



**Office of
Mental Health**

**ENGAGEMENT OVER ENFORCEMENT: EFFECTIVE
ENGAGEMENT STRATEGIES FOR ACT PROVIDERS
SERVING INDIVIDUALS ON AOT**

SEPTEMBER 28, 2026

TRAINING PURPOSE

- **Understand AOT background, criteria, and roles and levels of oversight**
- **Engagement is the foundation of effective ACT services – even when treatment is mandated**
- **Understand and explore the unique engagement challenges created by AOT and learn practical strategies for building trust and collaboration**
- **Increase participation without relying on threats, pressure, or power struggles and identify ways to preserve dignity, autonomy, and choice within mandated treatment**

LEARNING OBJECTIVES

By the end of this training participants will be able to:

- **Understand AOT background, eligibility criteria and levels of oversight**
- **Describe how mandated treatment can affect engagement and recognize common responses to perceived coercion and perceived loss of control**
- **Apply engagement strategies appropriate for ACT/AOT recipients**
- **Use motivational interviewing principles when recipients are ambivalent or resistant**
- **Distinguish compliance from meaningful engagement**
- **Develop collaborative responses to disengagement and refusal**

AOT BACKGROUND

In January 1999, Kendra Webdale was pushed from a NYC subway platform to her death. She was pushed by a man living in the community who was not being treated for his serious mental illness.

Kendra's Law (Mental Hygiene Law 9.60) was signed in August 1999 and went into effect on November 8th, 1999.

KENDRA'S LAW PURPOSE

Kendra's Law has a dual purpose:

- 1. To assist individuals experiencing behavioral health challenges/stressors to live safely in the community, and**
- 2. To maintain safety in the community**

ELIGIBILITY CRITERIA

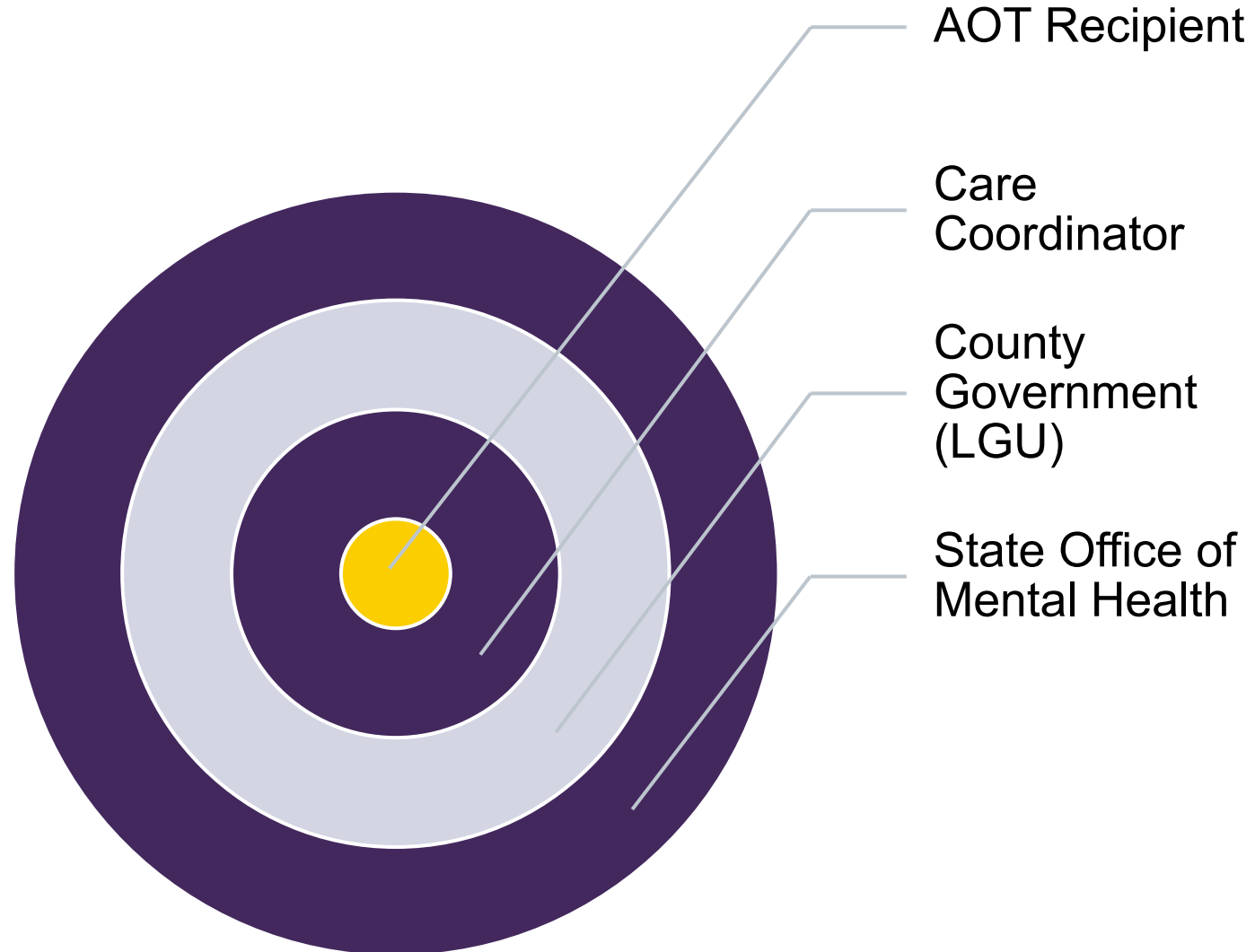
ELIGIBILITY CRITERIA

Eligibility criteria for AOT are based on all of the following factors and clinical determinations being met:

1. 18 years of age or older
2. Living with serious mental illness
3. Unlikely to live safely in the community without support/engagement
4. A lack of engagement with treatment for mental illness which has:
 - i. Been a significant factor in necessitating hospitalization or mental health treatment in a forensic setting at least twice within the last 36 months; OR
 - ii. Resulted in one or more acts of serious violence towards self or others, threats of violence, or attempts at serious harm to self or others within the last 48 months; OR
 - iii. Resulted in an AOT order that expired within the past 6 months and since the expiration of the order has experienced an increase in symptoms of mental illness that interferes with or limits their ability to comply or recommended treatment OR due to lack of compliance with treatment has undergone emergency observation, care and treatment or has been admitted for inpatient care or has been incarcerated
5. Unlikely to voluntarily participate in treatment
6. Court-ordered treatment is necessary to prevent relapse or deterioration
7. Likely to benefit. Previous non-compliance with court oversight or mandated treatment shall not preclude a finding that the person is likely to benefit from assisted outpatient treatment.

KEY ROLES AND LEVELS OF OVERSIGHT

CONCENTRIC CIRCLES OF OVERSIGHT



KEY ROLES AND RESPONSIBILITIES

Care Coordinator (Specialty MH Care Manager / ACT / IMT)

- Weekly contact with county AOT personnel – Observe/reviews and reports challenges/inconsistencies with court-ordered treatment plan and status of engagement
- Minimum weekly in-person contact with AOT recipient
- Support recipient in pursuit of all treatment/*recovery* plan goals (Not just AOT *treatment plan* Goals- Going back to school, opening bank account etc.)
- Assist in engagement with providers
- Statutory reporting requirements (CAIRS and Significant Event Reporting)

KEY ROLES AND RESPONSIBILITIES NYS MHL § 9.47 AND 9.48

County Director of Community Services (DCS) of the Local Government Unit (LGU)

- Accepts referrals of persons experiencing behavioral health challenges that MAY be in need of additional supports
- Conducts timely investigations on persons referred for AOT
- Files petitions for AOT when appropriate
- Coordinates timely delivery of services
- The Local Governing Unit (LGU) has a statutory role to govern the oversight of county and local not for profit service providers

KEY ROLES AND RESPONSIBILITIES NYS MHL § 7.17

OMH AOT Program Coordinator (Located at each field office)

- Oversees and monitors county AOT activities, including:
 - Timely completion of investigations
 - Timely provision of court-ordered services and to encourage creativity at the local level in service delivery
- Provides technical assistance to county AOT staff and programs (That is you! 😊)
- Receives statutorily required data points and requests follow up information when incidents/events occur
- Coordinates completion of AOT-related Performance Improvement Programs (PIP's) and reports outcomes and details to Central Office AOT staff

ENGAGEMENT CONSIDERATIONS

ACT + AOT: UNDERSTANDING THE CONTEXT

ACT Provides:

- Multidisciplinary, community-based services
- Frequent and flexible contact
- Outreach and services where recipients live and spend time
- Integrated treatment and rehabilitation

AOT Adds:

- A mandate to participate in specified treatment
- Court involvement and potential consequences for nonadherence
- A level of oversight from the Local Governing Unit (LGU)
- An inherent power differential between providers and recipients

How do we provide effective treatment when the recipient did not choose to enter treatment?

THE ENGAGEMENT PARADOX

- “You have to participate” can undermine intrinsic motivation
- Mandated treatment may create resistance, mistrust, or guardedness
- Recipients may participate behaviorally without being psychologically engaged
- Compliance ≠ Collaboration
- Engagement can develop **after** treatment begins.

You may not be able to offer a choice about whether treatment occurs, but you can maximize choice in **how** treatment occurs.

WHAT MIGHT BE BEHIND “RESISTANCE”

Instead of asking:

- “Why isn’t this recipient compliant?”

Consider:

- What is the recipient experiencing?
- What choices does the recipient feel they have lost?
- What previous experiences with treatment shape their response?
- Is the service being offered at the right time, place, and pace?
- Are we interpreting disagreement as noncompliance?

THE FIRST CONTACT

Goals of early engagement:

- Reduce perceived threat
- Establish predictability
- Demonstrate respect
- Learn what matters to the recipient
- Create shared goals
- Avoid turning the first interaction into an assessment checklist

Try:

- “I’d like to understand what you want your life to look like.”
- “Let’s figure out what would make working with our team less frustrating.”

ACKNOWLEDGE THE MANDATE

Avoid pretending the recipient 'voluntarily' chose treatment

Instead acknowledge it and create shared goals:

- “I know this isn’t something you asked for.”
- “The court has required treatment, and my job is to work with you not make your life harder.”
- “There are parts of the order we can’t change, but there are many things we can decide together.”
- “I’d rather hear from you directly than make assumptions about what you need.”

CHOICES WITHIN THE MANDATE

Instead of: *“You need to meet with the nurse.”*

Try: *“The nurse needs to check in with you. Would you rather meet today or tomorrow?”*

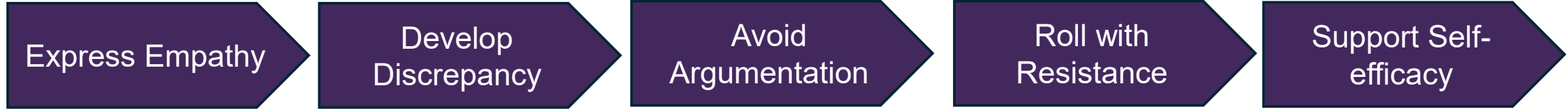
Other choices:

- Where to meet
- When to meet
- Identify a primary point of contact on the ACT team
- Goals to prioritize
- Communication method
- Who participates in meetings
- Which coping strategies to try
- Pace of skill development

Small choices can help restore a sense of agency.

MOTIVATIONAL INTERVIEWING

Key Principles



Motivational Interviewing is not a collection of tricks to make someone comply. It's a way of communicating that assumes:

- People have their own reasons for change
- Ambivalence is normal
- Arguments often increase resistance
- Collaboration is more effective than confrontation

RESPONDING TO RESISTANCE



“I don’t need treatment.
There’s nothing wrong with me.”

AVOID

“You obviously need treatment”

“AOT says you have to”

“Your history shows...”

TRY

“You don’t see treatment as necessary.”

“What makes you feel that way?”

“What has your experience with treatment been like?”

“What, if anything, would make treatment worth your time?”

ROLLING WITH RESISTANCE

Goal: Move from **argument** → **curiosity** → **collaboration**

Provider: *“You need to take your medication.”*

Recipient: *“I’m not taking it.”*

Provider: *“You’re not willing to take it right now. Tell me what concerns you most about it.”*

Explore:

- **Side effects**
- **Beliefs about medication**
- **Previous experiences**
- **Cultural factors**
- **Practical barriers**
- **Alternatives the recipients would consider (refer to Psychiatric Advance Directive if one exists)**
- **What the recipient hopes to accomplish**

REFELCTIVE LISTENING

SIMPLE REFLECTION

“You’re frustrated.”

DOUBLE- SIDED REFELCTION

“Part of you doesn’t think treatment is necessary, and another part really wants to avoid another hospitalization.”

COMPLEX REFELCTION

“It feels like decisions are being made about your life without you.”

VALIDATION WITHOUT AGREEMENT

Validation does not mean agreeing with everything a recipient says.

You can communicate:

- Understanding of distrust, anger, resistance to medication, disagreement with diagnosis

While still maintaining:

- Clinical responsibilities
- Safety responsibilities
- AOT requirements
- Professional boundaries

CULTURAL HUMILITY & ENGAGEMENT

Consider how engagement may be affected by:

- **Race and ethnicity**
- **Culture**
- **Language**
- **Religion/spirituality**
- **Gender and identity**
- **Family/community expectations**
- **Experiences with discrimination**
- **Experiences with police, hospitals, and/or other systems**

Ask rather than assume:

“How does your community understand what you’re experiencing?”

“What would respectful treatment look like to you?”

“Have there been experiences with providers that make it difficult to trust us?”

REFUSALS

PAUSE FIRST!

Ask yourself:

- What are they refusing?
- Why?
- Is there a safety issue?
- Is there a practical barrier?
- Is the refusal about the intervention or about feeling a lack of control?

Then consider:

- Negotiating
- Offering alternatives
- Change the timing
- Try another team member
- Revisit later

Don't turn every "no" into a battle or transport order

TRANSPORT ORDERS

9.60 Transport orders may occur when a physician determines that:

- An individual is not meeting the requirements of court-ordered treatment (AOT treatment plan), **and**
- Efforts were made to secure cooperation/compliance, **and**
- The individual may need involuntary admission to a hospital

Then:

- The County DCS may order the removal and transport of the individual to a hospital for examination to determine the need for civil commitment
- The examination is not to exceed 72 hours
- Removals should NOT be used punitively, but rather in a way to engage the recipient.
- This can be an opportunity for the county and treatment team and hospital to have a case conference to plan a creative intervention.
- Failure to comply with an AOT order is not grounds for involuntary civil commitment, a finding of contempt of court, or medication over objection.
- It is crucial to the continuity of care that information is shared when an individual has an interaction with a removal. Care Coordination can provide the hospital with a copy of the individual's AOT order and should also be considered the "hub" of communication between the hospital and the LGU where the person is/resides. Hospitals have up to 72 hours to hold a patient for observation to determine if they meet inpatient standards. It is during this time, ACT information can be vital.

STRENGTHS-BASED ENGAGEMENT

Don't let the treatment plan become a list of problems.

Explore:

- **What is the recipient good at?**
- **What has helped them survive?**
- **What relationships matter?**
- **What gives them purpose?**
- **What do they want more of?**
- **What have they already accomplished?**

Connect treatment to the recipient's goals not just the system's goals!

COMMON ENGAGEMENT MISTAKES

The Compliance Trap

- Focusing primarily on attendance, medication, and paperwork

The Expert Trap

- Assuming the provider knows best

The Court Trap

- Using the AOT order as the primary engagement tool

The Fix-It Trap

- Jumping into solutions before understanding the problem

The Power Struggle

- Trying to “win” the interaction

The Documentation Trap

- Documenting what the recipient did wrong rather than what the team tried

TEAM CONSISTENCY MATTERS

Recipients notice when:

- One staff member says something different from another
- Expectations change depending on who is working
- Information isn't shared
- Staff communicate primarily about “noncompliance”

ACT Teams should establish:

- Consistent messaging
- Clear roles
- Shared engagement strategies
- Consistent boundaries
- Regular team discussion of engagement challenges

THE ENGAGEMENT TOOLBOX

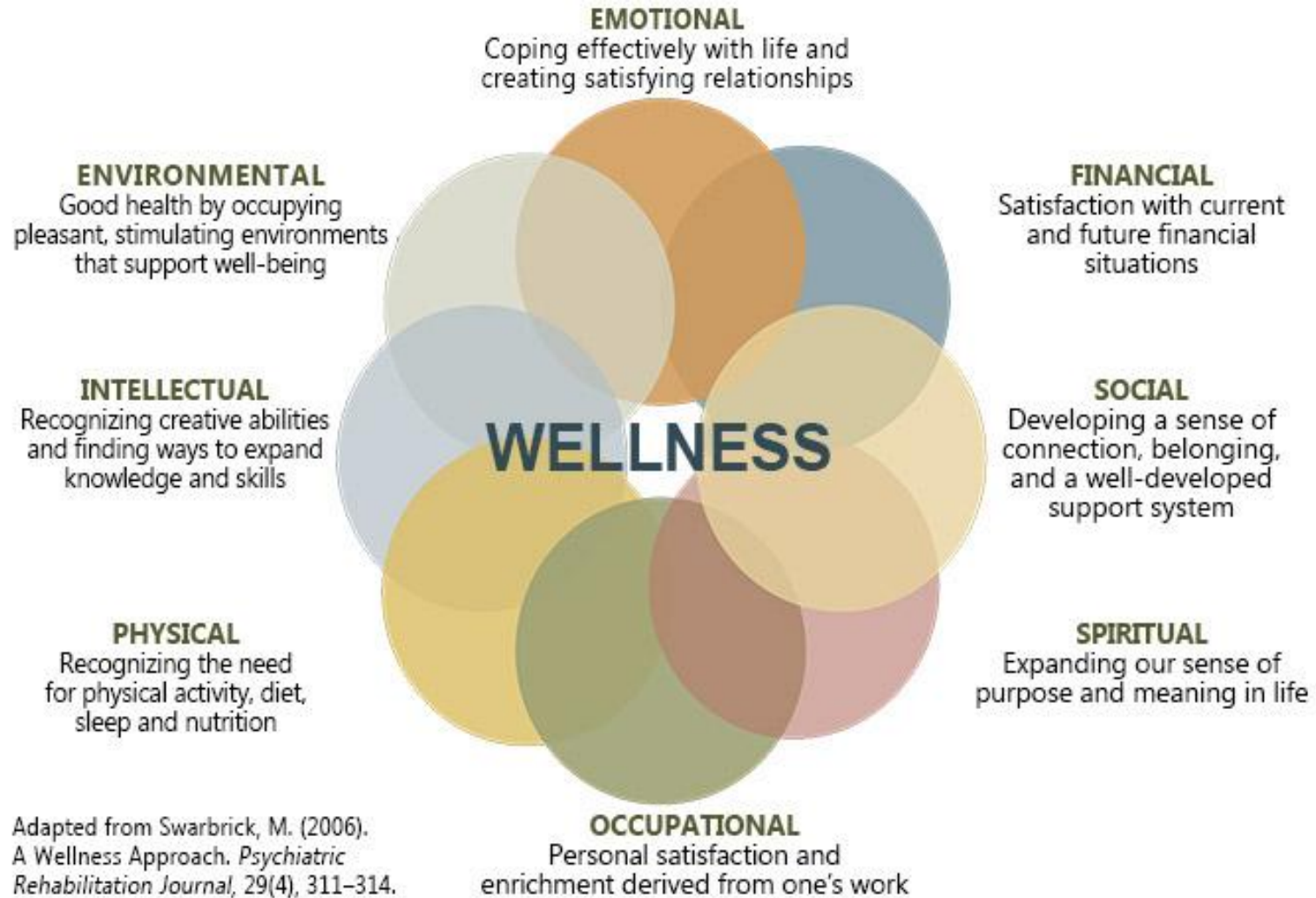
When stuck, try:

- **Reflect before responding**
- **Ask one more question**
- **Offer two choices**
- **Validate the emotion**
- **Acknowledge the mandate**
- **Ask what would make treatment more useful**
- **Connect treatment to their goals**
- **Reduce unnecessary demands**
- **Change the staff member, locations, or timing**
- **Come back later**
- **Keep the relationship intact**

FROM COMPLIANCE TO ENGAGEMENT

Compliance-focused	Engagement-focused
“Did they follow the order?”	“What is helping them participate?”
“They refused.”	“What led to the refusal?”
“They’re resistant.”	“What are they telling us?”
“They don’t have insight.”	“How do they understand their situation?”
“We need to make them...”	“How can we increase collaboration?”
“They missed an appointment.”	“What got in the way?”

SWARBRICK'S 8 DIMENSIONS OF WELLNESS



ENHANCED VOLUNTARY AGREEMENTS (EVAS)

ENHANCED VOLUNTARY AGREEMENTS (EVAS)

An Enhanced Voluntary Agreement, or EVA, is a collaborative agreement between the Director of Community Services (DCS) or their designee and an individual to establish a service plan that will support the individual's needs and their continued success in the community on a **voluntary** basis.

EVA's can be up to 12 months in duration and may be extended or terminated as the DCS/designee and individual agree.

EVA Service Plans:

- Must include care management at a minimum service level of HH+
 - ACT, Health Home Care Management, Intensive Mobile Treatment, or Non-Medicaid Care Management
- May included:
 - Clinic (MHOTRS)
 - Psychiatric Rehabilitation supports: PROS, CCBHC, or CORE
 - Non-clinical services: peer-led programming, housing, vocational/pre-vocational services
 - Medication management

ENHANCED VOLUNTARY AGREEMENTS (EVAS)

EVA Criteria:

18 years of age or older

Diagnosed with a serious mental illness

Unlikely to engage in traditional voluntary services

AND one of the following:

A lack of engagement with treatment for mental illness which has:

Been a significant factor in necessitating hospitalization or mental health treatment in a forensic setting at least twice within the last 36 months; or

Resulted in one or more acts of serious violence towards self or others, threats of violence, or attempts at serious harm to self or others within the last 48 months

OR

The individual is stepping down from an AOT order

OR

A DCS or designee may consider an EVA when the above criteria are not met, but the DCS or designee feels the individual would benefit from an EVA

ENHANCED VOLUNTARY AGREEMENTS (EVAS)

DCS or designee

- Develop Service Plan with individual
- Oversight of implementation and compliance with Service Plan
- Submit required data to OMH

Care Coordination

- Facilitate and monitor an integrated plan of care
- Use a person-centered and recovery-orientated approach
- Provide updates to the DCS or designee at least monthly
- Communicate across service providers and natural supports
- Notify DCS or designee when Significant Events (individual or other's safety is at risk due to the actions/behaviors of the EVA individual) occur

EVA vs AOT

	AOT	EVA
Legal Status	Court Mandated (Judge's Order)	Voluntary (Signed Agreement)
Process	Legal petition, hearings, testimony	Collaborative clinical planning
Duration	Up to 1 year (renewal by court)	Flexible (typically 6-12 months, renewable)
Non-compliance	Can trigger a 72-hour clinical evaluation	Triggers clinical outreach & plan review
Stigma	Can feel coercive or punitive	Empowers choice and self-advocacy

KEY TAKEAWAYS

- Mandated treatment does not mean adversarial treatment
- Engagement is built through repeated experiences of respect, consistency, and honesty
- Acknowledge the mandate
- Maximize choice wherever the order and clinical responsibilities allow
- Curiosity is more productive than confrontation
- Resistance can provide information
- The relationship itself is an intervention
- Our goal is not simply compliance. It is to help recipient becoming meaningfully engaged in their recovery.
- Engagement is not something we demand from recipients. It is something we build with them.

WHAT THE NUMBERS SAY ABOUT AOT

- Reduced Incarcerations by 73%
- Reduced Episodes of Homelessness by 66%
- Decreased frequency and duration of hospitalizations by 67%
- Greater engagement in services and use of prescribed medications
- Outcomes at the end of the order: Half leave AOT in a positive manner, and under 10% leave for reasons unrelated to mental health/behavioral health challenges

Source: AOT Website data (Fueled by CAIRS Data entered by AOT Care Coordination) September 2026

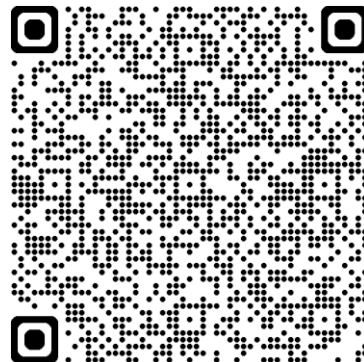
[Assisted Outpatient Treatment](#)

ADDITIONAL INFORMATION

To learn more about Kendra's Law, visit the OMH website:

<https://my.omh.ny.gov/bi/aot>

THANK YOU!





Office of Mental Health