



Catalyst

A NEWSLETTER FROM THE TREATMENT ADVOCACY CENTER | FALL 2022

TREATMENT ADVOCACY CENTER HOSTS 2022

National Assisted Outpatient Treatment Symposium & Learning Collaborative



More than 300 champions, implementers and practitioners of AOT gather in San Antonio

Treatment Advocacy Center is excited to host our second National Assisted Outpatient Treatment Symposium & Learning Collaborative this month in San Antonio, Texas. After more than two years of connecting through video screens due to the pandemic, we welcome the chance to convene as a movement in a live, face-to-face and collaborative environment. This two-day symposium brings together AOT champions, practitioners and implementers from all across the country to further AOT implementation in our communities.

"This gathering contributes to Treatment Advocacy Center's efforts to be recognized as the go-to national experts on the proper way to both

understand and implement AOT," said Treatment Advocacy Center Executive Director Lisa Dailey. She added that the symposium allows attendees to learn from one another, build on what they know, and celebrate the many lives transformed by AOT.

The symposium consists of captivating keynote addresses, useful workshops and stimulating discussions. Workshops include such varied topics as "The Fundamentals of AOT," "Tips for Improving Your Program" and "Expanding Your Program's Reach." The symposium also includes a focus group to understand and communicate what families want out of AOT.

Dailey is hosting an impactful conversation about AOT's contribution

to the crisis continuum being established with the rollout of the new mental health crisis hotline, 988, which was implemented nationally this past July. She plans to "focus on where AOT fits into that, as it is basically a front end and a back end part of a continuum of care for people." AOT, said Dailey, is necessary "both to avoid crisis and to safely return to the community after crisis, serving to prevent any kind of revolving door situation from occurring in the future."

We are also excited to have the opportunity to learn from two dynamic keynote speakers, Dr. Xavier Amador and Corey Minor Smith.

Dr. Amador is an internationally renowned clinical psychologist with 30 years of clinical experience as a therapist

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Our movement gathers momentum



This January begins Treatment Advocacy Center's 25th anniversary year, and as we look ahead to the celebration of this major milestone, it occurs to me just how our organization has grown and evolved over the past quarter century.

As you'll read in this issue of *Catalyst*, we have added several important new roles and welcomed some new faces ("Spotlight on Talent," page 10) to our organization since I wrote to you last, and I encourage you to read about a few of these talented professionals in this issue.

But beyond the size of our staff, we have grown in even more meaningful ways.

For starters, our impact has never been greater. As you'll read in these pages, our advocacy staff crisscrossed the country this year making key reforms to assisted outpatient treatment laws and helping to expand access to this lifesaving program ("Access Granted," page 8).

Our AOT implementation team, which has provided technical assistance to more than 30 AOT programs around the country, has been tapped to help five Pennsylvania counties pilot new AOT programs, reversing years of inaction on AOT in that important state.

The Office of Research and Public Affairs released its newest study last month, revealing key insights about the intersection of gender and severe mental illness that will aid us in understanding and effectively treating women with SMI. ("The Story Behind the Numbers," page 6).

That impact is being widely noticed and felt. Treatment Advocacy Center's experts and research were the basis of more than 300 news articles last year. We were also invited to join the CEO Alliance for Mental Health, where we are working collaboratively with partners like NAMI and Mental Health America to build consensus at the national level for our key priorities, including decriminalizing mental illness and restoring desperately needed psychiatric treatment beds.

But perhaps the best example of how we have grown is demonstrated by the national movement we have become. You, our network of loyal supporters, are connecting with us in more ways than ever. We are learning from each other and drawing strength from each other. We gather this month at our second National AOT Symposium and Learning Collaborative, as a movement, united in our belief that AOT saves lives and united in our quest to make sure that our loved ones with SMI are never left behind (cover story).

I am so proud to lead this organization as we head into our 25th year, and I am so proud to be in this fight with you.

Lisa Dailey

and personal experience as a family caregiver of two close relatives with severe mental illness. His extensive work studying schizophrenia, as well as bipolar and other disorders, has made him a leader in his field. The CEO of the Henry Amador Center on Anosognosia, his keynote address will discuss his research into anosognosia and his philosophy for helping those diagnosed with severe mental illness.

Author of a motivational memoir, *#Driven*, Corey Minor Smith joins us to talk about her experience as a daughter of a parent with severe mental illness. Growing up living with a father who was diagnosed with schizophrenia, Smith's life was unstable — she moved 21 times and attended 14 different schools before graduating from high school. Her life story inspired her to become a mental health advocate. Smith serves as an advocate from the perspective of a child who may have benefited from the implementation of AOT in her community when she lived with a parent with untreated severe mental illness.

In addition to the inspiring roster of mental health professionals, researchers and motivational speakers, the symposium features AOT graduates who have become advocates for its implementation. Bradley Tarr, the first person to both enter and graduate from the Richland County, Ohio, AOT program, will share his moving story and answer questions about his firsthand experience. He hopes that his story will reinforce that "AOT is a holistic approach to helping people with mental illness where people aren't treated as a number or quota." Through his willingness to be raw and share his own experiences, Tarr "wants the message to be spread far and wide that it is not a sign of weakness for people to reach out for help."

AOT Policy Advisor Betsy Johnson said that in addition to the compelling lineup of speakers, this gathering affords family members the rare opportunity to be in community with each other and be inspired by one another. "Family members being with other family members and seeing how many of them have succeeded in getting quality



Famed River Walk in host city San Antonio

programs started in their communities will make them feel like they can do it too," said Johnson.

Johnson added the caveat that the symposium is not meant solely for experienced AOT champions, implementers and practitioners, but also for novices and those simply curious to learn more about AOT. "We tried to put a program together that meets the needs of all attendees no matter where they are on their AOT journey," said Johnson.

Treatment Advocacy Center selected San Antonio, Texas, as the venue for this year's symposium to highlight the success of Bexar County's AOT program. Bexar County is the first community in Texas to create a court-centric model of AOT. Probate Court Judge Oscar Kazen was its driving force. As a judge formerly presiding over therapeutic drug court, he realized that "we could help people with mental illness using that same model. What you do as a judge shouldn't be measured by the number of people you throw in jail, but how many lives you can change."

Johnson said that Kazen's AOT program is having such a positive impact on people with severe mental illness in his community that "we really wanted to give him an opportunity to showcase what he's doing."

Said Kazen: "I hope we break the myth that AOT is going to create an influx of new patients, since AOT is a tool for the patients we're already serving." He said his goal is to "show people that AOT doesn't have to be a new program; it can be a supplement — a tool — for the people you're already serving in your community."

Kazen also said that he hopes attendees will take some time to enjoy the sights and sounds of San Antonio. "San Antonio is a wonderful destination for people to work and play," and attendees of the conference will "get an opportunity to do both while they're here."

For example, Treatment Advocacy Center has reserved five riverboats for Thursday evening. Attendees who choose to participate can take a 35-minute narrated boat cruise down the scenic San Antonio River.

This is the second iteration of the national AOT symposium. The first such gathering, which took place in Columbus, Ohio in 2019, led to multiple new AOT programs being established in Ohio and throughout the country. This year's symposium, said Johnson, will help people "remember why this work is so important, and, even on the days where they might get frustrated, that memory will stick with them."

A LEGACY OF HELPING FAMILIES

A generous bequest from supporter Joan C. Scott will help launch the Joan C. Scott Family Resource Center

Treatment Advocacy Center is very excited to announce a \$766,000 bequest from the estate of our longtime supporter and friend, Joan C. Scott.

Scott understood the world of severe mental illness through the lens of a mother. In 2013, Scott's son, Douglas, who had a history of hospitalization for symptoms of bipolar disorder and alcoholism, visited the emergency room for psychiatric evaluation three times in the span of a few short weeks. He was discharged each time.

Five days after his third trip to the hospital, Douglas Scott killed his father and Joan C. Scott's husband of 57 years, Norman Scott. By the time of Norman Scott's death, Douglas had been hospitalized and released over 23 times, despite his instability. "He had so many chances to get help," Joan C. Scott told the South Florida *Sun-Sentinel* in 2016. "Police said he fell through the cracks."

The way our broken mental health care system failed her son wasn't acceptable to Scott, who reached out to Treatment Advocacy Center for assistance. Brian Stettin, Treatment Advocacy Center's former policy director, fielded a helpline call to assist Scott in navigating her son's revolving door of hospitalization and incarceration.

After receiving our assistance, Scott became an ally of and donor to Treatment Advocacy Center, leaving a generous bequest to our organization in her will. Joan C. Scott died on June 8, 2021, in Pompano Beach, Florida. We are honored that she chose to prioritize the elimination of barriers to effective treatment for those with severe mental illness while planning her legacy.

"We admire Joan C. Scott because she committed [herself] to making things better. She understood the hurdles that people face with severe mental illness," Treatment Advocacy Center Executive Director Lisa Dailey said. "She really was an amazing woman."

In a 2013 *Personally Speaking* Blog for our website, Scott explained that "it's too late for us, but it's not too late for other families living with a loved one's untreated mental illness, and the Treatment Advocacy Center is the organization that's there to help." Scott's donation not only honors the legacy of a dedicated mother who fought for her son above all, but



Joan C. Scott

also supports Treatment Advocacy Center's continuation of the work about which she was so passionate.

Thanks to Scott's generous bequest, Treatment Advocacy Center will be launching the Joan C. Scott Family Resource Center on our website later this year. This center will provide general materials to aid families in helping their loved ones with severe mental illness, including information about assisted outpatient treatment, how to get help and who they can contact for assistance. We will create new audio, video and

written resources to provide relevant, state-specific information for families across the United States.

This center will also target underserved communities to ensure that our resources are reaching those who need them most. This includes having information available in multiple languages, so we can expand our reach as much as possible. Furthermore, this center will allow families to easily access information that is relevant to their situation and location. It will help families like Scott's navigate the barriers to effective treatment for people with severe mental illness.

"It's really an excellent reminder to all of us about the reason that we do this work. We do this work because many of us are family members, and we're all people who know family members who are affected by severe mental illness," said Dailey.

Financial support from generous donors like Joan C. Scott allow us to continue to assist families who may feel alone navigating severe mental illness. "We want to be that resource for families, and donations give us a really great opportunity to do better at that," added Dailey.

We are lucky to have supporters we consider family. You, too, can aid in Treatment Advocacy Center's mission by donating to our organization. If you have the capacity to give, this gift can guarantee your legacy — like Joan C. Scott's — will live on and help others.

Reach out to Treatment Advocacy Center's Director of Development Kelly Russo by emailing russok@treatmentadvocacycenter.org or calling 571-970-2222 to make your gift today.

Stanley Medical Research Institute Update

Misreporting of Results of Research in Psychiatry

By Jana Caylor Bowcut and Mark Weiser, M.D.

The following is a report from the Stanley Medical Research Institute, a supporting organization of Treatment Advocacy Center.

The Stanley Medical Research Institute funds randomized controlled trials on compounds for the treatment of schizophrenia or bipolar disorder, in which participants are randomly assigned to receive a drug or placebo to determine its effectiveness. RCTs are considered the gold standard for testing the effectiveness of a drug.

There are two main biases in presentation of RCT results. Publication bias occurs when studies are more likely to be published if they have a desired, generally positive result. Without publication of negative findings, an ineffective drug may be perceived as effective because only the positive studies are available to the scientific community. The second bias is outcome reporting bias, in which investigators report and/or emphasize outcomes that are positive and beneficial to patients while downplaying or hiding results that do not show benefit. Similarly, investigators sometimes change their study design midway through it, and/or change the statistical analyses, to improve the likelihood of a positive result.

These biases distort clinical research, as pooled results from published studies may lead to overestimation of a drug's effectiveness. In addition, they lead to repeated testing of ineffective compounds and expose volunteer patients to unnecessary risk and the inconveniences of procedures for the sake of drugs that have been tested and failed. Drug development suffers, as scientists are unable to learn from one

another's experiences and effectively utilize funding and resources.

In a recent study, "Misreporting of Results of Research in Psychiatry," published in *Schizophrenia Bulletin* in 2021, we explored whether these biases are present in the field of psychiatry, by testing for publication bias and outcome reporting bias in research SMRI funded between 2000 and 2011.

When researchers apply for funding from the Stanley Medical Research Institute, they submit a study protocol, which outlines the rationale and how they intend to carry out their studies. By comparing protocols to the corresponding peer-reviewed journal publications, we determined the extent to which these biases are present. We collected data on which studies were funded but not performed, performed but not published (publication bias) or published in a biased fashion (outcome reporting bias). We hypothesized that we would find high rates of publication bias and outcome reporting bias.

Publication bias was determined by classifying all completed RCTs as positive or negative, meaning they either showed statistically significant improvement with study medication (positive) or did not (negative). This helped us determine if a statistically higher percentage of positive as opposed to negative studies were published, indicating publication bias.

Outcome reporting bias was determined by comparing protocols to their corresponding publications. We looked for changes in study design, sample size and duration of medication administration. Were study aims clearly described? Were proposed statistical methods ultimately used? If there were discrepancies between what researchers

proposed and what they actually did, this would indicate outcome reporting bias.

Between 2000 and 2011, SMRI funded 280 RCTs; 238 were completed. Of the completed studies, 86 (36.1%) were positive and 152 (63.9%) were negative. There was clear evidence of publication bias. While 65% of all studies were published, 86% (74/86) of those with positive findings, but only 53% (80/152) of those with negative findings were published. Ninety studies were completed but not published. Approximately \$25 million was spent, and 6,500 patients were exposed to study procedures in these unpublished studies.

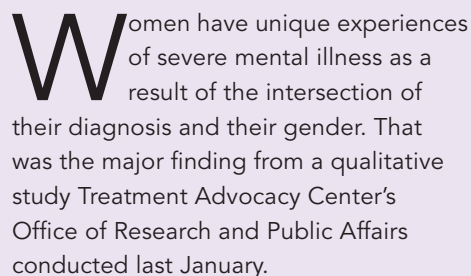
Outcome reporting bias was common. In 70% of published manuscripts, there were major discrepancies between the manuscript and the original RCT protocol, including change in the primary outcome tested, reduction in the number of patient groups or number of patients tested, and changes in statistics.

In summary, we found concerning evidence of publication bias and outcome reporting bias in a large number of RCTs for schizophrenia and bipolar disorder. It is important to note that publication bias and outcome reporting bias are common in other medical fields and not specific to psychiatry. These data have major implications regarding the validity of clinical trial reports published in the literature, which influence psychiatrists' treatment decisions.

Jana Caylor Bowcut is the treatment trials administrator at the Stanley Medical Research Institute.

Mark Weiser, M.D., is Stanley Medical Research Institute's associate director for treatment trials.

Office of Research and Public Affairs conducts focus group to examine the intersection of gender and severe mental illness



- Women with severe mental illness have long faced institutional biases — the inherent tendency of societal structures to support biased outcomes based on prejudices or stereotypes — because of their gender and diagnoses. Their symptoms are less likely to be taken seriously by clinicians and they are more likely to

- There are larger barriers to treatment for women with severe mental illnesses than for men with the same disorders, including greater difficulty in accessing inpatient psychiatric beds.
- Social isolation and relationship challenges are very common problems for women with severe mental illness. Motherhood is possible and can be very fulfilling for those women who want children. However, some women feel that the burden of their illness is too much or that they do not want to pass on the genes associated with their mental illness to their children.

- The long road to stability can be empowering for women with severe mental illness. Many of the focus group participants felt inspired to share their stories with the hope of educating and demonstrating to other women that living a fulfilling life is possible.

This project was initiated as a follow-up to earlier research by ORPA of women's experiences living with SMI. This work showed that women with SMI are more likely to be incarcerated, re-incarcerated or victimized than the general population, experience a greater risk of suicide and vulnerability to non-psychiatric health issues, and are disproportionately likely to self-harm while incarcerated. It also showed that women with an SMI diagnosis are less likely to receive necessary hospital services and more likely to lose custody of their children, have a co-occurring disorder and experience stigma than their male counterparts.



The hope with this study was that, when taken together with the earlier quantitative research, a more accurate picture of the unique experiences of women living with a SMI diagnosis would emerge.

"We knew that we wanted to make it a qualitative study to hear directly about women's experiences with their mental illnesses. Hearing from individuals with SMI is the best way to piece together solutions and policy that directly affect their well-being," said Nina Robertson, a former research intern who helped conceive the project.

"Qualitative data is an incredibly important addition to any research field; it helps to inform why people act the way they do and tells a story that numbers alone cannot," said Research and Policy Manager Kelli South. "Research already shows that women with severe mental illness are disproportionately impacted by certain factors. We wanted this project to contribute to that research base, while also calling attention to, and

"Our goal was to listen to people's stories and hear firsthand about the experiences of women with severe mental illness."

inspiring others to pursue, future research in the area. Our goal was to listen to people's stories and hear firsthand about the experiences of women with severe mental illness."

Director of Research Elizabeth Sinclair Hancq had the idea to hire a graphic illustrator to record the study. "Graphic recording is a creative way to summarize and present findings of a focus group that qualitative results cannot. We wanted to beautifully illustrate the experiences of these women to capture their stories in a meaningful way," she said.

The 12 participants in the study had various diagnoses, including bipolar disorder, schizophrenia, major depressive disorder, schizoaffective disorder, and borderline personality disorder; for many women, several of these were co-occurring diagnoses. Robertson facilitated conversations to frame the experiences of women living with SMI. Some of the topics illustrated included treatment experiences, barriers and access, relationships, parenthood and the decision of whether or not to become a parent, crisis experiences and contacts, among others.

This study is an impactful addition to the existing body of research on the intersection of womanhood and an SMI diagnosis. "It was clear that there was a lack of research regarding women's experiences with SMI," said Robertson. "We hope to impact future studies of women with SMI and encourage similar projects that amplify their experiences."

Access Granted

Advocacy team eliminates barriers to compassionate care across the country



Director of Advocacy Michael Gray (center) called for the passage and funding of LD1994 in an April 1 speech outside the Maine State House, where he was joined by (left to right) Nancy Boucher, Dale Hamilton, former Maine State Sen. John Nutting, Jeanne Gore, Maine State Sen. Ned Claxton (D-Androscoggin) and Dr. Henry Skinner.

Treatment Advocacy Center continues to identify and remove legal barriers blocking many individuals with severe mental illness from accessing timely and effective treatment. Through the improvement of statutes and the elimination of harmful legal provisions, the Advocacy Department helped reduce a variety of barriers to accessing assisted outpatient treatment in six states during the 2022 legislative sessions.

Our advocacy staff helped draft bills and advance them through the legislative process by testifying and by mobilizing advocates, who we provided with email story forms they could send directly to key legislators. As a result, we succeeded in making meaningful reforms to assisted outpatient treatment laws in Alabama, Georgia, Kentucky, Maine, Virginia and Washington. Alongside our partners on the ground, we worked to ensure that changes to local AOT laws reflected each state's unique needs and increased access to compassionate care for people with SMI.

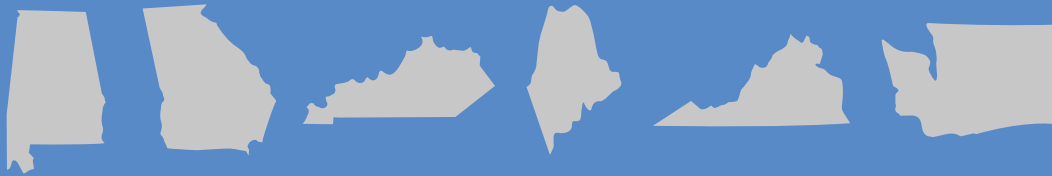
significant reform. We also worked with legislators and grassroots advocates to improve AOT criteria in Alabama, Georgia, Kentucky, Virginia and Washington.

Building on conversations our staff held last year with the Georgia Behavioral Health Reform and Innovation Commission, Georgia passed legislation to expand resources and infrastructure for AOT by establishing a three-year AOT grant program for five sites, in addition to improving the AOT criteria.

In Virginia, where programs are struggling to interpret and implement the state's AOT statute, our staff helped draft and advance HB 633, which made important clarifications to the language.

In addition to our state-level advocacy efforts, we have continued to engage both Congress and the Substance Abuse and Mental Health Services Administration to ensure that the federal AOT grant program is as effective as possible in serving grantee communities and expanding the knowledge base on these life-saving programs.

We succeeded in making meaningful reforms to AOT laws in Alabama, Georgia, Kentucky, Maine, Virginia and Washington



Historically, in Maine, AOT petitioners (including private hospitals, intensive case managers, assertive community treatment teams or county sheriffs) have been disincentivized from initiating an AOT referral at the time of discharge because the state requires petitioners to pay the legal fees. State Sen. Ned Claxton introduced LD 1994 to remedy this barrier by creating a fund to cover the costs of initiating AOT petitions for up to 200 individuals each year.

At a pivotal juncture, when the bill had passed a state Senate committee but it remained unclear whether it would pass the legislature with the necessary funding, Director of Advocacy Michael Gray flew to the state capital to meet with key legislators and help pass the bill. Gray joined former Maine State Sen. John Nutting and the National Shattering Silence Coalition to host a press conference April 1 outside the Maine State House in Augusta. "There is a barrier, and it's not AOT. It's the way it's being administered in some cases," said Gray in his speech. "The House and Senate must pass and fund LD 1994 if this legislature wants to help people thrive in the community and not go in and out of a revolving door of hospitals, jails and homelessness that they are all too often caught in."

Ultimately, the Maine State Legislature voted to allocate the funds. By helping Maine enact LD 1994, we successfully removed a long-standing barrier to step-down AOT, which allows for continued treatment in the community following a hospitalization.

Maine was not the only state whose AOT criteria needed

Our staff successfully worked to ensure three key program improvements were included in reauthorization bills currently under consideration. S 4170 and HR 7666 address mental health reforms in the U.S. Senate and the U.S. House of Representatives, respectively. Both bills would increase the pool of AOT grantees by making existing programs eligible. They also clarify that AOT takes place in a civil (as opposed to criminal) court by adding the word "civil" to the definition. Last, S 4170 and HR 7666 require more robust data collection and reporting to help increase the knowledge base on AOT outcomes.

In collaboration with our Office of Research and Public Affairs, the advocacy team secured language in S 4170 to study the outcomes of various AOT programs. Comparative research will be critical in understanding the impact of differences in AOT eligibility criteria under state laws, as well as the impact of variations in program design, such as having an actively engaged AOT judge.

We were instrumental in the establishment of the grant program nearly a decade ago, and since then, our AOT implementation team has offered technical assistance to grantee programs across the country — including to 11 of the 17 programs awarded grants in 2020.

We are thrilled to see the progress of our work to make compassionate care like AOT accessible to people with severe mental illness in every community.

SPOTLIGHT ON TALENT

From new hires to internal promotions, Treatment Advocacy Center continues to invest in talented professionals in order to maintain its reputation as the premiere organization dedicated to eliminating barriers to the treatment of severe mental illnesses. We're excited to introduce you to some of the new faces within our organization and reintroduce you to others who are taking on new challenges. Be sure to check out future issues of *Catalyst* for additional spotlights on our fabulous team.



KATHY DAY SENIOR FAMILY LIAISON

Kathy Day has affectionately nicknamed herself Treatment Advocacy Center's professional Googler.

"I field calls and emails from people across the country. I work to find out their needs and I figure out what to research online for different people's situations. I try to leave everyone with at least one resource. Some people just need to vent, but I really want to give family members the tools to learn the system and find help for their loved one," she said.

Officially, Day has taken on the brand-

new role of senior family liaison, and her signature warm, welcoming personality is perfect for the job. Embodying the mission of our organization by working to help family members across the country overcome barriers to treatment for their loved ones with severe mental illness, she describes her process as an individualistic approach – she listens to families, talks with them, and helps brainstorm potential ways to solve the current issue at hand.

Day, who is based out of Folsom, California, is doing the on-the-ground work to empower families with the resources necessary to support their loved ones with

severe mental illness. When her family member was diagnosed with schizophrenia in 2010, Day learned how to advocate at the state and local levels. After recognizing the barriers to accessible treatment information, she became inspired and took the initiative to educate herself on the issues and share that knowledge with others — ultimately becoming the liaison that she herself once needed.

Day regards her role as complementary to the work of the Advocacy and AOT Implementation departments. "I work with the family members while other teams deep dive into changing the laws."



KELLY RUSSO DIRECTOR OF DEVELOPMENT

Treatment Advocacy Center's new director of development, Kelly Russo, believes that fundraising is reciprocal. Her 15 years of development experience,

including her most recent stint as director of field resource development at NAMI, have taught her that gratitude and building interpersonal relationships with donors go a long way. "Our donors keep us going. Their

passion for the cause inspires my work every day. I don't want the only time I talk to someone to be when I am asking for money. I want to remember the thank you. That, to me, is where I'm really putting my focus," said Russo.

Russo said she hopes that she and her team will not only succeed in supporting the current operations of the organization but raise the money needed to grow its capacity and broaden its impact. "When

people think of those eliminating barriers to accessible treatment for individuals with severe mental illness, I want them to think of Treatment Advocacy Center." She said she's particularly excited about the organization's upcoming 25th anniversary next year.

"I'm hoping to host a celebration to recognize what we've been doing here at Treatment Advocacy Center. Seeing what this organization has accomplished in the last 25 years renders me speechless," said Russo.



MICHAEL GRAY DIRECTOR OF ADVOCACY

It's rare to see someone's eyes light up when talking about the workings of the federal government. However, for Treatment Advocacy Center's

recently promoted director of advocacy, Michael Gray, federal legislative policy is his bread and butter. "I could talk for hours about this," said Gray.

Beyond his impressive credentials, which include a Juris Doctor, a master's degree in

urban planning and experience serving as the former executive director of NAMI Louisville, Michael Gray is passionate about his hopes for the future work of the Advocacy Department. "We are building the capacity to do a lot more in the Advocacy Department, but also organizationally. We are going to continue to do what we do so well, while also doing things that we've never done before," he said.

One of his team's top priorities will be to work with a broad coalition of advocacy partners to eliminate legislative barriers to

treatment for individuals with severe mental illness, chief among them the IMD exclusion, which limits the financial accessibility of inpatient treatment for Medicaid recipients. Gray wants Treatment Advocacy Center to take the lead in championing the IMD exclusion's full repeal in Congress, though he knows this will be a tough battle. "It's not going to be a short-term process," said Gray. "Ten years from now, I hope that Medicaid enrollees with severe mental illness have access to hospital beds."

Personally Speaking: I've Seen the Power of Assisted Outpatient Treatment Firsthand

By Vianney Lopez

I am a licensed chemical dependency counselor, and I started working as part of an assisted outpatient treatment team in El Paso, Texas, two years ago. My caseload is small, which allows me to have a personal relationship with every client. I've picked up clients and taken them to job interviews, taken the bus with them to the mall so they're able to get out of the house, and simply talked to them about their day. This helps me develop trust with the client, and the clients are able to talk freely with me about how they are doing and how the AOT team can support them.

In addition to gaining their trust and listening to them, I educate my clients on the importance of taking their psychotropic medications and refraining from mind-altering drugs. With COVID-19 protocols in place, I was only doing individual sessions, but now I am also leading group sessions. It's a great way to show my clients that they are not alone in their battle.

We talk about what co-occurring disorders are, what chemical dependency is and how to use coping skills to live a recovery-oriented lifestyle.

Our AOT team truly knows and understands what working as a team really means; we offer each other help, advice and guidance. We communicate well with one another about what we are doing with each one of our clients so that we can pick up where the other left off. It makes no difference if it's a caseworker, licensed chemical dependency counselor, supervisor or judge who is speaking to a client. We are fully aware of what is going on with the client so that we can help them feel safe to speak to any of us about what they may need or want out of their AOT program.

Before working with the AOT team, I didn't understand what people with severe mental illness went through. I thought



I thought a schizophrenia diagnosis meant a person had no chance of a "normal" life. That isn't the case today. I've seen how AOT can change a person's life.

a schizophrenia diagnosis meant a person had no chance of a "normal" life. That isn't the case today. I've seen how AOT can change a person's life.

I worked with a 30-year-old woman diagnosed with schizophrenia who, when we first met, didn't speak, didn't shower and didn't do much throughout her day except sleep. Today, she is waking up early to attend her adult daycare program, where she gets to play bingo, exercise and as she says, "have some good morning coffee."

Another client I've had the pleasure of working with, and who has schizophrenia, is now working part-time as a host in a popular and busy restaurant while attending El Paso Community College to get an associate's degree in biology. When we first met, she refused to take her medication and didn't believe she needed AOT services.

A third individual, who has bipolar disorder, is becoming a peer support specialist and has the best relationship

ever with his parents, who were ready to give up on him when we first met.

AOT has educated me on mental health and the capabilities individuals have if given an opportunity without judgment. I have learned the true meaning of treating the individual and not the disease. I have learned to listen to my clients' needs and not put them in a cookie-cutter program that wasn't ever going to help them succeed. AOT truly focuses on helping individuals succeed at their pace, at their capabilities and at their goals.

I've seen the power of AOT, and I can't wait to help more clients see it too.

Vianney Lopez is a licensed chemical dependency counselor in El Paso, Texas, where she lives with her partner. She is the mother of two adult children and a grandmother.



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