

City Council Work Session Transcript – 10/6/2026

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[9:00:30 AM]

>> Good morning everyone. We. A quorum is present, and I will call the meeting to order the work session. Meeting to order at 9:00. It is tuee speakers. And by the way, I will be chairing the meeting today. The mayor is out of town. Is away on important city business.

[9:00:53 AM]

>> Thank you. Mayor pro tem on item B one. Speaking remotely, Melissa shearer.

[9:01:05 AM]

>> Good morning. This is Melissa shearer and I am speaking on behalf of myself, not on Travis county. But my role is I am the mental health public defender. And I am calling today because I wanted to update the council on what's been happening with no wrong door. From our perspective. My I, as I've said many times to a pd Cary Rogers, everyone that's doing the wrong door. We are supportive of getting our clients the services that they need and getting them into long term stability. Our office has been open for 19 years, and we have lawyers and social workers and caseworkers were 2 to 1. Social social service back to lawyers. And so we have deep, long intensive case management relationships with these clients. And my biggest concern is that the no wrong door program has declined to allow the defense to be included in the staffing that they are doing with all of the other providers and the prosecution.

[9:02:20 AM]

Another huge concern for me is that I'm aware that the the sops were changed that were supposed to address some of our concerns, but they actually don't. I specifically said that we did not want our client mirandized when they are seen by police. If this is supposed to be something that is a case management role and not a law enforcement role, then our clients should not be placed in that kind of a position where evidence could be used against them in the future, if they make any statements that are incriminating. We want to work with no wrong door. We provided safeguards that we think are appropriate.

[9:03:10 AM]

>> Thank you very much.

[9:03:11 AM]

>> Also speaking remotely on item B one, nihar Patel.

[9:03:19 AM]

>> Good morning, mayor and council members. My name is Neil Patel. I'm an internal medicine physician who works in the public health safety net system. Here. I and my team care for people with severe mental illness, substance use disorders, and complex medical and social conditions that require appropriate medical care and care coordination. I fully support the goal of connecting people with complex medical and behavioral health needs to services, but engagement with care must never come at the cost of privacy, liberty, autonomy or due process. The record for no wrong door thus far shows troubling practices. As Melissa mentioned, officers repeatedly approaching people in jail without counsel, seeking leases that permit sharing psychiatric and medical records with police and prosecutors, and making bond recommendations tied to no wrong door contacts. The the program uses eight or more arrests as a primary selection criteria. Arrests. Measure.

[9:04:18 AM]

Police. Contact. Not clinical. Need. Building outreach teams. Building outreach around arrest history will both deter care and deepen harms in already overpoliced communities. As a physician, I swore an oath to do no harm. Medical providers cannot be placed in an ethical quandary where clinical care becomes a pathway to surveillance or enforcement. I fully support funding, treatment and care coordination, but not funding for response to medical and mental health needs. And we must protect privacy and hipaa standards. One of the things I would recommend an independent community and inclusive oversight of this program with real enforcement power. I do think that we can improve care and care coordination for austinians. Care that really, truly will save lives and improve health. But we must protect rights. And we need to prioritize treatment, equity, and civil liberties.

[9:05:15 AM]

Through this process. Thank you.

[9:05:21 AM]

>> Speaking on item b1 remotely Cole weaver.

[9:05:29 AM]

>> Hello? Can you hear me?

[9:05:32 AM]

>> Yes, we can hear you.

[9:05:35 AM]

>> Okay. My name is Cole weaver. I. I am a member of united workers care, but I'm not really speaking on behalf of them today. I'm speaking specifically as a peer support specialist that has lived experience with psychiatric hospitalization and what they have represented to me and and why I am very, very weary of the no wonders program in its current form, because. Pastoral care in any way, shape or form has never helped me. And I know several of my peers, clients at integral care that it never helped them

either. Because, and it doesn't, it doesn't matter if it's law enforcement or if it's, you know, involuntary commitment. I'm against expanding that. I'm against, you know, making it to where the community members are increasingly surveilled. And now there's the possibility of detentions being warrantless at that point. I know that there are other experts in this meeting that are going to be speaking more about what is actually the core issues with core concerns with no wrong door. But I just want to state my position that. Mental health care needs to be collaborative.

[9:07:16 AM]

Collaborative, collaborative. It needs to be person centered because when it's not and when it's involuntary. And when rights are when the autonomy is violated because of whatever for a variety of unjust reasons, I am going to be against that.

[9:07:42 AM]

>> Thank you very much.

[9:07:43 AM]

>> And I.

[9:07:45 AM]

>> Will now move to in-person speakers on item b1, Bradley Hargis, bill Bryce, Lisa Huffman, Ryan. Poppy. Please state your name and begin speaking.

[9:08:05 AM]

>> Good morning, mayor pro tem and council members. I'm Bradley Hargis with the capital area private defender service. Our attorneys represent more than 18,000 people who cannot afford counsel last year. We protect their rights, provide an independent voice, and understand the legal consequences of decisions about treatment and services. No wrong door sits at the intersection of criminal justice and health care. It's vulnerable. Clients need support and respects both. The program is well intended, but

implementation without adequate safeguards is causing harm. We have documented officers seeking bond conditions outside the ordinary legal process, and attempts to have clients released directly to officers against their wishes. This program has disrupted ongoing casework without adequately addressing the risks and interactions between police and clients facing charges. Clients, liberty, autonomy and defense are at stake. Good intentions cannot substitute for access to counsel and enforceable protections. We ask council to require three things.

[9:09:05 AM]

First include defense providers in the memorandum of understanding and revise it to address the reasonable concerns that we have expressed. Second, include defense organizations in every staffing concerning their clients before decisions are made. Our expertise, our experience, and our knowledge of their legal circumstances are essential to meaningful interventions. Third, establish written safeguards addressing counsel's access before interviews or release of information. Informed and voluntary consent. Confidentiality the use of statements in criminal cases, and appropriate limits on communication with courts and prosecutors. No wrong door can not responsibly move forward without respecting the rights the attorneys protect. Our client should not have to risk their defense to receive care. Please make defense participation in enforceable safeguards a condition of moving forward. Thank Yu.

[9:09:59 AM]

>> Thank you, Mr. Harris. Mr. Bryce.

[9:10:02 AM]

>> Good morning, council members and city manager. I'm bill Bryce with the downtown Austin alliance speaking in support of no wrong door. I represent the downtown alliance on the no wrong door coalition. And the significance of this collaboration to identify and provide care for people who cycle through our criminal justice, health care and homeless systems cannot be overstated. These are people with severe behavioral health issues who are unable to make decisions in their own best interest, and, due to insufficient resources and coordination, languish on our streets and in our jail. Through no wrong door, local law enforcement and criminal justice, health care, city and county officials and homeless service agencies are collaborating to identify and provide crisis care and step down services for this population, no matter where they enter these systems. No wrong door is identified. 950 high utilizers whose untreated illness and homeless cost taxpayers an estimated 137 million a year without solving the problem. And we see many of these people living on the streets downtown day after day, not getting the help they need.

[9:11:02 AM]

They cycle through jail courts, hospitals, psych facilities and social services, and are often released after a quick fix, only to cycle through the systems again and again through no wrong door. Local partners are working to properly treat and restore people who languish on our streets and in our jails. But this problem is not unique to Austin. At recent Texas house and senate hearings, urban and rural police departments, sheriffs associations, district and county attorneys, local mental health authorities and social service providers from across the state testified on how this problem affects health and safety and exceeds resources in their communities. It costs they can't afford. The downtown alliance applauds no wrong door. As we strive to rally stakeholders and encourage legislators to fill critical crisis service gaps, and we encourage you to put the full weight of the city of Austin behind it. Thank you.

[9:11:54 AM]

>> Thank you very much.

[9:11:58 AM]

>> Good morning, city manager and council members. My name is Lisa and I'm the founder of family bridge, a privately funded nonprofit that provides temporary hotel respite for families with children who are car camping. I also served on the parks and rec board, where I started a homelessness working group and have spent several years studying homelessness solutions around the country. I want to start by recounting a conversation I had with an APD officer who's part of the no wrong door team. He told me a story about a specific encounter with a high utilizer woman he clearly cared for and was concerned for her well-being. He had the knowledge and the decision making to know what step to take next. I was struck by his compassion and dedication and that he chose to be part of the no wrong door team. But I'm here today because I believe no wrong door represents something our community desperately needs coordinated care for the high utilizer population who suffers severe mental illness and have complex needs prior to no wrong door, the only access to care for high utilizers was fragmented. We could stabilize someone in a psychotic state, but without a continuum of care, we would send that person back to the street. The city began asking the right questions. How do we help people who are cycling through ers, jails, streets and our mental health system without ever reaching stability? I'm speaking about what I'm seeing. Having worked in this space for several years.

[9:13:26 AM]

The city is now leading the effort in redefining the multiple agency relationships that allow coordinated care, and no wrong door to happen. All the partners are working together in a unified effort. When one of our high utilizers is having a crisis, the first step is stabilization if necessary, and then they are given the option to consent to further treatment. I understand the concern about civil rights. I also understand the state of Texas has protections in place for those who voluntarily commit to treatment, and a person can opt out at any time.

[9:14:00 AM]

>> Thank you very much.

[9:14:04 AM]

>> Good morning council. My name is Ryan poppy, and I am here on behalf of cw, a local 6154, and the united workers of integral care. Our members work every day with people experiencing serious mental illness, substance use disorders, and other complex behavioral health needs. Our position today is fairly straightforward. We support the goal of no wrong door, but the program cannot successfully connect people to care at the very mechanisms it uses. Destroys the trust required to provide that care. Our mission isn't only to advocate for our members, it's also to speak up for the people and the communities they serve every day. We agree the current cycle of crisis arrests, stabilization and release is not working, and we agree that the individual should be at the center of the response. But the principle must extend to how the program operates. You cannot say, trust us, we're here to help you while creating pathways for detention that undermine that trust. You cannot earn someone's trust and then ask them while in crisis, jailed and without an attorney present to disclose deeply personal, medical and psychiatric information. And you cannot call this a pathway to treatment. While police officers are making recommendations to courts about someone's bond for behavioral health professionals, trust is part of the treatment. Uwic isn't asking council to throw the baby out with the bathwater.

[9:15:44 AM]

No wrong door addresses a real problem and connecting people to sustained care rather than cycling them through emergency rooms, jails and crisis services is the right goal, but streamline the services, not the civil liberties. We ask council to establish clear safeguards around law enforcement's involvement, medical privacy, legal representation and due process.

[9:16:08 AM]

>> Thank you, Mr. Bobby.

[9:16:13 AM]

>> Next, speaking on item b1, Elizabeth baker, Kate Graziani, Nick Hudson, Lily Hughes.

[9:16:29 AM]

>> Good morning.

[9:16:30 AM]

>> My name is Elizabeth baker. I'm the executive director of the other ones foundation, and I'm here today to support the no wrong door initiative. Prior to joining the other ones foundation, between the years of 2015 and 2021, I developed and oversaw assertive community treatment teams at integral care. Most of the people served by these teams had frequent interactions with a P D, E M, S, ers and jails and our teams. Sorry, my teams at the time would not have been able to do their jobs without their support. The most successful interventions were when the teams collaborated with first responder teams to develop an ongoing care plan. When this happened, the interventions weren't just built around a single crisis. They were built around a person's needs. Austin has a long history of multidisciplinary responses and utilization of by name lists for the most vulnerable people in our community. We saw it through the 100,000 homes campaign in 2012. We saw it through the downtown Austin community court high utilizer lists in 2015, and we saw it through host and multiple collaborative street outreach efforts. In each of these initiatives, the most meaningful progress occurred when agencies shared information, built relationships, and accepted collective responsibility for small group of people with high needs. And that was occurring in both routine care and in crisis care. At Esperanza, we see that people who achieve stability are almost always the ones supported by a coordinated network that remains engaged long enough to earn trust and create a pathway forward. And I believe that the no wrong door model recognizes this important truth, that no single system can solve these challenges in a silo, and that relationships matter. With careful attention to effective use of data systems and roles for each team member, this can be a really impactful project. I encourage council to continue supporting this effort and thank you for your time.

[9:18:22 AM]

>> Thank you, Mr. Baker.

[9:18:25 AM]

>> Good morning council city manager. My name is Kate Graziani. I'm one of the co-directors of vocal Texas, and I'm a resident of district four. And I am here to join the voices calling for more transparency and accountability on the no wrong door program. Paired with the city's new sweeps enhancement plan, which also is a pd led. We have some serious concerns about the no wrong door initiative, another initiative developed behind closed doors and without the community experts that need to be part of creating real solutions that work for our unhoused community. Now, we fully support expanding mental health care and housing options for people who need it. We've been calling for that for for years, but part of our concerns about this program in particular is that the first I heard about a no wrong door type program was actually during testimony at the capitol over the summer, the Texas public policy foundation and the Cicero institute were testifying on behalf of programs that use post adjudication to force treatment for people who are unhoused and in crisis, calling for a data sharing at the individual level.

[9:19:46 AM]

Then I saw the no wrong door memo here for our program locally, and it sounded eerily similar to what they were advocating for at the capitol. And so I know you all know this, but tppf and the Cicero institute are trump aligned think tanks. They are most concerned with dismantling housing first programs. They're not concerned with keeping our community safe and housed. And the Cicero institute was founded by a tech billionaire, Joe Lonsdale. And we know that these programs are more political than they are about helping people. So while the city has refused to work with experts like our public, our mental health public defender's office, they're calling on trump aligned think tanks to help develop programing. And that is deeply, deeply concerning.

[9:20:32 AM]

>> Thank you.

[9:20:36 AM]

>> Good morning. My name is Lily Hughes. I'm a district five resident, a social worker and the capacity building manager at Texas harm reduction alliance. I am here to ask for a pause in implementing the no wrong door program. It's incredibly frustrating to see memos with promises of referring people to programs that offer long term stability. What programs are those? Is that referring to the housing agencies with wraparound services that are already unable to keep up with demand? The same housing agencies and social services that were facing drastic budget cuts in the proposed budget? Is there some secret utopia of services that only a pd knows about? Does a single person in this planning process have any idea what the substance use treatment landscape currently looks like in Texas? Have any of you desperately called on behalf of a client who was begging to get a bed in a treatment center, only to be repeatedly denied? Have you had a client or watched a client deteriorate in a mental health crisis while frantically calling inpatient psychiatric services or respite care? I've lost count of how many times I've sat before this dais and talked about the people I love dying in the street because the care they need does not exist.

[9:21:41 AM]

And I can assure you, I fought for every single one of those people I fought against the underfunded and overburdened system of care. The no wrong door claims to be capable of referring its participants to every single document and press statement acts as if this program is already successful, all while promising to develop the system it needs to be successful. How can both be true? Why do the architects of this program need to lie about having the support of community stakeholders? Why is no wrong door being expanded so rapidly? Why can't we pause and actually plan out a coordinated community system of care? The only reason I can think of is because the goal of this program is not to provide care. It is to institutionalize, incarcerate, and punish people who use drugs, people with mental illness, and people experiencing homelessness. But what do I know? I'm just a social worker that works with the population this program is targeting. I'm just a person with lived experience in substance use and recovery. I'm just a grieving community member who has built the relationships with the people. Billionaires want to sweep away.

[9:22:39 AM]

>> Thank you very much.

[9:22:42 AM]

>> Continue on. Item b1. This will be the last speaker. Matthew. Malika.

[9:23:01 AM]

>> Good morning, council members. Matthew Malika, executive director, ending community homelessness coalition I'm speaking this morning in support of the no wrong door initiative. Echo has been a collaborator in the work to bring this initiative. To this point, we share many of the reservations of our partners, the homelessness response system. So I want to share why we're in support. The no wrong door initiative needs to be viewed in the context of our current system right now to support people experiencing significant mental health and substance use episodes on our streets. Currently, people in crisis are engaged mainly by law enforcement. Without the support of licensed clinical professionals, they are forced into a carceral system that is not focused on treatment and support, rather warehousing and behavior management. Then they are sent right back to the street where the cycle continues. Disrupting that cycle takes collaboration and outside the box relationships that promote care coordination and have the same end game in mind. Supportive housing with access to person centered treatment and creating a sense of belonging and community. The no wrong door initiative is not currently and can't become about the perception of creating safety through the relocation of people to other parts of the city, where their mental health and substance use continues to go untreated and ignored. The the. The no wrong door initiative is not currently and can't become about creating detention camps full of people who have been consistently marginalized and ignored for the sake of public safety. Council members. The no wrong door initiative is not perfect, but it's progress.

[9:24:25 AM]

There is now much more community oversight around people in a significant mental health or substance use episode are treated, and where they end up through a 17 party data sharing agreement, we're better equipped to coordinate care and ensure placement to the best possible environment that takes into account the level of service need and the will the participant receiving services. Mayor and council members. I've spent my entire career advocating against the criminalization of homelessness, against the institutionalization of people as a first resort for care, and against the punitive response to street homelessness in the name of so-called public safety. As a board member for the national coalition for the homeless and a governing member of the national health care for the homeless council, I've contributed to reports about hate crimes against homeless people and anti-homeless architecture that make our streets and parks unwelcome spaces for people who have nowhere.

[9:25:10 AM]

>> Else to say. Thank you very much, Mr. Malika.

[9:25:13 AM]

>> That concludes all speakers.

[9:25:15 AM]

>> All right. And with all speakers called, and we'll go ahead and move on to our agenda item B one. And let me go ahead and have staff come on down and give the presentation.

[9:25:31 AM]

>> Thank you council member. As the team gets prepared to present, I want to first thank you for requesting this briefing. Staff will be here to present an overview of the no wrong door program. No wrong door is a city and partner led coordinated crisis care program across 17 organizations here in Austin, Travis county. While the program remains in development, the most significant achievements to date is the enhanced relationship and communication across so many partners working in this particular space. I know we have many of those partners with us today, and I thank them in advance for being here. With that, I will turn it over to Mr. Robert Kingham to begin the presentation.

[9:26:16 AM]

>> Thank you, city manager. Good morning, mayor pro tem and council. I'm Robert King, administrator of the Austin community court, and thank you for the opportunity to provide an update regarding no wrong door and our work around coordinated crisis care this morning. I'm excited to be joined by our colleagues across the community who are helping lead this work. Julie Wheeler from Travis county, David Gray with Austin homelessness strategies and operations. Jeff Richardson with Integral Care. Chief Luckritz with Austin-Travis County EMS, Assistant Chief Harold with Austin Police Department, and Doctor Lee and Sidney Harris of Central Health. I appreciate everyone being here today to share their perspective on our coordinated response for no wrong door. So no wrong door is really about a challenge that you've heard that cuts across several of our systems. We have individuals in our community with extremely complex needs who interact repeatedly with homeless services, behavioral health, law enforcement, emergency medical, the courts, and other parts of our safety net system. Each of those systems are doing important work, but the question we are trying to address through no wrong door is how do we move from multiple systems responding to the same person in crisis often? And those systems working around that person? That's the focus of today's briefing. So we'll begin the briefing ground by grounding the discussion and where we are today, the current state of our homelessness response system, our behavioral health and crisis response systems. And we'll talk about the specific issues. No wrong door is intended to address.

[9:28:07 AM]

And then finally, what a more coordinated future state would look like for our community. As we go through the presentation, I think you'll see that this isn't about creating another standalone program. It's about better connecting and leveraging the significant resources and expertise that already exist in our community today. So before talking specifically about no wrong door, I think it's important to recognize that this work did not begin in a vacuum. It builds directly on priorities that council has established over a number of years through multiple resolutions. Council has asked us to strengthen our response system at the intersections of homelessness, mental health, health care and the criminal justice system. Council has also consistently emphasized better coordination, whether that's through outreach, crisis response, connections to care, housing or initiatives like heal. No wrong door brings those priorities around a particular challenging population. The people with complex needs who repeatedly interact with all of these systems. So in many respects, the work is about taking the direction council has already provided and asking, how can we better organize our collective response around the individual rather than individual systems?

[9:29:40 AM]

So to understand where no wrong door is headed, we first need to understand the systems we're building from. And I want to start by emphasizing something incredibly important for this conversation. Austin is not starting from scratch. We have already made significant investment and built some very strong models for responding to homelessness, behavioral health needs and mental health crisis. And Austin has been a leader in developing alternatives to criminal emergency response models. Austin was the first community in the country to add a mental health option to 911. Austin cares brings together a P D ems and integral care to coordinate care for people who frequently rely on all three of these systems. Integral cares em cot team responds to mental health crisis calls in collaboration with law enforcement and ems, community health paramedics and integral care clinicians are integrated in ktec to support calls as they come in for individuals experiencing mental health crisis and host is another example many of us know very well. It brings together homeless strategies and operations. A pde, ems integral care and the community care to engage people experiencing homelessness and connect them to housing, case management, health care, behavioral health services, and substance use services as well. These are significant assets, and they demonstrate that we already know how to collaborate across organizational boundaries. So the challenge isn't that Austin has no response. In many ways. We have a very robust response.

[9:31:29 AM]

The challenge is what happens when an individual's needs are so complex that they repeatedly touch several of these systems at the same time. And that's really where the no wrong door conversation begins. And now I'll turn it over to Julie wheeler with Travis county.

[9:31:50 AM]

>> Good morning everyone. Team members and city manager Broadnax. I'm Julie wheeler, the intergovernmental relations officer for the county. My commissioners court, unfortunately, was not able to be here today because they're actually conducting their own meeting right now. Thank you so much for the opportunity to be here, though, and share with you some of the foundational work of Travis county and our partners at integral care and central health in this space. For a number of years now, the county has been exploring how to build out the mental health crisis care continuum so that individuals in crisis can access care without first engaging with the criminal justice system, which is unfortunately the catalyst for most interventions. We know that the jail has become the largest provider of mental health care, not just in Travis county, but also across the entire country. And though we aren't unique, the court wanted to find solutions to break the cycle of people entering the county jail due to problematic nonviolent behaviors that were mostly the result of untreated mental health disorders and substance use disorders. In may 2022, the court employed the Dell medical school to study ways to improve outcomes for residents in crisis, pulling data from a multi year lookback.

[9:32:59 AM]

Looking at the county's highest utilizers of the system, the Dell study convened a steering committee with a major list of stakeholders, including a P D involvement, echo representatives from our probate court and other legal divisions, as well as a number of community organizations. They then convened eight different working groups to address specific gaps within the intersection of the criminal, legal and mental health systems. They looked at law enforcement interaction and arrest, central booking, mental health evaluations, legal representation, adjudication in jail and preventions, alternatives to competency restoration, and successful reentry. With these. With this work, there were five recommendations that came out of it, which you see on the slide underneath you a five things that we could immediately start to try to implement. These recommendations, fill several critical gaps and remove existing barriers to optimal outcomes that, once implemented, could lead to a dramatic shift in how individuals mental health disorders who intersect the criminal legal system are treated, while concurrently ensuring the safety of both the person and the community. I did want to flag that the court has already started working on all of these initiatives. One of the ones I really wanted to highlight was implementation of council at first appearance, which gives individuals legal counsel from the very beginning of engaging with the criminal justice system. A number of these are also underway and are underway in collaboration with our partners. The mental health forensic report gave us a roadmap of the elements necessary to building out a better pathway for individuals in crisis. However, I do want to highlight that among those five recommendations, the most needed solution is also the most challenging to

implement in Travis county. There are limited options for individuals in crisis to receive adequate support or complex high acuity health needs, or police drop off locations. When there are interactions with law enforcement, our community is in dire need of a mental health crisis center, building off of the recommendations of the mental health forensic report, Travis county initiated a collaborative crisis diversion program in April of 2023. Not wanting to wait for the mental health crisis center, the initiative was intended to leverage existing programs and facilities to expand community services to immediately address, address jail diversion needs through both deflection and diversion. The pilot program was designed and funded through a \$7 million subaward to integral care over a three year period to initiate a collaborative crisis diversion program, including the expansion of integral care psychiatric emergency services, otherwise known as pes, and the creation of the therapeutic diversion program. The slide in front of you, you've got a little snapshot of both of those programs just for the public to be aware of. Ps is a walk in mental health urgent care clinic for individuals having a behavioral health crisis, and serves as a deflection and diversion from the criminal legal system.

[9:35:51 AM]

Adults experiencing a mental health crisis in Travis county can receive voluntary care services there, regardless of their ability to pay. Since January 6th of 2025, the ps has been available for drop off by law enforcement for. With 24 over seven access. The therapeutic diversion program is a 25 bed facility that offers extended therapeutic respite care with wraparound services for adults with mental health, substance use disorder, or intellectual and developmental disabilities who need ongoing behavioral health. The effort is designed so that people can stay up to 90 days to stabilize and transition into housing. As of may, 219 people have gone through tdp, and I did want to flag that while tdp has received over 600 referrals for this treatment, there are only 25 beds available, highlighting the urgent need that for expansion of this type of service. With these pilots, the county is getting real life data to help inform necessary design elements for the eventual mental health crisis center. At the same time, these pilots are allowing the community to access services that would otherwise not be available.

[9:36:58 AM]

Along with funding to continue both ps and tdp, the county has made significant investments in mental health services, including \$91 million of dedicated one time funds for the construction of a mental health crisis center, and \$15 million in ongoing funds for deflection and diversion programs to connect residents with appropriate services and alternatives to incarceration. There are a number of other investments that the county made in its most recent budget, including money for assisted outpatient treatment, money for Travis county transformation project to support restorative justice practices for youth, and \$1.5 million to continue the assertive community treatment team. When the county was invited to participate with the city as they work towards no wrong door, we were excited to see how their hyper focus on their own identified high utilizer list will complement our broader efforts to provide better outcomes for individuals with mental health and substance use disorders, collaboration across all

partners and entities is vital for successfully building out a robust mental health care system. With the alignment between the county, city, central health and integral care were much closer to establishing a mental health crisis center, which you will hear more about in later slides.

[9:38:11 AM]

>> Thank you. And now we will transition over to David gray, director of home, Austin homelessness strategies and operations.

[9:38:20 AM]

>> Thank you. Good morning, mayor pro tem, members of the council and city manager Broadnax David gray, the director for Austin homeless strategies and operations. And I just want to talk to you a little bit today about the current state of our homeless response system and how this high utilizer population fits, or I guess currently doesn't really fit within the investments that we've been able to make as a community. In terms of the current state, our homeless response system overall is becoming much more efficient and much more effective at helping people stay housed or quickly get rehoused. According to the most recently published state of the system report from the Indian community homeless coalition, or echo. What we're seeing is that our investments across the continuum of care are delivering real results for our community. What we've seen is a decline in first time homelessness by 5%, which represents the first time decline in first time homelessness since 2020. We also see that more people are moving into housing or remaining housed than ever before, with over 3000 people housed through not just city, and nearly 70% of those move ins occurred with minimal housing assistance. We've also seen a significant decrease in the wait time for housing for people who are on the wait list, whether that's coordinated assessments and coordinated entry lists or other lists. And I think what this goes to demonstrate is really the results of the investments made by the city, by philanthropy and other partners in building out our homeless response system. And so on behalf of our office and our community of homeless response partners, we really want to thank council for your support, the investments that we've made from prevention all the way to permanent supportive housing are delivering real results, and we're proud of that. We know we still have more work to do, but we are proud of the direction that we're heading.

[9:40:22 AM]

That being said, there is this high utilizer population that we're here talking about today that the no wrong door initiative aims to solve for within the homeless response system. These high utilizers are typically folks who experience chronic homelessness and have some high degree of behavioral or physical or mental health need. And when we talk about chronic homelessness, we're talking about

individuals who have lived unsheltered, homeless for more than 12 months or have experienced multiple stints of homelessness that total 212 months over the course of about a three year period. When we look at our homeless response system, particularly our homeless shelters, which oftentimes are the front doors into other services in order to live and be successful in a homeless shelter, individuals have to be able to perform their activities of daily living. This means they have to be able to bathe themselves, dress themselves, toilet themselves, feed themselves. We do not have the licensed staff within our shelters to provide these types of services to clients.

[9:41:31 AM]

Oftentimes, our high utilizer population are not able to do these activities and therefore we're not able to serve them. The clients who cannot perform these activities that they're living require a higher level of care than what we're able to provide. Oftentimes, that higher level of care needs to occur within a licensed health center, such as a state hospital, an acute care hospital or state supported living center, or a similar type of facility. The lack of suitable beds for these individuals means that these folks oftentimes will cycle in and out of our hospitals, in and out of our jails, and they return to the streets. And you see these individuals in your districts. I know my staff see these individuals every day through our street outreach and our public space management work. And I personally hear about these individuals all the time, because I'm the one who gets the calls from our residents and from our constituents when these individuals need help and prior to no wrong door, the truth of the matter is, is that we had very little coordination and ability to serve these folks.

[9:42:34 AM]

We are very grateful as a department, to have our colleagues at central health and integral care dedicating real resources that you hear about in just a moment. And those resources will expand beds and services for these folks. And so thank you, doctor Lee and doctor Richardson to my left, to my right for the investments that you're making. That being said, we're also mindful of the fact that more regional and state investments will be necessary to meet the demand. But before we talk about what those investments might look like, I'd actually like to hand the presentation off to doctor Richardson to my left to talk about the current state of the work that integral care is doing to serve this population and to serve our community. So doctor Richardson.

[9:43:18 AM]

>> Thank you David. Good morning everyone. Good to see you all. Really as much of it would be fun for me to read these slides to you guys in detail. I'm going to talk a little bit about them specifically. But first off let you know my background. I'm, I'm a I've been a social worker for 41 years. I'm a clinician. I've

been the CEO at integral care for almost three years. And I've done work in this space my entire career in terms of developing community based systems. And I'm also a father of a 30 year old son with mental illness. So I know what it's like to be on all sides of this. And I really want to appreciate all the all the sentiments that you've heard today. It is a complex, challenging system, and this no wrong door initiative is really incredible in terms of its ability to coordinate and integrate all of these different partners. And I think that's something that ever since I've been here in Austin, I've seen that's critical that you don't see everywhere. Is this level of collaboration from the city, the county and local partners to make this work. The the folks that we're talking about with this initiative are some of the most challenging folks that our system has not served well. And so it's up to us to come up with creative solutions to make sure we maintain that engagement in a crisis. But more importantly, after the crisis, helping people get on the pathway to recovery. And I'm here to tell you that people do recover from mental illness. People live successful, meaningful life. If we're able to provide the right ingredients of services at the right time, integral care does have a full continuum of services, and I'll touch on that in a moment, but it's not complete. We this community continues to grow and evolve, and our systems need to grow and evolve and expand to meet them. There's significant gaps in service. You've heard some folks already talk about that, and that's why this initiative becomes so important for us to align and maximize the existing resources that we have, and use those in the most successful way possible. So just to touch on our continuum of services, because I really think this is important when we talk about what matters here, these are the no wrong door initiative.

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Is is one as, as the the title says, it's no wrong door. But once we're able to get people the support that they need, it's building the trust, building the treatment and building the engagement to help people stay in care, not going from one crisis to the next. So our our services include traditional outpatient community based crisis diversion. You heard Julie talk about this a moment ago. Some of the services that we're doing with the county, many crisis diversion programs are nine, eight, eight program. Our 911 partnership, our mobile outreach services, and most recently, over the past couple of years, the expansion of our pps service, where both someone from the community, ems, police and others can drop by and be evaluated 24 over seven for a range of options that that may be available to that individual. The last thing that's not on this list that I just should talk about is that we also have a partnership to actually purchase beds in inpatient facilities in and around town, but the scale and the need is far greater than our resources to do it. Right now. We have more work to do in this space, but our role also as the local mental health authority is also contracting and partnering and building a network of partners that help meet these goals.

[9:46:49 AM]

This is, again, something that we do alone. We do it with all these folks at this table and all, all of our community advocates and all of our partners to make this work. So just to touch on what Robert said

earlier that we have made, we have been doing work in the space. Austin has been doing this work. Travis county has been doing this work. All of us have been working together on a number of initiatives that are listed on here, and some of these have been going on for a long time. So we do have experience working across these domains. This particular initiative is really focusing on some of the most challenging folks, and I'll talk in a minute about some of the clinical needs that these folks present. But our community has experience working across the traditional boundaries to get this, this work done. And as you can see on this list, the, the investments from the county, the city, central health, the state, and many others to make this happen are critical.

[9:47:50 AM]

Integral care is not a taxing authority. We are dependent on the support from all of our partners and to work together to make all of this happen. So we have a list of programs on here, and you may be saying, oh, this is great, we got this list. So why do we need this other program? This program is really targeting a very high touch, high need group of folks that need very, very focused coordination. I keep telling someone to switch the slides and that's me. So let's talk about this for a second, which is one of the things that we have been doing as part of the no wrong door discussion is to sort of look at data, to talk about profiling the some of the folks that need these services most critically. And again, from a clinical and healthcare perspective, these folks are folks who have may have a chronic and persistent illness like schizophrenia that may be a lifelong condition. There's not yet a cure for schizophrenia, but there's plenty of treatments that allow people to live successful, meaningful lives if those supports in the right place at the right time and are available to people when and how they need them. And so to touch on some of this data of the 2% of the folks that were arrested during this period of time, nearly 2% of those of those individuals accounted for 17% of all arrests, 85% experience homelessness, and 55% experienced some range of behavioral health issues. And again, not every person is different. Their needs are different. What what they come with, with, and present themselves with is not just a mental illness. It may be addictions, it may be being unhoused. It may be dealing with a traumatic crisis. Many of the much of the work that we do now with kids and children is also looking at adverse childhood experiences and trauma. Many of the folks that are in this group have experienced a range of traumas that have further complicated their willingness, and about engaging anyone in care. So it is a very challenging group of folks. 50% of this population have been rearrested within ten weeks. At one point or another, someone may have had a touch point with the integral care system. But again, as you saw earlier, there's a lot of ways that people can engage our system. And if they're not engaged in a long term way, that's not going to be helpful to them. And we haven't done our job. 15% have at least one psych hospital inpatient. And frankly, that number to me is shockingly low. To me, that shows another evidence of some of the things that we need to work on our community around access for inpatient and psychiatric inpatient capacity. 8% have been in residential programs. Again, an area of concern that I have about making sure that we can scale that out further. And at least 43% have had at least one psych inpatient hospitalization in 12

[9:50:51 AM]

months. And again, the average length of stay in an inpatient facility is very short. People spend anywhere from 3 to 7 days, not a long time to be able to get some of the issues resolved that may have got you there in the first place, along with all the medical complications that someone may experience. And again, for us, this is a population of folks that we all are committed to and passionate about caring for. And that's why this initiative matters so much. And then the last thing I'm just going to touch on before I hand it back to Robert, one is, is that when we look at having a continuum or having services that's not sufficient, we need to be able to further scale out and meet the needs of folks, both in preventative care but also in high need, high touch services and some areas that we really need to keep focusing in on. One is professionals continuing to draw in and recruit and retain psychiatrists, physicians, therapists, others who want to do this work and are passionate about this critical work in our community.

[9:52:00 AM]

Inpatient capacity, particularly at Austin state hospital, beautiful new facility, but it's at 100% capacity. Our ability to take advantage of that as a resource is limited. And in our community and as a whole in the metro area, we've seen a decline in inpatient psychiatric beds, and this number is even smaller. When you start looking at Travis county specifically. And when you start looking at inpatient beds, they're not all the same. Children need a specific set of interventions. Folks who are struggling with mental health and addiction needs need a unique set of interventions. And so simply having a bed is not sufficient. Being able to provide the clinical care that that person needs is key. And the reason that's key is that breaks this cycle that we've been talking about. If people are actually able to get the treatment and the support, it breaks this cycle. If not, we continue to see what we're seeing now, which is people moving from one crisis to the next. We operate 85 intermediate step down and transitional beds, as you heard David say earlier, you know, having housing is a critical piece of this, but not, not not having sufficient supports in place. People will not be able to succeed. And so having that support to help people maintain their success and their housing, getting medication support, being able to be supportive for any of their medical, comorbid medical conditions. And this is the same for the sobering center. The sobering center has been a critical resource. But again, alone, it's not successful. It has to be tied to everything that we do. So we have made tremendous progress in this community. And I can tell you, having worked in other places and done consulting all over the country, what we are doing here in Austin is pretty fantastic. We just need to scale it out and start having everyone work together. Robert.

[9:53:53 AM]

>> Thanks, Jeff and Julie and David for that, that information. So we've heard about the growing demand for services and the limits that exist in our community. This slide shows what it looks like with people that we're talking about regarding no wrong door of repeatedly cycling through the emergency

response, hospitals and justice systems, the meadows mental health policy institute estimates that about 950 people in Travis county have both high needs and high risk of justice involvement. The estimated annual cost across the systems serving this population is approximately \$144,000

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>> Per year, and that totals \$137 million annually statewide. The estimate is roughly 3.2 billion each year to serve this population in our current systems. The examples at the bottom of the slide make the pattern more tangible. One person generated an ems incident about every four days. Another generated a fire response about every seven days, and a third generated a police incident about every four days. These are separate examples from each department. The figures include ems charges and selected wage costs. And this just gives us a partial view of the resources involved in repeated responses. Each response meets an immediate need. The concern is what happens between those responses, whether the person is connected to sustained treatment, follow up, and support that can help prevent the next crisis. As no wrongdoer develops, we are broadening how we identify high system use to include other systems beyond public safety.

[9:55:57 AM]

Our focus is on patterns of repeated context and complex needs. Mental illness and homelessness are not crimes, and identifying someone for coordinated care requires more than diagnosis or housing status. The community courts expertise provides another example of why sustained coordination matters. At the community court, we see the same pattern of repeated contact over time. This looks at 25 of our most frequent court utilizers over the past two years. Those 25 individuals accounted for 1043 cases, and an average of almost 42 cases per person in that two year time period. So that means within this group, contact range from approximately every ten days to every 23 days for these 2025 individuals. Each case involves work by staff and other interactions with the justice system for this individual, the frequency of interactions often show how often we're coming back in contact with the same people.

[9:57:15 AM]

It also creates an opportunity. Our repeated contact can help us understand the person's needs. It significantly helps in building a relationship and to connect court involvement with case management services. So no wrong door can strengthen that work by helping helping the organization serving that person. Act on a shared plan and maintain continuity between these encounters. So the goal is to use these points of contact to support a coordinated intervention that addresses the needs contributing to repeated involvement. We want to see more stability for the individual and fewer recurring crises across

the system serving them. So with that context, I'll turn it over to chief Luckritz to walk us through the future state we are working towards.

[9:58:14 AM]

>> Good morning, rob Luckritz, chief of austin-travis county ems. Again, thank you for the opportunity to be here today. So we've talked extensively about the problem statement we've all recognized, and I think everyone here understands the challenges that we face here in the city of Austin, which are similar to what we see across the country. We've also talked about the various services and the great initiatives that we have here in the city of Austin, and the leaps and bounds that we've made in progress towards addressing some of these issues. But when we think about how it is that each of the individuals that are up here on stage and many of the folks that are in the audience approach these. What we do find is that very often we're operating in silos and that we're making great progress individually, and we're addressing those individuals that present to us individually. But sometimes the place where someone presents is not the best solution for that individual. And so from a high level, as we think about what.

[9:59:15 AM]

No wrong doors is, it's first and foremost the ability to eliminate those silos, to expand our ability for all of the resources addressing mental health, homelessness, substance abuse, and others across the continuum and identify how it is that we can better coordinate. First and foremost, how we can coordinate the crisis. Care for those that are encountering an acute issue. How can we respond to the immediate needs of those individuals so that we can then move forward with building individualized service plans that utilizes those resources appropriately? No. Wrong doors is called no wrong doors, because there is no wrong door for individuals experiencing a mental health crisis or with long term mental health needs, regardless of who it is that they contact, they should be able to get the services that are necessary for them. Now, when we think about how it is that we operationalize this concept of no wrong doors, the first thing that we need to do is to meet them where they are.

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So many of these individuals are out in the community, and we have to identify who they are. And each of us have different ways of identifying who those individuals might be. We need to build a rapport. We need to build a relationship. We need to build trust. And for each individual that looks a little bit different as to who they trust and how they trust them. But regardless of who it is that they are interacting with, we need to understand what the circumstances are and what needs it is that they have, and we need to connect them with options for service that align to what their immediate needs are in that moment, and perform warm handoffs to whoever it is that can best provide those services. Then as

we move forward for those individuals that voluntarily agree to become part of this program, the key is how it is that we build that connective tissue. How do we build a coordinated response? How do we bring all of us together for a collaborative, long term solution for these individuals?

[10:01:31 AM]

How do we coordinate something that is specific to that individual individualized care? How is it that we can collectively connect those acute utilizers to the most appropriate services? And that's what we're doing when we come together in no wrong doors. We are trying to identify what are the individual needs, how do we break the silos down? Right? Once we once we come together as a team, how do we provide coordination? How do we share? Because sometimes it may not be as simple as just taking that individual somewhere else, because these individuals have complex needs that cross disciplines, they may need multiple services and we can only coordinate those if we're all working together. Because sometimes while someone may have a long term need that may be able to be provided by one individual or one provider here, sitting down here, it can only be achieved after something is accomplished by another provider. And so we have to operate together in order for us to be in order for us to be successful. And it allows us to provide direct connections to those clinical interventions provided by integral care and others that are so essential to the long term stability of these individuals. By implementing no wrong doors, we're building something that is integrated and responsive, something that meets the individuals as they are today, but also builds an infrastructure and pathways for us to come together as a team to support these individuals in the future, and to respond to the needs of the overall community. This is a this is not a single group. This is not just the city of Austin. This is not just public safety. This is coordination of 17 individual organizations that have signed memorandums of understanding to become a part of this team, including the city of Austin, Travis county, our health care partners that are so essential. Ascension saint David's are, of course, our integral care partners. And on Wright, this is not just a city of Austin issue, and we can't solve it just as the city of Austin and Travis county.

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This is not something that can be solved just with government. It's a partnership between government, between public safety, between healthcare, between behavioral health providers and others. Of course, all stakeholders that have engaged with us to help us because they're the boots on the ground. They're the ones that see this firsthand alongside our public safety individuals and our health care providers. Right? Those community partners that are experiencing this can help us as we move forward with the solution. Now, who is it that we're serving? All of this comes back to one thing that at least I know. I've spoken here many times about the social determinants of health. Those individuals experiencing challenges like serious mental illness, substance abuse, chronic medical conditions, homelessness, and trauma. These are the individuals that we are targeting and those individuals that fall within the top 1%

of our high utilizers for behavioral health emergencies, substance use related emergencies, and arrests. And with that, I'll turn it over to chief Harold from APD.

[10:04:45 AM]

>> Thank you very much. Good morning, mayor pro tem. Good morning, council, and good morning, Mr. City manager Broadnax. My name is mayor Harold. I'm the chief of strategic initiatives for the Austin police department. Today I just want to talk to to you for a few minutes. From a policing perspective of what we are seeing every day, we are all here discussing the intersection of chronic chronic homelessness, being chronically mentally ill and or suffering from a severe addiction. And in addition to that, when you take a closer evaluation of what's going on with this very small subset of the unhoused community, what you are seeing is a vicious cycle every day occurring in Austin, where somebody in this very small, vulnerable population is being arrested for a low level crime, being taken to jail, into a hospital, sitting back to the streets. And this cycle continues on a daily basis on the streets of Austin. It is occurring right now as we speak.

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But as a police leader, to stop this vicious cycle from occurring, you have to go deeper into the analysis of this small group of people that we're all here today concerned about, and you start to see alarming patterns jump out at you. One, we know this population is disproportionately impacted by crime. In addition, we know there's evidence of victim offender overlap in this population. But when you look at this in greater detail, what you will find is really alarming that if you're simply unhoused in the city of Austin, you are two times more likely to be a victim of sexual assault. If you are unhoused and experiencing a mental health challenge, you were four times likely to become a victim of sexual assault. If you are unhoused and experiencing mental health challenges and you are a woman, you are 20 times more likely to become a victim of a sexual assault. As a police leader and former former social worker, I find this completely unacceptable.

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So what? What are we doing as a public safety infrastructure to measure these outcomes, to know if we're impacting this vulnerable group in a positive way? I can tell you preliminarily, public safety interactions are going down. Specifically, police interactions are going down with this small population. And why is that important? Because the more we engage and the more that you see police interactions going down with this vulnerable group of people, the less likely that cycle is to happen over and over and over again. We are already stabilizing our most vulnerable on this top 100 list, and we are providing basic stabilization, whether that's basic identification, maybe that's shelter beds, maybe that's

reconnection back to social services. Maybe that's connecting back with family members. We are also seeing a dramatic increase in social service outcomes, including housing options for this vulnerable group of people as well. But the important thing is, is to stop that cycle that I talked about before. And preliminarily, that is exactly what we're seeing. I think this is probably one of the most powerful slides. As a police leader I have seen. This is approximately over the course of the last 90 days. And what we are seeing is before no wrong door started, one of these top 99 high utilizers was having a crisis contact in our community by either the police or ems every 11 days. Now that is a crisis. Contact every 16 days. To put that into further context, that's ten fewer contacts per person per year, with a 30% 31% reduction in police contacts. If you break that down further, if you take the top 28, that means the most complex, the most vulnerable, suffering from complex issues before no wrong door, this small group of people was having a crisis care contact every six days in our community.

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Now, after no wrong door that extends out to 14 days. When you extrapolate that over the year, that's 35 fewer contacts per person per year with a 57% reduction in police contacts. So so far, we have 300 plus fewer police contacts with APD officers. And you start to see that other social service agencies are increasing. They are going up at the same time, police contacts are going down. So I want to talk about a couple real life examples from our data sets. We will call this gentleman Oscar. Before no wrong door Oscar was being contacted by the police department ten times a month. In addition, Oscar was being contacted by ems almost 11 times a month. After no wrong door, Oscar dropped down to 2.8 times to be seen by a police officer and 3.5 times seen by ems. Collectively, that's a 74% reduction in police contact and a 66% reduction in ems calls.

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So we have stabilized Oscar. He has been reunited with his family and that he is engaged in the no wrong door process. And we are seeking long term housing for Oscar as we speak. On the other hand, when we look at eve and I will say this, I'm very proud of the work that doctor Ed Anderson. We are lucky to have him on our police staff because he is doing some really innovative work with no wrong door project. Thanks to doctor Ed Anderson, retired professor at the university of Tennessee and now working for us, he's really starting to pinpoint when we see one of these high utilizers go into acute crisis on our streets. And so with eve from June of 2025 to March of 2026, you will see that she had five over five monthly contacts with ems in April to August of 2026. You see that escalate to 8.3 times emergency detentions, which I think that all of the clinicians up here are probably the most traumatic system to put one of these high utilizers in. It is a very traumatic experience to be taken to an emergency room and be evaluated.

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So be between the times of December 20th 4th to September 26th, eve was seen in the emergency detention over one times per month. But as we see eve escalating from February to June of 2026, you see that skyrocket to four point time 4.5 times. And what we saw with eve is that her escalation was getting serious. And I can tell you from experience that without intervention with eve, she would either end up committing a serious felony requiring a jail, a long duration of jail time, or unfortunately, worse in what we see is sometimes people like eve die in our streets because intervention doesn't come quick enough right now because of no wrong door and a team effort by everybody at this table. Eve is now at the hospital receiving intensive care and the treatment that she deserves and the treatment that will get her into a long term stabilization area. And then finally, from a police leader's perspective, this isn't just Austin. This is occurring in every city across America, whether you're a large city, a rural area. This is a real tragedy in this country.

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And I've seen it for far too long decades. What we're trying to do is really close these service gaps down with our partners, and we're trying to reduce police contacts because we know that if we reduce police contacts, then we've stopped that cycle and people are actually getting the help that they need. We really are trying to emphasize contacts with the service based industries, entities increasing. And that is what we're seeing right now. We are seeing ems contacts increasing. We are seeing other social services, integral care, central health, all of these other network safety networks for this vulnerable group of people increase. And that is what we want. And I think most excitingly is we're seeing a high rate of program participation, participation. I think one of the coolest things that I've seen is right now, out of those 99 high utilizers, 40% of them have signed individual consent agreements with no wrong door. That means that they understand that there's help, that they can actually get help, the help that they need, and they want to be engaged with all of the people up here in front of you today to make their lives better. And I'm going to turn it over to doctor Patrick Lee.

[10:15:06 AM]

>> Thank you. Good morning, mayor pro tem vela, council members city manager Broadnax pat Lee, president and CEO of central health. I want to spend a few minutes talking about central health's role in this work and the health care infrastructure we are building to earn the trust of our community and support people before, during and after a crisis. Just a few weeks ago, our board of managers and the Travis county commissioners court approved our fiscal year 2027 budget, which includes significant investments in crisis and recovery care services that are closely aligned with the goals of no wrong door. We've been using this iceberg visual to illustrate how we think about that work. So at the tip of the iceberg are the people and the crises we see most visibly, perhaps around 950 individuals with complex mental health needs, substance use needs, physical health and housing needs who repeatedly cycle

among emergency departments, hospitals, the jail and the street. As a primary care physician, I think of those 950 people as the most visible symptom of a deeper underlying problem, and central health's role is to help address the root causes of the underlying problem by building the care infrastructure beneath the water line, services that prevent crises, where possible, respond appropriately when they occur, and help people stay connected to care afterward.

[10:16:32 AM]

And that includes \$73.5 million in existing crisis and recovery care investments the central house makes across mental health, addiction treatment, homelessness and care for people involved in the justice system. Much of that work has been built over years alongside many of the partners here today, including integral care, ems, the city, the county, the sobering center, Texas harm reduction alliance, our housing partners and our community organizations. One relevant example is our existing partnership with ems through our bridge clinic and street and mobile medicine teams, which serve unhoused individuals with complex needs in our community through ems collaborative care communications center or c4, paramedics can identify the bridge clinic as an alternative to taking that patient to the emergency department and bring eligible patients with lower acuity needs directly to our clinical team at bridge. We also work with ems, community health paramedics who join our teams in the field to help coordinate care and follow up with high risk patients to do this work. Ems and central health currently share limited clinical information and data needed for care coordination through a secure, hipaa compliant platform called pulsera. Notably, that information is not shared with law enforcement. We are working together with our partners to determine how we can develop processes legally and responsibly to ensure we can protect patient privacy and dignity while connecting people to the healthcare services they need. Our bridge clinic and street teams are just one example of the crisis and recovery care infrastructure that we're continuing to fund and expand in fy 27. We are also continuing to invest in behavioral health crisis care, including inpatient psychiatric services, counseling and case management services provided medical care as well. The new crisis care team, with two psychiatrists, two case managers and a counselor, focused on more complex needs.

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We're investing in services to help people stabilize and stay connected to care and housing after a crisis, including our medical respite program, transitions of care program, our skilled nursing facility, and justice involved teams and programs that work to get people connected with permanent supportive housing. And we're growing our investments in addiction treatment and recovery care, including by providing funding for sobering center operations for medication assisted treatment and long acting injectables at the Travis county jail and through our naloxone distribution program, we see no wrong doors and opportunity to build on these kinds of coordinated relationships and make them work together more effectively. Altogether, central health is investing 127.5 million in crisis and recovery care in fy 27, aligning our clinical and care coordination services with both no wrong door and the county's

broader diversion and deflection work. This issue is larger than any one of us with the city, the county and other partners coming together with their own resources and capabilities alongside ours, we can do even more to help people avoid repeated crises and stay connected to care. At the tip of the iceberg, we noted 54 million in new mental health investments that we're making in their two major areas, where investing the most. The largest commitment is 33.1 million for psychiatric emergency and inpatient capacity, including ten psychiatric emergency department bays and 22 inpatient psychiatric beds.

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Travis county does not currently have a dedicated psychiatric emergency department, so we're working to close that gap. We've also designated 16 million toward establishing a mental health crisis center with the city, the county and other partners, which you hear about in a moment, and the remaining investments here strengthen the rest of that system through additional crisis care capacity, primary care for people involved in the justice system, medication assisted treatment, long acting injectables, and funding for additional psychiatric emergency services with our partners at integral care. And together, all these investments are about creating more appropriate places for people to get care, making it easier for them to connect to the right care before a crisis becomes an emergency. And with that, I'll turn it over to Sydney Harris, our senior consultant for behavioral health, to walk through what that mental health crisis care system can look like in practice. From the healthcare perspective. Sydney.

[10:20:50 AM]

>> Thank you, doctor Lee. Thank you. Mayor pro tem vela, city manager Broadnax and council members appreciate your time this morning. I'm here to share what we've been working with with our partners from integral care, Dell medical school, Travis county, and members of the city. We have an accelerated expansion. Doctor Lee highlighted, we're looking to increase the psychiatric emergency to ten beds in psychiatric inpatient to 22 beds, and our partners at integral care are looking at what they can do at the Hermann center to increase to 16 inpatient beds. This is an accelerated expansion because the infrastructure of the city of Austin is very much needed to create the capacity for the mental health continuum. I think we've heard over time and time again this morning that we need to scale to the need of our population. So as everyone is working on the current services that are available and expanding those services, we also need to increase the infrastructure for the mental health and behavioral health care system. That is phase one and phase two. You've heard highlights of a mental health crisis center. This stems from the work Travis county has been doing since 2023 on the original diversion. But as research has indicated, a mental health crisis center is what we would like to see in Travis county, Austin. And as you can see, it increases the psych triage. This is an addition to what phase one has 40 adult beds, six youth extended observation. So once you go into a facility for triage, sometimes you need to stay a little bit longer. For people suffering with mental illness and behavioral health issues. So we would like to see extended observation, of course, sobering and withdrawal, 40 recliners and 20 single rooms for detox and increase in our psychiatric inpatient to 48 beds for adults and 12 youth and then

crisis residential. So the mental health system, behavioral health system needs a very long, long, excuse me, a longer runway for individuals to return to the recovery. So that's why you can see a staged approach within a single building. Our partners at Travis county are also looking at how do we create a justice annex that could be possibly tied to the central booking or the work that they're doing with the sheriff's office, because a lot of individuals do go into the criminal justice system who are living with a mental illness. So we need to make sure we're providing care as they are entering into the justice system and hopefully exiting quickly afterwards, and can be seen at the mental health crisis center. And then phase three. Again, the runway is long, so once an individual may leave the crisis center or the justice annex, we hope to see in the future a step down, which can include crisis, residential and crisis respite, and then hopefully that individual can return to their

[10:23:51 AM]

community, their loved ones, and receive care at outpatient for mental health, health care and substance use. This is again the proposed mental health continuum for Austin and Travis county. It's a very high level, and I hope to be able to come back and share more insights on the work that we've been doing with our partners in the near future. Thank you.

[10:24:13 AM]

>> All right. Thank you to all the presenters and community partners here today outlining the work that is being done under this no wrong door initiative and broader for our crisis care ecosystem in our community. So looking ahead for next steps, our next steps is to put this integrated approach into practice. This slide outlines four specific work areas. First, continue crisis care intervention, follow up and case management. Our partners will continue responding to immediate needs while strengthening the connections that help people remain engaged in crisis care or in care and after crisis, follow up and continuity will be essential to making this approach work. Second, measure outcomes and refined our metrics. We need to understand whether people are connecting to care, maintaining stability and experiencing fewer repeat crisis and system contacts. As we learn more, we can refine the measures to better capture both individual progress and the effect on the system serving them. Third addresses funding and legislation. We will identify the resources and any legislative changes needed to support the care continuum and bring those needs forward through the appropriate channels. That includes understanding the capacity required to sustain this work.

[10:25:47 AM]

Fourth is to report and recalibrate. Will use the results and the experience of our partners to assess what is working, identify gaps and adjust the approach. Those findings will also help inform future

updates to council. The direction is to organize our collective response around the individual, with clear coordination and continuity from crisis response through ongoing care. That is how we can help people achieve greater stability while reducing repeated demands across our systems. So I appreciate all of your time and attention. I know this was a lot of information provided, and I want to thank you for your continued attention to this work, and we welcome your questions.

[10:26:34 AM]

>> Thank you very much to mister kingdom and to all of the presenters. It is a lot of information to digest. To throw a little more information on there. I just also wanted to mention that the staff put out a memo on no wrong door just a few days ago, I think October 1st. That has additional background for for those that are listening and watching and following. And then finally, I just wanted to thank doctor Lee and central health in particular. They've made a very bold investment in mental health services in substance abuse. And I really appreciate that the leadership from from yourself, from your board, from your team, it's it's great. And we want to partner with you to, to address these issues. And again, business as usual is just not going to that's not going to work. The status quo is not sustainable. And with that, I'll. Council member zo qadri.

[10:27:33 AM]

>> Great. Thank you, mayor pro tem, I want to thank I want to kind of kick this kick this off by thanking the presenters. I appreciate you all and the presentation and everything you all do. I also want to thank a lot of the other speakers from from other agencies who do a lot of work on the ground, helping our own house community. You know, one of the reasons I decided to get into this space to begin with was to make a visible difference, a real difference in helping our in-house community. So that's something that's really near and dear to me. When the no wrong door I guess concept came to be, I was really excited about it. You know, I believe what it could do, what it can be. But but I want to ask some questions on some of the comments that have been made by some of the speakers today. And then I know many of us, if not all of us on the council, had gotten a letter from the aclu of Texas, and it was signed on by other agencies. I wanted to also ask questions about about that as well. But but to kind of kick it off, I wanted to ask it was I think it was mentioned by a speaker today, what is the involvement of the Cicero institute and no wrong door.

[10:28:39 AM]

>> So there there is no involvement with that institute with no wrong door.

[10:28:45 AM]

>> Okay. So there's there's no there's no collaboration. There's no meetings that take place, nothing of that sort.

[10:28:53 AM]

>> They they are not in the organization and designing process for no wrong door. The services that are being provided. Okay.

[10:29:03 AM]

>> I think we have comment by director gray.

[10:29:06 AM]

>> Thank you. Council member David gray. Yeah, maybe. Let me let me clarify. I think as director king mentioned, Cicero institute has not been involved in no wrong door. I think where lines are getting crossed is our office has made it an intentional effort to engage with multiple folks from multiple organizations to talk about our homeless strategy and work that we're doing as a city and as a community to address unsheltered homelessness. As we think about the context that we're in being in the state of Texas and knowing that we have an upcoming legislative session, we know it's important to demonstrate to our state lawmakers and their staff that the city of Austin is having a positive impact in helping people get off the street and into homelessness. So as part of our office's work, we do meet with organizations like Cicero and tpf, just like we meet with organizations like vocal Texas and THA, we do not discount people because of their political ideologies or affiliations. We believe it is our job to meet with anybody and everybody who wants to do this work and do this work in good faith. And so I appreciate the question, but I also just want to be very clear that no wrong door has been championed by my colleagues sitting on this dais with me and the organizations who you saw represented on the slide with all of our partners. As for any meetings with Cicero and tpf that our agency is having, those are an opportunity for us to educate them on the work that we're doing so that they could help be champions for some of the causes that we we are working towards, but also an opportunity for us to listen and understand their perspective and where there are opportunities for us to do work together, we will do that work together, just like we do with any other organization that we meet with.

[10:31:03 AM]

>> Great. And then what I was going to ask next is groups like vocal tx, Texas harm reduction alliance, aclu of Texas. This group is committed to, to meeting with those groups as well.

[10:31:15 AM]

>> Absolutely, sir. Yes.

[10:31:17 AM]

>> Great. Thank you. And then I wanted to ask a few questions that are related to the letter that we got from the aclu, aclu of Texas. There are several bullet points. I don't want to go through all of them. I think my colleagues might have further questions on that. But there was three points that I that I kind of wanted to, to dive into and get clarity on. On one of them, it says no wrong door selects people by their arrest records, which measure contact with police rather than their health needs. Could someone comment on that?

[10:31:50 AM]

>> I'm going to take that one also. Sure. So I can I'll start with that one. Okay, great. I'll take that one also. And so when we as a, as a group of, of collaborators put together the initial high utilizer list, what we endeavored to do was look at individuals who have the most frequent points of contact with the criminal justice system, the health care system, and the homeless response system. So it is true that we worked with the Austin police department and their data analyst to understand who are the individuals in our community that are having multiple repeated contacts with APD. In some instances, folks who received upwards of a dozen police officer emergency detentions in less than a 48 hour period. So super high utilizers. We also went through a similar exercise with our health care partners over at austin-travis county ems, as well as the fire department. You saw some examples of that data represented today. And then when we acquired that information from our public safety partners, we then worked with echo to cross-reference that list with individuals who are in our homeless response system in our database, to come up with a list of folks who we can, can affirmatively say through real data, are actually cycling through the public safety system, the health care system, and the homeless response system. So the bottom line is that the list is a constellation of different lists. One of the challenges that has made that exercise so difficult is that historically, our agencies do not share data and information. There are some legal reasons why we can't and have not been able to do that.

[10:33:36 AM]

There's also client privacy reasons. And so a big part of the work has been figuring out how can we share data about clients who we are seeing cycle through our system with the sole purpose of figuring out how we break the clients out of those cycles. So the bottom line is, is that, yes, APD data is used, but so is health care data and homeless response data.

[10:34:00 AM]

>> Great, I appreciate that. Another point that was made was that Rhonda share sensitive information with police and prosecutors, with no assurance that it will stay out of criminal proceedings.

[10:34:15 AM]

>> Thank you for that question. I am not aware of us sharing sensitive data with prosecutors or anyone else. We've been very good in ensuring that we are all in compliance with our laws that govern the data that comes out of the police department. But I can guarantee you that the the top 99 on that list have a strong overlap with many of the people that you see up in front of you right now.

[10:34:47 AM]

>> Great. And then my last point of clarification from the letter, it talked about how APD approaches people in jail without notifying their lawyers and asking them to sign documents that affect their legal involvement.

[10:35:01 AM]

>> Austin police officers do meet people in jail. We meet people in jail, especially with the no wrong door because this is a maybe the only opportunity that we get to provide services before they go back into that vicious cycle that we all talked about. And the officers are trying to meet them either when they are exiting the jail system or while they're there to offer services, housing, substance abuse, whatever they need. And the only the majority of the individual consent. Reports, that is the paperwork

that we're trying to seek signature on just so they can get the services they need. But police, we are meeting people in the jail system to try to provide services for this high utilizer group.

[10:35:57 AM]

>> So the only documents they sign are documents about about consent. Is that what you're correct. And are lawyers present for for them while they're.

[10:36:06 AM]

>> We have put guardrails on that process. Our officers have just changed their standing operating procedures to make every effort to notify attorneys through. Through phone, through email. But we try our our darndest to get an attorney involved with this, because I know that they offer a lot of services that are very beneficial to the no wrong door program.

[10:36:33 AM]

>> Great council member. If I could just add something to that really quickly. Sorry, the county's sensitive to these issues and we look forward to the refinement of no, no wrong door processes to ensure that people are not unintentionally harmed by the the goodwill of this program, and that civil liberties are not unintentionally violated. So county has a responsibility to prosecute, defend. We run the jail, we run the courts. It's really important to get this right. And so we do appreciate the comments from aclu as well as some of the public defenders that testified earlier. And we welcome any way to ensure that there are those protections and that we don't have to have ongoing concerns about program design.

[10:37:12 AM]

>> And I appreciate those comments. And, I mean, you're right, we want to make sure we get this right, that we're able to have whatever refinements look like and make sure we have the guardrails where it's doing its job, but we're not. We're also protecting people and we're taking care of people and we're not giving up our values. So thank you for, for taking my time.

[10:37:33 AM]

>> Thank you very much. Councilmember Velasquez. Thank you. Chair.

[10:37:39 AM]

>> Can you outline some of the specialized training that our officers go through that are as part of no wrong door?

[10:37:48 AM]

>> Absolutely. I would say this is an elite group of no wrong door officers specifically trained in crisis intervention and specifically trained by integral care. I, I would put this group of officers up in front of anybody in the city doing this work. They understand the dynamics at play. They understand the complexity of the work. They receive 40 hours of crisis intervention training. But imagine this. These are these are the same officers that are doing the host program. So they're being trained in with David gray's group. They are working with the care unit as well. This is a group of officers that have volunteered to do this type of work. Some of them are clinicians themselves that have a long history of working in this area. So I would say they're the best of the best as it relates to working with this vulnerable and complex population that we're all discussing today.

[10:38:45 AM]

>> And council member Velasquez, I would point out there are additional slides that are available to the presentation that outline the specific trainings for a lot of the partners for no wrong door, including our public safety partners.

[10:39:00 AM]

>> Thank you. What other cities, counties, or organizations has the city reached out to seeking advice or support on the no wrong door initiative? And what are the the key takeaways from those engagements?

[10:39:14 AM]

>> David. Director gray, if you could take that, please.

[10:39:17 AM]

>> Sure, absolutely. Thank you. Councilmember. No. Wrong door is a new concept to the city of Austin. But fortunately, there are peer cities that have similar models that they deliver. For example, I know that there was a coalition of folks from Travis county, city of Austin, including APD and a few others who had the privilege of traveling to salt Lake City and seeing how their city operates a model similar to no wrong door, as well as a crisis care center similar to the one that central health and other partners are proposing for here in this community. And so we've done a lot of research, both site visits, as well as some kind of academic research literature reviews on what's going on in other communities. Obviously, every community is different. And so our goal, whether we're talking about this program or any other program that we do in this space, is to figure out how we take the lessons and the practices from those other communities and hyper localize it to Austin specific context.

[10:40:18 AM]

And that's exactly the work that we've done with this program.

[10:40:22 AM]

>> And I would also ask assistant chief Harold to provide context about her work in Boulder, which includes a lot of elements and similar similarities with no wrong door.

[10:40:34 AM]

>> Thank you, Robert. We did we did have a very similar program in Boulder, Colorado. I was the chief there, and it was very similar. And I, I will say the hardest thing at that time, we're almost at five years ago, since I was a chief, was getting disparate group of multidisciplinary teams to sign the mou, which we did in Boulder. And I think I'm proud of that work, because I think we were one of the first cities in the country to accomplish that. And so our our program still lives today in Boulder. They have, since I left, gotten through their 60 highest utilizers and found long term solutions for each of those clients. And I recently called back and visited Boulder just to see the impact of their program in Boulder. And I can tell you with the with the program similar to what we're doing in Austin. Plus they have a 24 over seven crisis care center now for their unhoused, which has proved to be so positive. And I'm proud of

the work that we did here. And there's little doubt in my mind that with the players that we have, we'll have the same success Boulder, Colorado, had, especially if we keep the vision as getting a 24 over seven crisis center that we can all utilize for some of these hardest to reach community members.

[10:41:59 AM]

>> Thank you. A year ago, we the city launched the Austin first pilot, a partnership between APD, EMS, integral care and the office of the chief medical officer to support our high acuity mental health incidents. What have we learned from that pilot and how is that being incorporated into. No wrong door?

[10:42:21 AM]

>> Chief Luckritz, can you please respond?

[10:42:30 AM]

>> The elements of Austin first, as we went through that pilot, you know, we've identified that that there were successes in that program. It is a separate program from what we do here with no wrong doors. You know, there is a lot of overlap between the individuals that are involved. And so we're still kind of exploring what that's going to look like for us in order to maximize the the time and staffing utilization across APD, across the EMS, and across integral care. So I think there's still probably more analysis to be done and more, more to come back to you with on that.

[10:43:05 AM]

>> Thank you. And one of the slides that touched on legislation that we'll be putting, I guess, before the the state our partnerships with the state are critical for this initiative. And I was curious how many pieces of legislation we're currently working on and how much input will the council have on that? And I believe we're. Yes, from.

[10:43:24 AM]

>> Our our legislative director is coming up.

[10:43:36 AM]

>> Thank you. Council member Carrie Rogers for the record legislative director. Excuse me. Tangled up in a bag down here? Yes. There in the appendix, there's a slide that refers to a number of legislative initiatives that we've been talking about with our partners. I think if we go back to the very beginning of the work and trying to identify our highest utilizers and how we could help them, the government relations office has sort of been shadowing that process to identify what were the gaps. Were there legislative remedies that might be needed to address some of these needs? And then, of course, working with our partners at integral care and central health and the county on what their interests were in pursuing during the next legislative session. We all what I've seen is we all have had a very strong interest in supporting our mental health population. I think there was something mentioned from mayor pro tem vela overnight regarding a bill that representative Howard was planning to bring forward in the next session. So so what you see on that slide, and I think if and I don't know if they have it up, if it's somewhere in the slide deck that they can pull up. But on the top of that slide are items that we've talked with partners.

[10:44:56 AM]

We agree these things we move forward with. They could be in standalone bills. It could be in one lump. Bill. We're still navigating that. As you all know, it's a very dynamic process on bills. And then the lower part are additional considerations that we're still talking through with our partners. I think one of them is pursuing funding for the 988 suicide hotline. Let me put my glasses on 988 for the suicide hotline supporting regional psych bed availability for those partners here who are calling around and trying to find proper placement for high acuity folks, as opposed to those manual call trees that they're doing right now. And then also supporting funding and expansion of our state supported living centers, which are really targeted at adults who are diagnosed with id or, excuse me, intellectual development disease before they were 18, that they're always going to need care. So it's really a continuum, kind of a menu of things that we're working through right now. And nothing is final at this point.

[10:46:08 AM]

>> Thank you all and thank you all for this. That's it. Mayor pro tem.

[10:46:13 AM]

>> Thank you, councilmember Siegel.

[10:46:15 AM]

>> Thank you, mayor pro tem and everyone for your presentation. I'm going to have some questions. I want to ask Mr. Bradley Hargis to come back up from capital area public defender service, if one of y'all can make room director Rogers, if you wouldn't mind staying and assistant director Harold, I have questions for you as well. Thanks, Jill. And so, Mr. Hodges, thank you so much for being here today. I was off the dais when you presented earlier, but I really appreciate your testimony and had a few follow up questions. Can you say more about the statement that you made, that there have been, quote, attempts to release clients directly to officers against their wishes?

[10:46:54 AM]

>> Yeah. Yes. I mean, we have several examples I'll mention as detailed the most recent one, which was on Thursday. We intercepted at the court process a request coming from a no wrong doors officer to have a bond condition placed on a client to be released only to the no wrong doors officer. So it would make it a condition of the bond for the person being released to jail, that they go with the no wrong doors officer to whatever place that officer was working to try to find a location for them. That particular client our caseworkers actually met with and knew we had an existing relationship that client would not have agreed to with the officer. It would not have been a good experience for either the officer or the client. She was in crisis. We spoke with her. She was adamant she would not go. The court found that to be a totally inappropriate request and didn't grant it. We have since worked out a treatment bed for her and she has agreed to go voluntarily, and our treatment team, our our, our case management team that has a relationship with her is transporting her. You know, that was just the most recent example. We've got others of bond condition requests where the the officers have contacted the courts directly trying to have bond conditions imposed on clients, and I could go on, but I want to respect the council's time.

[10:48:17 AM]

>> Well, could you share a little bit more about how capital area public defender service and maybe the public defender's office have been involved in wrongdoing?

[10:48:24 AM]

>> That's actually been the most frustrating part for us. We first learned of the program in April, when we were alerted by the court of an outreach from officers requesting bond conditions. You know, we engaged with the program to try to find out more about it. I'm sure that they will have some answers for you in a moment as well. From our perspective, we've we've worked hard to try to get our concerns addressed, to be invited to join the mou, to be able to participate fully, to have our concerns addressed so far to this time. Most recently, in the last few days, we've been told that since we are not a signatory on the mou and the data sharing agreement will no longer be allowed at staffing of our clients. And so I think there's a real challenge to us being involved. It's been very difficult to get clear answers. One of our first requests was just a one pager about what this program was to give to our attorneys, our attorneys receiving questions from clients about what this program was. We couldn't even explain what the program was. I, I heard in our presentation today about a mental health crisis in Travis county, which is without a doubt true. And I heard some amazing resources that a lot of organizations are doing, but there still was very little information about what no wrong doors actually does at that intersection. And that's been one of the most difficult pieces is to try to navigate because we are the people helping our clients navigate this system when it comes into the criminal justice system, because all of these clients that we're talking about when they talk about dozens of arrests, those are our clients, right? We are the ones that are handling the legal consequences of those cases. And if we cannot be involved in this and a stakeholder in this, then it's not going to be successful.

[10:50:15 AM]

It can't be if the people that are responsible for protecting their legal rights are not formally included.

[10:50:21 AM]

>> Since the kind of first public memo in August, I guess it was August 3rd was issued, have you seen any changes in how the program is administered?

[10:50:29 AM]

>> I don't know if I would say there are changes in the way the program is administered. And the extent that I'm not clear on the way the program is administered, I think it's still a start up and a development phase, and there's not a lot of mature proceedings. You know, one area that we did ask to have addressed, and I think there was an attempt to address it, was around some transparency with officers visiting clients while they have criminal criminal cases pending. Obviously, that puts you in a very different footing than many of the programs that are truly diversionary across the country that have

been analyzed, where people are being diverted away from the justice system without charges. We're engaging in the no wrong doors is engaging with people who have active criminal cases. You know, we've had officers question people about their pending criminal cases. That was obviously alarming to us. So one of the things we did see was a memo that came out. I know Melissa Scheer addressed the new policies, the police officer officers or the police department adopted. We actually went the wrong direction. We were asking for informed consent and transparency. It went more with Miranda rights and recorded statements, which actually makes those statements more likely to be used in court and not less so. I think there's room for improvement and for real work here. But we have to have a foundation from the beginning that respects the the full legal process and not just the the clinical needs of these clients because we are subjecting them to legal consequences to jail and to prison. And it's very important that this process respect that.

[10:52:03 AM]

And it hasn't yet gotten there.

[10:52:06 AM]

>> Earlier, assistant director Harold shared that maybe 40% of the people that are being targeted by the wrong door have signed a release of some sort. Are you aware of attorneys consenting or being present to those releases being signed?

[10:52:18 AM]

>> I'm not aware. We've almost ever been present when they were signed. We've been requested here of late, including today, to try to get a client to receive release, sign them. We're unclear on which one of our clients have actually signed releases. We no longer have access to the no wrong doors list, and so we can't even say which of our clients are on the no wrong doors list at the moment, or which have signed releases. I do know that our staff, who have talked with some of the clients that have signed releases, were very unclear on what the releases were intended to do. They understood that if they signed the release, someone was going to help them. There were someone was going to help them get housing, someone was going to help them get treatment, which I think is the overall goal. But they didn't understand that they were agreeing for data to be shared among prosecutors, police and treatment providers, and that anything they told anyone in that process could be shared and could be used against them. As of today, there's no legal protections in the in the process to prevent that from happening. There's no agreement the statements won't be used against participants. And so I think there's a lot of unclarity from clients that we've spoken with about what these releases actually mean to them, and what they've actually released and how they revoke it.

[10:53:31 AM]

One of our requests was a clear policy that, or a clear mechanism to allow clients to revoke their, their requests or their agreements to participate or their release of information. I don't think we've yet identified how we'll process revocations or that new releases really should be necessary each time there's new criminal charges, because obviously that changes the nature of the release. Maybe you are absolutely agreeable to it before you are facing prison time. Now, perhaps you don't want all these agencies collaborating against your legal interest.

[10:54:08 AM]

>> One aspect of no wrong door is to perhaps seek legislative changes that facilitate changes to civil commitment law, maybe to lower the standard. Do you know if in Travis county, public defenders are provided for for civil commitment processes.

[10:54:23 AM]

>> There are two staff attorneys that are labeled public defenders in the probate court. They do not work for the Travis county public defender, the Travis county mental health public defender, nor for the private defender service. But there are attorneys that should be part of that process. I don't personally we don't represent people in those civil commitments. I wouldn't want to really comment further besides to say that I've heard testimony here, and I will agree from my experience that any kind of civil commitment or arrest can be very traumatic to folks. And so there should be legal protections around that.

[10:54:59 AM]

>> Thank you. Just a couple more. And I guess I might have to pass back to you, mayor pro tem, before I ask the other questions, Mr. Hargis, you shared with my office that someone was arrested after getting a bolo or be on the lookout through no wrong door. Can you share something about that?

[10:55:16 AM]

>> Yeah, that it's not personally our client, but I'm aware of it. It was a client of the mental health public defender who shared that experience with us. It's a client that's been talked about quite a bit with no wrong doors, no wrong doors. Was interested in meeting with that client or locating that client in the community. So they put out a, to my understanding, a regular police bolo, be on the lookout, a regular street officer not associated with no wrong doors, of course, knew this client. They're high utilizer and went and detained that person. There was a search of the person that resulted in drugs being found, and that resulted in a felony charge and an arrest. Instead of the proposed or hoped diversion through the mental health system. So that client was arrested and charged with a felony.

[10:56:01 AM]

>> All right, before you go back to your seat, any last comments?

[10:56:06 AM]

>> No thank you. I just would like to say that we really do support the goals and the work of no wrong doors. You know, there's been a lot of different programs. Looked around. Salt Lake City was mentioned today. Project connect that specifically, one of their stakeholders is their public defender program. There. We want to be a partner in this. We have certain restrictions and expectations around protecting rights. It is our goal to support this. These are the clients that we work with every day. They need help, they need services, they need connection. But it has to be done in a way that protects their legal rights and needs as well. Thank you.

[10:56:43 AM]

>> Thank you sir. Mayor pro tem, if you just add me to the back of the stack. Thank you sir.

[10:56:48 AM]

>> Got it. Thank you, council member alter.

[10:56:50 AM]

>> Thank you. I appreciate all the information today. And I want to kind of take a little zoomed out approach and just have a, an understanding kind of, of the system, right? We're talking about a piece of the system, a group of individuals within the broader system who are using a lot of resources within that system. But, you know, it's talked about prioritizing resources, making sure that we can connect people where we need to connect them. And I just wanted to kind of understand that impact systematically. And I think where

[10:57:29 AM]

>> That starts for me. Mr. Richardson, you talked a little bit about the length of care, the type of care someone within this group might need that, you know, a couple days is, is not really going to cut it. And I wanted to understand how that might compare to and I know there's no regular or typical client, right. But but maybe someone who. Hasn't decompensated to the level that we're seeing many of these individuals is a couple days kind of enough for someone like that?

[10:58:10 AM]

>> Yeah, I know this sounds like an awful answer, but it depends. But, you know, I do think the answer, your first part of your question, which is people that are, have been out of getting any kind of active treatment, are probably struggling with co-occurring medical conditions have been on housed. You heard us talk a little bit about the really the trauma that sort of reinforces this. I think I also want to just before we go any further, to talk about how important trust is in this and that many of the folks that we're talking about here have lost trust in our ability to serve them and support them. So there's a lot of work that has to be done. But if somebody is at a at a point of being. Pio Eid Eid, meaning being able to go to an inpatient facility and hasn't gotten treatment in an extended period of time, there's really important clinical steps that you kind of go through that if you do it well, prevents that, that recidivism, that readmission that happens. And part of that is starting with making sure and evaluating their overall medical condition.

[10:59:18 AM]

And you heard a lot about the work that central health is doing. It's also ensuring that the medications that that person is on are prescribed. Any new ones. There's a period of time to observe how they're doing on those medications. There's also something that happens very often if somebody has not been in treatment for a while and happens, and this is something I, I, I treated folks my entire career. There are some people that don't have a lot of insight into their own illness and how it's affected their ability to function day in and day out. So having an, it's more than a couple of days to go into an inpatient setting and go, Jeff, you're cured. Keep up the good work. Here's your discharge plan. We hope it all

works out for you is going to fail for these folks. Once somebody leaves a hospital, it's the step down we talked about to having the ability to be in a residential, not a hospital, but a residential setting where they're getting additional supports to help that long range plan of recovery. When that happens, then this goes down a Progressive line that helps someone not recycle this, this really miserable loop that people are in that not only is bad, it is. We've talked a lot about the resource strain, but it really is something that if you're experiencing that, you're willingness to go through it again is challenge.

[11:00:38 AM]

Why go through it? So a lot of the work that we have to do is make sure that we're reaching people where they are. And you've heard some comments earlier about no wrong door. And, and I just think our whole process here and that all the work that we've done together has been built on building trust for the person we're serving that will build that and that that commitment. But from a clinical standpoint, there's a whole piece of this work that we need to spend more time and focus on. This is not a quick fix, but if it's done in a progression, it really does pay off both for that person's ability to live a satisfying, meaningful life. It also reduce costs. We've also seen data when someone is in active treatment and doing well, their overall cost, their overall medical health goes way up. People are willing to take their medications. You know, if they're on heart medications, diabetes, all these things that are really critical that happen when somebody is in active treatment.

[11:01:36 AM]

>> And both the work you're doing and the, you know, growth that you're trying to provide, as well as doctor Lee, what he talked about are we. I know we're not there today, but I guess help me understand that the timeline in building out that full continuum of care and the reason I'm asking this question is because I think about, you know, what, director gray, we've talked about for a long time and, you know, a couple of years back about how we were taking people who had permanent supportive level, permanent supportive housing level need. And we're putting them in rapid rehousing, knowing that wasn't the level of care they needed. And so it didn't work, right. They they were stable for a little while, but that program came to an end for them, and they ended up not far from where they started. And I want to make sure that if we're dedicating resources, dedicating very limited beds to individuals with a very high level of need, that right now we're putting them into a path that is successful, not just saying, okay, this is the best we've got. Because if at the end of their journey, they're not going to be in a place of success, then should we be focused on the population where we would have the greatest success? Sadly, to the exclusion of others, right?

[11:03:07 AM]

Everything is finite. And so I just want to kind of help, help me grapple with that.

[11:03:14 AM]

>> Yeah. I've been grappling this my whole career. This is a challenge. But I do think one of the things you just brought up, which is I think our pathway, and I'll let doctor Lee sort of help me with this. But in terms of what we what you saw on the slide earlier from central health, describing the different steps of things that we feel are imperative to get done, one of which is I mentioned earlier, which is the ability to expand inpatient capacity for people who have long term chronic needs, meaning not that quick three day turnaround. We, we, we're discussing both at our Hermann center location, converting that to, to a, a inpatient beds make it 15, 16 beds. Our pathway on that is hopefully to do something in the next year and a half, but it takes time, both from a regulatory. And I hate to bring it up, but money matters here. Right. We got to figure this out. So whatever we do to your point, councilman, we we don't want to say that this is a flash in the pan.

[11:04:14 AM]

This is this great, exciting program. In two years, we run out of money. And this has been traditionally the challenge we've had with behavioral health in the state of Texas. Funding is not durable. And so I think one of the work that we're doing with with central health and university UT and the county and the city is really thinking about how we could sustain that. And you've heard a couple mentions of the crisis center look in Salt Lake City, but these are all over the country. This model has been built out. That's going to take a little bit longer to build out, but that's much more comprehensive and deeper. Then the third piece is the ongoing work that we have to do to make sure that there's inpatient capacity that's meaningful for the people we're serving, and that's work that we can do. Now. Okay. Anything you want to add, sir?

[11:05:05 AM]

>> Thank you, Jeff, and thank you for the question. Council member, you may recall that slide that showed three phases. So the specific answer to your question from the point that we have agreement by ascension to go ahead and begin the evaluation and build out process for the first phase, inpatient psychiatric beds and Ed beds. Hopefully, about a year before, we could actually be seeing patients in that space. That would be the earliest service that comes online. There have to be some agreements in place to start that process. The next phase would be the mental health crisis center, which we're very excited about from the point that we say, go on that process. That would be new ground construction. So approximately four years, we will be having further discussions with the council to talk about the possibility of working together around the site of that crisis center. Some aspects there it operationally,

if it is close to the hospital, that has an advantage and if it is close to kind of downtown booking, that has an advantage for our justice colleagues. So location matters for that one, that would be about four years. And then the other components around step down. Similarly, we could probably build in that four year time frame, but we identify land and resources.

[11:06:21 AM]

And then a word on resources. There's the capital resources to build it, and then the operating resources to, to run it. And the operating and staffing components are sometimes the more challenging. So we have to look down the road to make sure that we can not only put up the right building, but ensure the right care is provided. And we believe that working together with the city and the county and our state colleagues continue to support the degree they do, that's how we create the foundation for that sustainable future resource flow that we need to provide the essential service.

[11:06:53 AM]

>> Okay. And it was touched on at various points, but I want to elevate a little bit. You know, the we talk about the step down, we talk about the continuum or the end of that process has to be housing, right? I mean, we we all know that if we fully get somebody stable, but then put them right back on the street at the end, we're going to be right back here again. And so, director gray, if you could talk a little bit about where the housing component is in this plan, I know we're, you know, we've done a great job the past few years. We had a really long pipeline that we have seen mostly come to fruition. But what's next for that, right? Where do we go from here to ensure that this all this investment isn't for naught?

[11:07:42 AM]

>> Yes, sir. Thank you, council member. You know, I'll say to that to that premise, I think for some of these no wrong door clients, the ultimate outcome will be housing. And that housing could be in a permanent supportive housing community. It could be residing with families and loved ones that are capable and able to take somebody back. Once that person is on a sustained system of treatment and care. But we also recognize that for some of our no wrong door clients, the ultimate outcome might be long term inpatient care as part of a beloved community. And that's not an outcome that we hope for. But I think that is, in some cases, the best outcome for those folks. You know, I think with no wrong door is really getting at is the outcome cannot be releasing people back to the street. There is no liberty in releasing somebody from jail just to have that person die on the street. There is no justice in that. And I think what our system is doing right now, with the resources that we have today, is figuring out how do we best support people with the beds available to us. And so we're able to get them to the ultimate outcome, which is housing. I was notified a couple of weeks ago about a client that a pd helped get

permanent housing at community first village, after that person had been cycling through our systems for 15 years. I have staff who are in elementary school 15 years ago.

[11:09:04 AM]

That's how long that is, just to put that into perspective. And so again, councilmember, our community and really you and others on this council have been a huge champion for building housing in this community, for providing the supportive services dollars to sustain folks who move into that housing and keep them engaged in systems of care. And we have no wrong door clients who have already moved into those units. But again, we also recognize that for some of our clients, the best possible outcome we can hope for is inpatient long term treatment. But I would argue that both of those outcomes are better than releasing people from jails or hospitals just to have those people perish on our streets.

[11:09:40 AM]

>> Yeah.

[11:09:41 AM]

>> Dave, if I could add to that, just one other comment, which is we have to start stop treating chronic someone with a chronic mental illness, which is a medical disease, like a one off success. If you have any other chronic diseases, we allow people to get ongoing treatment to help them be successful. If we treated diabetics the same way we treat people with mental illness, we would be doing nothing but sending people to the emergency room. So what we have to start thinking about is folks served in the no wrong door, and others who have a chronic mental health need. How do we ensure that we wrap those supports and maintain those? So they're not episodic, but they're there how and when people will need them and maintain that over a lifetime to help people not need these more intensive, very expensive and disruptive and traumatic encounters with the inpatient world, the, you know, incarceration. And as, as you heard earlier, our largest mental health inpatient facility right now is our jail system. We need we need to move it away from the jails and create a true system of care that allows that people to get that treatment.

[11:10:52 AM]

>> Very good. Well, in the interest of time, I'm going to just a couple very quick hits. No response necessary. But just. For I don't know who, who is the, the creator or the holder of the list, but to whomever that person may be, I know that a lot of these individuals are likely individuals we see downtown, right? We know that there is a concentration of individuals who especially have been chronically homeless are downtown. That being said, you know, I can think of a few in district five, and I know every district has their frequent fliers or whether their frequent fliers with you, they're definitely frequent fliers with our neighborhood. So if we could just kind of coordinate a little bit on, you know, those couple people where they are in this program and how we can help, I think that would be very helpful for, for all of us. Second, Carrie mentioned about working on legislation to the degree to which there is any kind of sub quorum put together to discuss that throughout the legislative session. You know, we'd love to be part of that conversation as well. And that concludes my remarks. I really appreciate all of you all today, and we'll keep chatting.

[11:12:18 AM]

>> Thank you. Councilmember councilmember Laine.

[11:12:21 AM]

>> Thank you. First, thanks to everyone both inside and outside the city who came together to put together this program. Today's presentation for being available to answer every council member, council offices questions last week and providing such robust written briefings in recent months. I am excited that we have 17 agencies at the table. Having signed the mou, I think we are poised to genuinely strengthen our collaboration across departments, agencies and between Austin and Travis county. I am also grateful to aclu and our public defenders and others who wrote and spoke to us to articulate concerns, which makes it possible to address issues at the most effective moment the beginning of a program when it is being piloted. And so, you know, I'm going to, in the interest of moving through my questions and comments quickly, I'm going to mix comments with questions. And but my first comment is, I hope that you'll give genuine consideration and. And for those of you who I know, I know that you are thoughtful in the implementation. Implementation of all of these programs, but genuine consideration to the maximum way that some of these concerns can be addressed, because that is the way to keep us as a council fully on board.

[11:13:30 AM]

And I include myself in that. So kicking it off there, we heard a lot. I would like to build on councilmember Siegel's questions as it relates to public defenders, given that one of the one of the very large goals of this program is to reduce arrests, reduce contacts with APD and and being tied up in the in

the justice system. I would love to hear from someone about the extent to which you think. First of all, critically important to be working with public defenders. That's part of their goals as well. So I think that this is an area that personally, I think needs to be strengthened. And I, I'd like to hear a little bit just of the extent to which you think that's possible. Is that the path we're on right now to strengthen that relationship and work more effectively with the public defenders?

[11:14:27 AM]

>> Thank you for the question. And yes, I, I want everybody to be part of this program because it's so impactful and so meaningful. I've really tried, since we started this program to include and be transparent with our friends at the public defender's office and other attorneys that have had concerns. I have been transparent by releasing the list. I have been transparent giving the mou, and I've been transparent, giving the individual consent decrees, and I will continue these partnerships. I promise you, my background serves me that I will be the last person standing at the table, waiting and hoping that we can move forward together, because I know that that is the best path forward in this work is so complex that if we don't all work together to find solutions, then these people are dying on the streets every day in Austin, and I just don't think that's acceptable. So you have my commitment that we will continue in the path of getting cooperation from everybody that touches these people. And most certainly, you know, public defenders attorneys do have a seat at the table. And I, I feel at this juncture that we're doing everything that we can to be transparent and to put guardrails around civil rights and civil liberties. And I will continue to do that and work toward that. And I've met with Melissa Scheer and Katy gio, and they have my personal cell phone, and I've made that commitment to both of them.

[11:16:08 AM]

>> Thank you.

[11:16:10 AM]

>> And I'm so sorry if I could jump in. I did want to say that really our broader goal, I think, at the county and really community wide is to focus more so on deflection. So trying to stop people from having to have those law enforcement engagements altogether. And really, until we have a criminal justice crisis center or a mental health crisis center, we really do have to kind of cobble things together. And unfortunately, that does mean a lot of engagement with law enforcement. And so once we can establish that and have those alternatives to arrest, it really will help to filter people away and hopefully not have to have those, those sorts of contacts. So it is it is a long term process. We really need to have a facility in place first. But I think as we build that out, it it is a community effort to try to figure out how do we work around not having the greatest resource that we really need to have?

[11:17:03 AM]

>> Yeah. And I thank you, chief, for asking, answering so many of our questions before this meeting. And I know we'll be following up as well. And I appreciate those comments as well. I, I agree that we are starting where we are and where we are is a lot of contact with police. And so I was this is one of the comments that I was leading up to is, you know, I read the process through which you all went to arrive at. We're going to look at eight arrests or more. And I think that that was a reasonable process. And given that we're starting from a place where I certainly in district six, most contact with the homeless population until the valiant efforts of director gray, after, you know, he came on board, got up to speed and began doing that. But there's a lot of contact with police. And that is just where we're starting. And so I think that that is, from what I've heard and read, a reasonable metric by which to size up this program and to make the most effective use of dollars in identifying individuals with whom we have a goal of reducing police contact.

[11:18:11 AM]

So I wanted to put that out there. Now, at the same time, and I, I may have missed it if we had this conversation, if anyone brought this up from the dais, but I've definitely seen discussion in the written materials. This being a program that focuses on post adjudication, diversion versus pretrial diversion. And, you know, I read the letter from the mayor that really placed an emphasis on post adjudication, diversion, and I read ACLU questioning about that. And so I will say that I believe that we are most effective figuring out how to, as much as possible, handle this with pretrial diversion. We're starting where we are, which is sometimes going to necessitate post adjudication diversion. But I don't believe, and I suspect my colleagues agree, that that's not where we want to go, should want to go. And I don't think that should be the basis of how we move forward. Happy to hear your thoughts.

[11:19:11 AM]

>> Thank you for the question. I think it's an important one, and I think chief Davis has really emphasized our cooperation with diversion and deflection. We have ongoing meetings with both the county attorney and the district attorney, and I think our relationships are really good, built on trust, and we are working hard on other programs that have to deal with deflection and diversion, and we will continue to do so. I also offer the no wrong door team is in a constant state of deflection and diverting people out of the criminal justice system. They do this work daily, but most certainly, I know if chief Davis was up here right now, you have her commitment that we will continue to try to deflect and divert as many people suffering from severe mental illness and unhoused with substance abuse addiction out of the criminal justice system, because that's why we're all here, is because that's not the right system for people to be

in. And so we're committed to that. I also would like to say that sometimes that is not possible, even though this population is disproportionately impacted by crime, we do have calls from community members. When somebody has committed a crime and sometimes the crimes are violent. And so we have to recognize that community members have a right to see their day in court as well. But we're we all have the framework and the understanding that this population, this vulnerable population is not served well in jail. And so we're doing everything we can to divert and deflect while also working with community members that are victims, sometimes at the hands of, of some of these people on the list, even though that's a rarity. It's, it's smaller in number, but we do have people on the list that if we don't get intervention, they end up with long jail sentences and they do commit felonies. And that's what we're trying to prevent, if that's helpful.

[11:21:28 AM]

Council member.

[11:21:30 AM]

>> Thank you. So I'm going to shift over towards data, baseline data. A few questions related to that. So, you know, we started from 950 individuals identified by consultant the meadows institute, I think, and we ultimately decided to focus on the 100 highest utilizers. Are you I mean, over time, people are going to move off that list, hopefully because of connection with services and breaking the cycle. Is part of your tracking already? Or if not, could you consider tracking once they've left that top 100? How long do they stay off? If they reemerge into the top 100? I just said that. How long did they stay off? And then also, if they disappear from that list, how often is that due to involuntary commitment or being in jail or prison? Like these are all factors that I'm hoping could be part of the data that you're tracking.

[11:22:35 AM]

>> We are. Excuse me. We are tracking that. And that's an important question. And I think this is where we're in a we're in a really good position right now to understand the dynamics almost in real time to understand exactly that. And I, I will offer that doctor Anderson, being a researcher himself, I am hoping that we really evaluate our success in a scientific manner. Most certainly, we are tracking the individuals we. If somebody leaves the list for any. One of those reasons that you mentioned, we have a standard that if they come off the list, if they haven't had any interaction with any of our systems in 90 days. But to your point, wouldn't it be awesome is if we tracked these people for a long time to really understand what worked, what didn't, and to really evaluate the no wrong door. So we're making sure that we have the outcomes that we want to have.

[11:23:35 AM]

And I'm, I'm excited because I think that this program should be brought to council every quarter. And we talk about questions like that. And we're engaged with council because the work is so vitally important to this community.

[11:23:53 AM]

>> Thank you. And you anticipated one of the last questions I was going to ask, which is the reporting cadence. And I don't know if it would be to full council or to a committee. But I will look forward to appearing at a committee if it's not one that I'm already on. I have a question about the this is on slide 36, the proposed metrics. I think. Third, from the end minimized repeat law enforcement crisis contacts. And then there's a bullet point beneath in. The first item is including repeat calls to the same location. And I'm just wondering what in our baseline data counts as a call to the location. Is it just 911? Is it 911311. I report? Austin. Is it the system that our council office uses to request assistance and not. There's no wrong answer. I just would like to know what counts as a call to a location.

[11:24:44 AM]

>> Well, we track that. We can track it to the specific point that somebody's calling on. And to your point, we should be tracking all three for to ensure that we're covering all metrics and all call points. So we have the capacity, we should be doing it to ensure that we're getting every data point that we have available into our evaluation.

[11:25:12 AM]

>> And councilmember, I could just build on that briefly. You know, to to the assistant chiefs point, I think part of it is oftentimes these are individuals who we know part of it is these individuals are in the same places, right? The same kind of hotspots. I think councilmember alter alluded to the fact that oftentimes these folks will be in downtown Austin, but they also exist across the city. And so when we think about how we help these clients and the neighborhoods in which they're residing in, we also want to be mindful of other residents, other businesses, other people experiencing homelessness in those areas as well. And so with that bullet point is really speaking to is are we seeing a reduction not just in the number of touch points that we're having with people, but also, are we seeing a reduction in hotspots? Can we say that we're making these areas safer for everybody to enjoy? And so I think like the

assistant chief said, yes, there are a variety of sources that we can look at to kind of pinpoint specific locations. And we do that through 911 and 311 outreach data et-cetera. But the underlying premise is if we can turn an area from from a hotspot to a to a hotspot. I think that's a clear metric that we're having impact not just in the life of the individual, but also having a real impact in the broader community.

[11:26:28 AM]

>> That's very helpful. Thank you, thank you. And we'll we'll definitely pick up the types of incoming in our follow up conversation. So I wanted to also mention. Council member.

[11:26:40 AM]

>> Yes. Could we could I come back to you and go over to Vanessa right quick and then we'll come back to you? Thank you. Just in the interest of time. Thank you. And council member Fuentes.

[11:26:53 AM]

>> Thank you. Thank you, colleagues, I think first, I just want to take a step back and get a sense of when can you talk us through. This is for director Harold. When no wrong door initially started. How long has no wrong door been in operation? At this point.

[11:27:10 AM]

>> I feel like approximately ten months, give or take a month or two. But the vast majority of the work, I would say within the last 90 days to 100 days after we had the mou signed by all of our parties, a lot of it was in the very beginning, just trying to mimic what we did in Boulder, Colorado, and that took some while to get the infrastructure up. We had numerous meetings with all the partners, but I would say it's been the last 100 days or so. The real work started.

[11:27:47 AM]

>> So for us, this is the first time we're getting a full, comprehensive briefing on the program of no wrong door, but it's only been in operation for about 100 days. At this point.

[11:27:57 AM]

>> Our meetings have been with the robust people that you see in front of you.

[11:28:02 AM]

>> Okay. I just really wanted to frame that or provide that context, because there's certainly a lot of questions that have been shared from the dais that we will continue to have. And I see this effort as evolving and ongoing, and it's incredible to see this many partners at the table working together. I've been on council now for six years. I cannot think of another initiative that is this collaborative and that has this built in framework of collaboration. So I know how challenging that is to pull off. So the fact that we're even at this place is something that I just want to give my deepest gratitude and congratulations, because that is a lot of hard work and a lot of effort to get us to this point. And with that being said, you know, in as the program evolves and what I want to lay out is that it started out as an a pd forward initiative. And from my understanding, it is now evolved and it will be an ems paramedic forward initiative. Can you speak to that, that change and what we can expect moving forward?

[11:29:07 AM]

>> Yeah. So as we kind of started through this program, you know, you know, navigating the data and whatnot, you know, the, the things that a pd was able to do as we kind of navigated the legal process around some of the data that we have and healthcare, you know, pd was able to kind of get started a little bit faster than some of us because we do have those certain restrictions. And so as we've worked through this process of the mou of the, you know, releases from from individuals, it's kind of allowed us the ability to reengage more from the ems perspective and take a deeper involvement. And so what that looks like for us moving forward is having, you know, really ems be the holder of a lot of the data, which has been from the beginning in terms of those releases and, and kind of helping to, to coordinate how to bring in different stakeholders. Because at times, you know, there may be instances where the individuals that we're reviewing need a broader sense of services, or it may be a little more of a narrow focus. So ems will be hosting the case conferencing biweekly, working with the individuals, working with identifying the appropriate resources moving forward and kind of taking that that lead ownership of the information.

[11:30:23 AM]

>> And from my understanding, also providing your own list of individuals who are high utilizers of our emergency care system and layering on different lists that are available from the partner so that we're getting a more holistic view of individuals who are high utilizers of the entire system. Is that right?

[11:30:41 AM]

>> That's correct. And one of the things that we are working through as an EMS led initiative is working with different data vendors that can help us that work through the various restrictions that we have, because we do recognize that really, we have to be very careful about who has access to what data. And so using things that can blind different data points that are relevant to the different stakeholders to make sure that, you know, for example, if you know, you know, from my organization or another organization that if we're looking at this collaborative data that there's nothing there, that those particular areas, whether it's sieges, whether it's HIPAA, that that data is not accessible to those individuals who should not have access to it.

[11:31:22 AM]

>> Right. That makes sense. And in this, and I know you didn't go over the proposed metric slide that's in the appendix for the presentation that's been laid out. But Director King, if you can share with us, you know, what does the defining the outcomes of the program, because we briefly, you know, received information on one of the metrics of how we're judging whether or not this program is successful is the interactions with police officers has gone down. But what other ways are we measuring the proposed success of this initiative?

[11:31:52 AM]

>> Yeah. I'll also invite assistant chief Harold to provide some additional context. But we look at it as a continuum. You know, one of the slides that we shared, there was a decrease number of Kahn of law enforcement contacts, but an increase in contacts with service providers, say, EMS or, or integral care. And so we're looking at this as an entire ecosystem where we're getting individuals flowing through the system. And so we want to see lower contacts at the beginning of the systems when individuals are experiencing mental health crisis and higher contacts towards the end of the system, where individuals are receiving the services they need to address their, their, their, their mental health crisis or their introduction into that system. And eventually long term outcomes would be less contacts throughout the entire ecosystem to where those individuals are in a supported environment where they have a higher level of, of self-sufficiency than they entered the system. But I would also ask chief Harold to provide any additional context.

[11:33:03 AM]

>> Thank you. I think I was just promoted to chief. I've been called an assistant director Murray. So I'm in an awkward space here.

[11:33:10 AM]

>> But how would you like to be referred to as it know.

[11:33:14 AM]

>> Any any of. It's fine. It's all good. I think that from a policing perspective, I would like to measure something that we don't do very well in this country and Europe does exceptionally well, is measure, repeat victimization. Some of those stats that I showed in the beginning, being a woman are really frightening. And so I would want to measure victimization rates in this population. I would want to measure, you know, just the basic needs of this population. Are we meeting them just to help somebody get an id just to see if somebody can get, you know, apply for medicaid. If we can get somebody a bed for the night so they don't freeze. All of these things are so important to measure. And that's why this is so exciting for me to be in front of council because I, I hope that you give us things that you would want to see. You know, we're just so lucky in the city to be partnered with researchers who can help us do all of that. And I could talk about evaluations that I want to see, but I think I think this is such a great program that we should all see things that we want to see individually as individual, because I think that we can get there if we all work collectively and collaboratively, and I would think that we will measure short term housing, long term housing. If somebody gets to go to their medical appointment that day, if somebody, you know, when we were in Salt Lake City, I think the the most interesting thing I heard is that some of these people are in crisis because they haven't seen a dentist in ten years and they have severe pain. I think we're better than that. I think that if we work collectively, we can get people into a dentist appointment. We should be measuring things like that.

[11:35:19 AM]

And so I think it's just up to all of us to see what we want to evaluate, and then we should hold ourselves accountable for the work. If that answers your question.

[11:35:30 AM]

>> Yes, it does. And I think this is also a really good opportunity for us to involve our community and stakeholders who are deeply involved in this issue area and invite them to provide their feedback and input as to what those outcomes and evaluations should look like. And for my colleagues on the dais, you know, we have a public health committee meeting tomorrow where the no wrong door initiative is one of our briefing items. So I invite everyone to continue the conversation. And for those watching online to join us and, you know, send us your feedback and input on what proposed outcomes we all want to see out of this initiative. Director Harold. And I'll call you director until I'm told otherwise. Can you speak to, you know, the public defender testimony earlier today gave some very specific examples of how officers are involved in, you know, or providing feedback on bond for these individuals. Can you just give us some context as to of the individuals who are on who are high utilizers, who have been identified for the no wrong door program, how many of those individuals have active cases?

[11:36:36 AM]

And if you can speak to active cases pending before a court, and if you can speak to some of the examples that the public defender provided.

[11:36:46 AM]

>> Well, I can speak to the bond issue because the bond issue occurred once, and it was an email and it mistakenly went to the wrong place. It went to a judge and not not another email that the officer was using. So that was a mistake that has been worked through with the judge. And that is the only time that I know of any officers requesting different bail bonds or conditions of their release. So that was the only one. The other concern was, I believe, with bolos being issued, the no wrong door team has issued three bolos, which are common practice in policing, and the one that the gentleman brought up was a case where the no wrong door team had secured a bed for one of our highest utilizers, but the time needed to get that person into the bed was like 24 hours. So the no wrong team door put a bolo out saying if you see this person, please call us the no wrong door team so we can ask if they would like to take advantage of this bed. And in that transaction, when the officer did see them, they committed another low level crime. They were searched and a significant amount of drugs were found on that person. But we didn't give up on that person. When they were transported to jail. We continued to seek that person out for the bed, and I think it was a successful story.

[11:38:14 AM]

>> So they were will they have access to that bed?

[11:38:17 AM]

>> Well, they did have access to it because we did intervene back at the jail system. Okay. Now, unfortunately, that is one of our hardest reached persons on our list. And I'm sure that if I said her name and her condition, everybody up here would know who I was talking about. And she she is cycling in and out of the treatment facilities right now, but finding long term solutions with her is proving very challenging. But we're still at it and we're still doing the work.

[11:38:49 AM]

>> And so you have shared that the public defender's office has been invited to participate, and you have had conversations with the office.

[11:38:56 AM]

>> Yes, ma'am.

[11:38:57 AM]

>> Okay. And with the be on the lookout, the bolos or do other law enforcement agencies have access to that information? Do they also receive notification?

[11:39:08 AM]

>> I know that the county structure does, and I would have to depend on Mr. Coppola from the legal team. I do not know if they go out of our county system or not. Yeah, I'll have to get back with you on that one. I'm not sure if.

[11:39:24 AM]

>> Okay.

[11:39:27 AM]

>> Yes. Did you hear that?

[11:39:32 AM]

>> Yes. Okay. The bolos stay within the city of Austin unless.

[11:39:35 AM]

>> It's an endangered person.

[11:39:37 AM]

>> Okay. Very good. And. The other kind of area I wanted to ask you about and shared. Let me know if you wanted to pass to someone else.

[11:39:49 AM]

>> If you want to make this a final question and then we can.

[11:39:52 AM]

>> Thank you. Yes, this will be my final question for now is, you know, we have heard some really incredible news with central health and Travis county's increased investment in mental health. And that's huge. And we thank you for that and are excited to see the new investment move forward and know how critical the commitment is to the overall mental health continuum of care, knowing that it is a continuum of care, and that we will be getting this new infusion of investment to help us. Doctor Richardson, can you talk us through, you know, what does it look like for us to have a fully funded

mental health plan when it comes to our community? If you can just give us a sense of knowing the I'm just trying to understand what the new investment that's coming out of central health in Travis county. You know, where does that put us on track with our c3 clinicians, our fully staffed em court? You know, what more does integral care need at this time to fully address the mental health needs of our community?

[11:40:48 AM]

>> Yeah. Well, thank you for that question. I think there's a couple pieces to that. Number one, the investments that both the county and central health have done and continue to do to help support both existing operations and these new initiatives, as you saw in that nice iceberg slide, it's both. I think we also, you know, we we have to work, as you heard earlier, with the state and particularly ensuring that they're maintaining their commitment and increasing it, I think I worry about there's always great new initiatives that we need to do. And all of these are critical, but we also need to scale and continue to grow existing sets of services to expand. You mentioned a few of those. Our outpatient clinic access. So more and more people we're seeing a trend across Texas is that fewer people have access to health care. And so people are rationing their needs and their health care. So there's a growing demand for a safety net. Services like ours, central health, community care, and so many of our partners in the city. So even if we do nothing, we're going backwards.

[11:41:59 AM]

So the reality is, is that these new investments are fabulous and are absolutely what we need to do. And we need to make sure that we're continuing to grow the basis of services, both in prevention and ongoing treatment, that keep people out of these crisis services to begin with.

[11:42:20 AM]

>> Thank you. Councilmember. You know, for us, we think about the continuum of prevention and control. So ultimately, at the far end of the spectrum is crisis and the jail and the street and the hospital. And the further we can move folks upstream toward prevention and control, the better. So we take a holistic view. We want to make sure people can afford their care. We provide the coverage they need, that they can get their care, ideally in a primary care setting where when their behavioral needs are stabilized, they can have that integrated together with their primary care, dental care, specialty care, women's health care, and so on. And that we have a smooth and continuous handoff with integral care, ems and others when folks need a more acute than that. I think those three phases that you saw laid out in the second slide we presented, if we can accomplish those three phases, that will be a significant step toward creating what we sometimes call system without edges.

[11:43:19 AM]

Continuous patient journey requires a system without edges. Wherever you find that edge, you will find patients either falling off the edge and getting hurt or backing up in front of it and waiting for care. And so we need to complete that loop, that racetrack, if you will, so that we can continue to move people to the next stage of their care. All the way to housing has been said earlier when that's the right destination. So crisis care, step down, care more impatient and Ed psych care. That's what we think is the next step. It would probably be important to state that we sit within a broader region that has unmet needs. And so we know that the more we build, the more folks will come. And so just saying that out loud, we've sized some of the investments for what we need in Travis county, but we understand that there are no hard boundaries. And so as the region grows, the needs will continue to grow.

[11:44:13 AM]

>> Thank you for that. And colleagues, you know, since we are going through a social service reset and a lot of our funding for mental health within the behavioral health services, within social services, as well as our homelessness response supports. You know, this, I'm really trying to understand what the system needs overall when it comes to mental health and what is the city's role and to what and what is our funding capacity, and where does it make sense to best direct our dollars and in a collaborative way that feeds into the larger effort here?

[11:44:44 AM]

>> Thank you, councilmember. Councilmember duchen.

[11:44:47 AM]

>> Thank you, chairman.

[11:44:48 AM]

>> Just to build on councilmember Fuentes's, I think we're we're doing that needs assessment for the next couple of months, that we'll get some answers, hopefully by spring about what that's going to look

like. I'm concerned. I've been concerned for quite some time that our strategy for these high utilizers we've been talking about today is both incredibly, if not catastrophically expensive and also not effective at resolving a lot of the underlying issues or connecting us with long term care strategies. And so it's, it's really clear to me after hearing the presentation. Thank you all, by the way, for all the information you've shared with us today that doing nothing is not the answer. And if there are concerns, less work together. Let's address them with intentionality. I know since I started serving, I've waded into issues in conversations that were otherwise kind of perceived as high risk and low reward, or maybe in simpler terms, more trouble than they're worth.

[11:45:53 AM]

Things like on animal services and invasive species and some land use issues. And I get it because we, we're all here for a limited time. And that time goes by incredibly quickly. And we have these limited opportunities to move the needles on things or make significant difference. And I really do believe this is one of those opportunities. And I've been on the periphery of the no wrong door conversation since I started trying to work with representative Howard and senator parker and others to try and figure out how to better approach the high utilizers of the legislature. And so, with apologies to my friends at central health, you know, when I saw the rapid budget increase, I was a little bit concerned, probably not a surprise to anybody. But expanding this space makes particular sense to me to address those long standing challenges that up until now, we've struggled with for how to approach this in either like an, you know, economic way, an effective way, or simply a way that's holistic. So with that said, I want to start with first, going back to the prior conversation that we had around concerns raised by the private defender service about bond conditions and releases and legal consequences for jail and prison in particular. I'd like to see if chief and or director Harold can help speak to some of that.

[11:47:29 AM]

>> Yes, sir. Could you just repeat the question really quickly?

[11:47:34 AM]

>> Sure. We heard some concerns from the private defender service about bond conditions, about specific instances they raised, about some legal consequences of jail and prison. I was hoping you could speak to some of that.

[11:47:49 AM]

>> Absolutely. I only know one time where one of the no wrong door officers, and it was an erroneous mistake of sending an email to a judge. And it went it went to a judge instead of the usual mechanism that a police officer has to discuss these issues, that that issue has been completely worked out. And that is the only time that happened. So I don't have any concerns there. I really have tried to be as transparent as possible with what we're doing with everybody that touches this vulnerable population, and I want people to be involved, and I want I want us to all work together to come up with creative solutions for this very hard to reach population. And if there's more that we can do, I'm more than willing to do that. But as far as our no wrong door team officers, I have no concerns from a legal perspective of the work they're doing every day. In fact, it's innovative, it's creative, and I applaud. I applaud their work, and they are on the front lines of this issue. The other thing that hasn't been mentioned today, Texas has a very interesting take on all of this, because a police officer is the only one in the state of Texas that can sign an emergency detention, something that I have never seen in my career.

[11:49:18 AM]

And I've been doing this a long time. We should have a broad base of people signing emergency detentions, clinicians, ems, specialty officers. That burden shouldn't just fall on us. That should be across systems, especially. Integral care clinicians that have so much knowledge. Central health doctors, I have just never seen a system like we have in Texas. And I, I would hope that at some point the state addresses that issue because right now, a police officer is the only one that can respond in crisis and take a person to the hospital for treatment. And so I'm hoping that gets expanded in the next session. Maybe it will, maybe it won't. But I hope, I hope to god it does, because I think that that'll just provide a broader safety net and take some of the burden off of the police officers trying to make these decisions in real time.

[11:50:21 AM]

And I can tell you that the police department has done everything that it can to make sure that all of our police officers are trained in this, but it is a heavy burden to have that. As the only person that can sign mental health holds for this vulnerable population. If that's helpful.

[11:50:37 AM]

>> That is. Thank you. And that's certainly something that we have alluded to earlier, that we have been trying to work with representative Howard and others on to to change the legislature, and we'll try

again, presumably this time as well. Next year. I'm not sure who the best person to try and answer this is. Maybe it's Robert, but is no wrong door advocating for involuntary holds. Who can speak to that?
David gray.

[11:51:04 AM]

>> Yeah, I think David, please.

[11:51:06 AM]

>> Sure. Councilmember. I short answer is no, we're not sitting here advocating necessarily for involuntary holds. However, I do think that we also recognize that for some people, the involuntary commitment might be the pathway into the service that they need. And this gets back to the point that queen Mary's was making a second ago, which is that, you know, I'm glad that joke landed. Well. Thank you. I've been here for a long time. We got to have some humor anyway. But but to the point that assistant chief Harold made that right now, police are the only ones who can do those police officer emergency detentions. And so. But for that reason, they are going to be involved. But if we can get somebody into a system of treatment and voluntarily, that's great. And we would welcome that too. The unfortunate reality, though, is that for some of the folks who are on these lists, the level of mental health challenge that they face is so severe that they cannot make that informed decision for themselves in that moment. I think that's also the reason why, though, once they are able to to get to a point where they they have the self-awareness and the ability to make an informed decision, it's at that point that we want to then meet with them again to say, hey, this is a program that's available to you to help put you on a pathway towards healing, not make you have to independently navigate these different systems. We're not giving you a pamphlet and telling you to go to a community care clinic next Tuesday. For more help, we're going to wrap the system of support around you if you're so willing to take it. And it is at that point that the individual will have a choice to make as to whether or not they choose to participate in the no wrong door program.

[11:52:49 AM]

>> Thank you for the clarity on that, and I'm glad you brought that up, because that's something that I've been struggling with also. And I know that we've talked in the presentation about, I think Oscar and eve, I know you've also been, I think, trying to help Mary, and I'm wondering if you're allowed to talk about it. How would Mary be served under the current system, especially with in light of what you just said, and how could she be served then under no wrong door? Alternatively.

[11:53:23 AM]

>> Thank you, council member. Yes, Mary. Mary is one of the most complex and saddest stories I've ever heard, both from a social work perspective and a policing perspective. Mary's been living on the streets of Austin for decades. She has cycled out of that horrible, vicious cycle that we're all talking about. It's hard to count how many times, but what's sad to me is when you talk about Mary, the data almost stops. A couple years ago. And that's because everybody has just stopped thinking that the systems in place can help Mary. And so we weren't receiving a lot of calls for service either through a crisis point. Ems fire. You can almost see the data. Just take a cliff nosedive down. And so the district attorney is the one that asked me to do this. He said, focus in on one of these high utilizers and see where the gaps are. And so we picked Mary to really walk through the systems. And I think because of the work that we've done with Mary so far across the board, everybody up here has touched Mary's life. We're we're really seeing the gap in one major system. And we have stabilized Mary. We have. She has received long term injectables. We have. House. Thanks to the work of integral care and clinical facilities. And we've stabilized her for a very long time. But now she's back on the street. And unfortunately, Mary is being trafficked for sex.

[11:55:18 AM]

And, and so we're all trying our best to make sure that we have a long term treatment plan. Her family is back engaged again because of the work of no wrong door. She is receiving treatment, even though that treatment right now is on the street. She is being talked to on a daily basis. But I think it's because of Mary's story and what I saw when I first got to Austin, the condition that Mary was in, because she would find solitude on the streets around the police department, and I could not believe that she was just laying in a gutter, not clothed. And so I think the no wrong team has used Mary as an example of why this work is so important. And I think the next step for Mary is going to be a bed, hopefully at the state hospital system that can provide her with the complex treatment plan that she needs and deserves, because her life story is very compelling. And while I'm so passionate about this work along with everybody up here, if that's helpful, council member.

[11:56:35 AM]

>> It is. I want to specifically hone in on what director gray said a few minutes ago, which is with somebody like this individual, are they in a position where they can make sound, legal or care decisions for themselves? I mean, is that help speak to that aspect of of the intervention here?

[11:57:00 AM]

>> Sure. So so for somebody like Mary, most of the time, no, Mary is not in a position to, to do that. And so when APD is called or law enforcement, it could be the constable's office or another law enforcement agency. There is essentially a checklist that that law enforcement professional will go through to determine whether or not an emergency detention is justified. And there are cases where our law enforcement partners have been called out to Mary, and they've gone through that list, and they determined at that moment of time, it was not justified to do an emergency hold, but we were able to provide aid anyway, because we know Mary and a lot of our paramedic partners and a lot of our street outreach partners. No, no. This individual there are also times when law enforcement was called and they went through the checklist and they determined that the emergency detention was warranted. You know, I do believe Mary's pathway into no wrong door was through. Pio Eid. What I can say is that Mary has continued to be connected to the no wrong door program.

[11:58:07 AM]

Before today's hearing, I was talking with the community member, and they brought this person up and mentioned that they've seen a lot of improvement in in seeing this person around town, and they're not part of the no wrong door program. And I think that's probably the biggest evidence of success for me personally, is, is the program still is the person still connected to the program? And are other people who do not see the quiet work happening in the background? Are they seeing the results of the quiet work that's happening? And that is happening. But but again, councilmember, there are cases where somebody like Mary, the involuntary commitment might be warranted. There are other times that that same day where maybe it's not, but the doors to the program are always open for those who need it. And we are not going to turn any of those 950 individuals away if they are willing to accept the services, or if we find them in a

[11:58:59 AM]

>> State where they cannot make that decision and that involuntary hold is necessary.

[11:59:03 AM]

>> Okay. Thank you for explaining that. I think that's probably my time. So I think I'm warranted might be able to come back around.

[11:59:11 AM]

>> Thank you, council member. If anybody that hasn't asked any questions, I don't. If council member Ellis, your. I'm just have a couple of quick questions. Then we'll go back to Mike and. Christa. Council member. Siegel. Council member Laine. We've heard and I really appreciate the overlay of the program, the goals, the the measures, the the partnerships. I would love to hear, to understand a little bit better about kind of what it does on a more kind of day to day level. And I maybe using the eve and Oscar examples, kind of what was happening with eve and Oscar before no wrong door and what is happening with even Oscar now that no wrong door is in existence, just to kind of get a better understanding of the changes that we're talking about, kind of on a day to day basis, both so that the council can understand and the public can understand what we're talking about.

[12:00:09 PM]

>> Sure. I'm happy to take the lead on that one. So so Oscar and eve, let's say Oscar is the no wrong door client. And eve is not. So typically eve would be a person who is homeless, cycling through health care, cycling through the criminal justice system. And essentially, at the point she is released, eve would receive a pamphlet from a hospital or from somebody at the jail or somebody at the shelter and say, hey, eve, here are all the resources available to you in our community. It's somewhat of an alphabet soup, but you can call any of these organizations and they will help you. We have your information. They will help you. Well, you ain't calling nobody, right? Let's just be honest. E very rarely is eve going to call somebody. More likely than not because of E's mental state. By the time eve hits the street again, she's starting to regress back into whatever that old pattern is, sometimes even worse. And as eve reappears through our system, this thing called her baseline gets reset. So. So your baseline is essentially your level of competency. And certain partners in the system are only required to restore eve back to eve's baseline. And so I could say, if somebody comes to my E.R. I'm going to treat them back to their baseline. I'm not going to cure them. Just get them back to the baseline, and then I can release them. Well, those partners also have the ability to reset the baseline. So maybe over time, much like Mary, eve's condition gets worse. And now we are redefining the baseline baselines, becoming lower and lower and lower to a point where we all say nothing we can do. And that's eve's story. And so eve perishes on the street, or eve commits a crime that lands her in jail for the rest of his life. And those are real outcomes. This might be an important opportunity for me to maybe reset a comment that was made earlier. No, wrong door is not an APD led initiative. It's actually an initiative that came out of our city manager's office. So the city manager convened a group of partners who are here represented today to say eve story is not acceptable. We cannot continue to have these eve's on in our community. It's a horrible outcome for eve. It's a horrible outcome for our community. It's a it's a huge expense to taxpayers. And it's inexcusable that our agencies cannot do the real handoffs and wrap the constellations of services around the eve, figure it out. So now you fast forward today to Oscar. Oscar story. Oscar maybe is somebody who is experiencing a mental health disorder, maybe having a mental health episode on south congress and the good residents of Austin call 911 and the downtown police officers show up and they're interacting with Oscar. Oscar might be at a point where he is not competent enough to to, to qualify for a voluntary hold. And so the police decide we're going to do

[12:03:09 PM]

an involuntary hold, or the police might decide we're going to take Oscar to the sobering center, or to a hospital or to another partner in this program. Now, this is Oscar story. That program or that partner might start the process. They will start the process of treating Oscar and triaging Oscar's needs before Oscar is released. An actual phone call is made to the officer, to the ems technician, or to our integral care partners to say, hey, we have Oscar. We know Oscar is on the no wrong door list. Oscar qualifies for release tomorrow. Do you have a place where we can bring Oscar to? We are not going to release Oscar to the street. We want to make sure that Oscar has real options for us to transfer him into another service that can provide ongoing care. Integral care might have a bed available. Integral care also might say we don't have a bed available today. Today's Tuesday. The bed is not going to be available until Friday. So then what happens in Oscar's story is we might get the call. And this is an actual person that I'm thinking of. Well, we'll get the call and we say, hey, we have a bed available at one of our shelters, maybe at north bridge. It's a single bed, but we don't have the staff to treat Oscar. We can provide Oscar with the room if you integral care can provide Oscar with the support. And they agreed to it. And so now we're leveraging our shelter bed with integral care case management to provide Oscar with that wraparound support. And so Oscar can move into the proper integral care facility to provide the ongoing treatment.

[12:04:44 PM]

And that level of handoff continues until Oscar voluntarily decides to leave the program, which Oscar can do, in which case we're a system of second chances. We will always welcome Oscar back. Or, as has happened, Oscar might transition. He might stabilize, get on a treatment plan and transition into a permanent supportive housing unit or long term care with family or long term care in a hospital system. But I think you can see the level of intentionality with the resources that we have is extremely different from what it was before the city manager's office initiated. No wrong door to what it is today. The missing elements in this story are the crisis care center and some of the longer term treatment beds. And you've heard our colleagues talk about how they're already taking the steps to fill in their gaps. But we recognize is that we couldn't wait till perfection before we started making progress. We absolutely had to start somewhere for these clients and for our community.

[12:05:43 PM]

I think the city manager and his executive team for giving us this charge. I'm really grateful for my partners in doing the work, and we are having those real outcomes. Mayor pro tem, one last thing that I'll say is that we didn't have the slide today, but we have had a slide in previous that we've used in

previous conversations that has actually showed a real example. I know I'm speaking in a hypothetical, but we actually have a real example of two client journeys. One who is no wrong door qualified and has not participated, the other who is no longer qualified and has participated. And you can see, even in the very short time that this program has initiated, you could see very real outcomes in those people's lives. And so we're happy to make that information available to you and of course, others here on the dais, if you would like it.

[12:06:29 PM]

>> If I could just add to that just again, from from the healthcare perspective, we have folks integral care serves over 30,000 people a year. And of that, we have a lot of people that are going through treatment right now that have been incredibly successful. Linked in with these treatment plans, linked in for overall health care and doing incredibly well. This point of contact and getting people engaged in treatment and then letting the healthcare folks take over is really key.

[12:06:57 PM]

>> I appreciate that. I think that was a really good example. Again, just trying to kind of understand what's actually happening. So we're really talking about communication and coordination when we talk about no wrong door, not necessarily kind of new array of services, but just making sure that, you know, we know what integral care is doing and integral care knows what ems is doing. And no, and I appreciate that. And I'll just briefly mention, for example, the sobering center. I know sobering center is one of the no wrong door partners, but, you know, the, the, the bridge program where, you know, they would get somebody and they would sober up and they would have that, you know, kind of come to Jesus moment where they're like, I need to stop, you know, I need to stop. And they were willing to get into treatment, but treatment was not going to be available for, you know, four days a week, whatever the case may be, if you tell that person, you know, call us on Thursday, you know, and let them out the door, you know, that, that, that, that feeling, that commitment is going to dissolve. And they're probably going to show up at the sobering center again, highly intoxicated again, maybe in jail. And it was that bridge program where it was like, we're going to hold you here for, you know, four days, five days until we can find a bed and then have that warm handoff from one institution to another institution. So you don't have those gaps. So anyway, I just, I appreciate very, very much that explanation. And it really does dovetail with the conversation that we've had there on that, the sobering center board. So again, let me. Council member Siegel.

[12:08:35 PM]

>> Thank you, mayor pro tem, and I guess, director Rogers, if if you have a couple minutes, I'd like you to come back. But colleagues, I guess I just want to use my time to try to make a nuanced point, which is there's a ton to really celebrate about this initiative, about the collaboration, about how hard it is to get 17 different agencies to collaborate on something like this, how necessary these types of interventions are. But at the same time, I think we are hearing that this is a work in progress. We've heard that a few times, and I just want to flag that while this is a work in progress, we're also sending messages to legislature demanding pretty specific policies from what I've read. And so I think there's a balance here about supporting the collaboration, celebrating the intention and work and resource focus, but also saying, have we sent the right message to the legislature in terms of of what our legislative office is doing? And so I just want to summarize what I think the community has responded to and spoken to my office about that.

[12:09:34 PM]

There's a contradiction between. Basically going back to the trump executive order of last year and the Cicero institute being directly opposed to housing first. That's like a national agenda that's fighting housing first. And so when we heard these questions earlier from councilmember zo qadri about collaboration with the Cicero institute, that it's speaking to that concern, that there's an agenda that's focused on criminalizing homelessness and then providing resources after the fact, instead of intervening before the fact. And as a council, we've endorsed housing first. We even took a step last December to adopt resolution like celebrating housing first as a strategy. But the trump executive order seeks to outlaw housing first. The Cicero institute is fighting against it, and the letter that the mayor sent to the sunset advisory commission that was included with the public memo that we got on August 3rd has this language the council member Laine, brought up. It says, you know, senator corker's, chair of the sunset advisory commission, quote, without question, diversion must be handled within a post adjudication structure in which a sentence is deferred pending successful completion of an extended mental health program.

[12:10:48 PM]

And that kind of post adjudication argument directly contradicts existing council policy for how we want to intervene. And we heard it from from the district attorney and some of the county folks. If if deflection is the goal, then we can't adopt this post adjudication strategy. So this is like nuance. And, you know, the team has spoken with my office and said that was basically not intended as a legislative direction. But we've we've already under, you know, the name of our mayor that this is our goal. And, and I think when I think of the legislative strategy that we adopt as a council, it didn't include that. Right. And so I guess I wanted to ask director Rogers, because I know you've been involved in these conversations, and this is an evolving effort. And this is by no means like an argument that we should throw out all this wonderful work because we made a mistake here. But is there a going to be an

attempt to clarify with senator corker or legislature that are advocacy for some sort of state law change is evolving, and that we're not asking for a post adjudication structure.

[12:11:59 PM]

>> Thank you, council member, for that question. As you know, the legislative process is a dynamic one, and you indicated and it is true that the items that we're working through are evolving. I indicated to your staff yesterday in most any conversation that we've had on this over the last several weeks, that there will be a number of one pagers and testimonies and additional communications as these two interim charges that were picked up in both the house and senate are taken up. Much of the letter that was communicated to chair Cole, course, following that sunset hearing was intended to counter some of the things that were said during the senate hearing, and I believe that that was part of it. I did discuss with your staff perhaps the incorrect term was used, but we had a conversation about pretrial diversion and deflection. And so I appreciated that education. But yes, I think there will be ample opportunity. As we said earlier, when we were talking about the legislative items, it is it is dynamic, it is changing. There's nothing set. There is a goal to have a legislative platform that is agreed, agreed upon across all the partners that are involved in no involved in no wrong door.

[12:13:16 PM]

There may be additional recommendations, but those will certainly be a part of legislative updates and briefing and communications that we continue to have with city council. But your feedback is noted, and I hear you and you have our office's commitment to continue to work with council on those.

[12:13:34 PM]

>> Thank you very much, director. And I just want to follow up on councilmember zo qadri question about the Cicero institute, because it is true that that your team has been meeting with them, including about no wrong door. Isn't that right?

[12:13:48 PM]

>> Back in September, I don't know if David's still here. Back in September, tpf had reached out to David as an opportunity to hear about David's work and his team's work in the homelessness strategy space. David invited me to that meeting, and at that meeting, Cicero was at that meeting. And so I would say

there have been conversations as needed, certainly with the testimony over the summer. We communicated excuse me, we communicated with them at that hearing. Thank you.

[12:14:21 PM]

>> Yeah, yeah. I mean, that's I think that's the advocate's concern, right? Is that that the agenda that they are funding in the state and nationally is kind of contrary to some existing council policies. Another letter, another aspect of the memorandum packet had a recommendation about the Texas health and safety code, chapter 574, to, quote, reduce state legal thresholds for involuntary psychiatric intervention. And so this is something that, you know, as a civil rights lawyer, was kind of a concern for me because right now there's a pretty high legal bar to have someone civilly committed. And there's even U.S. Supreme court cases about, you know, 14th amendment due process rights. And am I correct that we're no longer advocating to try to lower that legal threshold?

[12:15:12 PM]

>> No, sir. We are not advocating for that. That was in response to comments made at the hearing of what is the world of possible that the sunset commission should be studying in response to HHS going through sunset right now? It has never been a part of our legislative program, nor is it intended to be a part of our program.

[12:15:32 PM]

>> Okay, wonderful. Thank you.

[12:15:34 PM]

>> Siegel if I could just interject a little bit. Sorry.

[12:15:36 PM]

>> I'm sorry. No, I need to keep going because I want to stick with my time. Sorry. Okay. I'm just going to keep going with director Rogers, if that's okay. Or I guess this might be better directed to the city

manager, because I wanted to ask kind of more directly about the aclu letter and how we're going to respond to this. So, you know, one of the things that the aclu, so the aclu letter is concerned about notification of attorneys in regard to, you know, no wrong door outreach and whether that generates evidence that would be adverse to the person that we're we're intervening to support. And the memorandum that the city staff sent out last week says our standard operating procedures will require no wrong door officers to make reasonable efforts to notify attorneys for high utilizers prior to any jail interview. And my team looked at the sops, standard operating procedures. We did not find that. And so is that has that already been added to the sops?

[12:16:39 PM]

And maybe this is a question for mayors director slash, former chief Maris Herold. Yeah. Could you speak a little bit about like, how we're going to clean up this legal notification issue?

[12:16:52 PM]

>> Yes, it has been added to our standard operating procedure, and that we will do diligence to ensure that we make the proper notification of whomever is representing one of these high utilizer people. And yeah, it's been implemented.

[12:17:11 PM]

>> Okay. So does that mean that before any releases are signed, an attorney will be notified?

[12:17:18 PM]

>> Well, I think an important distinction right now is that the majority of the individual right consented. I want to say consent decree, but individual rights contracts, the majority are being handled by integral care. And then ems is going to take over that whole system. And then the only time that an officer would try to get that sign would be in a community setting with our partners. But there will be times when they go to jail that we will try to get them to sign the the agreement, and we hope that an attorney for them would be with us. And if not, we still have, in my opinion, a legal duty to respond to the jail, to try to get them treatment. And it is not to know anything about what crime they committed or past crimes. It is simply, do you want treatment? Do you want help? And how can we get you to the

right person? That that is it. And if we need to clean that up, I'm more than willing to to do that. But that that is what we've done thus far.

[12:18:29 PM]

>> Because the mou. The mou, whether ems administers the release or police department, the mou has information sharing across all the 17 partners. Right. So if we're creating a file that can be accessed by the police for purposes of prosecution, that's that's kind of where this concern is coming from.

[12:18:47 PM]

>> Okay. We can most certainly address some of those concerns, but I, I don't know if it'd be helpful to have Chris Coppola up to talk about the legality and what he has seen from his office and our work with the sops, with the public defenders, and maybe get his take, since he is the one that has approved these forms.

[12:19:12 PM]

>> Good afternoon council. Chris Coppola with the law department. Hope you can hear me. So yeah, I mean, in particular, yeah, we we did carefully design the release of information form across all of the partners had feedback into it, including the health care providers, ascension, integral care, etc. To make it a, you know, a robust release that would allow information sharing across the, the partners for the specific purpose, as stated in the mou, to use that information for the specific purpose of coordinating care. The way the mou reads is that there's a coordination care team that's supposed to meet to discuss that information.

[12:19:51 PM]

>> But does anything prevent the police department from using that information for a charge?

[12:19:56 PM]

>> Well, so there is a the mou itself does does indicate that the the information is supposed to be used specifically to coordinate care. There's even a provision in there which says that the partners are meant to take legal action actually to prevent release of information outside of the the confidential information outside of the mou. If they need to do that. It's primarily an information sharing tool. No partner, no, no partner is required to provide actual medical records. For example, things like psychotherapy notes or specifically excluded from sharing. So there's some definitely some limits around what shared and what kind of information is going to be discussed. It's mostly about, I think, discussing diagnoses, treatment plans and things like that.

[12:20:45 PM]

>> Thank you. Mr. Coppola. Have you looked at the proposed safeguards at the end of the aclu letter? I guess it's page 22 of the backup document here.

[12:20:55 PM]

>> I have I've seen it. I don't have it in front of me. I apologize.

[12:20:58 PM]

>> I guess. I don't know if this is a question for the law department or city manager, but has the city taken any steps to analyze the aclu safeguards and whether we can adopt them as a part of the no wrong door program?

[12:21:13 PM]

>> So, you know, like I said, councilmember, like miss Harold, said council member Siegel, I think, you know, some of the some of the proposed safeguards as we've been building this program have been incorporated into the sops. There is a provision in there requiring officers to make efforts to notify attorneys. For example, you know, one of the one of the examples that I heard this morning that I think miss shearer mentioned when she called in this morning, was something about not mirandizing people when they're interviewed in jail by an officer. You know, that's something that was analyzed. I think we talked with prosecutors about that, and it was decided that folks should know what their rights are, if they're going to be having a custodial interview with a police officer. So they should know they have the right to remain silent, for example. So that decision was made to continue to mirandize them in that

setting. So there's different things we have looked at. It's an evolving program. We're certainly, you know, I know there's willingness on management's part to continue to look into different solutions.

[12:22:13 PM]

>> Okay. Well, I'll wrap up, colleagues, as you can tell from my questions, I want to make sure that whatever our city team is, is lobbying for at the state ledge, that it's with our full awareness and agreement as a council. And I'm not sure that's completely been the case so far. And so I'm glad that public health is discussing this tomorrow. And I think before the city files any bills, we should be fully aware and we should be on board with any legal changes that we're seeking. Thank you.

[12:22:37 PM]

>> Thank you, councilmember. Councilmember Laine. Okay. Any further questions? Comments. All right. We thank you all very much for the presentation. Obviously, there's a lot of interest and engagement and look forward to continuing the conversation around no wrong door. We are going to postpone the executive session until Thursday when when the mayor returns. So with no further business before the dais, we are adjourned at 1223. Thank you very much.