



Office of Addiction
Services and Supports

Office of
Mental Health

Office for People With
Developmental Disabilities

Goals and Objectives 2024-2027 Franklin County Community Services

Suzanne Lavigne, Director of Community Services
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Goal 1

Goal 1: Title Housing

Goal 1: Target Completion Date Dec 31, 2025

Goal 1: Description Create housing opportunities for community members with mental health and co-occurring disorders in need of safe and affordable housing.

Goal 1: OASAS? Yes Goal 1: OMH? Yes Goal 1: OPWDD? Yes

Goal 1: Need Addressed 1 Housing

Goal 1: Need Addressed 2

Goal 1: Need Addressed 3

Goal 1, Objective 1: Title Harison Place

Goal 1, Objective 1, Target Completion Date Jan 31, 2024

Goal 1, Objective 1, Description Develop plans for a SPOA process for Harison Place to accept referrals for individuals with serious mental illness and substance use disorders (12 beds will be available for SMI and 8 beds will be available for SUD) (Franklin County Community Services, Citizen Advocates).

Goal 1, Objective 2: Title Funding application

Goal 1, Objective 2, Target Completion Date Jun 30, 2025

Goal 1, Objective 2, Description Prepare and submit a grant application to expand the housing continuum for homeless and transition-aged youth, and determine potential locations for the program, if it is funded (Franklin County Community Services).

Goal 1, Objective 3: Title Youth homelessness data

Goal 1, Objective 3, Target Completion Date Jan 31, 2025

Goal 1, Objective 3, Description In collaboration with the Franklin County Department of Social Services and school-based homelessness liaisons, establish a process for tracking the number and characteristics of youth and transition-aged youth experiencing homelessness, and report this data quarterly (Franklin County Department of Social Services, Franklin County Community Services).

Goal 1, Objective 4: Title Housing subcommittee

Goal 1, Objective 4, Target Completion Date Apr 30, 2024

Goal 1, Objective 4, Description Establish a subcommittee of the Community Services Board, comprised of board members and representatives of agencies that provide housing services. The charge of this committee will be to discuss housing needs, including best practices for landlord engagement to expand community-based rental housing opportunities for community members with mental health conditions, substance use disorders, and/or developmental disabilities (Community Services Board, Citizen Advocates, St. Joe's, Community Connections, Lakeside House, Akwesasne).

Goal 2

Goal 2: Title Crisis Services

Goal 2: Target Completion Date Dec 31, 2026

Goal 2: Description Ensure that crisis intervention and stabilization services are available and accessible to support Franklin County youth and adults who are experiencing mental health / co-occurring crises.

Goal 2: OASAS? Yes Goal 2: OMH? Yes Goal 2: OPWDD? Yes

Goal 2: Need Addressed 1 Crisis Services

Goal 2: Need Addressed 2

Goal 2: Need Addressed 3

Goal 2, Objective 1: Title 589 Children's Crisis Residence

Goal 2, Objective 1, Target Completion Date Jan 31, 2025

Goal 2, Objective 1, Description Once approved by OMH, begin implementing 589 Children's Crisis Residence services. Develop a system to track data to assess trends in clients served (i.e., numbers served, diagnostic information), and collect feedback regarding program strengths and challenges. Report these findings quarterly (Citizen Advocates).

Goal 2, Objective 2: Title TCI data collection

Goal 2, Objective 2, Target Completion Date Mar 31, 2025

Goal 2, Objective 2, Description A first cohort of county providers received the Therapeutic Crisis Intervention (TCI) train-the-trainer approach and are certified to train agency staff. These new trainers will begin analyzing data from their agencies' incident reports to assess needs and early impacts regarding TCI (Franklin County Community Services).

Goal 2, Objective 3: Title TCI train-the-trainer cohort

Goal 2, Objective 3, Target Completion Date Dec 31, 2025

Goal 2, Objective 3, Description A second TCI train-the-trainer cohort will begin in November 2023 to expand the number of county-based trainers, including staff from Citizen Advocates, Akwesasne, and Franklin County DSS. This new cohort of trainers will begin providing TCI training to approximately 100-150 agency staff (Franklin County Community Services).

Goal 2, Objective 4: Title AMC emergency department

Goal 2, Objective 4, Target Completion Date Sep 30, 2024

Goal 2, Objective 4, Description Adirondack Medical Center will repurpose 3 rooms in the Emergency Department to better support individuals waiting for an appropriate BH/IDD placement as a way to enhance safety, reduce environmental stimulation of the ED, and promote a more therapeutic environment (Adirondack Medical Center).

Goal 2, Objective 5: Title Alice Hyde MOU

Goal 2, Objective 5, Target Completion Date Jun 30, 2024

Goal 2, Objective 5, Description Establish an MOU between Alice Hyde hospital stakeholders, Malone police department staff, community-based mental health providers, and county leaders to develop assessment plans, share information, analyze trends, and develop strategies designed to improve care for community members presenting in the emergency department for a mental health crisis (Alice Hyde, Community Connections, Citizen Advocates, Franklin County Community Services).

Goal 2, Objective 6: Title Adirondack Medical Center MOU

Goal 2, Objective 6, Target Completion Date Jun 30, 2024

Goal 2, Objective 6, Description Establish an MOU between Adirondack Medical Center hospital stakeholders, Saranac lake and Tupper Lake Malone Police Department staff, community-based mental health providers, and county leaders to develop assessment plans, share information, analyze trends, and develop strategies designed to improve care for community members presenting in the emergency department for a mental health crisis (Adirondack Medical Center, Community Connections, Citizen Advocates, Franklin County Community Services).

Goal 2, Objective 7: Title TCI training for hospital staff

Goal 2, Objective 7, Target Completion Date Dec 31, 2025

Goal 2, Objective 7, Description Train hospital staff in Therapeutic Crisis Intervention (TCI) to improve trauma-informed service provision to community members entering the emergency department for a mental health crisis (Franklin County Community Services).

Goal 2, Objective 8: Title CSIDD presentation

Goal 2, Objective 8, Target Completion Date Jun 30, 2024

Goal 2, Objective 8, Description The Community Services board will host a presentation by OPWDD to raise awareness of CSIDD opportunities to support individuals experiencing a co-occurring crisis (OPWDD, CSIDD, Franklin County Community Services).

Goal 2, Objective 9: Title Crisis services training presentation

Goal 2, Objective 9, Target Completion Date Sep 30, 2024

Goal 2, Objective 9, Description Adirondack Arc, Citizen Advocates and OPWDD will provide a training presentation to educate staff about the needs of people with developmental disabilities who may require crisis services, including information about the supports and services available during a crisis (Citizen Advocates, OPWDD).

Goal 2, Objective 10: Title Strategies for individuals with IDD presenting in the ED

Goal 2, Objective 10, Target Completion Date Jan 31, 2026

Goal 2, Objective 10, Description Create strategies to better support individuals with IDD/co-occurring disorders when they present at hospital emergency departments in crisis situations. (Alice Hyde Medical Center, Adirondack Medical Center, Adirondack Arc, Citizen Advocates, OPWDD, YAI-CSSID, Franklin County Community Services).

Goal 3

Goal 3: Title Adverse Childhood Experiences

Goal 3: Target Completion Date Dec 31, 2027

Goal 3: Description Expand trauma-informed, school-based, and community-based services to youth to reduce the need for out-of-home placement and to improve long-term outcomes for youth and families.

Goal 3: OASAS? No Goal 3: OMH? Yes Goal 3: OPWDD? No

Goal 3: Need Addressed 1 Adverse Childhood Experiences

Goal 3: Need Addressed 2
Goal 3: Need Addressed 3

Goal 3, Objective 1: Title School-as-a-hub expansions
Goal 3, Objective 1, Target Completion Date Dec 31, 2027
Goal 3, Objective 1, Description Explore possibilities to scale the school-as-a-hub model to additional districts throughout the county (Malone; St. Regis Falls; Brushton; Salmon River). Through SAMHSA System of Care funding, Franklin County is currently implementing the model within the Tupper Lake, Saranac Lake, and Chateaugay school districts. This model provides intensive in-school mental health support services, including clinical services, care coordination, family support, youth peer support, and crisis support, to youth with serious emotional disturbances (SED). (Franklin County Community Services, school districts, partner organizations).

Goal 3, Objective 2: Title Implementation plan- school-as-a-hub model
Goal 3, Objective 2, Target Completion Date Jan 31, 2026
Goal 3, Objective 2, Description Create an implementation plan/manual for the "school as a hub model" currently implemented through the SAMHSA System of Care grant (Franklin County Community Services).

Goal 3, Objective 3: Title Flyer Connect
Goal 3, Objective 3, Target Completion Date Mar 31, 2024
Goal 3, Objective 3, Description To increase awareness of available services and improve the ease of navigating services, Franklin County recently partnered with Flyer Connect on the ReachWell app. This interactive app streamlines how families are informed about services and updates in the community through a user-friendly interface. County stakeholders will develop an implementation plan for introducing and deploying the app throughout the county. (System of Care Council, Franklin County Community Services).

Goal 3, Objective 4: Title Family Support Advocate expansion
Goal 3, Objective 4, Target Completion Date Dec 31, 2024
Goal 3, Objective 4, Description Expand the Family Support Advocate program to an additional school district. Family Support Advocates will work with families on social determinants of health, including housing needs, referrals, and transportation to service appointments (Community Connections).

Goal 4

Goal 4: Title Strengthening Relationships with Law Enforcement & First Responders
Goal 4: Target Completion Date Dec 31, 2025
Goal 4: Description Provide education and support to officers/first responders during and after calls involving individuals with mental health needs and co-occurring disorders to promote trauma-informed responses.
Goal 4: OASAS? Yes Goal 4: OMH? Yes Goal 4: OPWDD? Yes
Goal 4: Need Addressed 1 Other
Goal 4: Need Addressed 2
Goal 4: Need Addressed 3

Goal 4, Objective 1: Title Sequential intercept mapping implementation plan
Goal 4, Objective 1, Target Completion Date May 31, 2025
Goal 4, Objective 1, Description Reinvigorate an advisory council of law enforcement and provider agencies to create an implementation plan for Franklin County, based on the recommendations from the sequential intercept mapping process (held in March 2021) (Law Enforcement, Franklin County Community Services).

Goal 4, Objective 2: Title Law enforcement partnership workgroup
Goal 4, Objective 2, Target Completion Date May 30, 2024
Goal 4, Objective 2, Description Develop a workgroup between Citizen Advocates and Community Connections to foster coordination and collaboration regarding law enforcement partnerships (Citizen Advocates & Community Connections).

Goal 4, Objective 3: Title Tupper Lake PD outreach
Goal 4, Objective 3, Target Completion Date Apr 30, 2025
Goal 4, Objective 3, Description Conduct outreach efforts with the Tupper Lake Police Department to expand participation in the Crisis Intervention Team. (Community Connections, Franklin County Community Services).

Goal 4, Objective 4: Title Community resource officer
Goal 4, Objective 4, Target Completion Date Jul 31, 2024
Goal 4, Objective 4, Description Utilizing opioid settlement funds, the Saranac Lake PD will implement the COPE initiative (Community Outreach Prevention and Education), which will create a community resource officer position to provide support and outreach to community members (Saranac Lake Police Department).

Goal 4, Objective 5: Title Narcotics identification instrument
Goal 4, Objective 5, Target Completion Date Jul 31, 2024
Goal 4, Objective 5, Description Utilizing opioid settlement funds, Saranac Lake PD will purchase a field narcotics

identification instrument (TRU Narc) that allows them to detect substances such as fentanyl to prevent first responder overdose (Saranac Lake Police Department).

Goal 4, Objective 6: Title Naloxone & CPR training

Goal 4, Objective 6, Target Completion Date Jul 30, 2024

Goal 4, Objective 6, Description Utilizing opioid settlement funds, Saranac Lake Volunteer Rescue Squad will provide Naloxone, CPR, and non-compression CPR training to community-based agencies and first responders (Saranac Lake Volunteer Rescue Squad).

Goal 5

Goal 5: Title Workforce

Goal 5: Target Completion Date Dec 31, 2025

Goal 5: Description Develop and implement strategies to recruit and retain a highly skilled rural mental hygiene workforce.

Goal 5: OASAS? Yes Goal 5: OMH? Yes Goal 5: OPWDD? Yes

Goal 5: Need Addressed 1 Workforce

Goal 5: Need Addressed 2

Goal 5: Need Addressed 3

Goal 5, Objective 1: Title Workforce action plan

Goal 5, Objective 1, Target Completion Date Jun 30, 2025

Goal 5, Objective 1, Description As part of a workforce development initiative for the county, invite the Northern Area Health Education Center / Institute for Career Advancement in Medicine to provide a follow-up presentation to the Community Services Board, focused on developing an action plan for workforce recruitment and retention strategies (Community Services Board, Franklin County Community Services, participating agencies).

Goal 5, Objective 2: Title Workforce document

Goal 5, Objective 2, Target Completion Date Dec 31, 2025

Goal 5, Objective 2, Description Develop a document reflecting ideas and strategies for workforce recruitment and retention, based on feedback shared by participating agencies of the Community Services Board (Community Services Board, participating agencies).

Goal 5, Objective 3: Title BOCES partnership

Goal 5, Objective 3, Target Completion Date Dec 31, 2025

Goal 5, Objective 3, Description Explore opportunities to partner with the BOCES New Vision Education program to develop a workforce pathway for the human services field. Invite representatives from BOCES to present to the Community Services Board about current programming and possible partnership opportunities (Franklin County Community Services).

Goal 5, Objective 4: Title Workforce Development Board

Goal 5, Objective 4, Target Completion Date Jan 31, 2025

Goal 5, Objective 4, Description Members of the Community Services Board will work with the Franklin County Workforce Development Board to develop strategies for advancing recruitment and workforce housing opportunities (Franklin County Community Services Board).

Goal 5, Objective 5: Title NCCC scholarships

Goal 5, Objective 5, Target Completion Date Jul 31, 2024

Goal 5, Objective 5, Description North Country Community College will utilize opioid settlement funds to create scholarship opportunities for human service students, EMT students, and advanced EMT students (North Country Community College).

Goal 6

Goal 6: Title Prevention

Goal 6: Target Completion Date Dec 31, 2025

Goal 6: Description Strengthen existing prevention and engagement strategies to reduce substance use and improve mental health through education and support for youth, adults, and families.

Goal 6: OASAS? Yes Goal 6: OMH? No Goal 6: OPWDD? No

Goal 6: Need Addressed 1 Prevention

Goal 6: Need Addressed 2

Goal 6: Need Addressed 3

Goal 6, Objective 1: Title Mental health first aid pilot project

Goal 6, Objective 1, Target Completion Date Jan 31, 2025

Goal 6, Objective 1, Description Explore a pilot project within Akwesasne that would provide mental health first aid training to community members, allowing them to intervene when family or community members are struggling with addiction or mental health needs, in partnership with supporting clinicians (Akwesasne).

Goal 6, Objective 2: Title Saranac Lake Youth Center prevention activities

Goal 6, Objective 2, Target Completion Date Jul 31, 2024

Goal 6, Objective 2, Description Using opioid settlement funds, Saranac Lake Youth Center will provide substance use education and prevention, engage parents and youth in healthy activities, and provide resources and opportunities to families (Saranac Lake Youth Center).

Goal 6, Objective 3: Title NARCAN kits and syringe exchange

Goal 6, Objective 3, Target Completion Date Jul 31, 2024

Goal 6, Objective 3, Description Using opioid settlement funds, Public Health will provide NARCAN kits to the community and will implement a syringe exchange program (Franklin County Public Health).

Goal 6, Objective 4: Title Screening brief intervention and referral to treatment (SBIRT)

Goal 6, Objective 4, Target Completion Date Jul 31, 2024

Goal 6, Objective 4, Description Using opioid settlement funds, Public Health will support primary care through the introduction of Screening Brief Intervention and Referral to Treatment (SBIRT), a screening and referral process (Franklin County Public Health).

Goal 7

Goal 7: Title Outreach & Engagement

Goal 7: Target Completion Date Dec 31, 2024

Goal 7: Description Increase outreach, engagement, and clinical services through community education, support, and mobile treatment.

Goal 7: OASAS? Yes Goal 7: OMH? No Goal 7: OPWDD? No

Goal 7: Need Addressed 1 Other

Goal 7: Need Addressed 2

Goal 7: Need Addressed 3

Goal 7, Objective 1: Title Funding for mobile outreach

Goal 7, Objective 1, Target Completion Date Mar 31, 2024

Goal 7, Objective 1, Description St. Joe's and Citizen Advocates will pursue funding to increase mobile treatment outreach, engagement, and linkages to care (St. Joe's, Citizen Advocates).

Goal 7, Objective 2: Title BOCES Employee Assistance Program

Goal 7, Objective 2, Target Completion Date Jul 31, 2024

Goal 7, Objective 2, Description Franklin Essex and Hamilton BOCES will utilize opioid settlement funds to establish an Employee Assistance Program (EAP) coordinator position to support district staff and their families (FEH BOCES).

Goal 8

Goal 8: Title High Need Individuals

Goal 8: Target Completion Date Dec 31, 2026

Goal 8: Description Enhance collaboration between agencies to provide comprehensive supports to the highest-need community members with mental health, substance abuse, and IDD, and particularly those with co-occurring disorders.

Goal 8: OASAS? Yes Goal 8: OMH? Yes Goal 8: OPWDD? Yes

Goal 8: Need Addressed 1 Other

Goal 8: Need Addressed 2

Goal 8: Need Addressed 3

Goal 8, Objective 1: Title Cross agency MOU for peer support services

Goal 8, Objective 1, Target Completion Date Sep 30, 2024

Goal 8, Objective 1, Description The Franklin County Sheriff's office, Franklin County Community Services, Community Connections, and St. Joe's will execute an MOU to expand peer support services to individuals with substance use disorders who are incarcerated in Franklin County (Franklin County Sheriff's Office, Franklin County Community Services, St. Joe's, Community Connections).

Goal 8, Objective 2: Title Medication assisted treatment

Goal 8, Objective 2, Target Completion Date Jul 31, 2024

Goal 8, Objective 2, Description Franklin County Correctional Facility will utilize opioid settlement funds to provide medication-assisted treatment (MAT) and to establish a MAT coordinator (Franklin County Correctional Facility).

Goal 8, Objective 3: Title Application toward OTP licensure

Goal 8, Objective 3, Target Completion Date Jan 31, 2026

Goal 8, Objective 3, Description St. Joseph's Addiction Treatment and Recovery Centers and Citizen Advocates will collaboratively respond to the Comprehensive Integrated Outpatient Treatment Program RFA as a first step in attaining OTP Licensure. Upon approval, expand to provide OTP services through the mobile treatment units.



Update to 2024-2027 Goals and Objectives Franklin County Community Services

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Goal 1

Title	Housing	
Update		
OBJECTIVES		
Harison Place		Complete
Funding application		Ongoing
Youth homelessness data		Ongoing
Housing subcommittee		Ongoing
OBJECTIVE UPDATES		
Objective 1: Adult SPOA referral packet was updated on 10/3/23 to add Harison Place 20 units (12 units for SMI and 8 units for SUD). Harison Place starting accepting referrals in October 2024 and Individuals started moving in as of January 2024. All 20 units have been filled in April 2024 and there is now a waiting list for any potential vacancies.		

Goal 2

Title	Crisis Services	
Update		
OBJECTIVES		
589 Children's Crisis Residence		Ongoing
TCI data collection		Ongoing
TCI train-the-trainer cohort		Ongoing
AMC emergency department		Ongoing
Alice Hyde MOU		Ongoing
Adirondack Medical Center MOU		Ongoing
TCI training for hospital staff		Ongoing
CSIDD presentation		Ongoing
Crisis services training presentation		Ongoing
Strategies for individuals with IDD presenting in the ED		Ongoing
OBJECTIVE UPDATES		
Objective 5: This objective will be absorbed by a new objective: Establish a cross systems network to address barriers/challenges and increase supports to individuals with behavioral health (BH - mental health and substance use disorders) and intellectual/developmental disabilities (IDD).		

Objective 6: This objective will be absorbed by a new objective: Establish a cross systems network to address barriers/challenges and increase supports to individuals with behavioral health (BH - mental health and substance use disorders) and intellectual/developmental disabilities (IDD).

Goal 3

Title	Adverse Childhood Experiences	
Update		
OBJECTIVES		
School-as-a-hub expansions		Ongoing
Implementation plan- school-as-a-hub model		Ongoing
Flyer Connect		Ongoing
Family Support Advocate expansion		["]
OBJECTIVE UPDATES		
Objective 3: Flyer Connect, now referred to as the ReachWell app is an evolving project where progress has been made to increase awareness of available services and improve the ease of navigating services. Several Franklin County agencies have provided information needed to give a snapshot of the services available to youth and families in the community. Additional steps are needed to finalize the app before revealing ReachWell to the community.		

Goal 4

Title	Strengthening Relationships with Law Enforcement & First Responders	
Update		
OBJECTIVES		
Sequential intercept mapping implementation plan		Ongoing
Law enforcement partnership workgroup		Ongoing
Tupper Lake PD outreach		Ongoing
Community resource officer		Complete
Narcotics identification instrument		Complete
Naloxone & CPR training		Complete
OBJECTIVE UPDATES		
Objective 1: This objective will be absorbed by a new objective: Establish a cross systems network to address barriers/challenges and increase supports to individuals with behavioral health (BH - mental health and substance use disorders) and intellectual/developmental disabilities (IDD).		
Objective 2: This objective will be absorbed by a new objective: Establish a cross systems network to address barriers/challenges and increase supports to individuals with behavioral health (BH - mental health and substance use disorders) and intellectual/developmental disabilities (IDD).		
Objective 3: This objective will be absorbed by a new objective: Establish a cross systems network to address barriers/challenges and increase supports to individuals with behavioral health (BH - mental health and substance use disorders) and intellectual/developmental disabilities (IDD).		

Goal 5

Title	Workforce	
Update		

OBJECTIVES	
Workforce action plan	Ongoing
Workforce document	Ongoing
BOCES partnership	Ongoing
Workforce Development Board	Ongoing
NCCC scholarships	Complete
OBJECTIVE UPDATES	

Goal 6	
Title	Prevention
Update	
OBJECTIVES	
Mental health first aid pilot project	Ongoing
Saranac Lake Youth Center prevention activities	Complete
NARCAN kits and syringe exchange	Complete
Screening brief intervention and referral to treatment (SBIRT)	Ongoing
OBJECTIVE UPDATES	
Objective #1: St. Regis Mohawk Tribe Mental Health and SUD Services has initiated a prevention plan through their Zero Suicide Initiative to include community training with QPR and Mental Health First Aid. There have been 4 QPR trainings, two adult MH First Aid trainings and Two Youth MH First Aid Trainings provided to the community since March of 2024. This has been in partnership with their Zero Suicide Initiative, grant coordinator, mental health clinicians, CASAC counselors, Child and Youth Clinic Coordinator and Traditional medicine worker.	
Objective 3: Franklin County Public Health continues to pursue partnerships with primary care practices to establish SBIRT protocols.	

Goal 7	
Title	Outreach & Engagement
Update	
OBJECTIVES	
Funding for mobile outreach	Ongoing
BOCES Employee Assistance Program	Complete
OBJECTIVE UPDATES	
Objective 1: St. Joseph's secured funding for a multi-year funding agreement to provide Outreach and Engagement services. The funding expires in September of 2025. This has increased the agency's ability to provide outreach services including peers and transportation and engagement services including in-person and virtual services in the clinic and in-community. Citizen Advocates have targeted case managers provide engagement services to clients per their no-show policy to improve show rates and engage clients via Motivational Interviewing. The 589/Crisis Residences, know as the Behavioral Health Urgent Care operated by Citizen Advocates provides an expanded level of care for youth and adults therefore increasing linkages to care.	

Goal 8

Title	High Need Individuals	
Update		
OBJECTIVES		
Cross agency MOU for peer support services	Ongoing	
Medication assisted treatment	Complete	
Application toward OTP licensure	Ongoing	
OBJECTIVE UPDATES		
Objective 1: Peer services are offered through St. Joseph's when available and will continue to explore an MOU with Community Connections to increase services provision within the correctional facility. St. Joseph's is currently providing transitional case management that includes referral and linkages to Community Connections and other local services. St. Joe's certified peers are also available to support individuals transitioning after release.		
Objective 3: St. Joseph's was awarded the COTP RFA in 2023. The agency is working towards operationalizing the COTP in the Saranac Lake outpatient clinic. Once the COTP is operational, it is the intent of St. Joseph's to investigate the possibility of providing mobile OUD services in order to increase access to services.		



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Goal 1

Goal 1, 2026 Status Update: Ongoing

Goal 1, 2026 Status Update Description: Housing continues to be a priority need in Franklin County. The County does not have enough housing opportunities to serve the number of individuals on the SPOA wait list. Currently there are 131 individuals on the wait list:

- 1) 15 individuals are waiting for admission to a community residence
- 2) 22 individuals are waiting for admission to an Apartment Treatment Program (ATP)
- 3) 53 individuals waiting for admission to Harison Place and
- 4) 41 individuals are waiting for supportive housing.

The average days an individual waits to be admitted to a housing program is 95 days.

Goal 1 Objective 1, 2026 Status Update: Complete

Goal 1 Objective 1, 2026 Status Update Description: There are 53 individuals with open referrals on the SPOA waitlist for Harison Place. The average number of days an individual waits for an admission to housing program is 95 days.

Goal 1 Objective 2, 2026 Status Update: Complete

Goal 1 Objective 2, 2026 Status Update Description: It was determined that Franklin County would not pursue this funding opportunity.

Goal 1 Objective 3, 2026 Status Update: Ongoing

Goal 1 Objective 3, 2026 Status Update Description: As per Franklin County Department of Social Services quarterly numbers include:

Q1 2025: 2 males under the age of 21 and 5 families

Q2 2025: 2 females under the age of 21 and 11 families

The LGU is currently working with school district homelessness liaisons to track students who report as homeless but do not access support through DSS. These students may be staying with friends or other support systems.

Goal 1 Objective 4, 2026 Status Update: Complete

Goal 1 Objective 4, 2026 Status Update Description: The June 2025 Community Services Board included a discussion regarding how best to address this objective. It was decided this would become a standing agenda item for the CSB Integrated Subcommittee. The subcommittee is comprised of agency representatives across multiple agencies and county departments, many of which support individuals with housing needs.

Goal 2

Goal 2, 2026 Status Update: Ongoing

Goal 2, 2026 Status Update Description: The LGU works closely with community members, law enforcement and mental hygiene agencies to address crisis situations.

Goal 2 Objective 1, 2026 Status Update: Ongoing

Goal 2 Objective 1, 2026 Status Update Description: In 2024, the Malone Behavioral Health Urgent Care (BHUC) successfully admitted 32 unique children into the Children's Crisis Residence. In addition to these admissions, 36 children were assessed but not admitted. Reasons for non-admission included the need for a higher level of care, a child's unwillingness to remain in the program, or not meeting the criteria for admission. In such cases, clinicians worked closely with the youth and their families to complete a safety plan and coordinate a safe return to the community.

The partnership with the Department of Social Services (DSS) has continued to grow and strengthen, largely due to the leadership of the BHUC Associate Director. Bi-weekly collaborative meetings with DSS representatives have been instrumental in proactively addressing emerging concerns and coordinating care for young people in need.

Throughout the year, the Malone BHUC team actively engaged with community partners by participating in outreach events, meetings, and collaborative initiatives to enhance visibility, strengthen partnerships, and promote integrated care for children and families in crisis. Over the past three months, the Associate Director met with nine community partners to provide

education about the BHUC model and gather feedback. These collaborations were highly positive and served as a valuable resource for both the Associate Director and leadership, contributing to an increase in referrals.

Goal 2 Objective 2, 2026 Status Update: Ongoing

Goal 2 Objective 2, 2026 Status Update Description: Coaching Sessions and case reviews were determined to be more useful to the group and include a focus on skill application and refinement. Rather than a review of incident reports. Case reviews are also offered to include a discussion of the situation, brainstorming on the specific skills applied and other options that could have been used to support the individual.

Goal 2 Objective 3, 2026 Status Update: Ongoing

Goal 2 Objective 3, 2026 Status Update Description: Eight additional trainers from five Franklin County agencies were certified in November 2023.

Training momentum has stalled due to vacant positions, staffing challenges and the focus on the delivery of client services. There is a consideration to offer a third train the trainer to increase the number of certified trainers.

Goal 2 Objective 4, 2026 Status Update: Complete

Goal 2 Objective 4, 2026 Status Update Description: Upon further research and discussion, AMC leadership determined that the renovations would be too costly to repurpose the rooms.

Goal 2 Objective 5, 2026 Status Update: Complete

Goal 2 Objective 5, 2026 Status Update Description: Multiple systems sit on the Franklin County BH/IDD Cross Systems team to include, local hospitals, law enforcement, county departments and mental hygiene agencies. Additionally, representatives from OPWDD, CSIDD and CCOs are invited to attend. A workplan has been created with the top three priorities identified as: create a cross systems MOU and related protocols, establish a cross-systems crisis response team and provide education on the use of 9.41 and 9.45 custody/transport orders. The group participated in the following presentations:

- City of Rochester Person in Crisis (PIC) Team - program manager provided an overview of the initiative
- General Counsel CLMHD provide an over of MHL Article 9.41 and 9.45.

Goal 2 Objective 6, 2026 Status Update: Ongoing

Goal 2 Objective 6, 2026 Status Update Description: Two 3 - day direct training sessions were provided to Adirondack Medical Center (AMC) staff in Saranac Lake in October and December 2024. Refresher courses were provided in June 2025, and a second session will be provided in November 2025. Additional 3 - day direct trainings were scheduled with AMC to include June 2025 and October 2025. Outreach to Alice Hyde Medical Center will occur in the 4th quarter of 2025.

Goal 2 Objective 7, 2026 Status Update: Complete

Goal 2 Objective 7, 2026 Status Update Description: CSIDD (Crisis Services for Individuals with Intellectual and Development Disabilities) presented an overview of the service to the Cross Systems Network group on May 14th, 2024. The presentation included an overview of the service, how best to support an individual in crisis and how to make a referral. The presentation was scheduled for June 2024 CSB, however due to unforeseen circumstances, the meeting did not occur. NY-CSIDD representatives receive invitations to attend monthly Community Services Board meetings.

Goal 2 Objective 8, 2026 Status Update: Complete

Goal 2 Objective 8, 2026 Status Update Description: CSIDD (Crisis Services for Individuals with Intellectual and Development Disabilities) presented an overview of the service to the Cross Systems Network group on May 14th, 2024. The presentation included an overview of the service, how best to support an individual in crisis and how to make a referral. The presentation was scheduled for June 2024 CSB, however due to unforeseen circumstances, the meeting did not occur. NY-CSIDD representatives receive invitations to attend monthly Community Services Board meetings.

Goal 2 Objective 9, 2026 Status Update: Ongoing

Goal 2 Objective 9, 2026 Status Update Description: A cross-systems collaboration group through Alice Hyde Medical Center has been meeting to identify improved strategies in supporting individuals living with intellectual/developmental disabilities and co-occurring disorders when they present to the emergency department. Collaboration with agency partners, OPWDD and CSIDD is instrumental in supporting high-risk, high need and hard to reach individuals.

Goal 3

Goal 3, 2026 Status Update: Ongoing

Goal 3, 2026 Status Update Description: A No Cost Extension has been filed with SAMHSA to request funds to support the project for an additional year.

Goal 3 Objective 1, 2026 Status Update: Ongoing

Goal 3 Objective 1, 2026 Status Update Description: Franklin County LGU is currently working with the Malone Central School District to implement the school-as-a-hub model in district buildings. Current discussions include staffing and funding considerations.

Goal 3 Objective 2, 2026 Status Update: Ongoing

Goal 3 Objective 2, 2026 Status Update Description: The project team has participated in several focus groups to offer suggestions for documents, resource links and other important information that will be included in the sustainability guide. A web-based platform and hard copy manual will be developed to offer users a choice in how to access the information. It is hoped that a No Cost Extension will fund the project.

Goal 3 Objective 3, 2026 Status Update: Complete

Goal 3 Objective 3, 2026 Status Update Description: The Reachwell App is used as a resource guide for services and a calendar that includes upcoming events and training in Franklin County. The app's intent is to ensure Franklin County residents and services providers can access needed information in just one app. Since launched in 2024, there has been a total of 57 subscribers who can choose to join the Franklin County SOC group or the Franklin County providers group. At least five agencies in Franklin County are involved with the Reachwell App and will provide updated information so the app has up to date information on resources and events.

Goal 3 Objective 4, 2026 Status Update: Ongoing

Goal 3 Objective 4, 2026 Status Update Description: There are FSAs in the following districts: Saranac Lake, Chateaugay, Brushton-Moira and St. Regis Falls, Salmon River. There currently is a vacancy in Tupper Lake. Malone and Salmon River Districts currently do not have FSAs.

Goal 4

Goal 4, 2026 Status Update: Ongoing

Goal 4, 2026 Status Update Description: This area is a primary focus for Franklin County DCS/LGU.

Goal 4 Objective 1, 2026 Status Update: Complete

Goal 4 Objective 1, 2026 Status Update Description: Multiple systems sit on the Franklin County BH/IDD Cross Systems team to include a network of local hospitals, law enforcement, county departments and mental hygiene agencies. Additionally, representatives from OPWDD, CSIDD and CCOs are invited to attend. A workplan has been created with the top three priorities identified as: create a cross systems MOU and related protocols, establish a cross-systems crisis response team and provide education on the use of 9.41 and 9.45 custody/transport orders. The group participated in the following presentations:

- City of Rochester Person in Crisis (PIC) Team - program manager provided an overview of the initiative
- General Counsel CLMHD provided an overview of MHL Article 9.41 and 9.45.

Goal 4 Objective 2, 2026 Status Update: Complete

Goal 4 Objective 2, 2026 Status Update Description: 2 Officers were trained in Law Enforcement Against Drugs and Violence (LEAD) and Drug Abuse Resistance Education (DARE) curricula. Officers are working with the SL school district.

Goal 4 Objective 3, 2026 Status Update: Complete

Goal 4 Objective 3, 2026 Status Update Description: All members of the PD are trained to use the device. The device has been used multiple times, and the department has supported Tupper Lake and Lake Placid PDs.

Goal 4 Objective 4, 2026 Status Update: Complete

Goal 4 Objective 4, 2026 Status Update Description: 30 individuals were trained in Naloxone, CPR and AED. 6 adult/3 infant mannequins and 2 AED training devices were purchased for the training as well as for use in future training.

Goal 5

Goal 5, 2026 Status Update: Ongoing

Goal 5, 2026 Status Update Description: Workforce recruitment and retention continues to be a primary concern to the LGU, Community Services Board and agencies across multiple systems.

Goal 5 Objective 1, 2026 Status Update: Ongoing

Goal 5 Objective 1, 2026 Status Update Description: Franklin County Community Services Board will schedule a follow up presentation in the 4th quarter of 2025.

Goal 5 Objective 2, 2026 Status Update: Ongoing

Goal 5 Objective 2, 2026 Status Update Description: Franklin County agencies will begin compiling this information in the 4th quarter of 2025.

Goal 5 Objective 3, 2026 Status Update: Ongoing

Goal 5 Objective 3, 2026 Status Update Description: The Community Services Board will schedule a presentation for the 4th quarter of 2025.

Goal 5 Objective 4, 2026 Status Update: Not started

Goal 5 Objective 4, 2026 Status Update Description:

Goal 5 Objective 5, 2026 Status Update: **Complete**

Goal 5 Objective 5, 2026 Status Update Description: \$42,500 awarded to 15 students (8-Chem Dep, 3 HS, 3 Children/Families and 1 Advanced EMT) Some funds were used for marketing and outreach to students.

Goal 6

Goal 6, 2026 Status Update: **Complete**

Goal 6, 2026 Status Update Description:

Goal 6 Objective 1, 2026 Status Update: **Complete**

Goal 6 Objective 1, 2026 Status Update Description: Three Youth Mental Health First Aid courses were provided to the Akwesasne Mohawk tribe in the Spring of 2024 and Fall of 2024. A total of 27 Akwesasne members took the course and about 80% of those trained passed the course. Members who took the course worked in schools, at Mental Health and Addictions outpatient clinics, and youth community support programs. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders.

Goal 6 Objective 2, 2026 Status Update: **Complete**

Goal 6 Objective 2, 2026 Status Update Description: The funds supported:

- 5 youth who attended a certification course for outdoor safety/basic survival skills.
- 5 youth attended improvisation classes as part of activities offered through the center.
- 5 youth participated in assertiveness training and used those skills as part of "Talk, They Hear You" activity during a youth center open house.

Goal 6 Objective 3, 2026 Status Update: **Complete**

Goal 6 Objective 3, 2026 Status Update Description: 226 Naloxone trainings/kits; collaboration with Alice Hyde/Adirondack Medical Center, offset salary of community health worker. Public Health also worked with NY MATTERS to install a kiosk in Tupper Lake where community members can access a variety of harm reduction resources.

Goal 6 Objective 4, 2026 Status Update: **Not started**

Goal 6 Objective 4, 2026 Status Update Description: Public Health did not establish partnerships with primary care to establish SBIRT protocols.

Goal 7

Goal 7, 2026 Status Update: **Complete**

Goal 7, 2026 Status Update Description:

Goal 7 Objective 1, 2026 Status Update: **Complete**

Goal 7 Objective 1, 2026 Status Update Description: St. Joseph's Addiction Treatment and Recovery Centers and Citizen Advocates have established protocols to better serve community members in outreach and engagement in services.

Goal 7 Objective 2, 2026 Status Update: **Complete**

Goal 7 Objective 2, 2026 Status Update Description: The EAP position established at FEH BOCES. The program documented a 95% increase over the previous year in access to BH visits per 1000 members.

Goal 8

Goal 8, 2026 Status Update: **Ongoing**

Goal 8, 2026 Status Update Description: Work continues to establish cross systems protocols that support high need individuals in our communities.

Goal 8 Objective 1, 2026 Status Update: **Complete**

Goal 8 Objective 1, 2026 Status Update Description: An MOU for expanded peer support services at the Franklin County Correctional Facility was executed on 1/8/2025.

Goal 8 Objective 2, 2026 Status Update: **Complete**

Goal 8 Objective 2, 2026 Status Update Description: Funds were utilized to cover the cost of MAT.

Goal 8 Objective 3, 2026 Status Update: **Ongoing**

Goal 8 Objective 3, 2026 Status Update Description: Renovations are nearing completion at the Robert Reiss Community Service Center to accommodate the OTP clinic as part of the Comprehensive Integrated Outpatient Treatment Program. Services will include a full complement of MAT to treat individuals with lifesaving MOUD. The agency is considering the use of Mobile Methadone Units vs Medication Units in the Malone area. Logistical considerations (i.e., weather, maintenance, etc.) will be factors in the decision as to how best to regionalize this medication. St. Joseph's anticipates final approval by the end of 2025.



Office of Addiction
Services and Supports

Office of
Mental Health

Office for People With
Developmental Disabilities

2024 Needs Assessment Form Franklin County Community Services

Adverse Childhood Experiences Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Crisis Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Employment/volunteer (client) Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Adults Only

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): • Franklin County providers report that employment is a challenge for residents with mental health conditions, substance use conditions, and developmental disabilities.

- Franklin County has an unemployment rate of 6.6%, and 49.7% of residents are not in the labor force.

- Approximately 43% of Franklin County households do not earn enough income to afford necessities and are considered asset limited, income constrained, employed (ALICE) households (United Way of New York State, 2020). The rate of food insecurity in Franklin County is greater than the state average (14% FC vs. 11% NYS; CHR, 2022).

Forensics Yes

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Adults Only

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): • Franklin County Community Services observed an increase in adult 730 cases. When community members with mental health conditions and/or intellectual/developmental disabilities become involved with the justice system, a 730 examination is required to assess their capability to understand the charges against them and to assist in their own defense.

- There were 14 adult 730 cases in 2022, compared with 6 cases in 2021. Thus far in 2023 (January through June), there have been 11 adult 730 cases.

Housing Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Inpatient Treatment Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): • Behavioral health providers and hospital providers described a trend in the county: Community members with mental health conditions, substance use conditions, and developmental disabilities frequently present in local emergency departments, with some staying for an extended period. Those in need of 9.39 admissions are experiencing substantial wait times for placement.

- Franklin County providers reported significant barriers to securing inpatient services for individuals with complex needs—particularly regarding individuals with IDD diagnoses who are exhibiting aggressive behavior. Providers report a lack of inpatient referral options to meet the needs of these community members

- The most recent data available indicates that, of the 752 Franklin County residents receiving OPWDD services through Medicaid, 360 were dually diagnosed (NYS OPWDD, 2020, retrieved from the PSYCKES portal). Per Franklin County providers, it is particularly challenging to secure 939 placements for individuals who have both IDs and co-occurring disorders.

Prevention Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Residential Treatment Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): • According to providers, Franklin County is experiencing a high demand for 820 services, which are focused on stabilization and reintegration.

- Franklin County continues to receive SPOA referrals for youth in need of residential treatment facilities. In 2022, there were 5 referrals for youth residential treatment facilities, and there have been 5 referrals thus far in 2023 (January through June).

- SPOA referrals for adult residential treatment totaled 121 (41 community resident referrals; 22 apartment treatment referrals; 58 supportive housing referrals). Thus far in 2023 (January through June), there have been 59 residential referrals (19 community resident referrals, 11 apartment treatment

referrals, and 29 supportive housing referrals).

Respite Yes

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Youth Only

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): • Franklin County providers report high demand for 589 crisis services for both youth and adults.

- Providers from Citizen Advocates, which offers crisis respite services through the Crisis and Recovery Center, report that beds are typically full and thus are not always available to community members when they require the service.
- Franklin County providers articulated a need for peer-run respite services for adults with mental health needs.
- To date, OPWDD has not developed a rate that supports crisis respite services, which creates barriers to crisis services for individuals with IDD diagnoses.
- Franklin County providers also report a need to expand crisis respite options for children and youth. Hospital providers from Alice Hyde, for example, report that parents are bringing children to the emergency department due to a lack of respite services.

Transition Age Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): • Franklin County providers are reporting an increase in both housing and service needs among transition-aged youth (those between ages 16 and 24).

- A 2022 survey on housing and service needs of transition-aged youth was completed by 69 providers in the county. Approximately half of the respondents described mental health and addiction services as insufficient for transition-aged youth, while approximately three-quarters of the respondents indicated that housing and support services are insufficient.
- Providers report that transition-aged youth with intellectual/developmental disabilities who age out of school need higher-level community supports. However, IRAs in the county lack adequate staffing to house and support these individuals, resulting in extended wait times.

Workforce Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Adults Only

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): • Franklin County is a rural county located in the Adirondack Park. Its three largest population centers, Malone, Saranac Lake, and Tupper Lake, are separated by large tracts of publicly protected land. The size of the county, distance between population centers, and harsh winters contribute to access barriers to behavioral health services and supports, and to geographic isolation (Adirondack Community Health, 2019).

- According to Franklin County providers, transportation is one of the most significant barriers to service provision, particularly for individuals residing in the south end of the county. Transportation was one of the most frequently cited barriers to services in a recent survey of individuals using mental health services in Franklin County, thus requiring a need for providers to offer mobile services and to conduct more extensive outreach to those in the most geographically remote areas.

Outreach & Engagement Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Strengthening relationships with law enforcement/first responders Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

High need individuals Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

LGU Representative: Suzanne Lavigne

Submitted for: Franklin County Community Services



Office of Addiction
Services and Supports

Office of
Mental Health

Office for People With
Developmental Disabilities

2025 Needs Assessment Form Franklin County Community Services

Adverse Childhood Experiences Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Case Management/Care Coordination Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Crisis Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Cross System Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Forensics Yes

Applies to OASAS? No

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Housing Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Non-Clinical Supports Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

Outpatient Treatment Yes

Applies to OASAS? Yes
Applies to OMH? No
Applies to OPWDD? No
Need Applies to: Adults Only
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

Prevention Yes

Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? No
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

Residential Treatment Services Yes

Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? No
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): Currently Adult SPOA has a wait list of 53 adults waiting for residential services. There are 7 children waiting for either RTF or community residence placement.

Respite Yes

Applies to OASAS? No
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): There are not options locally for respite for those individuals living with intellectual/developmental disorders.

Transition Age Services Yes

Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Youth Only
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

Transportation Yes

Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): Very limited transportation options.

Workforce Yes

Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

LGU Representative: Suzanne Lavigne

Submitted for: Franklin County Community Services



**Office of Addiction
Services and Supports**

**Office of
Mental Health**

**Office for People With
Developmental Disabilities**

**2026 Needs Assessment Form
Franklin County Community Services**

Adverse Childhood Experiences Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Case Management/Care Coordination Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): There are youth and adults who require the supports of intensive case management as opposed to care coordination. Please refer to the attached document.

Crisis Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Cross System Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Forensics Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Adults Only

Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): Although not a standalone goal or objective, the need is discussed during Cross Systems Network meetings.

Housing Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Adults Only

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Prevention Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Residential Treatment Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? No

Need Applies to: Adults Only

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): To some degree this is addressed through our housing goal. We do not have the number of community residence or ATP opportunities to support the need in the community.

Transition Age Services Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Youth Only

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

Transportation Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? No

Need description (Optional): There is not adequate transportation services in the County.

Workforce Yes

Applies to OASAS? Yes

Applies to OMH? Yes

Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults

Do any of the Goals on the Goals and Objectives Form address this need? Yes

Need description (Optional):

LGU Representative: Suzanne Lavigne

Submitted for: Franklin County Community Services



Reinvesting In Intensive Case Management For New York's Youth With Complex Needs

Strengthening Local Systems of Care to Meet Rising Demand

May 2025

A White Paper Submitted by the New York State Conference of Local Mental Hygiene Directors

Executive Summary: Reinvesting in Intensive Case Management for New York’s Youth with Complex Needs

New York State is facing a growing youth mental health crisis, with unprecedented rates of psychiatric emergencies, increased hospitalizations, and fragmented care for children and young adults with serious emotional disturbances (SED), substance use disorders (SUD), intellectual/developmental disabilities (I/DD), and involvement in child welfare and juvenile justice systems. Even before the COVID-19 pandemic, many communities struggled to meet the needs of youth with complex challenges; today, those gaps have widened into urgent system failures.

At the same time, traditional care management models, particularly Health Home Care Management (HHCM), have proven inadequate for youth who require persistent, intensive support. High caseloads, limited engagement, and gaps in cross-system coordination leave many vulnerable young people without the timely interventions they need to stabilize and thrive. As Directors of Community Services (DCSs) across New York repeatedly note in their 2025 Local Services Plans, the current system is not working for the youth with the highest levels of need.

In response to this growing crisis, the New York State Conference of Local Mental Hygiene Directors (CLMHD) proposes a bold yet achievable solution: **the reinstatement of a modernized Intensive Case Management (ICM) model for youth and transition-age young adults**. This model would blend the proven successes of New York’s original ICM programs with updated, evidence-based practices to meet today’s realities and create a critically needed level of care between HHCM and Youth Assertive Community Treatment (ACT).

A modernized ICM model would feature:

- **Small caseloads** (8–12 youth per manager) to allow for frequent, high-touch engagement.
- **Support for individuals to include transition-age youth** (up to age 24)
- **24/7 crisis availability** and assertive outreach to prevent unnecessary hospitalizations.
- **Cross-system coordination**, ensuring collaboration among mental health, education, child welfare, juvenile justice systems, and other support systems.
- **Integration of family and youth peer supports** to build trust and engagement.
- **Emphasis on skill-building and advocacy**, not just referrals and paperwork.
- **Flexible, sustainable funding models** that support real-time service delivery.
- **Strong oversight from Local Governmental Units (LGUs)**, including the Single Point of Access (SPOA) mechanism, ensuring local responsiveness, prioritization, and accountability.

Research shows that earlier iterations of ICM programs significantly reduced psychiatric symptoms, hospitalizations, and system costs while improving school attendance, treatment participation, and family satisfaction (Evans, M. E., Boothroyd, R. A., & Armstrong, M. I., 1996). *Outcomes of Children and Youth Intensive Case Management in New York State. Psychiatric Quarterly*, 67(4), 351–363 - <https://doi.org/10.1007/BF02238768>). Local leaders have seen firsthand that intensive, personalized care coordination leads to better outcomes for youth and families—and that the absence of such supports leaves youth cycling between crisis services and emergency rooms without lasting stability.

By leveraging New York’s existing Local Governmental Unit (LGU) infrastructure and lessons learned from past successes, a modernized ICM system would offer a fiscally responsible and clinically effective approach to serving the youth most at risk of out-of-home placement, hospitalization, justice involvement, or long-term disengagement.

Reinvesting in ICM is not a step backward. It is a strategic advancement toward a responsive, accountable, and youth-centered system of care. With the right investments, partnerships, and commitment to flexibility, New York can ensure that no youth faces complex life challenges alone—and that families and communities across the state have the tools they need to support lasting stability and success.

Youth Mental Health at a Breaking Point

Across New York State, youth and young adults with serious mental health needs are experiencing a crisis of care. Over the past several years, exacerbated by the COVID-19 pandemic, rates of youth in psychiatric crisis have surged. Emergency departments and inpatient units, already limited for children, have been overwhelmed. Figure 1 below illustrates the rising trend of youth mental health emergency department (ED) visits in New York in recent years, which jumped sharply during 2020-2021 but, even today, remain far above pre-pandemic levels:

FIGURE 1: YOUTH MENTAL HEALTH ED VISITS IN NY (INDEXED TO 2019=100)

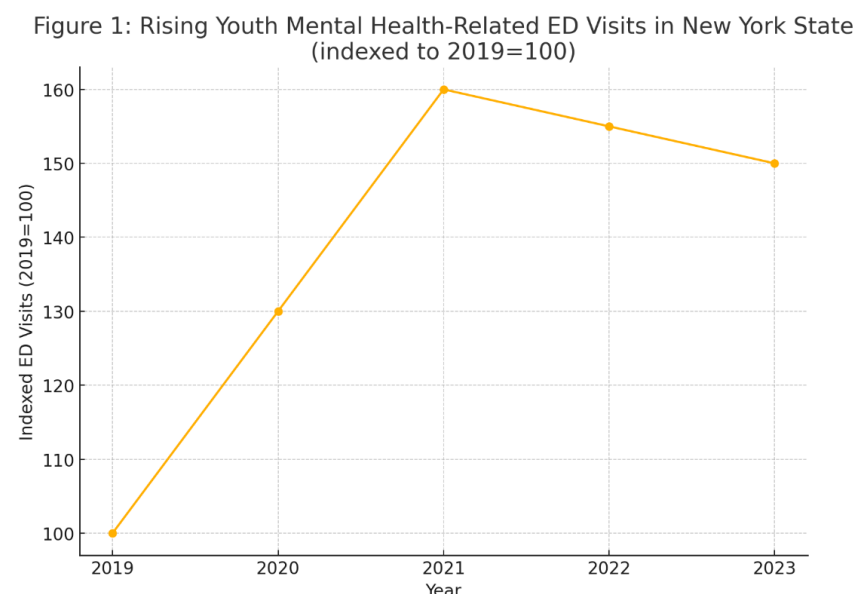


FIGURE 1: Rising youth mental health-related ED visits in New York State (indexed to 2019=100). Mental health crises among children “skyrocketed during the pandemic and have stayed elevated”, reflecting an ongoing high rate of psychiatric emergencies. Source: CLMHD analysis of 2025 Local Services Plans (LSPs); <https://doi.org/10.1542/peds.2022-060553>

Even before the pandemic, many communities lacked sufficient resources to stabilize youth with complex needs in their homes and communities. The pandemic’s disruptions – social isolation, school closures, trauma, and loss – only intensified underlying mental health issues and uncovered gaps in the system of care. Today, local mental health and social service systems are at a breaking point.

Children cycling through crisis services: Albany County’s 2025 plan describes how “hospital/ER diversions remain a significant ongoing challenge” and individuals (youth included) are “frequently ‘cycling’ through the crisis system (ERs, shelters, police contacts, etc.)” without achieving stability. Crucially, Albany notes that “much of what is reflected [for adults] also impacts the children’s crisis system; children and families are faced with increasing crisis situations but decreasing access to supportive services that could help stabilize their situation.” In other words, kids in crisis often aren’t getting the timely, intensive interventions needed to break the cycle. Children with severe emotional disturbances or co-occurring disorders are presenting with higher risks and more acute needs that community providers struggle to safely manage. The result is often repeated ER visits or resorting to law enforcement when situations escalate.

Limited inpatient and respite options: When youth do experience psychiatric emergencies, appropriate next levels of care are frequently unavailable. Many counties (especially rural ones) have no local child psychiatric beds, forcing families to send children far from home for hospitalization or to go without inpatient care. As noted above, in Dutchess County, for example, *“288 children were sent out of Dutchess County in one year for inpatient hospitalization”* due to the lack of a local child psychiatric unit. Neighboring Sullivan County similarly reports that children in crisis are often *“discharged home”* from the ER if no bed is immediately available, or if admitted, *“they are sent out of the county to a hospital 1.5–2 hours away,”* creating huge burdens on families. For less acute situations, one vital “pressure valve” service is short-term respite care – yet respite beds for youth are extremely scarce in many areas. Otsego County noted in 2025 that it *“is in need of respite beds for both adults and children... Most individuals end up sitting in the emergency departments for days... Some individuals sit in the emergency departments for weeks”* awaiting a safe discharge option. These conditions highlight a system stretched to its limits, where lack of capacity in one area (like inpatient or respite) creates ripple effects of strain throughout crisis services.

Transition-age youth falling through gaps: Transition-age youth (approximately 16–24) often have additional difficulty navigating services, as they may “age out” of children’s programs but do not transition smoothly into adult services. Several counties flag the need for better transitional support. For example, Schoharie County mentions that *“transitional planning support for severely disabled students is very limited... after high school [transition] is limited due to a lack of resources.”* Many 18–20-year-olds, though legally adults, still need youth-oriented engagement and may not fit well into adult health home care management or clinic programs. Without intensive guidance, they risk disengaging from services altogether, leading to homelessness, justice system involvement, or other adverse outcomes.

In summary, the current continuum of youth services in NYS has critical gaps at both ends: on the preventive/ support side (intensive in-home coordination, skill building, family support) and on the acute side (crisis stabilization, inpatient, respite). This is contributing to a scenario in which youth with complex needs bounce between inadequate outpatient care and overburdened emergency systems. The voices from county LSPs make it clear that a course correction is needed. The next sections will delve into one of the most frequently cited gaps – the lack of intensive case management – and how its absence has impacted youth outcomes across the state.

The Inadequacy of Current Care Management for Youth with Complex Needs

A dominant theme in 2025 Local Services Plans is that standard care management programs are not meeting the needs of youth with complex, high-level challenges. Under New York’s “Health Homes Serving Children” (HHSC) program (implemented in late 2016), children with serious emotional disturbance or chronic conditions receive care coordination through Medicaid health home care managers. While the intent was to provide an integrated approach to health and behavioral health needs, the reality has fallen short for the kids with the most complex needs, especially those who need multiple services across multiple systems. The Health Home model allows care managers to only broker services, providing referrals and linkages, but does not allow for the direct provision of care. This extraneous layer is problematic for a variety of reasons:

- Due to workforce shortages, needed in-community services, such as skill-building, are unavailable.
- Families find it burdensome and confusing to have numerous different providers in their home, and scheduling around other obligations is challenging.
- Health Home care managers lack capacity to provide robust crisis response and flexible interventions.
- Service dollars that once filled gaps for youth when no other resources were available are no longer accessible.
- Limited contact with youth and families does not facilitate the trusting relationships needed to support change, especially in times of crisis

Numerous counties explicitly state that the Health Home model lacks the intensity, responsiveness, and expertise that the former ICM paradigm provided.

“Not able to meet their level of service need”: Westchester County’s Department of Community Mental Health reported a decline in service quality when children’s ICM was eliminated. In its local plan update, Westchester observed that *“children and families who had been served under Intensive Case Management and were reduced to Health Home Care Management... have experienced many Health Home/Care Management programs not being able to meet their level of service need and respond in a timely and efficient way.”* In other words, youth who once had a dedicated case manager with a small caseload now get a care manager juggling dozens of cases, resulting in delayed or insufficient attention. Families that thrived under frequent ICM visits and hands-on support now may just receive an occasional check-in phone call from a care manager, nowhere near the “intensity” they require.

Referral and paperwork vs. engagement and skill-building: Schoharie County’s Community Services Board drew a sharp comparison between the old and new models, noting that New York’s current *“Care Coordination model is focused on referral and service linkage, without the previous Case Management focus on engagement and skill building.”* They conclude that *“the loss of the targeted case management program and transition into the Medicaid Health Home Care Management has resulted in adults and children receiving less adequate services for their needs.”* This is a powerful indictment: what used to be an active, personal support relationship (ICM workers often teaching youth coping skills, helping with school meetings, modeling behaviors for parents, etc.) has been largely reduced to bureaucratic functions of making referrals and monitoring from afar. The “care coordination” approach may check boxes, but it does not change lives for the better when delivered at a low intensity and lacks flexibility for individuals with acute needs.

Overwhelming caseloads and workforce issues: One reason Health Home care managers struggle to provide intensive support is the high caseloads and turnover inherent in the model. Health Home care management agencies must often assign each worker far more clients than an ICM worker would have had. For illustration, Figure 2 depicts the stark difference in caseloads:

FIGURE 2: AVERAGE CASELOAD PER CASE MANAGER

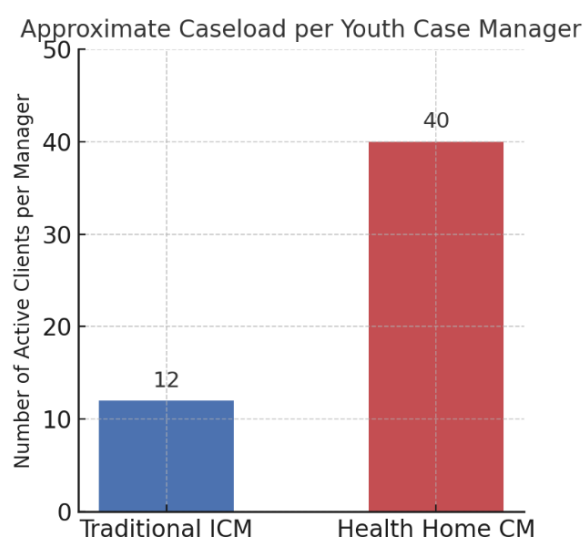


FIGURE 2: Approximate caseload per youth case manager under different models. Under traditional OMH ICM programs, a case manager might serve roughly 10–12 youth at a time, allowing for frequent contact (4 times per month) and intensive support. In contrast, Health Home care managers commonly carry many more clients (often 20–40), limiting the time and attention they can devote to each case.

Montgomery County noted in its plan that *“patients are not able to get the level of care they need to keep them from the hospital due to caseload sizes and the additional responsibilities of unqualified care managers.”* Health Home care managers are generally not required to have the same level of experience or training in mental health as the ICM staff did historically, and with large caseloads, even the most skilled care managers cannot provide intensive support. High turnover further disrupts continuity – Schoharie pointed out that *“high staff turnover rates disrupt service delivery and often leave individuals/families unsure about who their care coordinator is.”* While this comment was regarding OPWDD’s similar care coordination model, it echoes the experience in mental health Health Homes as well. Families frequently report having multiple care managers in a short span, needing to re-tell their story and lacking a consistent ally.

Insufficient outreach and engagement: A critical role of ICM was assertive outreach, not giving up on hard-to-engage youth. Several LSPs imply that the current system fails to effectively engage the most challenging cases. For instance, one rural county shared an anonymized case where *“services that [a youth with complex needs] wished to connect with were unable to accommodate [their] needs”*, and multiple programs across NYS denied the youth admission. Lacking any intensive case coordination to break through these barriers, *“the youth continued to escalate... until it resulted in legal charges due to assaulting another individual.”* This tragic outcome underscores how a determined ICM worker might have rallied appropriate services or creative solutions before things fell apart. Without such a coordinator, the youth’s needs went unaddressed until crisis and violence occurred. Health Home care managers are generally not equipped (nor expected) to perform this level of advocacy and troubleshooting, especially for clients who are initially resistant or whose cases span multiple systems.

Limited non-Medicaid coverage: Another shortcoming identified is the lack of slots for youth who aren’t Medicaid eligible. Sullivan County’s 2025 needs assessment notes, *“programs are generally at capacity and periodically unable to accept new referrals. In addition, there are limited non-Medicaid slots available in both children and adult care management programs.”* If a youth is uninsured or has private insurance that won’t pay for care management, they might get no service at all after hospital discharge or during a crisis. Under earlier models, state/local funding allowed some flexibility to serve such cases via ICM/SCM. Today, the system has become more siloed by funding source, leaving certain families behind.

In summary, the current care management approach—while useful for low-to-moderate-need populations—is insufficient for the subset of youth who need intensive, hands-on support. The words of one legal advocacy complaint (filed in 2022 on behalf of families) succinctly capture this reality: *“New York’s Health Homes do not provide the intensive care coordination services that children with severe or complex mental health conditions need.”* Instead of truly coordinating complex care, *“Health Homes act merely as a referral system, often simply informing families that services are unavailable or subject to waitlists.”* This referral-based model leaves no single accountable party to do the hard work of engaging the child and family, arranging creative supports, and following through on recommendations – roles that an ICM once fulfilled.

Given this evidence of inadequacy, it is of little surprise that counties across New York are calling for a return to more robust case management for youth. The next section highlights these local perspectives and the consensus emerging on the need to rebuild capacity for ICM services.

The Role of Local Government Units and the Case for Reinstated Intensive Case Management

Under New York State Mental Hygiene Law, each county and New York City is required to establish a Local Governmental Unit (LGU) responsible for the oversight, planning, and coordination of behavioral health services. The Director of Community Services (DCS) serves as the chief official of the LGU and holds statutory authority over the public mental hygiene system in their jurisdiction. DCSs administer the SPOA, convene cross-system stakeholders, and are accountable for ensuring that individuals with complex needs are prioritized and connected to appropriate care. LGUs act as the critical

bridge between state policy and local implementation. Their close proximity to service delivery and first-hand understanding of system gaps make them uniquely qualified to oversee flexible, responsive programs like ICM.

One key example of this is SPOA, which ensures that youth with Serious Emotional Disturbance (SED) and complex needs are appropriately triaged and connected to high-intensity services. SPOA serves as a centralized hub that brings together multiple service sectors to coordinate care and align resources around the youth and family. Embedding ICM within this structure allows for seamless referral, coordination, and accountability.

Including DCSs and LGUs in the design, implementation, and oversight of any modernized ICM model is not just advisable—it is essential. Their statutory authority, deep community knowledge, and capacity to integrate services across mental health, I/DD, education, child welfare, juvenile justice, and substance use systems ensure that ICM services will be targeted, effective, and sustainable. DCSs also maintain strong, working relationships with local child-serving systems and state partners, enabling them to collaboratively problem-solve and address barriers to care in real time.

As New York faces the possibility of Medicaid funding reductions, the urgency to adopt cost-effective, impact-driven models like ICM becomes more pronounced. Traditional systems, already strained under high caseloads and limited coordination, risk further decline in responsiveness and outcomes if Medicaid reimbursements are scaled back. In contrast, a modernized ICM model—anchored in small caseloads, assertive outreach, and cross-system coordination—offers a feasible and fiscally responsible solution to maintain and improve youth services in a challenging fiscal environment.

New York State has made substantial investments throughout the past decade in building a robust System of Care (SOC) for children and families, emphasizing cross-sector collaboration, individualized services, and community-based supports. At the center of this system are the DCSs, who lead LGUs in orchestrating mental health, substance use, developmental disability, and child welfare services at the county level. DCSs are uniquely positioned to convene stakeholders across systems—education, juvenile justice, child welfare, and health—to ensure that youth with complex needs receive coordinated, responsive care. SPOA is a core mechanism by which this coordination is operationalized at the local level. New York has the opportunity to leverage this existing infrastructure by strengthening the DCS-led coordination role and embedding ICM within the SOC framework. Doing so builds on proven capacity, promotes fiscal efficiency, and honors the principle that complex youth need a single, locally accountable system to guide their care.

Reinvesting in Intensive Case Management for New York’s Youth with Complex Needs

While New York State faces a growing crisis in youth mental health, local mental hygiene authorities report that current care management models are failing to meet the needs of children and transition-age youth with serious emotional disturbances. Since the transition to Health Home care management, many youth with complex needs and families have lost the intensive, hands-on support they once received under the former ICM programs. The consequences are evident in repeated psychiatric hospitalizations, emergency room boarding, and youth cycling through crisis services without sustained improvement. Behavioral health stakeholders across the state – from rural counties to major urban centers – are sounding alarms in their 2025 Local Services Plans (LSPs) about these service gaps and the strain on local systems.

This white paper makes a compelling case for reinstating a modernized ICM service for youth (including transition-age youth up to ~21-24) across New York State.

Documented Need: The 2025 LSPs of numerous counties highlight inadequate care coordination for youth with complex needs, loss of prior intensive services, and increasing crises. For example, Otsego County notes an urgent need for “more intensive case managers” to help youth with mental health and substance use issues and to address social determinants of health. Similarly, Westchester County observed that children who had been served under ICM were reduced to Health

Home Care Management, and many health home programs “were not able to meet their level of service need... in a timely and efficient way”. These on-the-ground perspectives illustrate a statewide trend, with 2/3 of counties’ LSPs indicating insufficient services to meet youth needs.

System Strains and Poor Outcomes: Without intensive care management, youth with complex multi-system involvement often fall through the cracks. Counties report rising youth mental health crises, frequent ER visits, and a lack of appropriate follow-up. Dutchess County, for instance, had 288 children sent out of the county in one year for inpatient psychiatric hospitalization due to a lack of local beds. Family engagement in care is difficult when distance becomes a factor, and discharge plans frequently lack resources embedded in the child’s home community. In many cases, children in crisis are either stuck in emergency departments for days or discharged home without adequate supports, only to deteriorate again. This cycle is costly, traumatic for families, and indicative of a missing layer of intensive support in the community.

Historical Success of ICM Programs

Research and experience in New York show that ICM can improve youth outcomes. New York’s original Children and Youth ICM program (established in 1988) was associated with reduced psychiatric symptoms, improved functioning, and fewer hospitalizations for youth with serious emotional disturbances. Reintroducing a modern ICM model would bridge the gap between basic care coordination and high-intensity crisis services (like Youth ACT teams), providing flexible, proactive support to the youth most at risk of out-of-home placement or harm.

Historical evaluations of New York State’s original Children and Youth Intensive Case Management (CYICM) program demonstrate clear benefits in improving behavioral health outcomes for youth with complex needs. Key findings include:

- **Reduced Psychiatric Symptoms and Hospitalizations:** A 1996 evaluation found that youth enrolled in ICM experienced significant reductions in psychiatric symptoms such as mood and behavioral disorders. The program also led to fewer psychiatric hospitalizations and shorter inpatient stays, compared to similar youth not receiving ICM services.
- **Improved Functional Outcomes:** Participants in ICM showed measurable improvements in day-to-day functioning, including better school attendance, improved peer and family relationships, and more consistent participation in treatment. ICM staff were instrumental in providing support during school and treatment engagement.
- **High Engagement and Family Satisfaction:** Youth and families reported high levels of satisfaction with ICM services. The consistent contact, advocacy, and personalized care helped build trust and improve service engagement.
- **Cost-Efficiency and System Impact:** While ICM required greater investment per participant, it resulted in system-wide cost savings by reducing the use of costly emergency, inpatient, and institutional services.

Source: Evans, M. E., Boothroyd, R. A., & Armstrong, M. I. (1996). *Outcomes of Children and Youth Intensive Case Management in New York State*. *Psychiatric Quarterly*, 67(4), 351–363.

Modernized ICM Model

The paper proposes a revamped ICM model tailored to today’s landscape. Key features include:

- **Small caseloads** (8–12 youth per manager) to allow for frequent, high-touch engagement.
- **Support for individuals to include transition-age youth** (up to age 24)
- **24/7 crisis availability** and assertive outreach to prevent unnecessary hospitalizations.

- **Cross-system coordination**, ensuring collaboration among mental health, education, child welfare, juvenile justice systems, and other support systems.
- **Integration of family and youth peer supports** to build trust and engagement.
- **Emphasis on skill-building and advocacy**, not just referrals and paperwork.
- **Flexible, sustainable funding models** that support real-time service delivery.
- **Strong oversight from Local Governmental Units (LGUs)**, ensuring local responsiveness and accountability.

This model would also incorporate accountability measures and data tracking to ensure that youth are progressing, and no one falls off the radar.

A modernized ICM model must include an updated and more flexible funding structure. Previously, Medicaid reimbursement was only available if a program delivered a minimum of four (4) face-to-face visits per youth within a calendar month. There was no option for partial reimbursement when fewer visits were completed. This led to delays in starting services, especially for referrals that came in after the middle of the month, thus creating unnecessary gaps in care. Programs also struggled to support staffing when they provided some services but couldn't bill at all. The ICM model will need the ability to receive partial reimbursement to sustain operations and maintain capacity, even if the full visit threshold isn't met. Oversight and accountability can still be ensured by requiring documentation that explains why the expected number of visits was not achieved.

A modernized ICM model would use service dollars in a flexible, strategic way to fill gaps when no other funding is available, ensuring that youth with complex needs receive timely, wraparound support. Specifically, a modernized ICM model would:

- **Address immediate, unmet needs** such as emergency housing, food, clothing, transportation, or communication tools (e.g., phones or tablets for telehealth).
- **Support family stabilization** efforts through respite care, childcare, or other resources that help keep youth in their homes and communities.
- **Facilitate engagement** by removing access barriers—covering costs like transportation to appointments or incentives for participation in services.
- **Bridge service gaps** for uninsured or underinsured youth by funding critical supports that are otherwise inaccessible.
- **Promote cross-system coordination** by funding services or supports that don't fall neatly under one system's responsibility.

Ultimately, service dollars in a modernized ICM would function as a flexible funding stream—locally managed and quickly deployable—to ensure care is not delayed due to red tape or rigid billing restrictions.

State-Local Partnership and Oversight: A strengthened partnership between LGUs and the NYS Office of Mental Health (OMH) is critical for success. LGUs should play a central role in identifying youth in need, overseeing ICM performance, and coordinating with providers. OMH, in turn, should fund and regulate the ICM programs, setting standards for caseloads, staffing qualifications, and outcomes. A collaborative oversight structure will ensure local accountability and that state resources are effectively reaching youth on the ground.

Voices from the Counties: Statewide Calls for Intensive Support

If one reads through the 2025 Local Services Plans of New York's 57 counties and New York City, a clear pattern emerges: almost every community identifies the need for better case management or care coordination for youth. In fact, "Case Management/Care Coordination" appears as a top identified need area in the majority of county needs assessment forms. Many plans go further, providing narrative examples or specific proposals to bolster ICM. Here, a few representative voices have been compiled from different regions to illustrate the breadth of concern:

Otsego County (Mohawk Valley region): Otsego's Community Services Board emphasizes the shortage of intensive case workers. They write: *"With an increase of individuals with MH and SUD issues, we need more intensive case managers. I would like to be able to hire a case manager for the clinic to help the clients meet social determinants that they need assistance with. This would allow the clinicians to focus on therapy while the case managers can assist with other needs."* This comment highlights how a lack of ICM not only hurts clients but also strains clinical services – therapists are spending time on housing, transportation, or paperwork issues that dedicated intensive case managers could handle. The result is less effective treatment and potential burnout of clinicians. Otsego sees intensive case managers as essential to filling these gaps and improving overall care.

Ulster County (Mid-Hudson region): Ulster's plan sets a formal goal to "improve care/case management service delivery" and even includes an action item to *"Get OMH to approve the addition of a second Intensive Case Manager in Ulster County."* The target was to have "a second intensive case manager operating in Ulster holding a full caseload" by the end of 2023. Ulster already had one ICM position (likely state-funded for adults) and found it valuable enough to push for another. The inclusion of this objective in the county plan signifies that local leaders believe more ICM capacity will directly benefit their residents. It also underscores the needed partnership with the state – Ulster cannot simply create an ICM on its own without OMH's approval and funding.

Sullivan County (Mid-Hudson region): As noted earlier, Sullivan County notes that the complexity of youth referred through SPOA has increased significantly, and that existing care management programs lack the capacity and intensity needed to effectively engage and stabilize these youth. They also point out a need for better coordination at discharge from hospitals, noting communication gaps between hospitals and community providers that leave individuals (including youth) without proper follow-up. Intensive case managers often acted as that bridge at discharge, ensuring plans were in place. Sullivan's experience reinforces that in the absence of such roles, youth can fall through the cracks when transitioning between levels of care.

Albany County (Capital Region): Albany's plan does not explicitly mention "ICM," but it calls for services that echo its functions. For example, Albany would *"benefit from the return of an adult Living Room and needs a youth Living Room"* (a Living Room is a peer-staffed diversion program for people in crisis) and notes that *"children and youth are presenting with higher needs... that are more difficult to stabilize; there is a continued need for children's respite"*. Underlying these points is the recognition that without intensive supports (like respite, crisis outreach, and engaged case management), youth with complex needs end up in the ER or worse. Albany explicitly states that the lack of such supports has led to children *"being impacted by the hospital/ER diversion issues"* just like adults. The county is essentially asking for more robust community-based interventions – a category into which ICM squarely falls.

New York City: While this paper focuses on county voices, it's worth noting that New York City's mental health plan (part of its ThriveNYC and ongoing initiatives) has also recognized care coordination challenges. The scale is different, but NYC has piloted programs like intensive care coordination for youth involved with the justice system and high-utilizers of psychiatric hospitals. Any statewide ICM strategy should encompass NYC as well, perhaps by augmenting

or realigning existing care management programs for youth in the city to ensure comparable intensity and LGU oversight as in the rest of the state.

To visualize how widely certain needs are cited, Figure 3 shows the number of NYS counties that identified select service needs related to youth in their 2025 plans (based on a review of LSP documents):

FIGURE 3: NY COUNTIES IDENTIFYING YOUTH SERVICE GAPS (2025)

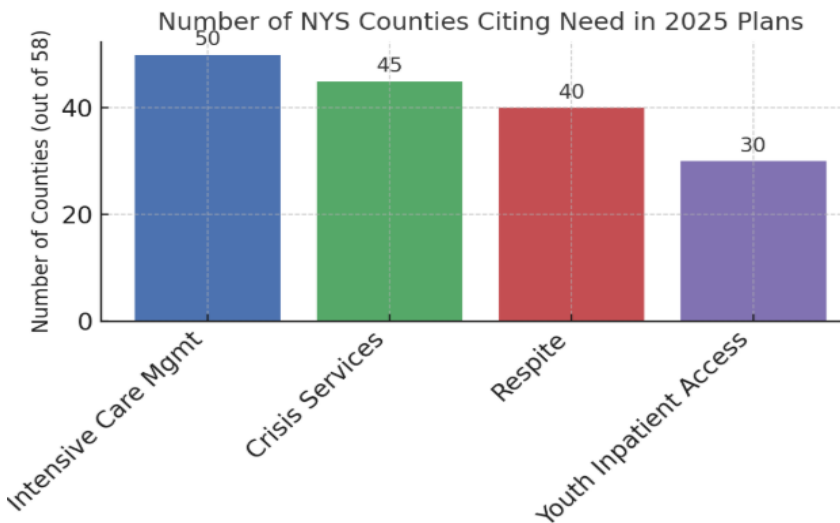


FIGURE 3: Prevalence of select youth service needs cited by NYS Local Services Plans (2025). Nearly all counties highlighted the need for improved ICM/care coordination for youth and related supports like crisis services and respite. A significant number also noted issues with youth inpatient access (lack of local beds, kids sent out-of-area). This illustrates a statewide consensus on gaps in the youth service continuum (Source: 2025 LSP Needs Assessment summaries).

The takeaway from the counties’ perspective is clear: there is strong consensus that more must be done to coordinate and manage care for youth with complex needs, and many believe that re-instating intensive, proactive case management is a key part of the solution. The counties are effectively asking the state to partner with them in rebuilding this capacity. As the ones closest to these youth and families, LGUs see firsthand the fallout of insufficient care coordination and are unified in calling for change.

A Vision for a Modernized Youth Intensive Case Management Program

Health Home Care Management (HHCM) reflects a broader shift toward Medicaid-funded, acuity-based care coordination. The HHCM model may be effective for individuals with lower acuity. However, it has not effectively served youth with complex needs due to limited reimbursement, administrative barriers, and higher caseloads.

By contrast, the ICM model had a higher-touch, lower-ratio approach, deeply embedded in local systems, which allowed staff to respond flexibly to crises, engage families intensively, and coordinate across fragmented systems. Although it lacked scalability and was costlier per child, its impact on outcomes for high-risk youth was significantly more robust.

To address the gaps identified, we propose developing a modernized ICM program for youth across New York State. This would not simply replicate the 1980s-era ICM in exact form but rather update and integrate it with today’s array of services and best practices. The goal is to create a high-intensity care management option that can be accessed for those youth and transition-age young adults who need it most, effectively creating a safety net of personalized support around the individual and family. Below, we outline the key elements and guiding principles of this model:

Small Caseloads Enabling High-Frequency Contact: The cornerstone of ICM is a low client-to-staff ratio. Each ICM care manager (often titled Intensive Case Manager or perhaps “Intensive Care Coordinator” in a new model) should have a

caseload on the order of 8–12 youth maximum. This contrasts sharply with the 25+ per care manager in Health Homes. With fewer clients, the ICM can visit or check in with each youth multiple times per week if needed, devote time to accompanying them to appointments, meeting with school personnel or family members, and so on. Regular, persistent contact builds trust and allows the ICM to catch brewing crises early. As Schoharie and other counties noted, engagement is a major focus – an ICM can spend the time to locate a youth who is hard to reach or creatively re-engage a family that has withdrawn, efforts that would be unfeasible under high caseloads.

Team-Based Approach Including Peers and Family Support: A modern ICM program can be enriched by incorporating peer support workers (e.g. young adult peers with lived experience with mental health challenges) and family peer advocates (parents or caregivers who have raised children with behavioral health issues). These peers would work alongside the professional case manager as part of an ICM Team. The peer can connect with the youth in ways professionals sometimes can't, serving as a mentor and role model, while the family peer can coach and support the caregivers in the home. This mirrors some aspects of the evidence-based “wraparound” model (which emphasizes a team driven by the family's vision and including natural supports). By adding peers, the ICM program also aligns with New York's expansion of Family and Youth Peer Support Services under Medicaid (CFTSS). Peers can extend the reach of the ICM and provide evening/weekend support as needed, further increasing the program's capacity to stabilize situations.

Holistic, “Whole-Person” Focus (Beyond Medical Model): Intensive Case Managers should address not only the youth's psychiatric treatment plan, but also the social determinants of health and practical needs that often dictate outcomes. Housing stability, school attendance, job training, social connections, and recreational activities are all within scope. In the words of the Otsego clinic director, having case managers assist with these needs “*allows clinicians to focus on therapy*” and ensures the youth's basic and social needs are met so that therapy and other treatments can be effective. The ICM should function as a central hub for coordinating all aspects of the youth's life: one day helping the family apply for benefits or find safer housing, the next day mediating with a school to obtain special education support, the next taking the youth to visit a potential vocational program – whatever is needed to keep the youth on a positive track. This whole-person approach was a hallmark of the old ICM and remains a critical need today, as fragmented systems often leave families to navigate a maze of services on their own.

Cross-System Coordination and Advocacy: Youth with complex needs are frequently involved in multiple systems (education, mental health, substance use, child welfare, developmental disabilities, juvenile justice). It is integral to the modern ICM model to coordinate across these silos. The ICM should convene regular team meetings (akin to a wraparound Child and Family Team) that include the family and all key providers or agency representatives working with the youth. By getting everyone to the table, the ICM ensures a unified plan and prevents “handoffs” from becoming dropped balls. If a youth is hospitalized or arrested, the ICM participates in discharge planning and advocates for appropriate aftercare or alternative dispositions. Several counties (e.g. Niagara, Erie) highlighted cross-systems initiatives in their plans – an ICM program can act as the glue within those initiatives, making them work at the individual level. Importantly, ICMs would also coordinate with the existing Health Homes: if a youth is enrolled in a Health Home, the ICM could either be the assigned care manager (if the program is structured under the Health Home umbrella) or work in parallel with clear role definitions. We recommend that for youth who qualify for ICM, the ICM becomes the care manager of record (avoiding duplication) but with enhanced responsibilities and a smaller caseload financed through state dollars.

24/7 Crisis Availability and Hospital Diversion: While ICMs are not formal emergency services, a modern program should include on-call support such that families have someone to call in a crisis who knows them. This could be rotated among a few ICM team members. The ability to promptly respond (by phone or in person) to a family in de-escalation can prevent unnecessary ER visits. In addition, ICMs can partner with new crisis stabilization programs (e.g. the youth Mobile Crisis teams and crisis residence programs that NYS is developing) – serving as aftercare coordinators whenever their clients use

those services. The ICM's intensive engagement also means they are well-positioned to notice early warning signs of crisis and implement preventive strategies (such as arranging a brief respite stay or extra therapy session) before the situation boils over. Home-Based Crisis Intervention (HBCI) programs, where they exist, are short-term; an ICM can dovetail with HBCI, ensuring that gains made in a 4–6-week crisis intervention are sustained thereafter by ongoing support.

Culturally Competent, Youth-Guided Services: The new ICM model should be person-centered and culturally sensitive. Youth and families must be partners in their care planning, with the ICM helping to amplify the youth's voice in what goals they want to pursue. New York's population is diverse; hiring ICM staff who reflect the communities served (in language, culture, etc.) will improve engagement. Additionally, specialized training should be given to ICMs on working with subpopulations such as LGBTQ+ youth, youth with co-occurring developmental disabilities, or those who have experienced complex trauma. Because ICMs will be deeply involved in families' lives, building trust and respecting values is paramount.

Policy and Funding Recommendations

To implement modernized ICM statewide, we recommend dedicated state funding (re-purposing or augmenting Medicaid and state aid dollars (**Appendix I**), potentially launching regional pilot programs, and establishing clear eligibility criteria through SPOA so that the youth with the highest needs are prioritized. Additionally, the State should consider re-instituting, or expanding where still available, non-Medicaid ICM slots for youth who are uninsured or underinsured – a gap highlighted in several county plans. Building the workforce pipeline (through incentives, training, and competitive salaries for ICM positions) is also essential, given workforce shortages.

Overall, reinstating a modernized ICM for youth is not a step backward to “how things were,” but a strategic advancement toward a more responsive, accountable system of care. It recognizes that current models are not sufficient for youth with the highest levels of need, and that additional, sustained support is necessary. DCSs, as leaders of New York's LGUs, are positioned to operationalize this model effectively based on their statutory roles and close understanding of local systems.

Reinvesting in ICM is both a fiscal and moral imperative. LGUs have the infrastructure, experience, and oversight capacity to deliver intensive care coordination, but they require state partnership to make implementation viable at scale. By modernizing ICM and embedding it within local frameworks like SPOA and the System of Care, under the guidance of DCSs, New York can address long-standing service gaps and improve continuity and outcomes for youth with complex needs. Reduce avoidable hospitalizations and out-of-home placements, and improve long-term outcomes for youth and families. This is not just about restoring a program—it's about making good on our commitment to meet youth where they are, with the right support, at the right time. By heeding the expertise of DCSs and the experiences of families across the state, New York can build a stronger, more coordinated continuum of care—and ensure that no high-risk young person is left to navigate complex challenges alone.

The New York State Conference of Local Mental Hygiene Directors (the Conference) is a statewide membership organization consisting of the Commissioner/Director of each of the state's 57 county mental hygiene departments (encompassing mental health, substance use, and intellectual/developmental disabilities) and the mental hygiene department of the City of New York. Also known as the Local Governmental Unit (LGU), the DCSs are county officials and have specific responsibilities and authority under the Local Services provisions of Article 41 of the Mental Hygiene Law (MHL) for planning, development, implementation, and oversight of services to adults and children in their counties affected by mental illness, substance use disorder, and intellectual/developmental disabilities.

Appendix I: Comparison of NYS Funding Models for Children’s Care Management

While HHCM represents a Medicaid-driven model focused on acuity-based payments and broader coordination, it often lacks the depth needed for youth with high needs. ICM, though more resource-intensive, provided high-impact, individualized support with strong outcomes for the most vulnerable populations.

1. Program Overview

Feature	Health Home Care Management (HHCM)	Intensive Case Management (ICM)
Population of Focus	Children with SED, chronic conditions, or trauma histories	Children and youth with SED and high-intensity needs, including co-occurring I/DD, SUD, and/or trauma histories
Care Model	Team-based coordination across physical, behavioral, and social services	Individualized, high-intensity care with frequent face-to-face engagement and coordination across systems of care; Youth Peer and Family Peer support integrated into the program
Assessment Tool	CANS-NY (Child and Adolescent Needs and Strengths – NY)	Evidence-based assessment tool (i.e. CANS-NY), clinical evaluation, and individualized needs-based planning

2. Funding and Reimbursement

Feature	HHCM	ICM
Funding Source	Medicaid PMPM based on acuity tiering	Blended Medicaid and State funding
Reimbursement Model	Tiered payments based on CANS-NY score	Flat rate per client/month, full reimbursement for achieving target units of service, allowance for partial reimbursement
Billing Requirements	Requires documentation of contacts and plan updates	Simpler documentation with a focus on engagement
Risk Sharing / VBP	Designed to transition to VBP	Not structured for risk-sharing

3. Service Intensity and Flexibility

Feature	HHCM	ICM
Caseload Sizes	1:25–1:40+	1:8–1:12
Flexibility of Engagement	Limited by billing codes	High-intensity outreach and home visits
Crisis Response	Limited; not designed for immediate crisis	Routine crisis management and system navigation
Service Dollars	Limited; not designed to include discretionary service dollars; relies on linkage and coordination with existing services	To ensure wraparound supports are available to youth when other funding mechanisms are unavailable.

4. Outcomes and System Impact

Feature	HHCM	ICM
Effectiveness for Youth with Complex Needs	Mixed; limited for complex cases	Proven reduction in hospitalizations and improved functioning
System Integration	Varies by provider	Embedded in local systems with cross-system coordination
Provider Feedback	Concerns about funding and burden	Valued for continuity and stabilization outcomes

Agency Name	Program Name	Program Type Name
Adirondack Health Institute	Adirondack Health Institute SMH CMA	Specialty Mental Health Care Management
Adirondack Medical Center	Colby Center Psychiatric Inpatient Unit	Inpatient Psychiatric Unit of a General Hospital
AIDS Council of Northeastern New York	Alliance For Positive Health- Plattsburgh SMH CMA	Specialty Mental Health Care Management
Citizen Advocates, Inc. dba North Star Indust	Adult BH HCBS Intentive Crisis Respite	Adult BH HCBS Intensive Crisis Respite
Citizen Advocates, Inc. dba North Star Indust	Adult BH JCBS Short-Term Crisis Respite	Adult BH HCBS Short-term Crisis Respite
Citizen Advocates, Inc. dba North Star Indust	Alternative Crisis Support - North	Advocacy/Support Services
Citizen Advocates, Inc. dba North Star Indust	CFTSS: Children's Mental Health Rehabilitation Services	CFTSS: Children's Mental Health Rehabilitation Services
Citizen Advocates, Inc. dba North Star Indust	CFTSS: Community Psychiatric Support and Treatment	CFTSS: Community Psychiatric Support and Treatment (CPST)
Citizen Advocates, Inc. dba North Star Indust	CFTSS: Family Peer Support Services (FPSS)	CFTSS: Family Peer Support Services (FPSS)
Citizen Advocates, Inc. dba North Star Indust	CFTSS: Mobile Crisis Intervention (CI)	CFTSS: Mobile Crisis Intervention (CI)
Citizen Advocates, Inc. dba North Star Indust	CFTSS: Other Licensed Practitioner (OLP)	CFTSS: Other Licensed Practitioner (OLP)
Citizen Advocates, Inc. dba North Star Indust	CFTSS: Psychosocial Rehabilitation (PSR)	CFTSS: Psychosocial Rehabilitation (PSR)
Citizen Advocates, Inc. dba North Star Indust	CFTSS: Youth Peer Support and Training (YPST)	CFTSS: Youth Peer Support (YPS)
Citizen Advocates, Inc. dba North Star Indust	CSS Non-Medicaid Care Coordination	Non-Medicaid Care Coordination
Citizen Advocates, Inc. dba North Star Indust	Citizen Ad Supp Housing/RCE SH Franklin Cty - Comm Svcs	Supportive Housing
Citizen Advocates, Inc. dba North Star Indust	Citizen Advocates Adirondack Youth Lodge	Children & Youth Community Residence
Citizen Advocates, Inc. dba North Star Indust	Citizen Advocates SMH CMA (AOT)	Specialty Mental Health Care Management
Citizen Advocates, Inc. dba North Star Indust	Citizen Advocates dba North Star SH - Comm Svc.	Supportive Housing
Citizen Advocates, Inc. dba North Star Indust	Citizen Advocates, Inc. dba North Star Ind. - HH NonMed CM	Health Home Non-Medicaid Care Management
Citizen Advocates, Inc. dba North Star Indust	Citizen Advocates, Inc. dba North Star Ind. - HHCM	Health Home Care Management
Citizen Advocates, Inc. dba North Star Indust	Clean Sweep/Micrographics	Affirmative Business/Industry
Citizen Advocates, Inc. dba North Star Indust	Crimson Phoenix	Psychosocial Club
Citizen Advocates, Inc. dba North Star Indust	Crisis Intervention	Crisis Intervention
Citizen Advocates, Inc. dba North Star Indust	Crisis Intervention/JS	Crisis Intervention
Citizen Advocates, Inc. dba North Star Indust	Enhanced Mentor Program	Family Peer Support Services - Children & Family
Citizen Advocates, Inc. dba North Star Indust	Expanded Parent Support Services	Family Peer Support Services - Children & Family
Citizen Advocates, Inc. dba North Star Indust	Franklin Academy High School	School Mental Health Program
Citizen Advocates, Inc. dba North Star Indust	Harrison Place Programs-OTH-Community Living	Supportive Single Room Occupancy (SP-SRO)
Citizen Advocates, Inc. dba North Star Indust	Health Home Care Management C&Y	Health Home Care Management
Citizen Advocates, Inc. dba North Star Indust	Health Home Non Medicaid Care Management C&Y	Health Home Non-Medicaid Care Management
Citizen Advocates, Inc. dba North Star Indust	Malone Behavioral Health Urgent Care	Children's Crisis Residence
Citizen Advocates, Inc. dba North Star Indust	Malone Behavioral Health Urgent Care	Intensive Crisis Residence
Citizen Advocates, Inc. dba North Star Indust	Malone Mental Health Center	Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
Citizen Advocates, Inc. dba North Star Indust	Malone Middle School	School Mental Health Program
Citizen Advocates, Inc. dba North Star Indust	Mountain Crest	Psychosocial Club
Citizen Advocates, Inc. dba North Star Indust	North Star Apartment Program	Apartment/Treatment
Citizen Advocates, Inc. dba North Star Indust	North Star BH Services - Transportation	Transportation

Citizen Advocates, Inc. dba North Star Indust	Ongoing Integrated Supported Employment Services	Ongoing Integrated Supported Employment Services
Citizen Advocates, Inc. dba North Star Indust	Ongoing Supported Employment (OSE)	Adult BH HCBS Ongoing Supported Employment (OSE)
Citizen Advocates, Inc. dba North Star Indust	Outreach	Outreach
Citizen Advocates, Inc. dba North Star Indust	Saranac Lake Mental Health Center	Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
Citizen Advocates, Inc. dba North Star Indust	School Program North	School Mental Health Program
Citizen Advocates, Inc. dba North Star Indust	School Program South	School Mental Health Program
Citizen Advocates, Inc. dba North Star Indust	Transition Management Services	Transition Management Services
Citizen Advocates, Inc. dba North Star Indust	Webster Street Community Residence	Congregate/Treatment
Franklin County Community Services	Adult SPOA	Single Point of Access (SPOA)
Franklin County Community Services	MENTAL HEALTH ADMINISTRATION	Coordinated Children's Service Initiative
Franklin County Community Services	Youth SPOA	Single Point of Access (SPOA)
HCR Care Management, LLC	HCR Care Management SMH CMA	Specialty Mental Health Care Management
Hudson Headwaters Health Network	Hudson Headwaters Health Network	Specialty Mental Health Care Management
Lakeside House, Inc.	Another's Purpose	Self-Help Programs
Lakeside House, Inc.	Lakeside House	Congregate/Treatment
Lakeside House, Inc.	Lakeside Supp Housing/Franklin County PC	Supportive Housing
Lakeside House, Inc.	Long Stay-Comm Svcs	Supportive Housing
Lakeside House, Inc.	Lakeside Supp Housing/RCE SH Franklin Cty - Comm Svcs	Supportive Housing
Lakeside House, Inc.	Lakeside Supported Housing/Franklin County-Comm. Svcs.	Supportive Housing
MHA of Franklin Co DBA Comm Conn of FC	Advocacy Services	Advocacy/Support Services
MHA of Franklin Co DBA Comm Conn of FC	CORE Empowerment Services-Peer Support	CORE Empowerment Services - Peer Supports
MHA of Franklin Co DBA Comm Conn of FC	Core Family Support and Training	CORE Family Support and Training (FST)
MHA of Franklin Co DBA Comm Conn of FC	Family Support Program	Family Peer Support Services - Children & Family
MHA of Franklin Co DBA Comm Conn of FC	Home Based Crisis Intervention	Home Based Crisis Intervention
MHA of Franklin Co DBA Comm Conn of FC	Outreach	Outreach
MHA of Franklin Co DBA Comm Conn of FC	Peer Recovery Center	Recovery Center
MHA of Franklin Co DBA Comm Conn of FC	Specialty CMA	Specialty Mental Health Care Management
St. Regis Mohawk Tribal Council	Advocacy	Advocacy/Support Services
St. Regis Mohawk Tribal Council	Multicultural Initiative	Multi-Cultural Initiative
St. Regis Mohawk Tribal Council	Outreach	Outreach
St. Regis Mohawk Tribal Council	Saint Regis Mohawk Tribe Mental Health Clinic	Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
St. Regis Mohawk Tribal Council	Salmon River Central School	School Mental Health Program
St. Regis Mohawk Tribal Council	St. Regis Mohawk School	School Mental Health Program