THE UNIVERSITY OF NEW MEXICO

Assisted Outpatient Treatment: Policy Expansion and a Contested Evidence Base Through 2026

Prepared By:

Alex Severson, Ph.D.

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Introduction

Assisted outpatient treatment (AOT) refers to court-ordered, community-based mental health treatment for individuals with serious mental illness (SMI) who have a documented history of not engaging with treatment voluntarily (Stettin et al., 2019; Treatment Advocacy Center, 2023). AOT programs typically target adults with repeated psychiatric hospitalizations, incarcerations, or violent behavior toward themselves or others, who are judged unlikely to survive safely in the community without supervision. The core logic of AOT is that a civil court order, and the symbolic weight of judicial involvement, often called the "black robe effect," will lead participants to treat adherence to medication and engagement with treatment services as a legal obligation, which in turn should lead to increased engagement with services and improvements across other outcomes, such as reductions in emergency department use and reductions in criminal behavior (Gilbert et al., 2010; Stettin et al., 2019; Treatment Advocacy Center, 2025). As of June 2026, 48 states and the District of Columbia have enacted some form of AOT statute, with Connecticut and Massachusetts remaining as the only states without statutory authority for court-ordered outpatient treatment (Hancq et al., 2024; Center for Public Representation et al., 2025).

AOT is rooted in the deinstitutionalization movement of the mid-twentieth century, which closed large state psychiatric hospitals and shifted care to community settings. Deinstitutionalization moved patients out of state hospitals faster than community mental health systems were scaled to receive them; although the Community Mental Health Act planned 1,500 community mental health centers, states built only about half, and the state mental hospital census fell by more than 90% over the next several decades (Grob, 1991; Fuller et al., 2025). Because of this mismatch, many individuals with SMI ended up cycling through emergency departments, jails, and periods of homelessness instead (Hewlett et al., 2026; Suh et al., 2026). AOT was developed as one policy response to this mismatch between discharge and community provider capacity, on the theory that judicially supervised care could connect people to services they would not otherwise receive. Early AOT statutes were enacted in North Carolina (1984) and the District of Columbia (1987), but the modern legislative push for AOT and related programs accelerated after high-profile incidents attributed to untreated mental illness. New York's Kendra's Law (1999), named after Kendra Webdale, who was pushed to her death in a subway station by an individual with untreated schizophrenia, became the template for most subsequent state statutes and the most studied AOT program in the country.

Federal interest in AOT expanded with the 2014 Protecting Access to Medicare Act, which authorized demonstration grants. SAMHSA has since awarded roughly $146 million across 63 grantees in three funding cycles (2016, 2020, 2024) (U.S. Government Accountability Office, 2025). The federal posture shifted further in July 2025, when President Trump issued an executive order, "Ending Crime and Disorder on America's Streets," and SAMHSA followed with a $10 million AOT funding opportunity for 2026 aligned with that order.

Despite this growing investment, the evidence base for AOT is, in our view, best described as contested. Earlier observational studies tended to report gains in participant engagement, reduced hospitalization use, and lower recidivism rates for program participants, but more recent and methodologically more

robust work (i.e., randomized controlled trials[1]) has often produced smaller or null estimates of program effects, and the cumulative picture across both peer-reviewed and federal reviews has been described by recent federal and aggregate reviews as inconclusive.

We structure the rest of the report into six different sections. First, we describe the theoretical foundations of the AOT model. Second, we summarize the history of AOT program implementation in New Mexico. Third, we describe how AOT programs are supposed to operate and how state statutes vary in their implementation elements. Fourth, we review the evidence on the associations between AOT program participation and treatment adherence, clinical outcomes, hospitalization, criminal justice involvement, social functioning, and cost-effectiveness. Fifth, we discuss the limitations of the existing evidence base and spotlight a few novel theoretical concerns with both the underlying logic of the AOT model's theory of change. Finally, we conclude by recapping broader takeaways from the evidence base and briefly comment on their implications for evaluating AOT in New Mexico moving forward.

Theoretical Foundations and Program Goals

As noted in the *Introduction*, AOT programs emerged in response to a recurring, post-deinstitutionalization cycle: individuals with SMI cycling through psychiatric hospitalizations, emergency departments, and jails and prison systems without establishing sustained connections to community-based care (Hiday, 2003). The core operational goals of AOT map directly onto each stage of this cycle: escalating frontline treatment adherence to maintain participant engagement between acute crises, reducing overuse of emergency services, minimizing psychiatric rehospitalization, and decreasing criminal justice involvement (Gearing et al., 2024).

How Professional Bodies Define AOT

The American Psychiatric Association's (APA) 2015 position statement describes AOT as a civil court procedure in which a judge orders a person with SMI to adhere to an outpatient treatment plan designed to prevent relapse and dangerous clinical deterioration (American Psychiatric Association, 2015). The APA emphasizes that AOT should be used as an intervention only after voluntary treatment options have been exhausted, reflecting an ethical mandate to balance patient autonomy with beneficence and public safety.

A subsequent implementation white paper by Stettin et al. (2019) operationalized this definition by specifying how AOT functions in practice. Stettin et al. define AOT as community-based mental health

[1] A randomized controlled trial (RCT) assigns individuals to an intervention or to a comparison group (i.e., a control group) by chance. This has the effect such that any baseline difference that could correlate with specific program outcomes (e.g., rates of anosognosia) between the two groups averages out across the sample. This is the only research design that can reliably isolate the causal effect of an intervention, because any post-randomization differences in outcomes cannot be attributed to differences in who chose to enroll, who had more extensive criminal histories at enrollment, or who had better access to services. RCTs are conventionally placed at the top of the "hierarchy of evidence" for this reason, meaning that we can have greater confidence that the estimates generated by them are robust against other sources of known biases in other types (i.e., observational) of study designs.

treatment delivered under civil court commitment to achieve two concurrent objectives: (a) motivating an adult who struggles with voluntary treatment adherence to fully engage with their treatment plan, and (b) focusing treatment providers' attention on keeping the individual actively engaged[2]. Ultimately, AOT seeks to maximize the safety and well-being of both the participant and the public by mitigating the downstream personal and societal consequences of treatment non-adherence.

Unlike conventional legal mandates, AOT is rarely enforced through criminal contempt of court. Some states explicitly prohibit holding non-adherent participants in contempt (Treatment Advocacy Center, 2023). Instead, the underlying program logic presumes that the judicial order itself is a sufficiently powerful behavioral lever, motivating participants to prioritize treatment adherence without the explicit coercion of jail time or sanctions. The legal mechanics describe how the order operates, not why a court order is thought to be needed at all. The clinical rationale for AOT rests on a unique feature of some variants of SMI that makes voluntary and consistent treatment engagement structurally difficult for the population the intervention targets.

Anosognosia: The Population AOT Is Designed For

The primary clinical explanation for the AOT target population's struggle to engage voluntarily in care is anosognosia. Anosognosia is a neurological condition in which an individual with SMI is genuinely unaware of their psychiatric condition. The clinical literature strictly distinguishes anosognosia from psychological denial. While an individual in denial recognizes that they may have a diagnosis but consciously refuses to accept it, a person with anosognosia suffers from a structural impairment in the neural networks responsible for self-monitoring and metacognition, including the prefrontal and insular cortices, which causes them to not recognize that they have the condition at all or explain away symptoms otherwise (Lehrer & Lorenz, 2014; Flashman et al., 2001). From the perspective of a patient with anosognosia, they do not have an SMI, and, because of this, there is no logical rationale to seek or maintain psychiatric care.

Anosognosia is commonly assumed to be particularly prevalent among the population targeted for AOT participation. Estimates from the Treatment Advocacy Center (TAC) suggest that approximately 60% of individuals with schizophrenia and 50% of individuals with bipolar disorder experience some degree of insight impairment, with roughly 30% and 20% respectively experiencing severe anosognosia (Treatment Advocacy Center, 2023); a recent narrative review places the schizophrenia range higher, with estimates that 50% to 98% of individuals with schizophrenia lack awareness that they have a mental illness depending on the measure and threshold used (Rose & Harvey, 2025). Empirically, poor insight is one of the strongest empirical predictors of medication non-adherence. A 2025 systematic review and meta-analysis[3] of pharmacotherapy non-adherence across mental disorders in resource-limited settings reported

[2] A defining feature of the AOT model is the "mutuality of responsibility" to the court (Stettin et al., 2019). Just as the court commits the participant to a prescribed regimen, the local treatment system is held legally and operationally accountable for delivering the necessary services in a timely, high-quality manner, often through a treatment plan explicitly folded into the judicial order.

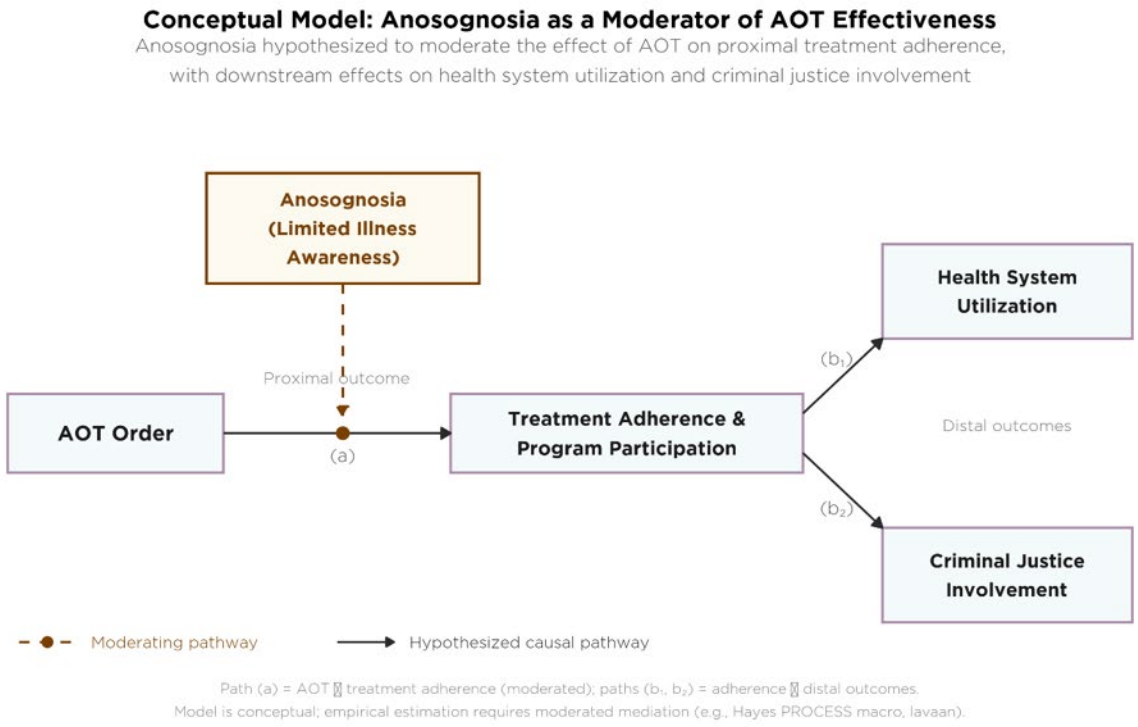
[3] A meta-analysis statistically pools the results of multiple studies on the same question to produce a single, more precise estimate of an intervention's effect, weighting each study by its sample size and statistical precision. Because it combines evidence across studies, a meta-

a pooled prevalence of non-adherence of 46% and identified impaired insight as a primary structural driver of non-adherence (Zewdu et al., 2025). A secondary analysis found that patients with moderate-to-severe insight impairment became medication non-adherent significantly earlier than those with intact insight (Kim et al., 2020). As we revisit later, the clinical and administrative tracking of anosognosia has only recently been standardized through the introduction of the ICD-10-CM code R41.85 (Anosognosia), effective October 1, 2024.

Despite its foundational role in justifying civil commitment, anosognosia, perhaps due to its lack of a diagnostic code prior to October 2024, remains largely unexplored in empirical evaluations of AOT programs. To date, to our knowledge, no published study has tested the baseline prevalence of anosognosia in AOT populations, whether a given participant's baseline anosognosia severity predicts their engagement with AOT over time and subsequent outcomes, or whether sustained participation in an AOT program gradually improves clinical insight across time, though this improvement is often asserted by reference to anecdotes in advocacy materials. The intervention's core theoretical logic (i.e., that a court order can interrupt cycles of treatment non-adherence even while a participant lacks illness awareness) remains empirically untested. For program evaluators, this is an important prospective research frontier. If insight impairment is the primary ethical and clinical justification for court-ordered care, examining its role as a moderator of AOT outcomes and tracking whether program engagement is associated with measurable gains in insight are important research questions for the field to take on going forward. We return to this point in the *Limitations* section of the present report.

analysis can detect effects too small to register reliably in any single study and can quantify how much the effect varies across implementations. Meta-analyses are typically embedded within systematic reviews, which is why they sit near the top of the "hierarchy of evidence".

Figure 1. *Conceptual Path Diagram of the Association Between Anosognosia and AOT Process and Outcomes*



The Black Robe Effect: What It Is and Why It Matters in New Mexico

The central, though frequently debated, behavioral mechanism by which AOT is theorized to induce treatment compliance is commonly referred to as the black robe effect. The black robe effect suggests that judicial authority and the symbolic presence of a judge exert a unique psychological influence on participant behavior, while concurrently placing a parallel accountability pressure on treatment providers to prioritize AOT participants for services (Treatment Advocacy Center [TAC], 2021).

The term black robe effect was coined by the TAC to capture the idea that a judge's authority and a participant's engagement with formal court process meaningfully increase the likelihood that a participant will engage with prescribed psychiatric treatment (Stettin et al., 2019; Hancq et al., 2024; Treatment Advocacy Center, 2025). The elements TAC assembles under this heading map onto two conceptually distinct compliance pathways that the literature treats interchangeably but that operate through different psychological mechanisms.

1. **The Deference and Accountability Pathway:** The first pathway holds that an AOT court order produces compliance through the legal-rational standing of the court itself, independent of how the participant experiences the process of their participation. Under this pathway, the means by which AOT causally leads to better participant outcomes (i.e., increased medication compliance; increased engagement with treatment providers) is located in the participant's recognition of the judge as an authority figure and the symbolic gravity of a binding legal instrument, such that, in the words of a sitting AOT judge, "just the knowledge of the existence of the order to the participant creates a black robe effect to comply" (Treatment Advocacy Center, 2025).

2. **The Procedural Justice Pathway:** The second pathway holds that the AOT court order produces compliance not through the court's authority, per se, and deference/respect accorded thereto, but through the participant's experience of the process of program participation as fair. Tyler (2006) presented evidence that perceived legitimacy and fairness predict compliance more reliably than the threat of sanction, and that individuals who experience legal authorities as neutral, respectful, and trustworthy are more likely to internalize legal norms. Within the TAC inventory, the elements that fit this pathway are the perception that an impartial third party has heard both sides and validated the participant's treatment plan and the motivational role of the judge during status hearings, where compassionate involvement is theorized to confer voice, respect, and recognition (Stettin et al., 2019; Treatment Advocacy Center, 2025)[4].

Despite being conceptually distinct, the two theoretical pathways are rarely separated in empirical work. Recent national evaluations have linked perceived procedural justice to better treatment retention outcomes (Johnson et al., 2024), but most studies still treat the black robe effect as a single construct rather than testing deference and procedural justice as competing mechanisms.

Which pathway is the true pathway through which the program exerts its causal effect carries concrete operational stakes for New Mexico because each pathway implies a different model for scaling up AOT across judicial districts. If compliance-deference does most of the causal heavy-lifting, then the mere presence of a judicial order may be sufficient to promote enhanced treatment compliance and program engagement, and uniform implementation across the state's judicial districts can rely primarily on that presence (i.e., differences in program implementation features across sites would have less of an effect on likely programmatic success). However, if procedural justice is the primary active theoretical ingredient, then implementation quality depends on features that are likely far more variable across judicial districts in practice (e.g., dedicated docket time, opportunities for participant voice, and the consistency of judicial demeanor across rural and urban benches). On the provider side, the same two-pathway ambiguity applies. AOT orders are used in New Mexico to compel providers to prioritize patients across difficult-to-reach geographies; whether, and to what extent, providers respond to that pressure because of the order's

[4] The AOT-specific evidence complicates the account. Munetz et al. (2014) found that former AOT participants reported higher perceived coercion and lower procedural justice from judges than mental health court graduates, and Goulet et al. (2023), in a Quebec community treatment order analog, found that patient experiences ranged from resignation to resistance, with one participant describing the order as "a type of a prison" even as psychiatrists reported the same orders proceeding "without much coercion."

formal authority (analogous to the compliance-deference pathway) or because of ongoing accountability to the court over time (analogous to the procedural-justice pathway) has not been established empirically.

How AOT Programs Operate: Process, Best Practices, and Cross-State Variation

The literature on AOT effectiveness pays less attention than one might expect to how programs are actually structured and delivered. This is an important research gap because the idea of what AOT should be encompasses a wide range of implementations that differ substantially in who initiates the process for participant referral, which services are bundled with the court order, how and to what extent the court remains involved over time, and what happens when participants disengage. A clear picture of how AOT is supposed to work, what high-quality implementation looks like, and where states differ is useful background for evaluating any specific program and for situating New Mexico's statute within the national landscape of AOT programs. In what follows, we describe the canonical AOT process as articulated in the most-cited implementation guide, summarize the major dimensions of state variation, and identify the program implementation features most consistently linked to better outcomes, to the extent that these are known.

The Canonical AOT Process: Nine Essential Elements

The Treatment Advocacy Center and the American Psychiatric Association's SMI Adviser jointly produced what has become the most-cited implementation guide in the AOT field: Stettin et al.'s (2019) *Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results*. The white paper describes nine essential elements that, in the authors' view, distinguish a well-implemented AOT program from a program that is AOT in name only.

1. Systematic identification of individuals within the service area who appear persistently non-adherent and meet statutory criteria.
2. Affirmative initiative by the mental health system to gather evidence and petition the court, rather than placing that burden on family members or other community actors.
3. Safeguards for participants' due process rights at all stages of the proceeding.
4. Clear and ongoing lines of communication between the court and the treatment team.
5. Provision of evidence-based services focused on engagement, stability, and safety in the community.
6. Continual evaluation and adjustment of the participant's treatment plan throughout the AOT period.
7. Specific protocols for responding when a participant struggles to engage.
8. End-of-period evaluation to determine whether the order should be renewed, transitioned to voluntary care, or terminated.
9. Continued connection to needed services upon transition out of the program.

Stettin et al. (2019) also describe operational building blocks for setting up an AOT program: securing buy-in from court, mental health, and law enforcement leadership; reaching a shared understanding of the governing statute and funding streams; agreeing in advance on the appropriate level of judicial engagement; establishing a clear oversight mechanism; codifying policies, procedures, and forms; and

committing to ongoing data collection for program improvement. Stettin et al. (2019) note that no implemented program incorporates all of these features in full. Rather, their framework is better thought of as a reference point against which programs can be benchmarked, not necessarily a description of the standard practice of any one specific AOT program.

Walking Through the Canonical Workflow

In Figure 2, we present a stage-by-stage visualization of the canonical AOT workflow. Prospective candidates for AOT referral are typically adults with SMI (i.e., most often schizophrenia-spectrum disorders, schizoaffective disorder, or bipolar I) who have a documented history of repeated psychiatric hospitalizations, incarcerations, or recent serious violence toward self or others, alongside a pattern of disengagement from voluntary outpatient care. Many also have significant anosognosia and do not regard themselves as needing the treatment being ordered, which is part of the clinical rationale for using a court-ordered framework with this population in the first place, though the latter is typically not a formal statutory requirement for referral.

Prospective candidates for AOT are typically identified through one of two pathways: step-down referrals from inpatient psychiatric care or correctional discharge, and step-up referrals from community sources. Typically, an authorized petitioner, as defined by statute, files a verified petition with the appropriate civil court, supported by an affidavit. Before the hearing, the designated local mental health authority usually conducts a pre-petition investigation to determine whether the respondent meets the statutory eligibility criteria, including the anchor criteria (i.e., number of hospitalizations within a specific period before the referral; the volume of violence-involved criminal charges picked up within a specific period before the referral). The court then holds a civil hearing at which the respondent has the right to counsel, and most state statutes apply a clear-and-convincing evidence standard consistent with the Supreme Court's holding in *Addington v. Texas*, *441 U.S. 418* (1979). If the court grants the petition, it enters a written order that, under best practice, incorporates a treatment plan which specifies the categories of services to be provided and the clinical team responsible for each, while leaving specific medications and dosages out of the order itself so that the clinical team retains flexibility to adjust treatment over time (Stettin et al., 2019).

Once the order is in place, the treatment team delivers services under a regime more intensive than ordinary outpatient care. Well-implemented programs typically combine outpatient pharmacotherapy and medication management, intensive case management or ACT-fidelity services, peer support, and housing assistance, and treat the listed treatment plan as a binding clinical agreement rather than as a procedural formality.

The court and the treatment team remain in regular contact during the order. In “active court” models of AOT, status hearings are scheduled at regular intervals, often every 30 to 90 days, and the treatment team, AOT coordinator, and participant appear together. In “passive court” models, the court receives written reports from the treatment team and intervenes only when the team flags material non-adherence (Hancq et al., 2024). When a participant disengages, the protocol begins with clinical outreach and plan revision. In jurisdictions whose statutes authorize it, the physician may request a peace officer to transport the participant to a hospital for up to a 72-hour evaluation, after which the team and the court decide whether to continue, modify, or escalate the order (Stettin et al., 2019). At the end of the order period, the team

and the court evaluate whether to seek renewal, transition the participant to voluntary care, or graduate the participant with a documented warm handoff to continuing services (Stettin et al., 2019; ASPE, 2024).

Figure 2. *The Canonical AOT Process Workflow*

AOT in New Mexico: Legislative History and Implementation

New Mexico's path to AOT legislation reflects both national trends and the state's unique behavioral health context. Recent legislative reports highlight known statewide gaps in access to behavioral health services and the reasons for these gaps, including workforce shortages, limited provider availability, and acute rural access challenges across much of the state (New Mexico Legislative Finance Committee, 2023; New Mexico Legislative Finance Committee, 2024). These conditions have contributed to a pattern in which individuals with SMI within the state frequently interact with law enforcement, cycle through emergency departments, and experience homelessness rather than receiving sustained outpatient care.

The initial push for an AOT statute in New Mexico came against the backdrop of a series of high-profile incidents that drew sustained attention to gaps in the state's behavioral health system. The 2014 fatal shooting of James Boyd by Albuquerque Police Department officers in the Sandia Foothills, which involved an individual with a documented history of mental illness, contributed to public debate about how the state responds to behavioral health crises (Oxford, 2016). The New Mexico Legislature enacted the Assisted Outpatient Treatment Act in 2016 (NMSA § 43-1B-1 et seq.) against this broader backdrop, which created a statutory framework for family members, hospital directors, treatment providers, and other designated parties to petition a district court judge for an order directing an adult with mental illness to participate in a specified outpatient treatment plan.

What Makes New Mexico's AOT Statute Distinctive

Several features set New Mexico's AOT statute apart from most other state statutes. One such feature is that the statute does not give courts enforcement powers beyond the symbolic authority of the court order itself. A respondent's failure to comply with an AOT order is not grounds for involuntary civil commitment or contempt of court (NMSA § 43-1B-13). However, the statute does provide a narrow, clinically-gated pathway to emergency evaluation:

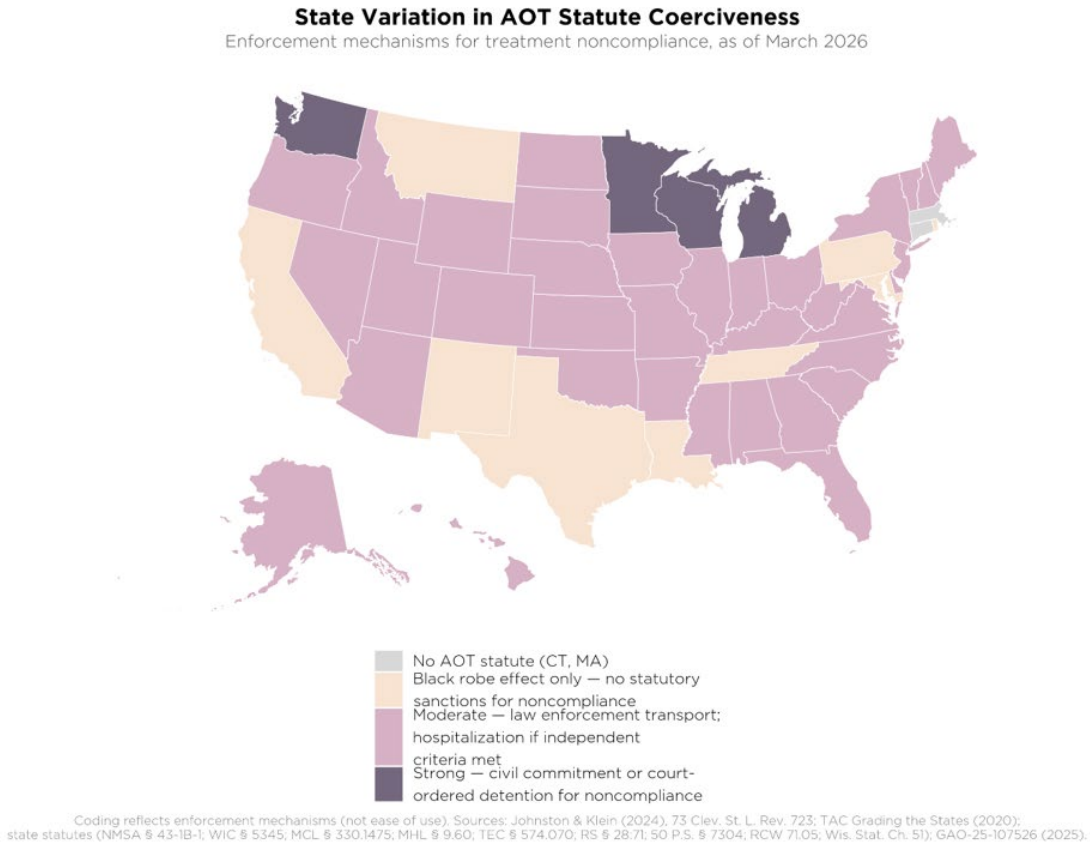
> *If a qualified professional determines that a respondent has materially failed to comply with the assisted outpatient treatment as ordered by the court, and believes that the respondent's condition is likely to result in serious harm to self or others, and that immediate detention is necessary to prevent such harm, the professional shall certify the need for detention and transport for emergency evaluation.* - NMSA § 43-1B-13.

Importantly, this mechanism is clinician-triggered, not court-triggered. It requires the harm-to-self-or-others standard to be met and routes the participant into the emergency evaluation pathway under the broader Mental Health and Developmental Disabilities Code.

Coercion in AOT statutes can be defined concretely along several dimensions: the breadth of eligibility criteria, the duration and renewability of initial orders, whether the statute permits court-based enforcement of the underlying order through contempt or civil commitment, whether peace-officer transport for noncompliance is authorized, and whether mandated medication adherence is administered or enforced.

Taken together, these features place New Mexico's AOT in the lower-coercion range of state statutes (see Figure 3). Failure to comply with the order is not itself grounds for involuntary civil commitment, contempt of court, forced medication, or the use of physical force or restraints, and the statute applies a least-restrictive-alternative standard with an emphasis on community-based services. By contrast, statutes such as New York's Kendra's Law authorize peace-officer transport of non-compliant participants for up to 72 hours of hospital observation and allow initial orders of up to twelve months with renewable terms. In New Mexico, noncompliance with an AOT order carries no comparable statutory sanction; the generally available emergency-evaluation pathway remains in place when statutory harm criteria are independently met, but it is not a tool the AOT order itself creates. The statute also requires local governments to contract with district courts to fund AOT programs, resulting in a decentralized implementation model and variation in program availability across counties (see Figure 4).

Figure 3. *State Variation In Assisted Outpatient Treatment Statute Coerciveness, June 2026*



Operating Programs

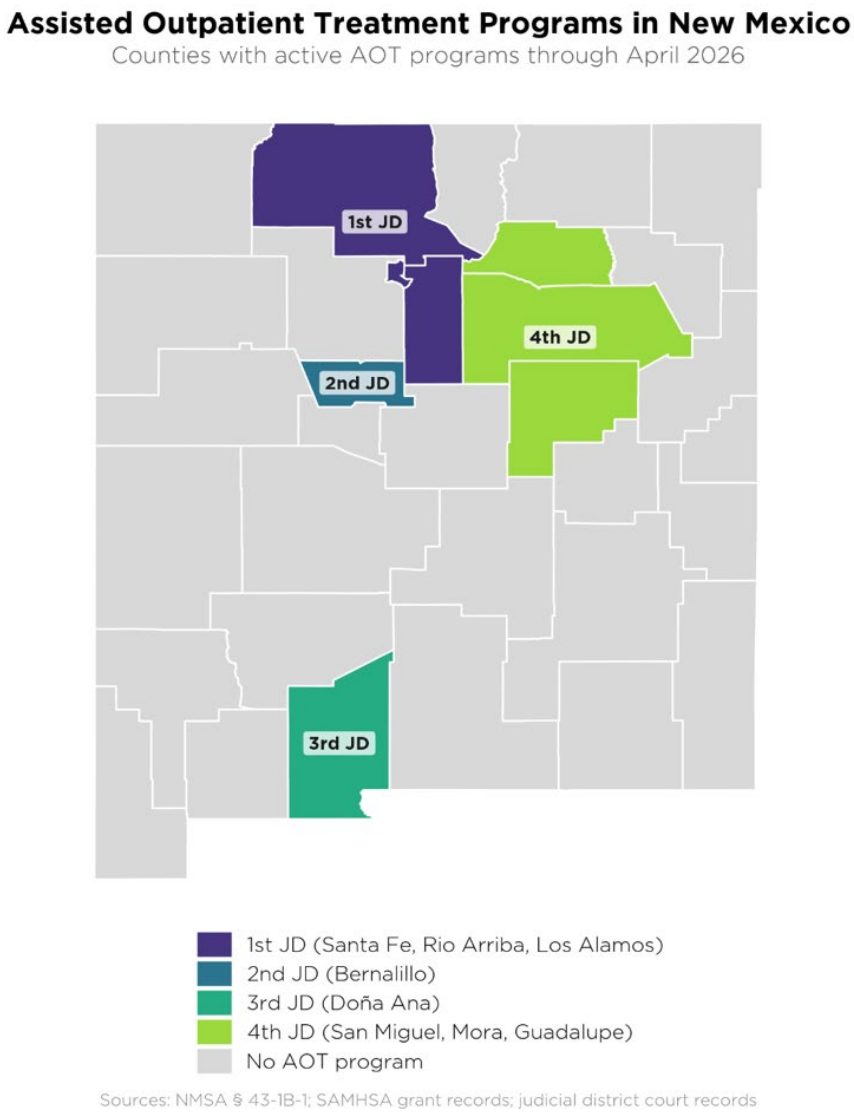
The first AOT program in New Mexico was established in Doña Ana County in 2016 under a four-year SAMHSA grant administered through the Third Judicial District Court. A second AOT program was implemented in Bernalillo County in 2019, also SAMHSA-funded, operating through the Second Judicial District Court in partnership with the City of Albuquerque's Department of Family and Community Services (City of Albuquerque, 2019; Second Judicial District Court, 2024). Two additional programs

came online in 2025 under state appropriations: the First Judicial District Court launched an AOT program serving Santa Fe, Rio Arriba, and Los Alamos counties on January 23, 2025, and the Fourth Judicial District Court launched a program serving San Miguel, Mora, and Guadalupe counties in November 2025. Together, these four programs, as of this report's drafting, constitute the entirety of court-ordered outpatient treatment currently operating in the state.

A defining structural feature of AOT in New Mexico, with implications for both delivery and evaluation, is its decentralization. Programs are administered at the judicial district level rather than directly through the New Mexico Administrative Office of the Courts, and each was established at different times, with different funding sources, and within different local court and district-specific sociodemographic contexts. As a result, the programs vary on practical dimensions that may correlate with subsequent outcome realization, such as eligibility intake, staffing capacities, status-hearing cadence, and the strength of connections to housing, peer support, and other wraparound services[5].

[5] Public documentation of these differences across districts is currently limited, though we are working on a process evaluation to address questions about cross-district variability in AOC implementation (Wilkins & Severson, 2026).

Figure 4. *Variation Across New Mexico Counties In AOT Implementation, April 2026*



This decentralization is consistent with the broader implementation literature, in which AOT implementation has varied widely across sites in ways that the 2025 Government Accountability Office (GAO) report identified as a primary challenge to drawing causal conclusions about which program features predict changes in participant outcomes (U.S. Government Accountability Office, 2025; Hancq et al., 2024).

For evaluation purposes, we note that decentralization across districts in various implementation features, although perhaps desirable from the perspective of making programs locally responsive and adaptable, complicates the ability to systematically evaluate programs across the state in two primary ways. First, outcomes observed in any one district could simply reflect unstandardized district-level program design elements (e.g., staffing of behavioral health supports) or geospatial/sociodemographic characteristics (e.g., proportion rural) as much as the underlying AOT mechanism itself, and second, pooling results

across districts risks masking substantively meaningful variation in how the orders are implemented and experienced.

Recent Legislative Activity: Senate Bill 3 (2025) and Senate Bill 3 (2026)

New Mexico's behavioral health system and the implementation environment for AOT programs have been reshaped by two recent waves of legislation. In 2025, the state legislature passed a coordinated package: Senate Bill 3, the Behavioral Health Reform and Investment Act (SB 3 2025), which restructured how behavioral health services are delivered statewide and divided New Mexico into 13 behavioral health regions, each tasked with identifying local priorities and submitting four-year plans through a new Behavioral Health Executive Committee; Senate Bill 1, which established a permanent Behavioral Health Trust Fund, with disbursements scheduled to begin in July 2026; and Senate Bill 2, which appropriated $200 million in seed funding for the trust (SB 2 2025). Together, this package began building both the delivery infrastructure and the financial scaffolding to support the expansion of the AOT program implementation beyond Bernalillo and Doña Ana counties. In 2026, the state legislature returned to a related question. Senate Bill 3 (SB 3 2026) updated the legal definitions of "harm to self" and "harm to others" in the AOT statute, broadening the criteria so that courts can initiate AOT earlier in a person's decline rather than waiting for an acute crisis.

The combined effect of these statutory changes was to widen the legal pathway into AOT from both the civil and criminal sides and to begin assembling the funding architecture to support statewide expansion of the program, but it is important to note that the statutes did not, on their own, add treatment capacity. Whether program expansion translates into additional participants receiving care will depend on whether community providers, case managers, and crisis-response teams can deliver the services the orders require.

Where Implementation Differs Across Sites

AOT implementation varies across sites along several dimensions: who initiates orders, how often the court convenes, what services are bundled with the order, and how the system responds when participants disengage. The academic literature, however, offers little guidance on which of these choices matter. To this end, Hancq et al. (2024) identified this as one of the field's larger gaps, noting that no published research has tested how process elements, such as the level of judicial engagement or the design of treatment-team accountability, are associated with outcomes.

However, the Johnson et al. (2024) Office of the Assistant Secretary for Planning and Evaluation (ASPE) evaluation of the SAMHSA AOT Grant Program was a partial exception. Across the six pilot sites, Johnson et al. reported heterogeneity at most implementation stages of the AOT process. At the eligibility stage, all participating states required some combination of an inability to meet basic needs and an unwillingness or unlikelihood to accept voluntary treatment, but practices diverged. In two sites, judges refused to issue an order to anyone who would not sign a voluntary agreement, a practice Johnson et al. described as inconsistent with state law. The share of petitions that resulted in orders varied widely: it was 100% at three sites, while the other three dismissed a nontrivial proportion of petitions. Initial hearings differed in average length, in whether the respondent was required to attend, and in how often attendance

was waived. Post-enrollment processes also differed across the same six sites. Periodic status hearings were used at three of six sites and not at the other three. Some providers issued pick-up orders for material non-compliance, whereas others did not. Renewal and closeout procedures, as well as the length of the initial order, also differed (e.g., 90 days at LifeStream versus 12 months at three sites). On the service side, five of the six sites used some form of assertive community treatment (ACT), but Johnson et al., (2024) noted that fidelity to ACT was neither consistently observed nor evaluated, and that AOT and ACT were sometimes discussed together by providers, even though they were intended to be distinct services. Dedicated AOT teams were in place at four of six sites; the remaining two bundled AOT with existing clinical teams.

GAO's 2025 review extended a version of this analysis into the next SAMHSA grant cohort. Among the six 2020-cycle grantees the GAO interviewed, five accepted voluntary participants and four allowed participants with pending criminal charges to enroll, two of which suspended or waived criminal charges contingent on AOT participation (GAO, 2025). ASPE's (2024) implementation report had flagged both practices as complicating any evaluation of AOT: voluntary enrollment conflicted with the underlying intent of an involuntary order, and enrolling participants with pending criminal charges introduced meaningful differences in the court orders themselves, the monitoring those participants received, and the consequences attached to nonadherence.

Implementation and process design matter because they directly shape whether an AOT program produces its intended outcomes among program participants. For example, Johnson et al. (2024) estimated that between 21% and 32% of the observed changes in clinical functioning outcomes (e.g., the modified Colorado Symptom Index, violence, suicidal ideation) was accounted for by a participant having appeared before a judge for at least one status hearing, with treatment adherence explaining an additional 6 to 14%. Moreover, the authors noted that status hearings and treatment adherence, considered together, accounted for roughly 72% of the observed change in mental health emergency department (ED) visits (Johnson et al., 2024). It is also important to note that some of these site-level differences were operationally observed but not statutorily specified. Order length, judicial engagement, responses to non-compliance, and accountability structures all varied across sites in ways not always explicitly set out in the governing statute. For an evaluation of any one AOT program, this means that documenting the statute's language is necessary but not a sufficient condition for understanding the on-the-ground implementation realities of program set-up; the operational choices that shape what the program actually does on the ground have to be quantified and measured directly at the site level.

Where State AOT Statutes Differ

Although the typical process flow of how AOT is supposed to work is well described, state statutes differ on several dimensions that meaningfully shape how programs operate. We summarize some of these key statutory differences below:

- **Who has standing to petition.** New York's Kendra's Law allows a broad set of petitioners, including roommates and adult relatives, hospital directors, treating psychiatrists, and probation officers (New York State Office of Mental Health, 2005). California's Laura's Law historically restricted petitioning to the county mental health director or designee, and the 2022 CARE Act

established a parallel civil-court pathway that opened petitioning to family members, household members, first responders, and providers. Florida limits petitioning to the administrator of a receiving facility or a designated department representative. Who has standing affects who actually gets enrolled and how quickly the system can act on identified candidates. The 2024 audit of New York's Office of Mental Health by the Office of the State Comptroller found considerable variation in how quickly local governmental units completed pre-petition investigations, with some routinely taking longer than six months despite an OMH guidance target (Office of the New York State Comptroller, 2024). The audit's findings reinforce the Stettin et al. (2019) emphasis on the system's affirmative duty to identify and act on candidates.

- **The eligibility threshold.** The 2025 GAO report found that 32 of the 47 states with AOT statutes use a "preventive" standard that allows an order to be issued based on predicted future deterioration, rather than current dangerousness. The rest require evidence that the respondent poses a present danger to self or others (U.S. Government Accountability Office, 2025). The preventive standard, which New Mexico's statute employs in modified form following SB 3's 2026 clarifications to "harm to self" and "harm to others," is generally regarded as more permissive of earlier intervention than a strict current-dangerousness standard.
- **Initial order duration and renewal pace.** The GAO report found that 17 states use a 90-day initial term, 15 use a 180-day initial term, 9 use a 12-month initial term, and 2 use a 60-day initial term (U.S. Government Accountability Office, 2025). Renewals across most state AOT regimes extend orders for up to 12 months at a time (e.g., NMSA § 43-1B-11; N.Y. Mental Hygiene Law § 9.60(k)). This dimension matters because, as noted below, order duration is one of the few process features for which the research base supports a relationship to outcomes.
- **Enforcement.** New York's Mental Hygiene Law § 9.60(n) authorizes a peace officer to take a non-compliant participant into custody and transport them to a hospital, where they may be retained for observation, care, and evaluation for up to 72 hours, though not for forced medication. California, Texas, and Arizona have similar but variably used provisions. A number of state statutes, including New Mexico's, attach no court-based enforcement to the AOT order itself (NMSA § 43-1B-13; Center for Public Representation et al., 2025). New Mexico sits at the lower-coercion end of this dimension: failure to comply with an AOT order is not grounds for involuntary civil commitment, contempt of court, or forced medication, and the only statutorily authorized detention pathway is a clinician-certified one, available only when material noncompliance is accompanied by likelihood of serious harm to self or others (NMSA § 43-1B-13). The decision to attach or omit a court-based enforcement mechanism is arguably the most consequential design choice in any AOT statute, because it determines whether the order functions as a binding legal obligation or an advisory one.
- **The service array the order can require.** State statutes vary in how prescriptive they are about which services an AOT order can or must include. New York's Kendra's Law explicitly enumerates a broad service menu (e.g., case management or assertive community treatment, medication, therapy, day or partial-day programming, educational and vocational supports, substance use treatment, and supervision of living arrangements) as services a court may order (N.Y. Mental Hygiene Law § 9.60(a)(1)). New Mexico's statute, by contrast, leaves the service array largely to the treatment team rather than specifying it in the law itself, with the order incorporating whatever plan the clinical team develops (NMSA § 43-1B-1 et seq.). In practice, what an order can actually mobilize depends as much on the local service system as on the

statutory text. Houston's AOT model illustrates the more integrated end of the spectrum, combining housing support, employment services, transportation, peer support, and multisystem liaisons that connect hospitals, courts, and clinical providers in a coordinated treatment pathway (Gearing et al., 2024; Washburn et al., 2025). Most implemented programs are less comprehensive, in part because the wraparound services Houston bundles together are not commonly named or required under state AOT statutes.

Best Practices and Process Features Linked to Outcomes

A consistent set of process features turns up across implementation guides, federal evaluations, and outcome studies. The New York evaluation by Swartz et al. (2009) identified several conditions associated with stronger AOT performance, including the pairing of orders with a meaningful infusion of new service capacity (e.g., intensive case management or ACT-fidelity services), orders lasting at least six months, the court order's effect on stimulating providers to prioritize AOT recipients for care, and the importance of judicial training and process consistency.

The systematic review by Lam et al. (2023) of 16 AOT studies reported significant effects on service engagement in pre-post designs, which compare participants' outcomes after enrollment to their own pre-enrollment baseline, and non-significant effects in case-control designs, which compare AOT participants to a separate non-AOT group matched on observable characteristics. We return to this contrast in the *Limitations* section.

The ASPE (2024) issue brief on judicial involvement used an engagement-plus-contact framework that rated six judicial behaviors and highlighted, among them, the use of periodic status hearings and direct communication between the judge and the treatment team.

Gearing et al. (2024) reported that the Houston AOT model's results rested on housing-first integration, inclusion of peer support specialists on the treatment team, an active court schedule with regular status hearings, and multi-system liaisons to coordinate across the court, hospital, and community providers.

The Johnson et al. (2025) multi-site evaluation identified two features with the largest moderating effects on outcomes: order duration of at least six months and successful order completion. Longer orders were associated with larger reductions in violent behavior (24.5% vs. 14.7%), suicidal ideation (27.4% vs. 21.4%), psychiatric inpatient nights (14.5 vs. 2.5 fewer), and homelessness (20.5% vs. 8.3%). Johnson et al. (2025) also reported that the step-up versus step-down referral pathway was not associated with outcome differences, and participants with criminal justice involvement at baseline showed treatment adherence and clinical functioning gains comparable to those without, alongside larger reductions in violent behavior (28.8% vs. 14.5%) and drug use (23.7% vs. 9.5%). Together, those findings suggested that excluding justice-involved candidates from program consideration was not supported by the available evidence.

The strength of the evidence behind these features varied. Order duration and order completion were the only ones whose links to outcomes had been tested in a multi-site quasi-experimental design[6] (Johnson et al., 2025). The rest were derived from descriptive program evaluations, implementation guides, and expert consensus and, to our knowledge, had not been formally compared across implementations.

The Evidence Base on Outcomes: What AOT Studies Have Found

Treatment Adherence and Clinical Outcomes

Evidence on AOT's effects on treatment engagement and clinical functioning varies across study designs. RCTs are the strongest test of whether AOT itself drives observed outcomes, because random assignment makes the AOT and comparison groups similar at baseline, while observational and pre-post studies cannot fully rule out the possibility that participants would have improved (or worsened) for reasons unrelated to the order. The earliest RCT, the Bellevue Hospital pilot conducted by Steadman et al., using data from 1994 and 1997, randomly assigned 142 individuals to AOT or to an equally intensive package of voluntary community services and found no significant differences between the two groups in rehospitalization rates, arrest rates, quality of life, symptoms, or treatment adherence (Steadman et al., 2001). The North Carolina RCT, using data from the mid-1990s, reported improved treatment adherence only among participants who remained on outpatient commitment for six months or longer alongside intensive services (Swartz et al., 2001), and early small-sample observational work from Ottawa and Multnomah County, Oregon reported higher rates of service contact and medication use among recipients of outpatient commitment relative to comparison groups (O'Brien & Farrell, 2005; Pollack et al., 2005).

Later observational evidence from New York's Kendra's Law program, drawing on administrative and clinical data collected between 1999 and 2007 as part of the Duke evaluation, reported higher medication adherence, higher appointment attendance, and greater engagement with case management among AOT clients than among non-AOT comparison groups (Busch et al., 2010; Swartz et al., 2010; Van Dorn et al., 2010). The Oxford Community Treatment Order Evaluation Trial (OCTET) randomized 333 patients in England between 2008 and 2011 and found no significant difference in hospital readmission rates between full community treatment orders (CTOs) and a comparison group of those placed on brief Section 17 leave (i.e., a UK Mental Health Act mechanism that allows detained patients to live in the community under the conditions of their existing hospital detention order), with no meaningful differences across order duration or recipient subgroups (Burns et al., 2013; Rugkåsa et al., 2015). Of note, UK CTOs differ from U.S. AOT statutes in important ways, but the OCTET findings are consistent with the Bellevue RCT results.

Three subsequent systematic reviews and meta-analyses have produced mixed conclusions on the association between AOT program participation and clinical outcomes: Barnett et al. (2018) pooled 41

[6] A quasi-experiment compares participants who received an intervention to a comparison group constructed without randomization, using statistical or design techniques (e.g., propensity matching, instrumental variables, or difference-in-differences) that approximate the comparison an RCT would generate. Quasi-experiments are stronger than ordinary observational studies because they explicitly attempt to address selection bias, but weaker than RCTs because they rely on assumptions about the comparison group that cannot be fully verified. They are the workhorse design when randomization is impractical or unethical, as is often the case with court-ordered treatment.

studies and found large effects favoring CTOs over comparison groups for hospital admissions, community service use, and treatment adherence, while noting that the largest associations were observed within pre-post studies, which compare participants to themselves before and after AOT but yet which tend to overstate program effects because people typically enter AOT at a crisis point and would have improved to some degree regardless; Lam et al. (2023) reported significant service-engagement associations only in the subset of 16 pre-post CTO designs, whereas results from case-control studies were not significantly different; and Kisely, McMahon, and Siskind (2023) found that CTO benefits shrank as rates of CTO use rose across jurisdictions, suggesting that gains in low-use settings may reflect who gets selected for an order rather than what the order itself does.

The most recent multi-site U.S. evaluation, across six SAMHSA-funded AOT programs between September 2017 and March 2021, found that among 392 AOT clients, appointment and treatment adherence improved by more than 24% and 20%, respectively, at 6- and 12-month follow-up relative to baseline, alongside improvements in symptoms, self-rated mental health, life satisfaction, and therapeutic alliance (Johnson et al., 2025); Houston-specific analyses from the same effort reported a 31% increase in medication adherence among 175 participants (Washburn et al., 2025).

Psychiatric Hospitalization

The earliest RCT evidence on AOT and hospitalization came from the Bellevue pilot, which reported no significant difference in rehospitalization rates between those randomly assigned to AOT and those in the control group (Steadman et al., 2001). The North Carolina RCT similarly showed no overall effect on hospitalization, though longer-duration orders combined with intensive services were associated with fewer admissions in follow-up analyses (Swanson et al., 2000; Swartz et al., 2001). Early descriptive evaluations from Ottawa, Washington, D.C., and Seminole County, Florida reported reductions in admissions and inpatient days but were limited by small samples and the absence of comparison groups (O'Brien & Farrell, 2005; Zanni & Stavis, 2007; Esposito et al., 2008).

The New York State Office of Mental Health's evaluation of Kendra's Law, covering enrollment from November 1999 through mid-2004, found that 77% fewer participants were hospitalized during enrollment compared with the three years prior, alongside a 56% reduction in length of hospital stay and a 44% reduction in harmful behaviors (NYS OMH, 2005). The Duke-led re-analysis of the same Kendra's Law cohort reported a 25% reduction in odds of admission during the first six months of an order and an additional 33% reduction during the next six months, with reductions persisting for six months after the order ended but tapering off thereafter, particularly without ongoing intensive case coordination (Swartz et al., 2010; Van Dorn et al., 2010).

The Cochrane systematic reviews by Kisely et al., drawing on the available RCT evidence, found that involuntary outpatient commitment did not produce statistically significant reductions in hospitalization beyond what intensive voluntary services already achieved (Kisely et al., 2011; 2017). The 2017 update, which incorporated OCTET, put the magnitude in concrete terms: 142 people would need to be placed under a CTO to prevent one additional rehospitalization compared with voluntary intensive services. The other 141 of every 142 would have had the same hospitalization outcome whether or not they were placed under the court order. The only positive clinical outcome in the meta-analysis was a reduction in

victimization, which was classified as low-quality evidence. A two-year Spanish study from Valencia found similar null results on hospitalization between outpatient commitment recipients and matched controls (Castells-Aulet et al., 2015).

Subsequent large administrative studies from outside the U.S. have produced more positive but non-randomized results: Harris et al. (2019) examined New South Wales records on 5,548 patients and found that CTOs were associated with lower likelihood of readmission and longer time to readmission while in force, and Beaglehole et al. (2021) examined 14,726 patients in New Zealand and reported significant decreases in admissions and increased psychiatric medication delivery, though neither could fully account for the clinical severity that drives CTO use. Munetz et al. (2019), examining 74 Summit County, Ohio AOT participants, reported significant reductions in admissions and inpatient days both during and after court orders, and notably found that AOT alone was associated with reductions comparable to AOT paired with an ACT team. A small observational study in Kentucky reported a 53% decrease in hospitalizations during AOT and a 67% reduction post-AOT among 67 participants, with parallel reductions in Medicaid spending (Brown et al., 2025). The Johnson et al. (2025) multi-site evaluation found that participants who spent at least six months under an AOT order showed larger reductions in psychiatric hospitalizations than those with shorter orders (14.5 fewer inpatient nights versus 8.3), a pattern echoing the longer-duration findings across the North Carolina, Kendra's Law, and Summit County cohorts.

Violence and Suicidal Ideation

The earliest evidence on AOT's effects on violence and suicidal ideation came from the North Carolina RCT, where outpatient commitment combined with intensive services was associated with both reduced violent behavior and reduced victimization among people with SMI (Swanson et al., 2000; Hiday et al., 2002), suggesting that structured treatment engagement may offer protective benefits beyond reducing harmful behavior by participants themselves. Subsequent New York observational analyses using mid-2000s data found lower rates of serious violence and suicidal behavior, alongside improved illness-related social functioning, among AOT participants relative to similar recently discharged comparisons (Phelan et al., 2010). The Johnson et al. (2025) multi-site evaluation found larger reductions in violence risk (24.5% versus 14.7%) and suicidal ideation (27.4% versus 21.4%) among participants who remained under AOT orders for longer periods, and the Houston site reported an 80% reduction in domestic violence incidents (Washburn et al., 2025). The most recent systematic review and meta-analysis on this domain pooled 11 CTO studies and found no significant benefits on aggression or criminal behavior, with null results holding across analyses by study design and comparison condition (Kisely, Bull, & Gill, 2025).

Arrest and Criminal Justice Contact

Evidence on AOT and criminal justice involvement is similarly mixed. The earliest data on this front came again from the North Carolina RCT, where participants on AOT orders longer than six months were significantly less likely to be arrested than individuals in a control group (Swanson et al., 2001), and small-sample observational work from Florida reported a 72% decrease in average days incarcerated among 21 participants (Esposito et al., 2008). The most cited observational evidence comes from the New

York AOT evaluation, where Gilbert et al. (2010), using data on participants from 2007 to 2009, found that individuals currently under or recently discharged from AOT orders had lower odds of arrest than comparable individuals with SMI who had not initiated AOT (1.9% under AOT versus 3.7% prior to AOT); a companion NYC clinic study found similarly reduced overall arrests but no effect on arrests for violent offenses (Link et al., 2011). The National Institute of Justice's CrimeSolutions program rated AOT as "Effective" in 2014 based on the Swanson et al. (2000), Gilbert et al. (2010), and Link et al. (2011) studies. A 2020 re-review of the same three studies under CrimeSolutions' updated Program Scoring Instrument revised the rating to "Promising" (CrimeSolutions, 2020).

The Johnson et al. (2025) multi-site evaluation reported that people with prior justice involvement at the point of AOT enrollment had greater reductions in violent behavior and arrests than those without prior justice involvement, and the Houston site reported a 33% decrease in time spent in correctional facilities (Washburn et al., 2025). The 2024 ASPE outcome report concluded that intensive voluntary services, specifically ACT or comparably intensive case management, produced arrest outcomes broadly comparable to those produced by court-ordered AOT, even for individuals with serious treatment adherence challenges (Johnson et al., 2024). The Kisely et al. (2025) meta-analysis subsequently found no significant CTO benefit on aggression or criminal behavior, consistent with that conclusion.

Social Functioning and Housing

Early analyses of the North Carolina RCT cohort reported reductions in caregiver burden during the first year of commitment and higher quality-of-life scores among participants with longer order durations (Swanson et al., 2003; Groff et al., 2004). Schneeberger et al. (2017), analyzing the New York AOT evaluation data, found that AOT's effects on psychotic symptoms appeared to run through the intensity of, and engagement with, accompanying mental health services rather than through the court order itself. Johnson et al. (2025) found reductions in homelessness at six months in the SAMHSA multi-site sample, though these effects were attenuated by the 12-month follow-up, consistent with the broader pattern in which AOT may produce short-term stabilization without generating durable improvements in social functioning absent ongoing support; participants who successfully completed orders showed greater symptom improvement and reduced homelessness. The Houston AOT Model, which incorporated housing-first elements (with up to twelve months of personal-care-home housing) as a prioritized program component, illustrates one approach to addressing this limitation, and outcomes data from the same site reported a 214% increase in housing stability and a 27% increase in social connectedness across 175 participants (Gearing et al., 2024; Washburn et al., 2025); however, most implemented AOT programs do not include dedicated housing services. The finding that the availability of multiple wraparound services, including housing, employment, and educational supports alongside behavioral health treatment, is more strongly associated with positive outcomes than any single intervention is consistent with the view that AOT's observed benefits may be largely attributable to the intensity of accompanying services rather than to the court order (or the hypothesized mechanisms underlying the black robe effect) itself.

Cost-Effectiveness

Existing research suggests that AOT may produce cost savings through reduced use of emergency and inpatient services, although the size of those savings varies considerably across studies. The earliest cost

analysis, from Seminole County, Florida, reported $14,455 in jail cost savings and $303,728 in hospital cost savings across 21 participants (Esposito et al., 2008). Swanson et al. (2013), analyzing 36 months of data on 634 AOT participants and 255 voluntary intensive-treatment recipients across NYC and five additional New York counties estimated that net costs to the state declined by roughly half in the first year of AOT in NYC and by a larger margin in the five-county sample, with further reductions in the second year, while cautioning that cost-effectiveness varied depending on implementation approach and available resources; a companion analysis found annual costs $17,594 lower for the outpatient commitment group than controls when orders were extended for six months or more in the North Carolina sample (Swartz & Swanson, 2013).

The ASPE outcome report found that AOT was associated with reductions in psychiatric emergency department and inpatient costs, noting that observed savings likely represent conservative estimates because they do not incorporate other potential savings related to public safety, including criminal justice involvement, and that the cost to set up a new AOT program varies widely depending on staff time and is larger when the court is involved throughout the order (Johnson et al., 2024). The most recent observational analysis, from Kentucky, reported Medicaid expenditure reductions averaging $1,326 per participant per month during AOT and $1,105 per month after AOT ended (Brown et al., 2025), broadly consistent with the pattern in larger samples of inpatient care being shifted to less intensive outpatient settings.

Ethical Concerns and Criticisms

AOT remains controversial, with critics raising concerns about coercion, restrictions on individual liberty, and potential harms associated with involuntary treatment. Disability rights advocates have argued that AOT violates the rights of people with SMI to make their own treatment decisions and that it expands the reach of courts into the lives of individuals who have not been convicted of crimes (Alliance for Rights and Recovery, 2025). Empirical work comparing AOT participants with mental health court graduates has found that AOT recipients report higher perceived coercion, lower procedural justice, and less hope at program exit, evidence that some critics interpret as consistent with a broader characterization of AOT as exerting social control over individuals with SMI (Munetz et al., 2014). A coalition of disability rights legal organizations led by the Center for Public Representation has argued that AOT is coercive and potentially ineffective, and that court mandates to adhere to prescribed medications, most often antipsychotics, compel recipients to take medications that may have harmful side effects (Center for Public Representation et al., 2025).

Proponents counter that the autonomy framing assumes a capacity for voluntary treatment decision-making that the AOT-target population often lacks. Because anosognosia commonly impairs the ability of individuals with SMI to recognize their illness or its consequences, advocates argue that a strict "right to refuse" framework can leave those most in need of care without it, with downstream harms including hospitalization, incarceration, victimization, and premature death (Treatment Advocacy Center, 2023). Proponents further contend that AOT should be understood as the least restrictive form of court-ordered intervention, designed to keep individuals in the community rather than in hospitals or jails, and that statutes such as New York's Kendra's Law include procedural safeguards including the right to counsel, an evidentiary hearing, and a specified standard of proof (American Psychiatric Association, 2015; Stettin

et al., 2019). The social control critique is also contested on the grounds that AOT imposes reciprocal obligations on the treatment system itself, requiring providers to deliver evidence-based, person-centered services in a timely manner; in this view, AOT functions less as a tool for controlling participants than as a structured commitment by the mental health system to a population it has historically underserved. Some program evaluations report participant improvements in perceived mental health, life satisfaction, and therapeutic alliance over the course of AOT enrollment, a pattern proponents view as consistent with the argument that AOT can be implemented in ways that participants come to regard as legitimate and helpful, although these subjective measures are typically collected by site clinicians and should be interpreted with that potential source of bias in mind (Johnson et al., 2025). Taken together, these competing perspectives reflect broader, unresolved debates about the appropriate balance between public safety, beneficence, and individual autonomy in mental health public policy.

Methodological Limitations and Research Gaps

The AOT outcome literature has well-known methodological limitations that limit the ability to draw strong, causal conclusions about whether the court order itself drives observed improvements. Recent reviews, including the Kisely, Bull, and Gill (2025) systematic review and meta-analysis, the Lam et al. (2023) systematic review, the Hancq et al. (2024) gap-analysis, and the U.S. Government Accountability Office's 2025 report (GAO-25-107526), converge on a similar set of methods-related concerns. We briefly describe some of the concerns identified in this literature below.

- **Selection bias in observational comparisons**. Studies that compare AOT participants with non-AOT participants risk attributing to AOT what is actually a baseline difference between groups, because individuals referred to AOT tend to be systematically more treatment-resistant and lower-functioning than those who are never referred. The direction of the resulting bias is not always obvious. A simple cross-sectional comparison would tend to make AOT participants look worse than comparison groups at follow-up, since the AOT group enters the comparison from a more impaired baseline. Two related dynamics complicate this picture. First, the matched comparison studies in this literature, such as the Kendra's Law evaluations (Gilbert et al., 2010; Van Dorn et al., 2010; Phelan et al., 2010), adjust for baseline differences on observable characteristics like prior hospitalizations and demographics, but they cannot adjust for the unobserved features that drive AOT referral in the first place, such as clinician judgment about engagement potential, family advocacy, and treatment-team relationships, and the direction of bias from those unobservables is not knowable in advance. Second, AOT enrollees almost always receive a more intensive service package than their comparison groups, so any apparent AOT advantage (which, compared against a comparison group that did not receive the same intensity of wraparound services, may reflect the service bundle rather than the court order itself (a point we return to below). The Kisely et al. (2025) meta-analysis and the GAO (2025) report flag the inability to fully account for these mechanisms as a primary limitation of the case-control literature.
- **Regression to the mean in pre-post designs**. Pre-post designs measure participants against their own pre-enrollment baseline, but AOT referral is, by design, typically precipitated by a crisis event (i.e., recent hospitalizations, decompensation, missed appointments), so the pre-enrollment window is an unusually elevated stretch, and outcomes might naturally drift back toward the

underlying average regardless of intervention. Consider a hypothetical AOT candidate who had five emergency department visits in the month before referral. That month, almost by definition, captured a symptom flare or life disruption severe enough to prompt the referral, and the following months would, on average, show fewer ED visits even if the participant received no intervention at all, because few people sustain that intensity of acute service use once the precipitating crisis passes (i.e., one cannot simply linearly extrapolate trendlines). The widely cited New York State Office of Mental Health (2005) evaluation of Kendra's Law is the primary example of regression to the mean in the literature, and the concern applies with particular force under Kendra's Law eligibility, which requires a documented history of multiple recent psychiatric hospitalizations and so enrolls people at the peak of their service-use trajectory by design. Lam et al. (2023) found this design dependence directly in their 16-study systematic review: pre-post analyses suggested that enrollment in AOT produced positive outcomes, whereas case-control analyses (which would not be susceptible to the regression-to-the-mean critique) did not. The difference between the two designs becomes intuitive once stated plainly. A pre-post design asks how much an AOT participant improved compared with their own worst month, and the answer is almost always a lot, whether or not AOT did anything, because that worst month is what got them referred in the first place. A case-control design asks how much an AOT participant improved compared with someone similar who did not get an order, and in that comparison, the natural drift away from a crisis peak shows up in both groups, so what is left over is closer to the actual contribution of AOT itself.

- **Confounding by secular trends**. Pre-post designs are also vulnerable to system-level changes during the study window that move outcomes in the same direction as the intervention would have, absent the trend. Stated differently, if hospitalizations had dropped anyway due to changes in the broader behavioral health system, some of the decline observed among AOT participants could reflect what the inpatient sector was doing for everyone, rather than what AOT was doing for these participants specifically. National and state-level psychiatric inpatient utilization declined substantially over the Kendra's Law evaluation window, reflecting bed closures, payer policy shifts, and broader changes in inpatient practice. Because of this, if an individual had, say, 6 inpatient psychiatric hospitalizations in the year before enrollment in AOT and 2 in the post-enrollment period, it is unclear whether the reduction observed in the post-period necessarily reflects the program working, per se, versus broader, often unmeasured or statistically unadjusted for, changes in the broader environment that would have reduced hospitalization rates anyway.
- **Conflation of the court-order effect with the intensive service environment.** AOT participants almost universally receive more intensive services than comparable individuals in voluntary treatment, which makes it difficult to attribute any observed improvement to the court order itself rather than to the wraparound services the order activates. Stated differently, AOT participants receive two things at once when their order is issued: a legal mandate to participate in treatment, and a more intensive package of services than they would have access to without the order. If their outcomes improve, it is difficult to say whether the improvement came from the legal elements (i.e., the black robe effect) or from the services that accompanied it, because the same people received both. The Steadman et al. (2001) Bellevue RCT and the Burns et al. (2013) OCTET trial came closest to isolating the court-order effect by holding service intensity constant across study arms, and both reported null differences in hospitalization, arrest, and treatment

adherence. The Cochrane reviews and meta-analyses by Kisely et al. (Kisely et al., 2011; 2017; Kisely, Bull, and Gill, 2025) treat this as the central unresolved confound in the literature.

- **Selection effects in dose-response and order-length comparisons**. The Johnson et al. (2025) multi-site evaluation compared participants in longer AOT orders to those in shorter orders and similarly contrasted order completers to non-completers. However, order duration and completion are themselves outcomes: participants who stabilize are more likely to have orders renewed and to complete them, so longer orders may reflect recovery rather than cause it, and apparent gains among completers may stem in part from selection rather than from extended judicial oversight. The intuition is that the direction of the causal arrow is unclear: the natural instinct may be to assume that longer orders and successful completions are the structural cause of better outcomes, but the correlation is equally consistent with the view that better outcomes are the cause of longer orders and completions. A participant who responds well to treatment is more likely to have an order renewed and to reach the end of it; a participant whose situation deteriorates is more likely to have the order ended early through hospitalization, incarceration, loss of contact, or non-renewal. The dose-response interpretation of the order-length and status-hearing findings reported in the outcomes section should be read in light of this concern.
- **Geographic and temporal narrowness**. The U.S. AOT evidence base is concentrated in a small number of jurisdictions, with much of it more than two decades old. The North Carolina RCTs (Swartz et al., 2001; Swanson et al., 2000), the Bellevue RCT (Steadman et al., 2001), and the bulk of subsequent observational work (Gilbert et al., 2010; Van Dorn et al., 2010; Phelan et al., 2010; New York State Office of Mental Health, 2005) are concentrated in New York and North Carolina and predate recent shifts in the inpatient psychiatric system, the housing safety net, and the criminal-justice diversion landscape. What this means practically is that whether a program that worked in mid-1990s North Carolina or 2000s New York would also work in New Mexico in 2026 cannot be assumed: the populations being served, the surrounding service infrastructure, and the broader legal and policy environment differ in ways that could plausibly amplify, dampen, or even reverse the effects reported in the original studies. Hancq et al. (2024), with particular emphasis on the predominance of New York-based evidence, identify this narrowness as a primary obstacle to generalizing findings to current programs operating in other jurisdictions.
- **Limited statistical power in randomized trials.** The major U.S. and U.K. randomized trials had modest sample sizes (e.g., the Steadman et al. 2001 Bellevue trial enrolled 142 participants; the Burns et al. 2013 OCTET trial enrolled 333), which limits the ability of any one trial to detect modest effects and contributes to the wide confidence intervals on pooled estimates in the Cochrane reviews by Kisely et al., (Kisely et al., 2011; 2017) and the Kisely, Bull, and Gill (2025) meta-analytic update. More concretely, small samples produce noisy estimates, and a real but modest benefit of AOT could fail to register as statistically significant in a trial of 142 or even 333 people. The shorthand "no significant difference" is often read as "no difference," but in trials of this size, the more accurate reading is that any real difference that exists is small enough that the study could not reliably distinguish it from chance.
- **Reliance on self-reported outcomes.** Several AOT evaluations rely on self-reported behaviors such as violent acts, illicit substance use, and homelessness when administrative records are unavailable or incomplete. The concern with self-reported outcomes is straightforward: participants who remain under a court order have reason to present themselves favorably to interviewers, especially when those interviewers are clinicians from the program itself. Whether

intentionally or not, this dynamic can skew the reported numbers, making the program appear more effective than it is. The GAO (2025) report flagged this, alongside voluntary enrollment at some grantee sites and small comparison-group samples, as a contributor to its inability to draw firm causal conclusions about AOT effectiveness.

Unique Limitations Identified by the UNM CARA Team

In this section, we highlight three theoretical and evidentiary concerns that, to our knowledge, have received limited direct treatment in the existing AOT outcome literature. The first two extend existing work on psychological reactance and treatment moderators into the AOT context; the third builds on Hancq et al. (2024) and Munetz et al. (2014) to argue that the conceptual conflation of judicial-deference and procedural-justice mechanisms in AOT research has not been adequately resolved. We believe these concerns are important to consider when researchers and program stakeholders evaluate the potential effectiveness of AOT program participation.

1. The Rationalist Compliance Assumption

One theoretical concern, which extends existing work on psychological reactance[7] into the AOT context, concerns whether the black robe effect can meaningfully operate as a behavioral mechanism in populations with significant anosognosia. As theorized by TAC, the black robe effect operates, in part, through a deference pathway: participants recognize the court's authority, perceive their participation in the treatment as legally obligated, and comply accordingly. This account implicitly assumes that participants possess sufficient awareness of their condition and the meaning of the legal proceeding to process the court order as a meaningful constraint on their behavior. However, anosognosia, which affects an estimated 40% to 50% of individuals diagnosed with schizophrenia, is characterized by impaired awareness of one's illness and, in more severe presentations, impaired insight into the nature and implications of one's own mental states and behaviors more broadly.

To the extent that AOT participants with significant anosognosia do not recognize themselves as having a condition requiring treatment, it is not clear that a court order directing them to treatment for that condition would activate the deference pathway the black robe effect presupposes. An alternative and arguably more plausible outcome is that individuals who reject that they have an SMI or diagnosable condition, and who are nonetheless court-ordered into treatment, respond with psychological reactance rather than deference to the court as a legitimate authority, experiencing the order as an illegitimate imposition and resisting engagement accordingly (Brehm, 1966; Steindl et al., 2015).

The literature on reactance in medical and psychiatric populations supports this concern: higher reactance is consistently associated with worse treatment adherence, lower satisfaction, and premature treatment

[7] Psychological reactance is the pushback people experience when they feel their freedom to choose or act has been threatened or constrained (Brehm 1966). Reactance tends to manifest as an effort to reassert threatened freedom, often by resisting, devaluing, or doing the opposite of what is asked. In the treatment context, a person who feels coerced into a course of care may push back against it even when they would otherwise have been willing to engage.

termination (Fogarty, 1997; De Las Cuevas and de Leon, 2024), and perceived coercion in psychiatric care is associated with weaker therapeutic relationships (Sheehan and Burns, 2011). Closer to the AOT context, Moore, Sellwood, and Stirling (2000) reported that psychological reactance, in interaction with perceived threat to freedom of choice, was among the strongest predictors of past treatment compliance in a sample of individuals with schizophrenia and schizoaffective disorder, establishing that the reactance pathway is operative in the same diagnostic population to which AOT is typically applied.

Qualitative work with patients under CTOs has documented coping responses spanning from resignation to active resistance, consistent with a reactance interpretation (Stensrud et al., 2015). Most directly relevant to the AOT context itself, Swartz et al. (2002) found in the North Carolina RCT that lower insight into illness was significantly associated with greater perceived coercion under the order. This is empirical evidence, from within the AOT literature itself, that the deference assumption runs in the wrong direction for the very subpopulation to which AOT is most often justified. If an individual does not believe they have done anything warranting intervention since they reject the underlying diagnosis, deference to the presumptive authority of the institution imposing that intervention cannot be assumed by default. Moreover, the existing AOT literature has not directly examined whether the relationship between AOT enrollment and outcomes varies with the presence of anosognosia; in the absence of true baseline prevalence rates of anosognosia or insight impairment (which are typically not quantified at the point of program intake), this also leaves open the possibility that a nontrivial proportion of the AOT population may fall outside the scope of the mechanism most commonly invoked to justify the intervention.

2. Anosognosia as Asserted Rationale, Not Tested Moderator

Many AOT advocacy materials supporting AOT invoke anosognosia as a foundational justification for the intervention, since it is thought that anosognosia leads to treatment noncompliance. However, no AOT statute requires anosognosia as an explicit eligibility criterion, no published evaluation reports its prevalence rate among enrolled participants, no evaluation work has tested how insight evolves over time throughout program participation, and none has tested whether insight impairment conditions AOT's associations with hospitalization, treatment adherence, or other primary outcomes. Stated differently, the clinical rationale for the program’s existence is asserted at the population-level and presumed to be true rather than directly verified at the individual-level.

Measuring insight at intake, tracking its trajectory, and testing it as a moderator (i.e., a variable that conditions the association between program enrollment and downstream outcomes like recidivism or inpatient hospitalizations) matter for three reasons. First, the prevalence claim is itself empirically testable: if anosognosia is what makes voluntary engagement with treatment unlikely, the proportion of AOT participants with clinically significant insight impairment is a basic empirical question current research cannot answer. Second, insight is not static; it can fluctuate with symptom course and treatment, so within-person change over an AOT enrollment is itself a candidate outcome distinct from hospitalization or treatment adherence. Third, existing evidence suggests that insight may shape how AOT is experienced, potentially altering the program’s effectiveness. In a systematic review of perceived coercion among patients on CTOs, Pridham et al. (2016) reported that two studies that measured insight directly at enrollment found that higher levels of insight were significantly associated with lower

perceived coercion, whereas most other CTO and AOT evaluations did not investigate the relationship at all. Perceived coercion, in turn, correlates with reduced endorsement of treatment benefit and weaker working alliances with providers. If the participants most often invoked to justify AOT, those with the lowest insight, are also those who experience the order as most coercive, the intervention's behavioral mechanism may operate differently across the insight gradient than the population-level rationale assumes.

The narrower empirical point is that the existing literature cannot answer whether AOT produces larger gains for participants with greater insight impairment, because the measurement infrastructure has not been in place. Closing the gap would require standardized insight measures at intake, ideally in jurisdictions with broader eligibility criteria where baseline variance is wider, tracking change over the order period, and reporting insight as a moderator rather than only as an outcome (i.e., seeing what associations exist between the anosognosia diagnostic flag and frequency and stability of program participation; success or non-success) and seeing how the presence of the diagnosis or not moderates downstream, post-enrollment outcomes (i.e., does program participation of individuals who have anosognosia relative to those who do not lead to larger reduction in post-enrollment psychiatric hospitalizations, recidivism, etc.).

3. The “Black Robe” Black Box

A third concern applies to the black robe effect as a theoretical construct on its own merits. The mechanism is regularly invoked as a plausible account of how court-ordered treatment produces engagement, but it has not been formally tested in a manner sufficient to rule out alternative explanations (e.g., the scope of wraparound service delivery) for the observed improvements in outcomes. Without research or implementation designs in place that vary the degree of judicial involvement while holding the scope of services provided constant, the black robe effect remains a theoretical inference rather than an established empirical finding.

Beyond the question of whether it operates at all, the AOT literature treats the black robe effect as a unitary mechanism, collapsing what are two conceptually different pathways for the program to exert a causal effect on program participants: a compliance-deference effect, in which participants engage with treatment because they perceive the court order as a binding legal obligation, and a procedural justice effect, in which engagement is mediated by perceptions of being heard, respected, and fairly treated by the judicial process. Munetz et al. (2014) compared AOT and mental health court participants and reported that AOT participants reported higher perceived coercion and lower procedural justice with the judge than mental health court graduates, suggesting that the procedural-justice channel may operate less effectively under AOT than under structurally similar programs that have invested more explicitly in fair-process design. Moreover, the framing implied by the term black robe effect itself, with its emphasis on the judge as the focal source of authority, more closely approximates the compliance-deference account than the procedural-justice account, yet procedural justice theory holds that the relevant perceptions which shape program participation and treatment compliance extend beyond the dyadic interaction between judge and participant to encompass broader evaluations of the legitimacy and fairness of the legal process. Conflating these mechanisms obscures potentially important distinctions in ways that matter for predicting whether a given AOT program will work or not: a deference-based account would

predict that any judicial involvement, regardless of its quality, would generate higher rates of treatment compliance, whereas a procedural justice account would predict that only interactions characterized by voice, neutrality, and respect would produce the engagement benefits attributed to AOT. The existing AOT literature has not used research designs capable of distinguishing between these accounts or decoupling their effects from service intensity, so the black robe account remains a largely unexamined theoretical assumption at the center of the AOT model.

Implications for New Mexico

The AOT literature, taken as a whole, supports a cautious and more contingent read of the intervention's potential value. Observational studies of New York's Kendra's Law and pre-post analyses of the SAMHSA-funded pilots consistently have generally reported improvements in participant treatment adherence, reductions in psychiatric hospitalization, and modest reductions in violent behavior and arrests during and after AOT (Swartz et al., 2010; Van Dorn et al., 2010; Phelan et al., 2010; Johnson et al., 2025). However, the strongest evidence from RCTs tend to report null program effects on outcomes (Steadman et al., 2001; Burns et al., 2013; Kiseley et al., 2024). The 2024 ASPE outcome evaluation and the GAO (2025) report generally converge on the conclusion that the apparent benefits of AOT, to the extent that they exist, may stem less from the legal compulsion of the court order than from the intensive service environment that the order itself activates.

A small number of process features consistently appear across implementation guides, federal evaluations, and outcome studies as features that may predict participant success, though it is important to reiterate that some of the apparent associations may reflect selection biases rather than true program effects [i.e., participants with longer stays in AOT or who are otherwise deemed “successful” completers may be more likely to have positive post-enrollment outcomes not because of the order length or the program itself, but because order length correlates with specific unmeasured traits of the participant (e.g., motivation), that, in turn, correlate with or predict the outcome of interest]. The length of the AOT order appears to correlate with improvements in post-enrollment outcomes. The comprehensiveness of the wraparound service array, including housing, peer support, substance-use treatment, and employment assistance alongside psychiatric care, also appears to be more strongly associated with positive outcomes than any single service component (Schneeberger et al., 2017; Gearing et al., 2024). The nature of judicial involvement may also be consequential: the ASPE outcome evaluation reported that between 21% and 32% of changes in clinical functioning among AOT participants were statistically associated with whether the participant had at least one status hearing during the order (ASPE, 2024).

New Mexico's AOT design choices place it at the lower-coercion end of the national landscape. Failure to comply with an order is not grounds for involuntary civil commitment, contempt of court, or forced medication (NMSA 1978, § 43-1B-13, enacted 2016), and Senate Bill 3 of the 2026 legislative session, which broadens involuntary civil commitment criteria by revising the definitions of "harm to self" and "harm to others," does not amend that non-enforcement design. In a design without court-based enforcement, the order operates primarily as an organizing instrument that mobilizes services and structures judicial engagement, and the procedural-justice character of the hearing is correspondingly more consequential. The 2024 legislative session appropriated $3 million to the Administrative Office of the Courts for AOT and competency-diversion pilot programs, and the 2025 Behavioral Health Reform

and Investment Act (Senate Bill 3 of the 2025 session) established 13 regional behavioral health districts administered by the Administrative Office of the Courts with broader operating funds for behavioral health, of which AOT is one eligible use. Together, these two funding streams give the state its first meaningful infrastructure for broader AOT delivery.

However, the cautionary lesson from other jurisdictions that have implemented AOT programs is that legislative authorization does not always translate into timely or substantively meaningful program implementation. For example, Maryland authorized AOT in 2024 (HB 576 and SB 453), but every Maryland jurisdiction deferred implementation decisions back to the state ahead of the January 2025 county-notification deadline, citing unsettled regulations, insufficient funding, and workforce constraints. Pennsylvania's 2018 authorization (Act 106) did not produce an operating program for the better part of a decade; most of Pennsylvania’s 67 counties have annually opted out, and Allegheny County became the first large county to commit to implementation in December 2025, with services launching in January 2026. In both cases, the rate-limiting constraints were service capacity, workforce, intake infrastructure, and judicial-administrative coordination at the local level. Whether the recent state investment delivers on AOT's promise in New Mexico may depend, in part, on how well the levers identified above, particularly wraparound service comprehensiveness and the procedural-justice quality of judicial engagement, are translated into operating practice.

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