



Community Mental Health Services

**New York State Budget
Fiscal Year 2005-2006**

A Briefing Book

February 2005

The Coalition of Voluntary Mental Health Agencies, Inc.
(New York City and environs)

State Fiscal Year 2005-2006 Budget Briefing Book

February 2005

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Coalition Response to the Governor's Proposed Executive Budget

- **Allocation of \$6 million (State share) to provide a rate increase for Article 31 clinics.**

The Coalition **enthusiastically supports** this initiative, which will help providers maintain vital clinical services in communities throughout New York. Clinic treatment is one of the most integral components of the State's mental health system, and this rate increase will allow providers, albeit on a temporary basis, to begin to address systemic funding gaps in the current program model. We are particularly pleased that the Governor's proposal recognizes the higher cost of providing clinic services to children.

In order to ensure the continued vitality of these critical programs in future years, **the Coalition will continue to advocate for the establishment of a cost-based funding structure for clinics and other outpatient treatment modalities. The Coalition will also continue to advocate for a differential rate for clinics that provide services to children and other specialty populations** above and beyond the modest increase included in the Governor's proposal.

- **Allocation of \$6.5 million to support a rate increase for the supported housing program.**

The Coalition **enthusiastically supports** this initiative, which will help providers, particularly those in New York City, continue to offer permanent housing to undomiciled New Yorkers in need. This rate increase will help preserve thousands of units of supported housing at a time when the city's homeless population is at an all-time high.

However, to address the issue of rising rents and associated expenses going forward, **the Coalition will continue to advocate for a rent pass-through for the supported housing program** similar to what exists for the Office of Mental Health's (OMH) licensed housing.

- **Reduction of \$3.9 million to community-based outpatient programs.**

The Coalition **opposes** further reductions to a sector that is already struggling to survive. We support efficiency, effectiveness and quality. But some agencies are forced to carry high administrative costs to comply with the plethora of unfunded mandates issued at every level of government. We also know that our providers absorbed a substantial reduction in last year's State budget. The community mental health sector must be strengthened, not weakened, if it is to continue to provide housing, treatment and services to hundreds of thousands of New Yorkers each year living with psychiatric disabilities.

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- **Establishment of thresholds for Continuing Day Treatment Programs.**

The Coalition is **greatly concerned** about a proposal to create a threshold for these important outpatient programs, which typically serve high-need consumers with dual diagnoses of mental health and substance abuse. In the absence of appropriate alternative settings where these consumers could access the help they need, the Coalition believes these services should be maintained at existing levels, particularly in areas of the State where OMH's new recovery-based license (PROS) has not yet been rolled out.

- **Elimination of mental health benefits under Family Health Plus.**

The Coalition **strongly opposes** this proposal which runs counter to the struggle for mental health parity in New York. It is not logical from a treatment perspective to ignore the dynamic interaction between physical and mental health. We stand together with advocates, providers, family members and consumers from across the State in opposing this short-sighted and potentially dangerous proposal.

- **Allocation of \$2 million to cover compliance cost of new Fingerprinting legislation.**

The Coalition **supports** this proposal, which will relieve providers of the financial burden of complying with yet another unfunded mandate. The new legislation will require fingerprints and background checks for all prospective employees of licensed mental health programs who might interact with consumers in a non-supervised setting.

- **Allocation of \$2.3 million to provide 245 additional Home & Community Based Waivers for children with psychiatric disabilities.**

The Coalition **supports** this proposal, which will allow children to receive services in home and at school rather than in more costly treatment facilities. We acknowledge the collaboration between OMH and the Office of Child and Family Services (OCFS) in developing this initiative.

The Case for a Trended Medicaid Rate Increase

The Need: The creation of a cost-based system for Article 31 clinics.

The Governor's Proposed Executive Budget for SFY 2005-2006 includes \$6 million (grossing up to \$24 million in total funds) for a rate increase for Article 31 clinics. We are deeply appreciative of Governor Pataki and OMH Commissioner Sharon Carpinello for their recognition of the crisis faced by clinic providers, and we look forward to working with both the Executive and the legislature in crafting a trended rate increase for this program that will address inflationary expenses going forward.

Background

Over the past twenty years, the State adopted a strategy to replace an increasing share of its mental health funding with federal Medicaid dollars. In 1980, Medicaid paid for roughly 35% of the State's entire mental health system. Today, it pays for nearly half. Article 31 outpatient programs, meanwhile, receive 76% of their funding through Medicaid. The State's decision to develop a new Medicaid-funded license for recovery-oriented programs will continue this trend even further. Unfortunately, the rates that currently exist for these and other ambulatory outpatient programs are declining in value each year when matched against the inflationary expenses incurred by our providers.

The Coalition recently completed an analysis from a survey that sought information on how providers address the deficits they incur in ambulatory outpatient programming. The preliminary results of our survey indicate that the current rates are wholly inadequate for the level of programming that OMH expects from our membership. The revenue for clinics, for example, pales in comparison to the expenses associated with operating these essential programs which treat tens of thousands of mental health consumers in New York City alone. The increasing cost of complying with federal, state and local mandates, which require more sophisticated and costly technological competence, only adds to the provider's burden.

The recent decision by a large social service agency to close four of their clinics altogether rather than operate them at mounting deficits each year speaks loudly to this issue. We obviously hope, for the sake of the entire community mental health sector, that this decision does not represent a trend among providers. But unless fiscal realities are addressed and structural changes are adopted, we fear it might.

Our Recommendation

Trended Rate Factor

As stated above, we are grateful for the allocation of \$6 million included in the Governor's proposed budget for an Article 31 clinic rate increase. This allocation will help providers maintain their clinic services for their consumers, and will alleviate, on a short-term basis, the crisis faced by this critical treatment modality.

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However, there is currently no mechanism in place to address the rising cost of doing business in New York for our providers. Insurance rates, utilities, rents and salaries continue to rise exponentially each year. Without a long-term solution, contract dollars, fees and other reimbursements will continue to fail to keep pace with inflation.

Currently, other health care sectors, including other behavioral health care sectors, receive annual trended rate increase from the State. As a result, these providers are better equipped to provide treatment to their client base without having to substitute service dollars to cover inflationary costs. This model could and should be replicated for the community mental health sector. **We ask for the support of the legislature to work with providers and the Executive branch to create a cost-based system for clinics.**

Clinic Services for Children: An Uncompensated Differential

The Need: A Differential Medicaid Rate for Children's Clinic Services.

Background

The Governor's proposed Executive Budget for SFY 2005-2006 includes \$6 million (grossing up to \$24 million in all funds) for a rate increase for Article 31 clinics. OMH tells us that a portion of this funding increase will be dedicated to enhancing the ability of children to receive clinic services. For clinic providers who don't currently offer weekend and evening hours for children and their caretakers, the Governor's proposal will offer them an incentive to do so. For those providers who already offer these hours, the Governor's proposal will offer them a higher rate that acknowledges the higher expenses. Since the cost for clinic services to children is exponentially higher than it is for adults, the Coalition is grateful to the Governor and OMH Commissioner Carpinello for acknowledging this cost differential.

Providers of clinic services to children receive the same base Medicaid rate for children as they do for adults (\$66), despite the cost differential. This cost disparity is attributable to several factors.

- The High Cost of Child Psychiatrists. As generally acknowledged by the SOMH and DOHMH, the demand for psychiatrists far exceeds the supply. Unfortunately, the supply of child psychiatrists, who require an additional year of study, is particularly low. Reports from the provider community note that a bilingual child psychiatrist can command up to \$300 an hour. This figure presents a major fiscal challenge for non-profit community based mental health providers. And the use of child psychiatrists is hardly optional -- current regulations require providers to retain child psychiatrists in the Interim Specialty Clinics that serve SED (Severely Emotionally Disturbed) children.
- The More Frequent Use of Child Psychiatrists. Children's mental health needs are enormously complex. The use of medication for treatment of psychiatric disabilities is far more complicated than it is for most adults. As a result, SED children are more likely to be seen by the psychiatrist on a weekly or semi-monthly basis, increasing the costs for the providers.
- Case Management & Collateral Costs. Children's treatment out of necessity involves a tremendous amount of case management and collateral visits. In general, children are seen with parents or guardians, thereby extending the length of the visit to an hour. Consequently, this reduces the number of clients that can be seen by a clinician and therefore increases the unit cost by reducing overall productivity.

Effective child treatment always involves case management with individuals significant in the child's life, such as teachers and guidance counselors. Unfortunately, only face-

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to-face contacts are reimbursable by Medicaid. All other means of communication, such as phone contacts, therefore only add to the per-unit cost for providers.

Most providers embrace Evidence Based Practices, which often require additional staff training. For clinics that are already struggling to make ends meet, the unfunded cost involved in this training only adds to the clinic's overall deficit.

Our Recommendation

As stated above, we are grateful for the acknowledgement by the Governor and OMH Commissioner Carpinello that clinic services for children are more costly to provide.

In short, clinic services for children are higher because so much more time and energy must go into each contact. The expectation that providers can offer a full complement of services at the existing base Medicaid rate of \$66 is simply not realistic. As the Governor's proposal takes form, we ask SOMH to consider the reality that the actual per-unit cost for children's clinic providers often exceeds \$130. A similar case can be made for providers who offer clinic services to the geriatric population, or to a specific high need population. **A rate increase that reflected this cost would allow clinic providers to more effectively serve their child consumers.**

The Crisis in Supported Housing

The Need: The creation of a trended rate increase to ensure that reimbursement rates track and reflect the inflationary costs of providing housing and services.

The Governor's Proposed Executive Budget for SFY 2005-2006 includes \$6.5 million for a rate increase for the supported housing program. This will allow for a rate increase of between 7.2% and 9.47% in the counties where the need is greatest, including New York City. We are deeply appreciative of Governor Pataki and OMH Commissioner Sharon Carpinello for their recognition of the crisis faced by supported housing providers, and we look forward to working with both the Executive and the legislature in crafting a trended rate increase for this program that will address inflationary expenses going forward.

Background

Each night, nearly 39,000 men, women and children sleep in city shelters and drop-in centers in New York City. The demand for permanent housing far exceeds the available supply. For homeless mental health consumers living in these transitional facilities, the options for permanent housing are few.

New York City's Department of Homeless Services estimates that fully one-third of the single adult shelter population suffer from psychiatric disorders and are in need of ongoing mental health treatment and services in a setting designed to fit their special needs. And while several models exist for mental health consumers depending on their level of functionality, perhaps no model has been quite as successful and cost-effective as OMH's Supported Housing program.

Combining a safe and affordable living environment with the role of personal choice in rehabilitation and recovery, the Supported Housing program has moved tens of thousands of homeless New Yorkers living with psychiatric disabilities out of shelters and drop-in centers and into permanent housing. The Governor's decision last year to add 600 new supported housing beds into the existing system further supports the argument for pursuing this model as an avenue out of the personally debilitating and exorbitantly expensive shelter system.

Indeed, recent studies point to a per-unit cost of \$25,000/year for a bed in a city shelter; the addition of mental health services only adds to that figure. The cost of a city jail or State prison is even higher, and the cost of an in-patient psychiatric bed exceeds \$120,000/year. Clearly the Supported Housing program, at under \$12,000/year, is a far more cost-effective, sensible and humane model for homeless New Yorkers living with psychiatric disabilities.

The Current State of Supported Housing

The State Office of Mental Health currently pays providers in New York City \$11,239 per unit of Supported Housing (or \$937/month). The model envisions a simple payment for rent and necessary support services. However, this figure is considerably below the HUD Fair Market Rate for just renting a one-bedroom apartment in New York City and the surrounding

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counties.¹ With the addition of \$2,343 in consumer contributions (through SSI/SSD), the total income for a unit of Supported Housing and the provision of social services comes to \$13,582 in New York City.

In a recent Coalition survey, however, providers told us that they're often unable to locate apartments for their tenants for less than \$1,100 per month, even outside of Manhattan. And whereas the original Supported Housing contracts established in 1990 envisioned a 54/46 ratio of housing expenses to social service expenses, the current reimbursement rates, when compared with 2004 rental costs, force many providers to spend upwards of 90% of their contract on housing costs. Accordingly, funding covers little, if any, casework and services, which are enormously important components in a provider's ability to promote treatment, stability and recovery. With consumers increasingly presenting complex diagnoses, the need for social services is paramount to the successful rehabilitation and recovery for these tenants.

The survey also found that the overwhelming majority of Supported Housing providers anticipate inflationary increases in their current rental rates. Most have seen increases from 3% to 10% over the course of the past three years, and have no reason to believe that similar increases won't occur over the next three years.

Faced with these inflationary rental increases, providers may be unable to renew prohibitively expensive leases due to stagnant, and thus inadequate, reimbursement rates, thereby negatively impacting on consumer's stability and renegeing on an implicit promise by the State. With 39,000 homeless New Yorkers currently sleeping in the City's emergency shelter system each night, any loss of permanent housing would be catastrophic.

Our Recommendation

Establishment of Structured Trend Factor

As stated above, we are grateful for the allocation of \$6.5 million included in the Governor's proposed budget for a supported housing rate increase. This allocation will help providers maintain their housing units for their consumers, and will alleviate, on a short-term basis, the crisis faced by this program.

However, in order to cover annual rent increases and serve the diverse needs of the over 10,000 men and women living in supported housing, a structured trend factor must be inserted into next year's contracts. Such a model in fact already exists in housing programs for New Yorkers living with developmental disabilities. **An examination and development of a "rent pass-through" and a trended increase for residential staff is critical if housing providers hope to remain financially viable in the years ahead.**

¹ FMR for a one-bedroom apartment is \$11,328 per year in the five boroughs of NYC; \$13,020 in Suffolk & Nassau Counties; and \$12,744 in Westchester County.

Co-Occurring Disorders: Incentivizing and Increasing Competencies

The Need: A pilot program for increasing agency dual diagnosis competencies and a differential reimbursement rate for services provided to individuals with dual diagnosis to cover the higher costs of providing these services.

Background

Co-occurrence is the rule not the exception. According to the recently released SAMHSA Toolkit on Evidence-Based Practice: "More than half of the adults with severe mental illness in public mental health systems are further impaired by the presence of co-occurring substance use disorders...Consumers are at risk for negative outcomes, including hospitalization, overdose, violence, legal problems, homelessness, victimization, HIV infection, and hepatitis. Additionally, mental health systems spend most of their resources on a small percentage of individuals with difficult problems, often consumers with dual disorders. Mental health services for these consumers cost, on average, nearly twice as much as for clients with single disorders." Poor outcomes for these clients contribute to the State's overall cost, given the high rates of hospitalization, emergency room use, detoxification and other associated expenses.

The Solution: Integrated Treatment

According to SAMHSA, "Consumers with dual disorders have high rates of recovery when provided integrated dual disorders treatment, which means combining mental health and substance abuse treatments within the same system of care. Integrated treatment leads to dual recovery and reduces costs. Effective treatment is good public policy."

In The Presidents' New Freedom Commission on Mental Health Report of the Subcommittee on Co-occurring Substance Abuse and Mental Disorders, "Individuals in integrated programs spent significantly less time in institutions, hospitals, emergency rooms, jails, and living in the streets homeless."

There is significant consensus in the field around evidence-based practices. OMH has repeatedly emphasized the importance of dissemination and implementation of evidence-based practices. Currently they are converting a large portion of mental health services to a PROS license where "integrated treatment for individuals with co-occurring mental health and substance abuse disorders" is listed as a required service. However, there has been no articulation of a plan to aid providers in meeting this requirement programmatically or fiscally, including the cost of training staff, lost productivity while staff is in training, higher rates of recidivism and relapse attributed to this population, and higher rates of staff burnout.

State Response To Date

In May of 2001, following a 3-year effort by OMH and OASAS, the Interagency Workgroup on Co-Occurring Mental Health and Addictive Disorders published a blueprint for developing a system of integrated services for persons with co-occurring disorders. The recommendations

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contained in the Task Force report, titled *Treating Co-Occurring Mental Health and Addictive Disorders in New York State: A Comprehensive View*, encompassed both residential and outpatient treatment services and included two sets of criteria called DDC (Dual Diagnosis Capable) and DDE (Dual Diagnosis Enhanced). Unfortunately, in the 4 years since the Task Force report was issued, the State has made very little progress in implementing any of its own recommendations. The MICA Institute, a cooperative venture of OMH, the NYC Dept. of Health and Mental Hygiene (DOHMH) and the Mental Health Association of New York City (MHA of NYC) has offered trainings on relevant topics in dual diagnosis treatment. Last year, 20+ individual staffers were trained on three different aspects of dual diagnosis treatment. At this rate, it would take more than 300 cycles of this training to train an estimated 6,000 employees in community-based mental health agencies in New York City on just these three topics. We commend the state for this training but assert that there persists an urgent need for additional training.

Training – Increasing the Competencies of a Sector

The community-based sector has long been plagued with high staff turn-over and burn-out rates, due in part to insufficient salaries and incentives for skilled practitioners to enter or remain in the sector. The dually diagnosed population requires that staff be trained in multiple skill sets that cross disciplines and transcend conventional offerings in university programs. In order for treatment to be effective and have positive outcomes, practitioners must be adequately trained to treat the entire client, not just one aspect of the client. In addition, training of executive-level staff and generating executive-level buy-in are crucial if system-wide adaptation of integrated treatment is to occur. Provider inclusion in the planning and development of any and all state and local trainings is absolutely necessary to ensure that trainings are addressing practical needs of front-line providers and their supervisory staff. Overall the State must engage in a committed long-term effort to cross-train every practitioner in both mental health and chemical dependency services in dual recovery competencies. We recognize that, with limited resources, training every individual staff member is not a feasible short-term goal.

We request a small budget allocation of \$120,000 to fund a pilot incentive program for 10 programs at \$10,000 each with a \$20,000 evaluation component. This funding would be used for on-site training of staff, ongoing technical assistance and development of additional evidence-based practice phase-specific treatment interventions at these programs to increase their dual diagnosis competence as a program. If a program becomes Dual Diagnosis Capable the institutionalized competence can continue beyond the tenure of any individual staff. In addition, protocols, program adaptations and innovations can be put in place to enhance outcomes for individuals with a dual diagnosis which will be measured by the evaluation component and assessed for replication at other agencies. The goal will be to create a self-sustaining learning community out of a network of trained and dual diagnosis competent programs. Staff from these agencies will be able to interact during trainings and increase connections for peer support.

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Pursuit of Federal Funding

SAMHSA periodically releases RFAs (Request for Applications) for State Incentive Grants around implementation of evidence-based practices and systems change. One of the focus areas is co-occurring disorders. It is our understanding that New York has failed to actively pursue these federal grants, allowing a valuable opportunity to develop pilot and demonstration projects in line with the recommendations of the State Task Force Report to slip away. We encourage the state to proactively pursue this and similar funding opportunities in the future.

Differential Rate for Integrated Dual Disorders Treatment Services

The cost of providing services to individuals with dual diagnoses is higher than the cost of providing services to an individual with a singular mental health disorder. Child psychiatrists charge higher rates because of required additional specialization, education, training and competencies. Dual recovery providers also need additional specialization, training, competencies and experience with multiple disorders across many delivery systems in order to provide effective treatment. It is logical that these professionals be compensated for their additional specialization and expertise. With current reimbursement rates, agencies are unable to offer salaries that reflect these higher competencies and therefore have difficulty hiring and maintaining staff that are able to effectively treat the individuals who walk through their doors. The Coalition is interested in working with the State to identify potential solutions to the under-funding of these services. One suggested solution is a differential rate that would be attached to services provided for an individual who is dually diagnosed and requires integrated mental health and substance abuse treatment. The Coalition would be pleased to coordinate a planning group with the state to evaluate the differential costs of providing IDDT in order to arrive at a rate that is truly reflective of the costs of providing services.

Medicaid Neutrality – The Implementation of Stigma Through Policy

The Need: The elimination of the discriminatory Medicaid Neutrality cap.

The Coalition and its members oppose the continuing cap on an increase in spending and expansion of mental health services regardless of demonstrated need, commonly referred to as “Medicaid Neutrality.” In Title 14 NYCRR Part 551.13, the regulations governing criteria for additional outpatient programs, it states that “in reviewing outpatient projects, the Office of Mental Health shall consider...for Medicaid or local assistance, the impact, source, and availability of the State share of such funds.” In essence, the State has placed a moratorium on expansion of outpatient mental health services unless an agency identifies alternative funding sources to cover the anticipated increase in spending of the State share of Medicaid. This cap is effectively the implementation of stigma through policy as it applies to mental health services alone among the health disciplines.

Capacity Limited Irrespective of Demonstrated Need

The community-based mental health system continues to struggle with how to expand capacity, extend hours, or establish satellite clinics to serve unmet mental health needs. In an environment where State policy, budget deficits and regulatory decisions restrict the expansion of community-based mental health services, meeting the need has become virtually impossible. Waiting lists, particularly for children’s services, but also for adult services are so common as to no longer be noteworthy. Simply put, New York’s mental health treatment system is full. In the name of fiscal prudence, we are tolerating family and community disruption, and are squandering precious human potential. We are short-changing New Yorkers in need while spending much more, in the long run, on additional resultant medical and social costs including: substance abuse disorders, hospitalization, violence, legal problems, homelessness, HIV infection and hepatitis.

Tying Providers’ Hands – Denying Innovation, Adaptation, Expansion and Growth

Efforts to expand mental health services to fill the gaps in services for the unmet need of targeted and identified populations have been very difficult and often unsuccessful due to the regulatory and fiscal barriers imposed by Medicaid Neutrality. As noted in a report by The Citizens Committee for Children, Paving the Way: New Directions for Children’s Mental Health Treatment Services, the choices faced by providers in need of additional capacity are bleak: “In these circumstances, the mental health agency could:

- 1) absorb the loss created by unreimbursed visits,
- 2) rely on other resources such as a private grant to cover its costs,
- 3) decide against increasing services, or
- 4) cut back visits at the main clinic treatment site and use the Medicaid savings to pay for new services.”

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Very simply, the Medicaid Neutrality cap forces both children and adults to wait weeks and months for a first appointment or to eventually seek much more expensive triage care in a hospital emergency room. This moratorium applies to the expansion of hours to meet the needs of working parents as well as any expansion of volume. It also precludes the possibility of innovation and adaptation to meet newly identified needs of special populations such as children in foster care.

In fact, the Coalition has been working with the Council of Family and Child Caring Agencies (COFCCA) to identify best practices in providing mental health services to children in foster care. Regrettably, the possibility of creating satellite clinics that are co-located with foster care agencies to provide more integrated and accessible treatment is currently prevented by Medicaid Neutrality.

Mental Health Parity

The Need: Enactment of Mental Health Parity in this year's legislative session.

The Governor's proposed budget for SFY 2005-2006 would eliminate mental health coverage for recipients of Family Health Plus (FHP). This proposal is enormously misguided and stands in marked opposition to recent attempts by both the Assembly and the Senate to enact mental health parity in New York State. We urge the legislature to reject this unsound proposal.

According to the National Institute of Mental Health, in any given year over 50 million American adults (20% of the population) suffer with a mental disorder. For children, one in five have behavioral, emotional or mental health problems. Without mental health services, these problems often exacerbate forcing increased utilization of higher cost and emergency care services, including community emergency rooms, community in-patient settings, and juvenile correction facilities.

In New York State insurers currently limit the number of inpatient and outpatient mental health visits per year and charge higher deductibles, co-payments, and/or co-insurance for mental health and substance abuse treatment than they do for treatment of physical health issues. Without timely access to necessary treatment families are often left with the cruel choice of depleting their financial resources or relinquishing custody of their child to the State in order to access appropriate care.

Parity also deserves support based on a cost analysis study of other states that have passed similar legislation. Despite concerns that costs would skyrocket, most states saw an initial increase of no more than 1% over previous rates; some states, such as Maryland, even saw a decrease in rates. Furthermore, the cost for mental health expenses themselves can drop, as was the experience in North Carolina. Businesses save money, since workers can avail themselves of mental health services while maintaining their employment – leading to increased productivity and decreased absenteeism.

Over 100 organizations statewide are seeking **enactment of mental health parity legislation** prohibiting insurance companies from requiring more out-of-pocket payment for mental health care than for physical health care. Thirty-three states across the country have already adopted parity legislation and we urge New York State to do the same.

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2005**

Ackerman Institute for the Family
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Association for Rehabilitative Case
Management and Housing
Astor Child Guidance Center
Baltic Street Mental Health Board
Barrier Free Living
Beacon of Hope House
Bergen Street Residence
Black Veterans for Social Justice, Inc.
Blanton-Peale Institute
Bleuler Psychotherapy Center, Inc.
Bowery Resident's Committee, Inc.
Boys and Girls Harbor
Bridge, Inc., The
Brooklyn AIDS Task Force
Brooklyn Bureau of Community Service
Brooklyn Community Housing & Services, Inc.
Brooklyn Psychiatric Center
Builders for the Family & Youth
Canarsie Aware
CASES (Center for Alternative Sentencing
& Employment Services)
Catholic Charities Counseling Service of N.Y.
Center for Preventive Psychiatry, Inc.*
Center for Urban Community Services
Children's Aid Society
Clubhouse of Suffolk, Inc.*
Columbia University - Harlem Rehabilitation
Center
Community Access, Inc.
Community Counseling & Mediation
Community Healthcare Network
CIDR
EAC, Inc. (Education & Assistance
Corporation)
Educational Alliance
The Family Center
F.E.G.S.
Fifth Avenue Center for Psychotherapy
(NYANA)

Fordham-Tremont CMHC
Fountain House
Goddard Riverside
Good Shepherd Services
Guidance Center of Brooklyn
H.I.R.E.
Hamilton-Madison House
Harlem-Dowling Westside Center
Henry Street Settlement
Hudson Guild
Institute for Community Living
Institute for the Puerto Rican/Hispanic
Elderly
International Center for the Disabled
Jewish Association of Services for the Aged
Jewish Board of Family & Children's Services
Jewish Child Care Association
Jewish Guild for the Blind
John Heuss House
Joseph P. Addabbo Family Health Center
Karen Horney Clinic, Inc.
League Treatment Center
Lexington Center for Mental Health Services
Lifeline Center for Child Development
Lenox Hill Neighborhood House
Lower East Side Service Center
Mental Health Providers of Western Queens
Metropolitan Center for Mental Health
Neighborhood Care Team
New York Psychotherapy & Counseling Center
New York Service Program for Older People
New York Society for the Deaf
Northside Center for Child Development
OHEL Children's Home & Family Services
Palladia, Inc.
Pathways to Housing, Inc.
Paul J. Cooper Center for Human Services
Pesach Tikvah – Door of Hope
Post Graduate Center for Mental Health
Project Hospitality

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Project for Psychiatric Outreach to the Homeless
Project Renewal
PSCH
Puerto Rican Family Institute
Queens Child Guidance Center
Riverdale Mental Health Association
Safe Horizon
Safe Space
Samaritan Village, Inc.
Samaritans of New York City, Inc.
Samuel Field YM-YWHA CAPE
Services for the Underserved
SI Behavioral Network
Sky Light Center
Spanish Speaking Elderly Council
RAICES
St. Francis Friends of the Poor
St. John's Episcopal Hospital Center
St. Vincent's Services

Staten Island Mental Health Society, Inc.
Steinway Child & Family Services
Supportive Housing Network of NY*
Transitional Services of New York, Inc.
Union Settlement Association
University Consultation & Treatment Center
University Settlement House
Upper Manhattan Mental Health Center
Urban Pathways
Venture House
Visiting Nurse Services of New York
Volunteers of America – Greater New York
Westchester Jewish Community Services*
Weston United Community Renewal, Inc.
William F. Ryan Community Health Center
Women in Need

* Signifies Associate Member