Public Health Committee Meeting Transcript – 03/09/2022

Title: ATXN-1 (24hr)
Channel: 6 - ATXN-1
Recorded On: 3/9/2022 6:00:00 AM
Original Air Date: 3/9/2022
Transcript Generated by SnapStream

Please note that the following transcript is for reference purposes and does not constitute the official record of actions taken during the meeting. For the official record of actions of the meeting, please refer to the Approved Minutes.

[9:44:22 AM]

>> Tovo: I'm chair Kathie tovo and I represent district 9 and I apologize for starting this meeting late. Most of us were outside at a proclamation and we are going to go ahead and get started. It is 9:44. So let's see -- I know that we're being joined by councilmember harper-madison who will be here with us shortly,a as well as mayor pro tem alter and so let's see if we can knock out some of the other issues first. The first is to approve minutes from our last meeting. Or -- apologies -- from the November 9, 2021 meeting and the February 9,2022 meetings. So is there a motion to approve those items? >> So moved. >> Tovo: Councilmember kitchen moves approval. I will second that. Let's see, all in favor? That is councilmembers kitchen, Fuentes and myself, and we have

[9:45:28 AM]

counselor harper-madison and mayor Adler off the dais. And next is the discussion and possible action to amend the public health committee's 2022 meeting calendar. Colleagues issue there's one change on this, and that is to move the meeting that had been scheduled in October to the 6th to avoid conflicting with yom kippur. Is there a motion to approve this revised calendar? Councilmember kitchen moves approval, and councilmember Fuentes second itself. And the same three in approval. And we talked last time and I think that we'll wait for the rest of our colleagues. We did talk about altering some of our schedules so we're not meeting quite every month, unless there's a need, just to make sure that our meetings are effective as possible. But we can take that up a little later. All right, let's see, number 3 is the selection of our sobering center. So Liz Boston, one of our wonderful city appointees, has taken a job outside of the state

[9:46:29 AM]

so did submit her resignation to the sobering center. Our staff have put out a solicitation of interested applicants for that position and it is still pending, so, please, let everybody know who might be interested and might have expertise to bring to that board that there's an open position. At this point we don't have a universe of applicants to meet with and to review and then to meet with so we're going to just leave this. And there is no possible action scheduled here today. But just keep your -- keep your eyes open, because we likely will have some applicants to have that and we'll have a special called section. Colleagues, number four is a briefing and discussion on issues related to homelessness and in conversations with our homeless strategy officer, we determined not to have this briefing today. And we usually do at every public health meeting, have a discussion about homelessness and a briefing. There was not any -- any

[9:47:32 AM]

additional -- there was not enough -- enough new information about the heal initiative and others to schedule it, given that this is also the time where our homeless strategy officer is deep in working on the rfp, so in the interest of making sure that she and her staff had the time, they needed to do that work really well, and I did go ahead and cancel this briefing. So I apologize. I know that is one of the things that we always get involved in and we really like to discuss. But we also want that rfp to be successful and we want our homeless strategy officer to be able to do all of the really critical work that she's engaged in. Councilmember kitchen? >> Kitchen: Yes, I think that's fine. I wanted to suggest that for our next meeting, that even if it's not timely for our homeless strategy officer to speak, although, of course, I'd like to hear from her if it is, and if it's not, I think that it would be helpful for our committee to

[9:48:34 AM]

get a briefing from central health on the respite and recouptive care program they've been working on and I'd really like to -- I think that it would be good for the whole committee to hear about it. I've been having some conversations with them and it's also a way for the public to hear what they've been working on. They've been evolving the program. It's in process, but I think that it would be useful to -- to have them come speak. I mentioned to them already that we may be asking for that. >> Tovo: Great. I think that is a great suggestion. Welcome to the dais, mayor Adler, mayor pro tem alter. Mayor, we have cleared one through four at this point. But I wanted to recognize you, if you would like to say a few words about the proclamation that you issued today in conjunction with our county -- county judge and many of us on the same council. >> Mayor Adler: I appreciate that.

[9:49:37 AM]

And I was proud to just stand up with you and our colleagues this morning with the district attorney and with the county attorney, with representatives of different organizations in our city and with Kai. It is frightening, frankly, horrific that our governor and attorney general have put trans-gender youth in their sights. Threatening those children and their families with prosecution that is not called for under law. It was -- it was a proud moment to be able to reaffirm that Austin is a safe place for -- for those families. I appreciated the opportunity to -- to welcome home Kai and

[9:50:38 AM]

her family who have moved to -- moved to Austin. But it's just real important that everyone in our community stands up and makes a very loud and visible statement that everybody in our community is respected and loved and appreciated, and that includes children and then families, especially those that are making the very difficult decisions with their families, with their physicians, with their clergy, with whoever it is that is important to them with respect to trans-gender affirming care. And the suggestion that the state can step in at this point and threaten people or scare people, or -- or diminish their care opportunity is just outrageous. And we stood up this morning as a group to say that. >> Tovo: Thank you, mayor. Thank you, mayor, and I

[9:51:40 AM]

appreciate that is certainly a matter of health and safety for so many in our community, and I think that is very appropriate. It was a very appropriate and an important reason for us to gather outside. And so, again, apologies that we started a bit late, but I hope that those of you watching and participating in this meeting really understand the really critical reason that we did that. So next we are -- and, mayor and mayor pro tem, just as a note, we are in the active process of soliciting new applicants for the sobering center. One of our fabulous board members did step off. And so, please, spread that among your networks if you would. >> Kitchen: Chair? I think we have some people waiting to testify online. I didn't know if you saw that. >> Tovo: Thank you. I did not, so, thank you. Councilmember, can you help me -- or vice-chair, if you have those names would you mind helping me with those?

[9:52:41 AM]

>> Sure, I don't have the names of who is waiting. >> Tovo: Got it. Well, yeah, let me go ahead and call for citizens' communications and I invite those who are gathered here. Scott, are you here for public communications? Well, thank you, and welcome, and you have >> Councilmember tovo, is it three

minutes or two? >> Tovo: Three minutes. >> Three? All right. Good morning, chair tovo and mayor and councilmembers. The city of Austin has donation opportunities that are on the utility bill, and in 2013 there were two changes that were made. One of them was the tree planting program fund was changed to the parks and library fund and that is -- I took that effort from start to finish and still work on trying to solicit more donations and working with staff from pard and the library department. And another change that was made was that a new fund was added that is called the public

[9:53:41 AM]

services educational assistance fund. That fund has a general purpose, and it is distributed to ISDs that are in the Austin energy service area. And they can do with it what they want and ISD uses it for energy conservation work. As you can see scrolling down, I asked for this report about twice per year. The public services educational assistance fund is trending $22,000 per year in total donations from ratepayers from the city of Austin. It is underperforming, the parks and library fund has gone from about $22,000 to $23,000 when it was tree planting only to $45,000 and $50,000 and the other fund is doing well, which is on the right-hand side, the parks and library fund is on the left-hand side, and the public services energy assistance fund is in the middle. A couple of years ago I had an idea and I started sharing it with some of the prominent non-profits that work on

[9:54:41 AM]

homelessness, such as echo, and life works, safe alliance and carry toss. And in those discussions that I've had with city staff as well, it's come to be known that there is interest from this idea. Part of giving is about appealing to someone on some level, where you get them to think about how they can help. What I am proposing to the city and now to the city council through this committee is that the city consider repurposing and re-naming the public services educational assistance fund that is distributed by Austin energy to school districts within their area and is underperforming in my opinion to the homeless student fund. And this fund would I believe increase in donations if it's appropriately marketed, which I will take some role in. And this would also, more importantly, raise awareness for this issue. It's an issue that I did not

[9:55:42 AM]

know much about until a couple of years ago, a year and a half ago, when I started asking and talking to people from the city and from non-profits. Aisd has collated information in which you see on your screen now is the data from 2019 and 2020. , that school year. As you can see, the second paragraph, due to covid in 2021, there wasn't any useful information. And down at the bottom, after the 2,113 amount of people who are homeless students there are more people out there who are homeless who

are students. Questions? >> Tovo: Okay, thank you very much, Scott, thank you for your past work, and thank you for being here today to talk. Okay, our first speaker, and I believe that he is a speaker online is Fred Lewis. And he -- Fred will be followed by Palso, and that's all of our speakers unless there's anyone else in the chambers to speak. Mr. Lewis, you have three

[9:56:43 AM]

minutes. >> Good morning, chair tovo and members. I am here to make a request that we be able to make a full presentation in April before the public health committee on simple health serious financial and operational problems. I would like for Nelson lender and the senator and myself and as well as others to speak. The naacp launched today a health equity first campaign to reform public hospital systems in Texas, because they're not serving the poor, nor taxpayers well. In Travis county we have 185,000 people that have no health coverage of any kind. That is who central health is supposed to be serving. There is a racial disparate

[9:57:45 AM]

impact of those without health insurance. Many people don't realize how stark it is. While 7% of the anglos in Travis county don't have health insurance, it's 15% of African-Americans. And 42% of hispanics have no health coverage. So how central health functions or doesn't function is very important to people of color and poor people. And the city of Austin, as you know, councilmember tovo, has a special role to play with central health because of the way that -- because of the fact that Austin was the last major Texas city with a municipal hospital in Brackenridge and, therefore, our council has the right to make appointments with central health that other cities don't make in other counties. And I want to talk about why we want to make a presentation and

[9:58:46 AM]

why we're asking the committee to call for an audit of central health. It is not well known that in this year's fiscal budget for central health -- and you can read it in their approved budget -- they raised their taxes to 6% but they reduced from $155 million to $101 million in the middle of a pandemic. And they increased their contingency reserve from $89 million to $298 million without really any public explanation. And those figures are really rather stark, and ask for a lot of questions. There are also problems like the state of Texas has been fined $8 3 million for donations, related to central health and the community care collaborative. And a whole host of other problems. The other thing is the central

[9:59:47 AM]

health is now paid the university of Texas medical school $280 million a year, $280 million over eight years, and yet there is no documentation of any kind that poor people received any healthcare for $280 million. And it's been 10 years of approving a tax increase for medical schools consistent with central health's mission which, of course, is to care for the poor. >> Tovo: Thank you, Mr. Lewis. Thank you for attending today and for those comments. And we will consider your request. Our next -- pardon me -- our next and final speaker for public communications today is also online and that is Palo Saldana. >> I'm paolo Saldana. And I'm with a coalition of

[10:00:49 AM]

volunteers of 20 Latino serving organizations and non-profit and civic and community organizations. We have about 35 Latino community leaders and a network of nearly 1,000 volunteers. In 2020, and in 2021 we served 120,000 families and provided access to barrier free-ppe supplies and flu shots and food, water, vaccine boosters and cultural relevant bilingual information resources and support. And our coalition launched and implemented a bilingual vaccine hesitancy plan to increase vaccinations within the Latino community. As we're entering year three of the pandemic, 1,441 austin-travis county residents have died of covid, and Latinos represent nearly 50% of those deaths. And in austin-travis county, one in three kids are Latino and they vary in access to childcare, education, affordable housing, transportation, and options, green space and healthy foods and healthcare, all of

[10:01:50 AM]

which are necessary to stay healthy and thrive. And, according to salute America health equity report, Latinos in Austin and Travis county face more socio-economic barriers and poor health outcomes than non-latino whites. These disparities are a direct result of the Jim crow redlining policies and the implementation of the infamous master plan by the city of Austin. And here we are 94 years later and our communities are still directly impacted by this institutional racism and equity class system and segregation. The covid pandemic has disproportionately devastated and impacted our black and brown communities, and it's crucial that we not only recognize the racial differences in covid cases and deaths, but also begin to understand the underlying mechanisms that gave rise to these disparities. So my request to you today is that you apply the same level of resolve and commitment to better understanding why Austin residents had failures in our drinking water supply, the 1,441

[10:02:52 AM]

residents of Austin and Travis county, and the 720 Latinos who died from our community that deserve better. At minimum a third-party audit of the pandemic emergency preparedness distribution of resources and support, the systematic process of decisions must be evaluated. And most importantly, the latino-led organizations that support our minority and low-income communities throughout this pandemic must have a seat at the table to provide firsthand accounts of our lived experiences and the lived experiences of the communities that we continue to serve. The pandemic showed why social and structural determinants of health matter. Now it is time for policymakers like yourselves to act. Thank you for allowing me to provide some testimony this morning. >> Tovo: Thank you, Mr. Saldana and thank you for your tremendous work throughout the pandemic and, of course, as a community leader before that as well. I think that your suggestion is a very important one. I know that when you and I spoke, you also talked about -- I think we also talked about the

[10:03:54 AM]

potential of having a community task force. So one potential model to look at the city's response during the pandemic might be to look back to the resolution, colleagues, that I did that had both an audit -- a very brief -- briefly constituted community task force as well to take -- to take some of that public testimony. So, we can certainly discuss that. Thanks again for being here. >> Thank you. >> Tovo: Anyone else? Okay. So, colleagues, we have mayor pro tem alter here for the briefing regarding the trauma recovery center. Is that a concern for anyone? >> Chair, I know that we had a speaker joining us online. Dr. Bosalari and I wanted to make sure that she's online? She is, okay, we're good to go. >> Tovo: Okay, great, anyone has a concern of stopping those two pieces? We'll take up next our briefing

[10:04:56 AM]

regarding the trauma recovery centers in Austin and councilmember Fuentes has also brought forward a resolution and we're now posted for potential action on that item. And then we'll conclude with our briefing on substance use disorder community planning process that several of us have been following. So, welcome to our presenter. This is -- let me just get back to it -- we have two presenters -- I'm sorry, three presenters today. Tara tucker with the alliance for safety and justice, Trisha Forbes from the alliance for safety and justice as well. And then online is Dr. Bosalari. Welcome, thank you for being here with us today. >> Good morning, thank you for having us. My name is Tara tucker and I'm a Texas state director for alliance for safety and justice. We're a multistate non-profit dedicated to doing advocacy in reducing our overreliance on

[10:05:57 AM]

incarceration and reallocating resources to community-based programs and organizations that work to provide trauma recovery services, preventions, diversions, and programs that are going to break our cycle of crime. Today with me is Trisha Forbes who is the state-wide manager for crime survivors for safety and justice. And also Dr. Bosalari, who is the founder of the San Francisco trauma recovery center, which is the first trauma recovery center . >> Thank you, good morning, mayor pro tem and councilmembers. I'm Trisha Forbes, as Tara said, and I'm part of crime survivors for safety and justice. We are a project of the alliance for safety and justice. We have more than 9,000 survivors of all kinds of crime and violence across the state of Texas. Many of them are here in Austin.

[10:06:58 AM]

And we do organizing to elevate the voices of survivors who are not often heard. Especially black and latinx communities, so thank you for having us today. >> So, again, today we're here to talk about the proposal before the council which is to fund the trauma recovery center. Trauma recovery centers are an excellent way to increase public safety and public health, and I know that you all have taken great strides to strengthen violence prevention and services for survivors and I believe that trauma recovery centers are the next logical step. Trauma recovery centers are one-stop centers that support victims through a violent crime and through the recovery process. They provide wide-ranging comprehensive supports -- actually, you can go to the next slide. Thanks. Comprehensive supports from

[10:07:59 AM]

mental health counseling and case management to navigating the justice system and helping with relocation and more. They are confidentially supporting -- um, they're in our communities and -- next slide. The model uses approved approaches to trauma-informed care to address the needs of survivors. They utilize assertive outreach, so that people are not just serviced in the center, but if they're unable to come to the center, the people in the center will go out to them and help them get what they need. So they can engage survivors in multiple ways. And then they also take referrals from multiple partners. They have clinical case

[10:08:59 AM]

management. And their mission is to help victims who are not being served by our traditional services. So one very important aspect of the trauma recovery centers is that they're going to service survivors who may not have filed police reports. So while we have great services through our current victims' services organizations, there are multiple people like I said that don't have access to those services because they have not filed. And so trauma recovery centers can help them where our other existing

services cannot. Next slide. Research has shown that the reports that we have put out that one in 10 survivors are not accessing traditional victims services.

[10:10:00 AM]

Again, this is trauma recovery centers create an opportunity for us to reach more people who would not be accessing traditional services. Next slide. >> Thank you, Tara. So I'm going to talk a little bit about prevention. The data also show that victims of violent crime are four times as likely to be repeat crime victims and that more than one-third of victims of violent crime have been repeatedly victimized. I'm a survivor of sexual assault and this was true for me after I was sexually assaulted as a teenager. Unfortunately, I was one of the statistics and went on to be sexually assaulted two more times in my teenage and young adult years. The comprehensive services that trauma recovery centers provide have an impact, not only on individuals, but also on families and whole communities.

[10:11:00 AM]

And they do prevent repeat victimization and break the cycle of crime and violence. Next slide, please. So why trauma recovery centers? They work hand-in-hand with existing victim services and community resources. And I know that this is a question that often comes up -- what about the resources that we already have in the community? And trauma recovery centers, I believe that 40 of them around the country now, have found that they work hand-in-hand with those to augment the services that already exist in our community. In fact, traditional victim services are one of the biggest sources of referrals to trauma recovery centers. They serve people who don't go through the criminal justice system. Again, like myself. And really importantly they serve people of color and people

[10:12:04 AM]

experiencing homelessness at much higher rates. I was able to listen to a little bit of the press conference outside this morning as well as some of the earlier items on your agenda today about people experiencing homelessness, such as foster youth, and these folks are at higher risk for victimization, and don't always access traditional services. Trauma recovery centers have been shown to prevent homelessness and also to help to pull people out of homelessness. When they have been victimized and they are able to access these services. They also are shown to increase access to victim compensation for survivors who are young and less educated. Next slide, please. So they serve survivors of a wider variety of crimes, including people experiencing

[10:13:06 AM]

community violence, such as stabbing victims, gunshot victims, as well as family members who have lost loved ones to violence. And many of our members in Austin who have spoken on this before are victims of gunshots, have lost their children to gun violence, and they have not had a place to go to receive the kind of culturally responsive services that they need to heal. They also are more cost effective and improve the health and the well-being of clients. And I believe that at this point we'll turn it over to Dr. Boccellari, who is the founder of the trauma recovery center model and is extremely knowledgeable and has firsthand experience over the many years that she's been behind implementing these around the country.

[10:14:07 AM]

>> Thank you so much, and it's such an honor to be joining us virtually. And I so much appreciate everyone's willingness to hear about the trauma recovery center. As has been mentioned, it was first started in San Francisco, but there are now 39 trcs in eight states across the country. And one of the things about this model is that we're very data driven. We feel very accountable to the people that we serve. And so from the very beginning, we wanted to collect data to see whether or not we were effective. And we actually did a randomized treatment trial where we randomized victims of violence. Two-thirds got the TRC model and one-third got usual care. And I should say what is usual care? For many victims of violent crime, for many victims of violent crime they're given a referral to a local mental

[10:15:08 AM]

health system, which actually can provide wonderful services, but many of our victims of violent crime have many, many barriers to access services. And one of the symptoms of PTSD is avoidance. So people don't want to talk about their problems because they end up often times having intrusive thoughts or flashbacks. So one of the things that ends up happening is that it pushes people into isolation and, again, oftentimes they avoid talking about their problems. The TRC tries to counter that by doing assertive outreach as you have already heard about. But some of the impacts -- so we ended up looking at sexual assault victims in San Francisco. We had data of rape victims, how many of them had accessed mental health services before TRC and how many after. And we were able to actually demonstrate that rape victims by being offered the TRC model, the

[10:16:10 AM]

increased access from 6% of rape victims to 71% actually getting into mental health services. We also were able for general victims of violent crime ended up increasing access to mental health services, 72%

assigned to TRC, accepted and received mental health services as compared to 38% of usual care victims of violent crime. And this is really interesting. We did not set out to increase cooperation with police it. Just wasn't one of the things that we were aiming to do, but we looked at it and we ended up finding that we had an increase by 69% in victims being willing to file police reports. We encouraged people to do it, and if they want to, we help them with it. And, of course, by filing police reports we can end up hopefully improving community safety as well. We ended up decreasing the rate

[10:17:12 AM]

of homelessness by 41%, and if I could have the next slide. We also looked at -- after receiving services and we were able to show that we had an improvement of 74%, showed an improvement in mental health, 51% physical health, 52% a decrease in alcohol abuse and, of course, we know that PTSD brings with it an increase in alcohol and substance use and we were able to show a decrease in that. After only 16 sessions of TRC services, we were able to decrease PTSD by 46%, depression decreased by 47%, and this data is not only true for San Francisco, but as trcs are being developed across the country, we've had similar results elsewhere. If I could have the next slide. And so we ended up also looking

[10:18:15 AM]

at the -- we did a cost analysis, and we ended up finding that TRC is much more cost effective than usual care by about 34%. And minimum cost of TRC is about $1 million annually. I will turn this back to Trisha and Tara to talk about the rest of this slide. >> Yeah, I want to also mention that while there's a cost savings in providing care to survivors this way, there is no cost to survivors to access these services. They are -- they service survivors to them, regardless of a filing of a police report or regardless of their immigration status. So it's truly open to everybody. The proposal in front of you today would -- the resolution would state that we ask -- that

[10:19:18 AM]

we look at partnering with the county to provide the funding for the center. So the ask would be $500,000 each with a minimum request of two years of funding. And for that, we could serve hundreds of survivors a year. Trisha? >> Thank you, Tara, and thank you Dr. B. One thing that we forgot to mention earlier that I think that is really important for the committee to know is that as a representative of crime survivors for safety and justice, I served on the -- the victims support and services working group of the task force. And that was a group of community providers, including our allies at APD victim services. So I wanted to just make sure for the record that everyone knows that funding a trauma

[10:20:19 AM]

recovery center in Austin was one of those key recommendations. >> And if anyone has any questions we would be happy to answer them. >> Tovo: Who would like to begin, councilmember Fuentes. >> Fuentes: Thank you. And I just want to give my gratitude and appreciation to Tara and Trisha and Dr. Boccellari for joining us today to talk about bringing a trauma recovery center to Austin. As you shared during your presentation, this is much needed, it's a proven, effective model. I mean, just seeing the rating of about how having a trauma recovery center that we've been able to increase the mental health services, and increase the reporting of crime, and decrease PTSD -- I mean, those are all important metrics for us to be sharing with the community, which is why I'm excited to be here today. And I don't have questions at this time, but when it's appropriate I'd like to lay out

[10:21:21 AM]

my recommendation. >> Tovo: Thank you. Councilmember kitchen. >> Kitchen: Thank you, councilmember Fuentes, and I look forward to you laying out your resolution. I really think that trauma recovery centers, it's really time for this in Austin. And, you know, I view them as a piece and a component of our whole healthcare delivery system. Which as we have been talking about, you know, public safety is much broader than what we traditionally think about public safety. Public safety extends to our healthcare system. And the health -- nationwide, the healthcare system is recognizing the importance of community-based care. And partnerships with community-based organizations in

[10:22:23 AM]

order to actually really -- actually have a chance at reaching people. So, and I think that as you mentioned that one of the benefits that trauma recovery centers serve is they really complement the existing healthcare system, but they're also accessible for people who -- there's so many different reasons that someone may not access a mental health center, you know, -- you know, you know much better than I, I could go into a long list of reasons. And there are barriers and there's health equity barriers and there's disparities in -- in cultural understanding. There's, you know, there's just a whole range of issues of why people don't have access. So I guess that I'm saying things that I know that you already know and have

[10:23:24 AM]

experienced. I just want to say that I recognize this is a very innovative model, and I appreciate you bringing it to us. And I see it as an important component, not as a -- not as something that we don't

need and not as something that we are already doing. So we need the healthcare system as a whole. So thank you all, and I really, really appreciate the data, the evidence-based approach to this, and your data analysis, because that -- you know, we always want to make sure that what we're proposing may sound like a good idea, but unless we measure results, we don't know if what we're doing is actually going to achieve what we think and need. So, I just want to thank you for bringing that data to us. >> Thank you. >> Thank you. >> Tovo: Yes, mayor pro tem. >> Alter: Thank you, good morning, and thank you for being

[10:24:25 AM]

with us. I believe that strongly that we need to have a public health approach to violence prevention. And I see a lot of promise in this model. I'm still learning some of the ins and outs and what works and I think that as a community, you know, we're going to need to -- to figure out what will work here in Austin with the configuration of players that we have. I wanted to ask Ms. Boccellari, and I'm sorry if it's Dr. Boccellari -- I'm not sure -- if you could speak to the number of staff that you see and the type of staff that work in these centers and the kind of location? I mean, right now we're kind of hearing this vague -- well, it's in all of these places and they do X, Y and Z, but I'd like a little bit more of the nuts and bolts of how it's run and some of the -- if you could also speak to the variation of the models in terms of who's running it. >> Yes, thank you for that question.

[10:25:26 AM]

So the TRC model has a number of core elements. And that's what defines the fidelity to the model. But one of the nice things about this model is that while there's a structure to it, it allows for enough flexibility so that each community can adapt it to local -- their local communities. So that's number one. Number two, it's made up of a multidisciplinary team of social workers, psychologists and a psychiatrist. And they all work together as a team to coordinate care. I think this is a very important piece, it is not the TRC, does not see itself as being defined to four walls of a particular location, but each client is assigned -- a coordinator of care. That coordinates the services, not only within the TRC, but across the entire system of care. So we end up hopefully

[10:26:29 AM]

leveraging existing community services and the TRC clinician helps to organize it. So instead of running all over Austin, for example, to get services, the coordinator will help to coordinate and make sure that everyone working with the client is all working toward the same aim as healing. Each -- you know, I can speak in terms of usually the budget for TRC is about a million dollars and, of course, it depends on the cost of salaries in a particular location, but I can give you an example. In San Francisco, you know, we have a little bit more than a million dollars. San Francisco is a very, very expensive but for that we have

about three to four social workers and a psychologist, a part-time psychiatrist. And we also do include in that and we suggest that there be

[10:27:31 AM]

some capacity to have like a data manager that will help -- to help to keep the TRC on track in terms of being accountable. You know, I also just want to point out that I think that the TRC -- for me it's never really been about this particular model. And I really want to stress that. It really has been about trying to change the system of care that often has already been pointed out that really leaves a lot of victims behind. So this is a very inclusive model. You know, we hire staff that are multilingual, and also reflect the communities that we serve which by and large have been Latino and black communities. I hope that answers your question. >> Alter: It does. And I think that it is really important as we go into this to understand that there's a lot of opportunity and, you know, I

[10:28:33 AM]

appreciate Trisha and Tara coming, you know, with a particular approach. But I think that we do have a lot of folks in our community who have worked on similar collaborations, and there are ways of working in our community that have worked, some that haven't worked, and, you know, opportunities to partner to make the funding more sustainable that we need to build that into the process as we go. So I don't want to get ahead of the resolution, but I think that, you know, for me it's -- it is really important that process that we go through if we decide as a council that we think this is something that belongs in our community, how it gets constructed and that process will affect its success and the buy-in we have from the various partners and the people who can participate. I had an opportunity to speak with Trisha and Tara -- I think that it was on Monday. And one of the things that I

[10:29:34 AM]

would still like a little bit more clarity on is the model that you are thinking of, which may not be the model where we end up on after we go through the process. As I understand it, it involved, sort of say public health having an rfp and then have an organization to do that. Can you speak either Ms. Boccellari, or the two of you, to the type of organization that would do this, and whether that kind of organization is already existing, and if it's not in our city, what happened in other places in terms of taking over the leadership of this kind of enterprise. >> I can tell you what is happening in the rest of the country. First of all, out of the 39 current trcs, about a third of them are affiliated with a level one trauma hospital. And in those cases, clients are easily identified on the trauma

[10:30:35 AM]

surgical units as recovering from physical injuries. Many other trcs are community based and have many different entry points into a TRC. The way that a lot of communities have adopted this is to craft a -- an rfp that is then sent out into the community. The grant application, you know, describes the core elements of the TRC and asks the applicant to address how they might go about setting up a TRC if they were given that award, and then there is a grant review process that goes on. And hopefully, you know, the best applicant is -- becomes the TRC. I think what this does, as I mentioned, it would then allow Austin to really think about this model and to figure out who do you think in your community -- what the qualifications and the

[10:31:36 AM]

characteristics of agencies in your community that you think would best serve the Austin community. So, again, I want to be very clear that while this is a model that has a lot of structure to it, you all can better define it. I don't -- I don't mean to impose myself in on this process, but if there is any way that I could support you, typically, you know, some of the states that I've worked with, I have helped them with the designing of the application process. And if indicated, I can help to be a grant reviewer, or just an advisor to the process. Once the TRC gets established, my team, which is a tiny little team, we can provide technical assistance. We have a technical assistance manual and we have an implementation guide, we have procedures that we are happy to share with people and happy to share with whatever agency ends

[10:32:37 AM]

up getting the funding for this. We do this just because we really believe in this model and we really believe that the time has come that communities have access to evidence-based care. >> Tovo: Did you want to speak if there were particular organizations that you have in mind? >> So we had one-on-ones with a few different organizations. And I think that one in particular that is -- that is doing parts of the model would be, like, the Austin literacy project. There's a couple of others but, really, you know, we would want to talk to more people and see if there are other people that are interested in applying for that rfp. >> And we know that many of you, you have extensive knowledge of the organizations that already exist and as Tara said when we started this process, we did talk to different organizations

[10:33:39 AM]

such as the literacy coalition at the time, which was surprising to me given their name, but they do help people to fill out victims services applications. And they do have, you know, the case management and counseling piece. The same with the ywca. There are organizations in our community that could have fidelity to the model and scale up some of the things that they're already doing. And instead of recommending a specific organization at this point, just going back to what Dr. Boccellari said in terms of utilizing her expertise in getting these up and running in 39 different communities around the country, I think that her organization as a resource helping city council potentially the county, the stakeholders to figure out what does look best in Austin based on who we have

[10:34:39 AM]

here that could potentially scale up. So, we're very appreciative of all of the time that she's put into this, and her willingness to help us and help you all through that process of finding the right organization or partnership of organizations that can scale up, and can have fidelity to the model. Because the core elements of the trauma recovery center I think are very important to keep in mind. Also I wanted to point out or reiterate what Dr. Boccellari said about them having kind of a template for the rfp that does outline all of these things that maybe are useful for council to review as well. >> Alter: Thank you. >> Tovo: I have a couple questions or at least one main one for Dr. Boccellari. In looking at what I think is a

[10:35:41 AM]

website, is your -- is your organization's website, it's the traumarecoverycentermodel.org, is that your organization? >> I'm sorry, that organization is specific to San Francisco. We also have a new website for the national alliance of trauma recovery centers. And the national alliance of trauma recovery centers is a coalition made up of all of the trcs across the country. You can look at both websites but the one that reviews around the country is www.nationalallianceandrecoveryc enters. >> Tovo: Thank you, I'll have to look at the alliance for safety and justice trauma recovery center website, because it looks at others around the country. This is a very interesting model and I'm really excited to be exploring it. What I'm seeing -- what I'm seeing on this page at least in

[10:36:42 AM]

looking at trauma centers in Illinois, California, Ohio, new Jersey and Georgia, seems to be largely lots of participation from the medical community, from -- that these are centered in hospitals or have strong participation from their medical community. Is that -- does that -- can you speak to that, I guess, Dr. Boccellari? >> Yes. >> Tovo: I know that you said one-third are affiliated with hospitals but the ones that I'm seeing here seem to be primarily to have strong participation at least from the medical community. >> You know, again, one-third of the trcs are affiliated with level one hospitals. The other trcs are

community-based. And the ones that are community based still do have relationships with local hospitals because the local hospitals are the ones that often are on the front lines doing the initial medical

[10:37:43 AM]

interventions for victims of violent crime. But there are many trcs that, again, are community based. There are some trcs that actually started out primarily being child advocacy centers and then spread out to become a TRC. You know, I think that's the other point that the TRC -- many victim services tend to silo victims, and so child advocacy centers and all really very important. We also see additional victims which are victims of community violence and family members of homicide. I will tell you that every community we have gone into, there has been a legitimate concern that existing victims services feel that the TRC is going to come and take over. And that's not the case at all. You know, we work actively with domestic violence shelters and rape crisis centers. We basically believe it takes an entire community to heal people

[10:38:44 AM]

from violence and we work very actively with the existing partners. And there's not been one example across the country where a TRC has come along that has ended up defunding another victims service. So it's a way of really bringing victims services together and, again, leveraging the existing services as well. >> Tovo: Yeah, thank you. And I guess that I'd like to invite either Tara or Trisha to speak to the same question, because I guess that is really the site that is most closely organized or connected with your work. And I also am interested in some of the other partners that you may have -- some of the other organizations, and I have a couple they wanted to ask if they've been involved. But let me open it up first to answering the same question about the medical -- the relationship that you see with medical community. >> Yeah, I would say and, again, in the conversations that we've had around this, we have done a couple of virtual site visits. We have included people from Seton to enter that

[10:39:45 AM]

conversation. So we have discussed the model and had very preliminary conversations with them. They showed some interest, but, you know, it's been a kind of a chaotic time. So I do see moving forward having that relationship with the hospital. And not just them being an entry point for people to the trauma recovery center, but being a partner as well. >> Tovo: Thank you. >> And that's another way that, you know, we can be creative about what this looks like in Austin. And as Dr. Boccellari said, in some places they are hospital based, but still physically located in the community. And I think -- it is important to point out that a lot of victims, especially if they've been in the hospital, they don't want to

go back into the hospital, right? They may be more comfortable going somewhere in the community. And so in other places we have

[10:40:45 AM]

interest from the level one trauma hospitals in kind of being the driver of this. We know that we have other amazing resources, such as central health, that could be brought into this conversation. Especially when we talk about opportunities for sustainable funding. And I think that Tara was going to talk a little bit about that as well, if that's okay for to us do that now. >> Tovo: Sure. That's actually one of the questions and some of the feedback that I had about the resolution that we're considering today is really setting up the process of exploration in a way that leads to that sustainable funding. So I am really interested in -- I'm really interested in making sure that the dialogue at this point is structured with those other voices here, like integral care, safe alliance, potentially the trauma-informed consortium of central Texas, and some of the others -- the hospitals, you

[10:41:46 AM]

know, the others, central health that you mentioned, and the other organizations that I think that are going to be where this really fits very squarely within their mission and they have expertise that will help, I think, to help to drive the model that is going to best work here in Austin. >> Tara, could we speak for just a minute -- >> Tovo: I'm sorry, are you engaged in conversations with any of the entities, as I mentioned, like the trauma informed consortium of central Texas or safe alliance? >> We did a presentation at the consortium early on, because we have been having these conversations and engaging people for about two years now. And as Tara said, it's been a chaotic time with covid. But we have talked with them and the safe alliance was actually on the victims' services and support committee of the task force for public safety.

[10:42:46 AM]

And so it was safe, it was APD victim services. There was a representative from care, and so we had an opportunity by serving on that committee to really educate those stakeholders about the trauma recovery center model. And so it was the key recommendation that came out of that. So these community partners know about the TRC model and they are supportive of the TRC model. And I think that you're right, that having this conversation on a deeper level -- once there is a commitment, you know, that the city and the county are committed to funding this, to making it happen, then figuring out where it goes. And where the rfp lands. And the nuts and bolts of it which, again, is something that

[10:43:47 AM]

Dr. Boccellari has helped so many communities to do through the implementation process. >> Tovo: Thank you. And, again, this comment may be best for the resolution as we talk about the resolution, but I think that it's really -- it falls so squarely in -- in the missions of places like integral care and central health and some of our medical partners that I would really like to see us structure the conversation in a way that involves them so that they can help to sustain that model over time. I think that you mentioned sustainable funding into that and that is really critical. So I think that setting it up and making sure that there's investment and energy in helping to craft that at the outset will help that to be sustainable, because I'm not sure that it's something -- I mean, it's certainly not something that the city of Austin could fund over the long run on its own. >> Right, right. And also the importance that big players are very important. So are smaller community groups. , I think, in making sure that in

[10:44:49 AM]

keeping it community based that they are part of the conversation as well. Especially stakeholders from the communities that are the most harmed right now and the least helped with services. And that don't access usual care. So I think that we strongly support that approach with bringing in the bigger players. And also making sure that it's ground in the community and that all of the stakeholders are involved so that there can be fidelity to the core principles of the model. And we have thought about the sustainability of it, because as you said, the city and the county, you know, may not be the long-term primary funders of it, and you mentioned all of the other stakeholders, including central health. And including Dell Seton, because that relationship is very, very important. And I believe Tara and

[10:45:52 AM]

Dr. Boccellari both have expertise on boca funding and other funding that will kick in, and so, Tara, did you want to -- >> Tovo: If you would, I see one of my colleagues has a question. Councilmember kitchen. >> Kitchen: Just quickly, I'd like to follow up on this -- on this part of the conversation, which I think that is good, but I want to back up for a minute. Can you describe the types of services that are provided through trauma recovery? And what I mean by that is -- and delineate or distinguish between medical care and peer support, and -- and assistance with social determinants of health. If you could just distinguish across those, because to my mind the medical model is -- it can be a part of this, but one of the things that having a community base can give you that you won't get from a traditional medical model that is a hospital

[10:46:54 AM]

system, or, you know, that is a clinic that's harder to get is that peer support and the -- and also the addressing the social determinants of health. So I know that these -- these models range in that kind -- in those types of services. Because it's dependent on the community and the community needs. But I'm curious about what you all have seen in the -- give us a flavor for the types of services and the types of professionals -- professionals and, you know, para-professionals who provide this kind of work. >> I think that is a good question. I'm sorry -- >> No, you -- >> Okay, I think is a great question. And one of the things that we

[10:47:55 AM]

learned early on that a lot of victims of violent crime need practical assistance, they need help with safe housing, they need help if they are homebound and getting out of the house. So it's a case management and a mental health model. We do everything from outreach if clients can't come to us, we go to them. We do the home visits. We provide lots of practical care. And oftentimes victims may be reluctant to go into mental health treatment because of the stigma related to it, but by providing them with a trusting case manager and other practical care it becomes an entry into mental health services. And when those mental health services are provided, they also can be provided in the person's home, in the community, now with covid, you know, via zoom mental health meetings.

[10:48:56 AM]

The mental health services that we provide are all using evidence-based mental health treatment, things like emdr, cognitive processing, those types of evidence-based treatment. We provide group treatment. We provide medication support services if the client is needing medication support, we provide substance abuse, and alcohol treatment or referral to primary alcohol and substance abuse treatment. So really wrap around services that meet the client where they are. If the person ends up, you know, we have seen a number of gunshot victims who end up being paraplegic and end up having a lot of medical needs, we have -- we don't provide the medical services, but we make sure that they get the medical services that they need and we help to coordinate with the primary care

[10:49:56 AM]

doctor around what else is needed. We can also provide work with the family. We provide support groups. So there's a whole range of services that is hopefully provided that, you know, we aim to provide in a very welcoming trauma-informed way. >> Kitchen: And can you speak -- just give us all an example of the type of professionals. So you may have -- do you have psychiatrists, psychologists? Or is

it more local mental health professionals? What exactly are -- just -- >> Yes -- >> Kitchen: I know that it ranges but just give us an example. >> The majority of the staff are licensed social workers and make up the bulk of the staff. And usually one or two psychologists. And a part-time psychiatrist. And many of the trcs also have peer counselors. And we absolutely support the use of peer counselors.

[10:50:57 AM]

And we also recognize those that some of our clients that have more severe PTSD symptoms where they can't sleep at night or they're suicidal or they're really agoraphonic and they need more, and that is when they have experience during the evidence-based treatment comes in. So it's a multidisciplinary team that works with the client. >> Kitchen: Okay. Thank you. That's very helpful. That's really what I was guessing but I wanted to understand better what your experience is. And so I agree with the conversations that we've been having. I mean, obviously, there's a range of types of entities that could -- that could respond to an rfp, for example, that could host this. I think that the important aspect of it that's different is that -- that community-based

[10:51:58 AM]

connection, you know, and those services that look at the whole person. Because what you often -- and that's -- that's -- that's not instead of, but that's in a referral relationship with your medical systems. So your hospitals are going to refer to a trauma recovery center. You're going to refer back to your hospitals. The clinic systems, you're going to do the same things for. So I just want to caution that we not be thinking that this has to be created by or sustained by or run by an existing medical-based institution or agency in our community. Because what's really important is that community-based approach. Now, obviously, this needs to be -- obviously, this kind of -- you would never operate something like this in a vacuum. Because, like you said, you're

[10:52:59 AM]

working with the whole person's needs. And so you have -- you have to have referral relationships, you know. So I think that there's a lot of opportunity to have a conversation about what works for Austin. There's a lot of different communities that could come to the -- you know, could come to the table to help with sustainability and/or to initiate, perhaps initiate and spin off, or perhaps just spin off. There's a lot of opportunities. I like -- maybe it's more of an rfq kind of approach to begin with that is a possibility for ideas to be shared. You know, our medical community has to be -- our medical and our social service in our community-based organizations need to be part of that conversation. So, thank you. >> Tovo: We are running behind and we need to move on to our next presentation which is also a pretty meaty topic.

[10:53:59 AM]

So councilmember Fuentes, I will recognize you. And thank you to our speakers and presenters and for all of your work and being part of this conversation today. Councilmember Fuentes. >> Fuentes: I would like to move adoption of this committee resolution. >> Tovo: Councilmember Fuentes moves approval. And councilmember kitchen seconds it. Thank you. >> Fuentes: Thanks, thank you so much, colleagues. As you can tell based on this presentation and from today's conversation we desperately need a trauma recovery center in Austin. And it is a conversation that has been happening in our community for the last two years. It's a recommendation that has comeut on of our reimagining public safety task force, and it is also part of the conversations that the Travis county commissioners court is having, with commissioner Brigid Shea. And it's important that we as the Austin city council move forward and starting -- or, you

[10:55:01 AM]

know, formalizing that conversation of what it would take to bring a trauma recovery center to Austin. And so this is what my recommendation resolution is focused on, is really looking at how can we focus in on that community-centered approach. We know that this type of model, a trauma recovery center model, is a powerful tool in healing communities and addressing our communities that are often suffering the most harm and have been left behind. We know that there are gaps in our system. Not everyone feels comfortable reporting crime. And so we need to have places where our community can go. We need to have a more robust system in place, and so this is what today's resolution focuses in on, is how do we start creating that systemic change. I believe that strongly that city council should be supporting the initial start-up costs of a trauma recovery center. And so what this resolution would do is direct staff to take a look at the feasibility and

[10:56:04 AM]

supporting the operation of a trauma recovery center. It asks staff to take a look at -- to identify potential funding sources from the city of Austin, up to $500,000 for year one and $500,000 for year two. So a total investment of $1 million. It also asks staff to do that collaborative work, both with Travis county, with Williamson county, and local hospitals, and other governmental partners. We realize that this is an opportunity for us to engage multiple stakeholders, and also, you know, making sure that our community stakeholders have a part in the process and in helping to shape what a trauma recovery center model looks like. I want to thank councilmember kitchen for serving as my co-sponsor this resolution, as well as mayor pro tem, for your -- you have been such a leader in this space. So I wanted to share my gratitude for the work that you've done.

[10:57:05 AM]

And, certainly, your support and providing feedback on this version 2 of the recommendation. And I think that, colleagues, everyone has a version two that has been redlined that shows some changes to the recommendation. And so with that, I will turn it over for comments and questions. >> Tovo: Yes, mayor pro tem. >> Alter: Thank you. Councilmember Fuentes, thank you for bringing this forward and recognizing the importance of how we address trauma in our community. I definitely see the need for trauma recovery center in our community. You know, I'm not on this committee, and so this kind of came up on me a little bit quickly, so I appreciate you working with me to -- to edit the original version so that we make sure that we build into the process the things that are necessary for a trauma recovery center to succeed as we proceed.

[10:58:08 AM]

I think, you know, some of those things really involve having folks who are familiar with some of the Austin pieces and the governmental elements of how we do a lot of these pieces, together with the models that are out there, we've had the benefit of trying some things where we've adapted models that are used elsewhere in a number of different ways into our community. And I think that we have some learnings from that, that we can take away, and we have a number of groups within our city that touch on this, whether it's in our public health, with our ovp, whether it's, frankly, our ems service. We have a new ems chief that is coming in with a lot of experience working with hospitals. We have a fabulous victims' services division, which we don't seem to be able to staff enough. So, I think that this is important as we move forward.

[10:59:09 AM]

And it is really important to me that we go through this process from beginning to end so that we can construct something that really works in Austin. I would just want to clarify that you're putting forward version two as your motion, and then I am not serving on the committee, so at the point that we move forward, I don't get to vote on it. If we could do something similar to what we did in Austin water and I'll let you take care of that, Vanessa, at the appropriate time. Thank you. >> Tovo: Yeah, thank you, I think that is a very exciting and an important direction and I appreciate you bringing it forward. I think -- and, you know, I also appreciate -- I appreciate our participants who have advocated for this, including our earlier task force. One thing that I would like to just offer as a suggestion to consider between here and council when it goes forward for consideration -- you know, there are different ways to set up this kind of exploration.

[11:00:09 AM]

And, certainly, one is the way that you've done it -- to asking the manager to kind of do the research and do the work and come back with a report. One thing that I think that kept the process moving really quickly with the sobering center was to structure it a bit differently and to compromise a compromise a stake gold and to have that work group to do the best practice research and to do some of the considerations, and judge brown, now judge brown chaired that work group. It was comprised, it's been a long time so I don't remember exactly who office that committee and it was comprised from the people like the judge who kept the idea alive. They looked at best practices and had support from staff but they were able to pull in the data from the appropriate city and county staff to help to inform the report and they looked at the best practices and then they were able to really

[11:01:11 AM]

provide respectations, but also to identify the questions that should be answered by those entities that might -- that might be best poised to be partners. In this case the county and the city. And then we followed up with kind of a small work group of elected leaders supported by our county and our city staff to answer some of those questions. And so as I think about different efforts and how -- and which ones have succeeded and which ones succeeded on shorter timetables, that may be one thing to consider. And one benefit of doing it in this setting is that the work group could be comprised of being long-term partners. And not just in shaping the model, but also helping and shaping the level of investment and I mean that in all of its senses. I think that it would help to broaden the base of investment in it, both political investment and also eventual financial investment.

[11:02:11 AM]

I would hate to see an effort like this begin and then not be sustainable beyond the two years of funding. So I think that broader-based investment is really critical to this success. And I want to be sure that when we start a commitment like this, that we have the ability to sustain it over time for all of those who will benefit from its services. So that's a suggestion that I would offer to you between here and council. >> Thank you, chair tovo, and thank you for that. We do want to work on a shorter timetable so I appreciate you referencing the sobering center as a model to look at and me and my team will look at any updates before it comes before council. >> Tovo: I don't know that it was a super speedy one but it was effective and it got us -- it really advanced the ball in a way that is sometimes harder to do with we're relying on our city manager and his staff, and, again, I think that it has the other benefit of not just keeping the process moving

[11:03:12 AM]

forward in a really deliberative manner, but, again, by getting that community buy-in that you just need to help an initiative to be successful. >> Fuentes: Thank you. And chair tovo, if we could have councilmember alter listed as a co-sponsor if it should go through to council. >> Tovo: Thank you, if the staff would note that. Mayor pro tem? >> Alter: Thank you, thank you councilmember Fuentes. What we did in Austin water is have everyone who was present in the committee, and then -- then we added the person who wasn't on the committee. I had one tiny edit councilmember Fuentes. We had been talking about the dollar amounts. And I'm just wondering if this would be slightly clearer to say up to $500,000 -- in part two of your be it resolved -- where it

[11:04:13 AM]

says up to $500,000 for the next two fiscal year to support the start-up costs of the center up to one million. If it would be simpler to say, of up to $500,000 for each of the next two years to support the cost of the start-up center without the other "For up to one million." >> Fuentes: Okay, yeah, I'm fine with that change. >> Alter: So for staff that would be inserting "Each of" between "For" and the next two fiscal years and deleting "Up to one million." >> Tovo: Okay, any other changes or discussion? All in favor? And that is -- those of us on the dais and the committee, councilmembers kitchen, Fuentes, tovo and mayor pro tem alter would like to be added as a sponsor. Councilmember kitchen?

[11:05:14 AM]

>> Kitchen: I have a question about the amendment. I want to make sure that I understood it. >> Mayor Adler: Councilmember tovo, I also raised my hand. >> Tovo: My apologies, mayor. >> Mayor Adler: That's okay. >> Kitchen: Do you want to take the mayor first or should I ask my question? >> Tovo: I think he was voting. >> Kitchen: Oh, okay. So, let's see -- so we changed it for up -- of -- I'm sorry, would you read that to me, and so -- >> So the original question was $500,000 over two years or $500,000 each year and councilmember Fuentes put forward a particular way of phrasing that. And I was suggesting that it might be clearer to say "Up to $500,000 for each of the next two fiscal years to support the start-up costs of the centers" because what we're asked by advocates is to do $500,000 for

[11:06:14 AM]

each of two years. >> Kitchen: But we're not changing the total of one million? >> Alter: No, it's just clarity. And, obviously, that can -- >> Kitchen: I think that it would be helpful to just still keep "For a total of one million" to avoid any kind of -- to make it clear that we're -- >> Tovo: Let's do this, since I took a vote and we voted, I think we'll need a motion to potentially reconsider if you have -- >> Kitchen: I don't

think that we have to do that right now. I might -- when it comes to us in front of council, I might want to change that language, because -- because I don't want it to sound like we're only committing to $500,000, you know -- I want it to be clear that we're talking about a million over two years. But you don't need to change it right now. >> Tovo: All right, thank you very much. Okay, great, thank you. Let's go ahead and move on to our next discussion. And that is our briefing regarding the substance use disorder community planning process which has been going on

[11:07:15 AM]

for quite a while in our [loss of audio] And Courtney Lucas, thank you for your willingness to let us to swap those two sessions around. Courtney is also a senior planner within the research and planning division of Travis county's health and human services. Welcome so much. This is a briefing and we're not scheduled for action on it. And I know that councilmember kitchen and I both attended some of those community planning meetings over the years, so I'm eager to hear where we are now with that process. Thank you. >> Hello, chair and mayor and councilmembers. Yes, I am joined by my colleague Rachel croft and we are both senior planners at research and planning division at Travis county health and human services. We were the two facilitators for the substance disuse disorder community planning process and we will do this briefing. Next slide, please.

[11:08:16 AM]

So today's purpose is to provide you with a briefing on the 2020-2021 substance use disorder community planning process. We have a lot of information to share with you during our limited time today as this represents two years of work. So we'll provide a high level overview of history and purpose. And community participation. Work process and products. Equity framework and next steps. We hope that you leave today's briefing with a fuller understanding of the two-year process that led to the final recommendations and our planned next steps to implement these results. Final recommendations are later in the slide deck in which after today we'll be moving forward more formally. Next slide. So before we get into the history, we just want to make sure that we're all working off the same definition. You may have seen substance abuse used in the past, but the preferred current terminology is

[11:09:19 AM]

substance use disorder or suds, and it's including health problems and disability and failure to meet major responsibilities at work, school or home. And the Travis county community has a long history with assessment in community planning efforts in sud. And these efforts over the past 20 years all made a clear recommendation to have a shared planning structure. However, the community has been unable

to agree on a collaborative planning process. So judge Eckhardt began to explore the coordination in the community via a health authority designation for integral care. And our mental health authority. And the community's reaction to this proposed change was mixed and charged. We had the judge to step back and to explore the community interests and coordinating the sud services and supports. So Travis county HHS hosted two community forums and were tasked

[11:10:19 AM]

by the judge to lead a community planning process to make recommendations around a future planning structure. Next slide. So a planning structure is a working title for an agreed upon shared table. Where the planning for suds could happen in a holistic and an effective way. What this looks like in practice could vary widely and it does range across issue areas in our community. For example, success by six, and the aging services council and they are all examples of planning structures in the community. So we think of an effective planning structure meets shared values, including those around racial equity, a defined scope, clear roles and functions, robust community participation, and a convening entity capable of the stewardship of and fidelity to all of those elements. It is critical that the community and the decision makers support, and participate

[11:11:20 AM]

in and orient about single shared table. This would promote a coordinated community approach to funding the service continuum, and while sharing that we address equity and inclusion in any plan developed from the shared table. So big picture, this sud planning structure allows the local government and the community to create and steward an sud community plan, with broad community support and buy-in, and identify, adjust or secure resources to address the service gaps, better serve residents through an sud plan through a framework of equity and accessibility. And implement strategies and a coordinated in a comprehensive manner throughout the community. And position the community to effectively to leverage more resources and to guide future decision-making for local authorities around sud-related issues and investment. Next slide. So this slide shows an overview

[11:12:22 AM]

of the phases of the sud community planning. These four phases represent the long view of what it will take to have an operational planning structure that is implementing a community plan for substance use disorders. The reality is that there are just no shortcuts to get there, so we have spent two years on this part of the process taking an approach unlike past times. Our approach is inclusive and comprehensive and collaborative. We have made efforts at various phases to include and inform all relevant and interested stakeholders, to build broad community support and involvement. Since we want all voices at

the same table. Through the course of this process we have reached out to almost 400 people to offer participation opportunities, and we continue to keep that group informed regularly. And so we feel like we have covered all of the necessary components in the right order of an effective planning structure that will work for our community. Our approach is rooted in our

[11:13:25 AM]

interest-based problem-solving methods and embodying our key facilitation principles. So the work is participant driven. Right now we are at the end of phase two, create a planning structure. And the goal of this phase was to make recommendations for what that future sud planning structure should look like. The goal was not to create or implement an sud plan. As that's the purview of the future planning structure. And this has been and remains an important distinction for us to communicate to stakeholders. So the line down the middle of the page shows the hand off from Travis county HHS to that future planning structure who will then work to develop and implement the community plan. And one quick note about the timeline shown here -- when this work began we initially projected the project to take the entirety of 2020, and soon after we started we entered into a global pandemic. And unsurprisingly this caused delays in timelines and timeline

[11:14:26 AM]

adjustments which is why this phase took a full two years to complete. Next slide. Strong community participation was an important part of this process so we invested a lot of time and attention to it, from start to finish. Our commitment to inclusion ensure that no one was turned away from participating, and we helped to match individuals to participation roles based on their interests and availability. As the pandemic progressed and turnover became more of an issue, we maintained this commitment by continuing to onboard new participants and match them to groups. So we have three main ways that people could stay connected to the work. The bulk of the time and the labor came from our work group. This group engaged in an intensive, collaborative process to make decisions together and craft recommendations. This group was made up of interested community members who could commit the time and the energy to the work. The leadership review group was

[11:15:26 AM]

intended for those in a leadership role who were in a position to apply a system-wide perspective and reviewing the work group results. They were invited to substantively to engage with the work and to provide feedback in order to improve the final products. Interested community members who may not have had the time or interest to participate in these groups, or wanted to participate in later phases of the work could opt to stay informed via regular email updates. One note that full membership rosters

for the group are included in the final recommendations document, which is part of your back-up. And so now I'm going to hand over to rainel to review the work plan on the next slide. >> Thank you, Courtney. So we'll dig into the plans, the timelines and the work flows now that we use throughout this process. And provide a brief overview of the progress that came out of it. This line shows a visual

[11:16:27 AM]

representation of the work plan that guided these two areas of work. From the very beginning, we knew that this project would need to be -- excuse me -- would need to be broken down and organized into smaller parts. So the first thing that we did with our work group participants was to co-create this work plan collaboratively. Figuring out what questions we needed to ask and answer together, in order to arrive at recommendations for our planning structure, and then figure out how to sequence that work. So I'll give a quick description of the visual here which we call our work plan wheel. In the center the dark blue slices of the wheel are the large phases of our work plan. These were the major topics that we worked through, starting in the top right with values and working our way around the wheel clock-wise. In the light blue ring are the deliverables from each phase. These were the tangible products that were created. And, lastly, surrounding the outside of wheel are the guiding questions that we had to answer

[11:17:28 AM]

in each phase in order to create those deliverables. So when you are looking at this graphic, the one thing that we would hope that you would take away from is that while the slices may look separate, they are deeply interconnected. There was a logic to the order of the content so that each phase could build on what came before. We wanted to make sure that by the time that we reached this final questions about the convening entity that the discussion was fully informed and built on a solid foundation of understanding. Taken all together, the cumulative -- excuse me -- the cumulative results of this process represent a clear and a robust scaffold for an sud planning structure. Next slide, please. This slide shows a simple illustration of our work flow and how we used the participant groups that Courtney described in order to create those deliverables. As the work group moved through each phase of their work plan, they created deliverables to go

[11:18:29 AM]

to the leadership group for review. The leadership group would provide reactions and suggestions. And the work group would then consider all of that feedback and make final revisions. In practice, this repeated for every deliverable, so that there was a continuous flow between the groups for the duration of the process. And right now we are on the far right of the work flow, when the holistic set of all deliverables is moving forward to the approval authorities. And Courtney and I have served as the

facilitators for this project, and judge Eckhardt assigned us because our division, research and planning, is trained in planning and group facilitation we covered process design and project management and managing the work flow represented on this slide and providing all in-meeting direct facilitation and all support. And as we move into the approval stage, Courtney and I will steward this through formal action round recommendations towards that hand off to a fully

[11:19:31 AM]

operationalized sud planning structure. Next slide, please. This table shows you the full results of the process. We know that this is a lot of information and it may not be fully readable on the screen so we have provided it here more as a reference. All are included in full in your back-up and the community can view them publicly and we'll have the link at the end of our slide deck today. But we demonstrate the depth of content that the work group created. We strongly encourage all interested parties to read the results in full. As you saw in the work plan, none of these deliverables are meant to stand alone. The recommendations are interdependent and as a whole they create that comprehensive blueprint for our planning structure. We also want to acknowledge our community participants and credit them for these very important and significant results. They have stayed committed to this planning process through a pandemic, timeline delays, they had to learn new technologies and new ways of working, and

[11:20:31 AM]

they showed patience, grace and dedication. They engaged deeply with this work and their tremendous effort has generated a promising vision for our community. Next slide, please. Before we talk about our next steps in the process, we want to pause briefly to highlight one of the areas that we think that was a major strength of the process, which was our workaround equity. So first a bit of background. The movement in the summer of 2020, coincided with the sud community planning process remaining virtually in June 2020. And we received participant feedback about the importance of the equity in the work, given the negative impacts of suds on people of color and the intersection of race, criminalization and substance use. Travis county HHS agreed that this was a priority and we have purchased consultation services from a skilled practitioner in race equity work. Dr. Martha Ramos cover, and our

[11:21:37 AM]

goal was to build equity and have it in the process structurally and not just as a stand-alone topic. So her work began by doing a review of our work plan and looking at incorporating anti-racism and into the questions, tasks and deliverables. We consulted with Dr. Ramos duffer to have effective activities with strong tie-ins to equity shoot. Y directly facilitated our work group members in two working sessions. Focused on identifying the impacts of racism on substance use disorders and developing a framework.

Following those sessions she provided direct support to HHS facilitators in building out those raw results into two final deliverables. During regular consultation sessions, Dr. Ramos duffer provided coaching around equity focus and professional use of

[11:22:37 AM]

self and understanding positionality and racialized meanings and historical context and techniques from an equity framework. And finally she completed an equity review of every completed deliverable, identifying any ways to incorporate anti-racist languages and practices and principles as a last step before finalizing the deliverables. So we believe that the work to center equity in this planning process was one of its strengths. Of course, this doesn't mean that we're done in applying the equity principles it will have to be an iterative process and we will demonstrate it. Next slide, please. So at this point we have wrapped up the community planning phase of this process, by posting the final results online, including public comments that were received in December and January. So we do invite interested community members to read the results at the link on this slide. And the full document is also included in your back-up today.

[11:23:38 AM]

We provided a process update to the Travis county commissioners court on January 27th. And between November and February, we have convened executive level conversations between Travis county health and human services and the city of Austin, including am Stephanie Howard and central health in order to have a coordinated strategy coming out of the final recommendations. And we have established an aligned pathway forward through our three approval authorities. We have next steps lined up, including first returning to the Travis county commissioners court on March 29th, and at that time we plan to bring forward a voting item for approval and direction around a recommended path. In April and may, we hope to work with our counterparts at the city to build out that court-approved recommendation while simultaneously working with central health leadership. And, lastly, if any of you have further questions after today we're happy to follow-up with materials or briefings, or provide further committee updates. Next slide, please.

[11:24:41 AM]

And that concludes our presentation. So at this time we'll look to the chair to see if there is enough time for questions from the committee. >> Tovo: Thank you very much, I appreciate that. That was a lot of terrain to cover, and I appreciate all of the work that you have done over the last few years to convene these important conversations and to move this worked for. Colleagues, we only have a few minutes for questions here today, though certainly we could ask them after today. Does anyone have something to

ask right now? Councilmember Fuentes. >> Fuentes: You know, without fully understanding the context of why the initial planning process didn't work, or just, you know, what happened then, you know, I appreciate this update. I guess that I'm struggling to understand what this means, you know, so we have a plan to how we're going to do the community planning and developing the plan for our substance use disorder treatment and prevention. You know, we know just last week

[11:25:42 AM]

we had -- what, 12 overdoses and many that were already linking to -- I know that the investigations are ongoing, but to opiates. So for me I think that we are at a point where this really has reached a level of crisis. And what our community needs to see is action and we need to be coordinated in that action and knowing that there are many different service providers and many partners that need to be involved in this collaborative work. And so I guess that I'm hesitating or I'm trying to understand what this means in relation -- like, we're -- like, how much longer are we going to be in a planning process versus when we will see an actual, like, planned product come together, so that we can better address the crisis that we're seeing? >> I think that I can take a stab at that. It's a big question, and there's a lot of history there.

[11:26:43 AM]

I think that the reality is that we had plans before, and one of the reasons that the plans that we've had before have not been put into action is because of this lack of a planning structure, a shared table, where everyone can sit together to do that implementation work. So this planning to plan has all been about establishing that shared table and trying to make recommendations around what it needs to look like. So that is why we have been in this long planning to plan phase. But the more specific question I think that you asked, which was about when will formal action move forward, I think that the answer to that is very soon. We're going to go back to the Travis county commissioners court on March 29th and we will be bringing forward an action item and at that point we will be able to take some more tangible steps forward to operationalize one of the options that the planning process did recommend. >> Fuentes: I guess to add to

[11:27:43 AM]

that, I think that we -- that we -- we recognized and acknowledged that there's a crisis right now, and that our planning process does not preclude action. And we think that many of the documents that we now have in that final recommendation packet could be used to build upon any actions that the community wants to take right now to address what's happening right now. We're hoping that having this planning structure fully functional in the future would make us much more agile and much more

nimble to be able to respond to crisis. And to have folks at that same table ready to mobilize in the future. But for right now, as this process is continuing its pathway forward, there are -- there are many things to build off of in those final recommendations that were from the community in hopes to -- to start addressing anything that

[11:28:44 AM]

needs to be addressed while we're ramping up that table. >> Fuentes: Thank you for that, that's super helpful and I appreciate you mentioning that this doesn't preclude any action from taking place right now to address the crisis that we're seeing of opiates in our community. And so I appreciate that feedback and I look forward to hearing how to the meeting with commissioners court goes later this month. Thank you. >> Tovo: Thank you. Any other thoughts on this to topic? Okay, it looks like we have a little bit of time to read the report in depth and to have conversations among ourselves, and with you, so thank you so much for this update. Colleagues, seeing nothing else on our agenda I would call this meeting adjourned. Thank you very much to all of our presenters and our staff.