SANTA FE COUNTY

BOARD OF COUNTY COMMISSIONERS

SPECIAL MEETING

April 14, 2023

Anna Hansen, Chair - District 2
Hank Hughes, Vice Chair - District 5
Camilla Bustamante – District 3
Justin Greene - District 1
Anna T. Hamilton - District 4

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1. A. This regular meeting of the Santa Fe Board of County Commissioners was called to order at approximately 9:20 a.m. by Chair Anna Hansen in the County Commission Chambers, 102 Grant Avenue, Santa Fe, New Mexico.

B. Roll Call

Roll was called by County Clerk Katharine Clark and indicated the presence of a quorum as follows:

Members Present:	**Members Excused:**
Commissioner Anna Hansen, Chair	None
Commissioner Hank Hughes, Vice Chair	
Commissioner Anna Hamilton	
Commissioner Camilla Bustamante	
Commissioner Justin Greene	

C. Approval of Agenda

CHAIR HANSEN: Manager Shaffer, is there any changes from the agenda?

GREG SHAFFER (County Manager): No, Madam Chair.

CHAIR HANSEN: What is the pleasure of the Board?

COMMISSIONER HAMILTON: I'll move to approve the agenda.

COMMISSIONER GREENE: I'll second.

CHAIR HANSEN: Okay, I have a motion by Commissioner Hamilton, a second by Commissioner Greene.

The motion passed by unanimous [5-0] voice vote.

2. MISCELLANEOUS ITEMS

A. Presentation on Adult Detention Facility

CHAIR HANSEN: Warden Williams, welcome. It's very good to see you.

DEREK WILLIAMS (Warden): Good morning. So thank you for having us this morning. I brought some of my staff. I'll start the presentation and then I'll move to some of my staff, have them identify themselves and there are some slides that are

relevant to their departments.

So first is the outline. This just basically talks about what we are going to be presenting within this power point presentation: personnel data the population of the Adult Detention Facility, medical support data, mental health and behavioral health data, programs for inmates, juvenile detention and overall security operations.

So starting off with security staff, this just kind of outlines how many full-time employees that we have, how many are filled, how many vacancies and the overall vacancy rate. You can see from looking at this out detention officers remains about 44 percent vacancies. This really came into effect with COVID. We saw a lot of reductions in applications coming through. We're starting to – we have rapid hiring events through Human Resources. They support us with Tuesdays. It's slowly starting to get a little better but we're still trying to enhance the recruiting efforts there.

Medical, and this is just all the other staff within the Adult Detention Facility. From looking at this we can just go straight to the nurses, medical staff, our RNs, our extra nurses, LPNs, they continue to have between a 50 or 60 percent vacancy. The saving grace in that is we have three contracted companies that provide nurses when we have shortages so when we have shortages there, that's where the agency nurses step in and they fill shifts for Ashley and we'll have her kind of touch on that when she comes up here in a few minutes.

Case managers, we currently have – we have six vacancies out of seven, so we're in competition from the Department of Corrections right now and that's kind of been a tough area to fill. I think we just hired somebody this week, so that's another area that we're lacking in, having a hard time filling.

Operations data, so this chart just indicates our intakes and releases. So you can see on the bottom we average about 4,790 intakes a year, and out of that, and then we get about 4,819 releases a year. So there's just a lot of movement coming in and out of that facility and the chart just kind of shows – it changes. It's an influx throughout the year. There's no real pattern to it. It just depends on – sometimes holidays and things of that nature come into effect but for the most part you can see there. For the amount of intakes we have we have just a little bit more releases, which keeps our population pretty stable. When you look at this, which is our daily average population, you can see back in 2021 we had a peak of about 416, and today we're at about 275. We drop down to about 250 sometimes.

I don't expect us to go back over probably 300 any time in the near future. That 416 peak in 2021; that was when we were still housing U.S. Marshals. When COVID hit and our staff – we lost some of our staff and we had a hard time getting staff back I made the decision with the support of the County Manager's Office to go ahead and move our U.S. Marshal focus just primary on our Santa Fe County residents, and that's really helped us keep our own population, thankfully.

So this just shows male compared to female population. Obviously, the males are primarily the large population. We only have about 23 percent of our population which are females.

Length of stay, for the first quarter, you can see a large part of that is zero to two days, 46 percent, so what that shows is a lot of people – thankfully with our Magistrate Court are daily looking at our housing rosters and they're making sure that they're very

timely and punctual with getting arraignments done, so a large percent of people that come in, they get booked, they're getting released by the time they get to arraignment.

I think this is important too because when we start talking about programming later, particular with like our Matrix program, this kind of explains why it's so hard to get a larger pool of participation in those programs because those programs were on that minimum 30 days and you can see for most of them we have such a transient population it's really hard to find people that are going to be there long enough to run through a program that's running 30 days plus.

Classification – so the initial classification is people coming in from the street, getting booked, processed, and then ultimately housed, so part of that last slide it's 40-something percent that's getting out within the first couple days. Then they initially get classified. They get moved from booking to population. So we do what we call a threat assessment based off of people that come in, so based off their charge list, any kind of violence, any kind of mental health, substance abuse, we factor in all those areas to kind of give us an idea of what kind of threat assessment they may or may not pose. Do they have predatorial behaviors? Things of that nature, and then we determine if they would be more fitting for a medium or high custody or low custody population setting.

In the red, you see it's a very small percentage there but those are people who have predatorial behaviors or mental health behaviors to a point where they cannot function in a congregate setting, either because we're afraid they're going to harm someone else or they're going to be victimized themselves. I'll give you an example. Sometimes we get a high profile inmate that gets booked into the facility who's been publicized in the paper for many sex crimes and things of that nature that they're pending. A lot of times, inmates in the back, they're watching the news; they're reading the paper, so if we feel that there's a high publicity about someone who has crimes that are not popular and could pose risks to them, then that may be an individual that we would put into our special housing or restrictive housing long enough to keep them safe and determine what's best for them as far as future residency goes.

Hearings, this just really shows the different partners in the judicial community that we work with and have hearings with. Obviously District Court. Rio Arriba, in fact we just signed a memorandum of understanding with them. The City of Santa Fe, Magistrate and then of course the City of Española. And you can see the total there. One quarter, January through March, almost 2,000 hearings have been conducted and it really shows how busy the staff are trying to keep these guys going.

Transports to hearings, District Court, Santa Fe Magistrate. The Sheriff's Office helps us with some of the other transports we have and we have a total of 214 there on a quarterly basis for transports.

CHAIR HANSEN: Warden, could I ask you a question at the moment?

WARDEN WILLIAMS: Yes, ma'am.

CHAIR HANSEN: Thank you. So are we – since we have eliminated the U.S. Marshal, does that mean that we're not taking any federal prisoners? Meaning we're not taking any tribal members from our county?

WARDEN WILLIAMS: That's correct. We're not taking any other than who we're required by statute to take at this point.

CHAIR HANSEN: So Commissioner Greene and I met with San I

yesterday and they are very concerned about this because they are part of our county and it's a burden on them at the moment to not be housed – for us not be housing tribal members and so I think we need to figure out a way to work with them so that that kind of burden is not so heavy on them, especially since they are residents of Santa Fe County.

WARDEN WILLIAMS: Staff was saying we do house some tribal, but let me explain. It depends on where their charges are out of. If their charges are out of Santa Fe County, then yes, we will take them. We haven't been taking other tribal members. And the reason I stopped that was because of our staffing, especially in security had dropped so low. I want to be sure that we say we're going to accept some out of county inmates, I want to make sure that I have good peace of mind that we're able to keep them safe and secure. If our numbers are low, our staff, I don't feel comfortable bringing in other than who we are statutorily required to, at least until we get more officers on line out of the academy.

CHAIR HANSEN: I think we do understand that because staffing, if you don't have the staff to take care of the inmates then you're creating a larger risk situation for the other inmates. But at the same time, if we can figure out a way to work with our tribal partners in Santa Fe County I think that would be really helpful.

WARDEN WILLIAMS: Yes, ma'am. Duly noted. Now, our medical team.

ASHLEY HANNAN: Good morning. My name is Ashley Hannan. I'm the Health Services Administrator for the Adult Detention Facility. We'll go through some of the statistics. So drug use, clearly a big topic. We've done – we started doing drug screens in January on the 3rd for every inmate who comes into the facility. We request that everyone submit to a drug screen. Obviously, we don't force anybody. However, out of all of the screenings that we've done – this is for the previous quarter, so up until March, a total of 555 positive screenings. So we tested 647 individuals. And so you can see on there, two or more substances were found in 80 percent, and fentanyl was in 63 percent of the samples that we tested.

So these are percentages of inmates who are seen by a medical provider. So you can see – and this is like the last five months, just to give you a bit of a broader range. You can see that out of the daily population in February of 280 people, just in that month alone 212 inmates were seen. So we're seeing large numbers, 87, 79, 88, 89, 76 percent, just for those months of people who are actually getting seen in the medical care.

This is another illustration for five months showing you sick calls and physician calls. Physician calls are going to refer to your chronic issues – individuals who have hypertension or who have seized, diabetes, some sort of chronic issue or ongoing medical treatment. A sick call is going to refer to when an inmate initiates a request for medical services based off some sort of issues they may be currently experiencing. So either way, they're being seen by medical care.

And this is specifically the physician calls. So you can see, like in January we have 320 times that there were inmates being seen just in that month, for various issues.

These are emergency room transfers. You can see they're in blue. It illustrates the number of transports that month to the emergency room. This is going to be once they're in our custody and we have initiated a need for emergency care or a higher level of care than what we can provide inside the facility. And in yellow you'll see the cost breakdown

for what it's costing us in man-hours to be able to facilitate that. So man-hours, ambulance, and mileage. So all of that goes into the cost for the emergency transfer. That's not the visit itself.

Non-emergent consults – these are going to be off-site consults for any sort of medical care that is needed outside of the facility where somebody may need to see an orthopedist. They maybe need to see a GYN, an OB – whatever the case may be. These are all the amount of non-emergent consults that were scheduled during that time.

And then this is going to be internal emergency responses. So this is any time that a code is called for an emergency. We utilize a code blue system for any medical emergency. It doesn't necessarily denote what most people think of a code blue where somebody's heart has stopped. We're talking about any medical emergency throughout the facility that we would have to respond to, and here's where you'll see those numbers. In yellow, for February and March – this is recent that we have started accounting for very specifically how many incidences where Narcan was used in that code situation. So you can see in February there were six instances where Narcan needed to be used and in March 5.

COVID-19 protocols, this kind of gives you a basic – Yes, ma'am.

CHAIR HANSEN: So I'm just going to ask this question. Is this because of the fentanyl use? Because I saw earlier in this presentation the fentanyl use was quite high, or in the drug testing. So is that what's happening is that just because we're having this huge influx of fentanyl?

MS. HANNAN: So, yes. To answer that question, I do believe so. I don't think we could put like a hard pin on it and say one way or another would definitely answer, because that's something you have to analyze. We have done an audit internally to look at these drug tests and to be able to kind of correlate what is this data giving us as far as the issues that there are with substance abuse in the community. What we find is that a good majority of people – and this is why we highlight it – help with the percentages of people who come in on one or more substance, two or more. And what we find is that oftentimes those folks who are coming in who are positive for more than one substance, they are positive for both opiates and some sort of stimulant, usually an amphetamine. And the half-life is so short we do see that if they're on an opiate such as fentanyl, the likelihood of having some sort of overdose within the first 48 hours of being in our facility is pretty high. And so this is why we've implemented all the measures that we've had to monitor, and this is where we're finding that we're using Narcan more often, when somebody's coming in on multiple drugs already in their system.

CHAIR HANSEN: Thank you.

MS. HANNAN: You're welcome.

CHAIR HANSEN: Commissioner Greene.

COMMISSIONER GREENE: Thank you very much. This is very informative and I'm really enjoying this actually. I like to understand the details, as strange as that sounds. About medical treatment, a question. Do you track like what the causes are? Is this violence for ER visits? Like people that get up to that level of having to have an emergency. Is it internal violence? Is it drug overdoses? Is it people that just have chronic issues like needing insulin or something like that? Do you track the granularity of that?

MS. HANNAN: So we do have Continuous Quality Improvement who does track various components of this actually help to put these numbers together. So do we track it specifically and report it out? Not necessarily. We do track it though. I don't think it's one or the other that there's going to be a high measure for any of those. It's going to be a combination of all of them. Our medical director is very diligent with erring on the side of caution. We're always going to be on the side of caution. We're not a hospital, unfortunately. We definitely have amazing, outstanding care, but we are limited, and that's where he errs on the side of caution. We always defer to our medical providers. So if he has determined that at this point a higher level of care for additional testing or something that is outside of our capability is warranted, that's when we would go ahead and transport. And those emergency transports that you see there are not necessarily all ambulance transports. Sometimes an ER visit is warranted outside of what would be considered a true emergency.

When we think of an emergency we think of something that is life or death or loss of limb, and that's not always the case. Sometimes what it really boils down to is – it's a level of care issue. Now, if we can appropriately get them scheduled with somebody on an off site, then that's what we will do. However, that's not always the case and we end up needing to have a higher level of care where we can get a CT scan or we can get additional laboratory blood work to find out is this an emergency situation where they need to actually continue to do further treatment, or is this more of a we can schedule you with a different type of provider on the outside and then they can do their workup. And we fall into a gray area where we don't have the capability for advance testing where I'm going to get results back immediately. We still send out our labs to a laboratory, which is not uncommon. And it takes several days to get back, and that person may not be in an appropriate setting to wait for three days to get results back.

So those are some of the rationales for why we would send somebody out, rather than it being very specific.

COMMISSIONER GREENE: Great. And so partially looking into the other side, the cause of it. Like what are their underlying – like was it a medical emergency, like an overdose that they had to get resuscitated and maybe brought there, or maybe they had some violence perpetrated on them inside and somebody got a broken leg and had to go to the hospital. So the granularity of the root causes, not necessarily why they going there.

And then I actually had another question somewhat related. Congratulations on rooting out somebody who was dealing inside the jail or bringing stuff in or whatever it was. Have you noticed a decrease? Has that stemmed the tide a little bit? Are you seeing anything in lower supply?

CHAIR HANSEN: Commissioner Greene, if I could – I think that they'll be going into some of these details.

COMMISSIONER GREENE: That may be a second question.

CHAIR HANSEN: So why don't we hold off. I think if we're asking questions about the topic. So please continue.

MS. HANNAN: So with our COVID-19 protocols, inmates who are showing signs or symptoms are tested. We utilize a rapid antigen test. Should they be positive they are moved to medical. They do a five-day quarantine as recommended by

the CDC, and then at that point, provided that they no longer have signs or symptoms, they are allowed to be back in the population with a surgical mask for an additional five days. And those are New Mexico Department of Health and CDC guidelines.

If we end up having an influx of positive inmates, an additional quarantine pod may be designated at that time, should we have more inmates than what we can house in medical. They all are monitored on a 30-minute basis. We do have management of symptoms, medication for that. And then again, based off of nursing assessments as well as our physician assessments should they need a higher level of care it is determined that they have worsening symptoms where they need to be seen or have outside services then we would go ahead and transfer them to the ER for a higher level of care at that point.

We do have sanitation in place to be able to properly sanitize and clean out any area that has had someone who is positive in it. I think that's it for my position.

MARK BOSCHELLI: I'm Mark Boschelli, Behavioral Health Manager, Rebecca Granger, our Psychiatric Prescriber.

REBECCA OTERO-GRANGER: Thank you, Madam Chair, Commissioners. Good morning. Thank you for welcoming us. I appreciate it.

MR. BOSCHELLI: I'm the Behavioral Health Manager, which basically means mental health plus substance abuse combined, become behavioral health. Currently we have a number of duties that we do to help out our Psychiatric Prescriber. We have cohort of five clinicians, six, including myself. One of the reasons why we are not really facing the workforce development issues is that over the last five years we've run a robust internship through three different universities. As a result we've been able to attract these employees, plus, by the Commissioners looking at the salaries and upping the salaries we've been able to staff up our positions.

As a result we do all these type of duties such as mental health intake assessments. You can see our numbers. We have a kiosk system, so everyone writes down in their pods about issues. Our clinicians are staffed at each one of the units, including medical. We go visit them, we do rounds on a daily basis. We make the psych referrals to our Prescriber. The person has to really meet that threshold that they're no longer on substances and we're seeing psychiatric issues that really warrant the use of our Prescriber to see them. You see our numbers; they're escalating up.

One of the big duties that we do, that takes place on a weekly basis is restrictive housing assessments. This is where we have a behavioral health clinician involved in when someone's brought out from the restrictive housing. We want to measure the mental status to see if there's any increase in suicide ideation or any type of psychotic processes. This is where around the nation people have lost – have been very vulnerable to lawsuits by not taking care of their individuals who have been restricted in their housing due to mental health issues or behavioral health issues.

In addition we do crisis interventions. You can see our numbers. Then we start doing our bigger duties, suicide assessments. You can see there in October, November, December – actually December went down a little bit, so we'll do face to face suicide assessments and interventions. Some of those interventions take place in our medical unit. People are brought down. They're observed on a 30-minute constant watch. Our highest level is a constant watch, which is equivalent to a psychiatric inpatient unit, we here we have staff watching them eyes-on 24 hours a day. There's usually security staff.

We back them up, and we're watching any other behaviors literally until we make a decision that we can clear them from that type of constant watch, and then move on to going into the general population.

MS. OTERO-GRANGER: My name is Rebecca Otero-Granger. I'm a psychiatric nurse practitioner and I've been at Santa Fe County now for about four years. These are numbers in regards to our sick calls, and our sick calls are generated from routine care, continuity care, from intake medications that are resumed upon intake, as well as any custody staff, admin referrals, administrative referrals from public concerns, nursing staff, re-entry, and management. So anybody, essentially, can make a referral to psychiatry, and they're seen accordingly in regards to their acuity.

There is a wide range of acuity in regards to the patients that I do see and that are on my panel, and they include routine chronic mental health care, urgent and emergent. I am on call. I do facilitate the constant watches as well as the 30-minute mental health watches that are less acute but still very serious.

We estimate about, on average because of the recidivism and the variable numbers that we have from intake and discharge, about 15 to 20 percent of seriously mentally ill people. My practice is a wide range in corrections from the Department of Corrections as well as other counties throughout the state. And I do recognize that our numbers are a little bit higher. We assume that that might even have an influence because of our close proximity to Las Vegas and some of the transient population that kind of wanders in, or just kind of is transient and winds up – or they relocated or come to Santa Fe County or offend in Santa Fe County.

These are the numbers, percentage of patients or inmates or detainees that are on medications under my care. We average about 70 percent. And again, those vary in acuity from as-needed medication to chronic medication for depression, and it also includes emergent medication that's given for safety reasons, and also chronic medications for serious mentally ill.

The formulary that we have at the facility is created jointly with our medical director, with Warden Williams and it's also in alignment with NCCHC standards. We're very diligent in following those national standards as well as ACA and NMAC. But our formulary primarily consists of non-addictive and non-habit-forming medication.

As a nurse practitioner I really emphasize holistic care in addressing all elements of mental health and physical well being and I'm extremely grateful for the support that I have from my medical director. He's very open and receptive to that. We try to be conservative when we can and teach them basics in regards to self-care – hydration, sleeping, sleep hygiene, and that's very important to be able to sustain what we're giving them and what we're teaching them, as opposed to throwing a pill at them and just hoping that it works and all falls together. But we have a very comprehensive approach. Behavioral health is very involved, so with the prescribing it is co-treatment with behavioral health therapy in groups, as well, even when there's not an addiction involved. Behavioral health is very much so involved with that.

As of right now, our numbers are – I know this is of interest to a lot of people in the community because of the numbers that we're seeing in regards to overdose, substance abuse, dependency. We're going to talk more about it but in regards to my role in medication assisted treat, also known as MAT, we are offering Naltrexone and

Vivitrol. Naltrexone is the oral pill, and it's given daily, once a day. And the Vivitrol injection is given monthly. And so the intent of that treatment is to block cravings and we've found that there is use and evidence that it's helpful in the impulsivity and it helps to reduce risks of self-injurious behavior. We're not using it along those lines but that's where we can make the connection in regards to addictive behavior.

As of right now, within the last 90 days, approximately the last 90 days we've given 15 injections of Vivitrol, and we have 24 patients on Naltrexone. And we'll go over more of the Matrix program, which supports this and the success of this and the re-entry program that helps us to ensure the continuity of this and hopefully we can look back in another five years and see how it's affected recidivism. Thank you.

CHAIR HANSEN: Thank you. That was very good. Keep going.

MR. BOSCHELLI: So hopefully you saw the newspaper article of our graduation class at the Matrix that occurred on Tuesday. The warden did invite the press in at that time. It's kind of a risky endeavor to do that, because we never know what our patients will actually say. We don't screen. They're able to say whatever they want and it actually turned out quite well.

The Matrix program is how we're trying to address the fentanyl issue, methamphetamine issue. If you notice, we have a very large substance abuse, psychiatric center called the detention facility. So the Matrix model provides a framework for engaging substance abusers in treatment and helping them to achieve abstinence. So this is a voluntary program. We do not force anybody in. A judge, quite frankly, cannot order anybody in to it. The lawyers can't order them in. They have to choose to do that. And please remember what the revolving door of the amount of clients coming in and really the length of stay is around 12 days. So we have to pick through that length of stay of 12 days to figure out who can be here for 30 days. So some get extended times and then we focus on those individuals in a group setting. Security, administration, behavioral health, psychiatry, we all talk together and say, okay, this person is chosen. Usually we have a cohort of around 90 individuals attempting to get into the program. Out of that we usually pick a cohort of around 12 individuals.

So patients learn about the issues critical to addiction and relapse and receive direction and support from a trained therapist. Once again, we have a cadre of five therapists plus one clinical intern, and they become familiar with the self-help programs of twelve steps. Patients are monitored for drug use through urine testing. We do an initial urine test. We do a mid-term urine test. We do a graduation urine test. So they have to stay sober during this process.

The therapists function simultaneously as a teacher and a coach. They're fostering a positive, encouraging relationship with the patients and using that relationship to reinforce positive behavioral change. So this is not a confrontational approach. This is not like TV where you see some of those intervention type styles. We actually use a very different style. We use a positive approach. The interaction between a therapist and a patient is authentic and direct, but we're not there to confront them.

Therapists are trained to conduct treatment sessions in a way that promotes the patients self-esteem, dignity and self-worth. Remember, these individuals are in jail. They are wearing outfits. They get told what to eat. We use that setting to help foster growth and actually to get them to change we use a motivational, interviewing type of

style. The positive relationship between the patient and therapist is critical to the patient retention – staying in the class. Treatment materials draw heavily on other tested treatment approaches. This is an evidence-based approach called the Matrix which includes elements of relapse prevention, group therapies, drug education and self-help participation. Detailed treatment manuals, called the Matrix in a Secured Setting, contain worksheets for individual sessions. Components include educational groups, early recovery skills groups, relapse prevention groups, combined sessions, urine tests, 12-step programs, relapse analysis. In other words, what's going to screw you up when you get out. So we poke holes in their plans, so they purposely have to come up with a more robust way that they're going to stay in recovery.

Additional new skills are modeled and practiced including mindfulness and distress tolerance from DBT – dialectical behavioral therapy. So we actually – believe it or not – we teach yoga skills. We teach mindfulness skills. We teach refusal skills, all these things so that when they go back out into the community they actually have a skill set with them. This is a robust program. Thirty days, two sessions a day. Most of the graduates will say they've never gone through a program like this, but once again, it's a controlled setting. We can control what comes into that setting. We isolate them from the other members of the detention facility.

So we started this basically in 2018. It gives you an idea. We just had another graduation class, so really we've had 12 rounds of the Matrix gone on. As of this reading, 196 inmates started the program. Sixty-six inmates of the males, 62 percent, they graduated the program. It's not that they were unsuccessful. A lot of people get pulled back into, when released, going into other substance abuse programs. That's the attrition rate. That's what happens. But as of note, three graduates, or only 4.5 percent, have reoffended from our data from 2018.

Now, think of this in comparison to what non-treated individuals have going into detention facilities and going back into recidivism. In the State of New Mexico it's around 58 percent. Nationally, it's around 85 percent. So we have some statistical anomaly going on here.

The females, we've done five rounds of the Matrix program for females, 45 inmates have started the program. Thirty-one inmates, 61 percent, have graduated the program. And even for the females, two graduates, or 6.5 percent have reoffended. Once again, the statistics are the same for recidivism for both males and females.

So we have something going on here. It takes a lot of work. It takes a lot of dedication. A lot of frustration on our part. Also, basically, it's a fun program to run. This is one of the reasons why we're able to retain our behavioral health staff.

CHAIR HANSEN: Thank you. I want to see if there's any questions about this particular program, especially since we have two new Commissioners. This program was initiated under Commissioner Hamilton and my watch in 2018, and I don't believe Commissioner Hughes was here during that. But I think it is really great to see the success rate that you have achieved and I want to recognize the warden for leading this effort, because he fought for this and the ones of us who were on the Commission at that time, we said, okay. Let's try this. Because it's a different approach but it is something that is happening in California. So I wanted to give the new Commissioners on the Board an opportunity to ask a few questions about the Matrix program. Okay. At this time. So

Commissioner Bustamante.

COMMISSIONER BUSTAMANTE: Madam Chair, thank you so much. I don't really have questions. I just can't keep myself from wanting to thank you so much for your good work. I hear commitment. I love to see – and I'll thank my colleagues who made sure that this was happening, but this is the best news I've heard in a long time. And to see the numbers and the low percentage of recidivism matters a lot. Why am I even saying that out loud? I'm so grateful, and that's really what I want to say. So thank you very much for your commitment and your good work, sincerely.

CHAIR HANSEN: Commissioner Greene.

COMMISSIONER GREENE: Thank you. I really appreciated that and it's amazing what you guys are doing. A similar feeling – great job. Seeing the forethought back in those days it's good to see the output of the jail system resulting in positive behaviors in the right direction. Have you gone back and looked at the five recidivists and figured out what could have been avoided? Not to try to bat a thousand, but –

MR. BOSCHELLI: Well, we have, and the nice thing is we have a good data system so I'm able to track as soon as someone comes in. Before I answer that, if I can say tied together with our MAT program, we're actually following the evidence based design of an MAT – a medication-plus-treatment. Medication alone had not been shown to be effective. Treatment alone has not been shown to be as effective as medication plus treatment. So we're actually doing what any university would attempt to do is combine them both.

Regarding the individuals who have recidivized, it's usually three days afterwards. They have overdosed. Fentanyl is so prevalent in all the substances. They'll tell you that they're smoking the blues, and in those pills, those pressed pills, we see methamphetamine. We see ecstasy, we see the fentanyl. They just fall prey to that and it's usually if they go back to their same setting, which is one of the reasons why the warden has helped and agreed to set up a re-entry pod that the graduates of the Matrix move into the re-entry pod. From the re-entry pod we have other programs now. So that's where that development came out of, the direct answers to interviewing those individuals who came back in.

COMMISSIONER GREENE: Great job, guys. Thank you.

CHAIR HANSEN: I also want to recognize that Life Link has also been working with you on this program. I think they play a vital part in helping people not revisit the jail. Commissioner Hughes.

COMMISSIONER HUGHES: Thank you, Madam Chair and I've heard about the Matrix program last year and this year and I'm glad you have some really good stats now that show how successful it is. As most of you know, I have personal experience getting off opiates from my back problems earlier in life, and so I know how hard that is. I guess my question – and I don't want to take anything away from the Matrix program, but my question is about people who may come into the jail on a methadone program or a different type of treatment program. How do we treat people who – and especially if they're only going to be there two or three days or five days. How do we make sure that they – and also, maybe they're on a Methadone program but the reason they're in jail is that they fell off the wagon. How do we work with those people to sort of get them back on track with whatever program they've chosen to do? Thank

you.

MS. OTERO-GRANGER: Thank you for the question. There's not necessarily a black and white answer for that but we make every attempt to continue their care that they receive on the outside. We definitely – there's a lot of things that affect our decision – the length of stay and their compliance with the treatment prior to coming in. What we have agreed and committed to is if someone is established on an MAT medication program such as Suboxone or Methadone, we do continue the medication if we are able to prove compliance with it, that there isn't any other illicit substances, and that's really what we're seeing and often times what we are seeing is that individuals that are on programs can often show up in the urine drug screen negative for some of those substances. So it's definitely on a case to case basis. It is a collective and collaborative agreement, but both Dr. Olivares and myself, when it was necessary, have our X-license and are able to proscribe. Methadone is without a doubt, regardless of other influences of polysubstance abuse with pregnant women 100 percent is continued immediately.

So Methadone is even more of a challenge than Suboxone because it is not recorded or reported to the Board of Pharmacy. So what we're also finding is that individuals on Methadone program can be involved in several programs and it's very difficult to track. So I have talked to several people, even through the DEA in expressing my concerns with that. I don't know that that's anything that's going to change in my career, but it definitely complicates things, considering the lethal doses that people are coming in on, and from other facilities. We take into consideration, are they going to prison, where they're not going to be able to continue this medication. So we're very mindful of that and their prognosis in trying to promote whatever is necessary to help them in recovery. Does that answer your question? I'm sorry.

COMMISSIONER HUGHES: Yes. Thank you. And I guess, are there other things you want to see going forward? I know you have the successful Matrix program which works really well, and I understand how you treat people when they come in. Are there other things that you envision going forward?

WARDEN WILLIAMS: I'm going to jump in real quick. I can't help myself because the Matrix is a very – I get very excited about the Matrix program. I won't beat this topic to death but I just want to reiterate real quick while I have this forum, how proud I am of the staff I have, because this Matrix program, I can tell you – I've been in the warden capacity for almost 16 years and I've never seen the kind of excitement, enthusiasm and progress that I've seen in this Matrix program. And that's because the people that are part of the staff are passionate about what they do. And I'm really glad that Nathan from the New Mexican took the time to come down and see it firsthand because let me tell you, it was very – those inmates got very emotional. They shared some very personal, intimate details about their lives.

One of the particularly was an overdose case about 35 days ago, about a week before he started the Matrix program. He basically was someone who was questioning if he was going to come back or not. And I went to talk to this young man the day after staff may have saved his life and the first thing he told was, can I do the Matrix program? And I'm like, absolutely. That's what the program is for.

We kind of joke about because Mark, sometimes I'll tell him, what do you think about this next group that we've got? And he'll say, this is a tough one. This is a tough

group. And I always smile because, I'm like, Dude, that's what we want. We want the toughest groups. Because if we can make a change out of them, we can make a change out of anybody.

I tell you what. To see the transition of these folks in 30 days, it's just – it would blow your mind. It's just amazing. And I'm really glad we made it through that field. I'm really proud of the staff. We go through, and first what we do is on the graduation is we go through and we just say, hey, we commend you and I talk a little bit about how proud I am of them and what they've gone through. But we talk about common denominators that they have together, recognizing and building unity between them. And then we have them go across individually. They read their own hand-written testimony about their experience in the program. And they're absolutely encouraged to be brutally honest. Whether it's something that we don't want to hear, we do want to hear because that's how we make this program better. And every one of them, those guys were on the verge of crying. You can just hear in their voices. It's just amazing.

And the feedback I heard from this last group was – I think three or four of that graduating class had been in and out of prison and they said they had never been to a program where they've seen staff actually make them feel like their lives matter. And what I say – and we started talking a little bit and we bring in some food and we celebrate with them, but this is absolutely, my personally favorite part of this job that I have, is being able to go to graduations with these guys and sit down with them for like two minutes, three minutes while they're eating and just share the excitement, the change in their voice, and I'll tell you, at that time, at that place, it doesn't feel like you're in a jail. It feels like you're in a cafeteria somewhere talking to these people.

And they even tell you in their testimonies, for a moment they don't even look at staff as staff and them as inmates. They just look at them with nothing but excitement and gratitude. And they were very vocal about it. They were nothing but commending of the staff and telling them thank you for being involved and the lessons they've learned and I could go on and on, but I just have to show my excitement but I'm very proud. Staff does not get the gratitude, nor will they ever bet the gratitude they really deserve from the public. To be fair, it's because the public only hears and sees a certain side. But it's times like these that I'm very proud and I'm glad the Commission has an opportunity to read the article that actually came out that was positive and I hope in the future you get more opportunities to see more progress.

And to follow what you're talking about as far as visions, because I've got a lot of ambition with this whole program. We started – Mark started a re-entry because what we recognized was we didn't want to lose the momentum with the excitement and this group staying together. And this group, they already see themselves as different than the general population. And they were telling us, that whenever they went to this program, a lot of the inmates were yelling at them and teasing them and why are you going into this program. And I was telling them it's because these people don't want what's the best for you. The people you think are your friends, they don't want the best for you. But we do. So if you're sincere about having a change in your life, and you want a better relationship with your family or maybe your children and you want to be a role model, then we'll give you the tools. But you heart's got to be in it.

They recognize that. And the brotherhood that these men come together in that 30

days is very impressive. They vocalize that they want to continue progressing and we don't want to lose all the efforts we put into them, so the next chapter is they go into what we're calling like a Phase 2, which is a re-entry cycle to the Matrix, and we encompass all the regular therapies, counseling. We're also throwing in some life skills and some other courses like that to help them along the way. And the goal is to keep that going.

But my big goal is down the road at some point, is to get some of these – and we already have some of these graduates who are voluntarily wanting to stay behind and be mentors to new inmates coming into the program. I thought it was a pretty neat testimony, but the bigger plan is to get some of these guys that when they get released from custody to where we can get them to go to a juvenile facility, like in Bernalillo County, and they can start these programs similar to like what Delancey Street does, to where now you have someone who's a recovery addict, who's been in and out of the system, jail or prison, who didn't think they had any chance of recovery, and now, not only are they maintaining sobriety and they're showing mentorship, but they're feeling empowered because they're getting to go to another group of people who maybe have some relation to them and they're able to teach them and maybe gain some of their retention of success with the juvenile side. Because it's my belief, just being in the penal system my entire life is that we wait sometimes until it's too late. It's not too late but it's much more difficult when a man is 34 years old and he's been living his entire life and now all of a sudden we're trying to get him to recognize changes that will produce a more healthy lifestyle for him.

But the juveniles is where I really personally feel like there's a missed connection and anyway, that's where my hopes are at down the future that we can get this moved on to the juvenile facility and we can get ex-addicts and ex-inmates to be a part of that program.

CHAIR HANSEN: Thank you, Warden. I'm going to move on forward because we're a little behind. But thank you. Thank you very much for all of that. I just want to share that yesterday I was at the inaugural of Hector Balderas and one of the things that Hector said was, you know, what made a difference in my life was that one of my coaches cared about what happened to me. And I think it's the same thing here is the ability to have somebody show that they care about you makes a difference in a person's life. So please come forward, Melissa.

MELISSA OBERG: Good morning, Madam Chair and Commissioners. My name is Melissa Oberg. I'm the program manager.

AARON GARCIA: I'm Aaron Garcia with re-entry.

Moo: Again, my name is Melissa Oberg. I'm the program manager. Our programs department offers a variety of programs to allow inmates to make self-improvements. We have Narcotics Anonymous, Alcoholics Anonymous, parenting classes, religious studies, substance abuse therapy, food handler course. These work in conjunction with re-entry to aid inmates in the return to the community, and efforts to reduce recidivism.

All these programs we do offer on a weekly basis to our inmate population. And here's a chart of people who attend these courses, and all these work in conjunction with re-entry to aid inmates in return to the community in efforts to reduce recidivism.

MR. GARCIA: For re-entry, w hat we do is we collaborate with

community programs. We work with social workers, with the court, and also Magistrate and District. Some of the programs, as you see is Hoy Recovery program, which is an inpatient program from 30- up to 90-day inpatient for treatment of substance abuse and addiction. Santa Fe Recovery offers again the same thing for inpatient, 30 to 90 days and also sober living up to 12 months. We also work with the MAT program where they continue with the Vivitrol treatments from jail to outside in the community.

Life Link, as Madam Chair stated, is very vital to our program because they work very closely with us to ensure that inmates are getting basic necessity needs such as identification, Social Security cards, transportation and emergency housing. Four Winds, again, is another treatment program that offers inpatient and outpatient treatment and of course the Santa Fe County LEAD program to assist with the diversion and assist in case management.

And then of course in the last quarter we had a total of 34 people that we've had medicated re-instated. We enrolled two individuals in the last quarter to Medicaid, and out of 11 people in the last quarter, ten of them made it into treatment. Thank you, Madam Chair and Commissioners.

CHAIR HANSEN: Thank you very, very much, Aaron and Melissa.

CARLOS MARKMAN-LOPEZ: Good morning, Madam Chair, County Commissioners. My name is Carlos Markman-Lopez and I'm the Chief of Security. Juvenile detention – so right now we're not holding any juveniles in custody. What we do, we do transport them from our facility as they arrive from different agencies to San Juan County at this time. As you can see up there on your computers it has how many we transport each month. It was up and down. The busiest month for us was September. What makes this difficult for us is how long we have to transport these juveniles. If they arrest somebody in the middle of the night, 1:00 in the morning, we have to provide two security staff to run transport for seven hours. [inaudible]

Right now, we also – it's not showing here, we transport these juveniles to – if they go to court we have to go pick them up and bring them all the way to Santa Fe. Or sometimes there might be a juvenile detained in another facility in Las Cruces or far away that we have to go pick up and deal with that. We also transport them back at times for release and deliver them to either juvenile probation or their parents.

Besides these transports, we do other types of transports that I don't have up there. We do basically a transport for medical appointments. We probably have between five to ten a week. We have court transports, we have transportation to any type of programs or shelters or anything like that. Any questions about the juvenile transports?

CHAIR HANSEN: I don't see any. Thank you.

MR. MARKMAN-LOPEZ: Security operations, I'm not going to take too long with my presentation but up here is the contraband. Up there you can see contraband, found the amount from last month of 2022 to February of this year. Six, seven, seven, three, seven, a total of 30. These are major contrabands, and I'll show you a picture of how they look.

Assaults, this is assaults. This is basically inmate against inmate, or against a staff member. We have right now in the month of November, the ones with the stars, it shows that we had one inmate on staff, and then two on staff in February. We had 18 assaults during that time. Disciplinary cases by month, a total of 308. They can be minor offenses

to major offenses. In-house disciplinary offense. Any questions?

COMMISSIONER BUSTAMANTE: Madam Chair, I have a question.

CHAIR HANSEN: Yes, Commissioner Bustamante.

COMMISSIONER BUSTAMANTE: So the assaults, am I understanding that there were 12 incidences of one inmate of staff assaults. So there's 12 incidences in November. Is that what that means? Or was there one – I'm not able to tell.

MR. MARKMAN-LOPEZ: Twelve assaults, one against staff.

COMMISSIONER BUSTAMANTE: Okay. So then with the two inmates on staff, there were 18 incidences in February.

MR. MARKMAN-LOPEZ: Eighteen incidences. Correct.

COMMISSIONER BUSTAMANTE: Thank you.

MR. MARKMAN-LOPEZ: Two of those 18 were against staff.

COMMISSIONER BUSTAMANTE: Thank you. Thank you for that clarification.

MR. MARKMAN-LOPEZ: Sorry. I get nervous some times.

CHAIR HANSEN: It's all right. We're happy that you're here. So thank you for being here and welcome.

MR. MARKMAN-LOPEZ: I can explain more if you have any questions. I know that you guys are doing a tour of the facility.

CHAIR HANSEN: Yes. We will be going to the facility shortly.

WARDEN WILLIAMS: So for the past five years we've had security threat intelligence unit, STIU. That encompassed and STIU coordinator, and then we had two canine handlers who were also STIU officers and their primary purpose was to function on drug interdiction, field operations, whether it has to do with staff, compromised staff, or inmates. Right here, this is just estimating house value of seized contraband. So in 2021, approximately $400,000 worth of narcotics were recovered from that STIU team. In 2022, $184,000. The reason you see such a change is obviously the population shifted in there.

Recently, because we had the STIU unit and then we had two investigators. And what we've done recently is we've combined them into one. So the STIU unit is phased out. Their functions have been encompassed into the investigators' role. So we have investigators who are now doing all the roles inside STIU on top of formal referrals they get for investigations on personnel matters and things of that nature.

And I know there was a comment earlier about a young man that we arrested. We had a partnership with local law enforcement where we were looking into an employee who we thought was compromised and we ended up being accurate in that and we have made an arrest and are moving forward with the prosecution on that. I'm proud about that also, because that shows the community that we take this serious regardless of where it's coming from. So anyway, that's what this talks about with the STIU.

As far as canine, we still currently have two trained canine animals there, Niko and Kia, I think is the female's name. We just got her recently. And they're actively used as canine dogs, actively to help us as an added tool to things like our body scanner, to help us search and try to be pro-active in finding narcotics and stopping them before they come into the facility.

CHAIR HANSEN: Yes, Commissioner Hamilton.

COMMISSIONER HAMILTON: Thank you. Could you just go back to the previous slide? The 2022, is that number for the first three months of 2022, or for all of 2022 plus the first three months of 2023? It makes a big difference. It says 2022 –

WARDEN WILLIAMS: It was just to March.

COMMISSIONER HAMILTON: To March of 2022. So that's last year. That means 2022, the rate is almost twice what it was in 2021?

WARDEN WILLIAMS: Yes. And I'll get into that. I'll talk a little bit more about that.

COMMISSIONER HAMILTON: And there are no numbers for 2023?

WARDEN WILLIAMS: Not yet. I don't think he's put it together just yet.

COMMISSIONER HAMILTON: That's not a problem. I was just clarifying so I understood. Thank you.

WARDEN WILLIAMS: Is this the most recent one? I know there's another one he was going to send over. This is just an example: 215 strips of Suboxone, and the gentleman that we were talking about earlier, a former employee who was arrested, Suboxone was what he had in his vehicle and that's what he was intending on smuggling into the facility. Suboxone is a huge financial gain opportunity for being smuggled in right now and of course, the higher the value of the Suboxone, it's all based off supply and demand, so at the times that are our staff do their analysis with inmates who are in there and they're getting the inside information about the value of Suboxone, it's based off of how much is currently available to them in there. So when you see the price of Suboxone being higher it's actually a good sign because it shows that there's less availability of it in the facility.

In this case right here, that's the approximately $196,000 worth of in-house Suboxone and of course there's a little bit of fentanyl pills and some meth in there. But this is not unusual for us to have finds like this. We just had a female a couple weeks ago, two females, a couple of weeks ago, we found something similar to this amount that she came in upon intake. Sometimes it's even planned. Sometimes these people are on probation or parole. They know that they've violated their conditions and they know that when they go with their PO they're going to be arrested, so sometimes they'll intentionally package narcotics and bring it in with the intention of trying to make some money off of it or to pay off debt that they've had from previous incarceration.

Here's just more examples of some of the contraband that the staff continuously find in the facility. That was it for contraband.

CHAIR HANSEN: Thank you, Warden. Any more questions before we move to the detention facility from anybody?

COMMISSIONER BUSTAMANTE: Madam Chair, I did make a request, I didn't understand better from our Legal, because I am involved with a project that is funded by the federal government for post-incarceration. It's called the Workforce Integration Network. I get no personal benefit from telling you this or for having people in the program, except that I do direct the project. So it is not a conflict, understanding that these are resources for people who are going into re-entry and lining them up with all the wrap-around services and jobs to move forward. There were over 500 applicants nationwide and 32 were awarded. So we have that asset and I look forward to having the navigators who are hired for this program work directly with your staff to help people

who are successfully coming out and moving on into workforce positions. So thank you for the opportunity to share this.

MANAGER SHAFFER: Thank you for that Commissioner, and Commissioners, before we do go on the tour I just wanted to highlight a few things. One of them touches on the same subject as Commissioner Bustamante, which was an effort – the community is exploring obviously, to make sure we are not duplicating efforts and are working in concert with other available resources. But it was to offer a pathway for folks who are leaving our Matrix program and leaving the jail to actually come to the County and actually receive employment opportunities at the County for appropriate positions that we have a challenge filling.

But coming along with that will be the robust wrap-around services you described. So as we continue to explore those efforts we'll ensure that we're not duplicating the resources that are already available, but we're thinking similarly in terms of how we can support that population while also helping to support the mission of the County.

Secondly, I just wanted to note that the declining population numbers are a driver in terms of our ability to offer some of these programs that the warden described, like the Matrix pod, like the re-entry pod as we have more space so we're able to offer these more robust services, because you're not in fact needing them to house inmates that are not charged under state crimes originating from the county.

In addition, in terms of looking at other new areas to potentially augment our operations, we are ready moving forward and the Health Services Administrator can help correct anything that I get wrong, to purchase equipment that will allow us to have more real-time drug testing of those individuals who are coming into our care, so we'll be actually able to analyze these specimens on site and have better real-time data in terms of those who would be at risk of detoxification and potential overdose who are coming into the facility.

I believe that our IT Department, working closely with Deputy County Manager Bernardino are about finished with a wi-fi project that would allow wi-fi services and connectivity throughout the entire Adult Detention Facility. That would enable further use of technology as we try to serve our population, both those who are at risk of overdose or detoxification-related incidents, as well as general security.

And with regard to medical operations, we will soon be releasing, I believe, and Elias, if I'm getting the timing wrong correct me. We'll soon be releasing an RFP that includes a variety of technological enhancements, but including a wearable technology that will allow our medical staff to monitor the vital signs of our at-risk inmates in real time, and in terms of notifications if there are any well known trends in terms of blood pressure as well as heart rate. That is moving forward through the RFP process in the short- to midterm. And again, the wi-fi connectivity is a very critical first step in allowing us to do that.

And then the last thing that I would note again, relative to the population levels, is lower population levels do allow us to also explore ways in which we might have more detoxification related services, which again would be primarily targeting those who are with us for a short period of time, where, as the warden said, the Matrix programs are really for those who are in our custody for extended periods of time, at least in excess of

30 days. So before we broke I did want to add those things for your information and consideration, and I would again defer to the warden and to the Deputy County Manager and our Health Services Administrator if I butchered any of the details.

CHAIR HANSEN: Thank you, Manager Shaffer. Commissioner Greene.

COMMISSIONER GREENE: Thank you for that, Manager Shaffer. That's good to address the technology and where the division is going and thank you for the presentation. Pretty impressed with all that you do and the outputs that you're doing. One other – two questions. One about the Rio Arriba MOU. You don't need to necessarily have to get into all the details but what are the impacts of it? Are we taking on their prison, their detainees? And is that the long and short of if? And then second question has to do with the electronic monitoring program that you guys have and seeing some sort of statistics on how many people you have on released monitoring and in whatever level of care you consider that program.

WARDEN WILLIAMS: So the first part, we of course try to be good neighbors to everyone around us, but our primary focus of course is Santa Fe County. With Rio Arriba, they reached out to me several months back. They were having a really difficult time. I don't know if their facility closed down, but it sounded like it was getting to that point. In the MOU, we also have language in there that ultimately gives us the right to accept or deny custody if we're not in a position to help someone out. So in similar terms, with Rio Arriba was that I did agree that we would help them on a case-by-case basis. Some of the guidelines were they have to call ahead of time to see if we have the availability. Depending on what the charges are, how long they anticipate the length of stay and in that they also help us out with some of the transporting of juveniles. So we try to take care of each other in that sense, but at the end of the day there's no set amount of people that we are committed to taking in from Rio Arriba. I prefer of course not to have any, because as the Manager spoke to, now that I focus just on Santa Fe County and people who have statutory issues and requirements within Santa Fe County we house. And the less I have of out of county, the more programs I can do which are ultimately going to change lives, hopefully, like we have been doing.

And your second part with EM, EM is no longer – we don't really have any ownership with that anymore at this point. District Court has taken that, thankfully from us, so we don't have that burden, although we do work hand in hand with District Court to help facilitate that and making sure there's a smooth transition underway.

CHAIR HANSEN: Thank you. But I am going to go back once again to the pueblos, just because they are – we have four within our county. Actually seven, but the main four are San I, Pojoaque, Nambe and Tesuque. And so if we can figure out a way to work with them to keep their residents in Santa Fe County. I understand it's a problem because they are considered federal inmates because they're sovereign nations, but they also are residents in our county. So if we can figure out some kind of MOU or something to work with the pueblos because when Governor Moquino brought that up yesterday I recognized it is probably not just a problem for San I but for all of the pueblos in our county.

WARDEN WILLIAMS: Yes, absolutely. Pueblos have a difficult time statewide finding places for incarceration. That's very true. We do have, Madam Chair, I'm going to go back and do a little – we do have some inmates in custody now that are

part of tribal, but I'm certain those charges are all within Santa Fe County. But I'll look into that a little bit. Was there any particular pueblo that was calling or was it just kind of all of them?

CHAIR HANSEN: No. We met with San I, myself and Commissioner Greene yesterday. We met with Governor Moquino and this was a topic that he brought up. So when we told him that we were meeting with you today and that we would share his concerns. So I want to be a good neighbor to San I and we're not neighbors; we're two sovereign nations.

WARDEN WILLIAMS: Absolutely.

CHAIR HANSEN: And be respectful of his request so that we can try and work with them. But I recognize that we are limited in certain regards because they are federal inmates when some charges happen. Commissioner Greene.

COMMISSIONER GREENE: Thank you for bringing that up and if there's a way to do like sort of an assessment to ask. We're meeting with Tesuque Pueblo on Monday. I'll put the same question to them, if they have that burden as well. But this is probably relatively easy to quantify, what the impact would be. Would it be five inmates a month? Would it be – how many? So I don't think you have the answer now but we should ask them to find out what we think the burden would be and what their need would be.

WARDEN WILLIAMS: There's just a lot of dynamics that come into it. And the circumstances are changing. Not only who the inmate is, does he have – one thing I – just to give you an example. When we were continuously housing for U.S. Marshals, I required that the U.S. Marshals send us some type of data about the inmates that we were going to get in custody. Because I needed to know, do they have gang ties, do they have drug debt? We had one individual who had connections to a cartel in Juarez. Those are pretty important factors for me to identify and look into before I accept custody. Not to say the pueblos have those same complications. They normally don't. But definitely, do they have any health issues? Do they have any mental health issues? Is this someone that as soon as I accept custody of them I'm going to end up transporting to the hospital and then I'm going to have to send two officers there around the clock because his liver is shutting down or he's got some other – those are all the factors I look into. But more importantly, Commissioner, I just – I'm very prideful. I take a lot of commitment and when I say that we're going to accept custody of someone, I want them to be able to know that that person is going to be safe and I can't – if I can't fully say that because I don't have my staffing up to par to where I feel that comfort level, then I have a hard time accepting them. So I do want to help out and I definitely will look into seeing when we can bring some of those back in a more consistent manner, but right now that's kind of where we're at and I just hope the Commission understands it's definitely our intent to help out where we can.

COMMISSIONER GREENE: Definitely. I'd like to follow up, just because it is in the Indian Services area, working in partnership with the tribes to try to get a federal grant to cover you, right through this MOU that they go source the money, that we may not be able to go get but because we are providing a service to the pueblos, we may be able to augment some of your pay or have some staffing incentives there as well. So I think there's some creativity to be looked at to how to help you out, not just

give you the burden. But thank you.

CHAIR HANSEN: And I do want to say respectfully, I recognize your limits on staffing, and that that is a really valid, valid point, that staffing is an issue in all correction facilities, not just Santa Fe County, and so it's not unique to us and I recognize that in this particular consideration. So thank you very much.

2. Adjourn for Site Visit and Inspection of the County Adult Detention Facility Pursuant to NMSA 1978 § 33-3-4

CHAIR HANSEN: And with that, is there a motion for us to adjourn and then go to the Adult Detention Facility. So can I have a motion to that regard? Commissioner Hamilton.

COMMISSIONER HAMILTON: Yes. Move to adjourn this meeting so that can go to the detention facility.

COMMISSIONER HUGHES: And I'll second that.

The motion passed by unanimous [5-0] voice vote.

Having completed the agenda and with no further business to come before this body, Chair Hansen declared this meeting adjourned at 10:46 a.m.

Approved by:

Anna Hansen, Chair
Board of County Commissioners

ATTEST TO:

KATHARINE E. CLARK
SANTA FE COUNTY CLERK

Respectfully submitted:

Karen Farrell, Wordswork
453 Cerrillos Road
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