Greene County Mental Health Center

905 GREENE COUNTY OFFICE BUILDING

CAIRO, NY 12413

2025 Annual Report

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Director of Community Services

& Mental Health Center Staff

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INTRODUCTION

The Greene County Mental Health Center (GCMHC) is an Article 31 Mental Health Outpatient Treatment and Rehabilitative Service licensed by the NYS Office of Mental Health (OMH). It employs a full contingent of professional staff, including Psychiatrists, Nurse Practitioners, Social Workers, RN's, LPN's, Case Managers, and our valued Support Staff. Our staff is dedicated to serving the residents of Greene County struggling with a variety of mental health disorders. Our compassionate and experienced staff members work together to provide a high level, patient-centered, comprehensive system of care.

EVALUATION OF 2025 GOALS

Workforce Development and Retention

Workforce development and retention continue to be one of our ongoing and highest priority goals. The workforce shortage in healthcare continues to affect the mental health industry and continues to pose an unpredictable threat to Greene County. By the end of 2025, GCMHC was poised to be fully staffed for the first time in several years, with all Mental Health Specialist and support staff positions filled. Due to the volatile staffing trends throughout the industry, however, this will continue to be a goal as we move into the future.

Disaster Mental Health Training

Greene County Mental Health, in cooperation with the Greene County Emergency Services Department, along with our counterparts in Columbia County, established a Disaster Mental Health plan to be enacted in the event of a disaster. We worked with Columbia County for both counties to have a mirrored plan. If one county's mental health system became incapacitated, the other county could assist. In addition to establishing this plan, all staff at Greene County Mental Health also participated in Disaster Mental Health training offered by OMH. This plan will continue to be reviewed and revised as needed going forward.

Crisis Intervention Training (CIT) Program, a Collaboration with G.C. Sherriff's Department

Due to the rural nature of our county and the limited range of mental health services available, law enforcement and emergency services are often the first responders to people having mental health crises. Because this is not an uncommon experience in rural communities, OMH has offered a grant initiative to address the issue.

Greene County Mental Health applied for and was awarded a grant to provide mental health and crisis intervention training to law enforcement to better address this issue within the county. In July 2025, twenty-three (23) participants from local law enforcement, emergency medical services (EMS), and corrections participated in a 40-hour crisis intervention training. Since then, Greene County Mental Health also participated in additional training with the rest of the Sheriff Deputies in the county. We also established a CIT Steering

Committee comprised of stakeholders to improve the County's response to people in mental health crises. The work of the Steering Committee will continue into 2026.

Expansion of Select Psychiatry Services

Throughout 2025, Greene County Mental Health began offering two new psychiatric services to its patients. One was a new assessment service to help accurately and reliably diagnose ADHD, traumatic brain injuries, dementia, and a variety of other conditions. This has been a successful service thus far which is also billable to insurance.

In the early fall of 2025, we also began offering a new medication treatment for treatment-resistant depression. The medicine for this new treatment must be administered on-site by a prescriber, and the patient must then be monitored by a nurse for the next two hours. While only a few patients have participated in this treatment thus far, we expect to see an increase in the future. This is a cutting-edge intervention and Greene County Mental Health is one of the first county mental health clinics in the states to offer it.

Changes to the DWYER Program

In 2025, the DWYER program went from being contracted by an outside agency to being run by the Greene County Human Services Department under the Veteran's Service Division. The goal for that change was to build a stronger relationship between the veteran's benefits services offered by the County and those who need services and support. It also helped provide a "no wrong door" approach when working with the veterans and their families. This new method also increased efficiency with direct referrals to county services and provides more opportunities for partners to get involved. In addition to this change, the program also relocated to a new location in Leeds.

Expansion of Online Health and Mental Health Resources for the Community

Greene County's Credible Mind site (https://greenecountyny.crediblemind.com/) launched in May 2025. We advertise the site in our monthly newsletters to clients, and the Greene County Human Resources Department has also been spreading the word to county employees about the topics featured each month. We will be exploring additional engagement strategies as we move into 2026.

As of October 1, 2025, there was a total of **1026** users. The most popular topics were Depression (171 users), Flourishing or Languishing (57 users), and Anxiety (56 users). A total of **274** assessments were completed. "Are Your Off Days a Sign of Depression" was the most popular (169 users), followed by the "Mental Health Check-in" (54 users) and "Are Your Worry Days a Sign of Anxiety" (39 users). The primary traffic source was Google Ads (692 users), followed by direct/email (170 users) and Search engine (141 users).

2026 GOALS

Planning and Preparation for the new Greene County Mental Health Building

Throughout 2025, Mental Health and County Administration teams met several times per month with members of the CPL architecture, engineering, and planning team to develop a new Community Services building for GCMHC. The County purchased a suitable site in Cairo for this purpose. Through frequent meetings and much collaboration, a layout and floor plan for the building were developed. The exterior aesthetics came together, and work began on planning for interior finishes, plumbing, electrical, HVAC, and IT needs. This has been a process that we have enjoyed being a part of and look forward to the ground-breaking happening in 2026.

Therefore, one of our goals for 2026 is to continue collaboration with the County Administration team and CPL as this project comes together. We will also begin planning for a move of our entire department, which will require much planning and coordination both within the department, and with other agencies.

AOT/EVA Expansion

Greene County Mental Health, functioning as the Local Governmental Unit (LGU), is required to offer an Assisted Outpatient Treatment (AOT) program pursuant to New York State Mental Hygiene Law. While we have done so since the law's inception many years ago, the State is now encouraging expansion of those programs and has provided funding accordingly.

In efforts to comply with the order for this expansion, Greene County Mental Health will be using this new state funding to create a full-time AOT Coordinator position which will be responsible for this program. Also, in accordance with this new initiative, the program will also begin to offer Enhanced Voluntary Agreements (EVA) for those clients who are at risk or going on an AOT order and/or as a step-down from an AOT order. This new position will also take on other roles in the clinic that relate to AOT/EVA-related duties, that due to previous staffing limitations, we were unable to perform. In the end, this funding and new position should facilitate an overall expansion of Greene County's AOT/EVA program.

CIT Program with G.C. Sheriff's Department Continued

As indicated above, the Crisis Intervention Team Program is aimed at establishing a crisis response plan for people in mental health crises. Most often in rural communities, it is law enforcement agencies who first respond to and interface with people in mental health crises. Many times, those responders do not have adequate training to skillfully deal with people in crisis. Further, there are many times when it would be better for those people to be served by other services and agencies than those responding. Consequently, the CIT Program is aimed at improving that system in the county.

While 2025 saw many law enforcement agencies participate in the initial Crisis Intervention Trainings, the CIT Program has also established a Steering Committee comprised of local stakeholders – including the Sheriff's Office, Mobile Crisis Assessment Team (MCAT), GCMHC, Greene County 911 Center, and others – who continue to find ways to better serve those people in need. Specifically, we are looking into effort to divert mental health calls away from law enforcement and toward more appropriate resources. The Committee is also looking at the needs in the community to more fully address this issue with additional resources and training.

Hospital Collaboration Efforts

Since Columbia Memorial Hospital (CMH) is the main hospital in our region to serve people with mental health needs, Greene County Mental Health works tirelessly with them to maintain and improve upon our collaborations. With many recent changes in the hospital's psychiatric services, it has required a re-examination of our current procedures and collaborations. This has resulted in regular meetings with administration from both CMH and GCMHC. This is expected to be an ongoing project throughout the year to improve collaborations, services, and the interface between our two organizations with the ultimate goal of providing better care for the residents of Greene County.

Workforce Development and Retention

As indicated above, workforce development and retention continue to be critical matters for all agencies in the mental health industry. The essential need for in-person, clinic-based services remains while many clinicians are opting for job opportunities which allow them to work fully remote. Greene County Mental Health has responded to these challenges by creating a career ladder for our social workers where we established a structured career progression for Mental Health Specialist employees, providing advancement opportunities

aligned with licensure levels. We have also followed the model of many of our neighboring county mental health clinics by offering various options for flexibility with our clinic's work schedules. We have also secured cost-free ways to provide some continuing education training, which is required for the social workers' licenses. All these efforts are aimed at retaining our valuable and highly trained workforce.

While at the time of this report, GCMHC enjoys being fully staffed, staffing changes are volatile right now in the industry, so focusing on workforce development and retention remains a high priority goal.

Fiscal Developments

The 2025 Mental Health Department budget – combined with the LGU, which includes OMH (Mental Health), OASAS (Office of Addiction Services and Supports; Substance Abuse), and OPWDD (Office for People with Developmental Disabilities) – saw an estimated cost of $491,639.00 to the County, which is $83,182.00 less than the $574,822.00 cost originally budgeted.

The clinic continued to maintain permanent telehealth certification under our OMH licensure, ensuring ongoing flexibility in scheduling and service delivery. This allowed us to effectively engage with clients and meet the needs of our community, whether through in-person services at multiple locations or via telehealth. In 2025, telehealth usage via telephone or video remained steady at approximately 23%, just slightly lower than 2024 levels. We continue to monitor usage trends and evaluate telehealth's evolving role, emphasizing the need for flexibility to provide comprehensive, client-centered care.

As we continue navigating the ever-changing field of mental health and the ongoing opioid epidemic, we face daily challenges and changes. Despite these obstacles, we remain committed to delivering evidence-based, clinically relevant services while being mindful of the financial impact on Greene County taxpayers. Looking ahead to the 2026 fiscal year, anticipated cost concerns include increased salary and inflationary expenses, billing obstacles including insurance coding and changes, as well as changes to Medicaid eligibility for clients.

As the LGU, we continue the oversight of state aid pass-through funding for our OMH and OASAS contract agencies. We keep the Greene County Community Services Board, which is responsible for selecting agencies to continue providing state aid-funded programs in Greene County, up to date on any issues or concerns.

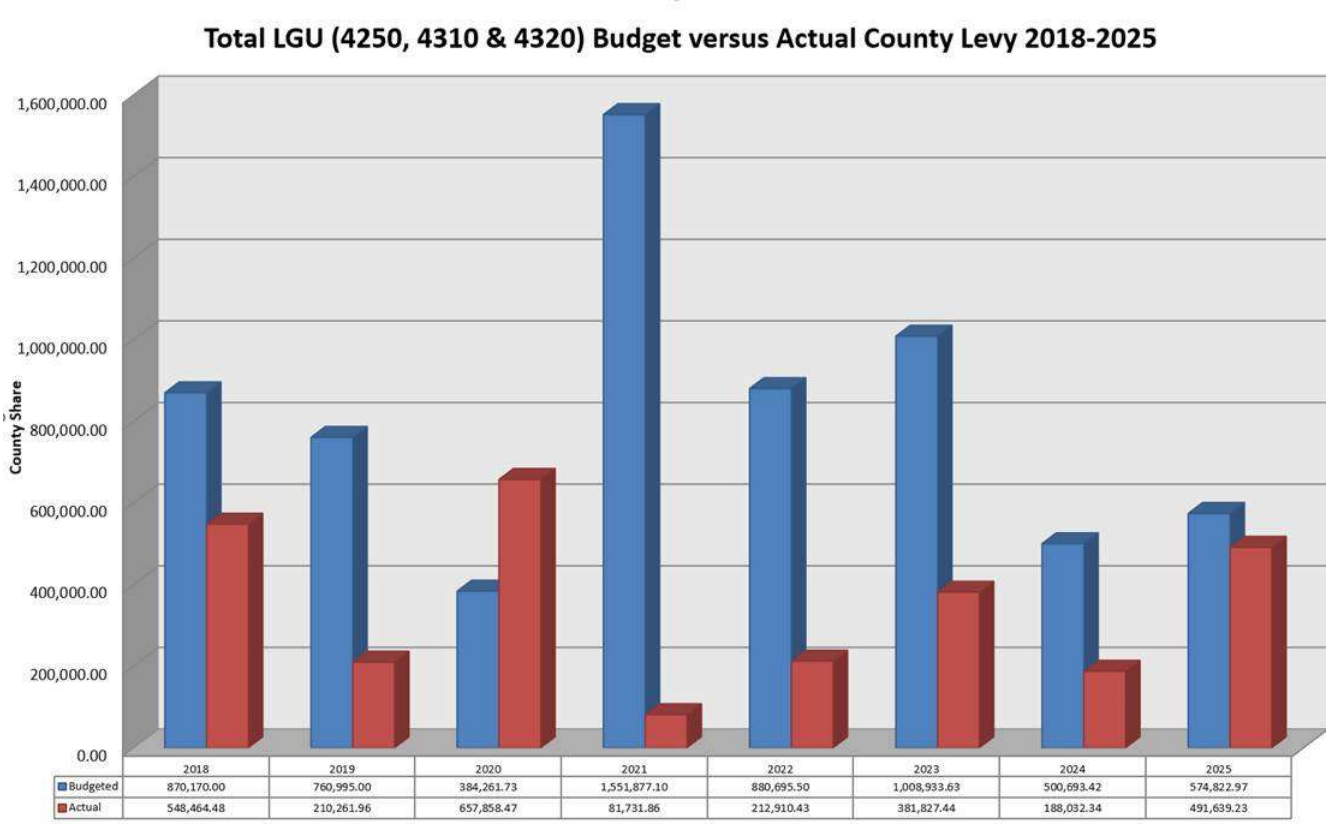
CENSUS INFORMATION

Over the course of 2025, Greene County Mental Health Center served a total of **1,443** unique individual clients; **988** Adults and **455** Children & Adolescents. We provided **26,743** units of service.

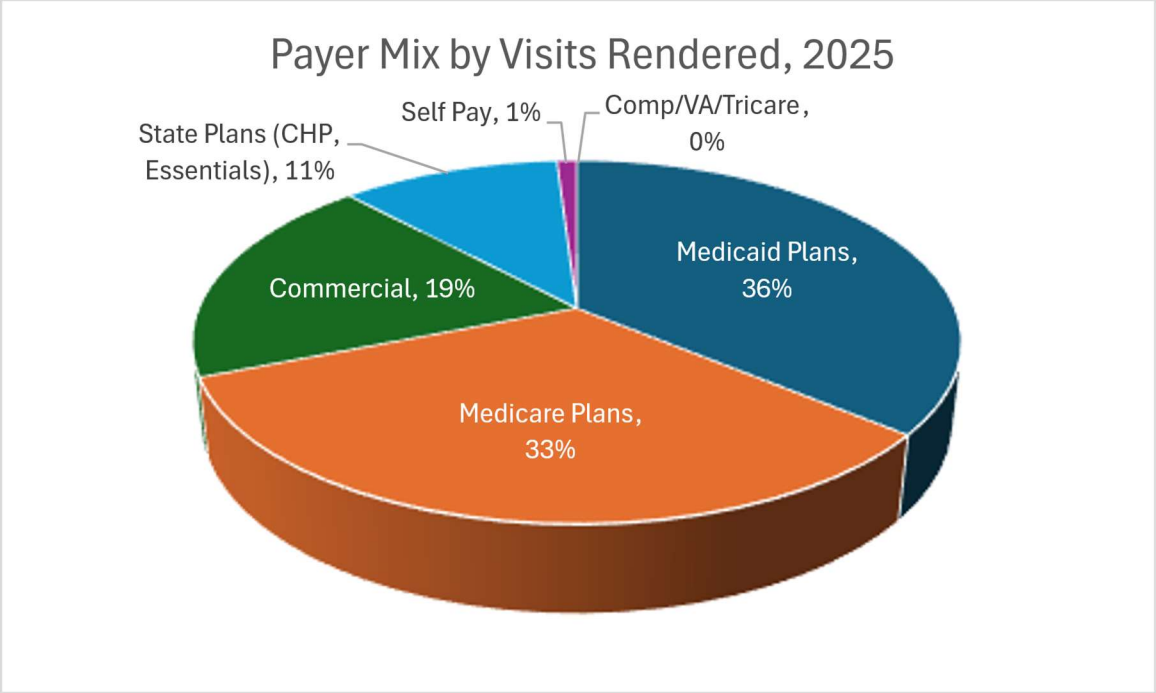
5 Year Census Data Comparison

YEAR:	**2021**	**2022**	**2023**	**2024**	**2025**
UNITS OF SERVICE:	22,547	27,481	26,436	25,269	26,743
ADULTS:	16,548	19,745	18,506	17,689	20,057
CHILDREN:	5,999	7,736	7,930	7,581	6,685
TOTAL UNIQUE INDIVIDUALS SERVED:	1,720	1,536	1,508	1,409	1,443
MALE:	42.85%	42.62%	43.43%	42.77%	43.50%
FEMALE:	57.15%	57.19%	56.44%	57.23%	56.50%

Budget vs Actual



Payer Mix by Patient vs Revenue Received



The Psychiatric Services and Clinical Knowledge Enhancement System

The Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES-Medicaid) is a HIPAA-compliant, web-based tool designed to improve quality and clinical decision-making within New York State's Medicaid population. Providers with access to PSYCKES can view quality indicator reports at various levels (state, region, county, agency, site, program, and client) to assess performance, identify individuals for clinical review, and inform treatment planning. These reports are updated monthly, and clinical data is refreshed weekly. Developed by OMH, PSYCKES uses Medicaid claims data to generate quality indicators and summarize treatment histories. All states are federally required to monitor Medicaid program quality, and many use administrative data like Medicaid claims to support these efforts. PSYCKES's quality indicators were developed with input from national experts and stakeholders, including providers, family members, and consumers. Greene County Mental Health receives an enhanced Medicaid rate per visit per client for its participation in the PSYCKES programs.

In the fall of 2024, a new Mental Health Outpatient Treatment and Rehabilitative Servies (MHOTRS) Quality Improvement Collaborative was announced. GCMHC continues to participate in the project aimed at improving access to mental health services. The goal is

to reduce client waitlists and waiting times by enhancing intake and discharge processes and creating capacity through step-down approaches and group work. Expected outcomes include reducing no-show or cancelled intakes, shortening the waiting time from first contact to admission and treatment initiation, increasing client participation in group treatment, and improving overall program capacity and efficiency.

Corporate Compliance, Quality Assurance, and Utilization Review

To ensure full compliance with Medicaid and Medicare billing requirements, the Office of the Medicaid Inspector General (OMIG) mandates that all clinics maintain a Corporate Compliance Plan. Greene County has adopted a plan that applies to both GCMHC and Greene County Public Health, with each department having its own specific plan.

The GCMHC Corporate Compliance Plan requires all staff to undergo annual training to refresh their knowledge and understanding of the plan. It also mandates quarterly self-audits to verify that medical documentation is complete, billing practices are followed, and to eliminate any risk of fraud, waste, or abuse of Medicaid and Medicare funds. Additionally, monthly verification is performed against exclusionary lists from the U.S. Department of Health and Human Services and the OMIG for all licensed employees.

Each quarterly self-audit has resulted in some returned funds, though these instances have decreased significantly with the addition of more frequent monthly Quality Assurance reviews. The returned funds were primarily due to missed documentation deadlines and were never the result of intentional fraud or abuse. When discrepancies occur, they are addressed with the staff member responsible, and additional training is provided as needed. GCMHC will continue to conduct quarterly self-audits to ensure high-quality care, accurate documentation, and proper billing in compliance with applicable regulations.

In 2025, GCMHC continued to monitor and track seven (7) key areas of compliance risk: billing, payment, medical necessity and quality of care, governance, mandatory reports, credentialing, and other risk factors. Staff have been trained in these areas, and procedures for tracking and monitoring have been put in place. The GCMHC fiscal department also employs various procedures to ensure that all billing is conducted properly and ethically.

Staffing News

Like many other County departments, Greene County Mental Health Center experienced several staffing challenges and changes in 2025.

Recruiting social workers with sufficient clinical experience remains a challenge for GCMHC, as many recent hires are new to the field and require weekly clinical supervision to support their transition into professional practice. This need for supervision impacts case assignments and revenue generation, as Medicare and certain commercial insurance providers do not reimburse for services rendered by Licensed Master's Level Social Workers.

In past years, post-pandemic workforce trends contributed to increased turnover, with social workers opting to establish private practices or seeking fully remote opportunities, but in 2025 we have been fortunate to see that trend start to level out. GCMHC continues to focus on strategic hiring, structured supervision, and proactive workforce retention efforts.

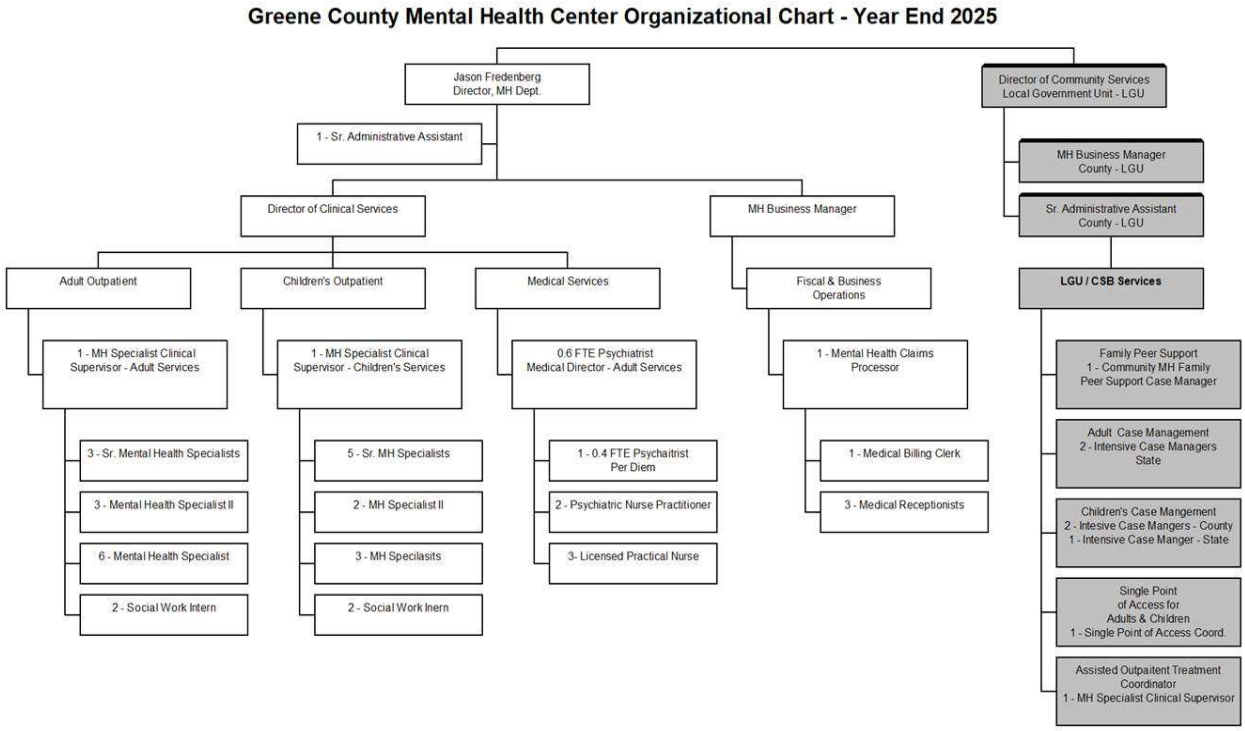
On the clinical side, a Nurse Practitioner vacancy was filled with a candidate who had completed two (2) clinical internships at GCMHC while studying at Pace University and was thus already acclimated to the clinic. We also filled two (2) vacant Mental Health Specialist positions, one being from within, with an Intensive Case Manager who obtained her master's in social work and became licensed.

Our state-shared adult Intensive Case Manager from Capital District Psychiatric Center retired after over thirty (30) years of service. The state did not refill the position, however, the funding to rehire came to Greene County through OMH state aid. In December 2025, we found a candidate and began the hiring process.

On the support staff side, we saw the resignation of two (2) Medical Receptionists. We were fortunately able to quickly refill both of those positions with qualified applicants. A Mental Health Claims Processor also resigned to move out of state and, in their place, a Senior Administrative Assistant was hired. An LPN working in our medical records department expressed the intent to retire in 2026. As a result, we began training a Medical Receptionist out of title to step in when the time came.

Providing field placement internships for master's-level students in social work and nursing continued to prove invaluable to the clinic. In 2025, GCMHC hosted four (4) MSW interns, three from the SUNY Albany School of Social Work, and one from the University of Buffalo.

Staff Organization Chart



Staff Training & Education

In 2025, we were excited to offer in-house staff development training sessions that resulted in free Continuing Education Credits for licensed staff. Other training courses attended during the year were those mandated by the County and OMH and outside educational opportunities.

In House Staff Development & In-Services

- Psychological First Aid
- Fundamentals of Disaster Mental Health Practice
- American Heart Association Lifesaver / AED
- Ethics & Boundaries

Mental Health Department Mandated Trainings

- Cultural Competency – Think Cultural from Dept. Health & Human Services
- Corporate Compliance
- Mandated Reporter

County Mandated Trainings

- Greene County Discrimination and Harassment Policy
- Workplace Violence Prevention Programs & Policy
- NYS Discrimination and Harassment Training
- Greene County Sexual Harassment Policy
- Bloodborne Pathogens
- HIPAA

Outside Educational Training Opportunities

- Eye Movement Desensitization and Reprocessing (EMDR)
- NIMRS Incident Investigation
- Reproductive Trauma
- Group Supervision Success
- Clinician's Guide to Parent Training
- NYS Incident Reporting
- Notary Public
- Obsessive Compulsive Disorder Treatment
- Trauma-Informed Culturally Competent Care
- Collaborative Assessment and Management of Suicidality (CAMS)

Community Engagement Events

In 2025, Greene County Mental Health Center participated in various events in the community; raising awareness on mental health issues, and the available services that GCMHC provides.

- Columbia-Greene Out of the Darkness Walk
- Coxsackie-Athens Rotary Mental Health Awareness Walk
- Greene County Youth Fair
- Cornell Hook & Ladder Community Health and Safety Outreach Day
- Youth Health Fair (Public Health)
- Interagency Connections Day at C-GCC
- National Night Out
- SUNY Albany School of Social Work Field and Career Fair
- Greene County Human Resources Benefits Fair
- Senior Day at the Point
- Trauma and Learning Presentation at WAJ School
- Developmental Disabilities Youth Transition Night

ADULT SERVICES

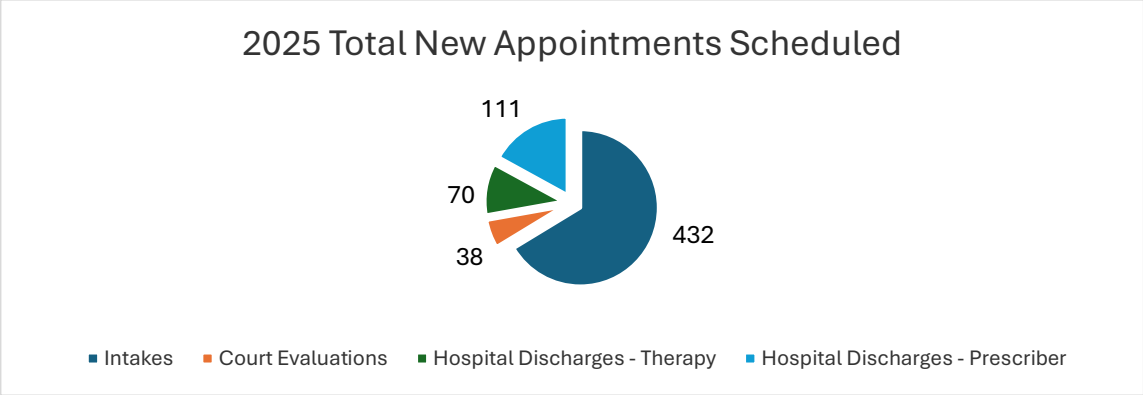
Adult Intakes

The adult intake process has evolved a few different times over the past couple of years. The clinic continued to experience a staffing shortage and a continued influx of need. Despite any challenges, the clinic was able to accept new clients, discharges from hospitals, rehabilitation facilities, jails, and prisons as well as court evaluations and acute cases.

For all of 2025, the clinic was able to regularly schedule intake appointments and assign clients to a permanent therapist in a timely manner. For this process, new clients would call the intake line, leave a message with their information, receive a call back to confirm being placed in a queue and then scheduled as appointments became available. The intake line was checked daily; calls were screened for acuity, need, and were given outside referral information when appropriate. Intake appointments were booked no more than two (2) weeks out, which exponentially helped the attendance of appointments as well as long-term engagement. Once scheduled, clients were tracked through their intake appointment and then placed on a list to be assigned to a permanent therapist.

In 2026, it is the clinic's goal to be able to schedule the regular number of intake appointments and have clients assigned to their permanent therapist directly upon completion of the intake process with little to no waiting times. The clinic continues to work on staff retention, client engagement, and appointment attendance.

Total scheduled appointments for the intake process in 2025 included: **432** new intake appointments, **38** court evaluations, **70** new hospital discharges scheduled with a therapist, and **111** new client hospital discharges were scheduled to meet with a prescriber.



Insight-Oriented Psychotherapy/Supportive Counseling

Adult therapists assess and treat individuals who are aged eighteen (18) and older. Our first contact with clients typically begins with an intake assessment which includes comprehensive information about the person as a whole. From there, therapists can make a preliminary diagnosis and treatment recommendations. Therapists also administer symptom screening tools that assist with diagnosing: the PHQ-9 screen for depression, the GAD-7 screen for anxiety, the CAGE-AID screen for lifetime alcohol and substance abuse, the RODS screen for opioid dependency, and the Fagerstrom screen for nicotine dependence. Our screening tools are evidence-based and have been shown to have good reliability and validity. Screenings are administered, at a minimum, on a yearly basis to track changes and improvements in clients' symptoms. Once a client is assigned to their therapist, a Comprehensive Treatment Plan is created and completed. Treatment planning is a collaborative process in which the client identifies their goals for treatment. Objectives, or how the client will work toward those goals, are listed. Often, the therapist will make suggestions and referrals for services that could assist the client with goal completion. The treatment plan is reviewed annually or updated sooner if there are changes in the treatment. For example, if the client identifies a need for medication, the assigned therapist will make a medication management referral so that the client can meet with our staff psychiatrist or nurse practitioner. At this time, the treatment plan would then be updated to reflect the change in services.

In addition to our normally scheduled intakes, we conduct assessments for clients who require court-ordered mental health evaluations. Our agency requires an order from the court prior to scheduling these appointments. We have provided these evaluations for Family Court, Criminal Court, and Greene County Drug Treatment Court. These assessments are like our typical intakes where we gather the client's biopsychosocial history and formulate initial diagnostic impressions. At the end of the assessment, the clinician provides treatment recommendations to the courts.

The Adult Team also provides services for clients who are on Assisted Outpatient Treatment (AOT) status which requires additional collaboration with our AOT coordinator and psychiatry staff. We provide specialized counseling services for clients with trauma histories; two (2) of our clinicians are certified Eye Movement Desensitization and Reprocessing (EMDR) therapists who specialize in evidence-based trauma treatment. In 2020, we also implemented a Medication Assisted Treatment (MAT) program in collaboration with Public Health to address unique issues associated with clients who struggle with Opioid Use Disorders (OUD).

The Adult Treatment Team has monthly meetings to discuss high-risk cases and clinical issues that arise. Sometimes we use these meetings to invite other community agencies to present to our staff. It is helpful to us to stay updated on programs in the community that could assist our clients. In 2025, we met with Oxford House and Columbia ReEntry, service providers that assist with housing for clients in recovery from substance use disorders and case management for justice-impacted individuals, respectively. Individual and group clinical supervision is provided on a regular basis to clinical staff. Participation in continuing education is required to maintain licensure and to ensure continued growth and training in the field of social work. In 2025, the Clinical Supervisor collaborated with The Alliance for Rights and Recovery to get free in-house presentations which resulted in our clinical staff earning Continuing Education hours at no cost. As a staff group, we also completed two required trainings: the Mandated Reporter Training and Cultural Competency Training. In May 2025, our therapists participated in a state-sponsored training for Disaster Mental Health Responder Training. This training was implemented in two parts: Psychological First Aid and Fundamentals of Disaster Mental Health Practice.

We also assume the role of educators. It is of the utmost importance to invest in the future of our profession and ensure that the next generation of social workers have proper training in the foundations of community mental health treatment. In 2025, the Adult Team welcomed two MSW students, both from the University at Albany. Relationships with academic institutions are beneficial for networking, especially when seeking new hires. Many of the clinicians we employ today are former MSW students who interned at GCMHC.

As a result of the 2020 COVID-19 pandemic, our therapists and psychiatry staff became rapidly acquainted with using telehealth as a means of providing services for our clients. In 2025, our clinical staff continued to utilize video and telephonic means to connect with clients for telehealth services. The clinic continues to offer telehealth psychotherapy services for clients who are appropriate for them, but in 2025, there was a continued trend towards requests for more in-person visits. Telehealth is a very useful option for clients who have limited access to transportation or have a chronic health condition that impairs them from visiting the clinic in-person. It is also a convenient option for those with busy work schedules or those who struggle to obtain childcare. In 2025, state regulations changed and we were able to offer sessions at clients' homes if needed. There are times when it is appropriate for therapists to meet with clients in their home: if a client is recovering from surgery, has a chronic illness, or is unable to ambulate well. This past year, we also have a therapist designated to meet clients at the Eliot at Catskill, an assisted living facility. While we can offer telehealth and home visits, our intake appointments are primarily conducted in-person at the clinic.

The Adult Treatment Team often refers clients to additional supportive services within and outside of our clinic. They coordinate with collateral agencies including:

- Primary Care Physicians / Public Health
- Care Managers/Care Coordinators
- Family Peer Advocates
- Hospitals
- GCDSS/APS
- Mental Health Association- PROS, MCAT
- Twin County Recovery Services/Greener Pathways
- Greene County Drug Treatment Court
- Greene County Probation and NYS Parole
- Single Point of Access (SPOA)
- Columbia ReEntry

At any given time, the Adult Treatment Team serves anywhere from **850-1,000** active clients. Full time adult therapists carry a caseload of **50-75** clients. Caseloads are determined by acuity, the severity of the client's symptoms. For example, a client newly diagnosed with Bipolar I Disorder who recently discharged from the hospital would require more intervention than a client whose symptoms are stable and are seen for supportive counseling once per month.

Adult Group Offerings

We are slowly gaining momentum with group offerings. Often, it is difficult to get clients to commit to attending a regular curriculum and some barriers exist with transportation, work, and childcare. Nonetheless, we now have adequate staffing to explore clinical needs for groups. Some members of our clinical staff completed a free training this year called "Learning to Love Groups." Participants learned how to facilitate groups by using the ROPES framework. Some proposals for future groups include Support for Transitional Youth, Anger Management, and Relapse Prevention. Below are groups that were offered in 2025 and are ongoing:

Women's Group – A psychotherapy group for adult women ages eighteen (18) and older. The group is designed to support women in their efforts to cope with daily stressors and build healthy relationships. It is offered weekly and remains open for those who wish to join while the group is in progress. It is facilitated by a licensed clinical social worker.

Men's Group – A psychotherapy group for adult men ages eighteen (18) and older. We have had a men's group in the past and now we finally have the staff to start it up again. It is a bi-weekly group. Members must also be existing clients of the clinic. The group is open format which means members can join at any time. Themes for the group include improving communication, building healthy relationships, and improving coping skills. It is facilitated by one to two (1-2) social workers.

DBT Group – In 2025, we offered a 12–13-week Dialectical Behavioral Therapy Group. The group was for adults aged eighteen (18) and older. DBT focused on skills training in four (4) modules: Core Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness. It is facilitated by two social workers and ran for 2 cycles in 2025. We are looking to offer it again in Spring/Summer 2026.

Medication Management – Psychiatry Services

In 2025, the clinic continued providing medication management services for adults and teens, maintaining access both in person and via telehealth. Demand for psychiatric prescriber services for children ages five to fourteen (5-14) continued to rise, while recruitment for this specialty remains critically understaffed across the state. To address this gap, the clinic partnered with private providers in the region to help ensure access to medication management for this population.

In 2025, the clinic employed two (2) full-time Psychiatric Nurse Practitioners (35 hours per week each) and two (2) part-time contracted Psychiatrists (with a combined total of up to 40 hours per week). Together, they provide medication management services to approximately **600** Greene County residents. Despite these efforts, there remains a pressing need for an additional child and adolescent prescriber.

The demand for medication evaluation and management remains high across all age groups, while prescriber availability is limited. If appropriate, GCMHC will refer less-complex cases to primary care providers or specialists if clients are unable to wait for an assessment.

Psychiatric prescribers at the clinic continue to try to prioritize the most severe and complex cases, aiming to transition stable patients to primary care providers for ongoing medication management. Despite offering consultation services to area primary care offices, clinic prescribers have found that primary care providers are becoming increasingly resistant to take the transfer of medication management for mental health clients. This resistance has at times limited the number of new clients GCMHC's prescribers can take.

Medication for Opiate Use Disorder (MOUD)

As part of a past PSYCKES Clinical Quality Improvement Initiative, the clinic continued its efforts to reduce opioid overdose deaths in 2025. Working with Greene County Family Planning, the clinic provided Medication for Opioid Use Disorder (MOUD) services alongside psychotherapy to support individuals struggling with addiction.

The clinic also strengthened partnerships with community substance use treatment providers, improving interagency referrals while reducing service duplication. By streamlining access to care, these efforts aim to enhance engagement in treatment and minimize the risk of individuals disengaging due to barriers associated with multiple providers.

Additionally, GCMHC operates a New York State Department of Health Opioid Overdose Prevention Program, which supplies Narcan kits and fentanyl test strips to clients, families, and community members.

Assisted Outpatient Treatment Program (AOT)

In 1999, New York State enacted legislation that provides for assisted outpatient treatment for certain people with mental illness who, in view of their treatment history, are unlikely to remain safe in their community without supervision. The law is commonly referred to as "Kendra's Law" and is set forth in Section 9.60 of the Mental Hygiene Law. It is a civil, not a criminal, law. This statewide initiative has been developed to assist clients who are non-compliant with treatment to obtain the mental health treatment they need and live safely in their community.

There are clear and precise AOT eligibility requirements. One of the seven (7) eligibility requirements is that clients having two (2) or more hospitalizations due to non-compliance within the last thirty-six (36) months or clients having one (1) or more acts of violence toward themself or others within the last forty-six (48) months. These clients can be at high risk in the community because of danger to oneself or others secondary to non-compliance with treatment. In 2024, the law was updated to include a statute that if a client is re-hospitalized within six (6) months after being discharged from AOT status, they can be placed back on an AOT. In 2025, there was one (1) Greene County resident released from prison on AOT status. Individuals under AOT receive priority access to case management, outpatient services and residential housing options.

Enhanced AOT or Enhanced Voluntary Agreement (EVA) is a less restrictive program. It is used prior to getting an AOT order or used in stepping a client down from an AOT order. This

program does not involve court orders but is helpful when a client is at high risk in the community and noncompliant with treatment. It allows for increased monitoring of the client and is less restrictive than the AOT order.

Significant Event Reports are filed with OMH when a client is on an AOT order and is noncompliant with treatment, or demonstrates other high risk behaviors in the community such as criminal activity, whether it is being accused, committing a criminal act, or being a victim of crime; danger to self or others; non-compliance with mandated treatment; homelessness; psychiatric inpatient hospitalization or emergency services used; psychiatric decompensation; death; substance abuse; risk of non-delivery of mandated services; and if an AOT client is missing.

Many of these AOT clients have co-occurring diagnoses, severe mental illness, and substance use disorder. Of the nine (9) active AOT clients Greene County Mental Health is responsible for monitoring, four (4) have co-occurring diagnoses. This is a trend being seen statewide that a large percentage of the AOT population have substance use disorders. However, it is a difficult problem to address through the AOT. The AOT plan can include referrals to substance use treatment, however, substance use treatment is, by its nature, voluntary. Treatment providers make great efforts to get clients into substance use treatment, but the AOT itself cannot mandate substance use treatment. The hope is that if a client can achieve psychiatric stability through mental health treatment, they will be able to effectively engage in substance use treatment as well.

The shortage of appropriate housing for AOT clients is another continuing and worsening trend in the Upper Hudson Valley region. This may be related to the acuity of the client, the need for licensed housing support, or the lack of affordable low-income housing in the area. Greene County is sorely lacking housing resources for this high-risk population. Safe housing options are necessary for improving quality of life for those afflicted with severe and persistent mental illness; basic needs are a must, especially if we are working towards reducing inpatient bed utilization and the strain on the criminal justice system.

To date, one hundred twenty-nine (129), Greene County residents have been referred to the AOT program. In 2025, nine (9) new or renewed AOT orders were issued. Currently, Greene Conty Mental Health has nine (9) clients with active AOT statuses.

In 2025, New York State issued funds to all counties to help develop AOT programs. One of the goals is for the Enhanced Voluntary Agreements to become more expansive and able to divert some need for the court-ordered AOT's. We are currently exploring ways to utilize the funding to best serve our client population and community need. Ultimately, the goal is to provide some of our most acute AOT/EVA clients with an opportunity for a good quality of life, access to resources, and reduce hospital utilization.

Forensic and Family Court Services

GCMHC continues to provide follow-up services for individuals released from Greene County Jail and the New York State Department of Corrections. To reduce the risk of individuals falling through the cracks post-release, GCMHC refers appropriate clients to the ReEntry Columbia Program. This program's goal is to reduce recidivism, increase public safety, help clients become independent productive citizens, and decrease county expenses associated with unaddressed needs of returning citizens.

We also continue to conduct court-ordered mental health evaluations for individuals incarcerated in the Greene County Jail, as requested by the courts. In 2025, four (4) individuals underwent these psychiatric evaluations.

Additionally, GCMHC provides comprehensive mental health evaluations for Greene County Family and Criminal Courts to assist judges in their decision-making. These evaluations, which are billable to insurance, serve both the court's needs and the individuals involved. Judges have reported that these assessments are highly valuable in their deliberations for both family and criminal court proceedings.

In 2025, a total of nineteen (19) Criminal and Family Court mental health evaluations were completed at the court's request.

Furthermore, GCMHC continues to conduct 730 Criminal Procedure Law (CPL) competency examinations as ordered by the courts in criminal proceedings. In 2025, three (3) individuals underwent these psychiatric evaluations with some being seen by multiple psychiatrists for a combined total of eight (8) evaluations completed.

Drug Treatment Court

Greene County Drug Treatment Court is an alternative to incarceration program to engage legal offenders – who were arrested on alcohol or drug related charges, or who have a demonstrated history of substance abuse – in treatment. GCMHC has collaborated with Greene County Drug Treatment Court since the inception of the alternatives to incarceration program.

The NYS regulations for Drug Treatment Courts require a representative from Mental Health to participate and hold a permanent role on the Drug Treatment Court Team. The purpose of the Drug Treatment Court Team is to monitor and discuss the weekly progress of the Drug Court participants and to collectively determine treatment recommendations, sanctions,

and rewards for the participants. The Team also discusses and makes decisions on new referrals to the program. The representative of Greene County Mental Health plays an important role by educating the team on mental health issues and psychotropic medications that relate to the participants. The representative also serves an important role in evaluating most of the new participants to the program and providing initial and ongoing treatment recommendations. Because many of the participants also end up engaging in services through GCMHC, the representative also serves as a liaison between the treatment providers and the Drug Treatment Court Team.

Greene County Drug Treatment Court has expanded to include an Opioid Intervention Court. Treating opioid use disorder (OUD) effectively, and preventing overdose, requires a collaborative approach across systems. Opioid Intervention Courts have become an opportunity to address this public health crisis and prevent overdose deaths by rapidly linking participants to evidence-based treatment including Medication for Addiction Treatment (MAT) and other recovery support services. In Intervention Court, mental health services are offered but not required as part of this program.

In 2025, the Director of Community Services and the Clinical Coordinator participated in stakeholders' meetings about the formation of a Behavioral Health Treatment Court (BHTC). While still in the planning phase, Behavioral Health Treatment Court is expected to roll out in 2026. The mission statement for this new problem-solving court is "*to offer individuals whose criminal justice involvement is related to their behavioral health, (including mental illness, substance use disorder, brain injury, or developmental disability), treatment-based alternatives to resolving their misdemeanor level criminal charges. BHTC seeks to decrease recidivism, increased public safety, and improve the criminal justice response to individuals living with a behavioral health issue.*"

The clinic's role in this problem-solving court would be very similar to how we function in Drug Treatment Court.

Single Point of Access for Residential and Care Management/Coordination Services

The Greene County Single Point of Access (SPOA) for Adult Services is a committee comprised of a coordinator from Greene County Community Service Board, as well as members of community supports and services, and the directors of residential services and community program management from Mental Health Association (MHA) of Columbia and Greene Counties and Gateway Hudson Valley. When appropriate or necessary, additional community stakeholders are invited to participate.

Over the past years, there has been a significant decrease in the number of housing referrals that SPOA has received. This has not been because there is a lack of people needing supportive housing, but due to people needing more immediate housing options that SPOA was able to provide, as well as lack of affordable housing. The number of referrals to DSS emergency housing, Community Action of Greene and Columbia Counties, and Catholic Charities continued to dramatically increase because there continues to be little to no movement among the SPOA housing programs.

In 2025, more referrals were received than in the past four (4) years due to a new partnership with Gateway Hudson Valley. They intend to provide more supportive apartment housing for Columbia and Greene County as apartments are located and funding is secured.

Most housing referrals continued to come from the Columbia Memorial Hospital Psychiatric Inpatient Unit as well as the Capitol District Psychiatric Center. The number of referrals from out-of-county agencies has increased as other counties are experiencing the same issues of lack of housing and long waitlists.

SPOA Housing Committee interviews to determine client eligibility and tours of facilities were all held in-person in 2025. Organizational and tracking measures continue to be the same; each client's file is scanned and available electronically for committee members, clients are added to an updated roster and their progress is tracked; case summaries continued to be completed in 2025.

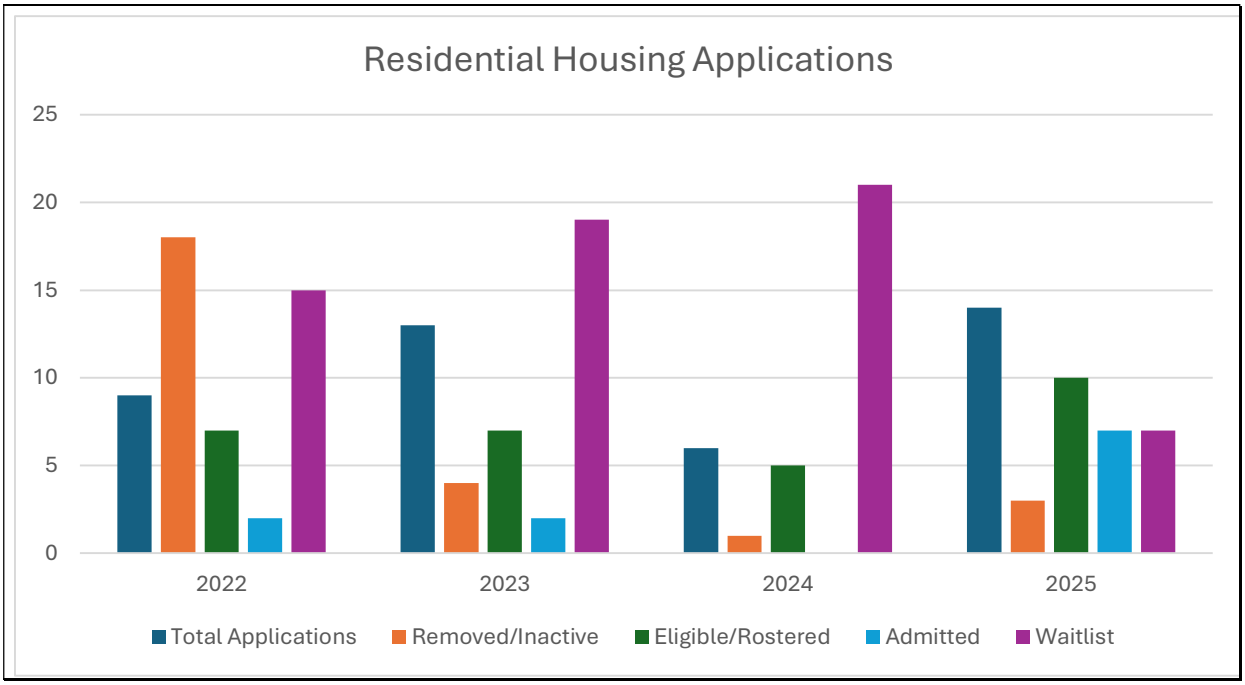
Residential Services

MHA provides housing for Greene County adult residents who have a psychiatric disability. There are three (3) distinct levels of housing that are reflective of the distinct levels of residential need.

High Cliff Terrace, a ten (10) bed, twenty-four-hour community residence, provides housing for individuals with a higher level of need for monitoring and who require a supervised setting as a first step toward learning skills for a step up to more independent living arrangements.

The Comprehensive Apartment Program (CAP) provides a less intense level of supervision allowing individuals to further develop skills for an even more independent level of living in their own apartment. Residents are assigned to a case manager through MHA who provides at least weekly (more when needed) contact to assist the resident with learning independent living skills. The CAP Program has a total of twenty-five (25) beds shared between Columbia and Greene Counties.

The Supportive Housing (SHUD) Apartment Program is the most independent residential setting wherein an individual receives a housing stipend like a Section 8 entitlement. They are assigned to a case manager from MHA who is required to provide a single monthly contact in direct conjunction with housing issues: collection of rent, monitoring ongoing condition of the apartment, and negotiations with landlord regarding repairs, tenant concerns, etc. SHUD has forty-five (45) beds with nine (9) of them dedicated to people coming out of a hospital or prison. Due to the continuing increase of rent prices in Greene County, some of the apartments are so expensive that they take up the funding for two (2) spaces. All recipients of a SHUD grant must also demonstrate eligibility with a psychiatric disability.



Residential Applications	2021	2022	2023	2024	2025
Total Applications	25	9	13	6	14
Removed/Inactive	8	18	4	1	2
Eligible/Rostered	7	4	7	5	10
Admitted	4	2	2	0	7
Wait List	36	15	19	21	7

There may appear to be a discrepancy between the number of applications eligible, the number admitted, and the number remaining rostered to the waitlist. This is because an individual may be deemed eligible for the service, but while awaiting an available placement the life circumstances and residential needs may have changed. Clients were removed from the Wait List as a result of moving out of the county, incarceration, moving in with a significant other or other family member, death; some individuals on the wait list from 2024 were placed in housing in 2025; individuals are carried over from other years; internal moves occur within each residential program that are not tracked here.

Applications are received primarily, but not limited to, following sources:

Inpatient Psychiatric

- Columbia Memorial Hospital
- Capital District Psychiatric Center (CDPC)
- Glens Falls Hospital
- Ellis Hospital

Regional Correctional Facilities

Community

- Outpatient Mental Health Providers: County & Private
- Care Coordination Providers: The Mental Health Association, Catholic Charities, The Alliance for Positive Health
- Primary Care Physicians
- Community residents
- Greene County Mental Health

Applications or referrals that were submitted but found to be incomplete are returned to the referral source and placed on a pending waitlist for ninety (90) days. If, following this three-month period, there was no contact with the referral source or applicant, or if there was no response to the requested documentation, the application would be made inactive and removed from the pending list. Applicants that are determined inappropriate for the housing resources above by the committee will be referred, if possible, to more appropriate placements, at which time the application would be returned to the applicant and referral source.

The Future of Residential Services

Appropriate and stable residential environments are a critical social determinant of health. Housing instability remains one of the strongest predictors of poor quality of life, including higher rates of recidivism, unemployment, incarceration, illicit drug use, and frequent use of emergency services such as shelters, emergency placement funds, and medical services. It also leads to increased involvement from law enforcement, first responders, and mental health mobile crisis teams. Housing instability often results in higher rates of involvement from Adult Protective Services (APS) and Child Protective Services (CPS) and can even extend into the judicial system.

An increasing number of psychiatrically impaired individuals are becoming involved with the judicial system. Many of these individuals are severely impaired by mental illness, which contributes to their involvement in legal matters. It is common to receive referrals from facilities seeking placements for individuals upon release, but applicants are often ineligible due to a lack of available structured settings in the area. As a result, referrals from the justice system are frequently directed out of the county for residential services.

Many recently released inmates, whether psychiatrically impaired or not, have limited or no family or social support. Upon incarceration, individuals often lose their housing and belongings, making it necessary for them to start over upon release.

Post-release inmates and clients under Assisted Outpatient Treatment (AOT) are typically placed at the top of the housing list. However, when AOT clients are prioritized, other clients may be bumped down, leaving them waiting for housing for two or more years.

The U.S. Department of Housing and Urban Development (HUD) estimates that more than 50% of individuals living in supportive housing programs have either a substance use disorder, a psychiatric disorder, or both. Tragically, drug overdose has become the leading cause of death among the homeless population, surpassing HIV/AIDS.

Community members seeking housing face significant challenges, including low housing stock, a lack of affordable options, and housing located in inaccessible areas with limited or no public transportation. Additionally, there is a lack of structured, skill-building, and restorative programs.

Greene County could greatly benefit from the development of new housing and the expansion of services in the following areas:

There remains a significant need for **permanent supervised housing** for the segment of the psychiatric population in Greene County that is aging and/or has multiple health issues and/or personality disorders which seriously compromise their ability to live independently, even with the assistance of an Intensive Case Manager. This subset of clients requires permanent and safe housing accommodation that provide medication oversight and assistance with their Activities of Daily Living (ADL's) beyond the scope of the current apartment programs.

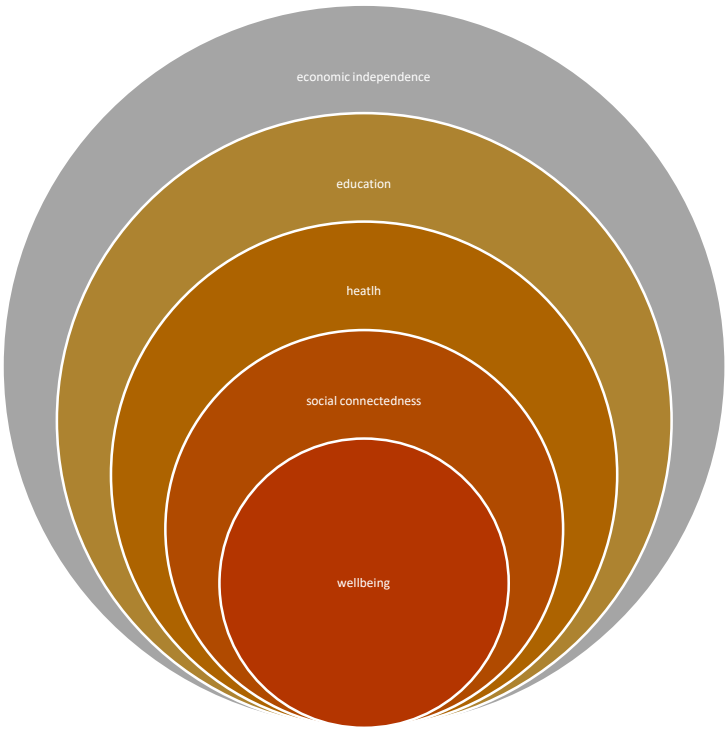
There remains a growing need for **permanent supervised housing** that transitions to permanent independent housing for individuals ages eighteen to twenty-four (18-24) years old transitioning from residential or foster placements or are no longer able to reside with family. This subset of clients requires permanent safe housing accommodations that provide oversight and assistance with learning independent living skills beyond the scope of the current apartment programs.

There has been an increased need for **permanent housing** for the growing segment of the population released from County Jail or other incarceration.

Adult Case Management Services

Adult Case Management is targeted to seriously mentally ill individuals in hope of increasing community tenure by decreasing the necessity for psychiatric inpatient admissions and ER visits. Generally, the targeted population consists of individuals who are at high risk of re-hospitalization, homelessness and at times involvement with the criminal justice system. Often clients' involvement with these systems results from non-compliance with recommended outpatient services and lack of community support to monitor functioning and needs. As a result of Kendra's Law passed by the NYS Legislature in 1999, Adult Intensive Case Managers (ICMs) are required by law to give priority to individuals who are court mandated to receive outpatient mental health treatment: Assisted Outpatient Treatment (AOT). These are individuals who have been assessed to be at risk in the community for danger to themselves or others, resulting from non-compliance with prescribed treatment.

Case Managers Focus On:



Case Management staff assist individuals in developing and maintaining viable living, working and social situations in the community by helping them to identify their needs and formulate realistic and attainable goals for self- sufficiency, support and economic independence. The Adult ICM's visit their clients minimally once per week. Greene County has both Intensive Case Managers and Care Coordinators (through MHA), both of whom

meet with their clients in the community, on psychiatric inpatient units, at mental health centers and in their homes to provide support, advocacy, linkage, coordination of care; monitoring compliance with treatment and diverting crisis by seeking to resolve identifiable stressors/triggers as they arise. Precipitants of crisis may include non-compliance with medication, onset of symptoms due to housing, financial, family and social stressors.

The Adult Intensive Case Managers maintain ongoing communication with all providers who are mutually working with the individual to assure adequacy, access and continuity of care; as well as to coordinate/negotiate and refer to assure provision of services. This process of collaboration includes, but is not limited to: DSS, Mental Health, Adult Protective Services, Probation/Parole, ACCESS-VR, MHA PROS and Supported Employment, medical providers, family, significant others, landlords, etc. The overall intent of all case management is to enhance the individual's quality of life (recovery) in the community and prevent psychiatric hospitalization.

Greene County Mental Health Center supervises three (3) Adult Intensive Case Managers (ICMs). Two of the ICMs/Care Managers are designated to Greene County through Capital District Psychiatric Services (CDPC). They serve clients with both Medicaid and Medicare. Both provide traditional services using legacy slots while also enrolling new applicants in the Health Home Services for Medicaid recipients. We partner with Health Home and Skyward Health for Medicaid billing.

Our third ICM is employed through Greene County. This ICM collaborates with the Department of Social Services, Public Health, and Mental Health to get referrals for clients who may need assistance with service linkage in the community.

Data management for Care Coordination (MHA) and Care Management (Greene County) is fully transitioned to Skyward Health (formerly known as SunRiver Health and Hudson River Health), the Health Home who is also responsible for reporting to the State of New York. In August 2020, the documentation platform transitioned from GSI to Relevant (also known as Foothold) and all data/charts were migrated to Relevant. Following the retirement of one of our main Care Coordinators, a total of thirteen (13) Active Enrolled clients are in the Relevant system for Greene County CMA.

Care Coordination

Care Coordination Services are a less intensive form of Care Management. For this service, individuals need to have a mental health or medical diagnosis and higher-than-average contacts with service systems, such as the ER, psychiatric inpatient and outpatient, and primary care.

Health Home Plus (HH+) is a more intensive Health Home Care Management service that was established for defined populations with Serious Mental Illness who are enrolled in a Health Home. To ensure the intensive needs of these clients are met, HH+ individuals receive more face-to-face contact and more interventions specific to their needs.

Over the course of this service year, applications for this less-intensive program were forwarded directly to MHA and The Alliance for Positive Health, bypassing the SPOA process in many instances, to facilitate enrollment into this program. The Care Coordination program works within the Hudson River Health Home, who assists with tracking and reporting to New York State, as well as monitoring outcomes. Therefore, for more complete data, SPOA refers to MHA and the Alliance for Positive Health directly.

It should be noted that applicants for Care Coordination do not go through the typical SPOA review and are instead referred directly to Care Coordination under the presumption of eligibility. The SPOA committee continues to review a small number of applications for this service when the request is for multiple service areas within the same application.

Enrollment and engagement in this service is not tracked by the SPOA for several reasons. It is at the time of intake for MHA Care Coordination program that some applicants are found to have relocated or refuse the service, or ineligible due to primary payer. SPOA is contacted when Health Home Plus (HH+) eligibility is requested for new enrollments or renewal each year.

As of December 31, 2025, MHA employed a team of eleven (11), which included their Director, Assistant Director, and nine (9) Care Coordinators. This was a higher employment rate than they have had in the past three (3) years! The average caseloads for Care Coordinators are thirty to forty (30-40) people depending on need. The Director and Assistant Director have been carrying caseloads of around ten to fifteen (10-15) when needed. In 2025, the total number of Greene County clients served was two-hundred-two (202) with forty-six (46) being Health Homes Plus and/or AOT and two (2) Non-Medicaid clients.

As time continues, more hospitals and inpatient facilities have begun referring directly to the Health Home and bypassing the SPOA process. This has led to our tracking numbers decreasing, but the data elaborated upon in the prior paragraphs is more representative of the care coordination program.

CHILDREN'S SERVICES

Child and Family Services

In 2025, the Children's Team at GCMHC continued to provide responsive and comprehensive treatment to children and families in Greene County. Our team of experienced therapists, case managers, and a family support specialist offer families a collaborative network of services and support. The services are accessible, family-driven, and available in multiple settings, including the clinic, via telehealth, in homes, and in school district satellite offices.

Throughout the year, providers have addressed a consistently high demand for youth mental health services amidst an ongoing staffing shortage in the field. Despite limited resources, the Children's Team was able to continue serving high-risk clients and those transitioning from higher levels of care. There was a temporary pause in intakes for non-acute cases which allowed the team to manage established caseloads while still prioritizing hospital follow-ups and high-risk community referrals. During this period, the school-based team continued to accept referrals and provide services at satellite offices.

The clinic has maintained a hybrid delivery model, offering remote services via video and phone to meet client's needs. While many children and families have chosen to return to in-person therapy, others have found virtual sessions to be beneficial. In a rural county with limited transportation and economic challenges, this flexibility has significantly improved client engagement and productivity. Clinic-based staff have observed a rising demand for in-person services over the past year and have worked to accommodate this need. Additionally, our school-based workers are available in schools throughout the academic year, including summer months, providing much-needed services to many Greene County students.

Initiating Children's Clinical Services at GCMHC

Parents may start the intake process by calling the clinic, completing required intake paperwork, and then completing a phone triage with the intake coordinator. This is consistent with both clinic-based and school-based services. The coordinator will then schedule an initial assessment with a therapist depending on acuity, school district, and staff availability. Children's intake assessments are scheduled in advance, and a legal guardian is required to participate and provide active consent for services. If a family is in crisis or an urgent assessment is needed, the coordinator will determine if they need an

expedited intake or may refer to emergency services including the Mobile Crisis Assessment Team (MCAT) or the ER.

At intake, our children's therapists complete a thorough biopsychosocial assessment including clinical diagnosis and treatment recommendations. In many instances, the children's team will complete an intake assessment in two (2) appointments, addressing risk and presenting issues at first meeting, and then gathering history and treatment planning as a follow up. This allows more time to engage a family and to gather necessary information to determine service needs. Our clinic does its best to minimize waiting times for intake and assignment, especially for youth and families. When staffing allows, the waiting time for an intake appointment with a children's therapist is a month or less and one to three (1-3) weeks for assignment, depending on acuity; both are well below industry standard.

Referral sources may include:

- Parents
- ER/Inpatient Programs
- Primary Care Offices
- School Staff
- Probation
- Department of Social Services
- Mobile Crisis Assessment Team

It is expected that the parent/guardian will contact the clinic to initiate services regardless of referral source.

Referral reasons – In 2025 many new referrals presented with the following issues:

- Anxiety
- Depression
- Behavioral Difficulties
- Attention Issues
- Family Adjustment/Disruption
- School Avoidance

High risk referrals often present with self-harm, suicidal thoughts, and aggression or threats. Younger children have been referred to address issues with significant family change or loss including witnessing violence, family disruption, and parental separation. The opioid

epidemic continues to prompt many referrals related to foster care placement, parenting and safety concerns, and adjustment to parent death by overdose. While the clinic does not provide substance abuse treatment, many youths present with substance use issues including alcohol, marijuana, and vaping. Children's team therapists work with clients and families to explore patterns and triggers, reduce harm, and link them to available resources. They may refer to Twin Counties Recovery Services or other area substance abuse services if necessary.

Verbal Therapy/Supportive Counseling

Children's therapists provide both individual and family therapy to a caseload of children and transitional age youth (18-21). Clinicians engage clients and families, assess immediate and long-term needs, and develop a treatment plan that is family-driven and youth-guided. Our clinicians are trauma-informed, trained in evidence-based practices, and regularly seek continuing education to enhance their skill sets. The clinic provides ongoing clinical supervision, professional development opportunities, and clinical case discussion to support our seasoned therapists in the challenging work they do.

The children's team often refers clients to additional supportive services within and outside of our clinic. They coordinate with collateral agencies including:

- School District Counseling and Administrative Staff
- Health Home and other supportive Case Managers
- Medical Professionals
- Law Guardians
- Child Protective Services
- Prevention/PINS Diversion
- Youth Bureau
- In-Patient/Partial Hospital Programs
- Probation
- Respite Services
- Family Support Worker
- Emergency Departments

At any given time, the children's team serves anywhere from **450-500** active clients. Several children's team therapists also see adult clients, primarily transitional age youth. This blend is reflected in the number above. Full time children's therapists carry a caseload of **45-50** clients depending on acuity.

School-Based Mental Health Services

GCMHC continues to provide school-based satellite programs in several Greene County school districts. School-based services increase access to services that many families would not be able to easily utilize. School-based workers are an integral part of their host school's Pupil Personnel team, collaborating with staff members, and providing behavioral and crisis support to students. Participating districts for the 2024-2025 school year include:

- Windham-Ashland-Jewett – 2 days per week
- Cairo-Durham
    - Elementary – 3 days per week
    - Middle/High School – 4 days per week
- Coxsackie-Athens
    - Coxsackie Elementary – 3 days per week
    - Edward J. Arthur Elementary – 1 day per week
    - Middle School – 3 days per week
    - High School – 4 days per week

School districts support these collaborations with approximately 20% funding (adjusted based on the number of days the clinician is at the school). Our Director of Community Services meets with school superintendents each spring to review satellite programs and has received consistently positive feedback about this service. School-based services are overseen by the Clinical Coordinator of Children's Services. The clinic continues to collaborate with school staff in districts not participating in the school-based program to accommodate referrals, manage crisis, communicate about high-risk students, and provide training when requested.

Child and Adolescent Medication Management

The clinic is fortunate to have two (2) Psychiatric Nurse Practitioners with experience serving children and adolescents. The Children's Team works closely with these providers, who see clients aged five and older and oversee medication management for many high-need youth at the clinic. Prescribers work closely with therapists and case managers as part of a clinical team.

There remains a significant demand for psychiatric medication evaluations and ongoing management in the region, while prescriber availability remains limited. When appropriate, less complex cases will be referred to primary care providers or specialists, particularly if

waiting times for assessment are too long. The clinic's child psychiatric prescribers continue to prioritize the most severe and complex cases, with the ultimate goal of transitioning stabilized clients to their primary care providers for ongoing medication management.

Children's Health Home Care Management

Greene County Mental Health employs two (2) full-time Health Home Care Managers. The county contracts with Children's Health Home of Upstate New York (CHHUNY) for documentation and billing of Health Home care coordination services. The clinic also has a half-time state item care manager shared between Greene and Schoharie County who carries a smaller caseload of Greene County youth. She often serves non-Medicaid referrals, though she has a blend of Health Home clients as well.

Health Home services through GCMHC are available to any child who meet certain criteria including:

- Have a qualifying mental health diagnosis
- Receiving ongoing mental health services from a licensed provider
- Demonstrate a certain level of functional impairments
- Are ages five to twenty-one (5-21)

Once deemed eligible, the care manager determines a child's acuity and needs by completing regular assessments, which drive the number of contacts per month as well as the problems and goals in the care plan. Referrals for care management come through SPOA, while most come from therapists, others are made by a hospital, parent, or other outside source. Care Management includes assessment of needs and progress towards goals, ongoing service coordination, and referrals to community resources.

Under the Health Home model, care managers serve a blended acuity caseload with an average of twelve to fourteen (12-14) clients each. Acuity level is determined by administering the Children & Adolescents Needs & Strengths (CANS) assessment bi-annually. Care managers provide at least one face-to-face contact per month in addition to assessment and care planning. While the role of care manager has become less hands-on and more data-driven over time, our care managers still make every effort to engage families and meet their needs under the new Health Home guidelines. They continue to be creative and supportive with their ability to connect families with available services in an area with limited resources.

This past year, SPOA has received a steady flow of children's case management referrals and clinic case managers have had full caseloads much of the year, often referring overflow to

outside agencies. Case managers have reported a continued high incidence of family crisis, lack of resources, referral to higher level of care (hospitalization, placement, etc.), and need for specialized evaluation (psychological, Autism Spectrum, etc.). Case Managers continue to work hard to fill gaps in access to programming, services, basic needs for the families they support.

This past year, the children's case management team was nominated for Greene County Employee Team of the Year award. While they did not receive the award, they were honored internally for the consistently exemplary work they do with children and families.

Family Support

GCMHC employs one (1) full-time family support worker. Family Peer Advocates have "lived experience" as the parent (adoptive, biological, foster) or primary caregiver of a child/youth with a social, emotional, behavioral, mental health, or developmental disability. They receive training to develop skills and strategies to empower and support other families. They foster effective parent-professional partnerships and promote the practice of family-driven and youth-guided approaches.

The family support workers receive referrals through Children's SPOA and directly from clinic therapists. Clients are provided with both formal and informal services which may include:

- Outreach and Information
- Engagement, Bridging and Transition Support
- Self-Advocacy, Self-Efficacy and Empowerment
- Community Connections and Natural Supports
- Parent Skill Development, and Promoting Effective Family-Driven Practice

For the past two (2) years, our family support worker has been able to bill for expanded services under the Mental Health Outpatient Treatment and Rehabilitative Servies (MHOTRS) program and is able to serve clients with both Medicaid and most private insurances if seen at the clinic. She has also continued to serve some adult clients, involving supportive family members and providing much-needed advocacy and skill building. Our family support worker continues to bill Medicaid for services under Child and Family Treatment and Support Services (CFTSS) for a select few clients who are not actively engaged in clinical treatment. This year, our family support worker has continued to engage the community by attending and tabling at local events, offering training and outreach as needed to schools, and presenting to collateral agencies.

School Avoidance Task Force/At Risk Youth Task Force

In 2025, the clinic continued to facilitate the At-Risk Youth Task Force, a multidisciplinary team convened in 2017 to address school avoidance in Greene County as well as other presenting issues. This task force has shifted focus over time to address a broader range of youth and community concerns. This meeting is attended by representatives from Greene County School districts and community providers. It is a forum to discuss a range of topics and trends affecting youth in our community. These include mental health issues, trauma, interface with the justice system, substance use issues, and improving communication and collaboration between agencies, schools, and families. The Task Force met three (3) times during the 2024-2025 school year and focused on new and changing community resources as well as providing a forum for collaboration.

Children's Team Staffing

In 2025, the clinic employed two (2) clinic-based therapists and six (6) school-based therapists. The children's team had a vacant clinic-based position for most of the year and was fortunate to hire a new therapist in December 2025. The clinic added an additional psychiatric nurse practitioner in 2025, now having two (2) staff prescribing for children ages 5 and older.

Additionally, the clinic employs two (2) full-time Health Home Care Managers and hosts one (1) part-time, state-employed Health Home Case Manager shared with Schoharie County. The clinic has one (1) full-time Family Support Worker who provides family support, advocacy, skill-building, and community outreach.

The Clinical Coordinator for Children's Services supervises most of the children's therapists, the children's Care Managers, and provides clinical supervision for the family support worker. She also serves as a liaison with other child-serving agencies in the county, sits on various committees related to children's services, and acts as a team leader while managing her personal caseload of children and transitional age youth.

A Clinical Supervisor, with split responsibilities between adult and children's teams, supervises the new clinic-based children's therapist, in addition to overseeing staff development, managing on-call and crisis services, and Greene County Family Court initiatives.

In-Service/Trainings

Representatives from the GCMHC children's team have offered formal and informal support to the community in a variety of ways. School-based workers have provided training and education about mental health needs to their host school districts on topics such as trauma-informed care in schools, emotional wellbeing, and accessing resources in the community.

Our family support worker is available to provide training in the community including mental health first aid and representing our clinic and mental health awareness at various open houses, fairs, and community events. These services are currently available remotely as well as in person.

High Risk Clients/Crisis Response

The clinic responds to calls from parents, schools, and community providers to help triage and problem solve the needs of high-risk youth. The clinic works with families to provide:

- Expedited intake or safety assessment, often within the same week of first contact
- 5-day follow-up appointments to children coming out of an inpatient hospitalization
- Health Home Care Management for hospital and residential discharges
- SPOA involvement for service assignment and tracking

The children's team maintains a watch list of high-risk children which is reviewed regularly during supervision and team meetings. There is ongoing discussion on how to improve safety planning and meet the needs of these children and family systems to help prevent future hospitalization and placement. The children's team maintains positive working relationships with the Mobile Crisis team, area hospitals, and all child-serving agencies so that response and collaboration is smooth in the event of a crisis.

Greene County Mental Health will continue its endeavors to provide children in our community with meaningful and individualized mental health services that promote emotional wellbeing. Our goal is to help children become successful in their home environments and communities, and to prevent higher levels of care. We have maintained a strong reputation among our clients and collateral agencies as a knowledgeable, reliable, and responsive team of mental health professionals who provide quality and comprehensive care.

Child & Family Single Point of Access (SPOA)

The Greene County SPOA Committee continues to work diligently to identify and provide supportive services to high-risk children and their families so that they can successfully meet goals and avoid hospitalization and placement.

The SPOA committee continues to host most meetings virtually the first Thursday of every month that are dedicated to a census update and utilization review. At the end of 2025, no in-person meetings were held but going forward, the committee plans to meet in person once per quarter. The working committee continued to include representatives from GCMHC as well as their Health Home Care Management Agency, Capitol District Psychiatric Center, Greene County Youth Bureau, Northern Rivers Case Management Agency, MHA, and a Family Peer Advocate. Area school districts, Greene County Probation, Ulster/Greene ARC, the Reach Center, and Catholic Charities continued to work with the committee on an "as needed" basis as well as other collateral agencies that may be invited depending on need and family involvement.

In 2025, SPOA continued utilizing care management services through Vanderheyden as well as Home-Based Crisis Intervention Services through Astor. Being able to refer to more agencies assists in reducing the time between the date of referral and the families receiving their in-home services. The Home-Based Crisis Intervention Program (HBCI) is an intensive, short-term family therapy program designed to prevent out-of-home placements, including psychiatric hospitalization, emergency department visits, or residential placement. To support families in crisis, services are held in the home, school, or community multiple times a week. HBCI is staffed with licensed clinicians who support the family in learning and practicing skills and strategies to safely manage emotions, thoughts, and behaviors. SPOA consistently received referrals for HBCI throughout the year and reported success from families who completed the program.

SPOA is encouraged to be the conduit for all care management referrals. Health Home services are available to any Medicaid eligible children who meet certain criteria including a significant mental health diagnosis, two qualifying health conditions, HIV, or Complex Trauma. This service may include ongoing assessment, care planning, care coordination and health monitoring, linkage and referrals, and family support. Out of forty-three (43) case management referrals received in 2025, twenty-two (22) qualified for Health Home Case management. The remaining twenty-one (21) referrals were enrolled with non-Health Home case management through MHA either due to their acuity or health insurance provider.

The SPOA committee is a referral source and tracking entity for both planned overnight and day respite services. Overnight respite is provided through the Northeast Parent and Child Society which coordinates with local therapeutic foster homes. Greene County has access

to 10-day respite slots which are assigned to children and families needing time and healthy connections outside of the home on a weekly basis. This service is provided through MHA and lasts an average of six (6) months at a time, with assignments monitored at monthly SPOA census meetings.

GCMHC employs a full-time Family Peer Advocate who has a caseload of parents and families identified through SPOA and the mental health clinic. This service is provided by phone, in the office, and in the home and community to meet families where they are and to promote healthy linkage and engagement in services. The Family Peer Advocate had a caseload of twenty (20) clients at the end of 2025. Their caseload numbers have remained consistent as referrals are steady and ready to replace any closed cases.

SPOA has also served as a referral mechanism for other services and support programs including Pre-PINS, Prevention, Intensive Aftercare Prevention Program (IAPP), mediation through Common Grounds, Twin County Recovery Services, Parent Support, Autism Connection, Children and Family Treatment and Support Services (CFTSS), and the Reach Center. SPOA is the referral source for two (2) out-of-home placement options: Community Residences (CRs) and Residential Treatment Facilities (RTFs), both administered by the New York State Office of Mental Health.

Two (2) new referrals were made to a CR and four (4) to RTF. In 2025, the SPOA Coordinator continued to participate in regular treatment team meetings for individuals from Greene County who were placed in a CR or RTF. In the past, SPOA was mostly included in these meetings once the facility was looking to discharge an individual back to the community. These meetings were held virtually throughout the year and gave SPOA a better idea of how to support these individuals upon discharge.

A Greene County SPOA representative continued to participate monthly in virtual statewide Children and Families Committee Meetings, quarterly in the Hudson River Children's SPOA collaboration with representatives from the New York State Office of Mental Health and attend periodic Systems of Care webinars.

In 2025, family meetings were held virtually on an as-needed basis; attendance included members from the Children's SPOA Committee, parents/guardians of the child, service providers from the child's school, representatives from the Department of Social Services, members of the IAPP through Northern Rivers, and discharge planners from several CRs.

Referrals for case management and family peer support came from many different sources including mental health clinics, parents self-referring, local school districts, Greene County Youth Bureau, Greene County Department of Social Services, and psychiatric hospitals. Case management continues to be the most utilized resource in the county for children and

families. Overall, there were forty-three (43) new referrals made to case management services (combining Health Home Care Management Agencies and MHA) in 2025. Other top referrals include fourteen (14) for Family Peer Advocate Services and twelve (12) for MHA respite. Respite had nine (9) people on the waitlist at the end of 2025.

Children's SPOA	**2022**	**2023**	**2024**	**2025**
Initial SPOA meetings	12	12	12	12
Referrals to Case Management	41	55	43	43
Referrals to Family Peer Advocate	17	31	24	14
Referrals to Respite	12	13	14	12

GREENE COUNTY COMMUNITY SERVICES BOARD

Greene County Community Service Board and Subcommittees

The Greene County Community Services Board (CSB) and its subcommittees oversee the Mental Health, Substance Abuse, and Developmental Disabilities programs in the county. Each body continues to review agencies and programs within their oversight areas to better understand gaps in service and the needs in the County. They have prioritized recommendations and evaluated potential funding streams for addressing these needs.

In accordance with Mental Hygiene laws, OMH, OASAS, and OPWDD are required to develop a Local Services Plan which is maintained by the OASAS Bureau of Information Technology. These plans are vital for New York State's long-term planning and budgeting. Following a Needs Assessment, updates to the 2024-2027 Local Services Plan were submitted in June 2025 by the Mental Health Business Manager. The plan prioritizes three key areas: Housing, Transportation, and Workforce.

Overview of Greene County Local Services Plan 2024-2027

Goal 1 – Increase access to safe, affordable, supportive, and workforce housing across all populations

- The Greene County CSB and Local Government Unit (LGU) will continue to advocate at the local and state level for safe, affordable, supportive, and workforce housing. Additionally, the CSB and LGU will work with the Greene County Department of Social Services Commissioner and local government to ensure our homeless population struggling with mental health, SUD, and/or developmental delays are provided with in county, safe, and supervised temporary housing.
- Advocate and collaborate with the Greene County Department of Social Services Commissioner and community agencies at the local government level in support of homeless shelter within the county that will provide a safe and supervised environment.
- Explore and engage with representatives from alternative residential options for those with SUD such sober living, faith based, and recovery residences in addition to continuing to advocate for and support the local OASAS certified women's residence expansion.
- Work with local nonprofit agencies and developers to expand mixed housing units that will provide additional levels of support for those individuals with mental health, SUD, or developmental delays while also providing affordable rents for working individuals.

2025 Update Goal 1

The need for a homeless shelter in Greene County remains critical. However, efforts continue to be challenged by a lack of support from elected officials, a shortage of affordable property, and rising construction costs post-COVID, all of which have hindered progress.

Greene County has entered its second year in contract with Oxford House, supporting the operation of a sober living residence for those with SUD. Due to a shortage of viable rentals, a former Oxford House alumni purchased a home in Catskill and is renting it to the organization. The "Rip Van Winkle House" opened in March 2025. This men's residence currently offers six beds, with five beds currently occupied and one application pending at the time of this report.

Twin County Recovery Services continues to look for properties to expand their OASAS certified women's residence.

Gateway was awarded a grant through the New York State Office of Mental Health (OMH) to provide five supported housing beds in Greene County. These units will be filled from the county's Single Point of Access (SPOA) list, ensuring targeted placement for those with the highest level of need. Gateway staff plan to regularly participate in SPOA meetings to streamline referrals and maintain close coordination with county services. In early 2025, Gateway signed a lease for office space located in Catskill, with operations slated to begin March 1st. A program director has been hired using startup funds, and the agency is actively searching for apartments to certify for use as supportive housing units. At this time, we can report that some apartments have opened.

While discussions around a mixed housing unit with Gateway Hudson Valley have not advanced in the past year, significant development has occurred in the Village of Tannersville. Construction is underway on a $31 million affordable housing project spearheaded by RUPCO, transforming the long-vacant Cold Spring Hotel site. The development will include 56 apartments targeted toward seniors and the local workforce: 40 units will serve households earning up to 90% of the Area Median Income, with 11 units prioritized for individuals who live or work in Greene County. Additionally, 15 units will be reserved for adults aged 55+ earning up to 60% of the Area Median Income. This initiative aligns with Governor Hochul's five-year, $25 billion housing plan.

Advocacy continues at both the state and local levels for expanded housing options for individuals with developmental disabilities through OPWDD, although no new housing projects have been implemented in the past year.

Goal 2 – Expand Transportation Services

- The Greene County CSB and LGU will work with the Greene County Mobility Manager and other municipal agencies to improve and expand access to transportation across the county that will allow individuals and families to access services within the county.
- Compile a complete and comprehensive listing of all available transportation provided by various agencies and municipalities within the county.
- Survey and poll service recipients and community to identify gaps in transportation services based on age, need, and geographic location.
- Increase community knowledge of available transportation options through social media, radio, and other forms of communication.

2025 Update Goal 2

Following a transitional period, the Arc Mid-Hudson has successfully hired a new Mobility Manager, who is now actively collaborating with Greene County CSB, LGU, and community stakeholders. Their shared goal is to develop and implement strategies that enhance transportation access and efficiency across Greene County.

Greene County Transit (GCT) has maintained all existing routes and is planning for future expansion. The Mobility Manager now has a comprehensive understanding of all transportation resources within Greene County and its surrounding areas, allowing for more coordinated service planning. Rider feedback is routinely collected and reviewed to identify and address service gaps.

Current transportation routes are published on the Greene County Transit website and available via a toll-free number. Printed route pamphlets are distributed through local service agencies, and the Mobility Manager actively participates in community events, local groups, and regional transportation council meetings. Social media remains a key tool in promoting available transportation options and sharing updates with the public.

Goal 3 – Workforce Recruitment & Retention

- The Greene County CSB and LGU will work with local governmental, non-profit, and for-profit agencies to advocate for competitive wages across all systems, create flexibility, and hybrid work options when appropriate in order to attract and retain qualified staff.
- Continue to advocate at the local, state and federal level for increased wages for all direct care staff.
- Explore the expansion of internship opportunities in an effort to introduce individuals to various direct care careers across all systems.

2025 Update Goal 3

The Greene County Mental Health Center, in partnership with the County and the CSEA Union, has successfully implemented a career ladder for Mental Health Specialist staff, supporting advancement opportunities aligned with licensure levels. Flexible and hybrid work schedules have also been introduced where appropriate. Despite these improvements, the Center continues to face challenges in recruiting qualified candidates to fill open Mental Health Specialist positions.

Workforce shortages are not limited to the County-operated clinic. OMH, OASAS, and OPWDD licensed agencies throughout Greene County continue to face critical staffing shortages and high turnover rates, resulting in none of these agencies currently being fully staffed. Both the OASAS and OPWDD provider agencies are struggling to meet their minimum service thresholds in the County due to these staffing deficits. These persistent and widespread workforce challenges remain the most significant barrier to delivering essential mental health, substance use, and developmental disability services in Greene County.

Advocacy efforts for improved direct care staff wages remain strong. Local OPWDD-funded agencies continue to participate in state-level legislative activities under the “Be Fair to Direct Care” campaign. These advocacy efforts persist across local, state, and federal levels to support competitive and sustainable wages for all direct care staff.

Internship development continues to be a vital strategy in workforce pipeline expansion. Greene County Mental Health Center and local nonprofit organizations maintain active partnerships with the SUNY Albany School of Social Welfare and other higher education institutions. Additionally, the Greene County Department of Human Services has expanded its internship collaboration with Catskill High School. As an official worksite through Columbia-Greene Workforce Employment NY, DHS offers student interns hands-on experience in departments such as Buildings & Grounds, County Administration, Food Services, and Vet2Vet. Paid summer internships through Workforce NY begin June 30th, and the high school-based internship program will resume in the fall.