With tremendous bipartisan support, Congress passed the landmark 21st Century Cures Act, formally acknowledging the long-standing failures of the US mental health system and laying the foundation for a more functional system better able to meet the needs of the sickest and most vulnerable Americans.

The bill was signed into law by President Obama in December 2016, and includes all of the mental health and criminal justice reform measures in Rep. Tim Murphy’s (R-PA) Helping Families in Mental Health Crisis Act and Sen. John Cornyn’s (R-TX) Mental Health and Safe Communities Act.

**Sowing the Seeds of Reform**

In January 2013, following the tragic Sandy Hook Elementary School shooting, Dr. E. Fuller Torrey, founder of the Treatment Advocacy Center, led the call for comprehensive federal mental health reform. Dr. Torrey and the Treatment Advocacy Center soon found a like-minded champion for reform in Rep. Murphy, a practicing psychologist with an understanding of our country’s failing treatment system.

For the next few years, Murphy worked with the Treatment Advocacy Center and other mental health organizations representing a range of needs to introduce and pass mental health legislation with the support of Congressional colleagues in both chambers and on both sides of the aisle.

The Treatment Advocacy Center was at the table every step of the way to ensure severe mental illness and access to treatment remained focus areas of every iteration of the bill. Ultimately, a very strong version of the Helping Families in Mental Health Crisis Act was included in the Cures Act along with Cornyn’s complementary legislation to reduce criminalization of mental illness. Murphy astutely referred to the passing of the Cures Act as “the final mile of a marathon.”

That may be true for Congress, but we have a long way to go; the government must fund and implement the mental health provisions in the Cures Act.

**Monumental Progress**

The mental health reform measures in the Cures Act reflect the priority issues of the Treatment Advocacy Center to help people with serious mental illness (SMI) and their families.

The Act’s provisions do not create a ceiling for change, but will help to elevate the national floor by providing better access to treatment, criminal justice diversion, data on the role of SMI in public systems and national recognition that people with SMI and their families deserve better than the status quo.

We will work tirelessly with our partners and advocates, on behalf of the individuals with severe mental illness and their families, to implement and strengthen these important changes.

CONTINUED ON PAGE 10
A MESSAGE FROM THE Executive Director

Lightning in a Bottle

As you review this issue of Catalyst, one theme is readily apparent — change has happened. For the first time in years, we have the winds at our back and new opportunities wherever we look — landmark federal legislation to reshape the national mental health system and finally focus on severe mental illness; our research that sparks nationwide interest and conversations at the highest levels; innovative partnerships in states like Ohio that directly help those most in need; and local communities, states and a federal government embracing our policies and programs at a pace that is sometimes difficult for even us to keep up with. We have caught lightning in a bottle.

Every one of our successes comes as a result of your hard work and sweat.

But as the folks who have been in the trenches for years, Catalyst readers know that these successes are a long time coming. What started out as an idea of E. Fuller Torrey, MD, has become a national movement; one that is shaking the mental health status quo and ensuring that real treatment and recovery are accessible for even those with the severe mental illness. As McDonald’s Ray Kroc explained, “Luck is a dividend of sweat.” And so we thank you, the families, consumers and treatment providers who have spent countless hours in countless different arenas across the nation to get us to this point. Every one of our successes comes as a result of your hard work and sweat.

As you will read throughout this issue, we are committed to leveraging every one of these opportunities. The harsh reality is our national mental health crisis is simply too big for us to succumb to the temptation to rest on our laurels and call this good enough. On the contrary, we need your support and engagement now more than ever.

This issue of Catalyst works to identify many of the items we’re focusing on in our upcoming agenda. We must work together to implement the many changes demanded by the mental health reform at the state and federal levels. We have an unprecedented opportunity to implement criminal justice reforms that will keep the most severely ill out of jails and prisons.

As the federal government, states and communities across the nation embrace assisted outpatient treatment, we must ensure that they have the tools they need to successfully implement the program, as we did in Ohio. Our bed wait model (page 8) is spurring interest from states across the country; we must ensure that we have the resources to both meet that need and keep putting out the groundbreaking reports that policymakers across the nation have come to rely on.

We know this is an ambitious agenda, but with your support, we know we can make it a reality.

John Snook

Spotlight Series on Mental Illness

The Boston Globe’s award-winning Spotlight Team wrapped up its series on mental illness in Massachusetts, publishing the final installments of “The Desperate and the Dead.”

In an article about the courts, the Spotlight Team noted the failure of the Massachusetts mental health system to pursue and establish mental health courts.

There are few alternatives to criminal courts for individuals with severe mental illness (SMI) in the state. The bulk of the $18 million a year it spends on mental health funding is spent on juvenile cases and the worst cases of SMI, leaving little else for the larger group of adult defendants with mental illness. This means the majority of those defendants are going to jail rather than treatment facilities. It also means that many defendants end up in drug diversion court instead by default, where their success depends on not using illegal drugs.

The lack of mental health courts and appropriate training, combined with the state’s inability to move these defendants to suitable treatment, has led to dire consequences for an already burdened system.

The final article looks to San Antonio, Texas, for possible fixes for flaws in Massachusetts’ mental health system.

Law enforcement, criminal justice and health officials in San Antonio have worked together over the past decade and a half to develop a mental health system that sets residents with severe mental illness up for treatment success.
A Leap Forward for People with Serious Mental Illness in Kentucky

HISTORIC OVERRIDE OF GOVERNOR’S VETO IS A VICTORY FOR MENTAL HEALTH ADVOCATES

In the closing hours of the 2017 legislative session in Kentucky, advocates rallied in the state house and legislators from both sides of the aisle voted nearly unanimously to override Gov. Bevin’s stunning veto of Tim’s Law (SB 91). The override is a historic first in the Treatment Advocacy Center’s 19-year history.

The House had moved the bill through the final stage of passage days earlier, by a vote of 95–0, before it lingered on the governor’s desk. Bevin vetoed the bill, igniting a firestorm of civic action on behalf of people with serious mental illness.

The law, named after Tim Morton and championed by his mother, Faye, corrects some significant problems that made Kentucky’s assisted outpatient treatment (AOT) statute ineffective.

Tim suffered from anosognosia, a condition that prevented him from recognizing the severity of his mental illness, and did not realize his need for medication. Because he was not considered dangerous most of the time, he was caught in a revolving door between involuntary hospitalization and no care at all.

Tim was hospitalized 37 times between the ages of 18 and 53, before passing away at 56 due to the toll illness took on his physical health. Faye was determined to prevent this outcome for other families — and now can count her long campaign as a success.

Tim’s Law will help end more preventable tragedies by allowing judges in Kentucky to order outpatient treatment for up to a year for people suffering from severe mental illness. The law would apply to those who are not able to recognize the severity of their condition and do not comply with treatment or medication. The individual must have been committed involuntarily at least twice in the 12 months prior to a judge ordering outpatient treatment.

Special acknowledgment goes to the countless Kentucky families who have spent years advocating and telling their stories. It is those stories and the relentless drive of advocates from across the state have allowed Kentucky to make this leap forward toward better care.

AOT must not be the last resort … it should be offered ‘before’ our loved one’s brain deteriorates. Advocates must learn to #LobbyLoud for solutions before the police are called — not after! We need better policies that don’t force our loved ones to become violent in order to gain access to #aBedInstead!

— GG Burns, Mother and Advocate for Mental Health Reform
**Around the States**

**CALIFORNIA**
Marin County will likely become the 18th county in California to adopt Laura’s Law, thanks in part to an aggressive campaign by advocates in the area. The Marin County Board of Supervisors voted unanimously to proceed with planning for a two-year pilot program, with a final vote to adopt expected this summer. Also in the state, Stanislaus County has launched a three-month review to explore whether to do likewise.

**MINNESOTA**
Working with advocates Doug and Nancy Reuter, an ambitious assisted outpatient treatment (AOT) bill, SF 836, was introduced that would extend the period of outpatient commitment to one year from the current limit of 90 days and would eliminate the requirement that individuals refuse treatment in order to be eligible for outpatient orders. The bill was sent to the Senate Judiciary Committee for consideration.

**TEXAS**
The Treatment Advocacy Center and NAMI Texas will cohost an AOT symposium in Austin in September 2017. Counties will be invited to register their team to participate in a day-long program on developing an effective AOT program. Teams should consist of county mental health leaders, judges who preside over civil commitment dockets, outpatient mental health providers, and leaders of peer and/or family advocacy groups. Invitations are expected to go out in late April.

**KANSAS**
In February, the Kansas House of Representatives passed HB 2240, which will allow treatment centers to hold individuals experiencing a mental health crisis for up to three days. The bill would require the center to assess the individual within four hours, before the first 24 hours has ended, and again before the end of the second day. The center would have to file an affidavit in the district court if it wants to hold the person a third day. Rep. Russ Jennings was quoted in the Kansas media saying, “Since our state hospital system is inadequate, there must be something to take its place. Good God, there are some things state government has to do.”

---

**Setting Up Ohio for AOT Success**

Treatment Advocacy Center’s Policy Director Brian Stettin and Legislative and Policy Advisor Betsy Johnson were back in Columbus, Ohio, in January. During this visit, they unveiled a new AOT toolkit, an invaluable resource for judges, sheriffs, mental health professionals and advocates across the state as they implement AOT laws.

The Ohio Civil Commitment and AOT Toolkit provides the blueprint for successful AOT implementation, and consists of the Ohio AOT Implementation Manual and the Judges’ Quick Reference Guide to the Ohio Law on Mental Health Civil Commitment.

CONTINUED ON PAGE 7
Pennsylvania

Treatment Advocacy Center advocates are working with legislators and government officials in Pennsylvania to change the most restrictive civil commitment criteria in the country. To that end, Rep. Thomas Murt, chair of the House Human Services Subcommittee on Mental Health, and Sen. Stewart Greenleaf, chair of the Senate Judiciary Committee, introduced HB 2423 to create separate criteria and a court path for assisted outpatient treatment. The measure has broad support in the legislature as well as the support of community behavioral health directors. We expect this bill to get floor time during this legislative session.

Ohio

The Treatment Advocacy Center, NAMI Ohio, Northeast Ohio Medical University and the Margaret Clark Morgan Foundation have announced plans to host a second AOT symposium in Columbus November 2017. Counties at all stages in their AOT development are being encouraged to attend. Since we convened the first symposium in April 2016, eight counties have adopted AOT and several more are in the early implementation phase.

Kentucky

On February 27, the Kentucky Senate passed Tim’s Law (SB 91) by a vote of 34–3 and on March 14, the House passed it by a vote of 95–0. After Gov. Bevin vetoed the bill, the legislature overrode it nearly unanimously. (See story on page 3.)

Maine

The Treatment Advocacy Center is beginning work with advocates and lawmakers to draft a legislative fix in Maine that would extend the state’s outstanding assisted outpatient treatment need-for-treatment standard to also include involuntary inpatient care.

Maryland

Because Maryland remains one of only four states without an AOT law, the Treatment Advocacy Center is working with lawmakers on a bill (HB 1383) to ensure the Baltimore federal AOT pilot program is legal, and that it can effectively serve the population for which it seeks to provide access to treatment. Currently, the pilot and proposed regulations will fail to provide legal and programmatic structure for a successful program. We had worked with Del. Erek Barron to introduce a comprehensive AOT bill, which he withdrew in favor of pursuing a more narrow approach to addressing the pilot. We anticipate the broader legislation will be reintroduced next session. The Treatment Advocacy Center is also working with advocacy organizations to strengthen the state’s medication over objection laws and bring them in line with those of the rest of the country.

West Virginia

Del. Amy Summers introduced HB 2808 on March 7 that would enable circuit court judges and mental hygiene commissioners to order a person who meets specific criteria into AOT. The bill passed the House Health and Human Resources Committee on March 9 and is pending in the House Judiciary Committee. It is unclear whether there is sufficient time remaining in this legislative session for the bill to pass the House and Senate prior to adjournment in April.
SAMHSA Takes AOT to the States

2016 was an unprecedented year for assisted outpatient treatment (AOT) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

First, SAMHSA announced its AOT demonstration grant awards to 17 communities representing more than 13.5 million people — from Mobile, Alabama, to Cheyenne, Wyoming. Valued at more than $13.4 million dollars, the start-up grants will help mental health organizations to establish AOT programs, like the one in Sparks, Nevada, (see below), which will make a significant difference in the lives of people with severe mental illness.

And before year’s end, we learned of SAMHSA’s interest in disseminating critical information on AOT to communities outside of the boundaries of the demonstration grant program.

SAMHSA will host three, two-day regional training sessions in summer 2017 at which mental health professionals, judges and advocates will learn how to establish and maintain a successful AOT program in their communities.

AOT Program Ramps Up in Reno

Last September, we heralded the allocation of $15 million in federal grants to support 17 new AOT programs across the nation. Now, just a few months later, many of these new AOT programs are up and running.

In February, Treatment Advocacy Center Policy Director Brian Stettin visited Northern Nevada Adult Mental Health Services (NNAMHS), a grant recipient serving the greater Reno area.

NNAMHS AOT Program Director Dr. Michelle Burke said, "AOT is an amazing model of compassionate treatment, advocacy and a pathway for individuals with persistent and serious mental illness to dream again about those things in life that they stopped believing could happen for them. This includes feeling safe and cared for, holistic health, mended relationships, jobs, creating new connections, fun, support for inevitable hard days, encouragement that they can live meaningful lives outside of jail, homelessness or hospitalization. We at NNAMHS AOT feel so incredibly fortunate to be a part of AOT and our clients’ journeys."

Before meeting with the newly hired staff and sharing insights with them on the practice of AOT, Brian had the simple pleasure of walking down the hallway of the new AOT unit and observing freshly mounted nameplates on the doors.

"It was unexpectedly moving to see the names and titles of the caring professionals who will be engaged every day in bettering the lives of people with severe mental illness," Brian explained. "It really brought home that the SAMHSA AOT grant program we fought so hard to establish isn’t just talk anymore; it’s reality."

We are proud to have played a role in the development of this program, and we look forward to their imminent success in helping clients live safely in the community. In time, NNAMHS and the other grantees will inspire many other mental health systems to implement the life-saving, evidence-based tool known as AOT.
FOR COURAGE AND TENACITY:
The 2016 Torrey Advocacy Commendation Recipients

The Treatment Advocacy Center has announced the recipients of the 2016 Torrey Advocacy Commendation, the organization’s highest honor in recognition of courageous efforts to make treatment possible for more people with severe mental illness.

The award, named for E. Fuller Torrey, MD, is given to individuals who, like Dr. Torrey himself, have exhibited courage and tenacity advocating for the right of individuals with severe mental illness to receive treatment even if they are unable to seek it.

We are delighted to recognize three individuals who worked diligently in New Mexico to make assisted outpatient treatment (AOT) a reality for individuals across the state: New Mexico State Sen. Mary Papen and US Sen. Pete Domenici and his wife Nancy Domenici.

New Mexico Senator
Mary Kay Papen

New Mexico Sen. Mary Kay Papen has been a tireless mental health advocate, raising her voice for the voiceless. She brings her personal passion to the issue as the grandmother of a person with serious mental illness.

On the wall in her office is a photo of her grandson, whom she discussed in a 2015 interview with watchdog.org:

“He’s schizophrenic and bipolar and there have been times when he would have been eligible for this,” she said. “I don’t want him killed. I don’t want the police shooting him, and I don’t want him to shoot somebody else.”

A longtime champion of AOT, Sen. Papen repeatedly introduced bills in the state legislature that would bring this long-overdue, life-saving measure to neglected and vulnerable New Mexicans. Last year, her efforts were rewarded with the passage of SB53, the “Assisted Outpatient Treatment Act.”

US Senator Pete Domenici and his wife Nancy

During his distinguished career as New Mexico’s six-term US senator, Pete Domenici was a leading voice of mental health reform. In retirement, Sen. Domenici and his wife Nancy remained passionate advocates for people with severe mental illness and their families.

The Domenicis’ support in 2016 was crucial to New Mexico’s enactment, at long last, of AOT. They made their case in an urgent appeal to Gov. Susana Martinez, calling for her to support legislation “of great importance” to authorize AOT:

We believe AOT is an essential tool in helping certain individuals with severe mental illness live safely in the community, and we lament that New Mexico is one of only five states without such a law. … The effectiveness of AOT in improving outcomes for the most challenging patients has been widely recognized.

In 2016, New Mexico became the 46th state to enact an AOT law, in part due to the leadership of the Torrey award recipients. We also extend our heartfelt appreciation to the families who told their personal stories and advocated diligently for access to treatment.

AOT Success
CONTINUED FROM PAGE 4

The Implementation Manual outlines the core elements of an effective AOT program. The information presented in the manual is intended to help get communities started on the right foot and describes the components and operational steps to implement a successful program. It has helpful flow charts throughout to aid in understanding the court process, as well as a Frequently Asked Questions section including actual questions that were posed by counties as they took steps to implement an AOT program.

The Judges’ Quick Reference Guide presents the relevant law in an outline form that is easier to navigate than the code itself. It is not intended as a substitute for the actual law, but to serve as a quick reference for judges while they are on the bench in determining what the law means. It includes the statutory citations throughout.

The toolkit was made possible with the generous support of the Margaret Clark Morgan Foundation. Our partners included Hocking College, retired Justice Evelyn Lundberg Stratton, NAMI Ohio and Northeast Ohio Medical University.

To download a copy of the toolkit, visit TreatmentAdvocacyCenter.org/AOT-toolkit.
Addressing a Critical Void

The Treatment Advocacy Center established the Office of Research and Public Affairs (ORPA) in 2015 to address overlooked or underreported public policy issues involving serious mental illness (SMI). ORPA’s research on the impact of SMI on law enforcement, for example, helped spur federal laws requiring nationwide data collection for the first time.

Now, less than two years later, ORPA continues to add to an impressive body of research on the consequences of untreated SMI. The two latest evidence-based reports, released November 2016 and January 2017 and discussed here, added fuel to the national conversation about SMI.

If you are interested in frequent research updates, follow ORPA on Twitter @TACResearch or sign up for Research Weekly at TreatmentAdvocacyCenter.org/stay-informed.

Small Changes, Major Impacts on Bed Waits for Mentally Ill Inmates Awaiting Trial

Relatively small changes in policies could reduce the mass incarceration of individuals with serious mental illness and its human and economic toll, according to a Treatment Advocacy Center report released in January 2017.

In Emptying the ‘New Asylums’: A Beds Capacity Model to Reduce Mental Illness Behind Bars, a mathematical model was used to project the impact of changing any one of three factors in the logjam of jailed mentally ill defendants awaiting trial.

The model assessed three impacts: reducing the number of people with serious mental illness arrested and added to bed waitlists, eliminating administrative and other non-clinical factors that lengthen state hospital stays, and increasing the number of beds.

The modeling project, based on queueing theory (the study of waits), projected the following striking results:

- In Florida, diverting two mentally ill offenders per month would reduce the average forensic bed wait in the state by 75%, from an average of 12 days to three days.
- In Texas, reducing the average hospital stay from 189 days to 186 days would reduce forensic bed waits from an average of two months to three days.
- In Wisconsin, increasing the number of forensic beds from 70 to 78 beds would reduce waits for competency services from nearly two months to two weeks.

The study’s queueing model was developed at the University of North Carolina at Chapel Hill’s Gillings School of Global Public Health and North Carolina University’s Edward P. Fitts Department of Industrial and Systems Engineering.

Since the report’s release, state and local officials from across the country have contacted us to learn how to use the model to reduce mass incarceration of the mentally ill and address bed shortages in their communities. We are optimistic that this model will be a game changer for people with mental illness, their families and their communities.

“Discharging patients ‘quicker but sicker’ may have the unintended consequence of fueling revolving-door hospitalization.”
Reducing Forensic Bed Wait Times

Experts from mental health and criminal justice gathered February 6 at the American Enterprise Institute in Washington, D.C., to address the nationwide shortage of forensic beds. The panel, Emptying the ‘New Asylums’, focused on the topic of our report with the same name and featured:

- Sally Satel, American Enterprise Institute
- Doris A. Fuller, Treatment Advocacy Center’s Office of Research and Public Policy
- Kristen Lich, PhD, MHSA, University of North Carolina
- Judge Steve Leifman, Miami-Dade County Court Criminal Division
- Matt Chase, National Association of Counties
- Mike Rezendes, The Boston Globe.

Participants covered facets of the forensic bed shortage issue, from the use of queueing theory to reduce forensic bed wait times, to the effective diversion program for competency restoration in Miami-Dade and its significant cost savings and improved outcomes.

“Putting someone in jail with mental illness for even a few days and then releasing them is not an improvement of public safety,” Leifman insisted. “If you want to really improve your public safety, improve the community mental health system.”

To watch the video of the event, visit AEI.org/events.

Shorter State Hospital Stays Linked to Faster Rehospitalization

States that hospitalize severely ill psychiatric patients for shorter periods of time have significantly higher readmission rates within 30 and 180 days of discharge than states with longer median stays, according a Treatment Advocacy Center report issued in November 2016.

The report, Released, Relapsed, Rehospitalized: Length of Stay and Readmission Rates in State Hospitals, suggests discharging patients “quicker but sicker” may have the unintended consequence of fueling revolving-door hospitalization, a pattern that disrupts mental health recovery and increases treatment costs.

ORPA analyzed 2015 federal data to find that patients in states with the shortest length of stay were nearly three times more likely to be readmitted to a state hospital at 30 days and 180 days than patients in states with the longest initial stays.

Reducing how long patients remain hospitalized is a common tactic for treating more patients without adding treatment beds. In 1955, the peak of state hospitalization, there were 560,000 beds available for an estimated 3.3 million American adults living with serious mental illness and other disabilities.

By early 2016, after more than half a century of deinstitutionalization, there were slightly fewer than 38,000 beds for 8.1 million people with the same conditions. In the same time frame, hospital stays for acute schizophrenia shrunk from an average of 42 days in 1980 to seven days by 2013.

Join our advocates in calling for effective treatment for those who need it most, providing them with a bed instead of incarceration or homelessness.
A Closer Look at Elements of the 21st Century Cures Act

The 21st Century Cure Act includes a host of Treatment Advocacy Center priorities, including provisions to reform the Substance Abuse and Mental Health Services Administration (SAMHSA), increase the number of psychiatric beds nationwide, address the criminalization of untreated serious mental illness (SMI), and collect data on the role untreated mental illness plays in our public lives.

Approximately one-third of the Act is dedicated to mental health reform. Among the important changes:

REFORM SAMHSA
• Create a new assistant secretary for mental health and substance use disorders to oversee SAMHSA and coordinate science and evidence-based programs and research across the federal government, with the aid of a newly established chief medical officer.
• Establish a new federal policy laboratory for mental health and substance use, to elevate and disseminate policy changes and service models that work based on evidence, research and science.

FUND AND STRENGTHEN EVIDENCE-BASED TREATMENT PROGRAMS FOR SMI
• Strengthen and expand critical assisted outpatient treatment (AOT) programs to help break the revolving-door cycle through a grant reauthorization and funding increase for states to implement AOT.
• Permit states to use Department of Justice (DOJ) grant funding for AOT in civil courts as an alternative to incarceration.
• Provide states with new innovative opportunities to deliver much-needed care in institutions for mental diseases (IMD) to adult Medicaid patients with SMI.

DECRIMINALIZE MENTAL ILLNESS
• Direct the attorney general to establish a pilot federal mental health court; and provide avenues for better screening and assessment of people with mental illness in the criminal justice system.
• Allow DOJ funding to help individuals with SMI transitioning out of jails and prisons, including housing assistance and mental health treatment.
• Provide additional grant opportunities to provide law enforcement and the court system with Crisis Intervention Team training and programs to divert people with SMI from the criminal justice system.

MANDATE DATA COLLECTION ON THE ROLE OF SMI IN PUBLIC ISSUES
• Require the SAMHSA assistant secretary to award competitive grants to develop databases on psychiatric beds, crisis stabilization units and residential treatment facilities.
• Require federal government reporting on federal, state and local costs of imprisonment for individuals with serious mental illness, including the number and types of crimes committed by mentally ill individuals.
• Require attorney general data collection and dissemination on the involvement of mental illness in all homicides, as well as deaths or serious bodily injuries involving law enforcement officers.
• Require the secretary of health and human services to conduct a study on the impact of recent federal regulations providing coverage of treatment in IMD facilities in Medicaid managed care plans.

CLARIFY THE HIPAA QUAGMIRE
• Define the circumstances under which healthcare providers and families can share and provide protected information about a loved one with SMI.
• Develop model programs and trainings for health care providers to clarify when information can be shared and trainings for patients and their families to understand their rights to protect and obtain treatment information.

PHONE CALLS AND HASHTAGS
A sincere thank you goes out to all advocates who told their elected officials to vote YES on mental health reform. You found them by phone, in person during office visits, and online via Facebook and Twitter. You demanded #MentalHealthReform and #aBedInstead, and Congress acted.

Kudos for your 21st-century advocacy.
**Shattering the HIPAA Handcuffs**

HIPAA. For those living with mental illness and their families, few words stir as many emotions.

Originally passed to create a national standard for the protection and sharing of certain health care information, the Health Insurance Portability and Accountability Act (HIPAA) provides a federal baseline of important patient confidentiality protections. But confusion and misunderstanding — especially regarding sharing and receiving mental health information — are common.

**WE WILL BE LAUNCHING A SPECIAL HIPAA Handcuffs SECTION ON OUR WEBSITE TO COLLECT YOUR STORIES AND TO PROVIDE EASY-TO-UNDERSTAND HIPAA INFORMATION TO DISPEL MYTHS AND MISUNDERSTANDINGS.**

Consequently, horror stories abound:

- Parents of persons with mental illness unable to find out when loved ones are discharged from a facility, or even whether they are receiving treatment there in the first place
- Caregivers at a loss as to what medications have been prescribed or whether they are being taken
- Doctors refusing to even listen to those with important information about a person’s treatment history

Too often, parents and caregivers feel blamed when something goes wrong, but are denied the tools to help ensure things go right.

It doesn’t have to be this way. Building on the momentum of the important HIPAA reforms included in the 21st Century Cures Act, the Treatment Advocacy Center will be working with policymakers, families and consumers to lead a national conversation about the realities of HIPAA and how misunderstandings about HIPAA can hinder effective treatment.

To succeed, we need you to share your stories of HIPAA handcuffs. We need you to make the case that the current process isn’t working and change must take place.

We will be launching a special HIPAA Handcuffs section on our website to collect your stories and to provide easy-to-understand HIPAA information to dispel myths and misunderstandings. We will provide opportunities to weigh in with federal policymakers on how to better educate treatment professionals on HIPAA and on aspects that need to be reformed.

And together, we will shatter the HIPAA handcuffs to help ensure privacy protections are respected and those in need get the treatment they deserve.

---

**SMRI Update**

CONTINUED FROM PAGE 12

between *T. gondii* infection and later risk of developing psychosis, and this research is consistent with possible inflammatory causes of schizophrenia and other psychotic disorders."

There are also major statistical problems with this study. The results of the initial analysis did in fact show a significant relationship between cat ownership in childhood and psychotic like thinking at age 13. The authors then statistically “corrected” for what they called “confounders,” causing it to no longer be statistically significant. However, some of the “confounders” used by the authors are really part of the causal pathway of how cat contact in childhood could lead to infection with *T. gondii*.

All of which is to say that this is a cautionary tale: Be skeptical. It should be added that the *Washington Post* was not the only media outlet that misreported the story. “Owning a cat won’t make you mentally ill, study says” was the headline on FoxNews.com. “Cat ownership not linked to mental health problems” was CNN.com’s reassuring take. “Cats don’t cause mental illness” headlined NBCNews.com. Cat owners breathed a collective sigh of relief.

The bottom line is that cats can be nice pets, but if you have children you should keep the cat indoors so it is unlikely to become infected.

---

The Stanley Medical Research Institute is a supporting organization of the Treatment Advocacy Center. Dr. Torrey serves as associate director of SMRI, where he oversees groundbreaking research on the causes and treatment of schizophrenia and bipolar disorder.
THE POLITICS OF SCIENCE REPORTING

Now that we have entered the era of “fake news,” it is more important than ever to be skeptical of science stories in the news. Personal bias and political considerations have always been part of the reporting process — think, for example, how vaccines and autism or global warming are covered. But with the multiplication of online sources for news stories, skepticism is more important than ever. Take, for example, the headline in the health section of the *Washington Post* on February 28, 2017: “There’s no evidence pet cats cause schizophrenia.” It certainly looks definitive, and the *Post* has a very good reputation. It must be true. Except that it isn’t.

The study being reported by the *Post* is a study done in response to multiple studies published by the Stanley Medical Research Institute over the past 20 years. We have examined a variety of infectious agents to ascertain whether they may play a role in causing inflammation of the brain in individuals with schizophrenia and bipolar disorder. Some of our strongest findings have linked a parasite, *Toxoplasma gondii*, to schizophrenia. The evidence includes the fact that individuals with schizophrenia are significantly more likely to have antibodies against this parasite, indicating a past infection. Since this parasite uses felines, including house cats, as its definitive host, we also published three studies reporting that owning a cat in childhood was a modest risk factor for later developing schizophrenia. A fourth study done in Turkey reported the same thing, and we are aware of five other studies of this in process.

The study in question, published in *Psychological Medicine* by colleagues in England, looked at cat ownership at age 4 and 10 and compared that to strange, psychotic-like thinking at ages 13 and 18. Such thinking, relatively common in adolescents, has been loosely linked to the later development of schizophrenia, but the vast majority of adolescents who have such thinking never develop schizophrenia. Thus, this study, in contrast to the four previous studies, did not use schizophrenia as an outcome because the study cohort is not yet old enough to develop the disease. Contrary to the headlines, this study actually has nothing directly to do with schizophrenia. On the contrary, the authors of this study wrote, “there is good evidence to support an association

CONTINUED ON PAGE 11