Public Safety Committee Meeting Transcript – 07/09/2020

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[2:06:03 PM]

>> Flannigan: It is 2:05 P.M. We are on the venture dais here for the public safety committee. I'm councilmember Jimmy Flannigan here on this committee. I have vice-chair Casar and mayor pro tem Garza as well as councilmembers kitchen, alter and tovo joining the meeting so far, although others may join as we move forward. I think councilmember Ellis is coming in right now. I've moved you in as a panelist, councilmember Ellis, so you are also with us in the meeting. So as I normally do at the beginning of these virtual meetings, just to do a quick technology check, I am the host of the meeting so I will be able to move folks in and out of the panelists. If you are a panelist you will be able to he on owe I see councilmember harper-madison as joined us, fantastic. If you are a panelist you will be able to turn on your audio and video, but if you are not a panelist you won't be able to do that. I move folks in and out of

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that space to keep the meeting somewhat manageable. Also, rather than just continually asking everyone to mute themselves, I will mute you if you're not talking and have forgotten to mute yourself. Please do not take it personally. But you will still have the ability to unmute yourself if you are a panelist. These have gone pretty well so far through that -- through process, but we'll all just kind of keep our wits about us on the technology side. Today's agenda, we are going to be covering a long list of issues related to alternative methods of community safety and emergency response. We have a packed agenda. Councilmember Casar's staff posted to the message board yesterday our hope to stick to a

pretty tight timeline. So how we'll proceed is I will bring on speakers in groups. First we'll have amber good win with justice action fund

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and we'll talk about gun violence and we'll bring on mental health response panelists, Tim black, Andy hoffmiceter and bj. And we'll have the homelessness and substance abuse, and family violence J listing names]. And we'll bring on our APD officers, Shelly port and Chris Perkins and [indiscernible]. Hopefully that will leave us time for any cleanup conversation. Every workshop that we're doing, these are not traditional committee meetings. And this is intended to be a workshop for the public, for us to hear from the folks who actually do this work in the community. In this case what we're going to try to do in these blocks is have our panelists lay out what it is they do specifically for today's conversation, the way that policing impacts the work that they do and whether or not the service they provide is compatible to,

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replacement for, part of policing both how it's been traditionally done as as we brainstorm into the future. Please try to keep it to five minutes. It does remind me back in my council race days going into a council forum and they would say solve traffic, you have one minute to explain. It's not easy to do, but we'll go as quickly as we can. And councilmembers, in each of those blocks we will do questions because these topics, while there is overlap there is enough distinction that I think we should take questions in each block. I'll preference committees from the committee members first. Let's try to keep our remarks to actual questions so that we can get through as much of this as we can today. Also it should be noted today we are not going to be solving the problem. This is again a one in a series of public safety committee workshops. We're trying to daylight different ideas, different concerns, different challenges. This is the public version of this work. There is also a working

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group happening on the city side, but this is intended to be the public facing side of it. Also many of our panelists today provide service now in the community. This conversation is not about whether or not the service provided today is good or bad. This is about coming together in this moment and thinking about how we could take this stuff on the next level, match the services being provided to the need expressed in our community, under our kind of general umbrella of reimaging or rethinking or reforming or whatever R word you want to start with about policing in the community. Hopefully this is a productive conversation. I'm going to try to get through stuff pretty quickly. I'm right at 2:10 to start at gun violence. Any community members want to start in before we start. Councilmember Casar? >>

Casar: Please look at the schedule we posted on the message board. I know the chair can keep us to it, but out of respect that all of the panelists

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that we invited can say their piece. >> Flannigan: Mayor pro tem? >> Garza: I'm curious about if this will be able to present and if not they will do it another time. In the context of like budget, if what they provide, if there's any comparisons to other cities, if what they provide, how it affects budgets and that would be helpful if they're prepared, if that would extend it beyond what we're prepared for today, I understand. >> Flannigan: I think the challenge ultimately is a time constraint, so I think this is a good opportunity to daylight information you have even if we don't have a full hour to dig into the detail. And then for councilmembers to ask questions for additional data we're not hearing about, that will hopefully provide a forum where we can then kind of go back and solicit that information. I see mayor Adler has joined the meeting as well. Okay. Let us go ahead and begin with our first speaker, amber Goodwin with the community action justice

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fund. Amber, I've brought you into the meeting would you like to test your audio? >> Hi. Can you hear me? >> Flannigan: We can. >> I can't see you all, but can you see me? >> Flannigan: Have you turned on your video? >> Just for time parameters, we have five minutes or 10 minutes to speak? >> Flannigan: We have 15 for both your initial comments and questions. >> Great. So I was prepared for about 10 minutes, but I'm going to try and cut it down so I can actually get to the councilmembers questions on some of the budgeting so I'll stop so we can talk a little about that. But mayor Adler, chair Flannigan, vice-chair Casar, public safety committee,

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thank you for inviting me to speak today. I want to talk specifically about solutions to build a policy pathway to prevent gun violence in Austin. And I really want to talk about doing this in the midst of while we're all healing in the city of Austin. I am really proud to be the mayor's appointee to the gun violence task force that was started last November. I sit with 10 other members as well. Part of what I want to discuss today we will also be providing in a report in the next couple of weeks to the city council as well. Just for context, gun violence has always been a complex resolution system in America. Shootings are up across the country and in Austin communities need new tools and new approaches to diagnose the problem. In the midst of covid-19 in the summer up ticks of gun violence and police violence, we need to listen to communities on the front lines of what we are calling a public health

epidemic on gun violence. In Austin, law enforcement and policing actually controls most of the data, the media and the policy

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responses that support a narrative that punishment many times is the goal. When in fact many of us are asking for liberation from all forms of violence that includes police violence. I join with other public health experts in believing a healing approach centered on the community is actually the answer. I will skip over a couple of things. Today I'm asking the Austin city council to become solutions oriented and implement two solutions rooted in community led practices to fund peace and no more violence. Money should be die vested from the police department and other criminal bodies to first fund a permanent office of violence prevention with a full-time director or chief community safety officer to coordinate citywide gun violence prevention and intervention services. Second, to invest in evidence-based programs designed to promote healing. Prevent further trauma and lay the groundwork for economic growth for Austin. The city of Austin has the opportunity to learn from cities like New York, Oakland, Dallas, New York

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City, Philadelphia where community based efforts have reduced gun violence and actually paid back into what taxpayers already pay every time someone is shot or survives and is shot in the city of Austin. Those will focus on prevention, intervention and healing. One of the evidence-based models I will explain very briefly is called hospital-based interventions. Gun violence claims tens of thousands of Americans lives every single year and mass killings account for less than one percent of all of the shootings that happen in America. So I want to double down on that. Many times we focus not only as policymakers, but in the news on mass shootings when they count for one percent of all the shootings that happen every single year. A majority of gun violence in Austin and particular homicides is largely concentrated in communities of color. It's not just when someone is shot and killed, but when someone survives. Research shows that in the neighborhoods with the most gun violence in America a small percentage of the people are actually inciting

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most of the violence. In cities the size of Austin, less than one half of of one percent is part of the actual crime happening. It's a very small percentage of the people. Residential segregation is one of the hall marks of structural racism, a reflection and reinforcement of the structural and institutionalized racism. Many residents of Austin continue to live in racially and economically segregated neighborhoods. For decades the police department in Austin has led to traumatizing black and brown communities and

destructive cycles racism, overpolicing and protection. They ask the questions I would ask the city council to think about. One, where did the problem of gun violence begin, and how do we prevent it from happening in the first place? The recommendations I have for you today on these two issues will require the city of Austin to invest financial resources that are already strained.

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The costs are actually negligible compared to the toll we are already paying for gun violence every single day. The first critical step and I'll accept over these quick and get to questions. The first critical step would be to establish an office of violence prevention. This it office could be very much like offices across the country. There's dozens of cities that have actual offices of violence prevention. We believe that not only on the task force, but other community members that the office should sit in association with the department of health or be a standalone office in the city with its own budget and staff. This is a strategy that many cities have used across the country. This money from the city should be diverted from the APD police budget to establish an office of prevention. The second critical step would be for evidence-based prevention strategies. I'll talk more about what those are, but I'll skip ahead to one in particular I would like to bring up today, which is a type of violence prevention that is based in hospital-based intervention and it's called

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hvips. So these are programs that have shown the efficacy of -- I can't imagine another public health violence in cities with hospital intervention. This is based in a program that was started in California in 1994 and studies showed that intervening at the hospital is much more likely to have an impact because young people find themselves at a cross road. They can either choose to retaliate or transform their traumatic experience. And so the hvip strategy really is working with public health professionals doing their job, but to talk to people at highest risk of committing violence or having violence against them and becoming victims. Case managers help clients access resources that will promote safety and recovery. And studies have shown that this form of intervention actually saves hospitals and cities money by preventing future injuries, both for the patient and anybody who that would actually

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potentially retaliate against. Mayor and city council, the systems in place for many people who look like me in Austin to prevent actions of violence are not working. We need a proactive public health approach in healing, survivorship and justice and not overpolicing. We will work with other advocates and community members you will hear from today directly every single day. The people who are closest to the pain and doing this work on the ground to better understand the exact dollar number needed. I can

tell you what we've been thinking about in terms of the task force. But this cause in preventing future gun violence must be contained. Thank you for inviting me here today and I appreciate any questions that you may have. >> Flannigan: Councilmembers? Councilmember Casar. >> Casar: Thank you, Ms. Goodwin for everything you do and on the task

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force. While Austin is a safe city compared to other cities, we know that in communities like parts of my district, there is a significant amount of harm and to where a lot of our gun violence is concentrated and our strategies so far have not prevented that gun violence. Just enforcement is not getting people the prevention that they need. So I appreciate what you've brought up. Do you have numbers on how much other cities are investing in these things, like the hospital and intervention program or the offices of violence prevention? >> Yeah. So in cities like -- it's hard to compare us to new York City so I'll a try not to do that. Most cities, I think medium size cities, spend anywhere from about 250,000, which is locally I think insignificant, but the city of Minneapolis has earmarked around 250 to $400,000 a year for some sort of office

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of violence prevention that works on gun violence. But then there are cities that spend upwards of 60, 70, 80, $100 million. I'll just say in comparison, cost comparison, every time someone is shot and killed, there's obviously a public safety cost to that, whether it's going to taxpayers or the city. So I'm happy to share and send over information on just what we know in terms of like when someone is shot and killed, how much that actually costs and what we've been asking people is to how much the prevention would cost on the front end. And some of these programs that I will send over to you all, the cost benefit of them putting in around I think a dollar per one of these violence intervention programs, the city actually gets back around 16 to $18. So it's a cost savings and it's adding in cost to the economic value of the city while promoting healing. >> Flannigan: I'm curious about what is the -- in your understanding, what is the work that an office of violence prevention does? What is the actual work that

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they do? >> Yeah. I have actually -- that was part of what I was going to say. I will just say very quickly. So a lot of what they would do is actually coordinate a lot of the data and resources that we need to understand what gun violence actually looks like in this city and work with a lot of the intervention programs that I mentioned previously. So in Milwaukee and other cities that have started offices of violence prevention when Milwaukee started theirs in their department of health they hired somebody and I can tell you sitting on the task force with really wonderful people it was really hard to try to come

up with ideas to tell the city council and mayor because it wasn't our full-time job. We were getting distracted by other things and we also, to be quite frank, we didn't have enough data and resources to actually diagnose the problem. I think the same way we would diagnose an issue of health, we want a centralized location to talk to the health department, the city council, the people working on domestic violence and other issues. So they centralize all the

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different resources and kind of -- they actually do create pretty much an ecological system of how violence needs to be treated as a disease. They have a system in new York called the New York City crisis management city. So it's a violence prevention program, but what it is doing is actually preventing vises and it's a -- crisis and it's a management system. It's not one person deciding on gun violence. They're working with all the different city agencies to make sure that everyone is on the same page about how gun violence and violence intervention can work and they're also working with cbo's and community-based organizations throughout the city to make sure they're evaluating the city resources that are being put into violence prevention and also trying to figure out other ways to be more innovative because what's been working in Oakland may not work in Austin, right? So they do a lot of evaluation to make sure that there's efficacy between what the programs are actually saying what they're doing and what they actually do. >> Flannigan: Thank you. To be fair to you, you went first and so our future

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speakers now know they don't have to say all the introductory stuff about wanting us to reallocate budgets. That's why we're here. We'll give you a few extra minutes to this topic. In order, I think councilmember kitchen you had your hand up. As a reminder, if we could keep our last few stuff to three or four months that would -- minutes, that would get us moving right along. >> I'll defer to councilmember alter. >> Flannigan: I think the mayor was next and then councilmember alter. >> Mayor Adler: I just want to thank Ms. Goodwin for the work she's doing on that task force and for her testimony here. You said there was a report that was coming out from that group here. It's real close to that, the bits and pieces of that that you have communicated to our office are all real exciting and I think the recurrent theme in it going to the chair's question is we need to start thinking about these things differently than we are and how we address them differently. And having an advocate inside the system can really be helpful. That's all, thanks.

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>> Thank you. >> Flannigan: Councilmember alter. >> Alter: Thank you. Ms. Goodwin I really appreciate all your work leading the gun violence prevention task force. We included in item 96 that we should be

considering an office of violence prevention, anticipating the work that would come out from the task force, and I'm really looking forward to this specific report and I hope we can also have some additional conversations out of this meeting as well. But I wanted to ask you to dive in a little bit more to the good models because part of charting this out it's not enough for us to say we want to have a model and have the intention of finding ways to do that. As policymakers we have to chart out how we get from here to there and the steps in between. So that we can have a system that's effective for Austin. So can you speak to the cities that you think are doing this well and the cities that we could avoid,

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you know, their models as well. >> Sure. I will say there is -- there's basically four types of models. And all of this will be in the report. And I obviously want to thank you for your leadership in helping out with a lot of the gun violence initiatives. But one model that you may all have heard of that started in Boston in the '80s and '90s is called cease-fire. I can send information on that. So that is one that heavily involves law enforcement as the first trigger to make sure that people in the community are not pre--- are not doing any more gun violence. Another model is called cure violence. And that's part of this public health ecosystem. So it was actually started by a group of physicians. And that also is a system that that's the New York City crisis management system that building this ecological model on where the gun violence started and how to prevent it, but also

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works with violence interrupters. Similar to the hospital based intervention, the cure violence mention hires people who may have the lived experience of being a person who is a former shooter or somebody from the community and they're called violence interventionists, but they're people from the community who talk the same talk and walk the same walk and really understand the communities and can go into the communities using evidence, using data and using the bare credible message and say we need to stop the violence. So when you hear from cities like New York City, parts of Chicago and San Francisco and Oakland they're using some sort of cure violence model. And I mentioned the hospital-based intervention. That's a popular model too started by physicians as well. That's the first line of defense in that basis is working and starting inside the hospitals when somebody at already been high risk because they're in the hospital system. So working with people in the hospitals to educate people. And the last one that is a little bit more innovative and it has a ton of

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information on it too is called advanced piece and that's a program disasterred off Richmond, Colorado. One of the first offices of violence prevention. Richmond, California. The mayor and Oakland and -- in

Stockton and in Richmond both have done and implemented the offices of neighborhood safety and seen dramatic reductions. When I say that I don't mean 10, 15%, I mean upwards ever 60 percent in a three year time period. I would say whatever funding mechanism it should be multi-year. We won't see results for probably the first 12 to 18 months and then you will probably -- what we've seen is there's been a dramatic dropoff in homicide reductions and harm and crime after about 12 months to 18 months. >> Alter: Thank you T I want to underscore a comment you made early on that most of the gun violence situations are not the mass shootings. And so I think this is something that the task force has looked closely at, but I just want to

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underscore that there are lots of different types of gun violence and whatever we set up is going to have to be able to target what's prevalent in Austin and use what we can to really target it to the challenges we have in Austin within the frameworks that we're allowed to as a city government to address things. And so I very much support community-based violence prevention strategy and thinking about what an office like this would look like. But for my colleagues, I also want to mention that there are also steps that we can take with respect to gun storage and public awareness that address some of the issues that are in Austin that combined with this I think are going to really help us toss address the gun violence stuff and I look forward to continuing to work with you, Ms. Goodwin on these issues. >> Flannigan: Okay. I think we really have to move along. Our next topic is going to be one where there's a lot of great. Thank you for your brief time this morning. Hope you don't mind if we

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tap into you to participate again in the future. I'm also very interested in the hospital-based interventions because, frankly, I'm wondering if central health might be participating in a budget sense or Travis county participating in a budget sense. Councilmember tovo, were you -- >> Tovo: Just a super quick thank you. You had talked about forwarding on some information and I would ask if you would forward it on to all of us. I think the examples are really exciting and I like to review it as well. >> I'll make sure that everything that the task force has done, myself and 10 other folks, is in there and we've had a couple of separate pieces that will also put in there and make sure that it gets to everybody. >> Flannigan: We'll make sure that any information sent to any of the committee members gets back to the clerk for distribution to the whole council. Thank you so much. Our next topic, mental health response. I'm going to bring in

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Mr. Black, and Mr. Hoffmiser, if I can find them in my list. And bj. There we go. Okay. Mental health response. Mr. Black, your program has been on everybody's lips over the last month. So I am very interested to hear what you have to say. Why don't you go ahead and start and then I'll have our other two speakers go. >> Absolutely. I'll try to be as brief as possible. I want to start off by thanking the council for giving me an opportunity to talk about the paramos a little bit today. Andy, I owe you a phone call and Greg, it's good to see you again. So rather than going into a lot of detail about kind of the program that 40,000-foot view, there were a few things that I wanted to highlight about our behavioral health first responder program. The first of those is just a recognition of where we fall in that full scope of public safety services in our

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community. Kahoots is responding to 70% of the generated calls that come through the communication center. It's not just 911 or non-emergency. That's really kind of looking at the entire call volume coming through that colostomy, being answered by the call takers. Our team responds to all the calls on the priority channels as the rest of the community so we hear every call that officers go out on so it gives us the opportunity to respond alongside or instead of the officers that haven't made it to our units. That also means as unarmed civilian first responders we have that direct line of communication to police in those rare circumstances where things do escalate really beyond our ability to maintain a safe scene. You know, just on our own. To that extent about an eighth of our calls do involve law enforcement in some capacity. The majority of those calls are situations where based on preliminary call details. A call was initiated for police, they show up on scene and recognize as soon as they get there that needs

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that behavioral health first response instead. Last calendar year we responded to 24,000 calls for service in our metro area. And only had 150 situations that escalated to the point where we needed support from police to maintain a physically safe environment. So that's 150 code three lights and sirens cover requests out of 24,000 responded for our metro area last year. >> Casar: And Tim, sorry to interrupt you. Because we're all moving so fast, we didn't get to -- because we're live on TV, some folks are like, wow, this is incredible. How can I support this program? Tim is in from out of town and from out of state. >> Casar: So we're trying to figure out how we can expand your kind of molds here in Austin. So -- your model here in Austin. Thank you. On screen it's hard for people to know you're far away. >> Yes, I am coming to you from Eugene, Oregon. That's where the kahoots program has been based since our inception in 1989. As I was saying, about half

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of our calls based on that initial presenting information would be categorized as behavioral health response. But what we have seen is that all of our calls in one way or the other are about social determine unanimous of health, whether it's related to poverty, access to traditional medical and behavioral health resources, if it's mistrust of public institutions, even just something as simple as the ability to get from point O to point B, these are all different circumstances that kahoots is able to address and by being able to come in and address those special determinants of health, alongside addiction, housing, behavioral and physical health, we're really able to provide an opportunity for folks to be diverted from the emergency room or from contact with law enforcement and ultimately jail time simply by being there to really address those needs before they escalate to the point that you see a situation that would require police involvement directly. When we're looking at the successes of our program, what we're looking at isn't

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necessarily, you know, how many demographics boxes can we check? It's really looking at what is your impact in the community. Around the best ways that we can measure our impact are in the diversions from the hospital, from the criminal legal system and our connections to those other services. So when we look at the homeless count in our community, out of that volume of folks who are considered unhoused or housing insecure, how many connections are we able to make through those other resources so we can empower somebody to really get shelter, get employment, whatever it means to them to feel stable and in a place where they can move forward with their own lives. And finally, just to really kind of highlight the value of this program, you know, we are not responding just to behavioral health calls. Like I said, those do make up the bulk of our responses, but there are so many other things that we do beyond just responding for folks who are experiencing

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suicidal ideation or other health crisis. We're responding for all of those requests for housing crisis, for folks who are really confused and overwhelmed by the list of resources that they might have been given when they went to sign up for food stamps and how do you call 50 places when you're not even really sure whether you will be able to make it to your appointment tomorrow with your therapist. We provide wellness checks. We are the first responder for every reported subject down call in our community. And what that means is anybody who is not up and walking around. Folks sleeping in the park. Someone who is intoxicated and rolled up in a doorway downtown. Those are what we handle in our community. I'll wrap up by highlighting the budget. The kahoots operating budget, including communications expenses, comes out to about $2.2 million a year. We estimate that we are saving our metro area upwards of 20 to $25 million a year.

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So that's almost a 10 to 1 return on investment based on the cost of operating our program versus what we're able to save our community in diversions from the jail and from the emergency rooms alone. And I'll keep it brief because I'm sure there are lots of other questions and I don't want to end up answering some of these questions ahead of time. So I'd love to hear what other folks have to say. >> Flannigan: We have two more speakers and we'll go real quick and then take questions. Ms. Wagner, would you like to cover your part? Get yourself unmuted. There you go. >> Does that work? Awesome. All right. Thank you guys for the opportunity to visit with you again today. As you know, in 2019, the meadows mental health policy institute undertook an expansive analysis of Austin's first response systems to mental health calls for service. And in doing so kahoots out of Oregon was one of the programs that we reviewed

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and all of the elements there. But we also took a look at project Ethan out of Houston, the multi-disciplinary team designs that you will find in Dallas, Abilene, Tulsa and Oklahoma. We looked at San Antonio, Houston and others. And the recommendations in our report were actually a combination of the best elements of each of these programs that had success anchored to them, but that were also uniquely developed to fit kind of what is the novel nature of the city of Austin. We looked at everything from the infrastructure with the city such as demographics and socioeconomics of certain neighborhoods, the travel around time. Some of your programs such as community court systems. Your community paramedic systems. The arch, the unique relationships that exist between integral care, the fire department and the police department. And actually with that resulted in was a unique program design that was

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specifically fitted for Austin. And it is unique. It does have a medical forward response that is intended. It's not a law enforcement response at all. And since it is so unique there's not a lot of data elements that can be tied to directly to this program design, however, there is a program very similar to it. In Texas that takes into account the status, the permissive and prohibitive status in Texas that are associated with both medic and law enforcement services. So let me just provide you a few of those data elements. And then go on to answer any questions that you may have about the design. The design that the meadows and health policy institute report includes, like I said, is a medically forward project design. It starts in dispatch with clinical triage, which is critical in any kind of diversion or alternative response to mental health calls for service because you have to know from the moment of that phone call what is the best and safest agency to send. But then it continues

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through a community health paramedic approach partnered with law enforcement and social services. And again that law enforcement partnership is specific to status that are here in Texas. But if we look at the design very similar, and we're going to look at the Dallas design, because it provides us with an inner city comparison. The Dallas project that is similar, but not exact to the Austin design only operates in one zip code in Dallas. And that zip code is very comparative to its neighboring project patrol districts. When we look that since it's launch there have been 1,083 officer hours diverted away from mental health calls for service and the program is only a year and a half years old. That's a savings of about $50,000 a month in total. But again, it's 1,083 hours that police officers have not responded to a mental health call for service. And at a time in Austin where the city was seeing a 30% increase in law enforcement emergency detentions at psychiatric emergency rooms across the city, the project area saw a

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25% decrease in those very same psychiatric emergency presentations. Interestingly, because the project does address homelessness, housing vulnerability, substance abuse, quality of life and mental health calls for service, while Dallas was seeing an uptick in crime, the project area, which is in south central Dallas, which is a very heavy crime area in Dallas, this particular project area was the only area in the city that saw a decrease in quality of life citations and arrests as well as quality of life encounters with law enforcement. The rest of the neighboring patrol districts saw upwards of a 33% in those contracts while this area was seeing a decrease. So when we take the trend and look at it across a life-span of a year, an implementation of a project very similar to the design that Austin has now would result in 18 full-time equivalent police resources or ftes being diverted away from mental health calls for service and an

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average savings of $1.9 million per year with high fidelity implementation. We look at that raise said in comparison to Dallas because there's not another program design like the one that you have for Austin and that's because there's not another city like Austin. The infrastructure, the highway design, the dynamics of your neighborhoods, the culturally relevant areas that are within your city that require very specific response. We couldn't just take a program and plop it down in Austin and expect it to work. We wanted to design it around those things that make Austin unique. But with a high fidelity implementation of the Austin plan we would expect to see full diversion of mental health calls without a public safety element away from law enforcement to the specialized team or to other more appropriate services, as well as similar fiscal returns that we've seen in Dallas. I want to wrap up, but I want to also give a quick support to something that I heard from our first speaker when she was speaking about

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ogu neighborhood plans and cure violence and a criminallologist, those are some of the highest return gun violence reduction programs that you can lay your hands on. >> Flannigan: Thank you, Ms. Wagner. Mr. Hoffmiser, I see your video is on. If you're there and can hit the high notes from ems? Or we'll take questions for Mr. Black and Ms. Wagner. Members, any questions? All right, councilmember kitchen, why don't you start us off? >> Kitchen: I'd just invite Mr. Hoffmiser or Andy if he is here to speak up. So -- okay, so thank you. Thank you both. This is very helpful. So my question, I know we only have a few minutes, is so bj, as you mentioned we had the meadows report and I know the meadows report also took advantage of learning from the kahoots program as

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well as the other programs that you mentioned. So can you just tell us since we have -- we initiated our program last year and so we've -- we've only been doing it for a short amount of time, can you just hit the top three things that you think are the most important things for us to accomplish. As part of this program to fully effectuate the program? >> Absolutely. First fidelity. If fidelity to the model design is very important, with the Austin plan because it was designed around the specifics of your city and your infrastructure and those things that make Austin unique, but the most important program element would be you've got to have triage, clinical triage in your dispatch. When when we looked at the information from the previous six years, every single unfortunate encounter with APD was when that officer didn't know what kind of call he was going to. When you can triage that and

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dispatch and send the most appropriate resources or most informed resources, your chances of a poor outcome are drastically reduced or eliminated. If you had to pick one area, you've got to have that clinical knowledge in triage and dispatch. The second area would be using telemedicine to the best of your advantage, Austin is a difficult city. And I love Austin, it's a difficult city to drive around, so it's a difficult city to get resources from point a to point B. But when you have telehealth and it's the right kind of call, that clinical expertise is on site immediately. >> Kitchen: Thank you. I see Andy is available. >> Flannigan: Would you like to add your part? >> Sure. Everybody can hear me okay? All right. Very good. Yeah, so here in Austin we partnered with integral care in their expanded mobile

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crisis outreach team back in 2013, and the way we currently operate is that a 911 call comes in, and if it is routed to ems, our dispatcher or our call takers begin a standardized triage approach which is -- it's -- it's a internationally accredited model and it helps us determine what kind of call we're responding to, what resources we should send and how quickly we should send them. And then it also helps prioritize. So we're sending the closest appropriate resource as quickly as possible. Right now when somebody calls in and they are experiencing a mental health crisis or they are seeking out mental health assistance at least from ems, what we do is we go through the standard set of questions, and what it does it will

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categorize it as a psychiatric emergency and there are different levels of priority to that. Everybody from somebody who may actively have a knife threatening suicide to someone who is called as they don't know who else to call and they are just seeking stance but there's no danger or weapons involved. That call is prioritized and then it's dispatched to our ambulance crews, and the closest available ambulance is sent. Now, at that point when it falls into a certain category and those priorities are set so think of it in terms of highest priority, prior to 1, would be where there's an imminent threat of some kind of danger or threat to life or limb. Then priority 5 would be the one that based on the way the questions were answered there doesn't appear to be any immediate threat and it doesn't require lights and sirens and the same response something more critical would. For those calls, we

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automatically have -- we actually have emcot built into our situation so they are automatically dispatched. We do that for a you mean can of reasons. The priority 5 calls, there's no indication of violence or weapons involved and we don't want to have emcot started and just say they happen to be around the corner and happen to show up to a call there's any kind of violence or threat. Emcot is automatically dispatched. We provided them radios and they have awry channel to communicate with our dispatch correctly. They confirm response and respond along with the ambulance crew. The way it's set up, they are not partnered with a paramedic in the same vehicle that respond to the call. They may be off doing another call, maybe they will be helping with a -- some sort of a follow-up or response with the police department, but they confirm their response and then they arrive on scene.

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Our medics will just confirm that there's no medical necessity to transport to the emergency room. We'll want to make sure, and we have a set criteria for that and basically we just want to make sure that somebody hasn't ingested something or tried to cut themselves to a point where it requires sutures. But if the patient meets those -- meet those criterion, we provide emcot as an option for that particular

patient. The patient does have the ability to refuse. The patient can refuse emcot and can still request transport to the emergency room. And so that's part of the equation there. The other part of that is that when police -- if the patient requires an immediate detention because of an immediate threat to life or some sort of deterioration in their mental condition, then only the police department, only peace officers in the state of Texas and certain judges

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and court staff have the about it to implement an emergency detention, one that can be implemented right now before the patient can officially leave the scene. So that's an important difference between some programs and especially the -- what we're doing here in Austin. There are from the outset at the beginning of the call, we also have to take into account what kind of indicators there are for things like violence or weapons. That's one of the questions this standardized in that particular set of questions for that call type is that is there violence or are there weapons available or involved. And if there are, we automatically start with the police department. The police department may be the initial agency that receives this call, then they may request us for that as well. So that's kind of that in a nutshell. Over the last few months, we've also started

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prioritizing paramedics to respond to those calls and we'll send the closest paramedic that's available to those calls as a way to start implementing the model similar to what they've done in Dallas. The only difference we just don't have the clinician sitting in the car with us, but we are moving in that direction. >> Flannigan: Councilmember Casar. >> Casar: So take advantage of the fact we've got Tim here except he just disappeared off the screen. Is he still here? >> I'm here. >> Casar: We've got Tim here and experts locally. So -- and bj, if you could keep it really brief as far as highlighting what some of the anticipated program differences might be between here and what's in Eugene. We already heard about the difference in emergency detentions, but one, what other differences are there, and two, what would it

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take -- do we anticipate we could get to that level of scale of something like 17% of the 911 calls. So I would like to hear that really briefly and then give Tim a chance to say, well, those difference might make sense or we tried some of those things especially as relates to telemedicine. There's still some debate about what we should or shouldn't do there. I think we want to learn from each other and know what the actual differences are. >> Sure. >> Sure, I'll take a few minutes to jump in first. Somebody wave at me if I'm talking on mute. But I think one of the first things is cahoots is an amazing program, but

you've seen, Oregon is a town of less than 200,000 people, whereas Austin is a major meth area and growing faster every day. When you think about the program design for Austin, it has to be the grand scale

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that Austin is. You have to have the best use of technology. And so incorporating telehealth services from the moment of 911 call to an end's guys out there in an ambulance to a police car having telehealth in a police car with over one million people and growing, you cannot hire yourself enough people to address this problem. So you have to use technology to the greatest extent that you can. We also have to consider that Austin is unique in its demographics, and so you want to make sure that you target your response to the areas why, for instance, when we looked at mental health calls for service across the city of Austin in a three-year period, there are three areas that stand out, east Austin east of 183 off Loyola lane, north Austin south of 183 and south Austin south of 290. So you can't really have a citywide response unless you are going to dedicate, you

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know, $10 million or more to it that's going to blanket the city. So you need to make sure you design a system that can respond to your city citywide but also focus those specific and valuable resources on the areas of most need. And so that's where you would need a hybrid of telehealth and in-person response that would pair a paramedic with a social officer with certain areas of the city, but scale that response down to telehealth and medics for telehealth and law enforcement without such a high call volume. The design for Austin you currently have takes into account the scale, the size, the demographics and the specific Texas statutes that require a police officer to do an emergency detention, and I think those are the things that are really most different than what you see in Eugene. Eugene is a fantastic program, but Austin is a large metropolitan area. >> Flannigan: Mr. Black, would you like to add anything?

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>> I think with the city a size of Austin there is going to be a need for telehealth for more robust mobile crisis response. One of the things we've experienced in Eugene is that many of the patients that we're working with are not in a place where they have reliable access to the means for telemedicine without some sort of responders coming out to them. Furthermore, there's a lot of our intervention that's informed by the physical environment. You know, where we're having that intervention. Particularly if somebody is unhoused, we are able to facilitate a lot more meaningful interaction with somebody because we're right there with them in that immediate Vern to allows to empathize with the weather

but having that face to face interaction particularly now where social action is very limited. Many of the folks we're working with are oppressed and being shunned even more

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with the level of concern in our community and that's one place telemedicine is going to, you know, potentially impose a barrier. As we look at what Austin needs, I think there is going to be a hybrid, but there really does need to be an eye towards having a new type of first responder that is trained specifically to respond to behavioral health issues so we're not in situations where we have a co-response where somebody in crisis is forced to have interaction with an unformed and armed officer. There are going to be situations where someone has even experienced adversity with ems. Maybe not in Austin, but maybe when they lived in Oklahoma they got roughed up by paramedics on an overdose call. We need to be mindful of the past interactions that various communities have had with traditional public safety resources as we look at this combination of new first responders and telemedicine access. But bj is right, Eugene is a completely different city,

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different demographics, different means of getting around town than Austin so we're going to have to look at something nuanced and oriented around the needs of Austin. Cahoots is not a cookie cutter program that can be plopped in Austin. There's lesson from 31 years, but with an eye towards developing something that is really designed specifically to meet Austin's needs. >> Flannigan: Mayor pro tem? >> Garza: Just for clarification, Ms. Wideman, were you saying that it would have to be hybrid or -- you said something about or it would cost like $10 million. But I may have misunderstood. What was the $10 million part? >> The program that is currently designed for Austin is exactly what Tim was describing. It is a program that's designed specifically to immediate Austin's needs taking into account your

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infrastructure, the difficulty in traveling around the city, the nuances of where your calls happen and the cultural relevance of those neighborhoods. Also taking into account the type of responder whether it's medic, whether it's law enforcement, whether it's social worker with telemedicine. So that program that is currently designed is exactly what he was describing. It takes into account lessons learned and what it would look like in Austin. But to have something that required an in-person response or a dual co-responder that was medic and social worker or social worker with backup, in person all the time would be extraordinarily expensive. If you went to an in-person response, that could be up to $10 million or

more depending on the class of the person you hired. The hybrid experience is an Austin plan now is priced out much less than that and also has potential for returning in its first year

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alone $2 million. >> Flannigan: I know, Mr. Black, I think you have to leave at 3:00. Thank you for joining us remotely. The one up side of these remote meetings it's much easier to P in folks who have different experiences so thank you for sex spending time with us. >> Thank you. >> Flannigan: Do you have anything else, mayor pro tem? >> Garza: It wasn't a question, just to make the point, this sounds weird, but $10 million is not a lot especially when compared to the -- our budget as a whole. I'd love to hear what speakers think is -- what would be the system if money wasn't an issue. I don't want the -- because 10 million, you know, three months ago would have been unimaginable maybe and I think we're in a different time. >> Flannigan: And I think it's all relative to what

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percent of calls do we think we're diverting for that service. If it's a large percentage, obviously the math is different. Councilmember kitchen. >> Kitchen: I just wanted to say I'll reach out to Tim. I'm very interested in what he's doing specifically for homeless population. We have a host team here and I'm curious about how those relate so I'll reach out to him on that. I agree with the mayor pro tem the dollars are not -- not what we want to look at first as a limiting factor. We want the design. But I think I hear bj saying that that's the way she included the design in the meadows program. But we can think about that. And then finally, I would just say we are all learning how useful video can be. Telehealth and telemedicine has been underutilized for years throughout the country. And it is an amazing resource when you have physical -- I mean it just takes time to get from one

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space to another space in a big city like ours. And telehealth is a technology tool that -- that we really need to maximize. It doesn't mean it works in all circumstances, that we need to use it in all circumstances, but it's a huge resource and we're finding that out now as part of covid and other situations. I'm sorry, do you want me to stop? >> Flannigan: I do. Thanks, councilmember kitchen. You and I have had long conversations about that. I want to move on, it's a great pivot into our homelessness and substance abuse situation. Thank you so much for joining our meeting today. I am going to bring up -- we've got mamolika and Kate and joy coming into the meeting.

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>> While we make that transition -- we just lost her. Never mind. >> Flannigan: I was moving them out. We're transitioning. But if you want to daylight something. >> Harper-madison: I do. I just wanted to know as we're gathering information, one of the things I would like to extract is what do those comparable municipalities have in the way of resources for mental health treatment. I know it's pretty dismal in the city of Austin. So if we're talking about diversion of resources from the criminal justice system into a different more appropriate system, I would just like to know what resources they have on the treatment end. Where are they taking people. And other cities that have had greater success that just have more resources in that department. >> Flannigan: That's a great point. We all know the statistics of Travis county being the largest mental health provider. That's not going to be a good system for us. >> Harper-madison: It gives us an opportunity to daylight that part of -- as we're speaking of broken

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systems. >> Flannigan: Ms. Mamolika. I have a presentation sent to me, but it talks about covid and I don't know if that's the presentation you are intending to use. >> Sure, yeah, good afternoon, councilmembers. It is part of a presentation to use today. The title slide probably is a little misguided, but happy to walk through it. I think Kate with the Texas production lines were going to kick us off in sort of a joint discussion here. >> Flannigan: All right. So I am -- >> We're going to have you go first so we can tie it all up. >> Great. Happy to do it. >> Flannigan: Are you seeing the screen? >> I'm starting to. >> Flannigan: Did it come

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up? >> Not for me. I can work of a -- work off my slides. >> Flannigan: It was hard in the last meeting we were in too. >> I'll set the stage a little bit. Good afternoon, everyone. I just want to make sure you all know in talking with joy and Kate, we thought it would be more impactful to have this discussion together as harm reduction practices and housing first philosophy for people experiencing homelessness, especially chronic homelessness as shown being the most effective way to end somebody's homelessness. And so I think that we, you know, in discussion and conjunction we saw the schedule come out and that was released for this meeting, thought it would be best if we got together and did our presentations and discussions with you all.

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And a history of working with the harm reduce alliance, joy, executive director, is on echoes board of director so I wanted to mention that ahead of the discussion. >> And I'm happy to be part of this discussion. Representing both agencies. >> Flannigan: Are you all seeing the slides? >> No. >> Flannigan: Well, our I.T. Staff is going to have to look at how that works because it didn't work in the last meeting. >> Sure, and I'm happy to -- I put together a presentation because I thought it would be important for you all to see some of the work that's happening now currently associated with housing high-risk individuals per covid purposes but also the folks that -- there it is.

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That's the perfect slide to start on right there. Thank you, councilmember. When we talk about where we need funding in our community now, and we've all had this conversation before, you can need services for people experiencing homelessness and housing is a place that can be very impactful when looking at the budget and shifting funds around. We have said and stated many times that we think it is very cost efficient to house people experiencing homelessness with appropriate wrap-around services, and we don't believe that the current, you know, model for interacting with people experiencing homelessness, like policing is not a way as we've all added in this discussion to be experiencing homelessness. We think the most effective and impactful way is through housing and we're going to

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talk about that and costs associated with that today. The first couple slides, the first slide here talks about the current targeted population for housing assistance. And I wanted to use the covid population for a couple reasons. One is that typically if you are at high risk for covid, you are one of the most vulnerable people in our community from a health care perspective, substance use perspective and mental health perspective. We're going to go over that more today. This is the criteria in terms of how we're prioritizing the resources needed today. >> Flannigan: I don't want to push you too much, but you don't have to tell everyone the full story of homelessness in our community. We'll try to stay focused the public safety impacts and there's limited time. >> Got it. Well, right now we've got our identified through the covid cohort is we have 971 folks who are high risk

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based on the CDC guidelines for having a negative impact on if they were to get covid, potentially fatal impact. These are where they are currently reside,. Some of them are in our emergency shelter system at the arch and some are unsheltered. The next slide would be great. Sorry, week move to the next slide, councilmember Flannigan. >> Casar: It looks like maybe councilmember Flannigan's internet is getting

interrupted. >> So the other -- the next slide that would be presented talks specifically about race, ethnicity and

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what we all know most recent point in time count shows 36% of the folks experiencing unsheltered homelessness in our community are black, African-American. We have high proportions of black African-American people represented in our systems overall here. And we believe that -- that targeting funds for people experiencing homelessness can impact that and be -- have a racial equity impact. All of the funding and housing resources I want to make sure we tie in that the services associated with these resources, for permanent supportive housing and rapid rehousing need to be administered using a harm reduction approach. And what that means is meeting the people where they are at with their substance use and sharing that regardless of where you are at with substance use, and joy and Kate will go into this more.

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We are going to provide housing first before we require you to address those issues, the substance use or mental health issues that you may have. Some of these slides, there are costs associated with them. For the rehousing strategy, and we're -- sort of looking at total costs for folks whether you are in the pro lodges or not of upwards of about $24.5 million to ensure that we can house the high-risk folks for covid over the next year. Again, without the slides, it's difficult to walk through and show you various benchmarks, but I'm sure the slides can be distributed and I'm happy to answer any questions associated with the presentation. But we need essentially for permanent supportive housing, we had 357 people fall into the bucket of need

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for permanent supportive housing at a total cost of $10.3 million. And we had about 614 households that fell on the intervention scale for rapid rehousing for a total cost of $14.3 million. The -- another thing I think worth mentioning is that we all ran an analysis on what the investment would need to be associated with the pro lodge residence and we have those gaps too because I know that's something council has been focused on. And I think the -- ultimately -- I'll let joy and Kate take over, about out the most effective strategy for engaging this population of people experiencing homelessness, chronic homelessness that's existing in our community, of which we have a really high percentage of folks experiencing chronic homelessness in our system,

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about 48%, which is a much higher number than other communities of our size. And that's I think because we don't have really well developed harm reduction strategies for engaging that population. So I will -- we can go through the slides. I see councilmember Flannigan is back, but I'll let joy and Kate speak to their work. >> Flannigan: While you jump in, my web X platform crashed so I'm getting my stuff put back together. >> Thank you for the opportunity to have a conversation with you all today about harm reduction. So I just want to give a brief definition of harm reduction. And harm reduction is evidence based model that aims at reducing drug-related harm experienced by individuals and communities.

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It's also a social justice movement built on the belief that people that use drugs be treated with dignity and they have the right if that's what their choice is to use drugs, that they should not be penalized from any other services because they are currently using. Some examples of harm reduction are permanent housing with volunteer services, as Matt was talking. Housing first is very [inaudible] That is used across the country. And it's low barrier and we understand that you are targeting the most chronically homeless people with substance use issues and mental health and they are not successful in high barrier programs. Medicated assisted treatment is another harm reduction strategy. And for all of us bike

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helmets and seat belts. So harm reduction is really a practical approach to a complicated situation. Why harm reduction? It decreases overdoses. HIV, hepatitis C, infections decrease. Fewer interactions with the criminal legal system. Fewer E.R. Visits. Most people are housed and stay housed. Most people connect to treatment, and more people find a path to recovery. Our biggest request is that people want to be connected to recovery services. So we were formed in 19 -- in -- 2019 as a mobile out reach with [inaudible] Funding from the state. Currently we offer mobile

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outreach services that connect people. We connect with people living in encampments who are injecting drugs. We provide them with supplies and we connect them with recovery coaching and treatment if that's what they want. We've been able to set aside in our budget five weeks of paid treatment for medicaid assisted treatment and then work with the client and had been working with integral care for sustainable funding, but that funding is no longer available [inaudible]. The drop-in

center, we offer bathroom, snacks, access to a recovery coach, a place to chill. We haven't been able to be open because of covid, but we do have people that come by and get supplies from us.

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And harm reduction is really for the folks that we all know are very committed to continuing to use. So we're not talking about the people that are -- like ready for recovery. We're talking about people that are in pre-contemplation stage in the continuum of the recovery role. So we believe harm reduction is part of the continuum of care for recovery. So Kate? >> Thanks, joy. I'm Kate, I'm the operations and policy director. I work with joy. And I'll keep my comments brief, I know we're running behind, but there are questions that have come up even when thinking about 911 mental health crises calls. So I think about a law enforcement response to substance use.

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We know it fails in a number of ways. We -- I think y'all are aware that, you know, when looking at our felony possession of a controlled substance less than a gram arrests in Travis county, we're looking at 29% are for black individuals and about half of them originate from a traffic stop. But also I want you to know that about 5% of those originate from a behavioral health crisis call or overdose and in the case of overdoses, I'm sure you are aware APD has recently refused a donation of naloxone. We also know that officers unfortunately will watch someone being revived usually by ems, either take them to the hospital or follow them to the hospital and once they've been released, they arrest them on possession charges. So we have a lot of practices in our community

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that cause harm when we're thinking about substance use, which we understand is a public health issue. Another factor is the sobering center. And I want to also tie it into our -- because emcot has been brought in, I want to tie it in. Law enforcement has a couple of diversion programs they can utilize. One of them being our emcot team and one being our sobering center. You probably are more intimately aware of some of the challenges, but I want you to understand that hundreds of people with mental health diagnosis are arrested for criminal trespass every year. 100% are eligible for emcot. Law enforcement does not utilize emcot. So they have a diversion program at their disposal, they are not using it. Same for the sobering center. We understand that if somebody has a small amount

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of drugs on them and are intoxicated, the sobering center would accept somebody who is intoxicated using a illicit substance, but APD is not utilizing the sobering center and they could. Our organization office there brief before we moved into our drop-in center. And so we see an opportunity here to partner with the sobering center, with echo. Our program is now up and running after its first year of completion where we can look at the intersections of homelessness, mental health and substance use using harm reduction model to just really move that out of the realm of law enforcement response altogether. And think about strategies and solutions that exist in other cities. And so with that in mind, I think a couple programs that I wanted to make sure we talked about, one obviously the housing first model you

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are familiar with. Another is direct access to housing. And I think Matt and joy have firsthand experience with those programs in the bay area. But I think as a way to talk about mental health, I think councilmember kitchen asked a question about resources. I think we do have a lack of resources when it comes to access to care, but we also -- I mean housing is just so critical. In a community that's increasingly unaffordable, I think we have to be pairing services with housing. And I think there are so many barriers for folks to access even these housing programs, even substance use disorder treatment programs, right? There's so many barriers, we need harm reduction as that bridge, as joy was saying. Really working with folks who are not going to engage, they haven't engaged and they probably had bad experiences. Maybe they did ask for help

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and were told you have a criminal history so we're not going to allow you you in this program. Or if you are high when you show up, we're going to kick you out immediately. There's so many barriers we erect. In moving towards a public health approach to behavioral health issues such as substance use and mental health crises, an expansion of harm reduction programs in cooperation with echo and [inaudible]. What harm reduction programs look like in other cities include extended hour drop-in centers that not only have for peer, staff, they have medical staff, they can do wound care, people can take showers and do laundry. Then on demand access to methadone, our meddation assisted treatment. Somebody could be at the sobering center and get inducted or they could come into our drop-in center since they are operating as a 24-hour clinic. Right now integral care's

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second street methadone clinic has a six to nine-month waiting list which for somebody trying to get off opiates could be a death sentence. We also can look at recovery coaching and connection to housing for somebody pre-released from incarceration. Something other harm reduction programs do. They act as sort of a reentry peer support coordinator or health navigator. Then I think we need to talk about pre-arrest deflection and using the sobering center to bring down those arrests on possession of less than a gram for somebody who is intoxicated. So those are all the things we would like to be able to provide to this community, and I'll end there so we have time for questions. >> Flannigan: And, of course, we're really tight on time, but I want to thank all three of you. We'll take some questions. I think there's a lot of interesting concepts here as we think about alternatives to enforcement response.

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I could hear as you all were talking how we need to be engaging the county in these conversations as well because it seems like a lot of the financial savings to taxpayers might actually happen on the county side with relationship to jail. We may not see those cost savings because we're going to be shifting resources to provide services in new ways, but there mate be savings on the county -- there may be savings on the county side. Questions? Councilmember Casar. >> Casar: We have the budget coming out on Monday. I'm sure you all will email the council what these things would cost as far as reallocating funds from enforcement strategies to prevention and harm reduction strategies. But can you give us quickly top line some costs for what it takes to house people, what it takes to get people the treatment and care they need at the scale you think we should do. >> Yeah, so I can take the first stab at this. Just looking at the fir

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cohort of folks, there are 971 folks high risk, unsheltered or in the pro lodges. We know our point in time count that a self-report count we see anywhere between 60 and 65% of the folks reporting a substance use disorder that are experiencing unsheltered homelessness. We've got to house those, you know, 971 folks, about a $25 million annual cost associated with that. 25.6. That's to bring housing and supportive services like the harm reduction services Kate and joy mentioned in housing. And to get folks engaged off the street, engaged with our, you know, with our harm reduction strategies and into housing. So there are other costs associated with some of the diversion tactics that joy mentioned and Kate mentioned that they can speak to, but that's the budget associated with housing and providing harm reduction support

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services to that population. >> Casar: And that's 25 million more increase above and beyond what we do now. >> Yes, and it's also above and beyond the C.A.R.E.S. Act funding that came into the -- >> Casar: That's 25 million in recurring funds per year. >> Right. >> So just to high level budget numbers, thinking through some of the things that I listed towards the end of my comments about expanding access and hours at our drop-in center, we would also want to expand our mobile outreach services. That's a big element of how we connect with people. Almost everybody we meet through going to encampments and building relationships, so we want to be able to amp those up. So we're looking at to be able to expand our drop-in center and expand access to

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methadone so there's no waiting list for somebody who wants to get on treatment. We're looking at about a million dollars. >> Flannigan: Councilmember kitchen. >> Kitchen: Thank you. So Matt, what would be the additional cost for permanent supportive housing, in other words, the dollars it takes on top of the 25 million to help people move from housing to permanent housing? Or are you including that in your estimate of 25 million? >> The $25 million will house the 971 folks we identified as being the highest risk from a vulnerability -- health care vulnerability standpoint. That's not the total number to get to -- obviously to get towards functional zero or the actual need based on some of the modeling we've done. That number is close to $126 million.

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So does that answer your question, councilmember kitchen? >> Kitchen: So the 25 million you are including is not for shelter housing, it's it's for permanent housing. >> Correct. >> Kitchen: All the services it takes to help someone get to permanent housing. Whether social services, mental health services, harm reduction services or first month rent. >> Yes. >> Kitchen: Is what you are accounting for. >> For those 971 individuals, it's that amount of money for those folks, that's correct. >> Kitchen: Okay. Yeah. Okay. This is great. Thank you very much. I can talk to you off line, but I'd also like to delve into what it would take to get us to functional zero. >> I would love to talk about that. >> Flannigan: I think there still is some good conversation to be had about how standing up some of these additional services can help us reallocate where we're currently sending

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policing resources because we're only looking at enforcement actions versus compliance or protection or supportive actions. That's just obviously the whole works because we can't invent money out of nothing. >> One quick point. One of the things I want to harp on, the harm reduction services Kate and joy are talking about, if we're able to get those types of services into our community, ultimately we'll be

driving down the cost of housing long-term. Those are the type of resources we can divert people out of the system more quickly. It's the tourniquet on the hose of folks coming into the system. Both of these because we failed on -- for folks for so long, both of these investments are needed, but we need to also be considerate of how we can start the folks through harm reduction practices on an outreach level out of our system more quickly. I want to make sure we highlight that part of the

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discussion there, much needed resources as well. >> Thank you. >> Flannigan: Mayor, did you have something? >> Mayor Adler: Just wanted to indicate support. I was enjoying the conversation. >> Thanks, mayor. >> Flannigan: Thank you so much. Thank you for your participation today. We need to get into our family violence conversation so I'm going to bring in -- let's see if we have everybody here. Kelly white and Melinda, there she is, and Courtney. >> Good afternoon. >> Flannigan: Hello, hello. >> Hi. >> Flannigan: We can see and hear you loud and clear. Ms. White, do you want to test your audio?

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Try one more time. There we go. >> Now I'm unmuted? >> Flannigan: Yeah, sound great. Miss Cantu, are you here? >> I'm hear. Can you see me? >> Flannigan: We can hear you, your video is not coming in. You all -- great, we can see you. You all have been following along so we don't have to give you what we want to hear from you. Ms. White, Ms. Can too, why don't you start and we'll have Ms. Santana. >> Thank you for having me. I'm going to give an overview and turn it over to Melinda who is our vice president of housing and support services. As stated up front this is a huge issue. Family violence is enormous. The needs are enormous and there's plenty of room for multiple strategies and I think you are going to hear about multiple strategies today. Safe also sent you an overview of safe's position

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on police and public safety in Austin, the city of Austin. And that short paper will provide a lot more detail on safe's position regarding our beliefs and recommendations for how the city of Austin might consider moving forward in thinking about public safety through the lens creating peaceful, safe and equitable communities. It strikes me as you talk about this that we already do massive alternatives to law enforcement and the reality is we need more. What we have is so horribly, horribly -- it's just not enough. Law enforcement and child protective services confirm over 11,000 cases a year of family violence in Austin. The actual number is much higher because abuse lives in the shadows and secrecy. Safe served 6,628 clients in 2019. 49% of which were hispanic Latino, 22% white, 16% Barack Obama African-American, 2% Asian.

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We also provide services specifically for people who are deaf and people with disabilities and we are part of the city of austin/travis county family violence high risk team. More than 50% of direct service staff are bilingual and our senior leadership team and board are representatives of the diverse community we serve. We offer a myriad of services. It includes court based legal advocacy healthy parenting, counseling, rapid rehousing for youth and families experiencing homelessness and abuse, permanent housing through low-income tax project, 24-hour chat, text and call safe line and what I'm going to talk about today, we have a 105-bed family shelter. Safe has fewer emergency shelter beds today, available today than it had 15 years ago. Almost all safe programs operate with lengthy waiting lists and the status quo isn't acceptable.

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In 2019 the board established adopted a new strategic plan that prioritized increasing emergency shelter for survivors of family violence. One advocate used the word, what this really is is a murder prevention program. That's correct. That's what it is. We weren't meeting the need pre covid and the situation now the dire. 5,687 people have called us since covid started, but is a to 25% or between 850 and 1100 calls rate as moderate to high lethal. The assessment is also utilized by APD because it was designed for use by law enforcement and domestic violence programs. Our safe line director is certified in doing that assessment. As an example, day before yesterday we had four families, that's moms with children, and another five single women with cda scores of 18 or above.

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That is high, high lethaltime donated risk. Another 12, six women and six families were at moderate lethality risk. Every effort is made to get these individuals behind the gate and if we're not able to we do extensive safety planning and they are offered alternative referrals. Behind the gate is an intense focus on safety. It's important and also the attention to case management and the support services is equally important when we consider long-term change. Not having to address the long-term homelessness of which family violence is a huge issue. Rarely is it a matter of nights of shelter and all is well they are on their way. I was once in a shelter. I went with my two children, and I know I was the exception. I knew it then because I was white, I was middle class, I was college educated, I had

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reliable transportation, I had connections, a good job, a home, and really importantly because of all that law enforcement believed me when I said that I was going to be killed. I only needed to be in shelter for a few days and I was able to get in and get out. I didn't need all those services, but I was the exception to the norm. Most people that is not the case. So we've been working really hard to create services to address that -- those programs that we see, that what we call our murder prevention program. I'm going to turn it over to Melinda to talk more about that. >> Thanks, Kelly. Can everybody hear me? Good. So just -- I just want to say that thank you, thank you so much. Part of what we really started to do as we started -- as we moved into this pandemic is we knew survives were going to need additional support and we knew that we needed to

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address precautions in social distancing as well as additional sanitation specifically in our congregate care settings, which is the behind the Gates programming. So what we really started to do as an organization is really start to think about how we can get some of those more discreet spaces for immediate shelter. Now, over the years we've actually worked closely with APD and victim services in the hospitals to immediately serve high-risk survivors. As most of you know, we are in our shelter and I've been there since 1990, almost always full, we're constantly trying to -- it's a chess game trying to figure where people are inside, where they can go, those outside how they can get in and trying constantly to think about overall safety. We really were starting to think about how we identify those and how APD and the hospitals were going to figure out how to get people maybe back home and into our

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shelter. If we weren't able to do that we work with them to identify hotels. Now, what I found out over the course of the years is that many of those survivors were really scared, they felt isolated and they were frightened and concerned and particularly if they had children, it was really difficult for them to go from leading a very, very scary situation into a hotel where they might have felt isolated. So as I was thinking and shelter leadership was thinking, what we really started to do is think about on the back end of shelter what years ago we used to call transitional shelter, that model where we had people who had been in she wanter who had gotten supportive services who maybe had gotten protective orders already in place. They were much safer, but they were waiting to go into the next safe place. A lot of times that is

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housing in our community. And I just have to say just the information that joy and Matt talked about and Kate talked about earlier, that really looking at housing first and peer support and harm reduction, those are really philosophies I've grown up around and really are very well suited to survivors in this community. And I would say say so many of the people in our community who are rolls are also trauma survivors as well. Just thinking about that model, we were looking at how we could work with maybe one hotel, and we had a few things that we really wanted to take into consideration. We wanted a single point of entry because we know danger levels. We wanted a place children would feel comfortable and safe. We wanted close access to public transportation and food. And we wanted staff to be able to work with a team of staff in a hotel where they could work collaboratively and do some training and

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support because we know just the myriad of issues and services that survivors come with. What we decided to do was staff this particular program, the shelter away program, with dedicated employees that would be responsive to the adults and the children staying in the shelter away program. Really I am a children's advocate by heart and one of the very most important things that I know is that kids can sometimes feel forgotten and also have such huge fear and they are sometimes not comfortable talking to their parent about it because they've made huge steps in trying to get safe, they don't to additionally burden them with their own concerns. We wanted to put a lot of resources to those kids. Our shelter away program is set up to really offer hotel in one specific hotel in

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Austin, but we wanted to make sure that the families who are moving over there had a lower lethality risk. We want to make sure they had a housing plan. As you heard from Matt earlier, there's a lot of advocacy and support that goes into getting people long-term, safe, affordable housing in our community and going from a shelter program into housing can be quite difficult, and all of the other resources that people may need, accessing mainstream benefits. And sometimes for people who have been so isolated within their domestic violence situation that they have no idea what's the first step. So all of that advocacy we wanted to make sure that that piece was done before these folks moved into our shelter away program. So lower levels of risk and also really these folks had an active housing plan in

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place. >> Flannigan: Great. Thank you. I want us to keep moving along. Ms. Santana, why don't you take a minute or two and talk about your program, then we'll do questions. >> Absolutely. Thanks for having us. I just wanted to share some information about the alternative models for policing. I think that's what the call is about. But for survivors the past seven years we've been working with displaced and homeless

victims of various forms of domestic violence as a public health issue. We've noticed police officers in general in our interactions and conversation with them, we've done focus groups, they are unafter well dealing with victims they encounter. We meet regularly with law enforcement and they criteria there's a lot of man-hours when officers have to drive from point to point and there's no place for victims to go. To quote retired police officer -- police chief Tom Smith, we can spend up to eight hours easily in a car just looking for a safe

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place for victims to go because shelters are full. The goal of APD is mitigate anyway danger and remove the vulnerable party from the scene. We've enlisted the services of victim services and the crisis response team to further that assistance for clients. We believe that we could reallocate some of the APD budget to truly be beneficial in assisting victims in the following ways. The allocation of more budget to hire more victim services counselors such as moving that money to the victim services counselors group. There are 13 currently and they are dealing with all the lethal cases that come in to APD, they are going to traffic fatalities, child abuse, if we could have a dedicated team just for domestic violence and family assault and sexual assault that would be great. Additional funding for caseworkers. Supporting npos and service providers for victims as they are placed in a safe environment.

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Once they are placed in that environment, I think they mentioned this isolation that victims feel when you have case management and you have connection either through phone calls, the virtual ways we've had to do it since covid-19 became a thing, clients are more likely to move forward. Also additional training for APD officers as they respond to these calls. The methodology these officers are using is in our experience in the last seven years, it's inconsistent. Sometimes it puts our victims at risk. Also I feel like there is a lack of technology that law enforcement can be using. We are working with APD right now to create a tool where they know where available safe spaces are. I don't necessarily agree one hotel is a smart move. A safety net of hotels that when a client might be found in one hotel, they can be moved to another hotel on the other side of town is vital. We've had that happen several times where a client

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would be in a hotel and now we have a safety net across the city. This platform was created and it's available to APD in a pilot so they can find available safe spaces. Since we've been doing these different technologies and different tactics, since April 13, we have had 86 interactions with law enforcement where we will be able to quickly place dbsa clients and trafficking victims within an hour. We've had over 1,000 calls to our phone bank and our offices for assistance. We've placed over 100 families in our

safety net of hotels across the Austin area, and we've assisted 18 of those families to move into permanent housing during covid-19. I agree with Tim, I agree with Matt, the housing first option is the best option. Clients witness they are safe are looking for a way for them not to have to go back to their abuse. We've modeled a lot of programming to the center in Denver where they have that

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housing first option. So I am open for the more conversations about this, but I feel like the impact of all of this comes from a coordinate effort of the city of Austin, APD, Travis county, the service providers, non-profits, local shelters like safe and hope alliance in Round Rock and the 1200 available hotel rooms made available through the Austin hotel and lodging association. More funding to address this. In this way we're all collaborating would provide an exponential impact for the whole city. >> Flannigan: Thank you. I think it's a great -- it's a great layout to see the suite of solutions that are necessary for such a complex problem. It will be some good work to into into the types of diversion services that have been provided in the past to have a kind of quantify we may have walked down this road a little already and look more from our APD folks

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and others about how much time is being spent on things that maybe didn't have to be officer spent on those things, even if it's not as much as a first response alternative, a four-hour or eight power call becomes a one-hour call. Any questions from councilmembers? Councilmember Casar. >> Casar: Thank you for sharing, and I had not -- I didn't know that we are at fewer shelter beds now than 15 years ago. So thank you for sharing that. As far as budget numbers because we have a budget coming out Monday, what would be a significant and meaningful investment for getting public safety for a lot of the -- of your clients, a lot of our neighbors that are experiencing family violence? >> I would like to answer that question. >> Flannigan: Ms. Santana, then Ms. White.

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>> We know once clients are placed in their hotel, they normally start our program at about $2,500. That's to get them placed to take care of them for a couple of weeks, provide food resources, counseling support and case management support. Once we're trying to rehouse them, it's between three and $5,000 because that includes all the reletting costs, associated moving fees, all of the things that would come up as a result of somebody trying to move N total, we look at the total costs for that budget to be close to $5.6 million. And we're looking at providing that for about 300 families a year. >> So we could increase in looking at our initial plan would be that we would be able to increase our shelter beds with hotel, and mind you beds is a -- it's a -- it fluctuates because it has to do with families.

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So we generally factor in an adult with two children so we could increase our shelter beds by about 90 shelter beds a year. 90 shelter beds. We could go up by 90 shelter beds, we haven't figured how many that would be in a year. We could do that for about $1.2 million a year or $110,000 a month. >> Casar: And that would be the operating costs with the city making a capital investment in the building? >> Correct. Correct. We would not be doing that -- the building. And let me just say, may we talk about shelter away that we will not be able to continue that unless we have funding for it which we don't have so we're looking at that as -- it's been really successful and wonderful and we may not be able to continue it. >> Casar: What's the funding gap? >> I don't want to say an

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amount and have it wrong. >> Casar: That's fine. >> Of interest and just to add in because we talk about rapid rehousing, we had three large hud grants to do rapid rehousing. We have partners in the rapid rehousing [inaudible] And we also then have two domestic violence rapid rehousing grants for homeless families that have experienced abuse and to do rapid rehousing for them. Each of those grants require somewhere around four to $500,000 match. That's also a challenge for us. >> That's an understatement. Right now at shelter away with five to ten families it's about $8,000 a month. >> Flannigan: And to be clear, we're not doing budget work right in this moment. We're just trying to get councilmembers and the public a sense of scale.

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The budget process is going to be a complicated one given the pandemic, tax caps. >> If you could get these numbers into the budget by Monday -- [laughter] -- We would do a happy dance. >> Flannigan: Ms. Santana, did you have something to add? >> The high -- [inaudible] There are times we have clients that because of their situation they should totally be inside of a shelter, inside of the walls. For those who don't need that, it's really important for us to be coming up with an innovative strategies for where they should be and we should be collaborating and partnering to create that safety net for those clients. Right now I want -- we can't really talk about budget because we're not talking collaboratively with all the service providers that provide all of those resources. >> Flannigan: It's been a challenge in a lot of areas. We've had that challenge on homelessness, workforce development, and we're all

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trying to figure better ways to streamline the ecosystem around every community challenge. Any other questions? We have one more set of panels. Councilmember harper-madison. >> Harper-madison: Fortunately in the interest of time, Ms. Santana just answered two of my questions especially as pertains to collaboration with service providers. I just wanted to -- I heard somebody say earlier on the importance of collaboration between service providers, plural, and I just want to make sure that we're open to exploring what all the options are, and I appreciate I think Ms. White might have said -- I'm sorry, I forget who, but something about the ecosystem that surrounds this particular topic and subject matter. I appreciate we're looking at it comprehensively. The other question I shelter beds, Ms. -- Question I have, Ms. San taken in, you said -- because we're not talking budget I think I'll ask off line what you think

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the number -- I will ask from a practical application perspective what does make certain that public safety folks have the appropriate DV and sa training? What does that look like? As we're doing an audit around training academy right now, what should we be paying attention to? Are there other cities who are getting it right? Any guidance you can offer us there. >> Thank you. We worked with the center in Denver and did a pretty comprehensive study of their program. Literally they have a police substation inside their building. On much of the training other staff members are receiving, so are these law enforcement agents, law enforcement, the department does. So they are working very, very closely. I don't think there's enough training and I would -- I will get those numbers for you because it's so inconsistent from officer to

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officer how they are handling clients. I think if they have more consistent training, that was black and white and then passed off, the client to victim services for more handling and then off to service providers, they would be a lot happier about that as well. I'll get you that information. I'll be happy to. >> Harper-madison: I appreciate that very much. It makes me think about the ems presentation earlier when you mentioned to dispatch disparities. I would venture to guess it's the same across the country. I think the closer we can get to a unilateral expectation around training the better off we are. Thank you. >> Flannigan: Thank you for your time today. We're going to move on the our last set of panelists. We are -- we've got a few APD folks on the line. Get my list pulled up here. Okay. Let me get everybody in here.

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Officer Borden, detective Perkins, officer Villarreal. Officer board even, are you there? >> Yes, can you hear me. >> Flannigan: Yes we can. Perkins? >> Can you hear me? >> Flannigan: Yes. Perkins? >> Here. >> Flannigan: You have been waiting patiently back stage and we've got a few minutes, but I'm interested in hearing kind of your experience on the job and in these areas that we talked about today, gun violence, mental health, homelessness, substance abuse, family violence, obviously these are big topics, but as we think about alternative response or even making your jobs easier where you are not spending as many hours on a call, what kind of experience or information might you add to the conversation today?

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>> If it's okay, I would like for Chris to start off and go to Shelly. I know we're short on time, if I don't talk today, that's okay with me. >> Flannigan: And me, officers. Detective Perkins, why don't you start off. >> I've been with the police department for about 21 years now. Thomas asked me to come here kind of from an historical perspective when it deals with crisis intervention. I actually several mayors ago was on a mayors mental health task force. I was a full time cit officer with the Austin police department back in the early 2000s. I trained the majority of the police officers back then, the new ones that were coming in and the folks on the street. I also traveled around the country and taught a few other places. I first wanted to talk about a lot of things councilman

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Flannigan brought up. I grabbed some data from the police department. Currently we have about 19% of our calls for service have a mental health component attached to it. When it comes to I guess unbun bundling police services, I don't think average police officer would disagree that there are other ways to handle this. But the reality of the situation is, and if we're trying to educate everybody that's listening today, Texas has a pretty rigid state statute when it talks about dealing with those folks in severe crisis. And I said this back in 2002 when I stirs started, I don't know why we're sending a police officer, but in the state of Texas right now, only a police officer can get someone into a psychiatric facility on an emergency detention without a warrant. The other option is an order of protective custody. In Travis county we have one probate judge who deals with

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that. That essentially means a psychiatrist has to draw something up, get it to that probate judge, that judge has to sign off and when you are dealing with someone in severe crisis who is truly in danger due to mental health status at that point in time, you don't have those seconds. So to completely unmarry us from the process would take a lot more than I think we could do just on a local level. But I've seen a lot

of progress being made in the city with emcot and with more and more training. Our police officers have continued to train well beyond what I taught back in 2002. Shelly is going to talk about the host team. I think there's a lot of good things we I think there's a lot of good things we can do, but if you're asking from our perspective would it be beneficial to lower the amount of these type of calls that police officers go to, you're not going to get disagreement from probably anybody in my line of work. But we still have -- we still have a lot of issues

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to overcome and there are certain situations that you just can't remove us from. If somebody is actively violent. You just can't remove us from that particular situation, but I've been well aware of the Eugene model for a long time and to see they respond to more things. I still work quite a bit of time on patrol and I can tell you we get dispatched all the time to people just sleeping. And I -- it still doesn't make sense to me why a uniformed officer has to go to someone sleeping. It's not against the law to sleep in the city of Austin. It isn't. I don't know -- we're dispatched, we have to go. That's the way things you. You come up with a model that you send someone out there to walk them up and -- wake them up and ask those questions, is there anything I can do for you, I think that would be good. And if you could keep the average patrol officer from responding to what is essentially one-fifth of the calls, you could free them up to do things that are really important, to get out in the community, to get to

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know the neighborhoods. It's something we've got away from because we're so cultured, because we're responding to so many different types of things. So that's just my thoughts on what's going on. >> Flannigan: Thank you, detective. Officer bore don, did you want to add? >> Yes, thank you for adding me. I agree with Chris 100%. Anything we can do to assist the mental health system in the way it's currently being run I don't think you will get anybody in a police department that's going to gripe about that. I do have the pleasure of being on the host team. And Chris mentioned 19% of our calls have a mental health aspect to it. I work in the downtown in the west campus area and I tend to believe it's higher, at least for my daily endeavors. You know, a lot of times we're just out making contacts with homeless individuals and a mental health issue will come up. It's something that you just

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can't walk away from. We're dealing with -- a lot of times when we are involved we're dealing with people that are truly in crisis to the point where a citizen is walking by and they're scared. If you've never seen anybody in crisis, it can be a scary thing, and we have people calling 911 just on the surface of what they're observing, they're not even involved. So again, we have to respond to those. Sometimes

they're severe situations where I can't call emcot. This person isn't going to go with them willingly. They may not be to a point where they're a danger to themselves or others, but they're so volatile that you just can't turn them over to a crisis counselor that's arriving in their personal vehicle and trying to get that person to go with them isn't realistic. It's not an option sometimes. I've had to take people in on a police officer's commitment during the course

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of a day, take them to yellow pod at Dell Seton and before the end of my day -- by the time my day is coming to Andy I see that person walking down the street. I've taken them there because they've become a danger to themselves or somebody else, yet they -- they walked away from the hospital. And for me that's frustrating and I know it's frustrating for other others. Sometimes being a part of host we have the ability to go into the hospital, we have the time and the commitment to that person to go in and advocate for them. And we can dined of push for something more to happen. But a lot of times these people get lost in the shuffle of being at a hospital and that's unfortunate. So anything that -- anything that anybody can do to improve the well-being of these people that are exposed out there, they're on the streets, they're not in a house or have family members that are looking out for them. They're out there with a mental illness and they're on the streets. And it's a devastating thing to watch.

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So anything that can be done to improve that, any officer in our department is going to applaud it. >> Flannigan: Well, thank you. I want to let -- we're a few minutes over our scheduled time. I think we can fudge our time a little bit. But I just wanted to thank y'all again for continuing to participate in the workshops. Again, with all of our community experts that joined us this time around. We're mixing up the format every time, every issue is going to take a different approach. I think that's the watch phrase for literally everything we're talking about. We need a much more nuanced approach to all this stuff. And important for the public to know that we're doing this work as a community. And nobody's -- I don't think it's fair to say that there's some absolute answer to every question. This is hard stuff and if we're talking about a thing that you do 50% one way and 50% another way now, if we can tweak that up to 80/20, you've saved money, you've targeted your response. You haven't eliminated

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entirely -- because there are just some things that happen. You have to be prepared for some things that happen. But sometimes I think we send the wrong tool to the wrong problem. And y'all end up being the tool for every problem and that's the challenge we've got to address. Any last questions? Councilmember kitchen? >> Kitchen: Okay. Officer Borden, perhaps we could talk about this offline

because I don't want to take up too much time, but I would really like to understand what improvements you think would be helpful for the host team? I have a great respect for what you all do with host, and whether it's additional host teams, which is one thing that I've looked at for awhile, or whether it's something else, I would love to know what that is. And one thing you just pointed to, which is the fact that I think it's something that councilmember harper-madison asked about earlier, you have to have some place to take people to.

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So I'm just opening up that conversation for later and I'll follow up with you. I'd like to understand what specifically your thoughts might be that we could have. >> Yes. I think our team would love to meet with you and talk about it. >> Flannigan: Officer Villareal, would you like to add something? >> Yes, sir. I just wanted to thank you again for including us. I'll echo real quickly what Shelly and Chris have said. There's not going to be any push back from the police association on trying to find a better way to handle some of these calls. You know, Mrs. Santana from survive to thrive made a comment about having additional training. We're never going to -- we're going to take the position that our officers have enough training. We can always use more training. We recognize we could always be better in our service to the folks that we serve. And sitting here today, I'll tell you guys, I for a long

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time have strongly believed that, you know, the legislative aspect to part of the problem that we have in the state of Texas, it needs to take a collaboration between management and labor. We need to be on the same page when we go to the Lege to figure this out. Obviously it's a bigger issue than just a city of Austin issue. But we should be on the same page as we go to the Lege to -- as a state to reimagine what it means to serve the people in a mental health crisis. That's my commitment to you guys today and I greatly appreciate y'all's willingness to continue to engage us in these conversations. >> Flannigan: Thank you, officer. We definitely have to look at the whole system top to bottom. There are changes -- there are jobs the state needs to do like child protective services they fail at or foster care systems that they fail at. Certainly state laws that

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require officers, that's on our list too. Councilmember tovo, are you on the line now? >> Tovo: Yeah, I am on the line. Can you hear me? >> Flannigan: Go ahead. >> Tovo: Are you able to hear me? I've been on the line the whole time. I think I was just unable to be unmuted. Thank you, connector don for really all of your work getting host up and running. You've been just a vital part of that. We had a conversation about expanding host teams and I wondered if you could address [background typing sound] How

important that it is that there be a police officer as part of the host team. Part of the conversation we talked about just very, very briefly in early June just addressing the possibility of having host teams [indiscernible]? So if you could talk through really what the officer's roles are within that host team and if you could respond to that question.

[4:08:55 PM]

>> Yes, ma'am. I can only speak for myself. I was kind of handpicked for this position. I've worked downtown for 12 years and I had a pretty good knowledge base of a lot of the homeless people downtown. So I think -- I think an officer being on the host team is good for obviously a variety of safety reasons, but also it really comes down to your relationship with a lot of these people. I've known a lot of them for such a long time that they'll ask for me, especially now that I'm in this role. They know that I'm in a different position to where if they need something they can ask for me. I get calls from the day shift officers all the time, whether it's for clothing or for help with their medications being lost. So it works, it works for this team that we have because we have such a -- an

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intimate knowledge of our people. And I think that goes for myself and the other officer and our medic. We just -- we have a relationship with these people. So as long as an officer that maybe works south has a relationship with the community and has a trusted role, I think it's -- I think having a police officer on the team is a great idea. Because we have so many police officers out there, and they're just one -- one click of the radio they can get me or get help or somebody might need clothes. So as long as you have somebody that's willing to do it and has, you know, a knowledge base of the people, I think it's -- it's really a vital part of the team. >> Flannigan: Thank you, officer Borden and detective Perkins and officer Villareal. I want to allow my committee members to make any comments that they might wish.

[4:10:56 PM]

Councilmember Casar? >> Casar: I'd like to thank all the panelists and thank you to the officers for participating. And I appreciate that you shouldn't be thrown as the city's response to every challenge out there. And I just think that this is really a good session. I appreciate everybody coming together on this. You know, there's been some conversation about whether the council cares about violence that occurs in our city. And it couldn't be further from the truth that we don't care about violence. This whole session has been will how do we prevent harm and prevent violence and interrupt violence and reduce harm in our community. But as we heard in the first presentation, you know, while people that commit gun violence should be held accountable, that accountability process does not necessarily prevent gun violence. And in fact, gun violence is a contagion and so often someone who survives gun

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violence south Austin times a person who might commit it. So us finding ways to intervene in that I think is something that's really important we heard today. Obviously arrests -- you can't arrest your way out of substance abuse problems and arrest your way out of homelessness. So I think the conversation about how do we actually go in and treat those issues is really important. And of course as we know, the largest chunk of violent crime in our community is family violence and you can patrol the streets all you want. That does not prevent family violence that's going on inside of our own homes. And the fact that we have fewer shelter beds at, say, for example, today than 15 years ago just isn't acceptable. So I think this year we have a really important opportunity to invest in ways that will actually reduce the amount of harm in our community and in a way that we haven't before. Many of the programs that were presented to us today exist in other cities and

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just don't exist here. So if we can respond to mental health calls with mental health professionals, if we can house folks experiencing homelessness, treat people with substance use challenges and prevent gun violence before it occurs in the first place, I think that would be a really meaningful investment in public safety and I think that that's what the council is looking to do. >> Flannigan: Thank you, councilmember Casar. Councilmember tovo, are you still on the line? >> Tovo: Yeah. And again, I've been on the line the whole time. I just got bumped off the computer. >> Flannigan: Go ahead. >> Tovo: I apologize for being a disembodied voice. There was a conversation earlier about the sobering center. I absolutely recognize and applaud the effort to get more work on outreach, but I did want to just make the point that that exists in meniere's. You know, -- in many areas. Number one, I would like to say the sobering center is a year and a half old so it's

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very early. It has had a change in leadership that has changed [indiscernible], changed its focus a bit to hiring that next leader. And we have a wonderful one in Laura stovine on board. But there are multiple areas where there needs to be more outreach, including with UT, with ems, with APD, but I did want it to be out there and said that the police or any other entity is not bringing individuals to the sobering center. They are and we've had terrific participation from our board from assistant chief Chicon. Are there opportunities to expand that? Absolutely. We really need the community to assist in that. So especially because we're at a point where we want the community to invest their dollars in the sobering center as well, for them to know that it has been a success. [Indiscernible]. And I welcome both the panelists to give ideas about how to do that as well as [indiscernible].

[4:15:00 PM]

>> Flannigan: Thank you, councilmember tovo. I think the sobering center is a great example of that suite of alternative solutions to other problems. Councilmember kitchen. >> Kitchen: Just quickly, I would just say that -- thank you very much for this. This has been very enlightening and helpful to hear all this. I think that as a community we have -- we've invested in a number of programs already, like the host team and the mental health diversion team that we started last year. What we're learning is there's mu more that needs to be done in all of these areas. We can learn from other communities and we can continue to invest in what we've already started. And invest in a much bigger way. And then we also need to understand that in addition to investing in these programs like host and the mental health diversion and sobering center and others as councilmember tovo mentioned, you know, we need to work with the community

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as a whole because there's more to this system than what the city of Austin -- than the city's piece. >> Flannigan: Thank you, councilmember. Any other final comments? Well, thanks again to all of our panelists, the officers here with us who stuck with us all the way through the end. A lot of really great work, great ideas. Again for the public, this process is -- today is not going to answer finally all those questions, but help ensure that this work moves forward and at a deliberate pace and that all of the relevant experts and folks who do the work now and the desires of the public are considered as we go through this work. As councilmember Casar said, the budget -- the manager's budget comes out next week. He will almost certainly not have all of the amazing things that we're talking about here today because it takes time to build a budget. And even if we were to decide tomorrow to stand up a whole other agency focus on mental health, it still takes time to recruit and

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train and launch and do all the logistics and all the things. So I'm hearing some good stuff on the advocate side of the community where they're talking about goals over a couple of years. I think that's the right direction to be headed because that gives us time to ensure that we get these solutions right. We would hate to stand up things too quickly or too inefficiently and then they don't work and then we're back to where we started. I think there's a lot of good work going on. Again, Thomas, thank you for joining us. I hope that the police association continues to engage in productive conversations because I think we're all trying to do right by our community and make sure that we're protecting the public and doing everything that we can. So thanks to everybody. It is 4:17 P.M. And I adjourn this meeting of the public safety committee.