New York Lawyers
For The Public Interest, Inc.
151 West 30th Street, 11th Floor
New York, NY 10001-4007
Tel 212-244-4664 Fax 212-244-4570
TTD (212-244-3692
Email info@nylpi.org
Website www.nylpi.org

Implementation of "Kendra's Law" Is Severely Biased

April 7, 2005

Implementation of "Kendra's Law" Is Severely Biased

April 7, 2005

Introduction[1]

Since 1999 "Kendra's Law" has allowed New York courts to mandate some people with mental illness to accept outpatient treatment. It is about to sunset on June 30, 2005. The Legislature and Governor must decide whether to continue it, modify it or abandon it. We submit the law must be modified to eliminate compulsion in order to afford basic fairness, but its enhanced access to services for people in greatest need should be retained.

There are major racial, ethnic, and geographic disparities throughout New York State in the implementation of "Kendra's Law". Black people are almost five times as likely as White people to be subjected to this law – which dramatically reduces freedom of choice over their treatment and their lives - and Hispanic people are two and a half times as likely as non-Hispanic White people. People who live in New York City are more than four times as likely to be subjected to orders as people living in the rest of the state. Also, contrary to how it has been sold, the law is used mainly on people with multiple psychiatric hospitalizations but no histories of hurting others.

Until now these facts have gone largely unreported. They raise serious questions about our mental health system which we must address, and indicate that the "Kendra's Law" must not be extended in any form involving compulsion.

"Kendra's Law" for the first time authorized New York courts to mandate outpatient mental health treatment, with the court order backed up by the threat of seizure by police and a three-day lockup period in a psychiatric hospital in the event of "non-compliance."[2] This new law applies to any person with a mental illness who meets its broad criteria. It fundamentally alters mental health care in thousands of cases by reducing freedom of choice over many important aspects of life, making specified treatment compulsory, and causing treatment providers to abandon confidentiality to participate in monitoring and enforcement.

"Kendra's Law" has another feature, which unfortunately is now tied to compulsion. It provides a kind of "right to treatment": people subject to "Kendra's Law" court orders have priority access to services, some of which are scarce, and mental health officials are responsible for lining up the services ordered by the court. No right to outpatient treatment exists in our State except for those subjected to "Kendra's Law" compulsory court orders. A perverse result of this tie is that orders are sometimes sought simply to get people services.

As a society, we should *not* tolerate shortages of vital services which lead to rationing, but we have – for example, shortages of case managers and mental health housing have been obvious in recent years. But until we eliminate shortages, a system assigning priorities and providing a right to treatment on a voluntary basis is a rational idea. There is no reason, however, why enhanced access to services must be shackled to compulsion. It would be perfectly possible and sensible to prioritize certain people for services and guarantee that needed services are available to them, *without* taking away their privacy or freedom. This could be accomplished without resorting to courts or court orders.

In this report, we analyze information from the State itself to focus on facts it elects not to emphasize. Our principal findings are quite disturbing:

- Based on population, Black people in New York State are close to five times more likely than White people to be subjected to "Kendra's Law" court orders that dramatically reduce freedom of choice over their treatment and other basic aspects of their lives. Hispanic people are two and a half times more likely to be subjected to orders than White people.[3] White people are subjected to "Kendra's Law" orders far less than one would expect, based on population. Here is a summary of the statewide figures:

	Subject to Court Orders[4]	Population[5]
Blacks	42%	16%
Hispanics	21%	15%
Whites	34%	62%

- Severe racial and ethnic disparities exist whether one compares those subjected to the law to the general population, or to the narrower group with severe and persistent mental illnesses, whom one might expect to be especially likely to be subjected to the law. In other words, these disparities cannot be explained away by some racial or ethnic difference in the distribution of serious mental illness.

- Disparities exist not just in the state as a whole, but also in each geographic area where the law is used extensively.

- New York City accounts for 76% of court orders statewide, although it has only 42% of the state's population.[6] Nevertheless, disparities cannot be explained away by the distribution of people of different groups across the state or by New York City's heavy use of the law. While 42% of the people statewide subjected to court orders are Black, only 27% of New York City's population is Black.[7]

- Whether one is subject to the law depends greatly on where one lives. A dramatically disproportionate number of cases have occurred in New York City and Erie County**,** while in many counties the law is barely utilized or ignored. As of March 1, 2005, 14 of 62 counties in the State – almost one in four – still had no orders at all, while New York City had racked up 3,017. State data indicate the geographic disparities do not correspond to the distribution of serious mental illness.[8]

- The law is used primarily against people who have had more than one psychiatric hospitalization but no history of hurting others. This is true despite the fact that the very name of the law and the way it has been sold suggest it is aimed at people who commit random acts of violence. The State's own report indicates that only 15% had done any physical harm to another during the period before their orders started, meaning that 85% had not.[9]

Statistics alone cannot tell us why application of the law is so skewed racially and ethnically. There are a number of possibilities, including:

> conscious or unconscious bias on the part of some involved in referring and selecting people to whom to apply the law,
>
> people being selected from already-biased pools,
>
> unequal access to mental health treatment,
>
> Black or Hispanic people finding the treatment available less suited to their needs, and
>
> some combination of the above.[10]

But the facts very strongly indicate that in some way the failings of the mental health system are resulting in people of color disproportionately losing their freedom of choice.

Neither New York State nor the law's biggest user - New York City - appears to have made any attempt to understand or explain these figures, although the biased nature of implementation has been evident since the beginning of data collection. New York State did not even plan to collect data on the race or ethnicity of people subjected to the law until we publicly insisted. Both the State and the City have the ability as well as the obligation to probe what lies behind these numbers. To begin with, both can gather more refined statistics than we have access to – both maintain databases which include demographic and other data on people subjected to the law. Neither has provided us access. And in two major reports including one just released, the State's only comment has been that the pool of people subjected to court-ordered treatment is "diverse,"[11] and so far as we know the City has said nothing.

As the "Kendra's Law" sunset approaches, the State Office of Mental Health has released a report proclaiming great successes during the five years since it became effective.[12] Beyond doubt, the report demonstrates that there are many benefits to

providing enhanced access to services to people who especially need them, but more than that it does not show. The state's report appears on the surface to be credible and scientific, but in many ways it is really propaganda with charts. While it claims many apparent benefits for those subjected to court orders, it is impossible to tell from OMH's data what is accomplished by compulsion and what by enhanced access to services, both of which are brought into play by "Kendra's Law" as it is now written.[13] The report's methodology is very flawed in many other ways. It soft-peddles many facts that are unhelpful to pushing for re-enactment of compulsion, including that the law is used primarily on people with multiple hospitalizations but not histories of violence toward others. And it passes over without any meaningful comment the huge racial, ethnic and geographic disparities the State's own data show. (See Appendix C on some of the OMH report's shortcomings.)

We submit it is immoral and irresponsible to continue a system of compulsion that is so biased. It is also unconscionable to let time pass without being able to explain what is wrong with our mental health system that produces such biased effects. Like the proverbial canary in the mineshaft, the implementation of Kendra's Law provides a warning. When the bird dies, we must pay attention. And officials, who act in the name of all the people, must stop disproportionately taking away the freedom of some of the people – especially those who belong to groups that historically have been so oppressed.

We therefore submit that "Kendra's Law" must be substantially amended. It must be stripped of compulsion, but its enhanced access to services should continue. Ultimately, New York State must make high quality mental health services of all types fully available and acceptable to all who need them. Until that goal is achieved, the State may sensibly give high priority for scarce services to certain individuals, and hold officials responsible for making sure that services are available to them. The present criteria for "Kendra's Law" provide one reasonable definition of those for whom this might be done. *It can and must be done without taking away freedom or altering the traditional relationships of trust upon which successful mental health treatment is based.* The state can continue to offer the "right to treatment" in "Kendra's Law" while avoiding any racially, ethnically or geographically skewed losses of freedom and privacy, and that is what it should do.

Background

The State Legislature and Governor hurriedly approved "Kendra's Law" in 1999 following a blitz of publicity over a horrific tragedy in a New York City subway. Andrew Goldstein, a man with schizophrenia who was unable to secure the services he needed to stay well, pushed an innocent young woman, Kendra Webdale, into the path of an oncoming train, killing her.

The new law, which took effect in November 1999, permits a court to order certain people with mental illness to accept outpatient treatment for their illnesses. Orders can be very intrusive and take away freedom of choice in many fundamental aspects of people's lives.[14] Each order is required to include case management, and the case manager is required to report on the client's "compliance" to public mental health officials. Those actually providing treatment also report on "compliance," thus ending a large part of the confidentiality of treatment relationships which we ordinarily expect. In addition, orders can compel the taking of medications that may have serious side-effects, participation in individual or group therapy at a specified clinic, participation in day treatment or rehabilitation programs that take up a majority of people's daytime hours, residence in a particular place which may have extensive rules like curfews, and blood or urine testing to determine whether one is taking medication and/or abstaining from alcohol or street drugs.[15] In other words, the orders can control very fundamental aspects of life in which we traditionally expect to have freedom – not only how and where one is treated, but also by whom and with whom one must discuss deeply personal matters – and including where and with whom one lives. OMH figures on how often people subjected to court orders participate in various services also give some idea of how frequently these various kinds of treatment are mandated:

88% medication management,
75% individual & group therapy,
22% day programs,
40% substance abuse programs,
37% blood or urine testing, and
31% housing or housing support services.[16]

If a person subject to a court order does not "comply" and there is "reason to believe" that he or she meets the standard for involuntary hospitalization, the law permits the person to be picked up by the police and held involuntarily in a hospital for up to 72 hours before a decision must be made whether he or she actually does meet the legal

criteria for further involuntary hospitalization.[17] Frequently the individual is seized by armed, uniformed police, handcuffed, and transported to the hospital in a marked cruiser.

"Kendra's Law" can be applied to a wide range of people. They are not people who are presently considered dangerous to themselves or others - under New York law people who fit that description are confined in institutions.[18] The most important criteria are that one must have been hospitalized twice in the last three years, *or* have done, attempted or threatened some act of serious bodily harm to oneself or someone else in the last four years. The hospitalizations need not have been involuntary, and the act, attempt or threat need not have been taken seriously enough to lead to arrest or commitment to a hospital, but they must have resulted from "non-compliance" with recommended treatment. The two hospitalization prong is by far the most important in practice. The other criteria – other than age of 18 or older – are all subjective and based largely on psychiatric opinion or prediction.[19]

Passage of the law brought profound changes to the mental health system. Never before had a New York court been authorized to mandate that people with mental illnesses be made to take medications and accept services when not committed to a hospital.[20] For the first time, outpatient treatment providers were made part of a system of monitoring "compliance" with mandated treatment rather than required to treat the individual's acceptance or non-acceptance of treatment as part of a confidential relationship.

The drafters used clever language which is far from transparent. By naming the law after Kendra Webdale, they not only honored her memory, but also subtly suggested that it is concerned primarily with people who commit violence against others – which it is not. The name also suggests that Ms. Webdale might be alive today had her attacker been compelled to accept treatment – whereas in fact he was trying to get services but could not because they were expensive and/or in short supply.[21] The law also refers to the system of court-mandated treatment as "assisted outpatient treatment," although the concept is usually called by the more straightforward name "involuntary outpatient commitment."

"Kendra's Law" also created novel obligations for public mental health officials to line up specified treatment needed by particular individuals who are not in an

institution.[22] It created a kind of "right to treatment," but only for people compelled by court order to accept the treatment. "Kendra's Law" as we now know it inseparably ties this obligation for officials to provide services to compulsion for clients to accept them. There is no reason, however, why the obligation to provide services could not be created for the benefit of a defined high-need group of people, who are nevertheless left free to accept the services or not, and to enjoy the usual confidentiality in their treatment. Such an arrangement would not suffer from the great moral and ethical problems created by the present law, particularly in view of its racially, ethnically and geographically biased application.

Disparities in Detail

"Kendra's Law " is used very unevenly across the state. By far the biggest users of court orders are New York City and Nassau and Suffolk Counties on Long Island. March 1, 2005 state totals of orders issued are attached as Appendix B. Here is a summary:

New York City (5 counties or boroughs)	3,017 orders
Nassau County	163
Suffolk County	249
41 other counties combined	529
14 remaining counties	0
Total for all 62 counties including NYC	3,958

In other words, New York City had racked up 3,017 orders by March 1, 2005, and the two Long Island counties had quite significant numbers of orders, but after them the numbers fell off sharply, and there were still 14 of 62 counties – almost a quarter – with no orders at all. In addition, Erie County – which includes Buffalo - is a heavy user of the law, although not by way of court orders, as we will explain below. We will look in detail at the most active localities.

As already noted Black people account for 42% of "Kendra's Law" court orders statewide but make up only 16% of the population, Hispanic people account for 21% of the orders but make up only 15% of the population, and White people account for 34% of the orders although they make up 62% of the population.[23] The disparities are not just a statewide phenomenon. They exist even when one focuses on individual counties and boroughs.

Here is a table focusing on Black people in each New York City borough and Erie, Nassau and Suffolk Counties. It shows the portion of the general population they make up in each borough and county (first column). It shows also that Black people make up a far *greater* portion of those in each borough and county subjected to "Kendra's Law" orders (third column).

Borough/ County	% Gen. Pop. Black[24]	% "SPMI" Black (Non-Hispanic)[26]	% under court orders Black (Non-Hispanic)[25]
Bronx	36	32	50
Brooklyn	36	30	53
Manhattan	18	35	40
Queens	20	31	38
Staten Is.	10	16	26
Erie	13	25	45
Nassau	10	18	46
Suffolk	7	15	22

Could these disparities be explained by Black people as a group being more likely to be seriously mentally ill? The State's own statistics indicate that the disparities cannot be dismissed in this way. Those subjected to "Kendra's Law" are more likely to be Black even than people in the same borough or county whom treatment providers count as "severely and persistently mentally ill" or " SPMI" (second column) – *i.e.,* those whose serious illness might make them candidates for "Kendra's Law." The table clearly shows that by some means, Black people are disproportionately singled out for "Kendra's Law" orders in each of these localities.

Here is a statewide comparison of the racial and ethnic identification of those treatment providers count as "SPMI" with those subject to "Kendra's Law" orders:

	"SPMI"[27]	Court Orders
Black (non-Hispanic)	24%	42%
Hispanic	17%	21%
White (non-Hispanic)	57%	34%

By this comparison, Black people are almost three times as likely as their White counterparts to be subjected to "Kendra's Law" orders, and Hispanic people are twice as likely.[28]

Erie County operates somewhat differently under "Kendra's Law" from the other most active counties and requires a particular note. It puts far more emphasis on so-called "voluntary agreements" than on court orders. Statewide, "voluntary agreements" are used frequently, but court orders have outnumbered agreements 4 to 3 statewide.[29] However, in Erie County the relationship is reversed, and agreements outnumber orders 5 to 1.[30]

"Voluntary agreements" are voluntary only in name. They are entered under threat of court proceedings, which present a very intimidating prospect for some people who are mentally ill. Interviews with people who had signed them, with mental health agency staff and with lawyers indicated that in Erie County agreements are often extracted without the individual having the advice of a lawyer. It is clear that at least some who sign them are thoroughly intimidated and unsure of their options.

People picked out for "voluntary agreements" are asked to adhere to a prescribed treatment plan, and so long as they "comply," mental health officials agree to forego seeking court orders. "Voluntary agreements" do not require the expensive formalities for a court order – for example a physician's evaluation of the individual, the physician's affidavit and testimony, and an attorney's preparation of court papers and presentation of the case in court.

"Voluntary agreements" are similar in coercion to court orders. The monitoring arrangements that make up a large part of the coercive effect of court orders are present. So also is the threat of being taken to a hospital for evaluation, much as under a court order - except that the period of confinement before a decision is due on further confinement is shorter. On the other hand, the intimidating court hearing hangs over the individual's head, whereas under an order it has already occurred. In some locations including Erie County and New York City, "voluntary agreements" are written. In others they are oral.

The racial and ethnic makeup of Erie County's total "Kendra's Law" caseload has tended to be similar to its figures for court orders alone. As of April 1, 2002, including both court orders and "voluntary agreements," those "active" under its "Kendra's Law" program were 53% Black, 3% Hispanic and 44 % White.[31] Erie County's population is 13% Black, 3% Hispanic, and 81% White (Non-Hispanic).[32]

We have already noted that New York City has 76% of the state's court orders but only 42% of its population, and that only a few other areas are active in using "Kendra's Law." Can the very disproportionate distribution of orders throughout the state be explained by differences in the distribution of serious mental illness? Again, the state's own statistics indicate that the answer is "no."

	% of "SPMI" Statewide[33]	% of Court Orders Statewide
New York City	51%	76%
Long Island (Nassau & Suffolk)	10%	10%
Balance of State	39%	13%

A person counted as "SPMI" who lives in New York City is four and a half times as likely to be subjected to a "Kendra's Law" order as someone counted as "SPMI" who lives in the State in an area other than New York City or Long Island. Something other than the distribution of serious mental illness is at work. "Kendra's Law" leaves it mainly to localities to determine how much to rely on compulsion and how much effort and money to spend on court orders. Major political and philosophical differences must be at work. Most areas of the State appear to believe they can get treatment to people with very little use of coercion. Again, the result is unfair. Where one happens to live is a huge factor in determining whether one will lose freedom to a "Kendra's Law" order.

Conclusion

Our first principle should be to provide excellent mental health services to all who need them, which they will want to accept on a voluntary basis. But until we eliminate shortages, priority access to services can and should be provided to people who need them most, entirely without compulsion. "Kendra's Law" as now written inseparably ties the two together, but the law need not do that.

Regardless of what was intended, "Kendra's Law" brings compulsion down on the heads of Black people almost five times as often as on White people, based on population, and on Hispanic people two and a half times as often. The compulsion always involves a loss of confidentiality in treatment and of autonomy, and often takes over huge areas of people's decision-making about their lives. In addition, people who live in New York City, Long Island and Erie County are far more likely to lose their autonomy to

"Kendra's Law" than people elsewhere in the state. None of these disparities can be explained by the distribution of serious mental illness. They have not been addressed by those who support "Kendra's Law's" compulsion. They raise serious questions about the fairness of our mental health system overall, as well as specifically about "Kendra's Law." It is essential that we come to understand what lies behind these numbers. But whatever causes them, the failings of the system should not be disproportionately borne by people in certain groups, particularly those historically so oppressed.

Further, notwithstanding its name, the law is used primarily on people with multiple hospitalizations, but not histories of hurting others.

There is no evidence that compulsion in outpatient treatment accomplishes anything that cannot be achieved by enhanced voluntary access to services.

Five years are more than enough to show that "Kendra's Law" as now written causes fundamental injustice. The compulsion must end. It would be fine and sensible, on the other hand, to continue to prioritize high-need individuals for scarce services, so long as they remain scarce, and to continue to mandate public officials to line up services for those individuals.[34] That is the just, humane and wise policy the State should adopt now, to follow the sunset of the original "Kendra's Law."

---

[1] This report is the work of New York Lawyers for the Public Interest, which is solely responsible for its content. John A. Gresham, Senior Litigation Counsel, is responsible for its final form. We gratefully acknowledge financial support to monitor and report on the implementation of "Kendra's Law" from the New York Foundation, granted on an application supported by The Judge David L. Bazelon Center for Mental Health Law, Community Access, Disability Advocates, Inc., the Mental Health Empowerment Project, the New York Association of Psychiatric Rehabilitation Services, the New York Civil Liberties Union, and the Urban Justice Center, all of which have provided advice and assistance. Disability Advocates, Inc., and the Mental Health Empowerment Project specifically endorse our recommendations in this report. We gratefully acknowledge also the contributions of Steven R. Donziger, Esq., who helped with the research and provided an initial draft of this report, Dr. Natasha Frost, who assisted with the statistical analyses, and attorney/social worker Julia Spring, who analyzed "Kendra's Law" papers we secured from the state through the Freedom of Information Law.

[2] "Kendra's Law" is distinct from longstanding provisions of New York law that authorize courts to approve involuntary commitment to *inpatient* treatment in a hospital if a person poses a substantial threat of physical harm to self or to others. Under "Kendra's Law", courts mandate involuntary *outpatient* treatment for people who are *not* presently "dangerous to self or others." A copy of MHL § 9.60, the heart of Kendra's Law, is at Appendix A.

[3] Those subjected to the law tend to be male and younger as well as people of color. According to state data, 66% are male, and the average age is 37.5 years. New York State Office of Mental Health, Final

Report on the Status of Assisted Outpatient Treatment, March 1, 2005, at p. 9, *see* http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/.

[4] *Id.*

[5] 2000 U.S. census, *see* http://quickfacts.census.gov/qfd/states/36/3651000.html. The State Office of Mental Health and the Census Bureau use different race and ethnicity concepts in their figures. Even so, it is obvious that the disparities are massive. For example, OMH excludes people of Hispanic origin from its counts of both Black and White people. Census summary tables include figures on Whites not of Hispanic origin – the figures used in this report - but we are working with census figures for Black people that include those of Hispanic origin. If we could exclude Black people of Hispanic origin from the census figures for Blacks, the disparities we report would be even greater.

[6] Through March 1, 2005, *see* OMH's figures at Appendix B. The population figure is from the 2000 U.S. census.

[7] 2000 U.S. census, *see* http://quickfacts.census.gov/qfd/states/36/3651000.html.

[8] See pp. 8 & 11, below.

[9] OMH Final Report at pp. 9 & 16.

[10] According to the Surgeon General:

> **Striking Disparities in Mental Health Care Are Found for Racial and Ethnic Minorities**
>
> This Supplement documents the existence of several disparities affecting mental health care of racial and ethnic minorities compared with Whites:
>
> - Minorities have less access to, and availability of, mental health services.
> - Minorities are less likely to receive needed mental health services.
> - Minorities in treatment often receive a poorer quality of mental health care.
> - Minorities are underrepresented in mental health research.
>
> …
>
> More is known about the disparities than the reasons behind them. A constellation of barriers deters minorities from reaching treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness (DHHS, 1999). But additional barriers deter racial and ethnic minorities; mistrust and fear of treatment, racism and discrimination, and differences in language and communication. The ability for consumers[3] and providers to communicate with one another is essential for all aspects of health care, yet it carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between patient and clinician. More broadly, mental health care disparities may also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status. The cumulative weight and interplay of all barriers to care, not any single one alone, is likely responsible for mental health disparities.

U. S. Department of Health and Human Services, Mental Health: Culture, Race, and Ethnicity, Executive Summary, 2001, at 13, *see* http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-2.html.

[11] New York State Office of Mental Health, An Interim Report on the Status of Assisted Outpatient Treatment, January 1, 2003, at pp. 6-7, *see* http://www.omh.state.ny.us/omhweb/kendra%5Fweb/interimreport/aotreport.pdf, and OMH Final Report at p. 9.

[12] New York State Office of Mental Health, Final Report on the Status of Assisted Outpatient Treatment, March 1, 2005, *see* http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/.

[13] After reviewing the empirical studies – some far more sophisticated than OMH's report - and the experience of several states, the Rand Corporation concluded,

> There are no empirical data that allow us to assess the policy tradeoffs between involuntary outpatient treatment and alternatives such as assertive community treatment. However, we believe the policy question can be explicitly reframed: *"Does adding a court order to the provision of intensive treatment significantly improve outcomes over and above the intensive treatment itself?"* and, if so, *"Is the addition of such orders cost-effective?"* Unfortunately, the existing empirical studies do not provide a definitive answer to these questions either.

M. Susan Ridgely, Randy Borum and John Petrila, The Effectiveness of Involuntary Outpatient Treatment, Rand Corporation, 2001, at p. xix, *see* http://www.rand.org/publications/MR/MR1340/mr1340.sum.pdf.

[14] The individual has the right to "actively participate in the development" of the treatment plan which he or she will be ordered to follow, MHL s 9.600(i)(1) (see Appendix A), but this certainly does not mean that his or her wishes prevail on even a single detail. If the individual wanted to receive the treatment in the treatment plan, one would hope no one would think of bringing a "Kendra's Law" proceeding.

[15] MHL ş 9.60(a)(1) (see Appendix A).

[16] OMH Final Report at 11. Our own figures on the level of intrusiveness of the orders are from 93 sets of court papers from New York City and Erie County which we obtained (minus individual identifying information) from the Office of Mental Health under the Freedom of Information Law. Our figures for what was mandated in these cases are -

99% medication	53% combined treatment for mental illness & chemical abuse
45% individual or group therapy	69% blood and/or urine testing
41% day treatment	27% specified housing
9% education or	vocational programs.

Regardless of which set of figures is more informative, it is obvious that orders are often broadly intrusive, going far beyond case management and medication.

[17] MHL ş 9.60(n) (see Appendix A). This is a longer period than people can generally be held in a hospital before a decision must be made on whether they meet the criteria for continued confinement. For example, in a Comprehensive Psychiatric Emergency Program, an initial decision must be made within six hours, MHL ş 9.40(b). Monitoring of "compliance" and the length of this "evaluation period" are the main practical ingredients of compulsion under "Kendra's Law." There is also – of course – the inherently coercive effect of being ordered to do something in a court room by a judge.

[18] MHL ş 9.60(c) & (j)(2) (see Appendix A). Which and how many of the potentially "eligible" people are targeted is left largely up to local mental health officials. In theory a wide range of people can petition the court to issue an order - ş 9.60(e)(1). But in practice, because of the cost of an examination and testimony by a physician and the legal work to put on a case in court, most petitions are brought by public mental health officials, and most of the rest by hospitals. Therefore the degree to which the law is used is left largely to local decision.

[19] One of the criteria on which the testifying psychiatrist must persuade the judge is that the person is unlikely to participate in recommended treatment because of his or her illness, ş 9.60(c)(5) (see Appendix A). Proponents of coercion argue that some people with mental illness do not appreciate their illness or their need for treatment, and so must be coerced for their own good. But it is very difficult to understand why people of color would be several times as likely to fail to appreciate their need for treatment. Also, we believe the best approach is to make services people like, want and trust readily available to them.

[20]Most other states have passed some form of involuntary outpatient commitment law, but in the majority the laws apply only to people who meet the same criteria which would permit involuntary hospitalization, so they provide an alternative to confinement. New York's "Kendra's Law" casts a much wider net. Most states use outpatient commitment laws only rarely. *See, for example* E. Fuller Torrey and Robert J. Kaplan, A National Survey of the Use of Outpatient Commitment, 46 *Psychiatric Services* 78 (1995).

[21] Michael Winerip, *Bedlam in the Streets*, THE NEW YORK TIMES MAGAZINE, May 23, 1999, at 44.

[22] MHL şş 7.17(f)(2), 9.47(b), 9.48(a) & 9.60(j)(5). For many years Articles 7 & 41 of the Mental Hygiene Law have included requirements that public officials plan a system of care, but there were no obligations to provide care to any particular individual who needed it, other than the Constitutional requirements to provide needed care for those confined in institutions.

[23] North Carolina has a roughly similar law based on prediction of deterioration without treatment, N.C.G.S. ş 122C-263(d)(1). A study of its use in nine counties noted that two thirds of the people chosen for application of the law were Black, and almost all were poor. According to the Census Bureau, approximately 22% of North Carolina's people are Black. *Compare* Marvin S. Swartz, Jeffrey W. Swanson, Virginia Hiday *et al.*, A Randomized Controlled Trial of Outpatient Commitment in North Carolina, 52 *Psychiatric Services* 325, 327 (2001) *with* http://quickfacts.census.gov/qfd/states/37000.html.
[24] 2000 U.S. census.
[25] OMH figures for orders through November, 2001, obtained through the Freedom of Information Law.
[26] 1999 OMH Patient Characteristics Survey figures on people who were 18 years or older and classified "SPMI," which we obtained through FOIL. The survey covered over 166,000 people treated for mental illness throughout the state. People were classified as SPMI if treatment providers believed they had serious functional limitations because of mental illness. The second and third columns in this table use identical OMH race and ethnicity categories.
[27] Based on 1999 OMH Patient Characteristics Survey statistics for people classified as "SPMI" who were 18 years of age or over – obtained from OMH under FOIL. Both columns in this table use identical OMH race and ethnicity categories.
[28] Disparities based on a comparison of people under court orders to those counted as SPMI are startling and disturbing - 3:1 and 2:1 - but less extreme than disparities comparing those under orders to the general population – almost 5:1 and 2.5:1. *See* p. 2, above. The difference arises in part because treatment providers in New York State count Black (especially) and Hispanic people as SPMI more often than one would expect according to population, and White people less. The statewide figures are -

	General Population	SPMI over 18
Black	16%	24%
Hispanic	15%	17%
White	62%	57%

These differences also demand explanation and must be addressed. The "SPMI" over 18" figures here are derived from the 1999 OMH Patient Characteristics Survey.
[29] The ratio is about 3 orders to 1 agreement in New York City. See Appendix B.
[30] The State statistical tables use another equally non-transparent term for what are often called "voluntary agreements" - the tables refer to them as "Service Enhancements (Case Management & Oversight)." See Appendix B.
[31] Erie County Department of Mental Health, Statistical Information, Assisted Outpatient Treatment Program, April 1, 2002. To its credit, Erie County has recognized that the disparities are significant and put some effort into dealing with them.
[32] 2000 U.S. Census, *see* http://quickfacts.census.gov/qfd/states/36/36029.html.
[33] Based on 1999 OMH Patient Characteristics Survey, *see* http://www.omh.state.ny.us/omhweb/PCS/Survey99/index99.html.
[34] Given what has happened to date, it is essential to continue to collect demographic data on the program, even in a voluntary form.

Appendix A

Mental Hygiene Law ş 9.60 Assisted Outpatient Treatment

(a) Definitions. For purposes of this section, the following definitions shall apply:

(1) "assisted outpatient treatment" shall mean categories of outpatient services which have been ordered by the court pursuant to this section. Such treatment shall include case management services or assertive community treatment team services to provide care coordination, and may also include any of the following categories of services: medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; individual or group therapy; day or partial day programming activities; educational and vocational training or activities; alcohol or substance abuse treatment and counseling and periodic tests for the presence of alcohol or illegal drugs for persons with a history of alcohol or substance abuse; supervision of living arrangements; and any other services within a local or unified services plan developed pursuant to article forty-one of this chapter, [FN1] prescribed to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

(2) "director" shall mean the director of a hospital licensed or operated by the office of mental health which operates, directs and supervises an assisted outpatient treatment program, or the director of community services of a local governmental unit, as such term is defined in section 41.03 of this chapter, which operates, directs and supervises an assisted outpatient treatment program.

(3) "director of community services" shall have the same meaning as provided in article forty-one of this chapter.

(4) "assisted outpatient treatment program" shall mean a system to arrange for and coordinate the provision of assisted outpatient treatment, to monitor treatment compliance by assisted outpatients, to evaluate the condition or needs of assisted outpatients, to take appropriate steps to address the needs of such individuals, and to ensure compliance with court orders.

(5) "assisted outpatient" or "patient" shall mean the person under a court order to receive assisted outpatient treatment.

(6) "subject of the petition" or "subject" shall mean the person who is alleged in a petition, filed pursuant to the provisions of this section, to meet the criteria for assisted outpatient treatment.

(7) "correctional facility" or "local correctional facility" shall have the same meaning as defined in section two of the correction law.

(8) "health care proxy" and "health care agent" shall have the same meaning as defined in article 29-C of the public health law [FN2].

(9) "program coordinator" shall mean an individual appointed by the commissioner of mental health, pursuant to subdivision (f) of section 7.17 of this chapter, who is responsible for the oversight and monitoring of assisted outpatient treatment programs.

(b) The director of a hospital licensed or operated by the office of mental health may operate, direct and supervise an assisted outpatient treatment program as provided in this section, upon approval by the commissioner of mental health. The director of community services of a local governmental unit shall operate, direct and supervise an assisted outpatient treatment program as provided in this section, upon approval by the commissioner of mental health. Directors of community services of local governmental units shall be permitted to satisfy the provisions of this subdivision through the operation of joint assisted outpatient treatment programs. Nothing in this subdivision shall be interpreted to preclude the combination or coordination of efforts between and among local governmental units and hospitals in providing and coordinating assisted outpatient treatment.

(c) Criteria for assisted outpatient treatment. A patient may be ordered to obtain assisted outpatient treatment if the court finds that:

(1) the patient is eighteen years of age or older; and

(2) the patient is suffering from a mental illness; and

(3) the patient is unlikely to survive safely in the community without supervision, based on a clinical determination; and

(4) the patient has a history of lack of compliance with treatment for mental illness that has:

(i) at least twice within the last thirty-six 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 period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition or;

(ii) resulted in one or 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 forty-eight months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition; and

(5) the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; and

(6) in view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others as defined in section

9.01 of this article; and

(7) it is likely that the patient will benefit from assisted outpatient treatment; and

(8) if the patient has executed a health care proxy as defined in article 29-C of the public health law, that any directions included in such proxy shall be taken into account by the court in determining the written treatment plan.

(d) Nothing herein shall preclude a person with a health care proxy from being subject to a petition pursuant to this chapter and consistent with article 29-C of the public health law.

(e) Petition to the court. (1) A petition for an order authorizing assisted outpatient treatment may be filed in the supreme or county court in the county in which the subject of the petition is present or reasonably believed to be present. A petition to obtain an order authorizing assisted outpatient treatment may be initiated only by the following persons:

(i) any person eighteen years of age or older with whom the subject of the petition resides; or

(ii) the parent, spouse, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or

(iii) the director of a hospital in which the subject of the petition is hospitalized; or

(iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the subject of the petition resides; or

(v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; or

(vi) the director of community services, or his or her designee, or the social services official, as defined in the social services law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or

(vii) a parole officer or probation officer assigned to supervise the subject of the petition.

(2) The petition shall state:

(i) each of the criteria for assisted outpatient treatment as set forth in subdivision (c) of this section;

(ii) facts which support such petitioner's belief that the person who is the subject of the petition meets each criterion, provided that the hearing on the petition need not be limited to the stated facts; and

(iii) that the subject of the petition is present, or is reasonably believed to be present, within the county where such petition is filed.

(3) The petition shall be accompanied by an affirmation or affidavit of a physician, who shall not be the petitioner, and shall state either that:

(i) such physician has personally examined the person who is the subject of the petition no more than ten days prior to the submission of the petition, he or she recommends assisted outpatient treatment for the subject of the petition, and he or she is willing and able to testify at the hearing on the petition; or

(ii) no more than ten days prior to the filing of the petition, such physician or his or her designee has made appropriate attempts to elicit the cooperation of the subject of the petition but has not been successful in persuading the subject to submit to an examination, that such physician has reason to suspect that the subject of the petition meets the criteria for assisted outpatient treatment, and that such physician is willing and able to examine the subject of the petition and testify at the hearing on the petition.

(f) Service. The petitioner shall cause written notice of the petition to be given to the subject of the petition and a copy thereof shall be given personally or by mail to the persons listed in section 9.29 of this article, the mental hygiene legal service, the current health care agent appointed by the subject of the petition, if any such agent is known to the petitioner, the appropriate program coordinator, the appropriate director of community services, if such director is not the petitioner.

(g) Right to counsel. The subject of the petition shall have the right to be represented by the mental hygiene legal service, or other counsel at the expense of the subject of the petition, at all stages of a proceeding commenced under this section.

(h) Hearing. (1) Upon receipt by the court of the petition submitted pursuant to subdivision (e) of this section, the court shall fix the date for a hearing at a time not later than three days from the date such petition is received by the court, excluding Saturdays, Sundays and holidays. Adjournments shall be permitted only for good cause shown. In granting adjournments, the court shall consider the need for further examination by a physician or the potential need to provide assisted outpatient treatment expeditiously. The court shall cause the subject of the petition, any other person receiving notice pursuant to subdivision (f) of this section, the petitioner, the physician whose affirmation or affidavit accompanied the petition, the appropriate director, and such other persons as the court may determine to be advised of such date. Upon such date, or upon such other date to which the proceeding may be adjourned, the court shall hear testimony and, if it be deemed advisable and the subject of the petition is available, examine the subject alleged to be in need of assisted outpatient treatment in or out of court. If the subject of the petition does not appear at the hearing, and appropriate attempts to elicit the

attendance of the subject have failed, the court may conduct the hearing in such subject's absence. If the hearing is conducted without the subject of the petition present, the court shall set forth the factual basis for conducting the hearing without the presence of the subject of the petition.

(2) The court shall not order assisted outpatient treatment unless an examining physician, who has personally examined the subject of the petition within the time period commencing ten days before the filing of the petition, testifies in person at the hearing.

(3) If the subject of the petition has refused to be examined by a physician, the court may request the subject to consent to an examination by a physician appointed by the court. If the subject of the petition does not consent and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order peace officers, acting pursuant to their special duties, or police officers who are members of an authorized police department or force, or of a sheriff's department to take the subject of the petition into custody and transport him or her to a hospital for examination by a physician. Retention of the subject of the petition under such order shall not exceed twenty-four hours. The examination of the subject of the petition may be performed by the physician whose affirmation or affidavit accompanied the petition pursuant to paragraph three of subdivision (e) of this section, if such physician is privileged by such hospital or otherwise authorized by such hospital to do so. If such examination is performed by another physician of such hospital, the examining physician shall be authorized to consult with the physician whose affirmation or affidavit accompanied the petition regarding the issues of whether the allegations in the petition are true and whether the subject meets the criteria for assisted outpatient treatment.

(4) A physician who testifies pursuant to paragraph two of this subdivision shall state the facts which support the allegation that the subject meets each of the criteria for assisted outpatient treatment, and the treatment is the least restrictive alternative, the recommended assisted outpatient treatment, and the rationale for the recommended assisted outpatient treatment. If the recommended assisted outpatient treatment includes medication, such physician's testimony shall describe the types or classes of medication which should be authorized, shall describe the beneficial and detrimental physical and mental effects of such medication, and shall recommend whether such medication should be self-administered or administered by authorized personnel.

(5) The subject of the petition shall be afforded an opportunity to present evidence, to call witnesses on behalf of the subject, and to cross-examine adverse witnesses.

(i) (1) Written treatment plan. The court shall not order assisted outpatient treatment unless an examining physician appointed by the appropriate director develops and provides to the court a proposed written treatment plan. The written treatment plan shall include case management services or assertive community treatment teams to provide care coordination. The written treatment plan also shall include all categories of services, as set forth in paragraph one of subdivision (a) of this section, which such physician recommends that the subject of the petition should receive. If the written treatment plan includes medication, it shall state whether such medication should be self-administered or administered by authorized personnel, and shall specify type and dosage range of medication most likely to provide maximum benefit for the subject. If the written treatment plan includes alcohol or substance abuse counseling and treatment, such plan may include a provision requiring relevant testing for either alcohol or illegal substances

provided the physician's clinical basis for recommending such plan provides sufficient facts for the court to find (i) that such person has a history of alcohol or substance abuse that is clinically related to the mental illness; and (ii) that such testing is necessary to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others. In developing such a plan, the physician shall provide the following persons with an opportunity to actively participate in the development of such plan: the subject of the petition; the treating physician; and upon the request of the patient, an individual significant to the patient including any relative, close friend or individual otherwise concerned with the welfare of the subject. If the petitioner is a director, such plan shall be provided to the court no later than the date of the hearing on the petition.

(2) The court shall not order assisted outpatient treatment unless a physician testifies to explain the written proposed treatment plan. Such testimony shall state the categories of assisted outpatient treatment recommended, the rationale for each such category, facts which establish that such treatment is the least restrictive alternative, and, if the recommended assisted outpatient treatment includes medication, the types or classes of medication recommended, the beneficial and detrimental physical and mental effects of such medication, and whether such medication should be self-administered or administered by an authorized professional. If the petitioner is a director such testimony shall be given at the hearing on the petition.

(j) Disposition. (1) If after hearing all relevant evidence, the court finds that the subject of the petition does not meet the criteria for assisted outpatient treatment, the court shall dismiss the petition.

(2) If after hearing all relevant evidence, the court finds by clear and convincing evidence that the subject of the petition meets the criteria for assisted outpatient treatment, and there is no appropriate and feasible less restrictive alternative, the court shall be authorized to order the subject to receive assisted outpatient treatment for an initial period not to exceed six months. In fashioning the order, the court shall specifically make findings by clear and convincing evidence that the proposed treatment is the least restrictive treatment appropriate and feasible for the subject. The order shall state the categories of assisted outpatient treatment, as set forth in subdivision (a) of this section, which the subject is to receive, and the court may not order treatment that has not been recommended by the examining physician and included in the written treatment plan for assisted outpatient treatment as required by subdivision (i) of this section.

(3) If after hearing all relevant evidence the court finds by clear and convincing evidence that the subject of the petition meets the criteria for assisted outpatient treatment, and the court has yet to be provided with a written proposed treatment plan and testimony pursuant to subdivision (i) of this section, the court shall order the director of community services to provide the court with such plan and testimony no later than the third day, excluding Saturdays, Sundays and holidays, immediately following the date of such order. Upon receiving such plan and testimony, the court may order assisted outpatient treatment as provided in paragraph two of this subdivision.

(4) A court may order the patient to self-administer psychotropic drugs or accept the administration of such drugs by authorized personnel as part of an assisted outpatient treatment program. Such order may specify the type and dosage range of such psychotropic drugs and such order shall be effective for the duration of such assisted outpatient treatment.

(5) If the petitioner is the director of a hospital that operates an assisted outpatient treatment program, the court order shall direct the hospital director to provide or arrange for all categories of assisted outpatient treatment for the assisted outpatient throughout the period of the order. For all other persons, the order shall require the director of community services of the appropriate local governmental unit to provide or arrange for all categories of assisted outpatient treatment for the assisted outpatient throughout the period of the order.

(6) The director or his or her designee shall apply to the court for approval before instituting a proposed material change in the assisted outpatient treatment order unless such change is contemplated in the order. Non-material changes may be instituted by the assisted outpatient treatment program without court approval. For the purposes of this subdivision, a material change shall mean an addition or deletion of a category of assisted outpatient treatment from the order of the court, or any deviation without the patient's consent from the terms of an existing order relating to the administration of psychotropic drugs. Any such application for approval shall be served upon those persons required to be served with notice of a petition for an order authorizing assisted outpatient treatment.

(k) Applications for additional periods of treatment. If the director determines that the condition of such patient requires further assisted outpatient treatment, the director shall apply prior to the expiration of the period of assisted outpatient treatment ordered by the court for a second or subsequent order authorizing continued assisted outpatient treatment for a period not to exceed one year from the date of the order. The procedures for obtaining any order pursuant to this subdivision shall be in accordance with the provisions of the foregoing subdivisions of this section, provided that the time period included in subparagraphs (i) and (ii) of paragraph four of subdivision (c) of this section shall not be applicable in determining the appropriateness of additional periods of assisted outpatient treatment. Any court order requiring periodic blood tests or urinalysis for the presence of alcohol or illegal drugs shall be subject to review after six months by the physician who developed the written treatment plan or another physician designated by the director, and such physician shall be authorized to terminate such blood tests or urinalysis without further action by the court.

(*l*) Application for an order to stay, vacate or modify. In addition to any other right or remedy available by law with respect to the order for assisted outpatient treatment, the patient, mental hygiene legal service, or anyone acting on the patient's behalf may apply on notice to the appropriate director and the original petitioner, to the court to stay, vacate or modify the order.

(m) Appeals. Review of an order issued pursuant to this section shall be had in like manner as specified in section 9.35 of this article.

(n) Failure to comply with assisted outpatient treatment. Where in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and in the physician's clinical judgment, efforts were made to solicit compliance, and, in the clinical judgment of such physician, such patient may be in need of involuntary admission to a hospital pursuant to section 9.27 of this article, or for whom immediate observation, care and treatment may be necessary pursuant to section 9.39 or

9.40 of this article, such physician may request the director, the director's designee, or persons designated pursuant to section 9.37 of this article, to direct the removal of such patient to an appropriate hospital for an examination to determine if such person has a mental illness for which hospitalization is necessary pursuant to section 9.27, 9.39 or 9.40 of this article. Furthermore, if such assisted outpatient refuses to take medications as required by the court order, or he or she refuses to take, or fails a blood test, urinalysis, or alcohol or drug test as required by the court order, such physician may consider such refusal or failure when determining whether the assisted outpatient is in need of an examination to determine whether he or she has a mental illness for which hospitalization is necessary. Upon the request of such physician, the director, the director's designee, or persons designated pursuant to section 9.37 of this article, may direct peace officers, when acting pursuant to their special duties, or police officers who are members of an authorized police department or force or of a sheriff's department to take into custody and transport any such person to the hospital operating the assisted outpatient treatment program or to any hospital authorized by the director of community services to receive such persons. Such law enforcement officials shall carry out such directive. Upon the request of such physician, the director, the director's designee, or person designated pursuant to section 9.37 of this article, an ambulance service, as defined by subdivision two of section three thousand one of the public health law, or an approved mobile crisis outreach team as defined in section 9.58 of this article shall be authorized to take into custody and transport any such person to the hospital operating the assisted outpatient treatment program, or to any other hospital authorized by the director of community services to receive such persons. Such person may be retained for observation, care and treatment and further examination in the hospital for up to seventy-two hours to permit a physician to determine whether such person has a mental illness and is in need of involuntary care and treatment in a hospital pursuant to the provisions of this article. Any continued involuntary retention in such hospital beyond the initial seventy-two hour period shall be in accordance with the provisions of this article relating to the involuntary admission and retention of a person. If at any time during the seventy-two hour period the person is determined not to meet the involuntary admission and retention provisions of this article, and does not agree to stay in the hospital as a voluntary or informal patient, he or she must be released. Failure to comply with an order of assisted outpatient treatment shall not be grounds for involuntary civil commitment or a finding of contempt of court.

(o) Effect of determination that a person is in need of assisted outpatient treatment. The determination by a court that a patient is in need of assisted outpatient treatment under this section shall not be construed as or deemed to be a determination that such patient is incapacitated pursuant to article eighty-one of this chapter. [FN3]

(p) False petition. A person making a false statement or providing false information or false testimony in a petition or hearing under this section is subject to criminal prosecution pursuant to article one hundred seventy-five [FN4] or article two hundred ten of the penal law. [FN5]

(q) Exception. Nothing in this section shall be construed to affect the ability of the director of a hospital to receive, admit, or retain patients who otherwise meet the provisions of this article regarding receipt, retention or admission.

(r) Educational materials. The office of mental health, in consultation with the office of court administration, shall prepare educational and training materials on the use of this section, which shall be made available to local governmental units as defined in article

forty-one of this chapter, providers of services, judges, court personnel, law enforcement officials and the general public.

Appendix B

* Statewide AOT Report as of March 1, 2005

This report provides cumulative totals for individuals receiving AOT investigations, service enhancements (case management and oversight), and AOT court orders from November 1999 to the date noted above.

County	Investigations	Ongoing	Number of Clients Provided Service Enhancements (Case Management and Oversight)	Number of Clients Court Ordered
Statewide Total	10411	406	2961	3958
Change Since 2/1/05	+212	+1	+56	+50

* OMH has altered its reporting on AOT from an aggregate-based system to a client-based system. Henceforth, we will be reporting on the number of **individuals** being investigated, receiving service enhancements and/or being court-ordered under Kendra's Law rather than the total number of investigations, service enhancements and/or court orders.

---

* Central New York AOT Report as of March 1, 2005

This report provides cumulative totals for individuals receiving AOT investigations, service enhancements (case management and oversight), and AOT court orders from November 1999 to the date noted above.

County	Investigations	Ongoing	Number of Clients Provided Service Enhancements (Case Management and Oversight)	Number of Clients Court Ordered
Broome	26	0	2	7
Cayuga	14	1	7	2
Chenango	0	0	2	2
Clinton	35	0	33	0
Cortland	4	0	0	0
Delaware	1	0	0	1
Essex	7	0	4	0
Franklin	14	0	11	0
Fulton	15	0	4	8
Hamilton	2	0	0	0
Herkimer	13	1	8	0
Jefferson	35	2	14	4
Lewis	3	0	2	0
Madison	4	0	1	1
Montgomery	28	0	12	10
Oneida	414	5	165	15
Onondaga	93	12	45	8
Oswego	6	0	6	0
Otsego	36	0	3	4
St. Lawrence	38	1	14	2
Region Total	790	22	333	62
Change Since 2/1/05	+110	-2	+22	+0

* OMH has altered its reporting on AOT from an aggregate-based system to a client-based system. Henceforth, we will be reporting on the number of **individuals** being investigated, receiving service enhancements and/or being court-ordered under Kendra's Law rather than the total number of investigations, service enhancements and/or court orders. **There have been some slight adjustments to the numbers which we feel accurately reflect AOT activity among the various counties in the Central New York region.**

* Hudson River AOT Report as of March 1, 2005

This report provides cumulative totals for individuals receiving AOT investigations, service enhancements (case management and oversight), and AOT court orders from November 1999 to the date noted above.

County	Investigations	Ongoing	Number of Clients Provided Service Enhancements (Case Management and Oversight)	Number of Clients Court Ordered
Albany	212	16	56	59
Columbia	19	0	14	7
Dutchess	249	4	75	64
Greene	6	0	1	0
Orange	107	0	44	14
Putnam	20	2	9	3
Rensselaer	50	1	41	50
Rockland	73	2	45	17
Saratoga	29	3	16	7
Schenectady	61	2	33	6
Schoharie	10	0	4	2
Sullivan	33	2	18	2
Ulster	90	31	47	15
Warren	58	4	15	5
Washington	26	3	6	3
Westchester	561	31	142	82
Region Total	1605	101	566	339
Change Since 2/1/05	+22	-2	+6	+11

* OMH has altered its reporting on AOT from an aggregate-based system to a client-based system. Henceforth, we will be reporting on the number of **individuals** being investigated, receiving service enhancements and/or being court-ordered under Kendra's Law rather than the total number of investigations, service enhancements and/or court orders.

* Long Island AOT Report as of March 1, 2005

This report provides cumulative totals for individuals receiving AOT investigations, service enhancements (case management and oversight), and AOT court orders from November 1999 to the date noted above.

County	Investigations	Ongoing	Number of Clients Provided Service Enhancements (Case Management and Oversight)	Number of Clients Court Ordered
Nassau	371	22	67	163
Suffolk	550	39	157	249
Region Total	921	61	224	412
Change Since 2/1/05	+12	+10	+7	+6

* OMH has altered its reporting on AOT from an aggregate-based system to a client-based system. Henceforth, we will be reporting on the number of **individuals** being investigated, receiving service enhancements and/or being court-ordered under Kendra's Law rather than the total number of investigations, service enhancements and/or court orders.

---

* New York City AOT Report as of March 1, 2005

This report provides cumulative totals for individuals receiving AOT investigations, service enhancements (case management and oversight), and AOT court orders from November 1999 to the date noted above.

County	Investigations	Ongoing	Number of Clients Provided Service Enhancements (Case Management and Oversight)	Number of Clients Court Ordered
Region Total	5188	156	1016	3017
Change Since 2/1/05	+48	-4	+18	+33

* OMH has altered its reporting on AOT from an aggregate-based system to a client-based system. Henceforth, we will be reporting on the number of **individuals** being investigated, receiving service enhancements and/or being court-ordered under Kendra's Law rather than the total number of investigations, service enhancements and/or court orders.

---

* Western New York AOT Report as of March 1, 2005

This report provides cumulative totals for individuals receiving AOT investigations, service enhancements (case management and oversight), and AOT court orders from November 1999 to the date noted above.

County	Investigations	Ongoing	Number of Clients Provided Service Enhancements (Case Management and Oversight)	Number of Clients Court Ordered
Allegany	17	1	13	0
Cattaraugus	68	4	33	2
Chautauqua	90	13	47	4
Chemung	12	2	6	2
Erie	1178	9	348	70
Genesee	10	0	3	1
Livingston	5	1	1	0
Monroe	238	17	147	39
Niagara	190	12	170	2
Ontario	0	0	0	0
Orleans	22	1	9	3
Schuyler	1	0	1	0
Seneca	1	0	1	1
Steuben	20	5	13	1
Tioga	0	0	2	2
Tompkins	22	1	10	7
Wayne	4	0	0	1
Wyoming	28	0	17	1
Yates	1	0	1	0
Region Total	1907	66	822	128
Change Since 2/1/05	+20	-1	+3	+0

* OMH has altered its reporting on AOT from an aggregate-based system to a client-based system. Henceforth, we will be reporting on the number of **individuals** being investigated, receiving service enhancements and/or being court-ordered under Kendra's Law rather than the total number of investigations, service enhancements and/or court orders.

Appendix C

OMH"s Final Report on "Kendra's Law" Is Propaganda, Not Science

OMH's Final Report appears on the surface to be scientific and credible, and it surely shows that some benefits flow from enhanced services. But it has no scientific validity and shows no benefits from compulsion. It is really propaganda with charts.

The report contains almost no negative findings. Any objective evaluation would have offered some criticism.

The report claims many positive effects from "Kendra's Law," but it completely fails to show what produced them – better access to services or compulsion. The law as now written directs both to people under court orders. The report looks only at their combined effect, so it is impossible to tell what is accomplished by either. The most relevant scientific study – conducted under a similar pilot law at Bellevue Hospital in the 1990s – examined this question by using a control group. It compared two matched groups of people, both with enhanced services but only one with court orders. It found that better access to services reduced hospitalizations, but court orders added nothing in terms of people's staying with treatment, symptoms, functioning, frequency of hospitalization, arrest, quality of life, etc.[1] The Bellevue study suggests that all the benefits claimed by OMH's report may come from enhanced services, and none from compulsion. No one would object to providing service priority to a high-need group, but many object to compulsion under the present law. OMH's report ignores this vital distinction and provides no support for the effectiveness of compulsion.

"Kendra's Law" has been hyped as a response to individuals who commit random acts of violence. OMH's report soft-peddles the fact that it is actually used mostly on people without a history of hurting others, who have been hospitalized more than once. It buries in a table the fact that only 15% of those under court orders have done any physical harm to another in the period prior to their orders – so 85% have not.

The report soft-peddles the loss of control over their lives that people experience under court orders. They get not only guaranteed access to services, but also a case manager who reports to bureaucrats on their "compliance," plus mandates to "comply" with various services. In most cases these include specific medications, many of which have serious side effects; and often therapy at particular clinics (and so with particular therapists & therapy group members), programs that fill up their days, tests of blood or urine, and/or particular housing (which may determine roommates and often has strict rules). Here are some of the report's figures, which it presents as showing "participation," thus glossing over that "participation" is mandatory and involves a great loss of freedom:

88% medication management	40% substance abuse programs
75% individual & group therapy	37% blood or urine testing
22% day programs	31% housing or housing support services

The report is based almost entirely on opinions of case managers comparing their clients' functioning prior to and during court orders. This is a very weak basis for conclusions.

> Many of these "before & after" measurements are highly subjective. They include "effectively handle conflict," "manage assertiveness," "maintain support network" and "abuse alcohol." Even the measures of medication "compliance" are subjective and based on hearsay – case managers are seldom present to see whether clients take medications "as prescribed." And -
>
> Very often case managers compare clients' functioning before they worked with them to their functioning as their own clients. Of course the case managers are inclined to see their own efforts as effective. This is human nature. And -
>
> Case managers work for programs with state funding. It has been no secret that the state mental health bureaucracy from Governor Pataki down is bent on trumpeting a "success." Case managers know everyone up the line wants to see their clients "improve" under court orders. And -
>
> People subjected to court orders are under enormous pressure to tell case managers and others that they are accepting treatment as directed. Many are vulnerable people. They live under threat of seizure by police and confinement for at least three days in locked hospital wards if they fail to "comply." Can we assume that all will faithfully report how often they take their pills, for example?

The report touches none of the other obvious hard questions, such as –

> What are the treatment costs in lost trust and candor from clients who know that those who treat them will turn them in if they do not "comply"?
>
> Is it really necessary to take away people's freedom for the bureaucracy to become more responsive and organized?
>
> How many people have gone underground or moved to avoid orders? How many have avoided a mental health evaluation for fear of a second hospitalization that would make them "eligible" for a court order? All of these things happen.
>
> How many people could get actual treatment and services for the millions spent on the mechanics of compulsion?
>
> Why are 63% of the people under court orders Black or Hispanic, compared to 31% of our state's people? What is wrong with our mental health system that leads to Black people being almost 5 times as likely as White people to lose their freedom of choice, and Hispanic people 2.5 times as likely to do so?

---

[1] Henry Steadman, Kostas Gounis, Deborah Dennis, *et al.,* Assessing the New York City Involuntary Outpatient Commitment Pilot Program, 52 *Psychiatric Services* 330 (2001).