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ASSISTED OUTPATIENT TREATMENT IN NEW YORK STATE

The Case for Making Kendra's Law Permanent

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Executive Summary

Assisted outpatient treatment (AOT) is a procedure by which seriously mentally ill individuals are placed under a court-ordered treatment plan while continuing to live in the community. New York State's version of AOT is known as "Kendra's Law," named in accordance with the 1999 legislation that first authorized it. Kendra Webdale, a New York City resident, was pushed to her death in front of a subway train in January 1999 by a man with untreated schizophrenia.

Kendra's Law was originally enacted on a trial basis. It has been temporarily reauthorized twice and is up for reauthorization again during the current legislative session. This report will explain what Kendra's Law is and the role that it plays within New York's mental-health-care system; survey the literature on its effectiveness; and present an argument as to why state government should make the law permanent.

- Kendra's Law is designed to address untreated serious mental illness. Though the seriously mentally ill compose only 4% of New York City's adult population, they make up 11% of its jailed inmates and 25% of its adult shelter client population.

- The program is intended to help seriously mentally ill individuals who are stable enough to live in the community but only under the supervision of mental-health officials. Supervision may be necessary due to a history of incarceration, violence, hospitalization, and/or noncompliance with treatment.

- In 2016, 4,207 individuals were placed under an AOT court order in New York State—2,076 of them in New York City. These figures represent roughly half the total number of inpatient psychiatric beds in the state and city. All told, 14,618 individuals have been placed in assisted outpatient treatment since 1999.

- Evaluations by state as well as independent researchers have validated the effectiveness of Kendra's Law by showing improved outcomes for those under court order. According to the most recent data from the state Office of Mental Health (OMH), AOT has reduced the rate of hospitalization among those under court order by more than 60%, and the rate of both incarceration and homelessness by around 70%. The OMH tracks more than 40 separate outcome indicators for AOT, and most of those indicators register improvement.

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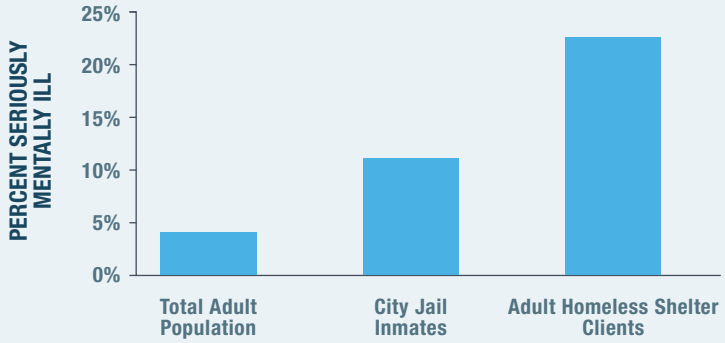
Introduction: What Is Assisted Outpatient Treatment?

Mental-illness policy reform has recently attracted increased interest from lawmakers in both parties and at all levels of government. One of the last major acts signed into law by the Obama administration was the 21st Century Cures Act.

This legislation contained several provisions aimed at refocusing the federal government's mental-health programs to serve the most severely mentally ill. One such provision allocated federal funds for state-run AOT programs. Through AOT, a judge can mandate adherence to treatment for a seriously mentally ill individual with a record of noncompliance with treatment provided on a purely voluntary basis. New York's "Kendra's Law," the nation's best-known AOT program, is designed to address the challenge of untreated serious mental illness in the state, where the serious mentally ill constitute a disproportionate share of New York City's jailed and homeless populations **(Figure 1)**.

FIGURE 1.

The Challenge of Untreated Serious Mental Illness in New York City



Source: NYC Dept. of Health and Mental Hygiene, "Serious Mental Illness Among New York City Adults," *NYC Vital Signs* 14, no. 2 (June 2015); Mayor's Office of Operations, "Mayor's Management Report," Sept. 2016, p. 82; U.S. Dept. of Housing and Urban Development, "HUD 2016 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations: NY-600 New York City CoC," Oct. 12, 2016.

About 40% of New York City residents with a serious mental illness did not receive any treatment for their condition in 2015.[1] According to a recent report by the New York Police Department's inspector general, patrol officers field more than 400 "mental crisis" calls per day, on average.[2] With a mentally ill population of more than 4,000 and a seriously mentally ill population of more than 1,000, Rikers Island is by far the largest psychiatric facility in New York State.[3] (No hospital run by the OMH has a budgeted capacity of larger than 370 beds.)[4] Because they use social-services, criminal-justice, and health programs at such high rates, seriously mentally ill individuals impose a heavy fiscal burden on state and local budgets. Psychiatric hospitals are particularly expensive: the OMH's average adult inpatient cost per person per day in FY16 was $869.

FIGURE 2.

Characteristics of Individuals Receiving Treatment Under Kendra's Law

	New York City	New York State
Percent incarcerated at some point prior to AOT	25%	28%
Percent hospitalized at some point prior to AOT	98%	97%
Percent with an episode of homelessness in their lifetime	28%	28%
Percent diagnosed with schizophrenia	77%	76%
Percent diagnosed with bipolar disorder	16%	17%

Source: New York State Office of Mental Health; data as of April 2017

AOT is meant for a specific subset of the mentally ill population. According to the official view of the American Psychiatric Association, one in four adults will experience a mental disorder at some point in their lives.[5] The vast majority of these individuals are facing challenges that do not affect their ability to live normal lives—and, to the extent that they need treatment at all, they will receive it in an outpatient setting. Serious mental illness—a thought or mood disorder different from substance abuse and developmental disability that is incapacitating if left untreated—affects roughly 4% of the adult population.[6] Though many of the seriously mentally ill can also meet their treatment needs through voluntary participation in outpatient services, this is not practical for everyone. Certain individuals often resist treatment because they do not recognize that they are ill, a condition known as "anosognosia," or "lack of insight." To prevent such individuals' illness from going untreated, some form of coercion must be applied, but this does not necessarily mean involuntary hospitalization.

As the name implies, assisted outpatient treatment provides mental-health services outside a hospital setting. "Assisted" denotes that these services are not delivered on a purely voluntary basis: participation is legally mandated by a court order issued by a judge. A seriously mentally ill individual who decides to forgo treatment based on a lack of recognition that he is, in fact, ill, cannot be seen to be deliberating and acting in a truly voluntary fashion. He must therefore be "assisted" into treatment.[7] AOT is also sometimes referred to as "involuntary outpatient commitment" or "outpatient civil commitment."

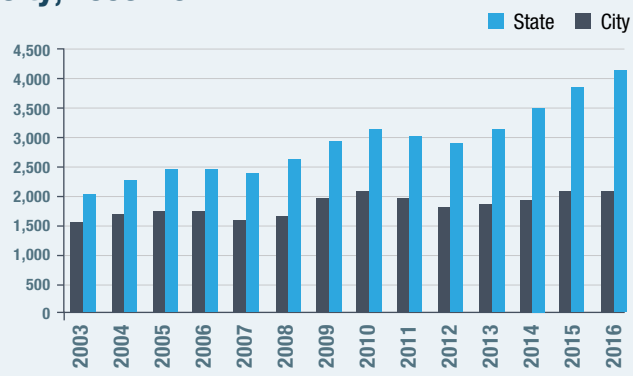
New York law sets strict guidelines for who can be considered for AOT. In addition to having been diagnosed with a mental illness, an individual must be 18 or older, be unlikely to live safely in the community without supervision (according to the judgment of the court and a psychiatrist), and must either have been incarcerated or hospitalized twice in the prior 36 months, or have committed, or threatened or attempted to commit, serious acts of violence to self or others, within the prior 48 months. These requirements are less strict than the standard for involuntary inpatient commitment. In New York State, someone must pose an imminent threat to self or others' safety in order to be committed to a hospital against his will. An AOT recipient, by contrast, may be viewed as posing a threat in the foreseeable future, based on a history of violence, but may also be judged not to be imminently dangerous.[8] Virtually all AOT recipients have had at least one psychiatric hospitalization prior to entering the program **(Figure 2)**. The most common diagnosis was schizophrenia, at 76% of all recipients; 17% had a bipolar diagnosis.

In 2016, 4,207 individuals were placed under an AOT court order in New York State, 2,076 of them in New York City **(Figure 3)**. Between 2003 and 2016, the city's share of total AOT recipients in the state declined from 76% to 49%, although the use of Kendra's Law, both inside and outside New York City, increased between 2013 and 2016. As part of his "NYC SAFE" initiative, which targets the intersection of violence and untreated mental illness, New York mayor Bill de Blasio has increased the number of New Yorkers in Kendra's Law by over 20%.[9] Since 1999, 14,618 individuals have been placed in Kendra's Law.[10]

Though all but four states have an AOT law,[11] nowhere is it used as often as in New York. As part of the law's

FIGURE 3.

Number of Unique Recipients under AOT Court Order, New York State and New York City, 2003-16



Source: New York State Office of Mental Health

FIGURE 4.

AOT Recipients Compared with Overall Mentally Ill Population, New York State and New York City

2015	All adults receiving public mental-health-care services	New York State	143,213
	Total unique AOT order recipients	New York State	3,931
2016	Seriously mentally ill individuals	New York State	865,000
	Total unique AOT order recipients	New York State	4,207
2015	All adults receiving public mental-health-care services	New York City region	71,247
	Total unique AOT order recipients	New York City	2,065
2012	Seriously mentally ill individuals (total)	New York City	239,000
	Total unique AOT order recipients	New York City	1,795

Source: New York City Department of Health and Mental Hygiene and New York State Office of Mental Health

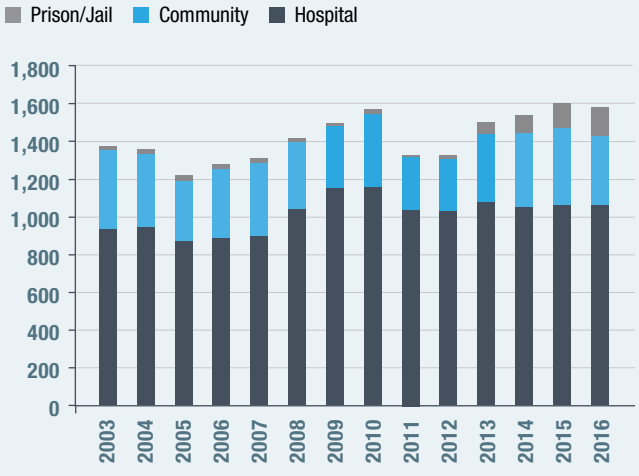
original design, state lawmakers required county mental-health authorities to set up local Kendra's Law programs. Crucially, to avoid imposing an unfunded mandate, state government provided local officials with resources to implement Kendra's Law.[12] The number of individuals under court order is particularly significant relative to the size of New York's inpatient mental-health-care system. AOT recipients represent roughly half the total number of adult psychiatric hospital beds in both the city (4,396 beds) and the state (8,678 beds).[13] Still, the total number of people under court order is small relative to the seriously mentally ill population, and those dependent on public mental-health-care services **(Figure 4)**. Even if use of Kendra's Law were doubled, as recommended by some advocates,[14] AOT would remain but one among several policy tools that the state must use in ensuring that the seriously mentally ill receive treatment.

In principle, many different parties can file an AOT petition—family members, roommates, social workers, and parole officers. However, about 70% of petitions are filed when a recipient is in the hospital **(Figure 5** and **Figure 6)**. AOT is not for people in a state of acute psychiatric crisis. Such individuals need to be stabilized at an inpatient facility.[15] Upon discharge, though, AOT can help these individuals maintain their stability in the community and prevent a readmission to a hospital. In this respect, AOT can be seen as a form of outpatient treatment in itself as well as a liaison between inpatient and outpatient forms of treatment.

For someone to be ordered into AOT, a judge must agree that the treatment program is likely to help and can, in fact, be implemented. Kendra's Law does not authorize forced medication. However, medication is frequently part of the court-mandated treatment program that could include counseling, participation in substance-abuse programs, and submitting to urine analysis and/or blood work. Kendra's Law always provides intensive case management to recipients. In the

FIGURE 5.

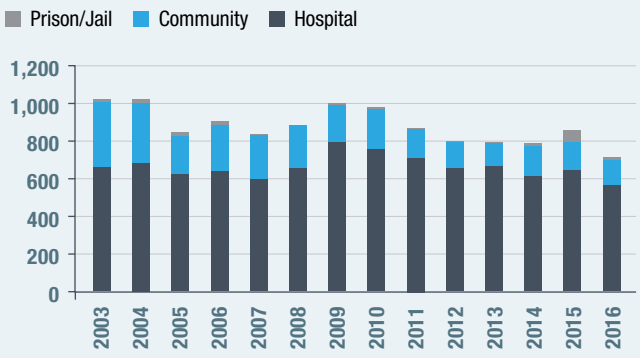
Origin of AOT Court Order Petitions, New York State, 2003–16



Source: New York State Office of Mental Health

FIGURE 6.

Origin of AOT Court Order Petitions, New York City, 2003–16



Source: New York State Office of Mental Health

FIGURE 7.

Select Outcomes of AOT Recipients in New York State and New York City, 1999–2017

	New York City	New York State	
Prior to AOT	98%	97%	Percent of AOT recipients **hospitalized** during their time in AOT compared with anytime in their lifetime prior to AOT
During AOT	38%	36%	
Percent Reduction	**61%**	**63%**	
Prior to AOT	25%	28%	Percent of AOT recipients **incarcerated** during their time in AOT compared with anytime in their lifetime prior to AOT
During AOT	8%	8%	
Percent Reduction	**68%**	**71%**	
Prior to AOT	28%	28%	Percent of AOT recipients who have been **homeless** during their time in AOT compared with anytime in their lifetime prior to AOT
During AOT	10%	9%	
Percent Reduction	**64%**	**68%**	
Prior to AOT	22%	28%	Percent of AOT recipients **receiving medication for a psychiatric condition** during their time in AOT compared with AOT
During AOT	84%	85%	
Percent Increase	**282%**	**204%**	

Source: New York State Office of Mental Health; "during AOT" data are as of the most recent follow-up.

event of noncompliance, a supervising psychiatrist can direct individuals in AOT to be picked up by law-enforcement authorities and taken to short-term detention at an acute psychiatric-care facility for evaluation for inpatient commitment. But the standards for admittance for long-term commitment under New York State law—dangerousness to self or others—are no different for someone in Kendra's Law from what they are for anyone else.

State law limits Kendra's Law court orders to one year, though they can be renewed and frequently are. Roughly half of all individuals in Kendra's Law since 1999 have remained in the program for over 18 months.[16] Studies of AOT have found that court orders need to last at least one year in order to be effective.[17]

Does It Work?

Several major studies have evaluated Kendra's Law's ability to improve outcomes for its participants and found positive results. The first study, by the state OMH, came out in 2005 and was required by the initial legislation. It found that AOT effected a reduction in recipients' rate of arrests and incarceration by 83% and 87%, respectively, a 77% decrease in hospitalization, and a 74% decline in homelessness. Adherence to medication roughly doubled, from 34% to 69%.[18]

State lawmakers commissioned another evaluation after temporarily reauthorizing Kendra's Law in 2005, this time by an independent group. This study came out in 2009 and was conducted by a research team led by leading AOT authorities Marvin Swartz and Jeffrey Swanson of Duke University.[19] They surveyed a large sample of Kendra's Law participants and their outcomes. AOT recipients were hospitalized at less than half the rate that they were during the six months prior to being put in Kendra's Law, and, for those who were hospitalized, the length of stay dropped from 18 days to 11, on average. Through qualitative research based on interviewing service providers, they also found evidence that Kendra's Law had a way of concentrating the mental-health-care system on AOT recipients and prioritizing their needs. While not a true randomized control trial, the 2009 study compared AOT recipients with a group that had entered treatment plans on a contractual basis. The researchers found that the former cohort experienced even stronger outcomes, thus providing support for what AOT proponents term a "black robe effect":[20] while all seriously mentally ill individuals benefit from increased services, the weight of the court order associated with Kendra's Law adds value.

A 2010 study by researchers affiliated with the Columbia Mailman School of Public Health found that 76 Kendra's Law participants were about four times less likely to commit acts of serious violence over a three-year period than a similar cohort who were not placed in the program.[21] A 2013 study by Swartz and Swanson and others found that, despite the ramp-up in government spending associated with Kendra's Law, it reduced spending on public services on recipients by more than 40%.[22]

The state OMH maintains a database that has tracked more than 40 separate outcomes of all court-ordered recipients from 1999 up through the present. They are organized into five categories: "Reduced Significant Events," "Increased Service Participation," "Increased

Engagement in Services and Adherence to Medication," "Improved Social and Community Functioning," "Improved Self Care," and "Reduced Incidence of Harmful Behavior." Most, if not all, of the indicators show that Kendra's Law participants have seen their condition improve after entering the program (see **Appendixes**). The share of recipients abusing alcohol dropped from 30% to 24% statewide, and the share of those involved in "any harmful behavior" dropped from 41% to 34%. Recipients experienced fewer difficulties in managing their medication and in "effectively handling conflict." They abused drugs less frequently and created fewer public disturbances. The four most important indicators—hospitalization, incarceration, homelessness, and receipt of medication—registered dramatic improvements for AOT participants **(Figure 7)**. While none of the outcome metrics indicates a return to perfect mental health, the OMH data as a whole present a compelling picture that Kendra's Law has fulfilled its goal of remediating untreated serious mental illness and its associated social ills.

Conclusion

It is hard to overstate the importance of Kendra's Law, as well as all the evidence supporting its effectiveness, to AOT's rise in status nationwide over recent years. The 21st Century Cures Act, which allocated federal funding for AOT, passed the U.S. Senate on a 94–5 vote, and the Helping Families in Mental Crisis Act, which formed the core of the sections dealing with mental illness, passed the House on a 422–2 vote.[23] Under President Obama, the Office of Justice Programs at the Department of Justice recognized AOT as an "effective" practice for reducing crime.[24] The American Psychiatric Association endorses AOT as a "useful tool to promote recovery."[25]

In light of the results, it would be appropriate for New York State lawmakers to formally abandon the original law's official premise that this program is simply an experiment. New York state senator Catharine Young (R., Cattaraugus County) has filed a bill to remove the sunset provision from Kendra's Law, instead of reauthorizing it on a temporary basis.[26] For three reasons, state government should make Kendra's Law permanent:

- ***History demonstrates the need for securing services and resources for the most seriously mentally ill individuals.*** The premise of the mental-illness policy reforms in the 21st Century Cures Act was that, despite spending over $100 billion a year on mental-health programs, the federal government has been insufficiently attentive to the needs of the seriously mentally ill. Going back to the beginning of the 20th century, psychiatrists and policymakers have always felt tempted to divert attention and resources away from the seriously mentally ill who are difficult to care for and, in some cases, never get better.[27] This risk has intensified in recent decades, as the number of "mental disorders" recognized by the medical community has increased with each new edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.[28] A strong AOT program, such as Kendra's Law, not only holds seriously mentally ill individuals accountable for participating in treatment; it holds the mental-health-care system accountable for providing it to them.[29] Resources for AOT, almost by definition, can only go toward seriously mentally ill individuals, who, because they are so challenging and costly to treat, frequently see their needs neglected by the mental-health-care system.[30]

- ***Treatment is the most promising form of prevention.*** Kendra's Law will always be associated with the risk of violence and disorder that comes from untreated serious mental illness. Some studies have found that AOT lowers the rate of arrest among participants, but the main goal is to increase the rate of treatment compliance. Our knowledge of the causes of serious mental illness is too vague to be of much use in preventing it and is likely to remain so for the foreseeable future. Thus, we should endeavor to treat it as aggressively and as early on as possible. AOT's ability to prevent a patient's deterioration is precisely what is shown by all the studies measuring how much it has reduced homelessness, hospitalizations, and arrests.

- ***Different seriously mentally ill subpopulations require different approaches.*** The American mental-health-care system is often criticized for being fragmented. But some fragmentation is inevitable, given the different forms and degrees of "mental illness" for which people need treatment. Prior to the 1960s, the U.S. government had one answer for treating serious mental illness: inpatient long-term care. The phasing out of that approach has forced the development of a range of outpatient services and programs reflecting seriously mentally ill individuals' varying abilities to live in the community. If there is one lesson that deinstitutionalization has taught, it is that we are going to need many different policy tools. AOT is intended for a niche population—stable enough to live in the community but needing supervision—a particularly challenging population in that it is ill-suited for either an involuntary-inpatient or voluntary-outpatient approach.

Many developments are under way in mental-illness policy in New York. But the competition for resources among different populations and services continues. It's important to note that the seriously mentally ill are in the most need of mental-health services, and the seriously mentally ill who are resistant to conventional outpatient treatment are the most needy of all. State officials can signal their commitment to these populations, as well as show their humility in acknowledging the complexity of this illness by making Kendra's Law permanent. Community services alone will never be sufficient.

Appendixes

APPENDIX A.

Outcomes of AOT Patients in New York City and New York State, 1999–2017: Increased Service Participation

	New York City	New York State	
Prior to AOT	16%	18%	Percent of AOT recipients receiving **care coordination services** during their time in AOT compared with prior to AOT
During AOT	100%	100%	
Percent Increase	**525%**	**456%**	
Prior to AOT	22%	28%	Percent of AOT recipients receiving **medication for a psychiatric condition** during their time in AOT compared with prior to AOT
During AOT	84%	85%	
Percent Increase	**282%**	**204%**	
Prior to AOT	9%	11%	Percent of AOT recipients receiving **housing and housing support services** during their time in AOT compared with prior to AOT
During AOT	36%	41%	
Percent Increase	**300%**	**273%**	
Prior to AOT	11%	12%	Percent of AOT recipients receiving **alcohol- or substance-abuse services** during their time in AOT compared with prior to AOT
During AOT	45%	43%	
Percent Increase	**309%**	**258%**	

Source: New York State Office of Mental Health; "during AOT" data are as of the most recent follow-up.

APPENDIX B.

Outcomes of AOT Recipients in New York State and City, 1999–2017: Increased Engagement in Services and Adherence to Medication and Improved Social and Community Functioning

	New York City	New York State	
At Onset of AOT	33%	33%	Percent of recipients who were **rated as having "excellent" or "good" service engagement** during their time in AOT compared with prior to AOT
During AOT	43%	44%	
Percent Increase	**30%**	**33%**	
At Onset of AOT	53%	54%	Percent of recipients who were **rated as "exactly" or "most of the time" adhering to medication** during their time in AOT compared with prior to AOT
During AOT	64%	66%	
Percent Increase	**21%**	**22%**	
Baseline	22%	25%	Percent of AOT recipients with **difficulties asking for help when needed** during their time in AOT compared with prior to AOT
During AOT	21%	22%	
Percent Reduction	**5%**	**12%**	
Baseline	13%	14%	Percent of AOT recipients with **difficulties communicating clearly** during their time in AOT compared with prior to AOT
During AOT	12%	13%	
Percent Reduction	**8%**	**7%**	
Baseline	42%	45%	Percent of AOT recipients with **difficulties effectively handling conflict** during their time in AOT compared with prior to AOT
During AOT	39%	40%	
Percent Reduction	**7%**	**11%**	
Baseline	27%	28%	Percent of AOT recipients with **difficulties engaging in social/family activities** during their time in AOT compared with prior to AOT
During AOT	25%	25%	
Percent Reduction	**7%**	**11%**	
Baseline	30%	33%	Percent of AOT recipients with **difficulties mantaining a support network** during their time in AOT compared with prior to AOT
During AOT	28%	29%	
Percent Reduction	**7%**	**12%**	
Baseline	39%	42%	Percent of AOT recipients with **difficulties managing assertiveness** during their time in AOT compared with prior to AOT
During AOT	36%	37%	
Percent Reduction	**8%**	**12%**	
Baseline	23%	23%	Percent of AOT recipients with **difficulties managing leisure time** during their time in AOT compared with prior to AOT
During AOT	21%	21%	
Percent Reduction	**9%**	**9%**	
Baseline	17%	18%	Percent of AOT recipients with **difficulties responding to social contact** during their time in AOT compared with prior to AOT
During AOT	16%	16%	
Percent Reduction	**6%**	**11%**	
Baseline	16%	18%	Percent of AOT recipients with **difficulties trusting at least one other person** during their time in AOT compared with prior to AOT
During AOT	14%	16%	
Percent Reduction	**13%**	**11%**	

Source: New York State Office of Mental Health; "during AOT" data are as of the most recent follow-up.

APPENDIX C.

Outcomes of AOT Recipients in New York State and City, 1999–2017: Improved Self-Care

	New York City	New York State	
Baseline	16%	17%	Percent of AOT recipients with **difficulties accessing community services** during their time in AOT compared with prior to AOT
During AOT	16%	17%	
Percent Reduction	**0%**	**0%**	
Baseline	8%	9%	Percent of AOT recipients with **difficulties accessing transportation** during their time in AOT compared with prior to AOT
During AOT	8%	8%	
Percent Reduction	**0%**	**11%**	
Baseline	6%	6%	Percent of AOT recipients with **difficulties avoiding dangers** during their time in AOT compared with prior to AOT
During AOT	6%	5%	
Percent Reduction	**0%**	**17%**	
Baseline	22%	24%	Percent of AOT recipients with **difficulties following through on health-care advice** during their time in AOT compared with prior to AOT
During AOT	22%	22%	
Percent Reduction	**0%**	**8%**	
Baseline	20%	24%	Percent of AOT recipients with **difficulties handling finances** during their time in AOT compared with prior to AOT
During AOT	21%	24%	
Percent Increase	**5%**	**0%**	
Baseline	8%	8%	Percent of AOT recipients with **difficulties maintaining adequate diet** during their time in AOT compared with prior to AOT
During AOT	9%	9%	
Percent Increase	**13%**	**13%**	
Baseline	6%	6%	Percent of AOT recipients with **difficulties maintaining adequate personal hygiene** during their time in AOT compared with prior to AOT
During AOT	6%	6%	
Percent Reduction	**0%**	**0%**	
Baseline	21%	22%	Percent of AOT recipients with **difficulties making and keeping appointments** during their time in AOT compared with prior to AOT
During AOT	20%	20%	
Percent Reduction	**5%**	**9%**	
Baseline	31%	33%	Percent of AOT recipients with **difficulties managing medications** during their time in AOT compared with prior to AOT
During AOT	27%	28%	
Percent Reduction	**13%**	**15%**	
Baseline	12%	11%	Percent of AOT recipients with **difficulties preparing meals** during their time in AOT compared with prior to AOT
During AOT	12%	11%	
Percent Reduction	**0%**	**8%**	
Baseline	12%	12%	Percent of AOT recipients with **difficulties shopping for food** during their time in AOT compared with prior to AOT
During AOT	12%	12%	
Percent Reduction	**0%**	**0%**	
Baseline	14%	14%	Percent of AOT recipients with **difficulties taking care of own living space** during their time in AOT compared with prior to AOT
During AOT	15%	15%	
Percent Increase	**7%**	**7%**	
Baseline	10%	10%	Percent of AOT recipients with **difficulties taking care of own possessions** during their time in AOT compared with prior to AOT
During AOT	10%	10%	
Percent Reduction	**0%**	**0%**	

Source: New York State Office of Mental Health; "during AOT" data are as of the most recent follow-up.

APPENDIX D.

Outcomes of AOT Recipients in New York State and City, 1999-2017: Reduced Incidence of Harmful Behavior

	New York City	New York State	
Baseline	36%	41%	Percent of AOT recipients with **one or more incidents of any harmful behavior reported** during their time in AOT compared with prior to AOT
During AOT	31%	34%	
Percent Reduction	**14%**	**17%**	
Baseline	27%	30%	Percent of AOT recipients with **one or more alcohol-abuse incidents reported** during their time in AOT compared with prior to AOT
During AOT	21%	24%	
Percent Reduction	**22%**	**20%**	
Baseline	29%	30%	Percent of AOT recipients with **one or more drug-abuse incidents reported** during their time in AOT compared with prior to AOT
During AOT	25%	25%	
Percent Reduction	**14%**	**17%**	
Baseline	11%	20%	Percent of AOT recipients with **one or more public disturbances reported** during their time in AOT compared with prior to AOT
During AOT	9%	10%	
Percent Reduction	**18%**	**50%**	
Baseline	5%	6%	Percent of AOT recipients with **one or more incidents of physically abusing/ assaulting others reported** during their time in AOT compared with prior to AOT
During AOT	6%	3%	
Percent Change	**20%**	**-50%**	
Baseline	4%	7%	Percent of AOT recipients with **one or more incidents of physically harming self/ attempting suicide reported** during their time in AOT compared with prior to AOT
During AOT	7%	3%	
Percent Change	**75%**	**-57%**	
Baseline	10%	2%	Percent of AOT recipients with **one or more incidents of being suspected of sexual abuse reported** during their time in AOT compared with prior to AOT
During AOT	9%	1%	
Percent Reduction	**10%**	**50%**	
Baseline	3%	5%	Percent of AOT recipients with **one or more incidents of taking property without permission reported** during their time in AOT compared with prior to AOT
During AOT	4%	3%	
Percent Change	**33%**	**-40%**	
Baseline	16%	20%	Percent of AOT recipients with **one or more incidents of threatened assault or physical violence reported** during their time in AOT compared with prior to AOT
During AOT	17%	10%	
Percent Change	**-6%**	**50%**	
Baseline	13%	25%	Percent of AOT recipients with **one or more incidents of verbally assaulting others reported** during their time in AOT compared with prior to AOT
During AOT	16%	14%	
Percent Change	**23%**	**-44%**	
Baseline	5%	7%	Percent of AOT recipients with **one or more incidents of wandering or running away reported** during their time in AOT compared with prior to AOT
During AOT	17%	5%	
Percent Change	**240%**	**-29%**	
Baseline	7%	9%	Percent of AOT recipients with **one or more incidents of damaging or destroying property reported** during their time in AOT compared with prior to AOT
During AOT	6%	5%	
Percent Reduction	**14%**	**44%**	
Baseline	0%	3%	Percent of AOT recipients with **one or more arsons reported** during their time in AOT compared with prior to AOT
During AOT	0%	2%	
Percent Reduction	**0%**	**33%**	
Baseline	11%	11%	Percent of AOT recipients with **one or more expressed suicide threats reported** during their time in AOT compared with prior to AOT
During AOT	7%	5%	
Percent Reduction	**36%**	**55%**	

Source: New York State Office of Mental Health; "during AOT" data are as of the most recent follow-up; "baseline" refers to during the 90 days prior to the onset of the court order.

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Abstract

Assisted outpatient treatment (AOT) is a procedure by which seriously mentally ill individuals are placed under a court-ordered treatment plan while continuing to live in the community. New York State's version of AOT is known as "Kendra's Law," named after Kendra Webdale, a New York City resident pushed to her death in front of a subway train in 1999 by a man with untreated schizophrenia.

Kendra's Law was enacted on a trial basis and has been temporarily reauthorized twice. It is up for reauthorization again during the current legislation session. Based on experience and extensive research, the state government should make the law permanent.

Key Findings

1. Kendra's Law helps seriously mentally ill individuals who are stable enough to live in the community but only under the supervision of mental-health officials. Supervision may be necessary due to a history of incarceration, violence, and/or hospitalization, or noncompliance with treatment. Though the seriously mentally ill compose only 4% of New York City's adult population, they make up 11% of its jailed inmates and 25% of its adult shelter client population.
2. In 2016, 4,207 individuals were placed under an AOT court order in New York State—2,076 of them in New York City. All told, 14,618 individuals have been placed in assisted outpatient treatment since 1999.
3. Evaluations by state as well as independent researchers have shown the effectiveness of AOT. According to the most recent data, in New York, AOT has reduced the rate of hospitalization among those under court order by more than 60%, the rate of incarceration and homelessness by around 70%. New York State's Office of Mental Health tracks more than 40 separate outcome indicators for AOT, and most of those indicators register improvement.
4. The Office of Justice Programs at the Department of Justice recognizes AOT as an "effective" practice for reducing crime. The American Psychiatric Association endorses AOT as a "useful tool to promote recovery."

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