Community Services Board- Mental Health Subcommittee

Quarter 4 meeting

December 17, 2024

1. **Welcome and Introductions:**

   Jamie Neckles (BMH), Ben McCarthy (BMH), Jennifer Kwon (BMH), Marnie Davidoff (CYF), Geoff Debery (CYF), Anastasia Roussos (CYF), Jordan Fenlon (CYF), Nicole Stratton (CYF), Anika Kalra (BCAARE), Rachel Vick (DOHMH), Lisa O'Connor (Safe Horizon), Rachel Saloman (Mental Health Advocate), Stephanie LeMelle (Director of Public Psychiatry at Columbia University), Scott Shapiro (Psychiatrist), Cheryl Hinds Leslie (Peer Advocate), Kathy Kent (OMH Office of Advocacy and Peer Support), Caroline Lewis (WNYC).

2. **Bureau of Mental Health Updates** (Jamie Neckles)

a. **Clubhouse:**

i. *We have 16 clubhouses open in NYC, and two more expected to open this fiscal year. (This includes 5 clubhouses that were not awarded contracts through our recent RFP and were subsequently designated with City Council funding to remain open).*

- *2 in Bronx*
- *4 in Brooklyn*
- *5 in Manhattan*
- *3 in Queens*
- *1 in Staten Island*

ii. *Clubhouses are an evidence- and place-based community for adults with SMI to support one another, socialize, and learn and practice skills for employment and recovery.*

iii. There will be 18 clubhouses open by the end of 2024.

b. **MH Crisis Services:**

Broadly speaking when we talk about crisis we say someone to call, someone to respond and somewhere to go.

i. *Demographic characteristics of individuals served by adult MCT*

1. *In FY23, 18,521 referrals were made to NYC MCTs, and the majority of MCT clients were Non-Hispanic Black (34%), male (50%), and between ages 21-39 (47%). MCTs serve adults across the full lifespan. Separate Children's MCTs serve people under 21, although occasionally MCTs may respond to individuals under 21.*
2. *In FY24,* 17,650 referrals were made to NYC MCTs, and the individuals served by MCT were primarily Non-Hispanic Black (36%), male (50.2%) and between ages 21-39 (46%).

ii. *Referrals and interventions*

1. *In FY23, 67% of the referred individuals (N=12,467) were successfully served by MCT in-person, virtually or indirectly, allowing the individual in crisis to remain in the community. At times, MCTs may assess some individuals to be in need of emergency in-person psychiatric evaluation. In these cases, they*

request ambulance transportation. In FY23, 4.5% of referred individuals (N=841) were transported to an emergency department.

2. *In FY24, 68% of the referred individuals (N=12,056) were successfully served by MCT in-person, virtually or indirectly, allowing the individual in crisis to remain in the community. At times, MCTs may assess some individuals to be in need of emergency in-person psychiatric evaluation. In these cases, they request ambulance transportation. In FY24, 4% of referred individuals (N=777) were transported to an emergency department.*

iii. *Post-intervention outcomes*

1. *In FY23 48% (N= 8,866) were referred to a service, and 58% of the referred individuals (N=5,181) attended an appointment.*
2. *70% of the individuals transported to an emergency department were admitted to either the psychiatric or a medical unit (N=592). The MCT intervention is closed at that time and the hospital works collaboratively with the patient from there on the inpatient treatment and discharge plan.*
3. *In FY24 54.5% (N=9631) were referred to a service, and 63% of the referred individuals (N=5,554) attended an appointment.*
4. *77% of the individuals transported to an emergency department were admitted to either the psychiatric or a medical unit (N=595). The MCT intervention is closed at that time and the hospital works collaboratively with the patient from there on the inpatient treatment and discharge plan.*

Questions

Question from MH CSB member: Has there been any change to MCT not being able to locate someone?

DOHMH: There are variable amounts of information from 988 referrals, most of the time when a contact from 988 results in a mobile crisis referral it is not from the person themselves. Depending on how well the referral source knows the person, the accuracy and the quality of the information may change. Internal referrals to a hospital based MCT often have much more information since the person is probably known to the system.

MH CSB: Attended appointment means a mental health appointment?

DOHMH: The MCT will visit the person, do evaluation and then refer for next steps—often a mental health appointment, if there is a substance use issue it may be for substance use as well.

MH CSB: Many people fall through the cracks of the system and going into the system without a diagnosis and coming out with one. I would love to see which system these folks are navigating. A lot of people will say they were in foster care their entire lives and then transitioned to mental health because the mental health system gave them a diagnosis.

DOHMH: MCT may know very little about what is going on with a referral. Not every de-escalation will result in a referral because it is not always indicated or necessary.

MH CSB: How does homelessness play into this?

DOHMH: Most MH crises happen in people's homes or in shelters not among street homeless individuals. These teams are not responding to people on the street, there are dedicated homeless outreach teams who are doing outreach to people on the street.

MH CSB : Some people call 988 but does 911 refer to 988 or MCT?

DOHMH: Currently 911 does not refer to 988 although that is a stated goal of 988 nationally. 911 does currently have the option to connect people to BHEARD which includes social workers and EMTs so that is an option when people do call 911. 988 may escalate to 911 if after some time on a call they assess that someone is in need of emergency services. Nearly 300,000 calls to 988 and these are the ones that lead to a MCT action, only one piece of the 988 system is MCT. Note that MCT referrals can also come from hospitals and other sources other than 988 and these numbers reflect that.

3. **Bureau of Children Youth and Families Updates**

a. **Social Media Report** (Nicole and Jordan):

i. *Overview of report*

1. Social Media Use and Frequency: A majority of children (54%), teens (93%) and parents (78%) use some form of social media. There are mixed perceptions among parents around whether the amount of time their child spends using social media is too much or not, but many feel that frequency of use is a concern. Of those surveyed, 107,000 parents1 of children age 8 to 12 years old (45%) and 172,000 parents of teens 13 to 17 years old (46%) feel their child uses social media too much.
2. Social Media and Mental Health: Our findings suggest that children who use social media experience higher rates of anxiety (16%) than children who do not use social media (12%). Teens who use social media experience anxiety (27%) and depression (14%) at higher rates than teens who do not (9% and 4%, respectively). While the 4% difference in anxiety rates among children is concerning, there is a much larger difference, up to 18%, for teens. Parents who use social media also report that they themselves are more likely to have depression or anxiety compared with parents who do not use it.
3. Conversations About Social Media Use: A majority of parents of NYC's children (65%) and teens (54%) report that they know how to, and do, talk to their child about social media. This number is higher than the national average, suggesting that efforts to raise awareness may have begun to work and should be continued.
4. A Resounding Majority of Parents Believe the Government Should Put Legal Restrictions on the Types of Access That Social Media Companies Give to Teens: Seventy-eight percent of parents want their government to protect teens by blocking access to some content on social media platforms. Given that we found that there are some positive reasons to use social media, we must be thoughtful in crafting legislation so that we can preserve the good while responding to this overwhelming demand for action.
5. Social forces, such as racial or economic status, shape awareness of the potential downsides of social media use: There is a 14% gap between parents who live in high-poverty ZIP codes (74%*) and parents who live in low-poverty ZIP codes (60%*) who believe they have enough information to talk to their child about social media use. What remains unclear is what information parents are receiving and whether that information is comprehensive of both benefits and potential harms.

Questions:

MH CSB: How old is the teen category?

DOHMH: 12-17

ii. *Discussion prompts:*

1. *Has social media been a topic of discussion within your communities and organizations? Is it a topic of concern?*

MH CSB: It is huge. We are looking at the way it is being used. It could be so valuable in promoting wellness but it is being used as a babysitter for children and teens. Cyber bullying is a big issue, also being used to lure people into human trafficking. We partner with Not on My Watch to do human trafficking prevention training. We need regulation in Washington.

MH CSB: Social media is a really big part of how young people that are homeless and in domestic violence shelters connect with neighborhoods, friends or family. This data is a really interesting point and makes us think about the potential and also the drawbacks of this tool.

DOHMH: Both great points and we want to emphasize that social media is a tool and that it depends on how this tool is used.

MH CSB: Do we have any other demographic information for these findings?

DOHMH: we do report other demographics such as neighborhood poverty, gender, etc

MH CSB: Do we have any criminal legal or school truancy data?

DOHMH: not with this report but definitely something we can look into in future surveys.

DOHMH: It is really helpful to hear these questions and helps give us ideas of what else we can be looking at in future surveys.

MH CSB: if we are going to target how social media is used we need to figure out what is causing it. What leads to this? What are the preventive things we can do to lessen the impact of this.

MH CSB: I believe that the data would show these demographic differences by race regardless of social media use.

MH CSB: Those who are more involved in other activities use social media less. White children are less likely to use social media because they are more economically sound and have things like after school programs.

MH CSB: Coming from OMH this is a big topic because this is the governors focus. Many times they talk of the surface level but not the other issues like young people being sex trafficked. A young person that is isolated and only thinking negative thoughts they are going to be fed that type of media. The state perspective is complete ban but that is not realistic. Many times parents buy their kids the phone because they are working all time. Toxic work environments with low pay, bad hours and high stress contribute to this.

DOHMH comment: Could be that people are feeling depressed or anxious and spending more time on social media. We don't know causality.

b. **Social Media Framework for Action** (Marnie) [note reference included document for additional OEA-approved talking points].

i. Accountability: Social media companies must change the design of their platforms to be safer for young people.

ii. Education and Support: Young people and their families need support to gain knowledge and skills to become healthier users of social media.

iii. Research: Studying the impacts of social media on NYC youth will help us advance our knowledge and address local needs.

MH CSB: Does any of this information include information on how to build a positive feed?

DOHMH: Some but this is exactly the type of feedback we are looking for in order to determine how we need to focus our effort and what our strategy of community education, engagement and training is going to be.

c. **Community Engagement** (Marnie)**:**

i. **DOHMH Youth Committee on Mental Health**

1. *As we reported in September, our plans originated from 2 initiatives: a) CYF's engagement with SUNY's Youth Agenda group, which recommended that the City create a youth advisory group on mental health and b) to incorporate youth voice into Bureau programs and policies on an ongoing basis, after our SAMHSA-funded project comes to an end.*
2. *The purpose of the Youth Committee on Mental Health is to have youth voice guide the programs, policies and strategies of the Bureau of Children, Youth and Families (CYF). Through the Committee, CYF will partner with youth to help ensure that the Bureau's programs and policies are responsive to their needs and priorities.*
3. *We concluded our application process; received over 200 applications and have selected 18 young people to serve on the Committee.*
4. *We have excited to have a diverse group of young people, half have lived experience of some kind, ages 16-24, represent all 5 boroughs, each with a 12-month commitment, receiving a $1,500 stipend (annual).*
5. *Meetings with CYF will be held every other month, with transparency about when the group's input will be considered advisory and when there are opportunities for shared decision-making.*
6. *The Committee has officially launch; members participated in a weekend retreat in October and has started to meet weekly.*

MH CSB: Where were youth recruited from?

DOHMH: Many many places, we connected with thousands of young people and we were very excited that we had 200 young people apply, conducted interviews with a select number and then chose 18. We also wanted to offer a real stipend which helps with youth being able to make the commitment to do this.

ii. Centering Children and Families in NYC System of Care

1. *Purpose: The Health Department will engage youth, families, providers, and other community stakeholders in CBPAR to assess their needs amidst the changing service landscape; identify gaps and barriers in the SOC; and design and implement effective solutions at the borough and citywide levels.*
2. *Conducted multiple community forums (19 forums) and received feedback from youth, family members and providers.*
3. *We started to share data back with participants and implement a participatory approach to interpreting community feedback. Excited to have funding to do this work.*
4. *Our next step is to identify priorities and develop community action groups to co-design solutions addressing those priority areas.*

4. Goals and Priorities for 2025

- Commercial insurance reform (provider participation and pay rates)
- Unique needs and challenges facing youth asylum seekers
- Physical spaces where Medicaid funded services are provided- Often dirty, dilapidated, run down. Need to be improved, creates a message that "you don't matter." Need to be decent, clean and staffed with care and concern.
- School refusal, especially returning to school post pandemic
- Increased fear and anxiety and LGBTQ+ communities
- Career advancement and supervision for peer workforce

Questions and Comments

DOHMH: As a subcommittee we can select our own areas that do not relate to these and we want to note that these have not be finalized yet by the Core CSB meeting.

MH CSB: piece in today's NYT about young adults getting together to do game night. We cannot ignore the boredom aspect that drives kids towards cellphone use. The challenge is that we are not funding those things but if we can affect policy change than we can get funding.

MH CSB: Junior achievement used to teach kids how to start businesses and these kids like money and expensive things and these kids could get involved and start businesses of their own.

MH CSB: Asylum seekers are not going to seek services if they are afraid of being deported under the next administration.