Essex County Correctional Facility Civilian Task Force

ANNUAL REPORT

2025

Essex County
Civilian Task Force

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ANNUAL REPORT CY2025

James E. "Jim" McGreevey
Hudson County, New Jersey

March 20, 2025

I am privileged to present the **2025 Annual Report** of the **Essex County Correctional Facility (ECCF) Civilian Task Force**. This report provides a comprehensive overview of the Task Force's efforts to promote transparency, accountability, and oversight in the ECCF's administration.

Since its inception, the Task Force has remained steadfast in its mission to ensure the dignity, health, and safety of individuals incarcerated at ECCF. Over the past year, we have conducted extensive site visits, engaged in meaningful dialogue with community stakeholders, and advocated for reforms that address pressing concerns, including medical, behavioral, and mental health services, conditions of confinement, and rehabilitation initiatives.

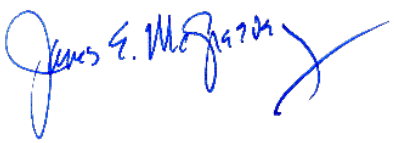
An estimated 33% of incarcerated individuals at ECCF are diagnosed with a serious mental illness, with 87% of them also experiencing a co-occurring substance use disorder. These figures emphasize the need for bolstered behavioral and mental health services and continued reforms to support this vulnerable population.

The 2025 report highlights our continued work in key areas such as strengthening oversight mechanisms to uphold standards of care and custodial practices; expanding access to mental health services, including establishing a step-down unit for individuals requiring structured reintegration; enhancing community engagement and transparency through public forums and independent investigations; and addressing critical staffing and policy gaps impacting inmate welfare and public safety.

We are grateful for the dedication of the Task Force members, county leadership, advocacy groups, and correctional facility staff, whose collaboration makes this work possible. While progress has been made, challenges remain. Our commitment to advocating for systemic improvements remains unwavering.

I encourage you to review this report and call for reforms that ensure fair and humane treatment for all individuals within our correctional system. We look forward to continued engagement and meaningful progress in the year ahead.

Best, fondly,



Jim McGreevey
Executive Director, New Jersey Reentry Corporation
Chair, Essex County Correctional Facility Civilian Task Force

Summary

This annual report provides a detailed overview of the Essex County Correctional Facility (ECCF) Civilian Task Force's activities and findings since the creation of the task force in 2021. The Task Force continues its mission to assess the Essex County criminal justice system, with a focus on ECCF's operational practices and conditions. In accordance to the ECCTF's bylaws, the purpose of the task force is to provide public oversight, transparency and accountability with respect to the policies, procedures, practices, supervision, management, and training at the ECCF.This report highlights significant visits, activities, community engagement efforts, and key recommendations for improving ECCF's policies and procedures.

OVERVIEW OF THE TASK FORCE

In 2019, the Essex County Board of County Commissioners approved Ordinance No. 0-2018-00017, establishing the Task Force to assist the Essex County Correctional Facility (ECCF) in meeting its custodial responsibilities to individuals incarcerated or detained at the facility and providing Essex County residents with an independent, public channel to ECCF. The Task Force was designed with the dual mission of enhancing the operations of ECCF while fostering transparency and accountability to the public.

As the Task Force was taking shape and strategizing on its priorities, the COVID-19 pandemic emerged as an unprecedented public health crisis. With the State of Emergency declared by Governor Phil Murphy in March 2020, the Task Force's initial plans were delayed. However, as the pandemic continued, the Task Force adapted its focus, recognizing the unique vulnerability of the incarcerated population. Inmates, already at higher risk due to the nature of their confinement, faced significant health challenges during the pandemic. In response, the Task Force worked collaboratively with ECCF's medical staff, monitoring evolving safety protocols such as testing, mask-wearing, and later, vaccination efforts. The Task Force also hosted Town Hall meetings and maintained direct lines of communication with the community, both virtually and in person, to provide updates, answer concerns, and offer oversight.

As ECCF emerged from the immediate impacts of the pandemic, the Task Force's ability to adjust and remain focused on its mission—ensuring the health, safety, and dignity of ECCF's population—proved to be a strength. In 2025, the Task Force continues its work with renewed focus, addressing new challenges and opportunities in the correctional environment, particularly in areas of mental health, medical services, and inmate rehabilitation. With increasing attention to improving facility operations, the Task Force has worked diligently on enhancing community relations, promoting transparency, and ensuring that public health standards are upheld.

ECCF serves as a county correctional facility housing individuals who are either awaiting trial, sentencing, or serving short sentences. These individuals, many of whom are Essex County residents, typically stay an average of 29 days.

OVERVIEW OF THE TASK FORCE

ECCF plays a crucial role in providing essential medical and behavioral health services to those incarcerated. These services, often serving as the primary care source for the individuals in the facility, extend beyond the facility's walls, impacting public health across the entire county. In addition to ensuring safe and dignified custodial care, ECCF holds a responsibility to the health services of the broader Essex County community.

The Essex County Board of Commissioners, along with Essex County Executive Joseph DiVincenzo, appointed Jose Linares, former Chief Judge of the U.S. District Court for the District of New Jersey, as Executive Director of the Task Force, and James McGreevey, former Governor of New Jersey and current Chair of the New Jersey Reentry Corporation, as the Task Force's Chair. The Board also allocated seven seats on the Task Force to represent various criminal justice organizations, with an additional seat designated to represent the general public.

Under the leadership of Judge Linares and Governor McGreevey, the eight seats were filled by individuals from diverse backgrounds, including a representative from a detainee advocacy group, an inmate advocacy group, a formerly incarcerated person, a corrections expert, a New Jersey criminal defense lawyer, a social justice advocate, a medical expert, and a member of the public.

In establishing the Task Force's initial by-laws and procedural goals, Essex County officials and Task Force leaders consulted a wide range of stakeholders, including public defenders, prosecutors, corrections officers, victims' advocates, civil rights leaders, elected officials, community activists, and clergy. Additionally, county administrators, commissioners, members of the ACLU-NJ, and representatives of Immigration and Customs Enforcement (ICE) detainee interests all played a role in developing the original ordinance and continue to contribute to the Task Force's ongoing evolution.

OVERVIEW OF THE TASK FORCE

Task Force Members as of March 2025

Task Force Designation	Member
Executive Director	Hon. Jose Linares
Chair	James E. McGreevey
Inmate Advocate	Noel Manyindo
Formerly Incarcerated	Imran Rabbani
Social Justice Advocate	Henry Klingeman
Member of the Public	Alessandra DeBlasio
Member of the Public	Kimberly Duva
NJ Criminal Defense Bar	Vacant
NJ or EC Corrections Officer & Active PBA	Vacant
Medical Field	Vacant

Major Activities & Key Findings

ECCF Visits

The Task Force has made the following site visits to ECCF in 2022-2025:

- October 21, 2021: Scheduled visit regarding the Special Housing Unit
- July 10, 2022: Unannounced Visit to ECCF
- Scheduled visits by the Task Force's Special Housing Unit (SHU) Sub-Committee:
  - October 12, 2022
  - November 2, 2022
  - November 7, 2022
- February 1, 2024: Orientation and tour for new Task Force members. Areas visited: Intake, Kitchen, Infirmary, Dorms, Pods, and Step-Down Unit. The Task Force met with Chief of Staff Phil Alagia and Director of Corrections Ronald Charles during this visit.
- February 1, 2025: Unannounced Visit to ECCF. Areas visited: Intake, Medical Infirmary, SHU, Forensic Cells, Mental Health Therapists Office, and Step-Down Unit.

INTERNAL TASK FORCE MEETINGS

In addition to external visits and community the task force held regular internal meetings to discuss ongoing projects, review data, and strategize next steps. The following is a list of internal task force meetings held between February 2023 and December 2024:

These meetings were pivotal in discussing and analyzing the findings from public complaints, facility visits, and other research efforts. The insights gained in these internal sessions played an important role in shaping the Task Force's recommendations and overall strategy for improving ECCF policies.

- February 22, 2023
- June 27, 2023
- July 26, 2023
- August 30, 2023
- September 27, 2023
- January 24, 2024
- February 28, 2024
- March 27, 2024
- April 24, 2024
- June 24, 2024
- July 24, 2024
- August 28, 2024
- December 2, 2024

TASK FORCE PUBLIC MEETINGS

Throughout the year, the Task Force hosted a series of public meetings to engage the community, gather feedback, and discuss key issues impacting [the relevant topic or sector]. These meetings served as an essential platform for transparency, allowing stakeholders, residents, and other interested parties to provide input and stay informed on the Task Force's activities. The meetings were structured to encourage open dialogue, with presentations from Task Force members followed by Q&A sessions. *For further information, please see Appendixes B, C, and D.*

- October 2, 2021
- January 29, 2022
- May 7, 2022
- July 23, 2022 Public Meeting regarding Medical Report
- October 22, 2022
- May 24, 2023
- September 20, 2023 Public Meeting regarding SHU Report
- October 29, 2024 Public Meeting regarding Mental Health Report

TASK FORCE MEETINGS WITH ECCF

The Task Force held several important meetings with key stakeholders along with the facility to address critical issues and collaborate on improvements related to the Essex County Correctional Facility (ECCF). These meetings provided valuable opportunities for dialogue and decision-making, ensuring that a wide range of perspectives was considered in the Task Force's ongoing work.

- June 29, 2023: Zoom meeting with Task Force, Director of Corrections Charles, Chief Alagia, and Adam Tucker, Public Information Officer for the Essex County Board of County Commissioners, to discuss issues related to an incident involving a corrections officer.

- October 4, 2023: Meeting with Chief Alagia, Judge Linares, and Governor McGreevey to discuss about nominations for Task Force.

- Various Dates: Meetings between Governor McGreevey and The Ambrose Group, LLC to assist in providing information for the September 15, 2022 Essex County Correctional Facility Final Report with Final Assessment and Critical Findings.

- July, 2024: Meeting between Professor Pamela Valera and MAT team at Facility to discuss various issues and recommendations for ECCF's MAT program.

COMPLAINTS SENT TO TASK FORCE

Throughout the year, the Task Force has received numerous complaints from a variety of sources, including anonymous groups, concerned citizens, facility staff, and inmates. The following summarizes the major complaints received and actions taken by the Task Force:

Complaints from Anonymous Concerned Citizen Group

The Task Force received multiple pieces of correspondence from an anonymous email address described as a "Concerned Citizen Group," outlining concerns about the following:

- Concern about adhering to the proper protocols in managing the Medical Department, MAT or the Mental health Department.
- Concerns regarding the Medical Service Management's treatment of Staff.
- Concerns regarding medical department leadership.
- Concerns regarding missing medications from MAT cart.
- Concerns that additional nurses need to be employed to improve medical services.
- Concerns regarding low retention of staff.
- Concerns regarding minimum wage payment of staff inadequate compensation. Concerns regarding back-up of lab work and lab results.
- Concerns about Medical Services being short-staffed.
- Concerns about employees at the Facility without the proper credentials.
- Concerns about turnover of staff and employees.
- Concerns regarding lack of office space for staff.

Action Taken: All correspondence and complaining documents were forwarded to Director of Corrections Ronald Charles, Essex County Counsel Jerome St. John, and Chief of Staff Phil Alagia for investigation and review by contract compliance team. Judge Linares clarified that the Task Force's jurisdiction does not extend to employment decisions at ECCF. Judge Linares confirmed that it is within the Task Force's purview to inquire and make recommendations about inmate care and factors that may affect it. Director Charles assured the Task Force that he had Heidi, who runs the Facility's Medical Monitor/Contract Compliance, looking into all of the accusations made by the Concerned Citizens Group. In addition, Director Charles and his Deputy Director have been meeting with the Director of Medical, Dr. Lionel Anicette, three to four times a week to ensure proper medical care is being provided to the inmates and the Facility is in compliance with NCCHC, NJ 10A:31, and ACA Standards.

Complaints Regarding the Warden Position

The Task Force received complaints that ECCF had not replaced the Warden position after Guy Cirillo's appointment as the Essex County Police Academy Division Director.

Action Taken: This matter was discussed with Director of Corrections Charles, who provided clarification regarding the Warden position. He confirmed that the Warden role has not yet been filled, noting that the position is not legally required. Notably, Hudson County and Union County also do not maintain a Warden position. Since the report, the Facility has appointed three Deputy Directors:

- **Deputy Director of Administrative Services – Regina Marrow**
- **Deputy Director of Custody Operations – Robert Cesaro**
- **Deputy Director of Inmate Programs and Community Partnerships – Dr. Roxanne Vega**

Complaints from Retired Lieutenant James Troisi (Fraternal Order of Police Lodge 106)

Correspondence was received from retired Lieutenant James Troisi, Vice President of the Fraternal Order of Police Lodge 106 and Recording Secretary for the New Jersey State Fraternal Order of Police, which contained concerns about staffing issues at ECCF.

Action Taken: Documents were forwarded to Director of Corrections Ronald Charles and Chief of Staff Phil Alagia for review and investigation. Director Charles noted that there were no staffing shortages in uniformed officers, but acknowledged Dr. Fleming's recommendation during public meetings for additional mental health professionals.

Concerns from Raymond Lord (Archdiocese of Newark Prison Ministry)

Raymond Lord from the Archdiocese of Newark Prison Ministry – came to Task Force meeting and expressed concern that there is difficulty in bringing religious materials, papers, and flowers into the facility. The group has not received clear guidance on the procedure, and as a temporary solution, officers are making copies of the materials. In addition, there are challenges with logistics in delivering religious services to detainees and the facility currently lacks a chaplain, with Dr. Vega addressing most inquiries from faith-based organizations.

Action Taken: The Task Force reached out to ECCF and Director Charles encouraged connecting Raymond Lord with Dr. Vega, who is in charge of religious services, to assist with some of the requests made by Mr. Lord.

SPREADSHEET OF VOICEMAIL COMPLAINTS

The Task Force received several complaints through voicemail, including issues with discrimination, excessive use of force, confiscation of tablets, poor food quality, medical treatment, and other facility-related concerns. Below are a list of the complaints received:

- **Complaint relating to discrimination based on LGBTQ+ identity – forwarded to Director Charles who made an inquiry and sent to Internal Affairs.**
- **Complaint relating to excessive use of force and destruction of property – sent to Director Charles who forwarded the matter to Internal Affairs.**
- **Complaint relating to confiscation of tablet and inability to communicate with attorney – forwarded to Office Paz who worked on rectifying the tablet situation.**
- **Note during an unannounced visit to ECCF on February 1, 2025, an inmate told Task Force members that he has not had his tablet. An inquiry was made and the Captain in charge of the SHU Unit explained that when the tablets break or become dysfunctional, sometimes there is a delay in getting new tablets from the vendor. The Task Force offered to help with communications with the vendor.**
- **Complaint from inmate relating to "quarantine" – forwarded to Office Paz who spoke with the inmate and resolved the issue.**
- **Multiple complaints about food at the Facility – forwarded to Officer Paz who responded that although the inmate claimed to be getting the same cold breakfast every day, the Facility runs on a six week food cycle with different meals always in rotation.**
- **Complaint from inmate relating to their "status on death row" – forwarded to Director Charles who explained that there is no death row because the death penalty doesn't exist in New Jersey.**
- **Complaint from inmate with diabetes who claims he is being deprived medical treatment for high blood sugar – forwarded to Officer Paz who personally contacted the medical services department in the jail to verify that the inmate is getting his blood sugar checked three times a day and being treated accordingly. Office Paz noted that the inmate has refused medication on more than one occasion.**
- **Complaint from an inmate that he is not receiving his commissary – forwarded to Officer Paz who responded that the inmate's commissary account was reviewed and there were multiple credits for items that were not available and the commissary was tasked to investigate further for signatures on receipts.**

Continued Voicemail Complaints

- Complaint from an inmate with a broken jaw who claimed that he needed to go to the hospital and have his stitches removed – forwarded to Officer Paz who responded that the inmate had been evaluated at the hospital and had a schedule appointment coming up. Office Paz went to visit the inmate and observed that the inmate had a wired jaw that was done at the hospital and the inmate was complaining about pain so Officer Paz was able to get the dentist Dr. Gray and Dr. Montilus to evaluate the inmate and give him the proper medication.
- Complaint from an inmate that the educational app he was using was removed from his tablet – forwarded to Officer Paz who responded that the Khan Academy and Telmate Education apps were promotional apps on the tablets that were phased out and replaced with Cypherworx for Education, but that decision was made by ViaPath/GTL and not ECCF.
- Complaint from an inmate who claims that one of the Corrections Officers was supposed to be prohibited from his unit and that he fears retaliation – sent to Officer Paz who forwarded to Director Charles and Internal Affairs for investigation.
- Multiple complaints from inmates that he has been in restrictive lockdown, not able to make phone calls, or shower – forwarded to Warden Cirillo who responded that the Facility was on a restrictive activity schedule due to safety and security protocols and that inmates are provided an opportunity to shower every three day. Finally, Warden Cirillo gave the inmate a tablet so that he could communicate with family.
- One inmate, who has been incarcerated at ECCF since 2018 and classified as forensic mental health status since 2021, left over 200 hundred voicemails for the Task Force. Some of his complaints included lack of a tablet, which was sent to Warden Cirillo who responded that the inmate was classified in the Forensic area of the Facility and lost his Table due to harassing correspondence to a grievance counsel previously employed at the Facility.
- On one occasion during an immediate wellness check, a Sergeant at the Facility asked the inmate, who was out on recreation time, about his well-being and asked if the inmate had any issues, but the inmate responded with a joke and didn't have any additional complaints.

Continued Voicemail Complaints

- This inmate's forensic status is evidence by some of his complaints including but not limited to the following: the inmate needs a "sniper" to "take out" one of the correctional officers; sanctions against the officers and manhunts to "put down" officers; being in the CIA, being undercover, needing the DEA and bomb squad; referencing relationships with high-profile celebrities, and multiple references to donations of millions of dollars to various entities.
- Complaint from inmate being held in Involuntary Protective Custody without a reason and without amenities – forwarded to Warden Cirillo who responded that the inmate was under investigation so he could not disclose the circumstances of the investigation. Warden Cirillo contacted the inmate's attorney several times and left messages to explain the situation.
- Complaint from inmate that he was supposed to be release but still stuck in Facility – forwarded to Officer Paz who responded that the inmate was being held for another NJ County, so ECCF could not release the inmate until all proper disposition/release paperwork was sent to ECCF.
- Complaint from inmate that he was being treated unfairly and discriminated against because he was LGBT – sent to Officer Paz who forwarded to Internal Affairs to investigate.
- Complaint from inmate that he was supposed to be transported to Court but was still stuck in ECCF and never transported – forwarded to Officer Paz who responded that the County Sheriff's Office is responsible for all transportation.
- Complaint from inmate's family member that she was unable to find inmate. The family member was called and it was discovered that the family member had been given the wrong jail name and inmate was actually at a different facility.
- Complaint from inmate that there was a rodent problem in his cell – forwarded to Office Paz who responded that the Facility's pest control vendor was contacted to come to ECCF and investigate.
- Complaint from inmate that he was stuck in lock-down – forwarded to Officer Paz who responded that the inmate was in the midst of a disciplinary incident and therefore, had a different recreation schedule.

INFORMATION FROM ECCF TO THE TASK FORCE

This section provides an overview of significant incidents and operational updates at the Essex County Correctional Facility (ECCF) over the past year. The following key areas are addressed: inmate deaths, officer suspensions, assaults on officers, and the implementation of a Reduced Activity Schedule (RAS). Each update includes relevant details and the actions taken in response to these events to ensure safety and accountability within the facility.

Inmate Deaths: Chief of Staff Phil Alagia or Director Charles notifies the Task Force of any inmate deaths, including the circumstances surrounding the death (e.g., natural causes, terminal illness, narcotics overdose) and the timeline leading up to it. They also provide information on the next steps for investigation, whether by the Facility's Internal Affairs or the Essex County Prosecutor's Office.

Officer Suspensions: Chief of Staff Phil Alagia or Director Charles informs the Task Force of any suspensions of Essex County Correctional Police Officers, detailing the circumstances surrounding the suspension (such as policy violations or use of force incidents). They also outline the next steps for investigation, whether by the Facility's Internal Affairs or the Essex County Prosecutor's Office.

Assaults on Officers: Chief of Staff Phil Alagia or Director Charles provides notice to the Task Force of any assaults by inmates against Essex County Correctional Police Officers, including the circumstances of the assault and the next steps for investigation, whether by the Facility's Internal Affairs or the Essex County Prosecutor's Office.

Reduced Activity Schedule (RAS): Chief of Staff Phil Alagia or Director Charles informs the Task Force when a Reduced Activity Schedule (RAS) is in place at the Facility. They assure the Task Force that essential services to the inmate population continue, including court proceedings, video conferencing, medical treatment, food services, legal visitation, and showers. During RAS, teams of correctional officers conduct targeted searches of the Facility based on intelligence, investigations, and data to ensure a safer environment for both inmates and staff.

REQUESTS FOR INFORMATION TO ECCF

Screening Tools for Analysis of Inmates with Mental Health Illness: The Task Force requested information on the screening tools used to assess inmates with mental health conditions.

Public Dashboard Development: Professor Valera has been working with Director Charles at ECCF to develop a Public Dashboard aimed at improving transparency regarding health initiatives and operations at the Facility. However, Professor Valera reported delays in implementing the dashboard due to the vacant position of Warden.

Trend Analysis on Inmate Deaths: Director Charles provided spreadsheets and charts detailing the deaths of inmates within ECCF from 2021 to 2024, including the circumstances surrounding each death.

Inmate Death Investigations: The Task Force requested information regarding the following inmate deaths:

- April 25, 2022: The investigation determined that the inmate died from a terminal illness after being hospitalized for a month prior to death.
- May 15, 2022: The investigation was ongoing by the Essex County Prosecutor's Office, so public information could not be released.
- May 24, 2022: The investigation was also ongoing by the Essex County Prosecutor's Office, and information could not be released.

Special Housing Unit (SHU) Information: The Task Force requested all documentation related to the Special Housing Unit (SHU). Note: All requested documents were provided to the SHU Sub-Committee, which incorporated the information into the SHU Report, discussed during the Public Meeting.

Medication-Assisted Treatment (MAT) Program Information: Information regarding the MAT program was requested by the Task Force.

Lockdown Information: The Task Force requested data on the frequency, duration, and causes of lockdowns at ECCF.

Continued requests for information to ECCF

Religious Congregate Activities: The Task Force requested a list of all religious congregate activities conducted at ECCF.

Investigation Report on Inmate Complaint: The Task Force requested an investigation report from the ECCF Internal Affairs Bureau/Special Investigative Department regarding an inmate's complaint alleging retaliatory behavior and misconduct by correctional officers.

Hygiene and Sanitation Concerns: Information was requested regarding potential hygiene and sanitation concerns at ECCF.

Staffing Issues for Mental Health Services: The Task Force requested information on recruitment efforts for mental health staff and the training programs available for mental health clinicians.

Educational and Recreational Opportunities for Inmates: The Task Force sought information on the educational and recreational opportunities available to inmates at ECCF.

Timely Notice of Inmate Deaths: Chief of Staff Phil Alagia consistently provided timely notice to the Task Force about inmate deaths and the circumstances surrounding each case, unless the investigation was confidential.

PowerPoint Presentation on the State of the Department: The Task Force received a PowerPoint presentation from the Essex County Police Department of Corrections and the County of Essex entitled "State of the Department – Public Safety Committee Meeting," which included information on budgetary matters, staffing, training, safety and security, and facility upgrades.

Ramadan Protocols within the Facility: The task force requested the facility to provide their policies and procedures put in place for the inmates who observe the Holy month of Ramadan. The task force provided a list of questions which was responded to by the facility on topics such as curated meal times, congregation, etc.

ACCOMPLISHMENTS BY ECCF

- **Creation of the Community Relations Office (CRO): Director of Corrections Charles established the Community Relations Office within his office to address inquiries and complaints. Officer Edilian Ramirez was initially selected to handle the CRO, assigning case numbers and dates for all complaints to ensure regular updates to Director Charles. When Officer Ramirez left, Officer Jacqueline Paz was appointed as the new Community Relations Officer. Director Charles introduced Officer Paz during the September 20, 2023 meeting, highlighting her ability to speak three languages (English, Spanish, and Portuguese), which ECCF emphasized as vital for effective community relations and communication with inmates' families and the Task Force.**
- **Hiring The Ambrose Group, LLC:**
  - **Essex County Correctional Facility hired the Ambrose Group to prepare the Final Report with Final Assessment and Critical Findings, dated September 15, 2022. The goal of hiring The Ambrose Group, LLC was for an assessment to enhance policy and improve the professional standards of conduct that promote optimum safety and sound best practices in the correctional workplace. The Ambrose Group LLC had the opportunity to review operational practices to identify potential vulnerabilities and make critical recommendations to improve the work environment of staff; safeguard employees and inmates alike; and improve prison facilities using new technologies.**
  - **The Essex County Correctional Facility hired The Ambrose Group to prepare the facility's Remediation & Mentoring Project, Assessment of the Essex County Police Academy & Leadership Training Final Report – 2023 & 2024, dated July 22, 2024. The goal of hiring The Ambrose Group, LLC was to monitor the remediation of the findings and recommendations presented in the initial assessment report. The Ambrose Group, LLC made the following complimentary findings about ECCF:**
  - **"It is particularly noteworthy that the County of Essex and the Essex County Department of Corrections (ECDOC) initiated proactive remediation measures not only after the release of The Ambrose Report, but also while the assessment was still underway. Additionally, The Ambrose Group worked closely with the ECDOC executive and command staff on managerial situations on an almost daily basis addressing unfolding concerns and offering guidance and direction. In many instances, these situations were unrelated to the remediation process proper."**

  - "Significant remediation activities included Administration; Internal Affairs; Training; Contraband; Use of Force; Intake, Classification, and Housing; and Medical. Additionally, self-initiated activities included a reorganization of the executive staff; adjustments to staffing and scheduling; revisions to policies; and the proactive requesting of an assessment by the National Institute of Corrections (NIC)."
  - "The Ambrose Group commends the ECDOC for having attained full compliance in their recent annual inspection conducted by the New Jersey Department of Corrections, which the ECDOC had not attained the prior two inspections. The Ambrose Group views this as a positive sign in the overall remediation of the ECCF."
  - "The Essex County Department of Corrections should take pride in their efforts to remediate the stated areas of concern. Both independently, and with the assistance of The Ambrose Group, they were not only able to remediate most of the identified areas of concern but also initiated several major changes of their own volition."

- In early 2024, Director Ronald Charles requested that the National Institute of Corrections ("NIC") and Department of Justice come to ECCF to perform an operational assessment.

- ECCF supported the Application for Medicaid Approval of Waiver to assist with inmates with mental health illness to be treated in alternative facilities, such as Silver Lakes Hospital, when mental facilities, such as Ann Klein Forensic Center, does not have availability for inmates. The New Jersey Application explained the significance of this request: "As part of the renewal application, the State requests expenditure authority to provide Medicaid reimbursement for up to four behavioral health care management visits for incarcerated Medicaid-enrolled individuals. These visits would be limited to individuals with behavioral health diagnoses, who are expected to return to the community within the following 60 days. This service would be intended to support continuity of care between the services provided inside of the correctional facility and the connections to services to be received after release. In particular, it would be intended to foster a care relationship between the individual and a community behavioral health provider, to ensure Medicaid coverage and awareness of how to utilize health benefits, and to arrange a post-

discharge appointment before release, giving the individual clarity on how and where to seek services after their release. This goal is of particular importance to individuals receiving medications for substance use disorders and serious mental illness, who may be at high risk if they experience any discontinuity of care."

- During the September 20, 2023 Public Meeting regarding the Task Force SHU Report, Governor McGreevey explained how important a Medicaid waiver would be. Specifically, Governor McGreevey congratulated Dr. Fleming, Dr. Anicette, Director of Corrections Charles, and the County Executive and the Chief of Staff in their attempts to have New Jersey grant a Medicaid waiver for patients at ECCF. Although it was not expanded, Governor McGreevey explained that there are efforts to approach the Centers for Medicare and Medicaid Services ("CMS"), CMS which oversees Medicaid. CMS will not permit the Medicaid reimbursement of a person within a correctional facility but the State of California was able to grant a waiver such that in the California Corrections System that they will provide psychiatric and mental health treatment. New Jersey has applied for such a federal Medicaid waiver from CMS but it was not granted. The Chief of Staff and the County Executive have asked to create an exemption to CMS on a pilot basis so that Essex would be considered as a pilot to be granted a waiver such that CMS or Medicaid dollars could be appropriated for individuals for this project. In addition, Dr. Chris Pernell of the Task Force has been a great support for this endeavor and has involved the Commissioner of Health who has attempted to advocate on behalf of the population at ECCF. As of the date of this Annual Report, the Application for a Medicaid Waiver has not been granted.

- During the September 20, 2023 Public Meeting regarding the Special Housing Unit ("SHU"), Director Charles explained that the Facility was working with the administration towards creating a dedicated mental health step-down unit. ECCF looked at the population and determined a means to carving out a space where the Facility could place the step-down patients from the SHU. This would allow the patients to receive programming and treatment by Dr. Fleming and the mental health clinicians because they will be in a step-down unit that does not contain the more serious, forensic-level patients. Dr. Anicette explained that it is important to truly engage these patients and that is why a step-down unit for the SHU would be extremely beneficial. This step-down unit was created and staffed in mid-December 2023. The SHU step-down unit has capacity for 64 patients who can benefit from enhanced engagement and programming for mental health illness. According to

Director Charles, the SHU step-down unit is staffed by officers with specialized training and will continue to be adjusted as needed to meet the Facility's evolving needs.

- Institution of new electronic system for monitoring movements and activities of inmates in the Special Housing Unit, called the PipeGuard System, which is owned by a company called Guard One. This would be used to replace the archaic system of hand-written log books for the activities of the inmates in the SHU. Director of Corrections Charles, who had previous experience establishing such an electronic system in the former Union County Facility, researched vendors and said that it is an extensive system which will be fully automated and will allow the Facility to see who is in the SHU, for what reason, when the inmate comes out of the SHU, when medical department saw the inmate, when the mental health clinicians saw the inmate, and when the inmates received commissary. There will be a six-hour training for the Corrections Officers on the new automated system. According to Director Charles, this PipeGuard System will allow ECCF, on an executive level, to monitor how much recreation time and commissary that an inmate receives, thereby improving the lives of SHU inmates by making sure they receive the appropriate amount of recreation time, etc.

- Director Charles initiated the creation of an alternative facility for mental health inmates who would qualify to go to Ann Klein Forensic Center but are unable due to lack of beds or space at Ann Klein Forensic Center. To that end, Director Charles successfully managed the transition of several inmates from ECCF to Silver Lakes Hospital in conjunction with the Essex County Courts, Essex County Prosecutor's Office, and Essex County Public Defender's Office to receive proper care for their mental health illnesses.

- Changes to the MAT Program and staffing to ensure that ECCF is following current department and facility policies and standards along with the National Standards of MAT programs.

- Notwithstanding the fact that ECCF is currently in compliance with the Prison Rape Elimination Act ("PREA") standards, in early 2025, Director Charles endeavored to apply for a Grant from the Bureau of Justice Assistance ("BJA") Office of Justice Programs entitled "FY25 Prison Rape Elimination Act Training

Curriculum for New Corrections Staff," which would enhance the training for the ECCF staff. Director Charles planned to apply for the Grant with the help of Dr. Valera, one of the predominant authors of the Task Force Medical Report in 2022 and the Task Force Mental Health Report in 2024.

- In order to take proactive measures to improve the medical services at ECCF, Director Charles retained the Nakamotto Group, a reputable national correctional firm, to conduct an unannounced audit of all medical services provided within the Facility. The three-member team is made up of a doctor, a nurse, and a medical administrator, all of whom possess extensive experience in medical services with correctional facilities and are well-versed in the National Commission on Correctional Health Care ("NCCHC") guidelines and the standards set by the American Correctional Association ("ACA") ensuring a comprehensive evaluation of ECCF's medical services.

- Creation of a monthly Newsletter from the Substance Abuse and Recreation Department to be shared with inmates on their tablets. The Substance Abuse and Recreation Department Newsletter shares information with all inmates regarding upcoming events, past events, and provide fitness, nutrition, and substance abuse education. This was done in an effort to expand knowledge and encourage program participation within the ECCF facility.

ECCF TAKING RECOMMENDATIONS FROM TASK FORCE

- After issuing the Task Force SHU Report, the Task Force expressed concern that ECCF was potentially violating ICRA by placing vulnerable populations of inmates, including those who have a history of psychotic illness or psychotic hospitalization, in disciplinary detention in the SHU. During the September 20, 2023 Public Meeting on the Task Force SHU Report, Director Charles explained that, as a result of the SHU Report, the Facility has made the effort to fix that situation and has removed approximately 75% of the vulnerable population from disciplinary detention, and the Facility continues to work on improving that number. Additionally, on September 18, 2024, a member of the SHU sub-committee gave a presentation to about 75 ECCF Supervisors on the law of isolated confinement, including a detailed review of the Inmate Confinement Reform Act (ICRA). Director Charles followed up this presentation by inviting a representative from the Task Force to speak at one of his Supervisors meetings to explain the law of isolated confinement in New Jersey as of 2024. This session focused on reviewing the statute (ICRA) with the Supervisors paragraph by paragraph. In addition, Dr. Fleming emphasized, and the Task Force acknowledged, that even with every effort and intent to adhere to the ICRA regulations, ECCF is constrained by the resources and space at the Facility, as well as the reality of a situation wherein someone who is seriously mentally ill and possibly a danger to himself or others, needs to be in a single cell to ensure safety. Dr. Pernell acknowledged that "the law is not perfect" because there will be times that an inmate suffers from severe mental illness, but because there is potential to cause harm, he must be put on disciplinary status due to the lack of adequate mental health resources.

- In addition, the Task Force SHU Report expressed concerns over the lack of educational and recreational opportunities for inmates housed in the SHU. As a result of the Task Force's findings and recommendations, the Facility has been offering religious services in the SHU from every affiliation. At the September 20, 2023 Public Meeting, Dr. Vega explained that she has over 15 volunteers from Volunteer Nation that provide services to inmates on a one-on-one setting or through Bible studies. With respect to recreational programming, inmates who are housed in SHU for Voluntary Protective Custody are permitted to continue any programs that were started while housed in General Population. for those who are in VPC—if they have started a program, we've allowed them to continue. For

example, Dr. Vega explained that there are OSHA programs and Construction programs that an inmate in SHU was working on completing so that when she leaves the Facility, Dr. Vega can connect her to services on the outside. This same inmate, who is housed in the SHU, was also participating a First Aid Course and CPR Course to obtain necessary certifications and entry into the Commercial Driver's License Program which would help in seeking employment upon leaving the Facility. In addition, Dr. Vega explained that the Facility's Recreational Specialist, Mark Knight, makes sure that recreational programming is offered to everyone in the Facility, including the SHU so if an inmate cannot participate in the big programming activities, Mr. Knight brings the activity to the inmate. For example, Dr. Vega explained that if inmates are not stable enough to participate in large group activities or in the gym, Mr. Knight will bring such inmates games, painting, paperwork, etc. for recreational opportunities in the SHU. Moreover, Dr. Vega emphasized that there are educational programs on the tablets that the inmates have while housed in the SHU. These educational programs including over 150 different types of certifications that the inmates can receive by participating on the tablet.

- The Task Force SHU Sub-Committee also noted that there is a WiFi problem in the SHU because many inmates were forced into awkward positions in order to obtain a signal for their tablets. After the Task Force's SHU Report recommended improvements, Director Charles instituted two different upgrades at ECCF. First, ECCF performed a half- million dollar upgrade in the Facility for medical personnel so that the medical staff could travel through the Facility and easily access Electronic Medical Records ("EMR"). In addition, Director Charles implemented a project specifically for the SHU to expand the WiFi for cell-to-cell access WiFi. This second initiative was completed in May, 2023 and it has rectified the WiFi problem so the SHU inmates have been extremely grateful.

- Dr. Anicette explained during the 10/29/24 Public Meeting regarding the Mental Health Report that ECCF took the information and feedback from the Task Force and developed a system for telemedicine at intake for the inmates. Dr. Anicette said that the telemedicine is used for medical purposes and nurse screenings but he thinks it might be possible to transition that into also using telemedicine for mental health treatments. Specifically, Dr. Anicette said that ECCF has worked with the Peter Hole Clinic at St. Michael's Hospital for the past year to create telehealth for HIV patients that has been extremely successful. Dr. Anicette said that he has been speaking with individuals at St. Michael's Hospital and University Hospital in the hopes that they can expand the telemedicine program for inmates.

The Task Force has made multiple inquiries as to the screening tools used for mental health illness at the Facility. Dr. Anicette and Dr. Fleming explained that the screening tools are very basic due to constraints on time and resources. During the September 20, 2023 Public Meeting regarding the SHU Report, Dr. Anicette and Dr. Fleming specifically explained the difficulties in their ability to deeply screen inmates because ECCF, as a correctional facility, has a different agenda that a normal hospital or medical center. Unfortunately, the initial screenings have to consider potential life threatening situations. Therefore, corrections officers must first determine if an inmate is homicidal, suicidal, or a threat in any way to himself, other inmates, correctional officers, of the Facility. On the first date of entry into ECCF, inmates must be booked and screened within 4 hours so the more detailed diagnoses for less dangerous mental illness can only happen later by Dr. Fleming and his mental health team.

- Dr. Anicette agreed that it would be helpful if Professor Valera and the Task Force could provide examples of standardized screening tools and assessment tools for jails to better diagnose mental health illness at ECCF intake. During the 10/29/24 Public Meeting regarding the Mental Health Report, Dr. Anicette represented that Dr. Fleming and Dr. Sandrock could review the assessment tools and the Facility would meet with the Electronic Medical Record Committee to facilitate creating the necessary IT for the screening tools and the necessary training. Professor Valera offered to prioritize the seven different screening tools that the Task Force has researched and suggested for the Facility.

- The Task Force made numerous recommendations to improve the MAT program at the Facility. Dr. Anicette explained that ECCF took the information and feedback from the Task Force and developed improvements to the MAT program. Dr. Anicette explained that ECCF now has 20 agencies that are linked to services and the Facility has a designated discharge planner who is at the Facility five days a week making plans for patients connecting them to different centers, the MAT center, and community based groups that can service them so that there's no lag. ECCF also has a connection with Walgreens so when an inmate leaves, the inmate receives a ticket for the No. 25 bus which then goes to Penn Station which has a Walgreens right across the street. Therefore, the former inmate can simply walk in to Walgreens with their jail ID and get their discharge medications, such as suboxone for example, from that pharmacy.

- The Task Force has been concerned with the treatment of inmates with mental illness and has provided a great deal of suggestions and recommendations to ECCF. As a result, Director Charles and Dr. Anicette worked tirelessly to establish a connection

with Silver Lakes Hospital and ultimately created a unit in Silver Lakes that takes former inmates from ECCF as patients upon discharge. These patients requires long-term care and Silver Lakes is able to house them for two to three months. Dr. Anicette said that Silver Lake has been successful in stabilizing patients because they are a truly dedicated organization that has been willing to work with ECCF to navigate all the complicated issues inherent to the Medicaid infrastructure. According to Dr. Anicette, Silver Lakes allows for a "warm hand off" because ECCF officers transport the patients to the unit where they will be housed and they are essentially discharged to case management.

- Director Charles acknowledged that mental health training for corrections officers is vital and based on the Task Force's suggestion, ECCF instituted mental health training, added the mental health training to the Facility's annual training module, and every corrections officer will get the mental health training. Professor Valera provided the training to the corrections officers and she said that after conducting the mental health training, the Facility surveyed the officers three months later. The corrections officers referred inmates suffering with mental illness at least 30 times because, as a result of the training, the corrections officers noticed inmates' irregular behaviors, inmates experiencing hallucinations, inmates behaving aggressively, inmates refusing to leave their cell or refusing to shower, and inmates with whom it was challenging to communicate. These results helped to demonstrate how beneficial the training was and the importance of important the mental health department at the Facility.

- With respect to pharmacological protocols, ECCF can't involuntarily force an inmate to take medication to treat a mental illness. However, Dr. Fleming has developed a policy at ECCF wherein if the medical staff notices that an inmate is decompensating due to lack of medication, the Facility can send the patient to another mental health agency, such as the Essex County Forensic Center to evaluate the patient. According to Dr. Anicette, once the patient sees how much better they are doing with medication and stabilizing, there is no need to use force to administer the medication for mental health treatment.

- Regarding the amount of staff for the mental health department at the Facility, during the October 29, 2024 public meeting regarding the Task Force Mental Health Report, Dr. Fleming explained that his staff can only do so much with the amount of people they have. Dr. Fleming explained that he is always looking to increase staff because it is really a numbers game and there are over 2,000 patients at ECCF but Dr. Fleming only

has a very small team of mental health clinicians. Dr. Fleming said that he would need 10 additional mental health professionals to fully staff the mental health step down unit so that patients who are actually mentally ill would be able to work towards improving in a clinical setting.

- The Task Force has repeatedly expressed concerns regarding staffing at ECCF. This matter was somewhat clarified during the September 20, 2023 Public Meeting discussing the Task Force SHU Report. During this meeting, Dr. Fleming explained that, as the Mental Health Director, is constrained by the amount of staff he has but he only has five mental health clinicians including one psychiatrist and one acute psychiatrist nurse for over 2000 inmates. Dr. Fleming explained that he would need more staff to improve the ability to better identify, better assess, and better triage inmates. Often, Dr. Fleming and his team are "putting out fires" in SHU with the more serious Forensic patients who could be a threat to themselves or other inmates. Accordingly, the mental health team does not always have time for inmates who are somewhat depressed, a little bit anxious, have anger management issues, or are just having coping skills issues. Dr. Fleming is concerned that these patients will potentially fall through the cracks because he simply does not have enough staff. To specifically understand the numbers, Dr. Fleming explained that out of approximately 2,000 inmates, 850 have some sort of mental health diagnosis. However, there are only 256 beds in the SHU unit and such capacity must also hold inmates under involuntary protective custody, voluntary protective custody and disciplinary issues.

- It is important to note that, during the September 20, 2023 Public Meeting on the SHU Report, Director Charles made a significant distinction between the under-staffed mental health and medical departments and the staffing from an operational or custodial standpoint. Director Charles emphasized that he is actually over hiring at the Facility. Specifically, Director Charles said that ECCF is budgeted for 580 Officers and as of 9/20/23, the Facility has 656 Officers. ECCF is budgeted for 8 Captains and actually has 10 Captains. ECCF is budgeted for 22 Lieutenants and actually has 28 Lieutenants. ECCF is budgeted for 56 Sergeants and actually has 57 Sergeants. ECCF is budgeted for 55 Civilians and has that exact amount. Therefore, Director Charles said there is a definite commitment from his office and from the County to keep hiring if the Facility needs because he never wants ECCF to be short-staffed or have potentially unsafe conditions for the staff or inmates.

- Director Charles further explained that the medical personnel at the Facility are hired through a vendor, CFG Health Network, that has a contract with ECCF. According to Director Charles, the contract calls for a certain amount of staff, doctors, nurses, LPNs, and RPNs. The Facility has a contract monitor who verifies what the County is paying for. If the Facility need to increase the medical personnel, ECCF and the County would need to reissue the contract or resurrect the RFP for additional staff. Director Charles said that he was willing to do that but he would need to determine if that would require a change to terms in the CFG contract and if there are regulations regarding the County's ability to submit a new RFP for an increase in the amount of clinical staff. This would require input from the County Executive's Office and the Chief of Staff.

- In addition, the SHU Report made note of the amount of full facility-wide lockdowns at ECCF which were based on violence and the SHU Sub-Committee recommended some sort of attempt to review and analyze the incidents of violence leading to lockdowns to improve the situation in the future. During the September 20, 2023 Public Meeting regarding the SHU Report, Director Charles described the new procedure instituted at ECCF wherein after every action or use of force, the Facility has a review committee of command level staff (Lieutenants, Sergeants and Captains), as well as the Executive Team, that reviews the incident to determine what the Facility did well, what the Facility needs to improve upon; and what the Facility can do to prevent such an incident from happening again. ECCF will then change any policies necessary to reflect these determinations and improve the conditions at the Facility to reduce such lockdowns. In September, 2023, ECCF implemented four months of CompStat. Director Charles explained that this program allows the Facility to review the inmate, review the increases in fights, and review increases in detention numbers so that, on an executive level, Director Charles can determine the reason for violence, ascertain which officers are involved in the incidents of violence, and attempt to discover whether there is any pattern to the violence. Director Charles was hopeful that this CompStat program and analysis of incidents of violence and use of force would help in developing training on a policy level that could result in less such incidents.

- Based on the recommendations of the Task Force and the Medical Sub-Committee's Report, Dr. Anicette met with the University Emergency Room Department to discuss properly managing opiate dependent pregnant females. Although Dr. Anicette emphasized that it is a "hotbed topic in corrections" and is very difficult to manage, the Task Force and Essex County refused to give up. Dr. Anicette met with

University Hospital and the Facility instituted a new workflow on how to manage patients who were opiate dependent pregnant females. As a result, when the Facility met with the Governmental Accountability Office ("GAO") who was doing a nationwide survey of how pregnant females are being treated, the GAO picked Essex County and found that Essex County was compliant and far exceeded what most custodial facilities were doing throughout the county. According to Dr. Anicette, the GAO's extreme gratitude towards Essex County's treatment of this subset of the population was due predominantly to the collaboration between ECCF and the Task Force.

- The Task Force Medical Sub-Committee's Report recommended screening for certain conditions including Hepatitis. During the September 20, 2023 Public Meeting on the SHU Report, Dr. Anicette reported that the Facility has launched an initiative to deal with the high volume of STD's by instituting a process for screening any new inmates for five different conditions, including hepatitis C, HIV, syphilis, via the new technology of a PCR test administered to an inmate during intake which provides results in thirty minutes. Thereafter, a nurse or nurse practitioner can assess and treat the patient.

ACCOLADES TO ECCF

- The American Correctional Association of Accreditation ("ACA"), which is a national accreditation agency recognized worldwide for accreditation standards in the correctional industry, conducted intensive evaluations of ECCF that culminated with the accreditation audit, a comprehensive assessment that encompasses every area of correctional operations. In 2022, ECCF received a passing percentage score of 100% for Mandatory Inspection Areas and 98.38 for Non-Mandatory Inspection Areas, improved from the 2019 percentage score of 97.90 for Mandatory Inspection Areas.

- On February 8, 2024, the State of New Jersey Department of Corrections sent a letter to Director of Corrections Ronald Charles at ECCF informing him that ECCF was 100% compliant with the Manual Standards for New Jersey Adult County Correctional Facilities" pursuant to New Jersey Administrative Code 10A:31. Specifically, it was noted that "Documentation showed funds utilized for Lexis Nexis accounts assigned to custody staff and maintenance/supplies for washing machines has been reimbursed to the Inmate Welfare Account."

- On January 9, 2025, Glenn A. Grant, Acting Administrative Director of the Courts for the New Jersey Administrative Office of the Courts sent a letter to Director of Corrections Ronald Charles expressing appreciation for the ECCF Mental Health Diversion Pilot Program, stating: "Your commitment to identifying individuals who would benefit from this pilot program and ensuring services and connections continue seamlessly upon their jail release has been instrumental to the program's success. Coordinating this effort requires significant logistics, resources, and timely action, and yet you and your team consistently rise to the challenge. Your partnership, alongside the work of your medical staff, reflects a true commitment to creating opportunities for individuals to rebuild their lives."

- On November 18, 2024, the State of New Jersey Department of Corrections sent a letter to Director of Corrections Ronald Charles at ECCF informing him that ECCF was 100% compliant with the Manual Standards for New Jersey Adult County Correctional Facilities" pursuant to New Jersey Administrative Code 10A:31. Specifically, it was noted that "New training on Isolated confinement for vulnerable population ("VP") has been conducted with supervisory staff. Offender Management system has also been updated to identify the vulnerable population. Updated policies and forms to

address the issue of disciplinary action against the VP population along with a separate housing unit identified as restrictive housing."

- On January 30, 2025, the New York City Department of Corrections announced a groundbreaking collaborative training partnership with the Essex County, NJ Department of Corrections. The inaugural training session was led by Sergeant Matt Walker of the Essex County Corrections Department, focusing on New Jersey's acclaimed Resiliency Officer Program ("ROP"), which is a pioneering initiative aimed at promoting mental health and well-being among law enforcement professionals. Grounded in the understanding that resilience is critical for high-stress professions, the program equips officers with tools to manage stress, recognize signs of burnout, and support colleagues facing mental health challenges.

- On August 21, 2024, ECCF received a letter from David Matos, President of the State Policeman's Benevolent Association Local 382, which represents over 600 Law Enforcement Corrections officers (87%) at ECCF, expressing support and confidence in Director Charles and stating "Director of Corrections Charles has set a high standard for our department and directing a departments, which has a facility of over 900 employees and 2,200 inmates is never easy task and at times requires bold leadership and unpopular decision making. Changing the culture of an agency is not an easy task. We support his vision for transforming it into an even more effective and efficient organization."

Summary of Reports

2021 Annual Report

The Task Force issued its Annual Report for 2021, which provided described the purpose and circumstances leading to the creation of the Task Force. In addition, the 2021 Annual Report provides a background description of the Facility at ECCF the proposed role of the Task Force. The 2021 Annual Report also provides extensive information regarding the initial activities of the Task Force on its inception, as well as the Task Force's activities in 2021, which included ongoing monitoring of issues at ECCF, collaboration with public stakeholders, conducting visits of the Facility, requests for information, and conducting public meetings. Following the release of the 2021 Annual Report, the Task Force issued the following reports, which are summarized below and reproduced in the Appendices: "The Determinants of Health Report" released by the Task Force Medical Sub-Committee in 2022; "Special Housing Units and the Isolated Confinement Restriction Act at the Essex County Correctional Facility" released by the Task Force SHU Sub-Committee in 2023; and "Behind the Wall: Transforming Mental Health Care in Local and County Jails" released by the Task Force Mental Health Sub-Committee in 2024.

Medical Report (2022)

The Task Force Medical Sub-Committee issued a Report in 2022 entitled "The Determinants of Health Report" The Determinants of Health Report is a comprehensive overview and background of the status of ECCF as it relates to the health, safety, and wellbeing of the inmates, staff, and correctional police officers. Understanding that persons housed at ECCF are being processed through the criminal justice system, it is important to recognize that this facility primarily houses individuals who have become increasingly relegated to the margins of American society that require complex medical and social services because of conditions such as substance use disorders, psychiatric illnesses, chronic health conditions, and pregnancy. This report includes over 200 contact hours (September 2021 through March 2022) of on-site jail visits, ethnographic observations, including a third shift visit (9pm-5am) at the facility, interviewing both female and male individuals in custody at ECCF, participating in unannounced visits, participating in public meetings, a tour of Delaney Hall, and reviews of testimonies and correspondences and public meetings between the ECCF and the ECCF Civilian Task Force. Despite the medical and mental health risks of incarceration, ECCF does show promising approaches to supporting the health and

well-being of their jail population. However, the intensity and complexity of imprisonment require a paradigm shift toward increasing state and local support for county jails and expanding medical and mental health programs with wraparound services that allow for re-entrant inmates to be served at one location. Specifically, the Task Force Medical Sub-Committee provided an overview of the current state of New Jersey corrections including the New Jersey Department of Corrections and demographic profile of the jail population. The Medical Sub-Committee also analyzed ECCF's Organizational Structure including the prison leadership and challenges in Corrections. Thereafter, the Medical Sub-Committee reviewed the following areas within ECCF: Pre-Booking Area or Process and Intake Area; Prison Rape Elimination Act; COVID-19 Testing; Quarantine; Booking Process; Care Package Upon Admission; Classification of Custody Level; COVID-19 Testing; PPE (Use of Surgical Masks); Medical Care Services; Medical Team Structure; Chronic Care Rates within ECCF; Process of Receiving Medical Care; Keep on Person Medication Self-Administration; Co-Pays within ECCF; Recommendations for Medical Care; Women's Health; Pregnancy and Delivery; Prenatal Care and Post-partum Care and Treatment; Dental Care; Medical Monitoring; Telehealth Program; Continuity of Care within ECCF's Medical Unit; Screening and Diagnostics of Mental Disorders; Treatments Available for Inmates with Mental Disorders; Prevalence of Mental Disorders at ECCF; Types of Psychiatric Diagnoses at ECCF; Forensic Mental Health Units; Discharge Process Related to Mental Health; Reflections on The Mental Health Department at ECCF; Challenges and Barriers to Treating Inmates with Mental Disorders; Overall Structure of the MAT Program; MAT Intake Procedures; Distribution of MAT on Daily Rounds; Options for MAT; Discharge and Jail Release Procedures for MAT; Patient Navigation of MAT Participants; Establishing Community Partners; Challenges to Effectively Adopting an MAT Program in the Correctional Setting; Return on Investment of MAT; The Cost of Recidivism; The Social Services and Reentry Staff Composition; Rehabilitation Services; Referral Services; Dining Services; Dietary Guidelines and ECCF; Water Quality; Technology including Tablets and Video Conferencing.

The Task Force Medical Sub-Committee made the following short term suggestions: increase staffing levels in medical, dental, mental health, and reentry services following the specific recommendations of department leaders based on the current level of needs; improve training of medical staff on Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI) related disclosures for all

treating hospitals and ambulatory care settings where inmates are supplied care; streamline communication and develop protocols with area hospitals and healthcare facilities to minimize instances where inmates are shuttled back and forth during obstetric, medical, and psychiatric cases; revisit nutrition distribution mechanisms to address inmate complaints of cold food and hunger; create a nonpartisan committee of experts in various fields that can oversee the jail to make recommendations regularly as a subcommittee of the ECCF Task Force; establish written policies regarding the

Keep on Person Medication Program (KOP) and distribute medical cards with medication information to each participant; strengthen transitions in care and consider whether there can be a Memorandum of Agreements with area hospitals; released inmates should be bridged to the date of their appointment in the community (or longer if they will not be able to obtain a new prescription upon their intake appointment), which is often the case; and New Jersey should apply for Section 1115 waivers to provide Medicaid coverage while people are incarcerated or in custody at ECCF.

The Task Force Medical Sub-Committee made the following long term suggestions: construct additional units meant to house inmates with mental health needs or who are LGBTQ+ identified to maximize psychological and social benefits; establish female-specific medical and therapeutic services to address this growing jail population; increase inpatient forensic psychiatric bed capacity where ECCF inmates are presently referred; construct rooms and spaces where group therapy or individual sessions can be conducted because the current availability of such facilities within the jail is minimal; prioritize a return to in-person therapy sessions on a jail-wide basis or facilitate telehealth visits with mental health counselors; establish a Research and Evaluation Unit to show best practices and strategies to promote quality control, enhance tracking and monitoring, and ensure effective management and supervision across the different units within ECCF; and create a jail dashboard to help raise awareness and increase transparency with the public about the characteristics of inmates incarcerated in jail and to address the frequent questions about the jail population ECCF receives.

SHU Report (2023)

The Task Force Special Housing Unit ("SHU") Sub-Committee issued a Report in 2023 entitled "Special Housing Units and the Isolated Confinement Restriction Act at the Essex County Correctional Facility." The SHU Sub-Committee reviewed ECCF's policies and practices regarding the isolated confinement of inmates in its SHU in the context of the New Jersey Isolated Confinement Restriction Act ("ICRA"), which significantly limits isolated confinement in jails and prisons throughout the state. The Sub-Committee addressed four related issues: (1) whether the ECCF is complying with ICRA; (2) if not, what conditions prevent full compliance; (3) what recommendations the Task Force might make to alter the conditions preventing compliance; and (4) what steps ECCF administrators could undertake to improve operations and inmate conditions in the SHU.

The SHU Sub-Committee found that ECCF has made substantial efforts at compliance with ICRA, including updated policies and practices. Placement in SHU status at ECCF is for legally permissible reasons and policies are in place that are consistent with ICRA. However, the SHU Sub-Committee could not conclude that the facility complies entirely with ICRA's prohibitions against excessive time in "isolated confinement" and the "isolated confinement" of vulnerable populations due to a lack of readily available records documenting inmates' out-of-cell time.

Moreover, the SHU Sub-Committee was also concerned that members of vulnerable populations, including individuals with disabilities, the elderly, and people with severe mental disorders, may be improperly placed in disciplinary detention and isolated confinement. In addition, the SHU Sub-Committee found that ECCF may not be in compliance with ICRA when it comes to long-term forensic cases by virtue of remaining in isolated confinement beyond ICRA maximum periods due to the fact that ECCF has been unable to transfer many long-term forensic inmates to psychiatric treatment centers due to a lack of available beds outside the facility. The SHU Sub-Committee also found that the conditions of isolated confinement might not be compliant with ICRA because inmates are denied some opportunities and programs available to other inmates. Beyond merely providing tablets and minimal clergy availability, more educational, work, and recreational activities may be provided. However, space and individual restrictions for many SHU-status inmates significantly complicate any enhancements.

With respect to the recordkeeping deficits that hampered the SHU Sub-Committee's review, ECCF maintains handwritten logbooks documenting out-of-cell time for inmates and no digital database exists. However, the SHU Sub-Committee learned that ECCF has been working on implementing the electronic PipeGuard system, which would provide global records of out-of-cell time.

The SHU Sub-Committee provides the following suggestions for ECCF to improve inmate health and continued review of SHU status for inmates.

1. **In all areas of SHU placement, whether or not technically "isolated confinement" under ICRA, the ECCF should implement policies and practices to evaluate the effects of SHU placement upon each inmate. The purpose of ICRA was to limit isolated confinement because of the deleterious psychological effects, but even when inmates are not technically in "isolated confinement," SHU status and isolation for anywhere close to 22 hours per day can damage long-term mental health.**
2. **Forensic inmates deemed level two or three do, where individual circumstances permit, congregate and thus are not technically in "isolated confinement," as ICRA defines. However, others, including level one forensic inmates in SHU, are indefinitely placed in isolated confinement based on their medical condition and this violates ICRA. Such inmates needing indefinite lockdown for 22 hours or more should be transferred to health care facilities in the area based on their clinical needs. If not possible, the ECCF must devise effective ways to ensure removal from "isolated confinement" for all inmates beyond ICRA time limits, such as by creating a step-down unit.**
3. **The ECCF should consider a type of step-down unit —not in isolated confinement — for inmates released after serving a maximum period of discipline according to disciplinary detention. ICRA imposes maximum time limits for isolated confinement in disciplinary detention, including 20 straight days and 30 days within any 60-day period. The SHU Sub-Committee was concerned about the potential for further violence upon other inmates or ECCF staff following such releases to general population. Although the ECCF may not have the necessary space or staffing resources, such a unit could effectively mitigate many issues caused by isolated confinement.**
4. **The Sub-Committee also recommended increased opportunities for educational programs, recreation, religious worship, and other activities for SHU-status inmates. There are significant restrictions on these opportunities that may constitute an ICRA violation.**

5. The ECCF should substantially upgrade the Wi-Fi for SHU-status inmates because current limitations restrict the use of tablets and force inmates to find Wi-Fi areas of their cells in awkward locations. This would improve inmate access to reading and legal materials.
6. The ECCF recordkeeping on inmates' timeframes in "isolated confinement" must be established and/or improved considerably. ICRA applies to situations when an inmate is in "isolated confinement." Calculating and documenting the timeframes used for each inmate is the critical question and records of out-of-cell time for all SHU-status inmates should be readily available to access to ensure ICRA compliance.

Mental Health Report (2024)

The Task Force Sub-Committee on Mental Health issued a Report in 2024 entitled "Behind the Wall: Transforming Mental Health Care in Local and County Jails." The Mental Health Sub-Committee emphasized that more than 9 million people cycle through United States local and county jail systems annually, and among those incarcerated in local and county jails, 44% of the incarcerated individuals have some form of mental health challenges significantly higher than in the general adult population. Local and county jails have progressively replaced mental health treatment centers as the primary source of mental health care due to closures or service reductions, which has resulted in a shift in the provision of inpatient treatment services for individuals with severe mental illness (SMI) who encounter law enforcement, with jails assuming a significant role in providing mental health services due to a substantial reduction in available psychiatric inpatient beds.

In Newark, New Jersey, Essex County Correctional Facility is one of the nation's largest jails – the facility holds more incarcerated individuals with SMI than any New Jersey psychiatric hospital. ECCF has a jail population 2,264 (95% men and 5% women). An estimated 33% (n=750) of incarcerated individuals are diagnosed with an SMI according to DSM 5 (standard classification of mental disorders used by mental health professionals) or ICD-10 codes (classification of diseases) and are currently undergoing some form of mental health treatment. Approximately 87% of the 750 incarcerated individuals with SMI (n=600) have a co-occurring disorder, and most often, the co-occurring diagnosis is related to substance use disorder. The most prevalent mental health diagnoses categorized at ECCF are the following: major depressive disorder (with anxious or paranoid features), schizophrenia, schizoaffective disorder, mood disorders (with psychotic, anxiety/depressive features, bipolar), anxiety

disorder, post-traumatic stress disorder ("PTSD"), delusional disorder, and substance use disorder, personality disorders (antisocial personality disorders) and developmental disorders.

The presence of SMI among incarcerated individuals not only exacerbates the risk of violence within these facilities but also elevates the potential for injuries among both correctional officers and the incarcerated population. Accordingly, there is an urgent need for tailored strategies and resources to address mental health needs effectively, ensuring the safety and well-being of all individuals within the correctional system. The Mental Health Sub-Committee encouraged New Jersey local and county jails to establish a process employing an administrative proceeding to authorize the involuntary medication of incarcerated individuals diagnosed with mental disorders, those considered gravely disabled, or those who present a significant risk of harm to themselves or others. Due to a limited number of psychiatric hospital beds, New Jersey jails often face challenges in transferring incarcerated patients in need of treatment but compelled to manage incarcerated individuals' mental health symptoms through alternative methods such as restraints, seclusion, or direct supervision rather than medication.

As discussed previously, the December 2023 Report from the Special Housing Unit Sub-Committee recommended the establishment of a specialized mental health unit that fosters a better transition from forensic status to the general incarcerated population. Therefore, in December 2023, ECCF unveiled a specialized housing pod, a "step-down" unit, designed to bridge the gap between the forensic unit placement (where intensive psychiatric care is provided) and the possibility of returning to the general incarcerated population. This unit is tailored for individuals who have been deemed stable enough through intensive mental health interventions but still require a structured setting for further recovery and preparation for reintegration.

In addition, Essex County provides Alternative to Incarceration Programs including reentry services, Alcohol Anonymous/Narcotic Anonymous services, religious services, Cognitive Behavioral Therapy, and anger management classes. Moreover, New Jersey employs Diversion Strategies which are designed for first-time justice involving individuals who enter the program before their case is decided. These strategies include Pretrial Intervention (PTI) for first-time offenders in Superior Court and is available for more severe crimes such as felonies or indictable charges; Conditional Discharge for first-time offenders charged with a municipal court drug offense but is only available for

minor drug offenses; and Conditional Dismissal first-time offenders in municipal court for various, less serious offenses.

The Mental Health Sub-Committee acknowledged that revamping mental health treatment in local and county jails necessitates a collaborative effort involving partnerships with community-based services, the medical professional community, state policy makers, and institutional anchors, such as the New Jersey Court system. This requires considering a systems framework approach such as the Sequential Intercept Model (SIM) to develop a strategy for mapping how individuals with mental health challenges navigate the criminal justice system, identifying resource availability, pinpointing service gaps, and planning for systemic changes. By way of example, the Mental Health Sub-Committee highlighted Yakima County, Washington, which established a Mental Health Crisis Stabilization Unit, Crisis Intervention Training for Law Enforcement, a Behavioral Health Diversion Program, a Mental Health Court, and a therapeutic court that is a dual Diagnosis Mental Health/Drug and Alcohol Court.

The Mental Health Report also highlighted various innovative strategies (e.g., evidence-based screening and classification tools, diversion programs, and reintegration strategies) being implemented at the local, national, and global levels within diverse county and local jail settings. The Mental Health Sub-Committee further called for urgent and targeted policy interventions to address the widespread mental health crisis in ECCF, emphasizing the need for enhanced resources, improved access to care, and the elimination of systemic barriers to treatment.

Specifically, the Mental Health Report recommended the implementation of a standardized mental health screening tool. Screening tools identify potential issues, assessment explores these issues in more detail, and diagnostic evaluation culminates in identifying specific mental health conditions, thereby guiding treatment and interventions. The choice of a mental health screening tool will depend on several factors at ECCF, including training the staff administering the screenings, resources available for follow up, and appropriate assessment. However, a precise mental health diagnosis requires using an evidence-based screening tool to identify potential mental health concerns, as this is the cornerstone of effective treatment. For incarcerated individuals, it ensures that they receive appropriate medication, therapy, and support services tailored to their specific conditions. These standardized mental health screenings represent an essential component of comprehensive healthcare services for

ECCF, aiming to address the complex needs of incarcerated individuals.

In addition, the Mental Health Report recommended that ECCF develop a mental health policy for the Step-Down Unit created in December 2023. This would entail the following: development of an objective statement for the Step-Down Unit including its purpose; definition of eligibility criteria; identification of staffing and training needs; description of treatment and support services including individualized treatment plans and therapeutic activities; risk Assessment of safety and security; planning for transition and continuity of care; development of a monitoring and evaluation plan; and creation of inmate rights and staff responsibilities.

The Mental Health Report provides examples of various initiatives to improve mental health policies across the United States in areas including Harris County Jail in Texas; Cook County's Jail in Illinois; Los Angeles Country Jail - Twin Towers Correctional Facility in California; and San Francisco County Jail in California. Furthermore, the Mental Health Report highlights and describes additional best practices across the nation including the afore-mentioned therapeutic court in Yakima County, Washington, the Miami Center for Mental Health Recovery; the initiative entitled "Strategies to Avoid Relapse and Recidivism" in Summit County, Colorado; the University of Colorado School of Medicine's new Wellness, Opportunity, Resiliency Through Health program; Utah diversion programs such as the Utah Conviction Alternatives Track; the "No Wrong Door" policy in Hillsborough, Florida; and the Pre-Trial Diversion and Recovery Program in East Baton Rouge Parish, Louisiana. Moreover, the Mental Health Report applauded the following countries which had notable mental health services, rehabilitation and re-entry programs, and community involvement: Japan, Singapore, Australia, England and Whales.

With respect to the ECCF, the Mental Health Sub-Committee explained that comprehensive strategy for implementing mental health interventions is essential. The foundation of this approach involves universal screening and assessment at intake, utilizing standardized tools to ensure the early identification of mental health issues, substance use disorders, and trauma. Additionally, it is crucial to build a multidisciplinary team of mental health professionals experienced in working with diverse populations and provide continuous training in mental health, trauma and de-escalation techniques for all jail staff are crucial first steps. Ideally individualized treatment plans should be developed for each incarcerated person with mental disorders,

incorporating a range of evidence-based practices and therapeutic approaches that acknowledge cultural and socioeconomics and specific mental health needs. Furthermore, addressing the high prevalence of co-occurring disorders through integrated treatment programs and ensuring continuity of care by establishing strong partnerships with community-based services are vital for supporting incarcerated people during and after their release.

The Mental Health Sub-Committee suggested creating therapeutic housing units and fostering a supportive jail culture, which can significantly enhance the mental health and well-being of people who are incarcerated, encouraging them to seek help when needed. Implementing telehealth services expands access to mental health professionals and specialists, while a robust data management system supports the monitoring and evaluation for mental health program effectiveness. Involving peer support specialists and strengthening community connections with local organizations and advocacy groups can provide additional layers of support and mentorship, reflecting the community's diversity. Regular evaluation of mental health interventions, informed by data and feedback from participants and staff, is essential for continuous improvement. By committing to these strategies and prioritizing mental health care, ECCF can make significant strides in improving the outcomes for incarcerated individuals with mental health needs, ultimately contributing to safer communities and better public health outcomes.

Importantly, the Mental Health Report emphasized that investing in mental health programs for individuals with mental disorders involved in the criminal justice system is critically important for several reasons. First, these programs offer a more humane and effective approach to dealing with people who have poor mental health conditions, recognizing that treatment and support can be more beneficial than incarceration. By addressing the root causes of criminogenic behavior, such as untreated mental disorders and drug addiction, diversion programs may significantly reduce recidivism rates, enhancing public safety in the long term. Furthermore, these initiatives alleviate the burden on overcrowded jail systems, allowing for better resource allocation and improving conditions for incarcerated people and staff. From an economic perspective, diversion and mental health programs are cost-effective, reducing the need for expensive incarceration and emergency health services by providing targeted, preventive care. Additionally, these programs support the reintegration of individuals into society, helping them to regain stability, access employment, and rebuild relationships, thereby

contributing to stronger and healthier communities. Investing in mental health ultimately reflects a commitment to justice reform, emphasizing rehabilitation over punishment and recognizing the dignity and potential of individuals with mental health issues within the criminal justice system.

For links to the full task force reports, refer to Appendix A.

Appendix A

Essex County Civilian Correctional Facility Task Force Reports

- **Essex County Civilian Oversight Task Force Annual Report 2021: https://essexdoc.com/wp-content/uploads/2023/03/CY2021-Annual-Report-ECTF-Task-Force.pdf**

- **The Determinants of Health Report 2022: https://essexdoc.com/wp-content/uploads/2023/03/Medical-Subcommittee-Report-for-Essex-County-Civilian-Task-Force4.30.22.pdf**

- **Special Housing Units and the Isolated Confinement Restriction Act at the Essex County Correctional Facility Report 2023: https://essexcountynj.org/wp-content/uploads/2023/FINAL%20Task%20Force%20SHU%20Subcommittee%20March%202023%20Report%20with%20Exhibits.pdf**

- **Behind the Wall: Transforming Mental Health Care in Local and County Jails 2024: http://essexdoc.com/wp-content/uploads/2024/10/MENTAL-HEALTH-REPORT-_4.1.2024_FULL.pdf**

ECCF Public Meeting on Medical Subcommittee Report

July 23, 2022

Essex County Task Force Public Hearing – Medical Subcommittee Report
July 23, 2022

Governor McGreevey (JM)'s introduced Dr. Chris Pernell (CP) and Professor Pam Valera (PV), as well as the work of the Medical Subcommittee and this year's report.

CP: We did this work because of the population at ECCF. As a public health and public health physician, it is so important to look at the most vulnerable and marginalized and historically excluded, and to think about the best way to care for this population. We looked at this opportunity to find ways to strengthen, to improve, and to identify opportunities for improvement through a social determinants of health and health equity lens. It was important for me as a medical expert on the TF that we assemble a credible list of thought leaders and practitioners in the space of correctional health, women's health, public health, addiction medicine, and health care/coordination. It's very important that we consider the best way to assess the strengths and assets and to assess the potential opportunities for improvement. I'd like to also thank the staff at ECCF; it is important we establish mutual trust in the beginning and a shared understanding of our goals. We were in the facility around the clock at all hours of the day; I'd like to thank Al Ortiz and his staff, who opened up and let us ask deep and probing questions. Lastly, I'd like to thank the medical and behavioral health staff as well. It was their ability to share their own insights and credible information that we were able to gather from. I'd like to introduce PV, who will walk us through a slide deck, which is a summary of what is included in a very robust report.

***PV**'s Slide Deck: DETERMINANTS OF HEALTH REPORT*

- Members of the Medical Subcommittee
- Key Recommendations – SHORT-TERM
    - Increase staffing levels in medical, dental, mental health, reentry services following the specific recommendations of department leaders based on the current level of needs (increasing # of those incarcerated)
    - Revisit nutrition distribution mechanisms to address inmate complaints of cold food and hunger
    - Establish written policies re the Keep on Person Medication Program (KOP) and distribute medical cards to each participant
    - Bridge released inmates with medications up until the date of their appointment in the community, or longer (especially for those released in the middle of the night – bridge to care needed)
    - Improve medical staff training on HIPAA and Protected Health Information (PHI) related disclosures for all treating hospitals & ambulatory care settings where inmates are supplied care (those in the community for providing care)
    - Streamline communication and protocols for transitions in care through a possible Memorandum of Agreement with area hospitals and healthcare facilities to minimize instances where inmates are shuttled back and forth during emergencies
    - NJ should apply for Section 1115 waivers to provide Medicaid coverage while incarcerated
- Key Recommendations – LONG-TERM

    - Increase inpatient forensic psychiatric bed capacity where ECCF inmates are presently referred
    - Create jail dashboard to raise awareness and increase transparency with the public about the characteristics of inmates incarcerated in jail and to address the frequent questions about the jail population that ECCF receives (COVID cases, general population, etc.)
    - Additional units for those with mental health needs, LGBYQ+-identified folks, women, etc. to maximize psychological and social benefits
    - Establish female-specific medical and therapeutic services to address this growing population
    - Construct rooms and spaces where group therapy or individual sessions can be conducted, while prioritizing a return to in-person therapy sessions on a jail-wide basis or facilitate telehealth visits with mental health counselors
    - Establish a Research and Evaluation Unit to show best practices and strategies to promote quality control, enhance tracking and monitoring, and ensure effective management and supervision across the different units within ECCF
- Demographic Characteristics of Jail Population
    - 97% of those incarcerated are awaiting trial, 3% are convicted
    - 96% male
    - Majority African American and Black (72.5%)
    - Growing middle-aged group
- Social Determinants of Health of Jail Inmates
    - Poverty – disproportionately distributing those incarcerated
    - This leads to higher uninsured rates, greater exposure to violence, trauma, and a lower likelihood of pursuing higher education thus lowering social mobility
    - Increased incidence of crime & arrests for those suffering from homelessness, substance use disorders, psychiatric & medical illnesses
    - Lack of affordable care perpetuates a cycle of poverty, recidivism, and incarceration – ECCF has therefore become the default provider of services
    - Overrepresentation of African American, Black, and Hispanic/Latino population among those incarcerated
- CO Staff and Medical Staff Breakdown
    - ECCF is modeled in a hierarchal formation governed by federal, state, and local policies
    - Strong leadership, extensive professional experience, and highly collaborative team
    - Correctional officers are required to follow a rigid command organized in terms of military rankings
    - High degree of self-control and emotional regulation
    - Predominantly male COs
    - Medical staff is very diverse and represent the diversity of those incarcerated, highly qualified
- Guiding Principles of Medical and Mental Healthcare Administration

    - 1,200 inmates suffer from a chronic condition, most are between 18-80 years old and have 1-2 comorbidities
    - ECCF currently has people in custody with hemophilia and geriatric inmates with dementia
    - Prevalence rates are not currently tracked – this is a recommendation
    - Guiding principle: Standard J-105 □ since most people are in custody awaiting trial, they can refuse everything and are still legally innocent; they need to consent to get services (the legislature can change this, however)
- The Impact of COVID-19 on ECCF
    - All inmates are provided and have access to PPE outside of their housing unit; mandated to wear when traveling to medical, court, law library, etc.
    - Vaccines provided and began when it was initiated with the public; provided weekly through joint program with the Essex County Department of Health in Newark
    - Voluntary vaccinations
    - 11 COVID-19 admissions to an area hospital from ECCF over the past 2 years; 1 COVID-related death
- Women's Health
    - Female inmates are a gender minority but have complex needs
    - Females in custody are likely to experience high rates of trauma stemming from IPV and substance use disorders
    - Increasing numbers of female persons of reproductive age
    - Need for availability of menstrual products, pregnancy and delivery care, prenatal care, post-partum treatment
    - **Dr. Lionel Anicette (LA)** highlighted the connection to high-risk clinic at University Hospital and the strengthening collaboration with them (opening up appointments, immunization help, women's clinic, medical and mental health services, MAT)
    - **JM** highlighted the women's clinic services and expertise that weren't available just a year ago
    - **CP**: Informed consent flourishes in an environment where there is shared decision-making. This is larger than practices at ECCF, but in health and healthcare more broadly, especially among historical excluded and marginalized communities/populations. When providers and institutions can be accountable to effective partnerships and understanding the health literacy of a person and the sociocultural factors that go into this, you see that informed consent increases.
- Mental and Behavioral Health
    - The number of inmates incarcerated at ECCF who suffer from mental illnesses and are in need of clinical care far exceeds the ability and existing resources of the Mental Health Department staff to provide evidence-based treatment – arguably a public health emergency
    - Only 8 mental health staff members provide mental health services to over 2,000 inmates
    - At least 30% of inmates self-report and/or show criteria for a mental disorder

    - Approx.. 75% of the inmates (about 525 individuals) with mental health diagnoses have a co-occurring disorder and most often the co-occurring diagnosis is a substance use disorder
    - **Dr. Jason Fleming (JF)**: I am the Mental Health Director, and I supervise a staff of 7 other clinicians who are masters-leveled train or psychiatrically trained, as well as a psychiatrist now who provide services to over 2,000 inmates. This is a difficult endeavor, and this means we have to prioritize cases. This leaves out a whole ~1,600 inmates (anxious, depressed, etc.) with psychiatric needs. The jail population has turned into the "general emergency room" that would be at your local hospital – a de facto psychiatric facility/emergency room, a general health facility, a substance abuse detox program and clinic. We don't have the ability to turn people away. We have to meet whomever they are at the door, assess their needs, and provide the best possible service with just the 8-person staff. We need to increase the number of services, with at least 25 mental health staff members. COVID has been exacerbating these needs.
- Medication Assisted Treatment Program – Medication for Opioid Use Disorder (MOUD)
    - Lack of capacity; just not enough beds
    - **JF**: Inmates get identified for psychiatric care at other centers – through judiciary process/court orders or the facility's mental health team's evaluations and process initiations. Once they are identified, we collaborate with the Department of Health and Human Services to get them the care they need. The folks in Trenton then confirm they are cleared for in-patient facilities, but the issue is that they don't always have beds. We are currently at 18 people who are cleared but on a waitlist. It could take 2 weeks or longer to finally get them the care they are identified and cleared for.
    - MOUD program provides treatment to people in custody identified through pre-booking and intake to have an opiate use disorder or alcohol use disorder
    - MAT began in 2020; serving 120 people as of February 2022
    - Recently, the program has grown to include more funding from the Comprehensive Opioid, Stimulant and Substance Use Program (COSSAP), funded by the US DOJ
    - Intake for MAT is conducted upon jail admission; MAT Team reviews the inmate's Nurse Assessment and the Practitioner's Intake Assessment
    - MAT Team has up to 3 days to meet with the inmate and decide eligibility
    - Group therapy has been suspended due to the pandemic; inmates are given opportunity to speak with a peer counselor for 45 min in addition to their usual phone call and rec time
    - Discharge coordinator begins developing a discharge plan when the inmate is admitted to the program, typically on the same day
    - **Pascale Augustine (PA)**: We have been able to provide the clients more services with counseling and mental health and MAT resources if they are released in a short period of time into the community. We try to link them to an in-patient or out-patient program; everyone who's linked we provide with medication to hold them for the necessary time or provide a bridge with a community partner. We

monitor up to 9 months post-release to see if they have relapsed, need additional services, etc. We have peer counselors and substance use counselors on board. We presently have 140 people enrolled in the program. Post-release in the community, we have about 275 people that we're monitoring on a monthly basis. Avg numbers have been about 225-250 people who we're screening for possible admission to the program. We do urine analyses and random drug tests. OD numbers have increased because of the prevalence of fentanyl (instead of heroin). Once we're aware of someone who may be going through withdrawal, the medication is prescribed immediately. Within 72 hours they are receiving medication.

- Summary
    - The Determinants of Health Report is a comprehensive overview and background of the status of ECCF as it relates to the health, safety, and wellbeing of the jail inmates, prison staff, and their officers.
    - The ECCF leadership have been transparent and collaborative through the process of making this report.

JM: The report is online. Two things: 1) we shouldn't just be responding to crises and have protocols in place before crises; and 2) importance of partnerships and collaboration.

CP: It is very important for the public to understand (those in the community, loved ones of those incarcerated, peers and professionals, etc.) that this was a methodical and comprehensive undertaking to understand with authenticity, truthfulness, and a systems approach what is happening at the facility as it pertains to health services. This had to be done through a systems lens; not the jail as a silo, but looking at the public at large. Partnerships are important because of the safe transitions of care – before, during, and after incarceration at ECCF. This is a population that is even more marginalized than "historically excluded." Systemic racism necessitated looking at demographics of the population as well as of the staff. I would like for the public to be aware of PV's expertise outside of ECCF and how that has informed the approach to how we went about assessing the conditions there. Lastly, I would say that there was a very intentional process of extracting information – hours spent, who we spoke with, supervised/unsupervised conversations, how we gathered data, etc. What we want to do from there – we have short-term and long-term recommendations. The short-term recommendations are what we can act on now, so those conversations have already begun. A part of that effort was the bringing together of medical supervisors and leadership at University Hospital to discuss the barriers in the transition points. This is underway already, and we have a process for a record of accountability. Some of the long-term issues are things we have discussed since the inception of this task force. JF said it best – the jail is being asked to do things that it wasn't originally designed to do – care for complex medical, mental, and behavioral health issues – which exacerbates the cracks in the larger system. We are only a part of the solution for this problem. There is an urgency around mental and behavioral health, and we want to bring in experts who can assist in a more comprehensive understanding.

PV: It's important to have the professional pedigree to understand best practices, as well as to have the lived experience to do a true deep dive into such a hidden phenomenon. I came with 20+

years of correctional experience in PA, NY, Riker's Island, etc. This was more about those who worked every day at the facilities, however. I observed all of the key players and leadership in the jail at different times of the day. I spoke with a number of incarcerated folks alone to get an understanding of how they were being treated. This wasn't the warden telling me who to speak to. I identified someone and just asked to speak with them. These conversations were unobstructed; I wanted to learn about their experiences. Women's health needs are very different, and I tried to understand this as well. I spoke with leadership, frontline staff, etc. The jail has to trust you to access information; much of the data has sensitive information. The key to this trust is understanding each other and understanding the misconceptions when thinking about people who run facilities such as ECCF. These conversations foster determining best solutions. The facility didn't shy away from the complexity and the issues; they acknowledged that the jail needs help. If we can provide comprehensive care, we can do a lot to reduce recidivism. I want to acknowledge the work that was done here. We did unannounced visits to understand the complexity. I fully believe that, if provided with enough resources, ECCF can become the center of excellence and a standard for the rest of the country.

CP: While we are able to applaud our partners and collaborators, that does not mean we were impartial. The data is the data. We were never met with resistance around inferences we made and what the data showed. The public should understand how important this was for the task force; it was important this was done in an unbiased approach. I think it's important to have on record that we have someone with credible and extensive expertise in this space.

Molly Linhorst (ACLU-NJ) Facebook Question: "I understand that the authors of this report interviewed people in the jail directly as a part of this report, which is great to hear. I'd like to learn more about how the interviews were conducted: How did you decide who to interview? What was their understanding of the Task Force and this report? Was there anyone who wanted to provide information who was not interviewed? Where were the interviews conducted and was there sufficient privacy? Who was in the room during the interview? Besides one-on-one conversations, were there other methods for gathering information directly from people in custody?"

CP: If you understand the gaps that are present in the justice-involved population from the literature base, as you are learning in the setting of ECCF, you can make more informed decisions when observing the population. It was important for PV to be there at third shift and that she was given access to the people we were interested in, like tier reps, women, etc. There was not an area of staff that was not spoken with, and there were iterative conversations to dive deeper and get clarity on issues. As for the understanding of the TF, we have worked to ensure that the public (family and loved ones, general public, incarcerated individuals etc.) have an awareness of the TF and what our charge is through virtual and in-person communication. We have a telephone number for people to call in, and we have a log of the calls. We have an email as well, and the medical committee took this info as a way to guide and direct our activities. It was important during our unannounced visits to ask people incarcerated what they know about the TF and how they know and to ensure they understand what our work is. We asked to see the handbook and asked how people are oriented into the space. We looked into individuals getting in touch with the TF to ensure they do are not met with retribution.

PV: Nobody who came forward and wanted to say something was not interviewed. The third shift begins at 10pm until 5am, so I was able to spend a lot of time with the women. I walked around and spoke to most of the women there, and they shared their concerns. There were also concerns about food and water, so I tried all of those things to experience it firsthand. I think people need to know and understand – I think all county and state officials should do this to reduce the misconceptions. Without pure leadership that is totally invested in the people, this wouldn't happen. If you're curious about ECCF, schedule a visit. If state officials want to prioritize this issue and see best practices, go to all of the jails and decide for yourself as a human if a facility is failing.

CP: When I was there on an unannounced visit, we were often in the common area for interviews with semi-privacy, sometimes in the presence of the tier rep. As for other methods of gathering info, there were one-on-one conversations, the review of data collected by the facility, narratives shared through emails, info shared through our hotline, info gathered in our public hearings. We had conversations about a survey for those incarcerated to send back to us, but there were some complications and we felt the priority was around direct 1-on-1 and confidential methods of gathering info. We will revisit the survey, however, that is more comprehensive beyond just health.

PV: The interviews were in private, enclosed spaces where the individual could share whatever they wanted with no fear of repercussions. When I visited the housing unit, there was an enclosed area where I could speak to the women. The interviews were lengthy, about 45 min-1 hour, and they talked about the conditions at the jail as well as the reasons for why they were there at the facility. I had the opportunity to participate in a tier 1 meeting, where I could hear the tier rep's concerns – the majority had to do with technology, not being able to access the tablets, connectivity issues, etc. I was able to speak with people in administration segregation. The jail opened the opportunity to speak with anyone we wished.

JM: The administration has been tremendous in providing unfettered access. The only thing I'll push back respectfully (while we've made great staffing improvements), but I think there was a challenge with the vendor. We're moving the right direction – increased staffing levels – but there are contractual/legal issues, timing issues (shifts, determining when and where they occur, etc.). We need staffing overnight and in the evening and in the morning. We need staffing when people are in acute distress, so some of those issues may be matters for attorneys, but after some push and pull, we've increased staffing levels with the vendors.

CP: This is a critical part of the conversation. The persons providing care and who work at the facility have been empathetic, introspective, and willing to listen to us speaking on the gaps. We spoke with the vendor and we had very pointed questions for them. It's been very important that we did this with a certain amount of rigor and seriousness. Dr. Anicette was able to speak about the challenge of staffing – this issue is not unique to ECCF. This occurs across the healthcare system at large but is exacerbated at jails, and the pandemic has further exacerbated the issue.

LA: We've had a number of successes in recruiting and retention since the publication of the report. We have retention and recruitment bonuses, recruitment fairs at the jail, we've toured over 40 health personnel at the jail, and we've added on 15 people to the staff over the last three months. The county freed up monies and put in different pools to subsidize care. We added RNs and added NPs to intake. We've added telehealth technicians, a full-time telehealth nurse, someone dedicated to grievances and responding to triages through the tablet, a clinical director, another level of management within the facility. We've added to our ancillary staffing as well as the staff that coordinates appointments (two additional people). The officer who Warden Cirillo brought is a PhD-prepared psychology student and former Marine, and he's a full-time officer. This jail is not your typical facility; I hear the skepticism in the questions we receive, but we're improving our recruitment. Within one week, those who apply to a job at ECCF will be interviewed, screened, and given orientation.

JM: There is also a nursing shortage nationwide and Essex is small, but Dr. Anicette is engaging in best practices.

LA: We have triple the recruiting bonus for nurses. We have given an increase, over 10-20%, for those who stay. We've given retention bonuses to everyone who's been here through June ($5,000) across the board. We're holding onto our staff, and our rates are competing our with any healthcare facility in the region.

Warden Guy Cirillo (GC): I'd like to share the reasons for this cooperation to ensure that we address the issue at hand – the safety and wellbeing of the inmate population. I remember our first interaction, and I think the key to this cooperation hinged on the fact that the TF came in with the intention of helping. Dr. Valera humanized the staff at the correctional facility, which we don't usually get the privilege of – having the benefit of the doubt. To trust but to verify – I am comfortable representing this notion on the behalf of the county administration. We appreciate tremendously that the TF came with the intention of helping without admonishing the staff and recognizing that we are humans who want to help and acknowledge we need help too.

Director Al Ortiz (AO): I want to echo that – when CP and PV came in, they shared they're looking for the truth, and we aligned with that at ECCF. We have a unique population and we have to be truthful and honest to confront the issues. Those who are incarcerated are still human beings.

PV: There are 2 million people incarcerated, and anyone can end up there because of the policies and laws enacted. This is an "us" issue. We are directly impacted by our criminal justice system, and we must work together as a community to help. What the jails need, especially ECCF, is institutional funding to better provide services, and this requires political will and some money to put into reentry, behavioral/mental health services, staffing/retention/recruitment, etc. to prioritize the lives of these people.

CP: This is heart work for me and so many others here. I have to emphasize that none of our rigorous requests were met with resistance. We all wanted to improve the outcomes and the

well-being and lives of the justice-involved population. The goal is zero harm, and this is the goal of all of healthcare. As long as we keep this goal in mind, we can ensure accountability and transparency and quality. This will be an ongoing process and will come back to the public as we make more progress. We welcome the public's involvement and their demanding of accountability, because this is what we demand of ourselves and of others in the process.

ECCF Public Meeting on SHU Report Minutes

September 20, 2023

ECCF Public Meeting on SHU Report Minutes
September 20, 2023

Attendees:
Dr. Pamela Valera (PM)
Dr. Chris Pernell (CP)
Alessandra DiBlasio (AD)
Rubin Sinis (RS)
Imran Rabbani (IR)
Governor Jim McGreevey (JM)
Jugde Jose Linares (JL)
Michele Vanderstreet (ML)

Director Ron Charles (RC)
Officer Jacqueline Paz, Community Relations (JP)
Regina Holmes Marrow, Deputy Director (RM)
Dr. Roxanne Vega, Division Head of Inmate Programs (RV)
Dr. Lionel Anicette, Medical Director (LA)
Dr. Jason Fleming, Mental Health Director (JF)

GM: Good afternoon. Thank you very much for joining with us at the ECCF Civilian Task Force public meeting, focused on the Special Housing Unit Report. I just would also like to thank, in a special way, Azreen Rehman from McCarter & English, who's done a tremendous job and I just wanted to say thank you to her for all of her hard work. In addition to the individuals who will introduce themselves. We're also very much honored to have the Judge with us and the purpose of this meeting, frankly, is to review the recently published Special Housing Unit Subcommittee Report. With that, I would just like to ask everyone to introduce themselves, starting first with the Chair of the Subcommittee, Rubin.

RS: Good evening, my name is Rubin Sinis.

AD: Good evening, Alessandra DiBlasio.

CP: Good evening, Dr. Chris Pernell.

PV: Good evening, Dr. Pamela Valera.

JL: Good evening, Jose Linares, as Executive Director of the Task Force. Excited to be here.

JM: Thank you Judge. We're very much honored. Again, as we often say, we're really grateful to the ECCF and the entirety of the team. And Director, if you're kind enough to introduce yourself.

RC: Good evening, everyone. Ron Charles, Director of Essex County Department of Corrections.

JM: And if I could just ask the members to speak into the microphone because we're Facebook Live. Thank you.

JP: Officer Jaqueline Paz, Community Relations.

RM: Regina Holmes Marrow, Deputy Director.

RV: Dr. Roxanne Vega, Division of Inmate Programs.

LA: Dr. Lionel Anicette, Medical Director.

JF: Dr. Jason Fleming, Mental Health Director.

JM: And I just want to say thank you to all the doctors that are here: Dr. Fleming, Dr. Anicette, Dr. Pernell whose obviously SAT scores were at least 150 points over mine. I appreciate you all being here, appreciate your time and your expertise. With that, my role here is relatively succinct, but through the efforts of the subcommittee, they reviewed both the structure, practices, and procedure of the Special Housing Unit (SHU) on a variety of issues—dealing with not only the unit, but the state guidelines which were recently implemented pursuant to state legislation. I just wanted to personally thank the entirety of the Task Force, the members that are here, as well as Imran Rabbani, who will also be joining us because they did a yeoman's effort. In the interest of public disclosure, the Task Force Subcommittee report has been published and it is freely available on our website which the community can access at ECCF Civilian Task Force Subcommittee Report. With that, I'd like to ask for introductory comments and then followed along with Alessandra and questioning of our facility team.

RS: Thank you, Governor. In 2019, New Jersey enacted the Isolated Confinement Restriction Act (ICRA) which went into effect on August 1st, 2020. In essence, that law restricted the time frames by which individuals would be locked away essentially—would not have interaction with others. It's very technically defined as essentially of 2 hours or less of having such access. That is isolated confinement. How that translates into Essex County Correctional facility deals with a concept called Special Housing Units. Now, I will say that Special Housing Units are by their nature—it's a misnomer. There is not a unit—it is essentially a status. One who is in a particular status may be considered in a specific status. Various status include: involuntary protective custody, voluntary protective custody, pre-disciplinary detention, disciplinary hearing, disciplinary detention, mental health status, and initial quarantined (but that's not what we were really focused on). Our role, as a subcommittee was to determine the extent to which the Essex County Correctional Facility has implemented the newly enacted legislation and to ensure that their practices are in compliance with law. I must say that we are very pleased with the responsiveness of the administration. They were very open with us. As we'll go into later, in particular, a lot of our inquiries had to do with mental health issues and we received some very frank feedback from the medical personnel and medical director at the facility. I also want to thank our medical subcommittee. We really have built up some of the excellent work in the Medical Subcommittee's report that was issued last year and our focus really was on and tonight on the purpose of the law. The purpose of the law is twofold. One, to ensure that there is not a misuse of such isolated confinement on one hand and on the other hand, to mitigate against the harms that are endemic in having people who are locked away for extended periods of time. And that has really been our focus. Our subcommittee has issued a report that the Task Force has adopted and issued. We've made a number of findings and recommendations which we'd like to target our questions to the administration today. We've found that the Essex County Correctional Facility has made significant efforts to comply with ICRA. They have in fact adopted policies that the statuses I described are in compliant with law. However, we did make certain findings that not all the practices are in compliance with ICRA. In particular, under ICRA, there is not supposed to be use of isolated confinement for vulnerable individuals. We found that, in fact, that it is being used for vulnerable individuals, particular ones with mental health issues. Furthermore, there are time restrictions contained within ICRA for the maximum use of isolated confinement and that is defined specifically as 20 straight days or 30 out of 60 days. We have found in certain instances, those certain forensic cases or inmates have been placed in isolated confinement beyond that. We've also found some blanks when it came to record-keeping. It was very difficult for our subcommittee to assess

on an individual basis or an overall basis whether a particular inmate or all inmates timing was satisfied in terms of ICRA. That is because there really is a dirt of record-keeping there, in terms of out-of-cell time. The administration frankly acknowledged to us that they were in the process of exploring a digital option called PipeGuard—perhaps they can tell us more about that. There are services available through technology companies that certain digital monitoring can be done to make greater access to information about inmates out-of-cell time on any given time. So, in addition to those specific requirements, per ICRA, we had other recommendations which we'll go into including to make life better for those individuals with the status of isolated confinement, to increase their ability to have other ability to have other resources, their ability to use Wi-FI services, and many other recommendations. With that, I'd like to turn it over to my colleague, to whom I thank for their work on this report: Alessandra DiBlasio and Imran Rabbani who will really dig down to the various recommendations we made and ask follow-up questions.

JL: Rubin, before that happens, I just wanted to commend the committee. I know and I want to tell the folks from the correctional facility that this indeed very vast and difficult for the committee. We understood that the committee, specifically Rubin, Alessandra, and Imran did an unbelievable job with the help of Doctor Pernell into digging into this stuff. While, at the same time, understanding the challenges—both financial, staffing, and other challenges that you had at the facility. Yet, being able to stay loyal to our task of being able to make recommendations and hopefully improving whatever can be improved under the circumstances and when you layer on top of all that with the difficulties. We're not just dealing with regular inmates, but inmates that have mental issues. They understood and it was obvious to me from some of the meetings that I participated in that that was a challenge that they wrestled with and how to do that especially when they're bumping up the ICRA requirements. I didn't want the night to go by without me commending the committee on the tremendous job they did on that. And I wanted to say to you folks that they clearly understood that you were having some challenges. A lot of the stuff that we were falling out with, or you were falling short with was because of the challenges that you have. We understand that. But the job of this task force is to hopefully come up with recommendations and ideas that can make things better for everybody.

AD: Good evening. I wanted to start us off with going through the report that we submitted and ask you in the very beginning about the record-keeping deficits that Mr. Sinis was talking about and if you have been able to implement the PipeGuard system at all yet.

RC: I want to echo the Judge's sentiments. From an operational standpoint and from a corrective standpoint, we believe that the report is a fair assessment of what happens at the jail. We look at it as a tool to take things that we are falling short on, and get better in, and things that we're doing good on, to improve those and become best practices in industry. Both myself and my staff have worked towards that since the report and as we go through the recommendations you will see, over the last few months, some of the things that we have put in place. So, I'm willing to take them anyway you wish to take them.

AD: Let's start it one-by-one and like all the other meetings, you'll just speak and we'll respond.

RC: So, the PipeGuard system is owned by a company called Guard One and throughout the county they handle those particular things in Special Housing Units. We interviewed other vendors and we came back with the system which is not the Pipe[Guard] System. It is actually the Guard One system. It's an enhanced system. The PipeGuard System is basically like a tormins. You go to each cell, each area. You tap the pipe towards the pin and it registers the time. We're getting away from that. We're going towards a fully-automated system where you'll be able to have digital reports and digital records of out-of-cell times for inmates, in-cell time activities, what they're doing every half-hour, every hour of the day. A supervisor will have in real time the times that the staff make the rounds or put in the intakes. They will then have—if they fall short of doing their rounds or putting their information in, the supervisor will then receive an email notification on his system. Then he or she will be able to go into the housing unit and say, "Listen, hey, you haven't made these rounds since last tour. You need to do this, you need to up this." More importantly from the system is the quarry of reports we can pull from the system. We'll be able to know who's

in Special Housing Units for what particular reason, when they're out, when medical came in to see them, when the mental health people came to see them, when they received commissary—all of that will be fully automated. It's an extensive system. We had to upgrade the Wi-Fi in the Special Housing Unit which we have done as well. We will talk about that because that was a separate recommendation. We should see that [system] come online sometime before Thanksgiving. It's more elaborate than just the PipeGuard system.

AD: Do the officers need training on the system?

RC: They will need about six-hour training. The manufacturer is going to come in and do it. We're going to have a training unit do it. We're going to walk them through how the system is operated, what reports they can pull from a supervisor, and an executive team will be able to pull quarter reports each day, each shift.

AD: Do you need additional staff, now that you'll have so much more information coming in? Or will you be able to use the staff that was doing everything by hand before?

RC: The staff that was doing it by hand are going to be able to automate things and become digital. So, hopefully, it'll be a less time consuming thing. They'll have the reports with a hit of a button.

AD: And the staff that is running that—do they have authorization to make changes if it turns out that the inmates are not getting out enough, aren't getting enough showers, or enough time in the law library? Once we can see it all with the system, do they have the authority to then make these changes?

RC: It would be the union supervisor, specifically. But then that would trickle down to the unit officer as well.

CP: Two quick questions, if I may, Alessandra. So, when you mention that you expect for the system to be fully functioning by the end of November—is that inclusive of training or will the training lag in some form?

RC: No, Doc. We are hoping that by Thanksgiving, we'll be fully up and running. The only part of that is the installing of the pins, but since we're not spread out throughout our whole geo, we're going to try this in the SHU. The manufacturer believes they could get it done in a couple of days.

CP: Okay, great. And then when you mentioned, with Alessandra's question, that if there are changes to be made to the unit supervisor. Is that something that needs a procedure to be laid out or you fought through a step-wise approach so when that happens, there aren't gaps in the actual performance.

RC: I had the system in Union County when I was a director there. So I'm using the policy and procedures that we had in Union County. We will just make it tailor-made for Essex County. So it shouldn't be more than a couple of days.

JM: Can you talk about the redundancy of the system? And to go to Chris's question, how to modify or asses its failure?

RC: First, on a custody and a security standpoint, we'll be able to see when the rounds are being made—when they're done, when they're not done. The supervisor will have the capability of making sure that the staff, if they happen to miss it, because they were doing another project, they'll be able to jump on that right away. Also, we'll be able to look at the end of the day when it comes to the executive level and say, "Hey, listen, these guys didn't receive enough recreation yesterday or we need to make sure they get enough recreation [time] or why was their commissary time cut short?" Those are all things that we're going to take a look at from a com-stat or daily receive and make the changes on that.

AD: I'll just move onto the next point and then my colleague Imran can take over. So, one of the things we noted up front in the report and then in part six under recommendations for improvement. We talked about developing policies and practices to review the psychological impact on inmates who are in SHU status. This would be particularly mental health and the voluntary who are there sometimes for 300 days, well beyond the twenty-day limit. Can you just give us an update on this status?

RC: From a custody standpoint, we have been reviewing the policies and matching them against best practices for the ACA, the NCCHC. We've made some changes to that. What we've done is we've created a classification unit just for inmates. Now that will be reviewed within the SHU. We also have a classification unit that will handle the whole classification of the jail. But, now we have individuals, with supervisors, who are just reviewing everyone who is either in the SHU or are anticipating that they will be going into the SHU. So, it's an evolving project which requires us to change policy. The state came about three weeks ago to exam our policy. They're coming again next week for a final review. So if there's any recommendations from the state, we will certainly implement those. From a clinical [standpoint], I'm going to defer to the two doctors.

AD: I think one of our biggest concerns was more staff. So do you have some feedback for us on that? We're asking that there be more evaluations more often so that would probably require more staff time.

RC: You're talking about clinical staff and medical staff, right?

AD: Yes.

RC: I am going to defer to the doctors on that end.

LA: First of all, thank you for the opportunity. I think it's always good and enlightening to come here and to discuss the nuts and bolts of what we do. So, the recommendation regarding staff which I think the Essex County Correctional Facility recognizes [as being] one of the key ingredients to create this program that promotes stability and the ability to manage these patients in the facility and also when we discharge. What we're looking to do and what we've been doing is we started recruiting. We worked on recruiting and retention. On a retention pathway, we've actually increased rates for the people that are there because there was a great migration in the county and folks were looking. So we made a commitment to them so we're not losing them to places like University Hospital. So, we've found ways to be able to engage our staff to have them understand that they're valuable. And the fact that we've kept over 90% of our staff throughout this pandemic year was a testament. Again, it was a work in progress because we kept having to look at our budget and our resources. But we've committed to our personal and human resources. We've also started some internship programs. We had some interns come in to try to groom people, groom that interest and cultivate that interest in working for us. In some ways, Doc (Dr.Fleming) has been very innovative. I'll let him talk about how he's been able to bring in some of these interns that are close to finishing and again have them have an early look at what we're doing. We also had some empty spaces that we have filled. So, we're close to almost fully filling out our staffing matrix which is not always the case when we're in front of this committee.

AD: And I think what we're trying to get at is not just more staff, but more involvement with the inmates in the SHU. And have you been able to come up with a way to have more evaluation time more often? Staffing is the first step, but they have to do something.

LA: You're right. Because if you have the staff and they don't have the work space that will enable them to engage the patients—that's a key element there. What we've been working with the administration to do is to create a dedicated mental health step-down. That's something that I think that was something that originated from here. I

think we're really on the verge. Can reschedule for next month? Because by next month, we'd be able to tell you. We've opened it because what we had to do is look at the population, look where we could consolidate, and with the deputy director and the director's lead, we've been basically able to carve out a space where we'll be able to step down patients from SHU. Our goal is to depopulate the ship with mental health. Those patients that are in doctrine—and I can definitely dive deeper into the details—but those that have not been decompensated, those that can bear to do group therapy, take them out of that environment, create a better therapeutic environment. And so, that unit is being cleansed. It's already been cleansed, it's [now] being painted. It's already been targeted for those patients. So, now, Doc [Dr.Fleming] is going through the selection to put the right group of patients together. But that's a real defining moment in changing how SHU operates.

JL: And that's going to be dedicated to mental health?

LA: Yes, that will be a dedicated mental health step-down [unit]. Right now, I think it's projected to take sixty-four [patients] and they'll be able to do some of the type of programming Doc's been wanting to do and the staff has been wanting to do. engaging the patients is really the key. I think Dr. Pernell was saying earlier—screening these patients, profiling them, and that's been done, so we know who's who. But now, what to do with them, they all can't be consolidated into that SHU unit.

AD: I was going to ask—and maybe Dr. Fleming can respond to this, but it's not just the mental health. We're very concerned about those whom we met, the voluntary people who are there the entire time. So, 300 days, 500 days. I mean, there's some extraordinary length there. We're concerned that they're also being evaluated because yes, they volunteered, but still, it takes a toll. So, we wanted to see what you were doing so those people are assessed and evaluated.

JF: I have a few thoughts. Again, thank you for the invitation and glad to be here. An answer to your question: all these evaluations, you're absolutely right. It takes people to actually do them. We have VPCs or IPCs which are on protective statuses, but it's a lengthy lesson.

CP: Can you define the acronyms?

JF: Involuntary protective custody, IPC. Voluntary protective custody, VPC. There are a lot of them with different needs. Some of them have mental health needs, substance abuse needs, some of them are involved in MAT programming and different things like that. But an answer to your question about the evaluations, I, as a mental health director, need a who's going to be doing them because there are a lot of people who do present with needs. Some don't, but in particular to their mental health, but it takes people, it takes staffing. So, I was going to get into this and some of the questions about staffing. I've said this every time I've had the opportunity to speak here or in other forums. As a mental health director myself, I have five mental health clinicians. I have one psychiatrist and one acute psychiatrist nurse for over 2000 inmates. I can't put it any other way. I literally can't put it any other way. So, when we're talking about doing evaluations, it ends up being someone who presents with a need to be evaluated, gets evaluated. As a result of that, some folks slip through the cracks or they aren't identified but additional staffing and you know, everybody's like, "I need more staff, I need more staff"…but I'm trying to explain to you the numbers and just how certain aspects of our ability to better identify, better assess, better triage folks who are in the facility could be improved by having [more staff]. If someone were to ask me, I could use 12 more mental health clinicians. Then we could actually get to the people who are just depressed or just a little bit anxious or just having coping skills or just have anger management issues. Instead, we're typically putting out fires in the SHU and then, sort of spillage outside of the SHU for folks who may require that level of care, but there's a space issue.

JM: Doctor, could you explain—and this could be helpful for someone who's not as well-versed as you and Dr. Anicette and Dr. Pernell—the percentage of those that are classified as suffering from mental illness, that trajectory

over these past years and what the future holds, and the imbalance in the institution? And secondly, as you did for me and I saw on the well, the number of clients, participants, or persons that are waiting for a transfer to state psychiatric facilities.

JF: You're hitting all my points. I appreciate you bringing it up. At the present time, there are approximately of that 2,000, about 850 of them have some mental health diagnosis. Now, it may be some form of mental health diagnosis or substance abuse diagnosis. It may be history of depression, history of anxiety, ADHD. So, there are some that meet the criteria for having a mental health diagnosis.

CP: Would you be able to say which one is most prevalent?

JF: Major depressive disorder, anxiety disorder, PTSD, schizophrenia, schizoaffective disorder, and actually wedged in between the two would be bipolar disorder. I would say a little less than maybe 40% of the population has a mental health diagnosis of some sorts. Majority of them are being prescribed medication or we are recommending that they take medication. We have a significant subset of that who do not take medication or refuse to take psychotropic medications.

JL: Of the ones that are in the SHU, what percentage is that? Because therein lies the problem, because that's not what the SHU was designed to be.

JF: Correct. So, two points. It was mentioned earlier that the SHU is a combination of statuses, but we actually do have two SHU units that were—for the lack of a better [way to say it]—was overrun with very, very, very mentally ill inmates, patients who have to be housed alone. We would be able to have all those statuses much more likely to be able to be maintained in the two SHU units that are at the facility.

CP: Can you say how many beds those are or how many persons can be in the SHU unit?

RC: The SHU lock unit for the housing units hold about 256.

JF: In particularly for the SHU—because there's no other unit to house the severely mentally ill, unfortunately—many of those cells are single cells because they have to be. These are some of the patients that would likely not come out for rec or exhaust our resources in regard to like codes or crisis or engaging in behaviors that put mental health staff, medical staff, and custody staff at risk for being assaulted, or having bodily fluids thrown on them. There's a lot going on that goes on in the SHU that requires a lot of time and resources of the few mental health staff that I have.
What I will say about the numbers who end up in the SHU—and I've only been there for three years and it's significantly increased. The number of severely mentally ill that arrives at our doorstep every night and the number of developmentally disabled who show up. There's not a whole lot that the community can do for these folks, but they show up at Essex County Correctional Facility because they got arrested. They're also in the SHU, they're also housed alone. We're making best efforts with my staff, with the medical staff to treat them, to support them, to get them out as soon as possible. And an answer to your question, this is primarily due to the lack of beds they have in psychiatric hospitals. Primarily, its two that we engage with: Trenton Psychiatric Hospital and Anne Klein Hospital. At this point, I have a waiting list of 13.

JM: And people could be on that waiting list for months.

JF: It could be months. And sometimes, there could be a court order were a judge says, "bump this person up the list." Sometimes there could be no rhyme or reason. It happens frequently, so there are some names that have been on the list that have gotten bumped.

JL: One of the recommendations that came out of the subcommittee is trying to explore a partnership with a psychiatric facility. Did we make any progress with that.

LA: We did, actually. So one of the initiatives that we've launched with leadership and my colleagues was to reach out to Silver Lakes Hospital. Silver Lakes Hospital has a number of beds--33, in fact—that they're willing to commit to such initiative where Dr. Fleming's patients that need that commitment to go into that setting, be stabilized, and then return back to the facility. We've reached out to the ownership of the hospital, the medicaid department. We've been able to have a conversation with the head of the medicaid department, Jennifer Jacobs, and make our case. She bought in. She actually was very forthright. She said, "I don't see why this shouldn't happen, but I could see all the logistical changes that have to happen."

JM: I just want to congratulate Dr. Fleming, Dr. Anicette and the Director and bluntly the County Executive and the Chief of Staff, because California was granted a Medicaid waiver. New Jersey, despite the best efforts of Commissioner Adelman and the Governor's office, they didn't expand it, but thanks to the Chief's leadership, they're considering possibly CMS. Not to get into the weeds, but CMS which oversees Medicaid will not permit the Medicaid reimbursement of a person within a correctional facility. So, California was able to grant a waiver such that in the California Corrections System that they will provide psychiatric and mental health treatment, but that requires a federal Medicaid waiver from CMS. New Jersey applied. Unfortunately, it wasn't given. New Jersey had a strong application but the Chief of Staff and the County Executive have asked to create an exemption to CMS on a pilot basis so that Essex would be considered as a pilot to be granted a waiver such that CMS or Medicaid dollars could be appropriated for individuals for this project which would be a game changer. I would just like to congratulate, on the merits, for their seeking those federal dollars which I think, as Dr. Fleming said months ago, is the way to go.

CP: Do we have a sense of the timeliness of that process?

LA: We do. We have, when you look at the stakeholders that would be the decision-makers, we literally got a yes from everybody. The difficulty is that they need to work on maneuvering federal guidelines for CMS for Medicaid and that interplays with State supervision of those resources. So, the point person is Jennifer Jacobs. It's a new initiative. The Executive Director would actually be the person that would lay out what the plan would cover. The ownership of the hospital has basically opened up to whatever they need to change policy and procedures wise. So, there's no push back from the hospital in terms of what needs to be done. Frankly, we're waiting for guidance from the state.

CP: So, specifically, from Jennifer Jacobs.

LA: Yes, she, herself, coined the [term] "A-Team of Medicaid." It was about 8 or 9 individuals who have been invested in that Department for years. The job they were tasked with was to collaborate and figure out logistically, or step-by-step, on how to enact this pilot.

JF: I'll ask if the Task Force has any juice or any ability to assist us with this because we met two Junes ago at Silver Lakes Hospital to start all this and here we are still. We are trying to break through the door to get these very, very ill people out to stabilization units so any assistance that the Task Force could be with that would be appreciated.

JM: Just so you know—thanks to Dr. Pernell, we actually requested a meeting with the Commissioner of Health, Dr. Kaitlin Bastone, who's tremendous. She's out of the Cooper System. Kaitlin's just been a great advocate for our population. We asked for a meeting with her.

CP: And to that point, I did follow-up with her about that meeting last week. So, we are trying to get that meeting bumped up.

JL: And to that point, if you guys have meetings that you think it would be helpful to have a representative of the Task Force present to make the argument for you—I think that would be helpful. I agree with you that through numbers, everyone's throwing in the same direction—that always helps. One of the other recommendations that your committee had to do with encouraging the county officials to find other areas of funding. And that's always the problem, right? But has any conversations taken place? And is there anywhere that we could be helpful with that as well.

LA: Actually, the jail has applied and won number of substantial grants and also partnered with some community providers that one in particular that the Director did sponsor and wrote a letter of support for was M-18. That was just awarded a few months ago, so those funds will be dedicated to doing re-entry and bringing in those counselors into the jail themselves.
CP: How many?

LA: Frankly, the money is about five-hundred thousand. So, again, how that's distributed personnel wise—they don't let me in that room, but they're going to use those funds for those purposes and that was a notable achievement. Again, this is a multi-layered problem, so if we look at where some of the rate-limited steps: docs, forensic patients probably represent the biggest issue of the day. And so what we're trying to do where we can get 33 beds—those are 33 patients that don't need to be in the SHU. They can be placed there under 24-hour mental health care. Then, if we can get another 64 to go into the mental health step-down, you're looking at 99 patients that no longer have to be within that She environment.

JF: Also, Silver Lake Hospital will be helping us with stabilization units. This wouldn't be necessarily long-term. This would be a 14-day or 28-day [term] as opposed to like months and months and months at times. Having the ability to send someone to a stabilization unit where they could be a treatment plan because it's a hospital setting as a opposed to a jail setting may increase compliance with medications and one of the things that doesn't occur because we don't have that option that those very mentally ill end up languishing in the facility. They're often too unstable to appear in court, so their court dates continue to get bumped back because they're not appearing. So their legal situations aren't being resolved by any means. I have a patient that I'm thinking of in particular whose last October, if he was stable enough to go to court, would of had his charges dismissed. He was with us up until a month ago, when we finally got a bed for him at Trenton Psychiatric but literally, if he had been stable enough to present to court, take his plea deal, [and be able to say] "I did this, I did that, I acknowledge my actions," and accept some sort of rehabilitation plan that would've included treatment in the community—he would have been gone a while ago. So, not having the ability to move sick people to a better environment where they can be more engaged in treatment at a higher level than simply a jail setting can provide. By not having that option, we're forced to have our SHU overrun and spilling into other units. It makes it very difficult for the staff because most of the time it's being taxed by very sick people. Again, we don't have the staffing or the ability to treat other folks in the general population who needs our services as well.

PM: That brings me to my question regarding your screening tools. Are you all using evidence-based screening tools prior to sending folks into the SHU. During pre-booking you have that assessment and from my understanding, those questions are just "yes or no." There's not really clear evidence-based guidelines to determine whether someone has a mental health diagnosis. So is that something that you guys are looking to change?

JF: We are. We've gotten questions from the Task Force about this in the past. We know, clinically, of who meets criteria for X, Y, and Z and that would identify what the mental health diagnosis was.

PV: Yes, but, not the assessment, but the screening prior to diagnosis.

JF: Correct. What is more concerning is the severity of the symptoms because we have many patients who suffer from schizophrenia or other diagnoses who are in that general population. It's the severity of the disorder or to how debilitating it is to the patient functioning that ultimately has them deemed appropriate for or needing to be placed in the SHU on a forensic status.

CP: We may not have the time for you to dive into this deeply because I want to respect my colleagues here to dive into additional recommendations, but it would be very helpful and also necessary if we can think through to what are the impediments to evaluating and launching the most appropriate screening tools because like you said, we have talked about this for quite some time and how can we help to remove those barriers so that can become a win for the facility and lead to a more appropriate identification of mental health issues or illnesses or appropriate placements of persons in the facility.

PV: And I'm happy to send those assessments to you.

JF: I'd appreciate that, yes. Please do. To be honest, the issue and the concern that I have is not the ability to diagnose them. It's the ability to get them the treatment they need once their diagnosis has been established.

CP: Heard and acknowledged. But I do believe we need to do both: ensure that we have evidence-based screening tools as well as when identified to have a certain diagnosis that you are getting the right treatment.
PV: The reason why I'm pushing this is because there will now be a dedicated mental health step-down unit. So how do evaluate which persons are going to enter that unit without the proper screening tools.

JM: But, there are screening tools, Pam and correct me if I'm wrong, Doctor. There may be a dirth of screening tools holding into general population, but there are screening tools taking place when people are in general population. I nthe sense that when I had the opportunity to meet with the health workers and the mental helath staff, they showed me the screening tools that they used and how the address the needs of persons even when they're in general population.

JF: They're determined when they aren't appropriate for general population.

JM: But, correct me if I'm wrong—but they do use screening tools when they're in general population and when it's a heightened level of mental health enrichment.

JF: Correct. That's usually mental health's first involvement with that or routinely as.

PV: But the pre-booking screening doesn't.

LA: I just want to make it clear that the correctional world has a different agenda. When someone's in pre-booking, there's only two things from a mental health standpoint that we want to know: if they're stable enough to move for housing purposes. Not so much diagnostically for what type of mood disorder they have. We want to know, are they suicidal? We want to know, are they homicidal? We want to know if that person is so decompensated that we shouldn't even let that person come to the jail or have them go directly to crisis. So, its really a spot-on picture of that person but again, I wouldn't want to read too much into the diagnostic at that point because frankly, there are people that are coming in there and that is the most anxiety-inducing moment in there lives and what we're seeing right there is not really them, but the circumstances. So we are really looking for that individual's safety and safety for the facility. Afterwards, doc (Dr.Fleming) and Fisher has all the wherewithal to handle in terms of the diagnostic piece of it. But when someone's coming in day one, we want to get that pre-booking done within 4 hours.

JM: Doc, to go to Professor Valera's point. Is there something as basic as a compass assessment that could be used between holding and general population?

LA: Not that you couldn't do it. But I think what you're going to find is that the screening tools are a combination of a number of evidence-based tools and they took out the heavy hitters and said, "can we use this to test." So it may not say specifically on top but they'll take those relevant set of questions and insect it. It took a number of studies to create that. If someone were to come in [and look at those questions] I don't think there's one that anyone of us would eliminate in terms of a screening because we do want to know if this is someone's first incarceration. We do want to know if they had a position of influence in their community. We do wonder if they had past issues. So, these are the things that are quick, sharp and they're done at a level that's not at a level of Dr. Fleming. They're done at a level of
LPN. They're done at a level of arming.

IR: For the sake of time, I think we want to move on. I think we want to focus on SHU specifically. I know we're beginning to discuss general population and intake.

JM: That was my fault, I'm sorry.

IR: And Dr. Fleming, as for your nomination of a person on the Task Force that you'd like, we nominate Governor McGreevey because he doesn't sleep. So, Dr. Anicette, you mentioned a step-down unit is in the works and hopefully next month will be taking in these forensic inmates. But, I think one of the populations that we wanted to focus on were the disciplinary detention inmates because what we want to make sure is that we're in compliance with ICRA with respect to the time restraint that we do have with them. I know there's a set time limit or set number of days that they could be held within SHU. Where are we currently with establishing the step-down unit for the disciplinary detention inmates?

RC: So, that's an operations question. I see two units being—and I have it in my notes. We are creating the mental health step-down unit—that's one. If you give me a few minutes, I can talk about it from a custody standpoint. The 2E3 has been designated as the unit. It has been totally rehab, repainted, the fixtures been upgraded, the lightings been fixed, the plumbings been all redone. The plan is to house Level 2 and 3 inmates there who are the least restrictors.

IR: 2E3 is for forensic inmates?

RC: Correct. Then, we're doing something with the staffing there and I think this is very important. I want the staff who are willing to work in that environment. I want them to—I don't want to say volunteer necessarily, because we'll make assignments if we need—but I pulled the staffing to who wants to work in that particular area of that program. I think that's important. So that's what we're going through now—the potential assignment of staff and that'll probably be done by mid-next week. Dr. Valera has graciously said that she would give them specific training. It's set for October 11th at the Police Academy. Dr. Fleming said he will go over the training. I think this is very key here because what we're teaching at the academies, what we're teaching at the orientation training, what we're teaching at the in-service training—we need a higher level training from the custody staff. So, we're hoping this will start to get the ball rolling. Then, as far as the programming of that unit, we're hoping to see self-programming, group activities, individual activities. I spent the last week with the Department of Justice and some of their recommendations are things like painting, puzzles and those types of activities for the housing unit. We're looking to Dr. Vega's office to bring some of that programming into this. I think there's also a need of transition once they're stable into general population because we want to limit the amount of people that are in the program. To your point, part two of that is the disciplined detention. We are looking to create what we call restrictive housing

program which basically answers that. Once you spend your time in detention, you'll be then stepped-down into a more custody environment where we have more privileges and then the next step would be general population. They won't have the restriction where they're locked in twenty hours a day. They'll have more time out, they'll have more privileges. The inmate services go on as well.

IR: Do you know when this will be implemented?

RC: So, I am looking to do this first probably within the next month. Once I get done with that, hopefully by the end of the year. There's some clinical component of that as well. Right now, anyone going into detention is reviewed by the medical and then periodically as well. We went to make the clinical part of this big as well. Because, as we know, being locked up does have a negative impact on a person's mental health.

RS: There's a quirk to the law that I just want to know if the facility is doing anything. My reading of ICRA is that while disciplinary detention is certainly an appropriate placement for those who deserve it or need it or there's probable cause to believe that. My reading is that those who are in vulnerable populations are not entitled to be placed in disciplinary detention. Is that, in practice, what's happening? Vulnerable populations include those with a history of psychiatric illnesses, or psychiatric hospitalization. Based on our review, I think those individuals are, in fact, being placed in disciplinary detention, is that correct?

RC: At the time of your review, that was probably the case.

RS: How about now?

RC: I would say, now, it's maybe not 100 percent, but we're significantly better.

RS: I appreciate you making the effort.

CP: What percentage is significant?

RC: 75%.

CP: So, at current, there are 25% persons who are among the vulnerable population who are still being housed in disciplinary detention?

RC: I don't have the exact numbers, but roughly, yes. That's an honest answer.

CP: What's an action plan to mitigate that.

RC: Couple of things: I think we need to go through training. The creation of these two housing units is very important. It's the space.

JL: That program that the Doctor was referring to earlier, would you be a part of that solution.

RC: Correct.

IR: That would take me to my next question. When we conducted a few tours of the facility. When Alessandra and I had come by to the SHU, we noticed just a lack of educational opportunities and recreational opportunities. There's a small area where SHU inmates are allowed to walk around, play with a ball, or jump rope. That was then. How have we sort of improved—whether it be educational programs, I know the tablet is a big medium for that--

recreational programs, religious programs. If you could just touch on those topics on by one, and let us know the current situation of that.

RC: I want to defer to Dr. Vega, but before I do, I think one of the points is by the assignment of Dr. Vega to handle all inmate programs was key in us increasing the general population programs and for the inmates in the SHU and mental health. She's done a phenomenal job of opening up many programs, so I will let her detail that.

RV: So, I will address. I'll start the religious services. In the SHU, religious services are offered. They're offered one by one. We have from every affiliation. Right now, I have over 15 volunteers from Volunteer Nation that provide services to them—one-by-one or in Bible studies. So if there's a room available, they're allowed to come out for that. Is that satisfactory for that? As far as recreational programming, for those who are in VPC—if they have started a program, we've allowed them to continue. We have OSHA and construction right now. We had a female inmate who signed herself in. She's almost finished. She's getting out next week. Then we can connect her to services when she gets out. We are allowing her to continue the OSHA and construction one-on-one. She is also being allowed to participate in the first aid CPR AED course so she can continue getting all of the certifications needed, so that she can get into the CDL program when she leaves here next week. So recreational programming is offered to everyone in the jail by Mr. Knight, who is the recreational specialist. If they cannot participate in the big programming activities, he brings it to them. If they are not stable enough to participate in those group activities or in the gym, he will bring them the games or whether its painting or paperwork, he'll bring it to them in the SHU. But there is educational programming on the tablet that they can participate in that they can get and receive certificates in. There's over 150 different types of certifications that they can receive on the tablet.

AD: If I can just ask, I missed the name of the individual you mentioned—

RV: Mr. Mark Knight

AD: Yes, Mr. Knight. That's one person for potentially 256 people in the SHU so that can take about half a year to get everybody. Again, is it staffing that you need, actual painting kits? What do you need? Because, to Mr. Rabbani and I, it appeared to us that there was almost nothing available: recreation time means you get out of your cell and that was it.

RV: So, Mr. Knight is one person but he does a great job at hitting everybody at the building. As far as staffing goes right now…I also teach at Rutgers University, so I am working with Rutgers University to bring in interns from the sports department so that he can have some interns, so that we can reach more people in the jail.

JF: What I could add if I could just for some clarity and context. ICRA, it's a standard—sort of like, in best practice when it all works out well, this is what we should be doing. Unfortunately, we work in a real-life and in real-time. For example, in the SHU, patients who are seriously mentally ill or even if they aren't, very physically aggressive, bullying, involved in gang activity. There are a lot of moving parts that also need to be taken into account. Let's say, for example, someone who has bipolar disorder who happens to assault an officer. In my opinion, he shouldn't be in restrictive housing, in a sort of therapeutic environment if his mental health condition is not allowing him to be adequately in that environment which is safe for himself and others. So, there will probably always be instances where a small percentage of patients who are in the SHU for disciplinary reasons or for mental health reasons who don't play well with others, can't play well with others. We need to be very creative in finding options for them, but again, ICRA—yes, in a perfect world, we would be doing those things, but I think what you're seeing as it relates to Essex County—whether it be staffing, physical space, or the types of the profile of a patient who are coming into the facility. Sometimes there isn't an ability to sort of make it work to fit within a standard. We'll always striving to do our best as it relates to that, but you know, at times, there's going to be someone with schizophrenia who's going to be on a disciplinary status. And how that disciplinary status looks like—we can get creative in how that person is

housed, but essentially, there are going to be times when there needs to be a disciplinary status is a part of a vulnerable population. Otherwise, others will be made vulnerable as a result of sort of the bending and over-allowing of certain people having access to services when maybe it does need to be a time when restriction is least necessary. We can monitor that, but you know.

CP: So, I just need some clarification on that. The law is not perfect. It's for what the average or standard person should have a right or entitlement to. Is it that because you have someone with a severe mental illness and you don't have a more appropriate place to treat or house them that if there are behaviors that can potentially harm others where you might say I would put that person in disciplinary status, but if I had the appropriate mental health resources, that would not be consideration.

JF: Correct.

CP: I think that's the point we should make and we should be careful to make that point especially because we're talking about historically excluded and marginalized populations.
RV: If I may just add one more thing as far as programming. For those who are not quite as stable enough to participate in programming, we do have a trauma specialist there and she does provide them with one-on-one counseling once a week, twice a week if needed. And she does give them activities to do whether it be adult coloring books or assignments—I do have staffing for that as well.

IR: Thank you for that. And you briefly mentioned that there are a significant amount of educational programs or software on the tablet. So one of the issues that the SHU subcommittee realized that there's a WiFI problem within SHU. So we noticed that many inmates were coming to the door in really awkward positions to receive signal or they'd be holding it up to the ceiling or by the window. The director, at the beginning, mentioned that there would be an upgrade to the WiFi. So if you were able to provide the
specifics, please do.

RC: Yeah, sure. So we did two upgrades. We did a half a million dollar upgrade in the facility for medical personnel so that the medical staff could then travel throughout the facility to tap into the EMR. So that was project number one. Project number two, specifically for the SHU, which was completed at the end of April and beginning of May is that the WiFi expansion in the SHU so that cell-to-cell now has WiFi. So if you're in the cell, you don't have to stand on top of the bunk, turn it south by southwest or those types of things. SO, it seems to be corrected the problem and they are greatly appreciative of that.

IR: So you have received feedback from the [inmates].

RC: Actually, I double-checked before we came today, so we had a meeting with the representatives and the staff that are there.

IR: I think if we could discuss—and this seems to be a theme within the medical staff and recreation with Mr. Knight—there just seems to be a lack of resources, a lack of staff. I just want to give credit to the facility and the Directors, as well as yourself, for doing the best you can, as well as giving us unequivocal access and transparency, but realistically, having one person Mr. Knight serve 200 plus people, it can be very demanding; it can be overwhelming. There should be a comprehensive approach. Our report suggested that there be nine medical staff who would serve the general population as well as the SHU. And they're likely overwhelmed. So how could be comprehensively tackle this issue?

RC: So, I have a commitment from the County Executive's office and the Chief of Staff, in terms of staff for medical and clinical, if the Task Force, if the medical department, or myself feel the need to increase—we have a

commitment from them to do whatever is needed staff-wise, from a clinical or medical standpoint. From an operational or custody standpoint, the year and half that I've been here, we're over hiring. So the notion that we are short custody staff is nothing further from the truth. We constantly hire. We've constantly promoted. I can get specific to the numbers. For officer wise, we're budgeted for 580 officers. I have 656 today. For captains, we're budgeted for 8. I have 10. Lieutenants, we're budgeted for 22. We have 28. Sergeants, we're budgeted for 56. We have 57. Civilians, we're budgeted for 55. We have 55. So the commitment from my office and from the county is to keep hiring if we need it. We never want to run the facility short or for unsafe conditions for the staff or for the inmates. That's how we've been proceeding the last 12 or 13 months.

CP: Can you just clarify for me? You just shared with us what's budgeted and then what's actually there in practice for the operational staff. So, we have pinpointed that for recreation, there is one person that has responsibility for—let's just be really honest—a number of people that would not allow that person to effectively perform their role. So, what is the process to say we need an additional staff person or we need cross-reference of staff who are able to do the same thing or we're going to have X amount of interns to support that. I think that's what Imran and others were trying to hear. And to put another thing on the table—I've been to multiple meetings and conversations where I've heard Dr. Fleming always say, "I could always use more mental health professionals, more mental health staff," and that number has ranged. And I think in our report, we may have said at least nine or so, and tonight, he said twelve. So, also what is the plan, in particular, around mental health professionals to improve dynamically that number. I understand and I applaud the facility for the mental health step-down, for the conversations that are being held with Sliver Lake and Medicaid. All oft hose are necessary, but what is also being done because we keep hearing a similar thread around the need for mental health staff.

AD: So, all those excess that you've told us that your over-budgeted for, can that money be moved to them if you're above.

RC: So we have a contract with CFG. And that contract calls for X amount of staff, doctors, nurses, LPNs, RPNs, and we have a contract monitor who verifies what the county's paying for. If there's a need to increase that, then we would have to go back an reissue the contract or resurrect the RFP for additional staff. I'm willing to do that. We just have to determine if that's going to be an increase CFG contract or for the other contract and if there's a change in the contract, the contractual laws are going to allow us have to go out for our RFP for the increase in X amount of clinical staff. So, if that's something that we all agree on, then we would have to speak to the County Executive's office and the Chief of Staff about an increase in the staff that will likely change the terms of the contract which we don't have to go out and offer for.

PV: I think we should consider that because enow we'll have a step-down unit who's going to supervising and monitoring that. Will that be one of your nine or seven clinicians who are also responsible for the 2,000 inmates the need mental health care. It's worth considering.

JM: While you're at it, the nurses. We have to take care of the nurses. The nurses do god's work.

LA: I did let the nurses know that at the last meeting you mentioned them.

JM: Well, I need to do more than mention them. I need to get their staffing numbers up. Can I just say to the Director that there's also, in fairness or in candor, that one of the challenges that those staffing numbers are higher but they're also personnel challenges in securing the day-to-day participation or the day-to-day engagement with staff, so that if staff is out for human resources reasons, or parental leave, or temporary medical leave that the facility then has to increase staff, increase personnel cost to compensate for the lack of physical presence of that staff.

RC: True.

JM: So, that creates another financial burden on the staff just to maintain full forcing credit in terms staffing issues, does it?

JL: And it can also create physical staffing problem. Not just financial pressures. Now the same things apply to having less people. And when people are out, or medical leave, or whatever it may be, we're already short-staffed to begin with—it exacerbates the problem.

CP: I think what I heard tonight is the willingness—not I think, I know what the Task Force needs is an action plan because we actually have heard previously that there's a willingness and consistent assessment from Dr. Fleming and others under the medical banner of what is needed to be able to address the mental health and the broader physical and medical needs of the populations. So, if the facility can think through what those steps are, Director, I heard you mentioned that there may need to renegotiation of the contract or RFP, but if we can think through that action plan, that gets us closer to approximating a solution and I do want to then tease out the point that's being raised by the Governor. Is there an issue with absenteeism? Is there an issue with excessive callouts? Is that stratified with certain populations within personnel. If so, are there efforts underway to mitigate that? There's abundant literature around workplace environment and when you begin to see those uptick in numbers, what can be done? I do also want to mention that I heard Dr. Anicette address that for medical staff somewhat, to say what incentives were put on the table so that there would be whether they're economic or other types of incentives to encourage and influence people to want to remain. I just want to know if you have a sense of that?

RC: Sure. So, even with the over hiring, the numbers are sober and I'll share a little bit. I have on family leave 120 officers. Either consistent or consecutive or intermittent. If you combine that with the unpaid lease about another 30, 40 and an average sick calls of about 60-80 daily.

JL: Daily?

RC: Daily. So you see the situation that's created everyday. That's why the Chief of Staff and the County Executive have given me the authority to keep hiring because we have to compensate for those numbers. Also, we have about 30-40 people at the police academy trained that we have to get to. We have about 90 more to do. With the new law coming out about licensing, that all needs to be done. We have to get everyone trained by the end of December. So, this last quarter is a busy time. So if you take all those numbers out, even with the relief factored in, staffing continues to be challenging.

JL: In your dialogue with the administration, it should be highlighted and prioritizing of this to somehow earmark some of the issues that we're dealing with, right? It's medical and clinical issues?

RC: Judge, we hiring 182 officers within the last 8 months. 182. I spoke last week with the Department of Justice. Some departments across the country don't even have 182 people on staff and we have 120 people on family leave. We have 80 people calling in sick everyday. And this is just the uniform staff—I'm not even talking about the medical staff. But this trickles down.

PV: What are the reasons that people are calling out sick?

RC: It's varied. It's so many.

CP: There's worth investment there, Director. If you look at workplace health literature, where you see excessive absenteeism and callouts, it's with workers who have a high burden or high load, but a low focus of control. So,

when a worker feels like there is little that they can do to change or mitigate the nature of their job, those pressures lead to certain behaviors to try to safeguard their well-being and you begin to see an uptick. Are there things—and it's hard, the challenge of your field—but are there things to consider of your workplace environment that can help stem to that.

RC: That's a great point and let me add to that. So, there are certainly those issues, certainly working in a correctional facility also impacts that. Number two, from when we're talking to exit meetings, staff, everyone saying that the lack of a contract for the last six and a half, seven months—that's a big issue, right? That's what we're hearing as well and quite frankly, the younger generation officers between 22 to 27 are not coming to work on the weekends.

CP: IS that where you have more of an issue?

RC: Believe it or not, it's the overnight shift.
JL: I am going to apologize. My partner Michele Vanderstreet is here. She's going to take over for me since I have another commitment.

JM: Thank you Judge.

JL: But she [Michele] was kind enough to come for the home stretch.

CP: I just want to put the point back around to recreation and Mr. Knight. Back to Imran's point is where you have over hiring, is it possible to either move some of that over budgeting or over hiring so we can supplement these areas that have been noted in particular?

RC: Mr. Knight is a department employee. So the increase in there, I can speak to the Chief of Staff and the County Executive's office. The medical because they're a vendor, I'll have to speak to the Chief of Staff about increasing that contract. I will make a commitment to the Task Force to deal with that over the next couple of days.

CP: Okay, thank you.

RS: Now, I just want to jump into something that really wasn't focused on in the report, but it does relate. One of the exceptions to the time requirements is a facility-wide lockdown. So, essentially, all bets are off. If there's a facility wide lockdown, the restrictions that are contained within the statute don't apply. We have seen, over the past couple years, there have been, you know, for extended periods of time, facility-wide lockdowns. I guess, if it's not, we didn't really preface this before today, but I wonder if you could in general, talk to us about that and to segue to what we've been talking about, does it relate in any way to the staff shortages we've been talking about.

RC: There are different codes, emergency codes that we have in place. Um there is only one code that will facilitate a facility-wide lockdown. There are some other things that happens throughout the day that we lockdown a particular unit or building. One of the reasons that we built the building like that was that Building 2, if there was an issue there, we can keep that secure and Building 3 and Building 4 can continue on with normal practices and or the dorms. That's the way I've operated since my return. The other part of that is that when we are in a particular building or pod, let's call it a lockdown, essential services continue and that is: medical, food services, court services—there's video conferencing, that's visits. Unless there's something very serious happening. So, since my return, we have not—I think one time we did [have a lockdown] when we had a blackout from public service and those types of things where we're on complete lockdown until we have the power from the grid back on. So, I think the facility being built the way it is, limits or should limit the amount of lockdowns and I think the important thing to know is that essential services do continue. What happened previously, I can't attest to.

JM: Well, I mean, one of our frustrations was during COVID and the amount of restrictions. I understand that COVID is unique in American history, but the amount of time people were spending in their cells which is obviously a concern to all of us and the ability to interact. And thanks to the leadership of the Chief, we've increased phone conversations with families, we've provided tablets, but still, there was the question of people getting out, showering, recreation, etcetera. It was difficult to coordinate and just to pivot of Rubin's thoughtful point, there are different types of lockdowns and restricted protocols. And as we go into the COVID season, which I unfortunately I suspect we are, just because of that sensitivity of allowing some level of movement that's mindful of what Dr. Pernell and Dr. Valera tried to do in terms of boosters of vaccinations of COVID to preserve the amount of freedom in the pods.

RS: Just to tie this down to the point. We knew based upon our review that the entire period from March 2nd to April 1, 2022, which I believe predated your tenure, there was a full facility-wide lockdown which, I believe, related to violence. I believe there was extensive spates of violence. Has there been any, if you will review the causes of these lockdowns, or any attempt to kind of analyze how it can happen in the future.

RC: So, we after every action or use of force, what we have in place now is a review committee of command level staff and that's lieutenants, sergeants and captains, along with the executive team. They review what happened: what we did well, what we need improvement on to do, and how we can not have this happen again. And that's reviewed. And then on if we have to change policy, we change policy to reflect that or to make things better. We are implementing a four month of Comstat—we've started it this month—to review the codes, to review the increases in fights, to review increases in detention numbers because I want to know from an executive level, why are these happening? Where are they happening? Is there some kind of pattern here to this? Is the same staff involved—quite frankly, that's something that I need to know. If Officer X is having 40% more use of force issues, we have to take a look at that from an executive level, form a training level, from a policy level. So those reviews are happening now. So I think you will see less and less of that happening as well.

RS: In fairness, we haven't been seeing a lot of complaints about misuse of the SHU. I mean the lockdowns, obviously no one's happy with that. But in terms of someone saying, I should not have been placed, or family members saying there's a problem—that really hasn't been an issue.

RC: That's good to hear.

RS: I wanted to give an opportunity to your colleagues who haven't spoken if they wanted to.

RC: Real quick—I want to introduce Officer Jacquline Paz. She replaced Officer Ramirez. She is the conduit from the Task Force. More importantly, she speaks three different languages.

RS: We'll stick to English.

RC: So, Director Ortiz was able to speak Spanish. I don't have that ability. So, I thought it was important for the community to speak to someone directly out of my office so we went through an elaborate interview process. We selected Officer Paz, so she is handling all the Task Force liaison stuff, the spreadsheet, and then the community relations stuff as far as parents, family members, loved ones calling up asking for information. And the Deputy Director, so I don't want to take any more of your time. Ladies, it's yours.

RM: Alright so, as the Deputy Director, I meet with the command staff almost everyday. We talk about different issues and we address a lot of the issues. I also walk inside the facility with one of the captains and I talk to the inmates as well as they do to see what's going on and see what we can do if there are any issues to resolve.

RS: If you were to pinpoint what the biggest consistent issue that you've heard about, what is it.

RM: It's a couple things. Like some days they don't like what they're being served and things like that, but we address it and it gets addressed in their state. You don't have those issues.

CP: Do you have a way of tracking what kinds of issues are being raised?

RM: Yes. We have an analytics team that actually captures the data and we do reports. So, we have a compliance unit also who goes around and they address issues also. And they write up a report. So when they actually do their assessment and walk around the facility, there's a report that's generated also.

CP: It would be helpful for…and thank you for reviewing that..I just want us to review it on record. Again, we've heard about it, but it would be helpful for the sake of the public for the Task Force to have an awareness of those fluctuations in those trend lines so that we could—even if like you're just doing coding or thematic analysis. These are the commonly heard issues or complaints. These are the top five. This is the frequency that we hear them. This is what it's looks like across six months to a year. These are the changes. That would be helpful to use and if I could, to go back to one of the recommendations that the medical subcommittee report because there also needs to be additional and increased awareness and transparcey to what is communicated to the community. You spoke about a public dashboard where the community can get a sense of appropriate the issues that the facility is dealing with and I don't have a sense if that's being considered. What are the limitations or barriers to that? But at least starting with the Task Force would be helpful to that.

RC: Doc, let me just jump on that. We are headed in that direction very quickly. Dr. Valera and I spoke about this. It's a matter of changing culture. Certainly, instituting analytics is across every sports, every labor force. Teaching the staff or the sleective staff how to track that, how to read that, how to is time-consuming so we're getting there. And we are going to upgrade the website. We're gonna have analytics and reports. We're going to have the dashboard on that. We're using the New York Department of Corrections dashboard as an example. It also was recommended from the Ambrose Report to create the dashboard, so we're getting there. We're going to be there soon and I appreciate the analytics—Dr. Valera would know. It's getting the staff to know exactly what we're looking for and why it's important because I think that's important as well.

PV: I think with training of staff, you want to identify a couple of officers that can do this kind of work.

AD: If I can second that, because of what we've done as a Task Force so far is that we started with what we thought was the most critical which was what was going on with the medical situation. Then we chose the SHU. We haven't touched on general population at all. I think this would be very important for us to understand what is lacking, what can be improved, but that might start us on maybe looking at conditions of confinement. the other thing I found very interesting is to help with the side of staff. You mentioned about improving well-being, so I don't want to leave staff out because it's a critical component. I think it would help us towards our next step if we can have that sort of feedback.

RC: I think it's a very important tool for management now to have the analytics. How do we measure how we're doing if we don't even know where we stand and certainly for the Task Force to have that information is important—and even the public I think.

JF: If I can briefly add to that with the release of the analytics, one of the challenges that I've had of providing over reports to Dr. Valera are questions that she poses about prevalence rates, incident rates, "Dr.Fleming can you share the numbers of the array of mental health diagnosis across the population at your facility broken down by race,

ethnicity…" and those are just things that we have not gathered up to this point. We don't have the folks to do it—to go through that painstaking process of going through every chart and pulling out individual pieces of information. So, some of this is infrastructure-related as it relates to the system that we use to gather the information in the beginning so then spreadsheets and searches can be conducted that would allow us to have a better ability to provide that information way more quickly than I've been able to provide to Dr. Valera.

IR: Thank you for that. Just two things on my end. I would like to personally thank Director Charles and Dr. Vega. I've reached out and this goes to the recreational and religious programming. There's an individual in Queens—I'm from Queens, New York, unfortunately. I should move to New Jersey. There's an individual that reached out and they wanted to donate some religious material and Chief Alga, Director Charles, and Dr. Vega were swift in responding and helping to coordinate that and hopefully that can be done by the holiday seasons—November or December. And second, just to reiterate what's being said by Dr. Pernell and the rest of the members sort of next steps and action steps, we've been on this Task Force for about three years and going four. So, the first phase was identifying the issues. We've just about identified most of the issues when it comes to the medical department, SHU, and we've briefly touched on general population and the overall issues within the facility. We've identified what solutions that we could potentially pursue to solve those problems and I think we are beginning to enter the phase where we start to take action to solve those problems. Like Dr. Fleming has alluded to, we're at your disposal and whatever resource we can provide to help with—whether it be Silver Lakes to expedite the process of getting that agreement to secure those beds for the forensic inmates, to get volunteers in the recreation programs in the forensic step-down unit that's being created, to start to understand and establish a step-down unit for the disciplinary inmates, as well as software programming for the tablets and issues that will come up nonetheless in the future. Anything that the Task Force can do know, in this phase where we're beginning to take that action. We should understand that we're here and we're in this together and we should be taking this step together to solve these problems together that we've identified.

RC: Thank you and that's how I and the executive team look at it. We're in this together. We're partners in this. I think you've seen a little bit tonight that we've taken some steps. Now, I think it's now pushing the ball over the goal line.

AD: I just wanted to give Officer Paz a chance to tell us what you'd like to say.

JP: I don't really have much to say aside from I'm very happy to be working with you and I will always do my best to give you guys rapid responses and make sure all your questions are answered.

AD: And the three languages that you speak?

JP: I speak English, Spanish and Portuguese.

LA: She doesn't like to boast, but I've had some interactions with her. Frankly, she's been a good liaison in between us and the community. Some family members call and contact her and she's really been a person that's cut through the lines of bureaucracy to get them answers. So it's really been a pleasure working with her to get things done because I'm really worried about mothers chasing me in the parking lot. I did want to bring to the committee's attention, though, because I do think the Task Force does do a job of prodding us into the right direction in a number of areas and so just recently, we met with University Emergency Department to talk about how to properly manage opiate dependent pregnant females. That's a very hotbed topic in corrections. It's very difficult to manage and I have to say in the beginning, the hospitals were a little adverse in even discussing it with us but we kept on. Essex County doesn't give up; Essex County Task Force really doesn't give up. So, we met with them and now we have a new workflow on how to manage those patients. That was the product of those interactions. Just two weeks ago, we met with, I think we were targeted, we met with the Governmental Accountability Office, GAO, and they're doing a

nationwide survey of how pregnant females are being treated and they happened to pick Essex County. I don't think it's by luck though. They targeted and wanted inside information and a number of the issues that Essex County Task Force brings up to us were on that list of questions. Two pages worth and every single one, they found that Essex County was compliant and at many times exceeded what was found throughout the county. From prebook, the screenings, the ability to get access and then placement services, social services, and mental health—they were pretty much without anything to give us in terms of input in terms of asking us so what more could we ask for? So we asked for the same thing we always ask for, more money. They were very gratified with what Essex County is producing in terms of this subset of the population. So I think this is due to a lot of the collaboration that's right here in this room.

AD: Thank you for sharing that.

RC: Also Doc, if you could inform the task force about the initiative with the Hep C and the—

LA: Absolutely. One of the initiatives that we've launched is that there's a high volume of STDs, STIs, sexually transmitted infections throughout the community. Unfortunately, the jail has become a reservoir for such and so, a lot of times it's not addressed. A lot of the times the testing is done in a haphazard fasting. There's a lot of tracking of positive tests. So, what we've tried to do to see if we can A, identify those patients at the door and then see if we can actually treat them is to design an STI initiative that's going to be designed out of intake. So when someone comes in, they'll be screened for 5 different conditions, so then, we'll be able to have a nurse and a nurse practitioner to assess and treat the person. We'll be using new technology that's base don PCR. So, we'll get the answers in 30 minutes as opposed to the usual one to two weeks to get an answer. So within that pre-book period, that four hour time, we'll be able to see the diagnoses and if it's a positive result, we'll be able to treat.

JM: And one of the diagnoses is Hep?

LA: We have hepatitis C. We also have HIV, syphillis.

JM: That was one of the recommendations in the report.

LA: We've been able to actionilze that.

JM: Seriously, Doc. That's phenomenal.

LA: It's the work of the think tank this is right here.

JM: I hate to say something so nice about Dr. Anicette, but on a serious note, that's tremendous. Just so you know, the Department of Corrections doesn't do it?

RC: Correct.

JM: The Department of Corrections say they don't test, because if they test they'll get results that they'll have to treat. But the fact that you're treating at intake, which was one of Dr. Pernell's recommendations, is to do the PCR tests, to do the rapid diagnosis.

LA: And to treat, in that regard.

JM: You can't bill CMS though for the medication right?

LA: No, but we actually petitioned the state and they carved out a portion of the STI program so the state's going to fund. As an outgrowth of that to treat the patients that are HIV patients, we were able to contract with a community provider so that Dr. Slim, Jihad Slim. He's actually conducting weekly HIV telemedicine sessions for the patients. It really is within one week of diagnosis where they're seeing an ID specialist and getting on antiviral treatment.

JM: Betcha you're the only correctional facility in the state that's doing this.

LA: We literally had a meeting last week with eight of them and none of them are doing anything like that.

CP: That's also information that the community should be aware of the progress; the advances; and what I call the brave practices of what you're all doing because the best practices have a certain amount of literature backing them and you can survey various stakeholder entities or systems and many of them would be doing it but the brave practices are the practices that none or one are doing and that's something that the community should be aware of.
JM: For our re-entry guys and gals, we have to take them after they come to reentry for the test and so for you to do this is groundbreaking. Congratulations. And to go to Dr. Pernell's point, with the Director's blessing, could you provide us a memo outlining the PCR test, the five test, HIV, and Hep C.

LA: We can prioritze and see where the technology was going. And if there's new technology that would allow them to wrap and test them. These are clear way of finding out.

JM: Could you give us something by next Tuesday or something?

LA: Absolutely.

JM: Thank you, Doctor.

AD: This might be a little strange, but you know when you walk into stores or something and you'll see a sign saying, "how many days without an injury." Maybe just to let the public know, I don't know if you could put banners inside the waiting area or a placard or something that says "Now treating for…"

CP: Do you have a bulletin board inside of the facility?

AD: I'm not high tech enough.

RC: We do and that's actually something to include in the website.

CP: Yeah you can do that on the website. You can do it visually for those who may not have access to technology. You can do something that can be visualized. Like when you walk onto a treatment floor or a clinical floor in a hospital, what information they want community families to know and oftentimes, they like to celebrate their win.

AD: Yeah, because it's nice to see the positive things because it's such a sad, unfortunate place to walk in as a family member. So, to see something positive would be good.

JM: Thank you. Is there any other concluding comments from the professionals.

CP: I just want to touch on something on the agenda. I do want to acknowledge that after going through the SHU report and the recommendations, we have had conversations pertaining to topic one on the agenda, specifically corrections officers, and we have had conversations around staffing situation in specific units, medical unit, and or mental health professionals but I did not recall hearing any discussions on hygiene and sanitation specifically within

the facility. We had asked three questions about that. If we could just get written responses to that question. I know it's late. I want people to be able to say concluding remarks. Just some written responses as a way for accounting purposes to say that we addressed this.

JM: Thanks Doctor.

JF: That's all. No concluding remarks.

CP: You may want to restate how many mental health professionals in your unit.

JF: I appreciate particularly hearing you voice those concerns for things that we're concerned about in our facility. As well as the willingness to actually assist us. You know, for a while, it's felt like we give you information, it shows up in these reports, everyone's complaining, people are concerned about what's going on inside Essex County Correctional Facility. We're asked about what our limitations are, the challenges are, we tell you and we try to share with as many people who would hear it. I appreciate this hearing more specifically your level of support in getting us the resources and assisting us in procuring the resource whatever they may be so that we can better serve a population. We all show up everyday because we care about them.

JM: Now, I just think Dr. Fleming is really impressive. How in front of his boss, he beats him up to ask for more resources with a smile and does it so smoothly. I just want to develop this kind of style. Doc.

LA: Whatever Dr. Fleming wants. I just think that's its commendable how the Essex County Task Force really has learned in a short amount of time how the jail operates. It really is a very dynamic environment. There's a lot of moving parts. There's laws that are passed that somehow don't make sense. We get to find how to apply them and in terms of what Dr. Pernell says, how to make action plans out of the questions that emerged from the audience. If you don't do anything, the subject falls apart. You've gotta pull that energy into the program. So, here it is. There's a lot of good things coming out of this. We got a challenge because the jail was not originally for that. But the actuality, those folks are there.

JM: Thanks Doc.

RM: I would like to say I like seeing everyone from the Task Force, to see who's all on the Task Force. And what Officer Paz who, as soon as she gets the email, she lets me know she has an email and sh'e eager to address the emails that she receives. From administrator's point, we're looking to be the gold standard in corrections. We're looking to do great things.

JP: I was very eager to come here today to really put a face to all of the names because I always read the names and the emails just in case any of you send me a separate email, I know who I'm dealing with. Please don't hesitate to reach out if there's anything you need from me. At the end, I would also like to give you guys my phone number. So just know I am available to you guys whenever needed. Thank you so much for having me.

RC: Real quick—so, I try to set a standard of gold standard in anything I do, but certainly in my profession. One of my goals of coming back to Essex County was I wanted to create a center of excellence and I truly mean that. I live this job. I've been in this 39 years. I live this job 24 hours, 7 days a week, all the time. Working towards that goal and Dr. Valera and I shared my feelings on that. I look at work in the Task Force as a partner in achieving that goal. I think the reports that you guys have done have been fair, have been truthful, and now I think it's time—we have to push the ball over the goal line. We've done some of those things, but now I think it's time to get some of the other stuff because we're close to being the center of excellence. I want to achieve that. I know other wardens say, "oh,

you have to deal with the Task Force," but I don't look at it that way. I truly don't. I look at it as another extension of my office or of the County Executive's office to actually achieve our goals. So, thank you for that truly.

JM: I just want to say thank you to Pam because Pam is balanced. She has great expertise and judgement. She spends a lot of time in the facility. Pam, and last thoughts?

PV: Thank you for the opportunity. Thank you for supporting the community and the staff. You all are amazing. It's not an easy job. For many of you, it's 24/7, so I really appreciate all that you do.

JM: And the great Dr. Chris Pernell. And I think Rubin referred to the medical report which was the basis of this.

CP: I truly, truly appreciate hearing where there has been progress and would only hope to amplify the communication between the Task Force and the facility. Also, to know that the Task Force is always willing to leverage its voice, we just need access into those conversations and again, I will put it on the record. I would come to any conversations you need me to come to—schedules willing. Especially around systems because that's the work I do and that's why I sit on this Task Force and so I thank you. I also do want to applaud Professor Valera for what she does, because it is brave work and it definitely is work that is above and beyond what many others have access to in a facility such as this. Then to applaud my peers on the Task Force on a very well done phenomenal job on the SHU report tonight.

AD: Not much in the way of concluding comments. I just want to thank Imran Rabbani and Rubin Sinins for their tremendous amount of virtually all of our report. SO, thank you so much.

JM: I just want to thank Rubin who spent an inordinate amount of time, his professionalism, his legal acuity, his judgement, working with the Correctional Facility as to what could be changed, what should be changed, what needed a larger framework, and for candidly pushing all of us to hold all of us, as well as the facility, accountable for best practices.

RS: Thank you to the facility for being cooperative and forthcoming with all your information.

JM: And that's saying a lot coming from a defense attorney.

RS: I'm not used to getting cooperation.

JM: Imran is our law student at Seton Hall Law School. Imran, thank you so much for your life experience and for your insight and your judgement.

IR: Thank you, Governor. I need to thank Rubin for spearheading the SHU Subcommittee initiative as well as working with Alessandra on the ground to get some of the information that we needed from the facility. It was just a pleasure to do the work in the SHU just because of how intense it is. The facility was amazing, extremely transparent. That's all. Thank you.

MV: I just want to say it's wonderful to see the cooperation and to see the advances made by the facility. I had a quick thought and I came in late, but I heard that we could use more people in the kind of recreation area and I'm wondering—

JM: Can we just wrap up?

MV: Sure. Okay. No problem. Thank you again all for your hard work and help.

JM: Thank you and I also want to thank Azreen on behalf of McCarter & English. I just ask if anyone is interested or the ECCF, there's a phone number and an email address. It's posted and I ask you to contact us and again, as we move down this path on mental health, mental health step-down, the CMS exemption, we're going to keep the public and we just also want to keep this a very dynamic, open, and transparent process. SO, if the public wants to engage directly with the Task Force, we ask you to do that—whether or not you're a person housed at the facility, whether you're a family member, whether you're an advocate. Part of our responsibility is to be accountable to the public. That's the charge of the task force so either you can contact us directly on the website. This is a specific SHU matter, there's also the report that we encourage you to read. And again, thank you Azreen Rehman on behalf of McCarter & English. I want to thank Judge Linares, all the members of the correctional facility, and all the members of the task force. It's a team effort, but our obligation is to the public to serve you, to be truthful, transparent and to change to the benefit of all those who walk those halls. Thank you very much and have a good evening. Goodbye.

Appendix D

ECCF Public Meeting on Mental Health Report Minutes

October 29, 2024

ECCF Public Meeting on Mental Health Report Minutes
October 29, 2024

Attendees:
Dr. Pamela Valera (PM)
Dr. Chris Pernell (CP)
Alessandra DeBlasio (AD)
Henry Klingeman (HK)
Governor Jim McGreevey (JM)
Michele Vanderstreet (ML)

Director Ron Charles (RC)
Officer Jacqueline Paz, Community Relations (JP)
Regina Holmes Marrow, Deputy Director (RM)
Dr. Lionel Anicette, Medical Director (LA)
Dr. Jason Fleming, Mental Health Director (JF)

JM: Good morning. My name is Jim McGreevey. On behalf of the ECCF Civilian Task Force, thank you for joining with us virtually on our public meeting focused upon our mental health report and I would just ask the members of the dais here to please introduce themselves starting with Michele Vanderstreet?

MV: Good morning, I am Michele Vanderstreet with McCarter and English.

AD: Good morning, I am Alessandra DeBlasio.

JM: — with the task force.

AD: with the task force.

CP: Good morning. Doctor Chris Pernell. Task Force.

PV: Good morning. Pamela Valera. Rutgers University. New Jersey Medical School.

HK: Henry Klingeman. Task force member.

JM: Thank you, Henry. And can we just ask the director and his team to introduce themselves.

RC: Good morning, everyone. Ron Charles, Director of Essex County Department of Corrections.

LA: Good morning. Doctor Anicette. Medical Director of Essex County Correctional Facility

RM: Good morning, Regina Marrow. Essex County Department of Corrections.

JP: Good morning, Officer Jacqueline Paz. Community Relations Officer.

JM: Thank you and the purpose of the hearing today is to obviously focus on the mental health report. We are very much grateful to Professor Pamela Valera and Dr. Chris Pernell for their work, but obviously we are concerned about the importance of thoughtful assessments at the facility, the importance of evidence-based screenings at intake, the multidisciplinary teams and roles undertaken by professionals. As well as the individualized treatment plans that are offered for those that are mentally ill and how do we tailor in thoughtful and integrated ways treatment within the facility, and lastly, looking at mental healthcare through technology and an opportunity for ECCF to be

among groundbreaking entities that will improve mental health, in terms of specifically this mental health report. And first, I'd like to ask if Professor Valera could initially explain the scope of the report, the dimensions of the report, how long it took before she undertook the findings.

PV: First, I want to thank, in deep gratitude, [the facility] with providing us the opportunity to meet with not only the medical and mental health providers but also be able to observe some of the dynamics that impact people that are incarcerated suffering from mental illness. This was a huge undertaking. It really provided an opportunity to understand that this is not a local issue- in terms of people suffering from mental illness or disorders — this is a national issue and I think the facility is doing their very best to look at innovative opportunities to think outside of the box. but there are hurdles, and a lot of that is not of their own making, but the infrastructure of jails. Jails, have become as many of you know, the defecto of serving people with medical and mental health disorders. The jails were not equipped and continue to not being equipped with the volume of people entering the facility who are suffering from unmet treated mental illness, suffering from trauma. While we continue to consider whether Essex County are doing the right things to address the issues, we have to think about this as a national issue too. What is the state doing to help those that suffer from mental disorders in correctional facilities? So let me just give you some statistics. In the United states, we are looking at 20%, 1 in 5 adults, or approximately 50 million people are living with mental disorders. and approximately 4.9%, 2.45 million adults are living with severe mental illness in New Jersey. 16.37% or 8.2 million adults are experiencing mental health challenges and these range from very significant severity from mild and moderate cases and Essex County serves all of those individuals - whether their mild, whether their severe or moderate. And unfortunately due to limited staff, they are only able to handle those who have severe mental disorders and that's unfortunate because I imagine that predominately the individuals who are incarcerated in Essex County need some sort of mental health, some sort of CBT, or DBT, or counseling to address some of the things they are experiencing whether that's childhood trauma or adverse childhood events. And so, when we think about where people get treatment, we know that 60% of adults and children with mental health challenges receive no treatment. Those seeking help must contend with the complex and expensive sense of barriers, challenging, timely, and ethnic and effective care and we know that there's a mental health professional shortage in the United States. So, where do people seek care and where do people get care and it's our local jail. Whether we like it or not. So, when we're thinking about mental health, you know, around 25% individuals also experience homelessness and they also report serious mental illness. These individuals are then, you know, unfortunately, become part of the criminal justice system and they also suffer from co-current issues such as opiate use disorder or substance use. So, we look at Correctional Facilities and we know that more than 9 million people cycle through US jails and that among those are in local and county jails. So, close to half which is 44% have some form of mental health challenges significantly higher than the general adult population. And so, this is a huge problem and I'm grateful for the opportunity for the jail to say, "we'll take it on. We'll get the task force to come in there and help us understand some of these things" I know we will be discussing other forms of recommendations but I also wanted to take this opportunity to say we really need to think outside of the box and I believe that Essex County is at the forefront of doing that.

JM: And, Pam, could you emphasize that for persons that are incarcerated—those mental health, those numbers are significantly exacerbated for individuals that are within incarcerate settings, whether county jails or state prisons.

PV: Yeah, I believe that they're even underreported. So, these are people that are coming in with already a mental diagnosis. And then when they go into booking, if they show some type of mental health symptology, then they triage to address those things but I think we have more millions of people that are impacted by the system itself but are also co-occurring. I think it's a really critical issue. Correctional facilities are dealing with not just symptoms of anxiety and depression. You're looking at psychiatric diagnoses, bipolar, schizophrenia, delusional, disorder, and issues. One of the things that we're also noticing, especially at Essex County which is really different from what we noticed years ago, is that we have people that are incarcerated that are on the spectrum. So we are looking at folks that have some sort of developmental disorder, reactive disorder - condition found in children due to not having formal healthy emotional attachments. There's oppositional defiant disorder, ADD, ADHD, and again the facilities are really not equipped to manage those things but they do their very best they can. These are complex mental health diagnoses, on top of other types of new, in my opinion, newly diagnoses, maybe they've been there before but after a couple years of being a part of the Task Force and providing documentation, we're seeing an increase of these types of disorders. Unfortunately, when we were trying to find those prevalence points inside the facility, it's not something that they have currently but I know that Doctor Fleming is looking into really flagging that more to see

what the prevalence part and what the percentage of other types of disorders such as autism spectrum, and other types of emotional attachment that might be prevalent in this facility.

JM: So, do you want. I would just ask Dr. Pernell, do you want to proceed with the presentation of the mental health report in terms of the summary of key findings for Chris, or Henry, or Alessandra. Would you like to make opening statements prior to Professor Valera's discussion.

CP: I'll just underscore what Professor Valera stated that we are looking at a local issue that is only symptomatic that is national in scope and significance and also, we're looking at a trend that is the result of a system failure and the system failure that I want to call out is how we identify the environmental and situational factors that predispose persons to develop mental and behavioral health disorders and how trauma or exposure to community violence or toxicity at critical life development points influence the likelihood of someone to ultimately be a part of the prison industrial complex and so with this hearing today, we hope to be able to identify not just best practices, but brave practices. and I'll define brave practices as opportunities to say we understand that where the system has gaps or where there are barriers driving these inquiries and what can we do in a more collaborative, or a more integrated approach to begin to solve some of these gaps. So, when we get into the particulars around what type of mental health assessment there is, what are the specific screening or diagnostic tools. It is in that vein that we are asking those types of questions and having that type of dialogue.

JM: Henry?

HK: Thank you, Governor. So, I wear a number of hats and among the hats I wear is a court-appointed representative of people who are held at the Essex County Jail pre-trial and I can tell you as a non-mental health professional, it's obvious that the jail, the facility is a stressful place for everybody—not just the people who are held there, but the people who work there and that should be obvious. And the way that I understand the issue, that even someone who is relatively stable - on the street, in the community - has a different disposition dealing with me when they're locked up. And I know that because I deal with people who are locked up, they are stressed, anxious, or depressed. They're sometimes even irrational in terms of the judgements they make about their own future and if I can get them released and get them into a court-supervised environment, either at home or elsewhere, their judgement improves. So, to me as a non-mental health professional, it's obvious that just being in the facility can add to the stress and I can't imagine what it's like for someone who has a pre-existing issue. So, I commend not only the Task Force, the doctors who just presented, but the facility folks who are working on this and dealing with this on a daily basis. It's a struggle under the best of circumstances.

JM: And, Henry, could you share the struggle and Dr. Pernell has talked about this previously, about connecting individuals as they leave the facility to individualized treatment plans and have them maintain the continuity of care to address their challenges - how difficult is that linkage.

HK: It's very difficult on a practical basis. The folks who get locked up by and large or indigent. Over 80% of criminal defendants get court-appointed lawyers. Why? Because they can't afford basic necessities much less the luxury of a lawyer. So, if they get released and under New Jersey's reformed release law, it's no longer a cash bail situation. They get released based on a variety of factors including perceived dangers or lack of dangerousness. But once they get out, they're still poor and they can't afford the kind of resources to get mental health treatment that a wealthier person may get. And, of course, the programs available to them are one limited and two, hard for someone without expertise in navigating those resources to obtain them. I primarily represent federal defendants and the US pre-trial services agency that supervises people on release who really pays attention to this. But on the state side, there's no analog and most of the folks who get locked up in Essex County are there on state charges not federal charges. There oughta be somebody on the outside or some agency on the outside that's guiding these people the same way that these pretrial services agencies are doing on the federal side. It's not the facility's problem. We're talking about people who are getting released. It's the community's problem.

JM: Thank you and with that, we kindly ask Professor Valera to begin to summarize the key findings of the report and discuss the recommendations that she submitted.

PV: One of the things that I've noticed is that there's not fair understanding between what an assessment, a screening, or a diagnosis is in terms of the tools being used and the facility does a really good job assessing those

that already have an existing mental health condition. But I think one of the things that I would recommend and this is not just for Essex County is to have a universal screening prior to assessed for their mental health disorder. IN that way, you can have a better idea of really the prevalence of your encrusted population. That includes looking at everyone coming in and I know that there's a screening tool that's being used, but that's not as comprehensive as some of the ones I've recommended. And they're fairly short and these are standardized. Most of them have been developed by scientists who have done this type of work and people always argue if this has been done in jails? So, the brief mental health screening tool has been done, so I would recommend having a universal screening that can be embedded in the CFG network. That way you can capture everyone as opposed to the only extreme folks that are coming in because you're missing a lot of people that need help. That way there's a better way to triage some of these things. I think the other thing that I love of about Essex County Correctional Facility is that they do inner-professional practice which means that they have many different types of providers that are coming in. You have your nurse staff, your social workers, your mental health professionals, and they all work together. I would just emphasize that further to have multi-disciplinary teams, not just people from the inside, but get support from people from the outside because there are a number of experts in the room. I'm looking at MJMS, which is a neighbor to the facility that would be able to lend their suggestions and advice on how to manage some of these critical cases.

JM: Can we hear from Dr. Anicette or from the Director as to what the assessments so that we can have more of a dynamic exchange. I think that's what Dr. Pernell had hoped for - it's that understanding that the assessment is difficult and Pam, I don't want to overstep but as of this date there isn't necessarily a best practice for incarcerate assessment.

RC: I'll start off and then hand the ball off. So, if there's a better way of doing things, certainly, we want to implement that and we're hoping that the comprehensive report and recommendations coming from here, we will be able to implement some of this stuff. I'm going to defer to Dr. A on the actual tool itself, but if there's experts in the community, if there are expertise and better ways of doing things, certainly, it's my support and philosophy to those to the facility.

LA: Absolutely. I haven't disagreed with anything different so far. I think that when we look at the screening process, I think Dr. Valera hit it on the head. Our job in the beginning is to see where people fit in. People come in from different walks of life. and unfortunately, they weren't invited there so they don't really come in the state of mind where you're willing to share. SO a lot of the times when they come in and usually the numbers are ranged between 40 to 60 a day. Like this morning, 16 males and 3 females that came in this morning to be screened and there's different objectives, different goals. Medically, we're probably looking to see if the person's stable enough to even be incarcerated. So, we do a pre-booking screen. A pre-booking screen is very elementary and basic. It's to see if you come into the facility and you're looking to do harm to yourself or you're so incapacitated or debilitated that you really need a higher level of care. That's something that we could offer and outside of our scope. So, sometimes we do end up deferring individuals to the hospital when they first are presented by the municipality. If they come in, arrested by officers or lay people. They may not understand that someone for instance, is having a cardiac event or maybe having an issue that needs to be addressed right away. So, that's usually our first stance in terms of assessment but then when the mental health part comes in in the pre-booking, it's to see someone that probably should have been diverted over to crisis because we do get that. We have patience. I mean, again, it's a very volatile situation. Someone's just been arrested. We don't know what the circumstance is. They may be willing to be very desperate at that point in time and so, some of the patients do get diverted into crisis and so, going back to something that I can now and Dr. Williams talked about. We reached out to the crisis managers at various hospitals to see if they can bring their crisis managers to come in and see the patients right then and there because then that complicates things because we have someone who's actively representing actively suicidal. Active suicidal ideations and now you're setting up another trip to leave from the jail to go to another setting. That's again a very dynamic place like a university or crisis centers. So one of the things we've been trying to do is literally connecting those crisis centers and say "hey we have someone here. It looked like they would really belong in your place. Could you do a screening even if its via telemedicine"

CP: Okay, I was going to ask if you could give us a sense of what is the status of that dialogue and what are the modalities that that assessment can be done by. When you begin to answer it via telemedicine that someone could be assessed. Is that something that's an eventuality? Is that something that requires additional dialogue? Is it something that the task force can leverage its position to help facilitate that because what I hope we could do today because we really have been discussing issues that we have been talking about in a longitudinal fashion, right? So, how can we

approach solutions? Some of these solutions are going to be a shorter ramp to implement and others of them are going to require more steps to the eventuality. So, where are we with those conversations? Is it likely that crisis personnel, local treatment centers or hospitals can evaluate persons coming into the facility during the pre-booking process who are found to be in crisis?

LA: Absolutely. And just to show that this process here is not in our process, right? So, it's very dynamic. So we get information and feedback from the task force. So, one of the things that we have been able to implement is telemedicine. So now we do have telemedicine at intake. We've been using it mainly for medical purposes and nurse screenings. So we could use it for crisis. So, we've met with the crisis team at Beth Israel also at university. We've had many crisis workers come to the jail to do those sessions. So we are getting closer in terms of meeting that goal of seamless connection. So, it's beyond the talk. We have the technology. We have the interest from those folks and they are seeing that it is a benefit as opposed to in bringing in me to look at the logistics. The inmate coming in with two-armed officers into your crisis center, probably not the ideal setting to get a new mental health evaluation. So this scene from their point perspective is that there is a benefit to have a crisis workers and sometimes we'll have them see two more people - two or three more when they're here. So it spares a couple of trips, not just one.

CP: Can I ask a follow up question to that? To Professor Valera's point - I'm hearing that in that pre-booking window and time frame immediately there is an acute evaluation whether a person is having a medical condition that requires in hospital care, right? And if that is true, then that person is diverted to that facility. Likewise, there are burgeoning opportunities to evaluate if there is an acute mental health crisis. And right now, those possibilities are being further realized via tele health and telemedicine, so outside of where it appears that pre-booking is more affective in ascertaining that there are more issues. Where are these opportunities to introduce some of the screening tools in particular the brief assessment that will get at the general population. It is not a person in acute crisis whether medical or from a mental health perspective, but this person may have undiagnosed or unknown or not yet able to communicate that they have these health issues. Where are the opportunities to do that? And if possible, I don't know if we have an example of a tool today that we can pull out specifically and say that this is the tool- are we able to pull this tool to give a definitive yes or no but I think that's where the conversation has to go?

LA: To echo the words here, we can because what we have now is a screening tool is really a compilation of different strategies. so, it would not be that difficult to take because the nurses do a screening within two to four hours of admission.. So this is after the pre-booking, then we would get someone to do the intake screen. So the nursing intake screen does have mental health questions on it. It's designed to find out who already has preexisting condition, who's in danger, and who needs mental health professional right away? But it could be that we can integrate some of the brief assessment tools like let's say the PHQ or D7 - one looking for anxiety. One look again, not to sound jaded, we're used to anxiety in the jails. But you know what? We could actually do a more comprehensive and concrete job of assessing it and giving you a score, and say this could lead to a problem down the road because what I do see from years and years of watching it is that someone presents a certain way on day one and then over time, they devolve. Over time. So, I've seen a lot of folks come in fully functioning, they're working, doing things that normal people do and then months later, you bump into someone who is dissociated, depressed, anxious, definitely checked out, maybe has lost a lot of hope. So, it wouldn't be a bad time to do it in the intake and we do, and I do see, I would say in terms of those questions, starting to be added to the intake. So it wouldn't be difficult, frankly. We could probably take those brief assessment tools. We have an IT committee and submit them to the EMR committee for the uptown medical record and then integrate them. I was saying a couple of weeks.

PV: Well, maybe like the first step is to review some of those screening tools and then, I think not integrate all of them, right? But like identify one that you think would be applicable to your facility because in the report, I listed a number of them and these have been shown, they are standardized screening tools and there's a couple of them specifically for jails. So we can take a look at that and have Dr. Fleming give us some feedback so we could see which one would resonate for you all.

CP: Just for the record, and for the listening public, can you repeat the committee that you said could review and let's give people a sense what are the specific steps that will happen from today for that committee to review the tools that Professor Valera is describing and what the outcomes of that could be on that horizon. I want us to make sure we document that.

LA: So, there's the EMR committee. That's the electronic medical record committee and they meet monthly and that committee basically looks at different aspects of our electronic medical record looking into see if it's functioning well, if its functioning efficiently, if it needs to be modified, if there are screens that need to be added, information needs to be taken away, so its always being groomed and trimmed. So, that's an ongoing dynamic type of a process. So, if a topic like this, we would present it to the next committee meeting in November. So November's meeting, it would be presented. We would have Dr. Fleming of course review all of the assessment tools.. Dr. Sandrock as well. And based on their report, then the IT committee would give about fastening and implementation face. Usually that includes rating it, debugging it, testing it, training folks. That process usually takes about 4-6 weeks. If you've done it before, you've seen for other processes. So, I would say if you started in November, maybe we'll get an early Christmas gift but probably a little after Christmas so January, you'll probably be able to implement it and have all the nurses trained because it really boils down to you gotta make it so that its possible for the staff that actually does the work, the online staff. Which you know, I give, you know the credit to them all the time because they're the ones who are receiving those 2,000 people a month.

JM: But, to go to Dr. Pernell's point, would it be helpful if Professor Valera or Dr. Pernell recommended an assessment tool or a ranking of an assessment tools? Because what I hear from what you just shared is that there isn't a standing committee to refer to review assessments. SO maybe perhaps if Professor Valera and Dr. Pernell and this committee forwarded to you a recommended protocol. Perhaps, you can consider for adoption.

LA: That actually would be ideal because we have all this extra intellectual equity sitting here and why not? So we can get the information and basically makes our job easier, and Dr. Fleming and Dr. Sandrock will be very familiar with those tools as well. So, that will fast-track this.

PV: We've identified seven screening tools that —

JM: But, I don't think we clearly prioritized them.

PV: No, we have not. And that's something that we can do.

JM: Asking an academic to prioritize. This may take longer than the report.

PV: I don't know about that but what I like about the tools that we identified was the fact that some of these are jail centered and so for example, the brief jail mental health screen is designed and used for local and county jails and it quickly identifies incarcerated individuals needing mental health services and includes 8 questions that's screens for major depression, manic episodes, psychiatric disorder, and thoughts of suicide and briefly, the other one is the jail screening tool. It's used to identify those who may have mental health or substance abuse that may be co-occurring. It assesses a wide range of not just the emotional, but also the behavioral problems so those are the two that have been specifically created for jail facilities. There are others here that we will take into consideration but those two, in that way, you screen everyone and like Dr. Anicette, you mentioned there might be an individual who have been there three weeks and start to decompose, but it was a missed opportunity. So, this way, everyone's screened and you sort of have a better sense of who's your population across the board.

RC: Governor, if I may. I just want to understand the task at hand or the next steps. Would it be pulling the best information from several different tools or would the task force be recommended one individual. I want to make sure we get this done because this is very important. Would it be pulling one or two lines from the different reports or would we be using 90%, 80% or would that recommendation come from the Task Force.

PV: It would be the entire tool because otherwise it would no longer be standardized if you start to pull questions. It would be one assessment, not two or three but one assessment that we recommend to be used and implemented in the facility.

RC: Thank you.

PV: So, we've discussed the role of a multi-disciplinary team, having an evidence-based screening tool, and there other sort of suggestions, especially since there is a high volume of people who are incarcerated suffering from

mental illness is to train your staff, your correctional police officers, and mental health team for incarcerated individuals, we were able to do that successfully for the step-down unit that we'll talk about in a little bit, but most of the officers were training in mental health first aid and I think that's been really successful because during the mental health report, we were able to reach out to them and see how often did they use the skills that they learned in the training and most of them did say that they have used them. In fact, they're also referring their outside friends and family members to mental health support,. So not only are they identifying symptoms inside the facility but they're able to share those and identify that issue in their personal life. So, I would suggest to having across the board training on mental health and that goes with your staff, so it's important for everyone to at least of some awareness of the difference between a behavioral issue and a mental health issue. You know, someone just having a bad day and needs a lot of attention or is it more severe than that? And then, I think that one thing that I didn't see much about and I think it's really critical and you mentioned that today is how to address that continuity of care and I didn't really see, and correct me if I'm wrong ,when someone's leaving the facility, is there mechanisms in place to help those re-enter society successfully whether there's a warm hand-off to an agency or to the FQHC and I didn't really see that. I always saw what was happening inside the facility ,so could you talk a little more about that continuative of care?

LA: Absolutely. So, I think that's one of the aspects of care that we've had to make lots of inroads in over the last couple years of Silver and you see evidence of it more so with the MAT program. With the MAT program, we do have 20 agencies that are linked to services. We have a designated discharge planner whose there five days a week making plans for these patients connecting them to different centers, the MAT center, and community based groups that can service them so that there's no lag. We have a connection with Walgreens - just to backtrack a little bit. When they leave, they go on the 25 bus. The 25 bus, they get a ticket for it and it goes to Penn Station. Right across the street from Penn Station is a Walgreens. So we made a connection with that Walgreens where they can walk in with just their jail ID and get their discharge medications from that pharmacy. So, we've been able to get some —

CP: How many people successfully make it to the Walgreens? Is there a way to track that? Do you have a sense of that.

LA: I've seen more patients of suboxone showing up. Like, look, I would say majority of patients of suboxone and they show up because they want the suboxone. Mental health, not so much.

CP: Okay, I think that would be a useful data point because it says, when you create these opportunities to fill gaps, are they effective and efficient at doing what you hope they would be able to do? So, if this person has to on their own volition get on a bus, go to Penn Station, leave Penn Station, go across the street, and check in if you will at this Walgreens to get their medication. It would be important to know from the perspective of the task force and the public this happens in 75% of the cases. We find that persons who have a co-occurring disease whether they're on suboxone are 90% likely to make the first warm hand off. So we can see if there are subsets of the population that are facing more barriers and we can think through are there opportunities for a person to be connected to a community health worker who is like a navigator, who is the person who receives this person upon reentering community so that they can get immediately connected to life-preserving and life-sustaining care.

LA: That definitely would be an idea. I don't know if we have such a connection when it comes to mental health, frankly. Most programs don't seem to be open to off-hours and weekends. In terms of designating someone, I haven't really seen any community groups or government groups that make that level of commitment to it. I would say it would have to be something new.

AD: I'm just wondering of how would we get that information because of privilege. Are the pharmacists entitled to say they distributed medication to people?

LA: We can look at it roughly through the billing. I do know from just the individuals calling when they leave that we get calls from patients that are receiving prescriptions for suboxone in terms of can i go to that pharmacy? can I pick it up? But not so much in terms of mental health. But again, this is someone who's suffering from mental health, let's say depression or anxiety, they may not be that inclined to go to a pharmacy and get medications.

CP: So, I'm raising this because these are opportunities not only for the facility or the jail to say this is how we will solve this but opportunity to present data to state and or local agencies to say this is a defined need and these are

opportunities in a collaborative fashion to solve this issue. Whether you think about how community health workers are being used, you think about how patient navigators are being used, it becomes a public health issue. In thinking if there are opportunities through state funding. Are there opportunities through local programming, local funding, right? This is where you create a demand for public functions, assurance, powers of government to begin to solve issues and you tie them to data points and that data can say, what is the likelihood of someone who is reentering society who has a diagnosis of a mental health/behavioral health condition. They're not connected or engaged immediately in a warm hand off to get their medications and or care. This person is then more likely to exhibit certain behaviors and the opportunities to either be re-incarcerated or to further decompensated and so those are conversations that we can help facilitate in the task force, but we need that type of data to be made available and where the facility has access to that information. We can begin to lift that and amplify that in the same vein in what we're doing in Medicaid. In the same vein of the things we're doing around, who can be, and what types of facilities that weren't previously possible.

LA: When it comes to community [parties, I think Silver Lakes has definitely been one of the few facilities that's been open to this in the past few years. We actually announced it in one of the task force meetings that we're pursuing that and it's come to fruition. So there is a unit in Silver Lakes right now that take our patients upon discharge. The ones that need long-term care and they're able to house them from two to three months using the results of eligibility and they've been successful in stabilizing patients. So that organization is really dedicated themselves and they, you know, they kind of rode that roller coaster with us in terms of the ups and downs of working with the Medicaid infrastructure as it may be, but we haven't really gotten that same level of dedication form some of the more senior general hospitals.

CP: I think it's an opportunity for the state to be very specific, to think about ways to solve these gaps. I do want to highlight what me and Professor Valera and I were just talking about that within the appendix of this report on its own page 21 in the appendix, I believe. There are a list of community-based organizations around mental behavioral health that could potentially be partners or collaborating in what I am instigating, and I'm using that word deliberately. We will not solve these health problems that are rooted in inequities until we look at the assurance power of government, right? And to give people a better understanding of what that is, during the COVID-19 pandemic - there was public health phase of the COVID-19 pandemic, you were able to get tests for free. You were able to get vaccines for free. You were able to get tests mailed to your home. That is the assurance power of government, right? So, it makes a case for the state to consider because this is a public health issue, what are better ways to solve these issues because this is also going to throw us into the conversation around the unhoused population. People who are re-entering community who have these mental and behavioral health conditions, then are at risk to be unhoused because those conditions are not being appropriately managed or cared for. So there are opportunities to have yields and benefits. It's not just specific to one sector or one domain.

LA: Yes, absolutely. We've been able to establish that Silver Lakes initiative. It does allow one to have a very warm hand off. The officers are transporting the patients to the unit to then be placed there and then being housed there and they're getting discharged to case management.

JM: So, if I can, Doctor, and I just wanted to flag for Professor Valera. We have a full list moving towards multi-disciplinary and trained professionals in staff training and we have about an hour left. So we should be moving at a regular clip so we can make sure that we can address the entirety of the report.

RC: Governor, can I just jump in about the training —

JM: So, we have an agreement of the assessment so that Professor Valera, Dr. Pernell, Dr. Henry, and Dr. Alessandra are going to submit to you a list of. Sorry, Director, so training?

RC: So the feedback that comes from the staff - I believe that it was tremendous and valuable and I've shared that with Dr. Valera. So, we've added that to our annual training module. So, every officer, every custody officer will get that training moving forward with the fourth quarter of this year.

JM: And when does this happen?

RC: So, we have a training calendar that requires training being broken down into quarters and we call it miss which is mandatory service training. So each quarter, we have a different requirement. So, we've added it to the last quarter of each year, but the other part of that is because I run the policy academy as well, we're also going to be putting that in the correctional policy officer training as well. So we've added it both on the academy level and the annual training as well.

JM: Thank you.

PV: Thank you. Excellent. I know that we're running out of time so we've talked about this mental health first aid training for correctional professionals. When we did that training, surveyed them back again, and three months later, at least they referred people within incarcerated suffering with mental illness at least 30 times. Some of those issues, they notice irregular behaviors, they notice that some folks experienced hallucinations. They were behaving aggressively, refusing to leave the cell, refusing to shower, and challenging to communicate. And so that was really great to know that these training helped really solidify the importance of just trying to get people into the mental health department. So, just moving along. I think we've already talked about -

JM: Can I just jump in? I don't know whether the director or doctors had any thoughts on…Obviously, the distinction between federal, state and the county on the question of compulsive adherence to medical protocols and pharmacological protocols. Do you have any opinion in terms of the possibility of changes to the state legislature to grapple with that difficult question?

LA: I think we have enough legislation afoot so we can implement the medications. I think the issue is more so the individuals. That organization's stance on it and taking on the liability that is inherent when you're forcing someone to do something against their will. So I think that's where there's some hesitancy. Let's say if someone goes to University Hospital or Bedfordshire Hospital, they're not really looking to force medications. A lot of the times they're looking for court orders. They're looking for things that maybe they don't need to kind of give themselves a bit of efficiency. But it really boils down to and we have a policy action that we developed with Dr. Fleming where if someone has demonstrated that they decompensated when you're not medicated, they can petition and have that person placed on involuntary force medication. We then send the tout to another mental health agency, the Essex County Forensic Center and they'll review a case to make sure there's appropriate vetting and using the Director's team to do it. Now, I've had the experience of using that policy in the state level and it works. Once those patients start seeing how much better they're performing, how they start basically stabilizing. Usually, the second or third time around, you're not even using any type of forces. Just letting them know that they're in that program and that you're going to give them the medication. So, basically if you come to opt out, we're going to give it to you. You have the option to opt out and they don't because they see how well they're doing with the medication.

PV: Okay, so, I think the most important thing that we have to recognize is that the mental health department - their staffing is very low. They have less than 11 at this point, maybe even less than that - 8. While we recognize all these opportunities, getting the tailoring approaches to meet diverse needs, addressing continuing of care, we have to address- we've spoken about this for a number of years now, the staffing ratio of the mental health department. There's no way to address the mental health inside the facility if we don't address the staffing ratio. And that you have one psychologist and clinical social workers mental health for you have eight folks for 2,700 people. So, unless we address that first, then all these wonderful things that we're providing recommendations are not going to be solved because the staffing ratio has to be addressed as a priority. And that's all I have.

JM: So, doctor do you want to proceed, though, I think on the points in terms of telling approaches to meet diverse needs in integrated treatment programs. Professor. Because those are the specific areas that I think were not necessarily of contention but would be valuable to have both doctors' feedback.

PV: Yeah, so Dr. Fleming had mentioned sort of the increase diversity of people with mental health, you know, you're looking at individuals who have autism and also personality disorders reaction, reactive disorders. So, one recommendation is to tailor these approaches, these mental health approaches, to meet these diverse needs. Another one is in an integrated treatment program where we didn't discuss the co-occurring substance use in mental illness or the opioid use and mental illness and so, is there a way for the mat program to work alongside with your population who are suffering from mental illness. Then, we spent a lot of time discussing the continuation of care and the challenges of care. We've already talked about telehealth and then we talked about expanding access to

mental health through technology, through telehealth services, but the main things is how to address the diversity in your mental health population and what types of approaches are you all doing to approach these things.

JF: Good morning, everyone. To answer your question, there's been a significant increase in diverse populations that hadn't been coming to jail before. More with are on the autism spectrum, developmental disabled, coming in with co-occurring and very significant co-occurring mental health substance abuse issues and an increase in significant personality disorders. They are who they are and gotten themselves in trouble or getting out of trouble and remaining in the system, because of personality, sort of something that continues to keep them unable to function successfully and remain in society. It puts a strain on the clinical mental health population. Now, we're encountering a new group of people who in some ways require or very much require their own treatment plans, their own space within the facility and carving that out has been difficult with the other challenges in these cases. We always say jail is a place where it's kinda like church where everybody shows up and they all get service in some way, shape, or form. They never get turned away. But so we're doing our best to meet that challenge while also facing the staffing issue we should bring up staffing because we can only do so much with the few people we have. We've had a lot of conversations more recently about how we as Essex County Correctional Facility and want to increase the staff so we can have the ability to treat populations with mental illnesses but then also many of them who need just open skills, need family reintegration, need assistance doing those little things that the system to stay on direction.

CP: Dr. Fleming or Director Charles, or anyone else - feel free to weigh in because periodically we return to this topic. We hear that discussions are being had around ways to increase the mental health staff but I still don't have a sense is there a deliberate pathway to creating those FTEs or roles. If you could maybe perhaps one of you, first, maybe Dr. Fleming, describe who is on the team right now. That could be through titles, through competencies, who they're able to care for and/or treat and what you see is a gap. Are you missing a discipline or are you missing a certain type of mental health professional? Or is it an amount issue, more numbers. Director Charles, if you want to weigh in on what are the next steps or the plan around having more staffing in the facility.

JF: What I can say is that mental health staff are all clinicians. Most of them are masters level or above trained and all licensed. Very well disciplined in the modalities of this. Honestly, it's best of luck. Staff discipline, knowledge, clinical expertise their issue. It's more of numbers issue, there are over 2,000 patients at the facility, could all be perspective patients honestly. There's only so much of us that could be seeing them. Most of our time is spent managing the very severe mentally ill at the facility. And again it prevents us from being able to help people who might need some pick me up or some adjustment in the way they do things or think about things. They're sort of persistently ill, persistent or chronically ill in significant amount of ongoing clinical care. It really is a number issue.

CP: How many more staff do you believe you need to care for the population?

JF: 10 additional mental health professionals would allow me to fully staff the mental health step down unit which created an opportunity for those who are actually mentally ill to actually work in clinical or program that you set in to incentives to get more wealth so that they're not in their beliefs previously housed in the SHU. Programming and the desire to want to get better as well as being able to service in treat those who are in a general population who again are quote unquote just depressed, just anxious, ,just have anger issues, domestic violence issues in spouses or others. We struggle to treat that population, more often than not we're doing our best to manage very ill people that shouldn't be in the facility in the first place.

JM: Could I just interrupt and ask the Director - I know the state, particularly Commissioner Adelman had considered securing a federal, waiver from CMS from Medicaid eligibility and I know Newark specifically, the county executive and the Chief of Staff were interested in the possibility of this facility securing a proportion of that aid. Have we moved at all in that direction?

RC: I haven't heard anything or coming to final.

JM: Could you follow up for us?

RC: Absolutely.

JM: Thanks, because to go to Dr. Pernell's point and Dr. Valera's point and Dr shamelessly encouraging an increase of his staffing levels at the Task force hearing which I appreciate.

RC: Yes.

JM: I appreciate how chutzpah. We should look to see, I know California was granted a waiver. I know New Jersey was reviewed. I know there was going to be a second application, but Essex was part of the original application. Could you just double-back to us?

RC: Sure thing.

RM: I would just like to add that recently, in our medical meeting with Dr. Anicette, we have addressed the issue with staff and we have pulled some of our social services staff that would assist in mental health. We have reentry people who are also qualified that will be assisting the mental health team.

PV: Are they clinical?

RM: Yes they are.

PV: They're clinical social workers or mental health professionals?

RM: Yes, we have two in reentry and we have two people in social services.

JM: But you're pulling them out of a different area which I respect but I think Doctor's point is, at the end of the day — No, and I appreciate your lack of a better phrase, entrepreneurial spirit — and probably as a Director's assistance. But I mean I think there's a clear recognition that considering the increase of mental illness, co-occurring disorders, particularly with addiction or alcoholism. We need to do more, but I admire your courage.

LA: We're also looking at trying to actually reduce the numbers because we do realize and Doc is definitely going to average it case by care because they get lost in the judicial system. And so a lot of times, they may not have a hearing. They come in a really minor charges. But because they can't present to work, you have to get cleared to before a judge and so after multiple times of not being able to clear to go see the judge, they miss the window of opportunity of early release. This kind of linger language in the facility. So a lot of times we're looking to see that we can get involved with that judicial process and let the judge know, you know what's happening and we've been able to get some judges to say, this case is so minor why don't we just downgrade this or give him all the time served for loitering and they've been here for months. So, those patients we're able to move them to another location outside the jail because now we have judges who gotten interested in their cases and so we're looking to do that more and more. So, the mental health team is meeting weekly to assess these cases and see based on the charges that they even belong in the jail.

JF: What we don't have particularly for the population who is people who are very ill aren't able to advocate for themselves in court. Almost like a legal advocate, in a sort of maybe a case management role, social work role, job responsibilities attempt to make the contact with attorneys or the judges because it depends on how your mental health is in commission and how savvy we are in communicating with, the courts. We end up fulfilling that role. What's the status? What's your next court date? We'll do our best on our end for Mr. or misses so and so report but really there is a need even in a part time basis. I could say full-time but even a part time basis for someone to have a role like that for similar to any ombudsman report of you.

JM: And doctor, could you explain for us the interaction with the state psychiatric institutions and that critical gap between Essex and State psychiatric institutions? In a sense of persons that would be best and appropriately housed in a state psychiatric institution and how that process occurs mindful of their criminal exposure.

JF: So typically, in state psychiatric hospital and the initiated by court order by those who have been identified as likely incompetent or questions about competence so that court order would initiate their transfer to state psychiatric hospital more often than not for us is the forensic center or Trenton Psychiatric Center where psychiatric and they

stay for 45 to 90 days, getting evaluated and get the results of the evaluation there have remained there in the process of them in getting initiated for psychiatric hospitalization. More often than not when it's a question about competency it does lead to psychiatric hospitalization.

JM: What's the interplay between legal representation and psychiatric review for those patients?

JF: The legal process will continue and typically the public defenders or private attorneys are involved in the process because they are the ones initiating signatures of the court orders and they're very much from step one aware of what happened with their client advocating in many cases because there are legal defense may be influenced of the result of very least competency evaluation along with an actual stint.

JM: Are there cases, doctor, where the correctional facility director would send someone out of the facility to a non-secure setting, a non-state psychiatric institution for the purpose of psychiatric therapy or treatment and then be returned to the facility?

JF: Yes, our relationship with University Hospital and North Beth Israel has served that purpose — issues getting folks actually admitted. That is our usually in a crisis situation for transports either of those hospitals or who could be in 14 days, 21 day schedule.

JM: Is there any personnel in the facility that is used to testify before superior court as to psychiatric predispositions?

JF: No, with the exception of a psychiatrist signing off, on RNS certificate, for others in need of a higher level thinking of someone to say on that. Full signs at which facilitates the hospitalization.

JM: Because that's a difficult space.

JF: Yeah, and there's time frames involved. The issues whether or not beds are available. A lot has to happen within a short period of time.

JM: Professor Valera, could you just share with us the note that you made regarding co-occurring disorders and continuity of care within the community?

PV: I think we have talked about the opportunity to address your co-occurring mental health and substance use better and I know we do a really good job with the MAT program and their continuity of care - there's a lot of warm hand-off. If there's a way to collaborate or partner with the MAT program to address those that are suffering from mental illness and opioid use that's really just really an opportunity to sort of broaden the reach and maybe expand some of the resources that are limited in the mental health unit.

JM: And, Doctor, you talked a little bit earlier about the Silver. Can you talk about what's happening now about the dynamism between the facility…

LA: So Silver Lakes does offer that opportunity to take in those co-occurring patients. So, they're perfectly willing.

JM: And what's the bed amount?

LA: 60 beds. The longest battle, frankly, is getting Medicaid to agree and that took about 18 months.

JM: So Medicaid is reimbursing at Silver. I'm sorry to be so pedestrian so if Jim McGreevey is at the Essex facility, how do I get to Silver Lakes. How does that happen?

LA: If you know how to get to Dr. Fleming. Basically they'll send their screener to the jail either that day or the next day. And they'll do an evaluation. The criteria's low. The threshold to get in is low. I mean, you can be unlike some other places, for Silver Lakes, you can be decompensated, you can have an active mental health condition, you can be in need of MAT or MOUD. They'll take those patients, so they really have a low threshold of that.

JM: And what is the average of the stay?

LA: Two months.

JM: Two months.

LA: Two-three months. They try to extend it. Of course, because this is life right? So, now that we have them there, now Medicaid's revamping their whole system again. So they have to recertify with all the large carriers. One of the largest carriers is Blue Cross Blue Shield. And they're very in terms of, their allowances for length for stay. So, we've had to kind of go in refers. So we used to be able to get patients connected to a carrier before they leave but now, because of this routine, the hospitals asked us to not do that. Let them go to the hospital and let them negotiate with the carrier for the length of stay because unfortunately when we would get the pre-approval, they would get pre-approval for 3 days, just a few days and really, the likelihood of stabilizing someone in 2-3 days is slim to none. So what they're able to do basically is find a system, a mechanism where they used straight Medicaid for the first 2 months. Then, they're forced to pick a carrier, but then they're picking a carrier that's more amenable to extending the state. So, it really it's kind of backwards because they're literally telling us don't place that person into insurance because your plans are really tight when it comes to giving allowances. You have to really be in a dire state and decompensated almost entirely.

JM: They don't place that person in insurance - you're talking about affordable care act, you're not talking about Medicaid. So, it's better that they be sustained on Medicaid. That's interesting because the Affordable Care Act is a lower level of reimbursement because typically those individuals -

LA: You have to undergo a certain level of peer review with their medicines and their criteria is really tough. I mean most of the time they recommend out patient care.

CP: No, I just had a clarifying question for the record and members of the public. So, they're referral to Silver Lake is coming from the mental health team at the facility and Silver Lakes has the capacity of 60 beds. SO, on average, how many persons who had been at the facility are receiving treatment at Silver Lake. I know that they're staying about 2-3 months, but how many persons are actually being referred and cared for at Silver Lake.

LA: Right now, they have standing, I believe the last sentence was 24 patients. We're trying to get more patients there because if you don't make the cut and you're not allowed to go to see the judge early on in the process, within the first 48 hours, then you stay. Then you have to get in front of the judge, and that's where Dr. Fleming and his team has been very instrumental as they work with the patients, presenting their cases to the judges, and the prosecutors are getting together saying, "you know what, this persons been in jail long enough" and they've done that. You started that program several weeks ago - about two months ago. And so, within those two months, and they just started releasing people about three weeks ago. So they met for several weeks, and about three weeks ago letting go of patients, those ones that have been languishing in that unit-now they're letting them go. So we had one last week, two the week before. The goal is every week to get some of those patients in front of judges, that's lengthier of a process.

JM: Yeah, but that's fascinating because we're almost dissuading individuals from achieving a greater level of independence from the Affordable Care Act by the virtue of Medicaid.

LA: But the good thing is Silver Lakes when they're being discharges, does attached them to their Affordable Care act. So, they do leave with insurance in hand, it's just getting them into the house.

JM: But the Affordable Care Act, though, has a discrete enrollment period.

Okay, so there's an exception year round.

LA: Yes, there's an exception year round. So, again, these are all the little nuances that we are learning to navigate in the system. There's a difference between specialty hospitals and general hospitals. So, general hospitals like University, Beth Israel, they can take people year-round even if they're incarcerated or not incarcerates, they can

take them. But, specialty hospitals like Silver Lakes can only accept you once all the judicial retainers have been removed. So, that's why that step with the interim step..

JM: Oh, so all the detainers have to be removed prior to.

LA: Yeah, so we work with team to have all the detainers relinquished.

JM: And that's a requirement of CMS, not Essex. So this way CMS can be pulled through and fast to the understanding that they're providing Medicaid insurance to non-custodial individuals.

CP: I just want to make sure I'm hearing and understanding correctly. So, through the waiver, we have persons who are incarcerated through the Medicaid insurance product that can be cared for at Silver Lake because that has the greater efficiency around length of stay. When these persons have exhausted the treatment period or window at Silver Lake, they are either sent back to the facility or they're discharged?

LA: No, they're placed in housing attached to their insurance.

CP: And at the point at being placed in housing, is that when they're on a non-Medicaid insurance product and they're on the Affordable Care marketplace.

LA: Yes.

JM: Thanks. Professor Valera. did you want to just touch base as to telehealth and medical health care through technology?

PV: Yeah, just briefly. I think there's opportunity to leverage telehealth. and I think having conversations with your partners, UH and Beth Israel to see how we can use telehealth to ensure that all of folks that are experiencing serious mental illness has some access to counseling to therapy at some point prior to release. And that's a larger conversation with all those different hospitals, but I think we have telehealth that's here to stay. The folks have tablets, maybe there's a way to access that opportunity. There's also, leveraging AI, as a way to just have some sort of communication with someone who's really in need of therapeutic approaches.

CP: Has there been any exploration of telehealth outside of the evaluation of persons in crisis?

LA: Yes, we were using it for about a year for HIV patients, so we were able to connect the Peter Hole Clinic at Saint Michael's Hospital and definitely one of the top at these hospitals - Dr.Slim was working with us and we were running clinics at the evening time and the patients really took to it. The participation was tremendous. There were hardly any no shows with that program and even our staff who were a little reluctant at first to do it saw the efficiency really started looking it as a benefit it. So we've definitely used it and would like to expand it given the opportunity.

CP: How does that opportunity present itself? What are those steps, wherever possible, I want us to be able to think through that we talk about a lot of rich ideas and opportunities but how do we get from the ideation phase to actual approval and implementation. So it is that you feel that you would need stronger relationships, with whether are hospitals or community-based programs that could offer these services via telehealth or is it that those facilities are saying that they don't have the resources to do it. Has a direct ask been made?

LA: We have spoken to these entities. Both factors later rolled on in terms of the availability of staff but I think the biggest thing is because it's almost like the person is going to have to do is the one that drew the short straw. It's not like there's this ready enthusiasm. Dr. Sue is a different kind of person. Yes, he's a highly regarded expert, but he's barely got his feet to eradicate infection disease. I don't see the same kind of energy from different entities that we spoke to too. I think that's a reason to that there's a lot of flux when it comes to leadership of these entities. So, you may speak to, like for instance, we spoke to the head of Saint Michaels for about three months running and we had a series of meetings within for some reason there was another person we're in front of and then similarly when we speak to University. I think over the last two years, they've probably had just as many leaders in that seat. Maybe

four different residents with that we meet with. So, again we may start a dialogue. It may be going through is another person that's there. So, I don't know if it's a lack of willingness or a lack of continuity. We're reacquainting ourselves with the new leadership and bring to figure out where we can make the inroads. On a positive note, we did meet extensively on the crisis management, so we did get from University that they agreed that it would benefit them to come to the jail.

CP: No, that's very good progress. While you were speaking and I'm not sure exactly what is the method or how we would do this but if we could facilitate a round-table, a focus and targeted summit on this issue where we're able to convene and bring the healthcare sector locally in the county and perhaps even the state to understand the findings of such reports. To create more of a critical mass of understanding, right? Around what the issue is and how we begin to solve and the reason why I'm saying this is because increasingly these hospitals either have community health improvement plans. They have health equity, strategic goals through their accreditation processes, local health departments, similarly have goals, and if we could use the information that we have to match where there is already intention whether that's intention because of a regulatory demand or attention because of a strategic or operational demand on part of the facility to say, "hey, in your community health improvement plan" these are publicly published on their websites or things of that nature. I don't know that everyone has the same level of understanding of what the issues are. It needs to arise from the most senior level because even if you continue to change their beliefs, it's that institutional knowledge gets lost when you're starting over. It's something for the task force to think about like what's next. We do these public hearings. Is there an opportunity to do a convening where we invite particular entities or representatives of healthcare facilities to have a conversation. We invite the facility to participate and so that's a way to also open dialogue and to create ways to solve these issues.

LA: I thank you for that because I think that one of the hospitals in the area that could definitely become a focus for these types of initiatives would be Saint Michael's Hospitals. It's no secret that they have maybe 100-200 empty beds right now. From talking to the folks at University Hospital, they would definitely want to lend a hand to one of their partners to try to create an environment where we could send mental health patients to get long-term care for them while their incarcerated because the problem is—and the Governor touched on it with Ann Klein and Trenton State. This 200 beds for the whole state. So, there's really not going to be much. So it doesn't work. So, and the doc is good at advocating. He calls these folks up and I think we probably have—

JM: He's shameless.

LA: And pridefully so. He fights for these faces. I do think we probably ranked number one in terms of counties that get admitted into Anne Klein because we have made some special arrangements for Anne Klein. For instance, if we have a patient that goes to Anne Klein, we continue to take care of the medical needs of the patient. If that patient needs outside consultation, we do it. Especially if that person needs transportation to go from different locations, the director accommodates. So, there's a lot of negotiations that have gone to have taken place that allows us to have if maybe when we see an inside track, we're getting our patients in but when it comes to the numbers, the sheer numbers to be in, there's no way that they could accommodate it. So, if we could get, you know, a certain percent, I mean 20, 30, 40 beds, we could fill those beds. So, it wouldn't be that we're putting a financial burden on that hospital. Those patients can be reimbursed because they have a general hospital. So, they do get reimbursed. Sometimes it's the people coming in, maybe they're not from the area, maybe they don't see the need and realize the consequences because frankly, I always kinda, it's ironic to me that they don't take in inmates because two months later, that same patient walks in with civilian clothes—the same patient, with no security. They're not taking that patient and the same patient walks in as soon as they get discharged and they live in the same area and now you take them in with no—so it is a bit perplexing, but again, maybe it's because we've never had all the players in the same room at the same time to discuss it and we go to each hospital individually.

CP: Yes.

JM: So, doctor would you be able to provide for Michele and in consultation for Professor Valera and Doctor Pernell those list of affiliated institutions both healthcare, psychiatric, and medical that would be appropriate for such a conversation. And to go to the I think the director's point and the Chief of staff's point, with the Doctor and Professor, is groundbreaking because this is a state problem, it's a national problem. But what you've done with Silver Lake, you provided a model. Albeit, you have to remove all detainers which is frustrating because there are

those individuals who that opportunity doesn't exist for. and so they anguish in the facility despite doctor's best efforts. So, professor, is there anything you'd like to discuss today? Henry? The great Dr. Pernell?

CP: No, just for the awareness for the public, we do have a spreadsheet where we are keeping track of issues related to mental and behavioral health and I've been reviewing that to see if we have received updates and so there are things around training of staff on best practices and mental and behavioral healthcare. We heard from Director Charles today about a significant milestone that will be achieved in the final quarter of the year. I've been listening for also an understanding of how we're going to implement some of the screening or assessment tools that have been recommended because this really has been an ongoing conversation that myself and Professor Valera have been a part of and I believe today we heard some specific steps, a prioritization of the screening and assessment tools on the part of the Task Force being presented to the facility, the mental health team, being able to vet those, ask questions or an EMR team and then wait it making its way to an IT implementation. And so, another issue on here that was something that we had been discussing and had a running tab was around staffing-those critical shortages when it comes to behavioral healthcare while we heard and acknowledge the creative solutioning around trying to utilize some staff who are in other programs whether reentry or otherwise. I do believe that will remain the number one issue in perspective of the task force is ensuring that we get to a critical mass because if we don't - we're scratching the surface and we're putting dressing on something that we could really do a better job of solving so I just want to make the public aware that we are tracking these issues. There's some things that we weren't able to get to today like staffing shortages, for instance, for recreational programs, the last update we had received was at the beginning of this year, and I believe there have been 12 staff that have been hired to handle the drug and alcohol program that has been taken in house. We will continue to resort to the spreadsheet. We have shared this with the facility. I think it's a great way for us to manage our dialogue and to keep track of the issues that we're working on in a timely fashion.

JM: And I just wanted to pick up and say thank you to Dr. Pernell and I just asked Michele to forward to the Doctor and Dr. Anicette the tracking so we're all on the same page as Director as to what is outstanding, what has been completed, and what's of continued concern. I just want to say that you to Dr. Pernell for her diligence and her follow-up to make sure that we're all on the same page. Be that as it may for Professor Valera, I think we'll follow up with the recommendations and the specific recommendation that Dr. Pernell underscored to bring institutions to bear to examine both the opportunities post, judicial restraint, and during the incarcerate period and I just wanted to ask the director or any member of his team for any concluding comments.

RC: I just want publicly thank Alessandra. She came in and did a training session, not related to mental health though. It was through the solitary confinement through the supervisors. So, that was something that was well received, needed as well. So, I just wanted to publicly thank you.

CP: I just also wanted to ask if there were any questions via social media or online.

JM: Would you like to make any comment?

Guest: My name is Ray Lord. I'm with the Archdiocese of Newark Prison Ministry. I've been doing this for 12 years. We've made - since doing this Essex County before we did Delaney and the private jails for the last two years, we've been doing this at the SHU mainly for the women at the facility. I want to say that there's been since the last year, there's been a tremendous improvement in the SHU as far as it's still a tense place, it's the corrections officers are just a lot more aware even though they can't make relationships work with people generally they're more aware of that and the other thing I'd like to say is that we know all these people, you know, and we go in and see them and they're individuals to us. Many of them have been in the system so long. They were in Delaney and Logan and other facilities and they're really, you know, they're people and it's hard because it's not just numbers and I think there's been tremendous improvement over the last few months in particular. And I want to thank everyone involved in the force.

JM: Thank you, Ray. What you said was very important and I should acknowledge Rubin Simmons who chaired the SHU report, a former member of the task force who was tremendous and really grateful that you recognize the improvements that have happened to the SHU unit and I want to thank Imran Rabbani, Alessandra, and particularly Rubin for I think articulating and detailing a report that reflected a review of compliance of state legislation but Alessandra, I just want to defer if there's any specific thoughts or recommendations or follow up?

AD: I may just put it back to the Director, but when I was there the training, I understand you were just opening up a unit or a wing which was to help relieve some of the pressure for the SHU which was for people with mental health issues that under ICRA can't be kept in the shoe beyond these vulnerable populations can't be. So if you could just maybe give us a status update.

RC: Yeah, so after that training session, we went back and sat down with the executive team and looked at if we could implement a vulnerable population pod tier if you want to call it and we were able to design one and we put into effect about a week after that. So, to be in compliance with the solitary confinement, so we created this unit. It's staffed by officers who have extensive training in the law who have had specialized training for those types of population and will continue to populate that part of the jail as needed. So we are moving in the right direction and I appreciate the comments. You know, coming to the meetings, reaching the reports, that's good. It's also nice to hear that we are making a difference. We are actually changing things and changing things for the future I appreciate that and I will pass that along to the staff as well.

JM: Thank you. Any other comments? Dr. Pernell?

CP: I just wanted to update that we have checked in and there's no questions online.

JM: So, there are no questions online, but I just want to show that I think healthy tension of the SHU report and all the work that Rubin did, Alessandra did, Imran did. The full committee did. The reaction, the response, there was a net response that appreciate the public's concern and support for the Task Force as we're embarking upon mental health Dr. Anicette, the conversations, we've had going back literally two years now in Silver Lake and providing alternative and trying to navigate the financial goals as well as opportunities with Doctor's leadership for increased clinical referral opportunities. So, thank you very much. Is there anybody else, Director, that wants to comment from your team?

RM: I just want to say I want to thank the Task Force for looking into, you know, mental health and willing to assist the department with getting help for the individuals in need. I'd like to say thank you.

JM: No, thank you and as Dr. Anicette said, you know, for our population of reentry and we're here at Essex County reentry site, 936 Bergen, approximately 74% of our clients have substance abuse issues. And traditionally, it was approximately 43-44% with co-occurring mental illness, we see that number increasing so we see that our population reflects roughly the population of Essex County Jail and state prisons. So, we just recognize the challenges and we're grateful for your entrepreneurial approach and Dr. Anicette and the entire team. Thank you, Doctor. And with that, is there anyone else Director?

RC: No.

JM: I just wanted to be clear that Professor Valera's report is on the website for the task force and our Facebook page. I've also posted it on our personal pages which encourages a wide distribution as my dear friend Phil Alagia said, you have us spending a lot of money for a statewide problem, but Essex County is the largest facility and I'm really grateful for Essex County's willingness to tread into these waters which are so critically important to provide these opportunities for the patient population. So, director and all, I want to say thank you because this labor has benefits that may take longer than we may desire but at the end of the say, I wanted to say thank you to the entire team but particularly to Professor Valera and particularly my dear friend for being diligent to the follow up to make sure at the end of the day, we provide the best clinical care to the individuals housed at Essex County. So thank you to Henry, Thank you to all those who assembled-Michelle, Alessandra, and all those who share in those task.Thank you. Have a good day. Take care.