Public Safety Committee Meeting Transcript – 08/17/2020

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>> Flannigan: It is 2:06 P.M., we are convening the meeting of the public safety committee. I am councilmember Flannigan chair. We have committee members vice-chair councilmember Casar, mayor pro tem Garza. I know our other committee member, councilmember harper-madison, is on her way, and then councilmembers kitchen and Ellis are also in attendance. Our agenda today really just has two items on it. We have a city charter required review of our municipal court judges. We are going to do a personnel review in executive session as is customary. And then we will have the remainder of the meeting to talk about our mental health first response. I see councilmember tovo and pool have also joined the meeting. Great to see you. With that I think we are prepared to go into executive session unless there is any objection to do so. All right. I will read the script. The committee will now go

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into closed session to take up one item. Pursuant to section 551.074 of the Texas government code the committee will consider item 3, discuss personnel issues related to municipal court judge performance evaluations. Hearing no objection, the committee now goes into executive session. [Executive session].

[2:35:42 PM]

>> Flannigan: We are out of closed session. In closed session we considered personnel matters related to item 3. Okay, we have with us councilmember kitchen, Ellis, pool and mayor Adler, and I know councilmember tovo was with us earlier. I'll be looking for you if you're in the backstage area. And of

course our committee members, councilmember harper-madison, vice-chair Casar and mayor pro tem Garza. So we're going to move on to our main event today, talking about mental health first response. So I'm going to bring in our speakers we've got from integral care and from city staff.

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Okay. I'll let people's videos turn on. So as I like to start every meeting. Just as a technology check in, I am host of the meeting. I will mute you if you forget to mute yourself. Don't take it personally. We will have our presenters. We've got a slide deck from integral care and also from APD. I think both are probably good to go through. For the councilmembers, its intention here is to present information that the public may not know so I know most of the stuff will know the stuff in these presentations, but I think it's a good reset on the information for the public to see this from the budget votes we took last week. So we'll start with incidents gallon care and do our APD presentation. It's probably wise to let our presenters make it all the way through and save your questions to the end. And then there should be plenty of time for

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conversation. Does that sound good to everybody? Is it. >> Councilmember, I just got a call from dawn Henley. She got disconnected and is logging on. Councilmember harper-madison. >> Harper-madison: Thank you, chair, for recognizing me. There was something I wanted to say before the meeting ended and this seemed like an appropriate place if why we're having an issue with somebody getting back in. I had an opportunity between Friday and Sunday have more than a dozen conversations with people in law enforcement positions, and those conversations were very much about them feeling like they're in the dark about what is taking place. And me recognizing that week talking about people's

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livelihoods and shouldn't feel like they're in the dark and should be able to ask questions. So with this opportunity and your recognition and my ability to speak on it, we need -- we 100% need for law enforcement professionals to know that our access to city legal is not exclusive to city council. You have access to city legal as well. If there are any questions that you have about what you can and can't ask in your role by way of the contract that we have, ask city legal. If you don't know whether or not you can ask a question, if you don't know whether or not you can say a thing or not say a here, ask city legal. You have access to them like we do. But most importantly you have access to the council. I've talked to multiple law enforcement professionals who didn't realize it is an opportunity that they have to even talk to us. They don't know they can talk to us I wanted to say

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publicly, you guys, you have access to us and you have success to city legal. If you have questions about your really difficult job and the inks that we as a council are doing that affect your job, your livelihood, you can absolute ask us questions and absolutely ask city legal questions. I don't want to be put in a position again where our law enforcement professionals don't know that they can ask us questions. That they can be a part of this process, they absolutely should be part of this process. The fact that they don't know that, that their leadership, both by way of APD and by way of Apa, aren't letting them know that they have the opportunity to ask us questions object a part ever this process of being -- we are the trend setters. We are going to be the revolutionary municipality that gets it right. I wholeheartedly believe that. We cannot do that without them contributing to the process. And if they don't know that

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we wholeheartedly welcome their contribution to the process, I thought why aren't we hearing from y'all? And what I was told by more than a dozen people over the course of the weekend is they didn't know they could be a part of that process. They didn't know they could talk to us. They didn't know they had access to city legal. That is extraordinarily important. I just wanted to put that out there on the record public facing that you have access to us. And we all -- not just me, but we all welcome you reaching out to us. We want you to reach out to us. We want you to be part of this process. Don't for a moment listen to anybody who says otherwise because it's not true. And that was all. Thank you, chair. >> Thank you, councilmember. Mayor pro tem, did you have your hand up? >> Casar: Yeah. I guess, councilmember harper-madison, I guess if you could just provide context for what that means to them? Because if I was a police officer listening, I don't know what you have access to city legal means?

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And I could understand -- I know the fire department there's a very strict chain of command that firefighters are supposed to follow as well as I would assume it's the same for police officers. So maybe this needs to be some kind of official memo that they have access to. Obviously I have always welcomed and had conversations with police officers and told them that to the extent that I can keep things confidential, but there's emails that -- I want to be careful of what we open up because they have to know that if anything they sent through city email is open records, any kind of text message is open records. I think it's good to make a statement like that just to make sure that they know what the parameters of that request to them or that

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invitation to them is. >> Harper-madison: I think you more or less said it. I appreciate that context. In terms of parameters, yes, anything that you send to our Austin Texas emails are subject to open records. But some of the questions that I was asked are really basic questions that we should be providing by way of a public facing memo that answers some of the questions. So people are asking me questions along the lines of whether or not their jobs energy jeopardy. Whether or not they can ask us a certain kind after question. They just don't know how and energy they are able to interact with us as a body. How and when they can interact with us as a committee. How and when they are able to interact with city legal. So yes, obviously I would say I appreciate your reminder about discretion. There's nothing that you could say to us at our

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austintexas.gov emails that wouldn't be answered. Some of the questions I received over the weekend are so very basic that it made me feel bad frankly that the police department leadership, the APD leadership, that frankly us as a municipality, we are not communicating with them in a way that they don't know anything. They really feel left in the dark right now. And as we are on the precipice of this revolutionary transformative change, I really wholeheartedly believe that there are other cities that are going to look to us for how to get it right. And if we're going to do that, then everybody has to be a part of the process. And I feel like they don't recognize that they can in fact be part of the process. In which case I think context wally what I'm trying to say is they have access to us. There's no reason why they can't communicate with us, why they can't testify before council. Why they can't ask city legal about the parameters

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there like you very eloquently stated, there are parameters, they are city employees and there are rules by way of their contract, but they don't even know that they can communicate with us. I find that problematic. So that's what I was trying to highlight and put some daylight on. Hopefully that helps. >> Flannigan: I think we'll be good to get to our agenda. Councilmember kitchen, I think assistant city manager Arrellano wanted to make a comment as well. I would like to get us to our agenda. Councilmember kitchen, if you could be quick. >> Kitchen: I'll be very, very quick. I wanted to thank councilmember harper-madison and also the mayor pro tem for their comments. And just because I think it's important for our police officers to hear from all of us, I just want to echo the sentiments. I want to permanently say thank you to our officers and their families who serve this city and they're dedicated to keeping people safe. And I want to just say to our deputy city manager

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nuria vandermyde, I want to say to her as we go through this reimagining process, the voices of officers are necessary voices at the table. Gland and we in fact have had officers join us in committee meetings too in the last few months. Rey. >> Thank you, chair. I wanted to leverage off these comments. Councilmember harper-madison, you and I had a very brief conversation about this. I'll make sure the department is communicating and what they can expect or not expect in terms of with respect to their positions on behalf of certainly the deputy city manager and my colleague, assistant city manager Chris shorter as we form the core leadership team and work with the city community we imagining task force. It is our intent to include the voices is of those on the frontline and officers.

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Rest assured we will follow up on that. >> Flannigan: If you mention his name we will bring him into the meeting. >> Beetle juice cares! I appreciate it. And rey has said it, not only do we anticipate meeting with all of our officers and the city manager earlier last month even sent a note to all of ppp saying that they should expect hrd and ourselves to have meetings with them and so we are following up. We have a meeting or I have -- several of us have meetings independently and together with victim services, internal affairs, support staff, 911, and forensics already in the works, most of those planned. And we will continue to go throughout the department to

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get information from staff. We cannot do this work without hearing from everyone's voices. And everyone's voices includes the police department. >> Flannigan: Okay. Let us get to the meat of our meeting today. Dawn, I see you there? >> I am here. I am having trouble with some of the videos, so I may not be able to involve it before my presentation. >> Flannigan: That is perfectly fine. I am sharing them. Can you see them? >> I can. >> Flannigan: Dawn, why don't you introduce yourself and take it away. >> I am dawn Hanley, the chief operations officer for integral care. And I want to thank you for the opportunity to speak today, and today we'll be covering some of our mobile crisis response. Next slide. So integral care supports

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adults and children living with mental illness, substance use disorder and intellectual and developmental disabilities. We help people build health and well-being so everyone has the full foundation to reach their full potential. Next slide? So toyed we're focusing the conversation on the mobile crisis response

and I think it's critical that we remember that when someone in our community is experiencing a mental health crisis that we see and value it as a health care emergency. Integral care's mobile crisis response consists of two teams. We have an expanded mobile crisis outreach team or emcot and volumes a mobile crisis team -- and also a mobile crisis team, emcot. These teams provide community based follow up services for up to 90 days after the initial crisis and they ensure that a person is

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supported throughout the duration of the crisis and link them to ongoing services. It important to note that these mobile teams are following the essential principles outlined by sampsa to provide psychiatric based crisis and crisis assessment, access to a prescriber as needed, diversion to appropriate community-based care and resources, and short-term follow-up to ensure that individual's immediate crisis is stabilized and the individual is linked with ongoing care and resources. Are. So the reason that we follow people for 90 days is because the crisis doesn't resolve in one interaction. It takes time for people to stabilize and recover, and many people who experience a mental health crisis need help beyond the 90 days. Without the ongoing clinic services and basic needs being met, many people will continue to have a crisis that will impact their health outcomes and local public systems. Next slide.

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In looking at our two teams, both mcot and emcot provide the services outlined by sampsa that I previously went over, but the main difference is how they are dispatched. So mcot was started in 2013. It's the largest team and works it justice systems to help people from emergency detention use, emergency detentions and psychiatric hospitalization. This team is exclusively dispatched by 911 through the request of law enforcement and Travis county ems. So beginning in this fiscal year in 2020, this team was also a able to provide a clinic on the floor of the 911 call center to field incoming mental health emergency calls in order to minimize the dispatch of a law enforcement officer in response to a mental health call.

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Emcot co-responds with first responders and provides mental health training and provide telehealth report. Mcot is about half the size of the emcot. It was developed in 2006. It's funded by Travis county and the state of Texas. This team is only dispatched by integral care's help line or hotline and it is a requirement of the state. So mcot fields referrals from calls anyone they receive from the community, including individuals who are having the mental health crisis, family members or it could be an organization such as a school that gives us a call. Next slide. This diagram is showing a visual of the 911 center pathway, trying to give a look at where we were, where we are and then where we could be in

our collaboration with our first responders. So somewhere between the where we are now and where we could be really represents the requested model or expansion of emcot. It's been a long-standing goal to have four options

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when people call 911. Do you need police, fire, ems or a mental health professional would be the optimal goal? In order to support this endeavor, integral care requests funds to expand personnel and hours of availability to 24/7 at the 911 call center and in the field. So in order to provide diversion opportunities at the time that someone is calling 91 for a mental health emergency, emcot will designate two clinics to be on the call center call at all times. So this change will strive to decrease wait times for callers and it will increase the number of calls that emcot can assist with. At least one clinician will be stationed at the APD section and we're working to have one clinician also stationed with the ems section. So both of these will be responsible for facilitating calls. They're transferred by both APD and ems. So building on the existing collaboration between ems and emcot, integral care

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also proposed caring ems community health paramedics with an emcot clinician overnight to expand community-based capacity to provide mental health crisis response for coverage for 24/7. The total expansion involves adding additional staff so we're going to be adding six and a half staff to cover the 911 call center aspect of the operation as well as three and a half staff to co-respond with ems. So so far this year, emcot stationed at the call center has been able to divert 85.4% of the calls from law enforcement. So with this new expanded model, it will allow us to improve and build on that success. Next slide. So the current model that we have with emcot costs $1.8 million. That's what we're doing

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today. And this has one clinician stationed on the floor of the 911 call center in the APD section. So you can see in each one of these bars it gives you a snapshot of what the staffing pattern would look like in each one of those years and so the fy2021 proposed model is a surprise and I will get there shortly. So the requested model where we can ask for additional dollars to expand mcot allows us to expand coverage at the call center. So this request was an additional $1.3 million so that will bring the total budget for next year to 3.15 million. So the proposed model that you see up there would be the wish list or the something to strive for as we look towards the future. In this proposed model it's an example of what it could look like if the project went fully to scale and it

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would enable mcot to cover 100% of APD, ems and 911 related calls. So this model is estimated at about an annual program operating cost of $6.2 million. In a fully scaled 100% model we envision altering the mcot experience a little bit with funding. All mcot positions that are assigned to the 911 dispatches would be paired with community health paramedics. More specifically that would represent the 911 dispatch involving a community health paramedic and one mcot clinician riding out together. This would allow for a timely response and a first responder immediate goal with one mental health professional and one paramedic who specializes in community health to provide us with an integrated health response. Next slide. So that takes us to the system of care. The impact to the system of

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care is a person doesn't live in crisis, right? We don't want them getting their ongoing care in a crisis model. They need specialized services and ongoing support to regain health. They need to be connected to a health home and the public system really lacks capacity to receive a higher volume of people who need step-down services and ongoing support. So integral care is open and committed to growing the emcot model so that we're available as the first response unit together with ems for 100% of the mental health emergency calls in Austin and Travis county. However, to improve the health outcomes and reduce the impact on the public system it's essential to consider what happens after a crisis. So I took a look at our current data and at approximately 60% of the people who were experiencing a mental health crisis that we are serving through emcot needs ongoing supports in a public system and they have no source of funds or any way to cover the cost of their care.

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So increases in crisis dollars need to really be coupled with an increase in outpatient ongoing services. Integral care's outpatient services can't continue to accommodate incident flux of people who interthrough the crisis system and need ongoing support without a way to expand our outpatient capacity. By way of example, ongoing supports for the outpatient behavioral health services is projected to be needed for next year just to accommodate the fy2021 expansion is about 1,680 people and that cost comes to about 8 million per year. Any further consideration of expanding mental health crisis response such as what is shown in the 100% response being fully scaled needs to be coupled with an expansion of ongoing outpatient to reduce repeat crisis and to make sure that we have access available for these folks. In closing, rapid -- there's rapid population growth in Austin and Travis county and coupled with our response to

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a pandemic it's really placed greater demand on first responders and behavioral health outpatient services. And when someone in our community is experiencing a mental health emergency, it is a health care emergency. Building on existing collaborations to bring integrated specialty care to those experiencing mental health crisis, it is the role of the mobile crisis outreach teams to expand and be that first line of response for all health emergencies. In addition we need to keep an eye forward for families and individuals beyond that crisis. Thank you. That concludes my report. >> Flannigan: Thank you, dawn. Really fascinating information. We also have a presentation on the crisis called diversion program and I don't know, assistant

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chiefs, who your intention is to handle this, but I have your presentation ready to go. Who wants to go? >> I believe APD has that. >> This is assistant chief. Thank you, chair and committee members. I just want to open up with a brief statement regarding APD's involvement. APD has long recognized that, you know, people that are in mental health crisis, that is a health crisis and not a criminal type of issue that the police necessarily need to be involved in. And that we should be and are looking for ways that we can divert those calls so that there is no law enforcement response. I think that everybody recognizes there will be those outlying cases that violence might be a factor,

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and for those obviously police response might be necessary and we'll work, you know, with the program to make those appropriate responses. But we really believe that the way forward begins at first contact which is the 911 call. And that's what this crisis called diversion program is all about. I would like to bring on from the APD side lieutenant Ken Murphy, who is our manager at ctec and manages this program to go ahead and run through the slide deck. Thank you. >> Thank you, chief and councilmembers. So our crisis call diversion program started last year. We started collaborating with integral care and ems in September of last year, and we traveled to Dallas, we traveled to Houston to take a look at their mental health programs and their clinicians embedded on their operations for the 911

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centers. And what came out of it was truly a unique program we developed just for Austin. In Dallas and Houston, there's no true diversion. The crisis counselors will speak to folks in crisis on the phone; however, they will still send a team of a police officer, an ems paramedic and a crisis counselor. What we developed here was a true diversion program. Next slide, please. So the crisis call diversion program

focuses on diverting appropriate mental health-related coleseed by APD's emergency division to a call center which we named c3 who is embed odd the operations floor. The goal is engage the caller in addressing mental health issues and the mental health treatment system as opposed to the criminal justice system. The c3 position will serve as an add-on service and

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does serve as an add-on service to a 911 operator answering a call with a suspected or confirmed behavioral crisis component. C3 provides the caller with complete triage screenings, assists with deescalation, emcot and provides other community referrals as net. If the caller still requests emergency response, the c3 will connect the caller bazitski being to the 911 operator and the 911 operator will dispatch police officers. Next slide, please. Currently the crisis center counselors C3s are available Monday through Friday 8:00 A.M. To 12:00 A.M. And our future expansion mentions having C3s available 24/7 and we will add on the fourth

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question to the triage of do you need police, fire, ems or mental health services. The C3s work on the operations floor and here at communications and they log on to our computer aided dispatch and solo com 911 systems to receive transfers from the 911 operators. It speeds up and simplifies the transfer and call process. Next slide, please. Some criteria. Calls are not eligible for c3 intervention if an individual is in possession of firearms, knives or any other weapons and by possession we mean physical possession at the time, not they have a knife or a firearm or a weapon in their home. But if they are actually in physical possession of the weapon at the time of the call. An individual under the influence of alcohol or drugs to the extent requiring medical intervention, overdose or detox situation, or exhibiting violent behavior.

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And as a note generally can assess a person who is intoxicated or on a mood altering substance if they can stand without assistance and participate in the assessment in a meaningful way. Ineligible for transfer are individuals threatening or at immaterial -- imminent risk. They are in possession of a weapon and threatening to hurt themselves immediately. Not just contemplating suicide or contemplating hurting themselves or someone else. When an individual has committed a crime, in other words family violence, if a crime has been committed and an officer must respond to a call, and we're not just talking about minor crimes, we're talking about a crime involving violence. Also ineligible are hot shot calls where life or property in danger and priority one calls with the exception of

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check welfare urge he knows. If the call does not have other disqualifiers. Next slide, please. Calls eligible for c3 intervention, caller experiencing a mental health crisis and not actively attempting suicide or physically violent towards themselves or others. Callers indicating there a verbal dispute only with a c3 with potentially resolve with intervention and there is no Rick of violence. Callers requesting police due to psychosis or altered state and are not physically violent. Parents requesting police due to child behavioral issues regardless whether the child has a known mental health issue and parenting issues. Also we receive many repeat callers with a known mental health history so our C3s help out in those situations. A caller experiencing mental health crisis and requesting mental health officer. So if someone calls up, which they do quite frequently and request a

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mental health officer, we discussed to send an officer and now we transfer them to the crisis center. A caller experiencing a mental health crisis and the call does not meet transfer criteria. If the 911 operator believes the c3 could assist in de-escalation prior to the officer's arrival. If there's a first person caller, our 911 operator will conference in the c3 and the c3 can help deescalate hopefully the situation prior to the officer's arrival providing a better outcome for not only the person in crisis but for the officers. When this is happening, the 911 parents also pudding in and listening and updating the call and the dispatcher is relaying the information to the officers while they are enroute to a call. And lastly, second-party callers concerned about the welfare of someone who has a known or potential mental health history or who is

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potentially suffering a mental health crisis at the time. Next slide, please. And again, this is in absence of diversion for those calls where officers must respond, the C3s can be a source of support during his or her immediate crisis, provide resources, and provide information on how the callers can -- can prepare themselves when officers arrive to deescalate the situation. Deescalate the crisis prior to APD arriving on scene which creates a safer environment for caller and first responders and provide additional information the the 911 operator which would otherwise be unknown to first responders arriving on scene. Next slide, please. Now, the 911 operator process, this is a little different than an outside -- and outside of the c3 process, and we implemented this on 9 December of 2019.

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Operators must complete a mandatory mental health field in our computer aided dispatch system for every call for service. There are some exceptions. Where it just doesn't make sense to ask the question, a reckless driver or during an accident so a mental health question will not be asked then or the field will be filled out with a no. But there is a mandatory field which indicates whether a situation may include a mental health component and it's a drop-down field so they can either select no for no or unknown or yes, yes, c3 ua which means it was a eligible call to transfer to c3, however, the c3 was either on another call or they were not working at the time of the call. 911 operators will ask the mandatory mental health screening question on every call for service, again with a few caveats, and something in this order, are you aware

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the subject is in mental health crisis. Next slide, please. Reporting the emergency communications division, we'll refer to as division, track all mental health calls data using two methods. One, the mental health field and cad, computer aided dispatch, and two, using two new final digs position codes for officers. When the officers close out the call and there's a mental health component, we can track it through 10811 which rates a report was written or 10812, there was no report written but there was a mental health component. Using a method of tracking at the onset and end of service allows a comprehensive data set answered by APD. Next slide. The division will include data on mental health calls for service in our monthly reports and provide

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quarterly overview of mental health calls to get substitute I executive staff. Tracks in summary and in a dashboard view including a percentage by priority, percentage by area command, percentage by council by address. All dispatch calls for service with a verified or suspected mental health component, all c3 transferred calls, all c3 eligible calls are included in this data set. Next slide -- I think that's it. I'm happy to take any questions the committee may have. >> Flannigan: All right, councilmembers, I have both the presentations pulled up if you have questions and you want me to pull a slide. Any of the committee members -- councilmember harper-madison, would you like to go first? >> Harper-madison: One of the last things said I'm curious about. What gets done with the information around the information that's gathered

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by council district? Who does that information benefit? I'm just curious about that. >> So, councilmember, right now it's just in our dashboard. I have received a few data requests for the information and I don't remember who from now, but it is available in case there are requests because that's one of the way we track all 911 call data is through by sector and by council member district. So we just included it in the mental health data set and dashboard as well. >> Harper-madison: I appreciate that very much. One of the other questions I have is so my colleagues and I have been having conversations about as we look through what it looks like to go through this transformative process and this reimagining process, one of the things we're very aware of, keenly aware of is that we need to have a place

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for people to go, right. So if we are talking about an emergent situation and someone needs to go somewhere where there's a professional, if it's a medication situation, a professional mental health intervention professional, then there needs to be a place. But the extension of that so often is in our conversations with people who work in the field is that there's so often the need for sort of a more long-term, more substantive solution including, you know, sort of intensive outpatient or, you know, medication regulation management, that kind of thing. I wonder if there are data points that we could use when we're having these conversation because this is mostly a state level conversation, right? Councilmember kitchen, she has so much, you know, in

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the way of experience and knowledge here, I sort of wonder if people like her who have so much in the way of knowledge and experience, subject matter expertise and people like me on the front end, if there's a way to dig through information to show what happened during these calls. Sort of follow-up information is what I'm asking. Like what happened as a result of the call? Did the person go to a place that was an emergent care space or go to the emergent care space and got the regulation around medication? Like what happens after these calls is what I'm curious about and if that's on a system that's currently in place, I would like to know the why and the how do we get a better outlook on what happens as a result of the emergent call.

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>> So councilmember, I think we can answer your question here in two parts. One, integral care as far as diversions, they keep track and they record the outcomes of their calls for the call diversions. Two, on the emergent calls where officers are sent, reports are written, and in those reports the officers indicate the outcome of the call and whether the person in crisis was admitted to a hospital or subsequently a

mental health facility. So we have -- we have the data available. It will take a little data mining, but we do track outcomes on both ends for emergent and our calls sent to our 3s and diverted from law enforcement. >> Harper-madison: Thank you, I don't think it quite answers my question but that

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also means there's not a continued system for following exactly how it all lines up, but councilmember kitchen's hand is up and she might have something to contribute. Thank you very much. I appreciate the response. >> Flannigan: Thank you. I also have the 911 chart we saw at the last public safety committee meeting and when you scroll down you already start to see the mh code. Is that the thing you were referring to? >> Yes, sir. >> Harper-madison: That's a part of it and thank you, I appreciate that, but I think what I'm asking anecdotally by way of experience with family members who needed more, like outside of the emergent nature of the call, I think I'm trying to figure how we as a body can be active participants in the continuation of care, like that whole continuum. That's one of the questions, but Ann, I see your hand up. >> Flannigan: I'm sorry, I wasn't trying to answer your

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question. Councilmember kitchen. >> Kitchen: Well, I think you are asking a really good question, councilmember harper-madison, and it's an example of some way we can help connect the dots because this kind of data would really be helpful in feeding into the system in the rest of the community. There's a psychiatric stakeholders group I'm looking forward to getting you involved with as soon as that meets again. It needs to meet again. But this kind of information shared with them can help identify the additional resources that are needed in the community, and I know that integral care is familiar with those, but there are other folks sitting at the table as part of that psychiatric stakeholder group including central health, integral care, and a number of other entities in the community, and really working towards making sure that we have the resources because, you are right, that's where it falls off. You know, I think people --

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dawn just mentioned you need at least a 90-day follow-up and you need much more than that, but there's no place for people to go. So they just cycle back in. And so as a community, we can do a lot to connect those dots and try to work with the rest of the community through the psychiatric stakeholder groups and also other means to say, look, our data shows us that you need X number of more resources. What's the plan for getting those? So anyway, thank you for bringing that up. >> Councilmember kitchen, this is dawn. Can I just add a comment to that? It's weird because I know you guys can't see me, but just to give you an idea, we actually do follow all of the individuals that we come in contact with so

we know where they went, where they were diverted to, if we were able to hook them up to services if they didn't want services because some folks have their own provider as

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well. Then some people don't need ongoing services because they are able to to resolve and maintain stability in the community. But that 60% do need to be linked. But anybody we've had interaction with through mobile out reach crisis team we're tracking and know where they are. I think we could find a way to do a report so it's an aggregate number so it's not -- so we could get an idea on who went inpatient, who was -- for example, who did we open up in inservice residential services and we use them a lot for mcot and they are not needing in-patient facilities. I think I could get that data and put it in groups or buckets so you could get an idea what that looks like. >> Harper-madison: Thank you. That would be very helpful. And if I may offer a way in

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form of anecdotal experience, and my family member is comfortable with sharing this information, for my particular family member the thing we found oftentimes was what we death bumping up against there's help when it's an emergency, but there's not that continuation of service when it's not an active emergency. In which case if there is nobody following, nobody making sure the medication is being regulated, if there is nobody tracking whether or not there's follow-up with doctor, that continuum where the emergency kept popping up, in which case then it became this repeated sort of emergency room visit, you know, and then this -- like -- what's the word I'm looking for? When a person can't cover the costs of their health care expenses, you know, and it just kept becoming this like repeated cycle, this cyclical thing whether it was cycling in and out of the emergency room. So that's ultimately what it is and I'm trying to get to the root of.

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Like how do we get to the bottom of that. I think you answered as much as you were able to. I look forward to continuing the conversation off line. >> It's an interesting question for me about the role between the city and the county. And who -- which jurisdiction should be doing what and who is in charge and which tax base is paying for which service. It might be another opportunity to consider some joint meetings like we did with cap metro, but to get us and the commissioners court at the same dais and talk through together who is going to handle which parts of the system. And I thought dawn, your point about how the -- we could build up a whole crisis response, but if there isn't a landing place, if there isn't the other two steps, stabilize and regain, you just cycle people in and out. That's a huge area of work, and councilmember

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harper-madison, as chair of the council's health and human services committee, I think it's a good -- more good work to be done digging into those details. Dawn -- >> Harper-madison: Thank you for that. I appreciate it and I think you are right. And I also think that conversation around indigent health care costs, that's how we can really sort of push it forward, you know, if we recognize there's so much work we have to do on the front end to sort of absolve that cogs cost on the back end. Thank you for highlighting that. >> Flannigan: It's just one of those things when you talk about amount of money, and dawn, I have a couple questions for you and other colleagues feel free to jump in. But when you talked about the scale and the cost of scale, you talked about the -- I want to bring the slide back up so we're all looking at the same one. Hold on. The ideal response slide.

[3:23:38 PM]

What do these percentages really mean? Because I think, you know, because remember this is a public meeting too so I want to make sure the public is understanding. I'm not sure I understand. So in that proposed model, when it says 100% of APD calls, we're not talking about anyone who calls 911 for APD could be diverted to integral care, right? So what is this referring to? >> So this is in the field, right? So right now we're just -- we can dispatch from 911 or in the field there might be a law enforcement officer or ems in the field requesting that we come out, and this proposed model would make sure that we had enough staffing to be available every time anybody called from in the field and we would be available to handle every call that came in the 911 call center by adding additional staff there. But we're actually going to get pretty close to that 100% in the requested model. We put 90 there because, you know, it's hard to get 100%,

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but I was dreaming on the fy 20-21 so I put 100%. But we're adding enough staff for us to handle for sure all the calls coming in to 911 and that's how we're going to get that mental health question up front. These other numbers about 25% of APD calls and 40% of ems, these are the ones that are in the field. Because right now with this expanded model, we have staffing where we can cover 24/7, but we're not partnered 100% with law enforcement or ems so there could be a time that we're tied up on a call and another officer or ems paramedic needs help and we wouldn't be able to get to them. That's just kind of giving a little bit of room in that area. But the use of telehealth too is an ex spannedder of a workforce and we could increase that to do more. >> Flannigan: Just to be clear, the percent of APD calls and percent of ems calls is the situation where an officer or a paramedic

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has been dispatched to a call and once they get there, they realize they need mental health support and make the call and somebody shows up. That's what that is. >> Correct. >> Flannigan: The ctec calls, are those calls you can just send mental health response? >> No, this is actually being able to field them. If somebody calls and say they want a mental health officer and asking the question, yes, this is a mental health call, they will hand those calls to us and we can field them and dispatch our own teams. So the difference would be on the fy 2021 requested model, we may or may not have the teams to send out so so that's not quite at 100%, but the proposed model would give us the ability to take the call and make sure we had enough depth to be on the scene. >> Flannigan: Again, just to be clear, those calls are able to be responded to without an APD presence. Is that right? >> Yes, and we're able to

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take them -- those are call center calls, 911 calls. >> Flannigan: But you don't have to send an officer too. These are calls you can just send your team. >> That's the hope. >> Flannigan: Because part of the diversion question as we think about the share of resources when are you sending an officer, when are you not. Mayor Adler and councilmember kitchen. >> Mayor Adler: I apologize if you've already asked this question. I understand increasing capacity means we have more of the ems where we want ems on the call. How does that impact, if it does, the amount of time that's required from APD or the number of officers required of APD? Does this diminish the workload for APD or the number of officers or is it just a function of having more people there with greater range of expertise? >> Well, if we're fielding the calls and dispatching, then that means APD is not

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involved at all. And I think this year we were able to see that 85.4% of the time law enforcement did not have to go of the calls that we were able to field on our own. >> Mayor Adler: And would those have been calls that ordinarily APD would have fielded and go to? >> APD or ems, yes, sir. >> Mayor Adler: Have you written that down, that statistic or analysis anywhere that I can see? >> Yes, sir. >> Mayor Adler: If you could send that to me and the others, that would be helpful. >> Sure. >> Mayor Adler: Thank you. >> Flannigan: Councilmember kitchen. >> Kitchen: Thank you, dawn. This is very helpful. As I understand what we're saying is that with the funding that we just voted on, we are to the point where we think we can answer all the diversion calls through 911 call center. The issue is where you get calls from other sources, like you said, if you get -- I think chair Flannigan gave

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a good example. If APD or ems goes out and realizes they need a mental health person, that's where we're -- where we could use -- where you are thinking that you could potentially use some more funding for -- for the emcot personnel, I guess. >> Yes, ma'am. >> Kitchen: That's the understanding, right? >> Yes, ma'am. Correct. >> Kitchen: Okay, so I have a question now about if we want to move to another slide, I wanted to talk some more about the dispatch protocol that we just went through. I am wondering -- I'm thinking that you are telling us that that is the current dispatch particle and I'm wondering if there is room for any of those list of items that are not dispatched through a counselor, yeah, not eligible for c3 intervention. So I'm wondering is the thinking that over time some of these might be or are

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these -- or have you -- because I know there was a change in the protocol a few months ago that you originally started with a more conservative, smaller protocol and then expanded it some. Is the thinking that some of these might be able to be expanded at some point? >> Councilmember kitchen, unfortunately no because we are at the point where we have included every non-emergency, non-imminent threat to life or property type of call. We can to divert to the c3. Last month we added the check welfare urgent with a second-party caller. Normally officers would have responded to those and since we added those, we've seen an almost double in call volume of the transfers to the c3. So it's working out well. You know, there's -- there's

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always room for improvement and so I don't want to say, you know, absolutely -- absolutely not, however, the vast majority of calls we are excluding from transfer are those imminent risk calls where someone is hurting themselves or hurting someone else. And those we cannot transfer to a crisis counselor. Does that make sense? >> Kitchen: Yeah, I have a question about a few items on this list to help me understand what they entail. So I think it's the last three that I have, like when an individual has committed a crime, I understand the family violence, but I'm wondering how the term "Crime" is interpreted and if it includes property crimes. And then I'm not certain what a hot shot call is or a priority one call. If you could speak to those three.

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>> Yes, ma'am. Well, a crime is -- what we're referring to there is a crime, yes, where there has been property damage and someone is calling about someone who has broken something on their property.

Of course, a family violence and assault, any -- any crime really where an officer needs to respond and write a report. Which is mandated by our current policy. Our hot shot calls are those calls where life and property are in imminent danger. Examples, disturbance hot shot where there's an active crime -- where there's an active feet going on. -- Fight going on. Crash hot shots where we have -- where we have people injured involved in a collision. Party one calls are the calls where they are just short of being a hot shot call where a crime has been

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committed or someone has been injured, but the suspect may or may not still be on scene. The incident is -- may or may not be still occurring, or the suspect just left and there is -- the quicker officers can get there, there's a high probability the officers may be able to find the suspect involved in the incident, whatever it was. >> Kitchen: One last question, chair, then I'll -- so what I have in mind that I'm thinking of is I'm wondering, so, for example, if there's a business, for example, who has someone on their premises who is an individual who is homeless, for example, and is exhibiting behaviors that are causing some concern for the business. Are those the kind of calls that we can consider having a mental health response for? And that's the kind of example I'm trying to think about is there -- is the

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potential there for mental health response? >> As we are right now in the program, those are difficult and those are things we have looked at because our counselor on scene really needs to talk with someone who is involved with the person in crisis. Like a family member or the person in crisis themselves. It's very -- it's very difficult for them to speak to someone not involved with the person in crisis, just a third party. However, we're hopeful in the future when we move to our phase 3 and we have the integrated emcot counselor with the community health paramedic, then yes, maybe we can send the team of those two to those calls instead of sending an officer. Does that make sense? >> Kitchen: Yeah. So with the funding that we're talking about to expand the program, that might be an area that you could look at. The reason I ask about that is my concern is that -- and

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I understand that it's hard to know when you get calls, but my concern is, you know, I do hear about situations that involve, like the situation I just mentioned and actually involving an individual experiencing homelessness and it may be a behavior issue, that it just seems to me that having a mental health professional involved might actually get to a more -- get to a -- potentially more lasting result because those are the kinds of things that the police officers have very limited tools to deal with. So thank you. >> Yes, ma'am, absolutely. And again, we're hopeful with the expansion of the program and

the field units coming online, we looked at the Eugene, Oregon program, the cahoots program and we could see where if we took some of their methodology and brought it here to

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Austin, with the teams in the field, we would have the ability to expand the calls and divert police and send those teams to those calls instead. So there's -- there are a plethora of calls we could hopefully expand to when we get the teams online. >> Flannigan: Plethora. That's an excellent word. Councilmember tovo, did I see your hand up? >> Tovo: Yes. Thank you. I guess my first question, thank you, this is really a very extremely informative presentation from APD as well as from integral care. Could we please get the APD presentation emailed? I don't see it linked on today's agenda and I need to go through some of these details a little more closely. >> Flannigan: I'll make sure that's handled, councilmember. >> Tovo: Great. Thanks.

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I think it would be helpful to put it online so the public could get to it. So what I'm trying to understand may be answered if I had a printout of the presentation, but I'm trying to go back and forth and really understand what the opportunities are for additional diversion. And councilmember kitchen, your question started to get to that. So I think my first question is for you, dawn, as I understood the statistic that you referenced, that you indicated you would get us additional information about, 84%, you are currently able to respond to 84% of the calls. When you are saying 84%, are you saying 84% of the calls that fit -- that fit the criteria as specified by -- with the exceptions as specified by APD on their slide in the c3

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presentation? >> So 85.4% number is actually of the calls that dispatch transferred to us, to our clinician on the floor and we were involved in that call, we were able to divert law enforcement away from having to respond that 85.4%. So every call that came in, just the ones that we received. >> Tovo: And are you receiving all of the calls that are eligible for safe reintervention? >> Right now we're not 24/7 so the expansion is going to afford us the opportunity to be 24/7. And you heard lieutenant Murphy present on we're working on the training of dispatch, we're providing training for them and these other protocols so that we can expand that number so more calls can be handed to

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us. >> Tovo: So I think this is clearly a conversation that began multiple budget sessions ago and we've expanded on it and we've had a lot of input through this budget cycle from the community. I think we're going to need some help sorting out these different pieces of information and putting them in conversation with one another. Today's presentations are a good start, but as I look at what are the additional opportunities for diversion, it sounds -- what I think I'm hearing is that when you go 24 hours, you will -- you are doing 84% of the calls that you get currently. So there's that 16% that can be -- that could be responded to with a mental health professional. Then when you go 24/7, there will be additional calls to which you can respond. But they will still be -- there will also be a universe -- always be a universe of calls that require a police response,

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and I think that we need to understand kind of how that all shakes out. Of the total calls, how many -- >> That's correct. [Multiple voices] >> Tovo: Some additional opportunity. >> Yes, ma'am. >> Tovo: It sounds like you believe the new resources will allow you to meet that opportunity. >> Right. I think we're going to get closer with that, but, you know, Texas law degrees state there will -- does state there will be times, you heard Ken talk about individuals at risk of harming themselves or others so in need of assistance for involuntary admission for in-patient stay. We would still need to have law enforcement respond because we'll need to do that because they are the only ones capable of providing that service for us. >> Tovo: That was one of my questions so thank you for answering that. I knew there were just certain professionals who could do involuntary commitments, and I know police officers are one of

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those professionals, and it sounds as if your staff are not. >> No. That's correct. >> Tovo: So they would need to be -- thank you. >> Not yet. Not unless we're able to get changes through legislation. Other states allow social workers or licensed professional staff to provide that intervention, but Texas does not. I mean one thing that we could look at doing to further it and we do a lot already is looking at policy and working with APD on doing a consult with us so that you have the mental health person on the line kind of evaluating with them the need. Because sometimes we automatically go to the highest level of needing to take them to in-patient when really if we could get on the phone and come up with other resources, we could convert them to a lower level. >> Tovo: Thank you. >> Yes, ma'am. >> Tovo: I had a couple other questions and these

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are I think for both of you. Your presentation talks about, I just want to be clear mental health officers, those are your professionals. Is that correct? Professionals employed by integral care? >> No, the mental health officers are actually APD. Some of them are cit certified, but I think that's how we're looking at that, either cit certification or that extra training related to mental health. >> Tovo: Thanks. I think -- and there may be -- I think in the past we've gotten various memos and it would be super helpful at some point to have a real clear, some kind of real clear guide to all the terminology if one doesn't already exist. So those mental health officers who have the cit training, are cit officers and have extra training, can you talk about the extent to

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which -- and this I think -- well, what kind of training are you providing to -- to officers, and then if we could turn the question back to -- to assistant chief chicone to talk about the extent to which is force more generally is trained for [inaudible] Care and responses. Dawn, if you could -- if dawn could answer the question first the kind of training referenced in your slide, and then if we could hear from APD about kind of those who are not cit officers or mental health officers, but have received training. >> Sure. So right now we provide training for all of the new cadets that are coming in. We've done mental health training for actually the entire police force, I think at this point. And what we've done to date

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is really around signs and symptoms of how to recognize if someone is struggling and might have an amino acid, but this has been -- a mental illness but this has been tailored to what state mandate requires. We've done additional work to do vignettes and practice and have been involved in doing pre and post-testing to make sure there's competency and skills there they were able to practice what they learned in those sessions. But what we're doing to at a date with the call takers to help improve the calls we receive is we're actually helping the call centers become mental health certified, we're doing a certificate, we're doing a very good curriculum and actually we came to this training to be chosen for them through the work, we had the justice coalition and grass roots

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membership at the meeting to help us look at what would be an appropriate training. They too went through the training and decided that this was -- it's an evidence based curriculum and it really is indepth and it allows a much broader reach than what we've traditionally done with the rest of the police force. >> Tovo: Great. And I'm not sure who the appropriate person is to ask, but I think it would be great if we got additional information about what kind of training is provided as part of the Kathie tovo let academy and what ongoing training is provided to our force. I think that's important for the

public to know as well because it has been a real conversation. >> Yes, ma'am. For the mental health part we're definitely on the syllabus and we can give you the number of hours related to mental health. >> Tovo: That's super. Thank you so much. And then if I could turn it back to APD.

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I think they had started a response. >> So with regard to the training, all of our officers receive for mental health response, and we'll use the terms crisis intervention officer or crisis intervention team and mental health officer interchangeably. At one point they were referred to as mhos and now it's cit. However, we do provide 80 hours going forward especially at this point, 80 hours of cit training to all of our officers, 40 hours is the basic course and that's provided during the academy, during that cadet instruction. And then once cadets graduate, they receive the intermediate or that second piece of the cit training towards the end of their probationary period. Our officers don't begin

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doing emergency commitments until they are off probation, and so we schedule that a little bit later on in their cadet -- in their training process so that it's fresh in their minds and they understand all the protocols. We have about 220 officers on our department that are designated to receive a cit stipend and are designated as cit officers. Those are the ones that we know as a department have already received the full 80 hours. The remainder who have only maybe received the first 40, we're catching them up right now. Covid has put a little of a -- you know, a halt on that or put a crimp in it because of not being able to gather in classrooms. And the -- what dawn was talking about with doing the role play and the scenario based training is extremely important for that kind of training.

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So we are trying to catch up in that. We are hoping to have everybody trained up by next year, probably going to be longer now, but we do have, you know, a good number of people on patrol right now hours of training. And can do an emergency detention if necessary. >> Tovo: Great. Thank you. Thank you for clearing up -- sorry. I forgot I'm using two different ways of talking. Anyway, thank you very much for that additional information. Thanks for clearing up the cit, mho, that they are one and the same and that the preferred term city this point is cit. That helps clarify some of this info for me. >> Flannigan: Mayor pro tem, did I see your hand up earlier? >> Garza: Yeah, I'm trying to reconcile a response to something that the mayor asked with something that councilmember tovo just asked. I thought the answer to the

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question, so the 85% is the percentage of calls that the ctec gets in directly and I thought was it dawn, I'm sorry -- I forgot. >> That's correct. >> Garza: Dawn. Said that those calls do get diverted from APD, but then I thought councilmember tovo's question said that those people in those calls are still APD or trying to understand the diversion. The 85%, are those police officers that respond just with higher training or there's -- >> No, that's our staff. That's emcot. So we're responding -- that 85 number represents a mental health professional going out in place of law enforcement. >> Garza: Okay, so those aren't police officers. >> Right. >> Garza: So the person that taste the call is not

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APD and the responds is not APD, right? >> Right. It comes in through 911, so it goes through the dispatch process. They identify as mental health call, transfer to clinician on floor and we take it from there. >> Garza: Then this is just a bigger question for everybody as we are brainstorming ab I feel like this is where councilmember tovo was going in her questioning. Because I remember when we first started to talk about all this diversion, and I just from my experience as an Austin firefighter, I remember that we -- we wouldn't even get to medical calls in some instances because along the triage and dispatch, it was -- it was found out that there was a weapon involved. So even fire -- they would tell us to stage. So even fire or ems couldn't enter a scene while the

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police officers kind of made sure that the scene was safe. And so when I was thinking of how we get to those calls where, you know, these are the exceptions to the ctec for being diverted or there was a crime committed, all those things, I'm interested to know if we're doing any work as we do the work to rethink our response because almost sometimes those are -- we're doing a really good job of the low hanging fruit, so to speak, I feel like we're on the right track, as councilmember tovo, we've been having these discussions, but it's the ones that end in I guess more disastrous kinds of

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ways where there's a weapon involved or someone reported a weapon involved, and so are we doing any kind of work around researching those kinds of incidents in those calls? Because many times the mere appearance of police officers is what scares people and escalates situations, especially when -- when someone is experiencing a mental health crisis. And so anecdotally I have been on scenes where just the presence of a police officer changes the interaction. And so I guess my question is are we doing some kind of work to determine how we change that part of it? Because to me that is -- that is the big

piece of the puzzle that we're trying to get at where we want people -- we want everyone to be safe including the people responding. And so that's why we're not sending just mental health

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professionals to calls where a weapon is involved, right in how do we get the person that does show up to be the person -- someone that is not immediately trained to think I need to protect myself, I need to protect my team is more of a, I don't know, negotiator, but also prepared to do what needs to be done so as, you know, obviously as little people in the situation get hurt. I don't know who that question is for and maybe that's just a broad thought process, but if anybody can answer it, please do. >> And so chair, if I may, mayor pro tem, I think that is the stuff of the reimagining effort, particularly in this arena of how to respond better in better ways to have better outcomes for those experiencing a mental health crisis and whether it's potentially one of those disqualifiers in place. So I imagine we have not started that research yet, but clearly that's on our plate to be able to see how

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other agencies are handling that and how can we improve outcomes here in Austin. >> Flannigan: And I think we did the 911 -- sought the initial 911 analysis, today we're talking specifically about mental health first response and it's not entirely clear what the ratio of calls is or the ratio of time spent on these calls, but it's an important component and there's a lot of other pieces to this. How might we reimagine traffic enforcement, handle the false alarm calls, so there's a lot of components to it. This might be the most challenging because it relies so much on systems we don't control. Councilmember kitchen. >> Kitchen: Yeah, I wanted to speak to some of the research done as part of the meadows report. And that doesn't mean there's more conversation that needs to happen more in the field trying things out, and I know one of the things

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you all have talked about is -- is the clinician's role in communicating with the officer if the officer is on the scene in a circumstance like you were talking about. Because I know there's been some conversation about the ability of the clinician to actually be talking with an officer in a circumstance that might fall into one of those categories where an officer needs to be on the scene. So I know that may be an area that you all are just now getting into, but maybe dawn can speak to that or one of the officers could speak to that. >> Yes, ma'am. We actually are piloting that and lieutenant Murphy can speak to it as well. And what they are doing is they are dispatching us into the call so if we have the individual that's escalated on the call, we're able to work on de-escalation and an officer gets to hear the call so he's aware of the

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scene when he gets there based on our conversation as we're trying to calm and stabilize as much as we can on the phone. Did I get that right, Ken? >> Yes, ma'am, almost. They won't be able to hear the conversation, however, as the information -- the 911 operator is on the phone with the crisis counselor while the crisis counselor is speaking to the person in crisis, and the 911 operator is entering dialogue into the call text and then the dispatcher relays the information in the call to the officer as the officer is responding. Or the officer can read it on their mobile data computer as they are responding to the call. >> Kitchen: So I'm not suggesting that that is the perfect way to do it, I'm just suggesting that is some ways that are being explored right now. And would just encourage, and I know you all are

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working on this, additional exploration of that so you can have the benefit of the clinician's experience and being on the scene as quickly as possible and being part of the communications as quickly as possible. So thanks for asking that question, mayor pro tem, because I think that that does get to the heart of what we're trying to work towards as part of this. >> Flannigan: One of the questions I had, dawn, just to remind me what you said and then maybe assistant chief you kind of -- the scale and cost to scale. So dawn, you said that to scale the mcot and the emcot or just the mcot?

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To scale to the proposed model it was a couple of million dollars, was that right? >> Right. So it's emcot. So our current expansion that you approved was 3.15 million, but the proposed -- if we were wanting to make sure we had staff available to connect for every call from anyone in the field, it's 6.2 million. >> Flannigan: But the 3 point whatever it is that we just did, that we think -- and councilmember kitchen said it too, that is getting us very close to the theoretical maximum of diversion away from law enforcement. >> Yes, sir. >> Flannigan: I mean that's a very exciting thing. But to the other part of the system, we've -- so we've made that investment, decided to make that investment and, you know, the public, you know, thinks you take a vote and things happen. The budget doesn't start until October 1.

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Nothin but by going to this expanded model, panned mcot -- expanded mcot, it will create more folks going into these other systems, right? >> Yes, sir. >> And those systems have not expanded yet? >> That

is correct. >> Flannigan: And if I remember what you said correctly, to expand those symptoms is eight million dollars. >> Correct. And that was just looking at outpatient services. To the legislative board, the lbb, has none analysis on peer, lmh's. So we were able to take that and apply it to the number of individuals that we're reaching through the crisis services just using the expansion model so next year we're look argument taking on an additional 1600 people into our system and that would cost us eight million dollars to be able to serve them through any of our --

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whatever service package level they would fall in because it varies from just needing to see a doctor to needing the full wraparound supports. >> Flannigan: Does integral care have information that speaks to the crisis cycle so those folks will avoid? What I'm trying to drill down to is we get X number of calls now because the expanded systems don't exist. If you build the expanded systems that call volume should decrease, right? >> That's correct. We actually did some analysis with the expanded mobile crisis outreach team, kind of a return on investment, if you will. We have some data that shows where the cost savings is by people not hitting the higher level of inpatient or the Ed's or law enforcement. Or jail for that matter. If we're avoiding incarceration. So you're able to see it costs much less to have an individual connected to a community based service than

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it does in a more restrictive service or in jail, which is ultimately restrictive. >> Flannigan: And all the more reason to have the county at the table, central health at the table and maybe some of the private health care providers in our community, major health care providers, and ultimately the costs get passed on to somebody else's insurance. All the more reason for us to be thinking about that. And when we talk about having just adopted a 1 point something billion dollar general fund budget, it doesn't seem ginormous in context for us to have effectively built out a system for a city of a million people. Is there something I'm missing? Is there more to it than what you've laid out? >> Yes. So eight million is just for next year's numbers. So if you want to talk about every mental health call that comes through the system, right, every call that we're not getting all the calls. So you get the whole city and every call there is, yeah, the number I think would be larger. I just took the expanded

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model because that was the number I knew what we were expecting to serve next year and so I used that as an example. So just by expanding an additional just under two thousand people it costs $8 million. But if we are able to serve even more people because we've got more folks in the field, more of the calls are coming to us and we're able to intervene, then you look at that total number and that 60 to

80% of those folks are the people that will need some service and they are unfunded. So that number could agree for sure. >> Flannigan: Councilmember kitchen? >> Kitchen: And I think you may be talking about the services part and not the housing part of it because for some -- it's not everybody, of course, but some percentage of those individuals are people who node Moore stable housing? >> 40% are. >> The eight million will not cover all the housing,

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it will just cover the service needs. >> Correct. >> Kitchen: So the other thing to understand is that -- and that number can be quite a bit more as we know we're experiencing from the work that we're doing around housing for individuals who are homeless. The other thing, chair Flannigan, that would be very interesting, is the table that is set at the moment to have these conversations is the psychiatric stakeholders committee. And it might be interesting to charge that committee or ask that committee to take on these -- this kind of conversation not that it has to be that committee, but that is the group that it's been formed that includes all of those folks that we're referring to, county -- I have to go back. They have all those players at the table. And have been instrumental in other -- in bring are other resources to the community like the guy Herman center was something worked on through that

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entity. So it would be -- I think it would be helpful to talk with that group and the leads there are central health and integral care about partnering with us to address these kinds of concerns that we're talking about. >> Flannigan: I think that's a really good idea and it's a great session 28 talk to our deputy city manager. I think there's a lot of value in the kind of public conversation that we do through the committee or you do through a council meeting, so there's probably value in having those kind of joint jurisdictional meeting in a forum that is broadcast to the community and archived. But there's more to the work you are going to do because you're not going to do the three hours every other week. And what was that called, psychiatric. >> Kitchen: Psychiatric

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smirks and it's chaired my David Evans and the executive director of central health. >> Flannigan: That sounds like a great parallel process where you have the policy makers who set the annual budget where most the funding and expenses lie. If you're not appropriately funding the mental health system then you're funding a lot of crisis response. That conversation and the table set with the elected to set the budgets in addition to the kind of private working group working groups. Deputy city manager Rivera, can you give us the update on the working group and on the working group and [indiscernible] [Echo on the line]. >> Sure. Thank you, councilmember Flannigan. I appreciate the opportunity and I think

assistant city manager Arrellano was right in terms this is an effort that we certainly have envisioned in this reimagining bucket, but

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these meetings are tremendously useful as we move forward to really set sort of the stage of some of the questions that we're already asking ourselves. It is kind of for us at least a precurse irrelevant of a deep dive with some of the stakeholders, including integral care. I'm excited to say that we're having our first city community task force meeting this evening and so we are moving ahead fast. I had mentioned to you all that our hope was to have three this month and we have in fact scheduled three this month. These initial ones really are sort of about onboarding and level setting and getting some preliminary information out there. We're hoping by the end of the three weeks to come out with a calendarization of priorities for the task force and to start to set the play for some of those work groups. I envision this is precisely the kind of deep dive that we have either with our community members or additional organizations as

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we move forward. I've mentioned too that we're also going to be talking to pd and I appreciate that this committee has certainly been taking information from police staff. We need to do the same on our end and set out some initial meetings with forensics, 911 and emergency dispatch, victim services, internal affairs, support staff. And through that I think we're going to start to if we will unpeel the union. Because if you've seen as this mental health conversation, it is not solving one end of the equation, but it has other repercussions throughout the community and we want to make sure that we look through those. I expect today will be the first of good on work and we will come back to the council and this committee. Periodly we clan on our end to provide at least monthly updates to all of council, but certainly are already talking to our staff, chair

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Flannigan, and to the vice-chair's staff. We are trying to fold them into some of our process so that we can precisely align what we are doing what happened this committee is doing because we just see such great synergy and the ability to leverage our collective work. >> Flannigan: Thank you. Councilmember tovo, did you have your hand up earlier? >> Tovo: I did. Sorry about that. Yes, I did, thank you. I just had a quick comment. The stakeholders' committee is a great idea, the psychiatric stakeholders' committee and I know they were kind of refiguring that so that they are really in a position to be able to make some decisions is. I want to say, though, just back to the point that dawn raised about the need for more -- as I

heard it, I hope I'm summarizing it correctly, the need for more inpatient services and more assistance, longer term assistance, so that individuals have an

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opportunity to get those kind was of services, not just in a crisis response system. I want to make it clear to anybody watching this, that is not something that the city is going to be able to achieve. This is something -- these are resources that we need to come from our health care community. These are resources that our other partners here in Austin are going to need to assist with. And I just think that's a really important point to be made and I think others of my colleagues have sort of referenced that as well. But we absolutely need our private health care community to participate in funding that solution, frankly. >> Flannigan: Thank you, councilmember tovo. I completely agree. Councilmember kitchen. >> Kitchen: With regard to -- could you speak to the task force meeting and how people can observe it? Is it a public meeting? Is it being broadcast? Speak to that for people.

[4:10:37 PM]

>> Councilmember, I will say that it is not a public meeting and it is not being broadcast in part because we want to move through our work rather quickly. And because we want to create a table of a lot of candor, we have, however, talked with our facilitators and I've mentioned this to our task force members and we had one on one conversations and we'll go into that tonight, about how do we try to be again transparent, how do we provide listening summaries of our meetings. We want to be -- we want to try to be as public as we can, but also provide enough space for us to be candid with each other as we do some of this work moving forward. And we're trying to balance that. So you know, I appreciate the fact that there's a lot of interest and so we will try to move forward as fast as we can and try to publish those summaries as fast as we can so everyone can share along. We have asked staff from the chair and the vice-chair of this committee because we want to be very aligned to

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be observers in that meeting. So we are hopeful that that will actually help us make sure that our two meetings are synced? It doesn't mean that we will always have the same thing happening, right? There are other topics of conversations that this body may want to have as we move our work, but we are going to try to move it forward and to keep our alignment that way. So we're hopeful in this approach and I'm sure that we will find out if there are other opinions or if there are other thoughts about that. But we are trying to be as transparent as we can while also providing a safe place space for people to converse because we also heard that very clearly both from staff and our community members. >>

Kitchen: Yes. I didn't mean to imply that it wouldn't be public. But I think perhaps what people don't understand or maybe I just haven't seen it is that what is the process

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for people to express they're thinking or their concerns or their opinion. We've talked about it some and I haven't seen it anywhere. I could easily be missing it. But I haven't seen anything definitive that I can tell folks that contact me, here's how you express your interest or your concerns or whatever. So we really need to understand so that we can tell -- so the public can feel like they have an avenue to participate or at least participate through sharing their questions or their concerns or whatever. So I know that was something that you all were going to get to, but can you speak to that? >> Sure. >> Kitchen: What can we tell people? >> I would say that soon, and I can't tell you what precise day, but soon -- and I hope it's this month -- we will have built out something in speak up Austin. We will have an email that folks can send things to. We are trying to create a variety of different

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mechanisms for people to share their thoughts. We have also had that first listening session and are taking feedback from the first listening sessions with the commission and tweaking that so that we can move forward some information and start to have even broader listening sessions and focus groups. And we will have when we have those set up we will actually put those dates and put that information on this website landing page that we're creating. So there will be avenues. All I can ask is just for a little patience as we build that out. But it will not be too much longer because we are trying to find a multitude of different ways that we can do that. I'll also say that the equity team has been working on their mini grant process so they can also empower other community organizations to host those facilitated listening sessions is as well and get us that information, creating those surveys and

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multiple language so that language is not a barrier to having this conversation with city staff. So we have a multitude of different avenues by which we are trying to get information. And we will continue to share that with you. Get that from our task force if there are additional opportunities and ways in which to do that. But we are committed to having this dialogue with the city of Austin in its broadest sense of the word. >> Flannigan: Any other questions? >> I will just add there is a lot of detail to dig in here and at some point it is, nuria, you and Spencer and rey, it is the staff's job to um implement. And I think the council and the community have been very clear what we're trying to accomplish. We have asked our officers

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to do too many jobs. We have asked them to do things that is burdened to the department in a way that is unsustainable. And we're not going to do that anymore. So we need to better design these systems to meet the needs of the public. And councilmember, I will thank you for what you said at the beginning of the meeting. When the we talk about the community we are inclusive of every person that lives in this community. And I find myself sometimes laughing where people think councilmembers are like congress where we go off and you're in another city 1,000 miles away. We're going to run into you at the grocery store. Like we live in this community everyday too. And we're not that far away. In fact, that's the beauty of the 10-1 system is that as councilmembers we are far more accessible to our districts than just about any other elected official. So I encourage, as I always do, encourage folks to reach out and email your councilmember. When do you that definitely say when district you live in because it helps us focus

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our attention on the folks who want to hear from their elected representative. And to the officers and to all of this work that we're doing, it is by necessity as a pragmatic matter going to take time. We are not laying anybody off. No one is using their jobs. There will be -- as a result of that there will be time to design these systems, to roll them out. I think one of the things that excited me about the presentation today was how these solutions scale incrementally. It is not all on arrest all off. It's sort of like building a hospital that you don't get to use it until it's completely built out. You can add more staff, divert another 10% of the calls, you can scale the situations up. To my mind that is the work that we are going to continue to do. It will happen on mental health first response, it will happen as we get through the 911 call

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analysis and we start learning other ways to unburden officers from all of the other work that don't need to be officers and let them focus on the work that does need to be officers. If not, because it is a requirement of state law but because the training can be specifically designed for officers to be specifically experts at those jobs. I just hope that folks are listening. And I know a lot of the media folks are listening and there's been frankly a lot of great reporting. And then a little bit of less than great reporting. The contents of the articles are great, but the headlines that stink. The content is good, but the headlines are terrible. Everyone has the got to keep reading and learning and join the council on this journey. As councilmember harper-madison said, we're going to lead the cup on this and we're -- lead the country on this, and lead it not that we did it fast or the most, but that we did it the best.

[4:18:42 PM]

That's why Austin is going to lead. Councilmember Casar. >> Casar: Thank you, chair. I think that's spot on. As we come up with more meetings, I do think that finding ways to make sure everything we passed gets implemented is really important because the only way for the theory to hold true that there will be fewer 911 calls and less harm is if the things we reinvested money into are implemented correctly, thoroughly and on skid. Schedule. We actually have to get through the homelessness solutions online at the faster clip than we have before. We have to get the mental health response going at scale and ramped up the way we described. We have to actually get the family violence shelter open and staffed and get that -- we have to do those things because otherwise the structure of what council put together only works if

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we actually are preventing the violence and harm through our proactive interventions, which was part of the promise. And so us continuing to have these meetings I think is a helpful way so that we all can check in on progress, hold ourselves accountable and get it done. So again, I'm so grateful for having revived this committee in this way. So thanks to everybody for participating. >> Flannigan: Thank you, councilmember. Councilmember harper-madison? %-@>> Harper-madison: Thank you, chair. I couldn't be more grateful to be surrounded by people who are much more eloquently spoken than I am. And some people the other night said you don't want to follow councilmember harper-madison. I just say what I'm thinking and what I'm feeling and that is not always a good thing. [Laughter] So I will say that I appreciate that I have colleagues who say things that are so much more eloquently spoken. You and councilmember Casar both made reference to

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things that I think people really, really need to go. And at the end of the day if we had to make a short story long, what we're telling folks is we hear you, we see you. You are important, you are valued and your contribution to the conversation is not lost outside. And I'm not just talking about the people, I'm not just talking about the tops. And the truth of the matter is is there's no different -- there's no space where the cops and the people are separate folks. They're the same people! They're the people that live in your neighborhoods. They're the people who serve proudly, serve their communities. There's no difference so when people say this crazy thing about either side or one side or the other, what are you talking about? We're all the same person. It's all the same people.

[4:21:44 PM]

There's no opposing sides by way of us talking about the relevance of the people who serve our community and the people who live in our communities. It's all the same people. So I really appreciate it. Y'all are so smart and so competent and so capable and say things in a way that I don't always have the ability to say. Thank you to all the folks who show up. I'm talking about my colleagues that I see -- and a kid, I see you, don't run away, and a kid. Thank y'all for showing up all the time to do this really hard job. And I would extend that to say thank you to law enforcement officers and people in the public safety perspective, thank y'all for showing up to do a really hard job. If anybody has told you that the council, we as a body, we don't like you, we hate

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you. Whatever the nasty thing is that they told you, please walk that back. Don't listen to these people that are telling you things that aren't true. We all do a really hard job and we include you in that perspective in terms of consideration. We know that you do a really hard job too. We're all doing really hard jobs and we all do it, most of us do it because we believe in the work, we believe in the people that we represent and show up for. So please keep showing up, keep representing and let's keep talking to one another. Because if we don't, then people say things that aren't true [dog barking]. And then -- hush, little dog. And then you may or may not believe it. Don't believe things that aren't true. We appreciate you. We appreciate all of us doing these hard public service jobs. You think we make enough money to do these jobs for

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ego!!?? Get out of here with that! [Laughter]. We don't even make enough money to do these jobs for ego. We do it because we believe it's the right thing to do. So thank you for everybody who keeps showing up to do the hard jobs for not enough money. And with that, thank you, chair. I appreciate you recognizing me. >> Flannigan: Thank you, councilmember. Any other final comments or questions? That's a perfect place to end. Assistant chief Chicon and Hoffmeister and sergeant king and lieutenant Murphy and dawn, thank you for joining us in the meeting today. I think it was really productive. A lot of great work. Integral care is going great stuff. I'm glad we were able to move the needle on these investments last week and it sounds like there's a lot more work to be done. We already knew that. Without objection, it is 4:24 P.M. We are adjourning this meeting of the public safety committee. Thanks, everything.

[4:24:51 PM]