culminated in the passage of a 1976 California law that actually tried to prevent physicians from prescribing it—a rare instance of direct legal interference with medical practice.

Meanwhile, what did the data about ECT actually show? Research from the mid-20th century was more susceptible to bias than more recent work, but hundreds of studies from a wide variety of institutions claimed it was effective. Shorter and Healy also argue that proponents of ECT were always concerned about the treatment's real side effects. By the 1950s, the use of better anesthetics and muscle relaxants helped control the seizures and made the procedure less violent. Other improvements sought to minimize memory loss. But the persistently suspect characterizations of ECT meant that many patients with mental illnesses who were unresponsive to drugs never received the treatment. As a result, some worsened and some died. This surely represents a

lot of potentially avoidable pain and suffering. The backlash against ECT, Shorter and Healy make clear, somehow led to a collective denial about what it could accomplish.

This selective reading of scientific data has been the downfall of many treatments besides ECT. In the 1930s, researchers published studies suggesting that removal of a portion of the breast plus radiation was as effective for treating breast cancer as disfiguring radical mastectomy, which necessitated removal of the breast, local lymph nodes, and both chest wall muscles on the affected side. Yet especially in the United States, where surgeons monopolized control of the disease, these data were ignored for decades. After women began demanding less extensive operations in the 1970s, additional studies validated the earlier findings.

In other instances, the reverse has occurred: therapies not justified by the data have achieved wide popularity. One example was hormone replacement therapy, which became popular when gynecologist Robert Wilson characterized menopause as an estrogen-deficiency disease in his 1966 book *Feminine Forever*. Ingesting synthetic estrogen, Wilson argued, would make women feel younger and also prevent osteoporotic fractures and heart disease. Although some critics questioned HRT from the outset, its harms became apparent only in the last few years, with the publication of definitive long-term studies. For decades, the combination of Wilson's salesmanship, drug company advertising, and the pathologizing of a normal stage of life led to the widespread adoption of a treatment not supported by the science.

These historical examples of science misused or ignored helped to usher in the now-powerful movement known as evidence-based medicine, which argues that treatments must be evaluated by the most sophisticated biostatistical and epidemiological tools. At the forefront is the randomized controlled trial, which eliminates many of the biases seen in older studies. And evidence-based medicine has come to the world of electroconvulsive therapy. Beginning in the 1980s, a series of expert task forces reviewed the existing data and concluded that in certain cases of mental illness, ECT is not only an acceptable, but a highly advantageous treatment. Its use is again on the rise, helping to alleviate the symptoms of certain patients with severe psychiatric diseases.

*Barron H. Lerner, Angelica Berrie-Arnold P. Gold Foundation associate professor of medicine and public health at Columbia University Medical Center, is the author, most recently, of When Illness Goes Public: Celebrity Patients and How We Look at Medicine.*

Article URL: <http://www.slate.com/id/2181158/>

## 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

#### *Support Group for Family Members, Friends & Care Givers*

Tuesdays, 5:30- 7:30 pm at Mission Mental Health,  
2712 Mission St. Child care and refreshments provided.  
Call Carmen Burgos at 415-401-2733

### 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., 2<sup>nd</sup> Floor Conf. Room. Call 519-0171

#### *OASIS (Office of Self Help)*

1095 Market Street at 7<sup>th</sup>, 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 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

#### *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  
2<sup>nd</sup> Wednesday at 6:30  
Contact Vickie at 661-5208
- 2) San Francisco General Hospital  
7<sup>th</sup> Floor, Room 7 M 30  
Tuesdays, 5:15 – 6:45 p.m.  
Call Susanne Killing at 558-5900

### Asian Mental Health Resources

The Culture to Culture Foundation's directory of Asian-American mental health services in the Bay Area can be accessed at [www.asianmentalhealth.info](http://www.asianmentalhealth.info). The Culture to Culture Foundation is a nonprofit, community-based organization dedicated to promoting mental health and emotional wellness within the San Francisco Bay Area's Asian-American community. For more information go to [www.culturetoculture.org](http://www.culturetoculture.org) or call 925-938-9988

## DBSA

### Depression and Bipolar Support Alliance of San Francisco



#### **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.

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fundraiser for all these affiliates.


The San Francisco Bay Area NAMI Walk will take place Saturday, May 31st at Speedway Meadow in Golden Gate Park. Walker check-in time is 9:30 a.m. and the official start time is 11 a.m. The walk is 5 kilometers (approximately 3 miles) in length. There is also a one-mile option.

Laurie encouraged all NAMI-SF members to organize a team, register online and create an individual and/or team webpage. Just go to: [www.namiwalksfbay.org](http://www.namiwalksfbay.org) for more information or call the Walk office at 800-556-2401. A team can consist of two people, a family, a business, a non-profit agency, or a bunch of friends.

Teambuilding and fundraising materials will be given out to team captains at a special kickoff event to be held in April. The Walk also needs corporate sponsors. Past sponsors have included Dixon Financial Services, Crestwood Behavioral Health, Bristol-Myers Squibb, and California Pacific Medical Center.

"Anybody you write a check to" is a potential sponsor, Laurie said, as she asked NAMI-SF members to join her in recruiting new sponsors in 2008. NAMI members can also volunteer to work the registration table, handout water and t-shirts, and mark off the walk trail.

"There is no such thing as too many volunteers," Pam said.



**The SFGH CAB  
CLOTHING PROJECT**

This program is a big help to consumers who are in need of clothes while they are at SF General Hospital.

Just call and they will pick up your donation or meet you at the front door of the hospital when you bring it in.

Please call Amelia Truman, 415-206-4465

**County Mental Health**

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

The Mobile Crisis Unit is  
**415-355-8300**

**Please renew  
your membership -  
use the form on the back page!**

*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**

1010 Gough St.  
San Francisco, CA 94109  
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[www.namif.org](http://www.namif.org)  
Contact us at [namif@fsasf.org](mailto:namif@fsasf.org)

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Send newsletter additions/submissions/  
change requests to [namif@fsasf.org](mailto:namif@fsasf.org)



## 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  
1010 Gough St.  
San Francisco, CA 94109

NAME \_\_\_\_\_

(Please Print)

ADDRESS \_\_\_\_\_

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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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