A Crisis in Inpatient Psychiatric Services in New York State Hospitals

New York State Nurses Association

Executive Summary

The landscape of psychiatric care, especially inpatient psychiatric care, has been going through a transformational shift that is accelerating. Much of the provision of care is now deinstitutionalized, and specialty psychiatric hospitals are diminished in both stature and capacity. Inpatient psychiatric beds are by majority located in general hospitals. In addition, due to this reduction and the increased involvement of police in mental health episodes, much of the provision of mental health care has now fallen to our carceral system.

The pandemic caused by the novel coronavirus, also known as COVID-19, is causing a reckoning in our health-care delivery system. Our reliance on just-in-time organization created capacity issues that our acute care facilities scrambled to address as cases in the Greater New York City Region began to rise. Governor Andrew Cuomo suspended regulatory procedures required by the NYS Department of Health to allow hospitals to make quick adjustments and scale up their bed capacity to meet the emergent demand. The governor also created capacity requirements regionally as hospitals began to resume normal operations as COVID-19 cases began to trend downward.

It is in this temporarily deregulated climate that our acute care providers have begun to make changes to their services that we believe are preludes to permanent closures of inpatient psychiatric beds. It is being done under the guise of adhering to and exercising the broad powers and flexibility granted to them by Governor Cuomo. However, many of these changes are changes that align with providers' pre-COVID goals of reducing inpatient psychiatric capacity, and also track with general industry trends.

This analysis will seek to do the following:

- Provide health-care industry context on psychiatric and behavioral health by describing broad trends that created deinstitutionalization of care.
- Analyze historical trends in psychiatric and behavioral health care in New York State, especially the role of acute care facilities in the provision of care.
- Analyze the current trends of reduction of inpatient psychiatric and behavioral health care in acute care facilities and focus on four health systems, three of which have made significant reductions during the pandemic:
    o Westchester Medical Center Health
    o NewYork-Presbyterian
    o Northwell Health
    o NYC Health + Hospitals
- Analyze the shift of the provision of mental health care away from our health-care institutions and into the police and carceral systems.
- Provide recommendations on how to address the looming mental health care crisis coming out of the COVID-19 pandemic.

Background—Psychiatric and Behavioral Health Care in the Historical Policy Context

Just over a decade ago, Harvard surgeon Atul Gawande published one of the most influential articles on health-care financing ever for the *New Yorker*. His piece "The Cost Conundrum" was rumored to be required reading in the Obama White House. While it specifically focused on Medicare costs in McAllen, Texas, the essence of the piece gave many readers their first understanding of how supply-driven demand leads to high prices for health-care services. Americans use too much of the wrong kind of health care, leading to wild overspending. With the passage of the Affordable Care Act (ACA), health-care system delivery reforms were suddenly prioritized. States had previously attempted to tweak their insurance regulations with programs like guaranteed issue and certain types of price controls. But by the beginning of implementation of the new Affordable Care Act, we reached an (oddly unquestioned) consensus about changing the delivery of care as a means to expand access, provide quality care and not bankrupt payers.

While America was being introduced to the concepts and language of the ACA's health-care reform and policymakers were championing many of the ideas proposed by Gawande (e.g., accountable care organizations [ACOs], value-based purchasing [VPB], Medicaid Health Homes, etc.), New York State had just entered an era of momentous change in its own health-care delivery system. The Berger Commission report, released in 2006, was in its first stages of implementation to be completed by 2009. The Berger Commission's focus was on, in its own parlance, "right-sizing" (i.e., decreasing) inpatient hospital capacity in New York State. The final recommendation involved inpatient capacity reductions at 48 hospitals of about 4,000 beds total. New York went from 29,230 inpatient beds in 2004 to 27,355 inpatient beds by 2009, a 6.4% reduction. By 2014, New York had 23,467 beds remaining, a 20% reduction from 2004 numbers, as bed reductions went beyond even the Berger Commission recommendations.[1] Right-sizing was a process thoroughly embraced by administrators as hospitals scrambled to consolidate into large, corporate systems and close entire facilities generating negative net revenue. During the same period, inpatient stays decreased in the aggregate by a greater amount, so occupancy rates either remained unchanged in some facilities or went down as well.

This push to remove care from inpatient settings and reduce admission and readmission rates through streamlined care management that provides efficient outpatient and ambulatory care has become mainstream for most health-care public policymakers. Many states received Medicaid Redesign Team grants to reorder their taxpayer-funded Medicaid programs to pay for health care based on value provided, rather than health-care services provided. New York State was no exception; it used an $8 billion grant from the NYS Department of Health and Human Services on the Delivery System Reform Incentive Payment Program (DSRIP). DSRIP used both financial carrots and sticks to incentivize preventative care projects, programs designed to tackle social determinants of health and provider cooperation (and consolidation) to theoretically provide more efficient and less-costly health care in New York's Medicaid program. The overarching goal was to reduce potentially preventable hospitalizations (including psych hospitalizations) by 25%.

There have been some very impressive improvements made in public health since the passage of the ACA, most notably, access to care has increased and the number of uninsured has decreased.

In states like New York with robust Medicaid programs and essential plans to fill in the gaps for those who don't qualify for Medicaid, the problem of the uninsured has started to look less dire. Yet even with all the gains made, some of the most vulnerable patients in the health-care system have fallen through the cracks. In the great health-care reform shuffle of the past decade, psychiatric and behavioral health services have been relegated to an afterthought, and New York state has been left with a fragmented care system that fails many of its citizens, ultimately filling up forensic institutions with patients needing psychiatric and behavioral health care. The new conventional wisdom that we just need to pay for different kinds of care has mostly failed patients in need of psychiatric care.

Psychiatric and behavioral health care in the United States went through its own major transformation long before "managed care" and "value-based purchasing" became health-care reform buzzwords. In the 1950s and '60s, most care for the mentally ill in the United States was provided via full institutionalization in massive state-run residential centers. Nearly everyone with a mental illness or developmental disability was warehoused in overcrowded and underfunded asylums. In 1955, there were nearly 95,000 New Yorkers living in state-run asylums. At its peak, Pilgrim Psychiatric Center on Long Island had about 14,000 patients (greater than the population of many county seats in New York State). A journalistic investigation into the horrid conditions at Staten Island's Willowbrook State School for children with intellectual disabilities led to public outcry and legislative and judicial action that hastened deinstitutionalization in New York and nationwide. By the late '90s, remaining asylums were effectively closed by the Supreme Court's *Olmstead v L.C.* decision, which required states to treat psych and behavioral health patients in the least restrictive setting as safely possible. In the place of state asylums, a new mental and behavioral health-care infrastructure was created, but often in a disjointed and haphazard way.

Examples of new care settings emerged: community mental health centers, supportive housing, the Program for Assertive Community Treatment (P/ACT), and assisted outpatient treatment (AOT). Hundreds of beds in former state asylums were converted from inpatient to residential beds where patients were free to come and go as they pleased.

Amid declining census, increasing cost, and a new paradigm that dictated that outpatient and ambulatory care provide the most value, inpatient capacity for psychiatric patients plummeted. This was first apparent in state psychiatric hospitals, where a 2013 budget plan to close 9 out of 15 was thwarted by advocates and lawmakers. Even so, remaining inpatient capacity was reduced by 20% between 2013 and 2018.[2] The 2,600, or average daily census, represented only 1% of the total population receiving any mental health services in New York State, but accounted for 20% of the NYS Office of Mental Health's (OMH) budget. It's easy to see how inpatient psychiatric beds ended up on the chopping block. While the state devised a detailed 4-year OMH Transition Plan for state psych hospitals to achieve its outpatient and ambulatory care goals, it curiously focused no attention at all on the non-state-run inpatient psych care capacity, as if it didn't regard the provision of mental health care to patients and communities as an integrated system at all.

Simply cutting inpatient beds in state psychiatric hospitals and transitioning people to outpatient services did not reduce the need for inpatient psychiatric services. Today we find ourselves in a

situation where New York State's acute care hospitals (aka Article 28 authorized Diagnostic and Treatment Centers) provide the largest share of inpatient psychiatric services. Just under a hundred of New York State's acute care hospitals have inpatient psych program beds.[3] Of the total available psych beds in the mental health-care system, New York State's psychiatric hospitals represent just under 30% of the state's inpatient psych capacity. Acute care hospitals now account for more than 68% of inpatient psych beds. (A small number, about 4% of the total psych census, of psych patients are treated at smaller Article 31 psychiatric hospitals as well. These hospitals have no acute care beds.)

The carceral system in New York is a point of care, albeit an involuntary one, that is often overlooked in health-care analysis. The seven forensic facilities in New York State provide inpatient psych care to the incarcerated and have 1,129 beds, equivalent to almost one-fifth of the total bed capacity of Article 28 inpatient psychiatric units.[4]

A critical piece of the mental health system in New York is the forensic care system. As we will see, when care isn't provided by state psych hospitals or Article 28 acute care hospitals, patients often get pushed into the forensic mental health-care system by default.

Table 1
New York State's Current Inpatient Psychiatric Care Infrastructure

Care type	Most common provider types
Inpatient	Article 28 general hospitals, NYS psych hospitals, and Article 31 private psych hospitals
Emergency	Mostly Article 28 general hospitals
Outpatient	independent and community-based providers and Article 28 general hospital-affiliated outpatient programs
Support	Independent and community-based providers
Residential	Independent and community-based providers, also NYS psych hospitals and Article 31 private psych hospitals
Correctional	Nearly exclusively NYS forensic/sex offender treatment facilities and occasionally contracted Article 28 general hospitals

Our focus here is on the critical inpatient psych (and to a lesser degree, behavioral health) care provided by New York State's Article 28 acute care hospitals and the correctional mental health system, and how recent changes in the provision of this care has been driven by both public policy and financial incentive. Specifically, we look at the decline in certified and available psych bed capacity at Article 28 acute care hospitals, the increase in psych service demand at Article 28 acute care hospitals, and the effect these changes have on other parts of the mental health care delivery system. These services are particularly critical in the time of a global pandemic. Yet just as the state pushed to cut its inpatient beds in state psych hospitals in 2013, Article 28 acute care hospitals are cutting available beds and services without regard for patients and communities. We believe that this is a looming threat to public health that remains stubbornly off the policy radar.

It is true, however, that most patients in need of mental health care can be treated in their communities. While New York State is consciously decreasing inpatient capacity for budgetary reasons, it still has not made a full commitment to modalities of treatment that are proven to work in the outpatient setting. Nearly as soon as New York State developed P/ACT in the early 1990s (a very successful program that provides community-based care to prevent hospitalization in people with severe mental illness [SMI]), an extensive wait list developed for services. Today, New York State's P/ACT has about 6,800 patients and is again essentially full. (Six states have statewide P/ACT programs according to the National Alliance on Mental Illness—New York is not one of them.) The 1999 Kendra's Law created a statutory framework for court-ordered assisted outpatient treatment (AOT) to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs. However, this was achieved via mandate on county departments of health rather than as a statewide program.

While we focus on inpatient psych care delivery here, it's important to note that overall mental health care delivery must be regarded as a system and that outpatient treatment modalities and inpatient programs are complementary along a continuum of care rather than competing treatments—and both must be adequate to meet the mental health needs of New Yorkers.[5]

How Many Psych Beds Does New York Need?

A key concept in understanding the mental health care delivery system is recognizing how woefully under-bedded the state is already in terms of inpatient psych capacity. We consulted papers by the Treatment Advocacy Center (TAC) and the National Association of State Mental Health Program Directors (NASMHPD) to find a consensus on what inpatient psych capacity is necessary to effectively treat a state's population of people with mental illness.[6] According to TAC's background research, the accepted range of capacity is between 40–60 beds per 100,000 population.[7] Across the 34-member Organisation for Economic Cooperation and Development (OECD), to which the United States belongs, the median number of psychiatric beds per 100,000 people in 2014 was 68.[8] Factors that effect this range include the percentage of the population with serious mental illness, the availability of alternative treatment modalities such as P/ACT and AOT, the overall length of stay for psych inpatients, and, finally, the flexibility of financing of inpatient beds. Based on these factors, New York State should have capacity above the median range. According to NASMHPD, New York only had 55.3 inpatient beds per 100,000 population as of 2014.

Inpatient Psych Bed Decline in "Post-Berger" New York

Despite the ongoing need for beds, overall psych beds in New York have declined since the implementation of the Berger Commission closure and restructuring recommendations. According to NYS Institutional Cost Reports (ICR), New York State had 6,055 certified inpatient psych beds in 2000. By 2018, that number had dropped 12% to 5,419. More than 25% of the loss has occurred since 2015.[9] It's important to remember, that unlike state psych hospitals where certified bed cuts are mandated by state legislation—psych bed reductions in acute care hospitals happen through two major processes: 1) hospital closure, and 2) changes to certified bed capacity via the Certificate of Need review process via the Public Health and Health

Planning Council (PHHPC), the DOH body that evaluates hospital applications for certification and decertification of services. Where and how these psych beds have been lost are the critical questions that will help inform why these beds are now gone. We organized our analysis into two distinct categories—by region and by hospital health systems and will discuss each separately.

Figure 1
Certified Psych Beds Statewide 2000–2018
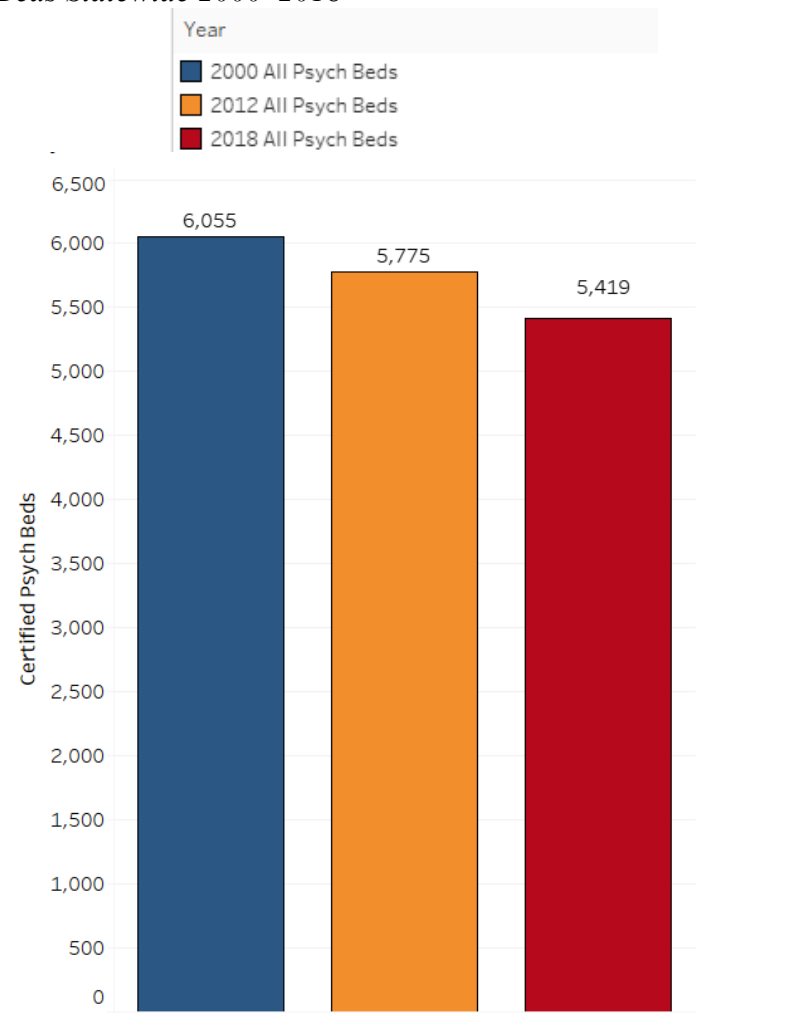
Source: NYS Institutional Cost Reports, 2000, 2012, 2018

Regionally, loss of psych beds is not uniform statewide. Some state regions have gained a small number of inpatient psych beds, the Mid-Hudson and Finger Lakes regions most notably, while most have lost beds. It is clear from the ICR data that Downstate (i.e., New York City and Long Island) has borne the brunt of the loss. New York City alone accounts for 72% of the decline in inpatient psych beds between 2000–2018, a total loss of 459 beds. Another 17% of the total bed decline (103 beds) is from the Long Island region. The remaining loss of 74 beds came from all other NYS regions combined. Note that New York City gained nearly 400,000 residents in this time frame.[10] Suffolk and Nassau counties also added nearly 100,000 people.[11]

Figure 2
Certified Psych Beds per Region 2000, 2012, and 2018

Year
- 2000 All Psych Beds
- 2012 All Psych Beds
- 2018 All Psych Beds
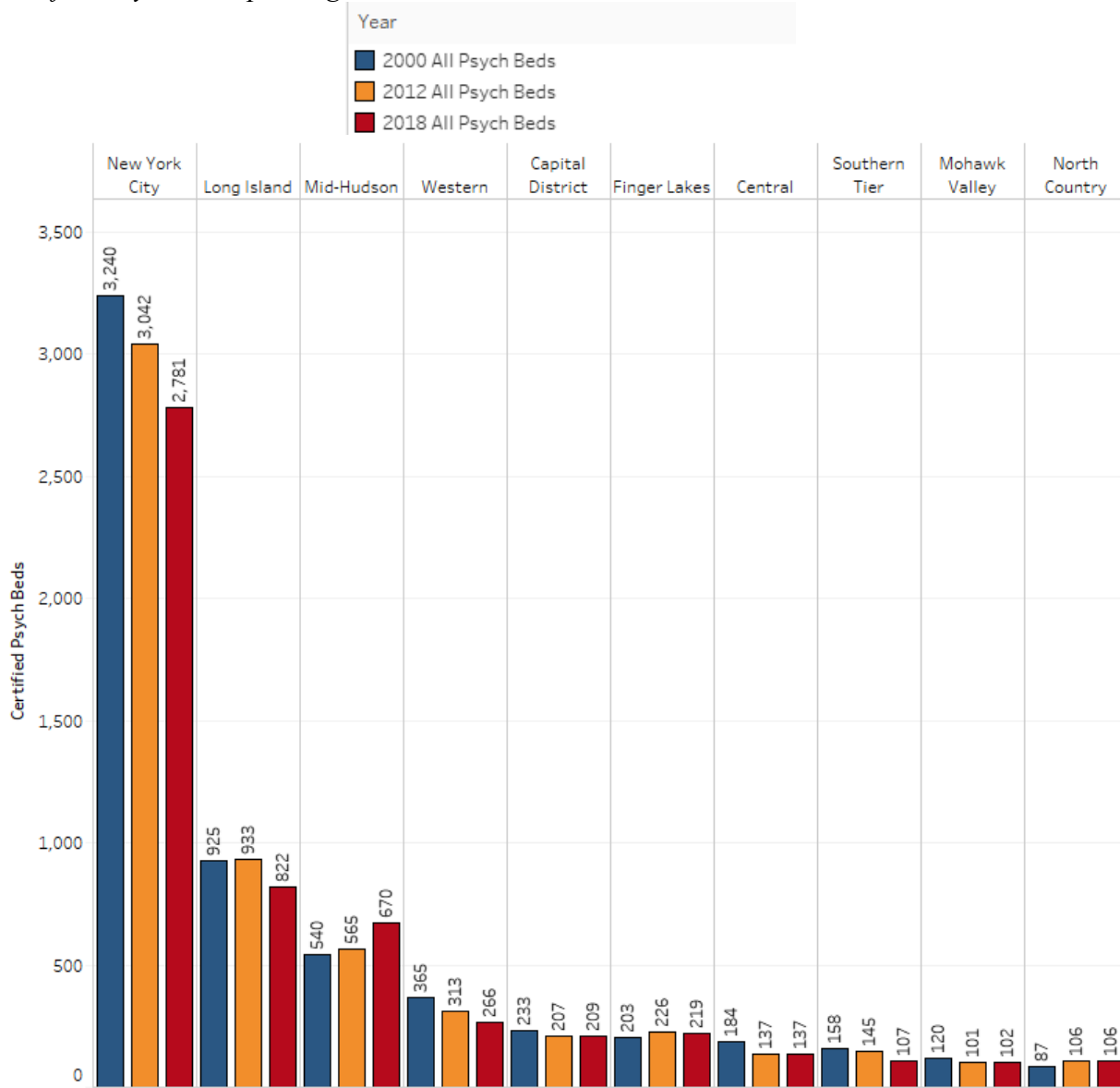
Source: NYS Institutional Cost Reports, 2000, 2012, 2018

To understand how these certified psych beds were lost, we looked at individual hospitals and hospitals systems over the same time frame. Two immediate critical points stand out in the time series data. First, the New York City Health + Hospitals System (NYC H+H), a public safety-net hospital system, holds the lion's share of certified inpatient psych capacity Downstate. Of the remaining 3,603 psych beds Downstate, 1,318 (37%) are in a NYC H+H facility. Second, nearly 67% of the psych bed decline was attributed to independent hospitals—hospitals not affiliated with any contemporary health system. Beds at 317 of 379 of were lost in hospital closures. A total of 260 of those beds were lost in the closure of Bayley Seton Hospital in Staten Island (66 beds) and Saint Vincent's Catholic Medical Centers in Manhattan (194 beds). Beds were also

lost with the closures of New York City's Cabrini Medical Center and North General Hospital. These facilities were of course all targets of the Berger Commission for downsizing or closure in 2007.[12]

While closures explain a large portion of the decline in psych beds, the rest of the psych bed decline is more dispersed but steady across hospital systems. In many cases, reductions came years after the Berger Commission-related cuts were made. Clearly, a different process than the rationalized reductions of a state panel is at work.

The primary payer for inpatient psych admissions in New York is the NYS Medicaid program. In 2018, there were about 117,000 inpatient psych discharges across the state.[13] About 75,300, or 65% of those discharges, were paid for by Medicaid.[14] Nearly 12% of Medicaid dollars for mental health care goes to inpatient hospitalization. Total Medicaid dollars spend on mental health in 2018 was about $2.2 billion. About $821 million of that went to inpatient psych hospitalizations—and most of that $685 billion went to Article 28 acute care hospitals.[15]

In contrast, federal government regulations stemming from the policy push toward deinstitutionalization prevent the state from receiving any Federal Medical Assistance Percentage (FMAP) for the cost of inpatient stays for adults at state psychiatric hospitals.[16] This gave the state an incentive to move the delivery of care to acute care hospital programs, but once it did, overall growth in spending was largely removed from the operational control of the OMH and placed with chief financial officers and revenue cycle managers of the state's public and private voluntary hospitals. Psych discharges at these acute care facilities started steadily increasing between 2000–2010. As a result, in 2010, the New York State Dept of Health (DOH) rolled out a new Inpatient Psych Reimbursement Methodology for the Medicaid program, the primary payer for these services. [17]

Figure 3
*Total Psych Discharges 2000, 2012, and 2018*
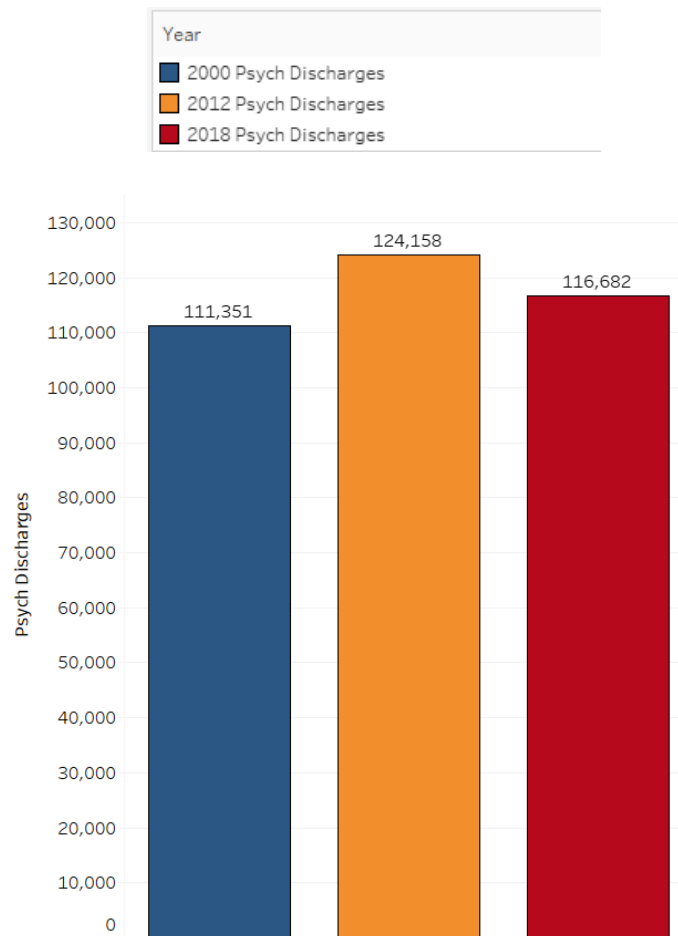
Source: NYS Institutional Cost Reports, 2000, 2012, 2018

The new reimbursement methodology was to be phased in over a 4-year time frame and contained $25 million in added transition funding to assist hospitals' "transition" to the new formula.[18] The new formula, DOH argued, would reduce the length of hospitalization stays for severe mental illness in New York, which up until 2010 had been the longest in the nation. Like most public health policymakers at the time, DOH was sure we could achieve better care outcomes with less (e.g., fewer hospitalizations and shorter hospitalizations). Even though the number one diagnosis-related group (DRG) for hospitalization in New York was—and still is— schizophrenia, the DOH decided to adjust payment for length of stays over 12 days by a factor of less than one (essentially a reduction in payment).

As the new reimbursement methodology went into effect, inpatient psych discharges increased. In 2012, there were just over 124,000 discharges compared to 111,400 in 2000. Discharge numbers hit their peaks in 2014 and 2015. In 2015 there were 83,000 inpatient psych discharges

covered by Medicaid.[19] When the new reimbursement methodology was fully implemented however, voluntary hospitals began announcing plans to shutter inpatient psych units.

**Figure 4**
Total Medicaid Psych Discharges 2014–2018
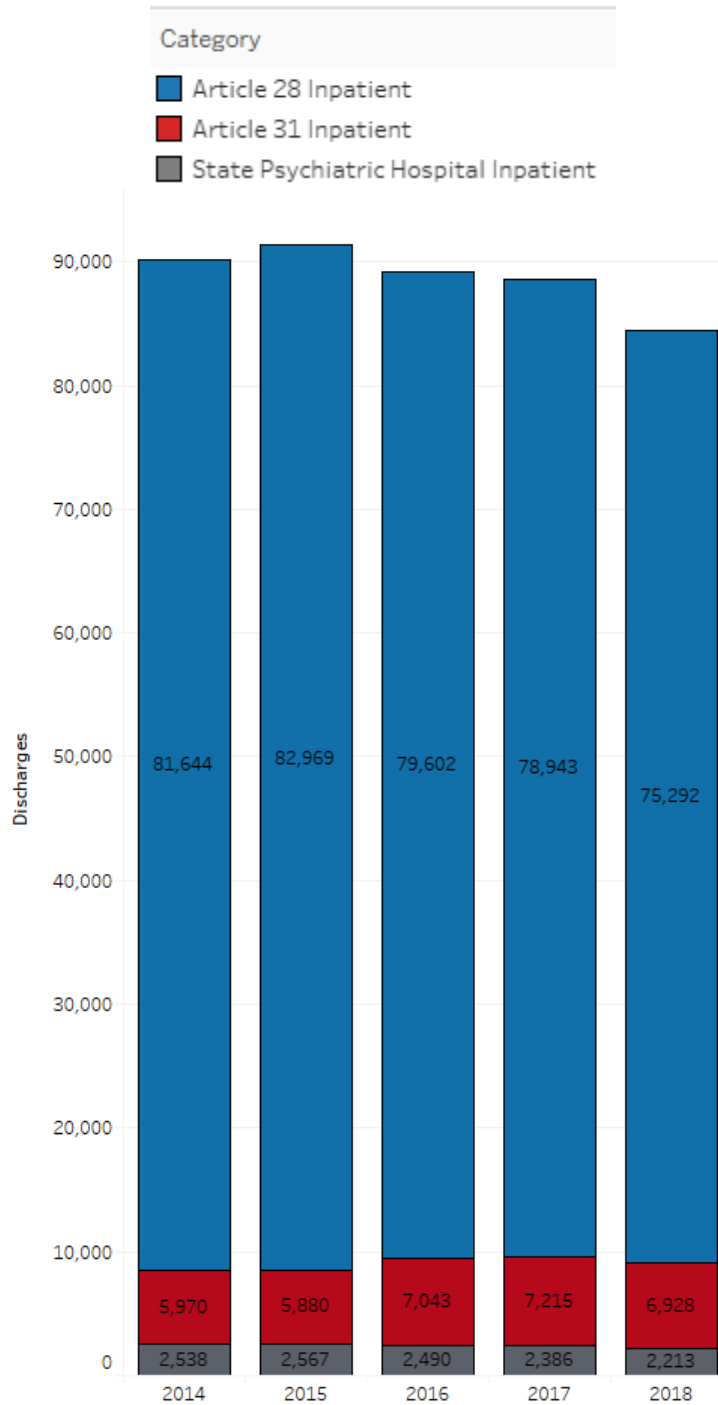
Source: NYS OMH Medicaid Population Characteristics and Service Utilization Trends

We examined net patient revenue (NPR) per psych discharge over the period and found that by 2018, the NPR of each psych discharge was just under $4,100. Adjusting for inflation, we found that the NPR for each psych discharge was $4,728 in 2012, down from $5,186 in 2000.[20]

Figure 5
*Net Patient Revenue per Discharge 2000–2018, Adjusted for Inflation*
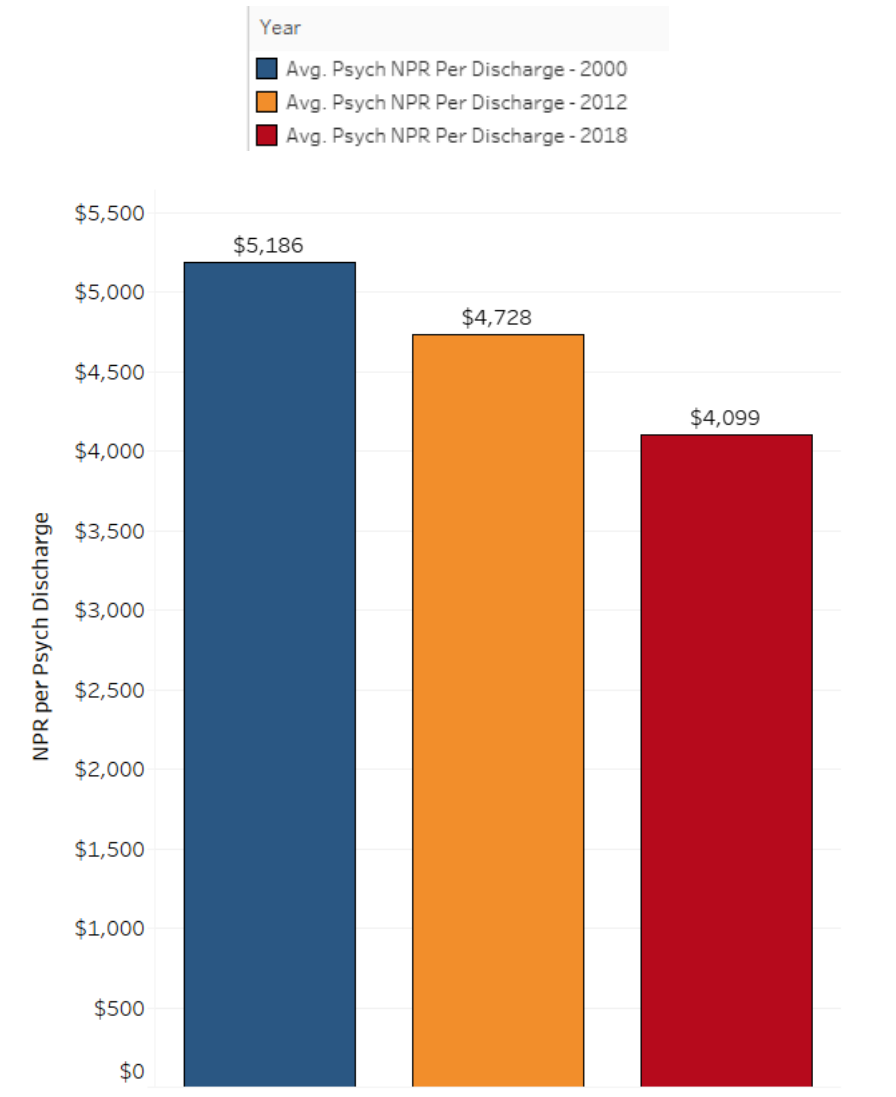
Source: NYS Institutional Cost Reports, 2000, 2012, 2018

There is also the consideration that, without lucrative procedures associated with each psych admission, psych beds do not generate enough NPR to make them desirable to hospitals. Inflation-adjusted NPR per bed dropped from just under $100,000 per bed in 2000 to about $88,000 per bed in 2018. In contrast, the average NPR per bed across all beds, regardless of type, was about $1.6 million in 2018.

Figure 6

Net Patient Revenue per Bed (2000–2018), Adjusted for Inflation
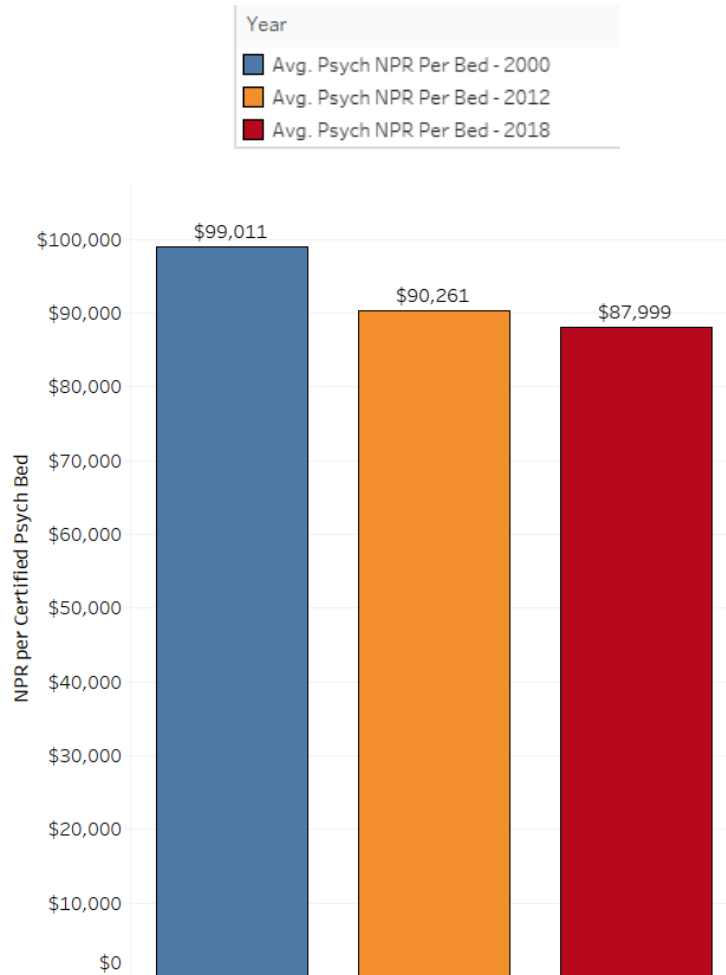
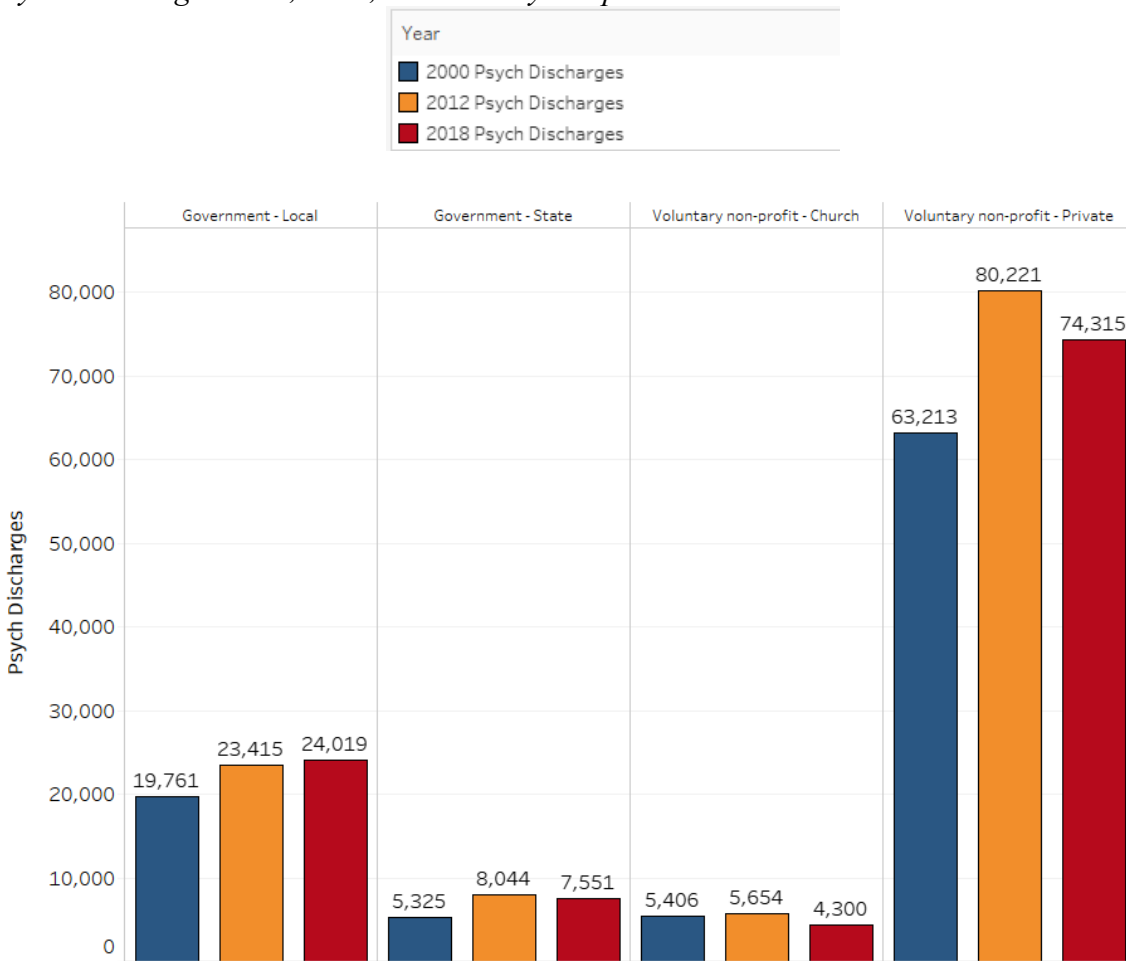*Source: NYS Institutional Cost Reports, 2000, 2012, 2018*

With the details of reimbursement for inpatient psych services in mind, we can now look back on the data and narrative of inpatient psych facility closures in the critical 2015–2018 time period. There is now even more proposals to close psych units being communicated nearly monthly in post-COVID-19 pandemic New York.

Inpatient Psych Bed Reductions, Select Health Care Systems

When looking at psych capacity and discharges in New York State, we must separate voluntary nonprofit health care systems from public, safety-net health-care systems. As private nonprofit hospitals shed psych patients, the burden is being picked up by public hospitals. A study by the NYC Independent Budget Office showed a 20% increase in mental health discharges at NYC Health + Hospitals during the 5-year period between 2009–2014, while New York City's

voluntary nonprofits showed a 5% decrease in discharges.[21] Our more recent data from 2012–2018 also shows an increase in discharges, albeit a smaller one, for local government-run hospitals statewide (the majority of all local government-controlled beds are at NYC H+H facilities). A similar decrease in discharges at voluntary nonprofit hospitals, including academic medical centers is also noted from 2012–2018.

Figure 7
Psych Discharges 2000, 2012, and 2018 by Hospital Form

Source: NYS Institutional Cost Reports, 2000, 2012, 2018

Public hospitals systems such as the NYC Health + Hospitals and State University of New York (SUNY) hospitals are inherently more responsive to political and community concerns, particularly protest.[22] While private hospital systems are mostly free to close services in communities that need them by petitioning the Public Health and Health Planning Council (sometimes even sidestepping that process as well), public hospitals that attempt to close services are usually met with community resistance and pushback from the legislators who represent those communities. As a result, the erosion of inpatient psych capacity is not nearly as pronounced in public systems as it is in private voluntary systems.

Some private voluntary systems are also showing elements of organizing into a hub-and-spoke model of health-care delivery, not just for psych, but all major medical, mental health, and long-term care services.[23] Whereas New York used to have full-service hospitals in communities that needed the care, we now see health systems organized into a hub or "main campus" and surrounded in its catchment area by a network of smaller hospitals (often with a particular specialty or unit not available elsewhere in the system except for the main campus—i.e., a "center of excellence"), and ever-larger and more-integrated primary, ambulatory care, and standalone urgent/emergency services (and physicians). Many of New York's health systems integrate primary care or command and control administrative functions in a centralized location as well. The next logical step that some systems are pursuing are EPO or exclusive provider organization-like insurance networks, somewhat modeled on California's Kaiser Health System. Even NYC Health + Hospitals is marketing its MetroPlus plan aggressively, with the city offering it to its public employees for zero co-pay or co-insurance.

This form of organization may come with certain operational advantages, particularly financial benefits in the way of cost efficiencies. But these organizations also tend to bring a consistency in patient experience due to their central management and policy-making. Care coordination may be easier for both the providers and patients to manage, but there are huge risks involved as well, the most obvious being congestion points at the hub of a service.

It also requires moving services out of certain communities and into a medical hub point. This has the potential, particularly in New York, of stranding certain patients (due to lower socioeconomic status or age) without options for care in their communities. Even when transportation is available, some patients who have been using a certain hospital or provider for decades may simply not want or know to travel to a different county to obtain services at a hub. Still, New York State is partnering with Uber and Lyft to provide medical transportation as hub-and-spoke services become the norm.[24]

We should look at inpatient psych bed reductions in this framework. Often consolidation of the hub-and-spoke model of health-care delivery is the implied purpose of applications to change certified beds on a hospital's operating certificate. In the era of Medicaid redesign and DSRIP, these changes are incentivized with grant funding and shared savings enhancements. Montefiore Health System for example received a $65 million NYS Transformation Grant to build a "medical village" consisting of outpatient and ambulatory care services in Mount Vernon, New York. But part of their proposal for amending its current operating certificates is to close down Mount Vernon Hospital and move inpatient psych bed capacity to the hub, Montefiore Medical Center in the Bronx. The process, which they started in 2016 shortly after acquiring Mount Vernon and New Rochelle hospitals, moved 22 inpatient psych beds to the hub. It is believed that upon acquisition of St. John's Riverside Hospital in Yonkers, that its inpatient psych capacity in Yonkers will be moved from the community to the Montefiore Medical Center hub as well.

Not all private voluntary hospitals systems are purely seeking this form of hub-and-spoke organization, but most private voluntary hospital systems include elements of it. Here we look at Westchester Medical Center, NewYork-Presbyterian, and Northwell Health, as all three of these

systems have announced recent changes and/or cuts to inpatient psych capacity. NewYork-Presbyterian as an entity is a product of a mid-'90s megamerger between the Presbyterian and New York hospitals—though to date, NYP has eschewed some of the more aggressive vertical integrations like an EPO network.[25] Northwell Health has more aggressively consolidated its management functions. It owns and operates its own medical billing entity, and at one point tried selling an EPO insurance product called CareConnect. It has aggressively purchased and integrated physicians' networks and runs its own brand of walk-in urgent health-care clinics. It monitors recent discharges for potential readmission from a centralized call center, and all its admissions and triage for emergency and inpatient psych care are done via a telehealth center in Manhattan.

Westchester Medical Center

Westchester Medical Center (WMC) is legally organized as a New York State public-benefit corporation, making it technically a public sector hospital. In recent years, it has been on an acquisitions spree, obtaining controlling interest and "parent" hospital status of Bon Secours hospital system in New York, the old St. Francis Hospital in Poughkeepsie (now MidHudson Regional Hospital), and the HealthAlliance of the Hudson Valley (HAHV) system in Kingston, consisting of a former Catholic hospital (Benedictine Hospital, now HAHV Mary's Avenue) and a public town hospital (Kingston Hospital, now HAHV Broadway). Westchester Medical Center controls these hospitals through intermediate corporate organizations that are not public-benefit corporations, therefore only the main Westchester Medical Center campus in Valhalla, New York, is considered a public sector hospital.

WMC's expansion into the Hudson Valley exemplifies the hub-and-spoke model. WMC has recently broken ground on a NYS Transformation Grant/DSRIP-funded project to convert HAHV into a "medical village" offering outpatient, ambulatory, and urgent care while HAHV Mary's Avenue will become the front face of inpatient services for Ulster County. However, an FBI and U.S. Attorneys Office investigation in 2014 and 2015 made clear that at least some of WMC's motivation for expanding up the Hudson River was to broaden referral opportunities to its main facility in Valhalla.[26] Very recently, WMC announced that inpatient psych capacity at the HAHV system in Kingston will be transferred in its entirety to MidHudson Regional Hospital in Poughkeepsie. (There is some dispute over whether this is a temporary or permanent change, and WMC has not responded to inquiries asking for clarification.)

WMC is an interesting case, because unlike most health systems in New York, the combined inpatient psych capacity of the facilities that make up the health system has actually seen *an increase* in inpatient psych capacity. The increase of inpatient psych beds in the WMC Health System is largely responsible for the increase in capacity of the Mid-Hudson region as whole. It is important to this analysis because of its recent announcement to move psych beds from Kingston to Poughkeepsie—which nurses say is an interim step for most patients to be transported to the main WMC campus in Valhalla.

Figure 8
WMC Psych Beds 2000, 2012, and 2018
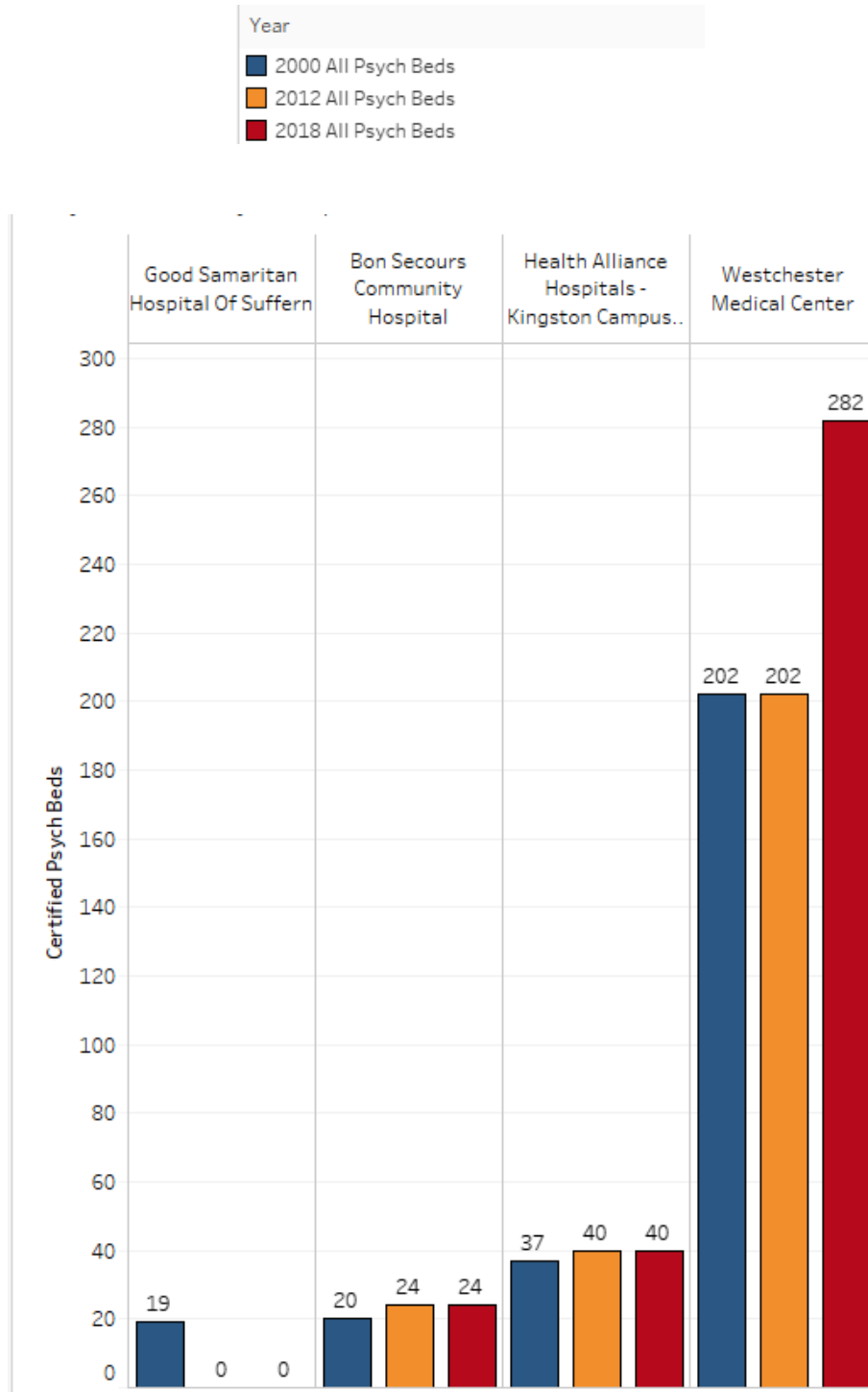
Source: NYS Institutional Cost Reports, 2000, 2012, 2018

Good Samaritan Hospital decertified its beds long before WMC took over their operations and other inpatient psych capacity has increased system wide by 87 beds, more than offsetting losses across all other Upstate regions.

The main WMC campus accounted for 82 of the 87 bed increase. Because the old St. Francis Hospital operating certificate number was merged into WMC's main operating certificate, we know that 40 of those 82 beds came from the acquisition of what is now MidHudson Regional Hospital. Still, few public hospitals or nonprofits have added inpatient capacity.

The issue with WMC is not with the quantity of available inpatient psych care, it is with the organization and geolocation of psych services. Removing inpatient psych fully to Poughkeepsie and ultimately to Northern Westchester County makes it exceedingly difficult for residents of Ulster County to access these needed services.[27] For someone with severe mental illness, even after the Medicaid payment reforms of 2010, length of stay per admission averages up to 10 days.[28] Family and visitor travel to Poughkeepsie and Valhalla over a long length of stay can be difficult or impossible, and if a readmission is needed (more likely for someone diagnosed with SMI), the patient will need to once again present locally and be transferred or rely on family and clinical support to transport them up the Hudson.

In the case of WMC, adding beds in a far-flung geographic location is effectively the same as a service cut to the community that is losing proximity to inpatient beds.

NewYork-Presbyterian

NewYork-Presbyterian (NYP) is in interesting case study because of its well-documented campaign to shadow close its inpatient psych unit at the Allen Pavilion and replace it with an operating room expansion of its more lucrative spinal center.[29] While NYP requested permission from PHHPC to decertify the psych beds from its operating certificate, NYP stopped staffing the beds with psychiatrists and nurses and announced to the staff that closure of the psych unit was imminent even before the request got to the formal PHHPC review process. Presbyterian has not yet received an amended operating certificate to remove these psych beds from the care delivery system.

Even without the removal of Allen's psych unit from its data, NYP has cut its psych capacity by nearly 80 beds, or 20%, over the last 18 years. It also removed a small number of beds from the Manhattan Gracie Square Hospital, which it claimed it would rely on for delivery of care after any shutdown of Allen psych. NYP has recently announced a plan to eliminate 50 psych beds from Methodist Hospital in Brooklyn without even bothering to feign asking DOH approval this time. (NYP COVID-19 Pandemic related psych closures will be discussed later.)

Figure 9
*NewYork-Presbyterian Psych Beds 2000, 2012, and 2018*
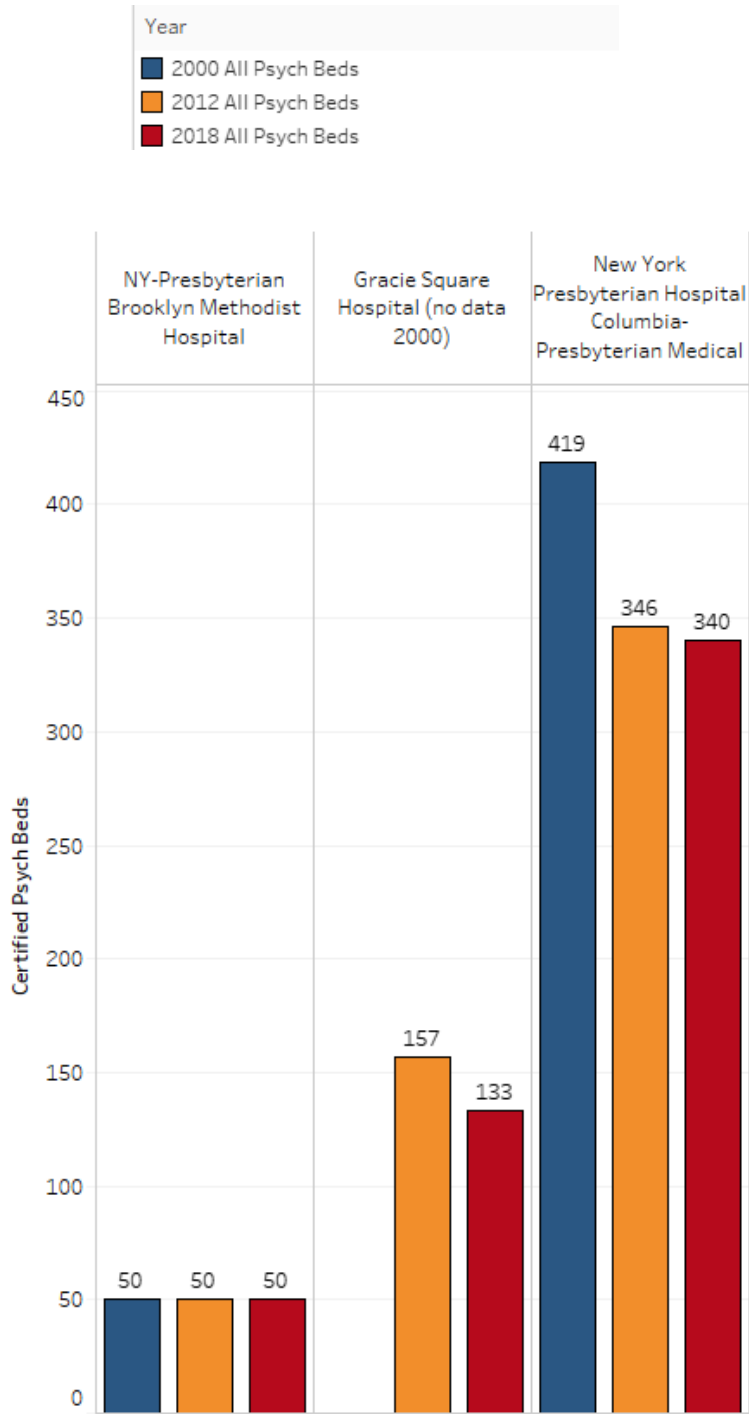
Source: NYS Institutional Cost Reports, 2000, 2012, 2018

Northwell Health

Northwell as a system is responsible for the second largest decline in inpatient psych capacity in NYS independent hospitals. This includes the now-closed Saint Vincent's facilities in Manhattan. Since 2000, 159 psych beds at Northwell facilities have disappeared, accounting for 25% of statewide closures. Northwell has achieved this reduction through a long history of takeovers and mergers that have slowly chipped away at overall psych capacity. After 2012, Northwell decertified 18 psych beds at Glen Cove Hospital, 21 psych beds at Long Island Jewish Valley Stream, 28 psych beds at Plainview Hospital, 20 beds at Southside Hospital in Bayshore, 29 psych beds at Staten Island University Hospital, and 26 beds at Syosset Hospital (with a plan to close the Syosset unit entirely in the near future). Its psych specialty hospital, Brunswick Hospital Center at South Oaks Hospital in Amityville has maintained its bed count at 124. Northwell scrapped a plan five years ago to move Syosset's certified psych beds to Brunswick.[30] Its flagship facility, Long Island Jewish Medical Center in New Hyde Park has maintained its 236 psych beds. And so far, Northwell has not slashed psych beds at Maimonides Medical Center in Brooklyn, which it recently acquired with the help of a state grant.

Northwell is an excellent example of what slow and steady reductions of capacity looks like over many mergers. Last year, Northwell opened an "emergency telehealth" center that performs (and prevents) intake and admissions for its systemwide inpatient psych beds at the old Saint Vincent's facility, which had previously been converted into a Northwell free standing emergency department.[31]

Figure 10
*Northwell Health System Psych Beds 2000, 2012, and 2018*
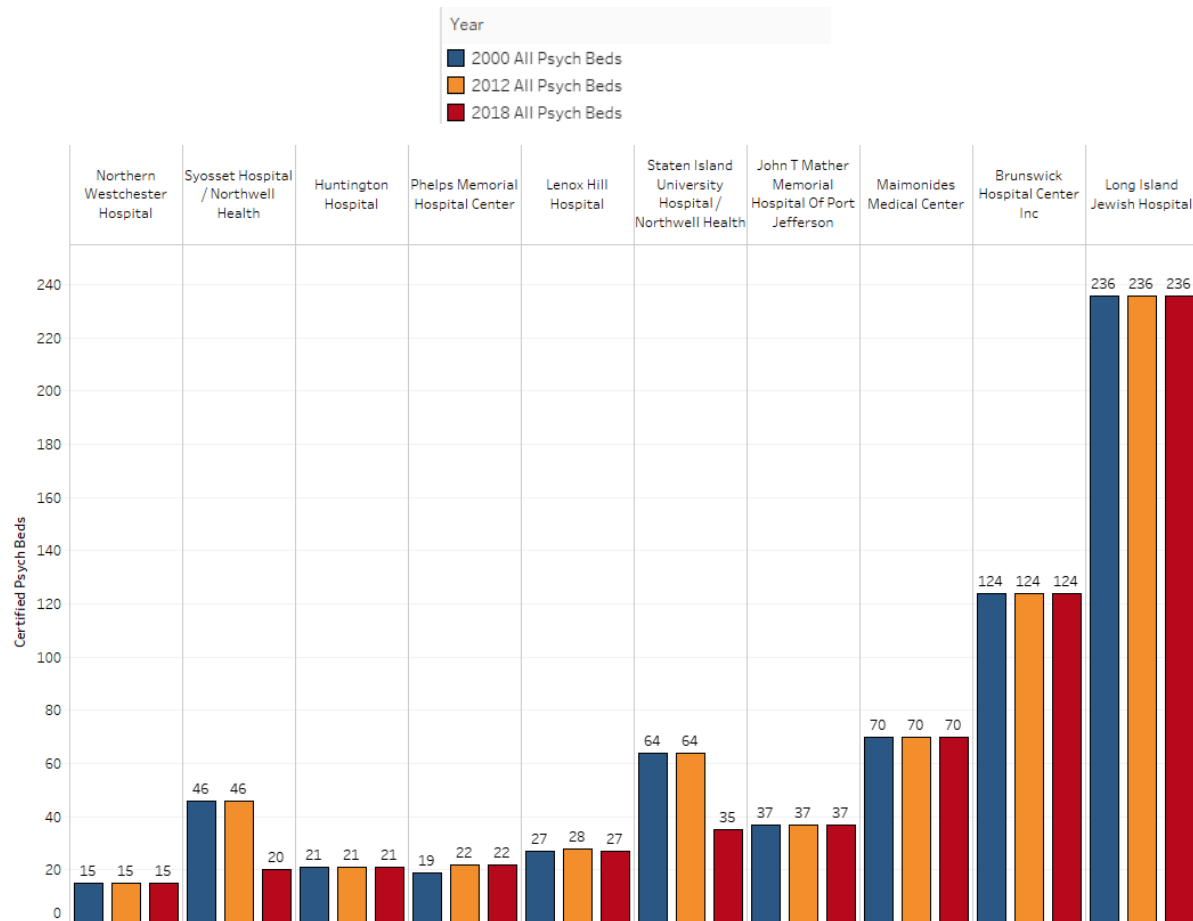
New York City Health + Hospitals System

As financial pressures to close psych beds in Article 28 voluntary nonprofit private hospitals mount, the public New York City Health + Hospitals System (NYC H+H), has been tasked with providing more and more inpatient mental health care to New Yorkers. According to the *New York Times* and IBO's study on New York City psych services, NYC H+H often ends up with patients with SMI who are unable to seek any other type of outpatient services or care. They present in the emergency department (ED) of a public hospital in serious crisis with few alternatives to hospitalization.[32] That patients would end up at NYC H+H facilities is not a surprise, as Bellevue, Kings County, and Elmhurst alone account for nearly 25% of Article 28 inpatient psych beds in New York City. In 2017, the NYC H+H system had nearly 70,000 ED visits stemming from mental illness.[33] Yet, Kings County and Elmhurst have both reduced certified psych bed capacity, as have Metropolitan Hospital, Jacobi Medical Center, and Queens Hospital Center. These bed reductions have come as discharges hit their highest levels in 20 years.[34]

Figure 11
NYC Health + Hospitals System Psych Beds 2000, 2012, and 2018
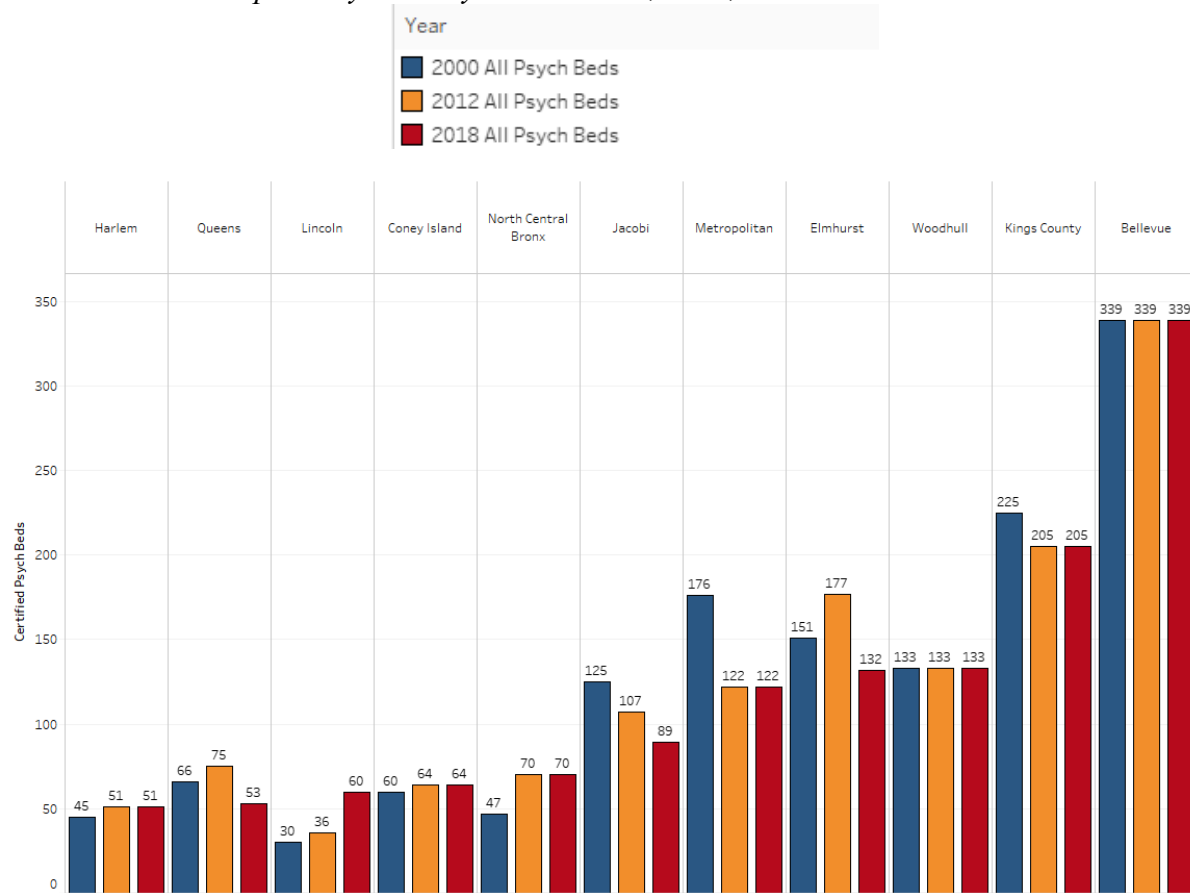
Source: NYS Institutional Cost Reports, 2018

__Mental Health and Corrections__

Psychiatric services feature prominently among the health needs of New York's prison population, both at the city and state levels. About half of New York City's incarcerated population is estimated to have a mental health diagnosis, a percentage which is on the rise.

Individuals with mental illness are vulnerable to cycling in and out of the correctional system—and, for some, the homeless shelter system as well—due to failures at multiple levels. Beginning with an emergency response system ill-equipped to serve the needs of the mentally ill and ending with a shrinking menu of treatment options available to individuals when they return to their communities, New Yorkers would be better served by expanding access to care outside the correctional system and releasing mentally ill detainees.

New York City and State have separate budgets for funding the correctional system, however New York City does receive some state and federal aid. Care for those with mental health diagnoses is provided by different government agencies or subcontracted to nongovernmental providers. At both levels, however, the overall correctional budget has decreased due to a declining jail population.

New York City's Correctional System

New York City allocates about $1.3 billion to the NYC Department of Correction (DOC) annually, as well as an additional $2.6 million towards the Board of Correction (BOC). For fiscal year 2021 (FY2021), this number dropped to $1.14 billion for the DOC in light of a series of budget cuts in response to the COVID-19 pandemic.[35] Health services in city jails are provided by Correctional Health Services, which is a division of the NYC H+H system. Health and Health Programs[1] spending for the city came in at just under $50 million in 2020, about $10 million less than two years prior.

The reduction in health spending follows a general trend in the DOC's allocations in response to a declining jail population; however, these spending cuts have only begun in the last several years. The average daily population (ADP) in NYC correctional facilities had 5,424 fewer people in 2019 than in 2009, but spending during that same period increased by $387 million. Likewise, the cost per detainee has risen by 85% since 2014 alone.[36]

Part of this drop can be explained by the yearslong effort to close Rikers Island, and replace the facility with several smaller, borough-based jails. The plan aims to reduce the city's jail population by three-quarters and reduce staff headcount through attrition, which will bring down the budget in the interim.[37]

As more people have left the system in recent years, the proportion of those incarcerated who have a mental health diagnosis has grown. In 2011, 32% of the ADP had a mental health diagnosis.[38] In 2014,[39] that number was 38%,[2] and by 2019, 45% of detainees had a mental health diagnosis. Approximately 17% of detainees today are diagnosed with an SMI.[40]

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[1] According to a city briefing paper, Health and Health Programs encompasses "...programs ranging from discharge planning services to various correctional industries, including the baker, tailor shop, laundry, and print shop. These programs are designed to keep individuals in custody healthy, as well as reduce recidivism."

[2] About 1/3 of that 38% was estimated to have a "serious mental illness".

Figure 12

Average Daily Population with a Mental Health Diagnosis 2011–2019
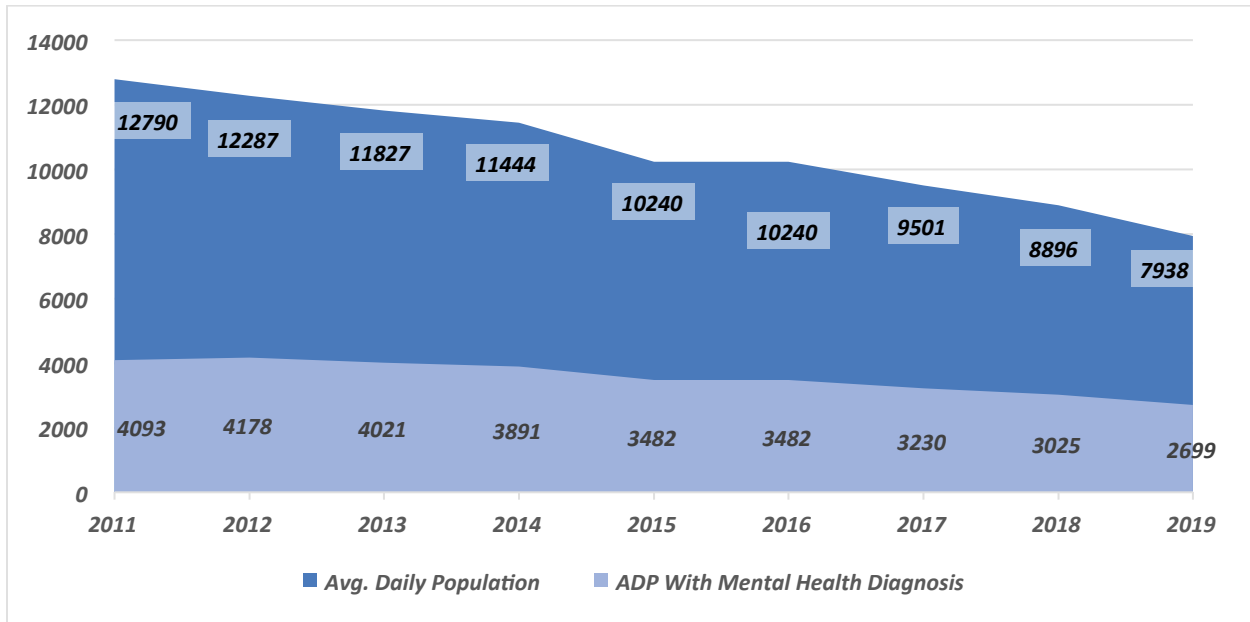
Mental Health Services in City Jails

Mental health care in jails is primarily provided in mental observation units, which are bedded units located within the correctional facilities themselves. At the moment, New York City has 17 of these mental observation units with 540 beds total. An additional 181 beds inside prison facilities are dedicated to the system's Program for Accelerating Clinical Effectiveness (PACE) and Clinical Alternatives to Punitive Segregation (CAPS), which aim to provide an alternative to solitary confinement as a punitive measure for individuals with mental health diagnoses.

The city correctional system also has two secure wards in NYC H+H hospitals for detainees in need of more serious psychiatric treatment. The Bellevue Hospital Prison Ward has 68 beds for men requiring acute care, and the Elmhurst Hospital Prison Ward has 14 beds for women requiring acute care.

The 2020 budget included a number of provisions to address the growing proportion of mentally ill detainees. The provisions focus on preventing incarceration, improving treatment for those already incarcerated, and bolstering the programs available to help transition those released back into their communities. These services will operate in collaboration with other city agencies, as well as the New York Police Department (NYPD), the NYC Department of Health and Mental Hygiene(DOHMH), and the mayor's office of mental health ThriveNYC. The plan will cost the city $323 million between fiscal year 2020 and 2023.[41]

Preventing Incarceration

For many New Yorkers who are experiencing a mental health crisis, calling 911 is the most readily available emergency service. However, not only has the NYPD experienced a ballooning number of mental health-related calls over the last decade,[42] but only about one-third of its officers have received the Crisis Intervention Training (CIT) that directly addresses mental health situations.[43] Moreover, a NYC Department of Investigation report found that several years into the program, there was still no mechanism in place to ensure CIT-trained officers were dispatched for mental health emergencies.[44]

Dispatching police officers to mental health calls, as opposed to behavioral health professionals, can be deadly at worst, and in other cases may result in worse outcomes for the patient on top of their arrest and incarceration. People with serious mental illnesses are not always responsive to police commands and can behave in ways that police perceive as defiant or threatening. If officers are not trained to de-escalate a situation, it can result in arrest leading to a series of events which continually return the patient to the carceral system.

One example, a case from Washington State involving Calvin, a 20-year old with severe bipolar disorder, illustrates how the cycle in and out of jail can begin. When police woke Calvin up, they assumed his erratic behavior was due to intoxication, and while he waited for his toxicology screening at the hospital, he was placed in involuntary treatment because of his symptoms. Although he was hospitalized, a bench warrant was still issued for Calvin's arrest, as he failed to arrive at his own arraignment.

His condition did not improve after his release, and despite having a serious mental illness, the next time Calvin interacted with police, the outstanding warrant landed him in jail. For individuals with serious diagnoses, jail time can drastically worsen their condition, not just due to the harsh environment and isolation, but also because—as in Calvin's case—it can disrupt access to medication and other treatment.[45]

The FY2020 measures build on a number of existing plans developed by ThriveNYC to provide emergency response led by mental health professionals. Three of these, Health Engagement and Assessment Teams (HEATs), Mobile Crisis Teams (MCTs), and Co-Response Teams (CRTs) are available through the NYC Well hotline. Out of the three, only the CRTs respond to 911 calls and include police officers.

CRTs are operated as a collaboration between DOHMH and NYPD and include two police officers and one mental health professional. They serve people with serious mental health or substance abuse challenges who pose an elevated risk of harm to themselves or others. They have been operational since 2016 and have served over 1,600 people since the program's inception.[46] However, the teams only began responding to 911 calls in 2020 and have not always dispatched CIT-trained officers. The FY2020 budget aims to add four new CRTs at a cost of $1.4 million.

MCTs respond to calls, which, according to a description on the NYC website, are situations "requiring prompt attention but not immediately life threatening."[47] There are currently 24 MCTs

in operation and they are tasked with conducting an assessment, referring the caller to community services, and following up several days later.[48] These teams have a far lower rate of visits that end in the emergency room, just 2.3% compared to 50% for police response to mental health calls.

However, MCRs have a limited scope. In order to transport patients to the hospital, or if the person presents an immediate threat, the team is directed to call 911. Once the police arrive, the team can stay on to advocate for the patient and make sure they receive proper care. Other limitations of the system include an average response time of 17 hours, and an overreliance on referrals to health services that are not always accessible to the patient.[49] New York City plans to add six more MRCs at a cost of $11.4 million.

The FY2020 budget also allocates $2.9 million to expand and continue HEAT. These teams are comprised of one clinician and one peer[3] tasked with reaching out to New Yorkers who call 911 frequently for mental health emergencies.[50] At the moment, teams do not respond to 911 calls, but instead are contacted by police or other city agencies, such as the NYC Department of Homeless Services.

On top of bringing in mental health professionals to respond to emergencies, the FY2020 budget also outlines a second approach—opening Support and Connection Centers where police can bring those in crisis as an alternative to keeping them in custody. The centers are bedded, and can host up to 19 people at a time for 5–10 nights each.

Support and Connections Centers will serve individuals in non-emergency situations, by stabilizing, engaging, and treating them. Police are instructed to drop individuals off at the center and leave immediately afterwards, with no requirement for that person to seek or receive help once they are brought there. The first two are located in the Bronx and East Harlem, and will be operated by Samaritan Daytop Village and Project Renewal, respectively.[51] The Harlem center opened in February 2020 and the other was to follow, but both have been interrupted by COVID-19.

Improving Treatment for Incarcerated Individuals

At present, mental health services within city correctional facilities are primarily provided in mental observation units, with additional secure wards in two hospitals for those needing more acute care. The effort to improve current mental health resources will focus on expanding what is currently available and incorporating more mental health resources into the new borough-based jails that will be built as part of the plan to close Rikers Island.

The newly built jails will have 40% of their beds considered "therapeutic beds," which will be in units adjacent to NYC H+H facilities, but away from the public and other patients. Patients needing various forms of continuous care, ranging from cancer treatment to psychiatric needs, will have access to these units. The plan will bring in 250 beds between Bellevue and Woodhull hospitals.[52]

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[3] *NYC defines a peer as someone who has previously experienced a mental health crisis.*

An additional $12.8 million is designated to expand PACE and CAPS services within facilities in order to provide alternatives to solitary confinement for individuals with mental illness.[4] In order to qualify for CAPS or PACE services, a patient must be characterized as SMI, meaning that solitary confinement could cause severe harm and possibly death. CAPS units are modeled after inpatient psychiatric programs and engage inmates in therapeutic activities out of isolation.[53]

PACE programs are units where both health and security personnel work to stabilize patients returning from court-based competency evaluations, inpatient hospitalization, or those with complex diagnoses requiring hospitalization.[54] Both CAPS and PACE units have operated since 2015 and there are currently six PACE units with 148 beds among them.[55]

Inmates at correctional facilities are able to attend mental health appointments with health services, although attendance at those meetings is not guaranteed, as is demonstrated in Correctional Health Service's monthly reports. In 2019, between 17% and 23% of scheduled mental health appointments were missed because the patient was "not produced by DOC," meaning that the facility did not bring them to their appointment.[56]

Transitioning Back Into the Community

New York City's budget measures to expand re-entry programs focus on access to housing, and neighborhood support networks, in addition to the discharge planning and re-entry services already available. Correctional Health Service works with nongovernmental agencies, primarily Empower Assist Care (EAC), to create discharge plans for mental health patients and facilitate continued access to care. EAC also operates a Community Re-Entry Assistance Network (CRAN) in each borough to help transition people with severe mental illness out of Rikers Island.[57] Discharge planning for individuals between 18–21 years of age is done in collaboration with ThriveNYC.[58]

New York State's Correctional System

New York State's correctional facilities have experienced a population decline over the last decade. There were 63,757 prisoners in the Department of Correction and Community Supervision (DOCCS) custody at the end of 2006, and 52,245 at the end of 2016, a decrease of 19%.[59] The allocation to DOCCS by the state also decreased, from $3.28 billion in FY2018 to $2.87 billion in FY2020.[60]

DOCCS prison population has decreased 41% since 1999, however the number of DOCCS staff has not decreased at the same rate. While in 2003 there were 3.2 inmates for every uniformed member of staff, that ratio today is 2.5 to 1.[61] Mental health services in DOCCS facilities are provided through OMH, which is allocated close to $330 million annually for mental health services in prison.[62]

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[4] *The state banned the use of solitary for the mentally ill in 2014.*

Mental Health Services in State Prisons

Care available to state prisoners ranges from admission to state psychiatric facilities to satellite outpatient clinics and mental health units in prisons. New York State forensic facilities offer inpatient care to patients deemed incompetent to stand trial, patients not responsible for their conduct due to mental illness, and pretrial and sentenced inmates in local and county jails who require involuntary admissions. Between them, the seven forensic facilities in the New York State have 1,129 beds, equivalent to almost one-fifth of the total bed capacity in Article 28 inpatient psychiatric units.

Table 2
NYS Forensic Facilities and Bed Counts

NYS Forensic Facility Name	Beds	Admission Types
Central New York Psychiatric Center	189	State and local inmates in need of inpatient care
Kirby Forensic Psychiatric Center	193	Felony defendants found incompetent to stand trial or not responsible for their actions
Mid-Hudson Forensic Psychiatric Center	274	Felony defendants found incompetent to stand trial or not responsible for their actions
Northeast Regional Forensic Unit	17	Pretrial detainees needing inpatient care; felony defendants found incompetent to stand trial
Rochester Regional Forensic Unit	84	Felony defendants found incompetent to stand trial or not responsible for their actions; pretrial detainees needing inpatient care
Central New York Psychiatric Center Secure Treatment Facility	280	Sex Offender Treatment Program participants
St. Lawrence Psychiatric Center Secure Treatment Facility	92	Sex Offender Treatment Program participants

Source: New York State Office of Mental Health Division of Forensic Services

One of these, the Central New York Psychiatric Center, also operates 28 outpatient units and 15 satellite units that are located within DOCCS facilities. The prison generally takes on a caseload of about 10,000 among all its programs.[63]

In order to qualify for involuntary hospitalization at a state forensic facility, an inmate needs to be evaluated by a physician, who confirms that the inmate poses a threat of serious harm to themselves or others. Inmates who require commitment are then brought to Central New York Psychiatric Center in Marcy, New York.[64]

An estimated 12% of the state prison population has a serious mental illness,[65] which is about 6,269 individuals—five times as many people as there are beds in the forensic hospital system.

Transitional and Re-entry Programs

OMH also offers transitional programs to help with re-entry into the community. The Parole and Support Treatment Program serves individuals with persistent substance abuse issues, who are

homeless and released in New York City. The Community Orientation and Re-entry Program helps male prisoners with severe mental illness transition out of Sing Sing Correctional Facility. And a similar program, the Re-entry Coordination Program, helps individuals with severe mental illness returning to New York City from state prison. OMH also operates intensive case-management programs for such individuals returning to New York City.[66]

Have Outcomes for Psych Patients and Incarcerated Persons Improved?

In evaluating the trends in care delivery for psych patients in New York State—the closing of many beds in the inpatient state psych hospital system, the reliance (or overreliance) on Article 28 acute care hospitals for provision of inpatient psych treatment, a promising but not-quite-fully realized outpatient treatment system for the severely mentally ill, and the mix of services proffered to inmates in the city and state corrections system—we need to circle back to the original question posed at the outset of the most recent mental health reform era. Are psych patients in New York getting the right amounts of the right kinds of care? Are we in fact doing more with less?

Unfortunately, because we do not treat mental health care as an integrated system, we only have disparate measurements to reflect disparate populations of the mentally ill. NYPD data anecdotally shows New York City's mental health crisis is deepening. NYC Council Speaker Corey Johnson noted in a council hearing that between 2015–2018, calls reporting emotionally disturbed persons increased about 23%. Similarly, according to Housing and Urban Development data, the number of individuals with SMI among the NYC homeless population jumped 23% during the same time frame.[67]

The nonprofit new organization ProPublica has, over the same time period, published a provocative series documenting the lack of supports for mentally ill adults in New York who were released from dangerous group homes per a federal judge's orders in 2014.[68] These case studies are informative, yet data tracking outcomes and the movement of mentally ill individuals from inpatient facilities to group homes to supported living (or the correctional mental health system) is almost nonexistent.

By our sadly crude measures, we expect mental health in the aggregate across the population of New York to further decline the longer the COVID-19 pandemic drags on. Limited data released by New York City and the National Alliance on Mental Illness (NAMI) show that calls to the NYC Well hotline and NAMI's suicide hotline have skyrocketed. Economic and physical health factors may also lead to more acute care treatment among currently stable patients with SMI.[69]

Conclusions and Recommendations

Recommendations for Inpatient Psych Services in Article 28 Acute Care Hospitals
First and foremost, the NYS Department of Health needs to stop the closures of inpatient psych beds. New York is severely under-bedded, and while the flood of hospital closures has eased to a trickle, the decertification of psych beds is still happening without regard to systemic capacity or the placement of services.

Since the COVID-19 pandemic hit New York, Governor Cuomo's executive order suspending all Certificate of Need applications for any service changes related to the pandemic response and the requirement that all hospitals hold at least 30% of facility beds (and ICU beds) open in case of a second surge, have emboldened hospital administrations to close, perhaps temporarily, but possibly permanently, their inpatient psych units. Patients, communities, families, and advocates have no way of getting answers or accountability and the NYS Department of Health has failed to provide any assurances that the temporary easing of restrictions will not be allowed to become permanent means for eliminating less-than-lucrative mental health services.

Minimum service levels based on the population in need must be established. We cannot rely on the Hospital Association of New York's assurances of self-regulation for service adequacy. Each health-care system, operating in financial self-interest, will continue to whittle away at psych services as long as its financially beneficial and rational for them to do so.

Finally, we need a state standard for safe staffing levels in psych units with qualified clinicians. We do not want to go back to a system where overwhelmed staff struggle to provide quality care. Patients who go without adequate treatment often end up in the correctional system where adequate treatment appears to be even harder to access. The next section looks at the New York City and State corrections systems and how adequate treatment and diversion can improve outcomes for this shadow mental health system.

Recommendations for Mental Health Services and Corrections

The deinstitutionalization movement, which aimed to reduce the reliance on inpatient psychiatric services and increase the use of outpatient care in the community, overburdened the United States' correctional system. As people requiring inpatient care were increasingly unable to access it, they have moved into the country's prisons and jails, where they do not have the resources they need for treatment.

In New York City, an increased recognition among lawmakers that people experiencing a mental health emergency do not belong in the carceral system has led to a slew of efforts to both divert them to community care and to treat those already incarcerated in a way that will, if nothing else, not severely exacerbate their illness.

However, with its $50 million plan to keep people with mental health diagnoses out of jail ($100 million when including homeless service programs), New York City's path fails to address the structural change necessary to break the cycle.

For both city and state governments, the approaches to diversion and a reduction in recidivism are restricted by a lack of continuing care in the community, which has only become more extreme under the COVID-19 pandemic. For instance, when asked about referrals to community mental health services, an individual who worked on an MCT between 2016 and 2018 said, "Many of the services you want for people are not even remotely available and people know it.[70]"

A solution to a problem which intersects heavily with the issues of poverty, health-care access and homelessness will always be limited in its results if larger, systemic issues are not addressed at the structural level. In order for care in the community to be effective, individuals need stable housing and access to a health-care provider so they can adhere to treatment.

While emergency response teams, diversion centers, and re-entry programs do address the fact that individuals with a mental illness do not belong in jail, they offer little—especially in light of the impending fiscal crisis—in the way of long-term solutions for keeping individuals out of the system. We believe that registered nurses and other frontline professionals are the answer to providing adequate emergency responses, to triage emergent situations in the community, and provide clinical guidance on when and if to bring patients to a facility.

The plan itself, implicitly recognizes that the services provided in inpatient care settings, like those the CAPS program is modeled after or those which will be offered in the new borough-based jails, are effective. It is essential, then, that New York State also fight to not just preserve, but expand the shrinking inpatient psychiatric capacity offered outside of correction facilities. Otherwise, New Yorkers will continue to require an emergency response when they are unable to access proper psychiatric care in their own communities.

Conclusions

The outbreak of the novel coronavirus has heightened the inherent structural issues present in how we deliver psychiatric services across New York State. The overall trends in Article 28 facilities to reduce inpatient capacity has driven a race to decouple inpatient care from certain areas of treatment to meet evolving clinical standards as well as maximize potential reimbursement. In the realm of psychiatric care, this has led to patients moving out of institutions and into the community. Many of these patients are not equipped for community-based or self-directed care. Cuts in services and capacity have left these patients with few, if any, options and have led to increasingly harsh encounters with law enforcement and our carceral system.

We believe that the only path forward is to stop these cuts immediately and for regulators to partner with stakeholders and frontline professionals to stymie the reductive state of inpatient psychiatric treatment in New York. Revitalizing inpatient capacity and incentivizing providers to maintain and expand existing bed capacity would be a good place to start. Having local law enforcement across the state pattern on ThriveNYC's incremental successes to address psychiatric issues in the community is a good start to change outcomes for patients in the community. Our nurses stand ready and willing to lead these reforms and work with local law enforcement to continue improving and expanding these programs across the state.

We also believe that continuing to address the social determinants of health and improving access to health-care coverage by passing the New York Health Act is an excellent first step toward ensuring that our psychiatric and behavioral health patients have stable and consistent access to providers. Many of our patients are unable to maintain stable employment, and are also unable to maintain connections to the state to obtain sponsored insurance like Medicaid. Passing

the New York Health Act would guarantee coverage and care for all New Yorkers and will certainly improve outcomes for psychiatric patients that seek care in our state.

The impending increase in need for timely psychiatric care is likely to increase as New Yorkers emerge from the COVID-19 crisis. It is vital that the state heed the call from frontline caregivers to begin improving conditions now, before we are faced with another mounting crisis and another resource shortage that we must scramble to meet. Our patients' lives' and well-being depend on it.

[1] *Citizen's Budget Commission Presentation – p. 6*
https://cbcny.org/sites/default/files/media/files/PRESENTATION_11292016_0.pdf
[2] *https://www.timesunion.com/local/article/Nine-state-psychiatric-centers-to-close-in-plan-4657459.php,*
https://www.manhattan-institute.org/deinstitutionalization-mental-illness-new-york-state-city
[3] *https://profiles.health.ny.gov/hospital/bed_type/Psychiatric+Beds*
[4] *https://omh.ny.gov/omhweb/forensic/bfs.htm*
[5] *See the recommendations of the Treatment Advocacy Center's paper "Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care" October 2017*
[6] *National Association of State Mental Health Program Directors, Trend in Psychiatric Inpatient Capacity, United States and Each State 1970 to 2014, August 2017*
[7] *Treatment Advocacy Center, Background Paper, September 2016, "Psychiatric Bed Supply Need Per Capita"*
[8] *Treatment Advocacy Center, Background Paper, September 2016, "Psychiatric Bed Supply Need Per Capita"*
[9] *MergerWatch, Empowering NY Consumers in an Era of Hospital Consolidation Table 2 p 13*
[10] *https://www1.nyc.gov/site/planning/planning-level/nyc-population/current-future-populations.page*
[11] *Office of the State Comptroller, Long Island Region Economic Snapshot*
[12] *Berger Commission Final Report*
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[14] *https://omh.ny.gov/omhweb/tableau/service-trend.html - Data Downloads*
[15] *https://omh.ny.gov/omhweb/tableau/county-profiles.html*
R2 Medicaid Utilization
[16] *They are considered Institutions of Mental Disease.*
[17] *https://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-07.htm#new*
[18] *See DOH presentation (PDF)*
[19] *https://omh.ny.gov/omhweb/tableau/service-trend.html*
[20] *https://www.propublica.org/series/right-to-fail*
[21] *https://ibo.nyc.ny.us/cgi-park2/2017/07/are-new-york-citys-public-hospitals-becoming-the-main-provider-of-inpatient-services-for-the-mentally-ill/*
[22] *There's a whole discussion of this in a book about Bellevue and I can't remember which one. H+H was the first system to really treat HIV in NY, they had one of the first truly integrated nursing corps etc. The book argued that were on the vanguard because their public sector status made them responsive to public pressure - unlike what is now NYU Langone.*
[23] *For an excellent case study and description of this model see:*
https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2341-x
[24] *https://www.axios.com/medicaid-uber-lyft-ride-sharing-transportation-patients-3aa3fc7b-1e51-4472-b39f-901a4a4bd68d.html*
[25] *https://www.advisory.com/daily-briefing/2016/05/02/lessons-from-the-c-suite*
[26] *https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-settles-civil-fraud-claims-against-westchester-medical-center WMC paid $18.8 million to settle Stark Act and Anti-Kickback Statute violations related to cardiology practice it had a financial interest in referring patients to WMC main campus for services.*
[27] *See Comment*
[28] *This is SPARCS Length of Stay data for schizophrenia admissions. Schizophrenia is the SMI diagnosis with the highest number of inpatient stays statewide*
[29] *https://www.thenation.com/article/archive/new-york-presbyterian-allen-hospital-psychiatric-ward/*
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[33] *https://ibo.nyc.ny.us/cgi-park2/2017/07/are-new-york-citys-public-hospitals-becoming-the-main-provider-of-inpatient-services-for-the-mentally-ill/*

[34] *https://ibo.nyc.ny.us/cgi-park2/2017/07/are-new-york-citys-public-hospitals-becoming-the-main-provider-of-inpatient-services-for-the-mentally-ill/*

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[36] *https://council.nyc.gov/budget/wp-content/uploads/sites/54/2020/03/072-DOC.pdf*

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[38] *https://www1.nyc.gov/assets/operations/downloads/pdf/pmmr2014/2014_pmmr.pdf*

[39] *http://criminaljustice.cityofnewyork.us/wp-content/uploads/2018/04/BHTF-First-Status-Report-8.15.pdf*

[40] Fiscal 2020 Preliminary Mayor's Management Report

[41] *https://nymag.com/intelligencer/2019/03/nyc-seeks-to-move-mentally-ill-inmates-to-hospitals.html*

[42] *https://docs.google.com/spreadsheets/d/e/2PACX-1vRF40pUlqeowxBls34OXQi44VZV4Cey6-TnQ8EFnDmop8ndOlQ-F064sQPx_LTBEgFbJy4nwdmT8poR/pubhtml*

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