

Addressing Mental Health

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High-profile tragedies linked to serious mental illness, such as the May mass shooting in Buffalo and subway platform shovings in New York City, have prompted mounting concern about the effectiveness and adequacy of New York State's mental health system. Media coverage of crimes committed by what police sometimes term "EDPs" (emotionally disturbed persons), as well as the growing number of homeless people with apparent psychiatric issues, have highlighted the question of whether New York's mental health system has sufficient capacity to meet the demand for crisis care.¹ New York City Mayor Eric Adams, as part of his broader pushes to reduce crime and subway disorder,² has called for more state action on mental health.³

New York's mental health system consists of a sprawling network of benefit programs and service providers, with city and county governments, community healthcare and hospital systems, nonprofits, and other private organizations playing important roles. But no one entity has more responsibility for this system than state government. Thus, to the extent that public dissatisfaction with mental health policy persists and increases, in New York City and elsewhere, the onus ultimately is on Albany to do something about it.

The leading goal of mental health policy should be providing effective treatment to people with mental disorders—especially those with serious mental illness.

Though it is not technically a diagnosis-based category, most people with serious mental illness have schizophrenia, bipolar disorder, or major depressive disorder. Only 4 to 5 percent of the general adult population falls into this category, but according to state Office of Mental Health (OMH) data, they represent most users of New York's public mental healthcare system. New York State's public mental health system—meaning programs either funded or authorized by the OMH—serves about 900,000 individuals annually. The vast majority (86 percent) of those served have a serious mental illness.⁴ The seriously mentally ill also drive most of the demand for system reform, such as through their involvement in high profile tragedies.

Public mental healthcare systems, to be effective, require many “inputs” such as public investment and an adequate supply of mental health professionals to provide treatment. On input measures, New York’s mental health system tends to look strong. In terms of outcomes, New York’s mental health system looks less impressive.

The Status Quo

One reason why people who need treatment don’t get it is their inability to access a provider, such as a therapist or psychiatrist. In the broader mental health debate, access to providers is now a top concern. The federal government deems mental health one of three official “Health Workforce Shortage Areas.”⁵ Increasing spending on compensation for mental health workers, as part of a broader initiative to “Rebuild Our Healthcare Economy,” was the top mental health priority highlighted by Governor Hochul in her January 2022 State of State speech and FY 2023 Executive Budget.⁶

In fact, ranked against other states, New York boasts an above average concentration of mental health professionals.⁷ In terms of psychiatrists—the profession of greatest relevance to untreated serious mental illness—the New York City metropolitan area ranks, by some measures, first in the nation.⁸ New York County (Manhattan) has more psychiatrists than any other county in the nation, whereas over half of counties in the U.S. don’t have one psychiatrist.⁹ The state as a whole ranks second in psychiatrist concentration, after California.¹⁰

However, the concentration of mental health professionals is not evenly distributed throughout the state. The number of mental health “providers” per 100,000 residents ranges from over 900 in the borough of Manhattan to less than 100 in the case of Greene, Montgomery, Herkimer, Hamilton, and Orleans counties.¹¹ However, political pressure to spend more on compensation for the mental health workforce, coming from advocates and legislators, is, if anything, greater in New York City than elsewhere in the state.¹²

Total Spending and Capacity

In a 2017 federal analysis of state mental health agency spending, New York ranked second in absolute terms and fifth on a per capita basis.¹³ In fiscal 2022, state spending on the OMH’s budget was about \$3.4 billion.¹⁴ That figure does not account for expenditures made through other programs, such as Medicaid, and expenditures at the city and county level. The state Medicaid program spent \$2.6 billion on mental health in 2020.¹⁵ The “mental hygiene” portion of the New York City Department of Health’s budget last year was \$680 million.¹⁶

In addition to spending and workforce, inpatient capacity is another mental health metric where New York has, in recent years, looked more robust than other states. But whereas state officials have been working to increase spending and the number of trained professionals, they have been working to reduce use of inpatient psychiatric services.

Hospital-based psychiatric care can be delivered through specialized hospitals or through general hospitals. Traditionally, New York’s public mental health system consisted almost exclusively of specialized hospitals run by state government. These “asylums” or “mental institutions” were, at their mid-1950s peak, host to over 90,000 beds. Since then, state government has shifted away from hospital-based care in general and also shifted hospital-based care from specialized hospitals to acute care general hospitals.

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State-run institutions, now known as “psychiatric centers,” are host to a total 2,000 adult beds and another 1,000 beds for forensic patients (such as those ruled mentally incompetent to stand trial on criminal charges) and children.¹⁷ Acute care (“Article 28”) general hospitals are host to about 4,500 adult beds. There are about 150 inpatient psychiatric programs statewide, about two-thirds of which operate out of a general hospital.¹⁸ Of the roughly 900,000 total clients served by the state mental health system (“organizations and programs licensed, funded and/or operated by OMH”) in 2022, only about 70,000 of them used inpatient programs.¹⁹

During the 2010s, state officials made deliberate pushes to reduce beds in both state psychiatric centers and acute care general hospitals. State psychiatric center bed reductions were driven by the “Transformation Plan” for the OMH, launched in 2014. Cuomo administration officials criticized New York’s “disproportionately large” “inpatient footprint” and the harm done by “costly” and “unnecessary” spending on hospital-based programs.²⁰ From 2014 through mid-2022, New York State has lost over 600 beds in adult non-forensic psychiatric centers.²¹ As recently as the FY22 budget cycle, the last of the Cuomo era, 200 state hospital beds were cut,²² justified as part of an urgent need to “right size” the system,²³ and policymakers seriously considered shutting down one facility, the Rockland’s Children Psychiatric Center.²⁴

Reductions in psychiatric beds in acute care general hospitals were brought about through changes to New York’s Medicaid program. Though Medicaid generally cannot be used for care for adults in specialized psychiatric centers, it is the chief funding source for psychiatric services in acute care general hospitals.²⁵ In 2010, the state health department argued that Medicaid-funded general hospitals had “[n]o incentives for length of stay reduction” when it came to psychiatric care.²⁶ Accordingly, state government restructured Medicaid reimbursement to reduce the daily rate the longer that someone stayed hospitalized.²⁷ This change has been criticized for incentivizing hospitals to release patients regardless of their clinical needs and to eliminate inpatient services altogether.²⁸ Inpatient care is one of the least-profitable services a hospital can offer.²⁹ According to the New York State Nurses Association, in 2018, psychiatric care generated \$88,000 “net patient revenue” per bed for hospitals whereas the average figure across all beds was \$1.6 million.³⁰

Psychiatric beds converted for Covid overflow, it was widely feared in 2020 and 2021, might not be brought back at all.³¹ To allay those fears, Governor Hochul authorized an increase in the Medicaid reimbursement rate to incentivize more provision of inpatient psychiatric care by private hospital systems.³²

Pressure for deeper bed cuts in psychiatric centers and outright hospital closures have recently eased somewhat, particularly with respect to facilities serving children and teenagers.³³ The Western New York Children’s Psychiatric Center, another facility threatened with closure under the Cuomo administration³⁴ (with support from then-Lieutenant Governor Hochul³⁵), is now receiving \$55 million in upgrades.³⁶

In early October, the Hochul administration announced that it would pursue a waiver from the IMD Exclusion to authorize Medicaid funding for state-run specialized psychiatric hospitals.³⁷ The waiver proposal argues that the increased Medicaid funds will help continue the previous Cuomo-era efforts to “aid in the state’s efforts to continue to transform the behavioral health service system.” That will mean “transforming selected (pilot site) state-run psychiatric hospitals, facilities, and campuses from long-term care institutions to community-based enhanced service delivery systems” towards the goal of “reducing the statewide average length of stay.”³⁸ In general, the administration remained supportive of minimizing the footprint of state-run specialized psychiatric hospitals.³⁹

The standard promise of cutting inpatient beds has always been better care at a lower cost. But, during the 2010s, that promise was not fulfilled in New York. Between 2015 and 2019, statewide, the average daily adult census for all inpatient facilities declined from 6,894 to 6,111. In the New York City Region, it declined from 3,676 to 3,135.⁴⁰ Those reductions coincided with a rise in mental health-related costs and pressures in other systems, such as homeless services, police departments, and corrections.⁴¹

Insurance

Debate over expanding access to treatment, in mental health, sometimes centers around insurance, another area where “on paper,” New York looks strong. New York has the eighth-lowest rate of uninsured in the nation⁴² and its Medicaid program is the most expensive in the nation on a per capita basis.⁴³ In its most recent annual rankings, which examine states’ prevalence rates of mental illness and rates of access to mental healthcare, Mental Health America ranks New York fifth overall.⁴⁴ New York has one of the lowest rates of “Adults With [any mental illness] Who Are Uninsured.”

Mental health advocates, in addition to promoting expanded access to health insurance, have emphasized tightening regulations on insurers, to require them to provide more mental health benefits. “Parity” regulations exist at both the federal (“Mental Health Parity and Addiction Equity Act,” 2008) and state (“Timothy’s Law,” 2006) levels. New York has recently strengthened reporting requirements for parity (“Mental Health and Substance Use Disorder Parity Reporting Act,” 2018) and parity has also been a focus of enforcement actions taken by the state attorney general.⁴⁵

Involuntary Care

Seriously mentally ill people sometimes decline to accept or submit to treatment that would benefit them. They do so for a few reasons, including a distaste for medication’s side effects and/or failure to accept that they have a mental illness (“lack of insight” or “anosognosia”). In such cases, involuntary treatment can become necessary.

Committing someone to a hospital, for their benefit but against their will, is the best-known form of involuntary treatment. New York State has one of the highest inpatient civil commitment standards in the nation.⁴⁶

It’s also possible to pursue involuntary treatment in an outpatient context. Kendra’s Law is a state program, administered by local health authorities, that allows courts to order treatment for seriously mentally ill individuals.⁴⁷ Named after Kendra Webdale—a young woman killed when she was pushed into the path of a subway train by a schizophrenic man who was off his meds—the law was enacted in 1999 with support from families of individuals with the most serious mental illnesses as a way to help their loved ones while simultaneously keeping society safer.⁴⁸ To be eligible for court-ordered involuntary outpatient treatment, someone must have a record of non-compliance with treatment that has led to a recent history of psychiatric hospitalization, violence and/or incarceration.⁴⁹

Guardianship (also sometimes referred to as “conservatorship”) is another important intervention that relies on the involvement of courts. With guardianship, courts transfer authority over life decisions, such as pertaining to personal finances, from a seriously mentally ill individual to a third party.⁵⁰

Outcomes

Despite New York's high spending, concentration of expertise, and robust insurance programs, mental health outcomes in the Empire State are not impressive, particularly when it comes to the seriously mentally ill. Two important outcomes are incarceration and homelessness. If one standard of effectiveness in mental health is keeping the seriously mentally ill out of homelessness and reducing their involvement with the criminal justice system, New York's mental health system performs no better than the much more poorly funded and less sophisticated systems found in other states.

In the state prisons, 25% of inmates have some sort of mental disorder.⁵¹ In New York City jails, 17% have a serious mental illness.⁵² These figures are comparable to other states.⁵³ New York City's jail system is host to over 1,000 inmates with a serious mental illness.⁵⁴ No hospital in the state has a patient census of over 340.⁵⁵ Statewide, homeless adults are estimated to be 25% severely mentally ill; that figure is also 25% in New York City and nationwide.⁵⁶

Moving Forward

To cope with the quality of life and public safety challenges posed by the seriously mentally ill, and to provide humane and effective treatment of those who most urgently need it, New York State officials should embrace these priority goals and principles.

- **Fund more inpatient psychiatric beds.** It is essential to relieve pressure on other service systems, reduce hospitals' fiscal incentives to discharge patients before clinically appropriate, reduce incentives to avoid admitting troubled patients in the first place, and reduce waits for beds.⁵⁷ Though the Hochul administration has taken some positive steps to build in-patient capacity, such as applying for a waiver from the IMD Exclusion and increasing Medicaid reimbursement, it also assigned a priority to reducing "unnecessary" spending on state psychiatric hospitals.⁵⁸ Inpatient psychiatric services can either be publicly-funded and privately provided, or entirely funded and provided by the public sector. The former model cannot be relied on since private health systems' commitment to inpatient care is likely to remain questionable. As of late November, *Gotham Gazette* reported, only 200 of the more than 1,000 former psychiatric beds repurposed during Covid had been restored.⁵⁹ Thus more focus should be placed on adding more staffed psychiatric beds within the OMH-run hospitals the state controls. A modest start to expanding the use of state psychiatric center space was made in October, with the opening of two "Transition to Home Units." Comprising 50 total beds, these will be operated out of state hospitals and are dedicated for "individuals aged 18 years or older with severe mental health illnesses who are experiencing homelessness."⁶⁰

New York operates more traditional state-run mental hospitals than any state in the nation.⁶¹ That should be viewed less as a problem to be solved (the Cuomo administration's view) than as a valuable asset to be preserved and enhanced. Unfortunately, the metrics needed to estimate the full cost of an expanded in-patient system are not readily available—but the cost of continued neglect in this area have become all too apparent.

- **Pass Mayor Eric Adams' "Psychiatric Crisis Care Legislative Agenda."** In late 2022, New York City's mayor unveiled a plan to expand access to involuntary care and make the experience of hospitalization more effective from a treatment perspective. It clarifies that the state's civil commitment standard authorizes involuntary hospitalization when someone's "basic living

needs” are not being met, requires doctors to consider patients’ past histories before releasing them, and requires hospitals to evaluate all discharges for Kendra’s Law. Most elements of this plan will require state legislation.⁶²

- **Target workforce investments to areas of greatest need.** Increased spending on mental health should flow primarily to rural areas and to programs that serve seriously mentally ill adults. However, the Hochul administration’s planned spending on compensation for mental health workers leaves unclear whether the money will be spent effectively. How much will go towards psychiatrists? How much will be targeted towards those regions outside of New York City that have a more compelling claim to be facing a shortage of professionals? How much will go towards professionals who will be serving the seriously mentally ill— those who, without treatment, are the greatest risk of violence, incarceration, and homelessness? In each case, if the answer does not boil down to “most of the money,” those investments will not address the crisis.
- **Expand Kendra’s Law.** Because of the Kendra’s Law’s success in reducing homelessness and incarceration for participants in the program, among other positive outcomes,⁶³ there is perennial interest in expanding the program. As of September, the number of people in Kendra’s Law is up about 20% compared with the same time last year, though it’s not clear that the recent legislation caused the increase.⁶⁴ The most promising route to further expansion lies through identifying more people who meet current eligibility criteria and who would benefit from the program but are not in it. Over 80% of court orders are filed by hospitals, as part of the discharge planning process.⁶⁵ Tens of thousands use inpatient services every year.⁶⁶ But statewide, only about 3,500 people are in Kendra’s Law, 1,600 in New York City.⁶⁷ Local governments or the state could exercise more oversight over hospitals to ensure that they are identifying the maximum number of discharged patients who would qualify for Kendra’s Law.
- **Increase supervision of the seriously mentally ill.** Seriously mentally ill individuals routinely “fall through the cracks” of the public mental health system. They stop engaging with a program they had been receiving treatment or services from, decompensate, and wind up homeless or incarcerated. In a community setting, supervision can be provided in multiple ways: regular attendance at a clubhouse program, supportive housing, a “step-down” residential program, Kendra’s Law, conservatorship, and probation-style diversion programs such as mental health courts. The desired intensity of the supervision will vary, depending on the individual. But in caring for the seriously mentally ill, there should always be a presumption in favor of supervision to reduce the risk of adverse outcomes. At the community level, separate programs serving the seriously mentally ill should coordinate more than they do now, such as through formal data-sharing agreements, to avoid losing track of troubled cases.⁶⁸
- **Reduce the mental illness burden on other systems.** Untreated serious mental illness continues to burden various agencies such as homeless services, police departments, courts, corrections systems, and transit systems.⁶⁹ This reality, just as much as any other outcome OMH is tracking, indicates that the state is not meeting its official goal of “better care, better health and better lives for those whom we serve at lower costs.”⁷⁰ A public mental health system with more integrity would burden other systems less.

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- ⁶⁷ “Kendra’s Law,” NYS Office of Mental Health.
- ⁶⁸ Stephen Eide and Carolyn D. Gorman, “The Continuum of Care: A Vision for Mental Health Reform,” Manhattan Institute, Sept. 15, 2022

- ⁶⁹ Stephen Eide, “Systems Under Strain: Deinstitutionalization in New York State and City,” Manhattan Institute, November 2018.
- ⁷⁰ “2017 Interim Report to the Statewide Comprehensive Plan,” New York State Office of Mental Health, p. iii.