# A 2014 SURVEY OF MICHIGAN PROBATE COURTS AND COMMUNITY MENTAL HEALTH SERVICES PROGRAMS REGARDING ASSISTED OUTPATIENT TREATMENT ("KEVIN'S LAW")

*The Mental Health Association in Michigan (MHAM) and Its*
*"Partners in Crisis" Mental Health-&-Justice Coalition*

Technical Assistance Provided by the Michigan Department of Community Health

Supported by a Grant from the Ethel & James Flinn Foundation (Detroit)

**March, 2015**

MHAM is a United Way Agency, Affiliated with Mental Health America

## TABLE OF CONTENTS




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## EXECUTIVE SUMMARY

Assisted Outpatient Treatment (AOT) law, also known as "Kevin's Law" in Michigan, has existed in the state since 2005. It attempts via Court order to connect community services to adults with severe mental illness who have had documented difficulties complying voluntarily with recommended mental health treatment.

As AOT appeared to be little used outside Oakland County, a statewide survey was undertaken of two key parties – Probate Courts and Community Mental Health Services Programs (CMHSPs). An 80% response rate came from the latter; 57% from the former.

Results confirmed scant usage of AOT across the state. The chief reason given for non-usage was that the state's existing law is too complex and confusing. There were also concerns from CMHSPs (which appeared to be more leery of AOT than were Courts) that it was too difficult to enforce subject compliance, and that Michigan has a potentially preferable civil commitment tool in alternative treatment orders (initial hospitalization followed by community care). Respondents did not check to any major degree the following reasons for community non-support of AOT: too coercive; requires Judges to make medical decisions; costs too much money.

Among reasons often checked for possible community support were: Every additional treatment tool welcome; Lesser commitment standard sometimes needed (AOT does not require imminent danger to self or others); Help with difficult cases; and Cost savings.

Many respondents were unaware of or uncertain about the fact that current Michigan law allows two avenues for an AOT order, not just one.

A majority of Court and CMHSP respondents had not received previous AOT training, and majorities from both groups would welcome it. No one cited the state as the source of any previous training provided.

Finally, in a question only for CMHSPs, the vast majority indicated they do not at this time try to track AOT outcomes separately from those of other clients.

Implications of the results are discussed, as is information subsequently provided through special interviews with Oakland County Probate Court and mental health officials, given that Oakland has likely been the state's highest-volume user of AOT the past ten years.

Recommendations if Michigan is to expand AOT (desired by the Executive Branch) are: revising the law for greater clarity; improving training efforts; persuading CMHSPs of the importance of AOT and the critical role they can play in it; establishing needed legislative appropriations (of a relatively modest amount); overcoming potential confusion about Court orders vs. Medicaid Medical Necessity criteria or local mental health eligibility guidelines; and formal evaluation of Michigan results.

# INTRODUCTION

Assisted Outpatient Treatment (AOT) law has existed in Michigan since 2005. It is often referred to in this state as "Kevin's Law." Under the law, someone with mental illness who has been noncompliant with recommended treatment, and whose noncompliance in recent years has contributed to difficulties for himself/herself, can be ordered by a Court to undergo outpatient treatment for up to 180 days.[1] The subject does not have to be deemed an imminent threat to self or others at the time of the order, unlike the way other Court orders for psychiatric treatment are so often handled.

In the decade since AOT law took effect in Michigan, there was widespread perception that the law was little used in the state, outside of Oakland County. To gain a better idea of usage and non-usage, as well as community perceptions of, attitudes toward, and knowledge about "Kevin's Law," we undertook a statewide survey of the two key local players in AOT implementation – Probate Courts and Community Mental Health Services Programs (CMHSPs).

A survey instrument was field-tested with five Probate Judges and five CMHSPs, and modified based on the feedback received. The revised instrument was postal-mailed in the summer of 2014 to all CMHSPs (46) and all Probate Courts (83) in the state. Up to two follow-up mailings were sent as necessary to potential respondents.

With one exception (an additional question for CMHSPs on assessing treatment outcome), all respondents were posed the same questions. The survey instrument for Courts is provided in Appendix A; the CMHSP instrument is in Appendix B.

Forty-seven Probate Courts (57%) and 37 CMHSPs (80%) responded to the survey. Court responses were fairly evenly split between Judges and Court Registers (clerks). Responses from CMHSPs were from various staff presumably assigned this task by CMHSP Executive Directors (to whom the survey had been mailed).

This report provides a picture of AOT usage, knowledge, attitudes, and perceptions from around the state. (Tabular survey results are presented in Appendix C.) Implications of the findings are discussed and recommendations offered. Additionally, supplemental information is provided from subsequent interviews conducted with Oakland County officials, given Oakland's role as the likely state leader in usage of "Kevin's Law."

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[1]The difficulties encountered the previous four years are at least two incarcerations or psychiatric hospitalizations, or the commission of a "serious" violent act or threat.

At the time this project was conceived and the survey distributed, we were unaware that Michigan's Executive Branch, under the leadership of Lt. Governor Brian Calley and the Governor's Mental Health Diversion Council, would subsequently appoint a special task force to examine past problems interfering with AOT usage, and to recommend solutions for such problems. The task force began meeting in October 2014, and had not completed its work as of March 9th. The results of this survey were shared with the task force.

## SURVEY RESULTS

Frequency of Usage

Options were: Not At All; 1-2 times p/yr.; 3-6 p/yr.; 7-10 p/yr.; over 10 p/yr.

79% of Courts and 73% of CMHSPs reported usage less than three times p/yr. (around half of each group Not At All)

13% of Courts and 24.5% of CMHSPs reported 3-10 times p/yr.

Four Courts (8.5%) and one CMHSP (2.7%) reported more than 10 cases p/yr. The one CMHSP, as would be expected, was Oakland, and the response from Oakland Probate matched that. The other three Courts at this level were Alger, Shiawassee and Tuscola. Shiawassee CMH reported 3-6 cases annually; Tuscola CMH and the CMH that includes Alger did not respond to the survey.

Reasons for Support in One's Community

Options were: Help with difficult cases; Law should be followed re applicable cases; Potential savings compared to hospitalization; Lesser commitment standard than immediate danger sometimes needed; Every additional treatment tool welcome; and Other. Respondents could check as many items as they wished.

The most support was for "Every additional treatment tool welcome" (64% Courts; 70% CMHSPs).

There was a virtual tie for the next-highest. "Lesser commitment standard sometimes needed" was 53% Courts and 54% CMHSPs, while "Help with difficult cases" had 47% from Courts and 65% from CMHSPs.

The one other item with considerable support was "Potential savings" – 47% Courts and 49% CMHSPs.

Interestingly, "Law should be followed" (re applicable cases) had 43% support from Courts, but only 22% from CMHSPs.

The lowest-rated response was "Other," selected by 21.3% of courts and 16.2% of CMHSPs. There was no discernible pattern to "Other" comments here, and some of them did not actually relate to reasons for AOT support. Two of the most germane comments were: only way to order case management (presently required to be part of AOT service); and helpful when the major problem is medication noncompliance. The former came from a Court; the latter from a CMHSP.

Reasons for Non-Support in One's Community

Options were: Too coercive; Too complex to understand/use; Expenditures too great; Not enough local interest for needed collaboration; Judges required to make medical decisions; and Other. Respondents could check as many items as desired.

Far and away, the two predominant responses were "Too complex" with 38% each from both sub-groups; and "Other" with 34% from Courts and 57% from CMHSPs. Nineteen of 21 CMHSPs checking "Other" provided open-ended comments, and open-ended responses expressing concerns will be discussed later in this section.

Interestingly, some of the AOT complaints raised over the years – i.e., "Too Coercive"; "Expenditures too great"; and "Judges required to make medical decisions" received little backing. CMHSPs were more likely to check the latter point (16.2% to 6.4%), while Courts were more likely to bring up expenditures (23.4% to 13.5%). Both sub-groups gave scant support to the coercion issue (6.4% of Courts and 2.7% of CMHSPs). There was also little support for the option that there isn't enough local interest in the issue (8.5% of Courts and 10.8% of CMHSPs).

Can AOT Only Be Considered under an AOT Petition Filing?

This question was asked because the Mental Health Code says in one place that AOT consideration must be initiated by an AOT petition, but in another place the Code states that Court review of "person requiring treatment" status (which would not have to be initiated by an AOT petition) can result in judicial order for AOT if the subject meets the eligibility criteria.

For whatever reason(s), there is much confusion – or varying interpretation – about this question. 38% of Courts and 56% of CMHSPs said an AOT petition is the only way to

stimulate consideration; 24% of Courts and 17% of CMHSPs said this isn't the only way; and 38% of Courts and 28% of CMHSPs indicated uncertainty.

AOT Training

11.6% of Courts reported previous training, compared to 38% of CMHSPs.

56% of Courts and 82% of CMHSPs believed they could benefit from AOT training.

So, interestingly, the sub-group with more previous training was most desirous of new training. But an important point here is that majorities have never received training and would like future training.

The most-cited sources of previous training were the Courts, with six CMHSPs citing Probate Court as the source, and three of the Court respondents citing Court Registers.

As to type of training needed, six Court respondents indicated training shouldn't just be for Courts but CMHSPs as well; five cited need for general awareness of AOT law and its processes/procedures; and two said petitioners would benefit from training.

On the CMHSP side, there were eight requests for general training on legal processes/procedures; five mentions that Courts also need training; four citations for training on enforcement/addressing noncompliance; and two mentions for comparing/contrasting AOT with alternative treatment orders, which start the subject in a hospital and complete the duration of the order in the community.

AOT Outcomes (asked only of CMHSPs)

CMHSPs were asked if they separately record AOT outcome data for comparison to other mental health cases, and what their general outcome perception has been.

On the first of these questions, three CMHSPs said Yes and 30 said No (four non-responses).

Re the second part of the question area, the predominant response was "Not applicable, as AOT Rarely or Never Used Here" (66%). "Generally positive" was 17%; "Generally negative" 3%; "Mixed per case" 11.4%; and "Too difficult to track" 3 percent. (Of the three CMHSPs reporting separate tracking, one answered "Generally positive"; one checked "Generally negative"; and one opted for "Mixed.")

Open-Ended Comments

Five survey items had open-ended comment opportunities. Looking across all open-ended comments that represented concerns (including those previously mentioned regarding training), the following were mentioned four times or more:

*Difficulty with subjects complying/enforcement – 17 cites, all but one of them from CMHSPs

*The existence of alternative treatment orders as something else local officials prefer using – 11, all but one from CMHSPs

*Local Judges don't like using AOT – 9, all from CMHSPs

*Problems with duration/continuation of AOT orders – 4, split evenly between Courts and CMHSPs

*CMHSPs/mental health community don't understand the law – 4, all from Courts

*Prosecutor role/involvement in AOT cases – 4, all from Courts (under the 2005 AOT law, prosecutors are not required to be involved with AOT cases; the comments here were mixed, not predominantly focusing on that aspect of the law)

*Court opinions/perceptions don't matter; if a case is before a Judge, he or she has to deal with what the law says - 4, all from Courts

## DISCUSSION OF RESULTS

It was no surprise that this investigation confirmed AOT has been little used in Michigan. The chief reason cited by both Courts and CMHSPs was the law being too complex and confusing. CMHSPs were also concerned about difficulty attaining and enforcing subject compliance (43%) and the potential competition between AOT orders and alternative treatment orders (27%).[2] Another 24% of CMHSPs made the claim that local Judges

2 Potentially contradicting this result was that 70% of CMHSPs supported "every additional treatment tool welcome" as a usage reason, and 65% cited potential help with difficult cases.

don't like using AOT, while almost a quarter of Courts (23.5%) were concerned about required expenditures possibly being too great.[3]

Two complaints heard verbally about AOT over the years – that it's too coercive and requires Judges to make medical decisions – did not receive much support.[4]

Several options among possible reasons for using AOT had substantial support. If Michigan is going to try promoting AOT usage, the results of this survey may prove helpful in marketing usage to Courts and CMHSPs, respectively.

The one question directly related to knowledge of Michigan AOT law did not reveal a high level of understanding. This underlines the importance of training if there is going to be greater emphasis on usage in Michigan. And a majority of Courts and CMHSPs believed training would be beneficial, while a majority of respondents from both groups reported no previous training, and no one cited the state as the source of any previous efforts.

If AOT is going to be broadened in Michigan, evaluative data will be important. Should treating entities be separately recording AOT subject outcomes and comparing them to those for non-AOT clients? If the answer is Yes, much work will need to be done, as few CMHSPs were using such an approach for the small number of cases that have been involved.

It was interesting to note that 24% of CMHSPs said Judges don't like using AOT, but no Court said that so directly. On the other side of the coin, 9% of Courts said CMHSPs and the mental health community don't understand AOT law. The varying perceptions each group has of the other, and whether such perceptions are accurate, will be important to ascertain if Michigan goes further with AOT.

Finally, the results of this survey indicate that CMHSPs may be more leery of AOT than are Courts. Almost half of Courts, but less than a quarter of CMHSPs, said AOT law should be followed for applicable cases. And virtually all concerns expressed about compliance/enforcement and relationship to alternative treatment orders came from CMHSPs. Further, while less than 7% of Courts were worried about the potential for Judges having to make medical decisions, this concern was cited by roughly one in six CMHSPs (16.2%). Since CMHSPs are the most likely local treatment entity available to

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[3] Michigan's 2005 AOT law was set up so that CMHSPs would provide treatment and, thus, bear the major cost responsibility (outside of Medicaid). But until Fiscal Year-15, there had never been any legislative appropriation specific to AOT. Only 13.5% of CMHSPs cited cost as a reason for non-usage. This could mean that AOT costs aren't proving to be the monster some feared. It could also reflect that there have been relatively few cases outside Oakland County so far. Further, while the survey was sent to CMHSP Executive Directors, they assigned other staff in almost all instances to respond to the instrument.

[4] Too coercive = 6.4% Courts and 2.7% CMHSPs; Judges required to make medical decisions = 6.4% Courts and 16.2% CMHSPs.

Courts, this is an important issue for continued examination and any necessary remediation.

## ADDITIONAL INFORMATION FROM OAKLAND COUNTY INTERVIEWS

As Oakland is the only county in Michigan that has widely used AOT law, post-survey interviewing was done with Oakland Probate Court and county mental health officials.

The five most significant points coming out of these interviews were:

1. AOT law as it presently exists left several regulatory holes and points of uncertainty to be dealt with. The county has made a "good faith" effort to interpret these gray areas so as to have operational AOT processes/procedures. Included has been the effective use of the CMHSP pre-admission screening program (Common Ground) to locate, communicate with, and assess AOT petition subjects.

2. Both Probate Court and mental health officials determined upon the law's enactment that the county must be prepared to move forward with (and not ignore) it. There has been strong cooperation and coordination among the various parties. AOT cannot work unless both the judicial and mental health officials in a community are willing to prepare for and use it.

3. Local officials do not have an automatic preference for AOT vs. alternative treatment orders. Both have been shown to have their place; one may preferable to the other given the circumstances of a particular case; and there should be room for both in the toolboxes of communities.

4. Local officials are placed in a potentially difficult situation when the subject of an AOT order does not meet Medical Necessity criteria established by Michigan Medicaid and/or the community's mental health network. If as a result Medicaid cannot pay for someone who is otherwise eligible, the CMHSP may have to use General Fund dollars (growing scarcer in Michigan) to support the subject's services. Difficulty finding residential or hospital beds[5] for AOT subjects – even when Medical Necessity is not an issue – was reported.

[5] When a subject under AOT is not compliant with the Court order, hospitalization for a short period can be ordered. Additionally, Oakland officials reported that some subjects are given a combined order of hospitalization and AOT, which is permissible under AOT law.

5. To better evaluate clinical and long-term cost outcomes for AOT cases, the community would need additional resources. Having already devoted newly additional resources to operationalize the 2005 AOT law, a comprehensive long-term investigation would require extra resources and expenditures.

## RECOMMENDATIONS

If AOT usage in Michigan is to be expanded:

1. Michigan AOT law should be revised for greater clarity. This will hopefully result from the special work the Executive Branch has undertaken toward this end.

2. The state should provide comprehensive training on AOT to, respectively, Probate Courts, CMHSPs, and local NAMI-Michigan chapters.[6] Family members need to be educated on what the process is and how to use it. And based on the results of this survey, points to be made with both Courts and CMHSPs are: AOT is another tool that can be used with difficult cases; a lesser civil commitment standard (per AOT) than imminent danger to self or others is sometimes critical in turning around a life; and both groups have important roles to play in AOT implementation and are capable of doing so effectively if desired. CMHSPs also need to hear that both AOT and alternative treatment orders have their place in the response toolbox – one is not automatically better than the other, and dealing with enforcement of noncompliance on an alternative treatment order can just be just as challenging as when encountered with AOT. Strategies for dealing with noncompliance regarding any court order should further be stressed.

3. Beyond training for and marketing with CMHSPs, DCH (as the party which contracts with CMHSPs) must assure that those entities make good-faith efforts to see that AOT orders are fulfilled. In the majority of cases, CMHSPs will be the only practical resource to which Courts can turn. Yet the results of this survey suggest CMHSPs are more wary than Courts of AOT. The information provided through special Oakland County interviews showed the importance of both Courts and CMHSPs cooperating and coordinating for effective AOT response.

4. While most AOT cases can and will be covered by Medicaid (meaning the federal government picks up virtually the entire tab), an appropriation for statewide treatment

[6] The National Alliance on Mental Illness (NAMI)-Michigan has chapters in almost half of state counties. Many persons in NAMI are family members of individuals with mental illness and are often petitioners for Court intervention with severe, uncontrolled cases.

of non-Medicaid AOT cases – at least in the first year of expanded usage – is needed. Based on the early years of the pioneering AOT program in New York, it is projected that an appropriation of $2 million would be required the first year. That is one-hundredth of one percent of the DCH budget.

5. State law, rule, and/or policy should clarify that a Court order for mental health treatment trumps local CMHSP eligibility guidelines and Medicaid Medical Necessity criteria that have been established by Michigan. The only exception to the latter should be instances where federal Medicaid law, rule, or policy prevents this.

6. AOT will have to be evaluated for its cost-effectiveness in Michigan. (Formal evaluations in other states have yielded promising results.) This is not happening right now. Although overall expenditures needed for this would not be relatively large, additional resources would have to be allocated. Michigan's universities can hopefully play a helpful role in this regard.

# **Appendix A –** Court Survey on AOT

_____ _____

Name of Your Court (please print)

Name of Person Responding (please print)

1. Frequency of Usage

Please indicate the degree to which you believe AOT is used in your community in a typical year. (Check one)

___ Not at all

___ One or two cases a year

___ Three-six cases a year

___ Seven-ten cases a year

___ More than ten cases a year

2. Reasons You Believe Exist in Your Community for Support of AOT Usage
(Check all that you think apply)

___ It can help deal with difficult cases

___ If legal paperwork is filed and eligibility criteria met, the law should be followed

___ There are potential cost-savings compared to immediate hospitalization of a subject

___ For some cases, a lesser commitment standard than immediate danger is needed

___ Every additional tool available to connect people with needed treatment is welcome

___ Other (please specify and print)

_____

_____

3. Reasons You Believe Exist in Your Community for Not Supporting AOT Usage
(Check all that you think apply)

____ We already had forced treatment in Mich. and shouldn't have added more coercion

____ The law is too complex to understand and operationalize

____ It does or could require expenditures beyond our community's means

____ Not enough interest in our community for the collaborative effort needed

____ Requires judges to make medical decisions, which they shouldn't be asked to do

____ Other (please specify and print)

_____

_____

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_____

4. Court Consideration of Whether AOT is Applicable and Should Be Used

Michigan's AOT law may lack clarity about the procedure(s) required to initiate court consideration of an AOT order. Is it your interpretation that such consideration can only be undertaken if an AOT petition has been filed with the court? (Check one)

____ Yes

____ No

____ Unsure

5. AOT Training

Has your court previously received any training regarding AOT? ___Yes ____No

If so, please specify and print the entity providing the training

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Would your court currently benefit from AOT training? ___Yes ___No

If so, please specify and print areas in which you would like to receive training

_____

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6. Please print in the space that follows any changes you believe necessary to state AOT law, or any other open-ended comments you wish to make about AOT in Michgan (or nationally).

*Open-Ended AOT Law Comments, Including Changes to Law (please print)*

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# **Appendix B –**CMHSP Survey on AOT

_____ _____

Name of Your CMHSP (please print)

Name of Person Responding (please print)

1. Frequency of Usage

Please indicate the degree to which you believe AOT is used in your community in a typical year. (Check one)

____ Not at all

____ One or two cases a year

____ Three-six cases a year

____ Seven-ten cases a year

____ More than ten cases a year

2. Reasons You Believe Exist in Your Community for Support of AOT Usage
(Check all that you think apply)

____ It can help deal with difficult cases

____ If legal paperwork is filed and eligibility criteria met, the law should be followed

____ There are potential cost-savings compared to immediate hospitalization of a subject

____ For some cases, a lesser commitment standard than immediate danger is needed

____ Every additional tool available to connect people with needed treatment is welcome

____ Other (please specify and print)

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_____

3. Reasons You Believe Exist in Your Community for Not Supporting AOT Usage
(Check all that you think apply)

____ We already had forced treatment in Mich. and shouldn't have added more coercion

____ The law is too complex to understand and operationalize

____ It does or could require expenditures beyond our community's means

____ Not enough interest in our community for the collaborative effort needed

____ Requires judges to make medical decisions, which they shouldn't be asked to do

____ Other (please specify and print)

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4. Results in Your Community

A. Does your CMHSP separately record AOT case data and compare it to other mental health cases?

_____Yes

_____No

B. In your estimation, the clinical outcomes of AOT cases in your community have been:
(check one)

_____Generally positive

_____Generally negative

_____Mixed on a case-by-case basis

_____Too difficult to track

_____Not applicable, as AOT rarely or never used here

5. Court Consideration of Whether AOT is Applicable and Should Be Used

Michigan's AOT law may lack clarity about the procedure(s) required to initiate court consideration of an AOT order. Is it your interpretation that such consideration can only be undertaken if an AOT petition has been filed with the court? (Check one)

____ Yes

____ No

____ Unsure

6. AOT Training

Has your CMHSP received previous training regarding AOT? ___Yes ____No

If so, please specify and print the entity providing the training

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Would your CMHSP currently benefit from AOT training? ___Yes ___No

If so, please specify and print areas in which you would like to receive training

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7. Please print in the following space any changes you believe necessary to state AOT law, or any other open-ended comments you wish to make about AOT in Michgan (or nationally).

*Open-Ended AOT Law Comments, Including Changes to Law (please print)*

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**APPENDIX C**
**Court/CMHSP Response Summary Comparison**

| **1. Frequency of AOT use** | **Court** | **CMHSP** |
|---|---|---|
| Not at all | 46.8% | 51.4% |
| One or two cases a year | 31.9% | 21.6% |
| Three to six cases a year | 8.5% | 18.9% |
| Seven to ten cases a year | 4.3% | 5.4% |
| More than ten cases a year | 8.5% | 2.7% |

| **2. Reasons in your community for support of AOT** | **Court** | **CMHSP** |
|---|---|---|
| It can help with difficult cases | 46.8% | 64.9% |
| If legal paperwork is filed and eligibility criteria met, the law should be followed | 42.6% | 21.6% |
| There are potential cost-savings compared to immediate hospitalization of a subject | 46.8% | 48.6% |
| For some cases, a lesser commitment standard than immediate danger is needed | 53.2% | 54.1% |
| Every additional tool available to connect people with needed treatment is welcome | 63.8% | 70.3% |
| Other | 21.3% | 16.2% |

| **3. Reasons in your community for not supporting AOT** | **Court** | **CMHSP** |
|---|---|---|
| We already had forced treatment in Michigan and shouldn't have added more coercion | 6.4% | 2.7% |
| The law is too complex to understand and operationalize | 38.3% | 37.8% |
| It does or could require expenditures beyond our community's means | 23.4% | 13.5% |
| Not enough interest in our community for the collaborative effort needed | 8.5% | 10.8% |
| Requires judges to make medical decisions, which they shouldn't be asked to do | 6.4% | 16.2% |
| Other | 34.0% | 56.8% |

| **4. AOT only considered if AOT petition filed?** | **Court** | **CMHSP** |
|---|---|---|
| Yes | 38.1% | 55.6% |
| No | 23.8% | 16.7% |

| | | |
|---|---|---|
| Unsure | 38.1% | 27.8% |

**5. AOT training**

| **Previously received training re. AOT?** | **Court** | **CMHSP** |
|---|---|---|
| Yes | 11.6% | 37.8% |
| No | 88.4% | 62.2% |

| **Could benefit from AOT training?** | **Court** | **CMHSP** |
|---|---|---|
| Yes | 55.6% | 81.8% |
| No | 44.4% | 18.2% |

**6. AOT Outcomes (asked only of CMH)**

| **Track Outcome Separately** | **CMHSP** |
|---|---|
| Yes | 9.1% |
| No | 90.9% |

| **Outcome Perceptions** | **CMHSP** |
|---|---|
| Positive | 17.1% |
| Negative | 2.9% |
| Mixed | 11.4% |
| Too difficult to track | 2.9% |
| Not applicable due to non-usage | 65.7% |

**7. Open-Ended Comment Concerns** (minimum four mentions)

*Compliance/enforcement – 17, all but one from CMHSPs

*Preference for alternative treatment orders - 11, all but one from CMHSPs

*Judges dislike AOT – 9, all from CMHSPs

*Duration/continuation of AOT orders – 4, split evenly between Courts and CMHSPs

*CMHSPs/mental health community don't understand the law – 4, all from Courts

*Prosecutor role/involvement in AOT cases – 4, all from Courts (under the 2005 AOT law, prosecutors are not required to be involved with AOT cases; the comments here were mixed, not predominantly focusing on that aspect of the law)

*Court opinions/perceptions don't matter; if a case is before a Judge, he or she has to deal with what the law says - 4, all from Courts