

Introduction to the Special Section on Assisted Outpatient Treatment in New York State

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This issue of *Psychiatric Services* includes a special section on the recent, legislatively mandated evaluation of New York State's assisted outpatient treatment (AOT) program (1). In 1999 the New York State Legislature enacted the state's first involuntary outpatient commitment statute, named "Kendra's Law" in memory of a young woman killed by a man with untreated mental illness. The statute authorizes a preventive form of court-ordered treatment, which is designed to take effect in advance of an illness exacerbation that would likely trigger involuntary inpatient commitment. Only a handful of states take this approach. Indeed, 44 states have involuntary outpatient commitment statutes, but most are not preventive in this sense. They set identical thresholds for inpatient and outpatient commitment, which places clinicians in the difficult position of judging an individual ill enough to be committed to the hospital while recommending outpatient treatment (2).

Kendra's Law is unique in that the intent of the statute is not simply to authorize court-ordered community treatment but also to provide the resources and oversight necessary for a viable, less restrictive alternative to involuntary hospitalization (1). Passage of the law included appropriations for AOT program administration, as well as substantial permanent increases in service dollars for both AOT and non-AOT consumers.

Whether Kendra's Law and the AOT program have succeeded—and at what cost to the liberty of AOT consumers and to the public resources they consume—is a matter of ongoing debate, especially in the fierce mental health policy arena of New York State. As evidence of the law's controversial status and of public ambivalence about its continuation, Kendra's Law is the only involuntary outpatient commitment statute that has yet to be made permanent; it has survived thus far on two, five-year statutory renewals.

Kendra's Law was initially authorized for a period of five years, with renewal made contingent on an internal evaluation of the AOT program by the New York State Office of Mental Health (OMH). OMH reported encouraging—albeit fiercely contested—evidence of AOT's effectiveness (3), and in 2005 the Legislature reauthorized AOT for a second five-year period. Because of ongoing controversy about the strength of the evidence of AOT's effectiveness, the 2005 reauthorization required an independent evaluation of the implementation and effectiveness of the AOT program, specifically addressing several areas of inquiry. These included a description of the AOT program, including regional and cultural differences across the state in AOT programs and their implementation; analysis of the level of consumers' engagement in mental health services during AOT and whether the dura-

tion of AOT influences engagement; comparison of outcomes of AOT participants with those of people with mental illness who receive enhanced outpatient services but are not in the AOT program; assessment of consumer perceptions of the AOT program; evaluation of post-AOT mental health service utilization and outcomes; and assessment of the impact of the AOT program on New York's mental health service system—specifically, whether the program affects the availability of resources for individuals with mental illness.

The New York State OMH issued a competitive request for proposals, and the contract was awarded to the Services Effectiveness Research Program in the Department of Psychiatry and Behavioral Sciences at Duke University School of Medicine, with a sub-contract to Policy Research Associates, Inc., of Delmar, New York. This project also received funding from the John D. and Catherine T. MacArthur Foundation Research Network on Mandated Community Treatment. I served as one of the principal investigators, along with Jeffrey W. Swanson, Ph.D., of Duke University Medical Center and Henry J. Steadman, Ph.D., and Pamela Clark Robbins, B.A., of Policy Research Associates.

The evaluation team analyzed AOT administrative records and clinical services data spanning nearly a decade (1999–2007). The team also collected and analyzed new data from key informant interviews throughout the state and from structured interviews with a new sample of AOT and voluntary service recipients in six selected counties. The complete report of the evaluation

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team is available online (1).

This special section presents key findings from the report. In the first article, Robbins and colleagues (4) report evidence of the variable implementation of Kendra's Law across New York State. The use of AOT in practice varies considerably across counties and regions in New York State. Notable regional differences were found in the use of two distinct models of AOT: AOT First and Enhanced Voluntary Services First. Data from interviews with key informants documented regional differences in how the AOT program has been implemented and administered, which raises questions about the fairness of the application of the statute.

In the second article my colleagues and I (5) report on a study of whether New York State's AOT program improves a range of policy-relevant outcomes for individuals while they are under court order. Our analysis of Medicaid claims and state records showed that compared with their pre-AOT experience, AOT participants experienced reduced rates of hospitalization, improved receipt of psychotropic medications, and improved receipt of intensive case management services. Analysis of data from case manager reports showed similar reductions in hospital admissions and improved engagement in services.

Van Dorn and coauthors (6) report on outcomes for AOT participants after their court order ended. They found that if the court order was kept in place longer than six months, the improved rates of medication possession and decreased hospitalizations were likely to persist after involuntary outpatient commitment ended. Although receipt of intensive case coordination services (assertive community treatment, intensive case management, or both) in the post-AOT period improved hospitalization and medication possession outcomes, individuals who had previous long-term court orders (more than six months) experienced these positive outcomes even when they did not receive ongoing intensive case coordination services. Finally, these data showed that former AOT recipients

were not deterred from voluntarily seeking and receiving intensive services once the court order was lifted.

The article by Swanson and colleagues (7) explores the issue of "queue jumping" raised by the AOT program. In the context of scarce resources for community-based services, a question arises about whether an involuntary treatment program, such as that mandated by Kendra's Law, diverts needed resources from individuals who seek services voluntarily. The authors report that initially the AOT program may have crowded out some individuals with serious mental illness who did not meet criteria for outpatient commitment. However, after the first three years of the AOT program, the increased service capacity funded during the start-up of the program also expanded services for those who did not qualify for court-ordered treatment.

Involvement in the criminal justice system has become an important outcome measure for community treatment programs that serve consumers at high risk of incarceration. The study by Gilbert and colleagues (8) compared arrest rates of consumers in the AOT program and consumers receiving voluntary treatment. They found a relative reduction in the odds of being arrested among AOT consumers. A reduction in arrests may be an important benefit of AOT as part of an effort to improve community-based treatment outcomes and reduce involvement in the criminal justice system.

In a companion study that was not included in the legislative report but that appears in this issue of *Psychiatric Services*, Busch and colleagues (9) examined regional changes in guideline-recommended medication possession among individuals with severe mental illness after implementation of the AOT program, including consumers who did not receive either AOT or intensive outpatient services. Although these authors observed improvements in medication possession in all three regions and across all treatment groups (those who ever received AOT, those who never received AOT but received enhanced services, and those who never received either interven-

tion), they also found that trajectories of improvement differed by region and that the treatment groups did not make similar gains across regions. Their results emphasize the need for policy makers to monitor changes in treatment quality regionally and among enrollees with varied treatment intensity needs who are served in the public mental health system.

Taken as a whole these articles and the full legislative report suggest that New York State's AOT program can improve a range of important outcomes for consumers, apparently without feared negative consequences, such as dissatisfaction with services received under court-ordered treatment. Stakeholders concerned with the effectiveness and appropriateness of court-ordered treatment continue to search for large, generalizable, and definitive empirical studies of AOT. Because of the design of this evaluation, we were not able to assess whether voluntary agreements are effective alternatives to initiating or continuing AOT—a source of disappointment to opponents of and advocates for AOT. A rigorous evaluation of alternatives to AOT, such as voluntary agreements, would require a carefully conducted randomized controlled trial. It is also important to recognize that New York's experience with AOT may not be generalizable to other states or countries with different service systems or resources. In fact, in the wake of the release of the legislative report and debate over renewal of the AOT program, a critical concern arose over the effect of severe New York State budget constraints on the AOT program's operations, its effectiveness, and equitable allocation of services to AOT and non-AOT consumers. As a result, Kendra's Law was not made permanent; once again, it was renewed for a limited five-year period. A critical question for stakeholders going forward is whether new evidence can be brought to bear to resolve New York's ambivalence about the program.

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