Independent Evaluation of New York State Assisted Outpatient Treatment

Final Report

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Acknowledgments

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Table of Contents

Executive Summary

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Introduction

Assisted Outpatient Treatment (AOT) is a system of civil commitment that mandates mental health services for people who have been determined to be at risk of harming themselves or others. Understanding the impact of AOT is a priority for state and local policymakers and the communities they serve.

The New York State Office of Mental Health contracted Human Services Research Institute and the University of Pittsburgh School of Social Work to conduct an independent evaluation of AOT policy and outcomes. The purpose of the evaluation was to 1) Assess the implementation status and operations of AOT as it varies across localities in New York State; and 2) Understand the experiences of people under current and recent AOT court orders, their families and other supporters, and communities through analysis of qualitative and quantitative data.

Findings

The team conducted interviews with 46 people under AOT, 25 family members, and 173 others—including providers, members of the judicial system, and AOT administrators. The team triangulated this qualitative data with statewide administrative data and a survey of AOT administrators in Local Government Units throughout the state. Findings show that AOT operates as a complex system in which benefits and harms occur simultaneously but arise from different components of the experience. The clearest and most consistent result is that positive outcomes are driven by access to needed services—such as Assertive Community Treatment, housing support, case management, Health Home Plus, and transportation support—all of which are available voluntarily with comparable outcomes.

Qualitative findings highlight widespread concerns about coercion and lack of agency. People under AOT frequently describe compliance (such as medication adherence or participation in services) as driven by fear of consequences rather than agreement with treatment. Entry into AOT often occurs under conditions that limit meaningful choice, including hospital discharge or criminal-legal pressure, with little discussion of less restrictive alternatives. Across planning, legal representation, and hearings, participation of the person under AOT is typically limited: treatment plans are often predetermined, hearings are brief and rarely contested, and AOT orders are overwhelmingly approved. Administrative data confirm these patterns, with AOT order approval rates exceeding 95%. Participants across the system—including people under AOT, legal professionals, and psychiatrists—report that contesting is unlikely to succeed.

Renewal and enforcement processes further shape outcomes. Many people under AOT report not understanding how or why orders are extended and experience renewals as automatic, contributing to a sense of indefinite oversight. The threat of removal to a hospital—though rarely enacted—plays a central role in maintaining compliance. System-level findings also point to

inconsistencies in implementation, gaps in data systems, and disparities in experiences, including disproportionate impacts of enforcement practices on people of color.

Quantitative analysis results are summarized in the exhibit below. Results show statistically significant improvements in the key outcomes, both among people under an AOT order and among a socio-demographically and clinically similar group of people who are voluntarily engaged in Assertive Community Treatment (ACT). Results of outcome comparisons between these two cohorts indicate that the AOT cohort had significantly better outcomes in four of the 10 outcomes, the voluntary ACT cohort had significantly better outcomes in two of the outcomes, and no significant cohort difference was detected in four of the outcomes. The positive outcomes of the voluntary comparison group, combined with the qualitative finding that voluntary intensive treatment options were not always clearly communicated to individuals determined to be AOT-eligible suggests that there is room for reduction in mandated treatment without a negative impact on desired outcomes.

Exhibit 1. *Summary of Outcome Analysis Results and Outcome Comparisons Between AOT Recipients and Voluntary ACT Participants*

Outcome Measure	AOT Pre-Post Change	Voluntary ACT Pre-Post Change	Cohort Comparison
Life Skills Associated with the Ability to Live Without Support (sometimes referred to as "functionality")	Significant Improvement	Significant Improvement	No Significant Difference
Housing Status	Significant Improvement	Significant Improvement	AOT Significantly Better
Employment Status	Significant Improvement	Significant Improvement	No Significant Difference
Risk of Harm to Others	Significant Improvement	Significant Improvement	AOT Significantly Better
At Least One MH Hospitalization	Significant Improvement	Significant Improvement	AOT Significantly Better
Number of MH Hospitalizations Among Those with at Least One MH Hospitalization	No Significant Change	Significant Improvement	No Significant Difference
Number of MH Inpatient Nights Among Those with at Least One MH Hospitalization	Significant Improvement	Significant Improvement	AOT Significantly Better
Average Number of Inpatient Nights per MH Hospitalization	Significant Improvement	Significant Improvement	No Significant Difference
At Least One Arrest	Significant Improvement	Significant Improvement	Voluntary ACT Significantly Better
Number of Arrests Among Those with at Least One Arrest	Significant Improvement	Significant Improvement	Voluntary ACT Significantly Better

Notes. MH = Mental Health. *Risk of Harm to Others* is a composite measure calculated as exhibiting at least one of the following five behaviors: property damage, public disturbance, verbal assault, physical violence, and child abuse/assault.

Quantitative results also suggest that outcomes could be improved by increasing access to psychosocial rehabilitation and Health Home Plus services to AOT clients and by routinizing outpatient follow up visits at least within a month after emergency department visits and hospital discharges.

On the whole, these findings suggest that efforts to encourage utilization of voluntary services and better inform people meeting AOT eligibility criteria about voluntary options will likely divert a substantial number from court-mandated treatment**.** The evidence suggests that AOT's primary positive impact lies in facilitating access to services, but that AOT's legal and procedural framework is associated with persistent concerns about fairness, voice, and agency across all phases of implementation. Our findings suggest that enhancing voluntary service pathways could produce similar outcomes without the attendant harms. In addition to strengthening the voluntary service infrastructure, improving procedural protections will minimize harms.

These findings should be interpreted in light of some methodological limitations:

- The size of the interview sample was limited by the time and resources available for the evaluation. Although an effort was made to interview a geographically diverse group of individuals with varied positions within the AOT system, the numbers we interviewed may not fully reflect the variability in implementation and diversity of experiences of people under AOT orders across the state. Participation of attorneys from Mental Health Legal Services was especially constrained by department- and attorney-level decisions.

- The quantitative data used for the evaluation come from administrative records not designed for research purposes. Linking records from multiple administrative sources into a single analysis dataset that contained all the information for an individual had its challenges. Some assumptions were necessary about individuals' identities, race/ethnicity affiliations, and event dates, which may have introduced some "noise" into the quantitative analysis. However, careful data validation indicated that the prevalence of linkage errors did not vary systematically with respect to characteristics and group membership. In other words, the potential error was evenly distributed across the analysis sample, and posed little systematic threat to the validity of our inferences.

Recommendations

The recommendations are organized into three tiers based on level of effort and system change. The Tiers and recommendations are explained in more detail in the section labeled "Discussion and Recommendations."

Tier 1

- **Expand voluntary pathways to services:** Strengthen and prioritize voluntary services (including Enhanced Voluntary Agreements), ensure access is not tied to AOT status, and support continuity of care.
- **Improve transparency and understanding:** Provide clear, plain-language, multilingual information about AOT rights, processes, and expectations at key points.
- **Ensure informed participation:** Require verification that people understand their rights, options, and how AOT works.
- **Strengthen access to information:** Guarantee timely access to records and a clear statement of rights, including how to challenge or modify an order.
- **Expand independent advocacy:** Provide ongoing, accessible self-advocacy support for people under AOT, separate from other services.
- **Support families and chosen supports:** Offer parallel education and guidance to families to help them navigate the process.
- **Standardize removal practices:** Clarify when removals should occur, reduce variability, and address racial disparities through guidance and training.
- **Focus on person-centered planning:** Require meaningful input from people in the development of their treatment plans, including goals in their own words, with regular review and flexibility.
- **Improve data and accountability:** Strengthen monitoring systems, incorporate service quality and lived experience data, and increase transparency.
- **Advance equity oversight:** Establish an equity monitoring framework and a review body to track disparities and drive corrective action.

Tier 2

- **Strengthen court practice and consistency:** Establish a community of practice for judges and court staff to share best practices, review data, and address bias and disparities in AOT adjudication.
- **Pilot enhanced judicial engagement:** Test an “active court” model with more direct interaction, status hearings, and evaluation of impacts on outcomes and perceived coercion.
- **Improve respondent engagement in court:** Expand communication supports, allow more time for participation, use trauma-informed approaches, and clarify decision-making capacity.
- **Enhance quality of legal representation:** Standardize attorney-client communication practices to ensure individuals understand their rights and can meaningfully participate.
- **Reduce reliance on coercive removals:** Expand nonpolice removal options, pilot specialized teams, and promote de-escalation and equity-focused training for law enforcement.
- **Improve dignity in enforcement practices:** Study and reduce the use of restraints (e.g., handcuffs) and address variation and disparities in removal practices.

- **Increase frequency and flexibility of plan review:** Require regular (e.g., quarterly) plan reviews and allow people under AOT to request changes as needs evolve.
- **Increase transparency through expanded data reporting:** Publicly report detailed data on court processes, outcomes, representation, removals, service access, and clinical practices.
- **Strengthen accountability through independent oversight:** Conduct regular audits of hearings, legal representation, service quality, and compliance with statutory requirements.

Tier 3

- **Strengthen decision-making capacity protections:** Require independent pre-hearing capacity assessments and ensure additional safeguards for people who cannot make informed decisions.
- **Reinforce least restrictive standards in law:** Codify and enforce the requirement that voluntary alternatives are tried first and that clear evidence shows court-ordered treatment is necessary.
- **Tighten eligibility and evidentiary standards:** Define clearer criteria for risk, benefit, and treatment need, and require strong, evidence-based justification linking nonadherence to harm.
- **Limit duration and prevent coercive initiation:** Default to shorter, time-limited orders, prohibit discharge conditioned on AOT acceptance, and require meaningful, informed consent to waive hearings.
- **Guarantee independent clinical evaluation:** Provide access to state-funded, independent evaluations with equal weight in court proceedings.
- **Strengthen legal representation:** Establish enforceable standards, reduce caseloads, require thorough respondent engagement, and ensure representation reflects the person's preferences.
- **Enhance court procedures and judicial oversight:** Set minimum hearing standards, expand judicial inquiry, improve training, and consider specialized courts to ensure fair, consistent decision-making.
- **Reform enforcement and renewal practices:** Limit involuntary transport to true emergencies, require hearings for noncompliance, and create a presumption against renewal when individuals are stable.
- **Increase accountability and oversight:** Establish independent ombuds and oversight bodies with authority to investigate complaints, review cases, and report on system performance.
- **Invest in long-term evaluation:** Require independent, longitudinal research to assess outcomes, equity impacts, quality of life, and the effectiveness of AOT compared to voluntary alternatives.

Conclusion

New York's AOT law was intended to provide a less restrictive alternative to hospitalization. Quantitative results showed significant improvements in all key outcomes for people under AOT as well as people participating voluntarily in intensive services, although the magnitude of these improvements differed between groups (see Exhibit 1). However, the overall findings of this evaluation also revealed implementation challenges and shortfalls in protecting clients' rights. The recommendations offer a phased roadmap to strengthen protection of civil rights, improve care quality, increase accountability, and expand access to voluntary intensive services—ensuring that court involvement is used only when truly necessary and that mandated treatment supports both well-being and autonomy.

Background

Assisted Outpatient Treatment (AOT) is a system of civil commitment that mandates mental health services for people who have been determined to be at risk of harming themselves or others. Understanding the impact of AOT is a priority for state and local policymakers and the communities they serve. The New York State Office of Mental Health (OMH) has a statutory obligation to evaluate the AOT Program and display the results in the public domain on an ongoing basis, and to periodically report evaluation results to the New York State Legislature. In 2003, OMH published an interim report that reviewed the implementation and preliminary outcomes of AOT recipients (New York State Office of Mental Health, 2003), followed by a final report in 2005 (New York State Office of Mental Health, 2005). The first independent evaluation of the program was conducted in 2009 by a team from Duke University (Swartz et al., 2009). That study focused on recipients' service engagement, outcomes, and perceptions of AOT, as well as AOT's impact on the public health system and regional variations in its implementation. During the 2022 legislative session, OMH committed to commissioning a second independent evaluation of the program. In 2024, OMH contracted Human Services Research Institute (HSRI), which partnered with the University of Pittsburgh School of Social Work, to conduct an independent evaluation of AOT policy and outcomes and produce a legislative report describing the findings of the evaluation.

Evaluation Approach

The purpose of the evaluation was to 1) Assess the implementation status and operations of AOT as it varies across localities in New York State; and 2) Understand the experiences of people under current and recent AOT court orders, their families and other supporters, and communities through mixed methods data analysis. Evaluators employed strategies to understand AOT in the context of the current mental health system and to explore variations in implementation and outcomes across regions and population groups. The approach acknowledged and accounted for the complexities of both the legal and clinical components of AOT and the combined goals of maintaining public safety and providing individual-level treatment and social services.

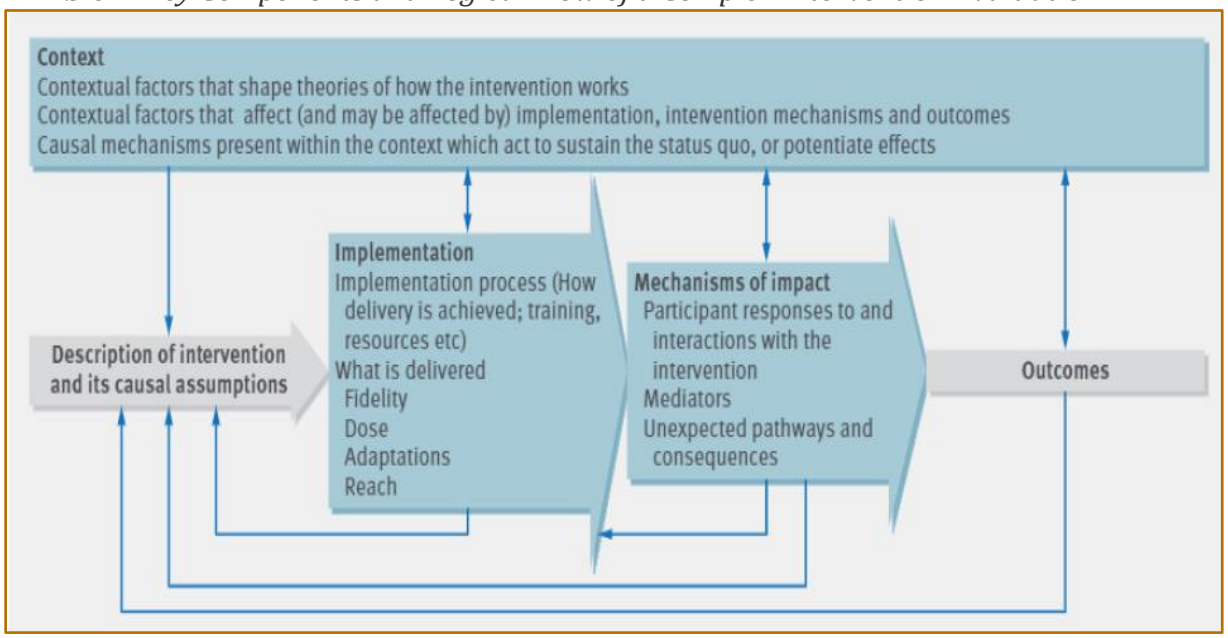
Assisted Outpatient Treatment as a Complex Intervention

The multi-system and multi-level nature of AOT qualify it as a complex intervention, defined as "interventions that comprise multiple interacting components" operating at "multiple organizational levels" (Moore et al., 2015). Given the involvement of multiple organizations with their own regulations and policies, complex interventions typically permit a level of flexibility in intervention delivery, a feature that resonates with the flexibility in AOT implementation that allows New York State's Local Governmental Units (LGUs) to use some discretion in line with their service systems and the populations they serve.

The study team structured the evaluation approach using the U.K.'s Medical Research Council (MRC) framework for complex intervention evaluations (Skivington et al., 2021). The framework aims to address complex questions for multilevel and multisector evaluations. Considerations include: effects of the implementation context, intended and unintended impacts, and the societal/organizational levels where impacts occur. The wide reach of complex interventions and their multilevel impact are best addressed through a mix of quantitative and qualitative methods (Booth et al., 2019).

Exhibit 1 shows the key elements and overarching logical flow of the complex intervention evaluation framework. Notably, implementation and its context and mechanisms of impact carry more weight than outcomes, since it is not possible to assess outcomes without a thorough understanding of the implementation context.

Exhibit 1. *Key Components and Logical Flow of a Complex Intervention Evaluation*



Source: Moore et al., 2015.

The matrix presented in Exhibit 2 summarizes the links between the design of this evaluation and MRC's conceptual framework developed for evaluating complex interventions (Craig et al., 2008). Further detail on data structures and measures of this evaluation are provided in "Methodology and Approach."

Exhibit 2. *Summary of Linkages Between the NY AOT Evaluation Design and the Complex Intervention Evaluation Conceptual Framework*

Dimension of Complexity in the Conceptual Framework	Implication for Design of the NY AOT Evaluation
Number of interacting components	Thorough understanding of the statutes and the modes of interaction and coordination among the state and local agencies involved in AOT implementation.
Variety of behaviors and roles required to deliver the intervention	Process evaluation to understand the roles and competencies required to deliver AOT across a wide range of professions and roles: providers, judges, lawyers, care coordinators, county Directors of Community Services (DCS) staff, law enforcement, hospitals, and more.
Variety of groups and societal levels impacted	Variability in outcomes will be related to factors at multiple levels, and they must be assessed at multiple levels with stratification and large sample sizes. AOT impacts the person under the AOT order, their families/supporters, and the community at large. Different population groups likely have different experiences and outcomes.
Number and variability of outcomes	Multiple outcomes measures must be examined within the clinical, socioeconomic, criminal/legal, and self-management domains. Many of the most critical outcomes are not present in available quantitative data, so combining qualitative and quantitative data is essential.
Degree of flexibility permitted in implementation delivery	It is critical to have a thorough understanding of the variability across LGUs in AOT implementation and their correlates (county characteristics). Some variation will be expected to improve outcomes within local contexts.

Current Evidence Base for AOT

AOT, also termed involuntary outpatient commitment (IOC) in the U.S. and community treatment orders (CTO) in much of the international literature, is a civil legal mechanism that authorizes a court to mandate outpatient mental health treatment. Eligibility for AOT typically requires evidence of a mental disorder; a documented history of treatment nonadherence leading to repeated psychiatric hospitalization or physical harm to self or others; and a clinical determination that the individual is unlikely to live safely in the community without supervision (Assisted Outpatient Treatment (AOT), 2026). Additionally, many statutes, including in New York City, require a determination that AOT is the least restrictive treatment available (Assisted Outpatient Treatment (AOT), 2026). AOT is currently authorized in 48 U.S. states, with implementation expanding markedly in recent decades (AOT Programs by State, 2026). However, AOT implementation varies substantially across jurisdictions with respect to eligibility

criteria, enforcement provisions, service intensity, and rate of use (Van Dorn et al., 2024). Despite growing implementation, the evidence base for AOT's effectiveness remains limited and inconclusive. The following review synthesizes what the evidence does and does not show regarding AOT's effectiveness and identifies gaps for contemporary U.S. AOT research. More detail on results from the current literature can be found in Appendix F.

Quantitative Evidence

The quantitative evidence base on AOT/CTO is largely characterized by three randomized controlled trials and a growing body of controlled and noncontrolled studies of mixed methodological quality. The three RCTs are the Bellevue Hospital pilot in New York City (Steadman et al., 2001; n=142), the Duke/North Carolina trial (Swartz, Swanson, and colleagues, 1999–2003; n=264 randomized, with a non-randomized cohort of 67 with violence histories), and the Oxford Community Treatment Order Evaluation Trial (OCTET) in the U.K. (Burns et al., 2013; n = 336). All three pre-specified intention-to-treat (ITT) analyses comparing court-ordered to non-court-ordered conditions failed to demonstrate statistically significant effects on many primary outcomes, including readmission, bed-days, arrest, medication adherence, or quality of life (Burns et al., 2013; Hiday et al., 2002; Steadman et al., 2001; Swanson et al., 2000; Swanson et al., 2001; Swanson et al., 2003; M. Swartz et al., 1999; M. S. Swartz et al., 2002; M. S. Swartz, Swanson, Hiday, et al., 2001; M. S. Swartz, Swanson, Wagner, et al., 2001). Bellevue found no group differences on rehospitalization or arrest over 11 months, although interpretability was limited by the non-implementation of pickup-order procedures and the a priori exclusion of participants with violence histories (Steadman et al., 2001). OCTET demonstrated that for CTO participants, despite spending substantially more time under compulsion than controls (median 183 vs. 8 days), there was no difference in readmissions between the two groups at 12 or 36 months (Burns et al., 2013, 2015). A notable exception within the ITT data across all three trials is the Duke study finding that criminal victimization was significantly reduced among OPC recipients, an effect that mediation analyses attributed indirectly to reduced violence, substance use, and improved adherence (Hiday et al., 2002). Additionally, in the Duke study, perceived coercion was significantly higher among OPC recipients in ITT analysis (M. S. Swartz et al., 2002).

Beyond the ITT analyses, the North Carolina trial generated a series of post-hoc, non-randomized comparisons of sustained OPC (≥180 days) plus intensive outpatient services (≥3 contacts/month) versus brief or no OPC. In these sub-analyses, sustained OPC combined with regular services was associated with substantially reduced admissions and bed-days, lower violence, fewer arrests among dual-system recidivists (prior hospitalizations and arrests), and less victimization (M. S. Swartz, Swanson, Hiday, et al., 2001). Other analyses additionally demonstrated higher predicted probability of above-median quality of life with extended OPC (>180 days) (Swanson et al., 2003). Effects were strongest among individuals with psychotic disorders compared to those with affective disorders (M. S. Swartz, Swanson, Hiday, et al.,

2001). However, these findings are not randomized comparisons: OPC duration and service intensity were not experimentally assigned. The 2017 Cochrane review pooled the three RCTs (n=749) and found no significant effects on hospitalization, bed-days, adherence, social functioning, quality of life, homelessness, arrest, or perceived coercion in the pooled analysis (S. R. Kisely et al., 2017). Here, victimization was found to be the only significant favorable outcome (S. R. Kisely et al., 2017).

In the intervening decades, a range of subsequent studies, both controlled and non-controlled/pre-post studies, have examined the effects of AOT. The Barnett et al. (2018) meta-analysis commissioned for the U.K. Independent Review of the Mental Health Act demonstrated that uncontrolled before-and-after (UBA) designs consistently show large favorable effects, whereas contemporaneous controlled designs show null effects on readmission and bed-days, with modest favorable effects only for outpatient service use, and non-significant effects on adherence (Barnett et al., 2018). Subsequent Australasian-focused meta-analyses (S. Kisely et al., 2021, 2023) reproduced this pattern within a large patient sample, though additionally demonstrated a consistent mortality benefit in controlled studies and an inverse relationship between jurisdictional CTO use rates and observed benefit. More specifically, these studies found that high-volume jurisdictions (>100 AOT orders per 100,000 population) demonstrated fewer reductions in readmission and bed-days than low-volume jurisdictions (<40 per 100,000), suggesting that appropriate targeting of those most likely to benefit from AOT may be more effective (S. Kisely et al., 2023).

Lam et al.'s systematic review and meta-analysis demonstrated similar findings: several pre-post UBA studies showed improved outcomes with respect to service contacts, emergency department (ED) visits, and violence in U.K., Spain, Australia, Canada, and U.S.-based data (Lam et al., 2023). However, higher quality controlled studies demonstrated non-significant findings (Lam et al., 2023). Kisely, Bull, and Gill's (2025) systematic review and meta-analysis found no significant effect on aggression or criminal behavior in pooled RCT and observational data, with effect sizes declining as study designs improved (S. Kisely et al., 2025). The 2024 Kisely et al. umbrella review of 17 papers from 14 systematic reviews concluded that benefits remain inconclusive, with most positive findings rated Class III (suggestive) evidence, and called for better targeting and more extensive research on potentials harms of AOT (S. Kisely et al., 2024). Cossu et al. similarly found insufficient evidence that adherence gains persist beyond the order period, with only two of six included studies showing post-CTO improvement (Cossu et al., 2024). In contrast to these studies, Segal's international review (2020) argues that RCT implementation flaws and disaggregated analyses support a more favorable interpretation regarding mortality benefits, victimization, adherence, and additionally indicate the possibility of improved access to physical health care while under AOT orders. Segal has likewise commented that the RCT findings may be inaccurate due to the inadequate randomization and implementation of the RCT (Segal, 2020).

Qualitative Evidence

The qualitative literature is characterized by a smaller set of reviews of international primary research, with minimal qualitative research in North America. Corring et al. completed a series of four systematic reviews (2017; 2018a; 2018b; 2019), which examined the perspectives of patients, clinicians, and family members before integrating all three stakeholder perspectives in a 2019 tri-stakeholder synthesis. The 2017 patient-perspective review identified 10 cross-cutting themes, of which three were particularly prominent: feelings of coercion and control, medication compliance perceived as the central focus of the order, and the conceptualization of CTO as a "safety net" against relapse (Corring et al., 2017). Clinicians endorse the benefits while struggling with the coercive mechanism, believe medication compliance is the central operative element, and acknowledge that implementation, monitoring, and administration could be improved (Corring, O'Reilly, et al., 2018). Families generally view benefits of CTO as outweighing disadvantages and report increased involvement in their family member's care while expressing dissatisfaction with the administrative aspects of the CTO process (Corring, O'Reilly, et al., 2018). The quality of the therapeutic relationship and the presence of procedural justice consistently emerge as moderators of how the experience is appraised (Corring et al., 2019). The 2019 tri-perspective synthesis cautioned that more settled and cooperative clients may be over-represented in primary qualitative samples, biasing findings toward more favorable patient appraisals, and noted that dissatisfaction with the CTO process is more pronounced among clients and families than among clinicians (Corring et al., 2019).

Plahouras et al. thematically analyzed 18 qualitative studies limited to patients with schizophrenia or schizoaffective disorder across 10 countries (predominantly the U.K., New Zealand, Sweden, and Australia) and organized findings into positive and negative experience categories. Patients reported satisfaction when their autonomy was respected and dissatisfaction when it was not. Patients additionally reported the retrospective recognition that mandated treatment had been beneficial, and identified communication deficits and inadequate information about their rights and the order itself as central negative aspects of the experience (Plahouras et al., 2020). Goulet et al. (2020) produced a meta-synthesis of 44 mixed methods and qualitative studies of involuntary treatment orders across multiple stakeholder groups and proposed an exploratory conceptual model organized around seven themes: orders as leverage to manage compliance and risk; legal concerns including questions about due process; "learning to play the game" as a strategy of pragmatic accommodation in which clients perform compliance to expedite discharge from compulsion; building a therapeutic relationship within a coercive context; positive and negative impacts of orders; family involvement; and discharge from compulsion (Goulet et al., 2020). Francombe Pridham et al. (2016) combined eight qualitative and seven quantitative studies of perceived coercion in CTOs, and found that patients on CTOs largely reported more coercion than voluntary patients (Pridham et al., 2016). These demonstrated substantial inter-study variation, though indicated a consistent inverse relationship between procedural justice and perceived coercion. This procedural-justice finding has been

reproduced across the broader literature, and is identified as a consistent moderator of patient experience across stakeholder reviews. The authors also flagged construct-validity uncertainty around applying the MacArthur AES to outpatient compulsion, noting that the instrument was designed for inpatient admission contexts and has not been independently re-validated for community use (Pridham et al., 2016).

Two other recent integrative reviews—de Waardt et al. (2022) and Khalil, Maude, and Ross (2025)—reaffirm many of the same qualitative themes. de Waardt et al. found that relatives and clinicians generally support CTO systems while patients express more hesitancy, although patients generally preferred mandated outpatient care to inpatient admission. All three groups expressed ambivalence; accessibility of care and a means to remain in contact during deterioration emerged as advantages, while restriction of autonomy, stigma, and a narrow focus on medication compliance were reported disadvantages with no clear differences between stakeholders with and without direct CTO experience (de Waardt et al., 2022). Khalil et al. organized their 2014–2025 evidence into four themes: consumers' perceptions of lost autonomy and of feeling restricted, uninformed, and distressed, with consumers commonly framing CTOs as punitive; carers' perceptions of impact on the consumer, including communication barriers and unmet support needs; clinicians' framing of CTO management as risk-mitigation that prioritizes consumer safety over autonomy; and the unresolved efficacy of CTO (Khalil et al., 2025). Maylea et al.'s (2025) narrative review and Kisely et al.'s (2024) umbrella review converge on a closing summary: consumer perspectives in the qualitative literature are framed by coercion and surveillance, with some consumers describing a breakdown of trust in mental health services that does not recover after the order ends and that impairs future engagement. By contrast, families and clinicians tend to regard CTOs as a "regrettable necessity" (Maylea et al., 2025). The Kisely et al. (2024) umbrella synthesis further emphasized that perceived lack of control consistently prevented people on CTOs from developing positive therapeutic relationships and identified confusion and disenchantment with the legal process itself as a separate cross-cutting theme. Both reviews emphasize that mitigation of the negative experience likely depends on the quality of individual clinician relationships and procedural fairness.

Gaps in the Literature

Several gaps in the evidence base bear directly on contemporary U.S. AOT research and policy.

- First, only three RCTs have ever been conducted—the most recent published in 2013 (OCTET) —and all were carried out in service systems that differ substantially from contemporary U.S. AOT programs; the Bellevue and North Carolina trials are over two decades old and predate the more widespread adoption of AOT, the expansion of assertive community treatment (ACT), supportive housing, and the greater ubiquity of peer-delivered services. No randomized trial has evaluated AOT as currently practiced in the U.S.

- Second, the U.S.-specific quantitative evidence is mostly observational and concentrated in New York; outside of Kendra's Law program evaluations, peer-reviewed outcome data on other state AOT programs are sparse. Implementation fidelity, statutory differences in eligibility and enforcement, and the degree to which AOT is bundled with intensive services rather than implemented as a standalone court order are inconsistently characterized across studies, making cross-jurisdiction synthesis difficult.
- Third, the qualitative evidence base is heavily international—drawn primarily from the U.K., Australia, New Zealand, and Canada—with very little U.S.-specific work, particularly regarding potential harms. Currently, patient, family, and clinician perspectives on AOT remain under-studied in the U.S., and family member voices in the existing primary literature are dominated by parents, with limited representation of spouses and siblings.
- Fourth, racial, ethnic, and cultural disparities, have not been adequately examined in U.S. AOT research. However, further exploration is much needed, as Kisely et al. (2021) documented over-representation of culturally and linguistically diverse migrants on Australasian CTOs, and Swartz et al. (2002) found African-American race independently predicted higher perceived coercion in the North Carolina RCT.
- Fifth, mechanism and dose-response questions remain unresolved: North Carolina post-hoc analyses suggest sustained orders combined with intensive services may be necessary, but clarification on the appropriate length of orders is needed.
- Sixth, the potential harms of AOT, including trauma, experiences of coercion, and difficulties with trust in mental health systems remain under-researched relative to benefits. In particular, there is limited research on AOT conducted by individuals with lived experience, including participatory or co-led research, introducing potential biases in methodology and interpretation.
- Finally, post-order longitudinal data are thin: only six studies have examined long-term adherence following discharge from a CTO (Cossu et al., 2024), and U.S. data on functional, mortality, recovery, and recidivism trajectories beyond the order period are virtually absent.

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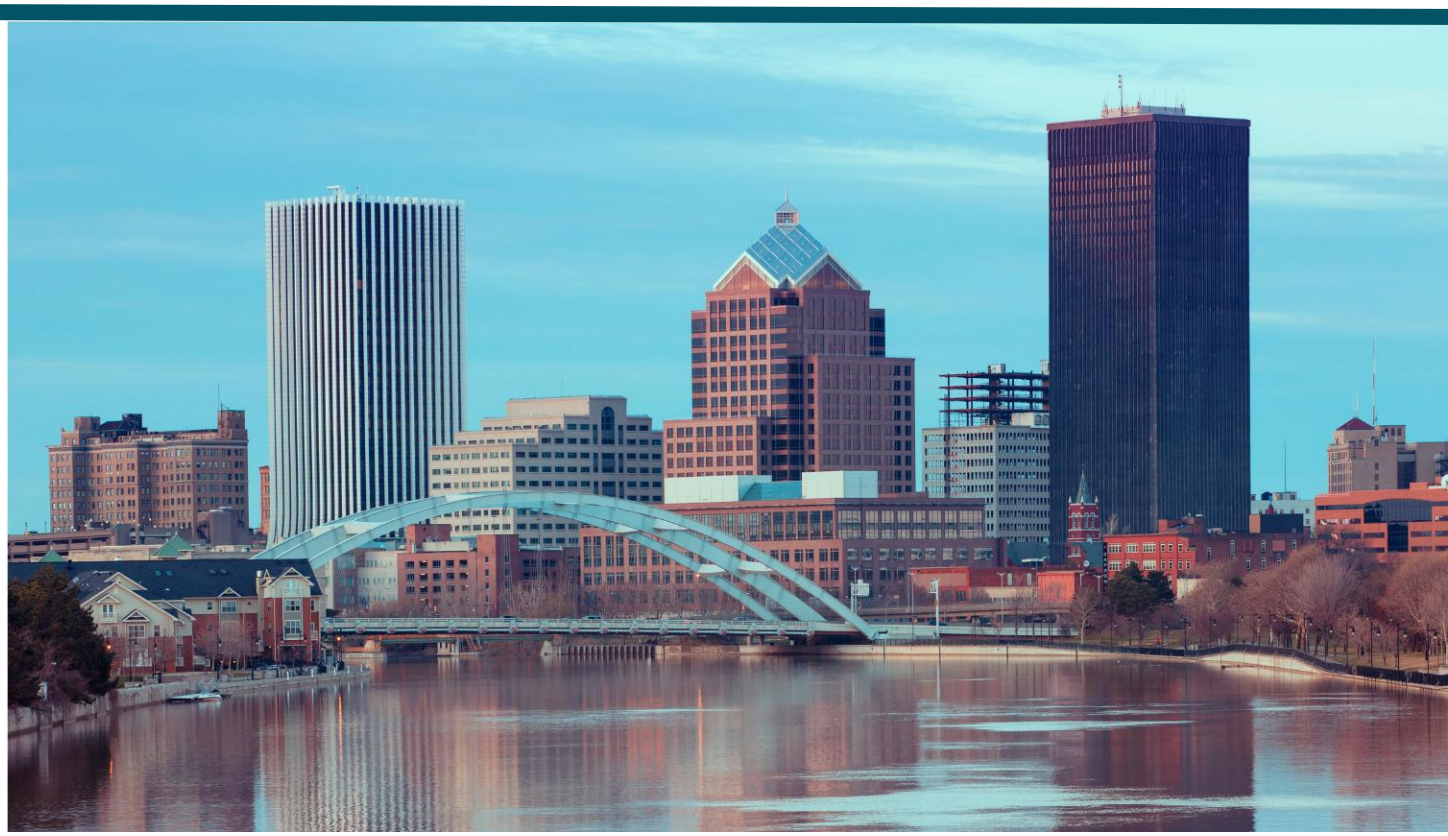


Methodology and Approach

The evaluation team used a range of methodologies[1] to analyze the various data sources for this evaluation.

Consultations

The evaluation team held virtual and in-person consultation meetings during the early stages of designing the evaluation and prior to data collection. The team held 30 consultation meetings with 114 people representing different types of perspectives (Exhibit 1).[2]

Exhibit 1. *Number of People Participating in Consultations, by Respondent Type*

Respondent Type	Number of People
Administrators	36
Providers	22
Family members/loved ones/supporters of people on AOT	18
Legal System Professionals	17
People with lived experience of AOT ("AOT recipients")	14
Advocates	8

Notes: 114 people participated in 30 consultations—either virtually or in-person. One person identified as having two roles.

Questions for the consultations centered around the following:

- Perspectives on AOT and its purpose
- Hypothesized benefits and harms of AOT
- Who AOT benefits and harms and whether AOT impacts some people differently than others
- What should be measured to understand the impacts of AOT
- Who the team needed to speak to understand impacts of AOT (people or groups that should be engaged)
- How to best reach and engage people who can speak to the impacts of AOT (especially people with lived experience)
- How to ensure data represent the diversity of New York State

[1] This document was developed with assistance from AI tools (Claude and Microsoft Copilot), with human review for quality assurance.
[2] In addition to the formal consultations, members of the evaluation team engaged a mix of peer providers, advocates, and people with lived experience of AOT during a session at the Alliance for Rights and Recovery conference in September 2024.

These consultations collected in the first year of the study were used to develop a set of working conceptual models detailing the structures, mechanisms, and outcomes of AOT that were used to shape interview guides and qualitative and quantitative analysis plans.

Site Visits

The evaluation team conducted at least one site visit in each of the five regions in New York State. These two-to-three-day site visits consisted of consultations, interviews, and observations of court processes conducted by two or three-person teams composed of staff from HSRI and/or the University of Pittsburgh. During the site visits, the team members conducted consultations and/or interviews with people with lived experience, administrators overseeing the AOT programs, providers, advocates, judges, and other legal system professionals. Observations of the AOT court hearings occurred in two regions. The groups of people interviewed during the site visits are included in totals noted below.

Data Collection and Sources

The evaluation's mixed-methods approach included qualitative and quantitative data collection and sources described below.

Qualitative Data

Semi-structured interviews were conducted in-person or virtually with people in varying roles and positions with respect to AOT. A total of 143 semi-structured interviews were conducted with 244 people for the evaluation.[3] The following exhibits show the numbers of interviews conducted, and people interviewed by OMH region; and the total number of people interviewed by respondent type and OMH region. The domains and question areas covered during the semi-structured interviews and detailed information about interviewee demographics are included in Appendix D.

[3] This number does not include the consultations that were conducted with 114 people prior to formal qualitative data collection

Exhibit 2. *Number of Interviews Conducted and People Interviewed, by OMH Region*

OMH Region	Number of Interviews Conducted	Number of People Interviewed
Central New York	22	41
Hudson River	40	61
Long Island	25	56
New York City	30	42
Western New York	21	39
Statewide Role	5	5
Totals	**143**	**244**

Exhibit 3. *Number of People Interviewed, by Respondent Type and OMH Region*

Respondent Type	Central New York	Hudson River	Long Island	New York City	Western New York	Statewide Role	Totals for Respondent Type (% of total)
Lived experience of AOT ("AOT recipients")	4	15	13	10	4	N/A	46 (19%)
Family members/loved ones/supporters of people on AOT	5	7	3	4	6	N/A	25 (10%)
Advocates	N/A	N/A	N/A	N/A	N/A	5	5 (2%)
Administrators (including DCS and AOT Coordinators)	5	7	3	12	7	N/A	34 (14%)
Psychiatrists	1	4	1	3	2	N/A	11 (5%)
ACT Provider	7	3	17	3	0	N/A	30 (12%)
HH+ or Other Care Coordination Provider	16	14	4	1	6	N/A	41 (17%)
Other types of providers (e.g. housing, inpatient, peer specialist, other executives/directors)	2	10	3	2	13	NA	30 (12%)
Legal system professionals	1	1	12	7	1	N/A	22 (9%)
Totals for OMH Region	**41**	**61**	**56**	**42**	**39**	**5**	**244 (100%)**

Note: Demographic information for people interviewed who completed the brief demographic survey is included in Appendix E, Exhibit E1-Exhibit E4.

Sampling and Recruitment

The team incorporated different sampling and recruitment approaches for different populations, paying particular attention to ensuring demographic diversity for people with lived experience and regional and role diversity for administrators, providers, advocates, and other professionals.

- **Sampling and Recruitment of People with Lived Experience.** The evaluation team created flyers for people with lived experience of AOT ("AOT recipients") detailing the purpose of the study and the interview process, including that interviews were confidential, voluntary, and provided participants with a $50 honorarium. These flyers were translated into the six most commonly spoken languages (Bengali, Chinese Simplified, Chinese Traditional, Haitian Creole, Russian, and Spanish). The flyers were posted on the project website and shared with OMH for distribution to the field offices and listservs that included providers who work with people under AOT orders. Flyers were also sent to contacts gathered during the consultation phase, provider and administrators who the team came in contact with through other components of the project, advocacy groups across the state (e.g., county NAMI chapters, Mental Health Association groups, peer run organizations). In addition, physical flyers were brough to statewide conferences where the interview team had public tables, and posted in high density behavioral health service neighborhoods in both the greater New York City metro area and in Buffalo. AOT recipients were encouraged to share flyers with other friends or contacts with other people under AOT orders.

Interested individuals were screened to ensure they were eligible (to confirm that they had been or were currently under an AOT order in New York State). The interview team attempted to schedule interviews with every individual who reached out or completed the contact form. While some prospective study participants could not be reached—typically because their phones had been disconnected or they had run out of cellphone minutes—all reachable individuals were interviewed either by phone, Zoom or in person.

- **Sampling and Recruitment of Family Members.** The evaluation team followed similar sampling and recruitment strategies for family members, chosen family, and other close supporters of people under AOT orders as for people with lived experience of AOT.
- **Sampling and Recruitment of Administrators and Providers.** Using quantitative data obtained for the study (see description below), the team identified a purposive sample of counties in each of the OMH regions to target for key informant interviews with administrators (DCS' and AOT coordinators) and providers. The team sampled for counties that had high and low rates of AOT per adult Medicaid population as well as those having other relevant characteristics such as the prevalence of Enhanced Voluntary Services (EVS). To ensure maximum opportunities for every county to participate in the evaluation, we also reached out to all DCS' and AOT Coordinators that

did not complete the DCS survey to offer an interview. Contact information for the AOT administrators was obtained from OMH and the NYS Conference of Local Mental Hygiene Directors website.[4]

To identify providers within the selected counties, the team worked with OMH Field Office Program Coordinators to identify provider agencies that served people under AOT orders and represented a range of provider roles (i.e., ACT, Health Home Care Management, housing). Contact information for providers were obtained from the OMH Field Offices. A member of the evaluation team emailed these providers, asking for an interview with staff that work with people under AOT orders.

- **Sampling and Recruitment of Legal System Professionals, Advocates, and other Providers.** For remaining groups, the evaluation team used a combination of convenience sampling (i.e., interviewing legal system professionals and providers located in the region of a site visit) and snowball sampling (i.e., reaching out to providers and advocates recommended by people who participated in consultations or other interviewees).

The evaluation team also emailed people who were identified during the consultation meetings as crucial sources of information or that completed an online interest form. The team shared the link to the online interest form through the project website and an evaluation infographic which OMH and other contacts within the state helped distribute that described the evaluation and included a link and a QR code to be scanned by interested people to reach the online interest form.

All family members, administrators, providers, advocates, and other professionals received a recruitment email from an evaluation team member where information regarding the evaluation was shared and asking if they were willing to participate in an interview. If people were willing to be interviewed, they were asked to provide dates and times that would work for them for an interview.

Interview Process

The Institutional Review Boards at the Nathan Kline Institute for Research and the University of Pittsburgh categorized the project as quality improvement and evaluation rather than human subjects research. The evaluation team nevertheless utilized a standard informed consent process, reading standard consent scripts to participants that included a description of the project, ways in which their data would and would not be used, their rights and protections, and ascertaining the voluntary nature of their participation. All conversations were audio-recorded and transcribed verbatim using either AI-based transcription software or a professional

[4] https://www.clmhd.org/contact_local_mental_hygiene_departments/

transcription service. For interviews transcribed using AI-based transcription software, a team member reviewed the transcript against the audio recording for accuracy.

All interviewers were trained in best practices in qualitative data collection and trauma-aware research. The interviewers met regularly to debrief, share reflections and troubleshoot emergent challenges.

- **Interview Process for People with Lived Experience.** Interviews with people with lived experience of AOT were scheduled for 60-120 minutes. The demographics survey for people with lived experience of AOT was completed during the interview, with the interviewer asking the person the demographic questions and directly filling out the demographic survey. The interviews were semi-structured and informed by a critical realist framework, focused on teasing out context–mechanism–outcome (CMO) pathways wherever possible; facilitators used an interview guide with various domains but allowed for significant flexibility to ensure depth of interviewing (see Appendix E for the domains and question areas covered). All but two of the interviews with people with lived experience of AOT were led by researchers with personal or family experience of SMI. All participants completed a standard consent process, identical to protocols otherwise used under the University of Pittsburgh IRB. After the interviews, participants were sent a thank you email if we had an email address for them. They were also provided a $50 honorarium in appreciation for their time.
- **Interview Process for Family Members, Administrators, Providers, Advocates, and Other Professionals.** Interviews with family members, administrators, providers, advocates and other professionals were scheduled for 60-90 minutes depending on the size of the group. The interviews were also semi-structured; facilitators used an interview guide with various domains but allowed for significant flexibility to align with interviewees' expertise and priorities (see Appendix E for the domains and question areas covered). During in-person interviews, participants were provided a QR code that took them to a brief demographic survey, the link to the survey was also shared with them and people who participated in a virtual interview in the thank you email. The demographics survey for family members was completed during the interview, with the interviewer asking the family member the demographic questions and directly filling out the demographic survey. Family member interviewees were provided a $50 honorarium in appreciation for their time.

Quantitative Data

This evaluation used quantitative data from three cohorts: Adults under an active AOT order as of January 1, 2018; adults with an active ACT episode as of January 1, 2018, and no AOT order; and adults eligible for Health Home Plus (HH+) services from the beginning of that program in 2020 and no AOT order or ACT episode. Data available for all three cohorts consisted of:

- Demographic characteristics including age (as of January 1, 2018), sex, race/ethnicity, and Medicare and Medicaid eligibility;
- Lifetime arrest history from the Division of Criminal Justice Services (DCJS) *Top Charge Database*;
- Medicaid data for outpatient, inpatient, emergency department, and pharmacy claims submitted between 2016 and 2023.

Additionally, for the AOT and ACT cohorts, data on lifetime assessment history were available from OMH's *Child and Adult Integrated Reporting System* (CAIRS) database. For the AOT cohort, we also had access to lifetime AOT court order history from OMH's *Tracking for AOT Cases and Treatments* (TACT) database.

- **CAIRS Database.** Information extracted from the CAIRS database consisted of assessment data from adults under an AOT order and people receiving ACT services, starting with an admission assessment, six-month follow-up throughout their treatment, and at discharge. The assessments included information on the individual's living situation, education, employment status, income sources, insurance status, wellbeing and risk factors, treatment plan, and functioning. Some adults went back into a later ACT episode or received a new AOT court order after being discharged from an earlier one.[5] The CAIRS data therefore contains assessments on multiple "episodes" with varying lengths of time in between. Each episode occurred at a different life stage, had different duration, involved a different treatment team, and a different treatment plan. Pre-post comparison across multiple episodes was therefore not feasible. In this evaluation, outcome analysis comparing pre- and post-measures focused on clients' initial episode on record. Depending on the type of pre-post comparison, the analysis sample may be further restricted to people whose initial episode fell within a certain period. In reporting analysis results, we describe in detail the inclusion/exclusion criteria of each specific analysis.

[5] 37.6% of the AOT cohort and 12.3% of the ACT cohort had multiple episodes.

- **TACT Database.** Data from the TACT database contained detailed administrative information about the court order, including dates, location of the court, petitioner type, and disposition, as well as significant events that occurred throughout the recipient's time under the order. All AOT orders have an expiration date after which a renewal order is required if it is determined that the recipient requires further mandatory outpatient treatment. In cases where the determination is to end the mandatory treatment, the reasons why the case no longer meets AOT criteria is also recorded in the database. Additional reasons why the order is ending, such as death or leaving the state, are also recorded. Typically, recipients have an initial order followed by a string of consecutive renewal orders, consisting of a single AOT "episode." As reflected in the CAIRS database, many people in the TACT data extract had multiple court order episodes, separated by varying lengths of time.
- **Medicaid Claims.** The majority of our AOT and ACT samples had at least one outpatient claim, as would be expected. We therefore used the outpatient claims database for information on diagnoses and outpatient services received separately for the eight years for which data were available. We then used inpatient and Emergency Room (ER) claims databases to calculate the numbers of hospitalizations, ER visits, and inpatient nights for each of the eight years. Pharmacy claims provided information on types and numbers of medications billed during each of the eight years. We used combinations of different claims databases to calculate several quality-of-care measures:
    - Presence of 7- and 30-day outpatient follow-up visits after hospital or ER discharge
    - Presence of claims for diabetes and hyperlipidemia screening for people on an antipsychotic medication
    - *Usual Provider of Care* Index (UPC)
    - *Continuity of Care Index* (COC) also known as *Bice-Boxerman Index*
- **County-Level Data from Secondary Sources.** As noted, the statutes regulating the AOT process have a degree of flexibility that allows LGUs to make some implementation choices, resulting in variations across counties in AOT-related practices and outcomes. County-level variations in mental health system characteristics and demographic and socioeconomic factors as well as other drivers of mental health are also expected to affect implementation and outcomes. Consultations with OMH regional directors suggested that the personal views and philosophies of senior county officials constitute yet another source of variability relevant to AOT implementation.

  This cross-county variability provided an opportunity for analyses to identify components of AOT implementation that are associated with multilevel outcomes. For this purpose, we developed a county-level database with two components: (1) publicly available data on counties' demographic and socioeconomic characteristics and drivers of mental health; and (2) a survey of county Directors of Community Services (DCS). Below we discussed the publicly available data and the DCS survey.

- **Publicly available data.** Demographic and socioeconomic characteristics and drivers of mental health for the counties in New York State were pulled from the following data sources:
    1. U.S. Census
    2. County Health Rankings
    3. U.S. Department of Housing and Urban Development
    4. OMH County Needs Assessment Database
    5. New York State AOT Court Orders Database
    6. OMH AOT Statewide Reports
- **Survey of County Directors of Community Services (DCS).** The survey was administered online to all county DCSs outside of New York City (NYC). AOT implementation in NYC is centralized across its five boroughs. Court systems and legal services, on the other hand, vary across boroughs. Given the unique structure of mental health services, and specifically, the AOT process in NYC, the survey was modified during a working meeting with that LGUs senior AOT leadership. The modified survey was completed on paper by the leadership to reflect institutional structure of AOT in NYC. The responses that varied by boroughs was distinguished from those that applied to all five boroughs. The DCS survey collected information regarding the structure of the community services system, AOT resources and implementation, and personal views about Kendra's Law and AOT. Survey data was merged with data from secondary sources to create a single county-level database.
- **Individual-Level Data.** The analysis files contained three groups of adults: (1) AOT recipients; (2) ACT recipients who are not under an AOT order; and (3) Medicaid enrollees eligible for Health Home Plus services who are not in groups 1 and 2. These three study groups are adults belonging to the state's Medicaid behavioral health population.[6] All adults in that population who belonged to one of the three study groups as of January 1, 2018, will be in the study sample. For those selected into the dataset, all available data between 2016 and 2023 was included in the analysis. Comparisons across the three groups was shaped by data availability. Analyses based on TACT data only included the AOT cohort. Analyses using CAIRS data included comparisons between the AOT and ACT cohorts. Analyses using DCJS arrest data and Medicaid claims data compared the AOT cohort to both the ACT and HH+ cohorts.

Described below are the data that were used from the following data sources.

1. **Medicaid Claims Data:** Data on diagnoses, service utilization, and treatment setting

[6] The Medicaid behavioral health population includes all enrollees with a diagnosis, a procedure, or a prescription related to mental health or substance use disorder.

2. **OMH TACT database:** Information about AOT recipients' full AOT history, including petition(s), court order(s), significant events during AOT, and justification of non-renewal decisions, as well as dates of these milestones
3. **CAIRS Data:** Results of assessments administered to AOT and ACT recipients at admission, six-month follow-up, and discharge will be available from OMH's CAIRS. The system collects data on demographics, socioeconomic status, diagnoses, treatment plan, emergency service utilization, mental health risk factors, substance use, functioning, social and self-management skills for New Yorkers receiving ACT or are under an AOT order.
4. **DCJS Top Charge Database:** Data on lifetime criminal history and individual histories of "finger printable" offences.

Data Protection & Security

The contact information, interview notes and transcripts for the key informant interviews and focus groups and the quantitative data used for the study were maintained in secure sites accessible only to HSRI and the University of Pittsburgh staff and subcontractors working on the project. Files stored on both the HSRI and University of Pittsburgh conform to the secure storage requirements of the respective institutions.

The quantitative datasets were maintained in HSRI's secure system with access allowed only for HSRI team members working on the evaluation. Data use agreements were signed with OMH for the demographic, CAIRS, TACT, and Medicaid claims data and with DCJS for the arrest data extracted from their Top Charge Database. All HSRI team members with access to the data are annually trained in HIPAA regulations and the organization's data security protocols. The quantitative data will be deleted from HSRI's system after the period indicated in the data use agreements.

HSRI maintains a Windows-based local area network that is securely firewalled to prevent unauthorized data access and data loss. Only approved members of the project team had access to project folders where data were stored.

Analytic Methods

Qualitative Data

The interview team used distinct approaches to coding and analysis for the interviews with people under AOT versus interviews with other groups. These methods are discussed separately in the sections that follow.

AOT Recipient Interview Analysis

Chapters 1 and 3 of this report apply a parallel two-track coding strategy: (a) human-led thematic coding and (b) systematic artificial intelligence (AI)-assisted coding using Claude. The strategy is designed to provide triangulation, bolster reliability, and yield quantized findings about mechanism prevalence and associated outcomes. Chapter 1 codes the experiential and outcome mechanisms through which AOT operates in clients' lives. Chapter 3 codes the legal-procedural pathway (initiation, consent, representation, hearing, plan formulation, renewal).

a) **Human-Led Thematic Coding.** The research team began with systematic open coding of client transcripts explicitly oriented around context-mechanism-outcome (CMO) framework. After reaching initial saturation, the team developed a visual CMO model mapping mechanisms to outcomes, then generated codes, grouped codes into mechanism categories through discussion, and refined the mechanism structure through team review against the source transcripts. The final mechanism structure includes nine mechanisms: M1-M9. Disagreements between coders surfaced in team meetings and were resolved through discussion against the source transcripts. The qualitative narrative and illustrative quotations in Chapter 1 derive from this coding track.

b) **AI-assisted Coding.** Following human-led thematic coding, the research team used a structured Claude-assisted context–mechanism–outcome (CMO) coding protocol to capture features of each mechanism and associated outcome patterns. The CMO protocol is anchored in a critical-realist analytic framework: it distinguishes the underlying mechanism (a property of the situation) from its observable outcome (what the person experiences), and treats context as the set of conditions that determine whether and how a mechanism produces particular outcomes. The CMO protocol applied complementary code families to each transcript, summarized in the tables below.

Exhibit 4. *Code Families for the Mechanisms and Outcomes Coding Protocol (Chapter 1)*

Code prefix	Family	What it captures
M1–M9	**Mechanism-domain codes**	The nine mechanism domains through which AOT operates in recipients' accounts. Each code application is anchored to a passage in the transcript.
H-*	**Harm outcome codes**	Recipient-reported harms attributed to the operation of one or more mechanisms. Code suffixes denote outcome domains: H-MED (medication-related harm), H-PSYCH (psychiatric or psychological harm), H-STRUCT (harm from structured / surveilled routine), H-REL (harm to relationships or social connections), H-SDEF (social-defeat harm).

Code prefix	Family	What it captures
B-*	**Benefit outcome codes**	Recipient-reported benefits attributed to the operation of one or more mechanisms. Code suffixes parallel the harm codes: B-MED, B-PSYCH, B-STRUCT, B-REL, B-CLIN (clinical-stability benefit).
C-*	**Context codes**	Conditions of the recipient's situation that moderate which outcomes a mechanism produces. Examples: C-TEMPORAL (duration of order or service contact), C-VOLUNTARINESS (client's framing of their entry into services), C-PROVIDER-RELATIONSHIP (quality of the moderating relationship).

Exhibit 5. *Code Families for the Judicial Process Coding Protocol (Chapter 3)*

Code prefix	Family	What it captures
P-INIT-*	Initiation pathways	How the AOT process was initiated (hospital, DCS, criminal-legal, self-initiated)
P-CONSENT-*	Consent/ acquiescence type	Whether the order was discharge-conditioned, counsel-advised, accepted as 'best interest', imposed, etc.
P-REP-*	Representation status	Quality of MHLS counsel engagement (absent, nominal, hand-down, substantive, effective)
P-HEAR-*	Hearing modality and presence	Whether the participant was present, in-person or virtual, the hearing stipulated or contested
P-PLAN-*	Plan formulation	Where and how the treatment plan was developed (inpatient, formal conference, outpatient)
P-RENEW-*	Renewal patterns	Awareness of and participation in renewal (aware, participating, unaware)
P-PICKUP-*	Pickup/removal events	Whether assisted transport occurred, was threatened, or was absent
PJ-*	Procedural-justice outcomes	Participant-reported experience of voice, fairness, futility, frustration, stigma, confusion, resignation, respect, being informed, and agency
PDP	Procedural-due-process element ratings	Per-element rating of Notice, Opportunity to be heard, Effective counsel, Impartial decision-maker, and Informed decision-making as ABSENT, FORMAL-ONLY, SUBSTANTIVE, or NOT-DETERMINABLE

The quantitative prevalence counts in the following tables remain advisory pending final researcher verification against the individual passage-level coded files (per the Phase 4B Aggregate, v2). Where the chapter reports both an overall-mechanism-presence figure and a narrower configuration-level or harm-specific figure, both are shown so the reader can apply the more conservative reading as appropriate. We also follow standard qualitative research practice in treating two specific features of the data as substantive findings rather than as methodological noise: (1) confirmations elicited through paraphrase-and-summarize cognitive interviewing technique are treated as client statements rather than as interviewer-leading artifacts, which reflects established practice for interviewing populations with psychiatric service contact; (2) non-recall of specific procedural or clinical events is treated as substantive data about the

client's experience of the system, not as missing data—being unable to recall when an order was renewed, or what was discussed at a treatment planning meeting, is itself an informationally valuable finding about how the system operates from the client's side.

We cross-reference administrative data from OMH's AOT system and quantitative analyses from the broader evaluation where these data converge with, contextualize, or qualify the qualitative mechanism findings. We treat administrative, quantitative, and qualitative data as triangulating sources; substantial divergences between them are noted as substantive findings rather than reconciled away. Where the qualitative findings document harms that the administrative data system does not measure, the divergence is reported as a finding regarding what existing NYS administrative and clinical outcome measures can and cannot detect. Full administrative and quantitative analyses appear in Chapter 4.

Content Analysis of Professional and Family Member Interviews

The qualitative coding team conducted content analysis of the interviews with professionals and family members using a mix of inductive and deductive approaches. We developed a preliminary inductive coding structure based on the conceptual model that was generated through consultations in the first year of the project. Additional deductive codes were added as they emerged through analysis of the data, which occurred iteratively over a six-month period. At least one researcher hand-coded each transcript, sorting passages according to codes. Secondary coding was completed on a sample of the interviews to identify areas of confusion and divergence in understanding amongst the team. The team members maintained analytic reflective memos and met weekly throughout the analysis period to discuss impressions, reconcile differences in understanding, and adjust the coding framework.

Reporting

Where qualitative findings are described in this report, clients are referred to by anonymized transcript identifiers. Quoted passages reproduce the client's spoken words; brackets indicate analyst substitutions for personally identifying details, ellipses indicate omitted material. Minor disfluencies (filler words, false starts) have been removed where doing so improves readability without altering substantive content. Every quoted passage was extracted directly from a verified source transcript and was quality checked by a human coder against the original audio or transcript.

Quantitative Data

Study cohorts and addressing group imbalances

The quantitative analysis used three mutually exclusive groups: (1) Adults under an AOT order as of 1/1/2018 (treated); (2) Adults who are not under an AOT order and are receiving ACT services as of 1/1/2018 (comparison); and (3) Adults not under an AOT order, not receiving ACT

services, and eligible for Health Home Plus (HH+) services as of the start of the HH+ program in 2020 (comparison).

The three groups had some similar characteristics—all three are adults identified as needing intensive mental health services. However, there may be remaining group imbalances in sociodemographic and clinical factors that threaten inference validity in outcome analyses. We controlled for these potential confounders in several different ways depending on the evaluation question being addressed. The HH+ group substantially differed from the AOT and ACT groups in terms of demographics and clinical factors such as diagnosis and treatment. Less information at the person level was available for the HH+ cohort compared to the ACT cohort; it was therefore not possible to identify a propensity model that provided sufficient balance across all three cohorts. The HH+ cohort also lacked data on key outcome measures of the evaluation, such as life skills, housing and employment status, and treatment and medication compliance. Cohort differences in outcomes were therefore reported by comparing the AOT and ACT cohorts.

To reduce the imbalances with the HH+ group, we only included in the analyses adults in this group who had a serious mental illness and received case management services for at least one year after becoming eligible for HH+. In pre-post comparisons of outcomes for which data were available for the HH+ cohort, we defined the year of eligibility as “intake year” and the following year as the “treatment period.” This provided us with a somewhat but not sufficiently similar comparison group (as explained further below) that received voluntary case management services. This group was included in bivariate tables showing pre-post comparisons and unadjusted cohort differences, but not in analyses that tested the significance of cohort differences in outcomes. In that sense, the ACT cohort is the only sufficiently comparable comparison group of our outcome evaluation.

There were relatively more similarities between the AOT and ACT groups with respect to these factors and a broader range of background data available for propensity modeling.

To compare the outcomes of AOT and ACT groups, we constructed a propensity model to balance the following inter-group differences that were found to differ significantly between the two groups:

- Demographic characteristics
    - Age
    - Sex
    - Race/ethnicity
- Primary diagnosis
    - Schizophrenia or a related psychosis
    - Substance use disorder
    - Depression

- Housing status
- Living arrangement
- Whether or not intake was during the COVID lockdown
- Medicaid eligibility
- Level of engagement with staff
- Medication adherence
- Whether had at least one arrest during the preceding year
- Number of arrests during the preceding year
- Number of mental health inpatient nights during the preceding year
- Number of substance use disorder inpatient nights during the preceding year

These factors were used to estimate a general linear model with logit link function to produce propensity scores, which were then used to calculate *inverse probability of treatment weights* ("propensity weights" for short) as follows:[7]

Weight for the AOT cohort: $\frac{1}{Propensity\ Score}$

Weight for the ACT cohort: $\frac{1}{(1-Propensity\ Score)}$

The propensity weights were effective in balancing the cohort differences listed above. The exhibit below compares the two cohorts on the measures included in the propensity model before and after propensity weighting.

Exhibit 6. *Characteristics at Intake Before and After Propensity Weighting*

	AOT Uncorrected	ACT Uncorrected	AOT Propensity Corrected	ACT Propensity Corrected
Younger than 44	68.5%	58.9%	65.8%	65.4%
Female	24.1%	38.0%	28.5%	29.3%
White only (no additional race/ethnicity reported)	35.7%	39.8%	37.1%	37.4%
Hispanic	20.6%	9.7%	16.5%	17.0%
Primary diagnosis Schizophrenia or related psychosis	70.3%	65.7%	74.6%	75.3%
Primary diagnosis SUD	28.1%	34.8%	31.7%	31.0%
Primary diagnosis Depression	6.2%	12.1%	9.3%	9.1%

[7] Chesnaye, N.C., Stel, V.S., Tripepi,G., Dekker, F.W., Fu, EL, Zoccali C., Jager, K.J. 2021. An introduction to inverse probability of treatment weighting in observational research. *Clinical Kidney Journal,15*(1), 14-20. doi: 10.1093/ckj/sfab158. PMID: 35035932; PMCID: PMC8757413.

	AOT Uncorrected	ACT Uncorrected	AOT Propensity Corrected	ACT Propensity Corrected
Homeless or unstably housed	11.2%	30.3%	19.0%	20.6%
Lives alone	16.5%	23.0%	18.5%	19.4%
Intake year during COVID lockdown	32.2%	25.7%	34.6%	35.0%
Medicaid eligible	95.2%	91.0%	100.0%	100.0%
Staff Engagement none or minimal	31.7%	33.7%	32.8%	33.9%
Takes medications exactly as prescribed	51.3%	40.8%	47.0%	48.1%
Had at least one arrest during prior year	19.9%	21.1%	20.9%	21.1%
Average number of arrests during prior year	0.38	0.47	0.39	0.47
Average MH inpatient nights during prior year	118.06	61.86	104.02	113.33
Average SUD inpatient nights during prior year	2.26	2.41	2.45	2.43

The propensity weights were applied in analyses that test differences in outcomes between AOT and ACT cohorts. We did not use weights in reporting the pre and post measures and testing the significance of the changes separately for each cohort, in order to show the actual magnitude of the changes.

The two cohorts also significantly differed in treatment duration: On average, 38 months for the AOT and 33 months for the ACT cohort. This factor was not included in the propensity model. Instead, it was entered as a covariate in multivariate models that tested the significance of pre-post differences within cohorts and outcome differences between AOT and ACT cohorts. Inclusion of treatment duration in these models was also useful in assessing its impact on outcomes and cohort differences.

Statistical techniques

Depending on the evaluation question, descriptive statistics, bivariate tests, or multivariate models were used. Descriptive statistics were the variable's distributional characteristics, such as means, medians, variances, and ranges. For testing the association between two variables, either parametric (e.g., z-test for the difference between two proportions, t-test for the difference between two means, ANOVA) or non-parametric (e.g., Wilcoxon's signed rank test, McNemar's test) significance tests were used.

For outcome analysis of data from CAIRS, we used repeated measures models controlling for approximate age at intake and duration of the episode in months to identify significant differences between intake and last assessments. Separate models were used for the AOT and ACT groups to test the significance of these pre-post differences. An additional set of difference-

in-differences models were used to compare outcomes between the two cohorts. These models were propensity-weighted. All multivariate models were subjected to diagnostic tests to examine model fit and corrections were made as needed.

To investigate the pre-post differences in hospitalizations, we calculated the change between the numbers of hospitalizations and of inpatient nights and conducted one-sample t-tests separately for the AOT and ACT groups. We then used weighted two-sample t-tests to compare the outcomes of the two groups. Similar steps were used to test pre-post differences in number of arrests.

Triangulation Between Qualitative and Quantitative Evidence

Qualitative and quantitative analyses occurred in parallel and informed each other. Some quantitative data analysts also collected qualitative data, forming a bridge between the two. Additionally, qualitative and quantitative analysis leads attended each other's review meetings to stay up to date with newly emerging evidence. If there were qualitative findings that could be tested through the available quantitative data, those were added to the quantitative analysis plan. For example, multiple providers mentioned that clients diagnosed with substance use or personality disorders were consistently less likely than others to respond to treatment. Qualitative data also suggested that people who received rehabilitation services, peer support, or community support services may have better overall outcomes. We quantitatively tested these hypotheses with the use of Medicaid claims data (see Chapter 4, section entitled "Factors Associated with AOT Outcomes"). Likewise, emerging quantitative results led to updates in the structure of interviews and focus groups. For example, racial/ethnic differences in experiences such as removals and in some AOT outcomes found during quantitative analysis resulted in increased attention to similar points that came up during interviews.

Quality Control Protocols

The project team has well-established standard operating procedures for checking the accuracy of analysis results. All quantitative analysis programs were developed in a tracking system that generated "breadcrumbs" from the original data to the final reported result. Every step from the initial data validation and analytic coding to the transfer of output into the report was recorded in a "proofing sheet" and reviewed by at least one analyst other than the original author. The step was signed off on by the reviewer after consensus was reached. This tracking system prevented any errors at early stages of data analysis from being carried over to later stages. It also established accountability so that pairs of team members responsible for the accuracy of each analytic step developed a sense of ownership over that piece.

All qualitative data presented in this report was checked against the original recording to verify accuracy.

Positionality and Reflexivity in Qualitative Data. The interview and coding team included individuals not only with direct personal or family experience, but very diverse experiences of the public mental health system. Notably, this includes experience of short- and long-term involuntary treatment, including in state hospitals, long-term treatment for schizophrenia, as well as experience as an initiator of involuntary treatment, as a family member of a loved one with long-term, severe schizophrenia, and as a provider in real-world mental health services. Over the course of the project and intensively so during coding, team members regularly discussed the impact of their own experiences and positionalities, and any impact on the coding or analytic process including strategies for minimizing bias in interviewing and coding.

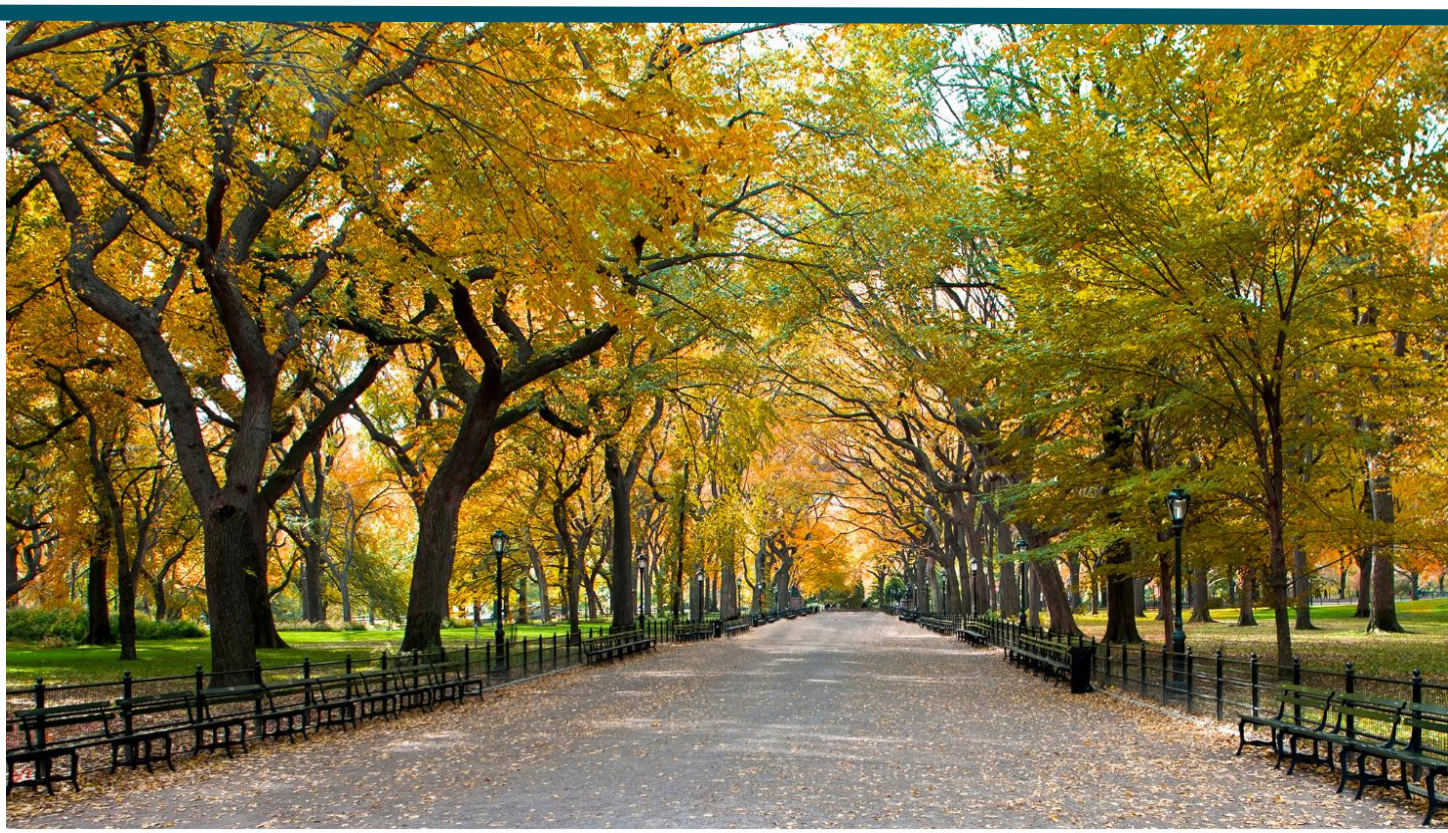
Limitations

***Qualitative*.** As noted in the Background section of the report, the U.S. AOT literature has heavily relied on administrative data. In order to compensate for the unavoidable limitations of such data, we attempted to conduct as much qualitative work as possible during the relatively short project period. However, both recruitment and in-depth interviewing and coding are time-consuming, limiting total sample size. The interview sample is too limited to reflect the variability in implementation and diversity of experiences of people under AOT orders across the state of New York. However, qualitative samples are rarely fully representative, and we both acknowledge the limits of our sample, and underscore the importance of future research with a longer project timeframe and the additional resources that would be needed to interview and substantially larger sample of clients and families, ideally with representation from every New York County.

Further, some mechanism configurations and themes in qualitative findings are based in a small number of interview transcripts; these are reported as such throughout. In Chapter 3 specifically, MHLS attorney participation was constrained by department- and attorney-level decisions. These decisions restricted formal interviews in most jurisdictions; the attorney coverage relies on a single audio-recorded MHLS interview supplemented by unrecorded consultations with MHLS department leadership across the state.

***Participatory Methods*.** Strong participatory methods require an equally strong investment in infrastructure, resources and the time required for truly collaborative planning and decision making. Use of such methods notoriously slows down the research process, and while we did our best to maintain participatory process, realistically the short project timeframe and limited resources led to compromises and less integration than would be ideal. For example, with a longer project timeframe and more resources for participatory approaches, the study team could have held further consultations with people who participated in interviews, sharing back key quantitative and qualitative findings and engaging with them to reflect on whether and how the findings resonate with their experience.

***Quantitative*.** The quantitative data used for the evaluation come from administrative records not designed for research purposes. Linking records from these multiple administrative sources into a single analysis dataset that contained all the information for an individual had its challenges. It was not feasible to match Medicaid claims and DCJS arrest data to the precise start and end dates of an individual's treatment period. We performed these matches at the level of years. That is, we used the individual's intake year to link to the number of arrests, hospitalizations, and other relevant events occurring during that year. This introduced a certain amount of slippage to the linkages. However, the level of "noise" associated with this slippage did not vary systematically with respect to characteristics and group membership. In other words, the error was evenly distributed and posed little *systematic* threat to the validity of our inferences. Another source of error is the algorithm used by DCJS to match our sample to the arrest data in their Top Charge Database. The algorithm used individuals' demographic data for record linkage, and was probability-based. As a result, there was some duplication in the linkage results. We conducted careful data cleaning to remove duplicates but had no way of correcting all linkage errors. We attempted to assess the level of mismatch by using demographic data available in both data sources. Since race/ethnicity of the arrestee was not consistent across multiple arrests, DCJS used "modal" race/ethnicity to identify a person's identity. We compared these modal data with demographic data we received from OMH and found over 80% agreement across race/ethnicity categories. However, the remaining disagreement between the two sources suggest that some level of error in identifying individuals would have been introduced during the linkage done by DCJS.



Elements of AOT and Contextual Factors

In this section we provide an overview of how AOT operates in New York State along with brief context on the respective roles of the New York State Office of Mental Health (OMH), the OMH field offices, and the county mental health agencies or local government units (LGUs) in administering and supporting AOT.

Office of Mental Health

OMH oversees a large, multifaceted public mental health system that serves nearly 800,000 individuals each year. Its mission is "to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances."[1] To achieve this, OMH operates 23 psychiatric centers, oversees the Nathan S. Kline Institute and New York Psychiatric Institute, and regulates and certifies more than 6,500 programs operated by local governments and nonprofit agencies.[2]

The New York public mental health system is composed of inpatient, outpatient, crisis, and support programs:[3]

- For adults, inpatient programs include beds in psychiatric units of general (Article 28) hospitals, state psychiatric centers and private psychiatric (Article 31) facilities.[4]
- Outpatient programs provide treatment and rehabilitation to those in need of community-based supports to maintain their mental health; these include programs such as Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS), Assertive Community Treatment (ACT) teams, Personalized Recovery-Oriented Services (PROS), Article 31 clinics, and day treatment programs.[4]
- Crisis programs provide rapid psychiatric and/or medical stabilization. These programs include Crisis Intervention, Crisis Residence, Crisis Respite, Home-Based Crisis Intervention, and Comprehensive Psychiatric Emergency Programs (CPEP). [4]
- Support programs help people live as independently as possible or with their families and include general support, care coordination, self-help, vocational, forensic, education, and residential services. [4]

OMH operates five regional field offices: Central New York, Hudson River, Long Island, New York City, and Western New York.

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[1] https://omh.ny.gov/omhweb/about/
[2] Ibid.
[3] New York State of Mental Health. (July 2025). *Profile of the New York State Public Mental Health System*.
[4] Ibid.

County Mental Health Organization — Local Government Units

New York State has 58 Directors of Community Services (DCS)/Mental Health Commissioners for the 57 counties and New York City (which comprises five counties), also known as Local Government Units (LGU).[5] The DCS within the LGUs have statutory authority and responsibility for the oversight and cross-system management of the local mental hygiene system to meet the needs of individuals and families in the community that are affected by mental illness, substance use disorders and/or intellectual/developmental disabilities.[6] The LGUs develop and oversee systems of care locally, working in partnership with the three NYS mental hygiene agencies — OMH, the Office of Addiction Services and Supports (OASAS) and the Office for People with Developmental Disabilities (OPWDD).[7] The LGUs have Single Point of Access (SPOA) programs for adults and children; these programs help connect people to mental health services. The counties/LGUs in each field office region are noted in Appendix B.

Kendra's Law/AOT in New York

Kendra's Law in New York (Chapter 408 of the Laws of 1999), enacted on August 9, 1999, establishes a legal basis for court-ordered AOT for people with a history of serious mental illness (SMI), hospitalizations, and/or violence attributable to SMI. The law is set forth in §9.60 of the Mental Hygiene Law (MHL) and is named in memory of Kendra Webdale, who died in January 1999 after being pushed in front of a New York City subway train by a man with a history of mental illness and hospitalizations.[8] Since its inception, the law has been reviewed periodically by the legislature for continuation and has undergone several amendments, including a technical correction in 2005 and amendments in 2010, 2013, 2017, 2022, and 2025. In 2022, the legislature extended the law's effect through June 30, 2027. Some of the amendments in 2025 took effect on August 7, 2025; others will become effective in July 2027. See Appendix C for a timeline of key related events.

Kendra's Law establishes the mechanisms for identifying individuals who could benefit from AOT; the procedures for obtaining court orders and completing the petition process; the requirements for serving notice and petitions to designated parties, including the individual, their nearest relative, Mental Hygiene Legal Services (MHLS), and the AOT coordinator; the eligibility

[5] https://www.clmhd.org/about_us/
[6] Ibid.
[7] https://www.clmhd.org/about_us/
[8] Assisted Outpatient Treatment: Kendra's Law

criteria for AOT; the process for developing and presenting a written treatment plan during the court hearing; the process for the hearing itself, including timelines and testimony requirements (the examining physician must testify; the individual and any other witnesses may testify); the disposition of the proceeding (petition is dismissed or approved), the length of the initial order, and the rules for extending orders for additional periods of up to one year; and the process for addressing lack of compliance (to be determined by a physician who can request a "pick-up or removal" order to transport a person to the hospital) as well as how long someone can be held (up to 72 hours) to determine if they meet the involuntary admission criteria. The court cannot issue an AOT order unless it finds that AOT is the least restrictive alternative for the individual.[9]

The eligibility criteria for AOT in New York State are that a person:

1. Is 18 years of age or older; and
2. Is suffering from a mental illness; and
3. Is unlikely to survive safely in the community without supervision, based on clinical determination; and
4. Has a history of lack of compliance with treatment for mental illness that has:
    i. except as otherwise in subparagraph (iii) of this paragraph, prior to the filing of the petition, at least twice within the last 36 months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; or
    ii. except as otherwise in subparagraph (iii) of this paragraph, prior to the filing of the petition, resulted in one of more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last 48 months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; or
    iii. notwithstanding subparagraphs (i) and (ii) of this paragraph, resulted in the issuance of a court order for AOT which has expired within the last six months, and since the expiration of the order,
        a) the person has experienced a substantial increase in symptoms of mental illness that substantially interferes with or limits the person's ability to comply with recommended treatment; or
        b) the person, due to a lack of compliance with recommended treatment, has undergone emergency observation, care, and treatment, or has been admitted for inpatient care or has been incarcerated.

[9] Ibid.

5. Is, as a result of his or her mental illness, unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community; and
6. In view of his or her treatment history and current behavior, is in need of AOT to prevent a relapse or deterioration that would be likely to result in serious harm to the person or others as defined in section 9.01; and
7. Is likely to benefit from AOT. Previous noncompliance with court oversight or mandated treatment shall not preclude a finding that the person is likely to benefit from AOT.[10]

Kendra's Law Implementation

OMH is responsible for statewide oversight and monitoring of the AOT program.[11] The OMH Statewide Director of AOT administers the program, supported by regional AOT program coordinators at each of the five field offices. These coordinators conduct service verification reviews to confirm the LGUs are providing services, ensure that LGUs are completing investigations, and act as the lead contact to troubleshoot issues.

OMH AOT staff also develop and disseminate guidelines and program standards, and OMH maintains data systems that contain information on significant events and quarterly status updates. OMH also manages funds earmarked for AOT populations — including an $18 million enhancement in the 2024-2025 budget to strengthen AOT oversight and implementation.

Implementation of AOT occurs at the local level, with LGUs responsible for:

- Accepting and investigating reports of persons who may be in need of AOT.
- Preparing and filing petitions for AOT in local supreme or county courts.
- Preparing and/or approving proposed AOT treatment plans.
- Ensuring services listed in AOT orders are delivered as written.
- Oversight and monitoring of services providers, including Health Home Plus and ACT teams.

Across all jurisdictions, an AOT coordinator coordinates all elements of the system that must be in place to ensure the person is connected to services. In counties with smaller populations, the DCS may also serve as the AOT coordinator; in others, AOT coordination may be one role of many held by a county staff person. For example, an AOT coordinator may also be the liaison between the LGU and treatment courts or other forensic programs. And in counties with larger populations, one or more staff positions are assigned specifically to AOT coordination.

[10] N.Y. Mental Hygiene Law Section 9.60 – Assisted outpatient treatment (2026)
[11] Assisted Outpatient Treatment: Program Administration

Statewide, 29% of LGUs have a dedicated AOT coordinator role. In the remaining 71%, the AOT coordinator also holds other responsibilities.

At the LGU level, the DCS/AOT coordinator keep track of their AOT orders and review each case monthly. They oversee the delivery of services to individuals receiving AOT. The LGU is responsible for submitting monthly data to OMH describing program utilization as well as quarterly summary data describing service utilization. Data submitted include significant events such as death, hospitalizations, and issuance of 9.60 Removal Orders, described later in this section.

In New York City, the clinical director of the New York City Department of Health and Mental Hygiene (DOHMH) oversees the implementation of AOT. For each borough there are AOT case monitors with dedicated supervisors who oversee the implementation of the AOT plan. A separate department of AOT investigators with dedicated supervisors handles initial petitions and renewals. There are also in-house data integrity staff and teams of attorneys and psychiatrists.

Rates of AOT Across Regions

As seen below, there is substantial variation across the state in the prevalence of AOT orders and Enhanced Voluntary Agreements.

Exhibit 1. *Variation Across the State in the Rate of AOT Orders and Enhanced Voluntary Agreements*

County	Region	EVA per 1,000 Adult Medicaid BH Population	AOT Orders per 1,000 Adult Medicaid BH Population
Broome	Central NY	0.0	9.2
Cayuga	Central NY	3.2	5.7
Chenango	Central NY	1.8	4.1
Clinton	Central NY	0.1	3.8
Cortland	Central NY	0.4	1.6
Delaware	Central NY	0.5	2.7
Essex	Central NY	2.5	9.9
Franklin	Central NY	7.2	4.0
Fulton	Central NY	1.3	16.1
Hamilton	Central NY	0.0	28.8
Herkimer	Central NY	0.0	0.3

County	Region	EVA per 1,000 Adult Medicaid BH Population	AOT Orders per 1,000 Adult Medicaid BH Population
Jefferson	Central NY	2.9	4.6
Lewis	Central NY	2.2	3.7
Madison	Central NY	0.9	0.9
Montgomery	Central NY	1.3	8.6
Oneida	Central NY	6.9	6.5
Onondaga	Central NY	4.1	3.8
Oswego	Central NY	1.3	1.0
Otsego	Central NY	0.4	1.0
Saint Lawrence	Central NY	5.7	5.6
Albany	Hudson River	2.6	5.6
Columbia	Hudson River	4.4	12.1
Dutchess	Hudson River	13.3	18.2
Greene	Hudson River	43.9	114.1
Orange	Hudson River	3.3	6.3
Putnam	Hudson River	9.9	23.0
Rensselaer	Hudson River	15.1	199.6
Rockland	Hudson River	1.2	7.6
Saratoga	Hudson River	2.7	13.3
Schenectady	Hudson River	2.0	5.9
Schoharie	Hudson River	5.7	3.0
Sullivan	Hudson River	30.0	45.8
Ulster	Hudson River	14.1	16.3
Warren	Hudson River	1.7	6.6
Washington	Hudson River	5.9	24.8
Westchester	Hudson River	1.3	5.1
Nassau	Long Island	2.9	11.3
Suffolk	Long Island	7.9	22.5
Bronx	NYC	8.6	38.4
Kings (Brooklyn)	NYC	9.3	24.4
New York (Manhattan)	NYC	6.5	15.7
Queens	NYC	25.9	36.3

County	Region	EVA per 1,000 Adult Medicaid BH Population	AOT Orders per 1,000 Adult Medicaid BH Population
Richmond (Staten Island)	NYC	9.3	46.5
Allegany	Western NY	6.8	2.0
Cattaraugus	Western NY	8.4	3.6
Chautauqua	Western NY	5.8	6.3
Chemung	Western NY	1.4	0.9
Erie	Western NY	14.2	14.2
Genesee	Western NY	0.8	9.2
Livingston	Western NY	1.3	2.1
Monroe	Western NY	0.0	32.6
Niagara	Western NY	3.5	12.5
Ontario	Western NY	0.3	2.3
Orleans	Western NY	2.6	4.1
Schuyler	Western NY	0.0	0.7
Seneca	Western NY	0.0	5.5
Steuben	Western NY	0.8	2.3
Tioga	Western NY	0.0	14.3
Tompkins	Western NY	1.2	6.3
Wayne	Western NY	0.0	4.2
Wyoming	Western NY	12.9	11.5
Yates	Western NY	0.0	0.6

Data sources: Numbers of AOT orders and EVAs come from the *OMH Monthly Report* (2023). Source for the size of the adult BH Medicaid population is the *OMH County Needs Assessment Dashboard*.

Judicial Processes and AOT Plan Development

The civil legal process of AOT begins when a petitioner (often the DCS or a hospital or correctional facility administrator) files a petition with the court. The petitioner will gather information demonstrating whether the person meets eligibility criteria for AOT. This includes obtaining medical records and an examination by a psychiatrist. The evaluating psychiatrist will meet with the person and create a written AOT treatment plan, referred to in this report as an AOT plan. Care coordination—either a Health Home Care Manager or an Assertive Community Treatment Team—is the only mandatory component of an AOT order. In nearly all cases, the court also requires medication, and commonly a person is also required to participate in outpatient therapy and supervised or supported housing.

Mental Hygiene Legal Services is a state agency that provides free legal representation to anyone subject to an AOT petition. When a petition is filed, MHLS is notified and meets with the person to explain their rights, including their right to a hearing before a judge. MHLS is present during the psychiatric examination and the hearing.

If the person decides to contest the petition, MHLS serves as their defense counsel in court and cross-examines the evaluating psychiatrist to challenge whether the person meets the legal criteria. The person, represented by their MHLS attorney, can also challenge the proposed AOT plan—arguing, for example, to remove specific requirements. The person is also legally entitled to call their own witnesses to testify on their behalf.

If the person does not contest the petition, the judge still presides over the hearing and the examining psychiatrist still provides testimony. In an uncontested hearing, the MHLS attorney will typically not cross-examine the psychiatrist.

In both contested and uncontested hearings, a judge reviews evidence of eligibility and the proposed AOT plan and determines whether to sign an order mandating the person to follow the AOT plan.

Service Monitoring and Significant Events

Once a person is under an AOT order, their care coordinator (either Health Home or ACT) is required to provide care coordination services, maintain regular contact, and monitor whether the person is attending appointments, taking mandated medication, and participating in any other services as documented in the AOT plan. The care coordinator is required to report significant events to the LGU. These include instances of noncompliance with the treatment plan, any acts of violence toward others, self-harm or suicide attempts, being out of contact with the treatment team, arrests or incarcerations, becoming homeless or being at risk of losing housing, psychiatric hospitalization, or deterioration of mental health symptoms. If a person refuses to participate in treatment, misses treatment appointments, or is missing, the DCS can authorize a 9.60 Removal Order that authorizes police or mobile crisis to transport a person to the hospital for a psychiatric evaluation.

Enhanced Voluntary Agreements

In some instances, an Enhanced Voluntary Agreement (EVA) is used in place of an AOT order. EVA terminology varies regionally; EVAs are referred to as Voluntary Service Agreements, Diversion Agreements, or other terms throughout the state. In this report, we use EVA. EVAs are a less-restrictive alternative for people who have agreed to engage voluntarily in services but who otherwise meet AOT criteria.

An EVA is a formal written agreement between a person and the DCS, and it involves the same level of services as an AOT but without a legal mandate. There is no court hearing, no mandated reporting of significant events, and no power to issue 9.60 removals. Although implementation varies widely across counties, recent amendments to Kendra's Law and OMH initiatives aim to formalize and strengthen the use of these agreements. They may serve as either a diversion from AOT or a step-down after an AOT order ends.

Chapter 1: Lived Experience Mechanisms and Outcomes

This chapter presents nine mechanisms and associated outcomes that emerged from qualitative interviews with people under AOT orders ("clients"). The findings presented are based on a systematic analysis of 46 interviews[1] with AOT clients. Using a critical-realist framework, as described in the Methodology section, the analysis reveals a complex intervention system with both potentially beneficial and harmful components operating simultaneously. For detailed findings on mechanisms and associated outcomes described in this section, see Appendix G.

For analysis of qualitative data from other groups (providers, administrators, legal system professionals, advocates, and family members), see Chapter 2. For analysis of AOT's associated legal process from the perspective of AOT clients, see Chapter 3.

Mechanism 1: Coercive Compliance and Ongoing Possibility of Hospitalization

AOT clients described beneficial and harmful outcomes related to perceived coercion. Some clients report perceived coercion as beneficial and leading to compliance with treatment they might otherwise have avoided. They note the benefits of psychiatric medication or abstinence from street drugs, and prevention of harm to self during acute psychosis or mania. However, largely, AOT clients report perceived coercion as harmful. Expressions of fear in response to implied or explicit coercion or the possibility of hospitalization, jail, or removal was identified across 44 of 46 interview transcripts (96%). Descriptions of harm include: loss of autonomy; negative impacts on self-confidence and broader sense of self, fear, psychological distress; negative feelings of surveillance and control; powerlessness; power imbalances with providers; and distrust in providers and the mental health system more broadly.

A minority subset of clients explicitly credited enforced behavioral change—such as taking medication or refraining from substance use—with significant benefits. While many providers we interviewed described primary or co-occurring substance use as a reason AOT orders fail, we most often encountered claims of direct benefits of AOT related to substance use:

> *Interviewer: "When we just first started talking, you said that you're someone who has found AOT helpful overall. What is it that—just sort of describe to me what you found helpful about it."*
>
> *Client 45: "Well, in the beginning, when I first started AOT, I would think about marijuana a lot. I would think about smoking cigarettes a lot. I would think about drinking a lot. But now, since time has passed, I think about it less and less. So for substances, for someone who uses substances for 10 years, for almost close to 10 years, I would say like seven-ish years, you realize that you don't need substances to be happy. When you spend time without using substances and you live life naturally, exercising, eating healthy, taking your medication*

[1] Note: In interviews, confirmations from clients elicited through a paraphrase-and-summarize cognitive interviewing technique are treated as client statements rather than as interviewer-leading artifacts. This reflects established practice for interviewing populations with psychiatric service contact.

when you're supposed to, as you're supposed to, taking time to experience life naturally and in a healthy way and through a lens of normalcy on medication—by normalcy, I mean medication that you're supposed to take—you realize that life is better the way it's supposed to be, not under the influence."

Interviewer: "Oh, OK. And do you feel like, if I'm understanding right…being forced to quit all the substances is kind of what led you to the realizations you just described?"

Client 45: "Well, I was forced. Yeah. But sometimes things happen for a reason."

Interviewer: "A different way of asking that is if there hadn't been a court mandate, what do you think would have happened?"

Client 45: "My life would have been ruined."

Interviewer: "Because you feel like you would have just kept using?"

Client 45: "Yes."

Interviewer: "OK. OK."

Client 45: ""Yes, [it] saved my life."

Interviewer: "Got it. And is that like—for you, that was the biggest thing? I mean, some people might say getting access to an ACT Team was super helpful, but it sounds like maybe the biggest thing was just sort of being forced to stop using drugs."

Client 45: "Yeah. The ACT Team helps, but they didn't put a gun to your head to tell you to stop using. AOT was the one that's like, 'Well, you have to stop using.'"

Another client gave a similar account:

Interviewer: "Do you think you'd be sort of in the same place that you are in your life if you hadn't been ordered into AOT?"

Client 19: "I'd probably be doing drugs right now."

Interviewer: "You'd probably be doing drugs."

Client 19: "Probably."

Interviewer: "And the order keeps you off the drugs."

Client 19: "It helps. OK. It's just marijuana and that's it."

For many clients, perceived coercion was not seen as unique to AOT but as a pervasive feature of the mental health services experience. One client described providers under AOT as consistent with providers across the mental health system:

"I would say, 95% or 90% of interactions with staff is a threat. They are threatening the patients. They're threatening me. Staff is the most threatening. I mean, I got used to it. I accepted it. When I was in the state hospital, and I was like, 'This is crazy. What happened in my life?' I just accepted it. But yeah, I mean, the mental health system is very threatening to the patient. That is the only way that the doctor—that's the only way the staff can get the

patient to cooperate. It's called coercion. Coercion comes with threats. You cannot coerce someone without threatening them." ~Client 37

Within the AOT context specifically, some clients described the perceived coercion as unambiguous:

"It was clear that what they wanted was compliance and that they made the rules and that I had to comply with their decisions and that failure to comply would result in more punishment. And so I got the message that I had to do what they wanted. I had to comply. And that was it. So that much was clear." ~Client 33

Others described AOT as presented as a choice but, in practice, functioning as an ultimatum. One client analyzed the framing at length, describing how the structure of the "offer" did not allow refusal:

"Yeah, it's all voluntary. Because it's like they finesse you in the hospital because I guess they don't want to make it mandatory. If they do it under duress and make it mandatory and do that shit to you, legally, they're scared that you could sue them. So, when they say it, they want to make a slick little, 'Oh, I got a deal. I got a proposition for you.' But they don't tell you it's a deal or proposition. They just propose an idea to you and say, 'This is what is necessary for you to take this next step in your life to continue on the right path. But basically, to let you out and let you go, to do the right thing, this is the plan that we have for you.'" ~Client 39

Later in the same interview, the client again said that what was framed as a voluntary "yes" was unrefusable:

"Yeah. You can't say no, but they don't let you know you can say no, but yeah. But the way they say that you could say no is by saying, 'Yeah, we got this idea for you. But if you don't want to do it, you could just stay here for longer.' That's how I say you could say—it's not, 'We're letting you go with this thing that can help you, but if you don't want it, you can just be on your own and go.'…So we're not letting you go. Basically, we're putting you in house arrest or whatever, or the closest thing to that." ~Client 39

Some clients noted disappointment or invalidation stemming from unjust or untrue assumptions about their behavior made by AOT providers or administrators. One client described being treated punitively despite full compliance:

"It was definitely an authoritative kind of a thing. … Well, it was like, this is what we're gonna do. And it came it came across as, like, a little bit punitive, which I was just kind of internally, like, rolling my eyes a little bit because I knew that I had done everything I could, like, you know, to be compliant." ~Client 10

Another described fear that asserting any oppositional position would trigger involuntary commitment, mentioning they avoid AOT court appearances out of that fear:

"I have a lawyer go for me because I'm just afraid if I go, they'll lock me up somewhere. They'll be like, 'Oh, well, you're fighting this, but we're going to lock you away'—I don't know where they lock you away. … Wherever they lock you away. So, I just go with it. I'm like, 'But at least I'm home.'" ~Client 42

Once enrolled in AOT, the perceived threat of involuntary hospitalization continued to function as the primary mechanism ensuring compliance. Clients described living with ongoing awareness that failure to comply with program requirements could result in forced hospitalization, and this fear shaped their daily decisions and behaviors. One client, asked whether they had any problem taking their medications, gave an answer in which adherence was explicitly conditional:

Interviewer: "You don't have a problem taking them."

Client 2: "Meds. Yeah. But that's because I'm on AOT cause I know that."

Interviewer: "Do you feel good?"

Client 2: "I could be if I miss my appointments I could be, you know, put back in the hospital for evaluation."

Another client described the AOT order as functioning specifically as a "consequence" that motivated their engagement with services:

"They help they keep me in track and, like, they helped me to have motivation to go to program and everything, see my counselors. … Like, I was I think if I didn't have the AOT order, if I if I know I was gonna end up back in the hospital or something, I would … go to the city councilors and everything. Like, I gotta have a, like, consequence." ~Client 32

In a third pattern—small but analytically important—the possibility of hospitalization was not a motivator for compliance because hospitalization was preferable to the client's community conditions:

"With AOT, if you're not taking your medication, they can put you back in the hospital. To be honest with you, I don't live in such a great—I mean, it's a nice apartment and stuff, but I don't care if they put me back in the hospital. They give you three meals a day, nice clean sheets every day. So that was one of the reasons why I didn't care about AOT because I don't care if they put me in the hospital." ~Client 14

While some clients expressed anger and frustration in response to perceived coercion, others expressed resignation and disbelief that these dynamics could be shifted:

Client 29: "It's a heavy handle for you that they can always do with an obstacle."

Interviewer: "So you're talking about—I heard a little bit of, 'oh, there's someone always watching you' in the surveillance—then that's not helpful for you."

Client 29: "No. There's always someone sending [you] to the hospital."

Interviewer: "Mhmm. There's always someone who's like, if you don't, it's time to go to the hospital."

Client 29: "Yeah-"

Interviewer: "… So you feel like there's definitely a power dynamic there."

Client 29: "Yeah."

Interviewer: "And then what do you think would make that feel more fair to you, I guess?"

Client 29: "I don't know. There's no way to change the power imbalance."

Interviewer: "Yeah. Like, some type of way for you to have more power or a say in what's going on."

Client 29: "Yeah. I don't know. There's no way to change it."

Some clients said the order helped prevent serious risks, like self-endangerment. At the same time, they had mixed feelings about the order and raised concerns about unequal enforcement across racial groups.

One client credited AOT with likely saving his life while underscoring racial disparities in implementation and asserting that, for some, AOT functions as a "life inhibitor" rather than a "life saver":

"I guess it's a paradox or something like that. On the one hand, I might have died. Someone might have killed me. I might have got run over by a car. There was a period in my psychosis where I pretended I was blind, and I closed my eyes and traveled through the subway system. And one time, I was blind and feeling around, and I found myself on the train tracks. And I opened my eyes, and I realized, 'I'm on the freaking train tracks.' And I jumped back onto the platform before a train could hit me. So these are the types of behaviors I was doing in my supernatural ecstatic state. And that's the type of behavior that the system is trying to prevent, I think. … So, for me, I think it may have indeed saved me from perishing. [But] AOT, the way it's implemented, there's racism in it. So, someone who is not as reckless as I was but happens to be Black might be enrolled in it against their will even when it's not super clear that they're a danger to themselves and somebody else. And that element of racism is extremely problematic. And not everyone on AOT needs—it's not a lifesaver for everyone. It's actually a life inhibitor for a lot of people. And that's not right. And I can't tell you—I haven't seen what it looks like on paper, but it probably looks a lot better on paper than how it is implemented." ~Client 35

Mechanism 2: Initiation Through Hospital Discharge 'Ultimatums'

Hospital discharge "ultimatums" were described as a common pathway of AOT initiation, with 30 of 46 clients (65%) describing some form of coerced agreement during hospitalization. No AOT client described coerced initiation as directly beneficial. However, rapid initiation did facilitate

discharge from hospital settings—settings which some clients found harmful or distressing—and provided connection to community services that might otherwise have been inaccessible. AOT client descriptions of harm through perceived coerced initiation include: violation of informed consent; feeling trapped or forced; distrust of providers and mental health care system; confusion about legal rights; trauma from loss of freedom; anger at perceived manipulation; and sense of powerlessness and objectification.

Some AOT clients expressed that while initiation felt coercive, they ultimately appreciated being connected to services.

> *Client 38: "It gave me the impetus to do it."*
>
> *Interviewer: "OK. So did you find being ordered then to services helpful, it sounds like?"*
>
> *Client 38: "It was not by choice."*
>
> *Interviewer: "OK. Yeah. But it was not by choice for sure."*
>
> *Client 38: "Yeah. But it was helpful."*
>
> *Interviewer: [later] "Can I ask what doesn't feel good about it?"*
>
> *Client 38: "It doesn't feel good that I didn't get any say in it."*

One client described an initiation pathway in which the proposal was brought by a trusted figure—the supervisor at the client's residence—rather than imposed by hospital staff:

> *Interviewer: "And so when they came to you and said, 'Oh, we're suggesting we're going to try to put you on AOT'—"*
>
> *Client 41: "The supervisor. The supervisor at my house."*
>
> *Interviewer: "Oh, the supervisor at your house? And they came into the hospital?"*
>
> *Client 41: "Yes."*
>
> *Interviewer: "OK. And how did you feel about that?"*
>
> *Client 41: "I was happy because I needed help."*

Many clients described their initiation onto AOT as occurring under duress during hospitalization, with the promise of discharge used as leverage to secure agreement to the order and waiver of the right to a hearing:

> *"Because I wanted to get out of the hospital…I was working with a gentleman—I just wanted to get out of the hospital and get back into the community and live my life. And I don't know if I rushed, but they put me into a group home. And in order to go into the group home, I had to sign an AOT order to be back in the community. And so I didn't want to, but I wanted to go. I wanted a cigarette. I wanted to be with my son. I just wanted to be free again." ~Client 40*

Another client described accepting the order under direct conditional framing:

"They put me on AOT. They said it'd be good for me. … So I was like, I don't have [any] choice but to sign the paperwork." ~Client 19

A third client described the structural pressure of being told to choose between AOT and a state psychiatric center:

"I just want to cooperate. I don't know. But, like, I had a bunch of people coming at me saying, if you don't do AOT, you gotta do this. And I was like, no. I rather do AOT." ~Client 22

A fourth client described the same dynamic, with the explicit alternative of continued hospitalization:

Client 29: "No. They were kinda pressuring taking the order."

Interviewer: "You said they were pressuring you?"

Client 29: "Yeah."

Interviewer: "Uh … can you describe what that pressure was like? Like, what made you feel pressured?"

Client 29: "Well, they weren't gonna release me at all, you know, if I didn't go on any order."

Interviewer: [later in the exchange] "Is there a reason that you decided you didn't wanna go [to the hearing]?"

Client 29: "It's just a lot of pressure to go, you know, to sign."

A fifth client described feeling that they did not fully understand what they were agreeing to until later:

"Yeah. They will let you out, but you have to do AOT. I mean, I feel like it feels like probation, like, the same thing. It's like, if you [do] what you have to do, we'll let you be out. If up in any way, we could just put you back in the hospital, and that's happened twice so far since I've been out.…But, yeah, nobody really told me anything. It was kinda like, oh, they're just there to help you, assist you, but I didn't know what a piece of shit it was gonna be until I got out, and they control everything." ~Client 31

Several clients described feeling deceived or misled about what they were agreeing to, having been presented explanations that they characterized as vague, incomplete, or actively misleading.

"They slick with it. They come and then they say, 'Oh, we're going to let you out, but on one condition, you got to do this AOT.' And they say, 'If you don't do the AOT, then you're going to stay in the hospital for longer until we think you're OK. But if you do this AOT, we let you out right now.' So what are you saying to me? So you're telling me that you don't think I'm OK because technically, you want to keep me in here longer, but you're also saying to me that, 'If you do this thing, we'll let you out.' You feel me? You don't care about—you just moving me on." ~Client 39

Additional clients across the sample echoed this conditional-release framing of hospital initiation, describing the same structural pattern in which discharge was contingent on agreement to AOT. Several reported that the substantive content of the order was either incompletely explained at the time of signing or only revealed later.

Across interviews, perceived coerced initiation contributed not only to perceptions of overall coerciveness and procedural injustice (see Chapter 3) but to a generalized sense of powerlessness and objectification.

> *Client 15: "I was homeless after my mother put me to the hospital."*
>
> *Interviewer: "Oh, your mother put you in the hospital? Yeah. She called somebody?"*
>
> *Client 15: "She called. She put me there."*
>
> *Interviewer: "Oh, she brought you there. OK. And how did you feel about going to the hospital?"*
>
> *Client 15: "Bad."*
>
> *Interviewer: [later] "What did you think should happen?"*
>
> *Client 15: "I don't know nothing. I didn't wanna go."*

Another client, summarizing the cumulative effect of the order across years, used the language of lost rights:

> *Client 37: "I lost my rights."*
>
> *Interviewer: "OK. Do you want to expand on that at all?"*
>
> *Client 37: "I was taken with no due process. I was drugged last 15 years. Whenever I interact with police, they see that I have the diagnosis. So they don't interact with me the same. Just I lost my rights."*
>
> *Interviewer: "Yeah. OK. All right. Well —"*
>
> *Client 37: "Confinement, drugging."*

Mechanism 3: Surveillance and Monitoring

Surveillance and monitoring appear in 35 of 46 client interviews. Some clients describe the structure and accountability as helpful, particularly where the regular contact comes with concrete case-management work the client values; a small number of clients explicitly identify monitoring itself—distinct from the support—as beneficial. Where harm is described in relation to surveillance and monitoring, themes include: loss of privacy; the experience of being untrusted; negative impacts on self-concept; restricted freedom of movement, including inability to travel outside the state; barriers to employment caused by the appointment burden; infantilization; community-level stigma when wellness checks and home visits are visible to neighbors.

About 12 of 46 clients interviewed—people whose pre-existing housing and case management were adequate at order initiation—described monitoring as the dominant experience of harm related to AOT. In the three to five cases that involve perceived racialized surveillance, monitoring operates on top of pre-existing patterns of racialized neighbor and police contact and produces measurable loss of community standing (these ideas are discussed further in Chapter 5).

When clients who described monitoring as beneficial were asked what specifically about the monitoring helped, most pointed to the support that came with the contact rather than to the observation itself. When interviewers explicitly separated the two—asking clients to distinguish between meeting regularly with a supportive provider and being monitored for compliance—only a small number of clients identified monitoring as the source of the benefit.

One client valued the monitoring oversight as a safety mechanism in its own right. Asked what part of the monitoring component had been helpful, he distinguished it from the rest of the order and named what monitoring was specifically doing:

> *"Well, just the sense that they're monitoring the impact of the medication upon my psychology and determining whether I'm safe and not reckless anymore and have a routine and do this and do that. And they check in frequently. And that type of monitoring … ensures that I'm safer than I was before AOT." ~Client 35*

Other clients framed the monitoring contact primarily in terms of what the contact made available—extra support, weekly check-in, concrete work on the client's behalf—rather than the actual function:

> *"I guess to have extra support. I don't know. That's just the extra support. So there's pros and cons, but I look at the pros. So the support, I see my case manager weekly once a week. So she checks in with me, just sees me once a week and helps me as much as she can." ~Client 40*

Another client, asked what was helpful about her case manager, answered with a one-line summary of what the relationship produced:

> *Interviewer 1: "Your case manager is the best? What is so helpful about them?"*
>
> *Client 38: "They get shit done."*
>
> *Interviewer: "Get stuff done for you. I like that. What kind of stuff are you working on with your case manager?"*
>
> *Client 38: "SSI."*

A smaller subset of clients framed the value of monitored compliance in instrumental terms—as evidence of stability they could present to landlords, for example. The accountability function and the instrumental function are linked: visible compliance under AOT operates as a kind of certification:

"It keeps me on track … It just makes [it] so I don't slip up. Because I feel like people wanna see that I'm on the right boat. Like, I'm in the right. I'm doing the right thing… It looks better for, like, apartments and stuff." ~Client 22

Clients who described monitoring as harmful identified five distinct components of the experience: the loss of control over daily movement, the experience of being checked on at home, the routine of biological verification through pill counts and blood work, the community-level stigma produced by visible provider and police visits, and the logistical burden of compliance itself.

For some clients, AOT monitoring echoed earlier experiences of surveillance in their communities. For Black and Hispanic/Latino clients in particular, monitoring operates on top of pre-existing patterns and perceptions of racialized surveillance rather than independently of them.

One client—a Black male homeowner—described the daily burden he experienced the summer before his AOT order, when daily wellness checks initiated by his neighbors forced him into a routine to prevent police visits. He believes the calls were placed by neighbors who did not want to see him outside.

"The voicelessness along the process can be best described in the fact that for the summer previous for the AOT, every day I woke up in the morning and it was a nice day and I decided to go outside. I asked, I first had to call the police department to tell them I was going outside today and that I did not need a wellness check. On the days that I did not call, they showed up for a wellness check and it took about an hour or two hours before they went away, and [it] messed up my entire day." ~Client 30

Asked to elaborate, he emphasized how the police response to the repeated neighbor calls left him feeling targeted and powerless:

"I kept on telling the police … I did not need a wellness check. I did not need you to be here. My neighbor, my neighbors are harassing me and they're using, they're weaponizing you against me. And you're not realizing that." ~Client 30

Elsewhere in the interview, he described this pattern, and the ability of neighbors to mobilize police against him, as racialized. He described the cumulative effect as a loss of standing in his own community—a loss of what he called "social capital"—a dynamic he felt continued once he was under AOT, when visible signs of state oversight shaped how his neighbors perceived him:

"I also lost a lot of like social capital with my neighbors and the people around me simply because of the fact that they knew that I was under such strong restriction or obligation by the government." ~Client 30

Another client described his concerns of racialized interpretations by administrators. Returning to ACT-team contact after a hospitalization, he describes how he believed a new team received him through the lens of race and recent hospitalization:

"The next team just gets what they left over, which is the irate African-American that came out of the hospital." ~Client 24

A separate set of accounts focused on the experience of being treated as untrustworthy by the monitoring system itself.

Interviewer: "Going back to those, the sort of the extra surveillance, the travel restrictions, etc. How has that impacted you?"
Client 9: "I just feel like I'm being more closely observed."
Interviewer: "OK. How does that leave you feeling?"
Client 9: "Like I'm not trusted."

Asked to expand further, she identified the AOT structure itself as the source of mistrust rather than any individual party:

"I mean, it's difficult to have this AOT order in place without being observed in a way that you're not trusted." ~Client 9

Another client described a pill-counting arrangement for medication adherence verification. A nurse came every two months to count her pills; the prescriber and nurse practitioner both asked at each appointment whether she was taking her medication. Seven years into her order, with her medication stable, the counting continued unchanged:

"And they always ask again, the psychiatrist, [the doctor], the nurse practitioner—always asks if I take my meds. Which is fine. I think that's a great idea. But I think too once you're stable on your meds, they shouldn't have to count your medication anymore because you're being stable and you're taking your medication. It's just a stressful thing like, 'Oh my God, what are they looking for?' Because I know I'm taking my medication." ~Client 42

The same client connected the verification stress to a broader sense of unfreedom that the order had imposed on her life:

"It's stressful. And it's like I don't need more stress in my life. I wish I was free. I know you don't influence this, [the doctor] does. But I want my freedom back to just live my life. I want to drive again. I do all these good things. Hence, of course, depending on my good health coming back. But I don't have that freedom now. And it's taking forever." ~Client 42

Client 42 also spoke about an explicit policy recommendation. Asked whether the frequency of her monitoring had ever lessened as she stabilized, she answered no, and drew an unfavorable comparison with probation:

Client 42: "I feel like [I'm] being checked up on, monitored. It's like I've graduated from that a long time ago. What they should do with probation is if the person's being compliant with—that is a great tip: If the person's being compliant with their medication, they should lessen how many times a week they need to see the social worker."

Interviewer: "Oh, that has never lessened for you?"

Client 42: "No, never. Probation does it, though. If you're really good at probation and it's towards your sentence and you're being compliant, they lessen the time you see the probation officer."

Restrictions on travel outside New York State recurred in several accounts. One client could not visit her boyfriend in South Carolina without risking a removal on return:

"I can't go to South Carolina right now because I'm on AOT order… I can leave the state, but then I'm not no longer on AOT, but then that's not the right thing to do… I'll be picked up by a cop back in New York. Like, if I come back to New York I'll go to the psych ward."
~Client 19

Travel restrictions interact with employment in ways that shape clients' broader life options. One client explained that AOT's required appointment schedule meant she could not work certain days, which constrained the kinds of jobs available to her:

"Emotionally, I guess it feels like I have no control over where my life is going. And sometimes I feel very stuck. It makes me feel depressed that I can't just start over. I'm kind of I have to follow the rules. And if I get a job, I can't work certain days of the week." ~Client 16

Whether AOT adds services the client did not previously have is a key distinction between positive and negative experiences. The following client had both housing and case management before AOT; the order's primary impact from her point of view was the additional reporting layer. Her statement captures how that oversight shaped her daily life:

Client 31: "I have to pack my meds, and I have to call them. Like, oh, I —"

Interviewer: "Who's them? Is that your housing people or your [case management] people or both?"

Client 31: "I guess they work together… you have to pack your meds and you have to tell them when you take it. Like, oh, I just took my meds. It's, like, miserable. Like, my whole life revolves around what people tell me to do."

Several clients described the time cost of the appointment schedule as a source of perceived harm distinct from the experience of being monitored.

"It's actually extremely detrimental because it eats up half a day. I have to call a Medicaid cab. I have to wait for the Medicaid cab. I have to go all the way over there. It's a half an hour. … And then once the Medicaid cab finally arrives, then I take another 30-minute trip back to the house. Before you know it, half the day's over. And I'm like, I can't get anything done. And then on days when I have depression and I'm trying to wake up and I can't and I need to sleep in and I need to delay stuff, it becomes a problem." ~Client 47

Additionally, clients reported that transport itself is unreliable. Another client described added costs when Medicaid cabs failed to arrive:

"Definitely the fact that you have to make a certain amount of appointments in a month. It can be a little bit stressful because you got to get the cab ride set up. And I have honestly

had a lot of problems getting cabs. I will go on Medicaid cab, and schedule my appointment, and then they'll never show up. And then I'm calling my ICM. And I'm like, 'They're still not here.' And she's calling these Ubers, and we're paying $50 here and there for an Uber. And it's just very inconvenient." ~Client 9

When asked what she would change about her AOT experience, the same client brought together the appointment burden, the discrimination she perceived in how she was treated under the order, and the cumulative experience of being talked down to:

"Well, I want to be able to leave the city. I would like to not have a million appointments every month. I would like to just not always be treated in—it's just deplorable. I don't even know how to explain it. Discriminative kind of way. I want to be respected regardless of what they feel I should have to work with. 'Oh, you're in AOT.' Yes. That doesn't mean you have the right to talk down to me… Yeah, and being pushed around." ~Client 9

Two clients described how they had worked around the verification structure of their orders. One client, describing an earlier AOT order, said she had not been taking her medication and had lied about it; the order had no injectable component and no biological verification of compliance:

"I lied to them, and I said that I was taking it." ~Client 33

A second client said he took the medication intermittently—only enough to ensure his blood draws registered the expected presence—and otherwise did not comply with the prescribed regimen:

Interviewer: "Were you taking them like a week before? Did you know when—the blood tests are random?"

Client 44: "No, not really. Basically, everything was."

Interviewer: "So were you kind of like not taking it a little bit, and then a week before, building off?"

Client 44: "Yeah. Just enough that they would know that I was on it, right?"

Mechanism 4: Medication Requirements and Bodily Autonomy

When asked about their experiences on AOT, 43 of the 46 clients interviewed (93%) raised issues related to medications and their effects. The following accounts describe the range of client reports of the effects of medication requirements associated with AOT. Potential benefits of this mechanism include: improved stability; symptom relief; and better relationships with family members. Some clients explicitly describe medication adherence as a positive outcome. Potential harms of this mechanism include: serious and often unaddressed physical side effects, cognitive side effects, sexual side effects, and emotional "blunting." Additionally, clients report loss of bodily autonomy, and concerns about the impacts of medications during pregnancy.

Taken together, the benefit accounts in this section show medication producing real value in some clients' lives—finding the right regimen, getting symptom stabilization, working with a psychiatrist who listens and adjusts. Across these accounts, the prescribing relationship appears to be the variable that determines whether the medication mechanism produces benefit, ambivalence, or perceived harm.

Some clients described the process of finding an effective medication regimen as helpful, particularly when psychiatrists were willing to adjust medications in response to reported side effects or treatment responses. Several clients contrasted these experiences with earlier ones—involuntary medication during hospitalization, or outpatient providers who made little effort to optimize prescribing—before the current AOT team.

One client described his psychiatrist as very helpful, and identified the combination of medications, not talk therapy alone, as what made the difference:

> *"Getting the right medications, kinda like getting the right combination on a lot. Really yeah. Really it was really helpful to me. Alleviate a lot of stress." ~Client 34*

Later in the same interview, when asked what a clinician could have done differently at an earlier point, the client returned to the same theme:

> *"Sometimes it's just getting the right medication. Sometimes ... you get to a certain point where you can't talk through anything else. That's not gonna help at that point. But you talked for years." ~Client 34*

Another client described arriving at a workable regimen after a long period of trial and error:

> *"Well, I like these meds. I feel like I finally found my balance... Well, nothing's going to cure me, but at least I feel like this is as normal as I'm going to get. I don't want to use the word normal, but as balanced as I'm going to get." ~Client 45*

He attributed the workable regimen specifically to a psychiatrist who practiced what he called medication minimalism:

> *"The good thing is I have a good doctor, [psychiatrist's name]. She's good. So she believes in minimalism. There's some doctors that are not like that. Some doctors just pile on medication and raise the medication and make you feel like you're mute and numb, and they just want to medicate you. My doctor believes in less medication is more, and exercise and diet is the way to go for better mental health and a healthy way of living. So my doctor has reduced my medication based on my lack of use in substances and any sort of drug use. I haven't used in a long time, a few years. So my doctor promised, as long as I don't use, she'll reduce my medication. And that's what's been happening. So it's really great." ~Client 45*

Several clients described symptom relief and a more stable mood after starting medication under AOT, particularly those who described bipolar or major depressive diagnoses.

One also connected his medication adherence to a reduction in substance-use cravings over time:

"Well, in the beginning, when I first started AOT, I would think about marijuana a lot. I would think about smoking cigarettes a lot. I would think about drinking a lot. But now, since time has passed, I think about it less and less. So for substances, for someone who uses substances for 10 years, for almost close to 10 years, I would say like 7-ish years, you realize that you don't need substances to be happy." ~Client 45

A small group of clients described working relationships with psychiatrists who listened, adjusted medications based on client feedback, and treated them with respect. An analysis of these relationships and their moderating effects on outcomes appears under Provider Relationship Quality.

Client 16 offered an extended account of a collaborative ACT-team relationship in which both the psychiatrist and the primary counselor were responsive:

"I get along with the psychiatrist. He actually listens to my opinions on my medication, and he'll make changes in response to what I'm reporting back to him. He's also recommended helpful sleep aids and supplements and stuff like that. I feel like, especially my primary counselor, we just have a very good relationship that will make me want to stay with the ACT team when the AOT order expires." ~Client 16

Client 21 contrasted her current AOT psychiatrist with a previous (pre-AOT) prescriber:

"So that psychiatrist I see now is very understanding. She does not force me. She does not yell at me. She does not put me down. She does not make me feel stupid like that other one did. And she really listened to me, and she understands. And she likes where I go. She likes my pharmacy. That's another plus." ~Client 21

Client 5 described supported medication discontinuation when his symptoms had improved—a rare pattern in the group, but one worth recording because it shows that the prescribing relationship under AOT can produce both downward and upward titration:

Interviewer: "You stopped the medications?"
Client 5: "No. No. They stopped the medication."
Interviewer: "They stopped it? … Did you guys talk about why?"
Client 5: "No. They just stopped it because I was doing so fine and very well, and they told me that I don't no longer need it."

Asked to say more about the conversation in which the medication was stopped, the same client described a process of joint decision-making:

"Well, we discussed it, the conversation, and they told me that I no longer need meds. And I thought I said that it was fine. And he said that I'm processing, and I'm doing so much better. And I'm doing fine, and he took me off the medication." ~Client 5

Some clients acknowledged that medication had helped them while still expressing discomfort with the process that imposed it.

> *"I'm not happy about the medication that they put me on. I'm kind of disappointed, but my fiancé always tells me it's working. So compared to how I was without it, compared to how I am now, there's been a significant amount of change and just progress, and notice I'm much better with taking it than with not. It helps me. It's like a person with diabetes, she tells me. And so I'm going to have to take this. And if not, then I could end up back into a hospital, and I don't want to go down that road again." ~Client 40*

Asked whether she was experiencing any side effects, this client clarified that her objection was not to the medication itself:

> *Interviewer: "So are you saying you experienced some side effects from the medication?"*
> *Client 40: "No."*
> *Interviewer: "Oh, OK. OK, just—"*
> *Client 40: "It's just the being forced to take a medication."*

Other clients described mandated medication as one of the elements of AOT that had "saved" their lives—either by preventing self-harm or by contributing, alongside housing and other supports, to overall stabilization.

A distinct pattern within the benefit accounts is one in which the client takes the medication, often reports it as helpful, and attributes adherence not to agreement with the treatment plan but to awareness that nonadherence could produce a return to the hospital. In these instances, the adherence looks voluntary but the motivation behind it differs. As shown in the following exhibit, this pattern is present in approximately 22 of 46 transcripts.

Exhibit 1.1. *Medication Requirements: Adherence Patterns*

Pattern	Transcripts (of 46)	Description
Perceived threat-mediated compliance: medication is taken, often reported as helpful, but adherence attributed by the client to fear of return to the hospital rather than to agreement with the treatment plan	Approximately 22 of 46 (48%)	The most prevalent benefit-relevant configuration in the coded data. Behavioral outcome looks like medication benefit; motivational pathway is threat avoidance. The client's account places the reason for adherence in the legal contingency rather than in their evaluation of the treatment.
Counter-case: medication endorsed independently of the perceived threat structure	Approximately 5 of 46	Clients who report taking the medication voluntarily and whose accounts do not link adherence to fear of hospitalization. The two pathways can in principle co-occur in the same person over time.

Pattern	Transcripts (of 46)	Description
Implication for adherence after the order ends	Empirically open	If adherence is held in place by the legal contingency, removal of the contingency might be expected to affect compliance. The interview data cannot test this directly.

Administrative data on medication adherence cannot differentiate between compliance driven by threat avoidance and compliance based on voluntary engagement, which means that some of what appears as positive medication outcomes in administrative data is being produced by the legal threat structure of AOT rather than by therapeutic agreement.

A smaller number of mentions (more often implicit than explicit) suggested that when medication is tolerated, appropriately matched, or adjusted in response to side effects, it can support stability and functioning. In these instances, clients often attributed the benefits to the medication's therapeutic effects but remained ambivalent or negative about the lack of choice. This suggests that the benefits identified are often independent of the coercive mechanism and might similarly have been achieved through supported decision-making or collaborative care models.

The clearest articulation of the pattern comes from a client who has just been asked how she feels about her medications:

> *Interviewer: "How do you feel about the medications, including, you know, any of the injectables?"*
>
> *Client 2: "I don't have a problem with any of [my medications]."*
>
> *[later in the interview]*
>
> *Interviewer: "OK. So, you are compliant. You take your medications 'cause you don't want to get picked up and go back to the hospital, do you?"*
>
> *Client 2: "Yeah."*
>
> *Interviewer: "Do you feel like the medications are helpful? Or harmful?"*
>
> *Client 2: "Helpful."*
>
> *Interviewer: "How are they helpful?"*
>
> *Client 2: "I just feel better …"*

Other clients describe the same concept in different language. One client, asked what was implied if he did not accept the order, located the perceived threat at the extreme end:

> *"But that was sort of implied that if I didn't go on the AOT, I would have to be permanently hospitalized, which is frightening… In and of itself." ~Client 3*

The same client later named the conditional nature of his current engagement with treatment, raising the possibility that compliance might not survive removal of the legal contingency. He locates the contingency in probation rather than AOT specifically:

> *"I'm sort of going to treatment now because of probation and maybe after that I'll stop." ~Client 3*

A third client described the threat structure as it was communicated to him at initiation:

> *"They just told me if I don't take my medication and if I don't—or if I relapse anything, then I will go back to the hospital." ~Client 36*

The above quotes illustrate a pattern that complicates any straightforward use of medication adherence as an outcome measure of AOT. The client takes the medication and reports that it helps them. When clients are asked why they take the medication, however, several describe motivations relating to a threat structure rather than the therapeutic value. The behavioral outcome and the motivational pathway are not the same finding.

A subset of cases (5 of 46) shows the opposite pattern: clients who endorse the medication independently of the threat structure, who take it voluntarily, and whose accounts do not link adherence to fear of return to the hospital. The two configurations are distinct motivational pathways, and a client can in principle move from one to the other over time.

Several clients described experiencing medication side effects but accepting them as part of treatment. One client who reported morning drowsiness framed it as something he simply lived with:

> *Interviewer: "Have you experienced any side effects with your medication?"*
> *Client 20: "Yes. I get drowsy in the morning when I take my meds."*
> *Interviewer: "OK. Is that something that's concerning to you, or is that just kind of part of the deal?"*
> *Client 20: "No, it's just part of it."*

Asked whether he had discussed the side effects with the prescribing psychiatrist, the same client described being told the effects were normal—though he registered a disagreement with the normalization, specifically around weight gain:

> *Interviewer: "Have you ever talked to the psychiatrist about the side effects?"*
> *Client 20: "Yes."*
> *Interviewer: "What did what did the psychiatrist say?"*
> *Client 20: "Well, he says it's normal. Some cause drowsiness and some cause weight gain. And stuff like that. But the weight gain ones aren't normal."*

Asked the summary question of whether he was overall OK on the medications, he confirmed:

> *Interviewer: "And then but you're even with the drowsiness, you're still OK on these meds then overall?"*
> *Client 20: "Yes."*

Many clients described psychiatrists who refused to consider medication changes despite reported side effects or requests to try alternatives. One client described an exchange with a psychiatrist operating from a fixed formulary of older antipsychotics:

> *Client 11: "There is a psychiatrist, but he's not approachable."*
>
> *Interviewer: "OK. Have you like, you've, like, how much have you met with him?"*
>
> *Client 11: "I met with him, but he's not willing to try new medication."*
>
> *Interviewer: Oh, OK. So just sort of, like, flat veto of anything new?"*
>
> *Client 11: "It was always old medications."*

Later in the same interview, when asked why the psychiatrist was so unwilling to consider changes, the client identified a fixed practice:

> *"I think he's set in his ways about what medication he's to use because he doesn't use many medications. He uses Haldol, Prolixin, and Invega, Zyprexa, and that's it." ~Client 11*

When asked if he had tried to share his concerns with other ACT team members, the client explained that he had but found little support:

> *Interviewer: "And have you ever tried raising concerns about the psychiatrist's non-responsiveness with other members of the ACT team, like saying, 'Hey. Will you intervene? Will you advocate for me?'—Anything like that?"*
> *Client 11: "I think they take sides."*
> *Interviewer: "OK. And meaning they take his side?"*
> *Client 11: "Yes."*

Long-acting injectable medications were a recurrent focus of medication concerns. While some clients chose injectables for practical reasons (ease of adherence), others described being pressured or required to accept injections despite physical discomfort, fear of needles, or concerns about side effects. In one account, an outpatient counseling relationship was framed as contingent on the client accepting an injection they were trying to refuse:

> *"Oh, thank goodness. I'll take the pill. I will not get injections because I hate needles. They give me marks. I bruise from them. And I had an incident in the hospital. Had my counselor call me and she said, if you don't get the needle, I can't be your counselor. I said, well, we'll work it out. I said, I can't take it. I said, it gives me bruises no matter what. Bruises! These with black and blue marks. And I hate needles. They scare me. And she says just once a month is much better. And I said, no. No. No. No. No. No way. No. I will take the pill. I'll pop the pills before I do anything. No liquid, oral, and no, um, injection." ~Client 21*

Across client interviews, descriptions of medication harm span multiple body systems and domains of functioning—cognition, emotion, sexuality, bodily integrity, and life participation.

Several clients described neurological sensations and movement-related side effects. One client described persistent auditory and somatic disturbances they attributed to Haldol, with the disturbances continuing into the night:

" I hear I hear static. … Well, all day. And, when I try to go to sleep, I hear static. And, I think it's from the Haldol, but, he [prescriber] thinks it's not from the Haldol." ~Client 11

Another client described headaches accompanied by sensory experiences, and said these effects were the reason they refused the medication:

"I would get these headaches, and I hear a crunching noise while the headache's happening. And so I'm like, I don't wanna take this drug. So I that was the first drug they put me on, and I just refused taking it. I didn't I didn't wanna take that anymore. Because, I mean, it was literally hurting me. It was hurting me terribly. And I had a noise that was associated with this, so that was weird… It gave it gave me akathisia is the word they give you." ~Client 6

The same client later described a reaction to an injectable formulation:

"Third drug they put me on was the injection. Now the injection made my feet burn. So when I'm walking, I had to elevate my foot, or if I stepped on it, it would burn my feet." ~Client 6

A prominent cluster of narratives described cognitive slowing, impaired speech, memory difficulties, and a "zombie" or intoxicated state that interfered with work, relationships, and self-trust. One client described lithium as producing a collapse of functioning and enduring impacts on self-belief:

"I couldn't function. I couldn't think straight. The lithium. Let's go there. Right? The lithium. I was working at [store], and I felt very shaky. I was my thinking was very slow. My speech was very slowed down. I couldn't speak properly. I was speaking … like, very slow, and I kept telling myself I feel stupid. I feel stupid. And I only had the toll on my thinking for so long to the point where I said I feel stupid… And I've been, you know, I cry, like, all the time because I am overcoming. And, you know, I have that 'I can't' mentality to this day because of all the thoughts that I thought on lithium." ~Client 26

Others described the injectable specifically as producing a depersonalized, flattened state. The client's description below is presented as a single statement, with an intervening interviewer question removed for clarity:

"Yes. The injectable has horrible side effects. It turns you into a … zombie, basically. The injectable makes you a zombie." ~Client 39

Another client described a sedating effect that shaped both their emotions and behavior:

"At one time, I was so numb on medication that I felt no emotions. I couldn't laugh. I couldn't smile. I couldn't cry. I wanted to feel emotion, but I felt absolutely no emotion. I couldn't feel anger. I couldn't feel sadness. Nothing. They had me on so much medication that I was just a shell of a human being. And my family didn't know how to respond." ~Client 38

Clients also perceived emotional blunting as a distinct harm—often framed as a barrier to meaning-making, relational connection, and a sense of aliveness. One client described emotional flattening as a persistent "veil" and a longing to regain affective life:

"There was a veil between me and—my emotions were kind of blunted from the medication. And that is something I prayed would come to an end eventually. I wanted to feel again. And so that was a problem I've had with medication ever since I started in 1998, and it continued in 2009, '10, whatever." ~Client 35

Another described mood dulling severe enough to alter daily pleasures and attentional capacity:

"It caused more it caused me depression, like, seriously depression because it dulled my mood. I couldn't pay attention to things for that long without like, certain things. I couldn't play my favorite video game anymore because I couldn't sit down and focus on it that well." ~Client 6

In some interviews, sedation is described as punitive, suggesting that medication is experienced as a tool of control rather than care.

"It's not medication. It's sedatives. I can imagine it feels like it's a military drug that sedates a person. It feels like it's truth serum. It feels like truth serum. It feels like something from Guantanamo, like some kind of terrible [drug]... Whenever I'm drugged, I feel more suggestible... I have less thoughts. I feel tired. It's a painful feeling... it's like a numb pain... It's almost like a handicap. It's like a mild handicap. Being sedated is like a mild handicap." ~Client 37

Weight gain was described as both distressing and, for some, entangled with disordered eating patterns. One client acknowledged medication calming effects while explicitly wishing to discontinue if autonomy were available:

"In terms of the medication I'm on, the medication calms me down, sort of. But in a way it has side effects ... makes you a little bit more plump, you gain weight ... I'd prefer not ... If I had the option, I would be off it." ~Client 3

Another described weight gain as severe and described restrictive behaviors in response, explicitly connecting hunger increases to nighttime medications.

"It's terrible...it's terrible with the weight gain with the psych meds. But I just make myself not eat. I bid [binge] maybe one or two times a week because of eating disorder, but it's way under control than what it was. I used to do it every night, get up in the middle of the night and eat. But I am just--... Because I take my visceral [med name] and [med name] at night. So it does make me hungry." ~Client 42

Across these accounts, weight gain is described alongside reports of not being heard by prescribers, and in some cases, of clients reducing how much they eat to offset the medication's effects.

Clients also described sexual and reproductive effects in terms that referenced bodily integrity, fertility, and identity. One client described disrupted menstruation and interpreted the experience through the lens of coercion:

"The medication is taken away taking away my womanhood. Like, I didn't get a period for eight months. That's not normal." ~Client 31

Later in the same interview, this client attributed the experience to a broader institutional project of population control:

> *"Medication, I believe it's the fucking, you know, the system, Illuminati, whatever. Like, trying to make everybody who, like, has quote mental health problems, like, population control, like, infertility. I can't have a baby even if I wanted to… AOT is despicable." ~Client 31*

Concerns about fertility and sexual functioning were also described in physiological detail:

> *"…in my semen, it changed… it looked like it might not be fertile… If I find out that I'm sterile from this stuff, my life will be devastated." ~Client 37*

Some clients described severe autonomic effects that felt alarming and medically consequential, including elevated resting heart rate and drooling during sleep:

> *"I have elevated resting heart rate, like, crazy high… I should have 80 beats per minute, but I'm actually averaging around 140 … all these medicines just have some terrible side effects… elevated resting heart rate. I drool in my sleep, so I have to put towels over my pillows… But at least I can sleep." ~Client 6*

A subset of accounts framed medication harms as cumulative and life-altering. One client described being medicated in ways that prevented reporting mistreatment and produced enduring cognitive injury:

> *"…they throw me in the quiet room and then give me an injection of medication I'm allergic to… makes me go to sleep and wake up and forget, and I can't report anything… medicated me for ten years, so I couldn't report anything… I was very, very, very smart… Not anymore… I told myself all the time, I can't. I can't. I can't… I could have had dementia." ~Client 26*

The same client went on to share concerns not just about herself but about others.

> *"People told the mental health counselors, I overheard them talking, saying people have been on AOT, mis-medicated to the point of dementia. It's gotten worse than my case on AOT. My case is not special. It's been worse. AOT needs to stop." ~Client 26*

Another client described medication-related harm as "damage," using a metaphor of bodily parts no longer working to highlight medication harm as cumulative injury:

> *"I went through about 30 different medications over the last 15 years… I'll say damage. That's probably the best word. I mean, if you got like an action figure and one of the arms don't work, it's like that's what happens when these medications go wrong. Something stops working. Your leg stops working. Your foot stops working. Your arm stops working. You lose your head." ~Client 43*

Finally, some clients described experiences where medication administration was intertwined with feelings of humiliation and bodily violation.

Client 35: It was humiliating—
Interviewer: It was humiliating?
Client 35: —because they pulled my pants down.

Mechanism 5: Stigma, Dignity, and Identity

Stigma and dignity-related harms appear in approximately half the client interview transcripts through explicit discussion, with mentions of humiliation, infantilization, silencing, and differential treatment present in a majority of these cases. In this sample, stigma and loss of dignity operate through two interconnected pathways:

1. **Direct mechanisms**: Court proceedings, diagnostic labeling, and the violence-prevention framing in Kendra's Law were described by clients as stigmatizing experiences.
2. **Amplifying mechanisms**: AOT is described as intensifying pre-existing mental health stigma by making it publicly legible through formal legal status, surveillance, and differential treatment.

Clients described psychiatric diagnosis and AOT status as labels carried across institutional settings, producing differential treatment in hospitals, the legal system, and community life.

> *"Well, I think by talking about being degraded, it brings up a lot of emotions. And it's bad enough that we're listed as bipolar, and you're treated totally different than the average person. By being listed as bipolar, when you go into the hospital, they treat you differently. When you get arrested, they treat you differently. When you're on AOT, you're treated differently. And I think there's still a lot of — we're treated as a lower-class citizen, so I don't know how else to explain it." ~Client 14*

Asked what would improve the experience, the same client identified language:

> *"And I think if they used better terminology and they used less abusive language that they could make it a lot better for the person who was on AOT." ~Client 14*

Some clients articulated this as suspension of rights and personhood, framing the mental health court as a forum in which evidentiary standards do not apply:

> *"I am a marginalized individual. I would say to them, 'I am a marginalized individual. I do not have the rights that you have. I do not have those rights. Once they get the diagnosis, you lose all your rights.' But I would say that the same is true for a prisoner, yet the difference between mental health and criminal prison is that in the reality, it's very obvious, but in the legal process, it's very different. A criminal investigation is different than a mental health investigation. So the mental health court is a witch trial. The mental health court is a witch trial. There is no evidence. There is nothing factual about the mental health court. It's all pretend. It's all for fun. It's a witch trial. When you go to criminal court, they produce evidence. And you can make a case. You can disagree with the prosecution. You cannot*

disagree with the mental health prosecution because the mental health prosecution claims that mental illness is a real phenomenon, and you can't disagree with that. And if you can't disagree with that, then remember that the prosecution says that's the law." ~Client 37

Clients described routine interactions in which their competence is discounted, their voices minimized, and they are positioned as problems to be managed rather than people capable of judgment.

"It really sucks because it's like I am not respected with my own finances. It's just a lot of disrespect, a lot of negativity. It's just like nobody cares about my abilities to take care of things. They just see me as some kind of a problem or something in the way to just maneuver for their better good. And it just makes me look bad, I guess." ~Client 9

Asked how this affected self-image, the client responded directly:

"I mean, it just ruins it. It's completely disrespectful. I'm being told I'm not good enough. It's like you have these feelings of inadequacy. Like I'm being discriminated against." ~Client 9

Other clients described impacts on self-concept that persisted beyond the immediate experience:

"Yeah. Well, I would say—this happened about six years ago or so, five or six years ago. And I mean, I would say that the whole thing, the mental health system, the courts, being falsely diagnosed and placed on medication, antipsychotic medication that I did not need, it's negatively affected my relationship with my parents… And it's also negatively affected my relationship with myself. I've got some lingering self-esteem issues because of having to go through that experience…the whole process was about a year and a half." ~Client 33

For a client who had practiced law before being placed under an AOT order, the loss of professional standing eroded their self-worth.

Client 8: "Drop. Drop. Drop. Low. Low. … Very low. Your self-esteem and your view of yourself dropped a lot."

Clients reported that AOT and psychiatric labeling materially restricted their ability to work and occupy valued adult roles, with their AOT status functioning as a barrier to roles the client would otherwise occupy.

Clients described being positioned as childlike through tone, surveillance, exclusion from decision-making, and threat of punishment. One client described the nurse administering long-acting injections:

"Sure. For example, on the day when I have to get my shot, I'm going to [the nurse's] room. She treats me like I'm some dumb little kid. And on top of that, she's just very pushy and controlling as far as AOT goes. It just makes me feel like I'm belittled, and I have no respect. And it's just like, 'Oh, wow. You're going to do this and you're going to do that.' And it's just like I want freedom more than I want to do with an AOT order that I get disgraced based upon." ~Client 9

Asked to elaborate on "disgraced," the client returned to the topic of surveillance:

> *"I mean, it's difficult to have this AOT order in place without being observed in a way that you're not trusted." ~Client 9*

Another client invoked a parental disciplinary frame to describe the felt threat embedded in the order:

> *"It's very involved. I know that it was involuntary. Even the doctor himself at the hospital said it was against my will. And that's a pretty obvious statement. He said it was against my will. Um, so I spoke with some people in Boston. Very nice people…They spoke with me constantly and said that wasn't nice what they did…But it was not a very healthy situation. It made me feel that if I didn't do what they said, I was gonna get it. You know how your mother said, 'You're gonna get it'? That's what it made me feel like. I was gonna get it." ~Client 21*

One client described the gap between how others narrated his treatment ("he's getting help") and what he carried internally. Court involvement transformed his private health matters into a publicly interpretable identity, reshaping family relationships through shame and anticipatory judgment.

> *"Yeah, I couldn't stand the sight of — the point is I didn't like who I was. You know what I'm saying? So it's like they might say like, 'Oh, he's getting help,' and tell everybody, 'Oh, see? He's finally getting help.' But really, it's like in my head and my heart, I'm like, 'I know these guys. I know my family loathes of me right now without really saying—without having to tell the world, tell the court system that this guy right here is receiving medical treatment.'" ~Client 44*

Asked directly whether stigma was the driver, Client 44 confirmed it:

> *Interviewer: "So do you think it was the stigma, mental health? Was that a big deal?"*
>
> *Client 44: "Yeah, the stigma. Yes. Absolutely."*

Clients experienced AOT as positioning them closer to the criminal justice system than to ordinary health care, even where they had no history of violence. This violence-prevention framing was not always named explicitly, but its logic was invoked through court process, police involvement, and the language of danger and control.

> *"All I'm saying is I'm being treated like a thief. That's how I'm being treated. I know. I know. I'm not lying. I'm being treated like a thief." ~Client 25*

Client 37 developed the same point at length, drawing the contrast between criminal court—where evidence must be produced—and what he experienced in mental health court.

Clients used morally charged language—"degraded," "disgrace," "humiliated"—to describe experiences arising through court processes, clinical encounters, and forced treatment. Some of

the quotes above ("treated as a lower-class citizen"; "disgraced based upon" the order; feeling like they were "gonna get it" if compliance failed) illustrate this same theme.

Clients described having their perspectives and self-knowledge systematically invalidated or overridden by provider and court authority. Speaking up was reinterpreted as evidence of illness rather than meaningful clinical information.

> *"They just treated me like I was schizophrenic. They didn't they didn't really — they didn't really believe — they wouldn't even consider what I was saying is how it felt." ~Client 6*

This mechanism has implications for the interpretation of quantitative findings. Interviews with people under AOT orders revealed a dynamic in which people may stop voicing their concerns because they believe that doing so is futile. Almost half (45%) of clients interviewed for this study expressed this sentiment. Analysis of administrative data cannot detect such patterns; a client who has stopped voicing their concerns may appear fully housing-stable and treatment-compliant on the administrative record while still experiencing a loss of agency. This finding suggests that further qualitative or survey research must accompany analysis of administrative data to depict a full account of AOT benefits and harms at the individual level.

Mechanism 6: Legal Coercion as Lived Experience

Legal coercion as lived experience is the most pervasive mechanism we identified, present in some way in every client interview transcript (46 of 46, 100%). It is also the mechanism that is least easily documented using standard clinical and administrative measures. Here, we describe four types of this mechanism: opaque exit pathways, gaps in knowledge and "informed consent" at both order initiation and renewal, opacity regarding the legal framework of AOT and renewal specifically, and collateral non-clinical harms arising from the legal status of AOT itself.

Potential harms associated with legal coercion include: resignation and entrapment under indefinite duration; informational disempowerment when consent processes are compressed or formalized without comprehension; collateral harms to employment, housing, custody, immigration status, professional licensing, and benefit determinations independent of any clinical mechanism; and identity-level damage from being held under a legal mandate experienced as criminalizing. In a substantial minority of cases, the client is not aware of the legal framework operating around them, producing what is described here as "invisible legal coercion."

No direct benefits of legal coercion were reported by AOT clients in our sample. Some clients describe the order as having enabled access to services they value, but the value attributed to the services does not extend to the legal coercion through which they were obtained.

One of the most prevalent harm patterns in the coded transcripts is the experience of being under an order with no visible endpoint. This pattern is present in approximately 25 of 46 transcripts (54%), with direct evidence in approximately 17 of 46 (37%). It is amplified by duration—longer orders and multiple cycles produce deeper resignation—and is partially

buffered by the quality of the provider relationship, where a responsive provider can explain the process and help the client orient within it. A small set of counter-cases (approximately 5 of 46) shows clients who understand the exit criteria and who consequently experience the order as a time-limited obligation rather than as indefinite subjugation. The presence of these counter-cases suggest that the opacity itself—rather than the duration—is the modifiable feature, and that procedural reforms such as clearer rights notification, attorney engagement that explains exit criteria, and plain-language discharge criteria at each renewal could in principle address some of the harm this pattern produces, without changing the underlying legal framework.

The clearest behavioral evidence of this pattern comes from a client who, after extended time under the order, a renewal hearing, and conversations with both his doctor and his lawyer, still did not understand how to end the order:

> *Interviewer: "Do you have a clear understanding of how you can get off AOT?"*
>
> *Client 4: "No."*
>
> *[Later in the same interview]*
>
> *Client 4: "It's OK to get out of AOT. Can I do it?"*

A client who has cycled through the order over many years names the cumulative effect of an open-ended legal mandate:

> *Interviewer: "How did it make you feel when they reinitiated AOT?"*
>
> *Client 11: "I don't feel comfortable about AOT because it takes over your existence."*
>
> *Interviewer: "Can you say more about what you mean by that, taking over your existence?"*
>
> *Client 11: "You don't have any control over it."*

Another client articulates the underlying expectation that contesting the order will not change the outcome:

> *"It's futile. Futile. I think that's the word." ~Client 14*

The same client describes the renewal moment in which he expected to be given a choice but was simply informed of the outcome:

> *"I was under the impression that they would give me a choice of what I wanted to do. And they gave me no choice at all. They just said, 'We're re-upping you another six months.'" ~Client 14*

Client 31 describes the same opacity from the position of someone trying to plan around it:

> *Interviewer: "Have you been told what you might need to get off of AOT?"*
>
> *Client 31: "Every November is whether they renew it or they get rid of it … I don't know if it would even help at this point for me to be good for [the next] four months."*

A second pattern within the legal-coercion mechanism is informational disempowerment at the point of initiation and at renewal. Clients describe themselves as having consented to something they did not understand, and as still not understanding it months or years into the order.

This pattern is present in 17 of 46 transcripts (37%), with direct evidence in 13 of 46 (28%). It is most evident in three situations: when discharge is conditioned on consent (with clients asked to accept AOT to leave inpatient care), in hearing waivers (when clients give up their right to a hearing without fully understanding it or its implications), and during renewals (when continuation is presented as a foregone conclusion rather than a decision in which the client has a voice). It is partially buffered by attorneys who explain options substantively rather than perfunctorily, and by providers who use the renewal moment as an occasion for genuine review. The clearest behavioral evidence of this pattern is clients who, three months or three years into an order, still cannot describe what the order requires, what their legal rights are, or how to bring it to an end.

The flattest articulation comes from a client three months into his order who, when asked what he had been told about the discharge process and how long the order would last, told the interviewer:

> *"I don't know. I don't know nothing." ~Client 15*

One client, when asked at the start of her interview whether she was currently under an AOT order, responded:

> *"Honestly, I don't even know." ~Client 43*

A client who reflected on her first order described a contestation right she did not learn she had until after the fact, when she proactively asked her public defender. The interviewer's paraphrase confirmation captures the pattern as the client accepted it:

> *"You didn't know much about it, but you didn't contest it, right? You went along with getting an order and doing the whole court process." [Interviewer to Client 2; client confirmed]*

A third pattern is the situation in which clients are unclear about the legal framework operating around them. They describe their treatment as voluntary, are unsure whether the order is currently active, or report having been told they are on AOT without a clear sense of what that means legally or procedurally.

A client whose order was finalized while he was an inpatient at a state psychiatric center described his own legal pathway from a position of distance:

> *"I didn't go to the judge, but they put my—I guess my case got put before a judge, and a judge ruled on it." ~Client 34*

A client whose AOT order is one of the most aligned with AOT procedures in the group—she attended her virtual hearing, was able to speak, was represented by counsel—nevertheless described the hearing in terms that show the legal frame did not register as a site of contestation:

"They were explaining what AOT was and what the process is. I don't remember the exact words… They didn't really even give me a choice to do with them." ~Client 28

The fourth configuration of the legal-coercion mechanism is collateral harm arising from the legal status itself, distinct from any clinical or therapeutic feature of the order. Clients describe consequences in employment (the order or its history affecting career trajectories), housing (landlords or facility operators citing the order as grounds for refusal), custody and family-court proceedings (the order being raised as evidence relevant to parental capacity), professional licensing (the order or its underlying mental-illness designation contributing to license loss), and mobility (geographic and travel restrictions that the client attributes to the order). These harms are not produced by the treatment delivered under the order but by the existence of the legal status itself, and they operate independently of whether the underlying clinical condition is well-managed. Clients reported that harms persisted beyond the formal discharge from AOT.

A client who had been a licensed attorney before her AOT order described the licensing consequence as a defining feature of the experience:

"I lost my license … I was in the AOT for a year. I was in hospital many times. It sucks. I didn't like it." ~Client 8

A client who is now a graduate student in social work described the collateral life-course consequence in compact terms:

"Well, it delays your life. It completely pushes it back." ~Client 47

A client trying to move from shared into independent housing described the AOT order as a recorded fact that closed off a housing option she was otherwise eligible for:

"I'm trying to get into a studio apartments there, but they say no because of your order." ~Client 21

A client describing her experience of the order's continuous reach over her movements named the cumulative effect on her sense of agency:

"My whole life revolves around what people tell me to do. And I just want, I wanna leave the country. I don't wanna deal with AOT anymore." ~Client 31

This pattern of collateral harm is present in 10 of 46 transcripts (22%) and is one of the most policy-actionable findings in the group, since the harms typically arise from how AOT status propagates through other administrative and institutional systems rather than from anything intrinsic to AOT itself.

Mechanism 7: Provider Relationship Quality as the Primary Moderator of Outcomes

The quality and consistency of relationships with case managers, therapists, and other individual providers shaped clients' AOT experiences. This mechanism was present in all transcripts

(100%) and operates as a moderating variable. One beneficial outcome associated with a positive provider relationship is its buffering of the potential negative impacts of AOT. Some clients strongly differentiated positive experiences with providers from negative experiences they linked to the administration of AOT (e.g., hospital initiation and court processes).

Harmful outcomes associated with a negative provider relationship included feelings of disempowerment or disrespect, and potential for negative views of services or supports the client might otherwise appreciate or seek. Negative relationships with prescribing providers further intensified negative experiences of AOT, as these relationships were closely tied to what was often viewed as its central component: medication.

Clients who described positive provider relationships used language emphasizing respect, genuine care, advocacy, and being treated as a full person rather than just a case or a diagnosis. These relationships were characterized by providers who listened, took client perspectives seriously, helped navigate systems, and maintained a consistent, supportive presence over time.

> *"[Provider] was absolutely amazing. She didn't treat me like, uh, you know, some sort of like, uh, criminal or, like, degenerate or anything like that. She treated me like a regular person. She would listen. She would talk to me. She would help me with various different things. You know, and she and she continues to be. Like, I'm still with her after all these years… Well, she just is a very caring, supportive, uh, person. No matter what, you're going through, she's always got good insights, you know, that and she gives me her insights, and I think about what she says a lot. And … just … the relationship that her and I have and the way that we communicate with each other, I don't really have that with anybody else." ~Client 7*

Another client emphasized the importance of a supportive team that understood their history and ongoing recovery efforts:

> *"They were very supportive. They were supportive of me, thankfully. So I felt like it's good to have good support because they knew about my struggles in the past. It was drugs and alcohol. And they knew I was trying to end the recovery. And I also went to recovery. I was going in and out of recovery just for mental health. So I felt like it was supportive. So it's good to have a supportive team." ~Client 28*

Some clients described case managers as consistently available and attentive:

> *"[ICM case manager] is the best, greatest, most amazing person ever. She will do anything … to help me out, to make me feel comfortable, and happy, and successful… Well, no matter what happens when things come up, she's always there for me. She always takes care of me. She's very good. She's very respectful and responsible. And she goes out of her way every day to make sure that I have everything I need, that I have food, everywhere my needs is met and my wants are looked into. She's really one of the most helpful people I've ever met." ~Client 9*

In relationships with mutual respect, clients could identify what made providers effective:

"It's really good, actually. 'Cause she has respect for me. I [have] respect for her and we have good conversations and sometimes it's not, you know, it's not bad. We can get along great and that's pretty much it." ~Client 1

Clients also valued providers with extensive experience who demonstrated competence and fairness:

"Her name is [Case Manager Name]. She's very nice, very fair. She's been working with, uh, AOT industry for, like, uh, twenty plus years. She know she knows her job. She's doing very well. She's done very good." ~Client 19

Some clients described provider relationships that amplified, rather than buffered, the harms of mandatory treatment. These relationships were characterized by providers who were dismissive of client concerns or enforced court orders punitively rather than supportively.

One client described a case manager who was helpful in some domains but whose role in enforcing the court order complicated the relationship:

Interviewer: "She's fine. She's OK? Yeah. Can you give me an example of her being just, like, what would make her better, do you think?"
Client 20: "Hmm, if she stopped calling the orders on me …"
Interviewer: "Oh, so she's the one enforcing the order?"
Client 20: "Yeah … So she's helpful because she call she does all this stuff, but she's not helpful because she keeps checking in on you too." ~Client 20

Another client contrasted providers who listened and advocated with those who "just don't listen" and impose their own agenda:

"Very unhelpful … Because I asked them to change the medications, and they never even consider what to say… Shut it down right away." ~Client 38

Clients described variation in provider quality, with some providers experienced as advocating for clients' perspectives and others as imposing treatment without regard to client input.

Mechanism 8: Structured Routine and Accountability

AOT imposes structure on clients' daily lives through required appointments, regular contact with providers, and the obligation to answer for compliance with all of them. The mechanism operates through mandated engagement: clients attend appointments, maintain contact with case managers, and participate in programmatic activities, or risk being found in violation of their order.

Structured routine and accountability was present in some form in 34 of 46 interview transcripts, or 74%. Structured routine combined with a supportive provider relationship—providing benefit—is present in 12 of 46 transcripts (26%). Without the supportive provider relationship, structured routine tends to be experienced as additional surveillance rather than as supportive accountability.

Associated beneficial outcomes of structured routine and accountability include: facilitates engagement, accountability both to self and accountability experienced vis-à-vis providers; diminished isolation, helpful structure, improved motivation to engage in behaviors the client experiences as good or healthy. Associated harmful outcomes include loss of autonomy, stress of compliance, excessive structure leading to fatigue or resentment; and some overlap with Mechanism 3: Surveillance and Monitoring.

Clients who described structured routine as beneficial identified one of three things as the source of the benefit: external accountability that interrupted a drift toward isolation or disengagement; a case manager or ACT team who actively worked on the client's behalf rather than only monitoring compliance; or, in a smaller subset, the instrumental value of demonstrable stability for other purposes, such as housing and employment. These three pathways are not mutually exclusive, and several clients named more than one.

Several clients described the regular contact built into AOT as something that broke a cycle they had previously fallen into when their own engagement with treatment lapsed. One client, asked what benefits his AOT order has provided, named this external accountability function:

> *"I guess they kept me on my toes. They could contact with my psychiatrist and my therapist because they meet me on my program. And that's it." ~Client 36*

Others identified the frequency of contact under AOT—specifically the weekly cadence—as the variable that made the difference. Yet, these clients did not attribute the benefit to AOT itself but to the level of service made available through AOT. Several clients said directly that they would have accepted the same services without AOT, including Client 18:

> *Client 18: "Expanded services. When you're at AOT, you see a worker every week."*
>
> *Interviewer: "Oh, OK."*
>
> *Client 18: "When you're with county mental health you see a worker once a month."*
>
> *Interviewer: "If the same services could be expanded without being tied to AOT or the order, though, is that something then that you would recommend?"*
>
> *Client 18: "Yeah."*

One client who had been visited twice a week by her ACT team described the contact as practically useful—the team helped with household needs and basic logistics:

> *"[They helped me with] some heat, hot water, some electricity, and they always came every twice a week to check up on me." ~Client 5*

Another client, when asked whether the same beneficial accountability he had described could be produced without AOT—through, for example, a regular meeting with someone who would still keep him on track—this client said yes. He framed the order itself as already on the way out, since he had stabilized:

Interviewer: "Do you think if you were able to work with someone without a court order and they would still they would still sort of keep you on track and help you be accountable? Do you think that the court ordered part would still be helpful for you or needed?"

Client 22: "Well, I'm just already showing now that I don't need AOT anymore. So I don't think it's needed."

Clients who experienced structured routine as harmful described two related but distinct concerns: loss of control over their daily schedule, and the experience of mandatory contact as monitoring rather than support.

Several clients described an evolution from initially welcoming the structure of AOT to experiencing it as too much over time:

Client 28: "I felt like I needed the structure, so I was OK with [the involuntary aspects]. But I don't think I would do it again because it's a little too stressful because you have to make a commitment."

Interviewer: "OK. … So you said when you got put on [AOT] … you kind of wanted the structure. But now looking back after you're no longer on AOT, you wouldn't want to be on AOT again."

Client 28: "Right. Because I like to do my own program and be more independent. Yeah."

In the above exchange, the client first identifies the perceived source of harm not in the structure itself but in the commitment—the legal requirement to follow the schedule regardless of whether she would have chosen to do so. Second, looking back from the position of someone who has completed the order, she names the preference for a self-directed routine as the reason she would not return to AOT, even though she had wanted the structure when she entered.

Some clients described the structure as filling their daily time in ways that displaced other activities they would have preferred. One client described her treatment plan as requiring case-manager contact once a month and group attendance every day. When asked what the groups were like, she described them as rehab-style sessions:

"Like … like rehab kind of stuff … We would get passed-out sheets and then there would be like a speaker at a podium. And then. We just listen to him. Her." ~Client 2

Another client, asked how he felt about the activities in his AOT plan, registered a mixed assessment in which the structure was tolerable but his underlying preference was for something else:

"Some days I do, some days I think it's kind of a little bit regressive and sort of I wish I was doing something else with my time. But you know, if I have to do it, I have to do it, you know." ~Client 3

Mechanism 9: Service Access and Concrete Supports

Mechanism 9 addresses material needs relevant to stability and day-to-day functioning. AOT facilitates access to tangible resources including housing assistance, transportation, SSI/SSDI application support, food assistance, cell phones, and other material necessities. Case managers actively help navigate bureaucratic systems and advocate for resources that clients may struggle to access independently. Although the interview team made explicit efforts to separate the direct impacts of AOT from service access, many clients struggled to separate them—claiming or assuming that the services they valued—such as the ACT team or more intensive case-management supports—could not be accessed in New York State without a court order. Mechanism 9 is present in some form in 45 of 46 of client transcripts, or 98%. Across 26 of 46 client transcripts (57%), clients described being grateful for services while simultaneously stating they would have engaged with those services voluntarily if provided access.

Clients who described receiving concrete supports consistently framed these as among the most valuable aspects of their AOT services. Several clients described specific instances where case managers provided critical material assistance:

> *"My case manager actually bought me a cell phone because I didn't have one coming on the way out... You need. You need a phone. ... I had a bunch like, supports and whatnot. Oh, if I needed like assistance... It's not bad. ... I had a peer specialist when I was in the hospital. We would go out to like [name of place] and get coffee or. You know, like maybe go to like ... the bus station to get me like a bus card or something? It's very useful. The supports. I have very useful." ~Client 2*

Another client described extensive assistance across multiple domains of practical need:

> *"My case manager has helped me significantly with signing up for the [transportation program]. It's for people with mental disabilities who need transportation. So she helped me sign up for that. Yeah. And she checks up on me ... she checks up with my benefits ... and housing and with signing up for school." ~Client 47*

For some clients, transportation assistance was described as the critical factor enabling treatment engagement:

> *Client 20: "I mean, the reason I wasn't taking [my medications] was because I didn't have any rides to my appointments. And I was homeless, so I was saying, 'Please, please, how can I get my meds?'*
>
> *Interviewer "So, like, if you had had access to your medications, you would have been on your medications."*
>
> *Client 20: "Yeah."*
>
> *Interviewer: "But it was just the transportation that was really an issue."*
>
> *Client 20: "Yeah."*

This account suggests that, in this case, "medication noncompliance" reflected unaddressed barriers to accessing prescribed treatment.

Another client also viewed AOT as a clear pathway to needed services:

> *Interviewer: "You're getting all of these services—do you think you'd get them if you weren't forced to by the order?"*
>
> *Client 19: "I don't think it'd be as helpful. I think the order is great."*
>
> *Interviewer: "OK. You think the order is great. What do you think is great about it?"*
>
> *Client 19: "That I get the help that I need."*
>
> *Interviewer: "OK. So correct me if I'm wrong, please. But it sounds like AOT helps you get—helps you access all these helpful services."*
>
> *Client 19: "If it wasn't for them, um, I don't think I'd be in an outpatient right now."*
>
> *Interviewer: "OK."*
>
> *Client 19: "I would probably just see a psych doctor once a month."*

An interview with a current AOT client and their partner also illustrates this viewpoint. The partner not under AOT described repeated attempts to be placed under AOT—because they sought services comparable to those they witnessed their partner receiving under AOT. Despite multiple hospitalizations and clear service needs, they were told they "didn't qualify" for AOT, remaining in voluntary services they described as insufficient:

> *Interviewer: "So, potentially, you feel like if you were on AOT, you would actually have an easier time accessing a larger number of, like, psychiatrists or something?"*
>
> *Partner: "Yes. Yes. Because I've been hospitalized too many times. I've been in and out of [Hospital 1], [Hospital 2], [Hospital 3]."*
>
> *Interviewer: "What do you feel would help you stay out of the hospital more? What is sort of missing that you wish you had?"*
>
> *Partner: "Support. A lot of support. I really don't get support. [Partner], and my uncle are my only supports. I'm in [outpatient program], and they really don't listen to me. They, like, really make my mental health more, like worse. Worse. They make it worse. They belittle me. They just treat me really bad and it's mental health. It's mental health and substance use. They belittle me, talk about me."*
>
> *Interviewer: "Right. And have you met [Partner]'s [AOT] care coordinator?*
>
> *Partner: "Oh yes. They have my phone number and everything."*
>
> *Interviewer: "And you feel like you would rather be working with a person like that?"*
>
> *Partner: "Yeah. Yes. [So then] I asked [current outpatient provider] about the AOT and they're like, 'Oh, you don't qualify for it.'" ~Family Member 24*

Across diverse counties and circumstances, clients consistently articulated that they would have willingly engaged with the same services if offered voluntarily. These statements came unprompted, emerging when interviewers asked clients to reflect on their AOT experience or imagine alternative pathways to support:

> *"I did actually do a presentation in front of our state lawmakers. Uh, they asked me to come and do a presentation in front of these people, you know, talking about my AOT experience. And something that I told them back then and something that I would still say now is, you know, I wish there were some other programs in place that like you say, you take the involuntary aspect away, and you help people find jobs, and you hook them up with a care coordinator or somebody to help them maneuver through life … I just wish there was something in place where people like me would get the services that they need before the court order." ~Client 7*

Another client called for pathways to intensive services that do not require court involvement.

> *Interviewer: "If you had been offered the same services, exactly the same, but without the court mandate, would you personally have preferred that or would be fine with the court mandate?"*
>
> *Client 36: "Well, I wouldn't do the court mandate. I'd just keep going to my appointments and do my blood work and take my medication myself."*

This dynamic complicates analysis of whether beneficial outcomes stem from the services themselves or from the legal mandate. Multiple clients explicitly stated they were already engaged in services before AOT initiation or would have willingly engaged if supports had been offered voluntarily.

Chapter 2: Professional and Family Mechanisms and Outcomes

This chapter presents 31 themes related to AOT mechanisms and associated outcomes that emerged from qualitative interviews with providers, administrators, legal system professionals, advocates, and family members—and from consultative notes and quantitative analysis of DCS survey and administrative data. Several specific components of AOT infrastructure and practice were identified as important mechanisms that shape the way AOT orders are carried out. These factors have a strong influence on whether AOT is able to produce its intended outcomes.

Theme 1: AOT Coordinator Role Is Dependent on the System's Capacity for Coordination

The AOT coordinator role involves liaising with people who use services and their families—and with community providers, police departments, emergency housing systems, courts, and hospitals—to facilitate support and respond to incidents that arise. The AOT coordinator is responsible for strengthening coordination within the mental health system (e.g., between a housing provider and a treatment team) or between the mental health systems and other systems (e.g., between treating providers and local law enforcement). Their work is either facilitated or challenged by the strength of the relationships between the LGU, its provider network, and other partners and by the quality of coordination pathways within the mental health system and between the mental health system and legal and social service systems.

> *"I think I'm in a unique position as the housing SPOA and AOT coordinator and the main contact for our state PC—keeping track of our folks and what they need and making those adjustments over time. It's a lot of work, but I've also been here a long time and know a lot of the [AOT] clients." ~Administrator 5*

Interviewees emphasized that best practice is more likely to be applied when the AOT coordinator is deeply familiar with the community and its various systems. This is easier to accomplish in smaller communities.

> *"I think the difference is urban versus rural. The bigger you are, the less likely you know about the person, less likely [to] have direct relationships with all your providers in your community … [and make] those connections." ~Administrator 12*

In urban areas where personal connections are infeasible, AOT coordinators are more reliant on systems that facilitate data sharing within large and complex networks. To coordinate an AOT, these networks must span multiple elements within the mental health system and must interface with criminal legal systems as well. When these networks are inadequate, it places a significant strain on AOT coordination functions that could potentially be alleviated through data system improvements.

> *"Criminal justice and clinical worlds, outpatient and inpatient, private hospitals and public—there's so much data that gets lost because the systems don't communicate with each other. And so we would*

really be able to work with patterns and systems a lot more efficiently and more easily if we just had a better data system to work with—[one] that was more unifying. Because I think right now we're guessing, we're assuming, we're chasing people down with phone calls. We're doing a lot of very analog-based work that really doesn't need to be that analog. You need to staff more people to do work that really doesn't require a body to do if you just have the right program, the right database, working across the system, [it] would save so much time." ~Administrator 21

Regardless of rurality, data shows that the AOT coordinator role and the tools at their disposal are key elements of AOT infrastructure, and that the work of AOT coordination is facilitated or hindered by the overall collaborative capacity of the mental health system. For further reference, DCS-reported quality of coordination within and across systems is reported in Appendix D.

Theme 2: LGU Leadership Perspectives on AOT Vary

In the DCS survey, respondents were asked to indicate their agreement with a series of statements about AOT. Statements expressed a range of ideas regarding the use of AOT.

Supportive statements in the DCS survey included:

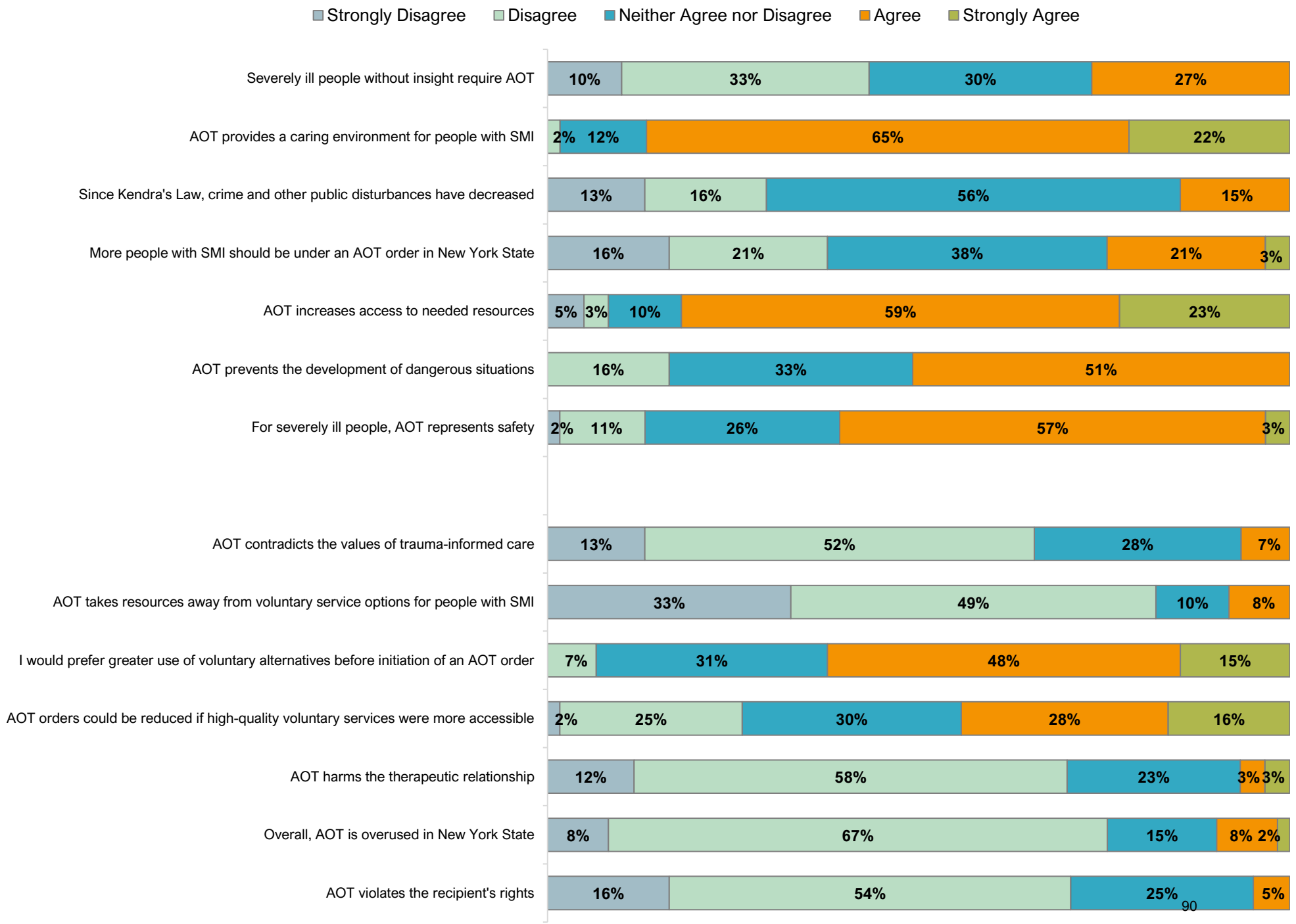
- Severely ill people without insight require AOT.
- AOT provides a caring environment for people with serious mental illness.
- Since Kendra's Law, crime and other public disturbances have decreased.
- More people with serious mental illness should be under an AOT order in NYS.
- AOT increases access to needed resources.
- AOT prevents the development of dangerous situations.
- For severely ill people, AOT represents safety.

Critical statements in the DCS survey included:

- AOT contradicts the values of trauma-informed care.
- AOT takes resources away from voluntary service options for people with serious mental illness.
- I would prefer greater use of voluntary alternatives before initiation of an AOT order.
- Use of AOT orders could be reduced if high-quality voluntary services were more accessible.
- AOT harms the therapeutic relationship.
- Overall, AOT is overused in NYS.
- AOT violates the recipient's rights.

Statewide, DCS survey respondents were more likely to agree with the supportive statements than the critical statements, although perspectives varied widely from respondent to respondent. The following exhibit depicts the range of administrator perspectives on AOT, with critical views grouped at the bottom of the figure and supportive at the top.

Exhibit 2.1. *Views on AOT*



A majority of administrators (63%) indicated they would prefer an increased emphasis on voluntary services before the use of an AOT order. One administrator describes that many people with complex needs will participate voluntarily if adequately engaged:

> *"Because a lot of the people that we have are very suicidal or let's say homicidal, they're willing to engage in treatment. They're here. They're seeing their therapist…they're on meds. You know, really what we're talking about are a very small subset of people who are not willing to participate in treatment and who are unsafe because they do not. And we don't have a lot of those people." ~ Administrator 13*

Just under half (44%) of administrators agreed that if more voluntary services were available, the need for AOT would decrease, highlighting the importance of understanding AOT in the context of the broader system. These findings support findings in Chapter 1 related to client preferences for voluntary engagement over court-ordered services.

> *"Now would I never need an AOT if I had enough ACT teams? Probably. I would much prefer to have 4 Forensic ACT teams than anything else." ~Administrator 3*

Variations in LGU leadership perspectives and in system contexts are highly consequential for the implementation of AOT across the state. A provider who serves people under AOT in multiple counties illustrates this point and describes how discretion exercised by the AOT coordinator results in variation in how AOT is administered.

> *"If you've seen AOT in one county, you've seen AOT in one county. It doesn't necessarily work the same way every place. And I'm not saying anybody's doing a bad job because I think that people do their due diligence, but it also depends upon the legal system, the providers and the individual person, maybe family members, or even how people interpret things. And some AOT coordinators want to give the individual—understandably so—more of the benefit of the doubt and more chances than others do." ~Provider 12 (serving multiple counties)*

Theme 3: Application of 'Likely to Benefit' Eligibility Criteria

Some AOT eligibility criteria—related to age, diagnosis, and history of hospitalizations—are concrete and consistently applied across the state. And as discussed in Chapters 1 and 3, interviews with people under AOT orders bring into question the consistency with which the less restrictive criteria is applied. From the perspective of professionals we interviewed, the "likely to benefit" criteria emerged as by far the most ambiguous and inconsistently applied.

> *"That's the one that's the most ambiguous … it's hard to tell in the big picture [who is] 'likely to benefit'? Obviously, we don't have a crystal ball. We don't know. We have social determinants of health to go on. We have what the AOT can provide [and] what it can't. Sometimes the linkage to care*

coordination, to care management is the most important thing. Which is, of course, the only thing that has to be in an AOT treatment plan. But the 'likely to benefit' is the one I think that we struggle with the most." ~Administrator 7

Administrators and community providers voiced some concern that hospitals and prisons may misapply the "likely to benefit" criteria, resulting in inappropriate referrals for some and a lack of referral for others who are likely to benefit.

"I think outside sources [are] really identifying people who would benefit from AOT. I think sometimes our hospitals … get it wrong [and] we're questioning why are they not putting this person in. We're asking them to help with it, and then they're not being cooperative with us. And then the person ends up in the psych center, or they end up in jail. That happens more likely than I would like to admit." ~Administrator 11

In several interviews, administrators posited that the "likely to benefit" criteria is inadequately applied in cases where a person is unlikely to adhere to the AOT order. They noted that people who are not deterred or influenced by the involvement of the court or by possibility of removals are unlikely to benefit from AOT:

"'Likelihood to benefit'—which is the criteria that I will argue all day sometimes with people—it's not there. There's no fear of being incarcerated. There's no fear of the court process." ~Administrator 26

In these instances, the AOT coordinator and/or DCS, sometimes in consultation with providers, must apply their own clinical judgement to determine whether to pursue the order.

"There's a real process that we go through with the hospital where we dialogue with them to begin with about the clinical course of treatment. … Does the person actually meet criteria in a very tangible way, but also in what we call the 'spirit of the law' … If you put everybody on AOT who had the amount of hospitalizations and had the dangerous episodes and needed an [intramuscular injection], you'd have half of [the county] on AOT, right? So, you really have to be able to go through all of the components of not only what's written in the statute, but also to say, is this within the confines or the spirit of the law? … It really means the clinical indication, like, is this going to be something that is actually doable and supportive to the person? And by doable I mean if they are regularly a missing person and have missing persons reports being filed, there's no point in us doing this because they're not likely to benefit." ~Administrator 8

Populations That May Be Less Likely to Benefit

In a majority of interviews with providers, and in several interviews with other professionals, interviewees consistently identified that the presence of a co-occurring substance use disorder could result in a person being less likely to benefit from AOT. Some of the challenges associated with substance use disorder are related to issues with enforceability of SUD treatment mandates in the AOT framework (discussed in Chapter 3). Other challenges, however, are related to the

idea that the clinical profile of people with a primary substance use disorder is inconsistent with the goal of compelled compliance with psychiatric medication.

> *"Sometimes we have referrals that are predominantly substance abuse. Just a marginal psychiatric kind of layer to that. That usually happens when they get admitted to a hospital in an intoxicated state, but they get a label of a psychiatric diagnosis in the process. And then that sort of carries them. But really, the bulk of the issues are really substance abuse-related. And so that individual is not likely to do as well with the court order or care about a court order." ~Administrator 21*

Relatedly, some interviewees noted that people with personality disorders, particularly antisocial personality disorder combined with a substance use disorder, may not see improved outcomes in terms of hospitalizations and arrests from AOT because they are not likely to be influenced by the presence of a court order.

> *"People … referred from the OMH pre-release, people in prisons in the [Department of Corrections], a lot of them have heavy duty substance use issues, and they also have a lot of characterological or personality disorder issues … There's no thought or mood disorder in there that would really qualify to be on AOT, and so we get these people on order. They are obviously oftentimes very dangerous to themselves and other people by nature of their substance use and their way of relating to the world, and we sometimes cannot remove them because even when they're on medication, they don't present differently than they are when they're off medication. And so they often end up being on everybody's radar … the mayor's, so-and-so's office top 10 list … And we're all bending over backward trying to get this person to be in a safe space … it's not appropriate. But also these people need a lot—but [not] what we can give them." ~Administrator 16*

Finally, several interviewees noted that those with co-occurring intellectual and developmental disabilities (IDD)—particularly those who may not have been diagnosed in childhood or who for other reasons are not served in the state's Office for People with Developmental Disabilities (OPWDD) system—may be inappropriately served by AOT.

> *"I think for us there's some, not quite exclusionary criteria, [but] criteria that makes this person really not likely to do well under an order. For example, someone with a lot of intellectual disability who is unable to really process the idea of being under a court order or having an obligation to attend treatment." ~Administrator 21*

> *"[It] is unfortunate, because in some cases I feel like it's more maybe their cognitive delay that's causing them to not be able to follow through with treatment. So, it feels like the AOT is almost punishing them in a way, but it's not really anything that is in their control." ~Provider 4*

Very few individuals in our sample had an IDD diagnosis in their Medicaid claims; less than 2% of the AOT cohort had an "Intellectual Disabilities and Related Conditions" diagnosis between 2016 and 2023. However, the high prevalence of this theme in our qualitative data suggests that this condition may be underdiagnosed, or some individuals with IDD may not have received a

billable service relevant to their diagnosis during the study period. A psychiatrist offers one explanation for this disjunction:

> *"We have a lot of immigrant populations who have never been through this system, have never been through [the] education [system], have never been tested, but clearly they have this, you know, biography, wherein clearly something's not right on an intellectual basis. You know, we feel for the families, we feel for the situation that the inpatient unit has to deal with, but it's not necessarily something that AOT is going to have a significant impact with … it's really extremely difficult because usually OPWDD requires at least an IQ score, and if someone's never been [IQ] tested, good luck trying to get a full grown adult who doesn't speak English tested somewhere." ~Administrator 21*

The above interviewee raises not only an issue with the inappropriately applied interventions but also a racial and disability justice issue; those at the intersection of disability, immigrant status, ethnicity, and language proficiency are more likely to be compelled to accept treatment that may not be clinically appropriate or effective. It also raises an issue with whether and how people access services for intellectual and developmental disability administered by OPWDD. When these access issues emerged in interviews, the OPWDD services were exclusively referred to as difficult or impossible to access.

> *"So that's one thing that we deal with. A lot of issues in our area is once somebody is treated by the mental health system, OPWDD will not take them." ~Provider 4*

> *"It's easier to get into Harvard than to get OPWDD services." ~Administrator 19*

Drivers of and Implications for the Misapplication of the "Likely to Benefit" Criteria

> *"I think it would very much help if there was a political recognition of that not everyone benefits from AOT and that the clinician should be able to feel freer to make that decision on a clinical basis." ~Administrator 19*

When a person is unlikely to benefit from AOT based on their diagnostic profile or patterns of past behavior, the pressures to pursue an AOT order may be related to risk and liability, or to political pressures to "do something."

> *"Axis II behaviors, the more personality type behaviors where no amount of psychiatric intervention is necessarily going to change this. They're going to need to engage in something more along the lines of behavioral therapy, DBT, CBT, that kind of stuff, where psychiatric medication isn't necessary. Med compliance isn't going to come into a role. There, I don't think an involuntary treatment plan is necessary. We work more on engagement with those individuals. They're going to have to want to engage in the process. Although there are times where the risk level is so high with those individuals that, you know, we need to take steps to, if nothing else, for a liability coverage on all pieces of the system." ~Administrator 4*

In discussing this dynamic, a hospital-based provider described the political pressures placed on the hospital to disregard community recommendations and err on the side of initiating an AOT order even when a person is unlikely to benefit. Consistent with a majority of professional interviews, this comment includes explicit mention of substance use as a key factor in AOT being less likely to benefit a person.

> *"Our physicians' writing the discharge order for a person to go in the community, who the community is saying won't benefit. But then if that person goes and does something very terrible, they're going to look at us. And why didn't you do an AOT? Because ultimately you could have, and so that's very challenging … There are people [for] whom Kendra's Law was really designed to try to help keep safe and keep in treatment, and I think there are a lot of those individuals who are using substances that it is not helping. This hasn't necessarily been it for them. It hasn't helped them. And again, I think AOT is great for many people and it keeps people well and it will hold them to attending treatment. It will hold providers to continue to work with them. But there are some other individuals that are I think very dangerous who this does not help them." ~Provider 5*

Interviewees expressed alarm that when legal liability concerns drive AOT decision-making, it leads to an overemphasis on risk management and compliance that ultimately detracts from providing person-centered support.

> *"We have a system where we want to put everything in place to cover ourselves. But in the process, we forget to treat the individual. What we are doing is treating the chart, not the individual. Because everybody is in fear. Everybody's afraid that the client might be the one that we end up letting go. And then the next day you see him on TikTok and everything else … But we forgot in the process that there's a human being too that we need to engage." ~Provider 6*

This dynamic is particularly critical to consider in light of the potential harms associated with AOT detailed in Chapter 1 and elsewhere in the report, and in light of the significant resource investment to pursue, monitor, and enforce AOT orders.

> *"Taking a good look at it to decide, is this helpful or not? And if it's not going well, get them wherever they need to be, right? Because you don't want to serve people where you're not helping them. It just delays them finding what they really need." ~Advocate 2*

Theme 4: AOT Orders Initiated in Institutional Settings

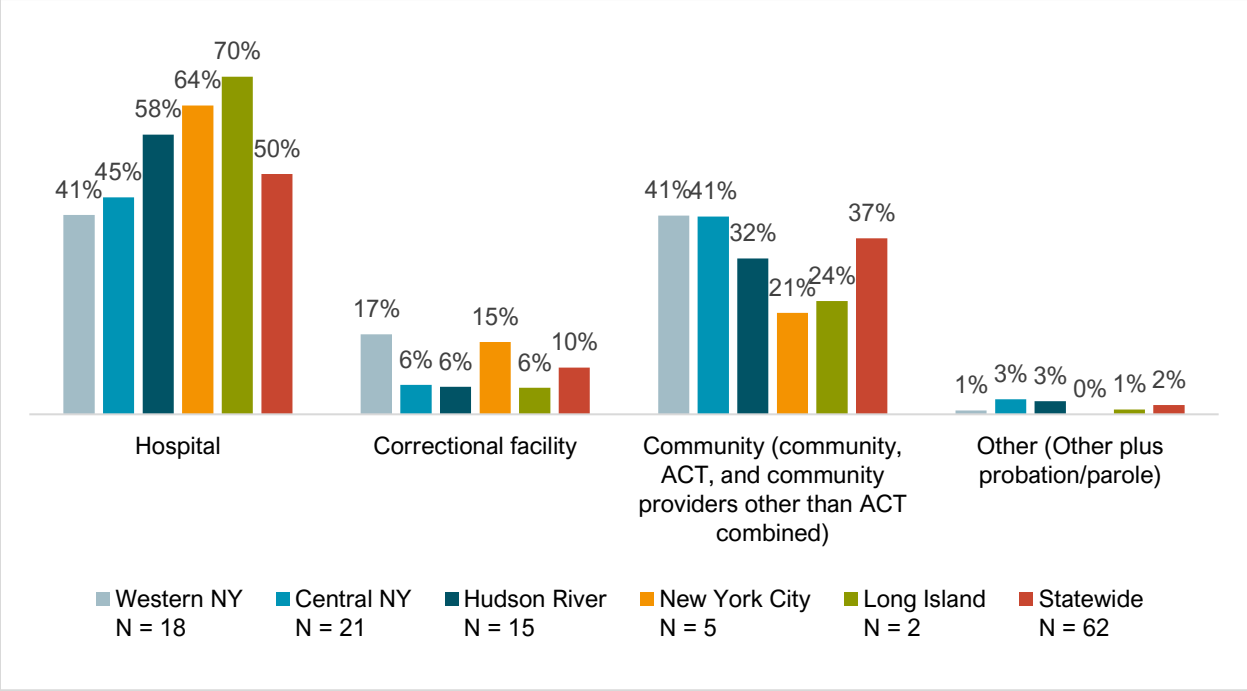
Described extensively in Chapters 1 and 3, when AOT is initiated while a person is held in a psychiatric hospital, it is common for a person to agree to sign a release of information if they believe their release is conditional on establishing an AOT order. Below are two of many quotes from administrators that illustrate this dynamic.

"I have gotten the impression from some people that it's leveraged as you have to have an AOT in order to get out of here. I don't think that's how [the petitioner] is saying it. But I can understand that that could be the perception of the person." ~Administrator 3

"So if it's coming from the hospital…people will say anything to get out of the hospital. So that's the unfortunate reality of the AOT, right? So they put this on the table. This is what we think is the best thing for you. And a lot of people will agree out of the gate. Like yes, I just wanna get out of here." ~Administrator 7

As shown in the following exhibit, there is regional variation in the source of AOT referrals across the state.

Exhibit 2.2. *AOT Initiation Settings*



Statewide, 50% of referrals are initiated from hospitals. The highest rates of hospital initiation are in New York City and Long Island, the regions with the highest numbers of AOT orders. In New York City, 64% of orders are initiated in hospitals and 15% are initiated in correctional facilities. About 10% of referrals statewide originate in correctional facilities, with Western New York having the highest proportion (17%), followed by New York City (15%).

Interviewees in New York City in particular attributed the high rates of institution-originated orders to a privacy law that functionally inhibits community-initiated orders. In 2011, the *Miguel M.* ruling of the New York Court of Appeals established that HIPAA privacy law prohibits the disclosure of a person's medical records to an AOT petitioner without a person's authorization. This has resulted in petitioners having much more difficulty obtaining records needed to

demonstrate the past hospitalizations eligibility criteria for AOT. Interviewees noted that in community-initiated referrals, a person is unlikely to agree to sign a release of information for the petitioner to access their records. In the absence of a person's authorization, the petitioner must file a subpoena to obtain hospital records through the courts, a step that can add weeks or months to the process of filing an AOT petition. New York City interviewees described how community investigations can take up to two years to complete because of the added steps and time it takes to obtain hospital records through the New York City court systems. They surmised that dynamics associated with the sharing of records to verify AOT eligibility have resulted in more AOT orders being initiated in hospitals and jails or prisons where a person is more likely to be compelled to release their medical records.

Theme 5: Person and Provider Involvement in the AOT Plan Development Process

The AOT plan is at the heart of AOT implementation, and interviews generated critical insights for whether and how AOT plan development contributes to outcomes. This theme briefly summarizes key challenges associated with the AOT plan development process. These are discussed further from the perspective of people under AOT orders in Chapter 3.

An advocate who is a proponent of AOT described an "ideal" AOT planning process, noting that this ideal may not be realized in current practice.

> *"Are we helping them to self-advocate for adjustments that they need for medications, which is often needed to try to figure out the right dosing that works well without having too many side effects for them? A program that's able to problem solve and proactively help the person … [to give them the] ability to advocate for themselves. That's really the goal, right?—to get well enough so that they are able to do those things." ~Advocate 2*

Involvement of the Person and Family in AOT Plan Development

There was variation in the extent to which professionals endorsed the person being involved in the treatment plan, but no interviewees described intensive involvement or shared decision-making such as the incorporation of decision aids or the use of psychiatric advance directives. In a few instances, professionals described specific times in which a treatment plan was adjusted based on the person's preference. However, most descriptions of treatment plan development described no involvement of the person, or more passive involvement without descriptions of back-and-forth dialogue. Consistent with the accounts from people under AOT orders detailed in Chapter 3, professional interviewees similarly described a dynamic in which a person is compelled to accept the treatment plan, particularly when an AOT order is initiated in a hospital setting. In a hospital setting, a person may not be in a position to engage in extensive

dialogue about treatment decisions, particularly when they are experiencing a loss of agency and feel they must accept AOT in order to leave the hospital.

> *"Most of these patients that were placed on AOT, it happened while they were in an inpatient psychiatric center…it wasn't in a setting that was conducive for being open-minded. For example, somebody who's in…inpatient psych…that person's been hospitalized for 30, 40 days…from a participant perspective, they just want to get out." ~Provider 9*

One provider noted that people under AOT orders are not offered the kinds of person-centered planning opportunities that voluntary participants are offered, suggesting a gap in practice that could be resolved or mitigated with additional guidance on whether and how person-centered planning is an expectation for people under AOT orders.

> *"I think something I'd like to see added is maybe more client participation … With every other client that's not AOT, they get to decide their plan of care, which means I do an assessment with them. We talk about their barriers, their strengths, their dreams, their goals, their concerns and the things they wish would change." ~Provider 27*

As discussed in Chapter 3, multiple family members expressed frustration that they were not included in the treatment planning process and not given information about treatment plans. This was particularly frustrating for family members who lived with the person and/or were their primary caregivers.

Involvement of Treating Providers and Local Administrators in AOT Plan Development

There was wide variation across interviews regarding the extent to which providers and AOT coordinators were consulted in the development of treatment plans. This is discussed in more detail in Chapter 3. When providers weren't consulted in the development of AOT plans, they noted this as a gap.

> *"If I could change one thing about AOT it would definitely be in regard to more openness [to] different referral pathways for our client. Like, obviously, they come to us with an order, but sometimes, you know, an hour with a psychiatrist, it's not enough to basically define this client's life for the rest of their life." ~Provider 23*

Commonly, AOT coordinators and providers identified that when initial treatment plans are developed in institutional settings, particularly those outside of the person's county of residence, they are developed without adequate input and coordination with local providers and the LGU.

> *"[When an out-of-county hospital develops the plan] chances are that staff doesn't understand the rural realities of our county and that they're developing this treatment plan and ordering somebody to a year of a treatment plan without too much consultation with the ACT team. They will send that treatment plan to the receiving treatment team and get a 'yea' or a 'nay', but it's really created and developed by people separate from those who will be carrying it out. …That's a fair amount of our orders, and I know how that affects us here. I can only imagine in other areas that's even more*

significant. So I would look at those and see what's the reality of what does that look like for somebody ordering somebody to receive a treatment that they haven't investigated? Three hours away from the ordering court and what is that really? And are we kind of going through the motions or is this really serving the individual? I don't know." ~Administrator 4

As this quote highlights, it is very important that the local AOT coordinator at minimum is involved in the development of a treatment plan when a person is discharged from the hospital, particularly when the hospital discharge planners are not deeply familiar with the local service system. A similar dynamic was noted when a person is released from prison on an AOT order.

"I think that was the big concern that we were noting with the referrals coming from the prisons. When they're coming from within our county, our county psychiatrist is very familiar with PROS [Personalized Recovery Oriented Services] versus clinic versus what's open, whereas the ones from the prison were saying this person needs to go to the [specific program] clinic. But there was zero chance this guy was getting to the clinic, and he really would benefit from like an ACT or a PROS program." ~Provider 13

This challenge was observed in rural and urban areas. Recently, New York City has set up a dedicated liaison role to support coordination between the correctional system and the community system for people on AOT orders.

Theme 6: AOT Plan Reviews and Flexibility

There appears to be significant variation from county to county in the extent to which administrators exercise discretion to adjust a treatment plan. Providers and administrators who endorsed robust strategies for involving the person also indicated that they are able to exercise flexibility in the plan, including the use of contingencies for medications and services. In other settings, changes seemed less frequent—with administrators noting that significant changes are not possible without returning to court. Providers operating in areas with limited flexibility highlighted that it inhibits their ability to engage with the person and tailor services so that they are maximally person-centered.

One promising practice is to establish a process for reviewing the plan once a person returns to the community:

"[In the initial AOT plan development process] I think they're certainly taking into account what the client would like, but that's probably more heavy on what the providers think the person probably needs because when you're starting an order, you don't typically have someone who's stable, right? But in our county, we do quarterly team meetings—and more often if needed, if there's something going on. So that's really where the team comes together with the client who's receiving the service to talk about each aspect of the categories of service, how they're going, and the client has the ability in front of their entire team to talk about that, and I think that most of the providers that we collaborate

[with] do a nice job of trying to find that balance of, OK, well, you don't want to go to PROS. We think it would benefit you. You know, how can we come up to a compromise about that? I certainly think they have a voice." ~Provider 14

Another provider laid out a similar recommendation, proposing a post-hospital review of the AOT plan with providers as an opportunity to provide education, confirm understanding, and identify additional supports that may facilitate improving a person's life.

"A requirement of individuals that are on AOT to have a case conference with the care coordinator, the ACT team to… clearly identify everything that's moving forward. So this could happen after they come out of the psych hospital. They're at home. The ACT team is going to make their introduction. There should be a meeting with a contract, with a signature that says they understand, with a care coordinator. And at that time, maybe list the needs that the participant wants. 'What would you like help with?' Communicate what AOT is. They don't know. A majority of them are not aware of their rights. They don't know what it means." ~Provider 9

One provider noted that shorter initial orders afford treating providers more flexibility to adjust and make changes and to meaningfully engage the person in the development of the AOT plan. This strategy is particularly useful when an order is initiated in the hospital, where the providers who developed the treatment plan may not be as familiar with the person.

Provider interviewees also called for more flexibility in the care coordination requirements, particularly when a person's order is close to expiring and an enhanced voluntary agreement is anticipated. One provider indicated that loosening the care management requirements might facilitate transitions to greater independence.

"With the way AOT is set up and it's under the specialty mental health care management through OMH, you have to do a minimum of four visits a month, and there's no way for that person to sort of comfortably step down while under that order. You have to go to an enhanced order to be able to step down to two face-to-faces a month. And I feel like we should be able to work somebody down to that enhanced level while on the order." ~Provider 12

Theme 7: Ambiguities With Substance Use Disorder Treatment Services in the AOT Plan

The inclusion of substance use disorder (SUD) treatment services in the AOT plan was a commonly raised topic in interviews. Almost universally, interviewees noted that it is not possible to mandate substance use services through AOT. Several factors contribute to this dynamic. In New York, most SUD treatment services are licensed through the Office of Addiction Services and Supports (OASAS) and not through OMH. Because AOT is an OMH program, OASAS-licensed programs are not bound by the same policies and practices for service prioritization and monitoring, making coordination and enforcement logistically far more complex. Further,

being under the influence of drugs or alcohol or skipping a toxicology test does not meet the threshold for involuntary psychiatric treatment, limiting the reach of 9.60 Removal Orders.

> *"You can put it in, but what are you going to do? If they are noncompliant, you're going to take them to an ER, that's not going to do anything." ~Administrator 19*

Some providers expressed confusion about how to interpret AOT monitoring and enforcement mechanisms, leading to frustration and inefficiencies.

> *"You'll see orders that have 'must do substance abuse treatment'. And following up with that is indicated by blood draws, urine drug screens, things of that nature. And there's a 9.60 order connected to people for a name…Nobody can stop smoking weed, unfortunately, so I'm really bringing people to get a UDS? Am I really bringing someone to get a blood screen, a blood draw? It's in the order, and so if I don't am I going to get hosed for that? Cause we are responsible for reviewing the order. So what exactly does all those things mean? I'm doing a significant event for every time my client is hitting the bong? Like that's just not even based in reality." ~Provider 16*

Further complicating the issue of integrating mental health and SUD services, interviewees indicated that substance use providers may not have the competencies to work with people with co-occurring mental health problems, particularly people with psychosis.

> *"It is increasingly difficult to get patients substance use care, especially from inpatient psych. Even if the entire treatment team agrees that the substance use is the primary reason someone keeps getting readmitted and having episodes say of the psychosis, many substance use facilities will not take our patients without some leg work…For example, let's say you have someone that has like schizophrenia or bipolar disorder, some sort of psychotic disorder. They self-medicate by smoking marijuana or whatever, have another psychotic episode, get back in the hospital. They're up to date on their medications. They need to address the substance use. There's no solid way to address that primarily. Substance [use] providers say that if they have the mental health issues that they can't facilitate…We just sent somebody home that we probably put in at least 6 to 8 referrals for substance [treatment] and they wouldn't do it…a lot [of it] was because of the mental health component." ~Provider 25*

One administrator voiced frustration that focused time and resources related to SUD divert resources from those who are more likely to benefit.

> *"The substance abuse piece takes time away from other clients to get healthy because their impact is so negative that they're getting removed all the time. You're having 100 case conferences just trying to get them to take one IM, you know, as opposed to taking care of your other 69 people that are more mental illness that can really benefit from your limited time and effort. So they drain the system. They drain the energy, they drain the money, and they don't get well. And other people on this side get ignored." ~Administrator 16*

These dynamics led some to conclude that SUD services should not be put in the treatment plan; others recommended changing the policy so that SUD services are mandated. It is unclear, however, whether such a mandate would be feasible or effective.

> *"I think most of us believe that, like with substance use, especially if the person isn't ready to do it, putting it on a civil court order doesn't make a whole lot of difference." ~Administrator 22*

> *"On the treatment plans, when it comes to substance use, there's not much that AOT is able to do. So for me, it's like then why put a tox on there?" ~Provider 19*

Theme 8: Ambiguities With Recovery-Oriented Services in the AOT Plan

Administrators expressed differing views—and, at times, confusion—about whether and how community-based recovery-oriented services could be incorporated into the AOT treatment plan. (The broader issue of how the AOT plan aligns with a person's overall plan of care, ideally a person-centered plan, is examined in depth in Chapter 3.)

New York's recovery-oriented service offerings are quite robust and include peer support, supported employment, and a range of psychosocial rehabilitation services delivered through a range of programs. For people who meet eligibility criteria for comprehensive wraparound supports (which overlap significantly with the eligibility criteria for AOT), recovery-oriented services are delivered as part of a comprehensive service package that also includes clinical treatment through ACT as well as through Personalized Recovery Oriented Services (PROS) and Community Oriented Recovery and Empowerment (CORE) services. The structure of administrative claims data made it difficult to determine whether people under AOT were receiving specific recovery-oriented services such as peer support or supported employment within these service bundles. Many other recovery-oriented services are financed outside of Medicaid and therefore cannot be assessed through quantitative data in this analysis, including services funded through state general revenue, federal block grants, private nonprofit initiatives, and other sources. These include peer wellness and drop-in centers, peer respite, clubhouses, NAMI peer-to-peer and family-to-family education programs, peer bridger programs and recovery support navigators, the INSET program (discussed in Theme 9), and numerous others. In assessments reported in CAIRS, providers indicate which services are in an overall plan of care for a person. In the first admission assessments of people under AOT in our sample, providers indicated that participants would be connected to self-help or peer support services (22%) and supported employment services (11%), although it is unknown whether participants received these services.

Interviewees with lived experience very rarely discussed receiving peer support or other recovery-oriented services—and never in relation to services received under an AOT order.

There were a few mentions of engagement in recovery supports in the family interviews. In one instance, a family member described a housing program facilitating access to employment supports which later resulted in long-term competitive employment.

> *"They got him enrolled in a good skills work program. The workers from the [housing program], they knew that he was motivated, so they enrolled him in this program held at the [local college] and they worked on interview skills, writing a good resume, and they had a job fair at the end of this program. And they gave each graduate [money], along with the opportunity to be interviewed by prospective employers." ~Family Member 22*

Providers rarely discussed connection to recovery-oriented services. When asked, they generally voiced confusion and ambivalence about whether and how to facilitate these connections:

> *"Yeah, I don't always add them in because they're really strictly voluntary. I don't know. Maybe I should. I don't know." ~Administrator 10*

> *"You know, I don't know the history of why we're not putting vocational services and peer services on it." ~Administrator 11*

One reason for low rates of participation in recovery-oriented services is that AOT coordinators and providers may be unclear about whether and how voluntary services can be introduced into the service plan for people under AOT orders. Other administrators identified barriers that limited access to these services for people under AOT. These barriers include providers who refuse referrals because they are unwilling to work with someone presenting on an involuntary basis, and providers who report they cannot comply with AOT reporting requirements. Several other administrators noted apprehension and confusion related to eligibility and duplicative billing. For example, some reported not pursuing voluntary peer support services or employment supports that might be viewed as part of the ACT service package—even when ACT teams, in some cases, did not offer peer or vocational services due to staffing limitations.

Theme 9: Ambiguities With the INSET Program

Another key recovery-oriented service in the New York mental health system is the Intensive and Sustained Engagement Team (INSET) program. INSET programs are funded by OMH, administered through the Office of Advocacy and Peer Support Services (OAPSS), operated by peer-run organizations, and designed specifically to support people who struggle to successfully engage with mental health services. At the time of writing, there are five INSET teams in operation across the state, with a sixth in development. INSET services are flexible and completely person-directed, designed to meet a person where they are at without restrictions whenever possible.

The OMH website describes INSET as being "for people at risk of involuntary treatment such as AOT, hospital stays, or criminal justice involvement" (New York State Office of Mental Health, n.d.). In consultations and interviews, however, there were divergent views and opinions about whether and how people under AOT should engage with INSET. Some advocates described INSET as being explicitly used as an AOT diversion tool. Other providers voiced concern that the involuntary nature of AOT is fundamentally incompatible with the voluntary emphasis of INSET, arguing that while people on AOT should not be precluded from participation in INSET, there should be no explicit policy linking the two programs.

> *"Committing this other program to AOT in that way, you're already putting INSET at a disadvantage. So I think INSET can and should stand on its own." ~Administrator 25*

Theme 10: Rare Instances of Petition Denial, Contested Hearings, and Attendance at Hearings Suggest Due Process Issues

Accounts of people with lived experience of AOT and converging data from professionals and family members point to concerns with the judicial process (see Chapter 3). Here, we explore dynamics associated with AOT petitions and hearings with quantitative data and a primary analysis of professional interviews.

Denials of AOT Petitions Are Rare

It is very uncommon for judges to deny AOT petitions. The following exhibit depicts the rates of AOT order denials by region in the history of AOT. Only four counties in the state had denial rates over 10%: Cattaraugus, Chemung, and Tompkins in the Western NY region and Otsego in the Central NY region.

Exhibit 2.3. *Petition denial rates by region*

State	Number of Petitions Filed	Percent of Petitions Denied
Western NY	4,688	5.6%
Central NY	1,336	2.7%
Hudson River	4,130	3.3%
New York City	22,503	4.3%
Long Island	4,045	5.8%
STATEWIDE	**36,702**	**4.4%**

Numbers reflect all petitions filed since the enactment of Kendra's Law through February 4, 2025. Reported by NY OMH and accessed on 5/1/2025 from Data.NY.gov.

Interviewees attributed the low rates of denials to the fact that by the time an AOT case reaches court, the petitioner (i.e., the LGU) is certain they have all the information needed to demonstrate the person's eligibility for AOT under current judicial processes.

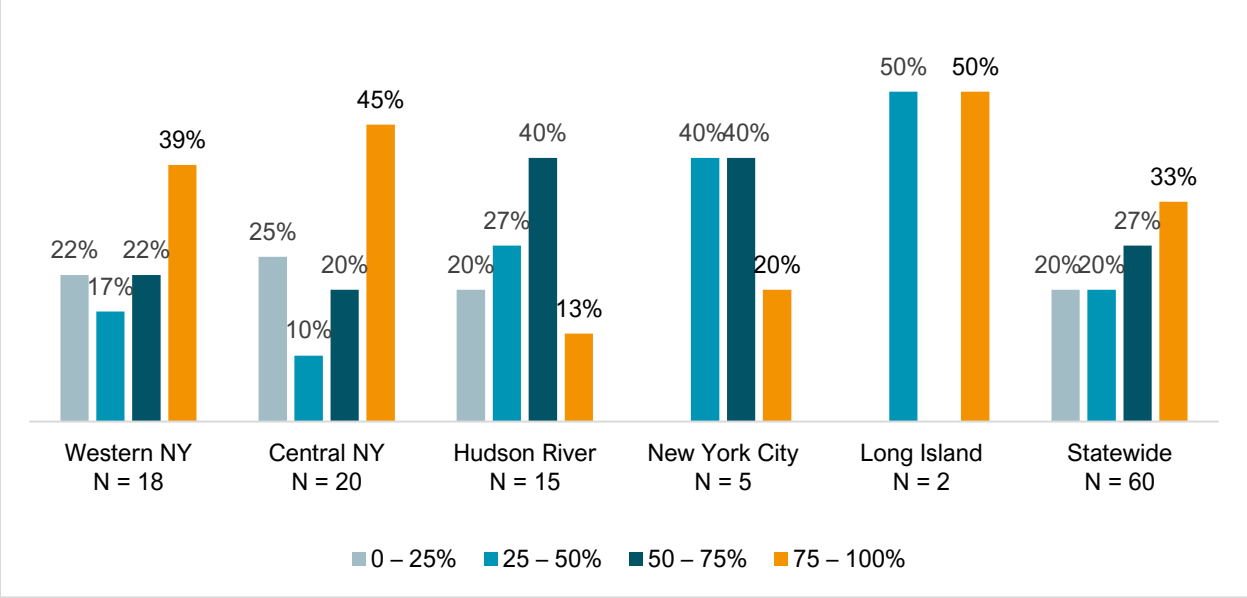
> *"Most of the time, almost always the cases are decided in our favor. And again, it's not because Mental Hygiene Legal Services isn't doing a good job. It's because the odds are really stacked against them. Because we're not going to go into court unless we know we've satisfied all the criteria…Then the judge doesn't have a lot to decide right at that point because…that's what a judge has to decide. Did it meet all the points of the statute?…We're not gonna go into court with something that doesn't meet criteria." ~Administrator 22*

> *"I think they're for 98% or 95% of the cases. They're very rote. The outcomes are more often than not that the order is issued, some extension is granted, and for those very few cases that are contested, there's a difficult battle for the respondents to show that they shouldn't have an order." ~Judge 2*

Contested Orders Are Relatively Rare

If a person agrees to follow the treatment plan, the order is determined to be uncontested. In these cases, the judge still reviews the paperwork, but a trial may not be held. The following exhibit depicts the approximate proportion of uncontested orders by region as reported by DCS. Statewide, it was most common for DCS to report that 75-100% of their orders were uncontested.

Exhibit 2.4. *Estimated Uncontested AOT Orders by Region*



When hearings are contested, it appears very rare that a person can develop a strong case for why they should not be on AOT (see extensive discussion in Chapter 3). Given the structure of the law and how it is applied, it is understandable that people find they have few options when

they disagree with the order. As one AOT coordinator noted, contesting an order is a "feeble contest" for the person who has neither the experience with the court setting nor the professional expertise to marshal evidence to support their case against a set of professionals who spend their days in a court setting and carry a host of clinical and legal credentials.

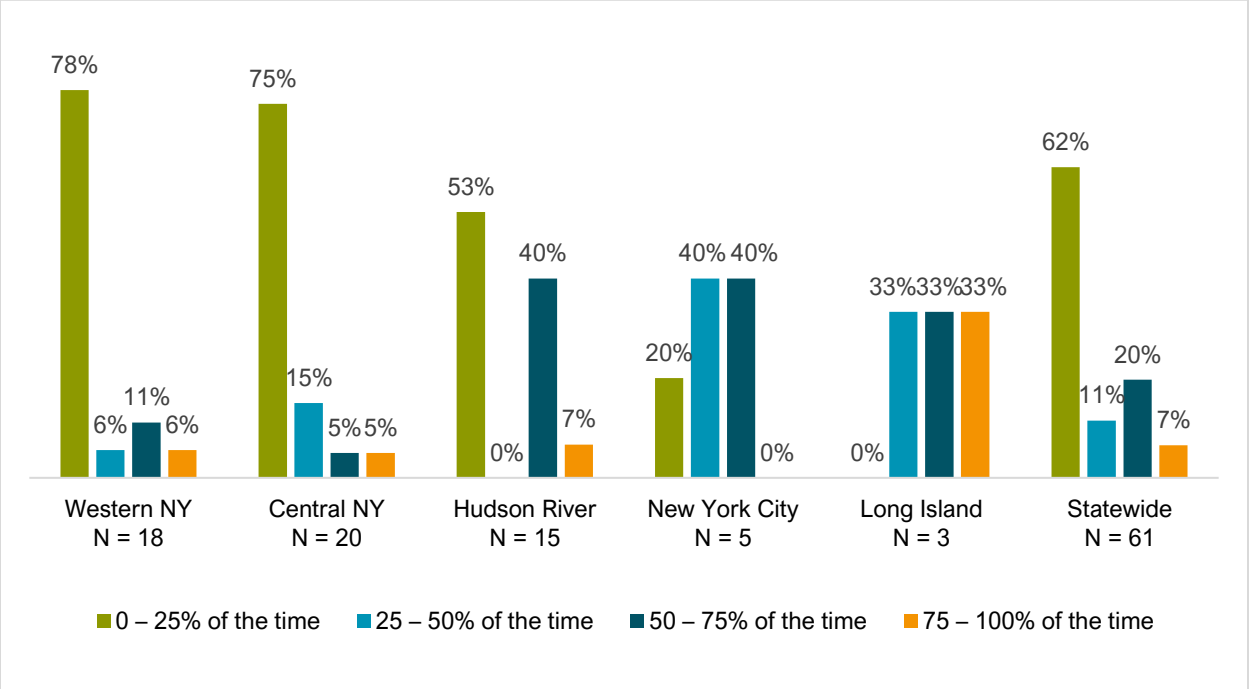
> *"It's a feeble contest because it's like there's a level of acceptance generally with the individuals that this is happening, but we're not going willingly. So even in court like they're not gonna put up a big opposition. But given a chance to speak, we're gonna let the judge know we don't want it. We don't want treatment. We don't need it." ~Administrator 4*

> *"I remember this one patient said to me, you know, and this is after multiple hearings, he said to me, 'You know, when I do bad you tell me I need more AOT, and when I do good you take all the credit for it.' And I said, 'You figured it out.'" ~ Administrator 24*

Attendance at Hearings Is Rare

Interviewees noted that it is rare for people to attend their hearings, which is consistent with data from the DCS survey. As shown in the following exhibit, 62% of DCS survey respondents reported that people attend their hearings 25% of the time or less; only a handful of the survey respondents indicated that people attend their hearings 75-100% of the time.

Exhibit 2.5. *Estimated Percentage of Hearings With Subject Attending by Region (%)*



In some areas people have the option of joining their hearing virtually, and in all cases administrators and providers are expected to provide support and encouragement for a person to attend their hearing. If a person does not attend their hearing, the petitioner must

demonstrate that they have met the law's "exertion of effort" requirement by making attempts to facilitate the person's attendance. If these attempts have been made and the person still does not attend, the hearing will continue and the MHLS will represent the person. When asked why so few people attend their hearings, one AOT coordinator noted:

> *"I think many of our folks are intimidated by authority figures, so going in front of a judge or having a proceeding in a courthouse may trigger them to think that this is a criminal proceeding. We do a lot of education that this is not a criminal proceeding. This is different, but we do have a population of folks that have had interface with law enforcement and criminal justice. And I think they are somewhat fearful that they're going to be locked up or incarcerated." ~Administrator 5*

Theme 11: Black Robe Effect and Role of Judicial Involvement

When asked about the impact of the courts on the behavior of people under AOT orders, providers gave examples of individuals who changed their behavior as a result of court involvement and others for whom it made no difference.

> *"It does benefit those people who believe that it has some type of consequence. Like I have a gentleman that literally thinks that there's a judge watching him, so he will follow it to the letter. Then I've had people just refuse everything and say, you know this, you can't do anything and we can't. So it all depends on the individual." ~Provider 16*

The "black robe effect" is a concept promoted by some advocates of AOT, and it was raised in several professional and family member interviews (notably, as described in Chapter 3, this was not endorsed by interviewees with lived experience of AOT). The black robe effect posits that people may be more motivated to comply with court-ordered treatment when someone in a position of authority (i.e., a judge) conveys that they care about the person and believes that they can comply with the requirements of the court. Providers reported wide variation in the extent to which behavior may be influenced by a black robe effect. In New York's current system, engagement with a judge is relatively minimal, particularly given the high rates of uncontested orders where a person will not appear in court. Some interviewees with experience in therapeutic courts contrasted their experiences with those courts with the AOT experience and noted that therapeutic courts afford more opportunities for the person to interact with the judge, which can be beneficial.

> *"When I first started the mental health court, I would see the defendants every week because I felt like I needed to know them, get to know them, and so much so by accident really, that I and it's carried on, you know, defendants will approach, come up to the bench and talk to me at the bench and establish a relationship. But I think it's very helpful. I think like any human relationship, neither one wants to disappoint the other. And so especially when you're dealing with people with a serious mental illness*

who probably everybody runs away from them. And to have an interaction like this with somebody that at least appears to have a position of authority, I think is very helpful." ~Judge 3

Professional interviewees with experience in drug court—including the provider quoted below, a peer specialist with lived experience as a drug court participant—hypothesized that a model of AOT that involves periodic check-ins with a more active and involved judge could promote engagement and associated positive outcomes.

"I went through drug court myself, and I would say that if that level [of judicial involvement] was AOT in New York, you would see a decent change...If [other provider name] brought her AOT client in front of a judge once a month and checked in with the judge, you would see drastic changes I think. I mean drug court saved my life." ~Provider 27

A 2025 report of the New York State Unified Court System Judicial Task Force on Mental Illness recommended piloting a model similar to the one described by interviewees who endorsed a positive impact of judicial involvement. The task force report recommends a two-year pilot of an active court model similar to that used in problem-solving courts and in AOT programs in other states in which the judge connects with the person, engages them in discussion about their goals, and holds periodic status conferences during the order to check in with the person and review progress toward their personal goals (New York State Judicial Task Force on Mental Illness, 2025).

Theme 12: AOT Explicitly Enhances Provider Accountability

Provider accountability was a prominent theme in a majority of interviews for this study. Interviewees commonly emphasized that the service monitoring component of AOT is a powerful mechanism to ensure a person is meaningfully engaged in services. It was relatively common for interviewees to emphasize that AOT compels both individuals and their providers to engage with one another.

"Realize, people think that a AOT is just monitoring the person who's on AOT. It's not. It's the service provider just as much that we're monitoring. I mean, I like to think of AOT as an arranged marriage in the hopes that the two parties will fall in love." ~Administrator 19

"What I knew about it, what I liked about it wasn't only the accountability on my [family member's] part, but the accountability on the state of New York to provide the care, to provide consistent care, to ensure my [family member] had his scripts on time." ~Family Member 4

Several AOT coordinators described service monitoring as an opportunity to provide support to providers to ensure they are adequately engaging the person and making adjustments to their services when needed to increase engagement.

"So if someone missed their injection appointment, we will try to, you know, figure out what were the barriers to them getting there? Did they say they were going to get up there themselves and they didn't? Did transportation come? Were they not available for the care manager to transport? You know, what were the barriers to them getting to that appointment? We will then try to reschedule with the client and the provider. And the care manager gets a little more involved in either transporting or meeting them at the hospital, setting up transportation, whatever the barriers are, we'll try to work through those barriers." ~Administrator 5

Theme 13: Providing Services to People Who Are Unhoused

Because of challenges associated with connecting people to housing, and the extremely limited housing availability across the state, a small but meaningful number of people are placed under AOT orders while they are unhoused. Exhibit 14 depicts the DCS survey respondents' estimated percentage of people under an active AOT order who are unhoused by region. Statewide, respondents estimated that 11% of people under AOT orders are unhoused, with higher rates in New York City and Long Island.

Exhibit 2.6. *Estimated Percentage of People Under an Active AOT Order Who Are Unhoused*

Region (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	9.8 (20.1)	0.0	0.0	75.0
Central NY (N=20)	9.9 (20.7)	0.0	0.0	75.0
Hudson River (N=15)	11.1 (9.7)	10.0	0.0	25.0
New York City (N=5)	14.0 (0.0)	14.0	14.0	14.0
Long Island (N=2)	20.0 (7.1)	20.0	15.0	25.0
STATEWIDE (N=61)	**11.1 (16.7)**	**3.0**	**0.0**	**75.0**

These figures align with those in the CAIRS data where providers indicate that 11% of people under AOT are unhoused at the time of their first assessment. For the most part, administrators noted that the reason for discharge without a residence is because of housing availability, not the person's choice. Because residential services are ultimately voluntary, there may be some scenarios where an unhoused person who refuses to accept housing may be discharged from a hospital with an AOT order.

> *"We have patients who will never stay in the house. They say you can put an AOT on me, but I will not stay. I'm going to just continue to take off. And right, you can't keep someone in a house. What it does is it ties that bed, that valuable resource that now no one else can live in that bed and are waiting for it because you tied it to someone who's on an AOT who's out there refusing to live in housing." ~Provider 5*

Providers and family members noted that it is particularly challenging to support people who are unhoused because it is difficult to find them.

> *"When she was in supportive housing … they had better access to call her directly. But then she disappeared… She willingly left supportive housing and she moved into a shelter… She entered into shelters throughout New York City … She had to first go to [Borough] and get registered in the shelter system. And then they kept on moving her here, there, and everywhere, from [shelter] to [shelter] to [shelter] all over the place … And then they had a hard time finding her to mandate her to go to these different programs. She just disappeared, she didn't want consistency, she wanted to be left alone … And at that point it was hard for the court system to locate her." ~Family Member 1*

In New York City, administrators described a policy that can result in unhoused people being lost to follow-up when they are discharged from a hospital into the city's shelter system, which is administered by the Department of Homeless Services. In current practice, when an unhoused person under an AOT order is discharged from a New York City hospital, they are sent to an "assessment shelter" where staff conduct medical, psychiatric, and social screenings to determine the most appropriate shelter placement. Administrators noted that this intermediary step increases the likelihood that people will remain disengaged, citing examples in which a person was moved from shelter to shelter, and care coordinators did not have access to information about where a person was located and were therefore unable to establish a connection.

Theme 14: Role of Families in Facilitating Service Engagement

Notably, providers and administrators described that in many instances people under AOT orders do not have relationships with family or have relationships that are not supportive of their well-being.

> *"The vast majority of my clients have nobody in their life, or worse, they do, but they don't want them to [participate in AOT] … I do a lot of psychoeducation working with family members to help them learn so they can be a good support and coordinate. But most people have nobody." ~Provider 26*

When family members are engaged, interviewees experience benefits and harms, depending on the nature of the relationship.

"That one was a success … His family was extremely supportive, which was a huge piece. They were willing to transport him and help him, help guide him along and make sure that he takes his meds, like they were able to really help … It was a team effort, but through everybody we were able to get him to go back into treatment, to go back on medications." ~Administrator 13

Other interviewees described fraught family relationships that add more complexity to the treatment dynamic. A provider offered a range of examples in which families can be supportive and in which families and providers can be at odds with one another.

"I try to [collaborate with family] optimally, it would be nice. Like, if a patient lives at a residence, we can have them monitor oral adherence. I try to avoid that with families because that's really bad for family relationships. So I try to avoid that, but a lot of times families can tell, we get collateral and how they're doing, and they will open the door sometimes for the police or crisis if they feel that their family member isn't doing well. Sometimes the families don't support the AOT, and then they actively keep the patient away from crisis and police. One of them kept the patient from getting the shot, told him he didn't need it." ~Psychiatrist 3

Theme 15: Gaps in Support for Families

A strong theme across multiple interview types was a lack of coordination with and support for families of people under AOT orders. This was described as a major priority and a major gap.

"So in my mind, and if you actually read HIPAA and the guidance, there should be two-way communication with families. So yes, families should be involved, and we want to be involved to the extent that we can just be supportive of treatment. We don't want to be expected to be the treatment providers, the case managers, the nurses, right? So we love it when people come to support our loved ones so that we can pull back and just be a mom or a dad." ~Advocate 2

Only a few interviewees described programs or services that directly support families of people under AOT orders. An organization that serves as a primary support for family members across the country, NAMI, is active in some parts of New York State, but its programming is variable, particularly as it relates to AOT.

"NAMI is a wonderful resource…There was one woman in my group who'd had experience with AOT and really was very helpful." ~Family Member 19

"My wish list is support for the family members to help them understand mental illness, to help them have a community where they can vet each other's experiences. So necessary. Back in the day, NAMI used to do this, so I called NAMI for this lady, and they're like, 'We don't really meet in person anymore. And now it's kind of on hold. Maybe we're trying to work towards Zoom meetings.' I'm like, do you have it in Spanish? Do you have in other languages?… And they're like, 'Oh, that's a good idea.'" ~Administrator 16

In one county, the LGU facilitates a support group for family members of people on AOT, and that was considered very successful in sharing information with families. A community provider described some strategies for supporting families, including providing information and education about the provider role (e.g., correcting the misperception that they are not able to force the person to accept treatment under AOT), and connecting the person to services that reduce the caregiving burden of families. In one example, a provider was able to work with a family to assist a person to move from the family home into a supported housing arrangement, reducing the caregiving burden and stress for the family.

> *"And that's when I'll explain like, hey, we can do housing though. Why don't we, if this is so challenging…This has dramatically improved relationships within families. If the client has their own independent... And then now you can visit the client in their apartment or their residence or what have you, still provide that support. But a lot of times the families feel is if they give up, they fail. It's a whole family dynamic and forget it. But again, that's why we have our family specialists on the ACT teams to kind of coordinate and navigate that." ~Provider 22*

Family support was indicated as a service gap across the mental health service continuum by family members and providers.

> *"I mean, they really don't give you any support. They support the patient to the extent that they do, but there's no family support whatsoever. And you know what? Mental illness is a family illness. It's not just one person, the patient, it's the family. It's the people that support her. So I find them definitely lacking there." ~Family Member 10*

Importantly, many families have been seeking support for their loved ones for months or years before an AOT order is initiated, often experiencing multiple negative or frustrating attempts to get help or to coordinate support with providers.

> *"I think with a lot of families too, they've had it by the time they get to us. Most cases that get to us should have gotten somebody else 15 times before they came to us." ~Administrator 16*

Theme 16: AOT Enables Family Members to Shift Focus and Energy to Themselves and Their Relationships

Some interviewees indicated that once an AOT order is in place, this provides opportunities to improve family relationships because the family is no longer put in an enforcement role, no longer needs to be the "bad guy," and can remove themselves from "power struggles."

> *"I think the AOT is a really good buffer between the patients and the family members taking some of the heat off the parents. And, you know, instead of the mom, and it's usually the mom statistically*

forcing the medication on their son, statistically. Instead, it's the judge, it's the county, it's the ACT team. And so that improves things." ~Administrator 28

One family member described that, once they no longer had responsibility as the primary caregiver, they could focus on their career and personal wellbeing.

"[The nurse] said to me…'We're taking care of [family member] now. Your [family member] is in a safe place. You don't need to take care of [family member] right now. We're taking care of them.' And I just remember it was like a stroke of insight…That first year or so … [they were] in services, back in the hospital and I was like, wait, what? Like I can like just be a 20-something-year-old person and focus on college and all the things that you would do. It was so wild, and I still remember that moment…it just gives people the space and the levity to just take care of themselves or take care of their other kids or whatever you got going on to take care of. Yeah, it was that first year and I finally, just started focusing on me, frankly." ~Family Member 6

Theme 17: Inconsistencies in 9.60 Removals

Under Section 9.60 of New York's Mental Hygiene Law, a person under an AOT order can be transported to a hospital for a psychiatric evaluation if they are not following their AOT treatment plan. Any of the following behaviors can trigger a removal process: Verbal refusals to accept medication or blood tests, canceled or missed appointments, or not responding to provider outreach for a period of time. Removals are initiated by a physician's written order which directs a crisis team, ambulance, or police to transport a person to a hospital, usually a psychiatric emergency room or CPEP.

In our sample of 11,553 people under AOT orders, 34% had at least one reported removal during the study period, and 17% had more than one removal. There was significant regional variation in removals. Exhibit 15 shows of the number of removals by region among people who did not change their region during the study period.

Exhibit 2.7. *Number of Removals by Region*

Number of Removals	% Western (N=1,787)	% Central (N=627)	% Hudson River (N=1,835)	% NYC (N=4,868)	% Long Island (N=1,477)
None	65.2%	71.0%	59.2%	68.5%	70.2%
One	16.9%	13.9%	16.3%	17.3%	13.6%
Two	7.9%	5.7%	8.9%	6.3%	7.9%
Three	3.6%	3.2%	4.4%	3.5%	3.2%
Four	1.8%	2.9%	3.3%	2.1%	1.6%
Five or more	4.4%	3.3%	7.8%	2.3%	3.5%

To further explore regional differences in the likelihood of having at least one removal and mean number of removals, we constructed logistic regression models adjusting for age, gender, race/ethnicity, and total number of significant events reported. The statistically significant differences were as follows:

- People who lived in the Hudson River region throughout the study period were 44% more likely than those in other regions to have at least one removal. Among those with at least one removal, the mean number of removals in the Hudson River region exceeded other regions by 0.9 removals.
- People who lived in New York City throughout the study period were 32% more likely than those in other regions to have at least one removal. Among those with at least one removal, there were no significant differences between New York City and other regions in the mean number of removals.
- People who lived in Long Island throughout the study period were 32% more likely than those in other regions to have at least one removal. Among those with at least one removal, however, the mean number of removals was lower in Long Island than other regions by 1.3 removals.

The regional variation described above is reflected in our qualitative interviews. Our qualitative data also suggests variation *within* regions: Across counties, and even within counties, there is significant inconsistency in how removals are applied. Providers and administrators reported differing thresholds for initiating a removal and variation in the flexibility and discretion used in deciding whether to pursue one. In one county, for example, a provider indicated that three refusals of an intramuscular (IM) injection automatically triggers initiation of a pickup order regardless of a person's circumstances or clinical presentation. In other counties, the decision to issue a pickup order comes only after careful consideration and consultation between providers and the LGU. There is also variation in the weight given to provider opinions about whether a pickup order should be issued, a source of frustration for several providers we spoke with.

> *"In my work in crisis I have seen people on AOT who have decompensated in the community for months and months and have missed several appointments before a pickup order is being done, and I have seen other people that have missed two days of medication and are sent in on an AOT pickup order." ~Provider 5*

Theme 18: 9.60 Removals' Heavy Reliance on Law Enforcement Introduces Risks of Harms

The Kendra's Law statute allows for 9.60 removal transports to be conducted by an approved mobile crisis team, an ambulance service, or police or peace officers. Data collected for this study suggests that the majority of removals are conducted by law enforcement without a

clinician present. In 66% of responses law enforcement officers conduct the removal without a clinician co-response, with law enforcement presence in most other removals (either in a primary role or co-responding with a). In New York City, where the Citywide Assistance Team (CAT) coordinates removals, there is a designated co-responder role to accompany a deputy sheriff on removals. However, the CAT team has not been fully staffed in several years, and functionally nearly all removals in New York City are conducted by trained and designated deputy sheriffs alone without a clinician co-responder. In our interviews we did not hear about any instances in which designated clinician co-responders regularly accompanied law enforcement officers to do removals. We did hear of some instances in which treating providers would coordinate with law enforcement during removals; these dynamics are discussed below.

Several interviewees, including law enforcement officers, indicated that removals should ideally be conducted by clinicians alone or by clinicians accompanied by law enforcement, with the latter serving in a backup role—and preferably officers with specialized training in mental illness and de-escalation.

> *"Leaving these guys in patrol and having an actual team that goes out, I think that would be so helpful and support everything that we do here, which is leaving these guys in service so that they're not sitting for three hours talking to somebody. Yeah, so I love that whole idea." ~Law Enforcement 1*

Interviewees emphasized that removal experiences often carry harm for clients. Nearly all removals involve being put in handcuffs and transported in a police car to a hospital against one's will.

> *"He's been taken handcuffed for no reason in the back of a police car to the hospital. You know no reason that that needs to be very traumatic." ~Family Member 4*

> *"If she's not compliant with getting a shot, I think AOT calls the police and the police come and get her and shackle her. They handcuff her. It's scary. It's happened to her a lot, but it's still a scary thing." ~Family Member 11*

It is well-documented in the research literature that any contacts with law enforcement carry the risk of escalation and violence, and several interviewees described such instances in their experiences with removals. As discussed in a later section, the experience of removals is particularly fraught for people of color, given the higher likelihood of traumatic encounters with police and historical and contemporary practices of over-policing and use of force in communities of color.

> *"Using force on somebody who's AOT looks horrible. There's no denying that." ~Law Enforcement 1*

> *"I did have an unfortunate situation where it was an individual on an AOT. I did a 9.60 Order for the police to come to the clinic and get him to bring him to the hospital because his safety was at risk given his drug use and the behaviors. The police came. He assaulted them and instead of bringing him to the hospital, they charged him and brought him to the county jail. … And then I felt I failed this person because I'm trying to get them help and then they get arrested." ~Provider 16*

Theme 19: Risks of Harm Compounded by Racial Disparities

To examine whether there are differences in removal practices across racial groups, we fitted logistic regression models adjusted for age, gender, and total number of significant events reported. Holding those factors constant, we found the following statistically significant differences:

People who identify as **White** and report no additional race/ethnicity are 11% less likely than others to have at least one removal
People who identify as **Black or African American** are 26% more likely than others to have at least one removal
People who identify as **Hispanic** are 15% less likely than others to have at least one removal

The number of removals among those who have at least one removal does not differ between any of the race/ethnicity categories.

If we view the number of significant events as a proxy for clinical deterioration and noncompliance, this analysis suggests that racial disparities persist even once those elements have been held constant. In other words, a Black person with a high number of significant events is more likely than white person with the same number of significant events to be removed.

In light of interviewee concerns about trauma and harm described above, and in light of research literature that documents that the risk of harm from law enforcement involvement is greater for Black people (Saleh et al., 2018; American Psychiatric Association, 2020), these findings indicate a need for ongoing data monitoring paired with corrective action strategies to address these disparities. These dynamics are discussed in greater detail in Chapter 5.

Theme 20: Delayed Timing of Removals Introduces Confusion

Because it can take several days or even weeks to process a removal, the timing of the removal may feel unexpected to the person experiencing it. When a person's noncompliance is due to them being missing, delays may be associated with an inability to locate the person. In New York City, providers and administrators noted that delays were a result of lack of capacity within the judicial system that processes removal orders.

When removals are initiated due to a lack of contact, which many are, it may be unclear to the person why they are being approached by law enforcement personnel for a removal. The resulting unpredictability of the removal can increase the likelihood of harms.

> *"I think it reminds a lot of people of being just arrested and like a carceral thing and like a punishment and there's a team. It feels overwhelming to them, overwhelming to family very often. Regardless, even if we've been talking about the potential for removal because of what we've observed over several visits, it will still kind of seem like a shock and surprise, especially when it's not, I think, a clear relationship between an event and the removal." ~Provider 10*

These delays can complicate communication and understanding between the person and their providers.

> *"And the refusal of medication, which you know, we only have so much medical staff and sometimes I think some consumers will see how much they can get away with in terms of like refusing or I only want to see this specific person. And then refusing it from that person, then refusing again and again. And then when they are finally removed, it feels kind of like an injustice because why now when things haven't changed? And so we've seen some upset from that to where it's like, oh, but I, you know, I refused it so many other times before, why now?" ~Provider 10*

One provider emphasized that delays also reduce the "value" of a removal to compel a person to engage in and accept treatment.

> *"If the team says to a client, well, we're going to have to do a removal order, and then the removal order doesn't happen for like 2 weeks … I think it loses a lot of its value. So I think something needs to be done to try to help speed that process along." ~Administrator 21*

Theme 21: Challenges in Coordination With Law Enforcement

Police departments vary in their coordination and collaboration practices around pickup orders. In some jurisdictions, particularly where the AOT coordinator has an established relationship with the police departments, there are clear protocols for removals. In other jurisdictions, relationships between the LGU and police departments are more complex. Interviewees often attributed coordination challenges to a lack of information about AOT on the part of law enforcement officers.

> *"The police here are not the friendliest. They don't accept it. I've had to bring Kendra's Law with me to police … This is actually because they get very confused … And I'm like, 'Well, this is my job, you know, they're on AOT, I have to do this, blah blah blah.' So we do get some pushback, and there's some departments that won't take one at all." ~Provider 26*

In most counties, particularly those with lower rates of AOT and those with more population density, law enforcement officers may only infrequently be involved in a removal, if at all. As a result, some officers may have very limited information about AOT and minimal experience with

it. This makes it important that all officers have clear and consistent information and protocols in place to respond appropriately when a removal order is filed.

> *"This is just one tiny piece of what cops are doing every single day." ~Law Enforcement 1*

> *"I feel like anytime I tell a police officer…they're like 'What's Kendra's Law? What is AOT?' So, I'm like, Oh my god, so now I'm pulling it up on Google for them, and they're just like, 'I don't understand.' I'm like no, you have to, literally begging police officers being like, you have to, please take them to get evaluated." ~Provider 21*

Theme 22: Misperceptions About Removals and Involuntary Treatment

It was very common for interviewees to point out that removals are limited in the extent to which they facilitate connection to involuntary treatment. Many groups confuse AOT with involuntary commitment mechanisms (e.g., a 9.39 Emergency Admission statute that permits a hospital to hold a person for up to 15 days) and/or with a Rivers petition, the legal mechanism used by hospitals to treat a person against their will. This confusion results in differing expectations for removals and frustration for those who expect that a removal will automatically result in a person complying with their AOT treatment plan. These misperceptions were reported as being widespread, resulting in providers, family members, and others around the person being at odds with others about whether and how to support a person on AOT.

> *"One of the processes that happens around AOT often is the complete misunderstanding of it by staff or people around the patients. People get it confused with forced medication. In New York State, an AOT order might include medications, different forms of treatment, housing, etc., etc., but it does not require patients to take medications. What it says is if the person doesn't follow the AOT order, they can be brought to the hospital for an evaluation. And that's not the way staff understand it, I found, particularly on the ACT team. And it's presented to the patient as you better take your med. You have a court order to take your medications." ~Psychiatrist 1*

.Very commonly, providers reported frustration that CPEPs and ERs would very quickly release a person after being brought in on a 9.60 Removal Order. From the hospital perspective, interviewees emphasized that if a person does not meet criteria for involuntary commitment and does not wish to be there, it is not legal or appropriate to hold them there.

> *"But eventually, you know, with a lot of removals that don't really go anywhere, especially on the hospital side, they get removed for three hours, they get discharged to the community, they get removed for a day, they get discharged to the community. Then you were just creating a new version of the revolving door, but now we're an agent in that door, and so are we really doing anything by just giving the ER business? You know, 6 times a month for someone that really isn't benefiting. So you*

know, that becomes a question that we discuss—like are we really making a difference in this person's life? And reasonable people can disagree about that." ~ Administrator 21

"If the patient doesn't cooperate, we send them to the emergency room. What for? I don't know what for. We do it. You know who gets punished for this? The staff who take them to the emergency room and wait for hours and hours." ~Administrator 20

Theme 23: Removals as Clinical Leverage

As described extensively in Chapter 1, many people under AOT orders have the misperception that a removal can result in involuntary treatment including forced medication. Even if a person is aware that they may not be held more than 72 hours or treated over objection, their behavior is influenced by the threat of being taken to a hospital by police in handcuffs. Providers described the prospect of a removal as a point of clinical leverage that can be used to compel a person to agree to participate in treatment and comply with medication.

"It comes down to, well, if you don't meet with us, they're gonna come knock your door down, pick you up, bring you to the hospital." ~Provider 22

"I mean, some people totally complain. They hate the fact they're on an AOT and they hate the fact that they feel like they have to take their medicine. I mean, truth be told, they still don't have to, but you know. They'll just take them to the hospital and that's what happens. If they pick them up and take them to the hospital, they're just going to send them back. So then we're able to kind of leverage that kind of thing. Like, I know you hate the hospital, so if you just take this, you're not going to get picked up." ~Provider 18

Interviewees also noted that many people on AOT orders disregard these threats. They noted that if a person under an AOT order has adequate understanding of the law, the persuasive power of AOT is diminished or eliminated. Very commonly, providers questioned the utility of a 9.60 Removal Order if it cannot guarantee that a person will receive treatment against their wishes.

"Some people have figured out the system, and it makes it so that AOT really has no teeth to support it. One of my patients has realized that if he gets brought into CPEP on the 9.60, which is the way the law is written, and I'm, like, I totally respect what he's doing. It's just that it's frustrating as a doctor. He goes in and he realizes that he can get evaluated and discharged without the shot, and you don't have to get the shot. You just are there for an evaluation. And, like, 100% that is the law. I would never, I totally respect that you're not there punitively. You're just there for an evaluation. But a lot of people, it expedites their discharge to get the shot. So we bring him in on a 9.60, and it doesn't do anything." ~Psychiatrist 3

The pickup order often results in a person voluntarily accepting treatment—almost always an intramuscular injection—while in the emergency department. This is not considered treatment

over objection because the person consents to receive the injection, but there is a strong element of coercion:

> *"Sometimes there's leverage of like you know, you're going to get admitted if you don't do this because then we have enough to say that you're going to decompensate. You're not safe in the community. Sometimes at that point the person's, you know, tired out and is willing to do it, and they are told by a different mental health professional, and they hear it in a different way, and then they'll take it." ~Administrator 8*

> *"We've been lucky. Like if people are missing an injection, then they typically agree to it when they get [taken to the hospital on a 9.60] because they don't want to be there. Yeah, I mean the hope is that they're deterred, you know, from being picked up and having their lives interrupted by being brought to the hospital because they're not compliant. Because the hope over the order is that they're gaining insight and education as to what their diagnosis is and why they need to take the medication that they're prescribed. I mean, that doesn't always, we have people, people who will never gain insight. But that's the hope." ~Administrator 9*

> *"All right, long story short. The first time he had to get the next injection, he refused. And they did a pickup order…They took him to the emergency room, he took the injection, and that was it. He never fought the injection after that." ~Family Member 18*

Taken together, professional interviewees' perspective on removals is that they are resource-intensive for providers, administrators, and law enforcement, and they are difficult to implement and may not result in connecting the person to increased care. Further, removals almost always mean law enforcement contact and transport in handcuffs—carrying a high risk of traumatization or re-traumatization. They are "effective" in compelling people to accept treatment in some cases, but these cases almost always involve an element of coercion because compliance hinges on a lack of rights awareness and/or passive acquiescence to treatment.

Theme 24: Opportunities to Use Non-Renewal Patterns to Drive Quality Improvement

Some interviewees expressed concern that for many people there isn't a clear path off AOT, and that it is rare to see people successfully "graduate" from it. Indeed, some interviewees were unclear what "success" means in the context of ending AOT. As one provider notes:

> *"It doesn't always seem to be a good path off of the AOT or a good plan for people. It's like we put them on AOT, and they just either stay on AOT or they end up coming off of AOT because it wasn't beneficial to them." ~Provider 5*

In another interview, two providers discussed these dynamics with one another:

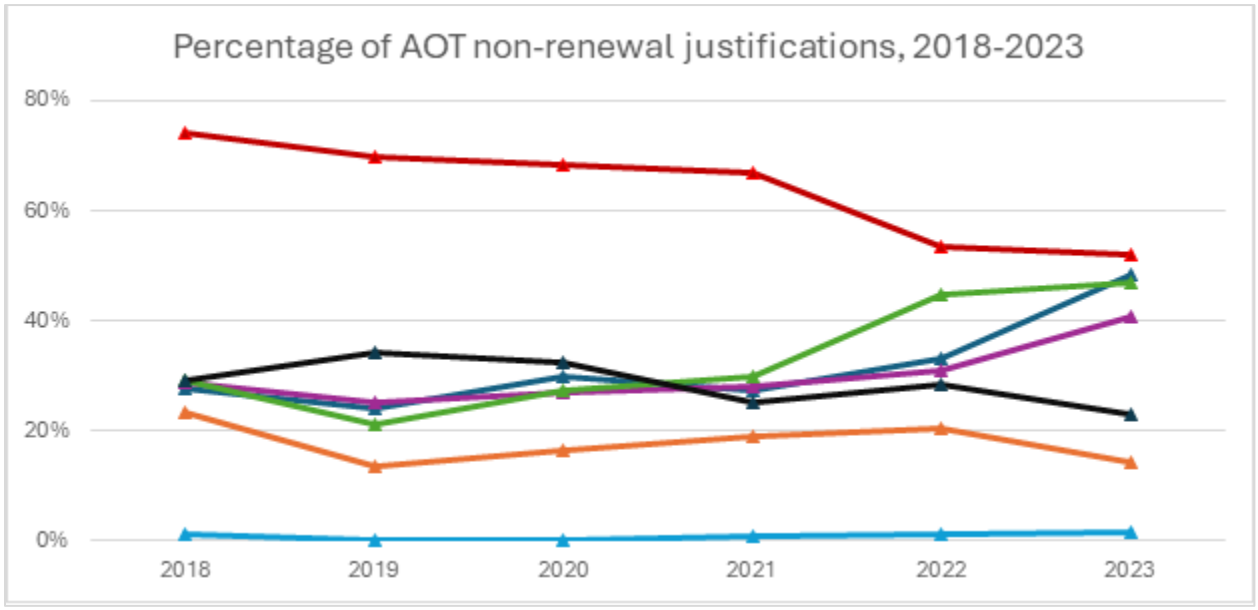
Provider A: "Have any of our AOT people ever successfully completed AOT? … Have any of our AOT people ever been successful?"

Provider B: "Everyone I worked with, it was almost like given that they were going to get a renewal of the order every year."

Provider A: "I think all of our AOT people have ended up in [hospital] at some point. I don't think we've ever had anybody head off into the sunset doing much better than when they came in."

In fact, OMH does collect data on the circumstances under which an AOT order is not renewed. When an AOT order is not renewed, the DCS are required to conduct a formal review and submit a determination of non-renewal justifying why the order will not be renewed. The following exhibit depicts the reasons for non-renewal from 2018 to 2023, the most recent year available.

Exhibit 2.8. *Percentage of AOT non-renewal justifications, 2018-2023*



Key

- AOT is no longer the least restrictive treatment alternative
- Likely to participate in voluntary outpatient treatment
- Participating in an enhanced voluntary agreement (EVA)
- No longer needs AOT to prevent a relapse or deterioration likely to result in serious harm to self/others
- Can survive safely in the community without supervision
- No longer likely to benefit from AOT
- No longer has a mental illness

The proportion of individuals whose AOT order is not renewed on the grounds that they are likely to participate in voluntary outpatient services (-♦-) steadily increased between 2019 and 2023 while the proportion already participating in an EVA at the time of the determination (-♦-) declined during the same period. It is noteworthy that these two non-renewal justifications were equally likely (approximately 30%) in 2018 but steadily diverged in later years. The growing gap between the number of people assessed as likely to accept voluntary services and the number who actually "graduate" from AOT with a voluntary agreement suggests an unmet need for additional voluntary outpatient resources. Strengthening discharge processes to ensure that individuals assessed as likely to participate voluntarily are connected to these services would also help close the gap. As noted in Chapters 1 and 3, people under AOT orders indicated that they would have agreed to services voluntarily if they had been offered. Further, many people we interviewed were under the impression that without an AOT order, they would lose access to services that they valued, and several people in interviews and consultations described experiences in which the termination of an AOT order precipitated termination of services. These findings further underscore the importance of assuring access to voluntary supports following an AOT order.

Less commonly observed in our sample, a handful of interviewees indicated that they may decide to not renew an order because it is not effective.

> *"[County] will vacate orders at times if we have somebody on an order and we do feel like it's causing them harm, and/or there's no benefit of the order. We can go back to the judge and say actually, we're not gonna do this anymore. This is not working and here's why. And we've done that a couple of times as well." ~Administrator 8*

In 2023, the most recent year available, "no longer likely to benefit from AOT" was provided as a reason in 14% of AOT orders that were not renewed. Ongoing monitoring of these trends could help to understand and address dynamics related to the application of the "likely to benefit" criterion and the use of EVAs discussed elsewhere in this chapter.

Theme 25: Renewal Reasons Other Than Clinical Determinations

Interviewees suggested that in some instances, renewals may be pursued for reasons other than clinical determinations. Providers may view the court order as a "security blanket" that ensures compliance, making them apprehensive about not renewing because they would assume risk if a person were to go off AOT and change their behaviors. Administrators described dynamics in which the providers may exert pressure on the LGU to pursue a renewal based more on perceived risk than clinical need.

In general, risk aversion and political pressures similar to those discussed in an earlier section on misapplication of the "likely to benefit" criterion were cited as a factor in renewing orders.

> *"Sometimes I think it's the fear of the unknown that keeps people on AOT instead of giving the client a chance because I feel like sometimes you have to allow people to fail…sometimes that's part of treatment…And then it might be that case you fight to get off AOT and then end up on the news. So now what we have is a system where everybody is functioning in fear and which is not fair to the client. Because that's all I hear from the staff is 'my license.' So if that's the fear, then what are we doing?" ~Provider 6*

These patterns suggest a need to revisit how renewal decisions are made and provide clear guidance to providers and administrators on how to ensure renewal decisions are driven by clinical determinations.

Theme 26: Transitioning to Shorter Order Duration May Mitigate Perceived Risk

Some AOT coordinators described a strategy of using shorter periods for renewals (e.g., renewing an order for six months that had previously been 12 months), particularly when a person seems to be meeting some but not all of the requirements in their treatment plan.

> *"If clients only want a six-month order, we will absolutely do a six-month order and meet more frequently. We do have a couple people that don't object, but they would want to get back together to revisit in six months and we absolutely do that." ~Administrator 5*

In current practice across the state, however, there is relatively little variation in the duration of orders, suggesting this practice is not widely used. As shown in the following two tables, the median duration of initial and renewal orders is close to six months (184 days) in New York City and one year (365 days) in all other regions in the state.

Exhibit 2.9. *Order Duration in Days by Region – Initial Orders*

Region	Number of Orders	Mean Duration	Median Duration	Minimum Duration	Maximum Duration
Western NY	3,055	336.4	365	123	366
Central NY	1,095	344.9	365	61	388
Hudson Valley	3,364	329.9	365	90	369
NYC	9,069	263.6	184	30	396
Long Island	2,270	306.0	364	30	370

NOTE: All regional mean duration are significantly different from each other ($p<0.01$).

Exhibit 2.10. *Order Duration in Days by Region – Renewal Orders*

Region	Number of Orders	Mean Duration	Median Duration	Minimum Duration	Maximum Duration
Western NY	3,238	353.5	365	90	371
Central NY	777	345.1	365	90	379
Hudson Valley	3,819	326.7	365	42	404
NYC	14,408	247.9	184	6	366
Long Island	5,498	291.8	364	42	372

NOTE: All regional mean duration are significantly different from each other ($p<0.01$).

Theme 27: EVA Use Before Implementing an AOT order

The following two exhibits depict DCS survey responses to how frequently EVAs are used as diversion from AOT orders and as a trial period before initiating a formal AOT order.

Exhibit 2.11. *EVA as Diversion From AOT, by Region*

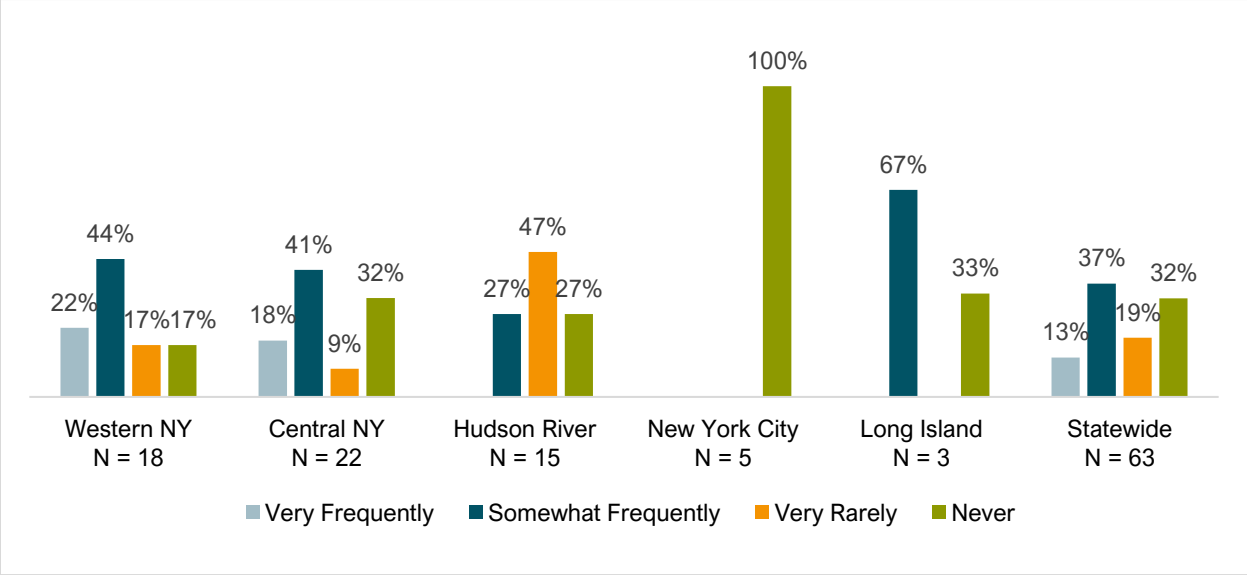
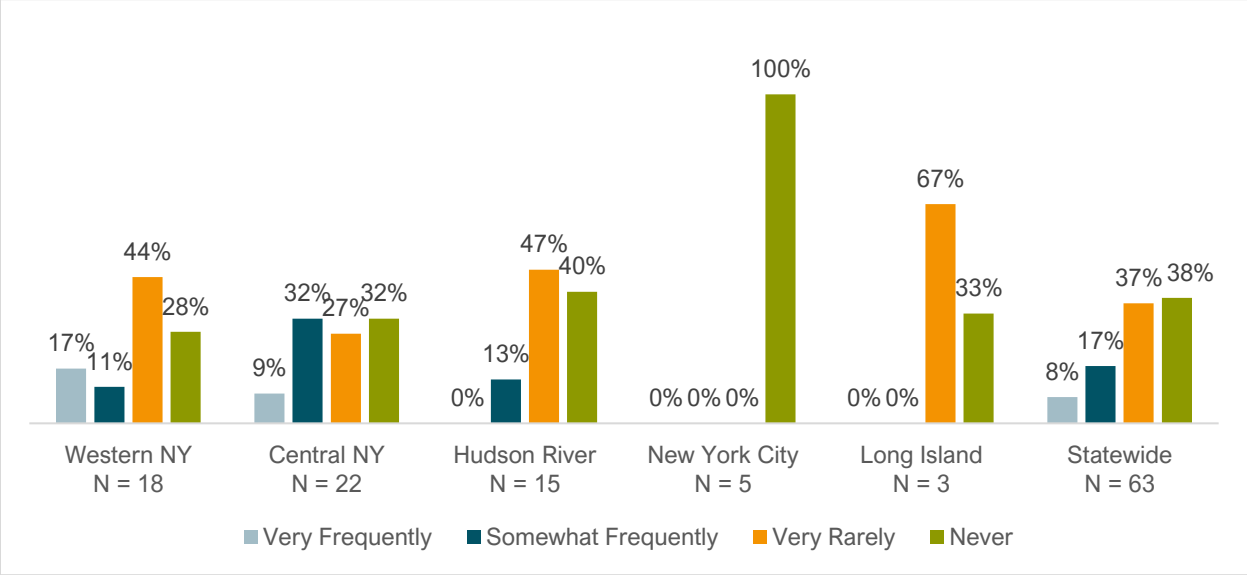


Exhibit 2.12. *EVA as Trial Period Before AOT Order by Region*



Notably, New York City never uses EVAs prior to AOT, as diversions or as trial periods. Counties in the Western and Central New York regions were more likely to use these approaches "very frequently" or "somewhat frequently" than other regions. This description of an EVA by an AOT coordinator in Central New York is representative of the approach to using EVAs prior to instituting an AOT:

> *"We try to individualize a service plan and come up with the least restrictive means...So it's just kind of individualized, we try to throw as many services as possible and see what sticks and try to really come up with an above-and-beyond LGU plan to support the individual, to really make sure. And usually that will work. You know if we're kind of taking, without the formal order, the AOT approach of prioritizing on the SPOA level and prioritizing on the county level, making sure that they're getting what they want or if there's something that we can help support a little bit, that oftentimes will lower the risk associated and an order won't be necessary at that point. They're still high clinical acuity, but not to the point where we would impose on someone's rights." ~Administrator 4*

In counties with smaller populations, administrators endorsed an approach in which they meet individually with a person and use the EVA as a means of avoiding the court process. There was consensus that EVAs are easier to implement in smaller communities where there are opportunities for the LGU staff to connect directly with the person, and where smaller provider networks lend themselves to stronger coordination.

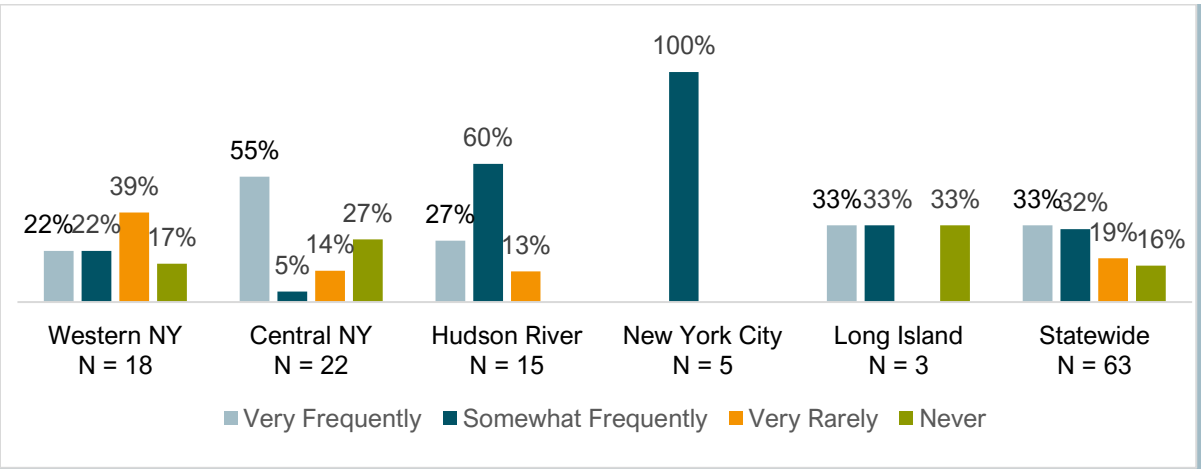
> *"What I have found works well is I personally reach out to that individual and I attempt to engage them in services. Some of them I've done enhanced service agreements, which is really just an agreement between me and them. You know, and it's like, OK, if you do this, then we won't need to go to court. And some of them actually do it." ~Administrator 2*

"I think diversion tends to work probably a little better in the smaller counties versus the bigger because it's a very tight knit group of providers." ~Provider 26

Theme 28: EVAs as "Step Down"

It was more common for administrators and providers to describe using EVAs as a way to "step down" from an AOT order. Exhibit 21 depicts the use of EVAs after an AOT.

Exhibit 2.13. *VA as Step Down From AOT Order, by Region*



New York City, Long Island, and Hudson River regions employ these approaches more frequently than the Western and Central regions, and about one-third of DCS survey respondents statewide indicated its use "very frequently." The use of EVAs to support transition off of an AOT order process is facilitated by the 2025 "Six-Month Lookback" revision to the statute that allows for an expedited petition process with no eligibility requirements related to a new act of violence or series of hospitalizations.

"Most of the time we utilize [an EVA] as an opportunity for a step down off of a court order. Once somebody's already been on it. And that, in tandem with the addition to the statute…where they added the language around being able to walk back to a court order more easily in the six-month period after expiration. Those two things in combination have been really successful for us in being able to let ourselves take a risk more easily to not renew the petition because that's really supportive for us and the providers and sort of like this code of protection to be able to dialogue with the person. Like we're not going to renew this, but I want to be really clear. We're watching closely for the next six months." ~Administrator 8

"We have a resident who's now our guy on the enhanced AOT. You know, when he was on AOT taking his meds we were doing the self-med program. He was holding meds in his room, doing great. He went to enhanced [voluntary agreement]. He was like, 'Ha ha ha ha ha.' He stopped taking his meds. And I was like, why? And we knew instantly he stopped. So we were like, what's going on? He's like, 'well, I

thought I'd be OK without them. And I don't have that order anymore.' And we're like, how did that work out for you? And he's like, 'not well', because he was in line to get into an apartment. And we said no. And we reeled it back." ~Provider 8

Issues related to EVAs are further discussed in Chapter 3.

Theme 29: Lack of Structure and Guidance in Current EVA Practice

One barrier to using EVAs is that there isn't a clear structure for EVAs that parallels the AOT structure. Unlike AOT, which is administered centrally and supported through the regional offices, reporting processes and infrastructure for EVAs are developed by the LGU. This results in more variation and also potentially more resources expended by the LGU.

"It also can be kind of a heavier lift because if you're doing that in a smaller community, that for me would take time out where I was, like, you know, calling providers or, you know, making sure people are kind of following through that stuff because they don't have to report, like, the weekly reports that we get for people on orders." ~Administrator 26

Notably, OMH is in the process of issuing guidance and structure to support broader implementation of EVAs across the state. This guidance will hopefully clarify confusion about EVAs and enhance infrastructure needed to facilitate EVAs consistently across the state.

The limited structure and guidance likely contributes to the wide variations in provider perceptions of and expectations for EVAs. Some providers vastly preferred EVAs and saw them as a useful tool. Others expressed deep skepticism about the utility of EVAs and found them to be an ineffectual waste of resources. It is likely that the variations in perceptions are a result of wide variation in EVA implementation.

"I don't know if this is unique to our rural reality or you know most of my time in this role has been here in this county, but we are always gonna catch more flies with honey. Treatment's always gonna be more effective from what we've seen if the individuals bought into it." ~Administrator 4

"I don't have a clue what diversion does. I have, people have explained it to me. I think it's completely useless. If somebody needs to be on AOT, they need to be on AOT…I don't know what the point is…If they just needed more supports, I wouldn't be pursuing AOT or ACT. We could give them more supports…Like, there's never been anything that's come of diversion. It's just occasionally more paperwork. They stay on a list somewhere, and we do everything exactly the same. We just have a bigger meeting about it. I think it's a complete waste. I try to avoid diversion, actually." ~Psychiatrist 3

Several interviewees were quick to point out that elements of coercion are still present in EVAs since noncompliance with the EVA results in AOT.

> *"It's often a LGU face to face with the individual and just say, hey, we're looking at court procedure. Most everybody we serve has significant trauma based in the courtroom of some sort, whether it be criminal, family court, going back to the childhood, going back to things in their adult life, you know. Nobody's trying to get in the courtroom, and when they're faced with that, it brings up a lot. And they will do a lot to avoid that. And sometimes that's enough of a carrot to say I don't want, we don't want to get attorneys involved." ~Administrator 4*

Interviewees expressed confusion over EVAs and noted that the people they work with are also confused about the process. More clarifications on the distinction between EVA and AOT and the uses of EVA could support stronger implementation.

Theme 30: Information and Education Gaps

Our study revealed a range of AOT information and education needs across multiple groups, including and especially people under AOT orders. These are described in further detail in Chapters 1 and 3.

For People Under AOT Orders

As described in Chapter 3, a minority of the people under AOT orders who we interviewed endorsed substantive engagement with their MHLS attorney. Beyond the role of MHLS, there are no specific programs or policies that provide information and education about the AOT process for people under AOT orders. Providers and administrators described a range of strategies for informing a person about AOT, but these strategies were largely limited to encouraging compliance with the AOT treatment plan. There was notably little description of information and education about a person's rights, the practical realities of AOT, and what to expect from the process. And no interviewees described materials or approaches that explicitly address the commonly held misperceptions about AOT.

> *"Most participants that are on AOT don't understand the law of AOT, what the limitations are, what's required of them. They don't know what AOT really means. They're fearful of it. They believe that it's a criminal offense. They don't want to go to jail. And so most of the time, the people I work with don't understand the law itself and what it means for them." ~Peer Provider 9*

This lack of education was attributed to a general devaluing of the person's perspective for some:

> *"God, no, at no point in 4 1/2 years, at no point was it explained to him. Probably there was never any respect for my [family member]. He's basically just a sub-human, I would say in the whole thing." ~Family Member 4*

Beyond education about the AOT process, one interviewee articulated the importance of conveying the ways in which AOT facilitates stronger connection to providers and creates

accountability to provide care and support in a manner that is maximally accessible to the participant. This is a reframing of AOT that is consistent with other aspirational descriptions of AOT illustrated in previous sections:

> *"I think that it would be to inform the participant about what the benefits are of this: To really put the onus on the clinical team that this is not about you [the participant] and what you're required to do, this is about us [the clinical team], it is that we need to be here with you and meet you where you're at for a long period. We're required to meet you where you're at. If you're on the park bench to meet you there. We're going to make sure you have food. We're going to communicate with you. We're going to keep in touch with you, make sure you're safe. That's what AOT should be. It should be an umbrella, a big hug, care, comfort, education." ~ Peer Provider 9*

For Family Members

Similarly, there is a great deal of confusion among families when it comes to AOT. They are exposed to misinformation from internet searches or even from calling resource lines that have inaccurate or insufficiently detailed information. Several administrators and providers noted that as a result of misinformation, families may have unrealistic expectations for what the AOT order can accomplish.

> *"Not a day goes by that I don't get a concerned parent of an adult who does not want the treatment that their family or natural supports wants. And when somebody gets on the internet and research that, the answer is AOT. That you can simply if they've tried other options, those guidelines read to somebody who has spent a lifetime supporting an individual—[as] the answer. Like this will just tie it up with a bow, and they'll get the treatment they need and we can move forward." ~Administrator 4*

> *"They call 311 or 988 and they give them misinformation about what AOT is. Then when we talk to them, we have to educate them as to what we can do [and] the limitations of what we can do—because they're calling us because we are the last resort." ~Administrator 16*

Families may also have unrealistic expectations about the time and effort it takes to initiate an AOT order because they may lack information about AOT's purpose and the legal requirements associated with AOT and involuntary commitment laws.

> *"Like, some family members will just call and be like, can you put my son on AOT? And it's like, we can't really, there's a process. They have to be hospitalized. … And they're like, 'yeah, but he's not taking his medications' or 'he's dangerous or he says he wants to kill himself.' And so, you know, some families in the community see it as kind of a first line, whereas we don't see it as a first line. We see it as the last outpatient line, so to speak, kind of, or not even last outpatient line. … I think there's just misunderstanding on how it works." ~Administrator 28*

In addition to limited information about highly complex mental health systems and laws, some family members may have limited understanding of mental health conditions and may be unaware that recovery from serious mental illness is possible.

"The thing that gets me every time is getting that phone call from a mom or a dad or a sister or brother saying, 'No one's helping my son. I don't know what to do. I don't know how to help him.' And I'll explain the process. And every single time, it's that it's just instilling that hope in families that they can get better because a lot of people have a misconception of, you know, a lot of psychotic-based disorders." ~Administrator 26

For Providers and Administrators

In addition to the training and education needs related to removals and EVAs referenced above, interviewees described a need for general education and information for providers and administrators about the goals and processes of AOT and EVS. Some providers without adequate understanding of AOT may make assumptions about AOT clients being dangerous and may prejudge people under AOT orders, contributing to discrimination and marginalization of people with serious mental health conditions.

"With housing, you know, you don't have to have the same training or standards compared to somebody, you know, like one of us clinicians … I think it just attests to the fact that they just need additional training and education. It's hard because a lot of them are right out of a bachelor's program [and] they don't always have like the clinical background to handle some of the needs. And they'll read [an AOT participant's] background that's from years ago, and they're like, 'Wow, they did that?' Yeah, that's not really fair." ~Provider 21

Another interviewee described a need for more detailed training for Health Home care management providers:

"When I go to look at how to run AOT in a Health Home, I have very little information. I have maybe one or two PowerPoints that give the general outline of what I should be driving [name] to do. I have a very small section and the Health Home Plus policy guide from the Department of Health that says [what] AOT requirements are for the Health Home Plus program. So from a supervisor standpoint, like I don't really have very much to go off of. I'm piecing it together from, you know, little policy documents online. There's not a good clear, concise, you know, your health home. This is what you have to do for your AOT people and this is how you should run it." ~Provider 27

Several AOT coordinators and DCS identified a need for more consolidated training materials for AOT administrators.

"They need a library. And coordinated tabulated taxonomy documentation that can be updated just like every other IT version of anything updates, and they say, 'New in this edition'. And you know, whatever they sort of refer back to things that were authored once a decade ago and say, well, this is our guidance, and I go, 'Except the statute changed in '22 and that's not correct.' So I don't know that there's been the resources and I certainly don't know that anybody has been allowed off the chain enough to fix it. But I'm not alone when I say that there's a great turnover of AOT coordinators, the people that are responsible for it, and there's no orientation manual for this." ~Administrator 3

For Law Enforcement Officers

For law enforcement officers, general training on de-escalation and mental health seemed to be relatively widespread, although some noted a general lack of competency as it relates to mental health topics. In the DCS Survey, about 85% of respondents indicated that Crisis Intervention Team (CIT) training was employed in their county. In New York City, the CAT team trains sheriff's deputies directly on AOT. Gaps in information and education are more related to AOT specifically. All officers receive some general information about AOT in their training academy. However, outside of New York City, the information officers receive once they are practicing in the field appears to be more variable. Interviewees outside of New York City described a need for more consistent, practical information about AOT's purpose and processes, and the law enforcement role in carrying out 9.60 Removal Orders.

Interviewees also noted that some parole and probation officers may not understand AOT and their role relative to AOT. They described a need for basic education on what AOT is and expectations for coordination between providers and law enforcement for people under AOT orders who are also on probation or parole.

For Judges

Finally, interviewees—including judges themselves—endorsed a need for ongoing training and education and shared that, in general, judges and their clerks receive very little formal orientation or training specific to AOT for their role.

When asked if there are occasions for judges to share experiences adjudicating AOT cases, one judge remarked:

> *"There's no occasions other than the judge that's in the courtroom next to me, who's my backup, who I essentially I took over for. I don't really talk about the Kendra cases with anyone else, and it would be helpful to have a different model to compare myself to... Continuing judicial education relating to the Kendra matters, I think would be really useful." ~Judge 2*

In general, having consistent judges who are familiar with the AOT process and the local mental health system context was seen as incredibly important. And there was wide variation in judicial knowledge and familiarity in these areas.

Theme 31: Importance of Gathering Lived Experience Input to Understand AOT

In a few interviews, providers and family members highlighted the potential value of incorporating the perspectives and experiences of people under AOT orders and their family members into the quality monitoring and improvement infrastructure of the AOT program.

"I think that AOT should ask the participants who are on it how they like their services, what's going on about it that's good? What's going on about it that's bad? They should do interviews of the participants directly and talk to them and find out what's going on. Is it helping? Isn't it helping? What is helping? What isn't helping? So direct information from the participants on AOT. I think that's extremely important. That'll help us navigate it. Instead of just asking providers, let's ask them, that'll give you a better understanding of what's working, what isn't working... And I also think evaluating participants after they're done with AOT, what they liked about it, what they didn't, what they think can be improved, just like you would any place else. If you go to a restaurant, you read a review, it's going to help. But we need to ask the people that are on it and have used it, what has helped, what hasn't helped, and I don't think we do that." ~Provider 9

"They should go through the ground and talk to these families, get real insights about what has been happening ... And you may not like it, but if you talk to families directly, and the professionals in that area, I think you come up with policies that are well defined." ~Family Member 23

Indeed, we found that when asked, people under AOT orders and family members had valuable perspectives and actionable and promising ideas for how the AOT program can be strengthened.

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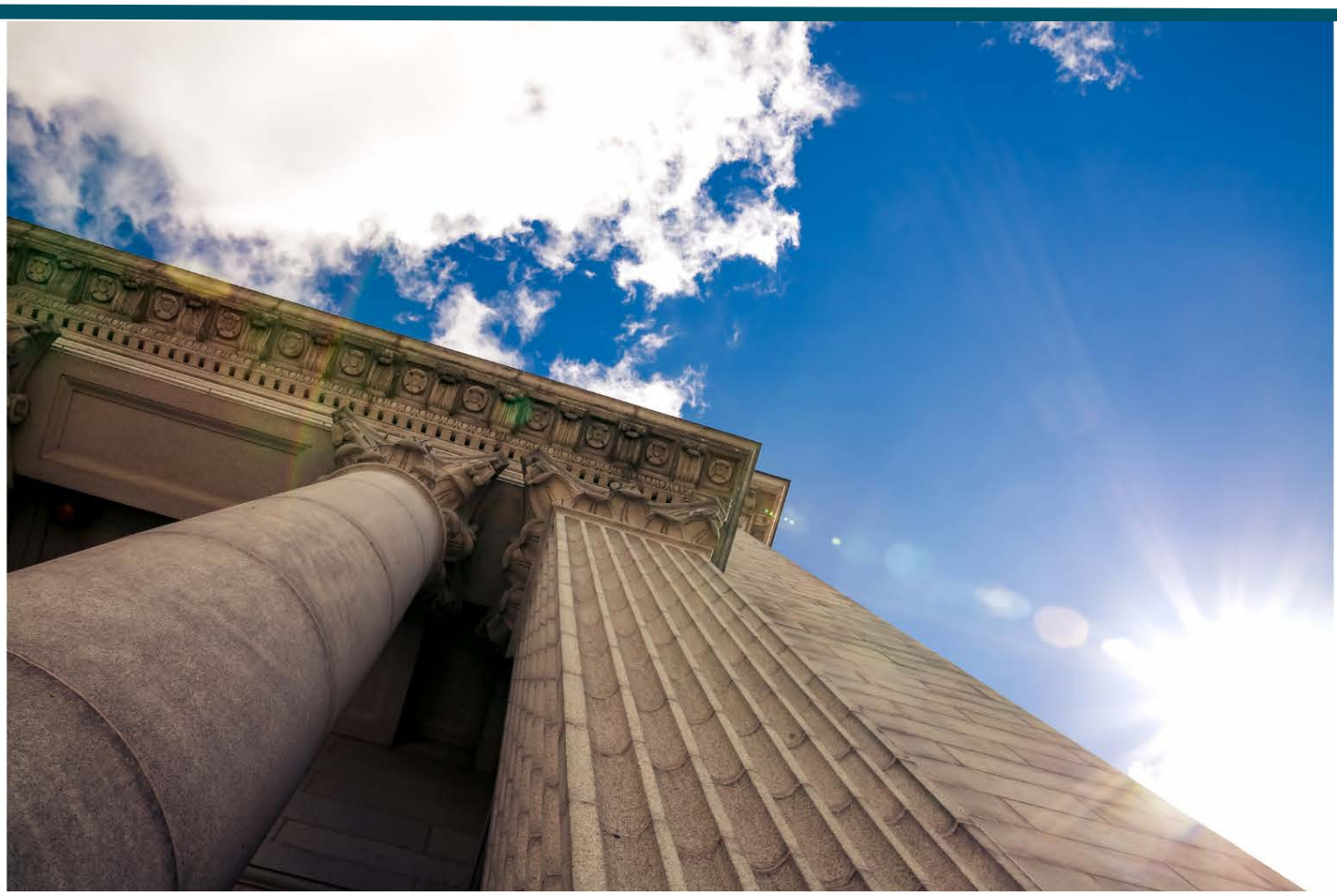

Chapter 3: Judicial Processes

This section presents seven themes that emerged from qualitative interviews with 46 people who are or have been under AOT orders ("AOT clients"). It also draws on corroborating information from interviews with psychiatrists, administrators, providers, attorneys, judges, advocates, and family members. Together, these data describe how the AOT legal process operates in practice across New York, covering the period from an initial order through plan development, legal representation, court hearings, and renewal.

Administrative data from OMH's AOT system—including court orders, order durations, petition denial rates, and non-renewal rationales—are used to help contextualize the findings. Full analyses appear in Chapter 4.

A full triangulation analysis that examines convergent and divergent findings across groups appears in Appendix G.

Theme 1: Pre-Hearing Decision-Making and Perceived Pressures

Of the 46 clients interviewed, 87% first came under an AOT order during an inpatient hospitalization rather than through a community petition. Of these, 63% (29 of 46 clients) described signing the order as a condition of hospital discharge. A smaller group (13%) entered through a criminal-legal pathway—such as probation, jail, or court referral—where they reported that AOT was an alternative to further confinement.

Clients frequently described making consequential decisions under challenging conditions, including waiving the right to a hearing during acute distress or agreeing to terms they reported not fully understanding. Others described a perception that not consenting to the order would mean remaining in the hospital longer and agreeing to AOT would mean they could leave the hospital.

> *"Yeah. There's lots of stuff going on… I just want to, I just wanted to cooperate. Like I don't know. I don't know. But, like, I had a bunch of people coming at me saying, if you don't do AOT, you gotta do this [stay in the hospital or state psychiatric center]. And I was like, no. I rather do AOT." ~Client 22*

> *"[Staff] weren't gonna release me at all, you know, if I didn't go on any order" ~Client 29*

As mentioned, 13% of the client sample described a criminal-legal pathway as the entry route to AOT:

> *"They offered it to me, and they said, 'It's up to you whether you want it or not, but we recommend it so you stay out of places like prison.'" ~Client 23*

Psychiatrists also described consent as being strongly shaped by hospital discharge:

"What makes them sign is the fact that they know this is part of how they get discharged. You know, so they know that. Definitely, no one wants to be here [in a hospital], right? So, ... I really want to get out of here, so I have to...[sign]. So, that's how that happens." ~Psychiatrist 2

"In the hospital, there's a lot of, I'll get you on AOT, and they agree to it because they think it expedites their discharge from the hospital. But there's not that, like, outside in the community, you don't have that." ~Psychiatrist 3

Theme 2: Consideration of Less Restrictive Alternatives Prior to AOT Initiation

The majority of clients reported that less restrictive alternatives, including enhanced voluntary agreements (EVAs), were not discussed with them in the period leading up to an AOT hearing or order. A significant proportion described actively wanting components of their AOT plan—including ACT teams, intensive case management, therapy, and supported housing—and, in many cases, having sought these services and supports voluntarily prior to AOT initiation. In this context, it is important to note that the majority of clients we interviewed came from urban, high-AOT-volume counties; we had no client participants from the two counties where, per our AOT coordinator interviews, use of EVAs was most consistent and proactive.

"Nobody talked about [less restrictive alternatives], which I think would have been helpful. Like, if they had just—yeah. I mean, they could've just referred me to case management, and maybe I would've taken up on it, without even being on AOT. But they don't—they didn't offer me anything less restrictive." ~Client 10

Interviewer: "Did the judge or anyone end up talking to you about any kind of less restrictive alternatives?"
Client 30: "No. As far as I can remember, I was told that this was for my best interest. And this was to help me stay safe and sound and making sure that I had the protection that I needed, which I don't believe was accurate."

Interviewer: "If you had just been offered the same help voluntarily, would you have accepted it?"
Client 18: "Yes."
Interviewer: "Okay. So why in your understanding did that come about even though you voluntarily actually wanted the services?"
Client 18: "That's right. You have to get a mandate on it."
Interviewer: "Okay. So your sense was that to access the services, there had to be the court." mandate?
Client 18: Yes.

One client expressed why involuntariness changes the experience when the underlying services are the same:

"I think voluntary would have been maybe a little better because it's—it basically, the whole thing, the way it was handed down was kind of like, well, this doctor doesn't really believe you. She thinks you're full of crap, and, um, she thinks you're noncompliant. Bad, bad, bad, bad, bad little girl. And then, you know, we're gonna get this judge involved, and it's gonna be like a court hearing. And now it—it now it feels like you're on trial." ~Client 10

In counties with limited use of EVAs, some providers described prioritizing AOT over voluntary alternatives, citing practical barriers such as service waitlists[1]:

"That's the only option…The easiest way to get someone in treatment is to do [an] AOT order. ACT is a waiting list." ~Provider 6

There was ambiguity amongst administrators and providers in application of the "least restrictive" criteria in the Kendra's Law statute. One provider called attention to what they perceived to be the lack of any serious attention to consideration of less restrictive alternatives:

"The criteria is supposed to be least restrictive, which I find often just isn't even mentioned explicitly. Right? It's like 'This is what we are doing. We're getting the AOT.'" ~Psychiatrist 1

And administrators from larger counties sometimes characterized the least restrictive requirement as subjective:

"All our AOTs traditionally have been served by ACT. It's just the most productive and fluid model to meet the individual's needs under the order. That being said, we try everything obviously first before, so if an individual hasn't had a chance to engage in ACT, that comes first—is, you know, to meet that least restrictive means." ~Administrator 4

In contrast, in lower population counties reporting substantial use of EVA, efforts to use AOT only when it truly amounted to the least restrictive alternative were emphasized:

"We tend to always try to engage people voluntarily. We're philosophically very sensitive to the fact that it infringes on people's rights in some ways, which really doesn't sit well with … us. But we recognize there's a need for it. We recognize sometimes people benefit from it, or sometimes it works, sometimes it doesn't. So we never jump to it quickly." ~Administrator 7

"And one of the other things that we regularly point to [to hospitals wanting to initiate AOT] that is included in the statute is making sure that the other least restrictive options have been tried. Because that's huge as well. Like, you know, eight times out of 10, we really want to see that ACT has been tried on a voluntary basis before we're going to put them on a court order, because if it hasn't, we don't know if something else is going to be able to support the person in the absence of a court order. We take that super seriously in [county]." ~Administrator 8

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[1] Regional variation and perspectives on the use of EVAs is discussed in Chapter 2, themes 27, 28, and 29.

This same administrator described actively pushing back on hospital referrals when alternatives haven't been tried:

> *"I also push back at times for the reason of, like I said, I want to make sure other things have been tried, which is the least restrictive language... Usually what I say then is … the spirit of the law, let's try to see if we can come up with some other things, and we might be the ones that know all the services more than the hospital, especially when the hospital is not in [town name in county]. Like, [county] might not be able to come up with a plan, like let's put peer, and PROS, and you know, a walk-in clinic appointment. So it's really … there's a good chance this person might have some support, so we help them make a plan and we try to get them to a place where at least we've tried something else [before initiating AOT]" ~Administrator 8*

Another rural county administrator described their thoughtful approach to diversion:

> *"So, I would probably say … there is a process where a judge could say that you have to be on this medication. We've seen it benefit you. We could do this if you just agree to meet with us and have a weekly care coordination, come to the clinic, do the things. … I had a girl that was in her early twenties sort of first kinda psychosis thing. And when I said go to court, she's crying and she's upset … her family was with her. And I'm like, you have to understand. We're trying to help and this is what's gonna help. And then she was like, okay. I'll take the stupid shot. And then started getting the injection." [When asked if they avoided court when a voluntary agreement was reached] "We don't need to go to court. I'm gonna write up this agreement, and then you're gonna sign it, and I'm gonna sign it. And they're for a year. I would negotiate down to six months if we needed to do that. But in my eyes, I see that as a way to then go to court if they start to not attend; to say, we attempted to do a voluntary agreement to give them the choice to kinda participate. They're not participating. So now we unfortunately have to come get the full order because they're still unwilling to participate" ~Administrator 26*

Another administrator emphasized the intentionality behind their lower volume approach:

> *"Our role is, especially when we get referrals, is to see if AOT is going to be the least restrictive alternative for treatment. So we want to be sure that the collaboration with outside providers as much as we can … is to know that everything else has been exhausted … Our main purpose is not to view it as, how do I say … the people are against AOT, if you will, see it as almost a punishment. And in [county] we don't see it that way. We try to explain to the clients themselves who are being referred that it's more of a safety net. You're struggling on the outside community for whatever reason, maybe they don't have the insight into believing they need this to maintain stabilization. We (myself and the AOT psychiatrist assigned to this unit) always have open communication with them in to seeing we're just here to support you, and once we feel you're engaged in treatment and you're functioning in the community safely, we'll see other options at that point. So, we truly view it as a safety net, and we move forward with it when we feel it, it's the least restrictive alternative for them." ~Administrator 14*

According to OMH administrative data, when clients are judged to no longer meet AOT criteria, the most common reason cited is that "AOT is no longer the least restrictive alternative" (59% of

these cases; see Chapter 4). The fact that this rationale appears so frequently at exit—while less restrictive alternatives are rarely discussed at entry—suggests that least-restrictive-alternative determinations are happening after someone has already been placed on an AOT order.

The data also show a widening gap between clients assessed as ready for voluntary treatment and those actually transitioned to voluntary services. The "no longer refusing to voluntarily participate" non-renewal rationale increased from 21% in 2019 to 46% in 2023, while step downs to EVAs declined from 33% to 22% (see Chapter 4). This pattern further indicates that less restrictive options are not being consistently pursued when people become eligible for them.

Theme 3: Client Participation in AOT Plan Development

The majority of clients (59%) described their AOT plan as having been put together without their active involvement. Eleven percent of the clients in our sample described having meaningful input into their plan. Approximately one quarter (24%) described a formal AOT planning conference—though the presence of a formal conference does not by itself indicate that the participant gave meaningful input. This finding supports accounts of minimal client involvement in provider and administrator interviews (see Chapter 2).

The plans clients saw were typically presented as already-written—"boilerplate," "standard language," "the same thing everyone gets." Family members similarly described being asked for limited input even when they and the client had requested a role.

Many clients recalled little about the plan development process or described accepting what was presented to them:

> *"It was definitely something that was, like, thrust upon me. There was no development of a plan. It was just, you know, this is what you're gonna do." ~Client 10*
>
> *"[I was never asked] is there anything you would want on there or not want on there?" ~Client 13*
>
> *"I vaguely remember [the plan development]. I don't remember really being a part of that... So I remember a plan being made for me, but I really don't feel that I had any particular say in the matter." ~Client 33*
>
> *"You mean did they talk without me? Yes. They did. Most certainly did... Definitely. Definitely... I have [a copy of the plan]. Yes... [But could I] change anything? No. Nothing. Nothing. I had to do what they say." ~Client 21*

Other clients described involvement in only a performative or perfunctory way, and that they had to pretend to have internalized goals that would be deemed acceptable:

> *"The treatment plan is [approached] like a survey. It's like, what do you want to accomplish with the mental health? So when I make my treatment plans, it's the same, it's the same every time. 'I want to stay out of the hospital. I want to stay on medication, and I want to get a job.' They always*

ask for three goals. I've been using those three same goals because, in my life, I have to do or had to do—I have to play the system. I have to give them an answer that will cause me less harm. So I [say I] want to take medication. I want to stay out of the hospital. I want to take medication. I want to get a job. So that's the treatment plan." ~Client 37

In other cases, clients emphasized the futility of trying to influence either the AOT plan or its initiation or renewal:

"No. I don't feel that they listened to you. They don't listen to you at all. They just go [with] what their agreement is because the psychiatrist—my psychiatrist was interviewed too, and I only had seen him like twice. And he made a big assumption that I should be on AOT. And he just went with there—he didn't go with how he had saw me because he saw me, and then he was like, 'Oh, you're doing so much better. Blah, blah, blah, blah.' And yet he put on the AOT, [said] that I should be on AOT. [Even though] I didn't feel like I should still be on AOT when they extended it for six months. But I wasn't going to argue with them. It's futile. Futile. I think that's the word. And [it's] not that they're not looking out for the best of people's interests, but I think it really makes you feel degraded. To be on AOT is a very degrading situation." ~Client 14

Not all clients described limited involvement in planning. As noted above, 11% reported more collaborative experiences in which their input appeared to be genuinely valued and incorporated. Notably, where agency works, it is described as occurring at venues other than the court hearing—that is, at renewal meetings, ACT team conferences, and AOT case management interviews.

"The first time I was up for renewal… I wanted the [program] piece of it to go away. I went into the AOT meeting and… stated a case for myself. They were agreeable to the whole thing… And took the [program] piece of it away." ~Client 7

"My family sat in with us, and the social work[er] and psychiatrist gave a treatment plan, yes… They had to evaluate me to get that treatment plan, meet with me, and see what my needs are and such like that. And also, my family members, sometimes one couldn't make it. So they might have had a substitute like my partner or my [sibling]. So we had a treatment plan for that. And my goals too. I had some goals to maybe go back to school or take a class." ~Client 28

Theme 4: Mental Hygiene Legal Services Attorney Interactions

Half the clients described their MHLS attorney as present at the hearing but not advocating in any substantive way. Another 30% described having no attorney involvement at all. Seven clients (15%) described substantive engagement with their attorney. None of the 46 clients described the attorney's involvement as resulting in a modified order, a successful petition contest, or a successful objection to a renewal. Even in the seven cases where the attorney engaged substantively, the order was still imposed.

With limited exceptions, clients described attorneys who appeared rushed, did not explain rights and options in depth, did not actively advocate for clients' interests, and in some cases appeared aligned with the clinical team.

Many clients describe meeting their attorneys for the first time immediately before hearings, in some cases meeting only briefly by phone, with limited or no opportunity for the attorney to become familiar with their situation, review their case, or build a relationship that might facilitate effective representation.

> *"I feel that my lawyer didn't get enough time to prepare because I'm served my subpoena to show up at court the day before. So she's probably getting it the day before, and we're showing up to court. So she doesn't have time to prep. And my last lawyer's final words before we went to court is, 'Don't say anything that's not spoken.' And I look at all the things that were turned into evidence that I disagreed with [but didn't say anything about], and I don't think I had the best lawyer." ~Client 24*

Some clients described attorneys who seemed unfocused on the case at hand or distracted, even in the courtroom:

> *"First of all, it was kind of sad because the lawyer kept looking at their watch like they had another appointment. But he was just [not really there]" ~Client 28*

Reflecting on their experiences of minimal representation, another client explicitly recommended changes:

> *"Have them be more active with their clients… Before the attorney meets with the doctor and speak to their clients a few weeks before and get on the same page, get to know their client, get to know how their client feels." ~Client 45*

Multiple clients described proceeding through AOT hearings without understanding that they had the right to contest the order, that they could request a hearing, or what the implications of accepting versus contesting would be. Some clients, even at the time we interviewed them, still did not understand, or reported never having understood, that they had the right to contest their order.

> *"The attorney said, 'Accept AOT or—' he didn't give me an option. Basically said to accept AOT, and that's it. Didn't give me an option. That's all they say, 'Accept AOT,' because they don't want to negate what the judge is saying or what the doctor is saying because they don't want to go through the process of fighting it. So they just say, 'Accept it, wait a year, and that's it.'" ~Client 45*

Another client spoke at length about their concerns with MHLS:

> *"The Mental Hygiene Legal Service lawyers are really not on the patient's side. They really don't believe that the patient should win at the retention hearing. When I ask them about it, they say they have to argue the law a certain way or whatever. But they never bring up—I think that if the mental hygiene legal service lawyers were real, if they were genuine, they would bring up due process rights. They would bring up freedom of speech… The lawyers, they kind of push for—I was*

speaking in one of my AOT cases, and the lawyer, as I was making the case better, it was like the lawyer could have really asked me questions to witness to the court about my side of the story, my experience. And the lawyer, because he told me he would let me talk, but he didn't really do it enough. I think these lawyers could be doing a much better job if they would really ask the patient about the rights that have been violated, and they took that stuff to court. [Instead] they seem to believe or push the belief of the mental health patient is mentally ill. And so they basically seem to assume that the patients are guilty before they even meet the patient... they don't seem to be able to argue with the doctor enough. If they could really—I think the biggest fault they have is they don't argue with a doctor enough." ~Client 37

Other clients also described MHLS failures to vigorously advocate for their client's interests, instead seeming aligned with the treatment system or appearing to view contesting orders as futile:

Interviewer: Do you remember meeting with an MHLS attorney?
Client 29: I met with somebody one time. I don't really remember how... I don't know. I guess they're, like, I don't know. They're there for the hospital, the doctors.

Interviewer: How many MHLS attorneys have you worked with?
Client 24: Two to three.
Interviewer: So you said [earlier] one of the lawyers was maybe not the most helpful...?
Client 24: She just said, "Don't talk."
Interviewer: What about the other lawyers? Do you feel like they were helpful and on your side?
Client 24: Not really. Not really. They just went [along] with everything.

When clients described their attorneys in positive terms, they often reported receiving little actual advocacy:

Interviewer: Did you find that [attorney] helpful?
Client: She was alright...
Interviewer: Did she advocate for your needs?
Client: No. ~Client 19

In other cases, client narratives seemed to suggest less an overt lack of advocacy than not providing the support or reassurance necessary to move past fears or anxieties about appearing in a courtroom. For example, a client described being alerted to options by her attorney, but this was followed by seemingly unproblematized acquiescence to fear of appearing before a judge as the primary reason for deciding not to contest an order and waive statutory rights to a hearing.

Some clients described attorneys who advocated actively on their behalf. One client had a notably positive experience:

> *"The attorney was great. I was psychotic in the supernatural, whatever you want to call it. And he was reasoning with me. He was like, 'Okay. What happened? What are the details? What do you want?' He was collecting data and information. And he was like a pal. He was such a friendly guy. And he really fought for me in the courtroom, but then they gave me a chance to speak, and then I blah. And then the judge said, 'Okay. He's crazy. That's it.' So [attorney's] case was going well up until that point. I remember he was trying to defend me to stay off medication. And that's what I recall. And of course, it failed. [But he really tried]" ~Client 35*

Similarly, another client described their public defender as truly fighting for their "freedom":

> *Interviewer: You said your public defender was really helpful. Do you remember what she did that was really helpful for you?*
> *Client: She fought for me.*
> *Interviewer: She fought for you? What did she fight for when you said she fought for you?*
> *Client: My freedom. ~Client 20*

Another client described counsel's engagement in terms that closely match what the statute envisions of effective MHLS representation—substantive presence, attentive listening, and considered advocacy:

> *"He was a voice of reason. And he was calm and soothing and listening and created space. And he was not overbearing. He was sort of like the gentle soul in the room." ~Client 35*

Attorneys we interviewed corroborated the broad pattern described by clients. In one example, an MHLS attorney described their role as helping the client navigate the process rather than contesting it:

> *"These cases are very difficult for me to win outright. So here's your avenues, here's your options, and you tell me what you want me to tell the judge. I take it from there. I'm a lot like a social worker and a counselor, sometimes, more than an attorney." ~Attorney 3*

A criminal-side attorney with experience in AOT-adjacent §7.30 retention hearings in New York City named a dynamic that many clients also described—that everyone in the courtroom knows each other except the client:

> *"The Mental Hygiene person is friends with the doctor, and they're friends with the AG person... that's fine because I know DAs, and I know that's not a problem. But when the client is so much the outsider—and again, in these spaces, I want to say every person was White except for the client, right?" ~Attorney 1*

An AOT-presiding judge described MHLS attorneys as "dedicated" and as people who "work hard for their clients."

Two psychiatrists described substantively engaged counsel and routine cross-examination, but they also described outcomes that struck them as effectively determined in advance and a process they characterized as lacking the substantive elements of due process they would expect to see.

Theme 5: Court Hearing Experiences

Two-thirds of clients described their hearing as a brief, uncontested proceeding in which they or their attorney stipulated to the order. In the cases where contestation did occur (20%), the order was still imposed. Many clients described limited opportunity to participate in the hearing or to question the evidence supporting the plan or order. One client described an opportunity that more closely reflected the full procedural participation envisioned by the statute.

Judges were widely described as deferring to the petitioning psychiatrist's recommendation. Slightly more than half the clients described the judge as procedurally present but not substantively engaged; 13% described the judge as effectively absent. The remaining cases involved virtual hearings or arrangements in which the client could not describe what the judge did. Most clients who formed a clear impression said the perceived lack of judicial neutrality eroded their trust in courts more generally.

The overarching finding is that procedural protections specified by 9.60 Removal Orders are present in formal terms across most proceedings but do not, at least for the clients in our sample, come together as an integrated substantive experience of due process.

Clients who did attend an AOT hearing reported that their hearings lasted between five and fifteen minutes.

> *Interviewer: So thinking about that AOT hearing with the judge, do you remember how long it was? Was it, like, a long hearing, or was it really short?*
> *Client: It was short. It was, like, five, ten minutes.*
> *Interviewer: What happened?*
> *Client: It was five, ten minutes.*
> *Interviewer: Okay. Do you kinda remember what happened in those five to ten minutes?*
> *Client: Honestly, I was, uh, when I went there, I was kinda like, like, nervous. I was I don't know. I remember I remember, like, very barely… I just went in there and, you know, it was just like, do you agree to this AOT? And I was like I said yes. And then. Do you understand this, this, and that? And I said, yeah. Yes. And then then they're like, "Alright. You'll be on AOT until further notice." ~Client 22*

> *Interviewer: And when you say it was kind of quick, can you estimate how many minutes that was?*
> *Client: I would say it was only about maybe 10 to 15 minutes. ~Client 28*

> *Client: It was quick.*
> *Interviewer: It was quick? Were there questions that you had for the lawyer?*
> *Client: No, because she was very precise. And it was very quick and precise. And I was out there within not even 15 minutes. Less than 15 minutes.*
> *Interviewer: The actual court case?*
> *Client: Yes. ~Client 41*

Clients described minimal opportunity to meaningfully participate, present their perspective, or challenge the evidence being used to support the order. One person describes the following sequence:

> *Client: When I went to court, the psychiatrist got up, swore himself in, and he goes into the chambers. And I said, "You can't do that. How the hell are you going into the chambers?" You know what I'm saying? He can't do that. The trial didn't even start yet. He going into chambers with them [judge], influence them that all that's said on these papers is true. So they asked me, did I have anything to say? I said, "No. Nobody can go back there [into the chambers]. I know this."*
> *Interviewer: Okay. So it sounds like your lawyer didn't object. The psychiatrist went back into the chambers, affirmed the evaluation findings that he had presumably submitted to the court. Were you able to hear that part of his testimony? Were you able to hear the psychiatrist when he was talking to the judge?*
> *Client: Nope. ~Client 25*

Clients described mixed perceptions of judges' fairness. Among the positive accounts, descriptions of judges as "nice" or "kind" may have reflected gratitude for basic courtesy rather than an experience in which clients felt their concerns were genuinely considered.

One client described feeling scared but having been treated respectfully:

> *Interviewer: You felt feel like the judge treated you fairly?*
> *Client: …Yeah, [they] asked how I was doing and stuff. I was a little scared to be in a courtroom, but yeah. Yeah. For sure. It can feel intimidating. Absolutely. ~Client 19*

Another person had a similar experience:

> *Interviewer: And what was the judge like?*
> *Client: Very nice. Very kind.*
> *Interviewer: Do you remember anything the judge might have had to say?*
> *Client: No. It was just, "Make sure to take your medicine and [inaudible] supposed to, and meet again."*

A third person provided a more critical perspective on judges, emphasizing that judicial decision-making appears driven by what providers have put into health records rather than current presentation or individual circumstances:

> *"I think, most of the time, if you have a record, that's what counts for the judge, not the story, not the reality. The record. I've seen people who don't have a record. When I say record, I mean like mental health record." ~Client 37*

Another person remarked on having felt disrespected during the hearing:

> *"I feel like I wasn't presented as a person but something that we can shove aside for now. It just made me feel, I don't know, not respected. And it seemed like the judge was best friends with the doctor." ~Client 9*

Some clients described hearings conducted remotely, by phone or video, which may diminish the ability to meaningfully participate or for the judge to adequately assess the individual's presentation and capacity.

> *Client: I didn't go to the court hearing.*
> *Interviewer: You didn't go to the court hearing … So they didn't even do like a virtual court hearing?*
> *Client: Yeah.*
> *Interviewer: OK, so you never met the judge?*
> *Client: Well, maybe I did. Oh yeah, no, I think I have it, but it was on the phone. The first time it was on the phone.*
> *Interviewer: Oh, so you did like a virtual—was it video or just a phone?*
> *Client: Just the phone. ~Client 2*

Another client described the virtual hearing modality with comparable disorientation, naming the platform itself only via interviewer prompting:

> *"And then the—this time around, for my—this AOT, the court—the court session, I don't know. It was video—like, what's that called? Like a— [Zoom.] Yeah. No. They said they—they increased my medication." ~Client 32*

Multiple clients described proceeding through hearings without fully understanding what was happening, what AOT entailed, or what rights they were waiving. One client described how they finally came to understand what AOT actually was from their ACT team after the fact, rather than from their attorney, the judge who presided over their hearing, or any other party involved in pre-trial meetings:

> *Interviewer: You first found out that you were going to be on AOT, um, from the judge. Is that right?*
> *Client 30: Yes.*
> *Interviewer: Uh, what went through your mind at that time? What was that like?*
> *Client 30: I didn't really fully understand what any of that meant.*
> *Interviewer: Was any of it explained to you by the judge?*
> *Client 30: Um, no, it was later explained to me by the ACT team as of the interactive meeting"*

Another client explicitly compared the due process protections (or lack thereof) in AOT proceedings to those in criminal proceedings, noting the stark disparities in procedural protections despite comparable liberty interests.

> *"Before I was in mental health, I used to work for legislators. I think the key point for them that I would want to tell them is that if you examine the cases and you compare the burden of evidence between the criminal and the mentally ill, the burden of evidence in mentally ill is the doctor's word. Person's word. And in criminal, it's pictures. It's witness. It's DNA. You can't really refute DNA. That's science. But mental health is pseudoscience." ~Client 37*

The same client iterated a similar point in a different way:

> *"The mental health court is a witch trial. There is no evidence. There is nothing factual about the mental health court. It's all pretend… When you go to criminal court, they produce evidence." ~Client 37*

Cases where the client or their attorney formally contested the order were rare: 7 of 46 (15%). The rates of contested cases amongst the sample were similar to those reported in the DCS survey. The 85% of the clients in this sample who did not contest should not automatically be interpreted as having voluntarily consented or substantively agreed with the order. Most clients described having limited time and information when the decision was made.

> *"I talked to my lawyer and told them I didn't want to contest it… It was more of a pain to contest it. If I contest it, then I got to go through a whole jump through hoops and stuff. And you're not going to win anyway. If you understand how AOT works, you're not going to win. You're not going to beat them. The only way to beat them is if you join them. So that's what I did, you know what I mean?" ~Client 14*

> *"So even the AOT hearing, they had my lawyer attend on behalf of me. However, before the [hearing], they went over the packet of information… it seemed like it was standard boilerplate stuff… 'Take your meds. Here's your doctor. Here's the medication. This is the time.'… That's exactly how it went. It was, 'This is what it is. That's what it's going to be.'" ~Client 47*

Several interviewees corroborated the broad pattern that AOT hearings are most often brief and uncontested. The following accounts illustrate how three interviewees from different positions describe this pattern:

> *"There are cases where Mental Hygiene Legal Services, the patient is sort of quasi consenting. So we'll just go through, have the DOHMH sort of make out their prime efficient case, establish the elements with the doctor's testimony. And then the Mental Hygiene Legal Services will say… 'We're not, you know, contesting it any further.'" ~Judge 1*

> *"I've seen people just become numb. They've had everything taken away from them with no kind of—and… they just no longer care. They just will, 'Tell me where to sign. Tell me what to say. I'll plead guilty.'" ~Attorney 1*

> *"The only reason someone was getting services or anything like that was because they were mandated to through AOT, and they had no desire to receive services, to be on medication, anything like that… I don't know how to phrase it besides forcing yourself on someone." ~Advocate 5*

Two judges shared that substantive decisions are not made in court, though from opposite positions: One viewed the absence of substantive contestation as a procedural problem, whereas the other felt it was appropriate.

> *"I am highly sensitive to the fact that I'm dealing with human beings, even though they're not appearing in court and their attorneys are essentially waiving… any position they might take, any*

opposition they might make in the cases, and they're practically all inquests before the court." ~Judge 2

"It's totally driven by the person and counsel. Absolutely has nothing to do with me. Nothing to do with the court ever." ~Judge 1

A psychiatrist's account from the petitioner side also describes the broadly uncontested nature of the hearings:

"95% of the time AOT hearings are uncontested, we call them mini hearings. It's basically I have to show my face. …They say everything that is in the treatment plan and in the AOT paperwork … 'Do you agree with it did you write it?. .. OK we're all set.'" ~Psychiatrist 2

OMH administrative data align with these qualitative findings. Statewide, only 4.4% of the 36,702 AOT petitions filed since Kendra's Law was enacted have been denied. Regional differences are modest: Central New York 2.7%, Hudson River 3.3%, New York City 4.3%, Western New York 5.6%, Long Island 5.8%. Only four counties statewide carry denial rates above 10%—Cattaraugus, Chemung, Otsego, and Tompkins—and all are small-volume jurisdictions where a single denied petition can shift the rate noticeably (see Chapter 4).

As reported in Chapter 2, statewide, 95.6% of petitions and 98.5% of renewals have been approved. These figures provide context for clients' reports that contesting a petition felt unlikely to succeed and that legal representation rarely altered the outcome.

Theme 6: Renewal Processes and Order Expirations

Half the clients reported being unaware of renewal proceedings when they occurred. Some did not realize their order had been renewed; a smaller number were uncertain whether they were currently under an order. Many also described not understanding how renewal decisions are made, what criteria are applied, or what would lead to an order ending. Fifteen of the 46 clients described themselves as aware of the renewal mechanism, and 12 reported having actively participated in a renewal proceeding. Others were aware that renewals occur but had never taken part in one.

Although a 9.60 removal order requires a fresh determination of whether statutory criteria continue to be met, including the least-restrictive-alternative requirement, clients did not describe experiencing this level of review. Clients generally described renewals as automatic—another year of court oversight, often without a hearing the person attended. They characterized them as something that happens to them rather than as a procedural event in which they have a role. Renewal proceedings, as they recounted them, involved far less scrutiny than initial hearings and in some cases no court appearance at all.

Some clients described knowing that renewal had occurred, but not understanding how it happened. Several described renewal as the expected outcome rather than as a decision

shaped by their own clinical or behavioral status. For instance, several reported being told they would graduate from the order and then be renewed; others expected the order to expire and then learned that it had not; still others learned about renewal happening without an articulated clinical reason.

One client, on AOT since 2019 and medication-adherent throughout, put it this way:

> *"It feels like a forever sentence. I don't understand. Some of the members from ACT would be like—well, [inaudible] health would be like, 'Oh, you're going to graduate.' And then it would just be renewed by [psychiatrist] every year. And it's not fair. I'm so compliant with my medication, and I feel great mentally, and I will stay compliant with my medication for the rest of my life. I don't understand why I understand this. What if I get married one day and have kids? Do I have to get checked on every week? A bit annoying." ~Client 42*

Asked what her psychiatrist says about the renewal, the same client described the explanation she gets:

> *"She never says if I'm ever going to get all that, or AOT. She just says, 'Oh, we're going to extend another year. I think you need more supervision.'" ~Client 42*

Another client described being surprised that the order had not ended at the point he had expected:

> *"I was like, 'Wow, after six months, am I really free from this?' But that was in my mind. But I probably inquired, and someone told me, 'No, they're going to do another six months.'" ~Client 35*

A third client described a case where the renewal duration was shortened because his treating clinician declined a year-long extension:

> *"I already went through six months of AOT, and then they added another six months to it. And my doctor said they wanted to add a year, AOT, and he said, 'No.' He said 'I only need him to have six months.'" ~Client 14*

Other clients describe the ongoing oversight in carceral terms:

> *"It feels like I have a probation officer… Because I have to—she calls me every week. I have to see her every week. ~Client 36*

Some clients described their renewal proceedings taking place in mental health offices rather than in court. The case manager prepares a report, the participant's attorney and doctor attend, and the judge signs off without the client ever being in a courtroom:

> *Client: At the hearing?*
> *Interviewer: Yeah. At the hearing.*
> *Client: It's only me or my lawyer and the doctor.*
> *Interviewer: Oh, okay. So this must have been, like, the renewing?*
> *Client: The case manager writes a report, and then the judge signs up on it.*

Interviewer: Okay. Uh, but did you actually go to court then?
Client: No. I go to an office, like, a mental health office. ~Client 19

The same client clarified the function of the office meeting:

Interviewer: So it sounds like you went to the—is that the—that's for the renewal and or discontinuation hearing, but not the initiation—not the beginning hearing....?
Client: You're right. Yeah. That's for continuation or dismissal. Yeah… And then they see how you're doing to see what meds you're on and how you're doing if you're taking your meds every day. Yeah. ~Client 19

When clients are given a reason for the renewal, the reason does not always invoke the criteria under which renewal is supposed to be assessed. One client was told the order would be extended because of an unrelated criminal case involving an ex-partner:

Client 16: "Yeah. Like I mentioned, they said, because I'm dealing with a court case with pressing charges against my ex, that they wanted to just keep it on for another six months while I'm going through that."
Interviewer: "Okay. And do you feel like those two issues are connected from your point of view?"
Client 16: "I mean, it definitely affects my mental health."

Client accounts of the order expiration process varied. Some described it as occurring automatically at the end of an order period, while others described a structured review involving their care team:

Interviewer: "Did they mention any [of] what happens at the end of the six months, or they just said it's six months?"
Client 13: "They said it would be discontinued. After a year after a year. I think it was a year. They said a year."
Interviewer: "Okay. They say it's, like, automatically discontinued or that."
Client 13: "Yeah. I think it's automatically discontinued, too. I have a meeting with the same team and get evaluation to see what's going on."

Only five clients were able to describe the criteria for discontinuation in concrete terms. One put it this way:

" I needed to comply. I needed to just get to the end of time without any major problems or any complications. Um, when time came, the AOT order expired and it wasn't up for renewal.
Interviewer: It seems like it was somewhat clear to you what you needed to do to get off?
Client: Just continue to meet with the ACT team and take suggestions as required and create an actionable plan for my life that would be beneficial to me." ~Client 30

OMH Administrative Data on Order Duration

OMH data on order duration include 46,593 court orders (see Chapter 4). The SAFE Act of 2013 shifted the minimum initial-order duration from 6 months to 12 months. Post-SAFE-Act, initial-order duration has stabilized around 11 months statewide; renewal-order duration is similar at

around 10 months. Regional variation is substantial: New York City initial orders average 8.6 months (mean 263.6 days, median 184); renewal orders in NYC average 8.1 months. All other regions average approximately 11 months for both initial and renewal orders, with median durations sitting at the 12-month statutory floor: Western New York 336.4 days mean, Central New York 344.9 days mean, Hudson Valley 329.9 days mean (medians 365 days in all three).

The New York City pattern reflects a sub-population of 6-month orders that does not appear elsewhere in the state—likely associated with criminal-legal-pathway initiations and shorter ACT-team episodes. Upstate and Long Island orders are dominated by 12-month orders at the statutory floor.

The duration data speaks to the unawareness finding: If the typical AOT order runs 11 to 12 months between renewal proceedings, a participant going through a renewal is doing so after roughly a year with no procedural contact in court. Renewal proceedings often happen without participant presence.

Administrative Data: Episode Structure

The OMH data on AOT episodes—defined as a sequence of court orders running from an initial order to a non-renewal decision—show a long-tailed distribution (see Chapter 4). A total of 65% of clients have only one episode; 19% have two; 13% have three or four; 3% have five or more. The mean is 1.6 episodes.

Within episodes, the number of court orders ranges from one to 26 (mean 2.5; see Chapter 4). Nearly half (46%) of episodes consist of a single order; 9% involve six or more consecutive renewal orders.

Clients who describe extended renewal trajectories are drawn from the small fraction with many consecutive orders. The structural features of renewal—long order durations, low contestation rates, low participant attendance—become more entrenched the longer a participant remains in the system. The qualitative cases of extended unawareness are not the population norm, but they document a subpopulation confirmed by the administrative data.

Theme 7: Power Imbalances, Compliance Pressure, and Enforcement

Clients described threats and compliance pressure both before and after an AOT order was issued. Some described explicit statements from clinical staff about the consequences of noncompliance; others described pressure they perceived as implicit. Approximately a dozen clients reported that a clinician or staff member described the consequences of noncompliance with the AOT.

A 9.60 removal is the enforcement mechanism that an AOT order authorizes: If a clinician reports that the person has failed to comply with material elements of the plan and suspects they are at risk, law enforcement may transport them to a designated facility for evaluation.

Two distinct phenomena appear in the client interviews. Actual removal—being transported to a hospital by law enforcement—occurred in 10 of 46 cases. Communication about the possibility of removal appeared in 32 of 46 cases, meaning the majority of clients who described it had not personally experienced an actual 9.60 removal.

Clients who described AOT in carceral terms (probation, parole, prison) frequently pointed to the 9.60 removal mechanism when asked what made the order feel that way. Of the 10 clients who experienced removal, five described it in carceral terms.

Other interviewee perspectives on 9.60 removals are discussed in Chapter 2, and OMH data on significant-event reports, including noncompliance and removal reports, are analyzed in Chapter 4.

> *"The cop is going to come pull you out of your house and take you to the hospital and see if you're coherent and give you a shot. That's what [my psychiatrist] told me." ~Client 25*
>
> *"[My doctor said] if you don't comply with the AOT, we're putting you in [state hospital]." ~Client 19*
>
> *"[Staff said] if you don't get better and make an effort to get better, you're going to get sent to [state psychiatric center]." ~Client 45*
>
> *"[I was told] 'If you don't do this… we're gonna have to put you in the hospital again.'" ~Client 21*
>
> *"They used to threaten me and say like, 'Oh, if you keep doing this, we're going to send you to a [state hospital].'" ~Client 39*

Two clients described family members invoking the AOT order or the prospect of hospitalization as a threat to compel cooperation:

> *"[My mother said] if you don't take it [medications], you're gonna go to the hospital." ~Client 26*
>
> *"[My father told me] I might be homeless if I don't go to the hospital. And if I go to the hospital, they'll drop the charges." ~Client 37*

Other clients described threats that were implicit rather than stated.

> *"No one said, 'Oh, well, you'll be hospitalized if you don't take them.' No one said that. But it was so obvious." ~Client 35*
>
> *"[It was] sort of implied that if I didn't go on the AOT, I would have to be permanently hospitalized." ~Client 3*

Chapter 4: Analysis of Quantitative Data

This chapter presents detailed findings of the evaluation team's quantitative data analysis of AOT.

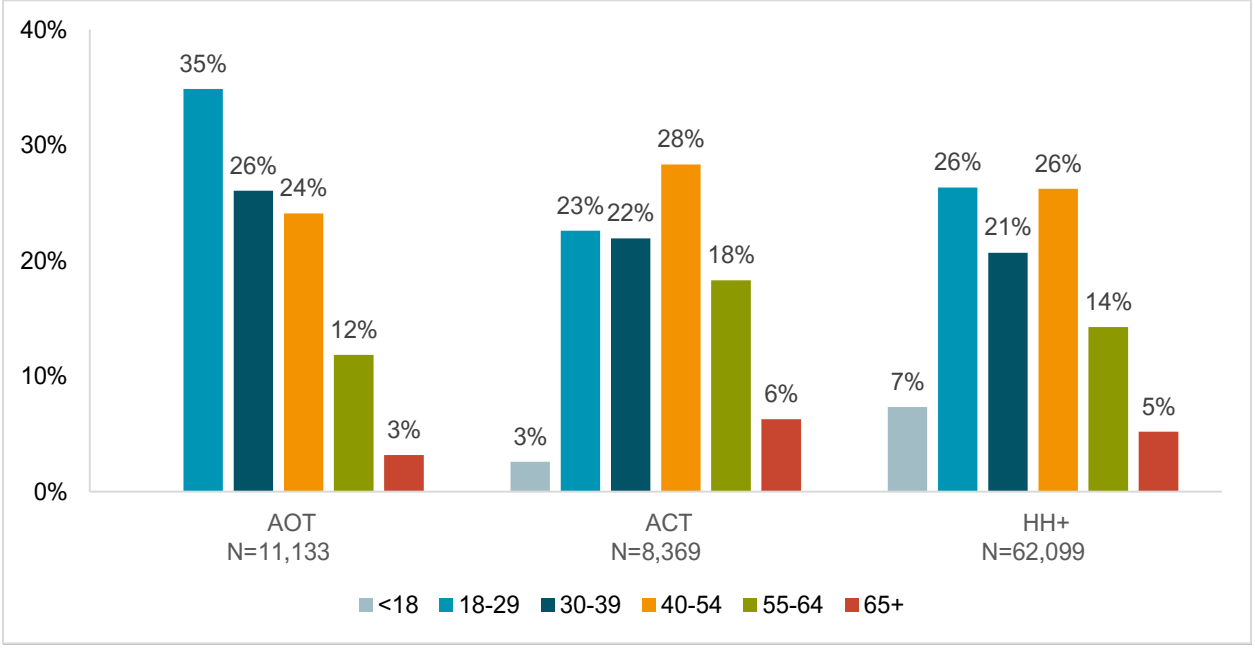
Sample Description

The data we received from OMH comprised of the following three cohorts:

- 11,553 individuals ("AOT recipients") under an active AOT order as of January 1, 2018;
- 8,369 individuals ("ACT participants")[1] with an active ACT episode as of January 1, 2018, and no AOT order; and
- 62,099 individuals eligible for Health Home Plus (HH+) services since the beginning of that program in 2020 and no active AOT order or ACT episode.

Exhibit 4.1 shows the age distributions of the cohorts as of January 1, 2018, after initial data validation. The AOT cohort is clearly tilted toward younger ages starting at age 18, the threshold for eligibility. The other two cohorts include small percentages of younger people and are more "bell-shaped" in their distribution, with the majority in the middle and fewer people at the two ends.

Exhibit 4.1. *Age Distribution of the Original Sample*



Note: "N" indicates the total number of people in each cohort with valid age data. The original data we received had 420 people younger than 18 in the AOT cohort. Given that youth younger than 18 are not eligible for AOT, we assumed these cases to be the result of data entry errors and assigned them a missing code during data validation.

[1] As mentioned in the Methodology section, the ACT cohort did not have an AOT order. In discussing the outcomes of the two cohorts, we refer to the ACT cohort as "voluntary ACT" to emphasize this point and to clearly distinguish this comparison sample from recipients of AOT who may be treated by an ACT team.

Considering that people younger than 18 are not eligible for AOT, we excluded all individuals below that age from our analysis to establish comparability across cohorts. Exhibit 4.2 shows the age distribution of the effective evaluation sample that excludes ACT and HH+ cases younger than 18.

Exhibit 4.2. *Age Distribution of the Effective Evaluation Sample*

	N	Minimum	Maximum	Mean	Standard
AOT	11,133	18	85	37.7	13.5
ACT	8,152	18	92	42.7	14.4
HH+	57,549	18	96	40.9	14.7

Note: Numbers in the "N" column are total numbers of people in each cohort with valid age data.

In the rest of this section, we provide an overall description of the three cohorts in the effective evaluation sample. It should be noted, however, that different portions of the analysis had different case selection strategies depending on the specific evaluation question being addressed.

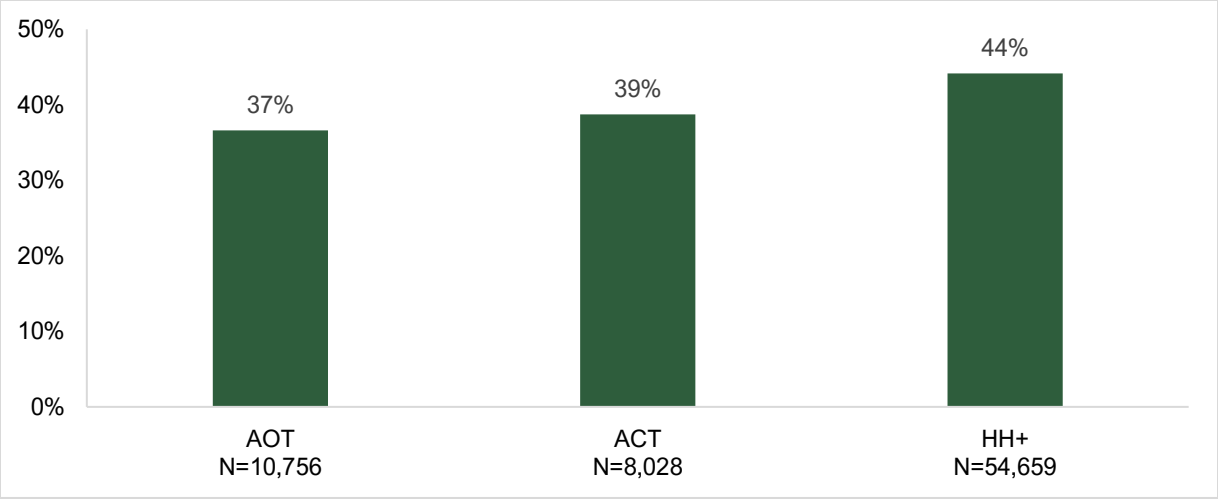
Exhibit 4.3 displays racial and ethnic distributions for the three cohorts in the evaluation sample. There were significant cohort differences in the representation of all race/ethnicity categories with the exception of the Native American/Alaska Native and Hawaiian or Other Pacific Islander categories that were evenly distributed across the three cohorts. The "Middle Eastern or North African" category is not part of OMH's current data collection; it was created by the evaluation team by coding open-text responses. Although small in numbers overall, the representation of Middle Easterners in the ACT cohort was significantly higher than the other two cohorts. When we separate the sample into those who only identified as "White" versus everyone else, we find that the three cohorts have significantly different representations of this category with the AOT cohort having the lowest and the HH+ cohort the highest percentage of White people (Exhibit 4.4).

Exhibit 4.3. *Racial and Ethnic Characteristics of the Evaluation Sample*

	AOT N	AOT %	ACT N	ACT %	HH+ N	HH+ %
Asian	522a	4.9%	267b	3.3%	53,073c	2.9%
Black or African American	4,027a	37.4%	3,673b	45.8%	17,705c	32.4%
Hawaiian or Other Pacific Islander	27a	0.3%	21a	0.3%	167a	0.3%
Hispanic	2,182a	20.3%	918b	11.4%	10,766a	19.7%
Middle Eastern or North African	10a	0.1%	26b	0.3%	37a	0.1%
Native American or Alaska Native	77a	0.7%	62a	0.8%	467a	0.9%
White	3,946a	36.7%	3,169b	39.5%	24,301c	44.5%
Reported "Multiracial" with no other race/ethnicity information	391a	3.5%	86b	1.1%	1,587c	2.8%

Note: Numbers in the "N" column are the numerators of the percentages. Looking across each row, cohorts with different letters in the "N" column have significantly different percentages from each other ($p<0.05$). Column percentages may add up to more than 100% because some people reported more than one racial/ethnic affiliation.

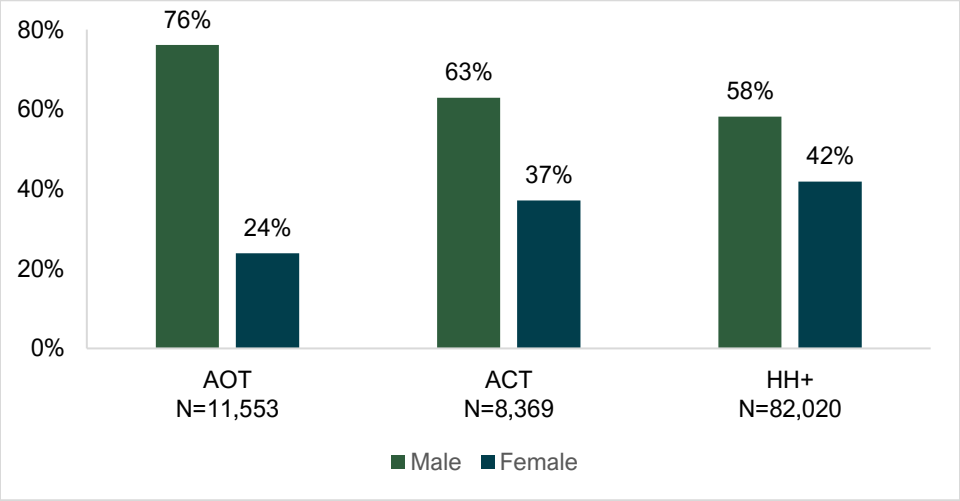
Exhibit 4.4. *Percentage Who Identified as 'White' With No Additional Racial/Ethnic Affiliations*



Note: "N" indicates the total number of people in each cohort with valid race/ethnicity data.

The sample is predominantly male (61.3%). Looking at the three cohorts separately, we find that cohorts significantly differ in their sex composition. Exhibit 4.5 shows that the AOT cohort has the lowest percentage of women (24%) and the HH+ cohort has the highest (42%), with the ACT cohort somewhere in between (37%).

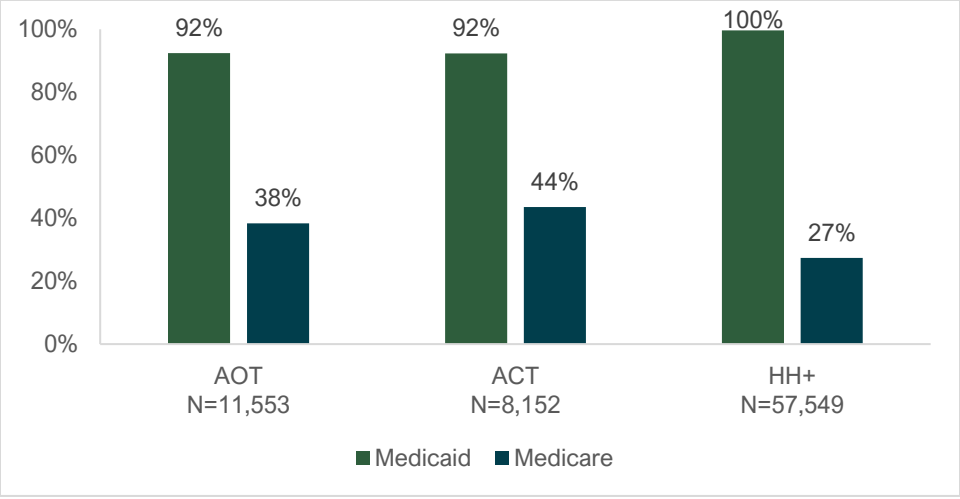
Exhibit 4.5. *Sex Composition of the Three Cohorts*



Note: "N" indicates the total number of people in each cohort with valid data on sex.

Exhibit 4.6 displays eligibility for public insurance for the three cohorts. Medicaid eligibility is a requirement for HH+ participation but not for AOT or ACT, although over 90% of the latter two cohorts are also Medicaid eligible. On the other hand, the three cohorts significantly differ in the proportion of Medicare-eligible participants with HH+ having the lowest percentage (27%) and ACT the highest (44%). Medicare eligibility is 38% in the AOT cohort. We would expect cohort differences in Medicare eligibility to be related to differences in age distribution. However, Medicare eligibility rates exceed the share of people ages 65+ in all three cohorts, suggesting that eligibility criteria other than age, such as disability, are also at play. Given that almost everyone in the sample is Medicaid-eligible, numbers for dual-eligibility (not shown) are similar to those for Medicare eligibility.

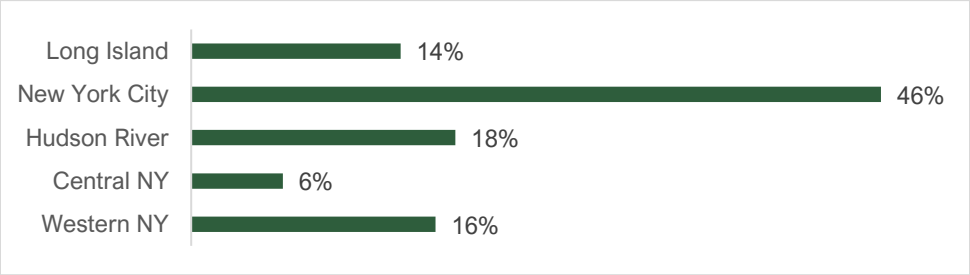
Exhibit 4.6. *Medicaid and Medicare Eligibility Rates by Cohort*



Note: "N" indicates the total number of people in each cohort with valid eligibility data.

Geographic information for the sample comes from data on court orders that records the county of each court hearing. Therefore, this information is only available for the AOT cohort. For people with multiple hearings in different counties, we used the location of the most recent court hearing. Close to half the AOT cohort (46%) had their most recent hearing in New York City (NYC). Exhibit 4.7 shows that the region with the smallest share of the sample was Central NY (6%).

Exhibit 4.7. *Geographic Distribution of the AOT Cohort*



Note: The chart is based on data from 11,553 individuals in the AOT cohort.

NYC is known to have a distinct racial/ethnic composition compared to other parts of the state. Given the high concentration of AOT recipients in this region, it is informative to compare the representation of race/ethnicity categories in this region to the rest of the state. Exhibit 4.8 indicates that NYC has significantly higher percentages of Asian, Black, and Hispanic AOT recipients and significantly lower representation of White recipients compared to the rest of the state.

Exhibit 4.8. *Racial and Ethnic Characteristics of the AOT Cohort by Region*

	New York City N	New York City %	All Other Regions N	All Other Regions %
Asian	366	7.4%	156	2.7% *
Black or African American	2179	43.8%	1848	32.0% *
Hawaiian or Other Pacific Islander	12	0.2%	15	0.3%
Hispanic	1477	29.7%	705	12.2% *
Middle Eastern or North African	^	^	^	^
Native American or Alaska Native	36	0.7%	41	0.7%
White	916	18.4%	3,030	52.4% *
Reported "Multiracial" with no other race/ethnicity information	179a	3.5%	212a	3.5%

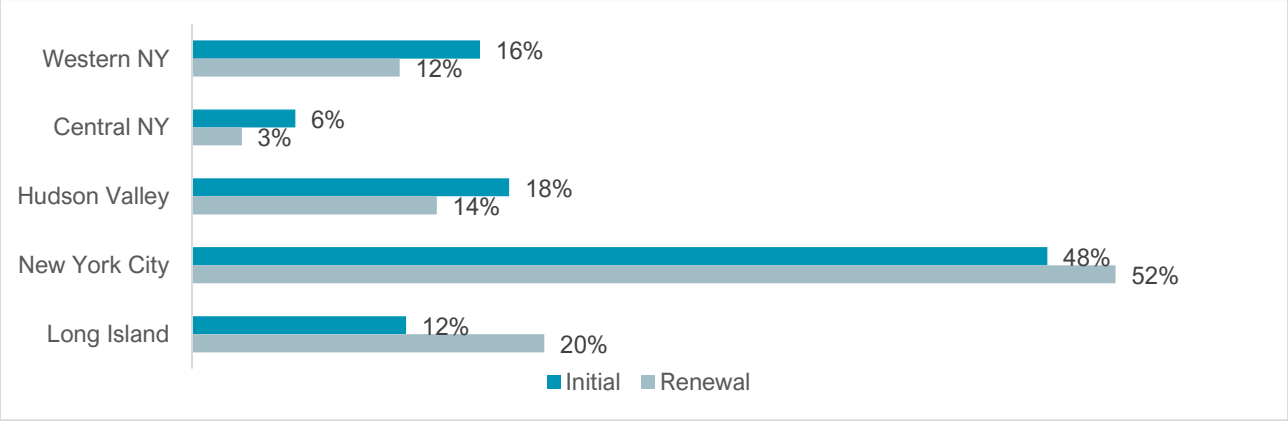
Note: Numbers in the "N" column are the numerators of the percentages. Column percentages may add up to more than 100% because some people reported more than one racial/ethnic affiliation.
* Significantly different from New York City ($p<0.05$).
^ Numbers in cells with fewer than 10 people are suppressed to maintain confidentiality.

Court Orders

Number, Location, Duration, and Source

Data for 46,593 court orders were available for this evaluation; 40.5% were initial and 59.5% were renewal orders. Order dates ranged from January 2000 to October 2024. Exhibit 4.9 displays the regional distribution of the orders in the evaluation sample. As expected, NYC has the largest share of both initial and renewal orders (48% and 52%, respectively). In NYC and Long Island, the regional share of renewal orders exceeds the share of initial orders whereas the opposite is the case in the other three regions.

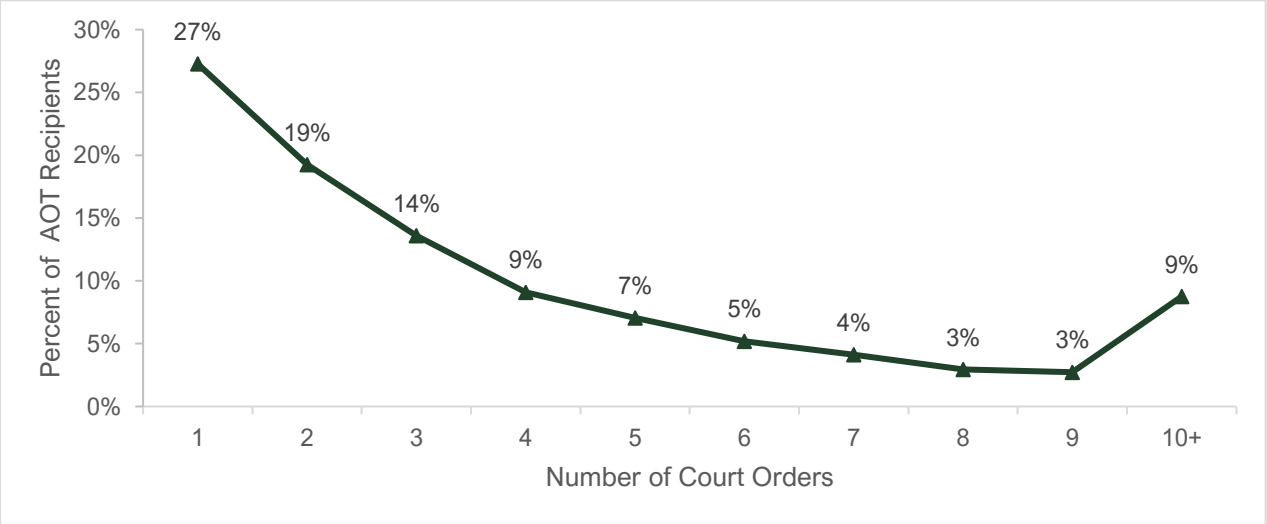
Exhibit 4.9. *Regional Distribution of Court Orders*



Note: The chart is based on data from 18,853 initial and 27,740 renewal orders.

The AOT recipients in our sample had, on average, four court orders, with a minimum of one and a maximum of 29 orders. As seen on Exhibit 4.10, 27% of recipients had a single order and 9% had 10 or more orders.

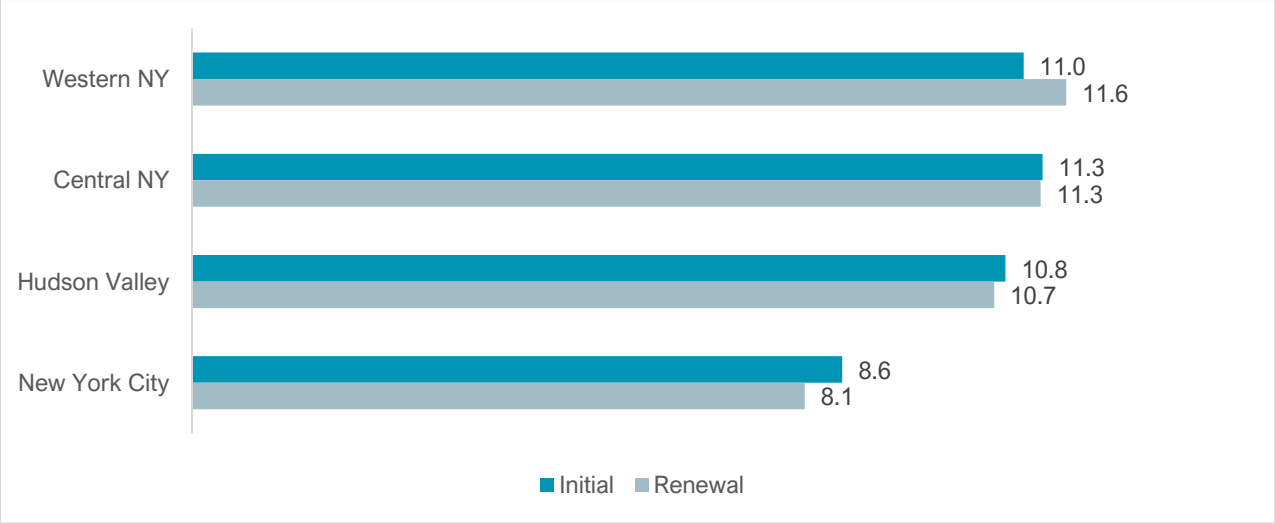
Exhibit 4.10. *Number of Court Orders per AOT Recipient*



Note: The chart is based on data from 11,553 AOT recipients.

Order duration, that is, the period between effective and expiration dates of an order, ranged from one month to 13 months[2] with an average of 9.4 months. There was no significant difference between the mean durations of initial and renewal orders. In all regions except NYC, average order duration was approximately 11 months. Both initial and renewal orders were significantly shorter in NYC (8.6 and 8.1 months) compared to the rest of the state (Exhibit 4.11).

Exhibit 4.11. *Average Duration of Court Orders in Months, by Region*

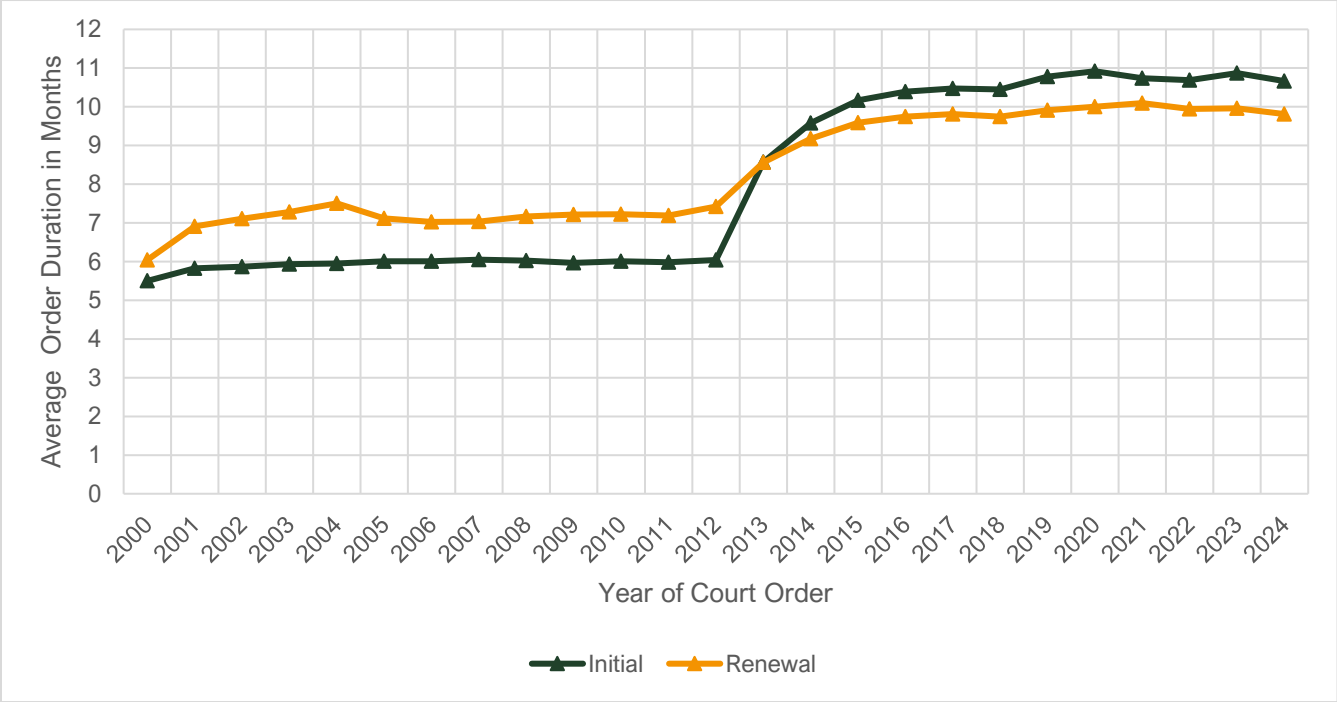


Note: The chart is based on data from 18,853 initial and 27,740 renewal orders.

[2] There was one order with duration less than one month and 4 orders with a 13-month duration. We assume that these had either a data entry error in their dates or were due to rounding errors.

Average order duration changed over the years, in line with changes in the legislation (Exhibit 4.12). Between 2000 and 2012, initial order duration was limited to six months, and during that period average order duration remained steady at this level. Orders could be renewed for up to a year. Average duration of renewal orders during this period were slightly above initial orders; they remained between six and eight months. The SAFE Act of 2013[3] increased the minimum duration of initial orders to 12 months, resulting in an increase in average duration from 10 months in 2014 and stabilizing around 11 months between 2019 and 2024. Unlike the pre-2013 period, average duration of renewal orders were *lower* than initial orders during 2014 – 2024, remaining relatively stable around 10 months.

Exhibit 4.12. *Average Order Duration by Order Type, 2000 – 2024*



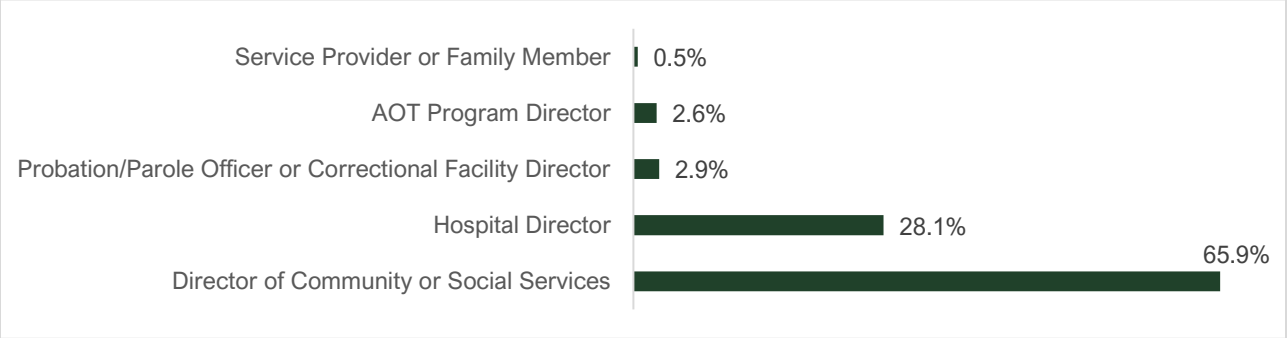
Note: The chart is based on data for 18,853 initial and 27,740 renewal orders. It is important to keep in mind that the evaluation data come from individuals who were under an active AOT order as of the beginning of 2018; AOT recipients with orders that expired before that date are not represented on the chart. E.g., there were fewer than 100 initial orders in 2000 and fewer than 100 renewal orders between 2000 and 2004. Percentages for these years are, therefore, less precise compared to later years.

An AOT court hearing is initiated with a petition from an authorized individual. Exhibit 4.13 displays the petitioners of record for the court orders included in the evaluation data. It should be noted that

[3] Ref.: Senate Bill S2230.

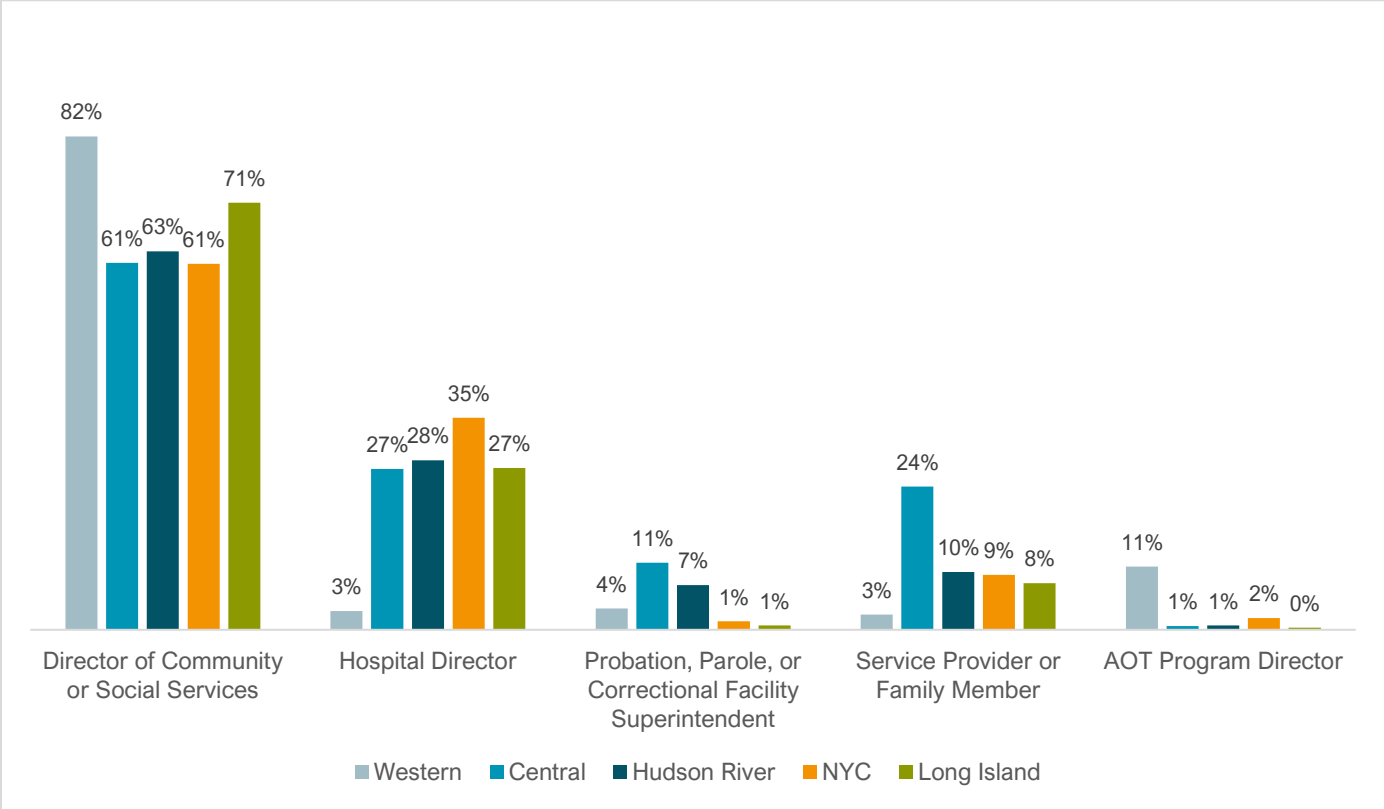
the petitioner of record is not necessarily the person who initially requested the court hearing. For example, although adult family members or roommates are authorized to initiate the process, they are encouraged to first contact their local mental health director for assistance. Preparing a case for a court hearing requires access to the person's protected health records and an examination by a psychiatrist who determines that AOT is appropriate. Family members and service providers often face challenges in accessing all the information required to petition the court, especially in cases where the person in question refuses to give their consent to an evaluation or the release of their health records. Hospitals and county directors are better equipped to access health records and assess whether the person meets AOT criteria. This is probably the reason why less than 1% of petitioners of record are family members or service providers, even though they would be expected to be the most knowledgeable about a person's behavioral health needs. They are likely to seek assistance from their local mental health directors who access evidence of need and prepare the petition, explaining why two-thirds of all petitioners of record are from county directors of community or social services. Hospitals are the next most likely petitioners (28%), most probably because AOT is regarded as an acceptable option for discharge from inpatient care and the patient's health records and psychiatric evaluation are readily available to the discharge planner.

Exhibit 4.13. *AOT Petitioners*



There are regional variations in petitioner types. For example, Western NY has the largest percentage of petitions by directors of community services (82%) and Central NY has the largest percentage of petitions by family members and service providers. The variation is probably due to a combination of differences in AOT implementation and location of institutions such as hospitals and correctional facilities (Exhibit 4.14).

Exhibit 4.14. *Percentage of Petitioner Categories by Region*

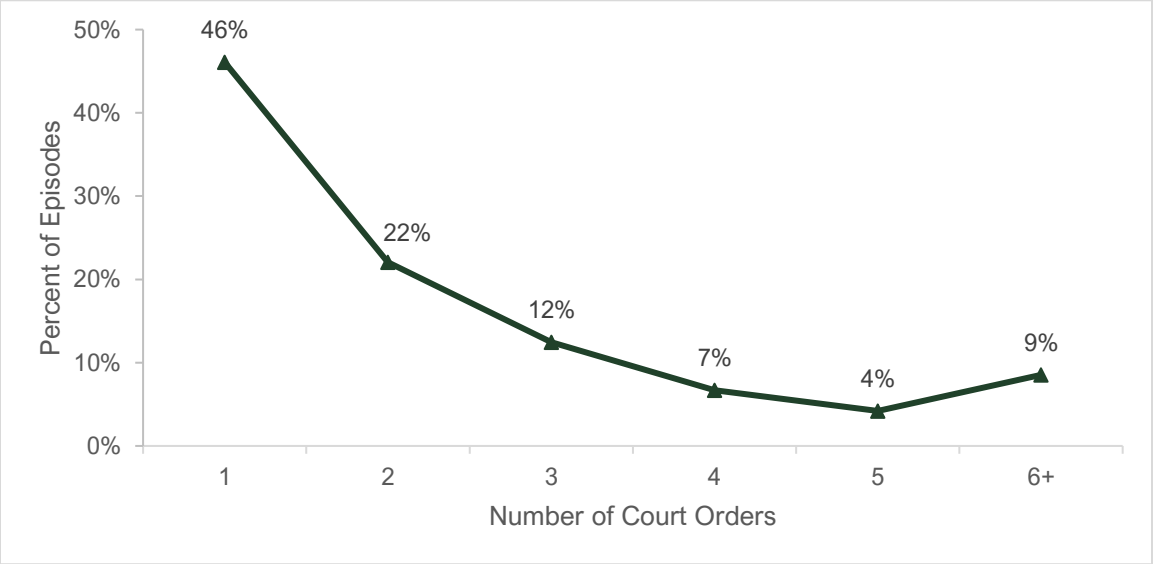


AOT 'Episodes'

We define an AOT episode as a sequence of court orders beginning with an initial order, followed by consecutive renewal orders, and ending with a non-renewal decision. If at a later time the person is again petitioned for an AOT, there is another initial court hearing followed by consecutive renewal decisions. In other words, a person may have multiple AOT episodes, sometimes separated by months or years. It is informative to focus on episodes in addition to individual court orders since they are more representative of the lived experience of AOT recipients, their families, and providers.

The 46,593 court orders in the evaluation data group into 18,853 episodes. The number of court orders per episode range from one to 26, with an average of 2.5 orders per episode. Looking at Exhibit 4.15, close to half (46%) of the episodes consist of a single order and 9% have six or more consecutive orders.

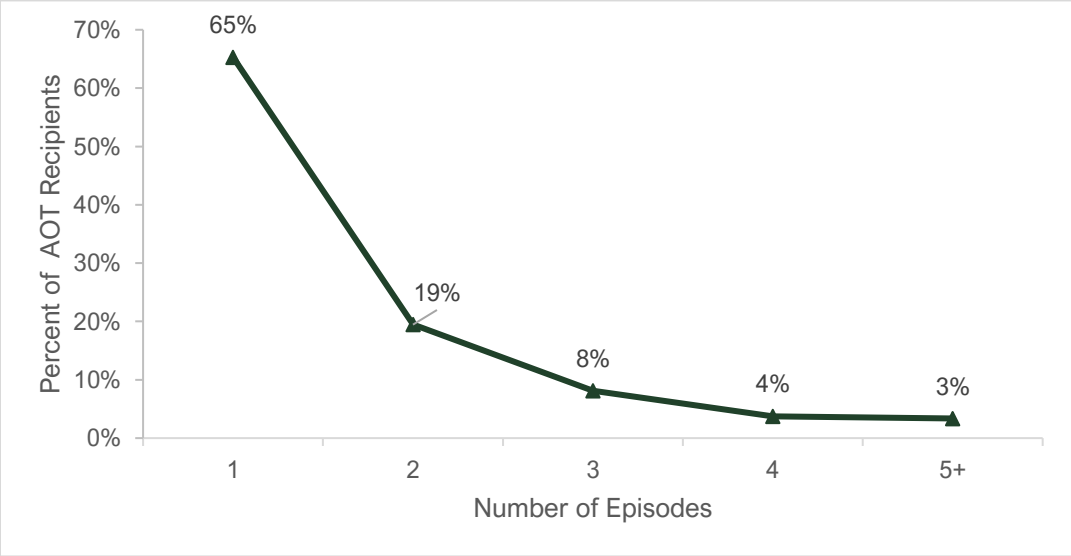
Exhibit 4.15. *Number of Court Orders per Episode*



Note: The chart is based on data from 18,853 episodes

The AOT recipients in our sample had, on average, 1.6 episodes, ranging between one and 12 episodes per recipient. Exhibit 4.16 shows that 65% of recipients had a single episode, 19% had two episodes, and 3% had five or more episodes.

Exhibit 4.16. *Number of Episodes per AOT Recipient*



Note: The chart is based on data from 11,553 AOT recipients.

Observing the large drop in numbers from having a single to two or more episodes, we further investigated the characteristics that differentiate AOT recipients with a single episode from other recipients. Multivariate logistic regression analysis of demographic characteristics found that age, sex, and race/ethnicity all had net significant effects on the likelihood of having a single episode. Holding age and race/ethnicity constant, female recipients were 24% more likely than their male peers to have a single episode; and holding sex and age constant, White recipients were 38% more likely than others to have a single episode. Holding race/ethnicity and sex constant, a 10-year increase in age increased a recipient's likelihood of having a single episode by approximately 16%.

Rationales for Non-Renewal of AOT Orders

There is a reporting requirement for directors of community services, introduced in 2013, to report the reasons for the decision to not renew an expiring AOT order. The decision can be because the person meets statutory non-renewal criteria, or they do not meet non-renewal criteria but are not renewed because of reasons such as death, hospitalization, incarceration, or being already set up with a voluntary treatment plan after order expiration. Non-renewal criteria are as follows:

- No longer suffering from a mental illness
- Likely to safely survive in the community without supervision
- No longer in need of AOT in order to prevent relapse or deterioration resulting in harm to self or others
- No longer refusing to voluntarily participate in treatment
- No longer likely to benefit from AOT
- AOT is no longer the least restrictive treatment alternative

Less than half (41%) of the 9,641 non-renewals in the evaluation dataset state that the person meets AOT non-renewal criteria. Exhibit 4.17 shows the frequency of specific criteria reported within this category. By far the most frequently cited non-renewal rationale for recipients who meet non-renewal criteria is that AOT is no longer the least restrictive treatment alternative (59%). The second most frequently cited reason in this category is that the recipient is likely to voluntarily continue treatment (36%). Less than 1% of the non-renewal rationales within this category is that the person no longer has a mental illness.

Exhibit 4.17. *Number and Percentage of Non-Renewal Reasons for Recipients Who Meet Non-Renewal Criteria*

	N	%
No longer suffering from a mental illness	30	0.8%
Likely to safely survive in the community without supervision	1,259	32.0%
No longer in need of AOT in order to prevent relapse or deterioration resulting in harm to self or others	1,252	31.8%
No longer refusing to voluntarily participate in treatment as a result of mental illness	1,431	36.4%
No longer likely to benefit from AOT	702	17.8%
AOT is no longer the least restrictive treatment alternative	2,311	58.7%

Note: Numbers in Column N are numerators of the percentages. The table is based on data from 3,934 non-renewal determinations associated with eligibility criteria. Reports of non-renewal reasons for a decision may include multiple reasons.

A non-renewal request may also be made even though the person does not meet statutory non-renewal criteria. This can happen if the person:

- Is deceased, hospitalized, or incarcerated
- Moved out of state, or otherwise cannot be located
- Will continue treatment under a voluntary enhanced service agreement (VSA)

One additional reason cited for non-renewal in this category is that a renewal petition was submitted but denied by the court. Exhibit 4.18 shows the frequency of non-renewal reasons for people who may not meet non-renewal criteria. The most frequently cited reasons in this category are that the person will continue treatment either in a hospital (25%) or in the community through a voluntary enhanced treatment agreement (24%). Less than 2% of renewal petitions were denied by the court.

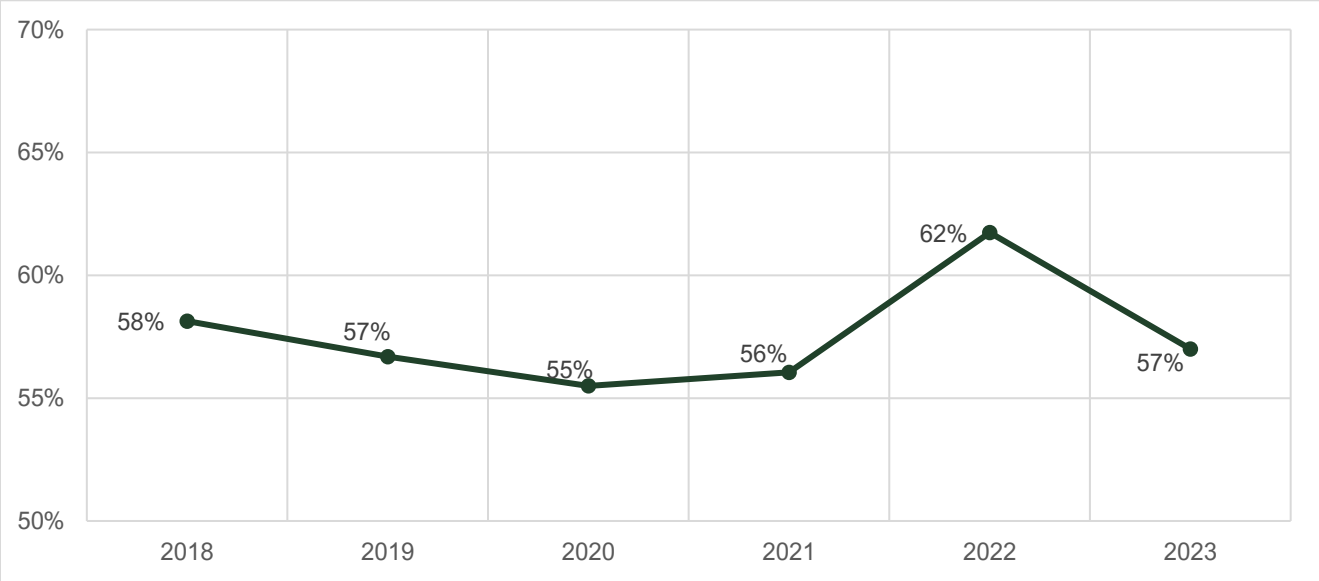
Exhibit 4.18. *Number and Percentage of Non-Renewal Reasons for People Who Do Not Meet Non-Renewal Criteria*

	N	%
Deceased at time of determination	39	0.7%
Hospitalized at time of determination	1,409	24.7%
Incarcerated at time of determination	655	11.5%
Will continue treatment under a voluntary enhanced service agreement (VSA) after order expiration	1,393	24.4%
Moved out of state	320	5.6%
Petitioner could not locate the recipient	594	10.4%
Renewal petition submitted but denied by the court	85	1.5%
Another reason not included in the above list	1,345	23.6%

Note: Numbers in Column N are numerators of the percentages. The table is based on data from 5,707 non-renewal determinations whose order was not renewed although they continued to meet AOT eligibility criteria.

We investigated further the non-renewal rationales that cite continued treatment after order expiration: (a) the recipient meets the non-renewal criterion of no longer refusing treatment; and (b) the recipient does not meet non-renewal criteria but is either hospitalized or will continue treatment under a VSA following order expiration. Exhibit 4.19 traces the prevalence during 2018 – 2023 of non-renewal orders even though the recipient meets renewal criteria. Prevalence rates for this non-renewal category remained stable between 2018 and 2023, only fluctuating slightly within the 55% - 58% range. There was a peak above 60% in 2022 but a return to the earlier level in 2023.

Exhibit 4.19. *Percentage of Non-Renewal Decisions Meeting Renewal Criteria*

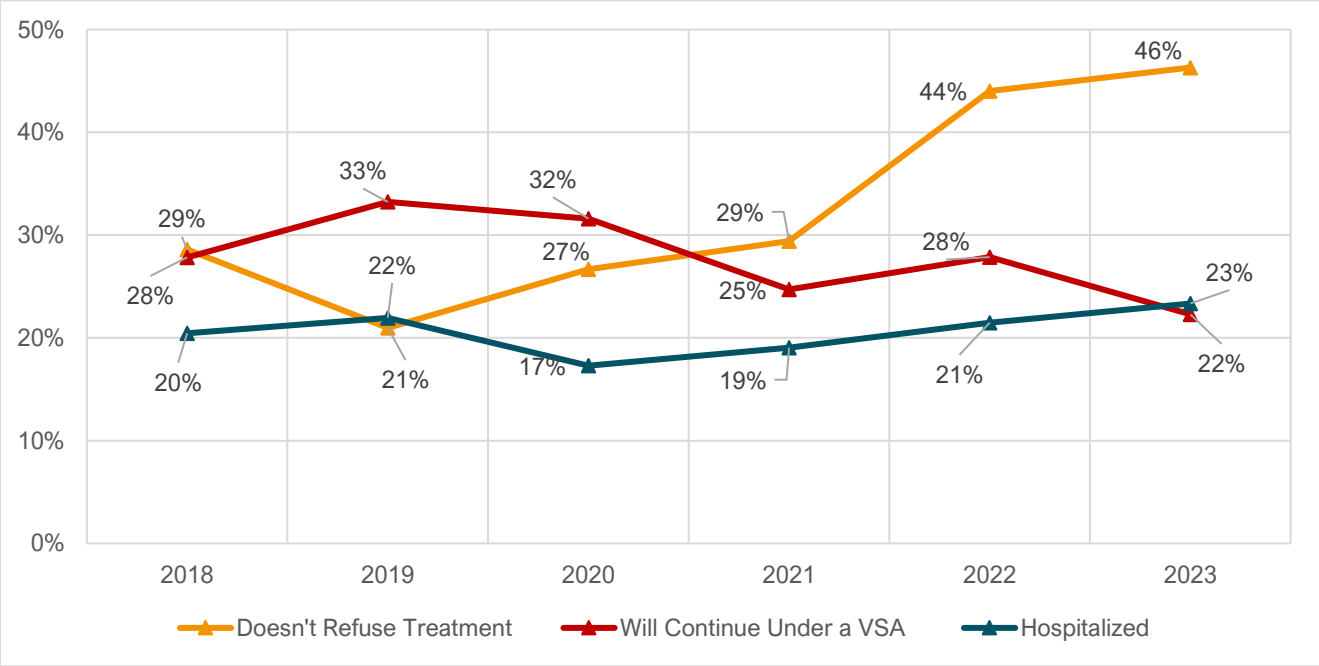


Note: The chart is based on a total of 7,026 non-renewal determinations made during 2018 – 2023 (approximately 1,100 – 1,200 during each year).

Exhibit 4.20 shows the prevalence of non-renewal determinations that suggest continued treatment after order expiration. Step-ups to inpatient treatment steadily increased from its lowest level of 17% in 2020 to its highest level of 23% in 2023. Step-downs to community-based voluntary treatment moved in the opposite direction, decreasing from its highest level of 33% in 2019 to its lowest level of 22% in 2023. That is, step-downs were more prevalent than step-ups throughout the period until 2023 when the two trends intersected. During this period, the *potential* for a step-down, that is, the share of non-renewals due to the recipient no longer refusing treatment, more than doubled, from a low of 21% in 2019 to a high of 46% in 2023.

This last trend may, at least partially, suggest an improvement in AOT recipients' acceptance of treatment. On the other hand, the increasing gap between recipients' willingness for voluntary treatment and actual step-downs to a voluntary community treatment model may suggest increasing unmet need for voluntary treatment options.

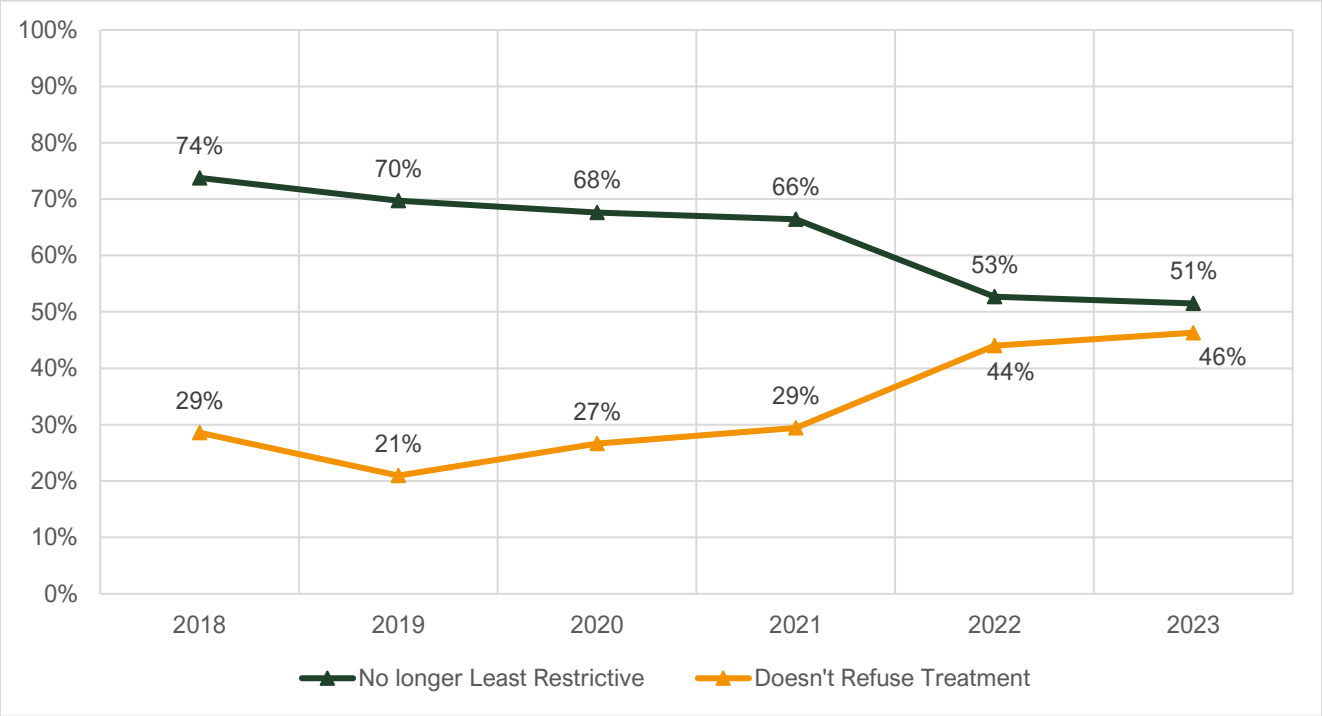
Exhibit 4.20. *Prevalence of Non-Renewal Decisions Associated with Continued Treatment*



Note: The chart is based on 2,987 non-renewal determinations that meet non-renewal criteria (within the 400-500 range each year) and 4,039 determinations that do not meet non-renewal criteria (within the 600-700 range each year).

Another non-renewal criterion with implications for step-down potential is that AOT is no longer the least restrictive treatment alternative (LRA) for the recipient. As mentioned earlier, this is cited as the rationale for over half of all determinations that meet non-renewal criteria. Considering that typically, AOT is the least restrictive treatment option for people who have serious mental illness but refuse treatment, the trend line for this rationale would be expected to have a similar trend line to the "doesn't refuse treatment" (DRT) rationale. Exhibit 4.21 indicates that this was not the case. In 2018, LRA was cited as 74% of non-renewal criteria while DRT's share was only 29%. The two trend lines then moved in opposite directions toward converging; in 2023, LRA was at 51% and DRT was at 46% of cited rationales. There are multiple possible explanations for the difference between these trend lines. For example, there could be changes over the years in policies, data collection systems and guidance documents, emphasis by administrators and providers on one or the other criterion, or changes in the availability of less restrictive treatment options. The available data are insufficient to determine which combination of factors account for the discrepant trend lines.

Exhibit 4.21. *Percentage of Determinations that Meet Non-Renewal Criteria, Citing 'No Longer Least Restrictive' and 'No Longer Refuses Treatment' Rationales*



Note: The chart is based on 2,987 determinations that meet non-renewal criteria (within the 400-500 range each year).

'Significant Events' Reported During AOT

AOT care management entities are required to file a report to their local AOT director within 24 hours of becoming aware of a list of events considered to be "significant." These reports are often reviewed during renewal hearings and have an impact on the outcome. Of the 11,553 AOT recipients in the evaluation sample, 65% had at least one significant even report and 48% had multiple reports filed between March 2000 and February 2025. The average recipient had one report per AOT order and among those who had at least one report, 74% had multiple reports. Exhibit 4.22 lists the event categories and numbers of recipients for whom the event type was reported. The events reported most frequently are non-compliance (35%) and removal (34%), followed by danger to self or others (27%), hospitalization/ER visit (23%) and missing (23%).

Exhibit 4.22. *Significant Event Types and Numbers/Percentages of Recipients with at Least One Report*

	N	%
Criminal Involvement – Arrested, incarcerated, accused of a crime, or violated probation/parole	1,801	15.6%
Became the victim of a crime – Suicide attempt, serious threat of suicide, self-harm other than suicide, serious threat of self-harm	150	1.3%
Danger to Others – Violence, serious threat of harm to others, inappropriate behavior toward children, arson or threat of arson	2,121	18.4%
Danger to Self – Attempted or plans to commit suicide, self-harm other than suicide, serious threat of self-harm	1,425	12.3%
Danger to Self or Others – At least one of the above two events	3,092	26.8%
Deceased – Death regardless of cause	520	4.5%
Homelessness – Lost or in imminent risk of losing housing	326	2.8%
Substance Abuse - Abuses drugs or alcohol or **f**ails or refuses a court ordered drug test	846	7.3%
Non-Compliance with Mandated Treatment – Refuses or seriously non-compliant with medication or other court-ordered services	4,067	35.2%
Psychiatric Decompensation – Acute relapse of psychiatric symptoms or need for assessment by a physician to determine whether transport to a hospital for a 72-hour evaluation should be ordered	1,063	9.2%
Psychiatric Inpatient or Emergency Services – Receives psychiatric emergency room or psychiatric inpatient hospital services	2,639	22.8%
Removal – Was the subject of a removal order	3,912	33.9%
Missing - Cannot be located and has had no credibly reported contact within 24 hours of the time the case manager or ACT team received notice that the patient was absent	2,676	23.2%

Note: Numbers in Column N are numerators of the percentages. The table is based on data from 11,553 individuals under an active AOT order as of January 1, 2018. Event definitions come from the OMH document titled Guidance for Reporting Significant Events.

Regional Variations

There were regional variations in significant event reporting. Exhibit 4.23 describes the number of significant event reports per AOT order for an average AOT recipient in the state's five regions. Average reports per order was highest in Long Island and Hudson River (1.4 in both) and lowest in New York City (0.7). Regional differences were significantly different from each other with the exception of Long Island and Hudson River that had identical averages.

Exhibit 4.23. *Number of Significant Event Reports per AOT Order for the Average Recipient*

	N	Mean	Minimum	Maximum
Western NY	1,882	1.05	0.0	17.0
Central NY	706	1.01	0.0	19.0
Hudson River	2,035	1.39	0.0	30.2
New York City	5,317	0.67	0.0	17.0
Long Island	1,613	1.44	0.0	24.5
STATEWIDE	**11,553**	**0.99**	**0.0**	**30.2**

Note: Numbers in the "N" column are total numbers of AOT Recipients in each region.

Demographic Variations

The likelihood of having a significant event report also varied by the demographic characteristics of the recipient and the type of event. We conducted demographic analysis of the likelihood of having at least one of the most frequently reported significant events by race/ethnicity, sex, and age. The race/ethnicity analysis focused on the three groups with sufficient sample sizes for reliable analysis—that is, AOT recipients who identified with White, Black/African American, and Hispanic/Latino categories, regardless of additional categories they may have reported. Of these three categories, White and Hispanic are the most likely to be reported together. Therefore, there is some overlap between those two categories. For the age analysis, we calculated the approximate age of the recipient at the time of the AOT order(s) using the person's age as of January 1, 2018, which was provided in the data we received.

The following discussion summarizes the demographic differences found to be statistically significant after adjusting for the recipient's number of AOT orders. The adjustments were made using multivariate logistic regression models with number of orders as covariate. The percent differences in likelihood cited below are derived from adjusted odds ratios estimated by the models.

Overall Significant Event Reports

- Black AOT recipients were 21% more likely to receive at least one significant event report and 18% more likely to receive multiple reports, compared to recipients who did not identify as Black.
- The likelihood of having at least one report was not significantly different between Hispanics and other race/ethnicity categories, but Hispanics were 13% less likely than others to have two or more reports.
- Female recipients were 12% less likely to receive at least one report but their odds of receiving multiple reports was not significantly different than their male peers.

- There were no significant age differences in the likelihood of at least one report but the likelihood of two or more reports significantly decreased with age. Approximately 80% of recipients ages 18 – 29 had multiple reports compared to 59% of those ages 65 or older.

Reports of Non-Compliance

- Black recipients were 31% more likely to have a non-compliance report compared to all other recipients.
- Those who identified as White were 13% less likely to have a non-compliance report.
- Age had a U-shaped association with having a non-compliance report, such that 58% of recipients ages 18 – 29 had a report, significantly higher from those ages 55 – 64 (48%). The percentage increased to 53% among recipients ages 65 or older. There was no significant difference between the youngest and oldest age groups.

Reports of Removal Orders

- Black recipients were 27% more likely than others to have a removal report and 23% more likely to have multiple removal reports.
- Hispanic recipients were 21% less likely to have a removal report and 28% less likely to have multiple reports.
- AOT recipients in the 18 – 29 age group had significantly higher rates of removal (57%) compared to the older age groups (in the 48% – 50% range). This age group also had higher rates of multiple removals (31%) compared to older recipients (in the 21% – 25% range).

Reports of Danger to Self or Others

- White recipients had 73% higher odds of being reported as posing a danger to themselves and Black recipients had 37% lower odds of a report of this type.
- Black recipients had 15% higher odds of being reported as a danger to others.
- Female recipients had 25% higher odds of having a “danger to self” report and 23% lower odds of a “danger to others” report compared to male recipients.
- Reports of danger to both self and to others steadily decreased with age. Forty-nine percent of recipients ages 18 – 29 had a report of danger to either self or to others, compared to 20% of those ages 65 or older.

Reports of Psychiatric Inpatient or Emergency Services

- Black recipients had 26% lower odds of being reported to receive inpatient or emergency psychiatric services and Hispanics had 21% lower odds, while White recipients had 73% higher odds of this type of report.
- Females had 26% higher odds of receiving this type of services compared to males.
- Age had a U-shaped association with receiving inpatient or emergency psychiatric services: 37% of the 18 – 29 age group had a report of this kind, decreasing to 32% in the 55 – 64 age group and increasing to 36% among recipients ages 65 or older.

'Missing, Cannot be Located' Reports

- White recipients had 46% lower odds of having a "missing" report while Black recipients had 64% higher odds and Hispanic recipients had 18% higher odds of this type of report.
- Female recipients were 13% less likely to be reported as missing compared to males.
- "Missing" reports steadily declined with age: 42% of the 18 – 29 age group had this type of report, down to 16% in the group ages 65 or older.

Outcomes Based on 6-Month Assessments

Outcome analysis compares the intake and most recent assessment levels of AOT and ACT cohorts on selected outcome measures. The two cohorts are then compared on these pre-post differences. Only individuals with data on both pre- and post-measure are included in this cohort-specific analysis to ensure that the same group of recipients are being included in the comparisons. The sample for the outcome analysis consists of 8,437 AOT recipients whose first assessment was on or after January 1, 2016, and last assessment on or before February 25, 2025, and 5,949 ACT participants with first and last assessments during the same period.

Although the AOT recipients and voluntary ACT participants are somewhat similar in their diagnoses and service models, they differ on multiple factors as measured prior to and at the start of their treatment. We conducted a comprehensive comparison of differences between the two cohorts and constructed a propensity model. The model predicts the probability of being in the AOT cohort given the characteristics that differ between the two cohorts. These probabilities, called "propensity scores," are used to create a weighting system to correct for the differences. The next section describes the propensity weighting system that was used to compare the outcomes of AOT and ACT cohorts.

There are two types of significance testing conducted as part of the outcome analysis. First, we tested whether the changes between intake and latest assessment are significant. For this purpose, we estimated multivariate general linear regression models with the measure as dependent variable and a flag indicating pre/post time point as independent variable. Covariates in these models were treatment duration and the person's approximate age at intake. Second, we estimated difference-in-differences models to test whether the change between pre and post time points is significantly different for the two cohorts. These models had the measure as dependent variable. The independent variables were the time-point flag (pre or post), cohort flag, and their interaction term and the covariate was treatment duration. These cohort comparison models were propensity-weighted to balance out cohort differences that could potentially confound the cohort effects. The next section describes the relevant cohort differences that were balanced by this weighting technique.

Treatment Engagement and Health Maintenance

Data for this section come from CAIRS assessments. Exhibits 4.24 and 4.25 compare levels of treatment compliance and capacity to manage own health between intake and latest assessments, for

the AOT and voluntary ACT cohorts, respectively. The results are similar for both cohorts indicating that capacity to maintain their own health without support significantly increased between intake and last assessment, as evidenced by significant decreases in the amount of support needed to manage one's own health, medications, and stressful life events. While the level of medication adherence significantly increased, engagement with treatment staff significantly decreased for both cohorts, suggesting the need for increased effort by AOT and voluntary ACT service providers to better engage their clients. There was no significant change in the prevalence of substance use disorder (SUD) diagnosis in either cohort between intake and latest assessment. The prevalence of an SUD diagnosis could be affected either by changes in the recipient's behavior or by changes in the level of undiagnosed (hence untreated) SUD. It is unclear how these different factors combined to yield the overall results of "no change"; therefore, it is not possible to characterize these result as either positive or negative outcomes.

Exhibit 4.24. *Factors Related to Treatment Compliance and Health Maintenance among AOT Recipients*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Engagement with Treatment Staff			**8,233**	**Significant Decrease**
None or minimal	31.0%	33.4%		
Somewhat or well	69.0%	66.6%		
Medication Adherence			**7,350**	**Significant Increase**
Takes sometimes, rarely, or entirely refuses	48.4%	36.3%		
Takes as exactly prescribed most or all of the time	51.6%	63.7%		
Substance Use			**7,859**	**No Significant Change**
Has current substance use disorder diagnosis	30.0%	30.5%		
Support Needed to Manage Own Health			**7,534**	**Significant Decrease**
No support need	32.5%	37.4%		
Some support need	40.7%	37.4%		
Significant support need or total dependence	26.9%	25.3%		
Support Needed to Manage Own Medications			**7,612**	**Significant Decrease**
No support need	16.6%	19.2%		
Some support need	32.0%	35.1%		
Significant support need or total dependence	51.4%	45.8%		
Support Needed to Manage Stressful Life Events			**7,432**	**Significant Decrease**
No support need	12.2%	19.8%		
Some support need	43.1%	45.9%		
Significant support need or total dependence	35.1%	27.5%		

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is $p<0.05$.

Exhibit 4.25. *Factors Related to Treatment Compliance and Health Maintenance among Voluntary ACT Participants*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Engagement with Treatment Staff			**5,894**	**Significant Decrease**
None or minimal	33.6%	39.3%		
Somewhat or well	66.4%	60.7%		
Medication Adherence			**4,841**	**Significant Increase**
Takes sometimes, rarely, or entirely refuses	58.7%	43.8%		
Takes as exactly prescribed most or all of the time	41.3%	56.2%		
Substance Use			**5,733**	**No Significant Change**
Has current substance use disorder diagnosis	36.0%	34.7%		
Support Needed to Manage Own Health			**5,449**	**Significant Decrease**
No support need	19.9%	25.3%		
Some support need	43.9%	42.2%		
Significant support need or total dependence	36.2%	32.6%		
Support Needed to Manage Own Medications			**5,343**	**Significant Decrease**
No support need	10.1%	10.9%		
Some support need	30.1%	35.1%		
Significant support need or total dependence	59.8%	54.0%		
Support Needed to Manage Stressful Life Events			**5,367**	**Significant Decrease**
No support need	5.8%	10.4%		
Some support need	37.6%	45.3%		
Significant support need or total dependence	46.9%	37.0%		

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is $p<0.05$.

Exhibit 4.26 summarizes the results of propensity-weighted outcome comparisons between the AOT and voluntary ACT cohorts. The AOT cohort had significantly better outcomes in improving engagement with staff and managing stressful events. The voluntary ACT cohort had a significantly higher increase in medication management. The voluntary ACT cohort also had higher reduction in the rate of substance use disorder diagnoses compared to the AOT cohort, although reductions were not significant for either

cohort. There were no significant cohort differences in outcomes associated with managing one's own health and medications and in managing stressful events.

Exhibit 4.26. *Adjusted* and Weighted** Cohort Comparisons of Change in Factors Related to Treatment Compliance and Health Maintenance*

Measure	AOT Significantly Better	Voluntary ACT Significantly Better	No Significant Cohort Difference
Engagement with Treatment Staff	✓		
Medication Adherence		✓	
Substance Use		✓	
Support Needed to Manage Own Health			✓
Support Needed to Manage Own Medications			✓
Support Needed to Manage Stressful Life Events	✓		

*Adjusted for age and number of months in treatment.
**Inverse probability of treatment weights derived from the propensity model. Significance criterion is set at $p<0.05$.

Housing and Employment Status

Exhibits 4.27 and 4.28 compare housing status at first and latest assessment for AOT and voluntary ACT cohorts, respectively. The voluntary ACT group had higher rates of homelessness at both time points but in both cohorts, homelessness significantly declined between the two time points.

Over 90% of both cohorts were unemployed or only had sporadic work at first assessment and less than 1% were engaged in supportive employment or job training. At last assessment there was significant improvement in both groups with decreases in unemployment and increases in both supportive employment or job training and in competitive integrated employment. The employment analysis was restricted to people below age 65.

The AOT cohort experienced significantly higher improvements in housing status while there was no cohort difference in employment outcomes (Exhibit 4.29).

Exhibit 4.27. *Housing Status and Employment Among AOT Recipients*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Housing Status			***8,214***	**Significant Improvement**
Homeless or unstably housed	10.9%	8.5%		
Employment Status (Ages 18 – 64)			*7,450*	**Significant Improvement**
Unemployed or sporadic/casual work	95.4%	90.5%		
Sheltered/supportive employment or job	0.5%	1.3%		
Competitive, integrated employment	4.1%	8.2%		

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is p<0.05.

Exhibit 4.28. *Housing Status and Employment Among Voluntary ACT Participants*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Housing Status			***5,751***	**Significant Improvement**
Homeless or unstably housed	29.2%	17.6%		
Employment Status (Ages 18 – 64)			***5,382***	**Significant Improvement**
Unemployed or sporadic/casual work	97.0%	92.9%		
Sheltered/supportive employment or job	0.6%	1.4%		
Competitive, integrated employment	2.4	5.7%		

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is p<0.05.

Exhibit 4.29. *Adjusted* and Weighted** Cohort Comparisons of Changes in Housing and Employment Status*

Measure	AOT Significantly Better	Voluntary ACT Significantly Better	No Significant Cohort Difference
Housing Status	✓		
Employment Status			✓

*Adjusted for age and number of months in treatment.
**Inverse probability of treatment weights derived from the propensity model. Significance criterion is set at p<0.05.

Life Skills

Exhibits 4.30 and 4.31 summarize changes in life skills support for AOT recipients and voluntary ACT participants, respectively. The assessment questions that provided the data were prefaced with, “How much support does this person need to…” This outcome domain therefore measures the support needed by the individual to manage life events and situations, as assessed by the case manager or ACT team lead. Decreases in the need for support within these diverse aspects of community living indicate increased capacity for independent living, and are, therefore, positive treatment outcomes.

Most of the measures within this domain show positive outcomes (i.e., significant decreases in support need) for both AOT recipients and voluntary ACT participants. The significant decrease in the composite measure of support need, calculated as the average of the measures in this domain, is further evidence of an overall improvement in functionality in both cohorts.

For the AOT cohort, improvement in overall support need (the composite measure) was restricted to recipients who did not have significant support need at intake: Percentage of recipients with significant support needs or who were totally dependent on others remained practically unchanged between intake (12%) and latest assessment (13%). Voluntary ACT participants also showed a weak but somewhat different outcome pattern among this category of participants: Percentage of recipients who had significant support needs or were totally dependent on others slightly decreased from 16% to 15% between intake and latest assessment.

One notable exception is self-care and other activities of daily living (ADLs), for which support need significantly *increased* for AOT participants and showed no significant change in either direction for voluntary ACT participants. Another negative finding was the absence of any change, in either cohort, in support needs to respond to emergencies and to maintain safety. Independently performing ADLs, protecting oneself in dangerous situations, and appropriately responding to emergencies are crucial for successful community living; both cohorts will benefit from increased opportunities to practice these skills.

The two cohorts had different outcomes in managing appointments. AOT recipients significantly increased their capacity to make and keep appointments whereas voluntary ACT participants experienced no change in their need for support in this area.

Exhibit 4.30. *Support Needs Among AOT Recipients*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Support Needed to Communicate Clearly, Seek Help When Needed, Access Community Services			**5,784**	**Significant Decrease**
No support need	30.4%	38.9%		
Some support need	45.5%	39.6%		
Significant support need or total dependence	24.1%	21.5%		
Support Needed to Manage Personal Finances			**7,205**	**Significant Decrease**
No support need	27.5%	32.7%		
Some support need	36.4%	35.6%		
Significant support need or total dependence	36.1%	31.7%		
Support Needed to Make and Keep Appointments			**7,558**	**Significant Decrease**
No support need	22.1%	23.6%		
Some support need	36.4%	36.9%		
Significant support need or total dependence	41.5%	39.6%		
Support Needed to Organize Leisure Activities			**7,330**	**Significant Decrease**
No support need	33.2%	40.3%		
Some support need	41.6%	36.8%		
Significant support need or total dependence	25.3%	22.9%		

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Support Needed for Self-Care and Other Activities of Daily Living			**7,618**	**Significant Increase**
No support need	47.8%	47.4%		
Some support need	35.0%	31.3%		
Significant support need or total dependence	17.2%	21.3%		
Support Needed to Establish and Maintain Social Relationships			**7,552**	**Significant Decrease**
No support need	30.1%	36.8%		
Some support need	44.0%	38.7%		
Significant support need or total dependence	26.0%	24.5%		
Support Needed to Respond to Emergencies and Maintain Safety			**7,460**	**No Significant Change**
No support need	56.9%	56.0%		
Some support need	26.8%	27.5%		
Significant support need or total dependence	16.3%	16.5%		
Composite Score: Overall Support Need for Independent Living			**7,846**	**Significant Decrease**
No support need	43.4%	52.7%		
Some support need	44.5%	34.7%		
Significant support need or total dependence	12.1%	12.6%		

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

Exhibit 4.31. *Support Needs Among Voluntary ACT Participants*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Support Needed to Communicate Clearly, Seek Help When Needed, Access Community Services			**3,867**	**Significant Decrease**
No support need	21.1%	29.9%		
Some support need	48.6%	43.7%		
Significant support need or total dependence	30.3%	26.4%		
Support Needed to Manage Personal Finances			**5,288**	**Significant Decrease**
No support need	19.4%	25.4%		
Some support need	37.8%	39.6%		
Significant support need or total dependence	42.8%	35.0%		
Support Needed to Make and Keep Appointments			**5,444**	**No Significant Change**
No support need	14.1%	15.3%		
Some support need	36.2%	35.7%		
Significant support need or total dependence	49.8%	49.0%		
Support Needed to Organize Leisure Activities			**5,369**	**Significant Decrease**
No support need	19.4%	27.1%		
Some support need	46.3%	43.6%		
Significant support need or total dependence	34.3%	29.3%		
Support Needed for Self-Care and Other Activities of Daily Living			**5,457**	**No Significant Change**
No support need	33.4%	36.9%		
Some support need	41.4%	35.6%		
Significant support need or total dependence	25.2%	27.6%		

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Support Needed to Establish and Maintain Social Relationships			**5,461**	**Significant Decrease**
No support need	18.5%	25.4%		
Some support need	46.0%	44.2%		
Significant support need or total dependence	35.5%	30.4%		
Support Needed to Respond to Emergencies and Maintain Safety			**5,275**	**No Significant Change**
No support need	51.6	50.5		
Some support need	27.2	28.4		
Significant support need or total dependence	21.2	21.1		
Composite Measure: Overall Support Need for Independent Living			**5,618**	**Significant Decrease**
No support need	32.0%	44.4%		
Some support need	52.3%	40.9%		
Significant support need or total dependence	15.7%	14.7%		

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

We conducted a propensity-weighted cohort comparison of changes in the composite scale of overall support need for independent living. The propensity-weighted comparison, adjusting for age and treatment duration, found no significant outcome difference in this summary measure between AOT and voluntary ACT cohorts.

Risks of Harm to the Person Under Treatment

Exhibits 4.32 and 4.33 display three measures of risk of harm to AOT recipients and voluntary ACT participants: suicidal ideation, suicide attempt, and victimization by others during the six months preceding the assessment. Only people with 12 or more months between intake and last assessment were included in these tables to avoid overlapping lookback periods. Risk of harm to the person significantly decreased between intake and latest assessment for both cohorts.

Cohort comparison of changes in indicators of risk of harm to the person under treatment found no significant differences between AOT and voluntary ACT (Exhibit 4.44).

Exhibit 4.32. *Risk of Harm to Self – AOT Recipients*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Suicidal Ideation	18.4%	6.4%	4,213	**Significant Decrease**
Attempted Suicide	13.4%	3.7%	4,095	**Significant Decrease**
Became Victim of Abuse	1.8%	0.5%	2,768	**Significant Decrease**

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

Exhibit 4.33. *Risk of Harm to Self – Voluntary ACT Participants*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Suicidal Ideation	20.6%	6.6%	2,962	**Significant Decrease**
Attempted Suicide	12.8%	3.1%	2,858	**Significant Decrease**
Became Victim of Abuse	1.9%	0.5%	2,075	**Significant Decrease**

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

Exhibit 4.34. *Adjusted* and Weighted** Cohort Comparisons of Change in Risk of Harm to Self*

Measure	AOT Significantly Better	Voluntary ACT Significantly Better	No Significant Cohort Difference
Suicidal Ideation			✓
Attempted Suicide			✓
Became Victim of Abuse			✓

*Adjusted for age and number of months in treatment.
**Inverse probability of treatment weights derived from the propensity model. Significance criterion is set at $p<0.05$.

Risks of Harm to Others

The six-month assessments of AOT and voluntary ACT cohorts included eight risk factors associated with the risk of harm to others. Factor analysis identified five of these as strong indicators of a single construct that reliably measures risk of harm to others:

- Damaging property
- Causing a public disturbance
- Verbally assaulting someone
- Assaulting/abusing a child
- Acting in a physically violent manner toward someone

Additionally, we constructed a summary measure indicating that at least one of the five factors observed during the past six months. Exhibits 4.35 and 4.36 show changes in these five factors and the summary measure for the two cohorts. All five risk factors and the summary measure significantly decreased between intake and latest assessment for both cohorts.

Exhibit 4.35. *Risk of Harm to Others – AOT Recipients*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Property Damage	19.7%	6.7%	3,726	**Significant Decrease**
Public Disturbance	30.6%	9.9%	4,176	**Significant Decrease**
Verbal Assault	34.3%	10.6%	4,341	**Significant Decrease**
Child Assault	9.8%	3.7%	3,443	**Significant Decrease**
Physical Violence	30.2%	9.2%	4,568	**Significant Decrease**
Summary Measure: At Least One of the Five Risk Factors	33.5%	12.8%	6,492	**Significant Decrease**

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

Exhibit 4.36. *Risk of Harm to Others – Voluntary ACT Participants*

Measure	Intake %	Latest Assessment %	Total N	Result of Significance Test
Property Damage	14.4%	5.7%	2,457	**Significant Decrease**
Public Disturbance	24.1%	8.7%	2,806	**Significant Decrease**
Verbal Assault	24.9%	8.7%	2,832	**Significant Decrease**
Child Assault	7.4%	2.4%	2,259	**Significant Decrease**
Physical Violence	20.9%	7.0%	2,914	**Significant Decrease**
Summary Measure: At Least One of the Five Risk Factors	26.6%	11.5%	4,077	**Significant Decrease**

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

We conducted a cohort comparison of change in the likelihood of having at least one of the five indicators of risk of harm to others. The propensity-weighted comparison, adjusting for age and treatment duration, found that the AOT cohort had significantly better outcomes in this summary measure.

Outcomes Associated with Inpatient Service Utilization

Using Medicaid claims data, we calculated inpatient mental health service utilization indicators during 12 months before and 12 months after treatment start date. For this analysis, data were available for all three cohorts. Of the two cohorts without a court order, the voluntary ACT sample should be considered the "full" comparison group, since we had sufficient information for this group for a propensity model that balanced the relevant differences from the AOT cohort. As noted in the "Methodology and Approach" chapter, differences between the AOT and HH+ cohorts could not be sufficiently balanced out. However, we made some case selection decisions to bring this cohort's analysis sample as close to the other two cohorts as possible. The analysis only included HH+-eligible individuals with a serious mental illness diagnosis who received case management services for at least one year after they became eligible. Their date of first eligibility serves as a "synthetic" intake point for the purposes of this analysis.

We first calculated the percentage of people who had at least one hospitalization during each time period, using data from all individuals with valid information. We then focused on those who had one or more hospitalizations to calculate number of hospitalizations and inpatient nights. Exhibit 4.37 summarizes the results of this analysis for the three cohorts, without any propensity weighting, to provide information about the actual numbers. The significance testing of the pre-post change for the table is conducted within each cohort. In all three cohorts, the percent with at least one hospitalization significantly decreased between the two timepoints. Average number of hospitalizations significantly decreased for the voluntary ACT and HH+ cohorts but no significant change was observed for the AOT cohort. Average number of inpatient nights among those who were hospitalized decreased for the AOT and voluntary ACT cohorts but not for the HH+ cohort. Average length of hospital stay significantly decreased for the AOT and voluntary ACT cohorts but significantly increased for the HH+ cohort.

Exhibit 4.37. *Inpatient Mental Health Service Utilization 12 Months Before and 12 Months After Treatment Start Date*

	1 Year Before Intake	1 Year After Intake	Total N	Result of Significance Test
AOT Cohort				
Percent with at least One MH Hospitalization	51.9%	35.9%	6,405	**Significant Decrease**
Average Number of MH Hospitalizations among those with at least One MH Hospitalization	2.1	2.1	1,362	**No Significant Change**
Average Number of MH Inpatient Nights among those with at least One MH Hospitalization	78.7	69.1	1,362	**Significant Decrease**
Average Number of Inpatient Nights per MH Hospitalization	52.2	41.6	1,362	**Significant Decrease**
Voluntary ACT Cohort				
Percent with at least One MH Hospitalization	43.8%	30.6%	4,128	**Significant Decrease**
Average Number of MH Hospitalizations among those with at least One MH Hospitalization	2.5	2.2	786	**Significant Decrease**
Average Number of MH Inpatient Nights among those with at least One MH Hospitalization	58.1	46.8	786	**Significant Decrease**
Average Number of Inpatient Nights per MH Hospitalization	32.1	27.1	786	**Significant Decrease**
HH+ Cohort				
Percent with at least One MH Hospitalization	36.2%	21.5%	21,089	**Significant Decrease**
Average Number of MH Hospitalizations among those with at least One MH Hospitalization	2.2	2.0	2,767	**Significant Decrease**
Average Number of MH Inpatient Nights among those with at least One MH Hospitalization	31.8	32.5	2,767	**No Significant Change**
Average Number of Inpatient Nights per MH Hospitalization	16.8	19.1	2,767	**Significant Increase**

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

Propensity-weighted comparison of AOT and voluntary ACT cohorts' outcomes showed that the AOT cohort had significantly higher reductions in the percentage with one or more hospitalizations and the voluntary ACT cohort experienced significantly larger reductions in the number of hospitalizations. There were no significant cohort differences in the average number of inpatient nights, and average length of hospital stay (Exhibit 4.38).

Exhibit 4.38. *Weighted* Cohort Comparisons of Changes in the Utilization of Inpatient Mental Health Services among Individuals with at Least One Hospitalization*

Measure	AOT Significantly Better	Voluntary ACT Significantly Better	No Significant Difference
Change in the Likelihood of Having at Least One MH Hospitalization	✓		
Change in Average Number of MH Hospitalizations among those with at least One MH Hospitalization			✓
Change in Average Number of MH Inpatient Nights among Those with at Least One MH Hospitalization	✓		
Change in Average Number of Inpatient Nights per MH Hospitalization			✓

*Inverse probability of treatment weights derived from the propensity model. Significance criterion is set at $p<0.05$.

Outcomes Associated with Incarceration

Using Top Charge Data provided by the Division of Criminal Justice Services, we compared the following two indicators one year before and one year after treatment start (intake) date:

- Likelihood of having at least one arrest
- Average number of arrests

For this analysis, as with inpatient service utilization in the previous section, data were available for all three cohorts. Of the two cohorts without a court order, the voluntary ACT sample should be considered the "full" comparison group, since we had sufficient information for this group for a propensity model that balanced the relevant differences from the AOT cohort. As noted in the "Methodology and Approach" chapter, differences between the AOT and HH+ cohorts could not be sufficiently balanced out. However, we made some case selection decisions to bring this cohort's analysis sample as close to the other two cohorts as possible. The analysis only included HH+-eligible individuals with a serious mental illness diagnosis who received case management services for at least one year after they became eligible. Their date of first eligibility serves as a "synthetic" intake point for the purposes of this analysis.

As seen in Exhibit 4.39, there were statistically significant decreases between the two timepoints for all three cohorts. Propensity-weighted comparison of AOT and voluntary ACT cohorts showed significantly better outcomes in the voluntary ACT cohort for both indicators (Exhibit 4.40).

Exhibit 4.39. *Arrests During the 12 Months Before and 12 Months After Treatment Start Date*

	1 Year Before Intake	1 Year After Intake	Total N	Result of Significance Test
AOT Cohort				
Likelihood of Having at Least One Arrest	19.7%	15.6%	7,994	**Significant Decrease**
Average Number Arrests among those with at least One Arrest	1.9	0.7	1,577	**Significant Decrease**
ACT Cohort				
Percent with at least One Arrest	21.0%	15.3%	5,332	**Significant Decrease**
Average Number Arrests among those with at least One Arrest	2.2	0.9	1,119	**Significant Decrease**
HH+ Cohort				
Percent with at least One Arrest	15.6%	12.7%	24,899	**Significant Decrease**
Average Number Arrests among Those with at Least One Arrest	2.0	0.8	3,892	**Significant Decrease**

Note: Numbers in the "Total N" column are total numbers of individuals with valid data at both intake and latest assessment for each indicated measure. Significance criterion is set at $p<0.05$.

Exhibit 4.40. *Weighted* Cohort Comparisons of Changes in the Likelihood and Number of Arrests*

Measure	AOT Significantly Better	Voluntary ACT Significantly Better	No Significant Difference
Change in the Likelihood of Having at Least One Arrest		✓	
Change in the Number Arrests among Those with at Least One Arrest		✓	

*Inverse probability of treatment weights derived from the propensity model. Significance criterion is set at $p<0.05$.

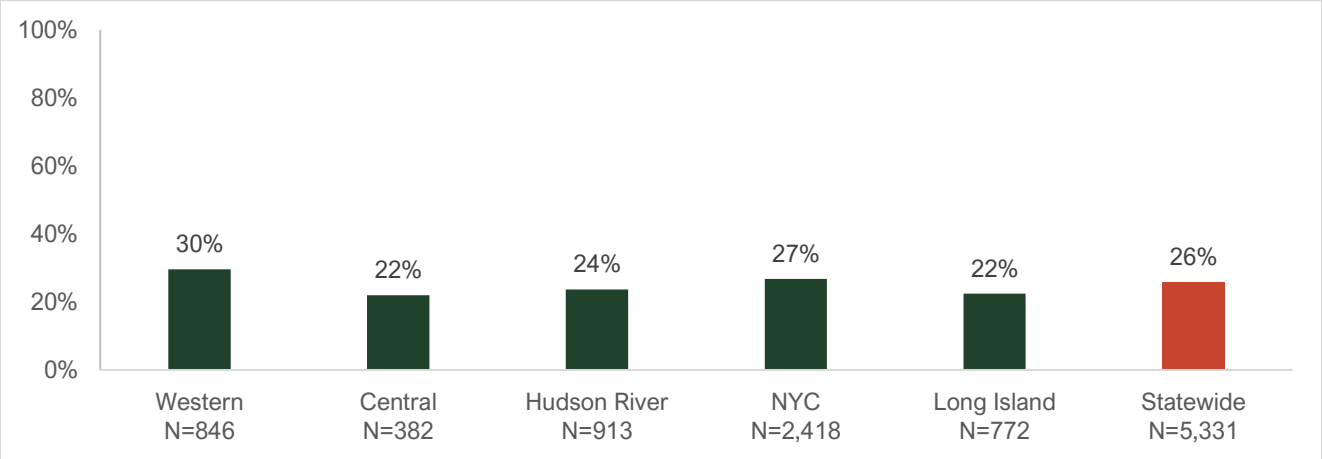
Improvements in Outcome Measures by Demographic Characteristics and Region

This section summarizes the results of analyses focused on the likelihood of AOT recipients to improve on the six key outcome measures of the evaluation: Life skills, housing status, employment status, inpatient mental health service utilization, and arrests. Recipients who had no room for improvement at the first timepoint (pre) and remained unchanged at the second timepoint (post) are excluded from the analyses.

Increases in Life Skills

As described in more detail earlier in this chapter, the measure of life skills, or put slightly differently, the capacity for independent living, is a multi-item scale combining the amount of support that the person needs to manage seven key activities of daily living (see Exhibit 4.30). Of the 5,331 recipients in our sample who had less than a perfect score at intake, 26% showed improvement at the latest assessment. We found no significant differences in age, sex, or race/ethnicity in the likelihood of improving on this measure. There were, however, regional differences as shown in Exhibit 4.41. The Western Region had a significantly higher improvement rate (30%) compared to other regions except New York City where the rate was comparable (27%).

Exhibit 4.41. *Percentage of AOT Recipients who Improved on the Life Skills Scale, by Region*



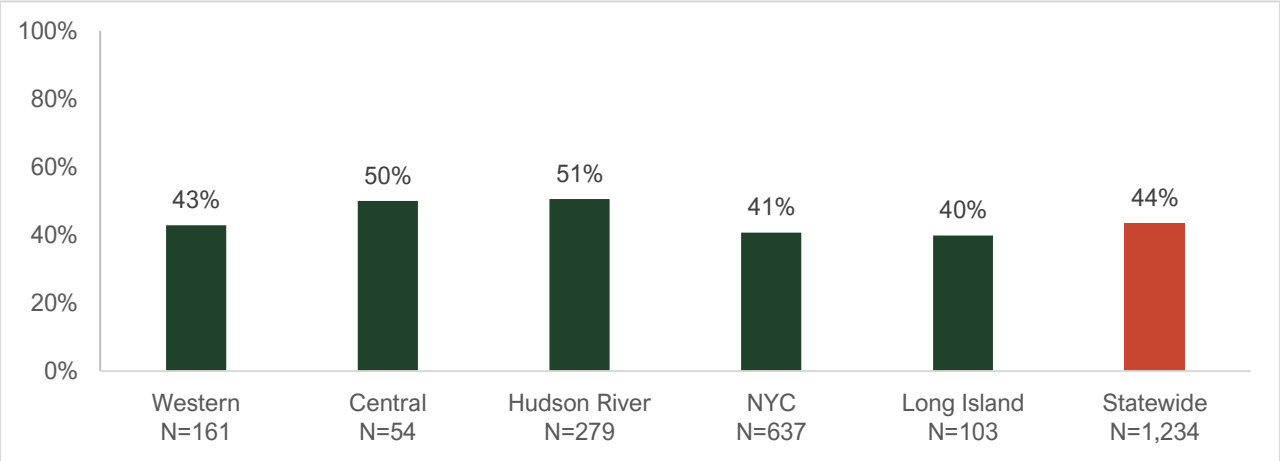
Note: N indicates the number of AOT recipients who had any room for improvement at intake assessment.

Improvements in Housing Status

Statewide, there were 1,234 AOT recipients who were homeless or unstably housed at intake and 44% were stably housed at last assessment. There were no significant sex and race/ethnicity differences in improvement rates. There was a significant age difference such that recipients ages 40 or older had a significantly higher rate (48%) than those ages 18 – 39 (41%). There were also some regional differences as seen in Exhibit 4.42. The Hudson River region had the highest rate of

improvement (51%)—significantly higher than New York City (41%), but not significantly different from the rest of the regions.

Exhibit 4.42. *Percentage of AOT Recipients who Improved Their Housing Status, by Region*



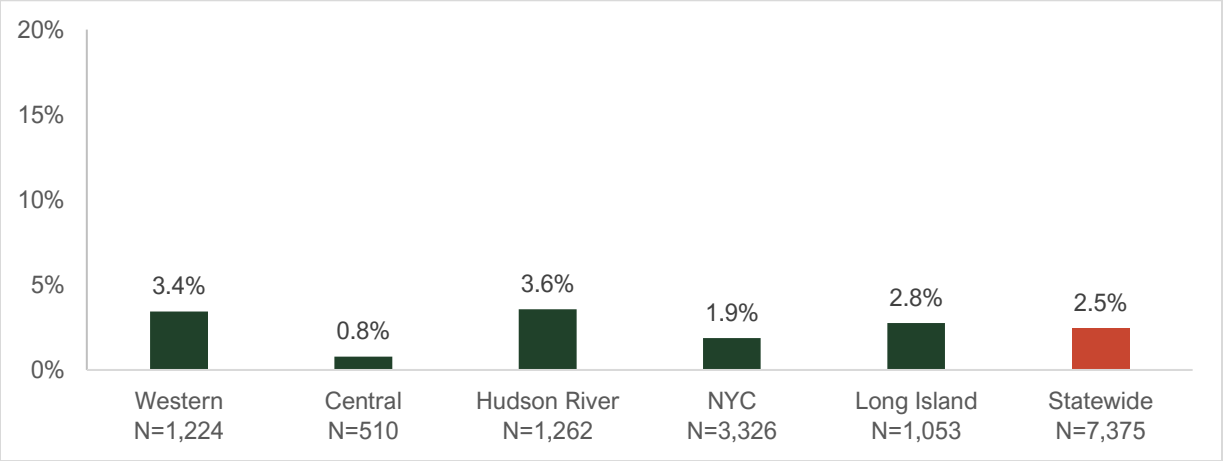
Note: N indicates the number of AOT recipients who were homeless or unstably housed at intake assessment.

Improvements in Employment Status

Employment status was coded into three categories: (1) unemployed or only has sporadic/casual work, (2) engaged in sheltered/supportive employment or job training, and (3) engaged in competitive, integrated employment. Any change in the direction from (1) to (3) was defined as an improvement. AOT recipients who were in category (3) at intake and stayed in that category through the last assessment were excluded from this analysis, as were people ages 65 or older. Of the remaining 7,375 recipients, only 2.5% showed an improvement in their employment status.

There was no significant sex difference in improvement rates while recipients ages 40 -64 had a significantly lower improvement rate (1.4%) compared to those ages 18 – 39 (3.0%) and Black/African American recipients had a significantly lower rate (2.0%) compared to other race/ethnicity groups (2.8%). Exhibit 4.43 shows regional differences in improvement rates. The Hudson River region had the highest rate (3.6%) followed by the Western region (3.4%) and Long Island (2.8%). There were no significant differences among these three regions but all three had rates significantly higher than the Central region. New York City's rate was also higher than the Central region but did not significantly differ from Long Island.

Exhibit 4.43. *Percentage of AOT Recipients who Improved Their Employment Status, by Region*



Note: N indicates the number of AOT recipients who had any room for improvement at intake assessment.

Declines in Inpatient Mental Health Service Utilization

As mentioned earlier in this chapter, the two timepoints for detecting change in inpatient service utilization were one year before and one year after intake (Time 1 and Time 2, respectively). In analyzing declines in inpatient service utilization between the pre and post timepoints, we used three separate definitions of improvement among those who had at least one hospitalization at Time 1, to represent multiple aspects of service utilization:

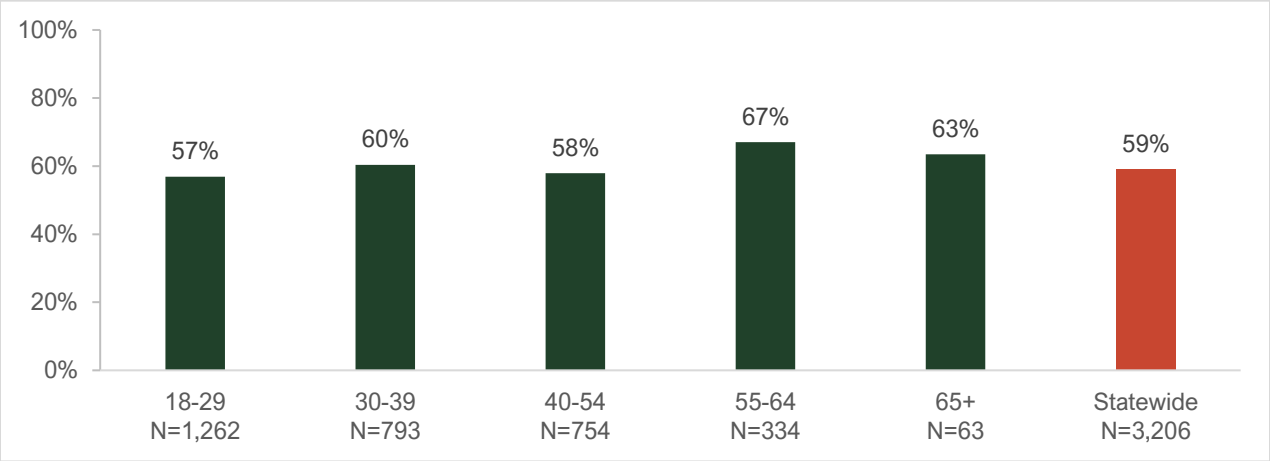
1. No post hospitalizations by Time 2.
2. The number of hospitalizations decreased by Time 2.
3. The total number of inpatient nights decreased by Time 2.

Individuals who had no hospitalizations during this two-year period were not included in these analyses. We did not include declines in the average length of hospital stays in the improvement analysis because inpatient nights per hospital stay cannot be calculated for people who had no hospitalizations at Time 2, even though they may have improved.

At Least One Hospitalization

There were 3,323 AOT recipients with at least one mental health hospitalization at Time 1 and over half (59%) of them had no hospitalizations at Time 2. There were no sex differences in this improvement rate. Recipients who identified as Black or African American had a significantly lower improvement rate (57%) compared to all other race/ethnicity groups (61%) and those who identified as White and reported no additional race/ethnicity affiliations had a significantly higher improvement rate (63%) compared to other groups (57%). Improvement rates varied by age as shown in Exhibit 4.44. Recipients ages 55 – 64 had the highest improvement rate (67%) followed by the 65+ age group (63%). There was no significant difference between these two groups but both their rates were significantly higher than the younger age groups.

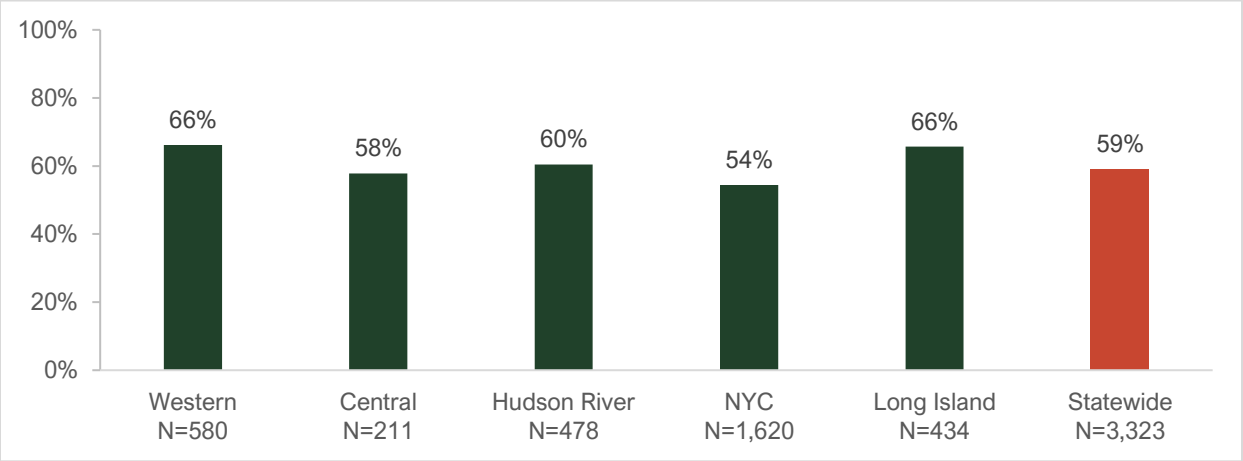
Exhibit 4.44. *Percentage of AOT Recipients who Had No Hospitalizations during the Year Following Intake Among Those Who Had at Least One Hospitalization During the Year Preceding Intake, by Age Group*



Note: N indicates the number of AOT recipients who had at least one hospitalization during the year preceding intake.

There are regional differences in hospitalization improvement rates as well (Exhibit 4.45). The Western region and Long Island have the highest improvement rates (66%) followed by the Hudson River region (60%). There are no significant differences among these three regions and their rates are significantly higher than the remaining two regions.

Exhibit 4.45. *Percentage of AOT Recipients who Had No Hospitalizations during the Year Following Intake Among Those Who Had at Least One Hospitalization During the Year Preceding Intake, by Region*



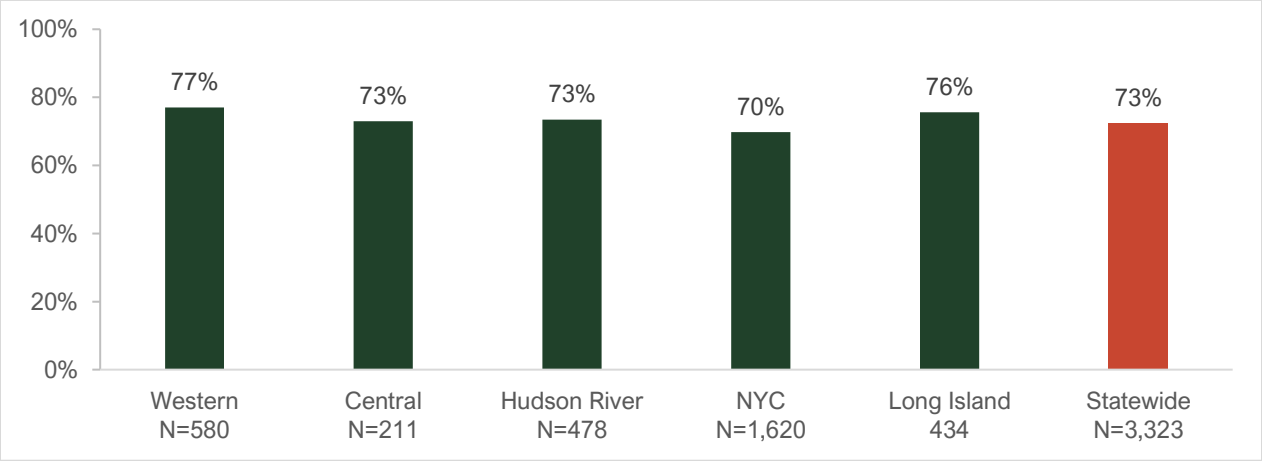
Note: N indicates the number of AOT recipients who had at least one hospitalization during the year preceding intake.

Number of Hospitalizations

Of the 3,323 recipients with at least one mental health hospitalization during the year preceding intake, 73% had a lower number of hospitalizations during the year following intake. There were no

significant differences in this percentage by age, sex, and race/ethnicity, although regional differences were observed, as seen in Exhibit 4.46. The Western region and Long Island had the highest improvement rates in the number of hospitalizations (77% and 76%, respectively), and New York City had a significantly lower rate (70%) than the highest two regions.

Exhibit 4.46. *Percentage of AOT Recipients who Decreased Their Total Number of Hospitalizations, by Region*

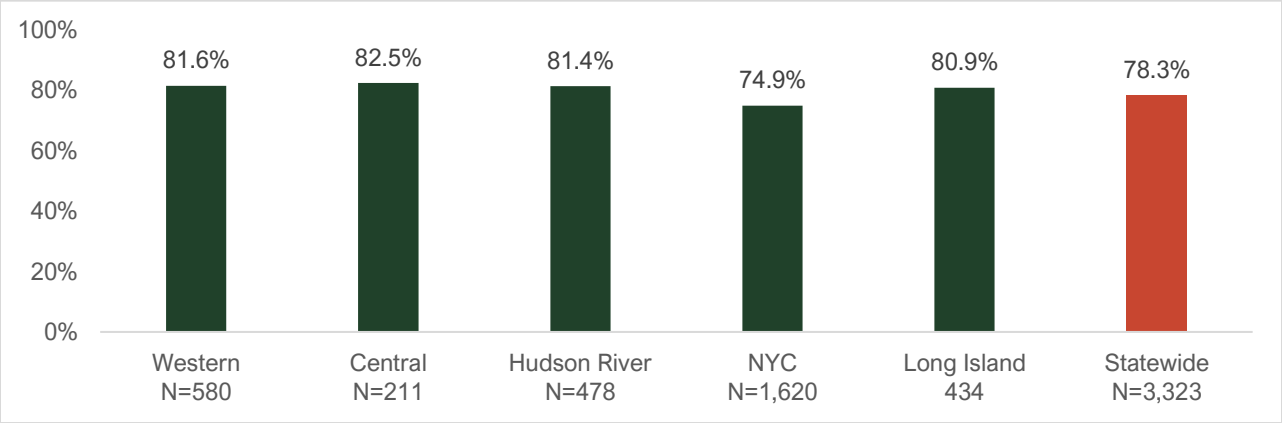


Note: N indicates the number of AOT recipients who had at least one hospitalization during the year preceding intake.

Number of Inpatient Nights

Of the 3,323 recipients with at least one mental health hospitalization during the year preceding intake, 78% decreased their total number of inpatient nights during the year following intake. There were no significant differences in this rate by age, sex, and race/ethnicity. The only significant regional difference was between New York City (75%) and the rest of the regions where the rate ranged between 81% and 82% (Exhibit 4.47).

Exhibit 4.47. *Percentage of AOT Recipients who Decreased Their Total Number of Inpatient Nights, by Region*



Declines in Incarceration

As mentioned earlier in this chapter, the two timepoints for detecting change in incarceration were one year before and one year after intake (Time 1 and Time 2, respectively). In analyzing declines in arrests between the pre and post timepoints, we used two indicators of improvement:

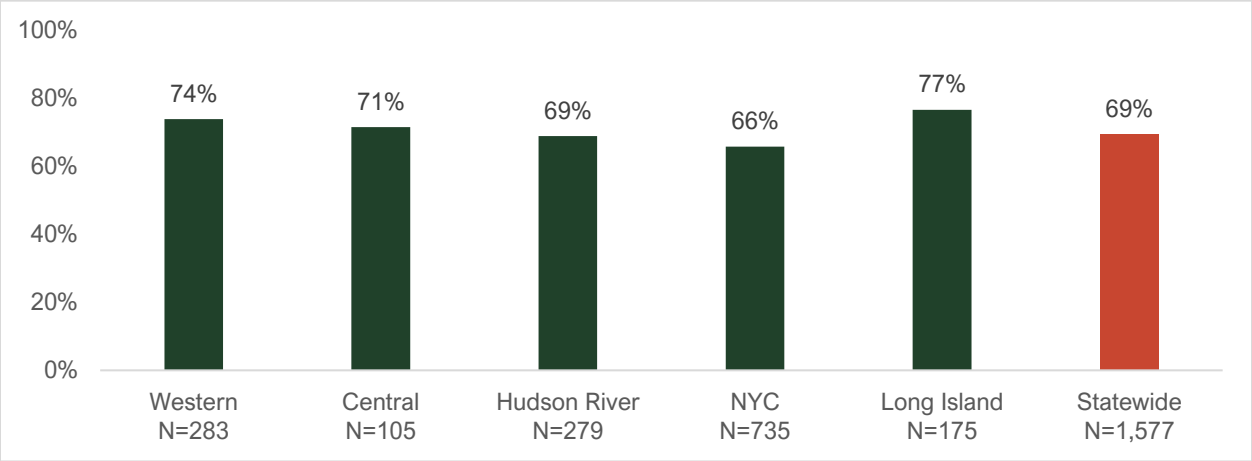
1. At least one arrest during Time 1 and no arrests by Time 2;
2. At least one arrest during Time 1 and the number of arrests declined by Time 2.

Individuals who had no arrests during this two-year period were not included in these analyses.

At Least One Arrest

Of the 1,577 AOT recipients who had at least one arrest during the year before intake, 69% had no arrests during the year after intake. Female recipients had a significantly higher percentage (75%) than their male peers (68%). Black recipients had a significantly lower percentage (64%) compared to the other race/ethnicity groups (74%) and recipients who identified as White only had a significantly higher percentage (79%) compared to others (66%). Recipients ages 40 or older had a higher percentage (76%) than those ages 18 – 39 (68%). Regional differences are shown in Exhibit 4.48. Long Island and the Western region had significantly higher percentages (77% and 74%, respectively) compared to the other three regions. New York City had the lowest percentage (66%).

Exhibit 4.48. *Percentage of AOT Recipients Who Had No Arrests During the Year Following Intake Among Those Who Had at Least One Arrest During the Year Preceding Intake, by Region*



Number of Arrests

Of the 1,577 AOT recipients who had at least one arrest during the year before intake, 80% had decreased the number of times they were arrested during the year following intake. Black recipients had a significantly lower percentage (76%) compared to all other race/ethnicity groups (83%) and White-only recipients had a higher percentage (86%) than the other groups (77%). No significant age, sex, and regional differences were found in the percentage who decreased the number of times they were arrested.

Factors Associated with AOT Outcomes

In this section, we report the results of analyses investigating the factors associated with the outcomes of AOT recipients. Again, we focus on the following outcomes:

1. Improvements in life skills (sometimes referred to as “functionality”) that correlate with the ability to live on one’s own;
2. Improvements in housing status
3. Improvements in employment status;
4. Decreases in inpatient mental health service utilization; and
5. Decreases in arrests.

The sample for this analysis consists of 8,437 individuals whose first AOT episode[4] started between 2016 and 2023. An improvement in the outcome measure between the first and last assessments of that episode (Time 1 and Time 2) constitute the dependent variables of the analysis for outcomes 1–3 above. For outcomes 4 and 5, we focused on improvements between the years preceding (Time 1) and following (Time 2) the initial AOT order. Cases where an outcome measure remained unchanged between Times 1 and 2 *and* there was no room for improvement at Time 1 are not included in the analysis for that outcome. Exhibit 4.49 shows overall improvement rates by outcome measure.

Exhibit 4.49. *Improvement Rates by Outcome Measure*

Measure	Percent Improved	N
Life Skills	25.7%	5,331
Housing Status	43.5%	1,234
Employment Status	2.5%	7,888
At least One MH Hospitalization	59.0%	3,323
Number of MH Hospitalizations	72.5%	3,323
Number of MH Inpatient Nights	78.3%	3,323
Average Length of Stay per MH Hospitalization	54.0%	1,362
At Least One Arrest	69.3%	1,577
Number of Arrests	79.5%	1,577

Note: N indicates the number of AOT recipients who had valid data for calculating the percentage.

There are obviously a large number of factors that mediate or moderate treatment outcomes. Rather than a complete and exhaustive investigation of all potential such factors for which data were available, we selected a smaller set of factors that have program and policy implications. It is important to keep in mind that the results reported in this section only suggest correlation, not causation.

[4] In this evaluation, an AOT episode is defined as a period starting with an initial AOT order followed by a sequence of renewal orders and ending with a non-renewal determination.

Diagnoses

The majority of AOT recipients in this sample have three primary diagnoses: Schizophrenia and related psychoses (74%), bipolar disorder (21%), and serious depressive disorder (9%).[5] Additionally, we investigated whether there was any diagnosis of a personality disorder or substance use disorder, two conditions that came up during interviews with providers as affecting treatment responses.

Schizophrenia and Related Psychoses

Bivariate analysis among recipients who were homeless at Time 1 found that those who had a primary diagnosis of schizophrenia were more likely to improve their housing status (45%) compared to those without this diagnosis. On the other hand, they were less likely to improve their employment status (2%). People with schizophrenia also had lower improvement rates of having at least one hospitalization (58%) and reducing their numbers of hospitalizations (72%) compared to those without this diagnosis.

Bipolar Disorder

Those with a primary diagnosis of bipolar disorder were more likely than others to improve their employment status (4%) but less likely than others to decrease their likelihood of having at least one hospitalization (55%), number of hospitalizations (70%), total inpatient nights (75%), average length of stay per hospitalization (48%), and the number of arrests (75%).

Serious Depressive Disorder

The only significant outcome impact of serious depressive disorder was in the number of arrests among those with at least one arrest at Time 1. People with this diagnosis had a lower improvement rate on this outcome (71%) compared to others.

Personality Disorders

We tested the impact of having any personality disorder diagnosis (typically secondary diagnoses in our sample) during the treatment period based on interviews with providers who reported challenges in engaging people with these disorders. We found that AOT recipients with this diagnosis have significantly lower improvement rates in the likelihood of at least one hospitalization (50%) and in the number or arrests (71%).

Substance Use Disorders

Challenges in treating people with serious mental illness who also had a substance use disorder also emerged as a theme in our qualitative analysis. We found that the AOT recipients with this diagnosis have significantly lower improvement rates in having at least one arrest (64%) and in the number of arrests (74%).

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[5] These numbers add up to slightly more than 100% due to rounding or a change in primary diagnosis during the treatment period, or both.

Services Received

Based on qualitative analysis of interviews conducted with service users, providers, and AOT administrators, we selected three service types for outcome testing.

Psychosocial Rehabilitation Services

Forty-nine percent of the sample received psychosocial rehabilitation services. These recipients had a significantly higher improvement rate in employment status (3%), number of MH hospitalizations (75%), number of MH inpatient nights (81%), and the likelihood of having at least one arrest (73%).

Comprehensive Community Supports

Twenty-eight percent of the sample received either comprehensive community supports. We did not find any significant association between receiving these services and improvements in life skills, housing status, or employment status, as suggested by qualitative findings. There were significant negative associations between receiving these services and improvement rates in inpatient MH service utilization. Recipients of these services were less likely than others to improve on the likelihood of at least one hospitalization (55%) and the number of hospitalizations (67%). It is possible that confounding factors are influencing these results. For example, AOT recipients judged to be more capable of independent living may be more likely to receive these services and have less room for improvement for the same reason. We were unable to fully control for this confounding effect because the available data were insufficient to accurately identify this group of recipients.

Health Home Plus Services

Forty-five percent of the sample received Health Home Plus services during their treatment period. These recipients had significantly higher improvement rates in the likelihood of at least one MH hospitalization (63%), number of MH hospitalizations (76%), number of MH inpatient nights (81%), likelihood of having at least one arrest (75%), and the number of arrests (82%). They had significantly lower improvement in their housing status (38%), probably because they were less likely to be homeless or unstably housed both at Time 1 and Time 2.

Outpatient Follow-up Visit After Psychiatric Emergencies and Hospital Discharges

Based on Medicaid claims data, we created flags for outpatient follow-up visits within a week and a month following psychiatric emergency department visits and mental health hospital discharges; these follow-up strategies are known to reduce hospital readmissions and crisis recurrence.[6,7] The

[6] Carter, J., Anoruo, N., & Schnipper, J. (2025). Refreshing the Evidence on Hospital Post-Discharge Follow-Up—Moving the Needle Against All Odds. *JAMA Network Open*. e2541281. doi:10.1001/jamanetworkopen.2025.41281.

[7] McCullumsmith, C., Clark, B., Blair, C., Cropsey, K., & Shelton, R. (2015). Rapid Follow-Up for Patients After Psychiatric Crisis. *Community Mental Health Journal. 51*, 139–144. doi.org/10.1007/s10597-014-9782-z.

flags were set if the person had at least one indicated follow-up during their treatment period. Exhibit 4.50 shows the prevalence of these follow-up visits in our sample.

Exhibit 4.50. *Percentage of AOT Recipients with Outpatient Follow-up Visits After an Emergency Department (ED) Visits and Mental Health Hospital Discharge*

Measure	%	N
7-Day Outpatient Follow-up after a Psychiatric ED Visit	17.0%	1,760
30-Day Outpatient Follow-up after a Psychiatric ED Visit	35.0%	1,901
7-Day Outpatient Follow-up after a Mental Health Hospital Discharge	53.8%	3,544
30-Day Outpatient Follow-up after a Mental Health Hospital Discharge	57.9%	3,728

Note: N indicates the number of AOT recipients who had valid data for calculating the percentage.

Bivariate comparisons of improvement rates between those who had and did not have the four outpatient follow-up types showed significant positive associations with outcomes:

- 7-day ED follow-up visits were associated with higher improvements in the number of MH inpatient nights (75%) and average length of MH hospital stays (65%);
- 30-day ED follow-up visits were associated with higher improvements in the number of inpatient nights (71%), likelihood of having at least one arrest (66%), and the number of arrests (78%);
- 7-day hospital discharge follow-up visits were associated with higher improvements in life skills (31%), number of inpatient nights (68%), likelihood of having at least one arrest (65%), and number of arrests (76%);
- 30-day hospital discharge follow-up visits were associated with higher improvements in the likelihood of at least one hospitalization ((41%), number of hospitalizations (60%), number of inpatient nights (71%), likelihood of having at least one arrest (66%), and number of arrests (78%).

Treatment Duration

For the purposes of this analysis, treatment duration was calculated as the number of months between the first and last assessments within the recipient's first AOT episode.[8] Treatment duration in

[8] An AOT "episode" is the period starting with the initial court order followed by consecutive renewal orders, and ending with a non-renewal determination.

this sample of AOT recipients ranged between less than a month and 108 months with a mean of 39 months and a median of 30 months. The relationship between treatment duration and treatment outcomes is complex. On one hand, treatment duration is a measure of dosage, which is expected to improve outcomes. On the other hand, symptom severity is negatively associated with outcomes *and* is likely to increase treatment duration. The interplay between the opposing dosage and severity effects resulted in different non-linear relationship between treatment duration and each of the outcomes. Available data were not sufficient to effectively control for the level of symptom severity. As a feasible alternative, we investigated the pattern of change in each outcome as treatment duration increased, and identified outcome-specific optimal duration periods.

For improvements in life skills, and housing status, the most meaningful duration cut point was 30 months, that is, the median duration of the sample. Life skills improvement rate at 1 – 30 months was 25%, increasing to 27% at 31+ months. Housing status improvement rate at 1 – 30 months was 41%, increasing to 46% at 31+ months. We found no association between treatment duration and improvement in employment status, most probably because the overall improvement rate was very low (2.5%).

The hospitalization and arrest outcomes were calculated by comparing 12 months before and after intake. For these outcomes, we found the optimal duration cut point to be 10 months. Comparison of improvement rates in outcomes related to hospitalizations and arrests before and after the 10-month cut point were as follows:

- **At least one hospitalization**. 1 – 10 months: 71%, 11+ months: 75%
- **Number of hospitalizations**. 1 – 10 months: 84%, 11+ months: 85%
- **Number of inpatient nights**. 1 – 10 months: 83%, 11+ months: 89%
- **Average length of hospital stay.** 1 – 10 months: 52%, 11+ months: 61%
- **At least one arrest**. 1 – 10 months: 70%, 11+ months: 81%
- **Number of arrests**. 1 – 10 months: 79%, 11+ months: 88%

In sum, although treatment duration does not have a clearly defined linear relationship with improvement rates, it was possible to identify cut points in the number of months of treatment such that rates above the cut points were higher than those below.

Contextual Factors

To test the association between regional characteristics and outcomes, we merged the person-level AOT sample with a region-level database consisting of data from the DCS Survey and publicly available secondary sources.

For this part of the analysis, the four hospital-related outcome measures were combined into a single improvement indicator, coded 1 if the person showed an improvement in any one of the four measures: at least one hospitalization, number of hospitalizations, number of inpatient nights, or average length of hospital stay, and 0 otherwise. Likewise, the two arrest measures were combined

into a single improvement indicator, coded as 1 if there was a decrease in the likelihood of at least one arrest or the number of arrests. Improvement in employment status was not included in this analysis because the low prevalence of improvement in the overall sample (2.5%) was a barrier to valid analysis. We estimated multilevel general linear models with region as the clustering factor to test for associations.

The regional factors we found to be associated with at least one of our outcome variables are discussed below. The significant associations reported below do not necessarily imply a direction of causality.

Median Days of Stay at an Emergency Shelter, Safe Haven Housing, or Transitional Housing. Data source for this factor is the U.S. Department of Housing and Urban Development's System Performance Measures Database. Across the five OMH regions, the measure ranged between 34 and 161 days with a mean of 81 days. AOT recipients living in a region with higher median days of stay had significantly lower likelihood of improving their housing status.

Supported Housing Occupancy Rate. Data source for this factor is the OMH County Needs Assessment Database. Across the five OMH regions, the measure ranged between 80% and 87% with a mean of 85%. We found a positive association with this regional rate and the rate of improvement in housing status.

Percent of the Population Living in Rural Areas. Data source for this factor is the U.S. Census Bureau. The regional averages ranged between 0% to 45% with a mean of 19%. This regional factor was negatively associated with improvement in housing status but positively associated with improvements in MH hospitalization-related outcomes.

Strength of Outpatient Clinical Services. Data source for this factor is the DCS Survey. County administrators were asked to rate the strength of their county's service system in several areas, on a scale of 1 (none or minimum strength) to 5 (maximum strength). Regional averages ranged between 3 and 4 with a mean of 3.6. This regional factor was positively associated with housing status and MH hospitalization-related improvement rates.

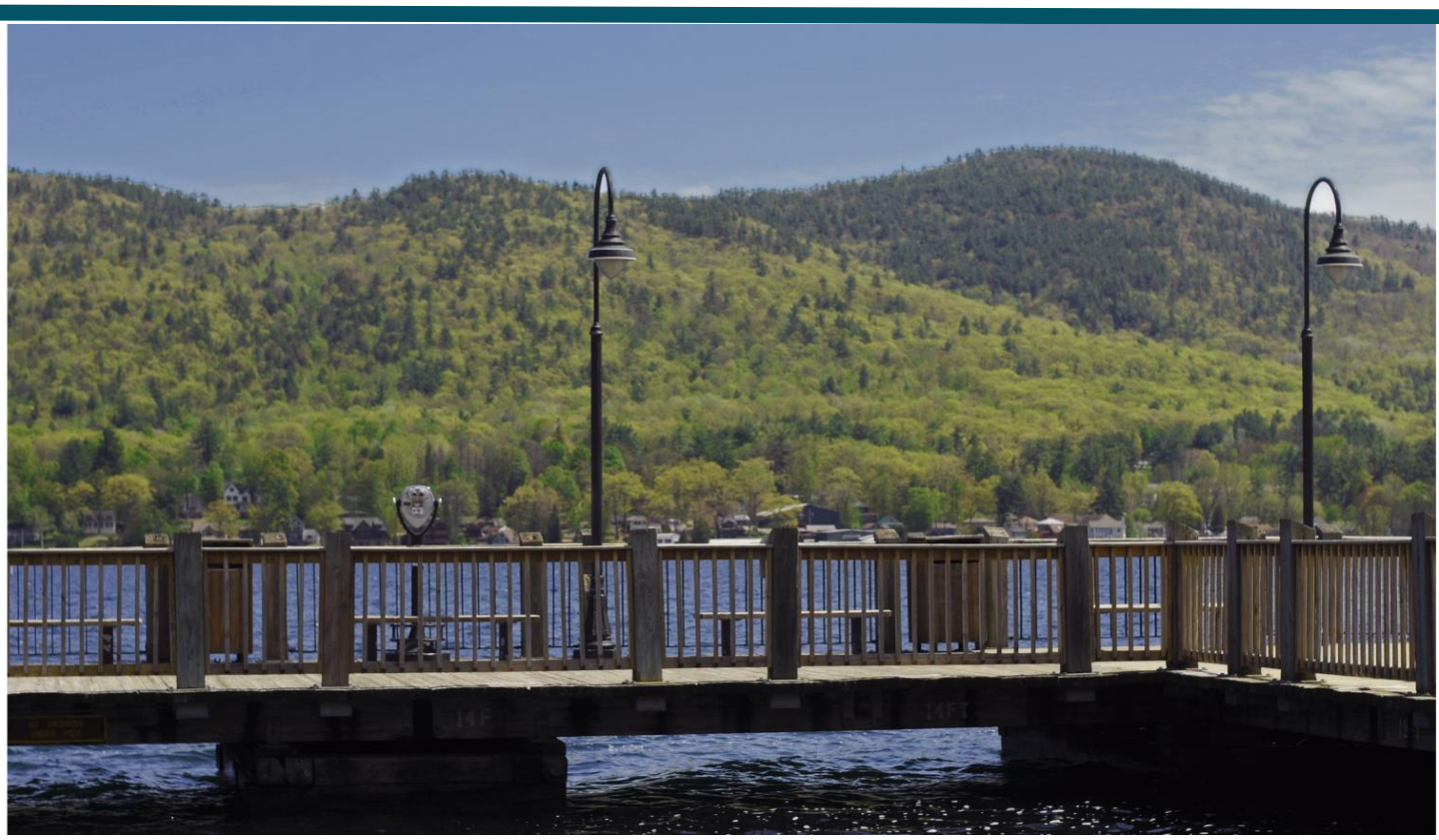
Strength of Prevention and Wellness Promotion Services. Data source for this factor is the DCS Survey item described in the previous paragraph. Regional averages ranged between 3.0 and 3.5 with a mean of 3.3. This regional factor was positively associated with improvements in arrest-related outcome measures.

Level of Collaboration Between the County DCS and Mental Health Advocacy Organizations. Data source for this factor is the DCS Survey. County administrators were asked to rate the level of the collaboration between their department and advocacy organizations representing mental health service users, on a scale of 1 (No collaboration) to 5 (highly collaborative relationship). Regional

averages ranged between 2 and 4 with a mean of 3.2. This regional factor was positively associated with improvements in arrest-related outcome measures.

Percent of Uncontested AOT Orders. Data source for this factor is the DCS Survey. County administrators were asked to estimate the percent of AOT orders that were not contested by the recipient. Response options were: 1 (0 – 25%), 2 (25 – 50%), 3 (50 – 75%), 4 (75 – 100%). Regional averages ranged between 2.5 and 3.0 with a mean of 2.8. This factor was negatively associated with improvement rates in housing status and life skills.

County Administrators' Personal Views AOT. Data source for this factor is the DCS Survey. County administrators were asked for their level of agreement with a list of statements about AOT on a scale of 1 (strongly disagree) and 5 (strongly agree). The survey provided an equal number of supportive and critical statements regarding AOT. We created two composite scales by taking the averages of supportive and critical statements. Regional averages of the "Critical of AOT" scale ranged between 2.3 to 2.7 with a mean of 2.5. That is, there were no regional averages that corresponded to agreement with the critical statements. Nonetheless, the "Critical of AOT" scale was significantly positively associated with improvement rates in housing status, life skills, hospitalization-related outcomes, and arrest-related outcomes. Our analysis did not detect any significant association between outcomes and the regional averages of the "Supportive of AOT" scale with regional averages between 3.2 and 3.4 with a mean of 3.3.



Chapter 5: Sociostructural Disparities in Mechanisms and Outcomes

In this chapter, we apply Critical Race Theory (CRT) to the findings. CRT is an interdisciplinary framework that examines how racism is embedded within laws, policies, institutions, and social structures, rather than how it is expressed through individual prejudice or bias. We applied this framework to interpret patterns in the data, recognizing racism as a structural and systemic feature of society and its institutions (Crenshaw, 1991; Delgado & Stefancic, 2017*)*.

Structural inequality in New York is well-documented across criminal legal, health, and mental health systems and is an important backdrop for our analyses. In New York City, Black residents are incarcerated in local jails at more than 11 times the rate of white residents, reflecting systemic differences across policing, charging, and pretrial detention practices (Data Collaborative for Justice, 2023). Black and Latino New Yorkers have been subjected to over 80% of police stops despite comprising less than half of the population, and this disproportionate representation has been linked with increases in psychiatric emergency visits among Black people in New York City (Das & Bruckner, 2023). And in New York City, Black and Latino people report worse health outcomes even at similar levels of wealth (Fordijuoh et al., 2026). These gaps reflect structural inequality because they are tied to how systems are designed (i.e., bail policies, policing practices, and health care access), not just individual choices or needs.

CRT guided our analysis by highlighting whether and how race, poverty, power, inequity, and historical legal injustices have shaped pathways into mandated care, differential clinical labeling, and disparities in surveillance and treatment experiences, particularly among Black and brown people (Crenshaw, 1991).

Race and Pathways to AOT

Administrator, provider, and advocate interviewees attributed the overrepresentation of Black and Latino people under AOT[1] to reliance on public-sector systems such as city hospitals, shelters, and crisis services. They said that poverty, homelessness, and under-resourced public systems shape who enters AOT and how "nonadherence" is interpreted. Several interviewees described AOT as fed by these public sector entry points, referring to city hospitals, shelters, and carceral settings where Black and brown people are disproportionately served.

> *"I think AOT is sought more through city hospitals, and so who tends to use more city hospitals would be people of color or even people who are Caucasian who don't have the financial resources to go to a private hospital." ~Administrator 17*

[1] Over half (58%) of the AOT cohort in the evaluation dataset are either Black or Hispanic/Latino whereas these groups constitute 46% of the state's population according to the 2020 Census.

Although race was frequently mentioned in these interviews, most explanations of racial disproportionality stopped short of interrogating institutional decision-making processes. In some interviews, disparities were framed as an unfortunate byproduct of poverty and limited resources rather than a predictable outcome of structurally unequal systems. Interviewees tended to frame race through patterns of differential institutional routing—who enters city hospitals rather than private care, who cycles through crisis systems, and who becomes visible to mandated treatment. From that vantage point, they attributed disparities to upstream factors such as housing and health care access rather than to decision-making across system referrals, hospitalizations, and court processes that inequitably impact people of color.

Structural Barriers and 'Non-Adherence'

A recurring theme was the reframing of structural barriers to wellness as individual nonadherence to treatment. Housing instability, food insecurity, poverty, and lack of transportation were routinely cited as barriers to voluntary engagement with treatment, yet these same conditions were also described as precipitating AOT. Several providers explicitly questioned the appropriateness of AOT for individuals experiencing homelessness, noting that survival needs must take precedence over treatment adherence. Nevertheless, treatment engagement through legal mechanisms remained common, suggesting a system-level tendency to manage structural failure through mandated care. Some administrators and providers framed AOT as a system's way to appear responsive ("doing something") when the underlying issue is social deprivation and underfunding.

> *"To me, putting somebody on AOT that is homeless is a waste of time. I think it's just [for] the system to say that they are doing something—but are we really doing something? I'm not so sure." ~Provider 6*

Even when providers critiqued this dynamic, describing AOT as ineffective or inappropriate for unhoused individuals, the system response remained largely coercive, highlighting a gap between provider insight and institutional practice.

Cultural Nuances and Family Dynamics

Providers and administrators frequently emphasized the role of culture and family dynamics in shaping engagement with mental health services. These discussions included beliefs about masculinity, shame, spirituality, and parental responsibility, as well as varying understandings of mental illness and medication across communities. However, cultural explanations were often framed as barriers or deficits (e.g., stigma, denial, lack of insight), rather than as responses to historical trauma, racism, or culturally misaligned services. This framing tended to individualize responsibility and obscure how systems may fail to offer culturally grounded or trustworthy care. For example, in interviews with providers and administrators, reluctance to accept medication or psychiatric treatment was commonly attributed to "cultural beliefs" as opposed to the historically grounded distrust of medical and legal institutions by people of color. The theme supports the concept of a gap

between how systems are designed and the cultural realities of the people they serve. This gap is evident in a disconnect between compliance with biomedical routines and culturally grounded engagement.

Language Access Policy and Practice

Language access emerged as an example of the gap between formal policy and lived practice. Interpretation services and language lines were widely available, yet providers and administrators described inconsistent use due to general staffing shortages, time constraints, and lack of enforcement. Providers and administrators said that access often depended on individual effort rather than institutional accountability. They said this dynamic contributed to uneven communication, limited family involvement, and fewer opportunities for informed consent and collaborative care.

> *"Some providers we really have to ask, 'OK, so how are you speaking with this person? Are you actually pulling up your phone and getting your interpreter on and having the conversation there, or are you just speaking to the person who can barely understand you [or] respond and say, OK bye?'... I think the providers are already able to [access a language line for interpretation], but I think you have to make the effort." ~Administrator 16*

While language access rights and resources exist, practical use is mediated by discretion, staffing, and system capacity—conditions that predictably disadvantage people with limited English proficiency.

Impacts of Law Enforcement Involvement

Racism was most commonly named in interviews in the context of law enforcement involvement. Interviewees linked AOT enforcement to broader patterns of racialized policing, noting that individuals with mental illness who are Black or brown experience heightened risk during police encounters. As noted in Chapter 2, interviewees described police pickups and removals as traumatic and dangerous. For people of color, these dynamics can reinforce fear, distrust, and reasons for medical disengagement. Adjusting for the total number of AOT orders received, Black people under AOT were 27% more likely to have at least one removal and 23% more likely to have multiple removals compared to other racial/ethnic groups. On the other hand, Hispanic people under AOT orders were 21% *less* likely to have at least one removal and 28% *less* likely to have multiple removals compared to other groups. This is the one area in which disparities are clearly observed within the implementation of AOT itself.

From a CRT perspective, this pattern is consistent with theories of racialized surveillance and structural vulnerability, in which individuals situated in under-resourced neighborhoods, public-sector care settings, and policed environments are more likely to encounter coercive behavioral health responses even when presenting with similar levels of clinical need (Crenshaw, 1991; Delgado & Stefancic, 2017; Sewell & Jefferson, 2016).

Regional variation further underscores the structural nature of enforcement patterns. Individuals residing in the Hudson River, New York City, and Long Island regions were significantly more likely to experience at least one removal; repeat removals were more common in the Hudson River and Central New York regions. These findings suggest that policies and practices, resource availability, and local enforcement cultures shape the likelihood of coercive response, aligning with scholarship documenting how behavioral health systems substitute surveillance and involuntary intervention for community-based supports in structurally marginalized contexts (Metzl, 2019; Stuart, 2016).

Our analysis of removals data suggests a "racialized funnel," where structural inequities in housing access, service access, and crisis-policing—not individual differences in clinical severity or motivation—shape pathways to AOT (Das & Bruckner, 2023). This aligns with CRT's assertion that nominally impartial eligibility standards and enforcement criteria can reproduce inequity when applied within structurally unequal systems (Bell, 1992; Crenshaw, 1991). These findings indicate that removals may function as administrative mechanisms of social control when care systems are under-resourced, particularly for Black communities disproportionately exposed to surveillance, transportation barriers, and institutional bias (Goff et al., 2016; Metzl, 2019).

Interpreting removals as evidence of noncompliance, which we observed is a common practice in AOT renewal hearings, risks pathologizing constraints—including homelessness, poverty, and limited culturally responsive care—rather than addressing the systemic conditions shaping treatment engagement. A structural reading of these findings indicates a need for equity-centered alternatives to police-linked enforcement, culturally grounded outreach, and explicit race-conscious monitoring of AOT implementation.

Experiences of Coercion

Finally, provider and administrator interviewees emphasized that their perceptions about coercion were shaped less by AOT itself than by how people under AOT were spoken to, whether their perspectives were seriously considered, and whether interactions with legal system personnel and providers felt respectful. Some interviewees connect coercive practices like handcuffed removals to racialized harm and describe the AOT process itself (renewals, questioning styles, tone) as potentially provoking or "triggering", particularly for people who have experienced racism.

> *"[After I started helping to facilitate renewal interviews with evaluating psychiatrists] I began preparing clients … to tell them that it may seem as though the person asking you questions is trying to bait you into some kind of a response—because of the phrasing [or] the tone of voice. The things that they would say could be very triggering, even to people who were doing very well in their treatment. And I think for people who have had experiences of like racism, classism, other kinds of isms—where they feel like they're being made to feel stupid or crazy, kind of in a position of being under someone—all of [these] things can come to bear." ~Provider 10*

This finding suggests that everyday interpersonal and institutional practices can determine whose experiences are legitimized within the system.

Advocate Perspectives on Sociostructural Inequalities

Advocates consistently frame racial disproportionality in AOT not as an anomaly of the program itself but as the predictable downstream result of structural racism embedded across housing, health care, education, and criminal legal systems. AOT is understood as a late-stage intervention for individuals, many of whose lives have been shaped by racism. Advocates linked mental health policy history, overdiagnosis of schizophrenia among Black men, and Civil Rights–era pathologization to contemporary AOT demographics. This perspective sets AOT as one node in a longer lineage of racial social control—dynamics that are documented in the scholarly literature on racial disparities in the mental health system (Schwartz & Blankenship, 2014; Metzl, 2010).

Interviewees described Black and brown communities, particularly Black men, as "starting behind the starting line" due to historical and ongoing forces such as redlining, Medicaid segregation, underinvestment in community services, and racially biased diagnostic practices. One attorney describes a source of bias in psychiatry in New York City:

> *"I've met doctors who never lived in New York City, but they work here—never lived in a city in their life. If you were to flip through their photos on their phone, you would probably not see a single Black or brown face. But here they are assessing someone who is a Black or brown person. And then they're reading that person's facial expressions or what the person says, and based on these things, making decisions that the person is 'angry' or 'Oh, this is aggressive or violent' … There's so many more layers to things that someone might [describe as] 'angry." ~Attorney 1*

These dynamics shape how behaviors are interpreted and how individuals accumulate system contacts. From this perspective, AOT eligibility criteria such as prior arrest, hospitalization, or homelessness operate as racialized filters that convert structurally produced exposure to surveillance and deprivation into clinical risk categories, disproportionately capturing Black men and other populations.

Another advocate speaking from the family perspective framed AOT as a life-saving alternative to incarceration, homelessness, or death. From this view, disproportionate representation of people of color reflects unequal exposure to risk, not discriminatory intent.

> *"I would much rather have that representation of people in AOT than incarcerated or in a grave." ~Advocate 2*

Other advocates argued that AOT functions as a bureaucratic replacement for culturally responsive services that were never adequately funded. In this frame, mandated treatment fills gaps left by policy failure, transforming unmet social needs into a psychiatric mandate.

> *"If I have a service for you that doesn't quite fit what your needs are, but I don't have any other service, the options are either force you into the service or say that you're noncompliant with what we've given you, and I think a lot of the system isn't responsive to why someone might not want those services." ~Advocate 1*

This tension reveals an unresolved ethical dilemma: whether AOT mitigates racial harm within a broken system or entrenches it by normalizing mandated treatment. Importantly, both positions acknowledge structural racism; however, they differ in whether AOT is seen as resistance to or reproduction of that structure. From a CRT perspective, this tension reflects structurally constrained survival choices. AOT may function as a 'lesser harm' within inequitable systems, even as it simultaneously normalizes coercion as care in communities already disproportionately subjected to surveillance and institutional control.

Advocates reported frustration and exhaustion when raising concerns about racism with policymakers. They characterized policymaker responses as tending toward high-level acknowledgments of structural racism without providing corresponding commitment to change. Additionally, several advocates highlighted that the voices of people of color are often absent from decision-making spaces while being most affected by AOT.

Taken together, advocate narratives position AOT not as an isolated policy but as a racially situated mechanism within a stratified mental health system. Advocates largely agree that racial disparities in AOT are real and consequential; disagreement centers on whether AOT mitigates harm or entrenches coercion in the absence of culturally responsive, adequately resourced alternatives. Using a CRT lens clarifies that this tension is not a contradiction but a reflection of how marginalized communities are forced to navigate survival within structurally constrained choices.

Summary: Inequality and Racism in AOT Is Inextricably Linked to Societal Inequality and Racism

Across interviews, participants consistently described AOT as operating within a landscape of deep structural inequality, even as they differed in how explicitly they named racism as a driving force. Racialized pathways (primarily through city hospitals and crisis systems), inconsistent language access in practice, cultural mismatches in engagement, and the trauma of law-enforcement involvement intersect to produce inequitable experiences and outcomes. These themes support interpretations that disparities are not incidental; they are patterned effects of institutionalized processes that appear neutral yet operate through unequal social conditions.

Taken together with our analyses of qualitative and quantitative data in other chapters, the findings indicate that AOT disparities are patterned outcomes of structural racism, produced through racially stratified service pathways, crisis and criminal legal system infrastructures, and

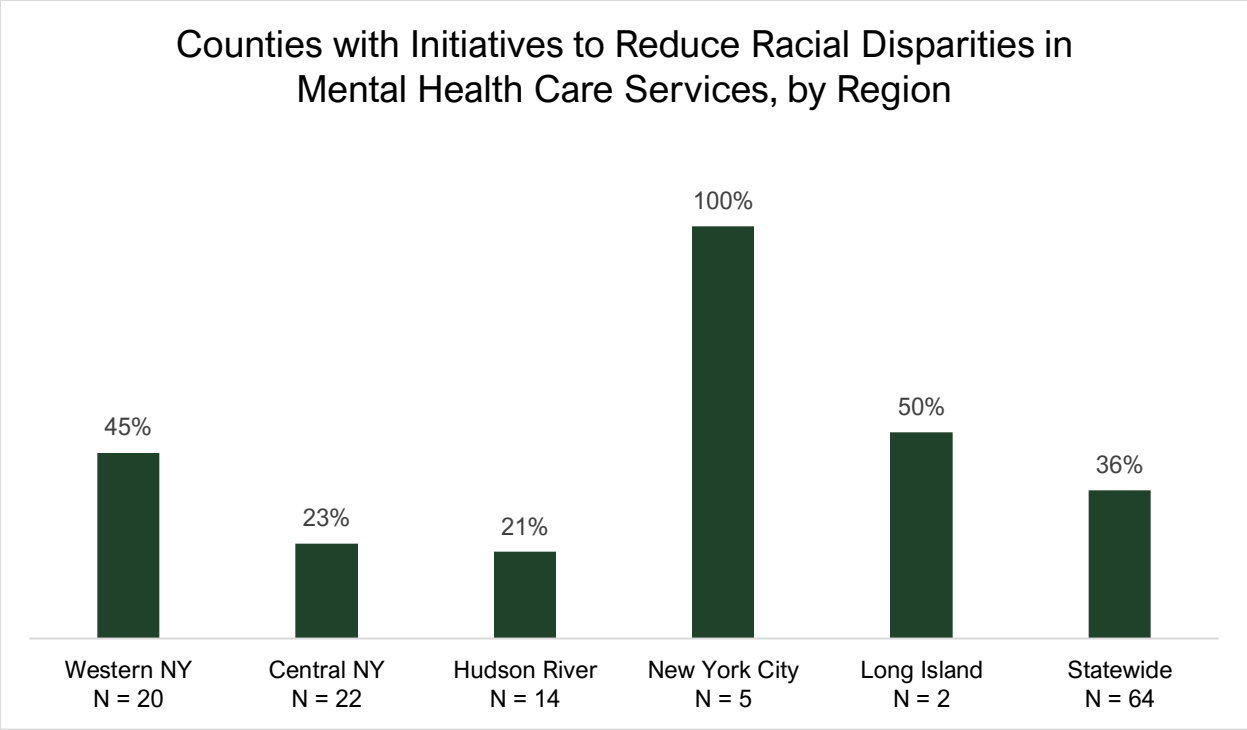
institutional interpretations that transform structural scarcity into individualized risk. In CRT terms, AOT functions not as a race-neutral policy tool but as a racially situated mechanism embedded within a broader ecosystem of inequality. Racial inequality within AOT does not operate solely through overt bias or explicit discrimination. Instead, it is embedded in structural conditions, institutional pathways, and everyday practices that shape who enters AOT, how behaviors are interpreted, and how coercion is racialized in practice. Themes suggest that AOT often functions as a downstream response to social and material inequities, particularly for people experiencing housing instability, reliance on public-sector treatment, and disproportionate exposure to the criminal-legal system. While some respondents explicitly named the impact on people of color as racism, others relied on cultural or socioeconomic explanations that nonetheless produced racially patterned outcomes. This pattern underscores the importance of examining AOT within a broader ecosystem of structural inequality, rather than as a standalone legal or clinical intervention for people who most often intersect with the system. We offer this quote from an attorney who was asked to reflect on how AOT impacts communities:

> *"It continues to kind of perpetuate racism and ideas of white supremacy. It continues to separate families, and weaken - when you separate a family, you weaken communities. It causes an alienation of an individual who can't trust a treatment provider or the treatment system from the system and then from their communities, which then also weakens communities. When you have someone that goes through an involuntary process, it causes trauma, which destabilizes someone, right? And when an individual is destabilized, then so goes the community."*
> *~Attorney 1*

Initiatives to Mitigate Sociostructural Disparities

Several jurisdictions in New York already have dedicated initiatives to address and mitigate racial disparities in access, quality, and experience of mental health services. Exhibit 5.1 depicts the proportion of LGUs with such initiatives by region from the DCS survey. New York City, an area with high rates of AOT and high levels of racial diversity, has initiatives in place. Statewide, however, only 36% of LGUs reported having these initiatives.

Exhibit 5.1. *Counties With Initiatives to Reduce Racial Disparities in Mental Health Services by Region*



Policy Implications of Sociostructural Analysis

Consistent with CRT, policy responses must extend beyond program optimization toward structural transformation. To mitigate these inequities and reduce the risk of racialized discrimination in AOT implementation, OMH will need to implement a multi-level reform strategy aligned with U.S. Department of Justice (DOJ) civil rights principles, OMH equity priorities, and disparities research in mental health systems (DOJ Civil Rights Division, 2016, 2022, 2023; New York State Office of Mental Health, 2022–2024; Snowden & Graaf, 2011; Alegría et al., 2019).

First, jurisdictions should require equity-impact monitoring across the full AOT continuum, including referrals, orders, renewals, terminations, critical incidents, and removals. These data should be disaggregated by gender, race, ethnicity, language, housing status, and referral source. This approach aligns with DOJ guidance on identifying and correcting disparate impact risks in behavioral health and law enforcement systems. It also supports OMH commitments to equity-centered performance accountability. Equity monitoring should be paired with corrective action processes in areas where patterns of racial or other disparities persist. This action item is consistent with CRT's emphasis on structural pattern recognition rather than individualized bias attribution.

Second, AOT eligibility and referral processes should be reviewed to ensure they are governed by a least restrictive alternative standard, requiring documented attempts to provide culturally responsive and community-defined supports prior to AOT. This includes housing peer navigation, flexible appointment structures, transportation assistance, and language-aligned engagement with people and their families and caregivers. These practices reflect DOJ disability rights and Olmstead compliance principles as well as OMH trauma-informed and recovery-oriented care expectations that prioritize voluntary participation when feasible. Consistent with CRT, such standards acknowledge that "nonadherence" often reflects structural deprivation rather than pathology.

Third, law enforcement involvement in AOT should be substantially minimized and replaced with health-first, peer-inclusive crisis responses except in cases of clearly documented imminent risk. Participants described police-mediated removals as racially traumatic and disproportionately experienced by Black and brown individuals, echoing prior research linking coercive psychiatric control to racialized surveillance systems (Livingston et al., 2016; Metzl, 2010). DOJ and OMH guidance increasingly emphasize non-police behavioral health response models; integrating such approaches into AOT could reduce racially disproportionate exposure to criminal legal risk.

Fourth, meaningful language access and cultural responsiveness must be treated as core compliance requirements rather than discretionary practice. Our data showed that formal interpreter availability does not guarantee real-world access, reflecting a structural gap frequently documented in behavioral health inequity research (Alegría et al., 2019). Consistent with DOJ Title VI Limited English Proficiency guidance and OMH cultural-competence standards, all OMH programs—including those serving people under AOT orders—should provide documentation of interpreter use, investment in high-need language staffing, and culturally grounded engagement strategies codesigned with families, peers, and community leaders.

Fifth, states should establish independent community-equity review and ombuds structures that include participation from peers, families, civil rights organizations, and community-based providers. These mechanisms would enable confidential grievance processes, provide for the review of contested cases, and identify system-level patterns of harm, aligning with CRT's insistence on community-centered accountability and experiential knowledge (Bell, 1992; Crenshaw, 1991).

Finally, AOT workforce development should include ongoing training on structural racism, diagnostic bias, trauma-responsive engagement, and culturally grounded alternatives to coercion, particularly for clinicians, courts, and hospital-based decision-makers. Prior scholarship demonstrates that racialized disparities in coercive psychiatric pathways are linked to institutional logics and labeling practices, not merely clinical presentation at the time of evaluation (Snowden & Graaf, 2011; Metzl, 2010). Embedding CRT-aligned training and

reflective practice into AOT systems supports a shift from deficit-based to cultural, structural and contextual interpretations of behavior and treatment engagement.

Taken together, these recommendations emphasize that reducing racialized inequities in AOT requires system redesign rather than case-by-case remediation. By aligning AOT policy and practice with DOJ civil rights standards, OMH equity priorities, and CRT's structural analytic lens, states can move toward an implementation model that minimizes coercion, strengthens culturally grounded voluntary supports, and advances population-level mental health equity.

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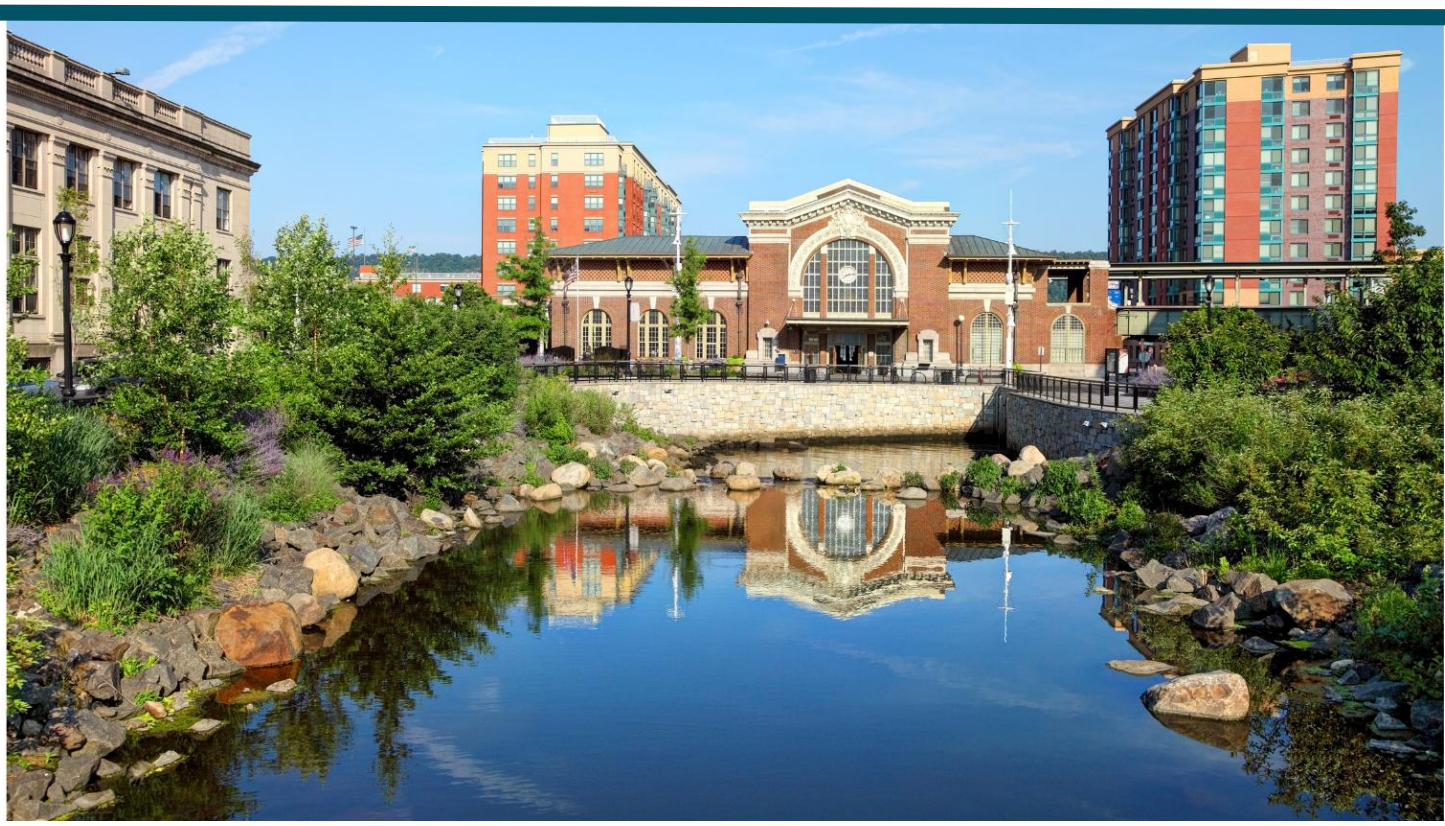


Discussion & Recommendations

This chapter presents brief summaries of the key findings from Chapters 1-5, followed by recommendations designed to preserve the builds on the findings from Chapters 1-5 to explore their implications and offers recommendations aimed at preserving the benefits of AOT while reducing reliance on coercion and strengthening voluntary, person-centered pathways to care. Consistent with earlier chapters, people under AOT orders are referred to as "AOT clients." in the summaries that follow.

Chapter 1 Summary

Chapter 1 shows that AOT operates as a mixed intervention system, where in which benefits and harms occur simultaneously, but are often driven by different parts of the experience.

Clients Value Services Over Legal Mandate

The most consistent finding is that AOT clients value the services they receive (such as housing support, case management, transportation, and regular provider contact) rather than the legal mandate itself. Nearly all clients in our sample describe these concrete supports as helpful to their stability, daily functioning, and ability to engage in care. Many explicitly state they would have accepted the same services voluntarily if they had been available without a court order, suggesting that positive outcomes are closely tied to service intensity and access, not to the coercive structure.

Perceived Coercion Drives Compliance but Masks Underlying Harm

At the same time, the legal and coercive aspects of AOT are widely described as harmful. Clients report fear, loss of autonomy, stigma, and ongoing pressure tied to the possibility of hospitalization, along with confusion about rights and limited ability to influence decisions. Many forms of apparent "compliance" (such as medication adherence or program participation) are described as driven by avoidance of consequences rather than genuine agreement with treatment. These dynamics can produce outwardly positive outcomes in administrative data while masking underlying distress, disengagement, or loss of agency.

Supportive Providers Buffer Harms

Experiences vary significantly depending on relationship quality and service delivery. Supportive, respectful providers and effective case management can buffer harms and make the experience more positive, while poor relationships amplify feelings of control and distrust. Similarly, structured routines and monitoring are experienced as helpful when they come with meaningful support, but as burdensome or punitive when they feel disconnected from the

client's needs. Medication shows a similar pattern: it can support stability when tailored and collaborative, but is often experienced as coercive, especially when side effects are not addressed.

Overall, the findings suggest that the **primary value of AOT lies in connecting people to intensive, practical supports, while the coercive legal framework introduces significant and widely reported harms.** The central implication is that many of the benefits attributed to AOT may be achievable through expanded voluntary access to the same services. This implication raises important questions about whether similar or better outcomes could be achieved without reliance on court-mandated treatment.

Chapter 2 Summary

Across interviews, the DCS survey, and analysis of administrative data, findings suggest that the implementation and impact of AOT is heavily influenced by the surrounding mental health and legal system infrastructure. Interviews with administrators, providers, and families suggest strong coordination, knowledgeable local leadership, and flexible, person-centered planning and service delivery appear to support better engagement. Fragmented data systems, uneven application of eligibility criteria, limited plan development with people, families, and providers, and variation in removal and renewal practices can undermine effectiveness.

Chapter 3 Summary

Our findings show that most clients enter AOT through pathways that make agreement feel unavoidable, often without fully understanding their rights or alternatives. Less restrictive options are rarely discussed, even when clients say they would have accepted services voluntarily. This suggests that AOT is frequently used as an entryway to services, rather than as a last-resort intervention.

Across planning, legal representation, and hearings, client input is limited and outcomes are largely predetermined. Treatment plans are typically set in advance, legal advocacy is often minimal, and hearings are brief and rarely contested, with almost all orders approved. As a result, formal procedural protections are present but do not translate into meaningful participation or influence over decisions.

Renewal and enforcement processes reinforce these dynamics over time. Clients often do not understand how or why orders are extended, and many experience renewals as automatic, creating a sense of indefinite oversight. The threat of removal to a hospital sustains compliance

even when rarely used. Overall, the system is widely experienced by the clients we interviewed as one where contesting is futile and where legal processes offer limited real opportunity for agency or change.

Chapter 4 Summary

Chapter 4 provides a detailed description of the quantitative analysis conducted for this evaluation. Results show statistically significant improvements in the key outcomes, both among people under an AOT order and among a socio-demographically and clinically similar group of people who are voluntarily engaged in assertive community treatment (ACT). Results of outcome comparisons between these two cohorts indicate that the AOT cohort had significantly better outcomes in three of the nine key outcomes, the voluntary ACT cohort faired significantly better in two of the outcomes, and no significant cohort difference was detected for four of the outcomes. Furthermore, the data does not support the widespread belief that people under an AOT order would not have voluntarily engaged in treatment otherwise. For example, we found that at intake, the level of engagement with treatment staff was assessed as "somewhat or well" for 69% of the AOT cohort compared to 66% of the voluntary ACT cohort. The intake assessment data also indicate that 52% of the AOT cohort took their medication as prescribed "most or all of the time," compared to 41% of the voluntary ACT cohort. These findings suggest that efforts to increase access to voluntary services and better inform people meeting AOT eligibility criteria about voluntary options will likely divert a substantial number from court-mandated treatment.

Chapter 5 Summary

Our findings reveal recurring concerns related to institutional initiation of orders, ambiguities around substance use and services, potential missed opportunities to connect people to recovery-oriented services, limited due process in hearings, and reliance on law enforcement for 9.60 removals in which people of color are overrepresented. Interviewees linked law-enforcement involvement, removals, and everyday institutional practices to trauma and distrust, particularly for Black and brown New Yorkers. The findings point to a need for clearer guidance, stronger voluntary service pathways, more consistent use of enhanced voluntary agreements, greater education for all parties, and deeper incorporation of lived experience into ongoing quality improvement and evaluation efforts.

Conclusion

The convergent testimony from individuals subject to AOT, family members, providers, coordinators, legal professionals, and advocates documents concerns across all phases of AOT

implementation: initiation, legal representation, judicial oversight, participation in treatment planning, and renewal processes.

While the statute envisions AOT as a least restrictive alternative implemented with procedural protections, client accounts describe a system that often operates as a mechanism for accessing services rather than as an intervention reserved for situations where compulsory treatment is necessary.

In examining how clients describe AOT proceedings as a whole—voice, fairness, respect, agency, and the broader felt sense of moving through the legal process—the dominant findings are negative. Over three quarters (78%) of the respondent sample describe some degree of voicelessness, and a similar percentage (74%) describe confusion about the process. Most clients feel that contesting would be futile (67%), and described the process as unfair (59%). Positive procedural-justice experiences (feeling adequately informed, feeling respected, feeling that one exercised meaningful agency) were comparatively rare. More than one-third (39%) describe some aspect of AOT using a carceral or criminal-legal analogy.

That said, a little over one quarter of clients (28%) describe being able to exercise agency at some procedural moment, and 17% describe being adequately informed; 11% remarked that they were treated with respect.

These findings have implications for policy and practice, which we address in the recommendations that follow. Key priorities include the need for enhanced scrutiny of least restrictive alternatives and the standard of proof that least restrictive alternatives have been exhausted; improved access to voluntary services in general, and EVAs specifically; strengthened legal representation, access to independent advocates, and judicial oversight; meaningful respondent participation in treatment planning; and clearer criteria and processes for order discontinuation.

Recommendations

We offer three sets of recommendations based on the study findings, organized by degree of control and complexity. People under AOT orders are described as “respondents”:

Tier 1: Operational or administrative changes within OMH’s direct control that can be taken in the coming weeks and months using existing statutory authority and resources. These actions can be piloted or implemented through guidance, training, or administrative action and are primarily operational in nature. They are intended to yield improvements in consistency, quality, and responsiveness to community priorities within the current AOT program. Funding allocations in the current budget afford OMH opportunities to implement these expansions in

practices and services to create, support, and monitor compliance with expanded standards for AOT and EVAs.

Tier 2: Actions requiring policy revision, regulatory change, or legislative action that involve a moderate investment of resources. These actions may be led by OMH but would involve partnerships with other entities (i.e., legislators, LGUs, courts, providers) and would require modest financial investment. They are feasible in the medium term but depend on community and legislative engagement.

Tier 3: Structural or system-level reforms extending beyond the AOT program itself, involving legislative changes, high levels of complexity, multi-agency action, and/or significant resource commitments. Tier 3 recommendations emphasize cross-system accountability and long-range planning, rethinking the role of AOT within the broader system.

Tier 1

A. Self-Advocacy Information and Support for People Under AOT and Families

1) **Create and distribute accessible materials to educate people under AOT orders and their families about the AOT process**
    - Require that LGUs provide documentation that the information was reviewed with the person and that their understanding was verified
    - Information should be available in multiple languages and written in plain, everyday language.
    - Information should be provided at multiple points in the AOT process process—including the service of petition, attorney meeting, planning conference, and service initiation
    - Information should include an AOT Respondent's Bill of Rights that describes:
    - Right to contest order and appeal
    - Right to legal representation
    - Right to independent evaluation
    - Right to participate in treatment planning
    - Right to refuse medication (with consequences)
    - Right to least restrictive alternative
    - Complaint and modification procedures
    - Contact information for local ombuds and advocacy organizations
    - Information should also include:
    - A description of the hearing process, monitoring, removals, renewals and processes for review of the order and the AOT plan once a person is placed under AOT

- Expectations for access to services in the AOT plan as well as services that may not be in the AOT plan
- Explicit information correcting misconceptions including:
- That an AOT order cannot be used to force a person to take medication
- That an AOT order cannot be used to hospitalize a person who does not meet criteria for involuntary hospitalization
- That service access is determined based on clinical eligibility and not the presence of an AOT order, and specifically that termination of AOT does not result in automatic termination of services
- That noncompliance with AOT cannot be used to arrest a person or put a person in jail

2) Guarantee access to records for people under AOT orders within five business days of request. People under AOT orders should be entitled to copies of the following documents:

- Petition and supporting documentation
- Psychiatric evaluations
- Treatment plans
- Court orders and findings
- Service provision records

3) **Provide ongoing self-advocacy support to all people under AOT orders. This support should extend beyond MHLS representation in the initiation and renewal processes. This support should:**

- Begin as soon as the order is initiated and be remain available through the termination of the AOT order
- Be provided by someone with training in civil and human rights, mental health systems, the ethics of coercion, structural racism and implicit bias, and trauma-responsive engagement strategies
- Be easily accessible to the person (e.g., available by phone, text, able to meet the person in the community) and responsive (e.g., gets back to the person within 1-2 business days)
- Involve education and guidance on the AOT process and the person's rights, including service provision, monitoring, removals, renewals, and termination
- Assist the person to represent their priorities and personal goals in the AOT treatment planning process
- Be independent of any organization that may be providing services to a person under an AOT order

4) **Provide education and support to all family (including chosen family) of people under AOT orders. Support should:**
    - Begin as soon as the order is initiated and be available through graduation/termination of the AOT order
    - Be provided by a someone with training in civil and human rights, mental health systems, the ethics of coercion, structural racism and implicit bias, trauma-responsive engagement strategies, and deep understanding of the family member experience (someone with lived experience as a family member may be uniquely suited to this role)
    - Be easily accessible to the family member (e.g., available by phone, text, able to meet the person in the community) and responsive (e.g., gets back to the person within 1-2 business days)
    - Involve education and guidance on the AOT process and their family member's rights, covering service provision, monitoring, removals, renewals, and termination
    - Be independent of any organization that may be providing services to a person under an AOT order

B. Guidance on the Removal Process

1) **Develop additional guidance on the process for initiating removals:**
    - Issue detailed guidance for AOT removals with a goal of eliminating racial bias and reducing precinct-to-precinct variability in removal processes and coordination protocols
    - Clarify "gray areas" about when to initiate a removal and when further follow-up or monitoring is better indicated
    - Create opportunities for best practice sharing across police departments to facilitate implementation of the guidance
    - Target training and technical assistance to areas with higher rates of racial disparities and areas experiencing implementation challenges (e.g., racially disproportionate removals, significant delays in processing removals, high numbers of removals that do not result in connection to treatment)
    - Establish benchmarks for removal rates for each region, and implement a regional practice review when removal rates exceed benchmarks
    - Invest in training and education for police departments that includes basic information about AOT including the role of providers in initiating removals

C. Guidance on the Treatment Planning Process

1) **Maximize a person's involvement in the development of the AOT treatment plan:**
   - Require that the AOT plan reflect the person's priorities and goals are included in in their own words, not paraphrased by others in the AOT plan
   - Require that the person be provided with a copy of their AOT plan written in plain language, free of clinical jargon
   - Require that the LGU and treating providers engage the person in a review of the AOT plan at least twice per year
   - Conduct a review of current practices in person-centered planning and shared decision-making, —including the use of decision aids and psychiatric advance directives, —in the practice of evaluating and treating psychiatrists involved in the AOT planning process. Identify specific areas for improvement and associated strategies and build these into future guidance and monitoring practices

2) **Ensure adequate opportunities for community providers to inform the development and of AOT plans:**
   - Develop a system for consultation with the LGU and/or local providers when a hospital or correctional facility is developing initial AOT plans (i.e., for people transferring from a state psychiatric center or correctional facility)
   - Establish guidance for evaluating psychiatrists and discharge planners on developing AOT plans so there is flexibility for community providers to adjust AOT plans to adapt to changing respondent preferences and circumstances when they return home. This could be through the use of contingencies and/or through guidance on creating shorter initial orders so that providers can adjust the AOT plan during a renewal
   - Establish guidance that stipulates adequate involvement of treating providers at all renewals, including in the decision whether to pursue a renewal
   - Establish guidance for LGUs to incorporate practices that accommodate adjustments to the AOT plan when clinically indicated and when it supports self-determination and engagement in services

3) **Develop and issue guidance on including substance use treatment services in AOT plans. Guidance should include:**
   - Maximizing integration of substance use treatment with other services in the AOT plan (e.g., ensure that people with co-occurring SUD are connected to service teams that offer integrated MH and SUD treatment)
   - Include substance use provider input in the development of the AOT plan if SUD services are indicated

- Only include toxicology tests when there is a specific clinical rationale to do so and when there is a specific plan of action if toxicology tests are positive
- Provide a clinical rationale for inclusion of SUD services beyond the presence of an SUD or indication of problematic substance use

D. Data Collection and Monitoring Practices

1) Revisit and adjust the current **AOT data monitoring strategy:**
    - When displaying pre-post comparisons of arrests, hospitalizations, and other outcomes, reflect a time-limited "pre" period rather than any lifetime occurrence
    - Require LGUs to report rates of EVAs as diversion and step-down from AOT
    - Incorporate service quality data into AOT monitoring
    - Review CAIRS data collection tools and processes to increase their utility in outcomes and quality monitoring
    - Gather and incorporate qualitative data on AOT participant and family/chosen family experience into the AOT data monitoring process. OAPSS could have a role in gathering experience feedback from people who use services and their families
    - Explore opportunities to link or unify AOT-related data across inpatient, outpatient, and criminal legal systems

2) **Develop an equity impact monitoring framework and establish an AOT equity review council to identify disparities by race or other characteristics in AOT and make recommendations for reducing those disparities. At a minimum, the framework should include the following components:**
    - An AOT equity review council composed of representatives from peer and family organizations, civil rights organizations, and community-based providers with a majority of members having direct lived experience of AOT or other coercive practices. The council would meet at least twice per year to review data and provide recommendations for reducing disparities
    - Disaggregate and publicly report data on AOT referrals, orders, renewals, critical incidents, and removals by gender, race, ethnicity, language, housing status, and referral source
    - Disaggregate outcome data (hospitalizations, arrests, and quality of life indicators) by gender, race, ethnicity, language, housing status, and referral source
    - Establish corrective action processes in areas where patterns of disparity are observed

E. AOT Initiation and EVA Practices

1) **Establish guidance for whether to pursue AOT for individuals least likely to benefit from AOT and develop a process for identifying people for whom AOT is ineffective and specifying alternative approaches for those individuals:**

- Increase clinician discretion in the application of the likely-to-benefit criterion
- Create guidance for LGUs, discharge planners, and providers for what to do when a person appears to be at high risk of danger to self or others but is unlikely to benefit from AOT
- Create technical assistance pathways for state and regional consultation with LGUs when an individual has been identified as not benefitting from AOT

2) Expand the use of EVAs through changes in policy and practice:

- Review and strengthen referral and investigation practices to verify that AOTs are is pursued only as a least restrictive alternative, including documented rationale for not first pursuing an EVA
- Require documentation of attempts to provide voluntary, culturally responsive, recovery-oriented services as part of AOT eligibility determination
- Issue formal guidance on EVA best practice that includes minimum specifications and FAQs
- Specify that EVAs should be used both as a diversion from AOT and a step-down from AOT
- Tailor guidance so that it is specific to hospitals (as the primary sites for AOT initiation), correctional facilities, and LGUs (most likely to be supporting renewals)
- Tailor guidance for high-volume and low-volume AOT settings
- Establish a policy to prioritize people on EVAs for housing and treatment services similar to practices that prioritize people under AOT orders
- Establish a learning community of LGUs representing low- and high-volume regions to implement the guidance, test novel strategies, and identify best practices. Revise the guidance based on the lessons from the learning community

3) Conduct a review of each region to ensure an equivalent voluntary service infrastructure so that intensive services are available and accessible without court orders. These include voluntary ACT teams, intensive case management, supported housing:

- Ensure that no service eligibility criteria formally or informally require AOT status

- **Prohibit providers from making services conditional on AOT, including in residential service contexts:**
    - Create clear and consistent guidance on the role of voluntary community-based services relative to AOT and EVAs

- Conduct an audit of whether and how service access may be discontinued when AOT orders are discontinued, and develop policies to safeguard service continuity when a person shifts from AOT to EVA or otherwise voluntary status
- Work with OAPSS and INSET programs to create best practice guidelines for engaging people who are under AOT orders and EVAs in the INSET program
- Develop and distribute guidance for providers and LGUs to support incorporation of CORE, PROS, and other voluntary recovery-oriented services into service packages for people under AOT orders and people on EVAs
- Develop and distribute guidance for providers to support people to access programs, services, and benefits that support independence and purpose (e.g., vocational rehabilitation, economic assistance programs, restoration of legal rights)
- Develop and distribute guidance for Critical Time Intervention, peer bridger, and other service coordination programs that support transition from hospital to community settings for people under AOT orders and EVAs

- **Continue to prioritize expansions of services and efforts to enhance quality and cultural responsiveness of voluntary services. Continue to:**
    - Expand high-fidelity ACT, IMT, and other intensive service models that are effective to support people under AOT orders
    - Ensure adequacy voluntary services in all counties and regions throughout the state, including rural and low-density counties
    - Prioritize integration of peer services into clinical services in alignment with peer support values and ethics
    - Prioritize efforts to enhance the cultural responsiveness of services—including developing culturally specific service programs and recruitment and retention of providers of color in the mental health workforce
    - Strengthen implementation of OMH's guidance on equity and trauma-informed care

Tier 2

A. Changes to Court Processes

- Create a community of practice for judges and clerks to gather and share information about the AOT process including education and information sharing on best practice. Topics could include:
    a. Discussion and identification of best practice in AOT adjudication
    b. Review of data points related to the use of AOT and their significance
    c. Creating an environment of respect and compassion

    d. Understanding how sociostructural factors shape disparities in AOT
    e. Working with implicit bias
- Pilot an "active court" model with enhanced judicial involvement, including involving direct interactions with the person and their providers and periodic status hearings hearings, to assess understand whether/how enhanced judicial involvement impacts on AOT experience and outcomes, such as that recommended by the Judicial Task Force on Mental Illness
    a. The pilot should include direct interviews with people under AOT orders to understand their experience and detailed plans to measure the level of coercion experienced by people in the pilot relative to people receiving services as usual. A pilot design should be informed by a close reading of the concerns outlined in this report and the policy recommendations offered in the next section
- Create and implement MHLS attorney-client communication protocols to facilitate a person's engagement in the court process
- Implement communication access services (interpreters, AAC devices, peer support specialists)
- Allocate extra time for respondents who need repeated explanations or processing time
- Establish trauma-informed approaches recognizing that recognize the impact of past hospitalization and the intimidating courtroom environment
- Establish a process for determining whether ambivalence, confusion, or disengagement reflects capacity limitations

B. Removal Practices

- Expand **nonpolice and less coercive removal practices**
    a. Conduct a review of the New York City CAT team to identify barriers to viable avenues for adequate staffing so that the model can be implemented as designed
    b. In non-NYC urban centers with high proportions of AOT orders (e.g., urban parts of Long Island as well as Buffalo, Rochester, and Syracuse), pilot and implement nonpolice removal teams and/or specialized teams within law enforcement departments
    c. Conduct a study to identify feasible policy options to minimize instances in which a person is brought to the hospital in handcuffs during removals
    d. Provide training and education for police departments that includes best practice in de-escalation and applying implicit bias, procedural justice, and CIT training to the AOT context

C. Treatment Planning Practices

- Require meaningful **respondent participation in comprehensive treatment planning** through strengthened planning conference procedures to improve consistency and quality across jurisdictions
    a. Hold planning conference only after respondent is discharged from acute inpatient care, unless infeasible (e.g., respondent is a long-term state psychiatric center inpatient)
    b. Within 48 hours of the meeting, provide the respondent with an agenda and a draft plan
    c. Encourage and support family attendance if the respondent authorizes it
- Incorporate the AOT treatment plan into a **comprehensive person-centered plan** in alignment with best practice in person-centered planning. Require documentation of the following elements:
    a. The respondent's goals and preferences, in the form of measurable recovery goals beyond symptom reduction
    b. Any rationale for not including the respondent's goals or preferences in the plan
    c. Discussion of past treatment experiences (what helped, what caused harm)
    d. Discussion of medication options, including alternatives and right to refuse and side effect monitoring and mitigation strategies
    e. Discussion of psychosocial interventions (therapy, supported employment, peer support)
    f. Crisis planning and advance directive development (with specific application to any crises or "noncompliance' that would lead to a removal order, hospitalization and/or treatment over objection once hospitalized)
    g. Identification of barriers to voluntary engagement
    h. Family and natural support involvement
    i. Incorporation of cultural, religious, and personal values
    j. Specific, measurable, achievable goals (not boilerplate language)
    k. A respondent signature indicating participation (not just agreement)
    l. Require more frequent plan review and modification
    m. Require a formal plan review every 90 days
    n. Document modifications to the plan based on respondent progress and preferences and any changes in service availability
    o. Enable a clear process for respondent-initiated modification requests outside of scheduled reviews

D. Data Collection and Monitoring Practices

- To increase transparency and accountability, require **expanded data collection and annual public reporting** beyond the current Kendra's Law dashboard. Reporting should include statewide and county-level data on:
    a. Number of petitions filed, granted, contested, and dismissed and the reasons for dismissal with demographic information
    b. Orders appealed and appeal outcomes
    c. Hearing duration and attendance
    d. Representation type (MHLS, private, pro se)
    e. Order duration and renewal rates
    f. Voluntary service diversions
    g. Removals, reasons for removals, police involvement in removals, and removal outcomes including rates of treatment over objection with demographic information
    h. Prescribing, including rates of antipsychotic polypharmacy, including prescription of three or more antipsychotics
    i. Screening for and changes in actual rates of serious side effects, including metabolic syndrome, heart disease, and Type 2 diabetes
    j. Assessment of civil rights compliance
    k. Complaints and plan modification requests
    l. Services ordered vs. services received
    m. Time from order to service initiation
- Establish regular **performance audits** of the AOT program. The audits should include:
    a. Random case file reviews by independent auditors (not OMH)
    b. Assessment of whether statutory requirements have been met
    c. Evaluation of hearing quality and judicial findings
    d. Attorney performance review
    e. Service availability and quality assessment, including assurance that equivalent voluntary intensive services are available in all counties

Tier 3

A. Pre-Hearing and Initiation Practices

- **Mandate a pre-hearing capacity assessment** to verify an individual's capacity to make treatment decisions before individuals can waive their right to a hearing or make binding decisions about legal representation. The assessment must:
    a. Be conducted by a qualified professional not involved in treatment or petition initiation
    b. Specifically evaluate capacity to:
    c. Understand the nature and consequences of AOT proceedings

d. Comprehend information about rights, including the right to contest
e. Appreciate the personal implications of accepting versus contesting an order
f. Rationally manipulate information to make an informed decision

- Establish protective procedures for individuals lacking **capacity to make informed decisions** and establish higher standards for those with demonstrated decisional capacity. When a person is found to lack capacity:
    a. They cannot waive hearing rights
    b. Appoint a guardian ad litem or qualified legal representative with training in decision-making support
    c. Require substantive judicial inquiry into whether treatment is truly medically appropriate and least restrictive
    d. Implement time-limited orders (maximum 3-6 months) with mandatory reassessment of capacity
- When a person is found to have unimpaired capacity, require clear and convincing evidence that:
    a. Less restrictive voluntary alternatives have been exhausted and documented
    b. Serious harm is imminent and substantially certain without intervention
    c. Proposed treatment is evidence-based and appropriate to the individual's specific condition
    d. Benefits substantially outweigh liberty deprivations
- **Codify Least Restrictive Alternatives (LRA) as statutory element** by amending §9.60. Require petitioners to prove by clear and convincing evidence that:
    a. Specific, less restrictive alternatives were considered and attempted or offered
    b. Each alternative was deemed unsuitable based on documented clinical and practical reasons
    c. No combination of voluntary services would adequately address identified needs
    d. Create presumption favoring voluntary services
    e. Establish rebuttable presumption that voluntary intensive services (EVAs with Intensive Case Management, ACT teams) are preferable to court-ordered treatment
    f. Require documentation that voluntary services were affirmatively offered and declined, or attempted and failed
    g. Burden on petitioner to demonstrate why voluntary engagement is impossible or insufficient
- **Define operational standards for key eligibility criteria** including "unlikely to survive safely," "unlikely to voluntarily participate," and "need for AOT." Recommended standards for each criteria are as follows:
    a. "Unlikely to survive safely"
    b. Must demonstrate imminent risk of serious physical harm within specific timeframe (30-90 days)

c. Requires evidence beyond general vulnerability or past adverse outcomes
d. Must account for protective factors and support systems
e. "Unlikely to voluntarily participate":
f. Cannot be based solely on past treatment discontinuation
g. Must distinguish informed refusal (due to side effects, ineffectiveness, values) from incapacity-based nonadherence
h. Requires evidence that voluntary engagement was offered and declined, not merely assumed
i. "Treatment likely to benefit":
j. Must demonstrate that proposed treatment is evidence-based for respondent's specific condition
k. Requires consideration of past treatment response, including adverse effects
l. Must show benefits substantially outweigh known risks and side effects

- Amend the statute to **require that petitioners establish a causal connection between nonadherence and harm**
    a. Clarify that statute requires evidence that treatment noncompliance caused adverse outcomes, not merely temporal association
    b. Prohibit consideration of adverse events unrelated to treatment status
    c. Require analysis of confounding factors (housing instability, poverty, trauma, discrimination)
- Amend the statute to **limit the duration of AOT orders based on risk certainty**
    a. For predictive determinations extending beyond 6 months, require heightened evidence of pattern stability
    b. Mandate 6-month orders as default, with 12-month orders reserved for compelling demonstrated need
    c. Require explicit judicial findings on time-limited nature of risk
- Amend the statute to **guard against pre-hearing coercion** and require informed consent for a hearing waiver
    a. Establish a minimum 7-day “cooling-off” period between service of petition and any hearing waiver decision, prohibiting any hospital discharge decisions contingent on AOT acceptance during this period
    b. Require respondents be in community or step-down setting (not acute inpatient) when making waiver decisions
    c. Require that a judge must personally conduct on-record inquiry before accepting any hearing waiver by:
    d. Verifying the respondent understands right to contest and hearing procedures
    e. Confirming waiver is knowing, voluntary, and not product of threats or coercion
    f. Assessing whether respondent had meaningful consultation with attorney
    g. Ensuring the respondent understands consequences of waiver and order duration

h. Prohibit conditional discharge practices by making unlawful any hospital statement that
discharge is contingent on AOT acceptance and requiring hospitals to document discharge planning independent of AOT status
i. Create private right of action for patients subjected to coercive discharge practices

- Guarantee a respondent's right to an **independent clinical evaluation** by creating a state-funded independent evaluation program.
    a. Establish a roster of independent forensic evaluators not affiliated with petitioning systems
    b. Provide automatic funding for one independent evaluation per respondent upon request
    c. Evaluations must occur within 10 days of request to avoid delaying proceedings
    d. Independent evaluators will receive the same records as the petitioning psychiatrist, including hospital notes, medication records, social history, and prior evaluations
    e. Independent evaluations admissible with same weight as petitioner's evidence
    f. Judges must explain on record why they credit one evaluation over another

B. Legal Representation Reforms

- Establish **mandatory practice standards for MHLS** with added resources to reach those standards. The standards should include:
    a. A face-to-face meeting with the respondent within 48 hours of assignment lasting a minimum of one hour in a private setting with use of plain language and communication accommodations
    b. A case investigation review of complete medical and social history records**;** consultation with treating providers, family members (with authorization), and collateral sources; investigation of voluntary service alternatives, and assessment of factual accuracy of petition allegations
    c. Respondent counseling that includes an explanation of all options (contest, negotiate, accept), realistic assessment of likelihood of success based on case facts, discussion of appeal rights and post-order modification procedures, and documentation of informed choice
    d. MHLS attorneys should have a maximum caseload of 60 active AOT cases per full-time attorney with lower limits (40 cases) for attorneys handling cases requiring enhanced advocacy (e.g., medication over objection, jury trials); MHLS workload assessments should account for travel time in rural areas
    e. Require continuing legal education for MHLS attorneys that includes an annual 12-hour CLE requirement specific to mental health law with:

f. Topics to include AOT criteria and defenses, clinical terminology, medications and medication side effects, communicating with respondents experiencing acute symptoms, implicit bias, trauma-informed advocacy
g. Guest presentations from psychiatrists and other clinicians, researchers, peer advocates and lived experience leaders, and civil rights experts
h. Create quality assurance mechanisms to assure standards are met met—including random case file audits by independent reviewers, respondent satisfaction surveys (anonymous, conducted by a third party), and a review of performance metrics including hearing attendance, motions filed, successful order modifications
i. Increase MHLS appropriations to support reduced caseloads and implementation and monitoring of practice standards

- **Codify that MHLS representation be respondent-directed** so that MHLS attorneys advocate for respondent-expressed preferences absent legal incapacity.
    a. Prohibit attorneys from second-guessing respondent decisions about contesting orders
    b. Prohibit attorneys from restraining advocacy to "maintain credibility" with judges
    c. Specify that the professional duty to advocate supersedes concern about judicial relationships
    d. Require attorneys to raise all colorable legal and factual defenses
    e. Prohibit respondents from waiving their right to a hearing without attorney contact by requiring a minimum of two meetings with an attorney before a waiver is accepted and attorney certification that the respondent understands the implications of the waiver
- **Guarantee family communication with the MHLS attorney** if authorized by the respondent. When respondents authorize family involvement, MHLS must communicate with family members to:
    a. Provide updates on case status, hearing dates, outcomes
    b. Consider family input regarding factual inaccuracies or less restrictive alternatives
    c. Balance family involvement with adult autonomy and confidentiality

C. Judicial Process Reforms

- Establish and monitor adherence to **minimum hearing standards** to strengthen hearing procedures and judicial oversight. Recommended standards are as follows:
    a. A minimum hearing allocation of 45 minutes for initial orders and 30 minutes for renewals, with additional time as needed for contested cases or complex facts
    b. Require that initial AOT hearings must be held in person unless the respondent specifically requests remote

c. Require that all virtual hearings be held with high-quality video and audio (no telephone-only hearings)
d. Require the respondent not be in hospital clothing or restraints unless it is a security necessity
e. Expanded judicial inquiry including personal colloquy with the respondent, opportunities for the respondent to present testimony and respond to allegations, and explicit findings on each statutory element
f. Requirement that the judge make specific findings about identified least restrictive alternatives and reasons for rejection, that voluntary services were offered, and that no less restrictive option would address needs
g. Ensure neutral decision-making making—including full consideration of the respondent's explanation for past events and treatment preferences
h. Ensure the respondent's voice is heard and validated in proceedings

- Require **initial and ongoing judicial training and specialization** to ensure judges have full knowledge of AOT law, civil procedure, and constitutional standards, and experience of psychiatric systems. The specialized training should cover:
  a. Constitutional standards for involuntary commitment and treatment
  b. AOT statutory criteria and burden of proof
  c. Psychiatric terminology and limitations of predictive testimony
  d. Communication with individuals experiencing acute symptoms
  e. Implicit bias and sanism in mental health proceedings
  f. Evidence-based practices in psychiatric treatment
  g. Annual 8-hour continuing education on mental health law developments
- **Create specialized AOT Courts** in areas with a high volume of AOT cases.
  a. Designate specific judges to hear all AOT cases in every judicial district
  b. A specialized court model will expand the system's capacity to:
  c. Develop legal system professional expertise through regular exposure to mental health law
  d. Establish relationships between court personnel and community mental health systems
  e. Implement therapeutic jurisprudence and procedural justice principles while maintaining due process

D. Order Enforcement and Renewal Reforms

- Amend the statute to **eliminate assisted transport for non-emergency situations and instead implement a hearing for noncompliance**.

a. At present, the statute's "assisted transport" provision allows involuntary transport to clinical evaluation based on noncompliance alone. Assisted transport should be used only when a person meets criteria for emergency psychiatric detention using the same standards that apply to individuals not under AOT
b. Assisted transport should not be used solely for medication noncompliance or missed appointments
c. When there is noncompliance with an AOT order, require a hearing with an opportunity for the respondent and their legal representation to explain reasons with consideration given to service quality, practical barriers, and treatment adverse effects: Create a plan for less restrictive interventions (plan modification, increased services)

- **Strengthen order renewal procedures** to allow for adequate judicial consideration of whether AOT remains necessary and the respondent's readiness for voluntary services, and opportunities for a person to contest continuation.
    a. Ensure the petitioner proves, by clear and convincing evidence since the last order, that the order remains necessary, less restrictive alternatives are still inadequate, and that the respondent continues to meet all statutory criteria
    b. Create a presumption against renewal if a person has fully complied with all order terms so that successful voluntary engagement supports order termination, not continuation
    c. Require that the judge engage in a personal colloquy with the respondent about their experience under the order

E. Oversight and Evaluation Reforms

- Establish an **AOT Ombuds Program** to receive and investigate complaints from people under AOT orders, family members, and advocates. The program should:
    a. Have the authority to intervene in court proceedings, request emergency hearings for rights violations, facilitate access to records and information for respondents and family members if authorized, assist with order modification requests, and refer serious violations to appropriate authorities
    b. Issue quarterly reports on systemic issues
- Establish an independent **AOT Oversight Commission** to ensure implementation of AOT in accordance with the law.
    a. Membership is appointed by the governor with Senate confirmation
    b. Must include representation from Disability Rights New York / New York PAIMI Contractor and disability rights experts
    c. At least half of members must identify as individuals with personal or family experience of civil commitment
    d. The Commission should have subpoena power for documents and testimony

e. The Commission should observe hearings, review case files, conduct interviews, review complaints, and issue findings and recommendations to the legislature on a regular basis

- Require an **independent, longitudinal outcome evaluation** that systematically tracks people under AOT across orders and renewals and following discontinuation of an order. The evaluation should assess the following outcomes:
    a. Mental health outcomes and recovery trajectories
    b. Social drivers of health and wellbeing (relationships, employment, housing)
    c. Quality of life and subjective wellbeing
    d. Voluntary service engagement after order expiration
    e. Cost-effectiveness of AOT compared to voluntary alternatives
    f. Medication prescribing practices and outcomes (side effect reporting and management, long-acting injectable use, consent and shared decision-making practices, prescribing quality and adherence to guidelines, physical health consequences of long-term medication use)

Conclusion

New York's Assisted Outpatient Treatment statute was enacted with the intention of providing a less restrictive alternative to hospitalization while ensuring individuals with serious mental illness receive necessary treatment. However, our evaluation suggests that systematic implementation challenges may undermine the therapeutic goals and constitutional protections the statute should embody.

The recommendations proposed in this document are designed to be actionable—a mix of statutory amendments, appropriations, administrative improvements, and practice changes that can be implemented in phases over time. They balance several crucial imperatives:

- **Strengthening civil rights protections:** Implementing constitutional standards for due process, equal protection, and right to refuse treatment while addressing the unique challenges of AOT proceedings.
- **Improving treatment quality:** Ensuring that court-ordered treatment prioritizes voluntary engagement and is evidence-based, individualized, recovery-oriented, and attentive to both therapeutic benefits and iatrogenic harms.
- **Enhancing system accountability:** Creating transparent oversight mechanisms, uniform standards, and meaningful responses to rights violations.
- **Addressing regional inconsistency:** Ensuring that due process protections and service availability are consistent across New York State, not dependent on county of residence.

- **Supporting least restrictive alternatives:** Developing a robust voluntary service infrastructure that genuinely makes court involvement a last resort.

Perhaps most importantly, these recommendations recognize that individuals with serious mental illness deserve both recovery-oriented, high-quality treatment and respect for their dignity and autonomy. There need does not need to be a conflict between civil rights and appropriate care:. A mental health system that provides robust voluntary services, engages individuals as partners in their own recovery, and reserves involuntary outpatient commitment for only the most extreme situations can better serve both public health and constitutional principles.

The New York State Legislature has the opportunity to make Kendra's Law a model for rights-oriented implementation of AOT. These reforms provide a roadmap for that transformation.

Appendix A: Acronyms

ACT	Assertive Community Treatment
AOT	Assisted Outpatient Treatment
CAIRS	Child and Adult Integrated Reporting System
CCHD	Computerized Criminal History Database
CEM	Coarsened Exact Match
CIT	Crisis Intervention Team
CPEP	Comprehensive Psychiatric Emergency Program
COC	Continuity of Care Index
CORE	Community Oriented Recovery and Empowerment
CTO	Community Treatment Order
DCS	Director of Community Services
DSS	Department of Social Services
DHS	Department of Homeless Services
DCJS	Division of Criminal Justice Services
ER/ED	Emergency Room / Emergency Department
EVA	Enhanced Voluntary Agreement
EVS	Enhanced Voluntary Services
EVSA	Enhanced Voluntary Service Agreement
HH+	Health Home Plus
HIPAA	Health Insurance Portability and Accountability Act
HSRI	Human Services Research Institute
ICM	Intensive Community Monitoring Program
IDD	Intellectual and Developmental Disabilities
IM	Intramuscular Injection
INSET	Intensive and Sustained Engagement Team
IOC	Involuntary Outpatient Commitment
IRB	Institutional Review Board
LGU	Local Governmental Unit
MCT	Mandated Community Treatment
MHL	Mental Hygiene Law
MHLS	Mental Hygiene Legal Services
MHOTRS	Mental Health Outpatient Treatment and Rehabilitative Services
MRC	Medical Research Council (UK)
NYS	New York State
OASAS	Office of Addiction Services and Supports
OMH	Office of Mental Health
OPWDD	Office for People with Developmental Disabilities
PROS	Personalized Recovery-Oriented Services
RCT	Randomized Controlled Trial
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants (or Drivers) of Health
SMI	Serious Mental Illness
SPOA	Single Point of Access
SUD	Substance Use Disorder
TACT	Tracking for AOT Cases and Treatments (Database)
UPC	Usual Provider of Care

Appendix B: NYS OMH Regions and Counties

NYS OMH Region/Field Office	Counties Included
1. Central New York	Broome Cayuga Chenango Clinton Cortland Delaware Essex Franklin Fulton Hamilton Herkimer Jefferson Lewis Madison Montgomery Oneida Onondaga Oswego Otsego St. Lawrence
2. Hudson River	Albany Columbia Dutchess Greene Orange Putnam Rensselaer Rockland Saratoga Schenectady Schoharie Sullivan Ulster Warren Washington Westchester
3. Long Island	Nassau Suffolk
4. New York City	Bronx Kings (Brooklyn) New York (Manhattan) Queens Richmond (Staten Island)
5. Western New York	Allegany Cattaraugus Chautauqua Chemung Erie Genesee Livingston Monroe Niagara Ontario Orleans Schuyler Seneca Steuben Tioga Tompkins Wayne Wyoming Yates

Appendix C: Key Timelines of Events Related to Kendra's Law

Pre-1999

1989: Involuntary outpatient commitment proposed by families of people with serious mental illness.
1994-1998: New York City Involuntary Outpatient Commitment Pilot Program at Bellevue Hospital in New York City (NYC), which largely laid the groundwork for Kendra's Law and AOT.

1999

January: Kendra Webdale pushed in front of a subway train by a man repeatedly hospitalized for schizophrenia.
January: Attorney General Eliot Spitzer announced a review of state laws governing the release of patients with mental illness.
January: Attorney General Spitzer proposed "outpatient commitment law" to be named "Kendra's Law" with permission from the Webdale family.
April: Charles Stevens, a man with a history of mental illness, was shot while wielding a sword at commuters on a Long Island train.
April: New York Times (NYT) editorials and op-ed called for passage of Kendra's Law.
April: Edgar Rivera was pushed in front of a subway train by a man with a history of mental illness. Rivera's legs were severed by the train.
May: Assembly Speaker Sheldon Silver signed onto Kendra's Law in a news conference with the Webdale family and Attorney Spitzer. On the same day, Governor Pataki announced a similar proposal.
May: Kendra's Law enacted as Bill No. A08477A
June: Governor Pataki and Speaker Silver announced agreement on Kendra's Law.
August: Governor Pataki signed Kendra's Law (Chapter 408 of the Laws of 1999), creating a statutory framework for court-ordered AOT.
November: Kendra's Law became effective and was designed to sunset every 5 years unless renewed (or made permanent.
November: Office of Mental Health (OMH) Guidelines for Initial Reporting by Local Governmental Units (LGUs) on Assisted Outpatient Treatment (AOT) became effective.

2000

June: Matter of Sarkis case regarding the statutory criteria of two hospitalizations for Kendra's Law.
September: Urcuyo, the first court challenge to the constitutionality of Kendra's Law, brought by the Mental Hygiene Legal Service (MHLS). All arguments were rejected.

2002

Undated: OMH promulgated AOT program standards.

2003

January: OMH issued the required Kendra's Law: An Interim Report on the Status of AOT and conducted a presentation.

2004

February: The Matter of K.L. case, a constitutional challenge brought on by MHLS. The challenge and appealed were rejected.
May: OMH revised AOT program standards.

2005

March: OMH updated the statutorily required 2003 Interim Report, released Kendra's Law Final Report on the Status of AOT and conducted a presentation.
June: Kendra's Law original sunset clause.
Undated: Chapter 137 of the Laws of 2005, Technical clarification regarding the eligibility criteria for AOT.
Undated: Chapter 158 of the Laws of 2005, amendments made to the AOT statute and sunset date for Kendra's Law extended until 2010.

2006

May: Kendra's Law is revised.

2008

June: Release of New York State/New York City Mental Health- Criminal Justice Panel: Report and Recommendations, which included recommendations on implementing systemic improvements to AOT.

2009

June: Release of the first evaluation of the AOT program conducted by Duke University School of Medicine, Policy Research Associates, and University of Virginia School of Law.

2010

October: Psychiatric Services published a special section on AOT in New York.
Undated: Two state lawmakers proposed legislation that would remove the sunset clause. Residents, they said, should have the security that Kendra's Law will always be there.
Undated: Chapter 111 of the Laws of 2010 – struck the reference to "unified services" in the definition of AOT.
Undated: Chapter 139 of the Laws of 2010 – extended the sunset date of Chapter 408 of the Laws of 1999 (Kendra's Law) from June 30, 2010, to June 30, 2015.

2011

April: Senate Bill S4881 introduced to enhance the AOT program and eliminate the expiration and repeal of Kendra's Law.
May: It was ruled in the case Matter of Miguel M v. Barron, 950 N.E. 2d 107 that federal law ("the HIPAA Privacy Rule") did not allow the City to obtain hospital records without the patient's consent.

2012

May: The Treatment Advocacy Center (TAC) provided revision/alternate to Senate Bill S4881.

2013

January: Chapter 1 of the Laws of 2013 (SAFE Act) amended Kendra's Law and extended it through 2017.
March: SAFE Act became effective.
November: Release of Revised Interim Guidelines for the Assignment of Persons with AOT Court Orders to Care Management in Health Home Environment.
Undated: OMH issues AOT County Transfer Guidance.

2014

February: OMH reissued Guidance for Reporting Significant Events.
September: OMH reissued Guidance for AOT Program Operation.
Undated: OMH introduced Health Home Plus (HH+) to target AOT population enrolled in HH.

2015

Undated: Chapter 382 of the Laws of 2015 allowed for the use of a psychiatrist employed by the state to provide the examination for and testify in court during "Kendra's Law" hearings in counties with a population under 80,000.

2016

October: OMH revised HH+ Program Guidance for AOT.

December: Memo to Managed Care Behavioral Health Medical Directors regarding use of Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to identify people with AOT orders and/or who received Assertive Community Treatment (ACT) services.

2017

February: OMH reissued Guidance for Reporting Significant Events.

April: Assisted Outpatient Treatment in New York State: The Case for Making Kendra's Law Permanent by Stephen Eide of the Manhattan Institute was published.

Undated: Chapter 67 of the Laws of 2017 extended Kendra's Law until 2022.

2018

April: Police killed a Brooklyn man (Saheed Vassell, a person with a bipolar disorder) who was wielding a pipe like a gun.

April: Several newspaper articles advocated for strengthening Kendra's Law**.**

April: Senate passed bill to make Kendra's Law permanent (S.516-b). The measure was not taken up by the Assembly.

2019

March: Senate Bill S4728 introduced to make the provisions of Kendra's Law permanent to enhance assisted outpatient program and eliminate the expiration and repeal of Kendra's Law.

2020

January: Senate Bill S4728 was referred to the NY – Mental Health and Developmental Disabilities Committee (Senate).

March: COVID-19 pandemic shutdowns began; New York declared a state disaster emergency on March 7, 2020.

March: Governor's Executive Order 202.8, dated March 7, 2020, as extended to October 23, 2020 by Executive Order 202.65, suspended all statutes of limitations regarding time sensitivity – including when AOT petitions and hearings needed to take place.

March: Under Administrative Order 75 from the New York Courts, AOT petitions were considered "Essential Applications" and were to be accepted for filing by county or clerk in paper or electronic filings. Extensions of AOT orders were also considered "Essential Applications." AOT orders set to expire on or after March 20, 2020 for which a petition for an extension of an order was or would be filed were extended.

September: FAQ for AOT revised. AOT orders set to expire on or after March 20, 2020 were extended.

2021

February: OMH Revised Guidance Effective February, 2021 Assignment of Persons with Assisted Outpatient Treatment Court Orders to Care Management in a Health Home Environment.
February: Four subway stabbings in NYC by Rigoberto Lopez, who was homeless and suffered from mental illness.
February: Gov. Andrew M. Cuomo suggested at a news conference that state lawmakers should revisit Kendra's Law.
February: Brooklyn Borough President Eric Adams and Councilman Ydanis Rodriguez – chair of the Transportation Committee – called for an expansion of social services coordinated with NYPD enforcement. Recommendations included strengthening Kendra's Law.
March: Advocates opposed expanding Kendra's Law. They advocated for expanding successful voluntary engagement and support innovations.
June: The COVID-19 state disaster emergency expired in New York.
September: OMH reissued Reporting AOT County Transfer.
October: Newspaper article regarding attacks by people who are mentally ill in the NYC subways. Called for expansion of Kendra's Law.

2022

January: Michelle Go was shoved onto subway tracks and killed by a train.
January/February: Newspaper articles published on the subject of subway shoving by people with serious mental illness.
January/February: Officials called for the expansion of state laws on mandatory treatment for mental illness.
February: Mayor Adams announced his "Subway Safety Plan" after the killing of Michelle Go.
February: Commissioner Sullivan issued guidance to law enforcement and emergency personnel that said they may take into custody "persons who appear to be mentally ill and who display an inability to meet basic living needs, even when there is no recent dangerous act" – a similar standard to the new AOT criteria.
February: Governor Hochul seek to extend Kendra's Law.
February: NYS Grassroot Advocates called for major investment in voluntary mental health services and housing over coercive treatment like AOT.
March: Mayor Adams and Gov. Hochul called for a strengthening of laws governing mental illness and treatment. This was as a result of Michelle Go subway death.
March: Advocates descended on Albany to oppose Kendra's Law Expansion.
March: Hochul included a version of guidance issued by Commissioner in her proposal to expand Kendra's Law in the budget – part of a 10-point public safety agenda revealed two weeks before the April 1 start of the fiscal year that also included controversial changes to the state's bail, discovery, and Raise the Age laws.
March: Advocates pushed against Governor Hochul's 10-point proposal.
March-April: "According to a statement from the governor's office, the state will conduct 'an independent study' comparing outcomes for people on AOT versus people receiving treatment voluntarily. The study to be conducted by June 30, 2026."
April: OMH Side Letter outlines OMH contracting for an independent study of mental health treatment outcomes and the outcome measures to be included in the study. The report is due by June 30, 2026.
April: FY2023 Enacted Budget extended Kendra's Law through 2027 and enacted the most significant substantive amendments since the 2005 overhaul. The amendments would make AOT orders function more effectively, remove procedural bars, and increase coordination between service providers. To better enable AOT hearings, physicians would be able to testify virtually. Courts would be able to issue AOT orders for individuals whose symptoms have worsened. And hospitals would be required to share patient information with the mental health professionals responsible for supervising AOT orders. The state would also conduct an independent study on mental health treatment outcomes for individuals on AOT compared to individuals receiving voluntary services by June 30, 2026.
June: OMH issued Screening Checklist for AOT.
November: Mayor Adams announced an 11-point legislative agenda to address the ongoing crisis of individuals experiencing severe mental illnesses left untreated and unsheltered in NYC streets and subways. Included in the agenda re five barriers that prevent the use of AOT, with individuals stuck in the mental health system revolving door.
Undated (maybe April): Chapter 56 of the Laws of 2022, Part UU, Subpart H extended section 9.60 of Mental Health Hygiene Law (Assisted Outpatient Treatment- AOT) through June 30, 2027**.** Changes were included.

2023

January: OMH conducted focus groups with individuals and family members with lived experience with AOT, and with advocates, in preparation for the RFP to evaluate AOT.
January: Guest opinion essay in NYT on family member navigating Kendra's Law.
January: Harvey Rosenthal piece in Mental Health Weekly Rejecting Coercion, Embracing Community Innovation, asked for more funding of community innovations.
May: Ending of COVID-19 related flexibilities afforded to providers regarding minimum billing standards and documentation requirements.
July: OMH released RFP for AOT Evaluation.
August: Person released from an AOT order shoved a woman onto the subway tracks, breaking her leg.
August: OMH released New York State Outpatient Treatment Guidance for Physicians.
October: OMH released Intensive and Sustained Engagement Teams Request for Proposal, which is part of Enhanced Voluntary Services which is for people that do not require court-ordered treatment but were willing to voluntarily participate in needed services.
December: NYT article "Kendra's Law Was Meant to Prevent Violence. It Failed Hundreds of Times" published. Report on an investigation they conducted that shows that "people under Kendra's Law orders have been accused of committing more than 380 subway shovings, beatings, stabbings and other violent acts in the past five years alone."

2024

January: Governor Hochul FY2025 Executive Budget proposed to invest $4.8 billion to address serious mental illness and youth mental health crisis.
January: OMH hired HSRI and the University of Pittsburgh to conduct an AOT study.
February: The Office of the State Comptroller (OSC)'s Tom DiNapoli released an audit stating that NYS OMH "needs to do better at overseeing timely treatment for individuals under a state law that requires people in a mental health crisis receive treatment" (it is regarding Kendra's Law).
February: NYT published an article on the OSC's audit.
August: OMH provided, as required, a response to the OSC final audit report.
December: Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness reissued and included people under AOT orders.

2025

January: Senate Bill S145 introduced to make the provisions of Kendra's Law permanent.
January: Governor Hochul in the State-of-the-State address called for expansion of involuntary commitment and strengthening of Kendra's Law. Discussed "safe streets and subways."
February: FY2026 Executive Briefing Book included sections "Bolster Involuntary Commitment and Assisted Outpatient Treatment (AOT) and "Modernize Mental Hygiene Law to Expand Access to Care."
May: Governor Hochul signs legislation to improve mental health care and strengthen treatment for serious mental illness as part of FY2026 Budget. The budget included $16.5 million to enhance county-level implementation of AOT as well as $2 million for OMH to add staff to provide additional oversight of AOT. The budget also modifies Kendra's Law so that new petitions can be filed within six months of an order expiring in instances when the individual becomes disconnected from care and experiences mental health symptoms that substantially interfere with their ability to comply with treatment or that result in emergency treatment, inpatient admission, or incarceration.
June: Governor Hochul announced she would ratify amendments to the Mental Hygiene Law (MHL) to "address gaps in the standards for involuntary commitment."
August: Amendments were made to §9.60 of MHL to expand the scope of Kendra's Law to improve continuity of care and address gaps in treatment compliance. Key change included expanding eligibility for re-AOT orders and aligning AOT eligibility with the broader expansion of emergency hospitalization criteria under MHL 9.39. The amendment repealed the 2022 extension of the law through June 30, 2027.

Appendix D: Interview Protocols

Mixed Methods Evaluation of the New York State's Assisted Outpatient Treatment (AOT) Program

Summary of Interview Guide Domains and Question Areas for People Under AOT Orders

Background/Involvement with AOT

- Where do you currently live, and where were you living when you were under AOT?
- What is the timeline of your AOT involvement?

Events Leading up to AOT

- What was life like before you were under AOT?
- What services were you getting or not getting?
- Why was AOT initiated, by whom, and under what circumstances?
- Were any voluntary alternatives considered or offered?

AOT Process

- Were you contacted by an attorney? What was that like?
- Did you attend your hearing? What was that like?
- What were the changes to your services?
- Were there any changes to your housing or living situation?

Removals, Renewals, and Discharge/Graduations

- Have you ever experienced a removal order? What happened?
- While you were on AOT, did you know what you needed to do to get off?
- How did you end up being discharged or stepped down? What happened after?

Impacts

- Do you think you'd be in the same place now if you hadn't been ordered into AOT? If yes, why? If not, what would be different?

Conclusion

- What would you want legislators to understand about the experience and personal impact of AOT?
- If you were speaking directly to policy makers, what (if anything) would you recommend changing about AOT laws or implementation?
- Anything else you want to circle back to or that you'd like to add to what we've already discussed?

Summary of Interview Guide Domains and Question Areas for Family Members/Loved Ones/Supporters

Background/Involvement with AOT

- Where does the individual currently live, and where were they living when under AOT?
- What is the timeline of their AOT involvement?

Events Leading up to AOT

- What was life like before they were under AOT?
- What services were they getting or not getting?
- Why was AOT initiated, by whom, and under what circumstances?
- Were any voluntary alternatives considered or offered?

AOT Process

- Were they contacted by an attorney? What was that like?
- Did you attend their hearing? Did they? What was that like?
- What were the changes to their services? What was included in their treatment plan? How flexible was the plan?
- Were there any changes to their housing or living situation?

Removals, Renewals, and Discharge/Graduations

- Did they ever experience a removal order? What happened?
- While they were on AOT, did they know what they needed to do to get off?
- How did they end up being discharged or stepped down? What happened after?

Impacts

- Do you think they'd be in the same place now if they hadn't been ordered into AOT? If yes, why? If not, what would be different?
- Was there anything about overall "involuntariness" of AOT that you or the person found helpful, harmful or neutral?

Conclusion

- What would you want legislators to understand about the experience and personal impact of AOT?

Summary of Interview Guide Domains and Question Areas for Advocates

Background/Involvement with AOT

- Personal and professional background
- Nature of involvement with AOT

Understanding of/Reflecting on AOT

- Purpose of, need for, and ideal implementation of AOT
- Use of AOT in your county/area/state

Advocacy Efforts Related to:

- AOT/Kendra's Law Legislation
- AOT education and information
- AOT processes
    - Order initiation
    - Court hearings
    - Treatment plans/Planning and compliance
    - Service provision
    - Removals/pick-ups
    - Renewals and non-renewals

Impacts, Strengths, and Challenges

- Positive impacts of AOT
- Negative impacts of AOT
- Strengths and challenges associated with AOT

Rights, Protections, and Socio-Cultural Factors

- Implications of AOT regarding legal and civil rights, and influence of socio-structural factors

General Question/Conclusion

- Further thoughts or others we should talk to

Summary of Interview Guide Domains and Question Areas for County Director of Community Services (DCS) or Designee and AOT Coordinators

Background/Involvement with AOT

- Organization and role
- Nature of involvement with AOT

Understanding of/Reflecting on AOT

- Purpose of, need for, and ideal implementation of AOT
- Use of AOT in your county/area

AOT Education and Information

- Kinds of education and information available for AOT, and how education/information might be improved

AOT Process

Experiences and perceptions related to (if relevant):

- Order initiation
- Court hearings
- Treatment plans/Planning and compliance
- Service provision
- Removals/pick-ups
- Renewals and non-renewals

Coordination Among Providers

- How coordination is going
- Suggestions for how coordination could be improved

Impacts, Strengths, and Challenges

- Positive impacts of AOT
- Negative impacts of AOT
- Strengths and challenges associated with AOT

Rights, Protections, and Socio-Cultural Factors

- Implications of AOT regarding legal and civil rights, and influence of socio-structural factors

General Question/Conclusion

- Further thoughts or others we should talk to

Summary of Interview Guide Domains and Question Areas for New York City AOT Program

Background/Involvement with AOT

- Organization and role
- Nature of involvement with AOT

Understanding of/Reflecting on AOT

- Purpose of, need for, and ideal implementation of AOT
- Use of AOT in your county/area

AOT Education and Information

- Kinds of education and information available for AOT, and how education/information might be improved

AOT Process

Experiences and perceptions related to (if relevant):

- Order initiation
- Court hearings
- Treatment plans/Planning and compliance
- Service provision
- Removals/pick-ups
- Renewals and non-renewals

Coordination Among Community Partners (Providers, First Responders, etc.)

- How coordination is going
- Suggestions for how coordination could be improved

Impacts, Strengths, and Challenges

- Positive impacts of AOT
- Negative impacts of AOT
- Strengths and challenges associated with AOT

Rights, Protections, and Socio-Cultural Factors

- Implications of AOT regarding legal and civil rights, and influence of socio-structural factors

General Question/Conclusion

- Further thoughts or others we should talk to

Summary of Interview Guide Domains and Question Areas for Providers

Background/Involvement with AOT

- Organization and role
- Nature of involvement with AOT

System of Care

- Strengths and most important services

Understanding of/Reflecting on AOT

- Purpose of, need for, and ideal implementation of AOT
- Use of AOT in your county/area

AOT Education and Information

- Kinds of education and information available for AOT, and how education/information might be improved

AOT Process

- Experiences and perceptions related to (if relevant):
- Order initiation
- Court hearings
- Treatment plans/Planning and compliance
- Service provision
- Removals/pick-ups
- Renewals and non-renewals

Coordination among Providers

- How coordination is going
- Suggestions for how coordination could be improved

Impacts, Strengths, and Challenges

- Positive impacts of AOT
- Negative impacts of AOT
- Strengths and challenges associated with AOT

Rights, Protections, and Socio-Cultural Factors

- Implications of AOT regarding legal and civil rights, and influence of socio-structural factors

General Question/Conclusion

- Further thoughts or others we should talk to

Summary of Interview Guide Domains and Question Areas for Legal System Professionals

Background/Involvement with AOT

- Organization and role
- Nature of involvement with AOT

Understanding of/Reflecting on AOT

- Purpose of, need for, and ideal implementation of AOT
- Use of AOT in your county/area

AOT Education and Information

- Kinds of education and information available for AOT, and how education/information might be improved

AOT Process

Experiences and perceptions related to (if relevant):

- Order initiation
- Court hearings
- Treatment plans/Planning and compliance
- Service provision
- Removals/pick-ups
- Renewals and non-renewals

Impacts, Strengths, and Challenges

- Positive impacts of AOT
- Negative impacts of AOT
- Strengths and challenges associated with AOT

Rights, Protections, and Socio-Cultural Factors

- Implications of AOT regarding legal and civil rights, and influence of socio-structural factors

General Questions/Conclusion

- Further thoughts or others we should talk to

Exhibit D.1. *Demographic Characteristics of People under AOT Orders: Comparison of People Interviewed for the Evaluation and the AOT Population*

	N of people interviewed	% of people interviewed	N of AOT Population	% of AOT Population
Region				
Central	4	9%	743	6%
Hudson River	15	33%	2,256	20%
Long Island	13	28%	1,555	13%
NYC	10	22%	5,141	44%
Western	4	9%	1,858	16%
Age				
18-29	6	13%	3,881	35%
30-39	19	42%	2,900	26%
40-54	9	20%	2,682	24%
55-64	9	20%	1,318	12%
65+	2	4%	352	3%
Race/Ethnicity				
American Indian or Alaska Native	2	4%	77	1%
Asian	1	2%	522	5%
Black or African American	14	30%	4,027	37%
Hispanic or Latino	14	30%	2,182	20%
Middle Eastern or North African	1	2%	10	0.1%
Native Hawaiian or Pacific Islander	1	2%	27	0.3%
White	24	52%	3,946	37%
Other	2	4%	391	4%
Gender/Sex[1]				
Man/Male	26	57%	8,795	76%
Woman/Female	20	43%	2,758	24%
Other	0	0%	NA	NA
Education				
8th grade or under	1	2%	374	4%
High school, no diploma	4	9%	1,794	20%
High school diploma or equivalent	8	18%	3,784	43%
Some college, no degree	17	39%	1,622	18%
Associate's degree or vocational training	4	9%	360	4%
Bachelor's degree	8	18%	623	7%
Graduate degree	2	5%	207	2%
Other education completed	0	0%	80	1%
Housing				
Private residence	23	51%	5,393	52%
Permanent or temporary housing with supports	14	31%	3,068	29%

[1] Interviewees were asked about their gender, with options of man, woman, non-binary, and other; the demographic data provided for the AOT cohort identified this characteristic as "sex" with options of male and female

	N of people interviewed	% of people interviewed	N of AOT Population	% of AOT Population
Jail/prison	0	0%	48	0.5%
Residential treatment facility, skilled nursing home, adult home, or inpatient hospital	6	13%	719	7%
Homeless/unhoused	1	2%	1,071	10%
Other living situation	0	0%	161	2%
Prefer not to answer	1	2%	NA	NA
Income/support				
Wages/salary or self-employment	5	11%	454	4%
SSI/SSDI	36	82%	5,895	56%
Veterans' benefits	0	0%	71	1%
Workers' compensation or disability insurance	0	0%	17	0.2%
Unemployment	0	0%	46	0.4%
Social Security or retirement or Survivors benefits	2	5%	168	2%
Public assistance or cash program (Supplemental Nutrition Assistance Program (SNAP)/Food Stamps, Temporary Assistance for Needy Families (TANF) Welfare Benefits)	29	66%	1,652	16%
Family/friends/other people or trust/inheritance	6	14%	460	4%
Other	6	14%	386	4%
None	1	2%	0	0%
Insurance				
Medicaid (including if pending)	39	89%	2,793	26%
Medicare	16	36%	531	5%
Medication grant program (MGP)	0	0%	23	0.2%
Private insurance	3	7%	71	1%
Diagnosis				
Bipolar disorder	32	73%	833	9%
Schizophrenia spectrum disorder (schizophrenia, schizoaffective, schizophreniform)	27	61%	8,019	82%
Major depression	11	25%	231	2%
Post-traumatic stress disorder (PTSD)	6	14%	337	3%
Substance use disorder	3	7%	317	3%
Anxiety disorder	11	25%	16	0.2%
Other psychiatric diagnosis[2]	6	14%	NA	NA
Prefer not to answer	1	2%	NA	NA

[2] Other psychiatric diagnoses listed in the other (please specify) field include: ADHD, autism spectrum disorder, past substance use, and trauma.

Exhibit D.2. *Additional Demographic Characteristics of People under AOT Orders Interviewed for the Evaluation*

	N of people interviewed	% of people interviewed
How people pay for housing		
Section 8 or other housing voucher	5	11%
Housing subsidy (e.g. reduced rent due to disability or income)	9	20%
Your own income/earnings	5	11%
SSI/SSDI	31	69%
Another form of income/cash assistance	3	7%
Financial support from family, loved ones, or close supporters	10	22%
Not applicable (currently homeless/unhoused)	1	2%
Section 8 or other housing voucher	2	4%
Homeless or unhoused in the past		
No	19	42%
Yes	26	58%
Length of time spent homeless or unhoused in the past		
<1 year	10	38%
1-2 years	11	42%
3+ years	3	12%
Prefer not to answer	2	8%
Criminal justice system involvement		
Not currently involved in the criminal justice system	25	60%
Previous involvement with the criminal justice system	17	40%
Currently under probation or parole supervision	3	7%
Currently have a restraining order against me	2	5%
Currently under order of conditions; order of release; mental health criminal procedure law (e.g., CPL 330.20 or 730)	0	0%
Currently under other alternatives to incarceration including drug court, mental health court, conditional release, pre-trial services	3	7%

Exhibit D.3. *Demographic Characteristics of Family Members, Loved Ones, and Supporters of People under AOT Orders who were Interviewed for the Evaluation*

	N of people interviewed	% of people interviewed
Region		
Central	4	8%
Hudson River	15	31%
Long Island	14	29%
NYC	11	23%
Western	4	8%
Age		
18-29	6	13%
30-39	19	40%
40-54	11	23%
55-64	9	19%
65+	2	4%
Race/Ethnicity		
American Indian or Alaska Native	2	4%
Asian	1	2%
Black or African American	14	29%
Hispanic or Latino	14	29%
Middle Eastern or North African	1	2%
Native Hawaiian or Pacific Islander	1	2%
White	26	54%
Other	2	4%
Gender/Sex		
Man	27	56%
Woman	21	44%
Other	0	0%
Education		
8th grade or under	2	4%
High school, no diploma	4	9%
High school diploma or equivalent	8	17%
Some college, no degree	17	37%
Associate's degree or vocational training	4	9%
Bachelor's degree	9	20%
Graduate degree	2	4%
Other education completed	0	0%

Exhibit D.4. *Demographic Characteristics of Administrators, Psychiatrists, Legal System Professionals, Other Providers, and Advocates who were Interviewed for the Evaluation*

	N of people interviewed	% of people interviewed
Region		
Central	32	19%
Hudson River	39	23%
Long Island	40	24%
NYC	28	17%
Western	29	17%
Age		
18-29	5	8%
30-39	17	27%
40-54	22	35%
55-64	16	25%
65+	3	5%
Race/Ethnicity		
American Indian or Alaska Native	2	2%
Asian	6	6%
Black or African American	13	12%
Hispanic or Latino	10	10%
Middle Eastern or North African	0	0%
Native Hawaiian or Pacific Islander	0	0%
White	80	76%
Other	1	1%
Gender/Sex		
Man	21	20%
Woman	81	77%
Non-Binary	3	3%
Other	0	0%

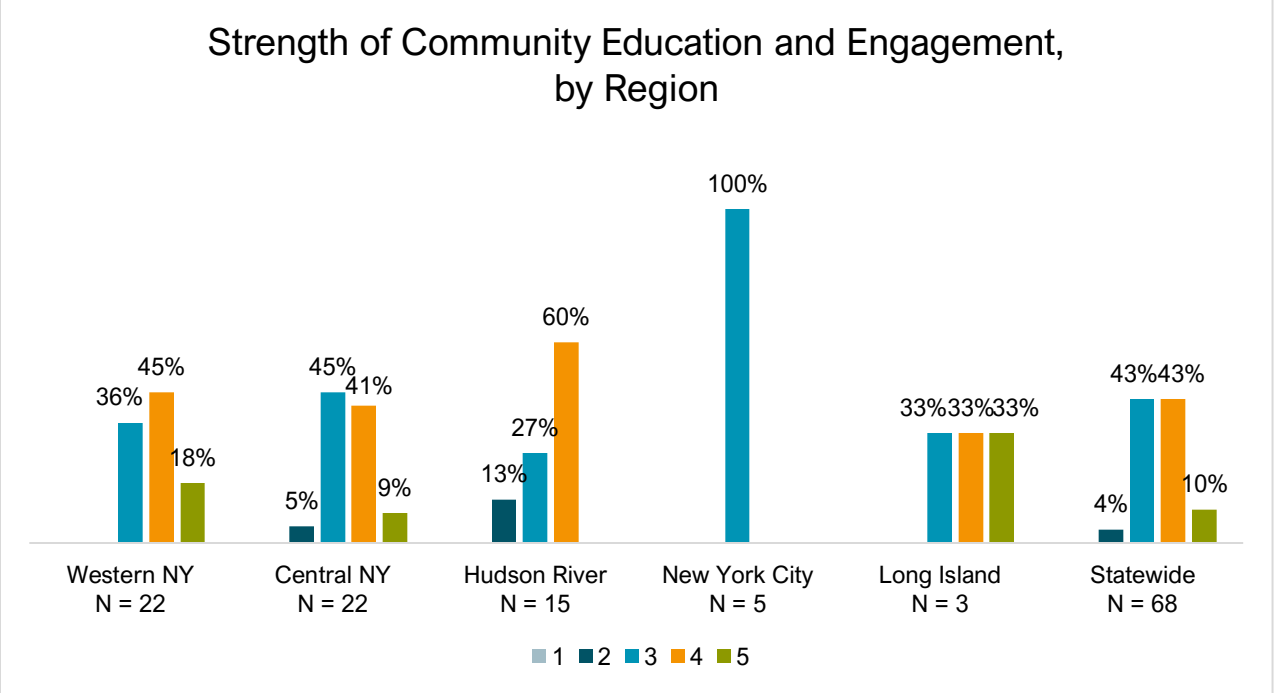
Appendix E: DCS Survey Results

The Service System

1. System Strengths: By system strengths, we mean the level and quality of services provided. How would you characterize the current strength of your community service system in the following areas? [Score on a scale of 1 to 5 with 1=None or Minimum strength and 5=Maximum Strength]

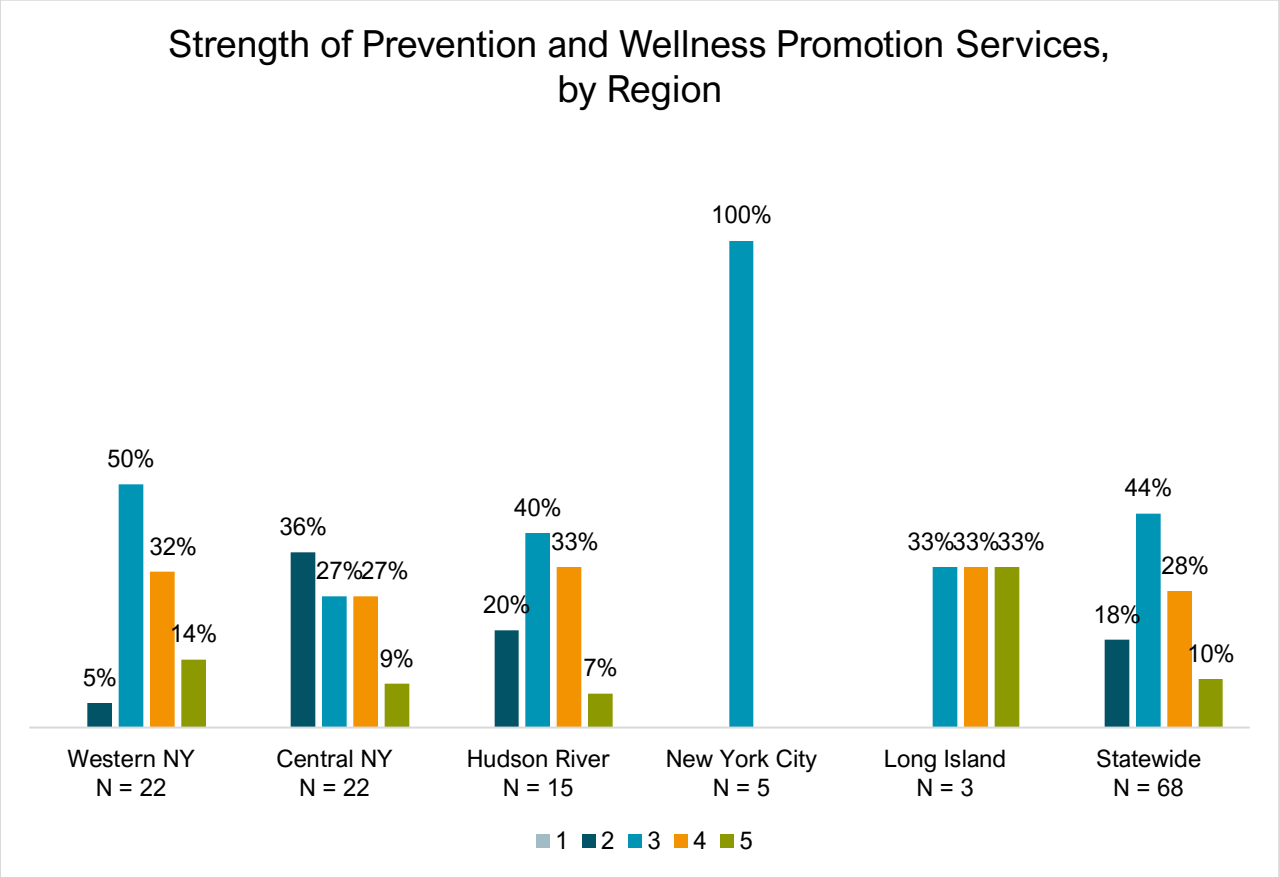
1a. Community education and engagement – Practices and services that promote awareness about services across the community

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.8 (0.7)	4.0	3.0	5.0
Central NY (N=22)	3.5 (0.7)	3.5	2.0	5.0
Hudson River (N=15)	3.5 (0.7)	4.0	2.0	4.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	4.0 (1.0)	4.0	3.0	5.0
STATEWIDE (N=68)	**3.6 (0.7)**	**4.0**	**2.0**	**5.0**



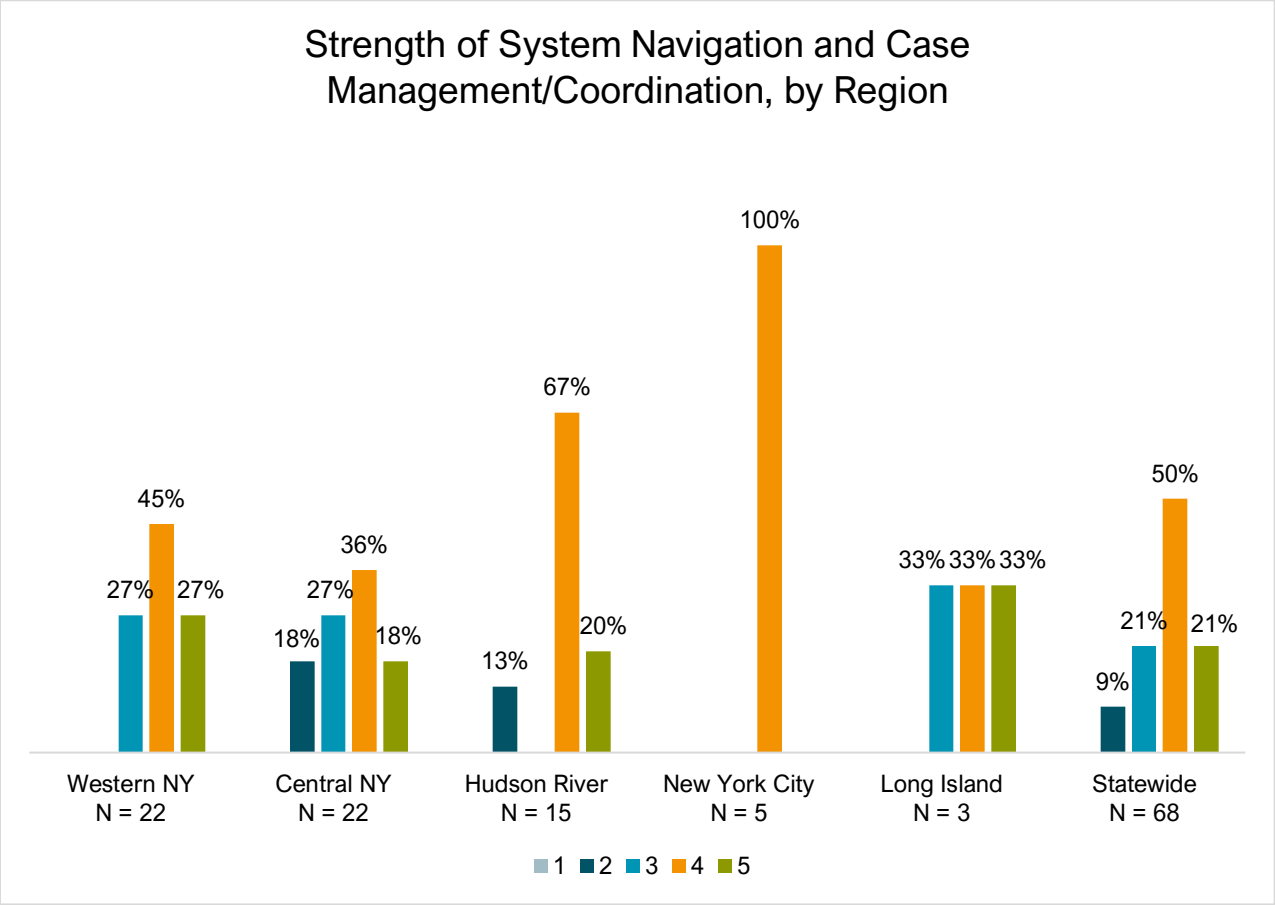
1b. Prevention and wellness promotion services – Targeted and universal programs and services that promote well-being and support early identification and prevention of mental health-related concerns

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.5 (0.8)	3.0	2.0	5.0
Central NY (N=22)	3.1 (1.0)	3.0	2.0	5.0
Hudson River (N=15)	3.3 (0.9)	3.0	2.0	5.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	4.0 (1.0)	4.0	3.0	5.0
STATEWIDE (N=68)	**3.3 (0.9)**	**3.0**	**2.0**	**5.0**



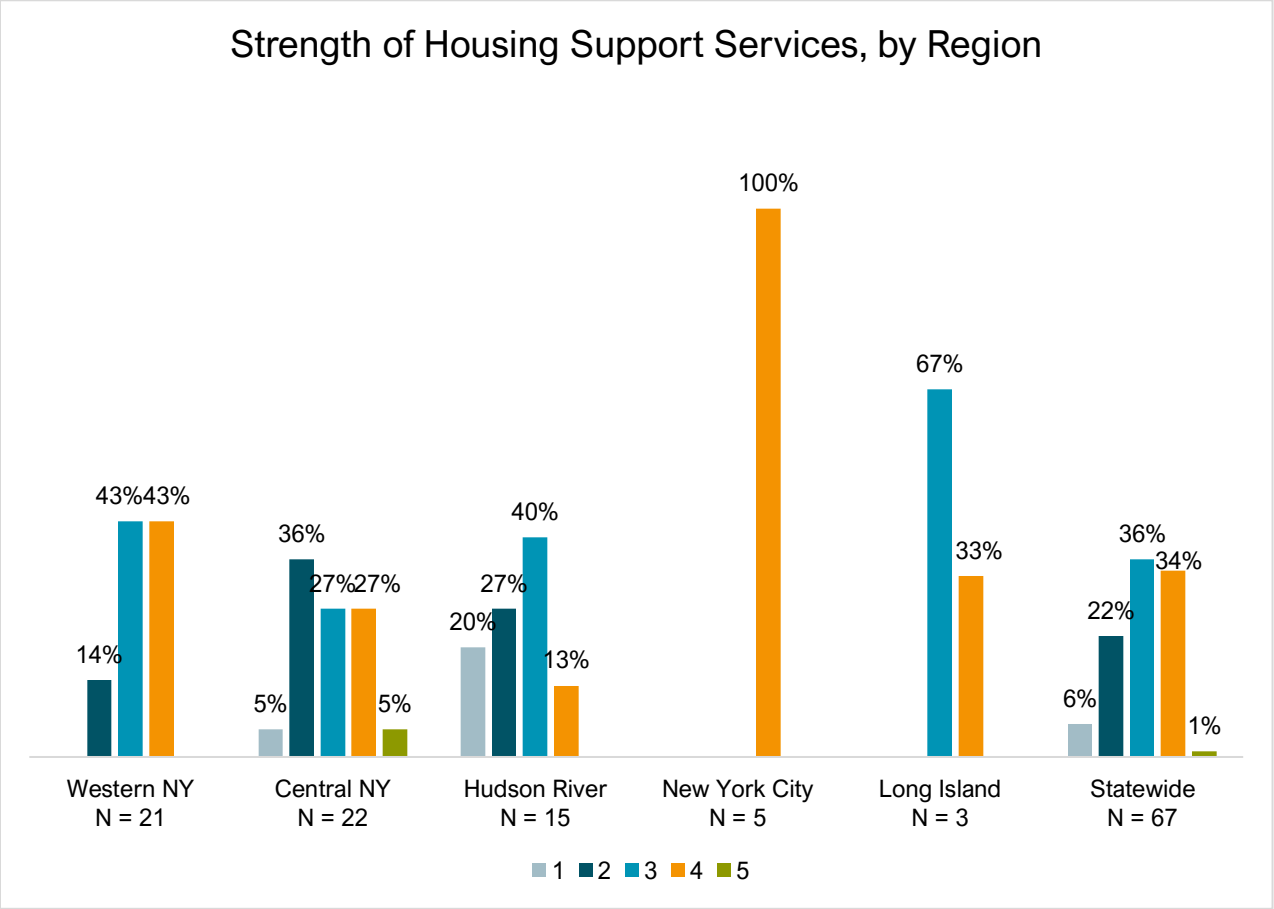
1c. System navigation and case management/coordination

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	4.0 (0.8)	4.0	3.0	5.0
Central NY (N=22)	3.5 (1.0)	4.0	2.0	5.0
Hudson River (N=15)	3.9 (0.9)	4.0	2.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	4.0 (1.0)	4.0	3.0	5.0
STATEWIDE (N=68)	**3.8 (0.9)**	**4.0**	**2.0**	**5.0**



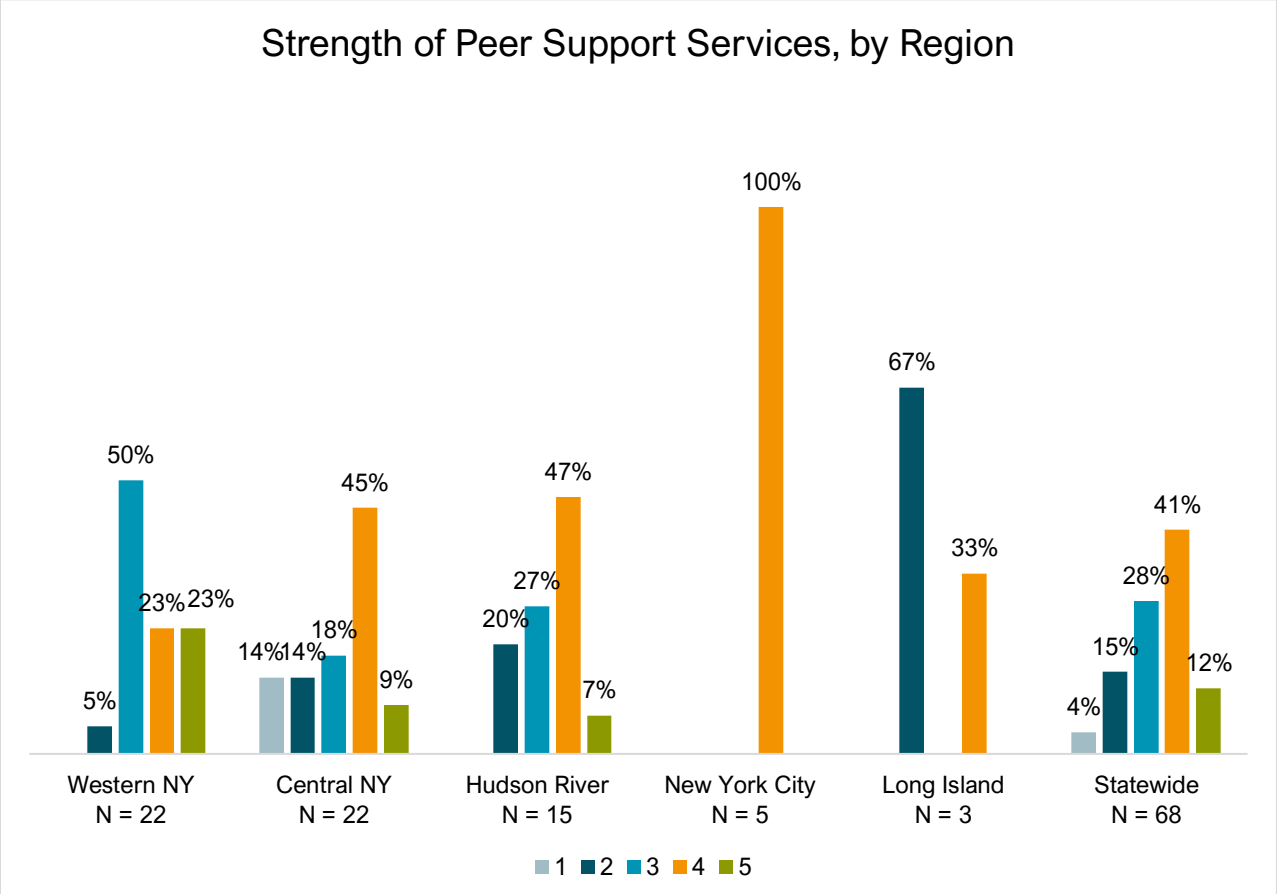
1d. Housing support services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=21)	3.3 (0.7)	3.0	2.0	4.0
Central NY (N=22)	2.9 (1.0)	3.0	1.0	5.0
Hudson River (N=15)	2.5 (1.0)	3.0	1.0	4.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	3.3 (0.6)	3.0	3.0	4.0
STATEWIDE (N=67)	**3.0 (0.9)**	**3.0**	**1.0**	**5.0**



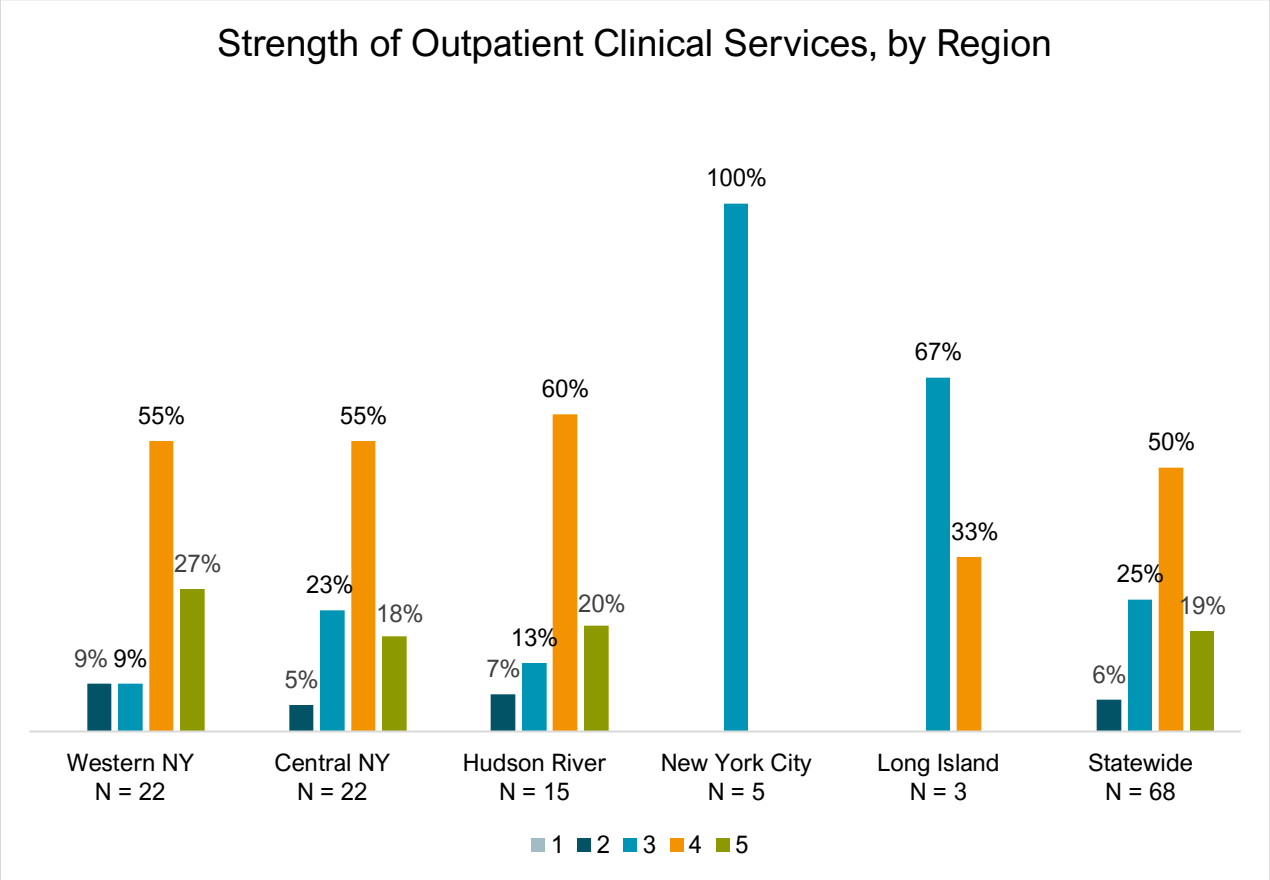
1e. Peer support services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.6 (0.9)	3.0	2.0	5.0
Central NY (N=22)	3.2 (1.2)	4.0	1.0	5.0
Hudson River (N=15)	3.4 (0.9)	4.0	2.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	2.7 (1.2)	2.0	2.0	4.0
STATEWIDE (N=68)	**3.4 (1.0)**	**4.0**	**1.0**	**5.0**



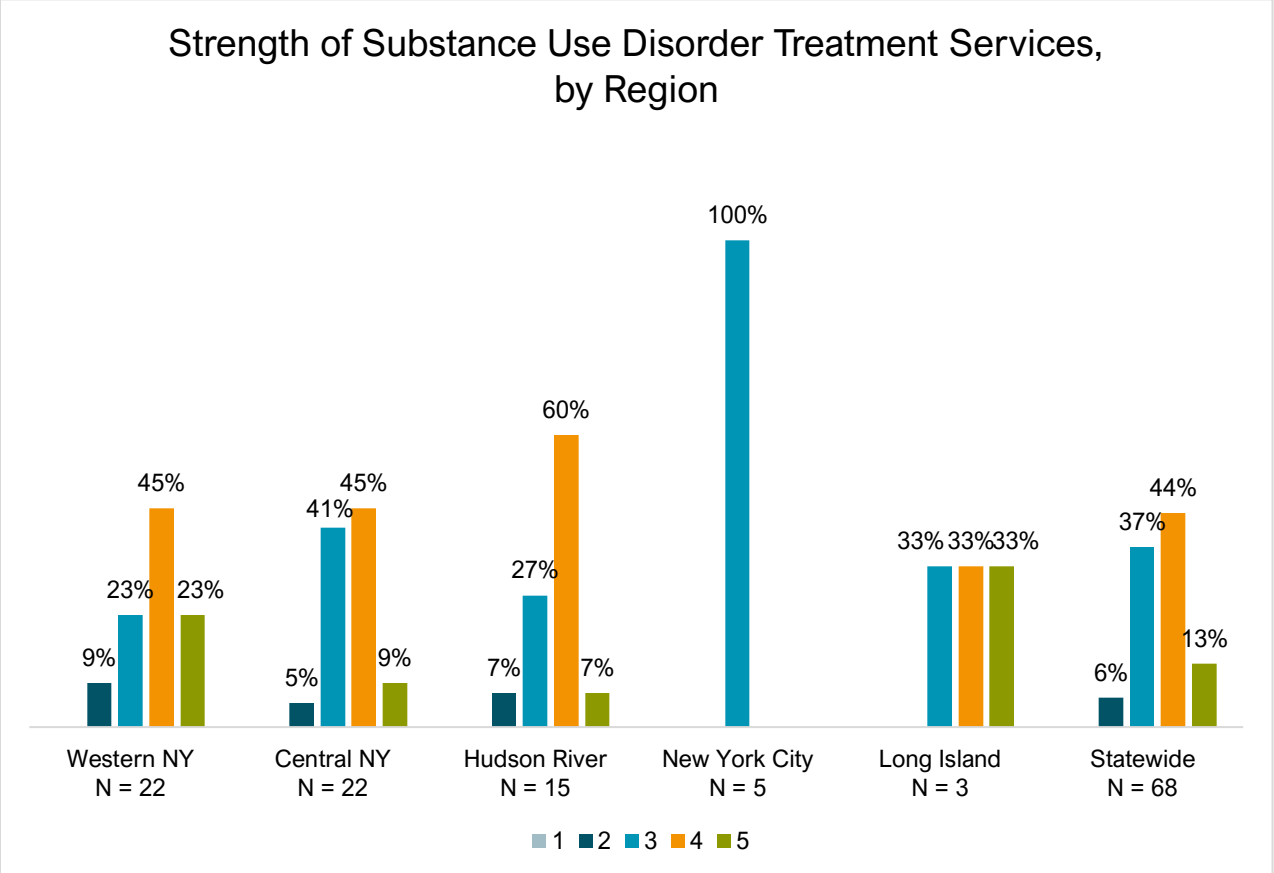
1f. Outpatient clinical services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	4.0 (0.9)	4.0	2.0	5.0
Central NY (N=22)	3.9 (0.8)	4.0	2.0	5.0
Hudson River (N=15)	3.9 (0.8)	4.0	2.0	5.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	3.3 (0.6)	3.0	3.0	4.0
STATEWIDE (N=68)	**3.8 (0.8)**	**4.0**	**2.0**	**5.0**



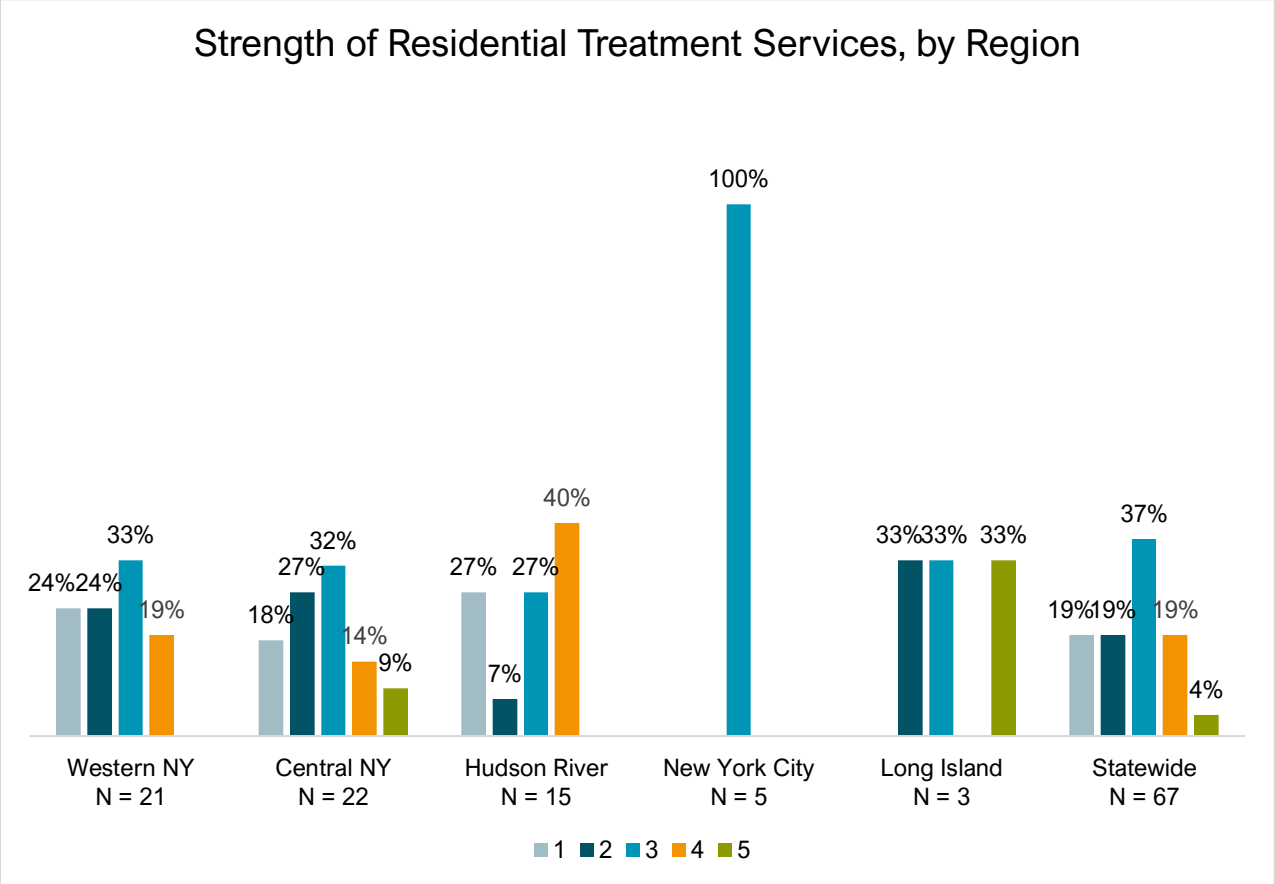
1g. Substance use disorder treatment services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.8 (0.9)	4.0	2.0	5.0
Central NY (N=22)	3.6 (0.7)	4.0	2.0	5.0
Hudson River (N=15)	3.7 (0.7)	4.0	2.0	5.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	4.0 (1.0)	4.0	3.0	5.0
STATEWIDE (N=68)	**3.6 (0.8)**	**4.0**	**2.0**	**5.0**



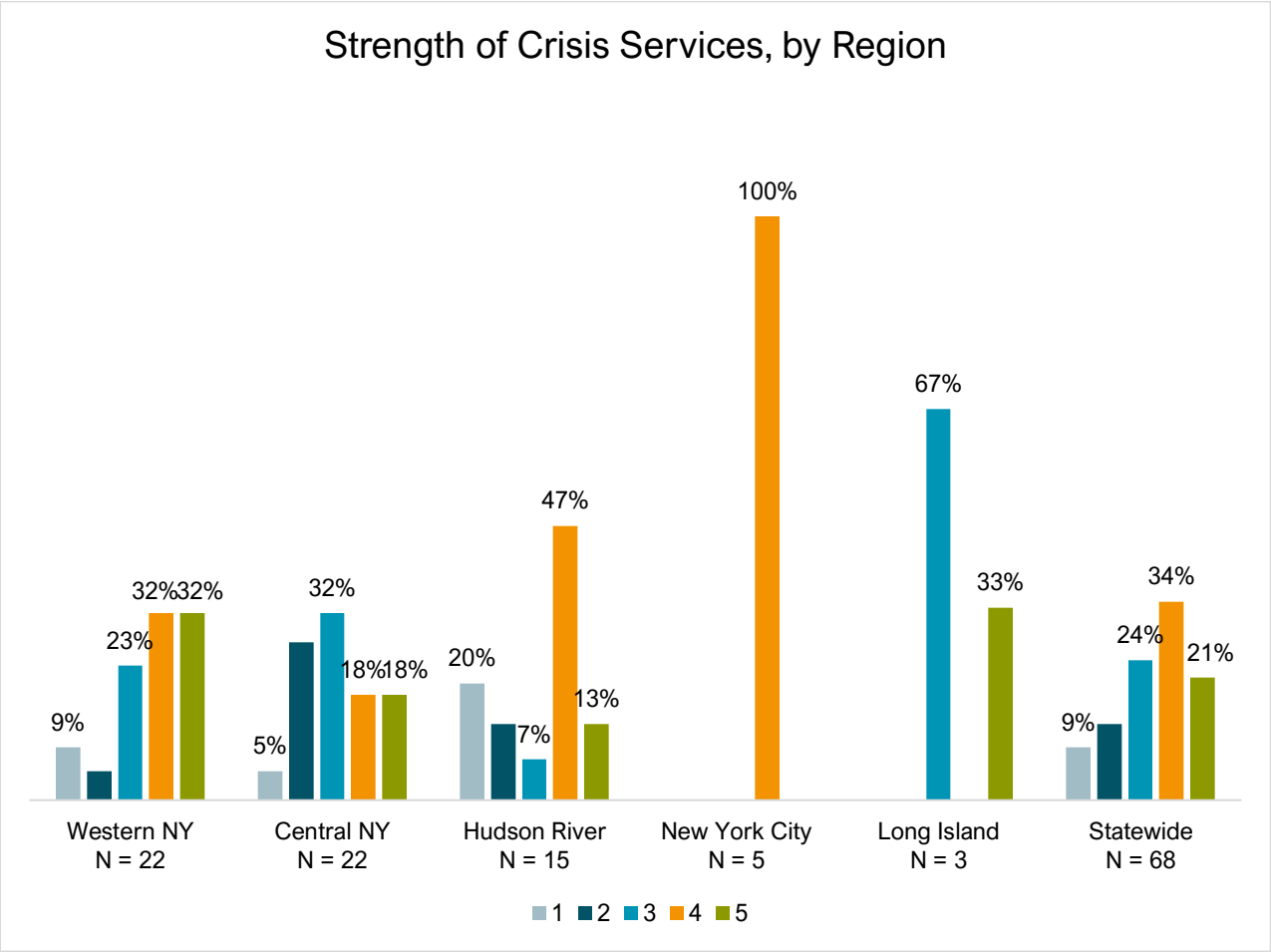
1h. Residential services – Services provided in structured, facility-based settings

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=21)	2.5 (1.1)	3.0	1.0	4.0
Central NY (N=22)	2.7 (1.2)	3.0	1.0	5.0
Hudson River (N=15)	2.8 (1.3)	3.0	1.0	4.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	3.3 (1.5)	3.0	2.0	5.0
STATEWIDE (N=67)	**2.7 (1.1)**	**3.0**	**1.0**	**5.0**



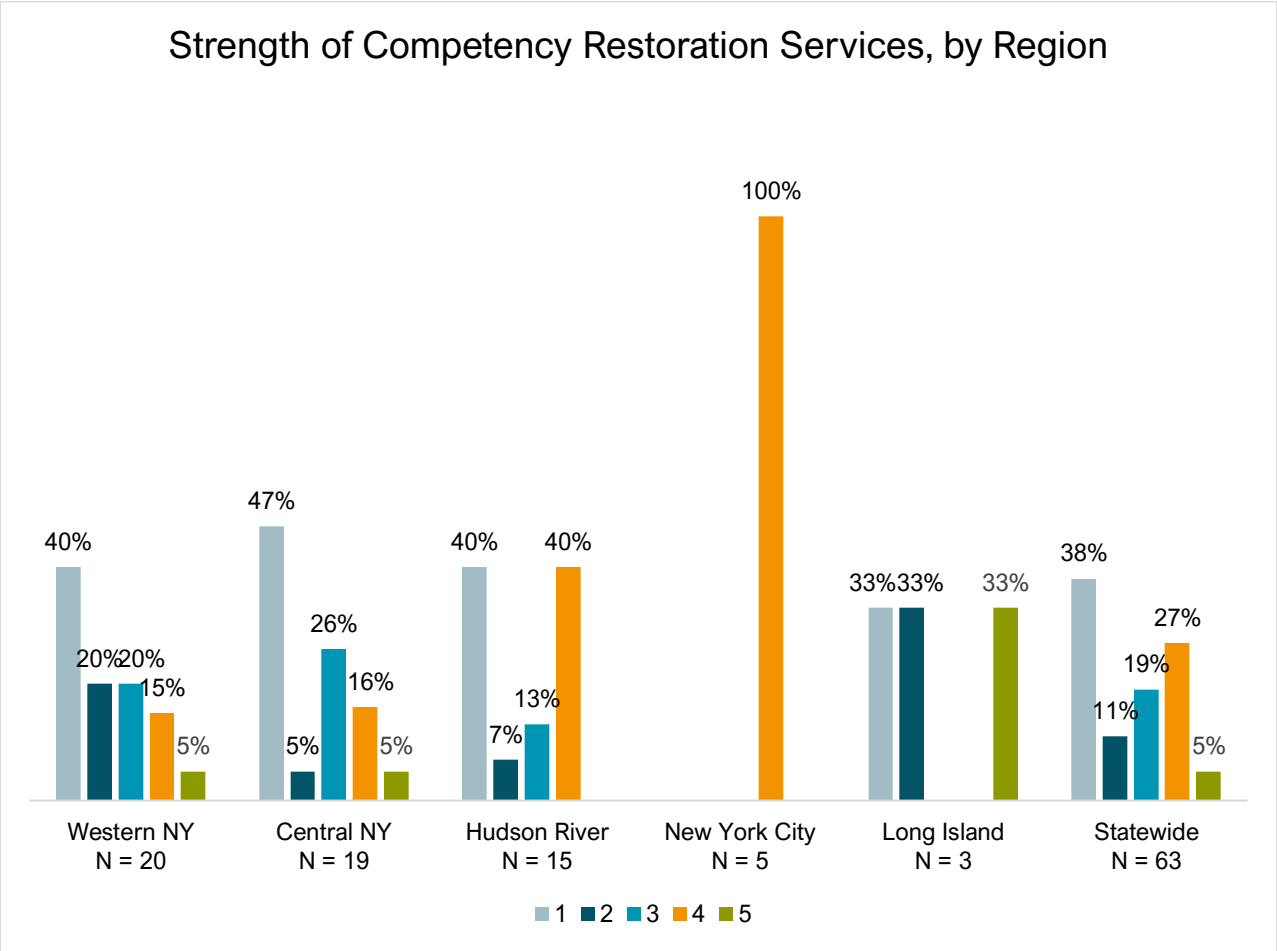
1i. Crisis services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.7 (1.2)	4.0	1.0	5.0
Central NY (N=22)	3.2 (1.2)	3.0	1.0	5.0
Hudson River (N=15)	3.2 (1.4)	4.0	1.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	3.7 (1.2)	3.0	3.0	5.0
STATEWIDE (N=68)	**3.4 (1.2)**	**4.0**	**1.0**	**5.0**



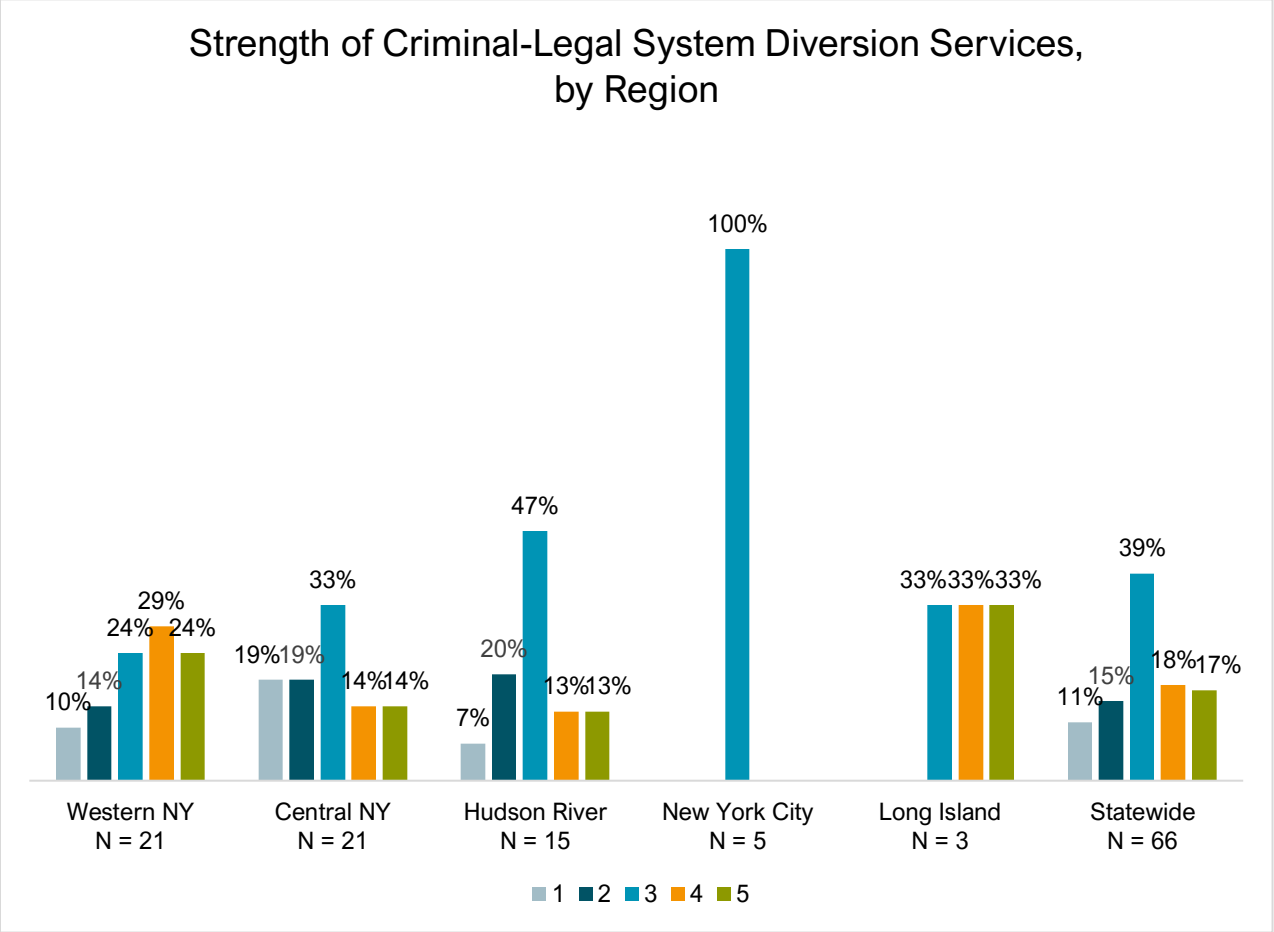
1j. Competency restoration services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=20)	2.3 (1.3)	2.0	1.0	5.0
Central NY (N=19)	2.3 (1.4)	2.0	1.0	5.0
Hudson River (N=15)	2.5 (1.4)	3.0	1.0	4.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	2.7 (2.1)	2.0	1.0	5.0
STATEWIDE (N=63)	**2.5 (1.4)**	**3.0**	**1.0**	**5.0**



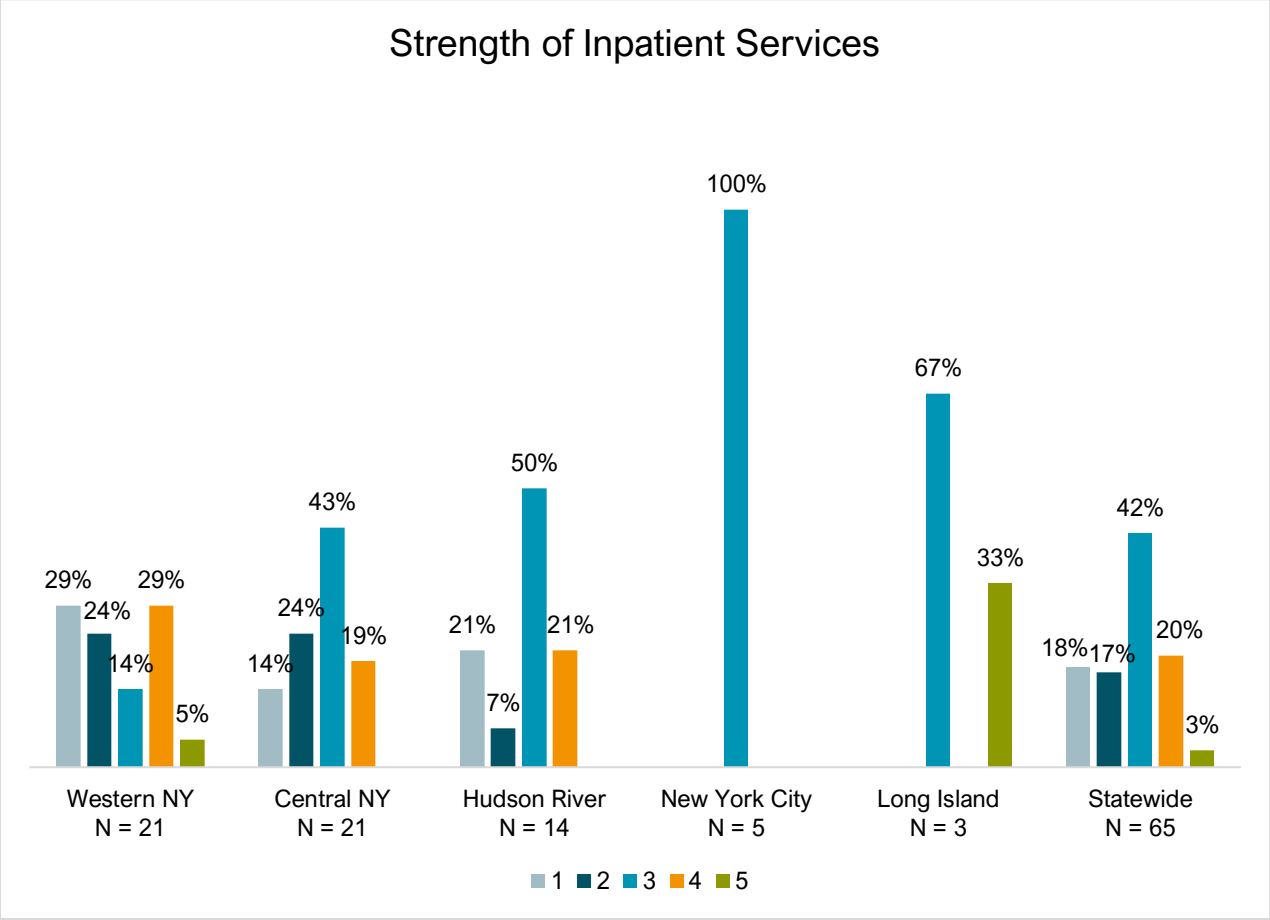
1k. Criminal legal system diversion services such as therapeutic courts

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=21)	3.4 (1.3)	4.0	1.0	5.0
Central NY (N=21)	2.9 (1.3)	3.0	1.0	5.0
Hudson River (N=15)	3.1 (1.1)	3.0	1.0	5.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	4.0 (1.0)	4.0	3.0	5.0
STATEWIDE (N=66)	**3.2 (1.2)**	**3.0**	**1.0**	**5.0**



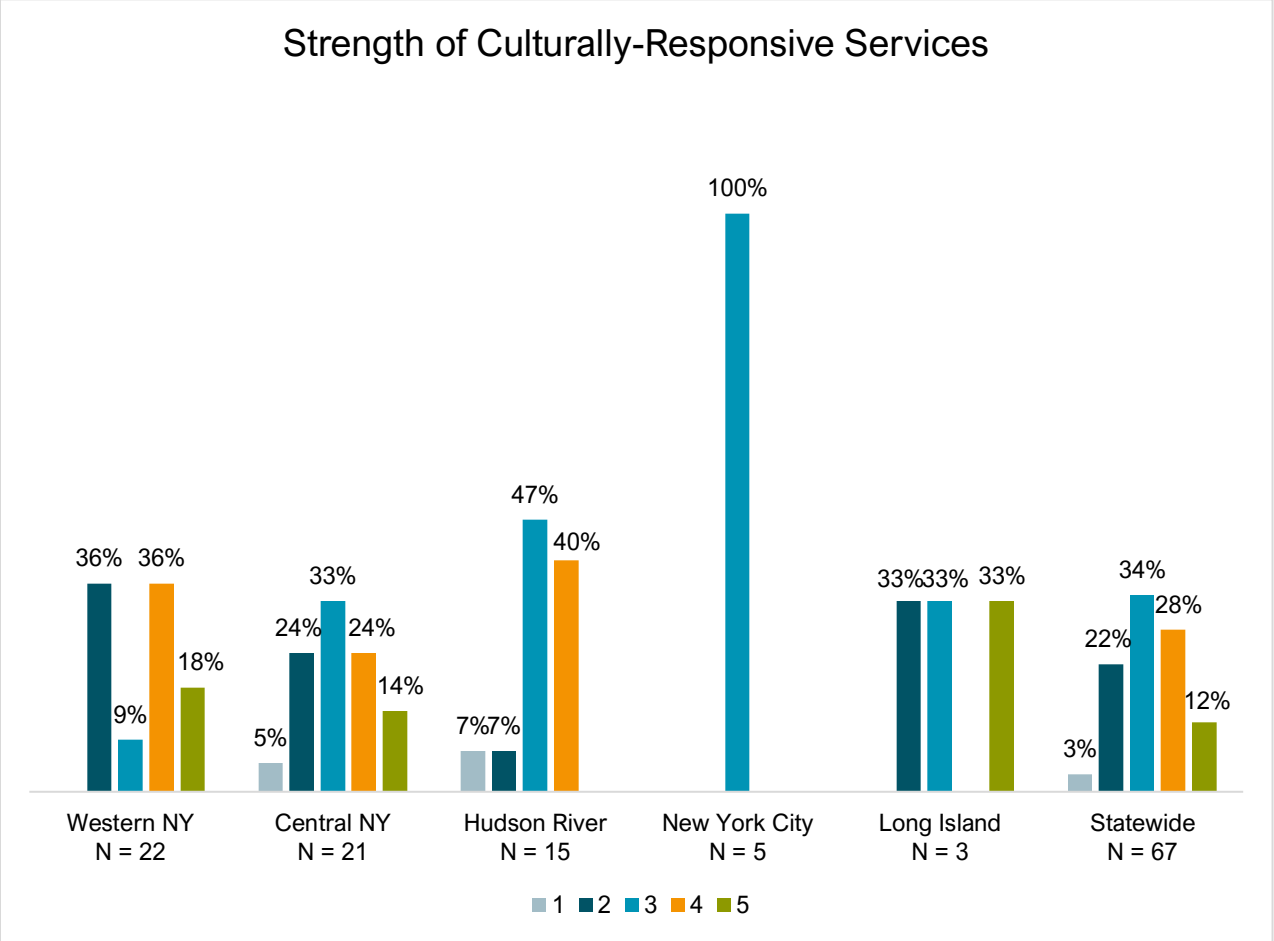
1l. Inpatient services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=21)	2.6 (1.3)	2.0	1.0	5.0
Central NY (N=21)	2.7 (1.0)	3.0	1.0	4.0
Hudson River (N=14)	2.7 (1.1)	3.0	1.0	4.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	3.7 (1.2)	3.0	3.0	5.0
STATEWIDE (N=65)	**2.7 (1.1)**	**3.0**	**1.0**	**5.0**



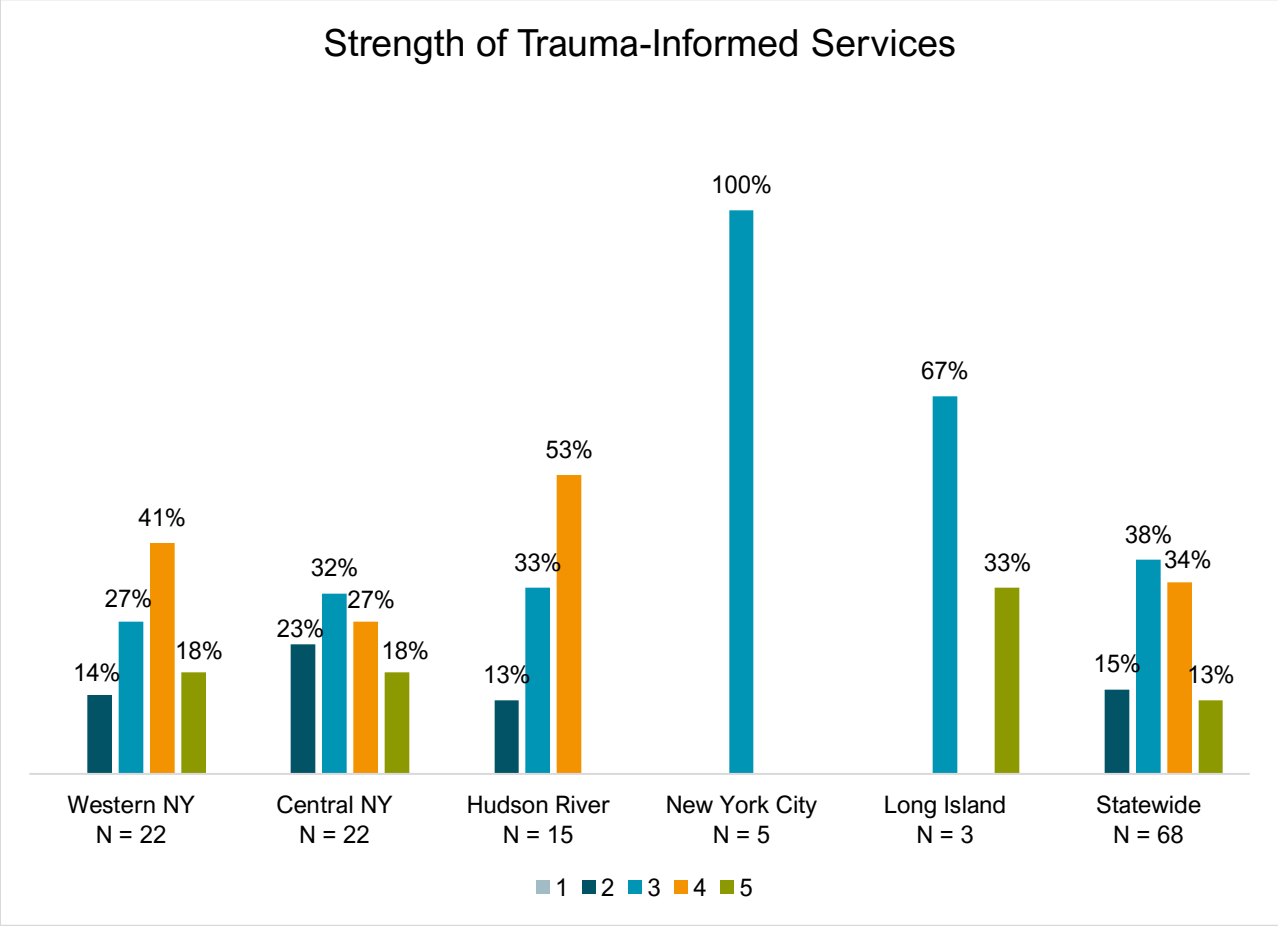
1m. Services that are culturally responsive

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.4 (1.2)	4.0	2.0	5.0
Central NY (N=21)	3.2 (1.1)	3.0	1.0	5.0
Hudson River (N=15)	3.2 (0.9)	3.0	1.0	4.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	3.3 (1.5)	3.0	2.0	5.0
STATEWIDE (N=67)	**3.2 (1.0)**	**3.0**	**1.0**	**5.0**



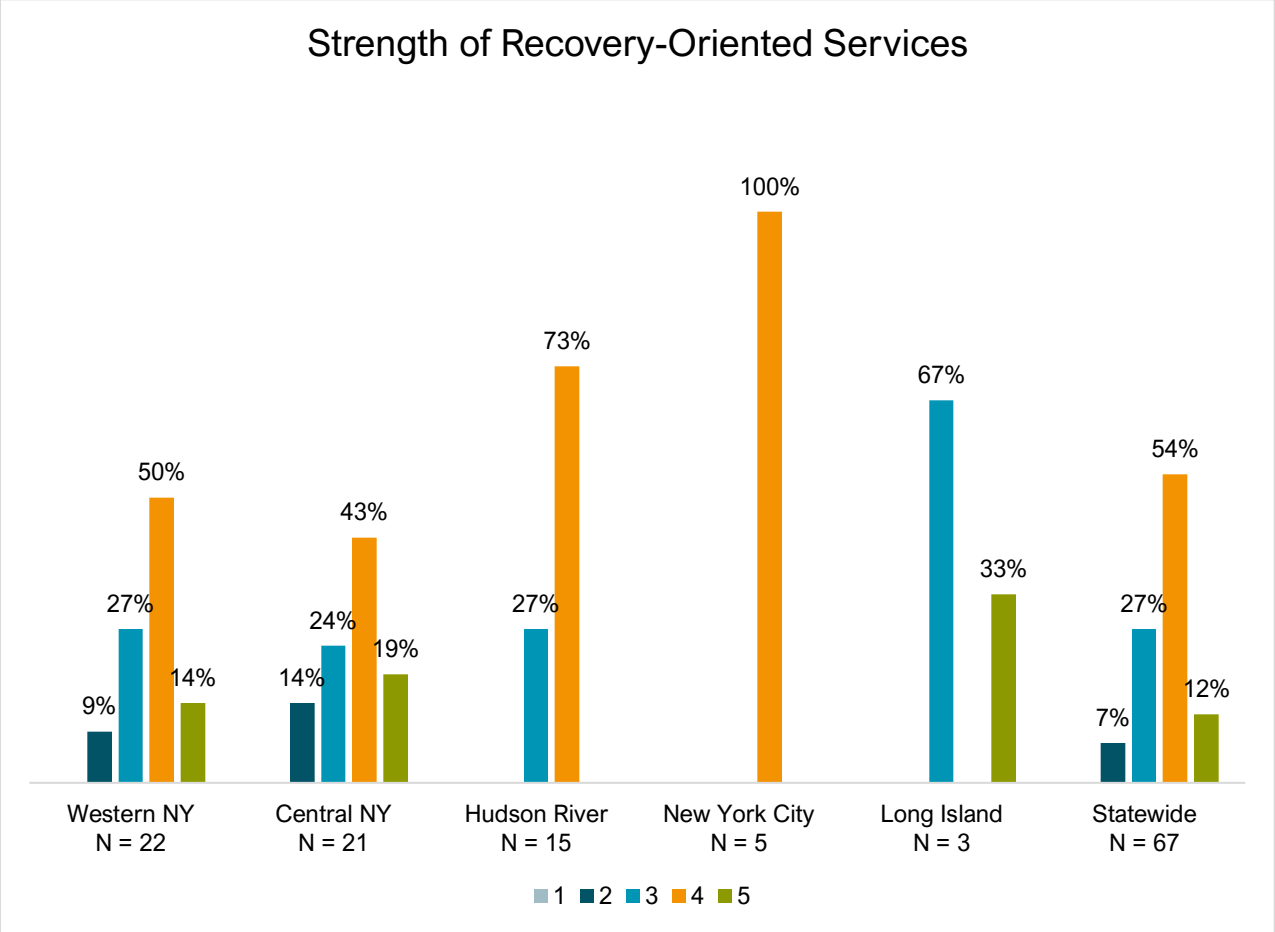
1n. Services that are trauma-informed

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.6 (1.0)	4.0	2.0	5.0
Central NY (N=22)	3.4 (1.1)	3.0	2.0	5.0
Hudson River (N=15)	3.4 (0.7)	4.0	2.0	4.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=3)	3.7 (1.2)	3.0	3.0	5.0
STATEWIDE (N=68)	**3.5 (0.9)**	**3.0**	**2.0**	**5.0**



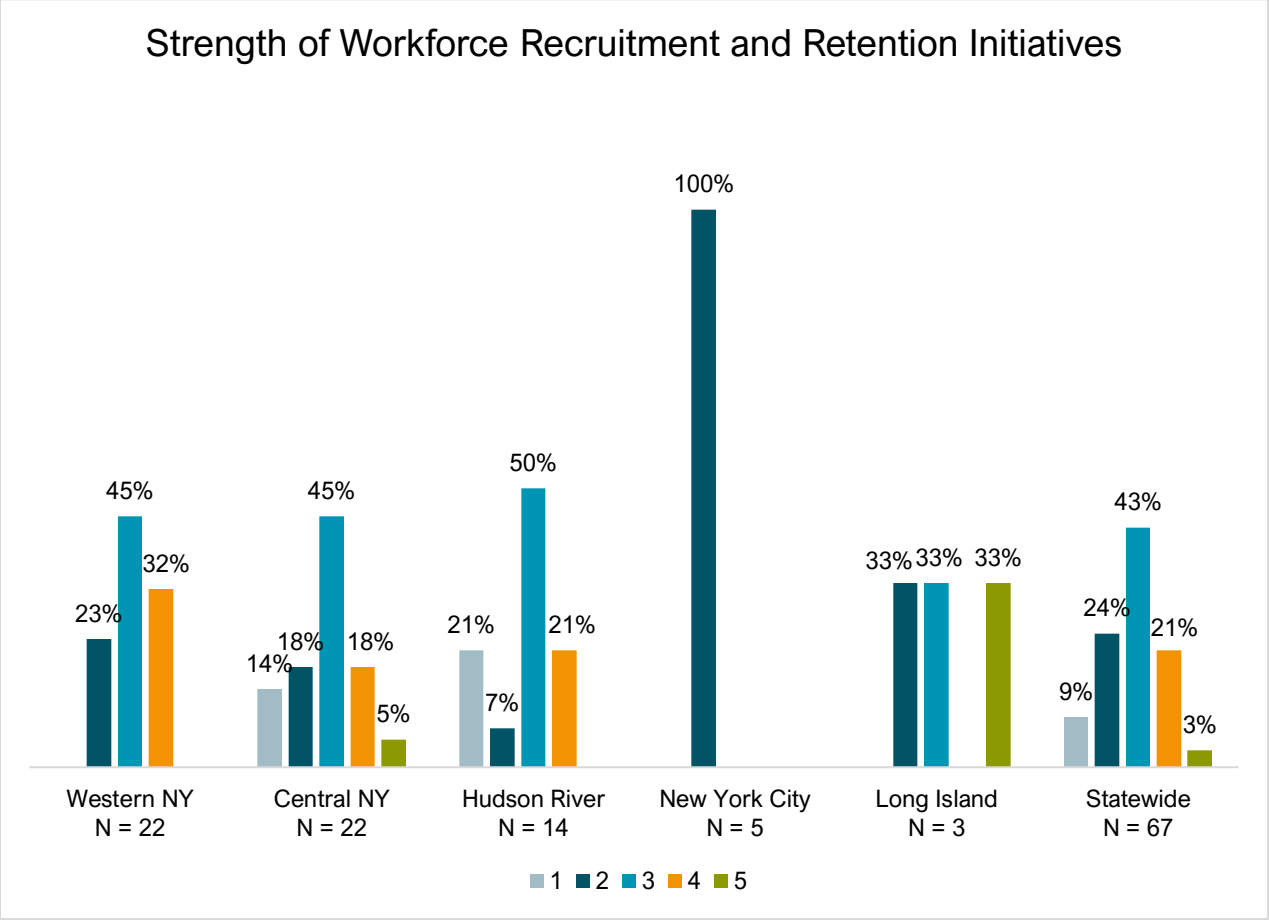
1o. Services that are recovery-oriented

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.7 (0.8)	4.0	2.0	5.0
Central NY (N=21)	3.7 (1.0)	4.0	2.0	5.0
Hudson River (N=15)	3.7 (0.5)	4.0	3.0	4.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	3.7 (1.2)	3.0	3.0	5.0
STATEWIDE (N=67)	**3.7 (0.8)**	**4.0**	**2.0**	**5.0**



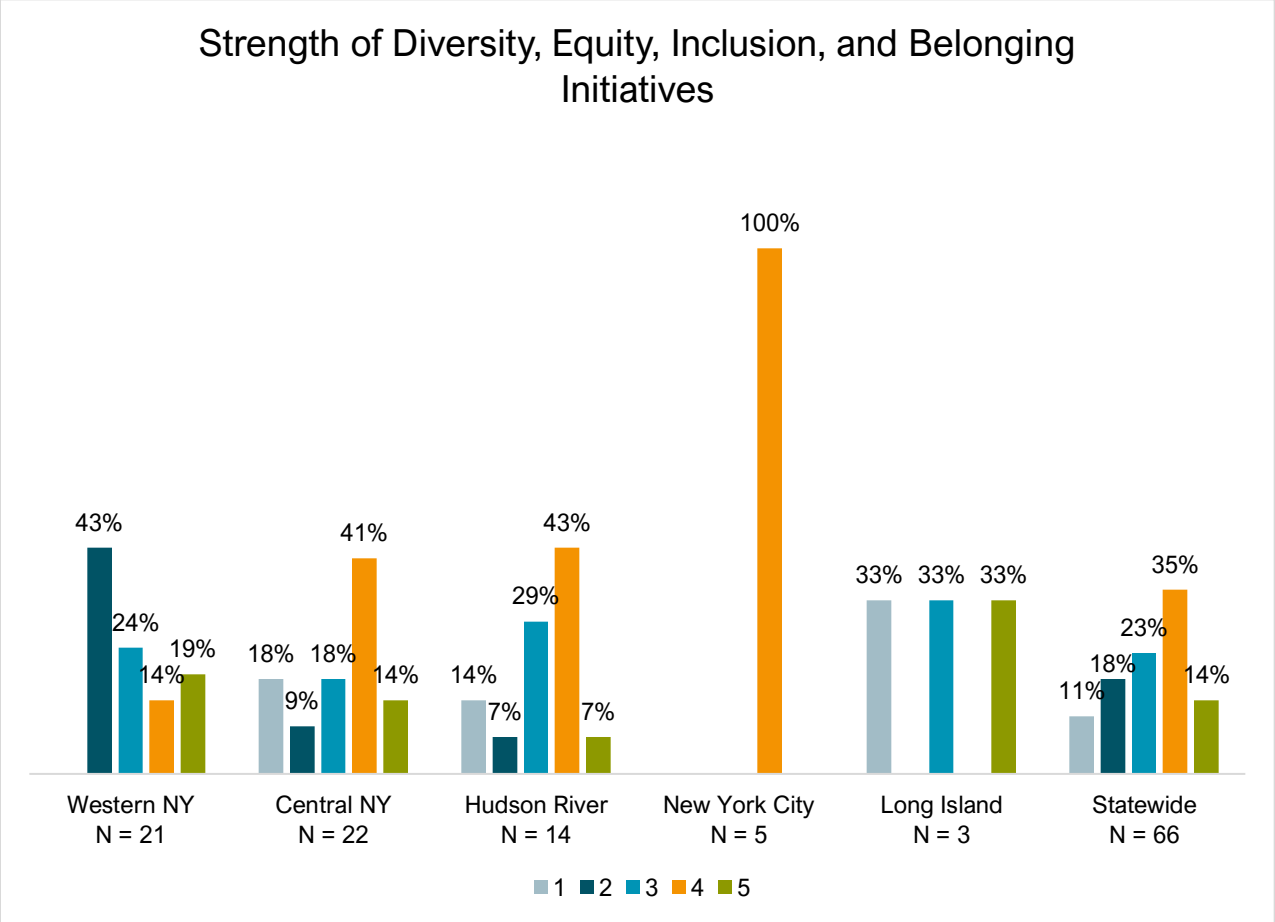
1p. Workforce recruitment and retention initiatives

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.1 (0.8)	3.0	2.0	4.0
Central NY (N=22)	2.8 (1.1)	3.0	1.0	5.0
Hudson River (N=14)	2.7 (1.1)	3.0	1.0	4.0
New York City (N=5)	2.0 (0.0)	2.0	2.0	2.0
Long Island (N=3)	3.3 (1.5)	3.0	2.0	5.0
STATEWIDE (N=67)	**2.9 (1.0)**	**3.0**	**1.0**	**5.0**



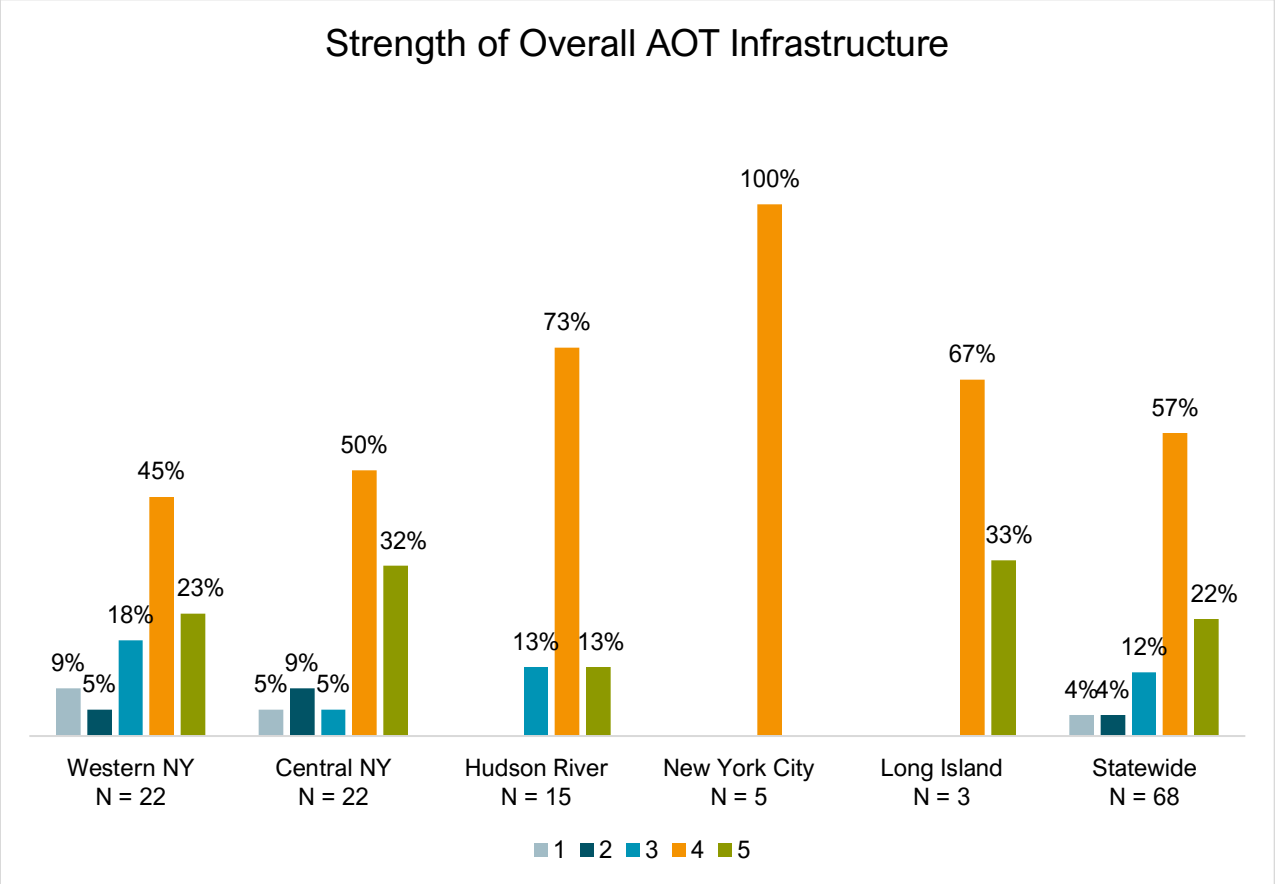
1q. Diversity, equity, inclusion, and belonging initiatives

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=21)	3.1 (1.2)	3.0	2.0	5.0
Central NY (N=22)	3.2 (1.3)	4.0	1.0	5.0
Hudson River (N=14)	3.2 (1.2)	3.5	1.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	3.0 (2.0)	3.0	1.0	5.0
STATEWIDE (N=66)	**3.2 (1.2)**	**3.0**	**1.0**	**5.0**

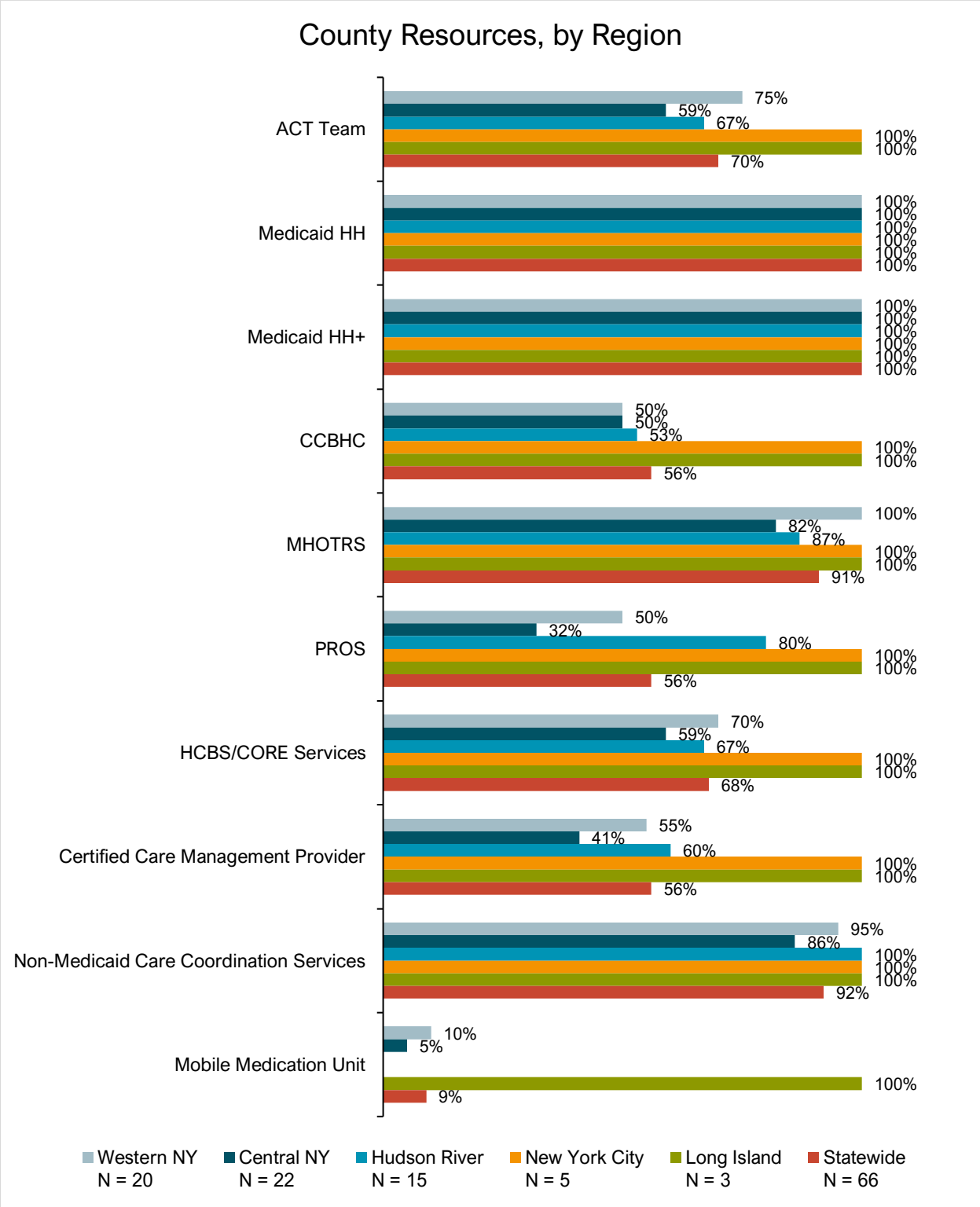


1r. Overall AOT infrastructure (e.g., coordinator[s], monitors, evaluators, processing of AOT orders)

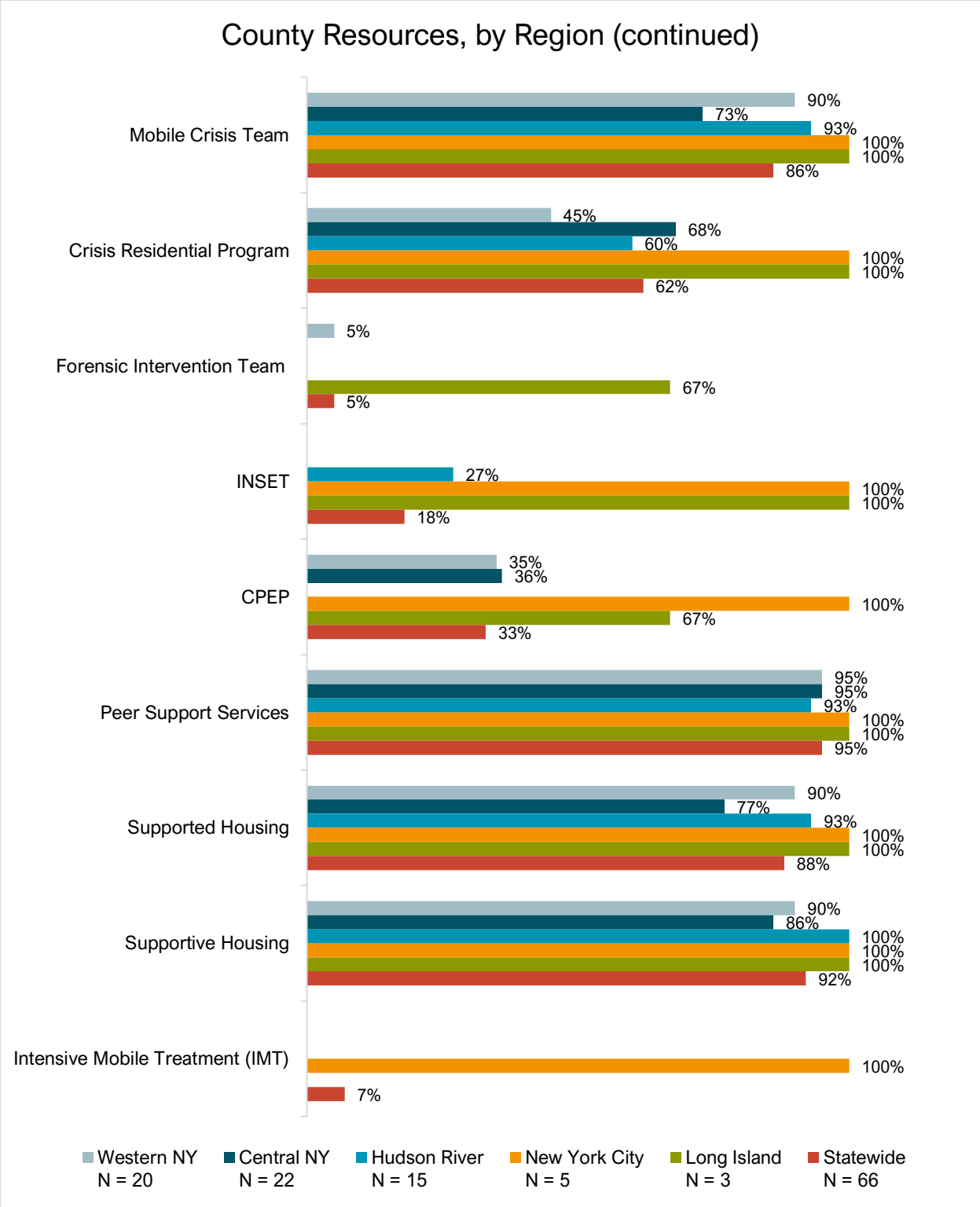
REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=22)	3.7 (1.2)	4.0	1.0	5.0
Central NY (N=22)	4.0 (1.1)	4.0	1.0	5.0
Hudson River (N=15)	4.0 (0.5)	4.0	3.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=3)	4.3 (0.6)	4.0	4.0	5.0
STATEWIDE (N=68)	**3.9 (1.0)**	**4.0**	**1.0**	**5.0**



2. Which of the following resources are available to residents of this county with serious mental illness (SMI), either through this or another county's service system? (Select all that apply).

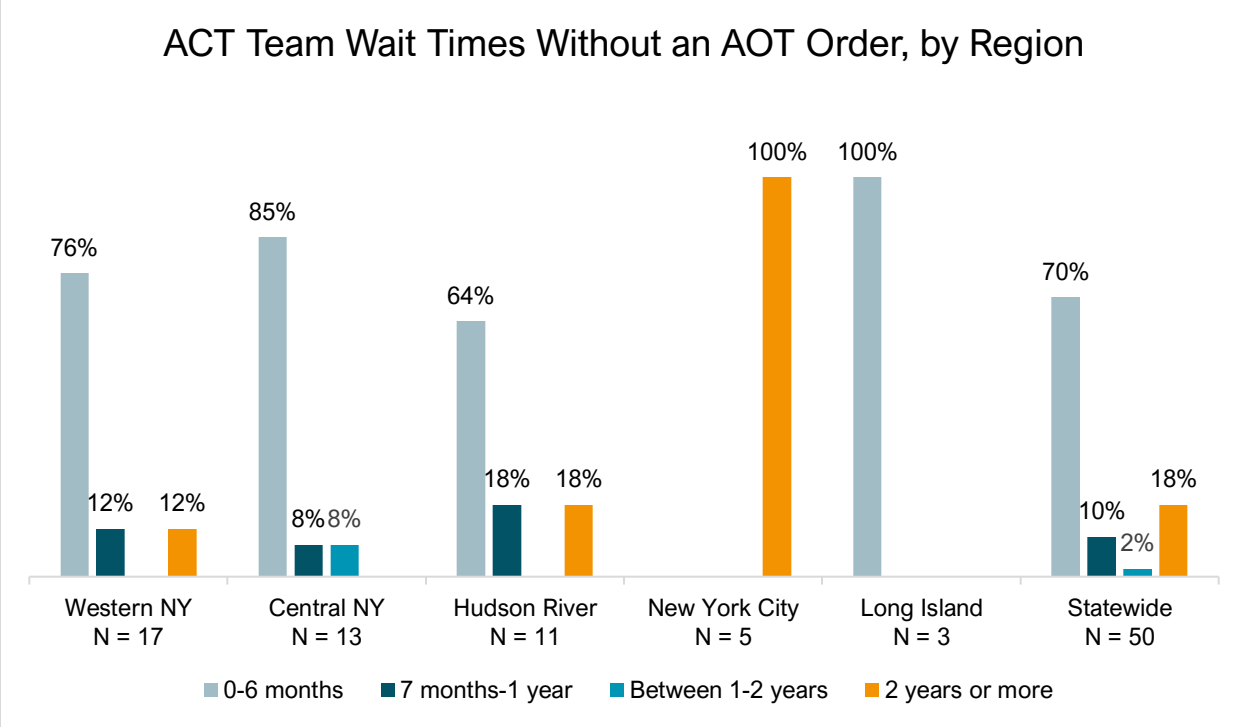


2. Which of the following resources are available to residents of this county with serious mental illness (SMI), either through this or another county's service system? (Select all that apply). (*Continued*)

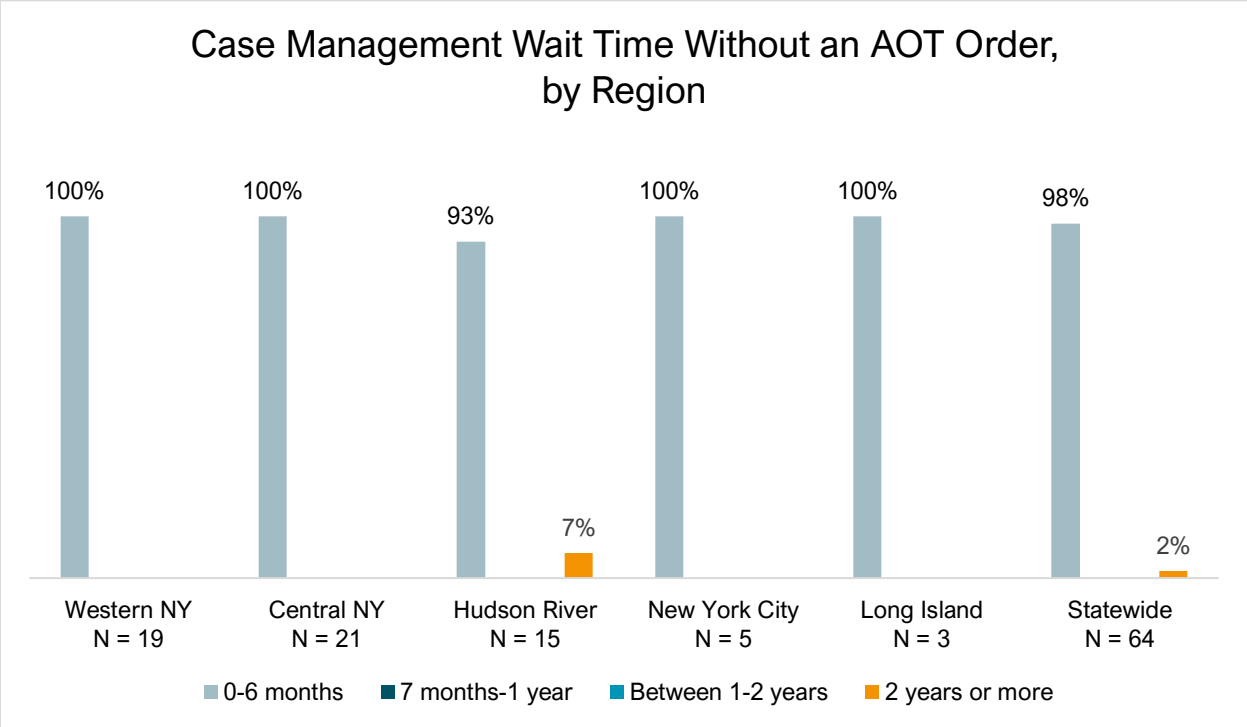


3. Approximately how long would a person in this county expect to wait for access to the following services in the absence of an AOT order:

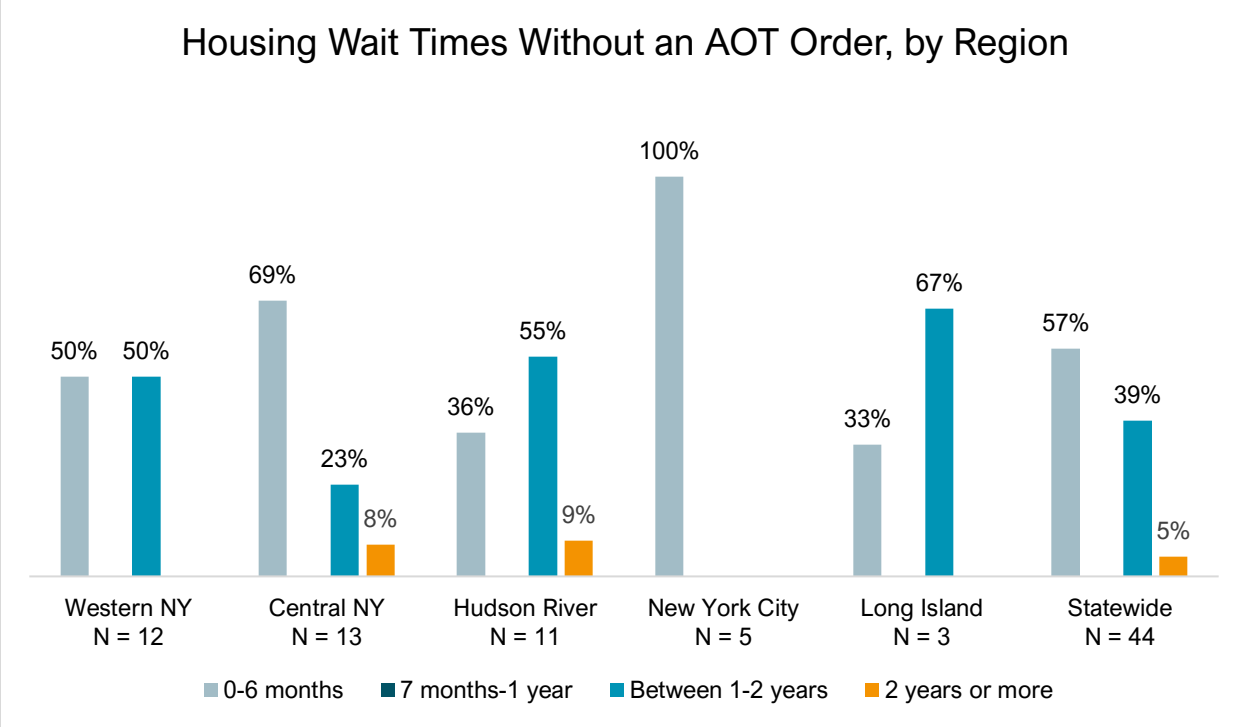
3a. Assertive Community Treatment (ACT)?



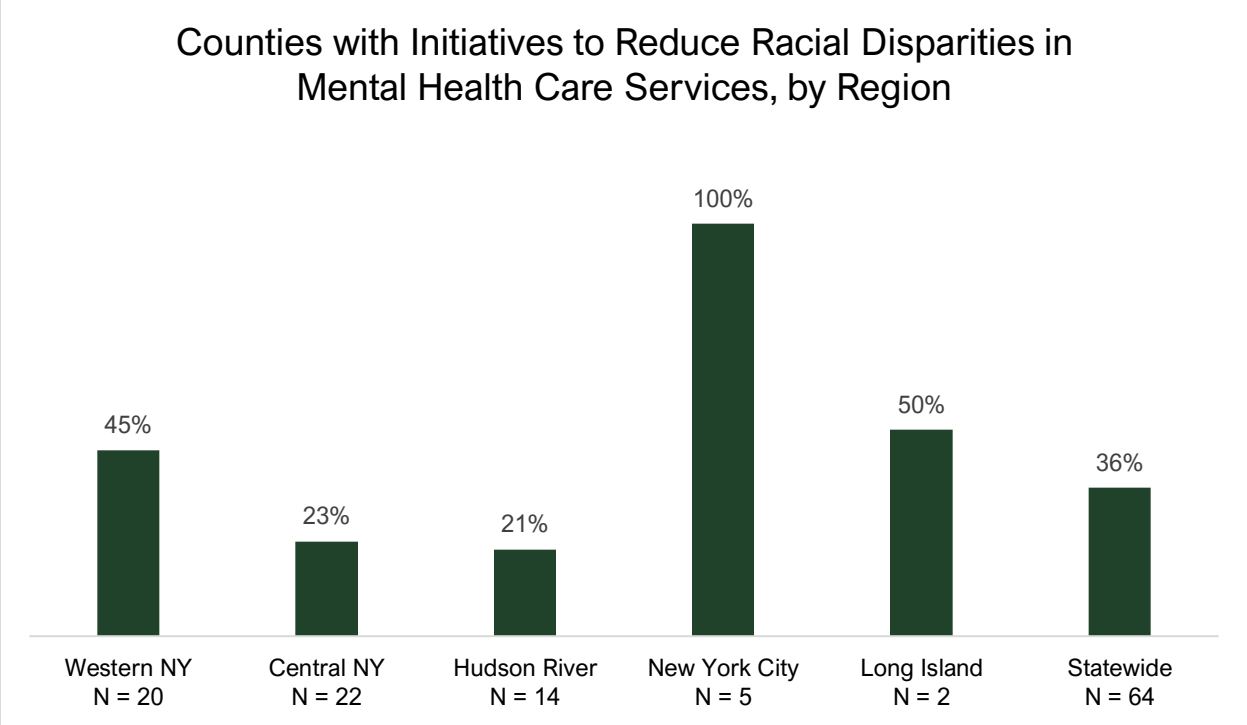
3b. Case management services other than ACT?



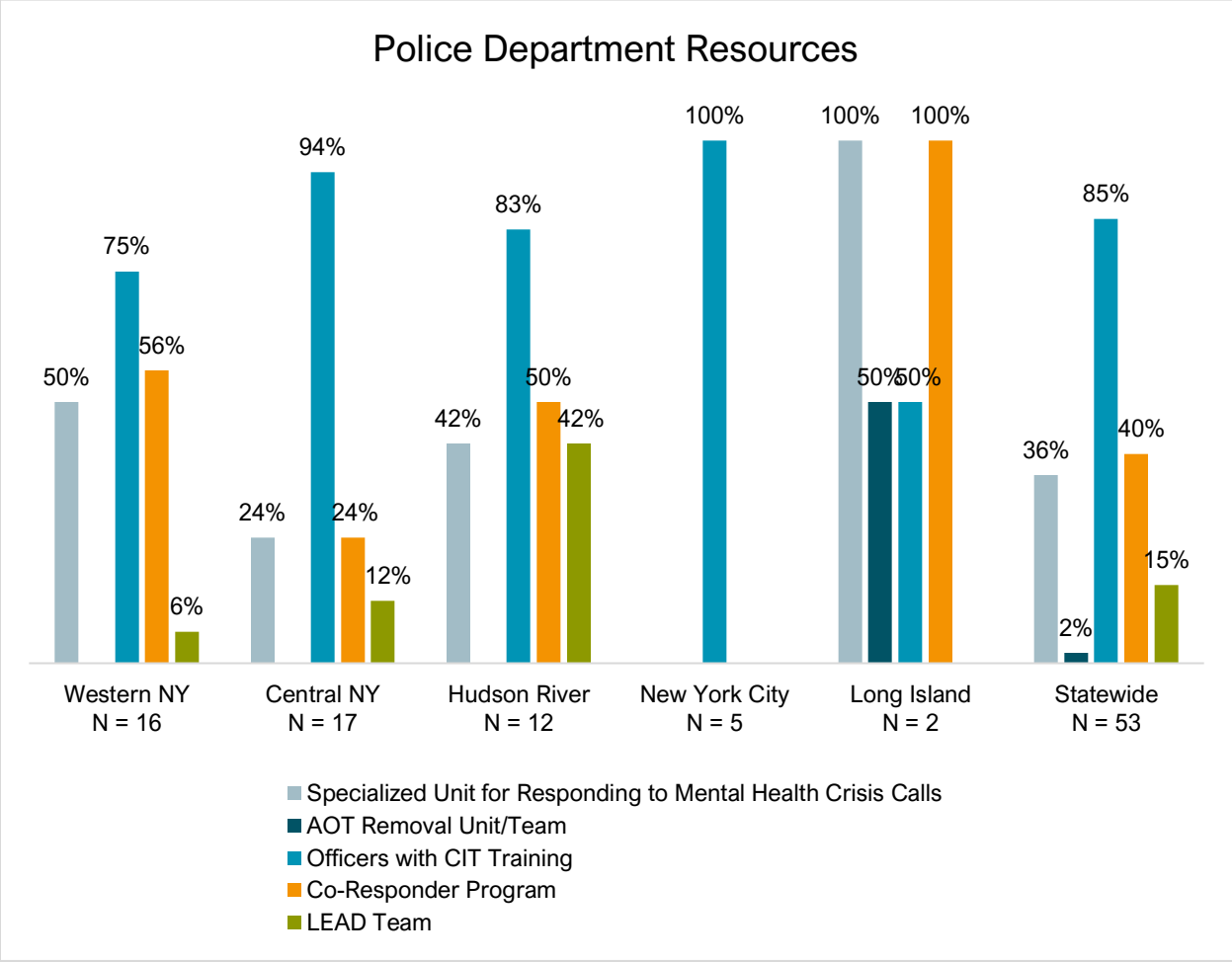
3c. Housing supports?



4. In this county, are there any dedicated initiatives to address/mitigate racial disparities in access, quality, or experience of mental health services?



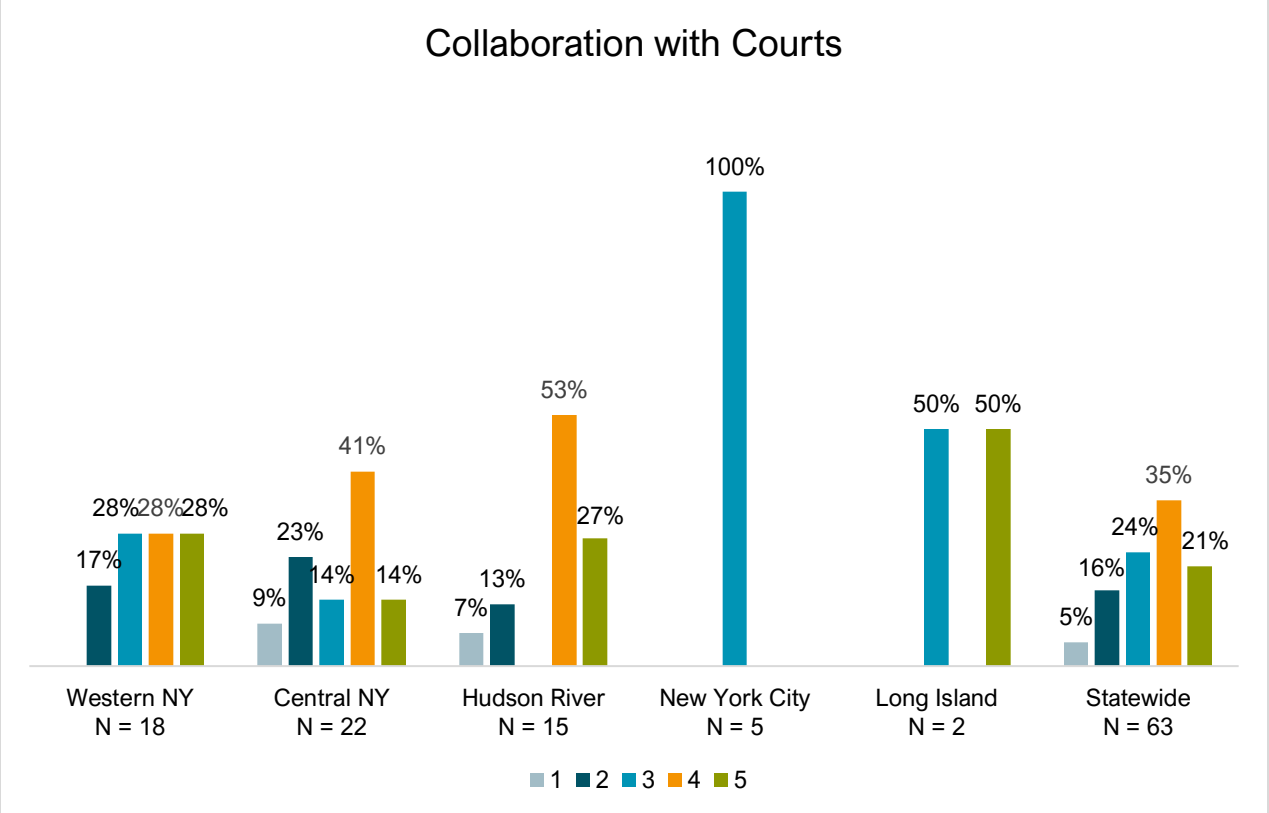
5. Does the local police department have... (select all that apply)



6. How would you characterize the level of collaboration between your department and each of the following entities? [Score on a scale of 1 to 5 with 1=No collaboration with this entity and 5=Highly collaborative relationship with this entity]

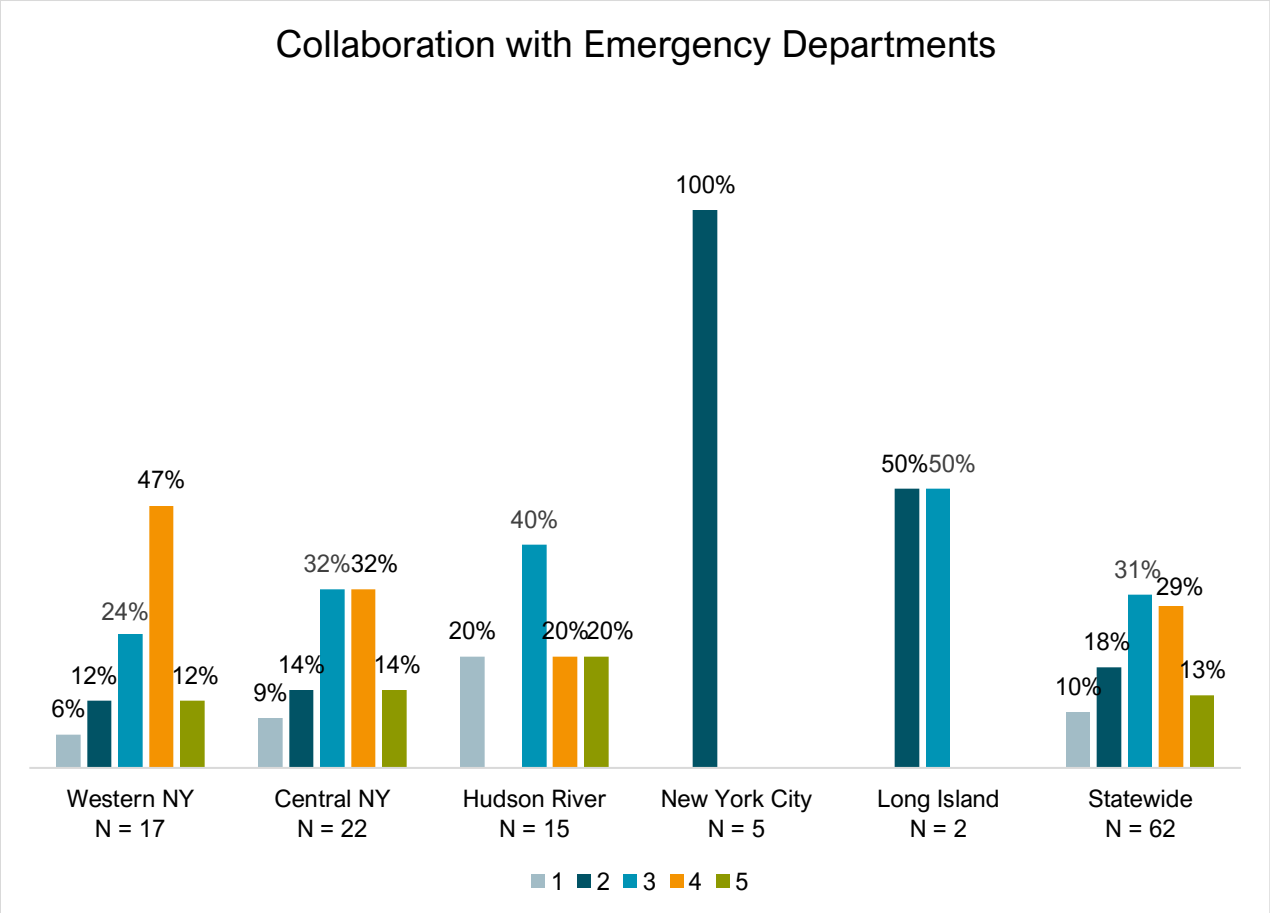
6a. Courts

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.7 (1.1)	4.0	2	5
Central NY (N=22)	3.3 (1.2)	4.0	1	5
Hudson River (N=15)	3.8 (1.2)	4.0	1	5
New York City (N=5)	3.0 (0.0)	3.0	3	3
Long Island (N=2)	4.0 (1.4)	4.0	3	5
STATEWIDE (N=63)	**3.5 (1.1)**	**4.0**	**1**	**5**



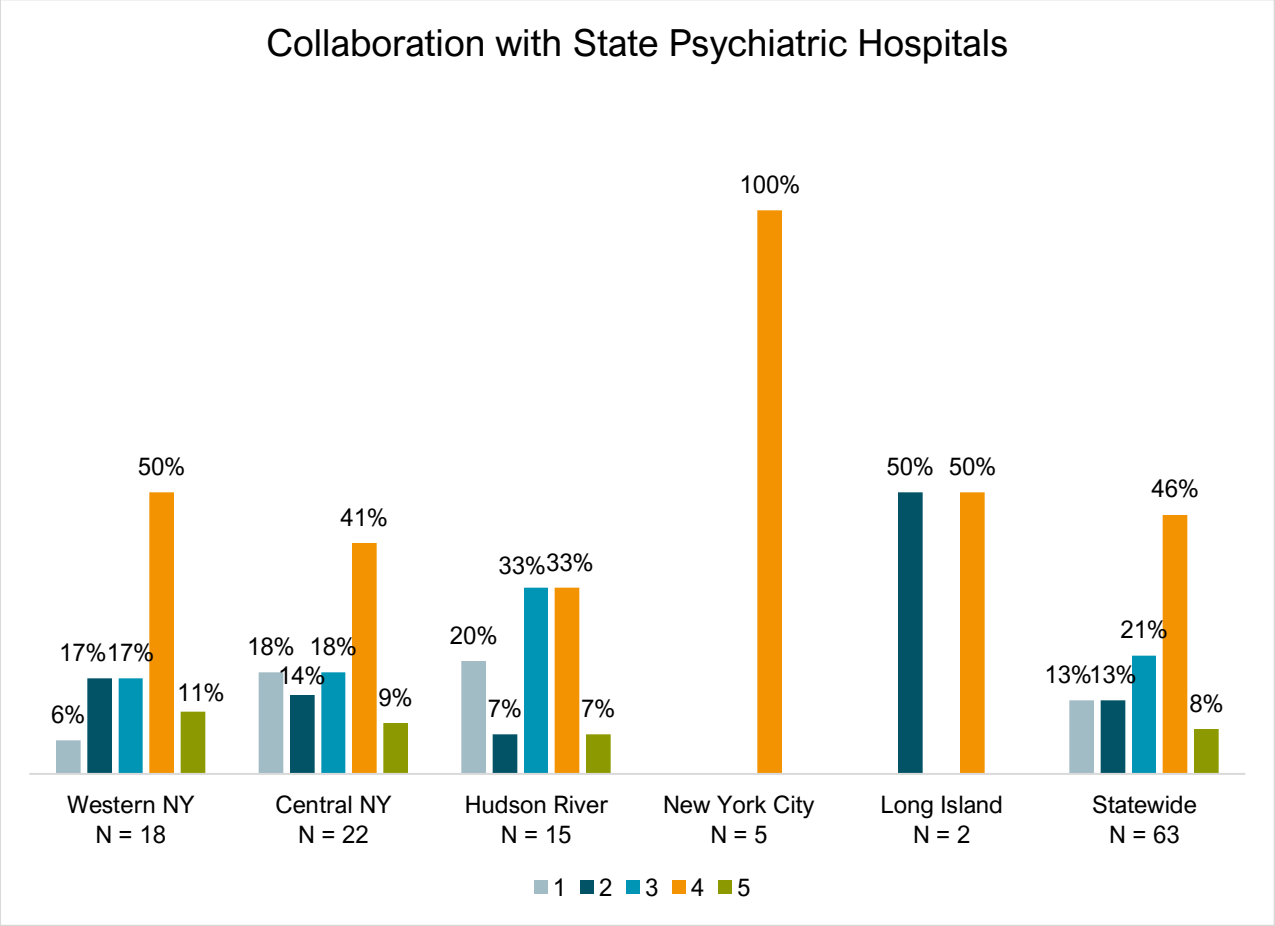
6b. Hospital emergency department

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=17)	3.5 (1.1)	4.0	1	5
Central NY (N=22)	3.3 (1.2)	3.0	1	5
Hudson River (N=15)	3.2 (1.4)	3.0	1	0
New York City (N=5)	2.0 (0.0)	2.0	2	2
Long Island (N=2)	2.5 (0.7)	2.5	2	3
STATEWIDE (N=62)	**3.2 (1.2)**	**3.0**	**1**	**5**



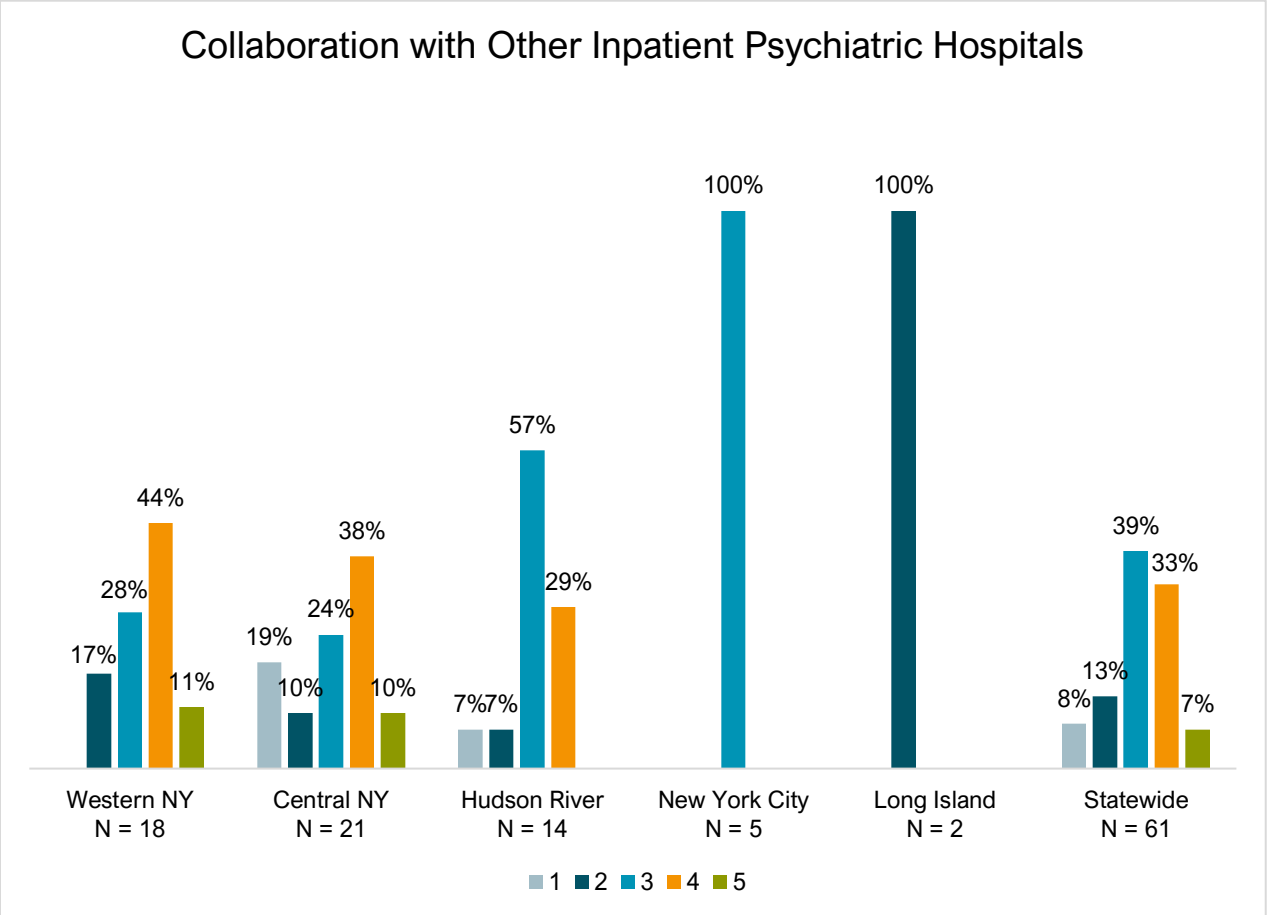
6c. State Psychiatric Centers

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.4 (1.1)	4.0	1	5
Central NY (N=22)	3.1 (1.3)	3.5	1	5
Hudson River (N=15)	3.0 (1.3)	3.0	1	5
New York City (N=5)	4.0 (0.0)	4.0	4	4
Long Island (N=2)	3.0 (1.4)	3.0	2	4
STATEWIDE (N=63)	**3.2 (1.2)**	**4.0**	**1**	**5**



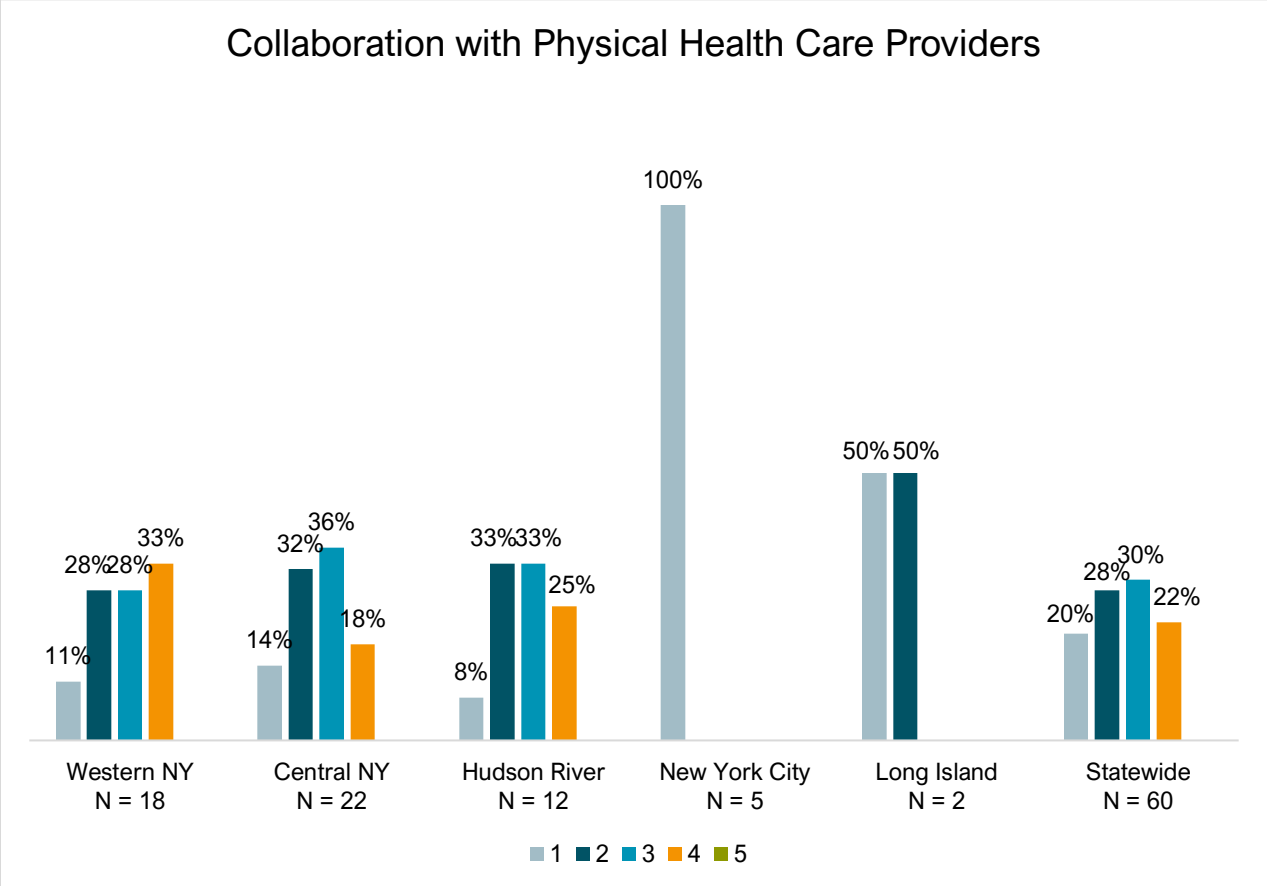
6d. Other Inpatient Psychiatric Facilities

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.5 (0.9)	4.0	2	5
Central NY (N=21)	3.1 (1.3)	3.0	1	5
Hudson River (N=14)	3.1 (0.8)	3.0	1	4
New York City (N=5)	3.0 (0.0)	3.0	3	3
Long Island (N=2)	2.0 (0.0)	2.0	2	2
STATEWIDE (N=61)	**3.2 (1.0)**	**3.0**	**1**	**5**



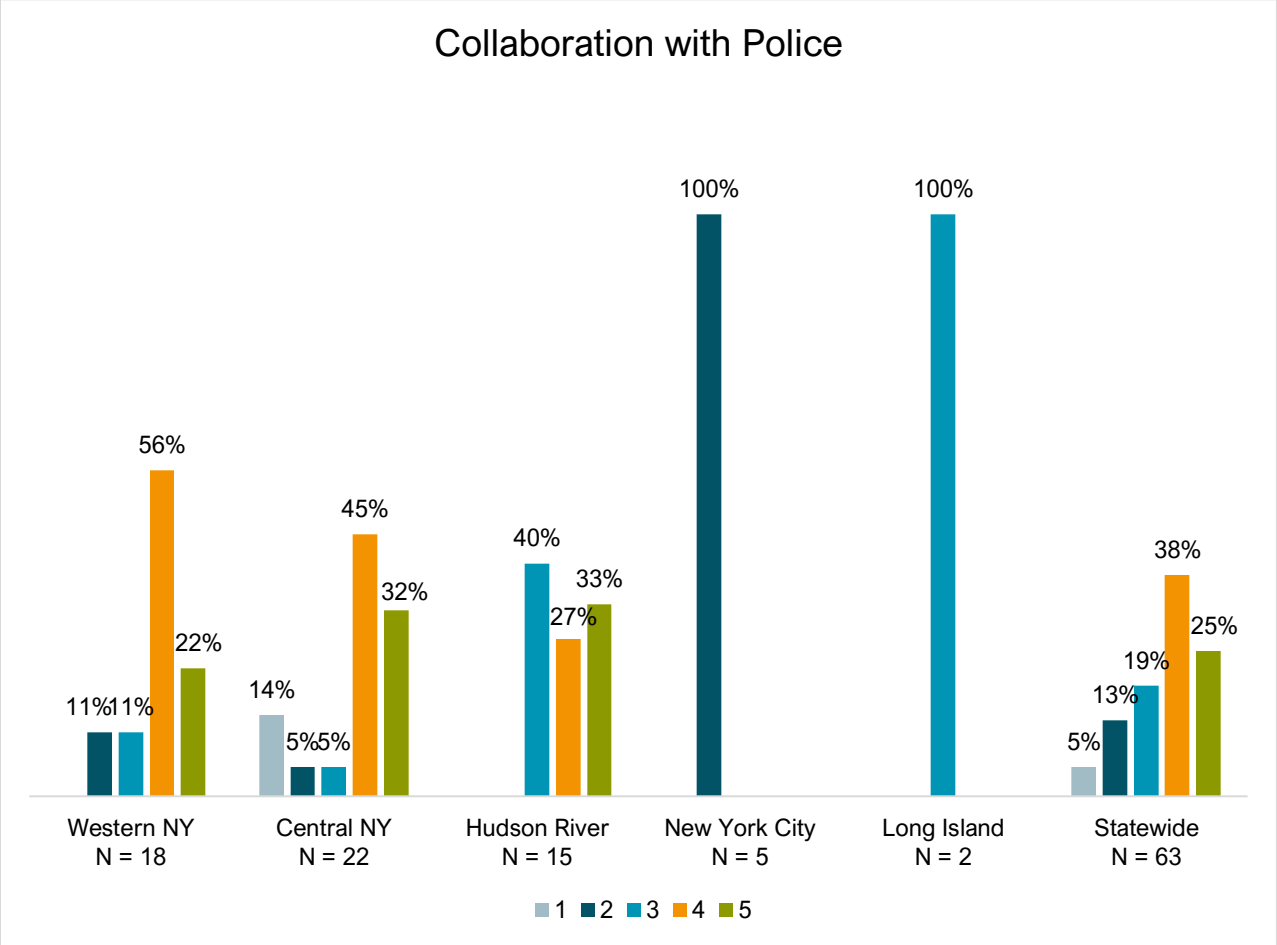
6e. Non-emergency physical health care providers

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.8 (1.0)	3.0	1	4
Central NY (N=22)	2.6 (1.0)	3.0	1	4
Hudson River (N=12)	2.8 (1.0)	3.0	1	4
New York City (N=5)	1.0 (0.0)	1.0	1	1
Long Island (N=2)	1.5 (0.7)	1.5	1	2
STATEWIDE (N=60)	**2.5 (1.0)**	**3.0**	**1**	**4**



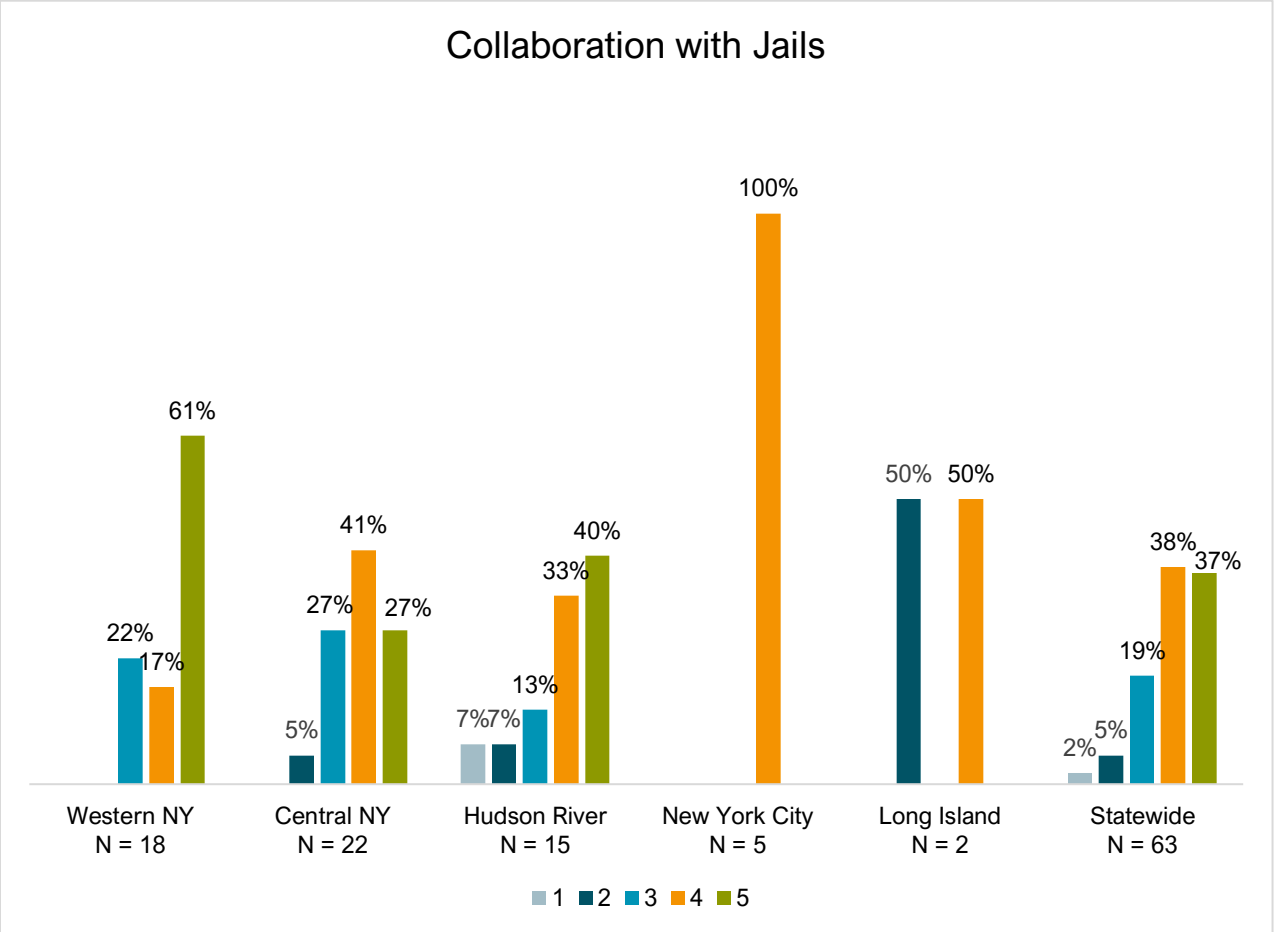
6f. Police department

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.9 (0.9)	4.0	2	5
Central NY (N=22)	3.8 (1.3)	4.0	1	5
Hudson River (N=15)	3.9 (0.9)	4.0	3	5
New York City (N=5)	2.0 (0.0)	2.0	2	2
Long Island (N=2)	3.0 (0.0)	3.0	3	3
STATEWIDE (N=63)	**3.7 (1.1)**	**4.0**	**1**	**5**



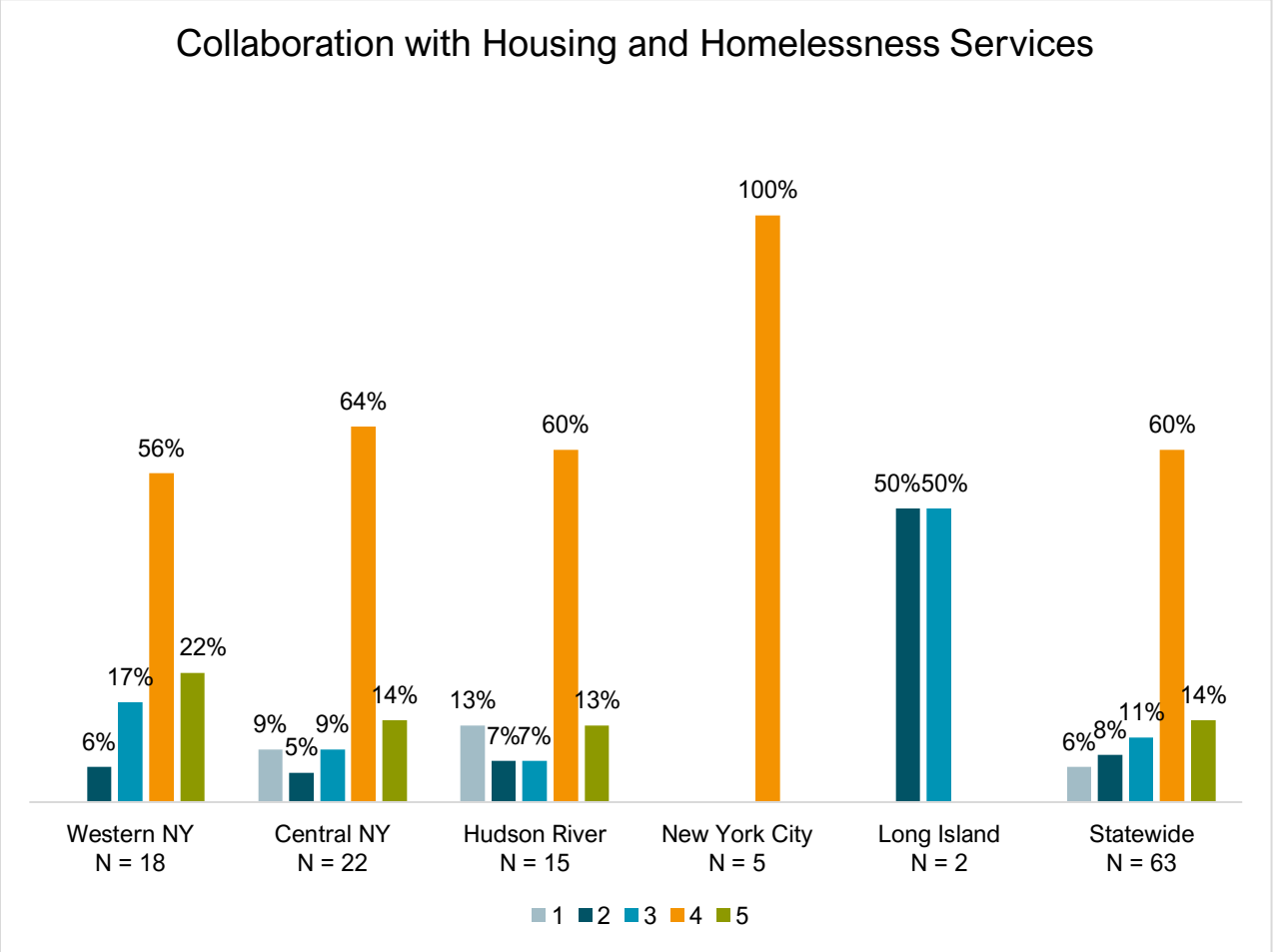
6g. Jails/County Sherriff

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	4.4 (0.8)	5.0	3	5
Central NY (N=22)	3.9 (0.9)	4.0	2	5
Hudson River (N=15)	3.9 (1.2)	4.0	1	5
New York City (N=5)	4.0 (0.0)	4.0	4	4
Long Island (N=2)	3.0 (1.4)	3.0	2	4
STATEWIDE (N=63)	**4.0 (0.9)**	**4.0**	**1**	**5**



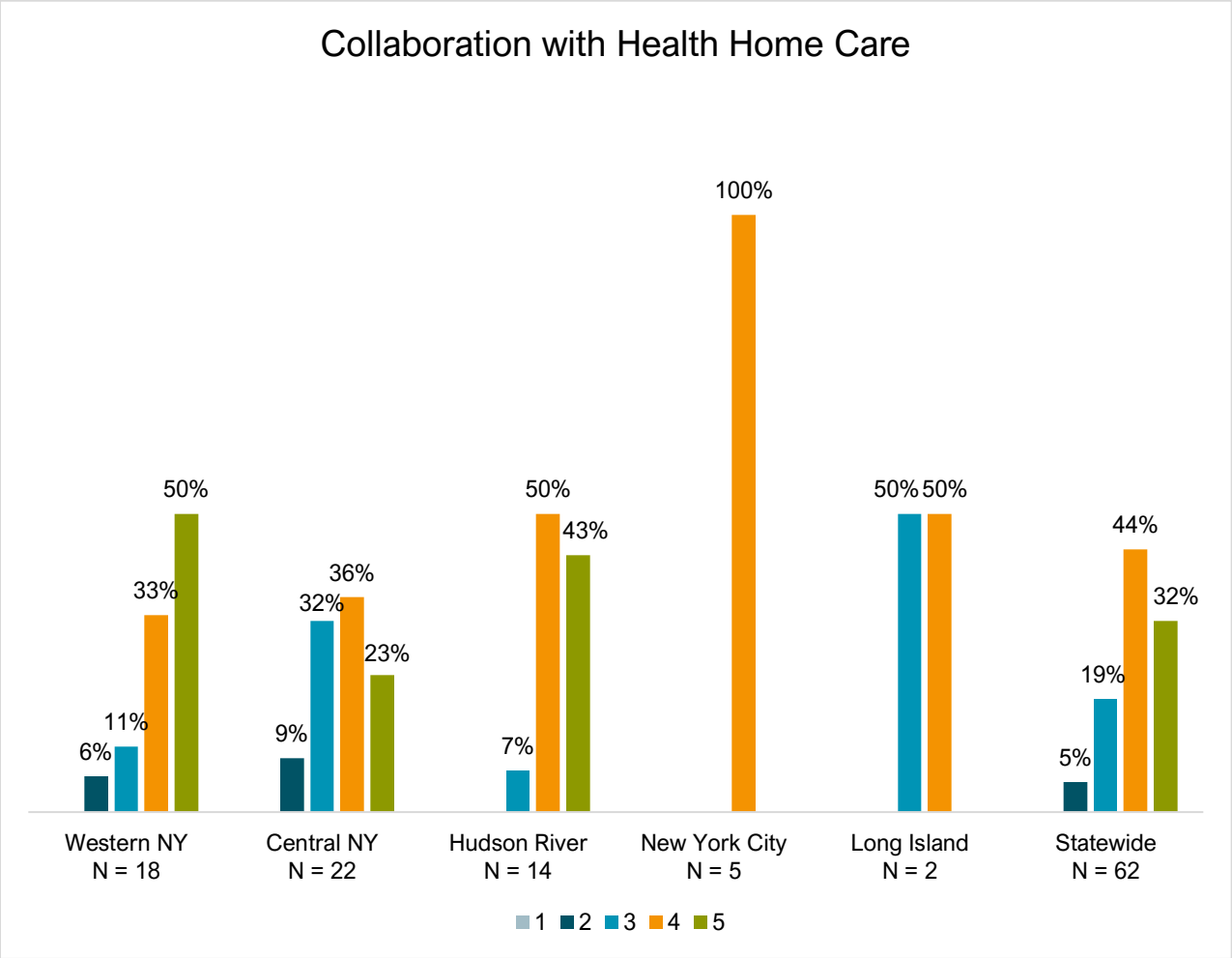
6h. Housing and homelessness services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.9 (0.8)	4.0	2	5
Central NY (N=22)	3.7 (1.1)	4.0	1	5
Hudson River (N=15)	3.5 (1.2)	4.0	1	5
New York City (N=5)	4.0 (0.0)	4.0	4	4
Long Island (N=2)	2.5 (0.7)	2.5	2	3
STATEWIDE (N=63)	**3.7 (1.0)**	**4.0**	**1**	**5**



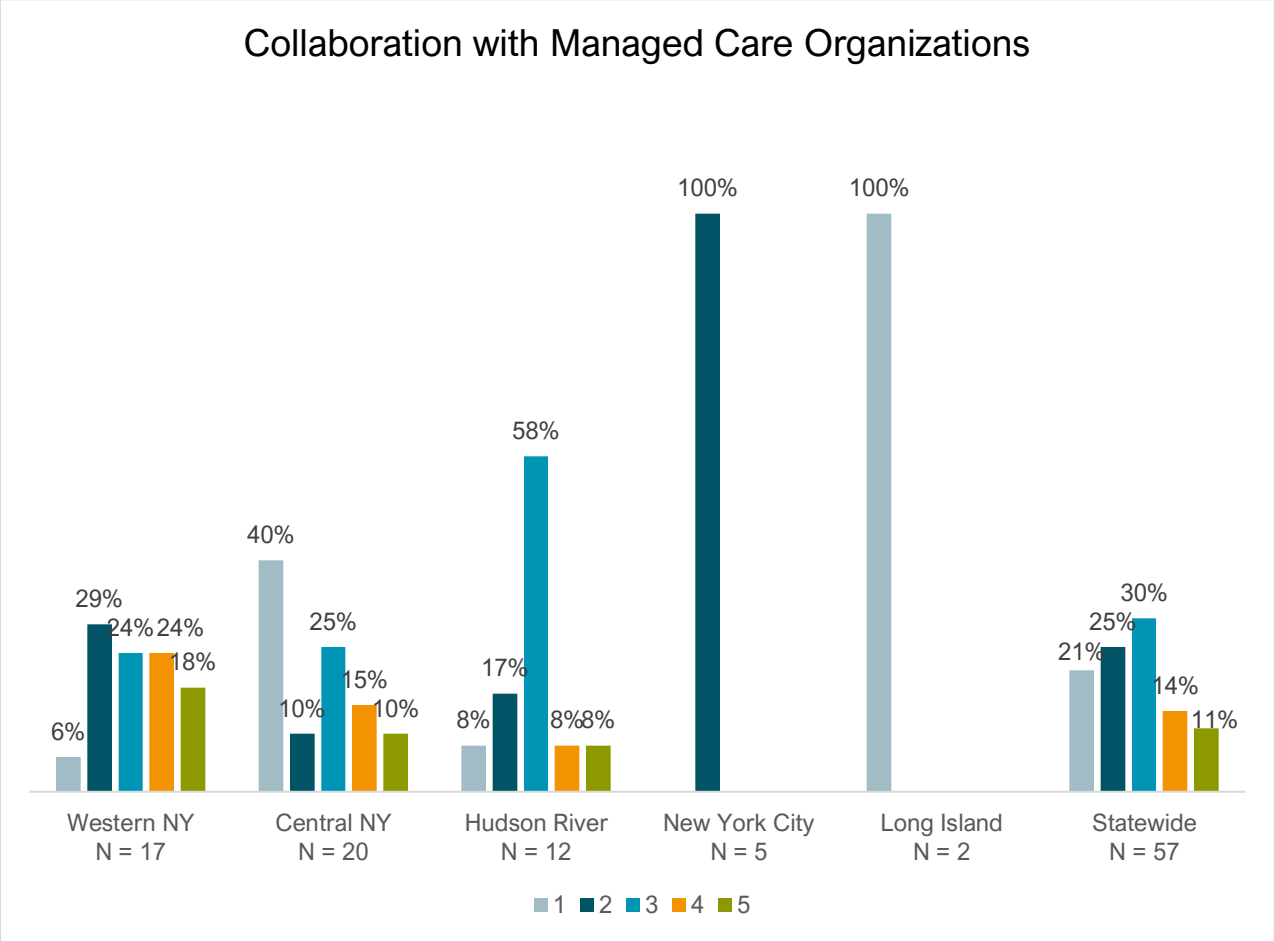
6i. Health home care managers

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	4.3 (0.9)	4.5	2	5
Central NY (N=22)	3.7 (0.9)	4.0	2	5
Hudson River (N=14)	4.4 (0.6)	4.0	3	5
New York City (N=5)	4.0 (0.0)	4.0	4	4
Long Island (N=2)	3.5 (0.7)	3.5	3	4
STATEWIDE (N=62)	**4.0 (0.8)**	**4.0**	**2**	**5**



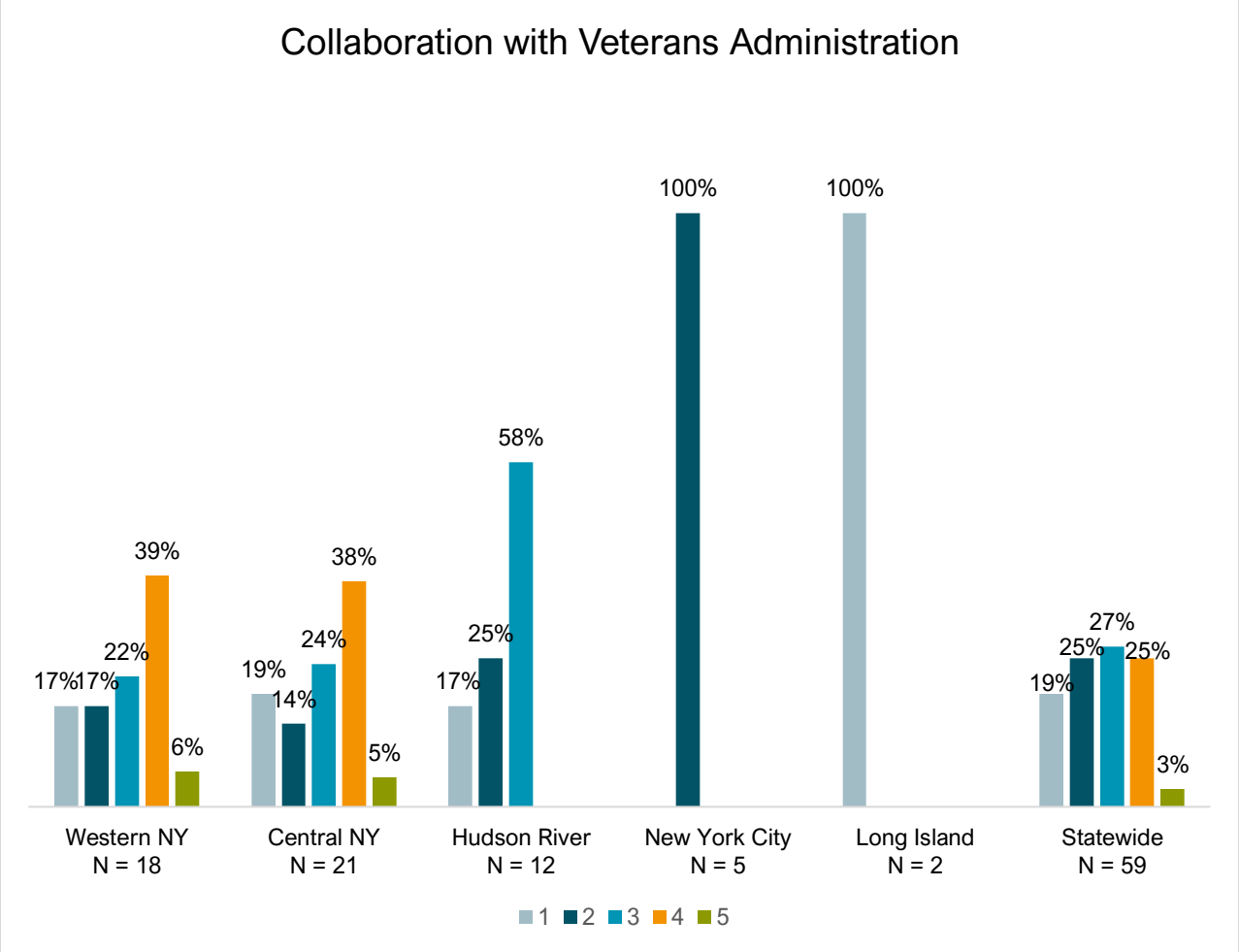
6j. Managed care organizations

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=17)	3.2 (1.2)	3.0	1	5
Central NY (N=20)	2.5 (1.4)	2.5	1	5
Hudson River (N=12)	2.9 (1.0)	3.0	1	5
New York City (N=5)	2.0 (0.0)	2.0	2	2
Long Island (N=2)	1.0 (0.0)	1.0	1	1
STATEWIDE (N=57)	**2.7 (1.3)**	**3.0**	**1**	**5**



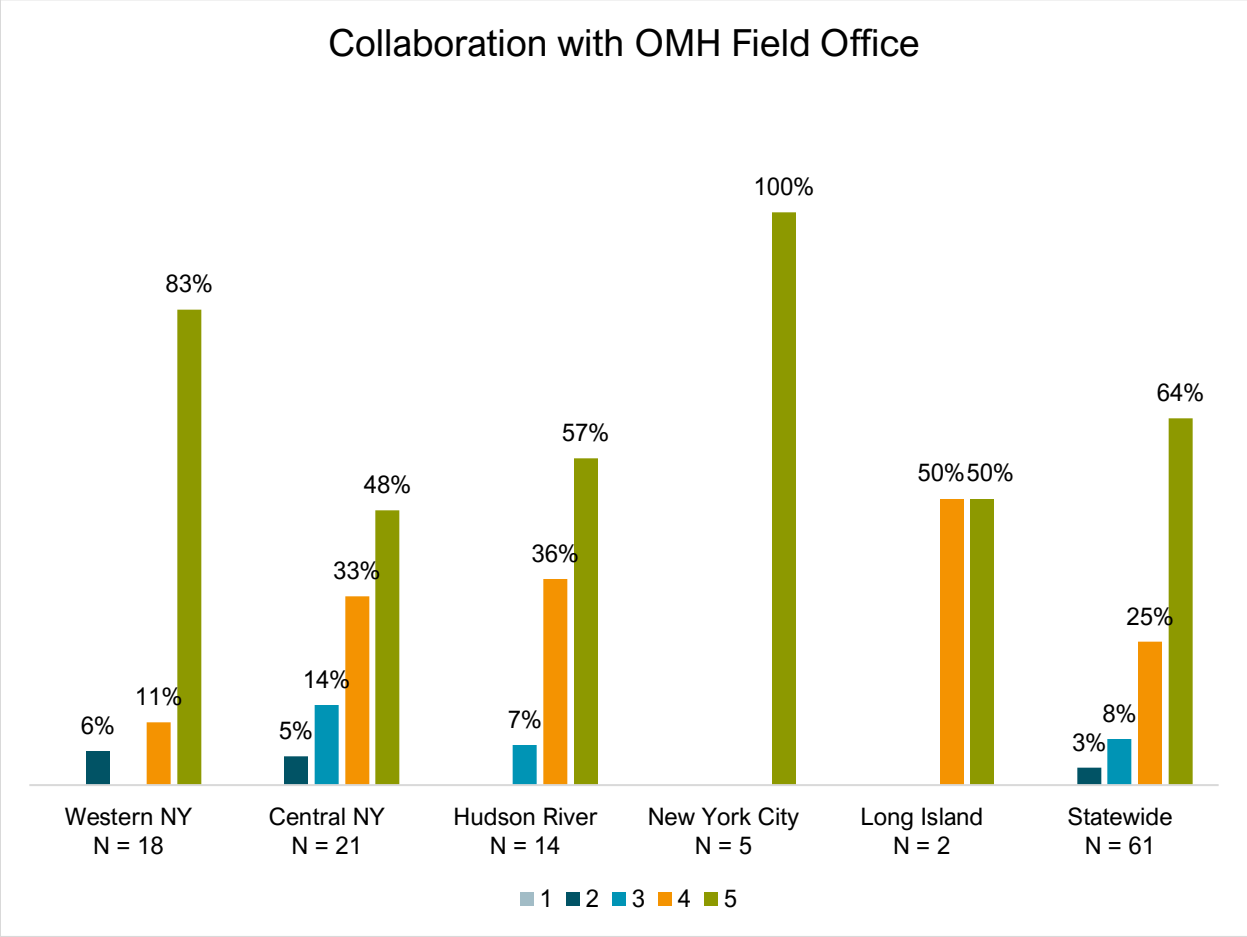
6k. The Veterans Administration

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.0 (1.2)	3.0	1	5
Central NY (N=21)	3.0 (1.2)	3.0	1	5
Hudson River (N=12)	2.4 (0.8)	3.0	1	3
New York City (N=5)	2.0 (0.0)	2.0	2	2
Long Island (N=2)	1.0 (0.0)	1.0	1	1
STATEWIDE (N=59)	**2.7 (1.1)**	**3.0**	**1**	**5**



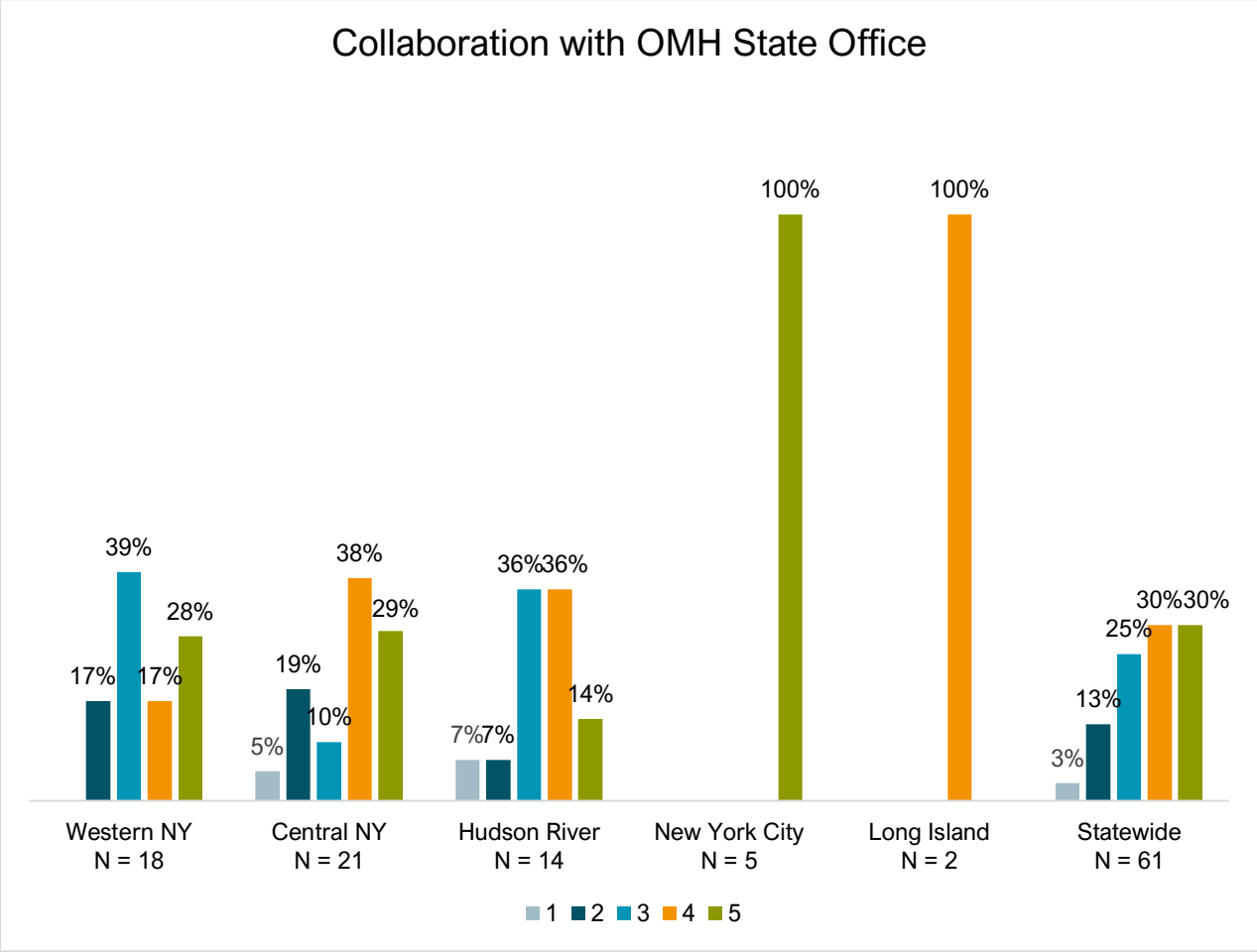
6l. Office of Mental Health Field Office

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	4.7 (0.8)	5.0	2	5
Central NY (N=21)	4.2 (0.9)	4.0	2	5
Hudson River (N=14)	4.5 (0.7)	5.0	3	5
New York City (N=5)	5.0 (0.0)	5.0	5	5
Long Island (N=2)	4.5 (0.7)	4.5	4	5
STATEWIDE (N=61)	**4.5 (0.8)**	**5.0**	**2**	**5**



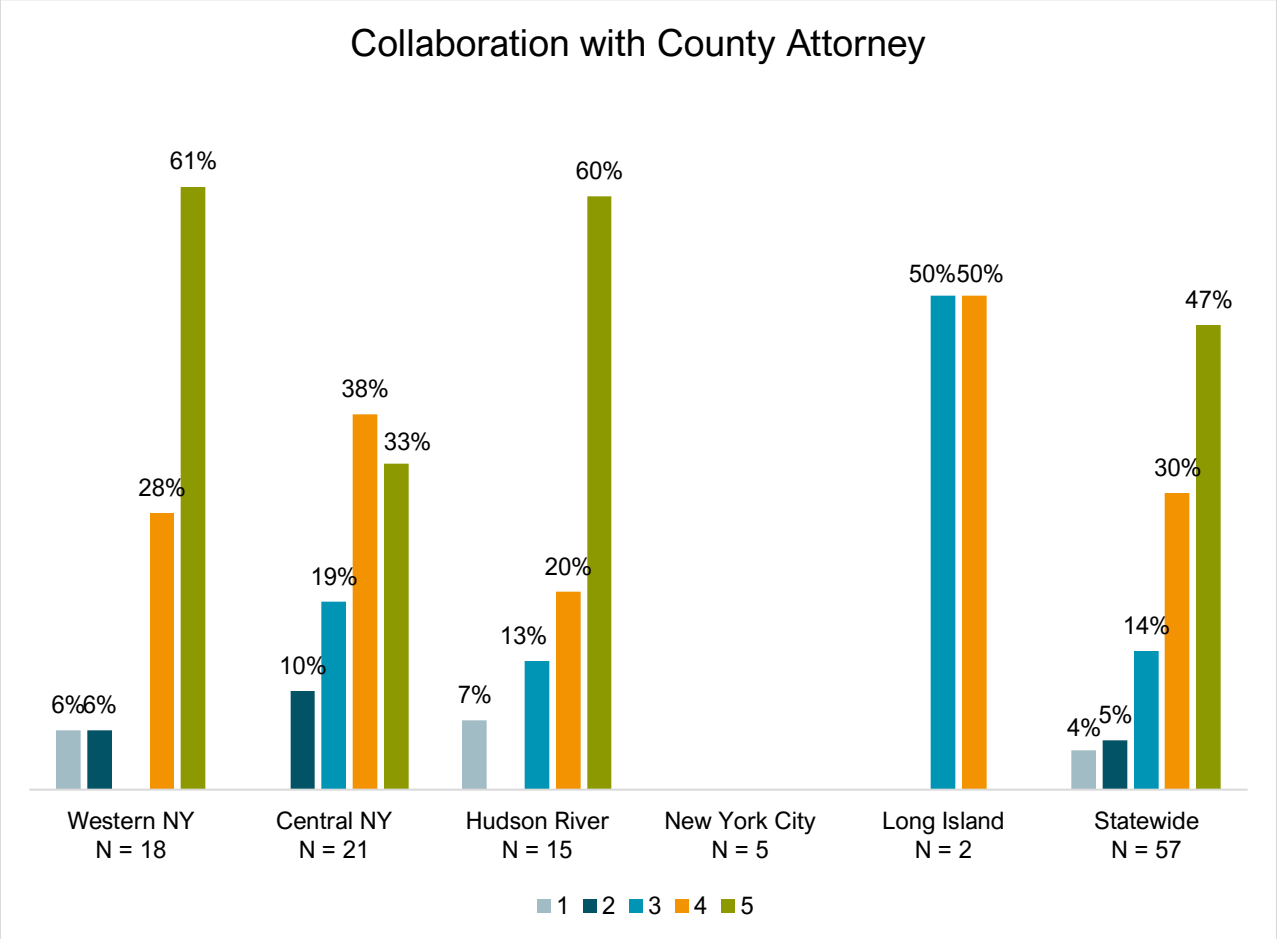
6m. Office of Mental Health State Office

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.6 (1.1)	3.0	2	5
Central NY (N=21)	3.7 (1.2)	4.0	1	5
Hudson River (N=14)	3.4 (1.1)	3.5	1	5
New York City (N=5)	5.0 (0.0)	5.0	5	5
Long Island (N=2)	4.0 (0.0)	4.0	4	4
STATEWIDE (N=61)	**3.7 (1.1)**	**4.0**	**1**	**5**



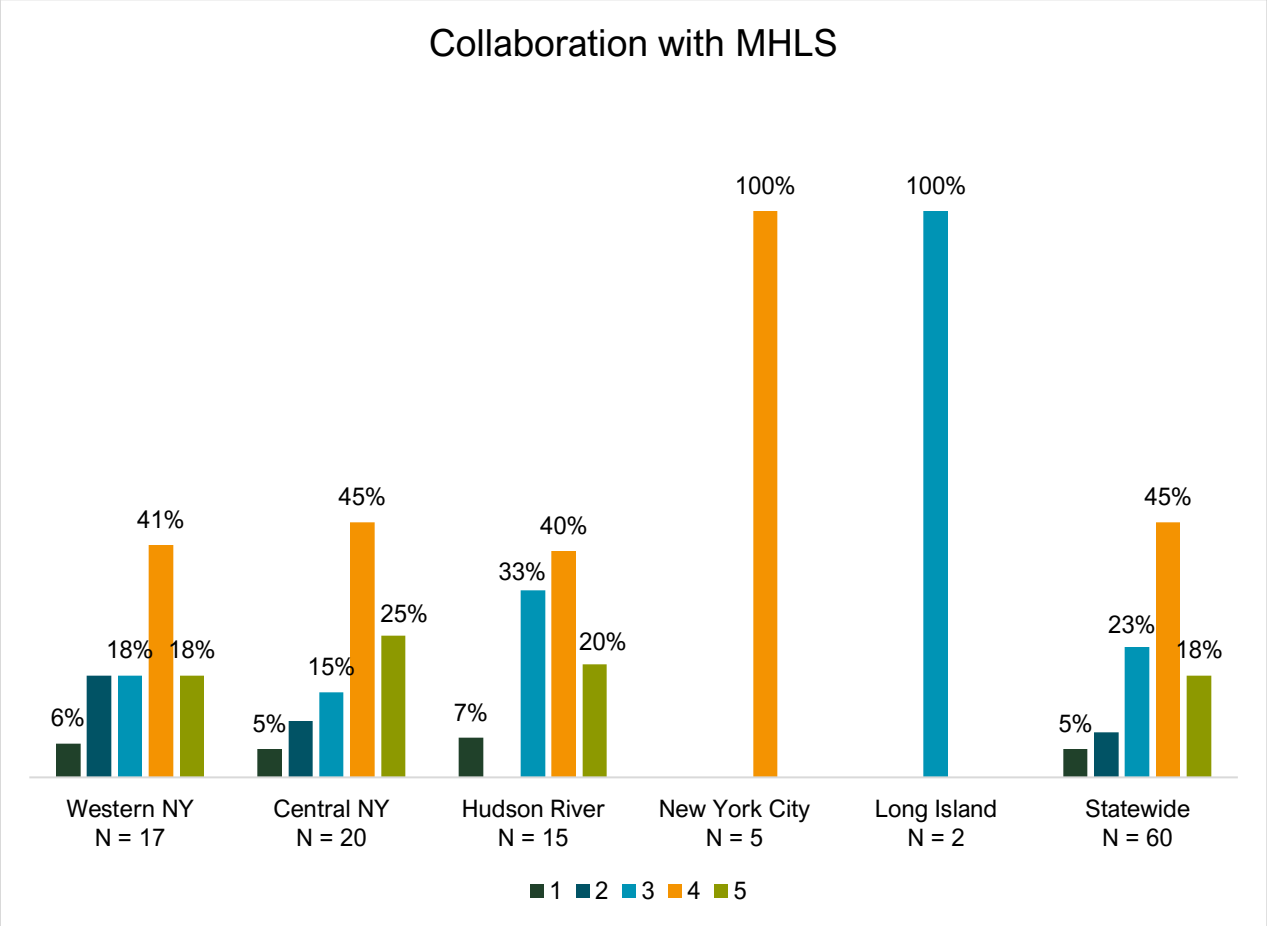
6n. The County Attorney

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	4.3 (1.1)	5.0	1	5
Central NY (N=21)	4.0 (1.0)	4.0	2	5
Hudson River (N=15)	4.3 (1.2)	5.0	1	5
New York City (N=0)	NA (NA)	NA	NA	NA
Long Island (N=2)	3.5 (0.7)	3.5	3	4
STATEWIDE (N=57)	**4.1 (1.1)**	**4.0**	**1**	**5**



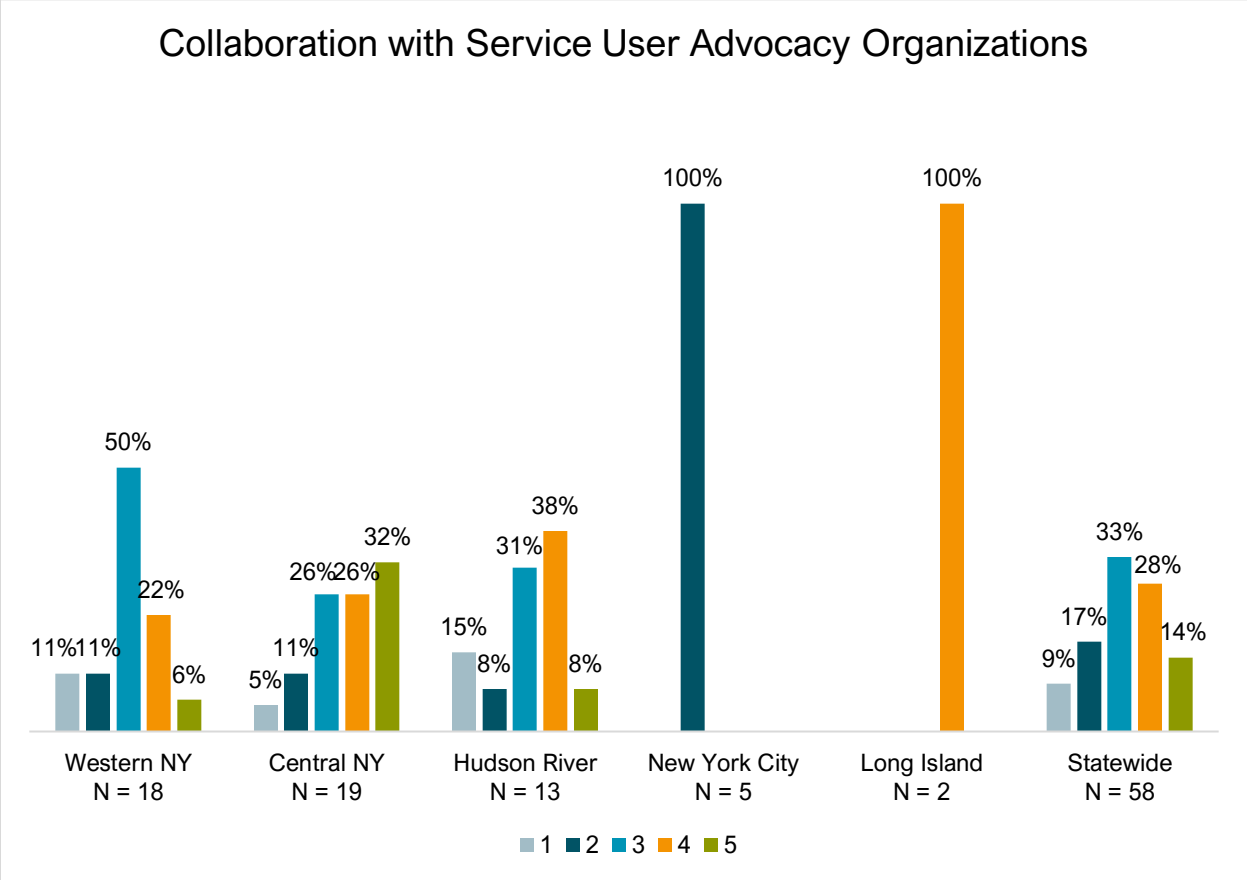
6o. Mental Hygiene Legal Services

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=17)	3.5 (1.2)	4.0	1	5
Central NY (N=20)	3.8 (1.1)	4.0	1	5
Hudson River (N=15)	3.7 (1.0)	4.0	1	5
New York City (N=5)	4.0 (0.0)	4.0	4	4
Long Island (N=2)	3.0 (0.0)	3.0	3	3
STATEWIDE (N=60)	**3.6 (1.0)**	**4.0**	**1**	**5**



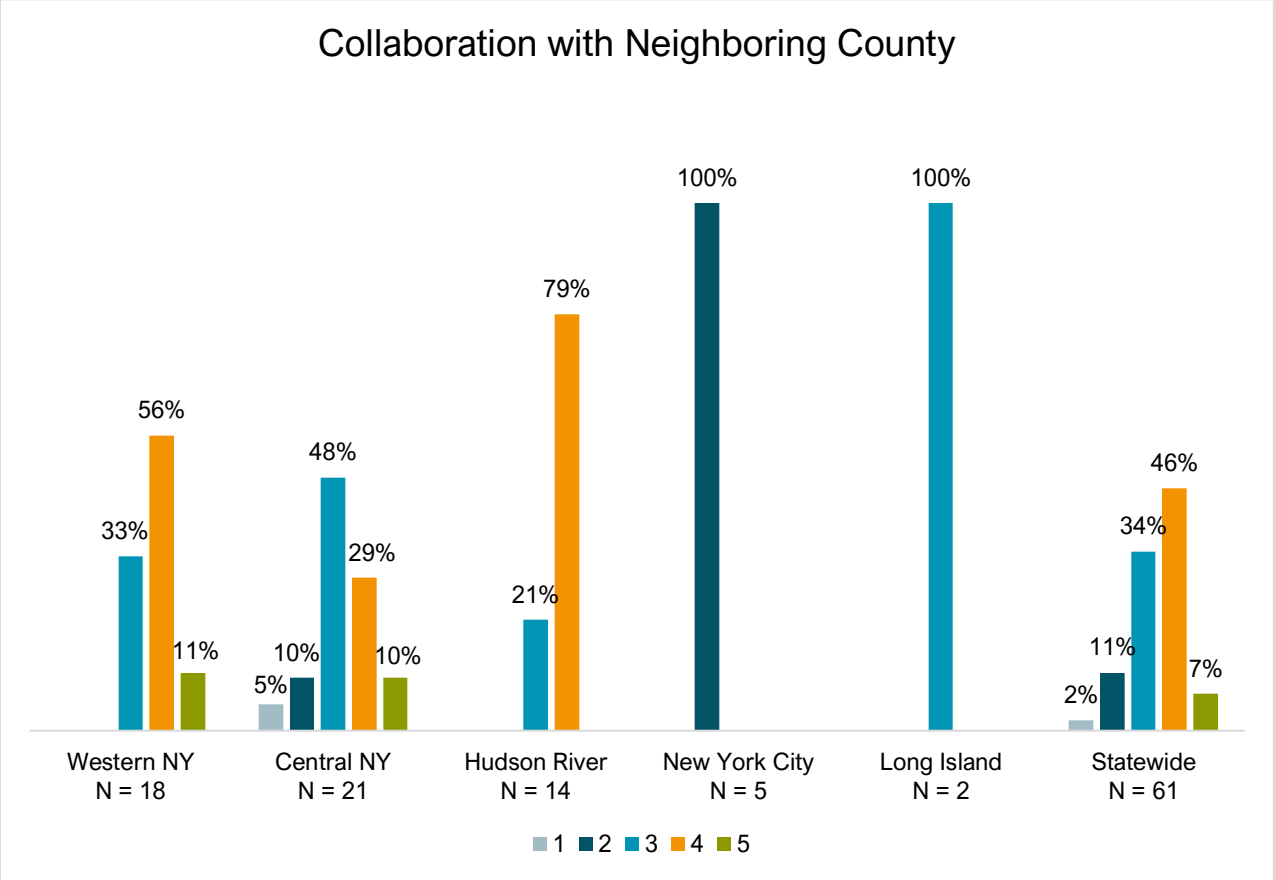
6p. Advocacy organizations representing mental health service users

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.0 (1.0)	3.0	1	5
Central NY (N=19)	3.7 (1.2)	4.0	1	5
Hudson River (N=13)	3.2 (1.2)	3.0	1	5
New York City (N=5)	2.0 (0.0)	2.0	2	2
Long Island (N=2)	4.0 (0.0)	4.0	4	4
STATEWIDE (N=58)	**3.2 (1.2)**	**3.0**	**1**	**5**



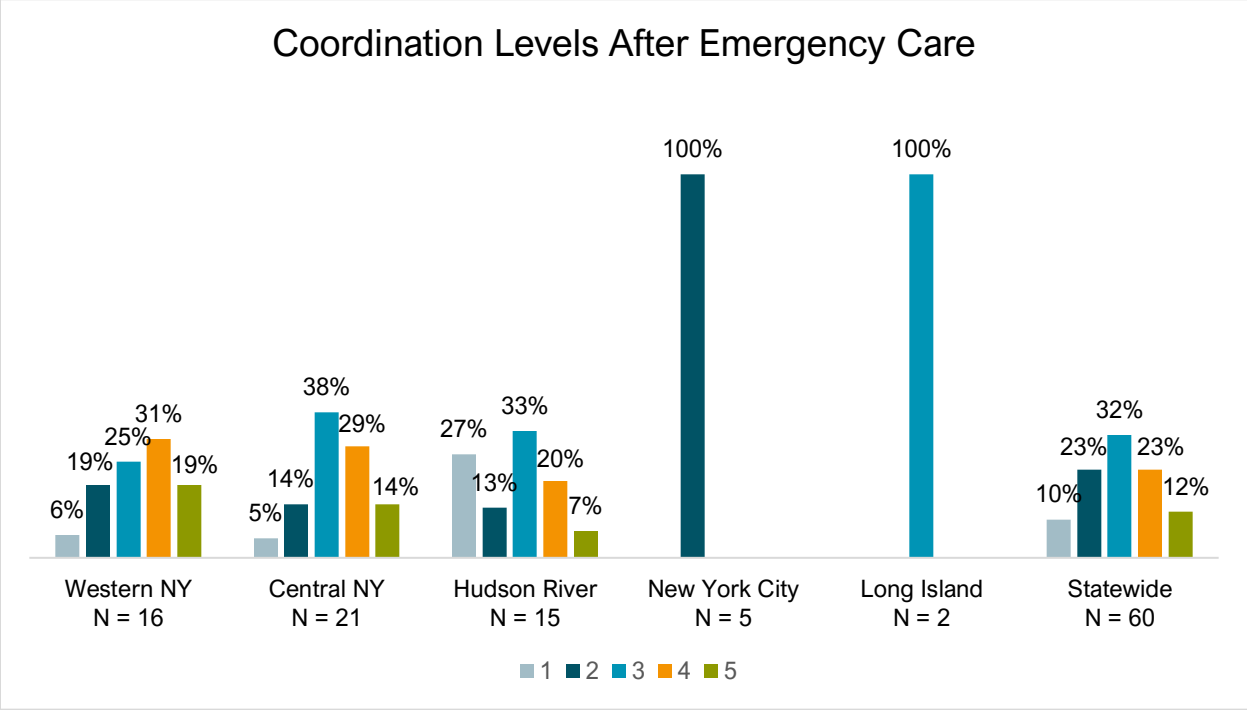
6q. Neighboring counties' behavioral health resources

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.8 (0.6)	4.0	3	5
Central NY (N=21)	3.3 (1.0)	3.0	1	5
Hudson River (N=14)	3.8 (0.4)	4.0	3	4
New York City (N=5)	2.0 (0.0)	2.0	2	2
Long Island (N=2)	3.0 (0.0)	3.0	3	3
STATEWIDE (N=61)	**3.4 (0.8)**	**4.0**	**1**	**5**



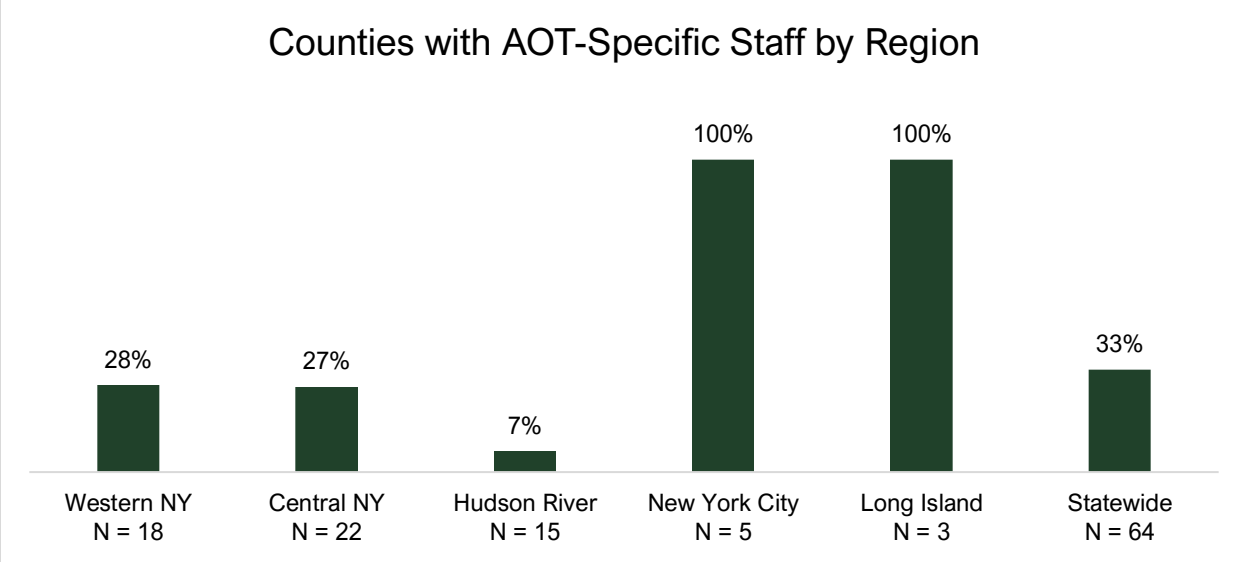
7. How would you rate the coordination/collaboration between this county's hospital emergency services and providers of other services that may be needed after emergency care, such as outpatient treatment providers, peer supports, or social service agencies? [Score on a scale of 1 to 5 with 1=No coordination/collaboration across services, and 5=Well-established system of collaboration/coordination]

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=16)	3.4 (1.2)	3.5	1	5
Central NY (N=21)	3.3 (1.1)	3.0	1	5
Hudson River (N=15)	2.7 (1.3)	3.0	1	5
New York City (N=5)	2.0 (0.0)	2.0	2	2
Long Island (N=2)	3.0 (0.0)	3.0	3	3
STATEWIDE (N=60)	**3.0 (1.2)**	**3.0**	**1**	**5**

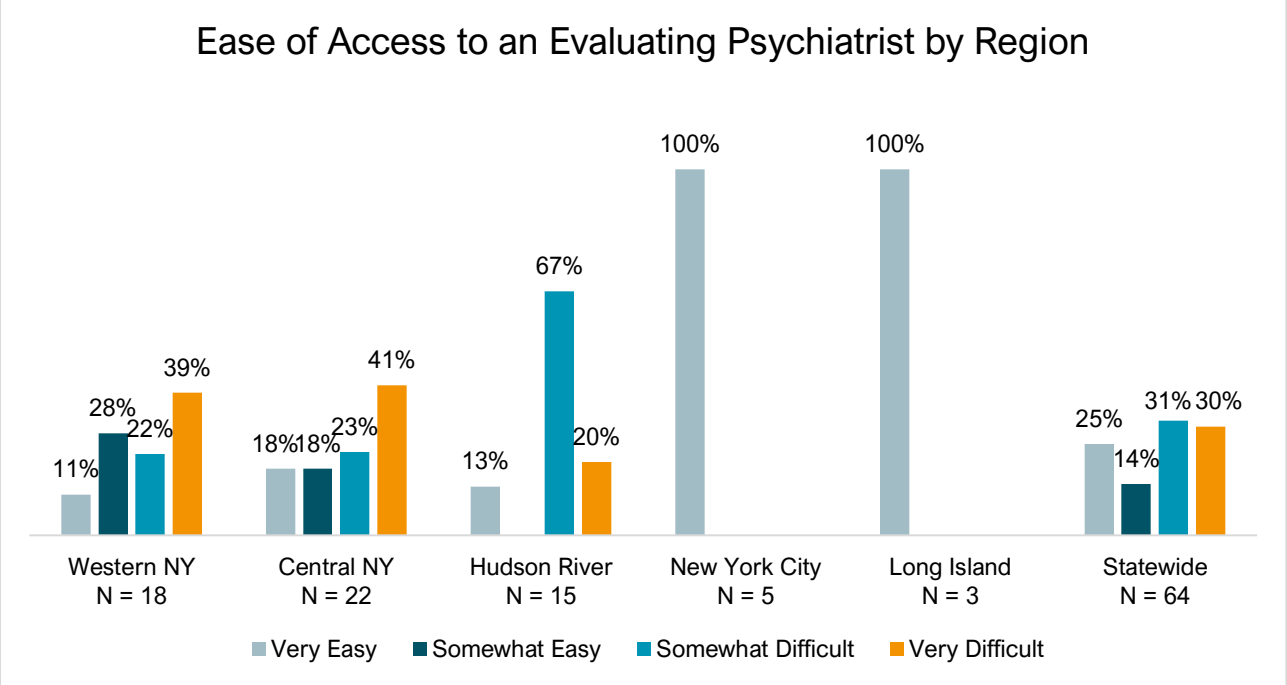


Assisted Outpatient Treatment Resources and Implementation

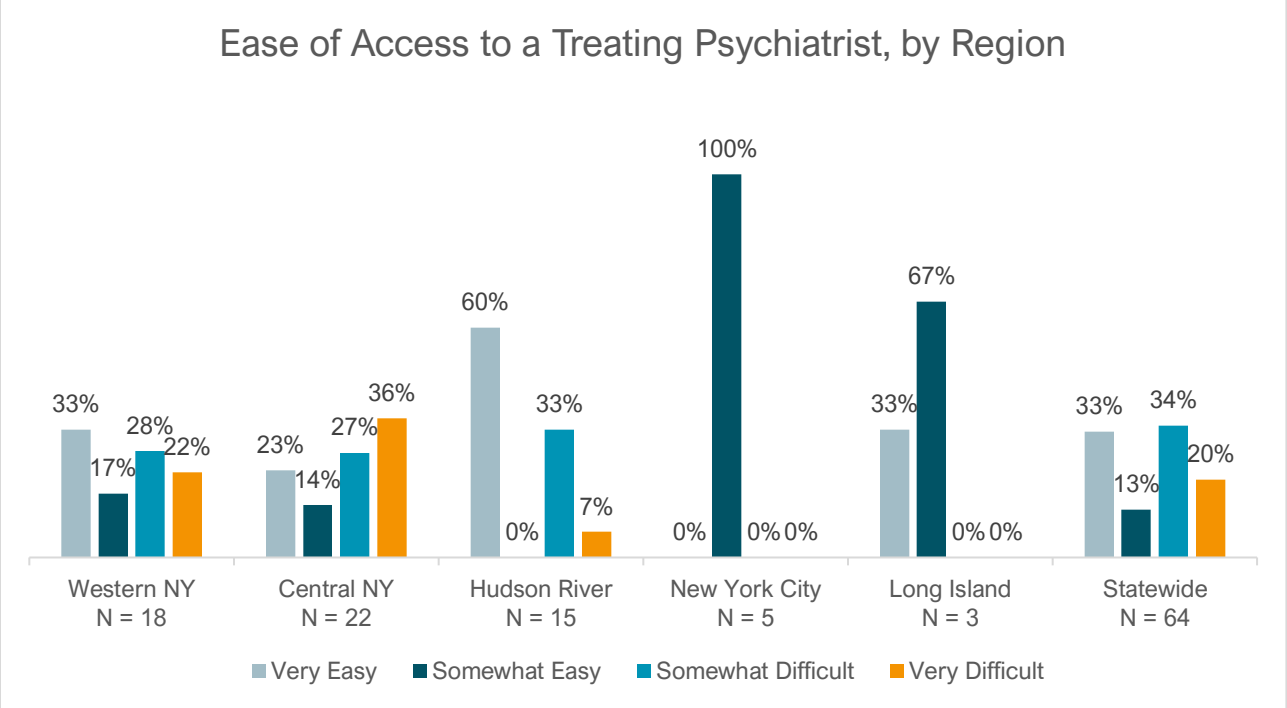
8. In addition to the AOT Coordinator, does the Department of Community Services have staff member(s) whose main role/responsibility is related to the AOT process?



9. In this county, how easy or difficult is it to access an evaluating psychiatrist for the AOT process?



10. In this county, how easy or difficult is it to access a treating psychiatrist for people under an AOT order?

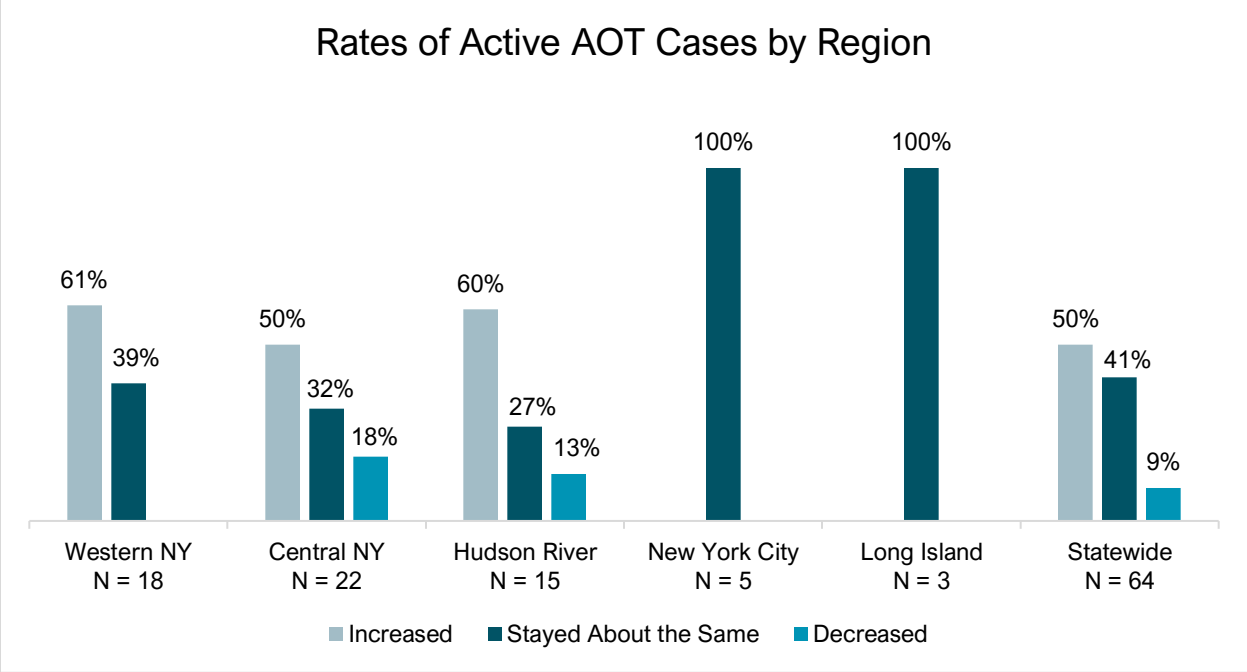


11. Please indicate the number of county staff members other than the AOT Coordinator that are available to fulfill each of the following roles. If a staff member fulfills more than one role, count them under each role. If no one is available for the role, please enter 0.

	Western NY (N=18)	Central NY (N=22)	Hudson River (N=15)	New York City (N=5)	Long Island (N=3)
Directly engage with the public to provide information and answer questions about AOT	1.1 (0.9)	1.1 (1.6)	1.2 (1.3)	108.0 (0.0)	7.0 (3.6)
Directly engage with AOT case managers when needed	1.8 (3.4)	1.1 (1.4)	1.1 (0.9)	88.0 (0.0)	7.0 (3.6)
Provide AOT-related training and technical assistance to providers and other system partners	1.0 (1.0)	0.9 (0.9)	0.7 (1.1)	27.0 (0.0)	3.7 (5.5)
Monitor, track, and analyze AOT-related data for evaluation and quality improvement purposes	0.8 (0.9)	0.8 (0.9)	0.7 (1.0)	10.0 (0.0)	2.3 (2.3)

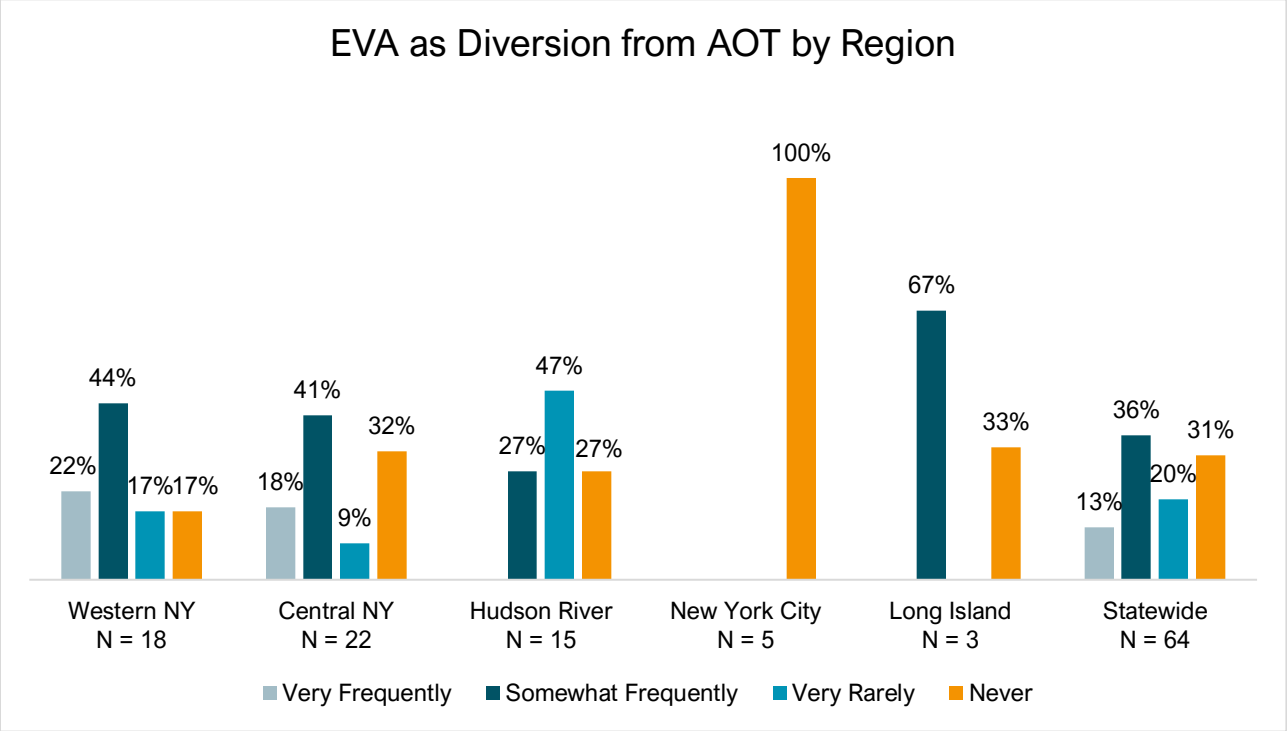
Notes: Values in this table show: mean (standard deviation)

12. During the past 12 months, active AOT cases in this county...

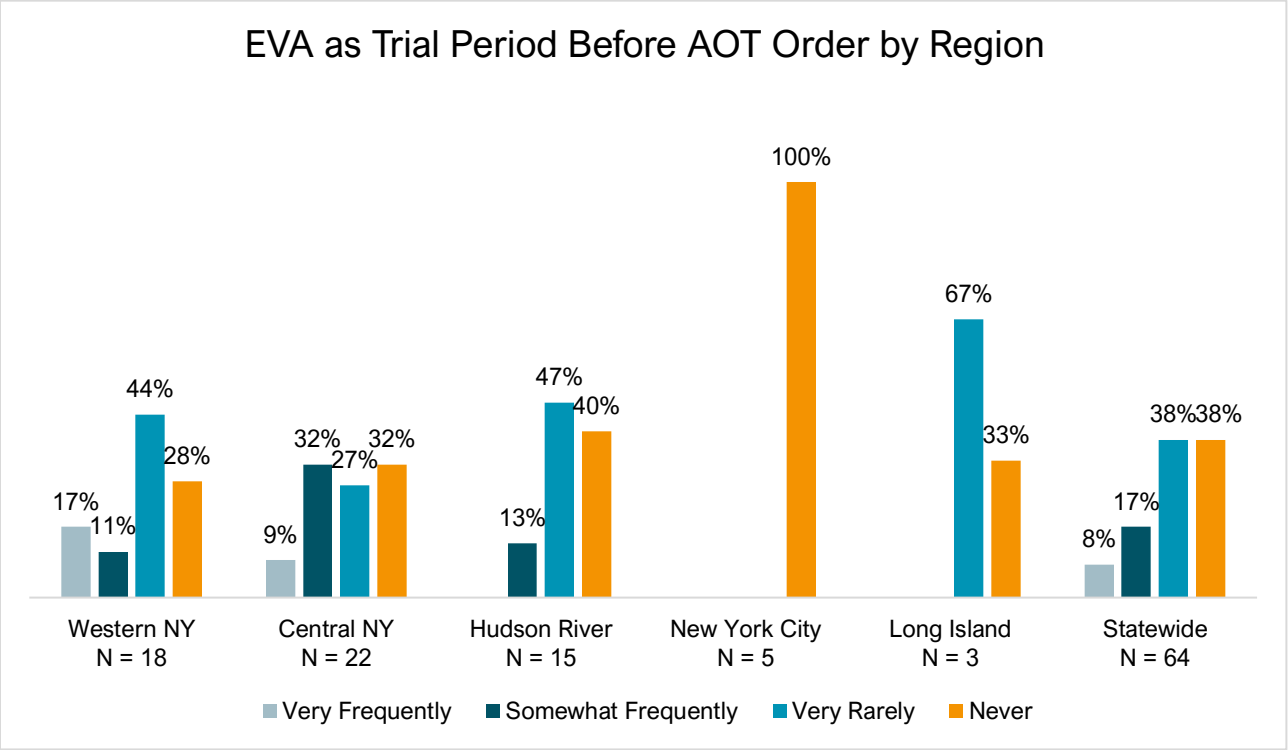


13. How frequently and for what purposes are Enhanced Voluntary Service Package Arrangements used in this county?

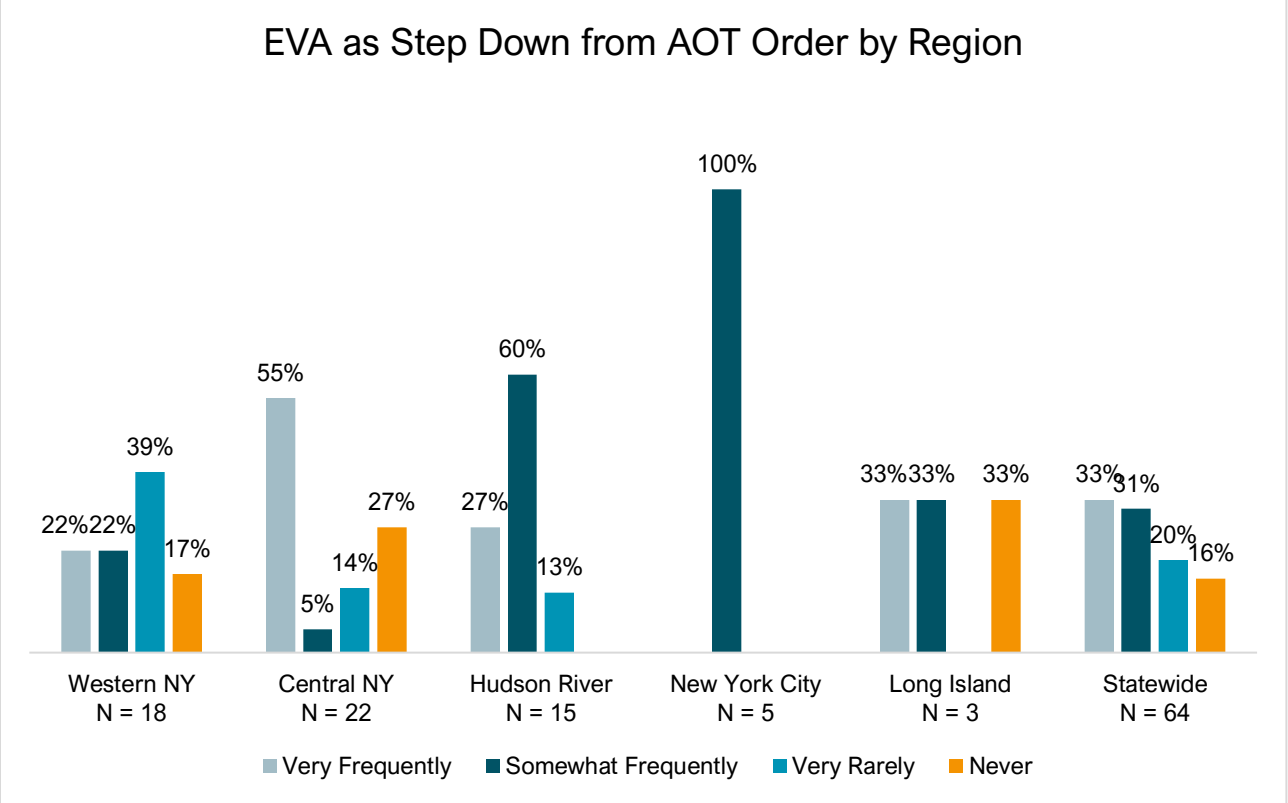
13a. EVA is used as a diversion from AOT orders



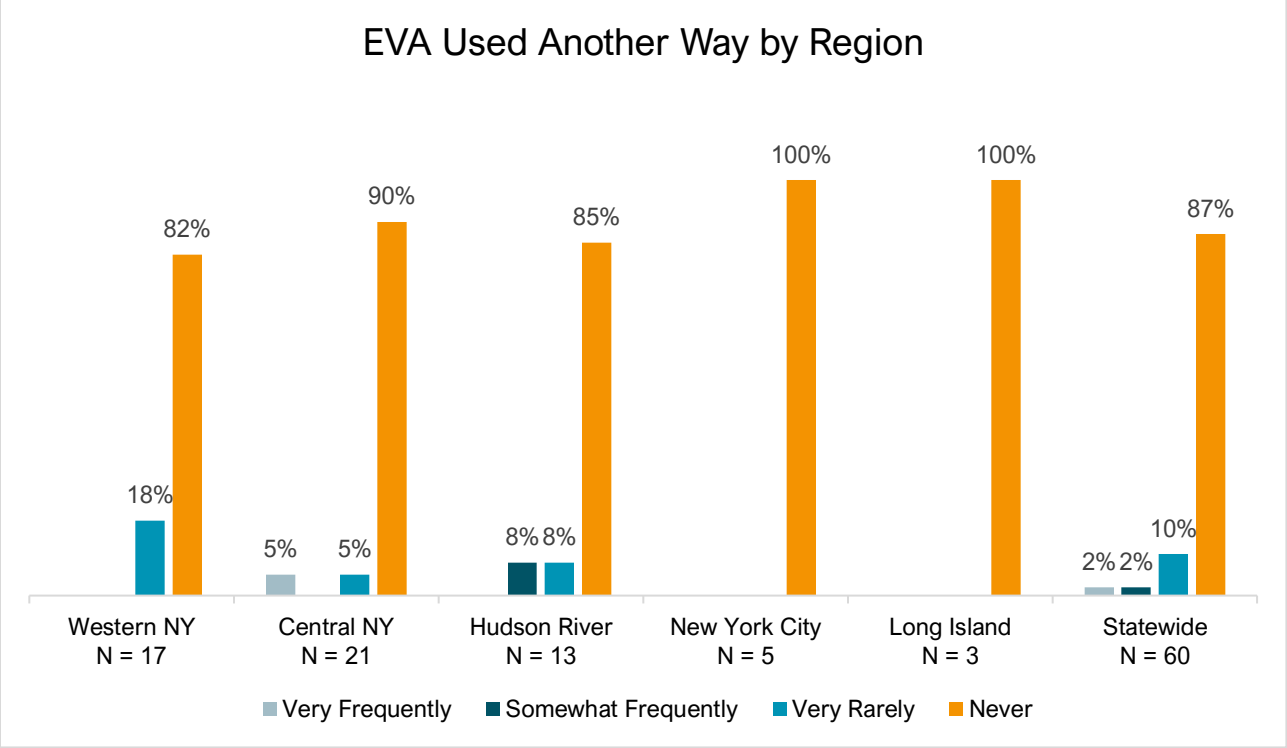
13b. EVA is used as a trial period before initiating a formal AOT order



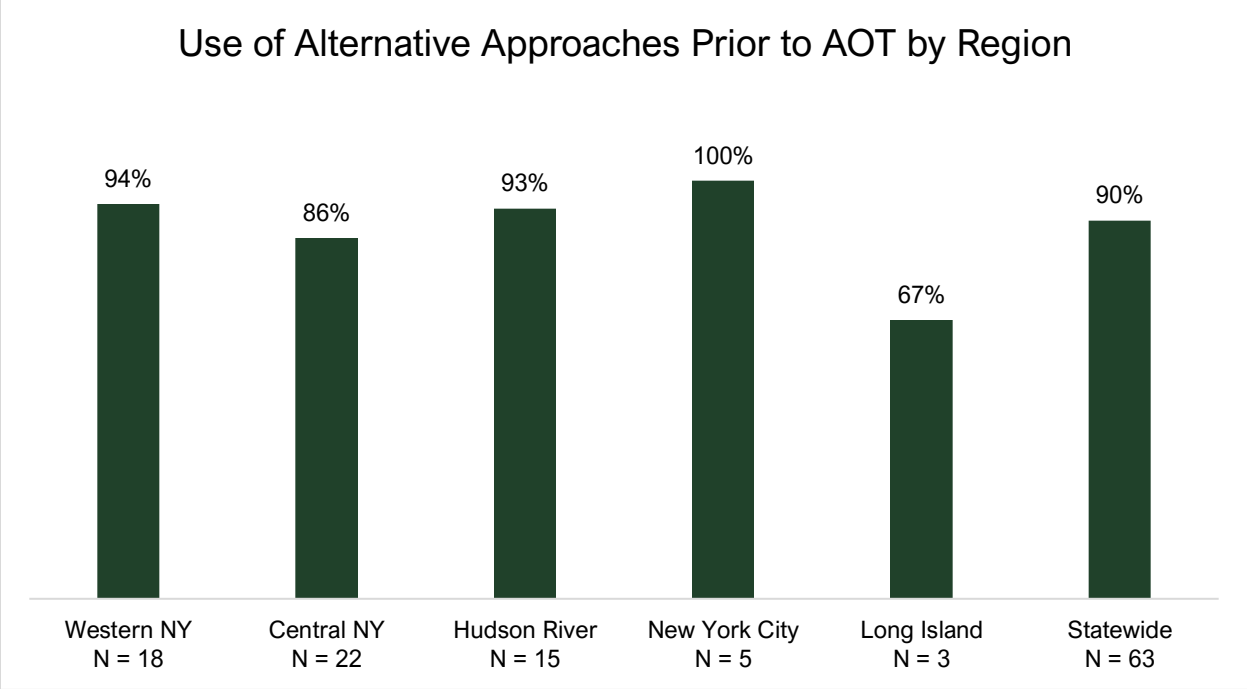
13c. EVA is used to support stepdown from an AOT order, following termination of the order.



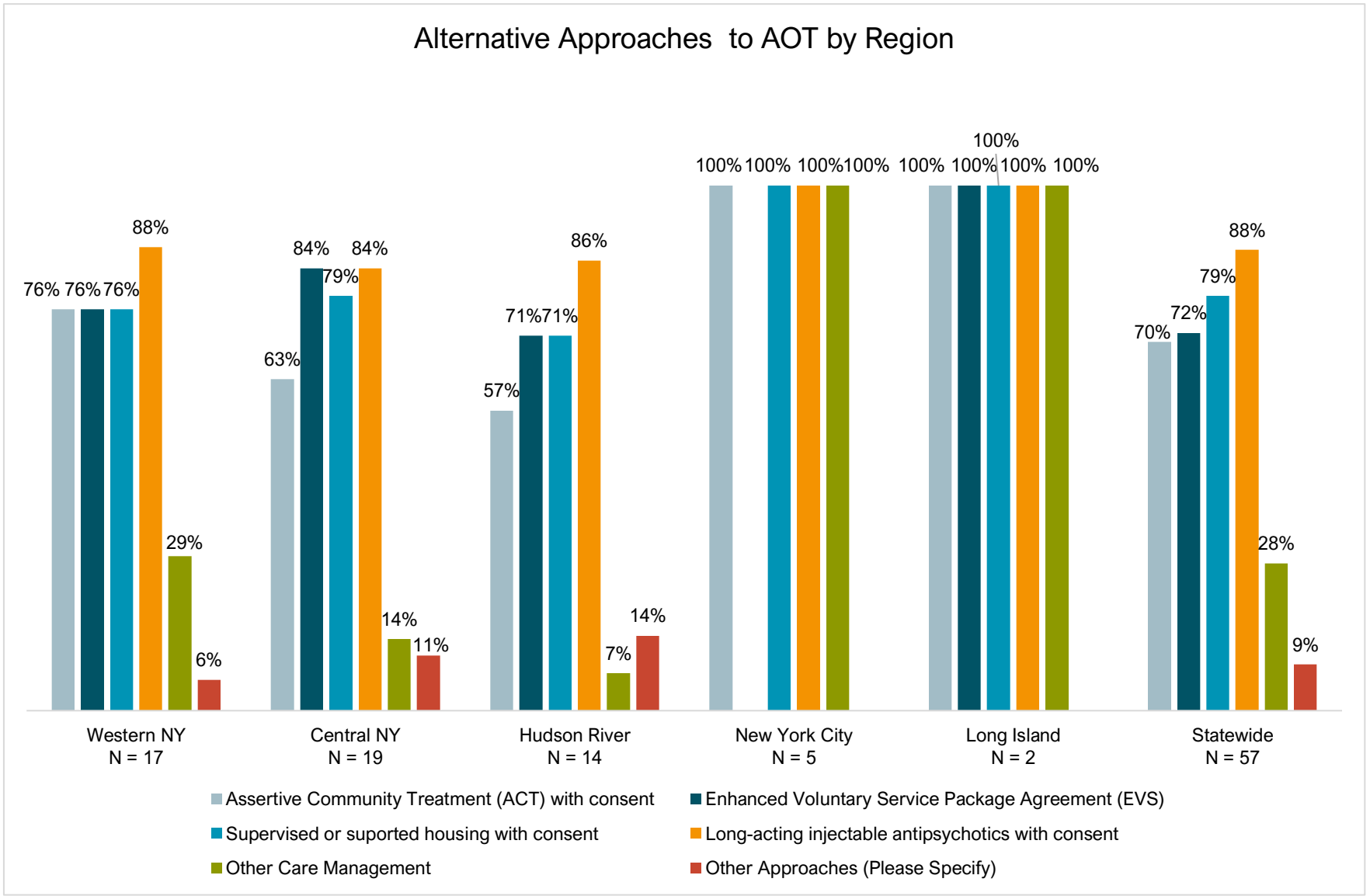
13d. EVA is used in some other way, not listed above.



14. In this county, are any approaches other than AOT considered before a legal AOT process is initiated?

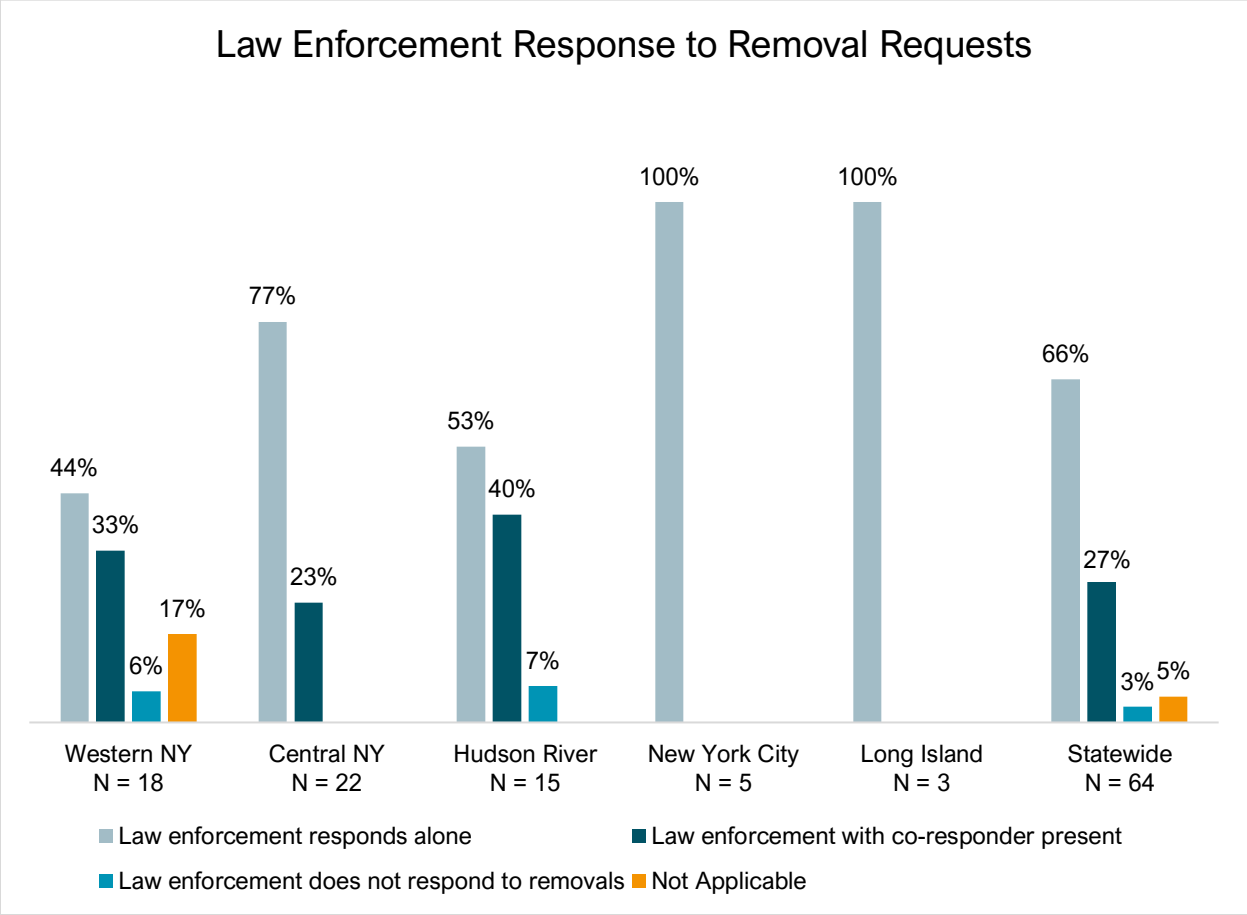


15. Which of the following approaches or supports are considered before a legal AOT process is initiated? (Check all that apply)

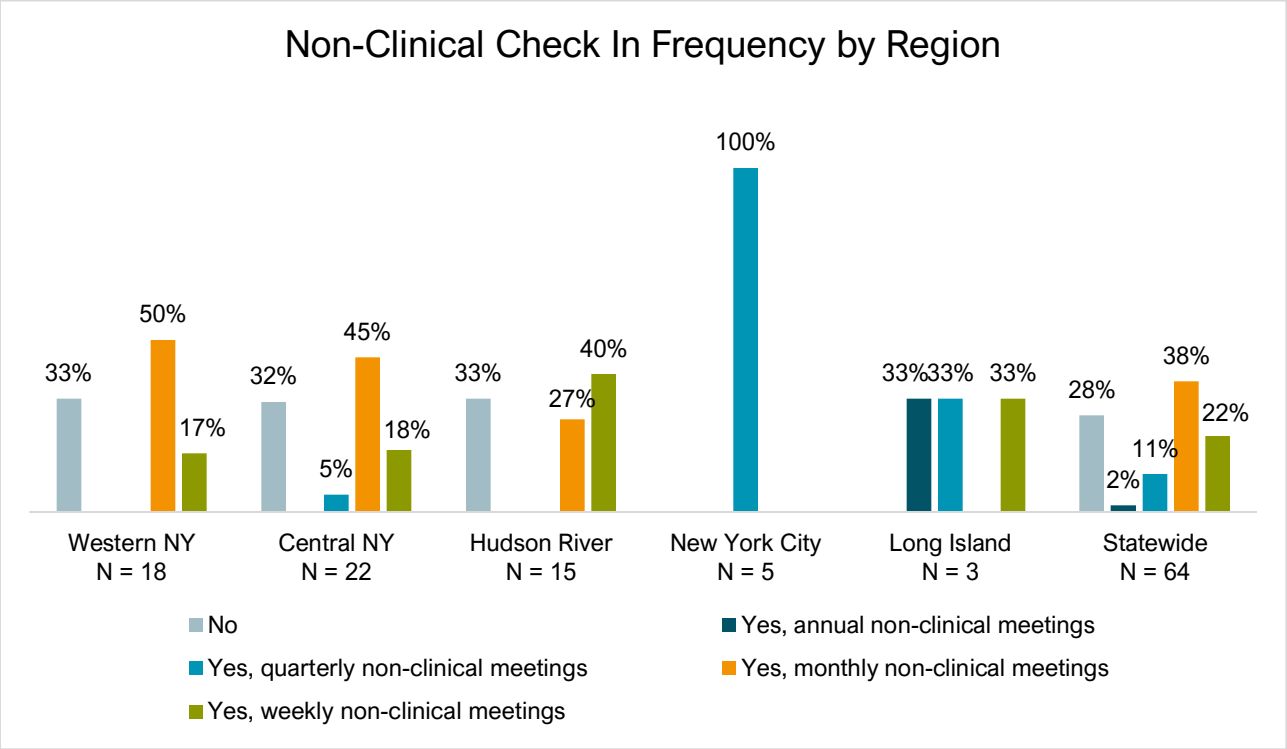


16. How does local law enforcement typically respond to AOT removal requests?

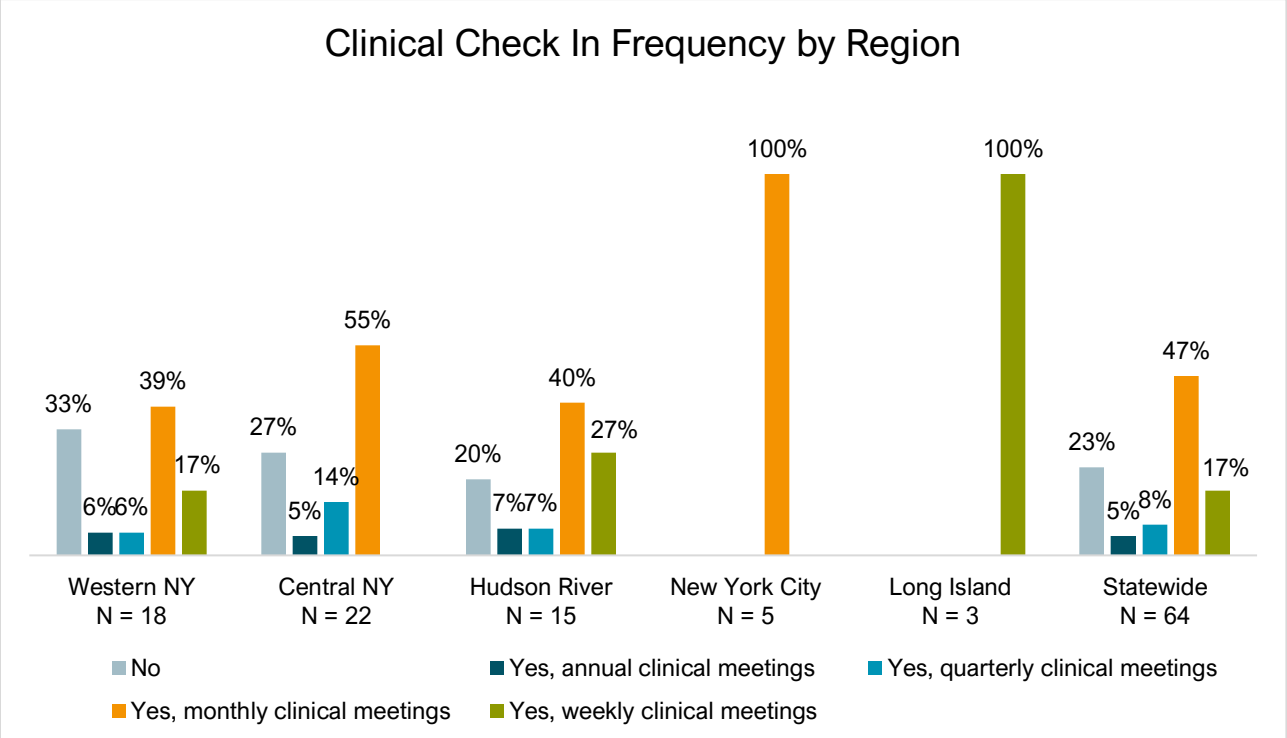
Presented below is a reduced version of the original question. “Law enforcement with co-responder present” is a combination of the following response options: “Co-response but law enforcement is in charge”; “Co-response and law enforcement takes a secondary role” and a subset of “Other” responses. Another subset of “Other” responses were recoded to “Not Applicable” as these counties did not have any experience with removals.



17. Do county AOT staff have regular non-clinical check-ins with AOT providers?



18. Do county AOT staff hold regular clinical meetings with AOT providers?



19. Thinking about the number of AOT requests/referrals received by this Department, approximately what percentage are initiated by the following petitioner categories?

19a. The community

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	11.3 (15.3)	5.0	0.0	50.0
Central NY (N=21)	6.4 (10.5)	0.0	0.0	40.0
Hudson River (N=15)	12.3 (25.2)	5.0	0.0	99.0
New York City (N=5)	14.0 (0.0)	14.0	14.0	14.0
Long Island (N=2)	7.5 (3.5)	7.5	5.0	10.0
STATEWIDE (N=62)	**9.8 (16.0)**	**5.0**	**0.0**	**99.0**

19b. Hospitals

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	41.3 (35.0)	41.5	0.0	100.0
Central NY (N=21)	45.0 (33.3)	40.0	0.0	100.0
Hudson River (N=15)	58.0 (34.4)	65.0	1.0	99.0
New York City (N=5)	64.0 (0.0)	64.0	64.0	64.0
Long Island (N=2)	70.0 (0.0)	70.0	70.0	70.0
STATEWIDE (N=62)	**49.8 (32.5)**	**50.0**	**0.0**	**100.0**

19c. ACT teams

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	9.5 (22.6)	0.0	0.0	75.0
Central NY (N=21)	8.3 (15.6)	0.0	0.0	50.0
Hudson River (N=15)	5.3 (8.8)	0.0	0.0	25.0
New York City (N=5)	2.0 (0.0)	2.0	2.0	2.0
Long Island (N=2)	6.0 (1.4)	6.0	5.0	7.0
STATEWIDE (N=62)	**7.2 (15.7)**	**0.0**	**0.0**	**75.0**

19d. Community providers other than ACT teams

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	20.4 (26.9)	10.0	0.0	100.0
Central NY (N=21)	26.3 (29.3)	20.0	0.0	90.0
Hudson River (N=15)	14.7 (20.0)	10.0	0.0	60.0
New York City (N=5)	5.0 (0.0)	5.0	5.0	5.0
Long Island (N=2)	10.0 (0.0)	10.0	10.0	10.0
STATEWIDE (N=62)	**19.5 (24.8)**	**10.0**	**0.0**	**100.0**

19e. Correctional facilities

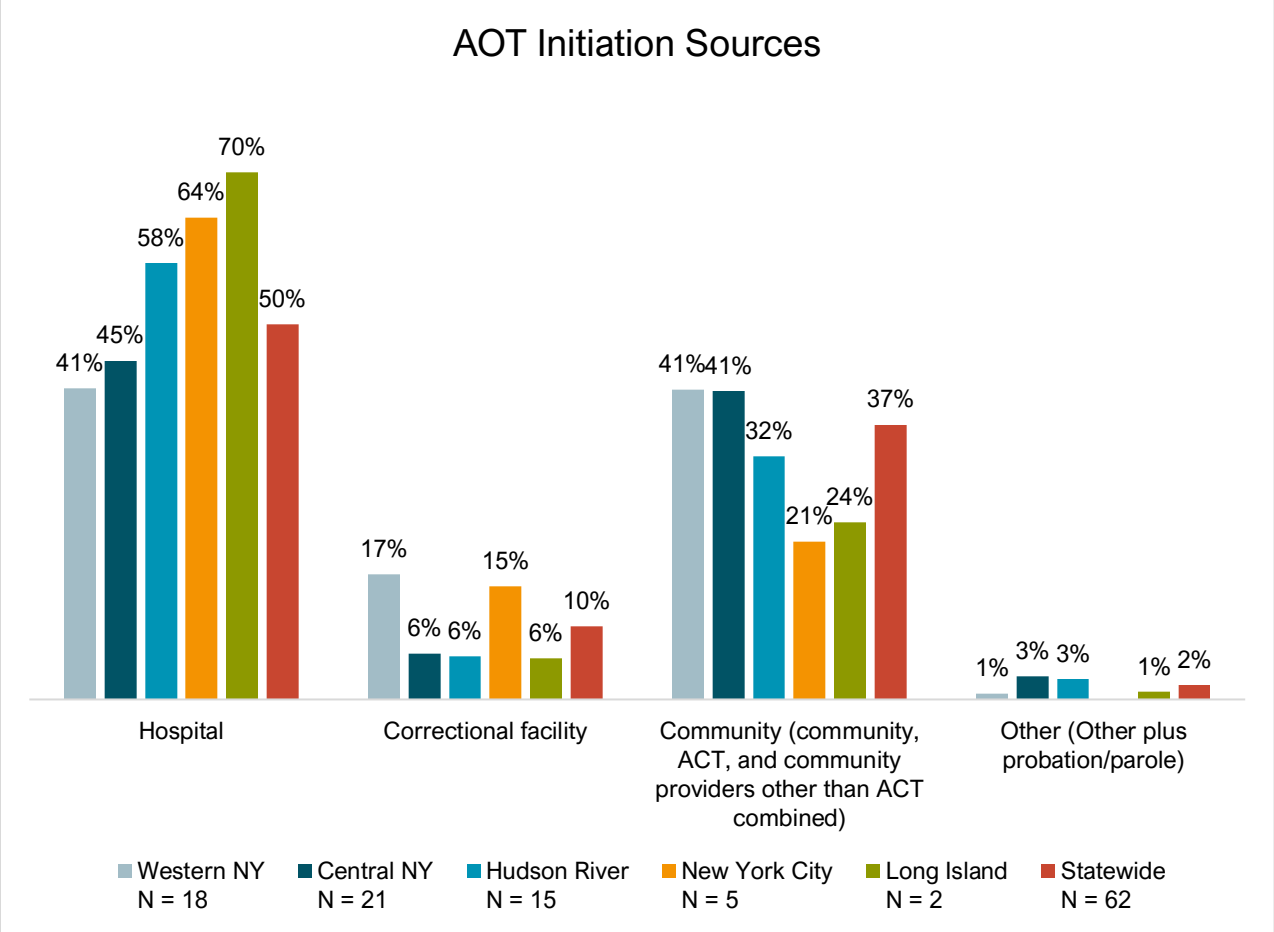
REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	16.6 (24.2)	5.0	0.0	80.0
Central NY (N=21)	6.1 (10.1)	0.0	0.0	35.0
Hudson River (N=15)	5.7 (7.2)	5.0	0.0	25.0
New York City (N=5)	15.0 (0.0)	15.0	15.0	15.0
Long Island (N=2)	5.5 (6.4)	5.5	1.0	10.0
STATEWIDE (N=62)	**9.7 (15.3)**	**5.0**	**0.0**	**80.0**

19f. Probation or Parole offices

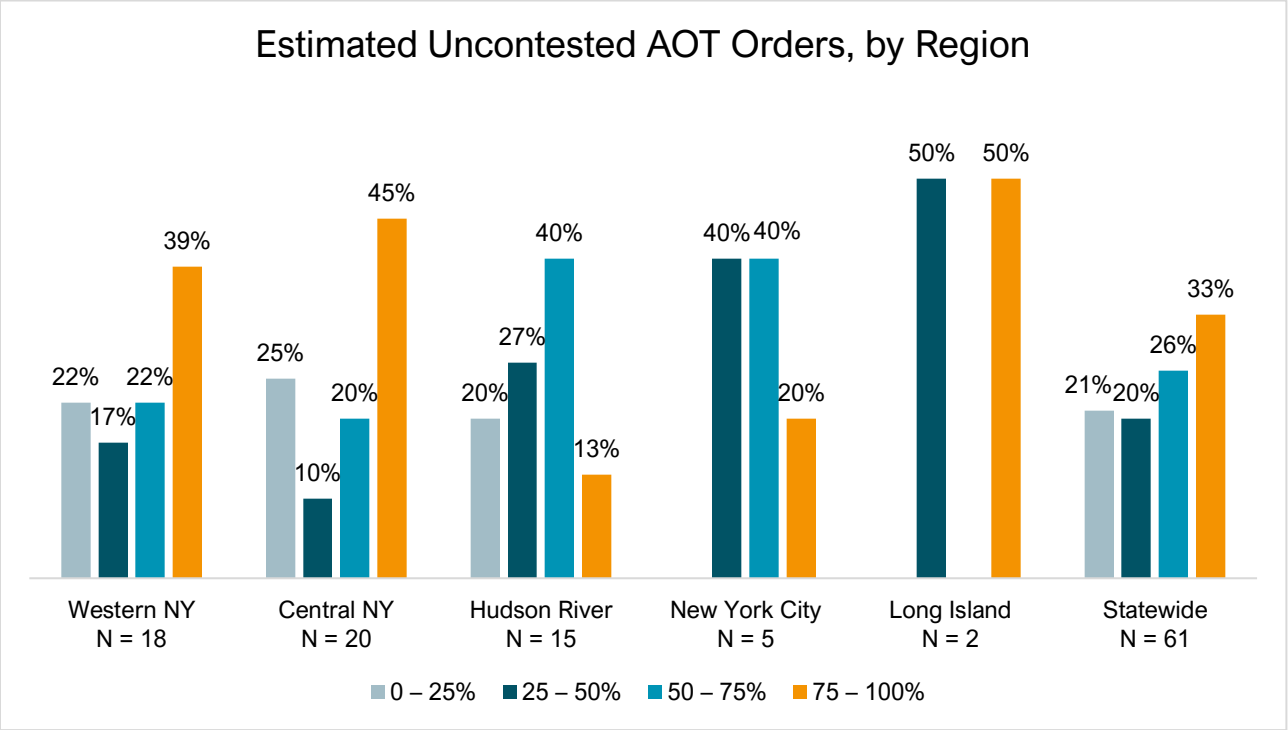
REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	0.8 (1.8)	0.0	0.0	5.0
Central NY (N=21)	1.4 (4.8)	0.0	0.0	20.0
Hudson River (N=15)	2.0 (5.3)	0.0	0.0	20.0
New York City (N=5)	0.0 (0.0)	0.0	0.0	0.0
Long Island (N=2)	1.0 (1.4)	1.0	0.0	2.0
STATEWIDE (N=62)	**1.2 (3.9)**	**0.0**	**0.0**	**20.0**

19g. Other

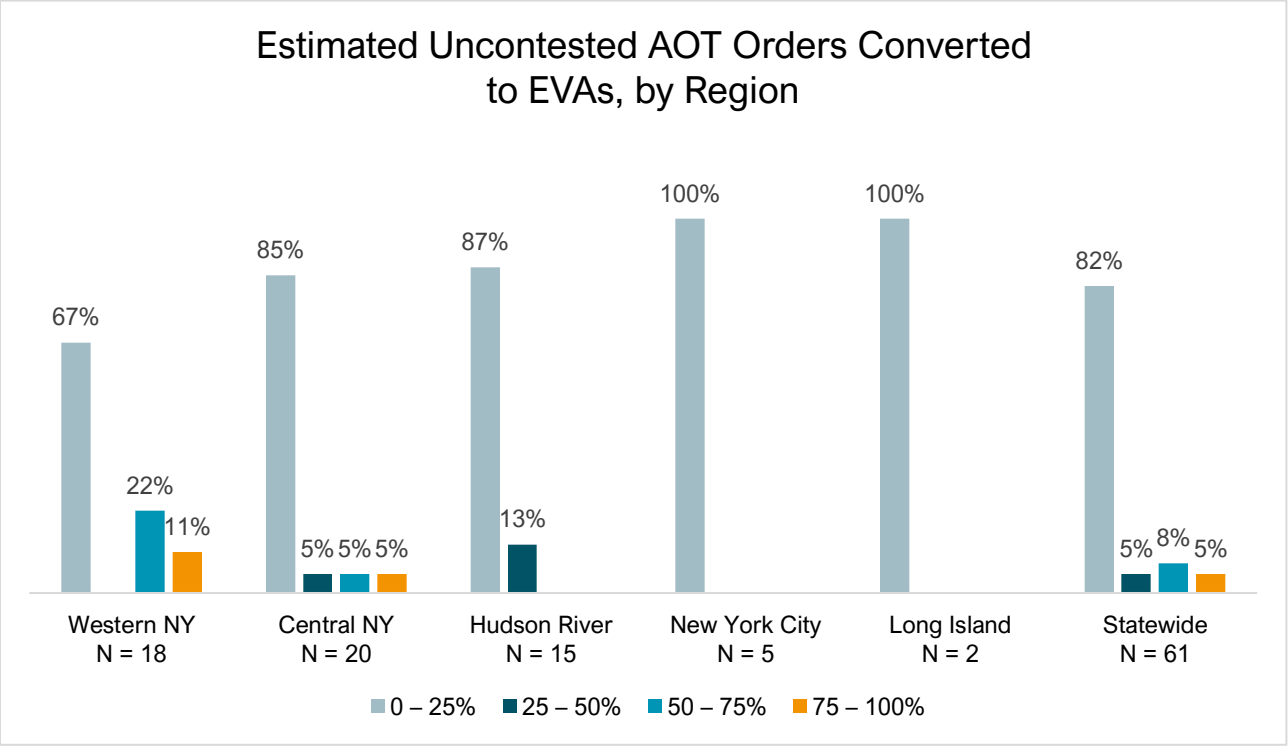
REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	0.0 (0.0)	0.0	0.0	0.0
Central NY (N=21)	1.7 (6.6)	0.0	0.0	30.0
Hudson River (N=15)	0.7 (2.6)	0.0	0.0	10.0
New York City (N=5)	0.0 (0.0)	0.0	0.0	0.0
Long Island (N=2)	0.0 (0.0)	0.0	0.0	0.0
STATEWIDE (N=62)	**0.7 (4.0)**	**0.0**	**0.0**	**30.0**



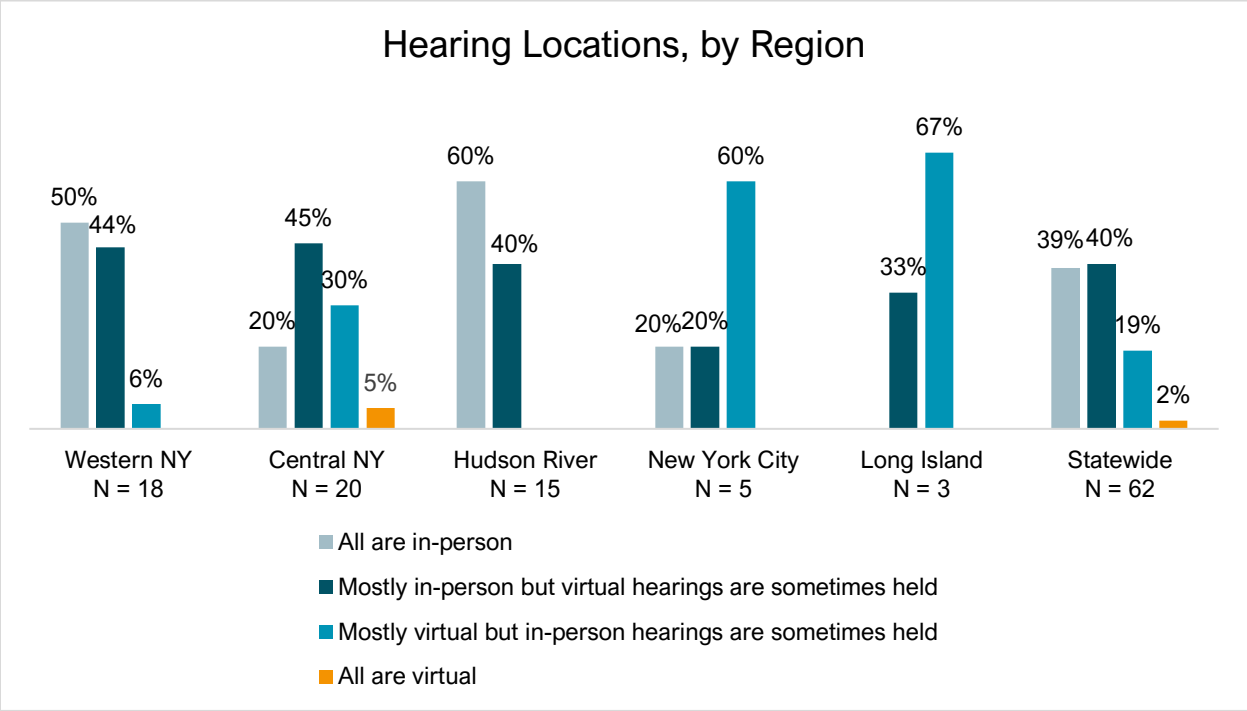
20. Approximately what percentage of AOT orders in this county are uncontested?



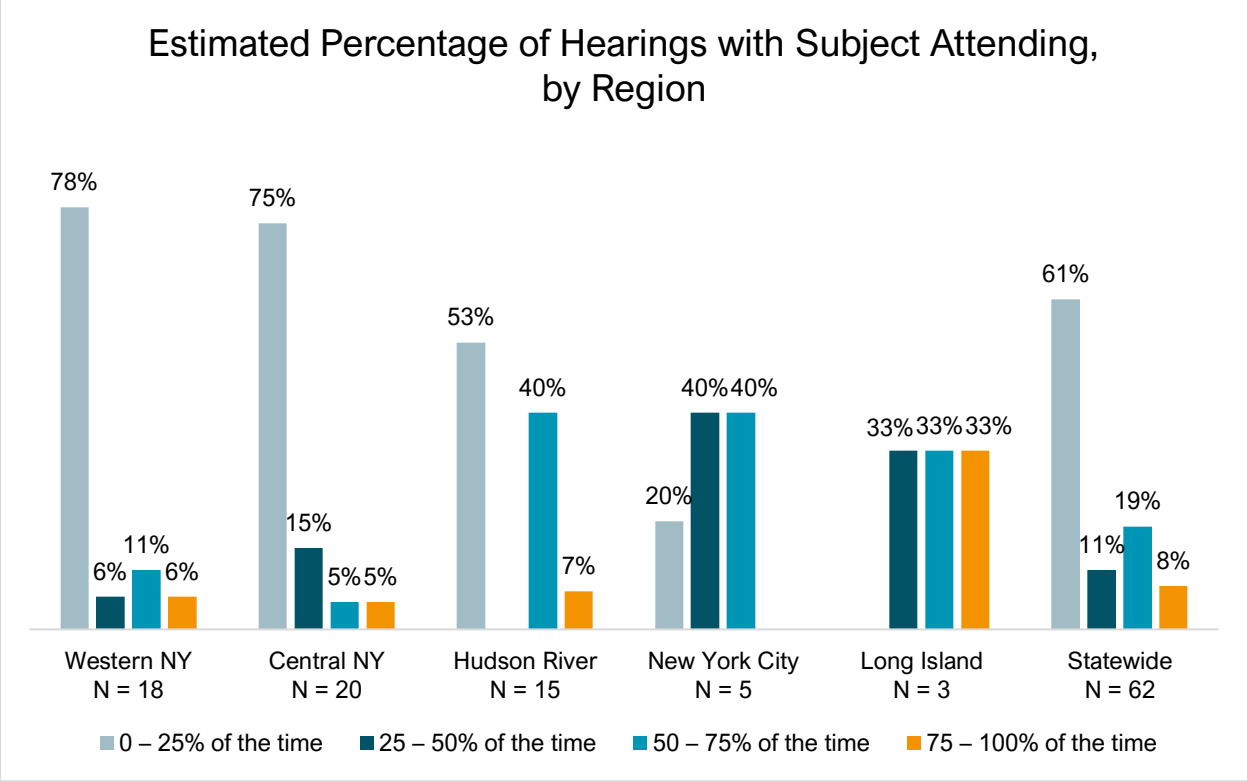
21. Approximately what percentage of uncontested AOT orders in this county are converted to an Enhanced Voluntary Service Package Agreement?



22. Are AOT hearings in this county in-person or virtual?



23. In this county, approximately what percentage of court hearings are held without the AOT subject in attendance (either in person or virtually?)



24. To the best of your knowledge, what percentage of people under an active AOT order in this county are unhoused?

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	9.8 (20.1)	0.0	0.0	75.0
Central NY (N=20)	9.9 (20.7)	0.0	0.0	75.0
Hudson River (N=15)	11.1 (9.7)	10.0	0.0	25.0
New York City (N=5)	14.0 (0.0)	14.0	14.0	14.0
Long Island (N=2)	20.0 (7.1)	20.0	15.0	25.0
STATEWIDE (N=61)	**11.1 (16.7)**	**3.0**	**0.0**	**75.0**

Opinions about Assisted Outpatient Treatment

25. To the best of your knowledge, what percentage of people under an AOT order benefit from the experience?

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	65.6 (30.2)	75.0	0.0	100.0
Central NY (N=20)	76.0 (14.7)	75.0	50.0	100.0
Hudson River (N=15)	83.0 (16.6)	90.0	50.0	100.0
New York City (N=5)	40.0 (0.0)	40.0	40.0	40.0
Long Island (N=2)	70.0 (14.1)	70.0	60.0	80.0
STATEWIDE (N=61)	**70.9 (23.3)**	**75.0**	**0.0**	**100.0**

26. The following are statements that some people make about AOT. Please indicate how much you agree or disagree with each. [Score on a scale of Strongly Disagree to Strongly Agree with Strongly Disagree=1, Disagree=2, Neither Agree nor Disagree=3, Agree=4, Strongly Agree=5]

Supportive of AOT Statements Composite Score (the average of the following statements for each survey response was taken to get this composite score: “Severely ill people without insight require AOT.”; “AOT provides a caring environment for people with serious mental illness.”; “Since Kendra’s Law, crime and other public disturbances have decreased.”; “More people with serious mental illness should be under an AOT order in NYS.”; “AOT increases access to needed resources.”; “AOT prevents the development of dangerous situations.”; “For severely ill people, AOT represents safety.”)

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.2 (0.6)	3.4	1.8	4.1
Central NY (N=20)	3.3 (0.5)	3.3	1.9	4.0
Hudson River (N=15)	3.4 (0.4)	3.6	2.6	3.9
New York City (N=5)	3.3 (0.0)	3.3	3.3	3.3
Long Island (N=2)	3.4 (0.2)	3.4	3.3	3.6
STATEWIDE (N=61)	**3.3 (0.5)**	**3.3**	**1.8**	**4.1**

Critical of AOT Statements Composite Score (the average of the following statements for each survey response was taken to get this composite score: “AOT contradicts the values of trauma-informed care.”; “AOT takes resources away from voluntary service options for people with serious mental illness.”; “I would prefer greater use of voluntary alternatives before initiation of an AOT order.”; “Use of AOT orders could be reduced if high-quality voluntary services were more accessible.”; “AOT harms the therapeutic relationship.”; “Overall, AOT is over-used in NYS.”; “AOT violates the recipient’s rights.”)

REGION (Number of Responses)	**Mean Score (Standard Deviation)**	**Median Score**	**Minimum Score**	**Maximum Score**
Western NY (N=18)	2.7 (0.5)	2.6	1.9	3.7
Central NY (N=20)	2.5 (0.6)	2.4	1.6	3.9
Hudson River (N=15)	2.6 (0.5)	2.4	2.0	4.1
New York City (N=5)	2.3 (0.0)	2.3	2.3	2.3
Long Island (N=2)	2.4 (0.5)	2.4	2.0	2.7
STATEWIDE (N=61)	**2.6 (0.5)**	**2.4**	**1.6**	**4.1**

26a. Severely ill people without insight require AOT.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.9 (0.9)	3.0	1.0	4.0
Central NY (N=20)	2.8 (1.1)	3.0	1.0	4.0
Hudson River (N=14)	2.6 (1.0)	3.0	1.0	4.0
New York City (N=5)	2.0 (0.0)	2.0	2.0	2.0
Long Island (N=2)	3.5 (0.7)	3.5	3.0	4.0
STATEWIDE (N=60)	**2.7 (1.0)**	**3.0**	**1.0**	**4.0**

26b. AOT provides a caring environment for people with serious mental illness.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=17)	4.1 (0.7)	4.0	3.0	5.0
Central NY (N=20)	4.2 (0.8)	4.0	2.0	5.0
Hudson River (N=15)	4.1 (0.5)	4.0	3.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=2)	3.5 (0.7)	3.5	3.0	4.0
STATEWIDE (N=60)	**4.1 (0.6)**	**4.0**	**2.0**	**5.0**

26c. AOT contradicts the values of trauma-informed care.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.6 (0.7)	3.0	1.0	4.0
Central NY (N=20)	2.3 (0.9)	2.0	1.0	4.0
Hudson River (N=15)	2.1 (0.7)	2.0	1.0	4.0
New York City (N=5)	2.0 (0.0)	2.0	2.0	2.0
Long Island (N=2)	2.0 (1.4)	2.0	1.0	3.0
STATEWIDE (N=61)	**2.3 (0.8)**	**2.0**	**1.0**	**4.0**

26d. Since Kendra's Law, crime and other public disturbances have decreased.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.7 (1.0)	3.0	1.0	4.0
Central NY (N=20)	2.4 (1.0)	3.0	1.0	4.0
Hudson River (N=15)	3.0 (0.7)	3.0	2.0	4.0
New York City (N=5)	3.0 (0.0)	3.0	3.0	3.0
Long Island (N=2)	3.0 (0.0)	3.0	3.0	3.0
STATEWIDE (N=61)	**2.7 (0.9)**	**3.0**	**1.0**	**4.0**

26e. AOT takes resources away from voluntary service options for people with serious mental illness.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.1 (1.0)	2.0	1.0	4.0
Central NY (N=20)	1.9 (0.7)	2.0	1.0	3.0
Hudson River (N=15)	2.1 (0.9)	2.0	1.0	4.0
New York City (N=5)	1.0 (0.0)	1.0	1.0	1.0
Long Island (N=2)	1.5 (0.7)	1.5	1.0	2.0
STATEWIDE (N=61)	**1.9 (0.9)**	**2.0**	**1.0**	**4.0**

26f. More people with serious mental illness should be under an AOT order in NYS.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.8 (1.0)	3.0	1.0	4.0
Central NY (N=20)	3.1 (1.0)	3.0	1.0	5.0
Hudson River (N=15)	2.8 (0.9)	3.0	1.0	5.0
New York City (N=5)	1.0 (0.0)	1.0	1.0	1.0
Long Island (N=2)	2.5 (0.7)	2.5	2.0	3.0
STATEWIDE (N=61)	**2.7 (1.1)**	**3.0**	**1.0**	**5.0**

26g. AOT increases access to needed resources.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.5 (1.3)	4.0	1.0	5.0
Central NY (N=20)	4.0 (0.7)	4.0	2.0	5.0
Hudson River (N=15)	4.0 (0.5)	4.0	3.0	5.0
New York City (N=5)	5.0 (0.0)	5.0	5.0	5.0
Long Island (N=2)	4.0 (0.0)	4.0	4.0	4.0
STATEWIDE (N=61)	**3.9 (1.0)**	**4.0**	**1.0**	**5.0**

26h. I would prefer greater use of voluntary alternatives before initiation of an AOT order.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.9 (0.9)	4.0	2.0	5.0
Central NY (N=20)	3.6 (0.9)	3.0	2.0	5.0
Hudson River (N=15)	3.6 (0.7)	4.0	2.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=2)	3.5 (0.7)	3.5	3.0	4.0
STATEWIDE (N=61)	**3.7 (0.8)**	**4.0**	**2.0**	**5.0**

26i. AOT prevents the development of dangerous situations.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.2 (0.8)	3.0	2.0	4.0
Central NY (N=20)	3.3 (0.7)	3.0	2.0	4.0
Hudson River (N=15)	3.4 (0.7)	4.0	2.0	4.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=2)	3.5 (0.7)	3.5	3.0	4.0
STATEWIDE (N=61)	**3.3 (0.8)**	**4.0**	**2.0**	**4.0**

26j. Use of AOT orders could be reduced if high-quality voluntary services were more accessible.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.3 (1.4)	3.0	1.0	5.0
Central NY (N=20)	3.4 (1.1)	3.0	2.0	5.0
Hudson River (N=15)	3.1 (0.8)	3.0	2.0	4.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=2)	3.0 (0.0)	3.0	3.0	3.0
STATEWIDE (N=61)	**3.3 (1.1)**	**3.0**	**1.0**	**5.0**

26k. AOT harms the therapeutic relationship.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.2 (1.1)	2.0	1.0	5.0
Central NY (N=19)	2.1 (0.6)	2.0	1.0	3.0
Hudson River (N=15)	2.5 (0.8)	2.0	2.0	5.0
New York City (N=5)	2.0 (0.0)	2.0	2.0	2.0
Long Island (N=2)	2.5 (0.7)	2.5	2.0	3.0
STATEWIDE (N=60)	**2.3 (0.8)**	**2.0**	**1.0**	**5.0**

26l. For severely ill people, AOT represents safety.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	3.4 (0.9)	4.0	2.0	5.0
Central NY (N=20)	3.3 (0.9)	3.5	1.0	4.0
Hudson River (N=15)	3.7 (0.7)	4.0	2.0	5.0
New York City (N=5)	4.0 (0.0)	4.0	4.0	4.0
Long Island (N=2)	4.0 (0.0)	4.0	4.0	4.0
STATEWIDE (N=61)	**3.5 (0.8)**	**4.0**	**1.0**	**5.0**

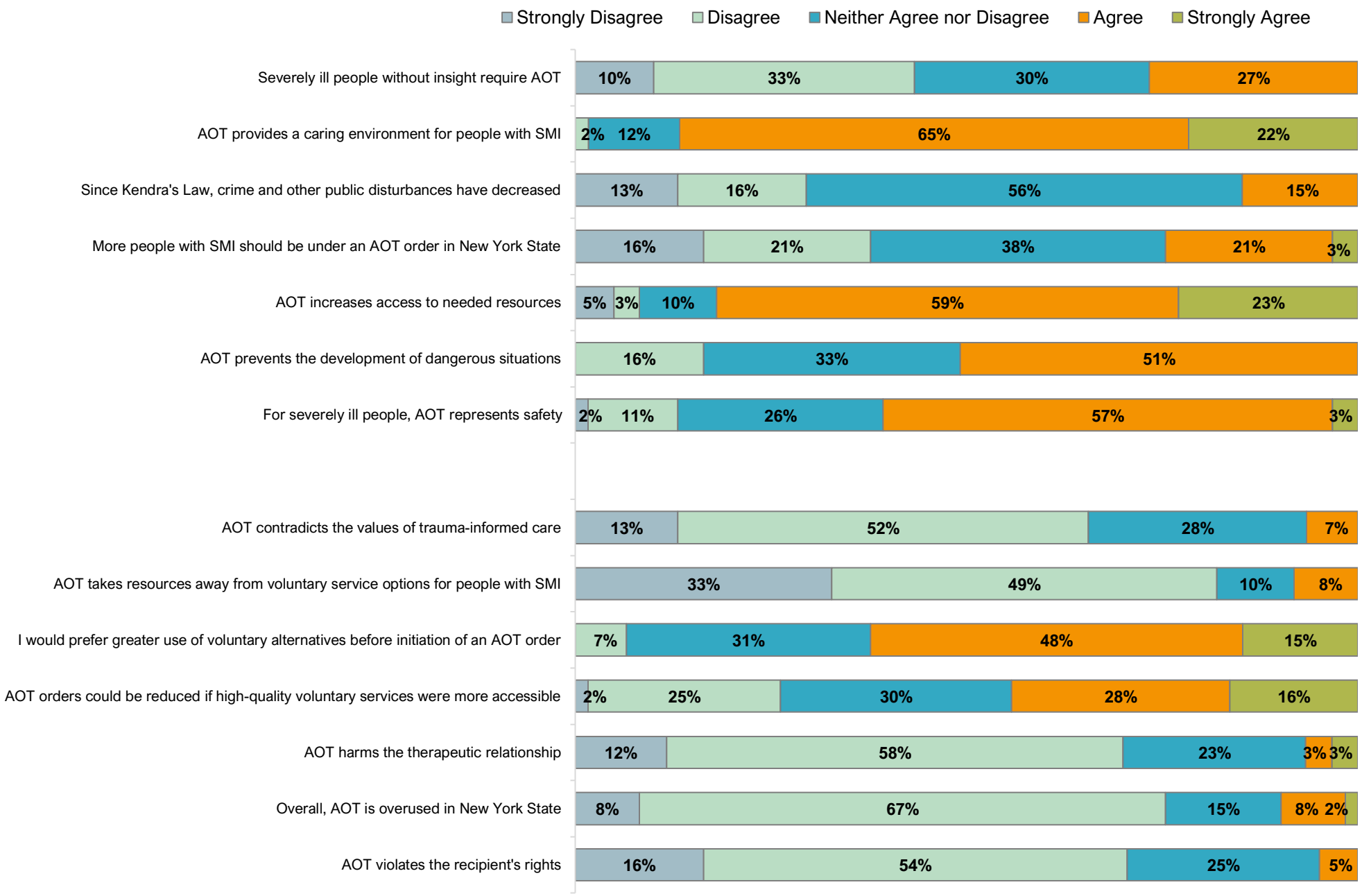
26m. Overall, AOT is over-used in NYS.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.6 (1.0)	2.0	1.0	5.0
Central NY (N=20)	2.1 (0.8)	2.0	1.0	4.0
Hudson River (N=15)	2.2 (0.6)	2.0	2.0	4.0
New York City (N=5)	2.0 (0.0)	2.0	2.0	2.0
Long Island (N=2)	2.0 (0.0)	2.0	2.0	2.0
STATEWIDE (N=61)	**2.3 (0.8)**	**2.0**	**1.0**	**5.0**

26n. AOT violates the recipient's rights.

REGION (Number of Responses)	Mean Score (Standard Deviation)	Median Score	Minimum Score	Maximum Score
Western NY (N=18)	2.3 (0.8)	2.0	1.0	4.0
Central NY (N=20)	2.2 (0.7)	2.0	1.0	3.0
Hudson River (N=15)	2.4 (0.7)	2.0	2.0	4.0
New York City (N=5)	1.0 (0.0)	1.0	1.0	1.0
Long Island (N=2)	2.0 (0.0)	2.0	2.0	2.0
STATEWIDE (N=61)	**2.2 (0.8)**	**2.0**	**1.0**	**4.0**

Views on AOT


Strongly Disagree
Disagree
Neither Agree nor Disagree
Agree
Strongly Agree
Severely ill people without insight require AOT
10%
33%
30%
27%
AOT provides a caring environment for people with SMI
2%
12%
65%
22%
Since Kendra's Law, crime and other public disturbances have decreased
13%
16%
56%
15%
More people with SMI should be under an AOT order in New York State
16%
21%
38%
21%
3%
AOT increases access to needed resources
5%
3%
10%
59%
23%
AOT prevents the development of dangerous situations
16%
33%
51%
For severely ill people, AOT represents safety
2%
11%
26%
57%
3%
AOT contradicts the values of trauma-informed care
13%
52%
28%
7%
AOT takes resources away from voluntary service options for people with SMI
33%
49%
10%
8%
I would prefer greater use of voluntary alternatives before initiation of an AOT order
7%
31%
48%
15%
AOT orders could be reduced if high-quality voluntary services were more accessible
2%
25%
30%
28%
16%
AOT harms the therapeutic relationship
12%
58%
23%
3%
3%
Overall, AOT is overused in New York State
8%
67%
15%
8%
2%
AOT violates the recipient's rights
16%
54%
25%
5%

Appendix F. Detailed Results from Current Literature

Exhibit F.1. *Narrative and Systematic Reviews of the Quantitative Literature*

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
Section A — Randomized Controlled Trials (n = 3)[a]						
1	**Steadman HJ, Gounis K, Dennis D, Hopper K, Roche B, Swartz M, Robbins PC.** Assessing the New York City involuntary outpatient commitment pilot program. *Psychiatric Services.* 2001;52(3):330–6.	RCT (Bellevue Hospital, NYC). OPC + enhanced services vs enhanced services alone. 11-month follow-up. Excluded patients with history of violence from randomization. 57% to 68% of subjects completed interviews at each follow-up point. OPC sanctions not enforced during study.	1 RCT	142 randomized • OPC: 78 • Control: 64 (ITT n=152 per 2017 Cochrane Review)	• Readmission @ 11–12 mo.: RR 1.17 (0.81, 1.69) — **NS** • Multiple readmissions: RR 1.87 (0.87, 4.01) — **NS** • Medication compliance: RR 0.96 (0.77, 1.19) — **NS** • **No significant difference** on other outcomes: rehospitalization, arrest, QoL, symptoms, perceived coercion.	No significant effect on any primary or secondary ITT outcome.
North Carolina RCT: publications in rows 2a–2h all derive from the same trial (n=331 enrolled, 264 randomized). Duration- and service exposure-based comparisons within the OPC group are post-hoc, non-randomized: OPC duration and service intensity / contact were not experimentally assigned.						
2a	**Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R.** Can involuntary outpatient	NC/Duke RCT. Primary outcome: hospital readmissions and bed-days during 12-month follow-up. Pre-specified ITT analysis comparing	1 RCT	264 randomized • OPC: 129 • Control: 135 (331 enrolled; 67 with	**ITT (randomized groups, pre-specified):** Readmission	No significant effect on ITT primary outcomes reported.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *American Journal of Psychiatry.* 1999;156(12):1968–75.	OPC vs control (randomized groups). Post-hoc sub-analyses by OPC duration (≥180 d vs <180 d) and diagnosis. All participants received case management.		violence history non-randomized and followed separately)	at 12 mo.: RR 0.89 (0.68, 1.15) — **NS** • Bed-days at 12 mo.: MD −1.24 (−15.16, 12.68) — **NS** • Medication compliance at 12 mo.: RR 1.03 (0.77, 1.37) — **NS** **Post-hoc, non-randomized duration and service intensity sub-analyses:** • Sustained OPC (≥180 d, mean 330 d) vs control: mean admissions reduced ~57%, bed-days reduced by ~20 — favors sustained OPC • Psychotic disorder subgroup (sustained OPC ≥180 d): readmissions reduced ~72%, bed-days reduced by ~28 — favors sustained OPC • Sustained OPC effective only when combined with intensive outpatient services (≥3 contacts/month). • No significant effect for affective disorder subgroup.	

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
2b	**Swanson JW, Swartz MS, Wagner HR, Burns BJ, Borum R, Hiday VA.** Involuntary out-patient commitment and reduction of violent behavior in persons with severe mental illness. *British Journal of Psychiatry.* 2000;176:324–31.	NC/Duke RCT. Primary outcome: any violent act during 12-month follow-up (composite from self-report, family/case manager interviews). Sample includes 264 randomized + 67 non-randomized hx of violence group. Duration comparisons are post-hoc and non-randomized.	1 RCT	331 enrolled (264 randomized + 67 violent non-randomized)	**ITT (randomized groups):** Violence rates between OPC and control groups -- **NS** **Post-hoc, non-randomized duration and service intensity analysis:** • Sustained OPC (≥180 d) 27% vs brief/no OPC 42% any violence: Fisher's exact p=0.049 • Post-hoc multivariable: sustained OPC + regular services (≥3/month) vs no sustained OPC + irregular services: 24% vs 48% violence — significantly lower • OPC effective on violence only when combined with regular services; neither alone was sufficient. • Effect held for psychotic and non-psychotic disorders.	No significant effect on ITT primary outcomes.
2c	**Swanson JW, Borum R, Swartz MS, Hiday VA, Wagner HR, Burns**	NC/Duke RCT. Outcome: any arrest during 12-month follow-up period	1 RCT	262 at 12-mo follow-up (from	**ITT (randomized groups):** 18.6% OPC vs 19.3% control arrested — **NS** (Fisher's exact, one-tail p=0.52)	No significant effect on ITT primary outcomes.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	BJ. Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? *Criminal Justice and Behavior.* 2001;28(2):156–89.	(official NC State Bureau of Investigation and Court records, supplemented by case manager reports). Sample: 262 at 12-month follow-up (114 control, 102 OPC, 46 violent OPC). Primary pre-specified analysis is ITT. Subgroup analyses are post-hoc.		331 enrolled)	[excluded individuals in OPC group with serious violence history] **Post-hoc, non-randomized sub-analysis (dual-system recidivists only):** • Extended OPC (≥180 d) 12% vs brief OPC 44% vs no OPC 47% arrested — $\chi^2=6.19$, df=2, $p<0.05$ • Post-hoc multivariable (full sample): extended OPC × dual recidivism interaction: OR 0.11 (0.02–0.80), $p<0.05$ — favors extended OPC in dual recidivists • Strongest independent predictors of arrest: prior criminal history, dual-system recidivism (OR 15.23), African-American + recent crime victim interaction (OR 3.24), substance abuse + nonadherence (OR 2.59).	
2d	**Swanson JW, Swartz MS, Elbogen EB, Wagner HR, Burns BJ.** Effects of	NC/Duke RCT. Outcome: subjective QoL (Lehman QoL scale, above/below	1 RCT	221 with 12-mo QoL data (subset	**ITT (randomized groups):** No significant difference in QoL between OPC and	No significant effect on ITT primary outcome reported.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law.* 2003;21:473–91.	group median) at 12 months. Pre-specified ITT comparison, and post-hoc duration sub-analysis. Path analysis examining mediation via treatment adherence, hospital admissions, and case manager contact.		of 262 randomized)	control groups at 12 months — **NS** **Post-hoc, non-randomized duration analysis:** • Extended OPC (≥180 d): predicted probability of above-median QoL = 0.67 vs 0.45 (brief OPC) vs 0.47 (no OPC) — significantly higher • Path analysis: OPC effect on QoL was indirect, mediated through improved treatment adherence, fewer hospital readmissions, lower symptom burden, and increased case management reminders. Increased perceived coercion moderated effect of OPC on QOL • Independent QoL predictors: better baseline QoL, medication adherence, lower symptom burden, better functioning.	
2e	**Swartz MS, Wagner HR, Swanson JW, Hiday VA, Burns BJ.** The perceived	NC/Duke RCT. Outcome: self-reported coercion at 12 months using	1 RCT	219 with 12-mo MAES data (from	**ITT (OPC vs control):** MAES coercion score significantly higher in OPC group: 5.51 vs	Perceived coercion significantly higher among OPC recipients in ITT analysis.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	coerciveness of involuntary outpatient commitment: findings from an experimental study. *Journal of the American Academy of Psychiatry and the Law.* 2002;30(2):207–17.	modified MacArthur Admission Experience Survey (MAES, 15-item, adapted for outpatient context). Pre-specified comparison of OPC vs control group on MAES scores. Multivariable logistic regression with days-in-OPC as continuous predictor.		331 enrolled)	3.80, p=0.002 — higher coercion in OPC • Duration of OPC: each additional day associated with higher perceived coercion, OR 1.003/day (1.001–1.005), p<0.05 (~10% increased risk per month) • Additional independent predictors of higher coercion: African-American race (OR 1.90), married/cohabitating (OR 0.33, protective), substance abuse (OR 2.25), greater symptom severity (BSI OR 1.61), lower illness insight (OR 0.83). • Case manager verbal reminders/warnings independently predicted higher coercion (OR 1.16) and substantially attenuated the OPC duration effect, rendering nonsignificant, when added to model. • Diagnosis of psychosis (vs mood disorder) associated with lower perceived coercion (OR 0.42).	

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
2f	**Hiday VA, Swartz MS, Swanson JW, Borum R, Wagner HR.** Impact of outpatient commitment on victimization of people with severe mental illness. *American Journal of Psychiatry.* 2002;159(8):1403–11.	NC/Duke RCT. Primary outcome: any criminal victimization (violent and non-violent) reported at 12-month interview. Pre-specified ITT comparison. Staged multivariate logistic regression controlling for social support, GAF, substance use, and non-random assignment to violent group.	1 RCT	223 with 12-mo victimization data (subset of 331 enrolled)	**ITT (randomized groups):** OPC group 24% victimized vs control 42%; Fisher's exact p<0.008 — **favors OPC** • Duration: each additional 10 OPC days ~3% lower risk of victimization (multivariate model, significant) • Victimization: NNT 6 (CI 6 to 6.5) to prevent 1 victimization event — this is the effect pooled in the Cochrane 2017 review: SMD −0.49 (−0.84, −0.17), p=0.004 • Mediation analysis: OPC's effect on victimization was fully mediated through reduced violence, reduced substance abuse, and improved medication adherence (OPC main effect NS when mediators controlled). • Baseline predictors of victimization: low social support, higher functional	ITT victimization significantly lower among OPC recipients.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
					impairment, substance use, homeless status, higher paranoia, prior victimization	
2g	**Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA.** Effects of involuntary outpatient commitment and depot antipsychotics on treatment adherence in persons with severe mental illness. *Journal of Nervous and Mental Disease.* 2001;189(9):583–92.	NC/Duke RCT. Outcome: treatment adherence (medication compliance, outpatient service contacts) during 12-month follow-up. Pre-specified ITT comparison plus post-hoc analysis of depot antipsychotic use as a moderator. Repeated-measures logistic regression.	1 RCT	258 randomized (from 331 enrolled)	**Repeated-measures analysis (pre-specified):** OPC group >6 months significantly more likely to be adherent with medication month-by-month compared with controls— favors OPC (when non-randomized sample included) • Sustained OPC (>6 months) associated with significantly more outpatient service contacts. • Depot antipsychotic use independently associated with improved adherence; no significant interaction with OPC status. **Post-hoc:** Duration sub-analyses (sustained vs brief OPC) show larger adherence effects in sustained OPC. • When non-randomized serious violence group	In non-randomized analysis, antipsychotic utilization significantly higher among OPC recipients versus controls.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
					excluded, no significant differences in treatment adherence	
2h	**Swartz MS, Swanson JW, Hiday VA, Wagner HR, Burns BJ, Borum R.** A randomized controlled trial of outpatient commitment in North Carolina. *Psychiatric Services.* 2001;52(3):325–9.	NC/Duke RCT. Non-technical overview paper synthesizing findings across all primary outcome publications (hospital, violence, arrests, victimization). Published as part of a special section on outpatient commitment. Not a new analysis — summarizes results from 2a–2g.	1 RCT	331 enrolled (264 randomized + 67 violent non-randomized)	Synthesis of 2a–2g findings. Key cross-cutting conclusions: • ITT: OPC vs control showed **no significant difference** on pre-specified analyses, including hospitalization, violence, arrests, or QoL. • Post-hoc, non-randomized analyses: sustained OPC (≥180 d) + intensive services associated with fewer hospitalizations, less violence, fewer arrests (dual-recidivists), less victimization	Summary of RCT papers listed above (no significant effect on hospitalization, violence, arrests or QoL, significant decrease in victimization).
3	**Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, Voysey M, Sinclair J, Priebe S.** Community treatment orders for	RCT (England, multi-site). CTO vs Section 17 leave. 12-month primary endpoint. Extended follow-up at 36 months reported in companion papers (Burns et al. Lancet	1 RCT	336 randomized • CTO: 167 • Section 17: 169	• Readmission @ 12 mo.: RR 0.99 (0.74, 1.32) — **NS** • Readmission @ 36 mo.: OR 0.71 (0.45, 1.11) — **NS** • Bed-days @ 12 mo.: MD −8.70 (−30.88, 13.48) — **NS**	No significant difference on any ITT primary or secondary outcome.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	patients with psychosis (OCTET): a randomised controlled trial. *The Lancet.* 2013;381(9878):1627–33.	Psychiatry 2015; Rugkåsa et al. Acta Psychiatr Scand 2015; Vergunst et al. SPPE 2017).		• 333 analyzed (166/167)	• Mean readmissions @ 12 mo.: MD −0.20 (−0.45, 0.05) — **NS** • Multiple readmissions: RR 0.56 (0.27, 1.17) — **NS** • Time under compulsion: median 182 d (CTO) vs 8 d (Sec 17), p<0.0001 — **CTO involves significantly more compulsion** • No significant differences in social functioning, symptoms, perceived coercion (Acta Psychiatrica Scandinavica paper), or QoL.	
*	**Cochrane 2017: Pooled analysis of all 3 RCTs** (Steadman 2001 + Swartz 1999 + Burns 2013). Random-effects meta-analysis. Kisely SR, Campbell LA, O'Reilly R. *Cochrane Database Systematic*	All 3 RCTs combined. US trials used court-ordered OPC vs entirely voluntary care. OCTET compared CTO vs Section 17 leave.	3 RCTs	n=749 in pool (Steadman ITT 152 + Swartz 264 + Burns 333)	• Readmission @ 12 mo.: (2 RCT): RR 0.98 (0.79, 1.21), I^2=0% — **NS** • Bed-days (2 RCT, SMD): −0.06 (−0.22, 0.10), I^2=97% — **NS** • Multiple readmissions (2 RCT): SMD 0.00 (−0.32, 0.31), I^2=80% — **NS**	CTO associated with reduced victimization. Pooled data demonstrates no other significant benefits of OPC.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	Review. 2017;(3):CD004408.				• GAF (2 RCT): SMD −0.11 (−0.32, 0.11) — **NS** • Adherence (2 RCT): SMD −0.01 (−0.23, 0.21) — **NS** • QoL (2 RCT): SMD −0.23 (−1.01, 0.54) — **NS** • Homelessness (2 RCT): SMD −0.26 (−0.60, 0.09) — **NS** • Arrest (2 RCT): SMD −0.02 (−0.31, 0.28) — NS • Perceived coercion (3 RCT): SMD 0.23 (−0.02, 0.47), p=0.06 — **NS** • Victimization (1 RCT — Hiday 2002): SMD −0.49 (−0.84, −0.17), p=0.004 — **favors CTO** • NNT 142 to prevent 1 readmission; NNT 6 for victimization.	

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
Section B — Quantitative Systematic Reviews and Meta-Analyses of Quantitative Data (Beyond 3 Extant RCTs)						
4	**Churchill R, Owen G, Singh S, Hotopf M.** International experiences of using community treatment orders. *London: Department of Health, Institute of Psychiatry; 2007.*	Narrative SR. International scope. First comprehensive international synthesis.	72 papers	Not pooled (narrative)	• No quantitative pooling. • Narrative: no consistent evidence that CTOs improve social functioning, arrests, homelessness, mental state, psychopathology, QoL, carer satisfaction, or perceived coercion.	"It is not possible to state whether community treatments orders (CTOs) are beneficial or harmful to patients."
5	**Maughan D, Molodynski A, Rugkåsa J, Burns T.** A systematic review of the effect of community treatment orders on service use. *Social Psychiatry and Psychiatric Epidemiology.* 2013;49(4):651–63.	SR (RCTs + observational). International. Service-use focus. Narrative synthesis.	18 studies	• 18 articles from 11 data sources, with Victoria (n=16,216) and New York (n=8,752) datasets dominating	• Narrative: RCTs uniformly showed no significant reductions in service use. • Observational studies conflicting significant effects for admission and bed-days reported in opposite directions depending on jurisdiction/dataset. • 3 medication studies from one dataset show increased medication adherence.	"There is now robust evidence in the literature that CTOs have no significant effects on hospitalization and other service use outcomes. Non-randomised studies continue to report conflicting results."
6	**Rugkåsa J.** Effectiveness of community treatment	International narrative SR.	19 studies	Not pooled	• Narrative: limited and inconsistent evidence.	"There is no evidence of patient benefit from

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	orders: the international evidence. *Canadian Journal of Psychiatry.* 2016;61(1):15–24.				• Controlled studies and RCTs uniformly show no significant effect on principal outcomes.	current CTO outcome studies.“
7	**Barnett P, Matthews H, Lloyd-Evans B, Mackay E, Pilling S, Johnson S.** Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis. *The Lancet Psychiatry.* 2018;5(12):1013–22.	SR + MA. RCTs + observational. Random-effects. Commissioned for UK Independent Review of the Mental Health Act.	41 studies (4 RCT, 15 case-control/ cohort, 22 pre-post)	Pre-post: 9,455 Controlled: 181,150	PRE-POST (UBA — confounded by regression-to-mean and selection): • Readmission: SMD 0.80 (0.53, 1.08), I^2=95% — favors CTO • Bed-days: SMD 0.66 (0.46, 0.85), I^2=94% — favors CTO • Community services: SMD 0.83 (0.46, 1.21), I^2=87% — favors CTO • Treatment adherence: SMD 2.12 (1.69, 2.55), I^2=0% — favors CTO CONTEMPORANEOUS CONTROLLED (RCT + adjusted observational): • Readmission: SMD −0.14 (−0.41, 0.14) — NS	“We found no consistent evidence that CCT reduces readmission or length of inpatient stay, although it might have some benefit in enforcing use of outpatient treatment or increasing service provision, or both.”

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
					• Bed-days: SMD 0.13 (−0.08, 0.34) — NS • Community services: SMD 0.38 (0.19, 0.58), p=0.0001 — favors CTO • Treatment adherence: SMD 0.91 (−0.70, 2.51) — NS	
8	**Segal SP.** The utility of outpatient civil commitment: investigating the evidence. *International Journal of Law and Psychiatry.* 2020;70:101565.	International review. Re-analysis emphasizing long-duration outcomes and disaggregated trial data.	~19 studies	Not pooled	• No new pooling. Argues RCTs improperly implemented, states should not be classified as RCTs. • Mortality (5 studies) — 14–38% reductions in all-cause mortality in 3 studies Physical illness diagnosis (2) — In one study, 40% more physical diagnoses on OCC; one no difference Crime/violence (11) — 4/11 reduced; 5 equivocal, 2 no difference Victimization (2) — both reduced	"This investigation finds replicated beneficial associations between OCC and direct measures of imminent harm indicating reductions in threats to health and safety. It also finds support for OCC as a less restrictive alternative to inpatient care."

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
					Adherence (11) — Busch 2010: MPR ↑31–40% OCC+ACT vs 8–19% neither. LRA/episode duration (8) — all 8 significant. OCC+ACT → fewer admissions; OCC + service cuts → more crisis returns (Segal frames as needed-treatment provision, not failure). .	
9	**Kisely S, Yu D, Maehashi S, Siskind D.** A systematic review and meta-analysis of predictors and outcomes of community treatment orders in Australia and New Zealand. *Australian & New Zealand Journal of Psychiatry.* 2021;55(7):650–65.	SR + MA. Australasia-specific. Adjusted observational (CBA) data only. Random-effects.	12 studies (31 publications, 24 in MA)	~218,034 (cases ~53,170; ctrls ~164,864)	• Readmission @ 12 mo.: (3 CBA): log-adj ratio 0.13 (−0.18, 0.44), I^2=96% — NS • Mean admissions (3 CBA): MD 0.06 (−0.25, 0.36), I^2=93% — NS • Bed-days (4 CBA): MD −1.78 (−4.55, 1.00), I^2=95% — NS • Community contacts (3 CBA): MD 15.39 (8.78, 22.01), p<0.0001 — favors CTO	"People from culturally and linguistically diverse or migrant backgrounds are more likely to be placed on a community treatment order. However, the evidence for effectiveness remains inconclusive and limited to orders of at least 2 years' duration. The restrictive nature of community treatment orders may not be outweighed by

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
					• Mortality (3 CBA): log-adj ratio −0.28 (−0.41, −0.15), p<0.0001 — favors CTO • Predictors: migrant/CALD background OR 1.40; male, single, not in work/study/home duties, comorbid substance use, prior serious jailed offense — all significant.	the inconclusive evidence for beneficial outcomes."
10	**Lam EHY, Lai ESK, Lai ECL, Lau E, Siu BWM, Tang DYY, et al.** Effect of community treatment orders on mental health service usage, emergency visits, and violence: a systematic review and meta-analysis. *East Asian Archives of Psychiatry.* 2023;33(2):37–43.	SR + MA. International. Service contacts, ED visits, violence. Random-effects.	16 studies (8 CBA + 8 UBA)	~71,000 across analyses	PRE-POST (UBA — confounded): • Community contacts: SMD 0.83 (0.51, 1.15), I^2=84% — favors CTO • ED visits: SMD −0.55 (−0.90, −0.20), I^2=85% — favors CTO • Violence: SMD −0.48 (−0.66, −0.30), I^2=95% — favors CTO CONTROLLED (CBA): • Community contacts: SMD 0.24 (−0.067, 0.55), I^2=99% — NS	"Case-control studies showed inconclusive evidence, but pre-post studies showed significant effects of CTOs in promoting service contacts and reducing emergency visits and violence."

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
					• ED visits: SMD −0.20 (−0.44, 0.05), I^2=0% — NS	
11	**Kisely S, McMahon L, Siskind D.** Benefits following community treatment orders have an inverse relationship with rates of use: meta-analysis and meta-regression. *BJPsych Open.* 2023;9(3):e68.	MA + meta-regression. Australasia. Adjusted CBA studies. Tests jurisdictional rate of CTO use as moderator.	16 studies (35 publications, 29 in MA)	~226,697 (cases ~56,541; controls ~170,156)	• Readmission @ 12 mo.: (8 CBA): OR 1.23 (1.08, 1.40), I^2=94%, p=0.001 — favors controls in this pooled analysis • Bed-days (7 CBA): MD 5.79 (−2.32, 13.91), I^2=95% — NS • Community contacts (4 CBA): MD 15.66 (13.31, 18.00), p<0.00001 — favors CTO **KEY META-REGRESSION:** Inverse relationship between CTO use rate and benefit — high-use jurisdictions (>100/100k) less likely to show reductions in readmission/bed-days than low-use (<40/100k) jurisdictions.	"There are marked differences in the possible predictors and outcomes of CTO placement between high- and low-use jurisdictions in Australia and New Zealand. These findings may have implications elsewhere and indicate that better-targeted CTO placement might improve outcomes."
12	**Kisely S, Zirnsak T, Corderoy A, Ryan CJ, Brophy L.** The benefits and harms	Umbrella review of SRs/MAs. Commissioned for Victorian	17 papers from 14	~247,630	• Synthesis only — no new pooling.	"The evidence for the benefits of community treatment orders remains inconclusive.

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	of community treatment orders for people diagnosed with psychiatric illnesses: a rapid umbrella review of systematic reviews and meta-analyses. *Australian & New Zealand Journal of Psychiatry.* 2024;58(7):555–70.	Independent Review of Compulsory Treatment.	SRs (incl. 4 MAs)		• Inpatient outcomes: UBA studies show benefit; controlled/RCT designs largely show no significant effect. • Community contacts: consistent increase across designs — favors CTO. RCT data favors neither. • Mortality: significantly reduced in CBA studies (Class III suggestive evidence) — favors CTO • Medication adherence — UBA and CBA showed improvements in medication adherence • Forensic/violence, QoL, symptoms, satisfaction: no consistent significant effects, some evidence for decreased victimization. • Evidence quality for any positive finding rated mostly Class III (suggestive).	At the very least, use should be better targeted to people most likely to benefit. More quantitative research on harms is indicated.”

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
13	**Cossu G, Kalcev G, Sancassiani F, Primavera D, Gyppaz D, Zreik T, Carta MG.** The long-term adherence following the end of Community Treatment Order: a systematic review. *Acta Psychiatrica Scandinavica.* 2024;150(2):78–90.	SR. Post-CTO adherence. International. Narrative synthesis.	6 studies	Not pooled (11–28 mo. follow-up)	• 2/6 studies reported significant improvement in post-CTO adherence. • 4/6 showed no positive effect; 1 showed decreased adherence after CTO ended.	"Scientific evidence supporting the hypothesis that CTO has a positive role on long-term adherence post-obligation is currently not sufficient. Given the importance of modern recovery-oriented approaches and the coercive nature of compulsory outpatient treatment, it is necessary that future studies ensure the role of CTO in effectively promoting adherence."
14	**Kisely S, Bull C, Gill N.** A systematic review and meta-analysis of the effect of community treatment orders on aggression or criminal behavior in people with a mental illness. *Epidemiology and Psychiatric Sciences.* 2025;34:e12.	SR + MA. International. Violence, aggression, arrests, criminal-justice contacts.	13 papers from 11 studies (2 RCTs, 9 obs.)	Varies by analysis (9 USA, 4 Australia)	• No significant differences for any outcome (violence, aggression, arrests, court appearances) between CTO cases and voluntary controls. • Effect size declined as study design quality improved — larger apparent effects in non-randomized self-reported data; null in adjusted/RCT designs.	"Results for all outcomes were non-significant, the effect size declining as study design improved from non-randomised data on self-reported criminal behavior, through third party criminal justice records and finally to RCTs. Similarly, there was no significant finding in

#	Study / Review	Type / Design	n studies (k)	Sample size (n)	Key findings & effect sizes (95% CI)	Summary / Conclusions
	(Corrigendum: 34:e18.)				• Subgroup analysis of serious criminal behavior: also non-significant.	the subgroup analysis of serious criminal behavior. On the limited available evidence, CTOs may not address aggression or criminal behavior in people with mental illness. This is possibly because the risk of violence is increased by comorbid or nonclinical variables, which are beyond the scope of CTOs.”

CTO/OPC; Red = significant finding favoring controls or disfavoring CTO; amber text = post-hoc or non-randomized analysis; ITT = intention-to-treat (pre-specified). NS = non-significant. SMD = standardized mean difference; MD = mean difference; RR = risk ratio; OR = odds ratio; CBA = controlled before/after; UBA = uncontrolled before/after.

[a]RR/SMD effect sizes with 95% CIs in the "Key findings & effect sizes" column for the individual RCT rows are extracted from or computed by the Cochrane 2017 review for purposes of meta-analytic comparison, while the original papers report effect measures in their original metrics (percentages with χ^2/Fisher's exact tests for binary outcomes; means with t-tests for continuous outcomes; ORs from logistic regression where used)

Exhibit F.2. *Narrative and Systematic Reviews of the Qualitative Literature*

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
Section A — Predominantly qualitative systematic reviews and qualitative meta-syntheses					
1	**Corring D, O'Reilly R, Sommerdyk C.** A systematic review of the views and experiences of subjects of community treatment orders. *International Journal of Law and Psychiatry.* 2017;52:74–80.	Qualitative SR. International (no geographic restriction). PsycINFO, PubMed, EMBASE, CINAHL + grey literature (inception–2015). Iterative comparative analysis (constant comparative method). *Subjects of OPCs (i.e., people placed on an OPC).*	**k = 22 / N = 581**	• Narrative synthesis only — no quality scoring or meta-synthesis weighting; quality assessed informally • Inclusion through 2015 only • Predominantly Anglo / North American / Australasian; non-English studies excluded	"Ten themes were found to be common among the research findings of the 22 papers. Three themes in particular were highlighted: feelings of coercion and control, medication seen as the main reason for a CTO and that the perception of CTOs as a safety net. Findings also highlight the ambivalence that subjects of CTOs [OPC] experience, the importance of the therapeutic relationship for successful engagement of the subject of the CTO and the complex role of coercion."
2	**Corring D, O'Reilly R, Sommerdyk C, Russell E.** What clinicians say about the experience of working with individuals on community treatment orders. *Psychiatric Services.* 2018;69(7):791–796.	Qualitative SR (clinician perspectives). International. PsycINFO, MEDLINE, EMBASE, CINAHL + grey literature	**k = 14 ~700 clinicians** across included	• Clinician samples are predominantly community psychiatrists and case-managers	"Three themes were identified: endorsement of the benefits of CTOs despite tensions both within and between clinicians concerning several aspects of CTOs;

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
		(inception–2016). Iterative comparative analysis. *Clinicians administering CTOs.*	primary studies	• Some of the included primary studies sampled clinicians who had self-selected to participate (response bias toward higher CTO endorsement).	belief that medication compliance is a central aspect of CTOs; and acknowledgment that there is room for improvement in CTO implementation, monitoring, and administration. Clinicians view CTOs as providing benefits to their clients but struggle with the coercive nature of these tools."
3	**Corring D, O'Reilly R, Sommerdyk C, Russell E.** What families have to say about community treatment orders (CTOs). *Canadian Journal of Community Mental Health.* 2018;37(2):1–12. AND Corring D, O'Reilly R, Sommerdyk C, Russell E.	Qualitative SR of family perspectives (2018b). PsycINFO, PubMed, EMBASE, CINAHL (inception–2016). *Families / supporters of people on CTOs*	**k = 12 (families);** Authors did not pool participant numbers.	• Narrative; no formal quality scoring. • 7 of 12 family-perspective studies overlap with de Waardt et al. 2022. • Family-member samples in included primary studies are typically small (median ~10–15 per study) and skew toward parents rather than spouses/siblings.	"Themes were identified: the benefits of CTOs outweigh the disadvantages, CTOs increased their involvement in care, and families were dissatisfied with aspects of the CTO process. Recommendations include how to maximize the benefits of CTOs, reduce administrative burdens and employ strategies to increase involvement of families in the care of their loved ones."

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
				• Self-selection bias: families willing to be interviewed may have stronger feelings in either direction about services.	
4	**Corring D, O'Reilly R, Sommerdyk C, Russell E.** The lived experience of community treatment orders (CTOs) from three perspectives: a constant comparative analysis of the results of three systematic reviews of published qualitative research. *International Journal of Law and Psychiatry.* 2019;66:101453.	Tri-perspective constant comparative synthesis across the 2017, 2018a, 2018b reviews (Corring 2019). PsycINFO, PubMed, EMBASE, CINAHL (inception–2016). Combines patients, clinicians, and families	**k = 48 across the three reviews combined (581 clients, 215 family members, and over 700 clinicians)**	Limitations as per above from individual studies; self-selection bias, some studies with small sample sizes, English-speaking studies	"We found common themes shared by all of the three stakeholder groups and other themes shared by two of the three groups. All three groups saw benefits that outweigh the coercive nature of CTOs [compared to hospitalization, table author's addition]. However there is a need for some skepticism regarding the representativeness of the people on CTOs group as it is possible that the selection of more settled and cooperative people on CTOs may bias the results to be more favorable to CTOs." Summary also noted greater dissatisfaction of process among family and

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
					clients compared to clinicians.
5	**Plahouras JE, Mehta S, Buchman DZ, Foussias G, Daskalakis ZJ, Blumberger DM.** Experiences with legally mandated treatment in patients with schizophrenia: a systematic review of qualitative studies. *European Psychiatry.* 2020;63(1):e39.	*Qualitative SR with thematic analysis. International. CINAHL Plus, EMBASE, MEDLINE, PsycINFO (1946/1981/1947/1806 – May 2019). PRISMA-compliant.* *Patients with schizophrenia or schizoaffective disorder under any form of legally mandated treatment (CTO, community care order, supervised discharge, involuntary inpatient).*	**k = 18** **N = 401 patients** From 10 countries: England (5), New Zealand (3), Australia (2), Sweden (2), and one each from Austria, Canada, Ireland, Japan, Norway, Scotland. 3 studies from same patient group.	• Restricted to studies where ≥50% of participants had schizophrenia / schizoaffective disorder — excludes affective psychoses, PTSD and personality disorder. • Mixes inpatient and outpatient compulsion; OPC effects not isolable. • English-language only. • A priori positive/negative binary coding scheme may not capture spectrum or ambivalence; acknowledged by authors as a limitation. • 7 of 18 studies overlap with de Waardt et al. 2022.	"For the thematic analysis, results were collated under two broad themes; positive patient experiences and negative patient experiences. Patients were satisfied when their autonomy was respected, and dissatisfied when it was not. Patients often retrospectively recognized that their treatment was beneficial. Furthermore, negative aspects of the treatment included deficits in communication and a lack of information."

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
6	**Goulet M-H, Pariseau-Legault P, Côté C, Klein A, Crocker AG.** Multiple stakeholders' perspectives of involuntary treatment orders: a meta-synthesis of the qualitative evidence toward an exploratory model. *International Journal of Forensic Mental Health.* 2020;19(1):18–32.	Qualitative meta-synthesis. International. PubMed, CINAHL, PsycINFO, Google Scholar, Web of Science (inception–2017). JBI critical appraisal. Includes ITO, CTO and conditional release orders. *Multi-stakeholder: service users, relatives, professionals, psychiatrists.*	**k = 44** Participant N not pooled across qualitative, mixed-method, ethnographic and case-study designs.	• Heterogeneous study designs (qualitative, ethnography, mixed methods, single case studies) limit thematic comparability. • Forensic and civil orders combined within the same synthesis. • 18 of 44 primary studies overlap with de Waardt et al. 2022 • Conceptual model is exploratory and not validated in subsequent primary work.	"Themes resulting from the analysis are: an ITO as leverage to manage compliance and risk; legal concerns; learning to play the game; building a therapeutic relationship in a coercive context; positive and negative impacts of ITOs; family involvement; and discharge. Based on these themes, an exploratory model of ITOs is proposed."
7	**Francombe Pridham KM, Berntson A, Simpson AIF, Law SF, Stergiopoulos V, Nakhost A.** Perception of coercion among patients with a psychiatric community treatment order: a literature review. *Psychiatric Services.* 2016;67(1):16–28.	Mixed-methods SR. Europe, Australia, New Zealand & North America. MEDLINE, EMBASE, PsycINFO, Social Work Abstracts, CINAHL, Social Sciences Abstracts, Web of Science, SSCI,	**k = 15 (8 qual + 7 quant)** Participant N not pooled.	• No formal quality assessment • Single-reviewer extraction in places • MacArthur AES was developed for inpatient admission and applied to	"The combined quantitative and qualitative evidence indicated that patients subject to CTOs felt more coerced than voluntary patients, although the level of coercion varied considerably among the studies. There was also an

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
		Scopus (inception–2014). *Perceived coercion in people on CTOs. Includes qualitative (k=8) and quantitative (k=7) studies, the latter mostly using the MacArthur Admission Experience Survey.*		community contexts in most quant studies — construct validity uncertain • 9 of 15 studies overlap with de Waardt et al. 2022	indication in both qualitative and quantitative studies of an inverse relationship between procedural justice and perceived coercion.”
Section B — Integrative reviews synthesizing qualitative and quantitative evidence on diverse or multiple stakeholder group views					
8	**de Waardt DA, van Melle AL, Widdershoven GAM, Bramer WM, van der Heijden FMMA, Rugkåsa J, Mulder CL.** Use of compulsory community treatment in mental healthcare: an integrative review of stakeholders' opinions. *Frontiers in Psychiatry.* 2022;13:1011961.	Integrative review (Whittemore & Knafl method). International. MEDLINE, EMBASE, PsycINFO, CINAHL, Web of Science Core Collection, CENTRAL, Google Scholar (inception–Aug 2021). *Four stakeholder groups: patients, significant others, mental-health workers*	**k = 55** included from 142 identified 29 included patient opinions; 14 significant others; 31 MH workers (some studies covered ≥1 group). Participant N: not pooled; patient samples in	• No formal critical-appraisal tool applied to included studies • Quantitative and qualitative outcomes summarized together — heterogeneity not addressed • Substantial overlap with earlier qualitative SRs (10 of 22 Corring 2017; 7 of 18 Plahouras 2020; 18 of 44 Goulet	“The majority in two of the three stakeholder groups (relatives and mental health workers) seemed to support a system that used CCT. Patients were more hesitant, but they generally preferred CCT over admission. All stakeholder groups expressed ambivalence. Their opinions did not differ clearly between those who did and did not have experience with CCT. Advantages mentioned most regarded accessibility of care and a way to remain in contact

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
			individual primary studies ranged from 6 to 202.	2020; 9 of 15 Pridham 2016).	with patients, especially during times of crisis or deterioration. The most mentioned disadvantage by all stakeholder groups was that CCT restricted autonomy and was coercive. Other disadvantages mentioned were that CCT was stigmatizing and that it focused too much on medication."
9	**Khalil F, Maude P, Ross A.** Perceptions and experiences of consumers with severe mental illness, carers and clinicians related to compulsory treatment orders (CTOs): an integrative review. *International Journal of Mental Health Nursing.* 2025;34:e70193.	Integrative review (Whittemore & Knafl). PsycINFO, CINAHL, Medline, Cochrane Library (2014–2025). PRISMA 2020; OSF-registered protocol. CASP quality assessment. *Tri-stakeholder: consumers, carers, clinicians.*	**k = 18 (from 664 identified)** 11 qualitative + 7 quantitative; consumer samples k=8; carer samples k=4; clinician samples k=5 (with overlap). Total participants not pooled; primary-study	• 10-year window (2014–2025) • Mixes qualitative and quantitative without separate synthesis • Heavy Australian skew (9 of 18 studies) — generalizability outside Australasia limited. • Carer evidence thin: only 3 substantive primary studies underpin all carer conclusions	"Four themes were identified: (1) Consumers' perceptions of lack of autonomy; (2) Carers' perceptions of the impact on the consumer; (3) Clinicians' and other service providers' understanding of CTO management; and (4) The efficacy of CTOs. Consumers reported feeling restricted, uninformed and distressed, while viewing CTOs as punitive. Carers cited communication barriers and lack of support. Clinicians prioritized mitigating

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
			qualitative samples ranged from n=5 to n=42.	• Authors note inherent interpretive susceptibility to author bias	consumer risk over autonomy. Although CTOs can offer consistent monitoring, their overall usefulness remains uncertain, and they may contribute to trauma."
Section C — Narrative review drawing substantively on the qualitative literature					
10	**Maylea C, Zirnsak T-M, Edan V, Armitage P, Robert H, Brophy L.** Ensuring compulsory treatment is used as a last resort: a narrative review of the knowledge about Community Treatment Orders. *Psychiatry, Psychology, and Law.* 2025 (published online 6 Jan 2025); doi:10.1080/13218719.2024.2421168.	Narrative review plus consultation with international experts. ProQuest, Scopus, Medline, PsycINFO, HeinOnline, Google Scholar; grey-literature search across 34 repositories (WHO, UN, jurisdictional reviews). *Three perspectives: clinical outcomes; lived experience and stakeholder views (drawing on Corring 2017/2018/2019); human rights critiques.*	**~495 peer-reviewed records after de-duplication** 3 papers identified for the specific question of reducing CTO rates. Participant N not pooled.	• Explicitly non-systematic methodology (Grant & Booth narrative method). • Substantial reliance on the three Corring reviews for the stakeholder-perspective evidence • No formal quality assessment of included papers.	"The literature shows that while consumer perspectives on CTO use do vary, their experiences are overwhelmingly of coercion, control and forced medication (15,77). …. In the lived experience and stakeholder perspective literature, consumers are overwhelmingly opposed to CTOs, while the views of family members and clinicians on CTOs may be summarized as viewing CTOs as a 'regrettable necessity'."

#	Review (citation)	Type / scope / methods	Studies (k) / Sample (N)	Key limitations	Authors' summary / conclusion
Section D — Umbrella review covering the qualitative evidence base					
11	**Kisely S, Zirnsak T, Corderoy A, Ryan CJ, Brophy L.** The benefits and harms of community treatment orders for people diagnosed with psychiatric illnesses: a rapid umbrella review of systematic reviews and meta-analyses. *Australian & New Zealand Journal of Psychiatry.* 2024;58(7):555–70.	Rapid umbrella review (Cochrane rapid-review methodology + Aromataris JBI umbrella-review guidance). Includes Corring 2017, Corring 2018a, Corring 2018b/2019, Plahouras 2020, Goulet 2020, Pridham 2016, de Waardt 2022 (i.e., all 7 predominantly qualitative reviews). *All stakeholders. Commissioned for the Victorian Independent Review of Compulsory Treatment.*	**7 qualitative SRs covering k≈180 primary qualitative studies** (with substantial cross-review overlap, mapped explicitly in Table 4). Total qualitative-study participants not separately pooled. *Quality: NIH rating all 7 qualitative SRs as Fair.*	• Vote-counted synthesis only; no new pooling of qualitative data. • Quality of all 7 qualitative SRs rated fair (formal meta-synthesis methods rarely used).	"People on CTOs reported mixed feelings about being on compulsory community treatment in all the studies. Benefits included feeling that there was a safety net to prevent them from relapsing or requiring a long-term hospital admission. However, these benefits came at a cost. Most commonly, this was a lack of self-determination and control over treatment for people made subject to CTOs (Corring et al., 2017; de Waardt et al., 2022; Plahouras et al., 2020). Importantly, coercion was a key barrier to building a therapeutic relationship with professionals while the person was on a CTO (Goulet et al., 2020).

Appendix G: Detailed Qualitative Findings

This appendix provides in-depth findings for mechanisms and themes of AOT, associated outcomes, and the judicial process from the perspectives of people under AOT orders ("AOT clients"), families, and professionals. Cross-cutting themes from Chapters 1 and 3 are also included here.

Chapter 1 Detailed Findings

Chapter 1 presents an analysis of 46 interviews with people currently or formerly under AOT order ("AOT clients"). Following are detailed findings from the nine mechanisms of AOT the research team identified.

Mechanism 1: Coercive Compliance and Ongoing Possibility of Hospitalization

Overall mechanism presence: 44 of 46 transcripts (96%). The table below summarizes the prevalence of the coercive-compliance mechanism in the coded transcripts.

Exhibit G.1. *Coercive Compliance: overall mechanism presence and prevalence*

Pattern	Transcripts (of 46)	Description
Overall mechanism presence—perceived threat-based coercion appears in the account in any form	44 of 46 (96%)	Possibility of hospitalization, removal, or other action is described, implied, or observed to be shaping behavior.
Court order generates perceived threat awareness that produces medication adherence rather than therapeutic agreement	22 of 46 (about 47%)	Behavioral outcome is positive—the medication is taken but the client attributes their adherence to fear rather than to agreement with the treatment plan.
Hospital initiation produces experienced lack of choice at entry	30 of 46 (direct evidence in approximately 25 of 46)	Client accepts the order because every option except compliance has been removed (typically, remaining hospitalized).

Pattern	Transcripts (of 46)	Description
Perceived threat mechanism does not work—return to hospital doesn't feel negative	2 to 3 of 46	The action (return to hospital) is described by the client as preferable to current community conditions, making the perceived threat ineffective.
Benefit attributed to enforced behavioral change (most often refraining from substance use)	3 to 4 of 46	A small subset of clients described enforced abstinence or enforced medication as having produced benefits they came to appreciate.

Mechanism 2: Initiation through Hospital Discharge 'Ultimatums'

Overall mechanism presence: 30 of 46 transcripts (65%). The table below summarizes the prevalence of the discharge-ultimatum configuration, along with two related patterns (informational deficit at the point of agreement; counter-cases where a trusted figure or self-request substantially buffered the initiation pathway).

Exhibit G.2. *Initiation through Hospital Discharge Ultimatums: presence and pattern prevalence*

Pattern	Transcripts (of 46)	Description
Overall mechanism presence—perceived coerced initiation through hospital ultimatums appears in the account in any form	30 of 46 (65%)	The mechanism appears in the client's account, with hospital initiation under conditions of constrained choice as the central feature.
Hospital initiation experienced as choiceless —perceived coerced acceptance to secure discharge	30 of 46 (direct evidence in 25 of 46)	The most prevalent single harm in the coded data. Client is hospitalized, told they will be placed on the order while still in hospital, given no alternatives, and accepts under conditions in which every option other than compliance has been removed.
Informational deficit at the point of agreement or waiver	17 of 46 (direct evidence in 13 of 46)	Client signed paperwork, attended a hearing, or waived the right to a hearing without understanding what was being agreed to or waived. Includes both incomplete explanation by hospital and attorney staff and, in some cases, decisions made in psychiatric states in which informed consent was likely impossible.

Pattern	Transcripts (of 46)	Description
Initiation pathway substantially buffered by a trusted figure or by self-request	3 of 46	A small set of counter-cases in which the order was proposed by a trusted figure or was requested by the client. The perceived harm produced by the initiation pathway is substantially reduced in these cases. The presence of these cases shows that the initiation pathway is a modifiable design feature, not a fixed property of the legal framework.

Mechanism 3: Surveillance and Monitoring

Overall mechanism presence: 35 of 46 transcripts (76%). The table below summarizes the prevalence of the surveillance mechanism, with the perceived-harm and racialized sub-patterns broken out separately.

Exhibit G.3. *Surveillance and Monitoring: overall mechanism presence and pattern prevalence*

Pattern	Transcripts (of 46)	Description
Overall mechanism presence — surveillance and monitoring appears in the account in any form	35 of 46 (76%)	Home visits, blood draws to verify medication adherence, wellness checks, and movement reporting are described as experienced features of the order.
Pattern: surveillance dominant because services were already in place	12 of 46 (26%)	When pre-existing housing and case management are adequate, the order adds visits and checks without adding service value, and the client experiences the order primarily through the monitoring contact.
Pattern: surveillance experienced in a racialized context	3 to 5 of 46	For Black and Latinx clients, monitoring is amplified by racial context: neighbors witnessing wellness checks, police involvement in welfare checks, and the public visibility of differential treatment. The mechanism operates on top of pre-existing racialized surveillance experiences rather than independently.

Mechanism 4: Medication Requirements and Bodily Autonomy

Overall mechanism presence: 43 of 46 transcripts (93%). The table below summarizes the prevalence of the medication-requirement mechanism, along with the dismissive prescriber perceived harm that drives much of the harm and the small case pattern in which forced medication is viewed positively.

Exhibit G.4. *Medication Requirements and Bodily Autonomy: overall mechanism presence, harm patterns, and the internalization counter case*

Pattern	Transcripts (of 46)	Description and contextual notes
Overall mechanism presence — medication-related experience appears in the account in any form (harmful, beneficial, or ambivalent)	43 of 46 (93%)	Medication-related experience is present in nearly every transcript. The mechanism is near-universal; the valence varies widely with prescriber quality and medication fit.
Dismissive prescriber plus removed leverage produces unaddressed perceived medical harm and erosion of the therapeutic relationship	20 of 46 (direct evidence in 16 of 46)	The dominant perceived harm configuration within the mechanism. Prescriber dismisses side-effect reports; the order removes any leverage the client might otherwise have to demand a medication review; the resulting medical harm is compounded by a breakdown in the prescribing relationship and, over time, by learned futility about self-advocacy.
A wrong diagnosis gets locked in by the court system, leading to more (and possibly unnecessary) diagnoses caused by treatment.	8 of 46	Initial misdiagnosis is locked in by a court-mandated medication order. Medication side effects are subsequently misread as evidence of underlying illness, producing further diagnostic escalation and additional medication.
Dependency on medication that perpetuates the order	5 to 8 of 46	Mandated medication produces physical dependency (notably with clozapine) in which discontinuation itself becomes dangerous, creating a physical trap that perpetuates the legal order.
Counter-case: initially forced medication or abstinence comes to be appreciated as beneficial	3 to 4 of 46 (about 7 to 8%)	In most of these cases, the client endorses the medication while objecting to the mandated treatment that imposed it. Internalization requires the four conditions named above; the

Pattern	Transcripts (of 46)	Description and contextual notes
		pattern coexists with continued objection to the legal mechanism in the same person.

Behaviorally, the outcome looks like medication benefit: appointments are kept, medications are taken, symptoms may stabilize. The motivational pathway, when the client is asked directly, rests on the legal mandate rather than the client's own evaluation. This pattern is present in approximately 22 of 46 transcripts and is the most prevalent benefit-relevant configuration in the corpus.

Mechanism 5: Stigma, Dignity, and Identity

Overall mechanism presence: 31 of 46 transcripts (67%). The table below summarizes the prevalence of the stigma-and-dignity mechanism, along with the collateral-harms-of-legal-status sub-pattern (impacts on employment, housing, custody, and professional licensing that arise from the existence of the legal status itself rather than from any treatment delivered under it).

Exhibit G.5. *Stigma, Dignity, and Identity: overall mechanism presence and related patterns*

Pattern	Transcripts (of 46)	Description
Overall mechanism presence — stigma, dignity and identity harms appear in the account in any form	31 of 46 (67%)	Differential treatment, infantilization, language of degradation, and the intersections of stigma of a psychiatric label with the stigma associated with order status and for clients of color, race.
Pattern: identity mismatch between the client's educational or vocational identity and the role assigned by the order	10 of 46 (21%)	Clients with vocational or professional histories (a degree, a trade, prior employment) Describe program activities, surveillance routines, and provider posture as positioning them in a role that does not match their self-understanding. The most pointed accounts come from clients whose pre-illness vocational capacity was substantial.
Pattern: legal status produces non-clinical harms beyond stigma	10 of 46 (21%)	Professional licensing restrictions, custody implications, financial control through a representative payee (including, in several non-recorded consultation accounts, allegations of payee misuse), geographic restrictions on travel.

Mechanism 6: Legal Coercion as Lived Experience

Overall mechanism presence: 46 of 46 transcripts (100%)—the most pervasive mechanism in the corpus, tied with Provider Relationship Quality. The table below summarizes the prevalence of the indefinite-duration / opaque-exit configuration within the Legal Coercion mechanism, along with the contextual moderators that amplify or buffer it. This configuration is one of the most prevalent harm patterns in the coded data and is the one most amenable to procedural reform within the existing statutory framework.

Exhibit G.6. *Indefinite duration and opaque exit pathways: prevalence and contextual moderators*

Pattern	Transcripts (of 46)	Description
Opacity of exit criteria and discharge pathway	25 of 46 (53%); direct evidence in approximately 17 of 46 (37%)	Headline figure for this subsection. Client does not know how to end the order, what would count as compliance sufficient for discharge, or when the current term will expire. The legal time-limit is real; the client's experience of the order is open-ended.
Counter-case: client understands exit criteria and treats the order as a time-limited obligation	5 of 46 (about 11%)	Where exit criteria are understood, the harm of opacity is reduced. The order is still experienced as constraining, but it does not produce the open-ended resignation pattern. These cases show that the opacity itself, not the duration, is the feature that produces the harm.
Contextual moderator: long duration amplifies the harm	Present in most long-duration cases	Each renewal cycle without clear discharge criteria deepens the sense that the order is indefinite. The cumulative effect of multiple opaque renewals is the basis of the 'it takes over your existence' framing.
Contextual moderator: a responsive provider relationship buffers the harm	Present in a subset of cases	Where a provider explains the process and gives the client orientation within it, the experience of opacity is reduced even when the duration is long. The buffering effect does not eliminate the harm but channels it toward

Pattern	Transcripts (of 46)	Description
		time-limited acceptance rather than resignation.

Distinct from immediate threat of hospitalization, surveillance and monitoring routines, and the medication coercion that can operate within these routines, legal coercion itself—the existence of the court order, its open-ended duration, the opacity of its exit pathway, and its possible collateral effects on the client's social and legal status—constitutes its own mechanism of harm. The harm operates regardless of whether any specific clinical, surveillance, or medication mechanism is currently producing observable distress—the order itself, as a background condition of life, is the mechanism.

Mechanism 7: Provider Relationship Quality as the Primary Moderator of Outcomes

Overall mechanism presence: 46 of 46 transcripts (100%). The table below summarizes the prevalence of the provider-relationship mechanism, along with the moderating effect on harm..

Exhibit G.7. Provider Relationship Quality: overall mechanism presence and the moderating effect on harm

Pattern	Transcripts (of 46)	Description
Overall mechanism presence—the provider relationship features in the account in any form	46 of 46 (100%)	Headline figure. Every client has at least some provider contact and the relationship features in every transcript.
Pattern: provider relationship operates as a positive moderator that buffers the harms of coercion and enables negotiation within the mandate	28 of 46 (61%)	Responsive prescribers willing to discuss medication changes; case managers who advocate for the client; relationships that have continuity over years rather than rapid turnover. The buffering effect is strongest when responsiveness is repeatedly demonstrated through action.
Pattern: no transcript in the coded data disconfirms the	0 of 46	Across 46 transcripts coded by multiple analysts, no case shows a client with a strong, responsive provider relationship who

Pattern	Transcripts (of 46)	Description
moderating function of the provider relationship		simultaneously reports the order's coercive mechanisms as predominantly harmful in the way that clients without such a relationship do. The provider relationship is the variable on which outcomes most consistently turn.
Pattern: provider relationship that combines support and enforcement functions can undermine its own protective effect	Present in a subset of cases	When the case manager who delivers support is also the person who initiates removals or who reframes client distress as evidence of decompensation, the client's willingness to disclose to the provider is reduced. The structural double role creates a chilling effect on the very disclosures the provider needs to be effective.

Supportive, respectful, and sustained relationships buffered some of the harms associated with AOT, but more dismissive or punitive relationships often compounded them. Clients emphasized that responsive providers—those who listened, advocated, and treated them with respect—could meaningfully improve their experience, even as they distinguished these interpersonal dynamics from the structure of the order itself. This moderating effect was evident in approximately 28 of 46 transcripts (61%) and was not contradicted in any case, making it one of the most consistent and actionable findings.

Mechanism 8: Structured Routine and Accountability (Beneficial When Combined with Supportive Provider Relationship)

Overall mechanism presence: 34 of 46 transcripts (74%). The table below summarizes the prevalence of the structured-routine mechanism, along with the conditional pattern in which the mechanism produces benefit only when combined with a supportive provider relationship.

Exhibit G.8. *Structured Routine and Accountability: overall mechanism presence and the role of the provider relationship*

Pattern	Transcripts (of 46)	Description
Overall mechanism presence —structured	34 of 46 (74%)	Headline figure. Required appointments, scheduled provider contact and programmed

Pattern	Transcripts (of 46)	Description
routine and accountability appear in the account in any form		activities are present in the account. Valence varies.
Pattern: structure plus a supportive provider relationship produces protective routine for clients with isolation-triggered depression	12 of 46 (26%)	The combination, not either alone, is what is experienced as beneficial. Clients name the combination specifically: 'extra support,' the case manager who 'checks in,' the predictability of contact that breaks an isolation cycle.
Pattern: structure experienced as the dominant burden — 'too much,' 'too stressful,' executive load of compliance	Present across the harm-dominant cases	Mandatory compliance with the scheduling burden becomes a source of anxiety in its own right, particularly for clients who experience the mandate as infantilizing or who would prefer to manage their own routine.

Structure can provide meaningful stability for some clients, particularly those who experience challenges with motivation, organization, or social isolation. Predictable check-ins and scheduled supports can interrupt cycles of disengagement and help maintain connection to treatment. However, the same structure can also be experienced as burdensome or coercive—contributing to stress, loss of autonomy, and a sense of constant monitoring when participation is driven by the risk of noncompliance.

How this structure is experienced depends less on the structure itself and more on the quality of the provider relationship. When providers are responsive, flexible, and deliver tangible value through appointments, structured routines are more likely to be experienced as supportive and beneficial. This benefit occurs in a smaller subset of cases (approximately 26%) and is consistently tied to the presence of a strong provider relationship. Without that moderating factor, structured routines are more often interpreted as surveillance rather than support, making this mechanism highly dependent on interpersonal context rather than design alone.

Mechanism 9: Service Access and Concrete Supports

Overall mechanism presence: 45 of 46 transcripts (98%). The table below summarizes the prevalence of the service-access mechanism, along with the proportion of clients who explicitly

valued concrete supports as a primary feature of the order. This is the mechanism with the highest prevalence of explicitly positive client evaluation in the coded corpus.

Exhibit G.9. *Service Access and Concrete Supports: overall mechanism presence and valuing patterns*

Pattern	Transcripts (of 46)	Description
Overall mechanism presence — service access and concrete supports appear in the account in any form	45 of 46 (98%)	Some form of concrete support — material assistance, system navigation, advocacy on benefits — is present in nearly every transcript. The mechanism is near-universal.
Pattern: concrete supports explicitly valued as among the most beneficial features of the order	26 of 46 (57%)	Clients name specific supports — a phone, a transit card, help with a benefits application, regular case management contact — as the things they value about the order.
Pattern: concerns about residential settings that combine service delivery with the role of representative payee	Encountered in non-recorded consultations rather than coded transcripts	Concerns include alleged misuse of benefits funds, difficulty saving for more independent living, and inability to regain self-payee status after the order expired.

AOT facilitates access to concrete supports—such as housing assistance, transportation, benefits (SSI/SSDI) support, food, and communication tools—by connecting clients with case managers who help navigate complex systems and advocate for resources. These supports address critical material needs and were among the most consistently valued aspects of AOT in client interviews. However, they are often accessed through the framework of a court order, raising questions—also voiced by clients—about whether similar benefits could be provided through strengthened voluntary service pathways.

Chapter 3 Detailed Findings

Theme 1: Pre-Hearing Decision-Making and Perceived Pressures

As noted in Chapter 3, AOT orders overwhelmingly originated from inpatient hospital settings: 40 of 46 clients (87%). The most common way clients come to be on an order is by acquiescing to it as a condition of being discharged from the hospital: 29 of 46 clients (63%) describe this discharge-conditioned acquiescence as their consent pathway. Cases where the client or their attorney formally contested the order on the record and the court overrode that contestation are much rarer: 7 of 46 (15%).

Exhibit G.10. *Initiation pathways*

Code	Description	N (DIRECT and INDIRECT	DIRECT-only
P-INIT-HOSP	Hospital-initiated (modal pathway)	40/46 (87%)	39/46 (85%)
P-INIT-CL	Criminal-legal pipeline (jail/court referral)	6/46 (13%)	5/46 (11%)
P-INIT-DCS	Direct community petition by clinical team	4/46 (9%)	4/46 (9%)
P-INIT-DCS-SELF	Client self-initiated request for AOT	2/46 (4%)	2/46 (4%)
P-INIT-FAM	Family-initiated petition	0/46 (0%)	0/46 (0%)
P-INIT-UNK	Initiation pathway unknown / unreported	0/46 (0%)	0/46 (0%)

Exhibit G.11. *Consent/acquiescence type*

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-CONSENT-DISCH	Acquiesced as condition of hospital discharge	29/46 (63%)	26/46 (57%)
P-CONSENT-COUNSEL	Acquiesced on counsel's advice	8/46 (17%)	7/46 (15%)
P-CONSENT-BEST	Accepted as 'best interest' framing	5/46 (11%)	5/46 (11%)

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-CONSENT-CL	Acquiesced to avoid criminal-legal consequence	4/46 (9%)	4/46 (9%)
P-CONSENT-WAIVER	Waived right to hearing	2/46 (4%)	2/46 (4%)
P-CONSENT-UNCODED	Acquiesced via informal/non-procedural channel; consent moment not captured by the documented sub-codes (candidate code added mid-pipeline)	1/46 (2%)	1/46 (2%)
P-CONSENT-IMPOSED	Formal contestation overridden by the court (Sense 1; see note below)	7/46 (15%)	7/46 (15%)

Formal Contestation vs. Internal Opposition

The 15% figure for formal court-overridden contestation is much smaller than the share of clients who oppose the order substantively. The remaining 85% divides into two groups: clients who consent in some meaningful sense (a small minority) and clients who acquiesce without substantively agreeing—most often because the alternative is continued hospitalization, because counsel advised against contestation, or because the procedural moment to contest came and went without the client understanding what it was.

The protocol marks this distinction as Sense 1 and Sense 2 contestation. Sense 1 is formal: the client or counsel opposed the order on the record, and the court overrode the opposition. The P-CONSENT-IMPOSED code captures these cases. Sense 2 is internal: the client did not formally contest the order but did not substantively agree to it either; their acquiescence runs alongside opposition that surfaces in the PJ-code cluster documented under Theme 7 (PJ-VOICELESS, PJ-UNFAIR, PJ-FRUSTRATION). Sense 2 is the dominant pattern in the dataset. Sense 1 appears in seven transcripts; Sense 2 appears in the large majority of the rest.

The distinction matters because formal consent metrics—the kind used in administrative data—record Sense 2 cases as voluntary. A court that issues an order without formal contestation produces a record in which the client agreed to the order. The dataset documents that most of those records reflect acquiescence under pressure, not agreement.

Converging Non-Client Decision-maker Findings

The following table aggregates the four non-client decision-maker groups' judgments on the hospital-initiated AOT with discharge that is conditioned on discharge or accompanied by implicit or explicit threats of extended hospitalization (client-side prevalence: P-INIT-HOSP 87%; P-CONSENT-DISCH 63%). Each cell reports the number of within-group profiles that corroborate, diverge from, mix, or do not address the client-dataset pattern. The right-hand column reports the modal group findings.

Exhibit G.12. *Convergence on hospital-initiation as the modal AOT entry pathway*

Group (N)	Corroborates	Diverges	Mixed	Not addressed	Modal group judgment
MHLS/county attorneys (N=5)	4	0	0	1	Corroborates
AOT and adjacent judges (N=3)	1	0	0	2	Mostly silent; corroborated where addressed
Psychiatrists (N=6)	6	0	0	0	Corroborates (unanimous)
Advocates (N=5)	2	0	1	2	Corroborates with caveats

The pattern documented from the client side as P-CONSENT-DISCH = 63% is described by the petitioner-side actors who operate the pathway in substantively identical terms: signing is a condition of discharge; agreement is a function of the discharge moment rather than of the merits of the order.

Non-contestation without informed waiver (cross-cutting candidate code)

Across all four groups, the typical client pattern described above is reported in some form, often using different language but with the same meaning. Advocates corroborate in 4/5 profiles, framed variously as acquiescence due to leverage tied to discharge or routine practice. Attorneys corroborate in 2/5 cases, with Attorney 1 explicitly describing a fear-based "just tell me where to sign" pattern of resignation seen among their own clients. Psychiatrists corroborate in 6/6 cases, with the candidate code P-CONSENT-UNCODED named as the single strongest point of within-group convergence. Within-group variation is principally mostly a matter of

valence and interpretation: pro-AOT advocates describe the same procedural facts (e.g., use of leverage to achieve consent) as critical advocates but present them as routine.

Administrative data convergence

OMH administrative records on petitioner-of-record across 18,853 initial and 27,740 renewal orders document that Directors of Community Services file 65.9% of petitions statewide, Community Hospital Directors 19.8%, OMH State Hospital Directors 8.3%, and family members and service providers combined account for less than 1%. The apparent gap between the 87% hospital-initiation prevalence the qualitative dataset documents (P-INIT-HOSP) and the 28% hospital-petitioner share is structurally consistent: hospital staff and family members who initiate AOT in practice typically work through the Director of Community Services, who becomes the petitioner of record, while the substantive initiating actor sits upstream of the formal petition for a full discussion of this dynamic). The administrative less than 1% family-petitioner rate independently confirms the P-INIT-FAM = 0/46 dataset finding as a statutory-structural feature, not a sampling artifact.

Theme 2: Consideration of Less Restrictive Alternatives Prior to AOT Initiation

Our evaluation suggests marked differences in implementation of AOT across counties—differences particularly pronounced with respect to understanding and operationalization of least restrictive alternatives and utilization of pre-AOT enhanced voluntary agreements (EVAs).

Converging Provider and Administrator Testimony

As noted above, a subset of the Directors of Community Services (DCS) and/or AOT coordinators we interviewed, almost always in smaller, more rural or less population-dense counties, reported significant use of EVAs or other alternatives to AOT and careful attention to statutory least restrictive alternatives language. Many larger urban counties never offer EVA before pursuing an AOT order. Supporting these observations, in our statewide DCS survey 31% of the 63 counties who responded reported never using EVA as a diversion from AOT, including Manhattan, the Bronx, Nassau, Kings, Queens and Staten Island. A further 25% who "very rarely" used EVA included Erie County. In contrast, 13% of counties reported very frequent use of EVA: generally rural or semi-rural, low-AOT-volume counties.

Theme 3: Client Participation in AOT Plan Development

The procedural-due-process (PDP) rating for Informed Decision-Making, which scores whether the client had access to the information needed to engage with the planning process, is ABSENT in 63% of cases—close to the P-PLAN-OUT statistics and consistent with what clients describe.

Exhibit G.13. *Plan formulation codes*

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-PLAN-IN	Client gave meaningful input on plan (inpatient setting)	5/46 (11%)	5/46 (11%)
P-PLAN-FORMAL	Plan developed in a formal AOT planning conference	11/46 (24%)	8/46 (17%)
P-PLAN-OUT	Plan developed outside the client's active involvement	27/46 (59%)	21/46 (46%)

Converging Non-Client Findings

The most common pattern on the client side is that clients describe being excluded from the formulation of their own treatment plan: 27 of 46 transcripts (59%) document this exclusion (P-PLAN-OUT), against 5 of 46 (11%) in which the client describes meaningful input (P-PLAN-IN). The following table reports how each decision-maker group responds to this finding.

Exhibit G.14. *Convergence on plan formulation exclusion (P-PLAN-OUT modal)*

Group (N)	Corroborates	Diverges	Mixed	Not addressed	Modal group judgment
MHLS/county attorneys (N=5)	3	1	0	1	Corroborates lack of meaningful involvement
Judges (N=3)	0	0	0	3	Not addressed
Psychiatrists (N=6)	6	0	0	0	Corroborates lack of meaningful involvement (unanimous)
Advocates (N=5)	3	0	1	1	Corroborates lack of meaningful involvement (strong)

The client data documents what the exclusion feels like: the plan as boilerplate, the plan as something they were never asked about.

Theme 4: Mental Hygiene Legal Services Attorney Interactions

Counsel was nominally present in half the corpus (23 of 46, 50%, P-REP-NOM) and reported as absent in just under a third (14 of 46, 30%, P-REP-ABS). Substantively engaged counsel was described by seven clients (15%, P-REP-SUB).

Exhibit G.15. *Representation status codes*

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-REP-ABS	Counsel absent / never met	14/46 (30%)	14/46 (30%)
P-REP-NOM	Counsel nominal (brief, perfunctory contact)	23/46 (50%)	22/46 (48%)
P-REP-HD	Counsel 'hand-down' (counsel speaks to client only to deliver outcome)	6/46 (13%)	4/46 (9%)
P-REP-SUB	Counsel engaged substantively with client	7/46 (15%)	7/46 (15%)
P-REP-EFF	Counsel's engagement produced a protective procedural outcome	0/46 (0%)	0/46 (0%)

As illustrated by the P-REP-SUB case in the dataset, in which counsel was described as substantively engaged, the order was nonetheless imposed. The case preserves the dataset-level finding that counsel's engagement does not, on client accounts, produce a protective adjudicative outcome (P-REP-EFF = 0/46) while documenting what substantive representation looks like when it occurs. The substance-vs-outcome distinction is structurally load-bearing: the modal MHLS problem documented across the dataset is not solely that counsel is absent or perfunctory, but that even substantively engaged counsel operates against a ceiling on achievable outcomes.

Converging Non-Client Findings

In 46 transcripts, no client describes an instance in which their attorney successfully contested the order. Half of clients describe counsel as nominally present (23 of 46, 50%, coded P-REP-NOM); about a third describe themselves as having had no awareness of attorney involvement at all (14 of 46, 30%). The remaining clients describe substantively engaged counsel—but never with a successful contestation outcome. The following table reports how each decision-maker group responds to this finding.

Exhibit G.16. *Convergence on nominal or absent representation (no effective contestation across the dataset)*

Group (N)	Corroborates	Diverges	Mixed	Not addressed	Modal group judgment
MHLS/county attorneys (N=5)	3	1	1	0	Corroborates (KR dissents on self-account)
AOT and adjacent judges (N=3)	2	0	0	1	Corroborates structurally with label variation
Psychiatrists (N=6)	4	0	2	0	Corroborates on outcome; mixed on counsel substance
Advocates (N=5)	2	0	0	3	Corroborates among profiles that address

Within-Group Variation

the broad corroboration is not uniform within groups. The variation is substantive on the question of whether counsel is engaged, even where it is consistent on the question of whether counsel can effectively contest.

Theme 5: Court Hearing Experiences

Most AOT hearings in the dataset are uncontested: 31 of 46 (67%) clients describe their disposition as stipulated, meaning the order issued without formal contestation on the record (P-HEAR-STIP). Nine of 46 (20%) describe a contested hearing (P-HEAR-CONTEST). Clients were present at the hearing in 27 of 46 cases (59%, P-HEAR-PRES); 23 of 46 (50%) describe themselves as having been absent. Of those present, 16 attended in person and eight attended virtually (by phone or video).

Exhibit G.17. *Hearing modality and presence codes*

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-HEAR-PRES	Client present at hearing	27/46 (59%)	27/46 (59%)
P-HEAR-ABS	Client absent from hearing	23/46 (50%)	22/46 (48%)
P-HEAR-IP	Hearing held in person	16/46 (35%)	16/46 (35%)
P-HEAR-VIRT	Hearing held virtually (phone or video)	8/46 (17%)	8/46 (17%)
P-HEAR-STIP	Stipulated / uncontested disposition	31/46 (67%)	20/46 (41%)
P-HEAR-CONTEST	Contested hearing	9/46 (20%)	9/46 (20%)

Procedural-Due-Process Ratings: Element-Level

The five procedural-due-process (PDP) elements—Notice, Opportunity to be heard, Effective counsel, Impartial , and Informed decision-making—were rated for each transcript on a four-level scale:

- ABSENT — the element did not operate at all
- FORMAL-ONLY — the procedural step happened on paper but did not function protectively for the client
- SUBSTANTIVE — the element operated as designed
- NOT-DETERMINABLE — the transcript does not contain enough information to rate the element

Across the five elements, SUBSTANTIVE ratings are rare. Opportunity to be heard reaches SUBSTANTIVE in 1 of 46 transcripts. Impartial reaches SUBSTANTIVE in 0 of 46. Informed decision-making reaches SUBSTANTIVE in 1 of 46. FORMAL-ONLY is the most common rating for Opportunity to be heard, Effective counsel, and Impartial; ABSENT is the most common rating for Informed decision-making (29 of 46, 63%). Notice is the only element where the ratings are roughly balanced across ABSENT, FORMAL-ONLY, and SUBSTANTIVE.

Exhibit G.18. *Procedural-due-process (PDP) element ratings*

PDP element	ABSENT	FORMAL-ONLY	SUBSTANTIVE	NOT-DETERMINABLE
Notice	15 (33%)	16 (35%)	13 (28%)	2 (4%)
Opportunity to be heard	22 (48%)	23 (50%)	1 (2%)	0 (0%)
Effective counsel	18 (39%)	22 (48%)	5 (11%)	1 (2%)
Impartial	6 (13%)	25 (54%)	0 (0%)	14 (30%)
Informed decision-making	29 (63%)	15 (33%)	1 (2%)	1 (2%)

The 14 NOT-DETERMINABLE ratings on Impartial (30% of the dataset) reflect a structural property of the proceeding rather than a missing-data problem: clients who were absent from the hearing, or who were present but cannot describe the judge's conduct in evaluable detail, cannot be rated on this element.

Procedural-Due-Process Ratings: Client-Level

The element-level ratings in the preceding table show how often each PDP element worked in isolation. The client-level profile in the following table shows whether the elements ever worked together for the same person.

Exhibit G.19. *Client-level PDP profile distribution (N=46)*

PDP profile	N	%	Defining features
All ABSENT	0	0%	All five PDP elements ABSENT in a single trajectory
Mostly ABSENT	~14	~30%	3–4 elements ABSENT; remainder FORMAL-ONLY or NOT-DET; no SUBSTANTIVE values

PDP profile	N	%	Defining features
Mostly FORMAL-ONLY	~16	~35%	3–4 elements FORMAL-ONLY; remainder ABSENT or NOT-DET; no or rare SUBSTANTIVE
Mixed	~12	~26%	Combination of ABSENT, FORMAL-ONLY, and one or more SUBSTANTIVE elements; profile does not concentrate at any single level
Mostly SUBSTANTIVE	0	0%	3–4 elements SUBSTANTIVE
All SUBSTANTIVE	0	0%	All five elements SUBSTANTIVE
Insufficient data / NOT-DET concentration	~4	~9%	Multiple NOT-DET ratings preclude profile classification
Total	~46	~100%	Small classification-boundary cases pending researcher verification; counts approximate (may shift ±1 per category)

No client has a Mostly SUBSTANTIVE or All SUBSTANTIVE PDP profile. Where individual elements operated substantively, they operated in isolation—never as a working set of protections across a single proceeding. The two dominant profiles are Mostly ABSENT (about 30%) and Mostly FORMAL-ONLY (about 35%), together accounting for around two thirds of the dataset. The 12 Mixed-profile cases include one or more SUBSTANTIVE elements alongside ABSENT or FORMAL-ONLY ones; these are not due-process-compliant profiles overall, but cases in which one or two procedural elements worked while others did not.

Read together, the two preceding tables describe a system in which the procedural protections specified by §9.60 are present in formal terms across most proceedings but do not, for any single client, come together as an integrated substantive experience of due process.

Findings with DIRECT-Only Confidence Holds

The findings below are reported with the headline figure (DIRECT and INDIRECT coding combined) alongside the conservative reading (DIRECT-only). Findings that hold at the DIRECT-only level should be treated as the conservative interpretation for policy purposes.

Exhibit G.20. *Key procedural-due-process findings with DIRECT-only holds (N=46)*

Finding	Headline (DIRECT and INDIRECT)	DIRECT-only
Counsel produced a protective procedural outcome (P-REP-EFF)	0/46 (0%)	0/46 (0%)
Opportunity to be heard rated SUBSTANTIVE	1/46 (≈2%)	1/46 (≈2%)
Impartial rated SUBSTANTIVE	0/46 (0%)	0/46 (0%)
Informed decision-making rated ABSENT	29/46 (63%)	29/46 (63%)
Voicelessness across the procedural arc (PJ-VOICELESS)	36/46 (78%)	28/46 (61%)
Futility of contestation (PJ-FUTILITY)	31/46 (67%)	21/46 (46%)
Unfairness (PJ-UNFAIR)	27/46 (59%)	25/46 (54%)
Positive being-informed register (PJ-INFORMED)	8/46 (17%)	6/46 (13%)
Positive being-respected register (PJ-RESPECTED)	5/46 (11%)	4/46 (9%)
Formal contestation overridden by court (Sense 1; P-CONSENT-IMPOSED)	7/46 (15%)	7/46 (15%)
Renewal-stage unawareness (P-RENEW-UNAWARE)	23/46 (50%)	13/46 (28%)
Mostly-SUBSTANTIVE or All-SUBSTANTIVE PDP profile (Table 3.5c)	0/46 (0%)	0/46 (0%)

The findings that do not depend on INDIRECT coding at all—P-REP-EFF, the SUBSTANTIVE rating counts, P-CONSENT-IMPOSED, the All- and Mostly-SUBSTANTIVE profile count—are the most conservative in the table. Among the findings that depend partially on INDIRECT coding, PJ-VOICELESS and PJ-FUTILITY show the largest gap between headline and DIRECT-only figures (78%→ 61%; 67%→ 46%). Both findings remain prevalent at the DIRECT-only level. PJ-RESIGNATION carries the largest INDIRECT dependence in the broader dataset and is not included here for that reason.

The Formal–Substantive Gap in Consent

The Sense 1/Sense 2 distinction introduced in Theme 1 anchors these findings. The seven cases of formal court-overridden contestation (Sense 1, P-CONSENT-IMPOSED, 15%) and the much larger group of clients who acquiesce without substantively agreeing (Sense 2, captured by the PJ-cluster figures of 59% to 78%) describe two different procedural patterns. Administrative measures that record stipulated orders as voluntary or agreed capture the 15% Sense 1 figure but undercount the 59% to 78% Sense 2 figure. The gap between the two is the difference between what the procedural record shows about consent and what AOT clients describe experiencing as consent.

Converging Non-Client Findings

Two client-side findings are examined against the dataset: that AOT hearings are most often brief and stipulated rather than contested (P-HEAR-STIP, 67%), and that two of the five PDP elements—Opportunity to be heard and Impartial —most commonly receive a FORMAL-ONLY rating (50% and 54%, respectively), with SUBSTANTIVE ratings rare to absent.

Exhibit G.21. *Convergence on brief stipulated hearings as the modal disposition*

Group (N)	Corroborates	Diverges	Mixed	Not addressed	Modal group judgment
MHLS / county attorneys (N=5)	3	1	0	1	Corroborates on disposition; mixed on duration
AOT and adjacent judges (N=3)	2	1	0	0	Mixed (Judge 1 diverges on duration)
Psychiatrists (N=6)	5	1	0	0	Corroborates (Psychiatrist selection-effect dissent)
Advocates (N=5)	2	0	0	3	Corroborates among profiles that address

FORMAL-ONLY Ratings on Opportunity to Be Heard and Impartial

Corroboration is even stronger and more uniform on the following finding than on the stipulated hearings finding above. Psychiatrists corroborate unanimously across both PDP elements. MHLS and county attorneys corroborate 4 of 5, with Attorney 3—whose self-account contrasts with his broader observation about the field—providing a SUBSTANTIVE self-rating. Judges corroborate on Opportunity to be heard; one judge's self-account on Impartial is flagged for

separate treatment because a judge rating himself on his own impartiality is methodologically distinct from rating the proceeding as a whole.

Exhibit G.22. *Convergence on FORMAL-ONLY PDP ratings for Opportunity-to-be-heard and Impartial*

Group (N)	Corroborates	Diverges	Mixed	Not addressed	Modal group judgment
MHLS / county attorneys (N=5)	4	1	0	0	Corroborates (Attorney 3 is SUBSTANTIVE self-account)
AOT and adjacent judges (N=3)	2	0	1	0	Opportunity converges; Impartial self-account flagged
Psychiatrists (N=6)	6	0	0	0	Corroborates (unanimous, both elements)
Advocates (N=5)	2	0	0	3	Corroborates among profiles that address

Theme 6: Renewal Processes and Order Expirations

Half the clients described some form of unawareness about how their AOT order continues from one term to the next. Half the clients (50%) are coded P-RENEW-UNAWARE—they do not know how renewal decisions are made, do not understand the procedural mechanism by which the order continues, or in some cases do not know that a renewal has occurred. The DIRECT-only figure for this code is 28% (13 of 46); the gap between the headline and DIRECT-only figures reflects that P-RENEW-UNAWARE is often visible through what clients get wrong about their own renewal rather than through explicit statements of not knowing.

Exhibit G.23. *Renewal pattern codes*

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-RENEW-AWARE	Aware of renewal mechanism / has been through renewal	15/46 (33%)	15/46 (33%)
P-RENEW-PARTIC	Actively participated in a renewal proceeding	12/46 (26%)	10/46 (22%)

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-RENEW-UNAWARE	Unaware of renewal mechanism or that renewal had occurred	23/46 (50%)	13/46 (28%)

This corresponds to the procedural justice code PJ-STIGMA-LEG, which is present in 18 of 46 transcripts (39%).

Converging Non-Client Decision-maker Findings

The client-side finding from Theme 6 is that half of clients describe some form of unawareness about how renewals work (P-RENEW-UNAWARE, 50% with INDIRECT, 28% DIRECT-only).

The LP protocol does not have a dedicated decision-maker-side renewal code. The closest available proxy is the IMPOSED sub-typology, which distinguishes formal contestation overridden at initiation from formal contestation overridden at renewal. The following table reports how each decision-maker group engages with this distinction.

Exhibit G.24. *Decision-maker convergence on the IMPOSED sub-typology (initiation-stage vs. renewal-stage)*

Group (N)	Corroborates	Diverges	Mixed	Not addressed	Modal group judgment
MHLS / county attorneys (N=5)	2	0	0	3	Partial corroboration on renewal-stage only
AOT and adjacent judges (N=3)	0	0	0	3	Not addressed
Psychiatrists (N=6)	1	0	2	3	Mostly silent; only CDPC distinguishes
Advocates (N=5)	0	0	0	5	Not addressed (uniform)

Decision-maker engagement with the renewal-specific question is thin overall. Judges and advocates do not address it. Psychiatrists are mostly silent: only one psychiatrist's account distinguishes between initiation-stage and renewal-stage proceedings explicitly. The MHLS and county attorney group provides what direct corroboration exists, and only at the level of two profiles.

Attorney-Side Accounts of Renewal Practice

Across all five attorney profiles, renewals are characterized as presumptive: renewals are typically not scrutinized in the average case. This attorney-side characterization is consistent with the client-side P-RENEW-UNAWARE finding. If the proceeding is procedurally lightweight on the petitioner side, clients on the respondent side have correspondingly little procedural event to be aware of.

Theme 7: Power Imbalances, Compliance Pressure, and Enforcement

Where the procedural-due-process ratings score whether each protective element operated, the procedural-justice (PJ) codes capture how clients describe the proceeding as a whole—voice, fairness, respect, agency, and the broader felt sense of moving through the legal process.

Six PJ codes appear in 59% or more of the corpus: voicelessness (PJ-VOICELESS, 78%), confusion about the process (PJ-CONFUSION, 74%), futility of contestation (PJ-FUTILITY, 67%), resigned acceptance of the order (PJ-RESIGNATION, 65%), frustration with the process (PJ-FRUSTRATION, 63%), and unfairness (PJ-UNFAIR, 59%). A seventh code—the carceral or criminal-legal analogy clients apply to AOT (PJ-STIGMA-LEG)—appears in 39%.

The corresponding positive codes are rare. Clients describe being able to exercise agency at some procedural moment in 28% of transcripts (PJ-AGENCY). They describe being adequately informed in 17% (PJ-INFORMED) and being treated with respect in 11% (PJ-RESPECTED).

Exhibit G.25. *Procedural-justice outcome codes*

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
PJ-VOICELESS	Client describes lacking voice in the proceeding	36/46 (78%)	28/46 (61%)
PJ-CONFUSION	Client describes confusion about the process / rights	34/46 (74%)	31/46 (67%)

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
PJ-FUTILITY	Client describes contesting / engaging as futile	31/46 (67%)	21/46 (46%)
PJ-RESIGNATION	Client describes resigned acceptance of the order	30/46 (65%)	12/46 (26%)
PJ-FRUSTRATION	Client describes frustration with the process	29/46 (63%)	22/46 (48%)
PJ-UNFAIR	Client describes the proceeding as unfair	27/46 (59%)	25/46 (54%)
PJ-STIGMA-LEG	Carceral / criminal-legal analogy (e.g., probation, trial)	18/46 (39%)	18/46 (39%)
PJ-AGENCY	Client describes exercising agency at some procedural moment	13/46 (28%)	12/46 (26%)
PJ-INFORMED	Client describes being adequately informed	8/46 (17%)	6/46 (13%)
PJ-RESPECTED	Client describes being treated with respect	5/46 (11%)	4/46 (9%)

The negative-positive pairings are where the structural finding sits. The voicelessness rate (78%) and the respected rate (11%) describe the same procedural arc from opposite sides; the same is true of the confusion rate (74%) and the informed rate (17%), and of the futility rate (67%) against the agency rate (28%). Across each pairing, the negative code appears at roughly three to seven times the prevalence of its positive counterpart. This is not a corpus in which procedural-justice outcomes are evenly distributed; it is a corpus in which the negative outcomes are modal and the positive outcomes occur as exceptions.

Conservative (DIRECT-Only) Reading

The headline figures combine DIRECT and INDIRECT coding. The conservative reading drops the INDIRECT codings and reports only what clients articulated explicitly. Most of the PJ findings hold at the DIRECT-only level, though several show meaningful gaps between the two figures.

Exhibit G.26. *Procedural-justice outcome codes with DIRECT-only holds (N=46)*

Code	N (DIRECT and INDIRECT)	DIRECT-only	Holds direct-only?
PJ-VOICELESS	36/46 (78%)	28/46 (61%)	Yes (partial; 8 INDIRECT removed)
PJ-CONFUSION	34/46 (74%)	31/46 (67%)	Yes (partial; 3 INDIRECT removed)
PJ-FUTILITY	31/46 (67%)	21/46 (46%)	Partial (10 INDIRECT removed)
PJ-RESIGNATION	30/46 (65%)	12/46 (26%)	Partial—large INDIRECT dependence (18 removed)
PJ-FRUSTRATION	29/46 (63%)	22/46 (48%)	Partial (7 INDIRECT removed)
PJ-UNFAIR	27/46 (59%)	25/46 (54%)	Yes (partial; 2 INDIRECT removed)
PJ-STIGMA-LEG	18/46 (39%)	18/46 (39%)	Yes (absolute)
PJ-AGENCY	13/46 (28%)	12/46 (26%)	Yes (partial; 1 INDIRECT removed)
PJ-INFORMED	8/46 (17%)	6/46 (13%)	Yes (partial; 2 INDIRECT removed)
PJ-RESPECTED	5/46 (11%)	4/46 (9%)	Yes (partial; 1 INDIRECT removed)

Converging Non-Client Decision-Maker Findings

Two client-side findings are investigated here for decision-maker corroboration: that voicelessness is experienced across the procedural arc (PJ-VOICELESS, 78%), and that the moments where clients exercise effective agency tend to fall outside the AOT court process—at renewal meetings and external team meetings rather than at initiation hearings (PJ-AGENCY, 28%). The tables below report each decision-maker group's position on these two findings.

Exhibit G.27. *Decision-maker convergence on PJ-VOICELESS*

Decision-maker group (N)	Corroborates	Diverges	Mixed	Not addressed	Overall Group Position
MHLS / county attorneys (N=5)	3	1	0	1	Corroborates (KR self-account divergence)
AOT and adjacent judges (N=3)	3	0	0	0	Corroborates strongly (under varied framings)
Psychiatrists (N=6)	3	0	3	0	Corroborates structurally; partial within-trajectory dissent
Advocates (N=5)	4	1	0	0	Corroborates (modal; 250828 reframes site of voice)

The corroboration runs across all four decision-maker groups; however, it is not uniform within groups. Advocate 2 does not dispute that respondents lack voice in the legal process, but argues that voice happens elsewhere, in peer-mediated clinical interaction after the order is in place. Three psychiatrists describe specific junctures at which voice does operate—duration negotiation, judges withholding rulings, informal clinical bargaining—that complicate but do not contradict the broader finding. One MHLS attorney reported that respondents have a substantive opportunity to speak at the AOT exam; this attorney also reports that respondents "rarely testify" because "they just want to get out of there," which can be interpreted as voicelessness in another form.

Exhibit G.28. *Decision-maker convergence on PJ-AGENCY at exit/modification stage outside courts*

Decision-maker group (N)	Corroborates	Diverges	Mixed	Not addressed	Modal group judgment
MHLS / county attorneys (N=5)	2	0	0	3	Partial corroboration on administrative-exit mechanism
AOT and adjacent judges (N=3)	0	0	0	3	Not addressed (bench does not see trajectory)
Psychiatrists (N=6)	6	0	0	0	Corroborates (with multiple specifications)
Advocates (N=5)	3	0	0	2	Corroborates and extends

All four decision-maker groups that address this finding corroborate it. None locates effective respondent agency within the §9.60 hearing process itself. What varies across groups is where the agency does work: MHLS attorneys and county attorneys describe administrative exit pathways; psychiatrists describe within-trajectory negotiation and clinical bargaining; advocates describe voluntary peer programs and peer-mediated escalation to providers. The judges interviewed did not address this finding, which is consistent with the fact that the bench sees the proceeding but not the trajectory that surrounds it.

Threat of Removal

The enforcement and threat of removal codes break down as follows:

- **Pickup event (P-PICKUP-EVENT)**: 10/46 cases (22%, all DIRECT). The client was transported by law enforcement or a custody-and-transport team while under the AOT order.
- **Pickup threat (P-PICKUP-THREAT)**: 32/46 cases (70%). DIRECT: 23/46 (50%); INDIRECT: 9/46 (20%). The client reported being told—by a clinician, lawyer, judge,

family member, or peer—that noncompliance with AOT would result in pickup, removal, hospitalization, jail, state-hospital transfer, or another forced consequence. DIRECT applies where the client states the threat in their own words, including quoted attributed speech ("they told me," "she said"). INDIRECT applies where the threat is established by analyst inference from the client's broader account, or by an interviewer paraphrase that the client confirms without elaborating.

- Both event and threat: 7/46 cases (15%).
- Event without documented threat: 3/46 cases (7%).
- Neither event nor documented threat (P-PICKUP-NONE): 11/46 cases (24%). Several are counter-cases discussed elsewhere in Chapter 3 where the interviewer asked directly whether the police were ever mentioned as a consequence and the client said no.

Exhibit G.29. *Enforcement and Threat Removal codes*

Code	Description	N (DIRECT and INDIRECT)	DIRECT-only
P-PICKUP-EVENT	Client transported by law enforcement or custody-and-transport team while under AOT order	10/46 (22%)	10/46 (22%)
P-PICKUP-THREAT	Client reported being told that noncompliance would result in pickup, removal, hospitalization, jail, transfer, or other forced consequence	32/46 (70%)	23/46 (50%)
P-PICKUP-EVENT + THREAT	Both pickup event and documented threat present	7/46 (15%)	N/A
P-PICKUP-EVENT only	Pickup event without documented threat	3/46 (7%)	N/A
P-PICKUP-NONE	Neither pickup event nor documented threat	11/46 (24%)	N/A

Cross-Cutting Themes

This section highlights cross-cutting themes from Chapters 1 and 3, drawing on interviews with individuals under AOT orders (referred to as “respondents”). It focuses on recurring patterns in client experiences, including how system dynamics shape outcomes beyond formal measures of compliance.

Chapter 1

Theme 1: Social Defeat and the Suppression of Voice Over Time

Social defeat emerges as a prominent theme in the transcripts, describing a psychological state in which prolonged, inescapable subordination leads individuals to believe that advocacy is futile and that the best strategy is simply to comply and endure.

This pattern matters for three reasons:

- It is one of the most prevalent harms in the coded data (see table below).
- It is invisible to compliance-based outcome measures: a respondent whose voice has been worn down may appear fully compliant, while the harm these metrics measure is the suppression of voice.
- The very harm being measured (reduced willingness to voice concerns) is likely to lead to under-reporting of harm in interview settings, which means the harm figures reported should be understood as conservative estimates rather than ceilings.

The table below summarizes the prevalence of the social-defeat outcome finding across the coded corpus, along with the three confirmed subtypes (temporal exhaustion, strategic compliance, and pharmacological silencing).

Exhibit G.30. *Social Defeat: prevalence and subtypes*

Subtype or pattern	Transcripts (of 46)	Description
Social defeat, directly articulated by the respondent	14 of 46 (30%)	Respondent uses explicit evaluative language ('futile,' 'tired of fighting,' 'I just play their game') to describe the conclusion that contesting will not work. This is the conservative reporting figure.
Social defeat, including cases identified through behavioral and contextual indicators	21 of 46 (46%)	Adds respondents who do not articulate the pattern in explicit evaluative language but whose behavior (withdrawal from advocacy, flat affect describing the order, suppressed reactions at renewal hearings) provides the evidence.

Subtype: temporal exhaustion	Present across the long-duration cases	The respondent has been in the system long enough that the capacity for advocacy has been depleted. Typical language: 'I'm tired of the fight.'
Subtype: strategic compliance	Present in a smaller subset	Compliance is a calculated performance, not agreement. The respondent maintains internal disagreement but treats voicing it as pointless. Typical language: 'I just play their game.'
Subtype: pharmacological silencing	Present in approximately 3 to 4 of 46	Medication effects (sedation, cognitive blunting) reduce the respondent's capacity to advocate during the narrow windows of clinical contact. The medication makes the respondent less able to raise concerns about the medication.
Protective factor: provider responsiveness	Approximately 8 of 46	Where the respondent's provider has demonstrated that voicing concerns can produce results—not simply warmth, but actual responsiveness—the pattern does not develop. The protective factor is responsiveness, not friendliness.

The pattern operates in respondent accounts as following. The first and most prevalent subtype is temporal exhaustion: respondents who have been in the system long enough that the capacity for advocacy has been depleted:

> *"I find them to be. Honestly, I'm not a big fan of them… I really just take them because that's what they want me to do… And I'm very tired of fighting… I'm very tired… I just I just kinda I just kinda go with the flow." ~Respondent 22*

The second subtype is strategic compliance: the respondent maintains internal disagreement with the order but treats voicing it as pointless. Compliance becomes a calculated performance:

> *"It's futile. Futile. I think that's the word… If you understand how AOT works, you're not going to win. You're not going to beat them. The only way to beat them is if you join them. So that's what I did… I just play their game." ~Respondent 14*

The same respondent goes on to ground the conclusion in his cumulative experience of the system, and articulates an explicit structural claim:

> *"I've been in this system for 30 years or whatever it is. And so I know what happens in the system, and they don't give you much rights. You lose your rights when you're in the mental health system." ~Respondent 14*

The third subtype is pharmacological silencing: medication effects (sedation, cognitive blunting) reduce the respondent's capacity to advocate during windows of clinical contact:

> *"Medicated me for 10 years, so I couldn't report anything. And I still can't report it because it happened so long ago." ~Respondent 26*

Theme 2: Internalized Coercion and Adaptive Preferences

Many respondents describe AOT as helpful, but often clarify that what they value are the services it provides—such as housing or case management—rather than the mandated nature of the order itself. This distinction suggests that perceived benefits may be tied more to access to supports than to the experience of coercion.

At the same time, some respondents express that AOT "saved their life" even while describing harms, reflecting how preferences can form under constrained choices. In nearly half of transcripts, respondents say they would have engaged voluntarily if those services had been available without a court order, indicating that positive outcomes attributed to AOT may instead reflect the impact of intensive services rather than the mandate itself.

Theme 3: Service Access Versus Coercion Confound

A recurring pattern across transcripts is that benefits attributed to AOT typically stem from service access rather than the involuntary nature of treatment. Respondents express appreciation for:

- Case management and advocacy
- Housing assistance
- Transportation
- Peer support
- Regular provider contact
- Concrete assistance with benefits, food, phones

Most respondents stated that they would have engaged voluntarily if offered these supports without court mandates. AOT as currently implemented bundles intensive community services with legal coercion, which limits the ability of this study (and existing AOT evaluations more broadly) to attribute benefits to either component independently.

Theme 4: Mechanism Interactions and Cumulative Burden

Respondents frequently described multiple harmful mechanisms as occurring concurrently rather than in isolation.

For example, respondents who described both surveillance and mandated medication often described these in combination, including a sense of constant monitoring alongside limited

bodily autonomy. Several respondents who described procedural concerns about their hearings also described a sense of powerlessness and invalidation that they linked to the combination of these factors.

Some respondents who acknowledged beneficial services nevertheless described AOT overall as traumatic, attributing this in part to the simultaneous operation of multiple perceived coercive mechanisms.

Theme 5: Provider Relationship as Harm Moderator

Quality relationships with individual providers were described by respondents as buffering some of the harms reported in connection with AOT. Respondents who described supportive case manager relationships often reported that these relationships moderated the experience of being under an AOT order, though they did not eliminate concerns about the order itself.

Respondents distinguished between providers who were experienced as respectful and responsive and those experienced as punitive or dismissive.

The table below summarizes the overall distribution of outcome profiles across the group:

Exhibit G.31. *Overall outcome distribution across the coded corpus*

Outcome profile	Transcripts	Defining features
Harm-only—no benefit reported anywhere in the account	2 of 46 (4%)	Complete absence of identified benefit. Typically associated with misdiagnosis or with the absence of any responsive provider.
Harm-dominant—harm substantially outweighs benefit	16 of 46 (35%)	Typical pattern: long duration, absent or harmful provider relationship, the legal coercion functioning as the dominant experienced mechanism.
Ambivalent—both harm and benefit present, often from different mechanisms	27 of 46 (59%)	The modal experience. The respondent experiences the order as simultaneously helpful (typically through services) and harmful (typically through coercion or medication). The two are not contradictions but coexisting features of a system that delivers valued services through unwanted constraints.
Benefit-dominant—benefit substantially outweighs harm	3 of 46 (7%)	All three cases share a specific profile: exceptional provider relationship, stable housing, short duration or invisible legal framework, and no stigma harm reported. These represent an upper bound rather than the typical experience.

Neutral or latent—respondent unaware of the legal framework	1 of 46 (2%)	The order is operating but the respondent has limited awareness of it. The weight of the legal mandate may become apparent only at discharge.
Benefit-only—no harm reported anywhere	0 of 46 (0%)	Does not occur in the coded corpus. Even the three benefit-dominant cases contain identifiable harms, typically around the legal initiation.

Theme 6. Service versus Coercion Attribution

The table below documents respondents' attributions of benefit. The directional finding is consistent across the group: when benefit is reported, it is attributed predominantly to services, relationships, and the respondent's own behavioral change, and only rarely to the court order itself.

Exhibit G.32. *Attribution of benefit across the coded corpus*

Attribution pattern	Transcripts	Description
Benefit attributed to services (case management, housing, provider relationship, structured routine)	26 of 46 (57%)	Respondents identify the factors that helped: they name services, not the legal mandate. The court order is invisible or irrelevant in their evaluation of what helped.
Benefit attributed exclusively to perceived coercion	0 of 46 (0%)	No respondent in the corpus attributes benefit to the mechanism alone. This is the most consistent finding in the dataset.
Mixed attribution—respondent cannot separate services from the order, or values both simultaneously	10 of 46 (21%)	Common framing: 'I needed the help, but I didn't need the court order.'
Perceived coercion as entryway—the order is recognized as the route to services but the services are what is valued	8 of 46 (17%)	Respondent acknowledges that without the order they would not have received the services; values the services, not the order.

Null benefit—no benefit reported from the order	3 of 46 (7%)	Respondent reports no benefit at all.
Self-endorsement of involuntary intervention for one's own case, declining to generalize	1 of 46 (2%)	A single respondent endorses involuntary intervention for himself on the basis of his own history but explicitly declines to extend the endorsement to others.

Chapter 3: Cross-Cutting Theme: The Futility of Contesting

Across all interviews, no participant described a case in which the procedural protections built into AOT fully functioned as intended. Contesting an order was widely viewed as futile, with legal professionals, providers, judges, and attorneys all reporting extremely low or nonexistent success rates. This creates a system in which acceptance often reflects a rational response to structural constraints rather than genuine agreement.

Importantly, concerns about due process, fairness, and limited choice were echoed not only by respondents but also by those implementing the system and even by family members who supported AOT. This broad agreement across s suggests that these issues reflect systemic implementation challenges, raising questions about whether the lack of meaningful choice is a problem that can be addressed through reform or is inherent to court-mandated outpatient treatment.