For BHPC Adult/SA Subcommittee
Summary Talking Points from NY State AOT Program Evaluation Report

Report dated June 30, 2009 and co-authored by experts from Duke University School of Medicine, Policy Research Associates, New York, and The MacArthur Foundation Research Network on Mandated Community Treatment, Univ of Virginia School of Law

Covers 1999-2007. In a 2005 snapshot the number of NY residents with SMI was 3% of the population, a quarter of whom were public recipients. Of those public beneficiaries, 6% received intensive case management or assertive community treatment and of that group, 27% were AOT recipients (N= 2,420).

- **New York's AOT program was accompanied by a significant infusion of new service dollars**
  - and findings may not generalize to other states, especially where new service dollars are not available.
  - $32 Million was appropriated annually for direct support of AOT programs. This included new case management slots and a $15 million medication grant program as well as prison and jail discharge managers...
  - Both ICM and ACT capacity was increased, the state allocating $125 million yearly for enhanced community services.

- **In 3/4 of all cases, it was actually used as a discharge planning tool for hospitalized patients.**
  - Thus AOT is largely used as a transition plan to improve the effectiveness of treatment following a hospitalization and as a method to reduce hospital recidivism.

- **70% of all AOT cases originated in the NY City area;**
  - In the remainder of the state, AOT was implemented and utilized at the discretion of counties. In some counties AOT has been rarely used; in several it has not been used at all.
  - Counties who did not implement AOT cited lack of infrastructure to support court orders in small counties as one reason. Others included local views of AOT as a reactionary approach to a high publicity incident.
  - All counties receive AOT money regardless of whether they have a program. Some counties used these funds to serve high-risk clients in other ways.

- **Outside NYC, counties often used enhanced voluntary service (EVS) agreement.**
  - AOT must be the least restrictive alternative. Although EVS is not a statutory process, it is used by many county AOT programs either before or after AOT. (North/South NY divide on this)

- **In the first few years (1999-2003) preferences for intensive case management services were given to AOT cases and non-AOT recipients were less likely to receive**
  - these intensive services, especially outside of NYC. Lack of continued growth of new service dollars will likely increase competition for access to services once again.

- **After 2003 new AOT orders leveled off and then declined.**
  - The new treatment capacity that accompanied the implementation of AOT was apparently then available to other individuals who needed these services, irrespective of AOT status.

- **AOT orders exert a critical effect on service providers**
  - stimulating their efforts to prioritize care for AOT recipients.

- **Perceptions of the AOT Program and experiences of stigma, coercion, and treatment satisfaction was not as negative as expected**
  - and was more strongly shaped by other experiences with mental illness and treatment.

- **Recipients who appear to sustain improvements are those who continue to receive intensive treatment services or received AOT services longer than 6 months.**

- **Forced medication is not part of the AOT program and requires meeting existing NY standards regarding rights to refuse treatment.**
  - After six month of AOT, the case managers' appraisal of recipients' nonadherence to medications changed from 47% to 33%. However, nonadherence increased again to 43% in the group of individuals who had been on AOT 12 months or more.