CUOMO for MAYOR

Addressing New York City's Mental Health Crisis

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Summary of Proposals

Proposal 1. Increase the supply of supportive housing units for the seriously mentally ill: Provide $2.6 billion in capital over five years to build at least 600 new units per year reserved specifically for single adults with serious mental illness and/or substance use disorders who are homeless or at risk of homelessness. Combined with fully implementing NYC 15/15, this will more than triple the number of permanent and congregate supportive housing units New York City has been opening annually – from approximately 500 units a year to 1,600 units per year.

Proposal 2. Expand access to community-based mental health services and supports: Expand access to effective integrated, community-based behavioral health services that integrate services for mental health and substance use disorders by extending clinic hours, incentivizing providers to accept insurance, and investing in flexible, low-barrier treatment models like mental health Clubhouses.

Proposal 3. Utilize technology to expand timely access: Utilize innovations in technology to increase access to mental health services, including for children and adolescents.

Proposal 4. Fill essential workforce shortages: Expand New York City's critical shortage of mental health workers by recruiting more "peers" who have a shared life experience with clients to the mental health workforce, implementing apprenticeship programs, and partnering with hospitals to expand fellowships for high-need specialties such as child psychiatrists.

Proposal 5. Unify and strengthen New York City's fragmented behavioral health delivery system: Streamline access through improved coordination among mental health, substance use disorder, and primary care medical services; overhaul New York City's Single Point of Access system to make it more responsive to high need cases; and enhance data-sharing and accountability across care management agencies and City-State partnerships.

Proposal 6. Address the unique mental health needs of children and adolescents: Expand access to youth mental health care by increasing the number of school-based mental health clinics, increasing the number while preserving existing school-based health centers, and addressing the child behavioral health workforce shortage through targeted training and recruitment.

Addressing New York City's Mental Health Crisis

Proposal 7. Improve outreach and engagement with the street homeless: Establish a centralized, cross-agency Street Population Management Unit to coordinate outreach, data sharing, and case management for New York City's chronic street homeless population with serious mental illness and/or substance use disorders – transforming fragmented efforts into a unified, accountable system that more strategically deploys services and tracks individual outcomes.

Proposal 8. Expand options for getting the street homeless into shelter, care, and housing: Scale low-barrier housing options such as Safe Haven shelters, crisis stabilization beds, and Housing First apartment units, to promote effective engagement with street homeless individuals with serious mental illness who will not enter the regular shelter system and transition them into long-term housing arrangements.

Proposal 9. Scale up crisis response services: Expand New York City's crisis response infrastructure by scaling 24/7 mobile crisis teams, securing the city's fair share of State-funded Crisis Stabilization Centers, and investing in non-police alternatives to respond to crises in which police presence may be counterproductive, as a means to reduce unnecessary hospitalizations and improve outcomes for individuals with serious mental illness.

Proposal 10. Improve utilization of civil inpatient psychiatric beds: Expand transitional residential programs to free up civil inpatient psychiatric bed capacity, ensure all discharges are screened for participation in a strengthened court-mandated Assisted Outpatient Treatment, and better integrate inpatient psychiatric care with aftercare community-based services to prevent the pattern of individuals cycling through the community back to emergency departments and inpatient psychiatric hospitalizations.

Proposal 11. Increase the number of forensic inpatient psychiatric beds: Expand New York City's forensic psychiatric beds capacity for individuals involved in the criminal justice system by directing NYC Health + Hospitals to add a minimum of 100 up to 200 new forensic inpatient psychiatric beds to address the growing number of justice-involved individuals with serious mental illness and keep them out of Rikers Island jails.

Proposal 12. Consistently enforce involuntary removal and involuntary commitment laws: Ensure consistent application of the newly codified "basic needs" standard for involuntary removal and involuntary commitment by strengthening execution and accountability across City agencies; provide an aftercare guarantee upon discharge that includes priority access to intensive community services—such as Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT) teams and peer support upon discharge to prevent the cycle of relapse and homelessness.

Addressing New York City's Mental Health Crisis

Proposal 13. Overhaul New York City's administration of the court-mandated Assisted Outpatient Treatment (AOT) program: Strengthen New York City's AOT program by mandating universal screening at discharge from hospitals and Rikers Island so that more individuals who would benefit from the program are enrolled, expanding treatment plans to cover a broader range of stability needs than just medication, and piloting a judicially supervised AOT model with regular court monitoring to improve engagement and treatment adherence among individuals with serious mental illness.

Proposal 14. Improve the Criminal Procedure Law Article 730 system for determinations of mental competency to stand trial: Expand forensic bed and clinical assessment capacity, ensuring timely evaluations, and requiring greater accountability from prosecutors, defense attorneys, and judges to ensure individuals with serious mental illness facing criminal charges are properly assessed and diverted to treatment when appropriate.

Addressing New York City's Mental Health Crisis

"Who do we help leaving a seriously mentally ill person sleeping in a cardboard box and claiming we are helping them by protecting their civil rights? Deinstitutionalization didn't mean dehumanization. Where is our competent compassion? We need to reach out to them and get them the help they need."

Gov. Andrew M. Cuomo

Executive Summary

New York City is experiencing a severe and growing behavioral health crisis marked by rising rates of serious mental illness, addiction, and related homelessness. This crisis has worsened since the COVID-19 pandemic, straining the City's health and public safety systems. Although only a small share of New Yorkers with serious mental illness ultimately act out in a way that puts themselves or others at risk, the social consequences of this behavior are vast.

This policy paper outlines Governor Andrew Cuomo's two-pronged strategy to address the challenges facing New York City related to caring for those with mental health challenges.

- **Strategy 1: Prevention.** First, Andrew Cuomo will focus on prevention and helping the many New Yorkers with mental health challenges to lead stable and productive lives, which requires strengthening the mental health system (as well as the related system for treating substance use disorders) to improve access to treatment and provide support before crises occur.

- **Strategy 2: Compassionate Crisis Response.** Second, Andrew Cuomo will focus on competent and compassionate crisis response and public safety when prevention and regular community-based service delivery for the seriously mentally ill fail. Key to success will be including intensive outreach to the seriously mentally ill, resources for stabilization, and inpatient psychiatric hospitalization when necessary. We must also make use of legal tools such as involuntary commitment so that individuals who would harm themselves or others are treated in inpatient hospital settings and subsequently supervised effectively through court-mandated outpatient treatment.

Addressing New York City's Mental Health Crisis

As mayor, Andrew Cuomo will put forward common sense and comprehensive improvements that can be made in almost every aspect of the way New York City manages mental health – especially for the seriously mentally ill.

As with other policy challenges facing New York City, grappling with seemingly intractable problems requires not only vision, but also leadership and effective and proven management experience to implement the systemic changes. Andrew Cuomo has vastly more experience—as Secretary of Housing and Urban Development, Governor, and Attorney General— than any other candidate in managing massive, interdisciplinary governmental programs and maintaining a relentless focus on making real progress will result in lasting change to better New York City.

Introduction

Particularly since the COVID-19 pandemic, an increasing number of New Yorkers are suffering from serious mental illness (SMI), as well as other mental health disorders and addiction. Many individuals have more than one mental health disorder, or substance use disorders which typically are referred to collectively as "behavioral health" problems.

According to a recent report by the NYC Department of Health and Mental Hygiene (DOHMH), as many as one in four New Yorkers face mental health challenges. [1] In addition, roughly a quarter of a million adults have SMI, which is defined as meaning that their mental condition constitutes a serious "functional impairment" that interferes with their ability to engage in life's major activities. [2]

Many of the New Yorkers sleeping in the streets or on the subways on any given night suffer from SMI, often compounded by substance use disorders. The official Homeless Outreach Population Estimate of "unsheltered" homeless people in New York City as of January 23, 2024, was 4,140, [3] although most experts believe this is likely an undercount. In addition, as of December 5, 2024, New York City's Department of Homeless Services (DHS) reported that 21,519 single adults were residing in the city shelter system, many of whom suffer from mental illness, often with a co-diagnosis of substance use disorders. [4]

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[1] "The State of Mental Health of New Yorkers." New York City Department of Health and Mental Health. May 2024. p. 37.
[2] "Mental Illness: Definitions." National Institutes of Mental Health. September 2024.
[3] "Homeless Outreach Population Estimate, 2024 Results." New York City Department of Homeless Services.
[4] "Review of the New York City Department of Homeless Services' Programs and Services." Office of the New York City Comptroller. August 21, 2023.

Addressing New York City's Mental Health Crisis

Although this paper focuses on serious mental illness, there is a complementary strategy to address substance use disorders. Simply put, we cannot meet the challenges of homeless New Yorkers without responding to the underlying problems of SMI and addiction. Addressing the problems of the most difficult cases of individuals with unmanaged SMI and addiction requires effectively executing all aspects of this strategy to keep these individuals safe and stable, with their conditions well-managed so they do not act out in a way that harms themselves, or threatens the quality of life and safety of themselves or their fellow New Yorkers.

Although there have been a number of initiatives put forward to address the serious and ongoing mental health challenges in New York City, they haven't achieved this goal. [5] To meet today's crisis, New York City must learn from past failures and refocus on a core set of priorities, while ensuring that progress can be measured.

Andrew Cuomo's Effective Experience and Record of results in Addressing Mental Health Challenges

Andrew Cuomo has deep familiarity and experience in understanding and effectively managing the issues related to homelessness among individuals with SMI and substance use disorders, having worked on these problems throughout his entire career. He began his involvement with these issues by founding one of New York City's major homeless services organizations in his twenties. In 1991, then-Mayor David Dinkins appointed him as the chair of the Commission on the Homeless, which culminated in a 1992 report titled "The Way Home: A New Direction in Social Policy." As Assistant Secretary for Community Planning and Development at the US Department of Housing and Urban Development beginning in 1993, he developed the Continuum of Care strategy, a comprehensive approach designed to help homeless individuals achieve self-sufficiency.

As Governor, he made significant progress on the issue of mental health, as well as addiction which was a critical priority. He championed many of the mental health programs currently administered by the Office of Mental Health, including Assertive Community Treatment (ACT), Certified Community Behavioral Health Clinics (CCBHCs), and the Empire State Supportive Housing Initiative (ESSHI).

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[5] For example, ThriveNYC was launched in 2015 under the de Blasio Administration and has since been restructured into the Mayor's Office of Community Mental Health. Thrive NYC was the most recent effort to comprehensively address behavioral health challenges. Unfortunately, ThriveNYC inadequately monitored and measured performance among its dozens of initiatives leaving the city unable to prove the value of the investment, or the lack thereof. See: "With Continued Lack of Clarity in ThriveNYC Spending and Purpose, Comptroller Stringer Issues Recommendations to Improve Accounting, Transparency and Outcomes for New Yorkers." Office of the New York City Comptroller. May 23, 2019.

Addressing New York City's Mental Health Crisis

A central principle of Andrew Cuomo's mental health agenda was the importance of increasing access to outpatient, community-based services, as opposed to providing services in much less accessible inpatient settings. Although inpatient psychiatric care is necessary at times, inpatient settings are often ineffective and inefficient places to deliver care – and there has been a profound shift in the level of mental health institutionalization over the years.

Andrew Cuomo also recognized the critical importance of prevention and providing mental health services for children and adolescents. Without appropriate early intervention efforts, mental health challenges in youth can become serious mental health conditions as they reach adulthood.

Andrew Cuomo Championed the Expansion of Permanent Supportive Housing for Individuals with Mental Illness

As governor, Andrew Cuomo substantially increased New York State's investment in permanent supportive housing for the seriously mentally ill. Homelessness advocates and supportive housing providers agree that permanent supportive housing, in which individuals with SMI can receive more intensive services where they live, is an essential solution to the problem of homelessness. Permanent supportive housing is now more frequently referred to as "congregate" supportive housing or "permanent congregate" supportive housing. [6] The term refers to supportive housing in which individuals with serious mental illness or other behavioral health needs live in their own apartment units within a single building with a critical mass of supportive housing units. This model is preferable to the "scattered-site" model of supportive housing, which involves isolated apartment units where it is more difficult to deliver services.

In addition, as governor, Andrew Cuomo created the $20 billion Empire State Supportive Housing Initiative (ESSHI) in 2016, creating at least 6,000 supportive housing units statewide (80% of which would be in New York City) by 2021, as part of a broader plan to create 20,000 supportive housing units statewide over 15 years. In addition to capital allocations to build supportive housing units, Andrew Cuomo provided $2.6 billion in operating funding over the first five years of ESSHI to fund the operating expenses and supportive services provided in the first 6,000 units in his program.

[6] Congregate supportive housing is different from congregate "community residences", because those facilities are technically transitional housing in which the residents do not have permanent rights as a tenant.

Addressing New York City's Mental Health Crisis

Andrew Cuomo's Policies Increased Community-Based Mental Health Services to Reach an Additional 200,000 New Yorkers

In 2014, Andrew Cuomo and the State Office of Mental Health (OMH) adopted the 2014 OMH Transformation Plan to reduce the number of underutilized inpatient psychiatric beds and reinvest the savings in community-based care. As a result of the OMH Transformation Plan, 200,000 more New Yorkers were receiving mental health services when he left office in 2021 than in 2014. Between 2014 and 2018, a total of 183 inpatient psychiatric beds at state psychiatric centers in New York City were decommissioned under the Transformation Plan – less than 5% of the number of inpatient psychiatric beds in New York City. [7] None of the beds closed were part of the "forensic" inpatient psychiatric system, which treats individuals involved in the criminal justice system.

The reduction in inpatient psychiatric beds under the OMH Transformation Plan was more than offset by the opening between 2014 and 2021 of community-based residential beds to house individuals who did not need inpatient psychiatric care. The number of units of these community-based residential beds and supportive housing beds opened during these years far exceeds the relatively small number of inpatient beds at state psychiatric centers that were decommissioned under the OMH Transformation Plan. Between 2014 and 2021, the state opened 2,373 supportive housing beds and 3,123 units of other types of community residences. [8]

[7] "Systems Under Strain: Deinstitutionalization in New York State and City." Stephen Eide. Manhattan Institute. November 29, 2018.

[8] Inpatient psychiatric beds in New York City exist in two main settings: state-operated psychiatric centers (including civil and forensic beds) and the inpatient psychiatric units of general hospitals. There were approximately 3,659 total adult inpatient psychiatric beds in New York City (including 207 State-operated forensic beds) as of September 2024, of which approximately 1,307 were in state psychiatric hospitals and approximately 2,352 in general hospitals. These beds are essentially fungible when it comes to individuals with SMI who are found among the street homeless. The 183 beds closed between 2014 and 2018 represented only 5% of the number of inpatient psychiatric beds in New York City. See "Inpatient Bed Capacity." New York State Office of Mental Health. September 2024.

Addressing New York City's Mental Health Crisis

Andrew Cuomo's Comprehensive Compassionate Action Plan to Address New York's Mental Health Crisis

Andrew Cuomo's plan to address New York's mental health crisis has two fundamental pillars: prevention and compassionate and effective crisis management. First, Andrew Cuomo will strengthen the mental health and substance use disorder delivery system to improve affected New Yorkers' health and well-being and to prevent crises. Second, Andrew Cuomo will build a strong, compassionate crisis response system to effectively intervene when early supports fail and individuals with serious mental illness pose a risk to themselves or others.

Part I: Enhance Prevention by Strengthening Health System

A well-functioning system for delivering mental health and substance use disorder services is crucial to maintaining the health and wellness of the large number of New Yorkers who suffer from these problems and for preventing more serious problems that burden many other vital services – the police, EMS, and emergency departments, for example – and which affect the quality of life of all New Yorkers.

- **Proposal 1. Increase the supply of supportive housing units for the seriously mentally ill: Provide $2.6 billion in capital over five years to build at least 600 new units per year reserved specifically for single adults with serious mental illness and/or substance use disorders who are homeless or at risk of homelessness. Combined with fully implementing NYC 15/15, this will more than triple the number of permanent and congregate supportive housing units New York City has been opening annually – from approximately 500 units a year to 1,600 units per year.**

The ability of individuals with SMI to function stably within society is hampered immeasurably when they become homeless. This is especially true when unhoused individuals are living on the street, but it is also true even when they are living in the shelter system.

Moreover, many individuals with SMI require ongoing services that are not available in traditional affordable housing. "Supportive housing" is affordable housing with on-site services that are designed to ensure the ongoing connection of residents with the community-based mental health services and, in many cases, services for substance use disorders which they need to remain stable.

Addressing New York City's Mental Health Crisis

Nearly all mental health advocates and policymakers agree that supportive housing is critically important to the health and well-being of the seriously mentally ill. Those who are fortunate enough to obtain a supportive housing unit have a much better chance of remaining housed than those placed in affordable but non-supportive housing. Supportive housing also resulted in a notable decrease in interactions with the hospital and criminal justice system.

The availability of supportive housing, however, is limited by the general difficulty in developing housing, as well as the substantial capital and ongoing operating costs of providing supportive housing services to residents. Nevertheless, there is strong evidence that at least part of the operating costs of supportive housing are offset by savings in other areas. Under Andrew Cuomo, the New York State Department of Health conducted a rigorous study of the impact of supportive housing on high Medicaid users, which concluded that the savings in Medicaid costs offset the costs of supportive housing for high Medicaid users. [9]

New York City created its first City-only funded supportive housing program in 2016. It matched New York State's total number of supportive housing units through its own "NYC 15/15" program in 2016 with the goal of creating 15,000 units by 2030, although only half of these units would be permanent congregate supportive housing units while the rest would be scattered-site. As of April 2024, there were 3,944 open units – 2,764 congregate and 1,180 scattered-site – and an additional 1,272 congregate units under construction. [10] Despite its goal of opening 1,000 units of supportive housing annually, New York City is actually opening only about 500 units of supportive housing annually, or one-half of its NYC 15/15 goal.

On April 28, 2025, Mayor Adams announced that henceforth all of New York City's new supportive housing in connection with the NYC 15/15 program will be permanent congregate supportive housing, with 80% of the commitment representing new units and 20% representing the preservation of existing supportive housing units – or roughly 800 new units per year and 200 preserved units per year through the end of 2030. [11]

Few investments New York City can have as positive an impact on the mental health crisis in New York City as the expansion of the number of permanent congregate supportive housing units. As Mayor, Andrew Cuomo will provide $2.6 billion in capital funding over five years to develop new permanent congregate supportive housing units over and above the NYC 15/15 target. This will increase the number of permanent congregate supportive housing units developed or preserved by New York City from approximately 1,000 per year to approximately 1,600 per year, or roughly tripling the number of supportive housing units New York City has actually been opening annually since the NYC 15/15 program began.

[9] "Medicaid Redesign Team Supportive Housing Evaluation Cost Report Year 3: Treatment versus Comparison Group, Investments versus Savings Analyses." New York State Department of Health and the Center for Human Services Research at the State University of New York at Albany.

[10] "The State of Supportive Housing." Supportive Housing Network of New York. Rachel Barth. April 4, 2024. p. 19.

[11] "Mayor Adams Unveils New Investments in Upcoming Mayoral Budget to Create More Homes, Connect More New Yorkers to Homes, Keep More New Yorkers in Homes." New York City Office of the Mayor. April 28, 2025.

Unlike ESSHI and NYC 15/15, which together have several dozen categories of eligibility, these additional units will be reserved solely for single adults with SMI and/or substance use disorders who make up the street homeless population.

The tables below show the estimated capital and operating costs of adding an additional 600 permanent congregate supportive housing beds annually. The capital costs are conservatively estimated and if high would result in more units of housing being constructed. Operating costs are based on the Supportive Housing Network of New York's 2024 "The State of Supportive Housing" report's estimates of operating costs for a single adult unit. [12]

Cumulative Capital Cost After 5 Years

Type	Supportive Housing Units	Capitial Subsidy Per Unit	Total Capital Costs
Congregate	3,000	$867,000	$2,601,000,000

Annual Cost of Services: Year 5 (assumes Year 5 costs are 1.2 times Year 1 costs)

Type	Supportive Housing Units	NYC 15/15 Single Adult Unit Rates			Total Costs	Cost Offset Factor	Net Cost
		NY 15/15 Services	NY 15/15 Rental Assistance	NY 15/15 Total			
Congregate	3,000	$17,500	$18,276	$42,931	$128,793,600	50%	$64,396,800

The economics of supportive housing seem punishing at first blush, but the cost of supportive housing can be offset in significant part by savings in other areas. The state realizes significant savings in its Medicaid program as a result of supportive housing, while New York City realizes savings in other areas, including the criminal justice system and its single adult shelter system.

[12] "The State of Supportive Housing", at p. 3, https://shnny.org/uploads/State_of_Supportive_Housing_4.4.24_final_.pdf

As shown in the tables above, NYC 15/15 currently spends more than $35,000 annually to provide supportive housing to single adults, which covers both the cost of rent for the supportive housing unit as well as the cost of supportive services. However, New York City spends in excess of $52,000 annually on shelters for single homeless adults [13] and, unlike family shelters where the cost is shared with the State, New York City effectively pays 100% of the cost of additional residents of single homeless shelters.

It is more difficult to estimate the marginal savings of reduced jail stays and hospital admissions, although it is fair to say that by almost any measure, it costs less for an individual to be in supportive housing than at Rikers Island or in a hospital. In short, the cost offsets associated with supportive housing are quite significant. [14]

- **Proposal 2. Expand access to community-based mental health services and supports: Expand access to effective integrated, community-based behavioral health services that integrate services for mental health and substance use disorders by extending clinic hours, incentivizing providers to accept insurance, and investing in flexible, low-barrier treatment models like mental health Clubhouses.**

When people talk about "limited access" to mental health and substance use disorder services, they are referring to the many barriers that make it difficult for individuals to receive the treatment they need to remain stabilized. According to DOHMH, 40% of individuals with SMI who seek treatment are unable to get it. [15] This lack of access to services is not evenly distributed throughout the city:

> "In the three neighborhoods with the highest connection to mental healthcare, nearly 70% of those with mental health needs receive treatment. In the three neighborhoods with the lowest connection to mental healthcare, only around 20% of those with mental health needs receive treatment." [16]

Expanding access to community-based mental health services is critical. New York City does not necessarily need more outpatient clinics, but rather expanded access to those that exist, through extended hours of operation. including evenings and weekends, and an expansion of clinics that are dually licensed for mental health and addiction treatment, so people with co-occurring conditions can access care in one place.

[13] "Cost Per Day For Single Adult Shelter Facilities." New York City Mayor's Office of Operations. Updated March 6, 2025.
[14] "New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis." New York City Department of Health and Mental Hygiene, New York City Human Resources Administration, and the New York State Office of Mental Health.
[15] "Mayor's Office of Community Health 2023 Annual Report on Critical Gaps in the Mental Healthcare System in New York City." New York City Mayor's Office of Community Mental Health. p. 8, footnote 22.
[16] Ibid at p. 6.

New York City can also improve access by expanding the use of less rigid programs (such as "Flexible ACT," which accommodates more flexible and adaptive delivery of mobile, interdisciplinary Assertive Community Treatment (ACT) teams), and psychosocial rehabilitation settings such as mental health "Clubhouses." Psychosocial settings such as Clubhouses are more accessible than mental health clinics because they do not require appointments and also provide non-medical supports. These more informal settings are important in helping individuals with serious mental illness to live successfully in the community.

New Yorkers also face considerable waits for first appointments for mental health services, particularly for individuals on Medicaid. Researchers in a 2023 study called 80 psychiatric offices in New York City, posing as Medicaid enrollees scheduling a first appointment. Only 36% of their calls resulted in an appointment, with a median wait time of 28 days. [17]

Earlier this year, New York State implemented regulations requiring health insurance plans to provide initial behavioral health appointments within 10 business days and to offer out-of-network coverage at in-network rates if timely access isn't available. [18] The City must take additional steps to educate the public about their rights under this regulation and provide enhanced resources for finding in-network providers.

Proposal 3. Utilize technology to expand timely access: Utilize innovations in technology to increase access to mental health services, including for children and adolescents.

Despite considerable federal and state funding for "988", associated response services are still underfunded and understaffed, so they are not available on the 24/7 basis that true crisis responsiveness requires. The City should add peer specialists and more mental health professionals to the 988 workforce and connect 988 to the helplines and resources the City provides for other health and social needs. These efforts to keep response times fast and calls satisfactory are necessary to establish the value of 988 as an effective alternative to 911.

There are many other ways to use technology to expand access to mental health services. For example, the free program Teenspace connects any of New York City's approximately 450,000 teenagers ages 13 to 17 with a licensed therapist with whom they can talk and text (operated through the Talkspace platform). As evidence of the efficacy of this technology-based approach, in its first six months, Teenspace saw 6,800 users – a majority of whom were students from low-income neighborhoods who subsequently reported improved mental health. [19]

[17] "Medicaid Enrollees Struggle to Find Psychiatric Care." Weill Cornell Medicine. July 31, 2024.
[18] "Governor Hochul Expands Access to Mental Health and Substance Use Disorder Treatment for New Yorkers." New York State Department of Financial Services. February 26, 2025.
[19] "Mayor Adams Celebrates Early Success of 'NYC Teenspace,' Free Tele-Mental Health Service for NYC Teenagers." New York City Office of the Mayor. May 23, 2024.

Proposal 4. Fill essential workforce shortages: Expand New York City's critical shortage of mental health workers by recruiting more "peers" who have a shared life experience with clients to the mental health workforce, implementing apprenticeship programs, and partnering with hospitals to expand fellowships for high-need specialties such as child psychiatrists.

Lack of staffing of mental health professionals is a threshold barrier to expanding community-based services. Community-based clinics must compete for staff against higher-paying private practices that allow for telehealth and may not even accept Medicaid, or in many cases, even Medicare or commercial insurance, as mentioned above. New clinicians are not entering the field fast enough to keep up with the increased demand.

The shortage of trained mental health clinicians is a national problem. New York State is already pursuing familiar strategies such as education and training programs combined with loan forgiveness programs. New York City should also develop more innovative solutions, such as working with the hospital sector to develop fellowship programs that focus on community, addiction, geriatric, and child psychiatry to attract more specialists into areas of acute need.

As discussed in connection with crisis response efforts, "peers" who have common lived experience with those they are trying to help are often more effective in communicating with the seriously mentally ill than social workers or even clinicians. The City should set a clear target for growing the peer workforce, and fully leverage opportunities established by the State Office of Mental Health to support individuals interested in becoming peer specialists and to integrate them throughout the care continuum.

Proposal 5. Unify and strengthen New York City's fragmented behavioral health delivery system: Streamline access through improved coordination among mental health, substance use disorder, and primary care medical services; overhaul New York City's Single Point of Access system to make it more responsive to high-need cases; and enhance data-sharing and accountability across care management agencies and City-State partnerships.

Fragmentation of the behavioral health delivery system too often leads to people falling through the cracks – sometimes with tragic effects. For example, patients frequently move between different managed care plans, experience disenrollment from clinical services, and fail to transition smoothly between providers. This lack of coordination, in turn, leads to repeated crises and emergency interventions rather than sustained engagement in care. For example, a 2023 report by the United Hospital Fund revealed that fewer than 40% of individuals discharged from psychiatric hospitalization received timely outpatient follow-up care. [20]

Unfortunately, New York City delivers behavioral health services through a patchwork system of providers. A decentralized system can work, but New York City's current behavioral health system suffers from a lack of coordination and integration. For example, community-based behavioral health services are provided through federally qualified health centers, Article 31 licensed mental health clinics and Article 32 licensed addiction treatment clinics, private practices, and primary care settings. While there are certain advantages to this approach, this widely distributed system also makes it more likely that people will fall through the cracks because these various providers are not as effectively coordinated and integrated as they should be.

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[20] "The Ripple Effects of the Adolescent Behavioral Health Crisis: Recent Trends and Impacts on American Adolescents, Families, and Society." United Hospital Fund. Giovanna Braganza and Amy Lin. April 2024.

Addressing New York City's Mental Health Crisis

One of the priorities for Andrew Cuomo is to fix the fragmentation of the behavioral health delivery system, for example by improving the coordination and integration of services. Although ultimately, individuals will be best served when there is better integration among all aspects of the social safety net, the immediate priority is to ensure integration with addiction services and with physical health and primary care services.

Care management agencies are intended to coordinate physical health, behavioral health, and social services, including supportive housing for their seriously mentally ill clients. However, these care management agencies do not have direct contracts with the state, but rather are indirectly contracted through intermediaries known as Health Homes. This structure makes it difficult to have clear performance metrics and accountability.

Moreover, centralization does not always work. The City's Single Point of Access (SPOA) system was designed to streamline access to intensive mental health services and supportive housing, but its centralized structure has instead created bottlenecks and limited providers' flexibility—delaying care and leaving many without timely support.

As mayor, Andrew Cuomo will pursue several strategies for better integration and coordination between mental health providers and addiction services providers, which comprise New York City's behavioral health care delivery system. First, he will ensure that there is strong coordination between city and state agencies. Second, he will reform the SPOA system to create fast access protocols for the highest need individuals, give providers more flexibility in managing referrals, and create more stratification of case management models that follow patients at different levels of need across levels of care. Third, he will enhance data-sharing among city agencies in the healthcare system, so providers have access to up-to-date information about patients' treatment histories and needs as they evolve.

Proposal 6. Address the unique mental health needs of children and adolescents: Expand access to youth mental health care by increasing the number of school-based mental health clinics, increasing the number while preserving existing school-based health centers, and addressing the child behavioral health workforce shortage through targeted training and recruitment.

New York City is home to over 1.6 million children and adolescents. A significant number, perhaps as many as 20% of adolescents have mental health concerns of varying types. This is a growing trend and a national phenomenon that requires a broad-based response from government and other social institutions.

These issues have become much more pronounced since the COVID-19 pandemic. National data from 2013 to 2023 showed significant increases in the percentage of students who experienced persistent feelings of sadness or hopelessness, seriously considered attempting suicide, made a suicide plan, or attempted suicide. [21] New York City's DOHMH has reported that in 2021, a shocking 16% of public high school students experienced suicidal ideation, while 9% attempted suicide. [22] The mental health needs of children and adolescents – social, developmental, and clinical differ from those of adults, and we cannot expect the system of adult mental health care and treatment to meet the unique needs of children and adolescents.

Enhancing the capacity to manage children and adolescents at crisis stabilization facilities, emergency departments, inpatient hospital settings, residential treatment facilities, or with home and community-based services will require an expanded workforce. New York City, like many places in the country, has a deep shortage of child psychiatrists. NYC Health + Hospitals, as well as not-for-profit general hospitals in New York, should prioritize this specialty in its training programs to help address this shortage.

Workforce solutions for a wider range of mental health staff should include training programs for students in high schools and colleges, apprenticeships, and intensified efforts to recruit peers into mental health professions.

As mayor, Andrew Cuomo's mental health strategy will also emphasize the importance of ensuring continuity of care. Many children and adolescents who are discharged from psychiatric hospitalization struggle to secure timely follow-up appointments. Fragmented systems and long waitlists exacerbate these gaps, creating a cycle of prolonged unmet need, insufficient recovery, and crisis.

One of the most important opportunities to expand access to mental health services for children and adolescents is to provide these services in schools. The presence of school-based health services, whether through School-Based Health Centers or School-Based Mental Health Clinics, ensures access to essential services free from challenges related to co-pays, transportation, parental time-off, school absence, or apprehension about going to an unfamiliar environment. While School-Based Health Centers provide behavioral health services or referrals, School-Based Mental Health Clinics provide more comprehensive assessment and mental health services, in addition to peer support, medication treatment, and crisis intervention.

[21] See, https://www.cdc.gov/yrbs/dstr/index.html#cdc_publication_summary_guidance-key-findings
[22] "Epi Data Brief: Suicide-related factors among New York City Public High School Students." New York City Department of Health and Mental Hygiene. November 2023.

Both types of clinics are important. However, in recent years, many school-based health centers and their sponsors have experienced financial distress. Between 2018 and 2024, seven sponsors closed 39 school-based health center sites, including 19 school-based health center sites closed by Health + Hospitals that served 13,768 students in 44 schools. Andrew Cuomo's mental health plan will prioritize preservation of school-based health centers as well as opening more school-based mental health clinics.

Part II: Compassionate Crisis Response to Protect Public Safety and the Well-being of the Individual in Crisis

A major contributor to the rising sense of crime and disorder in New York City is the behavior or condition of individuals with unmanaged SMI, often with active substance use disorder and experiencing homelessness. Although the absolute number of such individuals is very small compared to the total number of people in New York with mental illness, it does not take the actions of many individuals to create a sense of disorder and, in too many tragic cases, to result in violent crimes.

The essential first part of Andrew Cuomo's Mental Health plan is based on enhancing prevention and building a strong community-based behavioral health system. However, even with a dramatic overhaul of the system, it will not succeed 100% of the time.

Therefore, as mayor, Andrew Cuomo will focus on the seriously mentally ill who have not been able to remain stable through prevention efforts and community-based resources, and whose behavior presents a risk of harm to themselves or others.

- **Proposal 7. Improve outreach and engagement with the street homeless: Establish a centralized, cross-agency Street Population Management Unit to coordinate outreach, data sharing, and case management for New York City's chronic street homeless population with serious mental illness and/or substance use disorders – transforming fragmented efforts into a unified, accountable system that more strategically deploys services and tracks individual outcomes.**

Almost by definition, individuals with SMI who are living in the streets and subways have fallen through the cracks of the social safety net. Interventions to avoid mental health crises must therefore begin with intensive outreach and engagement with the street homeless population to connect them to services. Most of the street homeless population have had such negative experiences with the regular single adult shelter system that they will also need connection to a safe haven shelter (described below), crisis stabilization or transitional housing beds, or supportive housing to break the cycle of street homelessness.

This effort begins with a network of outreach and engagement programs designed to provide critical services and pathways to stability. These programs can seem like an alphabet soup to the uninitiated. Although each of these programs is worthwhile, they lack effective coordination and data sharing, which undermines effectiveness and accountability. Coordination is especially important because each of these outreach initiatives is competing for the finite number of beds targeted at the street homeless: safe haven shelters, crisis stabilization or transitional housing beds, and supported housing or apartment treatment units.

This lack of coordination, as well as the unsafe environments in many shelters, helps explain why the number of "unsheltered" individuals in New York City has increased in recent years despite the substantial increase in resources devoted to getting the homeless off the streets and out of the subways. Before addressing how Andrew Cuomo's plan calls for improving these outreach efforts, it makes sense to briefly describe them.

The Street Health Outreach & Wellness (SHOW) program, operated by NYC Health + Hospitals, is the largest of the outreach and engagement programs. Since its inception in 2021, SHOW has conducted approximately 269,000 engagements with the street homeless population. Many experts believe that the city would be better off contracting more outreach services out to community-based providers rather than city employees, because they can be more nimble than the city's outreach workers.

Teams in the Safe Options Support (SOS) program, managed primarily by the State OMH, are comprised of licensed clinicians, nurses, care managers, and peer advocates. As with SHOW, this program also focuses on individuals experiencing street homelessness primarily as a result of SMI and/or substance use disorders.

Two other programs are considered "co-response" teams because they combine mental health professionals with police officers. Subway Co-Response Outreach Teams (SCOUT) and a similar program called Partnership Assistance for Transit Homelessness (PATH) pair mental health professionals with police officers (from the MTA in the case of SCOUT and the NYPD in the case of PATH) to engage the street homeless in the subway system. The SCOUT program operates during the day, while the PATH program operates at night. [23]

These "co-response" programs focus on the smaller number of individuals who are in the midst of acute mental health crises. They seek to reduce disruptions while connecting individuals to treatment services and shelter. PATH teams typically include four police officers, a nurse, and two Department of Homeless Services service coordinators, working together to provide immediate support such as shelter referrals, case management, and mental health care. Both the SCOUT and PATH initiatives are relatively small and should be scaled if results continue to be promising.

[23] "Mayor Adams Announces New "Co-Response" Operation Focused on Serving More New Yorkers in Need on New York City Subways." New York City Office of the Mayor. October 10, 2024.

Addressing New York City's Mental Health Crisis

The targets of these efforts involve a relatively small number of individuals, mostly the roughly 2,000 individuals who are chronically street homeless and resistant to coming off the streets or subways to receive services and shelter. The city maintains what is informally known as "the list." This list, maintained jointly by the Department of Homeless Services (DHS), DOHMH, and NYC Health + Hospitals, tracks roughly 1,500 to 2,000 named individuals identified as persistently unsheltered and highly vulnerable. These individuals on the list are the people, usually with SMI and/or co-occurring substance use disorders, who cycle through emergency rooms, jails, and psychiatric facilities without long-term stabilization.

In theory, the list is meant to serve as a dynamic case management tool — a way to ensure that every person on it is assigned to a team, tracked over time, and connected to appropriate interventions. In practice, however, its utility is constrained by fragmented governance, siloed data systems, and uneven follow-through. Different city and state agencies — including DHS, DOHMH, NYC Health + Hospitals, the NYPD, OMH, and even the MTA — interact with these individuals but often lack real-time access to one another's data or a shared accountability structure to drive outcomes. This fragmentation means that even with the existence of the list, the city lacks a unified operational plan to move people from the streets into care and housing.

The city needs to be able to serve as "air traffic control" to strategically deploy services across the city in response to actionable data collected through outreach efforts and other behavioral health and social services touch-points.

To transform the list from a tracking mechanism into an active instrument of engagement and stabilization, Andrew Cuomo will establish a cross-agency "Street Population Management Unit" charged with the oversight of all individuals on the list. This unit would integrate case data across outreach teams, psychiatric facilities, and housing providers to assign each individual a lead agency and a named case manager, along with measurable goals.

Much like Compstat or the Coordinated Entry system used by New York City's Single Point of Access (SPOA) for supportive housing placements, the Street Population Management Unit would flag stalled cases, coordinate interventions such as court-mandated Assisted Outpatient Treatment (AOT) orders where warranted, and escalate complex cases to senior-level interagency teams to break through bureaucratic barriers.

In addition to more effectively "case managing" individual situations, Andrew Cuomo will improve the use of performance metrics to analyze and evaluate the overall impact of existing programs to identify which approaches are working and which are not. Currently, the size of the programs, as well as outcomes such as sustained housing, long-term mental health stabilization, and cost-effectiveness, are inconsistently tracked. This lack of granular transparency makes it impossible to fully assess program performance in managing these high-cost, high service-utilizing individuals, which in turn makes it difficult to allocate resources effectively.

Proposal 8. Expand options for getting the street homeless into shelter, care, and housing: Scale low-barrier housing options such as Safe Haven shelters, crisis stabilization beds, and Housing First apartment units, to promote effective engagement with street homeless individuals with serious mental illness who will not enter the regular shelter system and transition them into long-term housing arrangements.

The effectiveness of outreach and engagement efforts is closely tied to the availability of options for shelter and housing where services can be delivered. There is a consensus about the need for this array of options. But as with other parts of the mental health crisis, the challenge is not in identifying the options but rather in the execution of making them viable. These three avenues of options – safe haven shelters, stabilization housing and Housing First apartments – are briefly described below.

Safe Haven Shelters, Stabilization Housing and Housing First

"Safe haven" shelters are designed to appeal to street homeless individuals who are resistant to entering traditional shelters because of their relatively strict rules or the individuals' past negative experience in dormitory-style shelters. Safe haven shelters do not mandate abstinence or active treatment as conditions of entry and typically are smaller and less institutionalized than traditional single adult shelters. Safe haven shelters are intended to have a shorter transitional length of stay than regular shelters, although the lack of downstream housing opportunities often frustrates this goal.

The objective of safe haven shelters is to build trust with residents with a view to them gradually engaging with services and transitioning to longer-term transitional housing or permanent supportive housing. When such longer-term transitional housing or permanent housing beds are not available, it clogs up the pipeline of safe haven shelters and undermines the intention that safe haven shelters should involve relatively short-term transitional settings.

"Stabilization housing" has some similarities with safe haven shelters. It serves as a bridge for people who want to leave the street or traditional shelter but are not yet ready for permanent housing. Stabilization housing is limited to individuals who can care for themselves to a greater degree than those in an inpatient hospital setting. As with safe haven shelters, stabilization housing typically has fewer restrictions than traditional shelters, making it attractive to people who have been living on the street and have had bad experiences in traditional shelters.

The challenge with both safe haven shelters and stabilization housing is scaling them to meet the need. In late 2022, there were only 1,473 beds available across 26 different safe haven shelters in New York City, and beds for about 2,100 individuals in stabilization housing. [24] But associated siting and scaling challenges are such that they will only serve a fraction of the chronically homeless population with SMI and/or substance use disorders.

A third strategy is called "Housing First," which bypasses the shelter intake system entirely and the City's Single Point of Access system for matching individuals with supportive housing and places the chronically street homeless directly into supportive housing (or in some cases into transitional community residence) units. A key to the Housing First philosophy is that the program does not require individuals to address substance use, mental illness, or other behavioral issues as a precondition for receiving housing.

This approach makes it easier to get the street homeless off the street initially. However, it may make it more difficult to achieve success in the long run by ensuring that these individuals are engaged with community-based services and supports before they live independently in supportive housing or even the somewhat more structured community residence system. Supportive housing providers and operators of community residences sometimes complain that placing less stable individuals (which many of the street homeless are) into their projects is disruptive to what is already a fragile ecosystem.

The overriding problem with the Housing First strategy, however, is the lack of housing units available for this purpose. Particularly when Housing First is deployed in scattered-site apartments as opposed to congregate supportive housing settings, the reality is that wraparound services such as mental health treatment and substance use counseling are unlikely to be effectively applied, at least compared to congregate settings.

[24] "Housing First: A Proven Approach to Dramatically Reduce Street Homelessness." Office of the New York City Comptroller. June 28, 2023.

In short, Housing First is a valuable strategy, particularly in light of what may be overly restrictive rules for supportive housing placement. However, Housing First is not a silver bullet but rather an important part of a portfolio of approaches to enable the street homeless to get off the street and connected with care in a stable setting.

Proposal 9. Scale up crisis response services: Expand New York City's crisis response infrastructure by scaling 24/7 mobile crisis teams, securing the city's fair share of State-funded Crisis Stabilization Centers, and investing in non-police alternatives to respond to crises in which police presence may be counterproductive, as a means to reduce unnecessary hospitalizations and improve outcomes for individuals with serious mental illness.

Even with better outreach and engagement and more options to bring the street homeless into shelter and care, there will continue to be mental health crises of the type that, at a minimum, reduce the quality of life in New York City, and put the individuals involved at risk of harming themselves or others.

Crisis response services to deal with SMI and addiction is the right approach and, as mayor, Andrew Cuomo will expand this crisis response infrastructure. This expansion will include both mobile services that will meet people where they are and crisis stabilization centers to which individuals can be brought for stabilization.

While some services, such as the co-response teams described earlier, benefit from the involvement of law enforcement, concerns over police involvement in crisis response are often shared by communities and often by officers themselves, who are not trained clinicians and frequently report they should not be the ones handling these calls.

Mobile Crisis Teams

Mobile services, which bring services to New Yorkers rather than requiring them to come to a clinic, are also an important part of community-based services. Mobile Crisis Teams (MCT) receive referrals via 988 (New York City's mental health help line similar to 911), as well as from community members and providers, 365 days per year, between 8 am and 8 pm. They seek to respond to individuals in crisis within a few hours using a model of professional and paraprofessional staff, including peers. They aim to avoid unnecessary involvement of law enforcement, emergency departments, and hospitals. Andrew Cuomo will expand the mobile crisis team workforce to allow them to serve communities on a 24-hour basis, which would better serve the variable nature of mental health crisis needs throughout New York City.

Better access to mobile services would help interrupt the cycles described above by reducing the number of individuals who disengage from care and "decompensate," relapsing and becoming unstable to the point of needing hospital-level care. Mobile services that meet people where they are, paired with adequately resourced crisis stabilization centers, should be the foundation of a scaled, sustainable crisis response system.

Crisis Stabilization Centers

Crisis Stabilization Centers (CSCs) play an important role in the continuum of care between inpatient psychiatric hospitals and outpatient mental health clinics. CSCs are open 24 hours a day, seven days a week for stays of up to 24 hours for stabilization. Licensed clinicians make assessments and create care plans for after discharge. Mental health experts believe that CSCs are better suited for stabilizing individuals in the midst of a mental health crisis than hospital emergency departments.

The state issued a Request for Proposals in 2022 to establish both Intensive Crisis Stabilization Centers (ICSC) designed for individuals experiencing more severe behavioral health crises, and Supportive Crisis Stabilization Centers (SCSC), which are lower acuity settings for crisis stabilization. Unfortunately, less than one-third of these Stabilization Centers were awarded to providers based in New York City, despite New York City accounting for the majority of the need across the state.

New York City must have more crisis stabilization capacity, including getting its fair share of SCSC's and ICSC programs funded by the State to be located in New York City, commensurate with its large share of New Yorkers requiring the services.

Proposal 10. Improve utilization of civil inpatient psychiatric beds: Expand transitional residential programs to free up civil inpatient psychiatric bed capacity, ensure all discharges are screened for participation in a strengthened court-mandated Assisted Outpatient Treatment, and better integrate inpatient psychiatric care with aftercare community-based services to prevent the pattern of individuals cycling through the community back to emergency departments and inpatient psychiatric hospitalizations.

Addressing New York City's Mental Health Crisis

There are two types of inpatient psychiatric beds – civil beds and "forensic" beds for those involved with the criminal justice system. Both are important. Inpatient psychiatric care plays an indispensable role in the treatment of the seriously mentally ill. Inpatient care provides a secure environment in which patients can be treated, including against their will, when specific criteria are met. Inpatient settings allow for a higher level of clinical engagement, which is important for close observation and an integrated approach to treatment for those with particularly complex needs.

As of September 2024, New York State Office of Mental Health (OMH) data showed 3,452 adult civil inpatient psychiatric beds in New York City, of which approximately 1,100 were in State psychiatric centers; the balance was in general hospitals. [25] New York State's OMH Commissioner has testified to the sufficiency of capacity of civil inpatient psychiatric beds, including sufficient capacity to handle the increased number of individuals who are subject to involuntary commitment.

In her January 2025 State Budget Hearing, the Commissioner testified that the existing level of civil inpatient psychiatric beds was sufficient to manage an increase in patients if Governor Hochul's proposed change in the standard for involuntary commitment was enacted. She Said:

> "Currently, in New York State, the occupancy of our psychiatric services [beds] is about 80 to 82%.... So there is room within the community-based hospital system for the small increase in individuals from the change in the involuntary commitment law. After the pandemic, the occupancy was 95%. And that's why additional beds have been added in the community. But at the current time across the state, the occupancy is between 80-82%, which means there is sufficient space to expand [for admissions related to] the involuntary commitment law." [26]

New York City will work with OMH and not-for-profit hospitals with civil inpatient psychiatric beds in order to get a clear assessment of how many additional civil inpatient psychiatric beds are needed in New York City. Many clinicians believe that a substantial number of patients admitted for inpatient psychiatric care would benefit from longer stays, especially if they are not discharged into a stable and supportive environment. For that reason, individuals are often kept in inpatient beds simply because there is no housing option available other than to discharge the patient to a homeless shelter, which is not a conducive environment for sustained stability.

[25] "Inpatient Bed Capacity." New York State Office of Mental Health. September 2024.
[26] Commissioner Sullivan Testimony: Joint Legislative Hearing on 2025 Exec. Budget Proposal: Mental Hygiene. New Yor State Senate. February 5, 2025.

Another factor which affects the need for civil inpatient psychiatric beds is the availability of transitional residential programs for individuals with mental illness which provide step-down care from inpatient units. Although less intensive than inpatient care, transitional residential programs offer and give additional time to identify a suitable placement in supportive housing in the community.

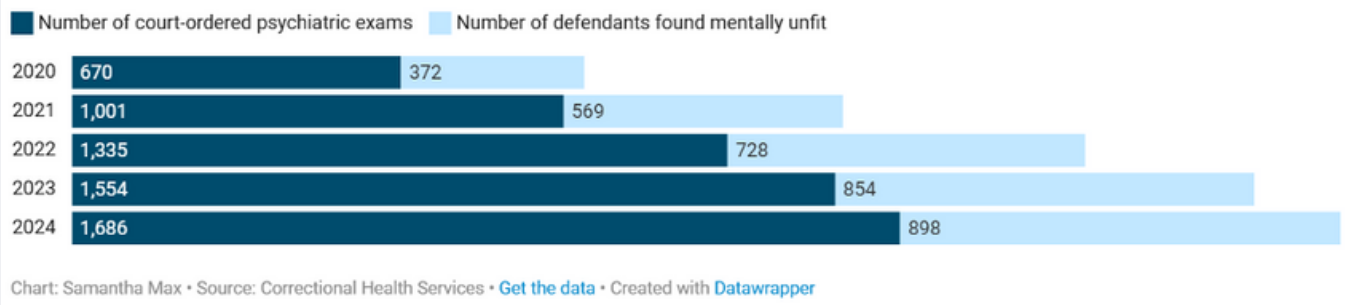
The issue of the capacity for inpatient psychiatric hospitalization is also related to the effectiveness of the community-based system of care. As discussed below, all patients discharged from an inpatient psychiatric hospitalization should be screened for participation in the court-mandated Intensive Assisted Outpatient Treatment (AOT) program, which also needs to be significantly strengthened in order to protect against a revolving door in which patients discharged from inpatient psychiatric care will decompensate in the community and soon be back in the emergency department.

Proposal 11. Increase the number of forensic inpatient psychiatric beds: Expand New York City's forensic psychiatric bed capacity for individuals involved in the criminal justice system by directing NYC Health + Hospitals to add a minimum of 100 up to 200 new forensic inpatient psychiatric beds to address the growing number of justice-involved individuals with serious mental illness and keep them out of Rikers Island jails.

Although it is not clear that there is insufficient capacity of civil inpatient psychiatric beds in New York City, it is clear there is a need for more capacity of forensic inpatient beds for individuals with SMI who are involved in the criminal justice system. One indication of this need is the significant increase in the number of seriously mentally ill individuals in the justice system who are subject to Article 730 of the Criminal Procedure Law to determine their mental competency to stand trial. As shown in the graph below, the number of criminal defendants found mentally unfit to stand trial in New York City courts has more than doubled since 2020, as judges have ordered an increased number of Article 730 psychiatric exams. [27]

[27] "NYC keeping people with mental illness on Rikers Island due to hospital bed shortage." Gothamist. Samantha Max and Charles Lane. April 7, 2025.

Addressing New York City's Mental Health Crisis



New York City's total forensic inpatient capacity hovers around 250–275 beds, which includes about 207 State forensic beds in New York City (all at the Kirby Forensic Psychiatric Center on Wards Island) [28] and approximately 50-75 forensic inpatient psychiatric beds located in NYC Health + Hospitals facilities – primarily at Bellevue and Elmhurst Hospitals. [29] The State FY26 Enacted Budget appropriated $126 million in funding for an additional 100 forensic inpatient psychiatric beds in New York City, expected to be located on Wards Island. [30]

Andrew Cuomo's Mental Health plan will direct Health + Hospitals to open a minimum of 100 additional forensic psychiatric inpatient beds, and up to a maximum of 200 additional forensic psychiatric inpatient beds, to better manage the unmet needs of seriously mentally ill individuals involved in the criminal justice system in New York City. Together with the 100 beds approved in the FY26 state budget, this proposed addition would expand New York City's forensic inpatient psychiatric bed capacity by at least 60% from today's levels. [31]

Proposal 12. Consistently enforce involuntary removal and involuntary commitment laws: Ensure consistent application of the newly codified "basic needs" standard for involuntary removal and involuntary commitment by strengthening execution and accountability across city agencies; provide an aftercare guarantee upon discharge that includes priority access to intensive community services—such as Assertive Community Treatment (ACT) and Intensive Mobile Treatment (IMT) teams and peer support upon discharge to prevent the cycle of relapse and homelessness.

[28] It is important to note that no forensic beds were closed under the OMH Transformation Plan.
[29] "Mental Health Housing and Treatment for Individuals with Serious Mental Illness in the NYC Jails." NYC Health and Hospitals. March 12, 2019.
[30] In addition, individuals under Article 730 orders may be sent to the other State forensic psychiatric centers outside of New York City, including Mid-Hudson Forensic Psychiatric Center in New Hampton, Central New York Psychiatric Center in Marcy, and Rochester Psychiatric Center, with a cumulative forensic capacity of 567.
[31] Scores Of People Deemed Unfit To Stand Trial Are Stuck on Rikers Island." The City. Reuven Blau. February 3, 2025.

When prevention and other measures have failed, it is sometimes necessary to involuntarily remove seriously mentally ill individuals to a hospital emergency department for evaluation, followed in some cases by involuntary commitment to inpatient psychiatric hospitalization. As Andrew Cuomo says at the beginning of this paper:

> *"Who do we help leaving a seriously mentally ill person sleeping in a cardboard box and claiming we are helping them by protecting their civil rights. Deinstitutionalization didn't mean dehumanization. Where is our competent compassion? We need to reach out to them and get them the help they need."*

The general legal standard for involuntary removal and involuntary commitment is that "the person is dangerous to himself or herself, or a substantial risk of physical harm to other persons...." [32] There has been much debate, however, about how this standard should be interpreted, particularly when it comes to the question of harm to oneself.

In 2021, Andrew Cuomo's Executive Budget included a proposal to statutorily change the standard of "harm to oneself" to include a situation in which individuals lacked the capacity to take care of their "basic needs." Although the legislature declined to adopt this statutory change in the involuntary standard, OMH issued a guidance memorandum in which it stated that its interpretation was that the "basic needs" standard was implied in the existing law. A 2022 memorandum to mental health providers from Dr. Ann Sullivan, the OMH Commissioner who was appointed by Andrew Cuomo in 2014, made clear the State's interpretation that the law authorized officers to remove for evaluation in a hospital emergency department and subsequent involuntary commitment to inpatient hospitalization of individuals:

> *"who appear to be mentally ill and are conducting themselves in a manner which... display[s] an inability to meet basic living needs, even when there is no recent dangerous act."* [33]

This inability to meet basic needs due to a mental health disorder is sometimes called a "grave disability" standard.

[32] N.Y. Mental Hyg. Law § 9.01

[33] "Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions." New York State Office of Mental Health. February 18, 2022.

Addressing New York City's Mental Health Crisis

A press release from New York City issued in December 2022 concurred with the Sullivan memo, stating:

> *"The City concurs with OMH on this interpretation of the law. If the circumstances support an objectively reasonable basis to conclude that the person appears to have a mental illness and cannot support their basic human needs to an extent that causes them harm, they may be removed for an evaluation."* [34]

New York City's press release went on to say that it was the City's position that "unawareness or delusional misapprehension of surroundings" or "delusional misapprehension of physical condition or health" could be grounds for removal. [35]

Notwithstanding these interpretations, the standards for involuntary removal to an emergency department for assessment and subsequent involuntary admission have not been consistently applied in New York City. Too many individuals who would meet the standard for removal have simply been ignored or left alone if voluntary efforts to convince the individual to enter care prove unsuccessful.

Governor Kathy Hochul in her FY26 Executive Budget included as one of her top priorities the codification of the "basic needs" standard for involuntary removal and commitment, which was adopted by the legislature. [36]

In addition to codifying the OMH interpretation of the "basic needs" standard, Governor Hochul's Executive Budget proposal facilitated the process of involuntary commitment by authorizing psychiatric nurse practitioners (in addition to physicians) to certify the need for involuntary care. Although as of this writing the final Budget bills have not been released, it has been publicly announced that this standard is slated to be codified in law as part of the budget agreement.

Although Governor Cuomo supported Governor Hochul's budget proposal to clarify the standard for involuntary removal and commitment (as well as related process improvements in her proposal) codifying a standard already supported by OMH and New York City since 2022 will not, on its own, change conditions on the ground. Doing so will require a clear and sustained commitment from the mayor and all relevant agencies to consistently exercise the remedies of involuntary removal. Just as importantly, hospitals must change their approach to involuntary commitment and actually admit patients who meet that criteria. Too often, individuals have been involuntarily removed to an emergency department only to be turned away because the hospital is not applying the "basic needs" criteria that was previously supported.

[34] "Mental Health Involuntary Removals." New York City Office of the Mayor. November 2022.
[35] Ibid.
[36] See Part EE. "FY 2026 New York State Executive Budget: Health and Mental Hygiene Article VII Legislation." New York State Division of the Budget. January 21, 2025.

Addressing New York City's Mental Health Crisis

The current reality—leaving too many seriously mentally ill individuals who cannot meet their basic needs or who pose a risk to others on the streets and subways or involuntarily removing them only to have hospitals not admit the patient on the grounds that they don't meet the involuntary commitment standard – is unacceptable.

Involuntary hospitalization accomplishes little if there are not sufficient and effective services following discharge, accompanied by a much stronger case management system to ensure that people with mental illness serious enough to wind up in an inpatient psychiatric hospitalization will remain compliant with the community-based services they need to remain stable. In the absence of supports, including transitional residential beds or supported housing, homeless individuals with SMI will just end up back on the street or subway.

That is why the whole system of community-based services and intensive case management that is part of Andrew Cuomo's Mental Health plan is so important. As mayor, Andrew Cuomo will ensure that his DOHMH will work tirelessly with providers, care management agencies, and OMH to create a stronger intensive case management system, transitional residential program, and supportive housing program so that discharging patients to a shelter becomes an exception to the rule.

Discharge from the hospital, or release from jail or prison, is a weak link in the management of care for many individuals with SMI. Recent State guidance [37] and regulations [38] that are designed to strengthen procedures in the hospital to ensure that hospitals sufficiently screen individuals for complex needs, admit them for a sufficient period of time, and adequately prepare them for discharge are steps in the right direction. But more should be done, including mandatory screening for court-mandated outpatient treatment under the AOT program.

As mayor, Andrew Cuomo will seek to have any individual who is involuntarily committed be automatically connected to priority access for community services upon discharge. This would include expanding hospital discharge planning requirements to include an "aftercare guarantee," ensuring, for example, that a mobile treatment team, such as Assertive Community Treatment (ACT) or Intensive Mobile Treatment (IMT), and a peer support worker engages the person upon their discharge.

[37] "Guidance on Evaluation and Discharge Practices for Comprehensive Psychiatric Emergency Programs (CPEP) and §9.39 Emergency Departments (ED)." New York State Office of Mental Health. October 2023.

[38] Amendment to section 405.19 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by section 2803 of the Public Health Law. New York State Department of Health.

These changes are necessary to interrupt the revolving door that so often sees patients cycle through the emergency department, inpatient unit, shelter or street, and sometimes jail. But as with all aspects of government, the key is not the regulations; the key is the execution, and accountability for effective execution must begin at the top.

Andrew Cuomo's plan will focus on ensuring that hand-offs between discharge and care in the community are strong enough to interrupt the "revolving door."

- **Proposal 13. Overhaul New York City's administration of the court-mandated Assisted Outpatient Treatment (AOT) program: Strengthen New York City's AOT program by mandating universal screening at discharge from hospitals and Rikers Island so that more individuals who would benefit from the program are enrolled, expanding treatment plans to cover a broader range of stability needs than just medication, and piloting a judicially supervised AOT model with regular court monitoring to improve engagement and treatment adherence among individuals with serious mental illness.**

Inpatient psychiatric hospitalizations typically end within 60 days and are often much shorter. Effective discharge planning from involuntary inpatient psychiatric care should connect individuals to outpatient services sufficient to manage their symptoms and meet their needs. Most individuals with SMI will voluntarily remain adherent to this treatment protocol. The fact remains, however, that a significant number of individuals require supervision to stay adherent to their service protocol in the community, because they may decompensate without it. In these instances, mandated outpatient treatment may be necessary and can be imposed by a court order known as an Assisted Outpatient Treatment (AOT) order.

AOT was established in New York in 1999 as part of a statute called Kendra's Law, which allows courts to mandate community-based treatment for adults with severe mental illness who meet specific criteria. [39] Kendra's Law authorizes court-ordered outpatient treatment for an initial period of one year, with a mandatory treatment plan. Although AOT is governed by state law, the administration of the program is managed by New York City and other counties, so the Mayor can have a significant impact on the effectiveness of the program.

[39] Per additional criteria established in MHL section 9.60, the individual must be unable to live safely in the community without supervision, be unlikely to seek outpatient treatment voluntarily, need AOT to prevent relapse or serious harm, and be likely to benefit from AOT. Further, they must have a history of treatment noncompliance that has led to either: 2 or more hospitalizations in the past 3 years, serious violent behavior or threats in the last 4 years (excluding periods of hospitalization or incarceration), or a court order for AOT that expired within the last 6 months and after which symptoms worsened.

Addressing New York City's Mental Health Crisis

The treatment involved in an AOT order is usually a combination of care management with medication management, therapy, medication-assisted treatment for substance use disorder when necessary, and other services. Individuals on AOT have priority access to Intensive Mobile Treatment (IMT) and Assertive Community Treatment (ACT), which involve four to six contacts between the team and the individual per month.
OMH data shows the number of individuals for whom court orders were issued since the implementation of Kendra's law (Nov. 1999), the number of people currently under court order, and the number of individuals who were under court order on this date one year ago, two, three, and four years ago: [40]

		Recipients under active court order on:				
County	**Since November 1999[41]**	**4/21/2021**	**4/21/2022**	**4/21/2023**	**4/21/2024**	**4/21/2025**
Bronx	4,020	380	349	465	509	437
Kings	3,104	333	354	367	369	360
New York	5,533	454	478	518	513	400
Queens	3,267	224	247	300	317	365
Richmond	809	79	72	78	72	94
Region Total	**16,733**	**1,468**	**1,499**	**1,725**	**1,778**	**1,655**

AOTs improve outcomes in many cases, as reflected in the table below: [42]

	Percent of AOT recipients that has been homeless, hospitalized, or incarcerated during their entire time in AOT compared to anytime in their lifetime prior to AOT.								
	Psychiatric Hospitalization			Incarceration			Homelessness		
County	**Prior to AOT**	**Most Recent Follow-up**	**Percent Reduction**	**Prior to AOT**	**Most Recent Follow-up**	**Percent Reduction**	**Prior to AOT**	**Most Recent Follow-up**	**Percent Reduction**
Bronx	94%	34%	64%	27%	8%	71%	28%	13%	56%
Kings	95%	39%	59%	27%	9%	66%	28%	13%	52%
New York	96%	37%	62%	27%	9%	69%	37%	17%	55%
Queens	96%	33%	65%	20%	6%	68%	17%	6%	67%
Richmond	98%	41%	58%	34%	7%	78%	21%	9%	57%
Region Total	95%	36%	**62%**	26%	8%	**69%**	29%	13%	**56%**

[40] "AOT Program Statistics: Recipients Under Court Order." New York State Office of Mental Health.
[41] In the column labeled "Since November 1999," the totals for counties/regions, when summed, are greater than the statewide total because recipients can be treated in different counties/regions at different times. The statewide total reflects the actual unduplicated recipient count.
[42] "AOT Program Statistics: Reduced Significant Events." New York State Office of Mental Health.

However, the data also show that less than half of individuals subject to AOT orders in New York City are engaged in their services even six months into their initial twelve-month order: [43]

OMH data from the past year suggests that the hospitalization rate in New York City of individuals who are removed to a hospital for assessment following noncompliance with their treatment plan is dramatically lower than in other parts of New York State. Of the 517 removals in New York City over the last 12 months, only 4% resulted in hospitalization. The rate of hospitalizations in Long Island and the Hudson Valley ranged from 16%-18%, while rates in the Central and Western regions were 32% and 61%, respectively. [44]

The AOT system, which is the highest level of supervision of individuals with SMI short of inpatient or residential treatment, has fundamental flaws. For example:

- Far fewer individuals are referred to AOT than should be, including many of the highest-risk individuals. For example, more individuals being released from Rikers Island and discharged from hospitals should be referred to AOT than in fact are. Andrew Cuomo will require that all individuals discharged from Rikers and Health + Hospitals facilities are screened for whether they should be subject to an AOT order and urge the State to require this of DOH-regulated private sector hospitals as well.

- AOT Orders and the corresponding treatment plans are too narrow. They do not address all the conditions necessary for individuals with SMI to remain stable in the community. For example, while medication may be an essential part of a treatment plan, an AOT recipient who is still unhoused or lacks other community support is unlikely to receive the full benefit of their AOT treatment plan. Housing is especially important because when an individual disengages from their treatment plan, it is harder for AOT programs to locate them to reengage if they are transient and isolated.

- Other procedural changes could significantly improve the design of the AOT program, although most would require some change in the Kendra's Law statute.

[43] "AOT Program Statistics: Recipient Outcomes: Engagement and Adherence." New York State Office of Mental Health.
[44] "AOT Program Statistics: Removals Resulting in Hospitalization." New York State Office of Mental Health.

The most significant fundamental flaw in the AOT program is the lack of consequences for noncompliance. AOT staff monitor individuals in the community and are supposed to follow up promptly on significant events reported within 24 hours by providers, including psychiatric hospitalizations, arrests, or if a client goes missing.

However, if an AOT recipient in New York refuses to comply with the mandatory treatment plan, [45] the only consequence is that they can be taken to an emergency department or comprehensive psychiatric emergency program (CPEP) for evaluation, where they can be held for up to 72 hours before either being admitted to inpatient psychiatric care or discharged. This is what is referred to as the "revolving door."

Andrew Cuomo will also seek to implement a recommendation of the New York Unified Court System's Judicial Task Force on Mental Illness to establish a pilot program of an AOT model with more ongoing judicial involvement. This model has been deployed with some success in other states and could improve the inadequate outcomes in New York City's current AOT system. The Judicial Task Force suggests that regularly scheduled and frequent status conferences with a judge to review progress in treatment and quality of life for AOT recipients would improve supervision and keep more individuals compliant with their treatment plan.

Proposal 14. Improve the Criminal Procedure Law Article 730 system for determinations of mental competency to stand trial: Expand forensic bed and clinical assessment capacity, increasing timely evaluations, and requiring greater accountability from prosecutors, defense attorneys, and judges to ensure individuals with serious mental illness facing criminal charges are properly assessed and diverted to treatment when appropriate.

Article 730 of the New York Criminal Procedure Law sets out procedures for determining whether a defendant is mentally fit to stand trial which requires that he or she can understand the proceedings and participate in their defense. Article 730 requires that a criminal court "must issue an order of examination when it is of the opinion that the defendant may be an incapacitated person." Yet, even with the sharp increase in Article 730 orders since 2020, the statute is still frequently ignored in many cases where its use would seem obvious.

[45] MHL section 9.60 notes that "[f]ailure to comply with an order of assisted outpatient treatment shall not be grounds for involuntary civil commitment or a finding of contempt of court."

Addressing New York City's Mental Health Crisis

In an op-ed in the New York Post discussing the case of Ramon Rivera, an offender with a long recidivist history who allegedly went on a stabbing spree in Manhattan in January killing three people, the president of the New York State Bail Association noted: "The 730.30 process has been the law forever — but the City of New York isn't deploying it as a strategy to protect the public from the homeless mentally ill." [46] The responsibility to request a mental competency exam falls on prosecutors, defense attorneys, and judges—yet these stakeholders often fail to consistently act even when defendants would apparently qualify for evaluation.

Patterns of noncompliance with treatment, crisis, and hospitalization are parallel to and, for many, intertwined with cycles of recidivism. For individuals with SMI who have criminal charges and are incapacitated by mental illness, Article 730 processes are superior to a traditional path through trial, sentencing, incarceration, and release—the last of which is a critical time for individuals to fall through the cracks again.

As with other parts of the mental health system, the Article 730 process needs to be comprehensively fixed, with solutions that include increased capacity of both forensic inpatient psychiatric beds, more clinicians to conduct the mental competency assessments on a much more timely basis, and, for individuals charged with minor crimes, diversion to outpatient programs that help these individuals return to stability and be better able to manage their behavior in the community. Andrew Cuomo will work with prosecutors, the defense bar, judges, and other stakeholders to fix this weak link in the public safety aspect of mental health.

[46] "Legal Aid DAs Ignored the Law and Let NYC Stabber Go Free." New York Post. Michelle Esquenazi. November 22, 2024.

Addressing New York City's Mental Health Crisis

Conclusion

Addressing the complex needs of individuals with SMI requires a comprehensive strategy that responds to both ends of the continuum of care for these individuals.

On one end, we must strengthen prevention efforts, expand access to community-based services, and ensure that people can engage with a responsive, high-quality behavioral health system, as well as have access to supportive housing services for those who require it to remain stable in the community.

At the other end of the continuum of care, we must have a robust infrastructure in place to respond effectively for those who are slipping through the cracks of the social safety net. This includes coordinated and effective outreach and engagement efforts, crisis response services, alternative short-term settings other than the regular shelter system or hospitalization, and the appropriate use of mechanisms such as involuntary removal and involuntary commitment when necessary, court-mandated outpatient treatment through the AOT program, and more consistent use of CPL Article 730 mental competency exams for those with indications of serious mental illness who are involved in the criminal justice system.

By effectively implementing the proposals in this paper, New York City will be able to break the vicious cycle of hospitalization, homelessness, and sometimes even incarceration of seriously mentally ill individuals, helping them, their families, and society at large.