



# **Community Behavioral Health Services**

## **New York State Budget Fiscal Year 2009-2010**

### **A Briefing Book**

February 2009

(212) 742-1600 [www.coalitionny.org](http://www.coalitionny.org)

**The Coalition of Behavioral Health Agencies, Inc.  
(New York City and environs)**

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*The Coalition of Behavioral Health Agencies, Inc. is the umbrella advocacy organization for non-profit community behavioral health sector of New York City and neighboring counties. The Coalition represents over 100 providers that collectively offer services, treatment and housing to more than 300,000 individuals and families in the five boroughs of the City and its metropolitan area. For more information on the Coalition, or for additional copies of our Budget Book, please contact Jason Lippman, Senior Associate for Policy and Advocacy, at (212) 742-1600 ext. 102, or via e-mail at [jlippman@coalitionny.org](mailto:jlippman@coalitionny.org).*

## **Executive Summary: Response to the Budget**

- **Propose Revenue Raising Options**

Offset proposed cuts to social services by raising the Personal Income Tax rate for the State's highest income earners;

Increase taxes on beer and wine to fund OASAS community based prevention, treatment and recovery programs

- **Oppose Cut to State Add-On to Supplemental Security Income (SSI) Program**

- **Oppose Cuts to Continuing Day Treatment (CDT) Programs**

An across the board cut does not consider the full diversity of individual consumers and CDT programs that serve needy and vulnerable populations;

The current Personalized Recovery Oriented Services (PROS) program being implemented in other parts of the State is complex, more expensive than available resources, and too inflexible and unsuitable for some CDT consumers;

The State should explore a PROS system appropriate to the needs of providers and consumers in the New York City area with adequate transitional support during changeover and in early phases of implementation;

Urge continued funding and support for programs currently serving specialized populations such as dependent, geriatric and AOT consumers until alternative models are developed.

- **Redirect Funding to Keep the Residential Treatment Facilities (RTF) Trend Factor**

- **Oppose Personal Needs Allowance (PNA) Cuts to OASAS Recipients**

- **Ensure Exemption from Social Work and Mental Health Practitioner Licensing Requirements**

Urge support for the Governor's proposal to extend the exemption for the social work and mental health practitioner licensing requirements for an additional four years through December 31, 2013

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Oppose contingencies or benchmarks in the provision for extension of the OMH, OASAS, OMRDD and OCFS (“O State Agencies”) exemption;  
Urge re-opening of the grandparenting provision for candidates who were originally qualified;

Urge that experience in any “O State Agency” licensed or certified program should count as experience towards an LCSW designation;

Urge more flexible and diverse State Education Department (SED) regulations that meet the needs of “O State Agency” providers

- **Support Fair Transformation and Funding for Clinic Rate Restructuring**

Phase out of COPS is inevitable but has complex implications for providers and consumers;

Support the importance of a committed and passionate workforce by promoting the value of full time staff with fringe benefits; this will benefit the workforce and the community and will promote continuity of consumer care;

Commercial and managed care insurance plans pay substandard and unaffordable rates; working people will find barriers to treatment in community based safety net clinics; parity laws are empty without adequate reimbursement for community based services;

Clinic reform is circumscribed and will be problematic with current fixed pot of money;

Rates should account for higher cost of services for children, geriatric clients, people mandated fro Assisted Outpatient Treatment (AOT) and consumers with co-occurring disorders;

Support and expand Governor’s establishment of indigent care pool for mental health clinics

- **Reform the Sex Offender Management and Treatment Act (SOMTA)**

Support for Governor’s reduction in budgeted growth of SOMTA;

Urge change in law to require secure containment and treatment of offenders with less costly non-hospital-based options;

Recommend investigation of alternative models from other states

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- **Dedicate Increase in Federal Medical Assistance Percentage (FMAP) to Medicaid and Maintain Current Level of Programming**

Urge dedicated Medicaid uses and county pass-down of any increases to FMAP from the Federal government

## **Propose Revenue Raising Options**

***The Need: Preserve social services funding by raising additional State revenue to offset the budget deficit and forestall some cuts.***

The 2009-10 Executive Budget addresses New York State's \$15 billion budget deficit by proposing cuts in human service programs that serve the State's most vulnerable citizens. Even though Governor Paterson has recommended tapping new revenue sources, the budget fails to adequately consider fair and progressive revenue enhancement opportunities. A fiscal solution based on shared sacrifice by all New Yorkers, should include reform of New York State's tax system to recapture lost revenue from past tax cuts on New York's highest income earners. By adding new tax brackets on the top income earners, New York State can generate a significant amount of new revenue and forestall drastic cuts to the human service sector.

In addition, the Governor proposes higher tax rates on the sale of beer and wine. We would add liquor to that list. Furthermore, the 2009-10 Executive Budget misses the opportunity to reinvest potential revenue from alcohol sales into OASAS prevention, treatment and recovery programs. By endorsing proposals that call for higher tax rates than what the Governor has proposed, this new source of revenue can be used to further hold back budget cuts and augment prevention, treatment and recovery programs for alcoholism. Furthermore, if consumers have to pay a higher price for alcoholic beverages, less alcohol might be consumed, perhaps reducing problem drinking and preventing more alcohol related illness and death.

### **Background and Impact**

Over the last 30 years, New York State has changed the tax code by cutting income tax rates on its wealthiest citizens. As a result of these measures, more affluent families wind up paying a lower proportion of their incomes in taxes than middle and lower earners, costing New York State billions of dollars in lost revenue each year. From 2003-2005, the Legislature endorsed a personal income tax increase by adding two new tax brackets for the top income earners. During this time period, the number of high income earners grew, and wealthy New Yorkers did not leave New York State.

Alcohol taxes in New York State are low when compared to the rest of the nation. Since 1991, alcohol taxes have fallen in New York State. By increasing the tax rate on beer, wine and liquor purchases, New York State will generate more revenue and possibly save lives. Every year, alcohol consumption kills about 4,000 New Yorkers and can cause liver disease, cancer, high blood pressure, stroke, car crashes, falls, suicides, crime and violence.

### **Our Recommendation**

Raise revenue and protect the social safety net by: (1) implementing a progressive tax system that increases the personal income tax on the State's highest earners; and (2) increasing taxes on beer, wine and liquor sales to fund OASAS prevention, treatment and recovery programs.

## **Oppose Cuts to State Add-On to Supplemental Security Income (SSI) Program**

***The Need: Protect the needs and wellbeing of SSI beneficiaries by restoring the cut to the SSI program.***

The 2009-10 Executive Budget fails to preserve the safety net for SSI beneficiaries by proposing to drastically cut the State add-on for the Supplemental Security Income (SSI) program in the Office of Temporary and Disability Administration (OTDA). SSI provides income for Americans who are very poor, have little or no work background, live with a disability or are senior citizens. During these hard economic times it is unconscionable to cut the SSI State supplement as this source of income is essential to the physical and emotional health, and wellbeing of recipients.

### **Background and Impact**

Over the last 20 years there have been no increases in the SSI State supplement, yet the Executive 2009-10 Budget proposes to cut the program by \$84 million in 2009-10 and \$70 million in 2010-11. Specifically, the proposed cut reduces the State monthly supplement from \$87 to \$63 (28%) for individuals living alone in the community; \$104 to \$77 (26%) for couples living together in the community; \$23 to \$7 (70%) for individuals living with others; and \$46 to \$25 (46%) for couples living with others.

Of the 600,000 New Yorkers who receive SSI, most spend their income on rent, utilities, food, clothing and other necessities. In addition, the State supplement assists individuals in paying for medical care, including deductibles and copayments. Without this vital

income, individuals will suffer life changing consequences; pay for rent or become homeless, pay for preventative doctor visits or end up in the emergency room.

### **Our Recommendation**

Protect the social safety net for SSI recipients by rescinding the cut to the SSI state supplement.

## **Oppose Cuts to Continuing Day Treatment (CDT) Programs**

***The Need: Maintain funding of CDT programs to meet the needs of the full continuum of individual consumers and programs.***

The Office of Mental Health (OMH) introduced emergency regulations to change the structure of Continuing Day Treatment programs on April 1, 2009 and cut reimbursement rates effective January 1, 2009, amounting to a \$4 million cut in fiscal year 2009-10. Continuing Day Treatment is an intensive service model designed to meet the needs of seriously and persistently mentally ill individuals. An across the board cut does not consider the full diversity of individual consumers and CDT programs. Moreover, we feel that OMH is advancing too fast on rate changes which may result in program closure without viable community service alternatives in place.

### **Background and Impact**

Some at OMH oppose the day treatment model by broadly claiming that all CDT programs are outdated, not recovery oriented and consumer length of stay is inordinately long. For many of The Coalition's members, dedicated to providing CDT services for consumers who have no other option; these broad assertions are not the case.

The new model will be based on a half day/full day schedule, with cuts implemented to rate tiers. In addition to a 5% cut to the first tier of 1 to 40 cumulative hours per month, the new tiered billing structure disincentivizes providers from serving consumers for more than 40 hours a month by imposing a greater cut. The result is that CDT providers are being forced to restructure staffing patterns, in many cases terminating staff to comply with the rates in OMH emergency regulations. These are vital services that already are underfunded, many of which are losing money or barely breaking even. Mergers or closure of programs will result. If providers shrink or merge without any viable alternative in place, some consumers are at risk of falling out of the public mental health system. As OMH endorses a transfer to a Personalized Recovery Oriented Services (PROS) program for New York City,

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partnership with the local government unit is a requisite in order to develop a citywide plan to ensure the safe transition of consumers into new services.

During these times of economic crises when startup dollars will not be readily available, PROS programs require high capitalization costs involving technology and staff changes. Some PROS programs from other parts of the State reported a drop-out rate as high as 30% of consumers that transition from their programs to PROS.

### **Our Recommendation**

Restore the \$4 million cut to CDT programs in fiscal year 2009-10 and pursue flexibility in CDT services. Provide adequate support for programs designed to serve specialized populations such as dependent, geriatric and AOT consumers. Explore a PROS system that offers alternatives appropriate to the needs of providers in the New York City, and make available transitional support for these providers during systemic changeover.

## **Restore 2009 Residential Treatment Facilities Trend Factor**

### ***The Need: Regulatory Reform that will enable the reallocation of funding for the Residential Treatment Facilities (RTF) trend factor***

The 2009-10 Executive Budget proposes to save \$1.1 million in the Office of Mental Health (OMH) by deferring the Residential Treatment Facilities (RTF) trend factor for one-year. This proposal will require RTF's to reconcile actual expenditures at the end of three years as opposed to two.

### **Background and Impact**

In New York State, OMH licensed Residential Treatment Facilities must wait two years to receive payment for services rendered. The current reimbursement methodology requires non-profit providers to lay out the total cost of operating the program (clinical treatment, prescription drugs, salary, benefits, personnel, capital, food, heating, cooling and maintenance costs) and wait for two years for a reconciliation of actual expenditures. The rate is then trended slightly for inflation.

In 2007, OMH mandated that RTFs contract for 24-hour on-call services of child psychiatrists and physicians *solely for the purpose of authorizing physical holds*. This mandate does not enhance the quality of care for children and adolescents. In order for non-profits to comply with the mandate, OMH provided a supplement in excess of \$2.3 million.

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Furthermore, this mandate exceeds Federal requirements which allow other licensed medical professionals, such as nurses, to fulfill this role. Currently, as part of their regular staffing, all RTFs employ nurses 24/7 who could easily fulfill the “physical holds” requirements.

**Our Recommendation**

Eliminate the regulatory mandate to contract for 24-hour on call services of child psychiatrists and physicians that resulted in Medicaid rate increases in excess of \$2.3 million and reallocate the funding for restoration of the RTF trend factor.

**Oppose Cuts to Personal Needs Allowance for  
OASAS Recipients**

***The Need: Maintain personal needs allowance funding for public assistance recipients residing in Office of Alcoholism and Substance Abuse Services (OASAS) treatment facilities.***

The 2009-10 Executive Budget proposes cutting the personal needs allowance (PNA) for public assistance recipients who reside in OASAS chemical dependence treatment facilities provided by the Office of Temporary and Disability Assistance (OTDA). The personal needs allowance program grants funding to cover all non-food expenses like clothing, transportation to job interviews and medical appointments, and personal hygiene supplies.

**Background and Impact**

The personal needs allowance cut targeted recipients who reside in OASAS’s chemical dependence treatment facilities. It specifically affects 7,000 people with addictive disease, who rely on public assistance to meet their basic needs.

The total cut amounts to \$4 million in 2009-10 and \$5 million in 2010-11. Since recipients in OASAS chemical dependence treatment facilities will see their monthly personal needs allowance fall from \$142 to \$45 (68%), many will choose to leave treatment programs prematurely in order to meet their financial needs. The Coalition also feels that the cut will deter people from entering treatment programs, increasing the potential for relapse and costing the State more in emergency services.

## **Our Recommendation**

Restore the personal need allowance for OASAS public assistance recipients to \$142 per month.

## **Ensure Exemption from Social Work and Mental Health Licensing Requirements**

*The Need: Address unintended consequences of the social work and mental health practitioner licensing requirements and extend the exemption for public sector practitioners until December 31, 2013.*

The social work and mental health licensing law that went into effect on September 1, 2004 created some unpredictable and untoward consequences for the public behavior health sector. While the law permitted a limited window of opportunity through a grandfathering provision for existing certified social workers (CSWs) to become Licensed Master Social Workers (LMSW) or Licensed Clinical Social Workers (LCSW), the window is now closed. Yet among our own membership exist hundreds of eligible social workers who were unable to take advantage of the opportunity for systemic reasons, beyond their personal control. Other professions affected by the licensing law include Creative Arts Therapists, Mental Health Counselors, and Marriage and Family Therapists.

## **Background and Impact**

As of January 1, 2010, professional staff in programs regulated, funded, operated or approved by the State "O" Agencies: Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Children and Family Services (OCFS), will no longer be exempt from regulations that would obstruct practice and billing.

Earlier this year, The Coalition conducted a survey of its members regarding the impact of the license changes. By and large, survey results noted that most programs cannot meet the 2010 deadline requiring adherence to the license changes. In essence, existing personnel does not meet the new requirements for LCSW, LMHC, Marriage and Family Therapists, etc. The extremely inflexible regulations developed by the State Education Department to meet experience requirements of the law, have resulted in a system wide bottleneck. If the 2010 sunset provision is not extended, agencies will not be able to maintain current volume, potentially placing consumers at risk; will fire certain licensed professionals such as LMSWs and LMHCs because of their inability to meet Medicaid and Medicare billing requirements; and, will not be able to supervise students from schools of social work because they lack LCSW capacity.

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Of equal concern to us is the impact of the licensing requirements on non-treatment programs, such as drop-in centers, outreach programs, clubhouses and other rehabilitative models. Because State Education Department requirements under the law are so strict about where LMSWs may gain their requisite experience, i.e. in treatment programs only, and because of the lure of the seemingly more valuable license, these programs, serving consumers with serious and persistent mental illness, will lose social work staff and be unable to fill their staffs with these valuable professionals. Since these programs are serving the very same populations, it is illogical that the experience they provide to workers would not be counted toward their licensing requirements. It would be a big loss for consumers if social workers gravitated away from these programs.

### **Our Recommendation**

The Coalition supports the Governor's proposal in the Executive 2009-10 Budget to extend the exemption for the social work and mental health practitioner licensing requirements for an additional four years through December 31, 2013. We also urge the Legislature to reopen the grandparenting provision for candidates who were originally qualified. Furthermore, any legislation for extension should contain no contingencies or benchmarks for licensing. Experience in any of the programs under the jurisdiction of the State "O" Agencies should count toward the LCSW degree requirements. Lastly, SED regulations must offer provisions that will meet the needs of public sector community based providers. SED must work with the "O" State Agencies to implement regulations that will assure the necessary flexibility and diversity to operate various treatment and non-treatment programs, and facilitate the work and billing of providers.

## **Support Fair Transformation and Funding for Clinic Rate Restructuring**

***The Need: A clinic reimbursement rate methodology that adequately supports the public mental health system.***

Since 2007, the Office of Mental Health (OMH) has undertaken an initiative to reform and restructure its clinic delivery system and reimbursement methodology while simultaneously phasing out Comprehensive Outpatient Programs (COPS) and other rate add-ons. Over the next several years, a fundamentally transformed Article 31 clinic system will be phased in with profound effects on the financial viability of the community mental health sector, on the quality of care and on access to care for consumers. Complex implications for community based providers in terms of maintaining an adequate workforce and sustaining vital mental health treatment services for consumers in every legislative district in New York State are inevitable.

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**Background and Impact**

An inadequate plan to phase out COPS coupled with a faulty rate design could potentially force large numbers of providers out of business, leaving thousands of consumers without services. Clinic reform must be predicated upon a new reimbursement methodology that provides a sustainable base rate and finances the cost of high intensive services: children, geriatrics, Assisted Outpatient Treatment (AOT) and treatment for co-occurring disorders. Through an intensive two year study conducted by The Coalition, we were able to conclude that \$150 is a suitable base cost for service, plus added weights to reflect differences in service intensity for specialized needs. Without such considerations the publicly funded mental health system and communities will experience adverse consequences to its workforce, consumers and continuity of care.

Across communities, working and middle class access to the public mental health system will disappear. Agencies will no longer be able to afford to treat all consumers, beginning with clients who pay on a sliding scale. Providers already have begun denying service to clients enrolled in commercial insurance and managed care companies due to substandard and low-priced rates. In a worse case scenario, those who have serious mental illness will be screened out of private and public practices. Working poor and middle class clients have an investment in the availability of services provided by public safety net clinics. In addition, without adequate reimbursement, clinical workers could be laid off or required to work reduced hours, losing their health insurance and benefits. This is politically harmful to the workforce and to the sector.

**Our Recommendation**

New York State should guarantee an adequate level of funding and reimbursement rates so that community based mental health providers can continue providing services to all consumers in need. The Coalition asks the Legislature to gather information from OMH on the impact of systemic change to constituents and providers in their districts. The Legislature should also require the Department of Insurance to collect data and report on the number of mental health services (visits) provided to commercially insured consumers. Analysis of the data will aid in the examination of how transition to the new system, as proposed, will affect the quality of consumer care for New Yorkers. We also support the Governor's proposal in the Executive 2009-10 Budget that appropriates \$5 million towards the establishment of an indigent care pool for mental health clinics, but question whether this amount is sufficient.

## **Reform the Sex Offender Management and Treatment Act (SOMTA)**

***The Need: Change the Sex Offender Management and Treatment Act to require secure containment and treatment of offenders in a less expensive setting than inpatient hospitals.***

With the State's budget deficit growing and substantial budget cuts being proposed, there is an opportunity for New York State to save dollars by systemically restructuring SOMTA. The Coalition proposes that sex offenders be confined and provided treatment in a secure environment in less costly ways, reinvesting these funds in community based mental health services rather than cutting these services.

### **Background and Impact**

SOMTA is New York State's civil confinement program to house recidivist sex offenders after they have completed their prison sentences or parole terms. It admits the most dangerous sex offenders (currently 11 per month) to an inpatient hospital ward in a State psychiatric facility, or in some cases, offenders live in the community under Strict and Intensive Supervision and Treatment (SIST). In the case of the inpatient model, there is limited evidence of clinical success for a hospital-based, service intensive program, and it is not cost-effective for New York tax payers. Not incidentally, having sex offenders in State hospitals increases the stigma for people with mental illness.

New York State currently spends about \$225,000 annually per inpatient sex offender. With 172 offenders currently receiving treatment, the annual cost adds up to about \$38 million. Current practice also requires the building of new facilities to house sexual predators. In comparison, Pennsylvania spends \$150,000 annually per offender, while New Jersey is at \$67,000. Texas operates an outpatient model, which costs \$17,391 per offender each year. New York should look into the Texas model and others.

### **Our Recommendation**

The Coalition supports the Governor's proposed \$14 million reduction in budgeted growth to SOMTA in the 2009-10 Executive Budget and proposes that the Legislature investigate alternative treatment models that are operating in other states. We urge a change in the law to require secure containment without the cost and professional expertise that treatment in State inpatient psychiatric facilities require. New York State can look into the possibility of confining offenders to a group residence on the outskirts of a prison or other secure location, utilizing ankle bracelets and GPS monitoring capabilities. Offenders can

be committed to such an environment with limited community access for outpatient treatment in a closely supervised program like the SIST model. Through programmatic adjustments like these, further cost savings can be achieved and redirected into community-based mental health services.

## **Support Designation of Federal Medicaid Assistance Percentages (FMAP) Funds to Medicaid Program**

***The Need: Designate Federal assistance for New York State in the form of an FMAP increase for Medicaid uses and county pass-down funding***

With an FMAP increase likely to be part of the American Recovery and Reinvestment Bill being debated by Congress, we would like New York State to ensure that any FMAP money be used solely for the State's Medicaid program.

### **Background and Impact**

In New York State, the Federal government currently pays 50% of the costs of Medicaid. County governments are required to share the cost of their Medicaid programs. The split in New York ends up being 50% Federal, 25% state and 25% local. With the American Recovery and Reinvestment Bill taking shape, New York State's Federal share is expected to rise significantly. An increase of about 5% would bring in billions of additional dollars. FMAP money should be used for Medicaid only, and passed down as assistance to local government units who also pay into the Medicaid system.

### **Our Recommendation**

Dedicate any FMAP increase solely to the Medicaid program, including local government units. This will help protect community based providers and the consumers receiving their services from the overwhelming state health care cuts, including the one's proposed on the behavioral health sector by the Governor in the Executive 2009-10 Budget.

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2009 Board of Directors**

**Executive Committee**

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Thelma Dye, Ph.D. <i>Treasurer</i>	Northside Center for Child Development
William S. Witherspoon, Jr. <i>Secretary</i>	Upper Manhattan Mental Health Center, Inc.
Peter Campanelli, Psy.D. <i>Past President</i>	Institute for Community Living
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Joel Copperman	CASES, Inc.
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Joan DiBlasi, Ph.D.	Astor Child Guidance Center
Rosa Gil, DSW	Comunilife
Fern Fleckman	William F. Ryan Community Health Center
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Sandra Hagan	The Child Center of New York
Tony Hannigan	Center for Urban Community Services, Inc.
Nancy Harvey, LMSW	Service Program for Older People
Elliot Klein	New York Psychotherapy and Counseling Center
Roy Leavitt	Greenwich House, Inc.
Paul Levine	Jewish Board of Family and Children's Services
Richard P. Motta	Volunteers of America – Greater New York
Jean Newburg	Weston United Community Renewal, Inc.
Edward Ross	International Center for the Disabled
Fred Shack, LMSW	Urban Pathways, Inc.
Robert Tobing	University Settlement
Matthew Warner, Psy.D.	Odyssey House, Inc.
Peter Yee	Hamilton Madison House, Inc.
Fern Zagor	Staten Island Mental Health Society, Inc.

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## **The Coalition of Behavioral Health Agencies, Inc.**

### **Member Agencies 2009**

AIDS Center of Queens County, The (ACQC)	Fordham-Tremont Community Mental Health Center (CMHC)
Association for Rehabilitative Case Management and Housing, The (ACMH)	Fountain House
Astor Child Guidance Center	Goddard Riverside Community Center
Barrier Free Living (BFL)	Good Shepherd Services, Inc.
Beacon of Hope House	Greenwich House, Inc.
Black Veterans for Social Justice, Inc.	Guidance Center, The (New Rochelle)*
Blanton-Peale Institute	Guidance Center of Brooklyn (an ICL affiliate)
Bleuler Psychotherapy Center, Inc. (BPC)	Hamilton-Madison House
Bowery Residents' Committee, Inc.	Henry Street Settlement
Bridge, Inc., The	Hospital Audiences Inc. (HAI)
Brooklyn AIDS Task Force	Hudson Guild
Brooklyn Bureau of Community Service (BBCS)	Institute for Community Living (ICL)
Brooklyn Community Housing & Services, Inc. (BCHS)	Institute for the Puerto Rican/Hispanic Elderly (Clinica Nueva)
Brooklyn Psychiatric Center, Inc.	International Center for the Disabled (ICD)
CAMBA (Church Avenue Merchants' Block Association)	Jewish Association of Services for the Aged (JASA)
Care for the Homeless	Jewish Board of Family & Children's Services (JBFCS)
CASES, Inc. (Center for Alternative Sentencing & Employment Services)	Jewish Child Care Association (JCCA)
Catholic Charities Neighborhood Services, Inc. (CCNS)	Jewish Guild for the Blind, The
Center for Behavioral Health Services	John Heuss House
Center for Urban Community Services (CUCS)	Joseph P. Addabbo Family Health Center, Inc.
Child Center for New York, The	Julia Dyckman Andrus Memorial
Children's Aid Society, The (CAS)	Karen Horney Clinic, Inc.
Clubhouse of Suffolk, Inc.*	League Treatment Center, The
Coalition for Hispanic Family Services	Lenox Hill Neighborhood House
Columbia University - Harlem Rehabilitation Center	Lexington Center for Mental Health Services
Comunilife	Lifeline Center for Child Development, Inc.
Community Counseling & Mediation	Lower East Side Service Center, inc. (LESC)
Community Healthcare Network	Mental Health Association of Westchester*
Education & Assistance Corporation, The (EAC)	Metropolitan Center for Mental Health (MCMH)
Educational Alliance, The	Metropolitan Council on Jewish Poverty
Family Services of Westchester*	Neighborhood Coalition for Shelter (NCS)
FEDCAP	New Alternatives for Children
F.E.G.S.	New York Psychotherapy & Counseling Center
Fifth Avenue Center for Psychotherapy (NYANA)	Northside Center for Child Development, Inc.
	Occupations, Inc.
	Odyssey House, Inc.
	OHEL Children's Home & Family Services

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Palladia, Inc.  
Paul J. Cooper Center for Human Services  
Pesach Tikvah – Door of Hope  
Postgraduate Center for Mental Health (PCMH)  
Project Hospitality (PH)  
Project Renewal, Inc.  
PSCH, Inc.  
Puerto Rican Family Institute, Inc.  
Rainbow Heights Club  
Riverdale Mental Health Association, Inc.  
SAGE Services and Advocacy for GLBT Elders  
Safe Horizon  
Safe Space  
Samaritan Village, Inc.  
Samaritans of New York  
Samuel Field YM-YWHA CAPE  
Sequoia Community Initiatives, Inc.  
Service Program for Older People, Inc. (SPOP)  
Services for the Underserved (SUS)  
Sky Light Center, Inc.  
Spanish Speaking Elderly Council-RAICES  
St. Francis Friends of the Poor

St. Vincent's Services (SVS)  
Staten Island Behavioral Network  
Staten Island Mental Health Society, Inc.  
Steinway Child & Family Services, Inc. (SCFS)  
Supportive Housing Network of NY\*  
Transitional Services of New York, Inc.  
Union Settlement Association  
University Consultation & Treatment Center  
University Settlement  
Upper Manhattan Mental Health Center, Inc.  
Urban Pathways, Inc.  
Venture House  
VidaCare  
Visiting Nurse Services of New York  
Volunteers of America-Greater New York  
Westchester Jewish Community Services\*  
(WJCS)  
Weston United Community Renewal, Inc.  
William F. Ryan Community Health Center

\* Signifies Affiliate Member