NY City Council hearing: *Oversight - Pre- and Post-Release Mental Health Services for Detained and Placed Youth.*
February 28, 2014
Testimony by Episcopal Social Services, delivered by Dr. John Shaw, Mental Health Administrator, Adolescent Residential Care
Contact: Mohan Sivaloganathan, Chief Development Officer | sivaloganathanm@e-s-s.org | 212-886-5604

1. About ESS

Episcopal Social Services (ESS) is a nonsectarian organization that positively impacts the lives of nearly 5,000 New Yorkers in low-income, high-need communities per year. Our work helps underprivileged youth gain academic skills, strong moral character, and pathways to future success, while also strengthening the well being of families and low-income communities. Our clients lack access to high-quality education, health services, and other basic tools that are commonplace for more affluent families in the New York metro region. ESS addresses this issue with programs that impact families from "birth to adulthood". We work to close the achievement gap before it begins with high-quality education; partner with families to improve their mental and physical health; and work with teens in foster care to make sure they can graduate high school, succeed in college, and pursue ambitious careers.

Our programs are located in the Bronx, Manhattan, Queens, and Brooklyn. Beginning in 2006, ESS opened its first Non Secure Detention facility, adding to its then four group homes for adolescents. Since then three additional NSD's have been added in recognition of the high level of performance and skill providing quality care to youth consistent with the objectives of juvenile justice reform efforts. We refer to our work as "reform" in that we provide an innovative approach and model for at-risk teens. In 2012 the Administration for Children's Services (ACS) awarded contracts for three Non Secure Placement contracts to ESS, initiating the Close to Home initiative in NYC. In September of 2012 ESS opened the first NSP in NYC, and by January 2013 had opened an additional two; two facilities are for male youth, one for female.

The tenacity, perseverance, and strong team work that was the hallmark of Adolescent Residential Care in ESS have seen us through the considerable growing pains of breaking the new grounds of the Close to Home initiative, and we have seen extremely positive results in the responses of the youth and their families to our attempts to heal and renew family ties, and to reintegrate the youth to their communities prior to discharge home. ESS has been clearly recognized as providing the capacity to reach benchmarks and be responsive to program goals at a level unmatched among provider agencies. We firmly believe that our eight years of experience providing non-secure detention programs, and applying the basic core principles and values of establishing a secure, therapeutic, and consistent environment for the youth in our NSPs has been key to our success in the Close to Home initiative.

Our main objective in ESS NSP is to provide a secure, safe, and supportive environment wherein each youth's positive potential can be identified and enhanced in order to provide them with life skills necessary for personal, academic, and professional success. Meeting this goal benefits communities as a whole as individual success equates to prevention of re-entry. A key component of the program that provides service not only to the youth and families, but adds needed balance to our model for juvenile justice reform, is our mental health treatment service array, all provided under ESS administration and supervision.

2. Background

The mental health needs of the population in Non Secure Placement are striking, both in frequency of psychiatric diagnosis by comparison with the average inner city adolescent population, and in kind. The numbers of youth reporting histories of exposure to extreme violence and loss of friends or family members to violence is very high (84%), and the incidence of major failures in successful adaptation to school is reported in over 90% of their histories. Post Traumatic Stress Disorder is often under diagnosed, but still higher than the expectable average, with the clinical, educational, and juvenile justice system emphasis having been on attention deficit and disruptive behavior disorders, dominating the youth's mental health history. Treatment of these disorders alone falls short of successfully accessing and engaging the positive energies that are part of their negative and rebellious adaptations, because it often fails to recognize and treat the significant trauma and sudden and multiple catastrophic losses that many of the youth have experienced The rage that covers and compensates for the loss, and the youth's entrapment in a cycle of increasingly negative attempts to assert themselves and their will to live and survive, is too often lost in the predominate focus on behavior disorders alone, and not recognized as hidden fonts of strength and resilience.

We as a society are living with the effects of failing to address the mental health needs of this population, and the Close to Home initiative is a bold and productive attempt to broaden the thinking and approaches to reducing recidivism without sacrificing the core values of detention and placement: A contained and secure environment in which safety and positive learning can occur, making possible the meaningful delivery of core mental health and social work services whose aims are strengthening families and community bonds.

3. Juvenile justice reform at ESS

To deliver transformative outcomes for our NSP population, we chose to implement the nationally recognized Missouri Model as our service delivery method. The Missouri Model has delivered impressive success in Missouri for a wide range of juvenile offenders, which makes it a logical choice of service delivery as we embark on a new age of youth rehabilitation.

Our work relies heavily on a combination of our traditional interdisciplinary team – with emphasis on team and team work—and the group process principles of the Missouri Model. Our

mental health services, which include clinical social work psychotherapists on each team in addition to ESS clinical psychology and psychiatry services, serve as a support to the fundamental relationships our residents have with the youth specialist staff, who provide the ongoing support of daily living relationships analogous to family life, as well as their fellow youth in the residence. In addition, the therapists provide an individualized availability as a balancing need to the group work emphasis of the Missouri Model, and work carefully within that model to support it. The therapists, in addition to individual psychotherapy services, are the link to mental health issues that are relevant to school performance, daily behaviors, and the social-emotional development of each youth, as well as the additional services such as ongoing psychiatric care, substance abuse, and creative arts therapy.

In my opinion, the role of mental health care in any setting outside of the traditional clinic or psychiatric hospital is to provide therapy that is shaped by the planning goals of the system of care providing services and intervention to the youth, as it is the failure at the point of intervention of the customary service models that leads to the extraordinary intervention of placement. The goal of the system of care is to identify those family and individual issues relevant to the failure of community services to achieve a positive enough effect that placement would not be necessary; in the case of mental health services, to identify and focus on those mental health issues relevant to why the youth is placed. Mental health services delivered without regard to the context of the program and its goals are often either off the mark, inconsistent with the larger treatment models of the program, or can even produce issues and considerations that might prolong stays; and while legitimate as issues, they are not central to why the efforts of the public system failed. In addition, the role of mental health therapists on the team is to help identify and promote positive modes of group process between the various members of the team, and to redirect the group process of the staff according to the same principles of the Missouri Model that are applied to the youth.

4. Success and innovation

Although we have run the Missouri Model in our NSPs for only one year, we've already seen dramatic improvement among the youths we serve. With respect to rehabilitation, we've made steady and significant progress in helping residents stay on track to release. While it is too early for recidivism data, the majority of the youths we've discharged have demonstrated significant positive changes in behavior and maturity. Additionally, with all of our youths attending Bronx Hope (a District 79 school), we've seen improvement in academic attendance and performance among our residents. Finally, bringing youth close to home and adding a clinical therapeutic approach has resulted in a near elimination of incidences and a dramatic change in resident behavior. The comprehensive nature of our work has created an environment that is conducive to positive change among youths, leading to strong signs of success after just a year.

The second area that I am very happy to enthusiastically present to the council is the extraordinary success we are having utilizing creative arts as a form of psychotherapy that is adjunctive both to the Missouri Model and traditional psychotherapy. I can attest based on my decades of providing psychotherapy to adolescents in care as a clinical psychologist that the degree of successful engagement with the teens is stunning, as they voluntarily provide - through their song lyrics, poems, writings, and drawings – details of their lives it would take me months to access at the peak of my skills as a therapist using verbal engagement alone. The process of writing, learning singing and performance skills, recording, performing, the effort and discipline involved, and fueled by the youth's desire to express and be heard, all open multiple avenues of skill building, reflection and expression of severe trauma, positive new bridges to connect to community and family, and capacity for receiving positive public acclaim and recognition that most or our youth have never experienced.

What I am describing is not something that any trained Licensed Creative Arts Therapist does not know first hand, but in our case, by coupling the extremely positive energy and motivation that the youth have for expression, with the goals of the program to provide positive alternatives to violence and rage, we have seen remarkable improvements in motivation and behavior change at the facilities, at school, and in the eyes of their families. In addition, the entire community of those who work in our NSPs are bound together through the youth's excitement in learning, and hearing them perform together, in a lasting and positive way that creates positive cohesion and recognition of what the youth can achieve, across all professional lines and boundaries, providing a common core of appreciation of what positive creations and productions are youth are indeed capable of providing.

Our plan at this point is to further sharpen the treatment model by combining Creative Arts Treatment with Dialectical Behavioral Therapy (DBT), a form of treatment recognized by national leaders in juvenile justice residential care as effective and durable. By combining the two we anticipate forging a treatment form that is highly engaging of the youth, by utilizing their desire for recognition and having an impact, and then by leading them through the steps necessary to a positive experience of significance and public acclaim. Through the imbedded DBT in the Creative Arts Treatment process they will also be learning a self care treatment method shown to improve emotional regulation, mindfulness, and interpersonal effectiveness; not surprisingly, all requirements of productively impacting others using the arts as a medium of engagement. In short, user-friendly psychotherapy for teens in trouble. And we have waiting lists.

Going forward, we hope to fully implement Creative Arts Therapy as an accessible program for all teens in our care. Additionally, we are constantly evaluating innovative methods for strengthening our juvenile justice reform efforts. We recognize there is no "one size fits all"

method, but we are proud of our results to date and look forward to continued growth with the support of the city and private funders who have expressed interest in our work.

5. Success stories

Karla was transferred to our NSP two months after its opening, as the first group of girls slowly began to adapt to the program. Karla was large framed, had a reputation for physical aggression, and had failed in her previous placement to adapt to the program. One weekend while visiting the home, and after she had established a record number of physical restraints in her first weeks there, I recognized that her speaking voice had a strong resonance and ring that often makes for a good singer. After introducing myself to her, I asked her if she enjoyed singing, and she promptly told me what I should do with myself; undeterred, I told her I recognized a singers voice when I heard one, and whether she liked it not, she had one. The following week Karla was listening to music with headphones, and I could hear her voice. It was very soft and lifting, had a wonderful pitch, and she carried the song beautifully. I tapped her on her shoulder and asked her if she would like "singing lessons", having already found a local music therapist who worked with teens in an inpatient mental health facility. She hesitated, then said yes. I told her it would start in three days, and as I was leaving she called out my name. It was remarkable to hear this big bad brawler of a girl shout "Thanks Shaw!" We brought her for weekly sessions which increased to twice weekly.

The weekly sessions, in combination with the home's approach to group development and care, led to improvement in Karla's behavior and disposition toward the future. The number of restraints dropped dramatically within two weeks of beginning treatment and she worked hard at school. We started to see Karla progress through the Missouri Model phases system, which indicates certain behavior and leadership levels that merit certain advancements in privileges. Karla was due to be discharged home to her mother in February of last year, and the night before discharge she got up and sang a rap song duet with one of the youth specialists, to over 100 youth and staff at our Black History celebration. While one never knows what the right combination of supports will be that work for any individual, I am certain her music therapy, and the challenges of discipline, expression, practice, and recognition she received there was key to accessing her positive side, which was as strong as her negative, only hidden. Her mother was filled with pride at her accomplishments. She ended the last night with our program with a beautiful makeover, lovely dress, indeed a diva, having come to us a brawler.

Alex began music therapy with four months left till his discharge. He was doing poorly in the program, being aggressive on family visits, and having a continuation of a very negative and disrespectful relationship with his mom. His attitude and outlook were saturated in machismo, and there was concern that if he did not improve his relationship with his mother and father, success after discharge was doubtful, and he would return to drug dealing. He had heard of the potential for making recordings of his rap lyrics in session with his therapist, and he was referred

for music therapy. His lyrics were not only expressive of feelings far deeper than his superficial and condescending behaviors toward others suggested, he also had an ability to shift and relearn voice patterns that interfered with his effectiveness at rapping. He asked after a few sessions if another youth could join him, as they worked on songs together. This was arranged, and the two began developing songs with sections for both, and were guided by the therapist to listen, identify, and express the emotions in the other's lyrics, and to support together the central theme of their song, as well as critiquing each others individual songs. One night, while listening to his friend rap, Alex told him that he was all wrong, that he was not going to accomplish what he wanted in that the words and gestures would make "her" run. Picking up on this, they shared with the therapist that the song, which was to be performed at an upcoming event, was to a particular girl in the audience. In this case, the former machismo driven arrogant Alex was giving advice how to appropriately make the girl feel wanted and respected.

The night of the performance the two boys sang their song "Where I Been Going", a reflection of where they came from, and their hopes for a positive future. His friend sang his song, and needless to say, by the end of the night, was holding hands with the girl he likely would have driven away without Alex's advice and help. Both of Alex's parents and siblings were there, beaming with pride and taking video of his performance, as so many parents are able to do, yet so few of our parents have an opportunity to do. The therapist had reported that the family, as well as Alex and his mom, were able to discuss and argue in a much less intense and destructive way, and that Alex, on a few occasions, had corrected his father for not being respectful enough to his mom. It was clear that Alex had pulled the proverbial 180, going from someone destined for a life of crime and fulfillment of stereotypes to blossoming into a mature young man with a positive future.

TESTIMONY
Regarding
Oversight: Pre- and Post-Release Mental Health Services for Detained and Placed Youth

The Council of the City of New York
Committee on General Welfare,
Stephen T. Levin, Chair
Committee on Juvenile Justice
Fernando Cabrera, Chair
Committee on Mental Health, Development Disability, Alcoholism, Drug Abuse and Disability Services
Andrew Cohen, Chair

February 28, 2014
New York, New York

The Legal Aid Society
199 Water Street
New York, NY 10038

Good morning. I am Lisa Freeman, Director of the Special Litigation & Law Reform Unit in the Legal Aid Society's Juvenile Rights Practice alongside Nancy Ginsburg, the Director of the Adolescent Intervention and Diversion Practice of the Criminal Practice. I wish to thank the Committee on General Welfare, the Committee on Juvenile Justice and the Committee on Mental Health, Development Disability, Alcoholism, Drug Abuse and Disability Services and Chairpersons Levin, Cabrera and Cohen for inviting us to speak about this important topic.

The Legal Aid Society is the nation's largest and oldest provider of legal services to low income families and individuals. Legal Aid's Juvenile Rights Practice provides comprehensive legal representation to children who appear before the New York City Family Courts in all five boroughs, in abuse, neglect, juvenile delinquency, and other proceedings affecting children's rights and welfare. Last year, our staff represented some 34,000 children, including approximately 4,000 who were charged in Family Court with juvenile delinquency, some of whom spent time in facilities run by or under the aegis of the NYC Agency for Children's Services' Division for Youth and Family Justice (DYFJ). During the last year, our Criminal Practice handled nearly 230,000 trial, appellate, and post-conviction cases for clients accused of criminal conduct. The Criminal Practice has a dedicated team of lawyers, social workers and investigators devoted to the unique needs of adolescents charged in adult court--the Adolescent Intervention and Diversion Project.

Our perspective comes from our daily contacts with children and their families, and also from our frequent interactions with the courts, social service providers, and State and City agencies, including DYFJ, the Office of Mental Health, the Department of

Health and Mental Hygiene, the many mental health providers throughout the city, and the NYS Office of Children and Family Services (OCFS). In addition to representing many thousands of children each year in trial and appellate courts, Legal Aid also pursues impact litigation and other law reform initiatives on behalf of our clients.

The Needs of Children in Detention and Placement

Legal Aid applauds the Council's inquiry into the mental health services available to court-involved youth. A critical piece of representing children and adolescents who are charged with committing offenses is to identify the collateral issues that must be addressed to stabilize their lives. All of our young clients are low-income and many have at least one significant social issue beyond poverty that causes instability in their lives. Often, this issue is mental illness and may include the co-occurring disorder of substance abuse.

We strongly believe that if access to mental health services were enhanced in our lowest-income communities, many fewer young people would enter the court system. Legal Aid would like to see increased services available to a broader range of people in the most underserved communities.

Characteristics of Court-Involved Children and Teens

The needs of youth who are detained and placed are far greater than those of youth in the general population. A recent study published by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, reported the results of the National Survey of Children's Exposure to Violence, a national study that is large and comprehensive in its assessment of victimization and delinquency. Its findings of most relevance to today's inquiry are as follows:

- Boys with histories of delinquency and victimization are considerably more likely to be further victimized than the boys who were victims but who are not delinquent- disclosing 6.3 and 4.5 different kinds of victimization in the past year, respectively. These boys had particularly greater percentages of sexual victimization (40% for delinquent-victim boys vs. 13% for primarily victim boys), and witnessing family violence (26% for delinquent-victim boys vs. 12% for primarily victim boys).

- Girls with histories of both delinquency and victimization were more victimized than those girls who were victims, but who were not delinquent- disclosing 6.4 and 4.2 different victimizations in the past year, respectively. The girls in the delinquent-victim category had higher victimization rates, particularly for sexual victimization, than the primarily victim girls. The rate of sexual victimization among delinquent-victim girls (58%) was more than twice that among the primarily victim girls (27%).

- Among both boys and girls, delinquent-victims tended to experience more life adversities and mental health symptoms than other groups. They also received less social support. The girls experienced higher rates of inconsistent/harsh parenting.

- Importantly, there were few significant differences among the primarily delinquent, primarily victim and delinquent-victim groups on features such as socioeconomic status, ethnicity, family structure, disability status, school performance or physical features.[1]

These national figures are consistent with our local findings. Indeed, "approximately 85 percent of young people assessed in secure detention intake reported at least one traumatic event, including sexual and physical abuse, and domestic or intimate partner violence. Furthermore, one in three young people screened positive for Post-Traumatic Stress Disorder (PTSD) and/or depression."[2] Exposure to trauma can also lead to substance abuse, mental illness and other self-harming behaviors.

According to Administration for Children's Services (ACS) data reflecting the detention population in Fiscal Year 2013, a total of 58% of youth in detention and

[1] Cuevas, C.A., Finkelhor, D., Shattuck, A., Turner, H., Hamby, S., October 2013. Children's Exposure to Violence and the Intersection Between Delinquency and Victimization. U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin.
[2] http://www.vera.org/sites/default/files/transition-brief-juvenile-detention-reform.pdf at 12.

placement were referred for and received mental health services.[3] Other studies show that nearly seven in ten youth involved with the justice system are experiencing a mental illness, and one in four of these youth exhibit severe functional impairment.[4] Additionally, many of our clients' parents suffer from the same histories in addition to unstable housing, histories of substance abuse, and intergenerational violence and trauma. In order to better understand the needs of the youth in their custody, the Administration for Children's Services recently began to examine the prevalence of cross-over youth--those who have had child welfare involvement and juvenile justice involvement, some of whom are held in juvenile detention and/or placement facilities. In fiscal year 2010, 48.2% of the detention admissions had current or past histories of child welfare involvement.

While a greater percentage of youth in the Family Courts have been diverted to community-based, alternative to detention and alternative to placement programs, the needs of the population of youth in detention has intensified. Just a few years ago, 90% of youth in secure detention were charged with offenses in Family Court, and only 10% were charged in Supreme Court as juvenile offenders.[5] Currently, secure detention[6] holds an almost equal split of juvenile delinquents and juvenile offenders. The most recent tally of the average length of stay of juvenile offenders in secure detention was

---

[3] http://www.nyc.gov/html/ops/downloads/pdf/pmmr2014/acs.pdf

[4] *Report on Juvenile Justice, Mental Health & Family Engagement*, p. 4, October 2013; https://www.mhanys.org/MH_update/wp-content/uploads/2013/11/MHANYS_Juvenile-Justice-Report-2013_Final.pdf*Id.*

[5] Juvenile delinquents are children over 7 and less than 16 years of age who are charged in Family Court with the commission of acts that would constitute a crime if committed by an adult. FCA §301.2(1). Juvenile offenders are youth aged 13-15 who are automatically charged in the adult criminal court system for an enumerated list of violent felonies. PL §10(18).

[6] There are two secure detention facilities in New York City: Crossroads in Brooklyn and Horizon in the Bronx.

143.2 days[7], significantly longer than the average stay of children detained from Family Court. Often, the youth who are held the longest have the most serious set of needs. For those youth with serious mentally illness who are awaiting placement in a residential mental health facility, where beds are scarce, the wait while detained can be as long as 8 months.

Focus on high poverty, under-resourced neighborhoods

The vast majority of individuals processed through the juvenile and adult courts come from five communities of New York City: Harlem, Bedford-Stuyvesant, Brownsville, East New York and the South Bronx.[8] South Jamaica and the Rockaways also have high representation in this category. These neighborhoods also share significant problems of poverty, inadequate services to meet high need, low performing schools, higher than average prevalence of health and mental health issues and substandard housing stock. While service availability has improved throughout these neighborhoods in the last few years, much more must be done to augment and expand existing services to address the persistent need.

The Legal Aid Society encourages the redirection of some percentage of funds dedicated to traditional law enforcement to preventive services. In recent years, New York City has seen significant reduction in the number of people incarcerated, while crime rates have remained low. The cost savings from the reduced use of incarceration should be dedicated to services, including mental health services, supportive of safer,

[7] Profile of Juvenile Offenders in Detention, NYC ACS, DYFJ, January 2014.
[8] http://gothamist.com/2013/05/01/these_interactive_charts_show_you_w.php

healthier, more productive communities.[9] This redirection could potentially divert children and adolescents from entry to the court system and prevent the need for detention.

Services in Detention

Mental health services are provided by a contract agency procured through a Request For Proposal (RFP) process. It is our understanding that the current provider was awarded the contract after presenting the lowest bid to the agency. Unfortunately, in this case, the services made available through this contract have proven inadequate for the high needs of this population of children. There is one psychiatrist for the two secure facilities and the non-secure facilities. If a child has a significant mental health crisis and the psychiatrist is in the other facility that day, s/he will not have access to a psychiatrist. There is no psychiatrist available on the weekends.

Additionally, the current mental health provider has refused to communicate about treatment issues with the Society's social workers and lawyers, even where we have provided a signed consent from the parent. Other than receiving a very brief, updated treatment report upon a request to the Office of Mental Health, which is necessary for residential mental health placement, we are prevented from having any other contact with the mental health providers in the detention facilities. This refusal to communicate contrasts sharply with the extensive contact Legal Aid has with community and hospital-based mental health providers for our clients who are not detained and are receiving mental health care. In the course of our representation of youth with trauma and mental health histories, we collect a great deal of information,

[9] Austin, J., Jacobson, M., How New York City Reduced Mass Incarceration: A Model for Change?, January 2013. available at http://www.vera.org/sites/default/files/resources/downloads/how-nyc-reduced-mass-incarceration.pdf.

including records of past treatment that would inform the treatment plan of our clients, but there is no mechanism available to directly share or discuss this information with the mental health provider in detention.

Given the prevalence of mental health issues among the kids in detention, a high quality provider available to fully assess and provide treatment addressing the past and current history, as well as a focus on behavioral therapy is essential. Unfortunately, the current level of mental health care significantly misses that mark. Quality mental health care in detention serves multiple purposes. First, it improves the well-being of youth in detention, an important end in and of itself. It also improves conditions for other youth and staff in the facility; improving the mental health of residents leads to better behavior and reduced incidents of aggressive behavior within the facilities, resulting in a safer environment for all. Finally, addressing mental health issues can improve residents' behavior which can reduce length of stay, leading to cost savings for the system.

We are hopeful that ACS will seek a high quality mental health provider in the upcoming RFP. We ask that the City Council be vigilant in its oversight of this contract process to ensure that a provider with sufficient staffing, experience and quality of service is chosen to provide mental health care to the high needs population of children and adolescents in detention.

It should be noted that we are encouraged by the trauma-informed screening and intervention training that is being done by Bellevue Hospital in the secure facilities. Funding, as provided by federal grant money, has made it possible to identify trauma among the youth and train the ACS staff in the facilities to recognize and address issues

of trauma among the youth and the staff themselves. Programs such as this should be encouraged and expanded.

Additionally, although the youth in detention attend school for much of the day in the facilities, there is little coordination of services between the school and facility staff. This again seems like a wasted opportunity to effectively communicate and create unified service plans within the facility. We encourage the Council to explore with ACS and the Department of Education ways in which service provision for youth with mental health issues can be improved and coordinated.

Restraints and Room Confinement

The Society remains deeply concerned regarding ACS' use of physical restraints and room confinement of youth. Indeed, based on conduct that occurred during the Bloomberg Administration, OCFS has placed ACS DYFJ on a Corrective Action Plan to reduce its high rate of restraints and room confinement. According to the September 2007 report prepared by New York's Committee on Restraint and Crisis Intervention Techniques, "all forms of physical restraint come with inherent risk due to the hazardous circumstances in which restraints are applied."[10] Such risks to children during the restraint process may include exposure to trauma and serious physical injury. Exposure to trauma for a population with a documented high rate of trauma prior to detention is a particularly troubling issue. "The use of restraints is recognized as an intervention of last resort."[11] Additionally, the detrimental effects of isolation on youth are well documented. Isolation is particularly harmful to youth with mental health needs

[10] "Behavior and Management: Coordinated Standards for Children's Systems of Care," Final Report to the Governor September 2007, developed by the Committee on Restraint and Crisis Intervention Techniques p. 11.
[11] Id. at 19.

and can exacerbate mental health conditions. Quality mental health treatment is essential to addressing the needs of young people in ACS custody and to preventing problematic behavior that may lead to physical restraints and room confinement. As noted below, a legacy problem from the Bloomberg Administration is that DYFJ lacks finalized policies and procedures for restraint and room confinement, Without final policies and corresponding training of staff, DYFJ continues to the run the risk that physical restraints and room confinement will be used inappropriately.

We further suggest that the frequent use of restraints is related, in part, to the lack of adequate mental health care as well as the lack of programming in DYFJ secure detention. Apart from school, there is essentially no funding for programming in DYFJ secure detention facilities. This is true even though it is well-accepted that keeping youth actively engaged can not only be educational, but is key to reducing violence. Indeed, as part of the Corrective Action Plan, OCFS has directed DYFJ to "expand the availability of programming . . . and increas[e] the assortment of recreational activities, social and cultural programming, educational and vocational programming etc. . . . *thereby reducing the idle time that appears to contribute to restraints.*" Programming can be very meaningful, providing needed self-esteem and opportunities for positive feedback, family engagement and personal growth.

Recent Changes to the Juvenile Justice System

The Legal Aid Society is pleased that the juvenile justice system in New York City has undergone significant changes in recent years. As a result of the landmark 2012 NYS Close to Home legislation, which mandates that all New York City youth placed by the Family Court as juvenile delinquents be placed at facilities within New York City, youth in non-secure placement are now largely placed within New York City,

and youth in limited secure placement will be starting this fall. These youth will be able to benefit from being close to their families, communities, and lawyers, and transition back into their communities more successfully. We additionally credit former OCFS Commissioner, now ACS Commissioner, Gladys Carrión with the closure of juvenile placement facilities in upstate New York and the efforts of the N.Y.C. Department of Probation and other City and State initiatives to keep children in their communities.

One essential priority that remains to be addressed after the end of the Bloomberg Administration is the lack of comprehensive policies and procedures for operating and overseeing the juvenile detention and placement systems. We urge Commissioner Carrion to develop and finalize juvenile justice policies for the agency, including those related to mental health treatment, restraints, and room confinement.

Services Under Close to Home (DYFJ Placement)

Assessment of Placed Youth

As part of Close to Home, a youth is evaluated by the DYFJ intake unit and then assigned to a particular facility. The procedures for gathering information relevant to the youth's mental health needs and then providing that information to the Close to Home facility requires improvement. The track record from the Bloomberg Administration is that often this information is not gathered or provided in a timely way. As a result, the Close to Home facility may not receive important background on the youth upon transfer, adding needless complication to this transition.

Placement for Seriously Mentally Ill Youth

Another legacy issue from the Bloomberg Administration is that there continues to be an inadequate number of beds for court-involved youth who have serious mentally illness, including those in DYFJ placement. As part of Close to Home, Children's Village, a service agency, has a limited number of beds designated for these youth, but there is no alternative if a youth does not do well in that environment. In addition, August Aichhorn is the only residential treatment facility[12] (RTF) with beds dedicated for youth in the juvenile justice system. However, these beds are only available to youth who have been placed with OCFS, not to youth placed through Close to Home. As a result, ACS should work with the NYS Office of Mental Health to actively seek to coordinate referrals to residential mental health facilities so that more appropriate placements are made for youth with serious mental illness, and additional beds are made available.

Finally, some Close to Home facilities are unable to adequately access psychiatric services. Because of this policy failure from the Bloomberg Administration, they send youth to acute care hospitals in the hope that they will obtain an appropriate psychiatric evaluation and treatment plan, resulting in unnecessary hospitalizations.

Reentry

One of the central goals of Close to Home is to link youth to services in the community to facilitate a smooth reentry. However, again based on the track record from the Bloomberg Administration, ACS needs to continue to improve their efforts in this regard. For example, in some instances, Functional Family Therapy (FFT), a

[12] A residential treatment facility providing long-term intensive treatment for children and adolescents operated by the NYS Office of Mental Health..

Formatted: Font: (Default) Arial

approach designed to integrate families into the youth's treatment, is being provided beginning at two months prior to the youth's anticipated discharge through the facility. However, upon release, the youth and family are referred to a new FFT provider in the community, negating the relationships that have been built over the prior two months and undermining one of the central goals of Close to Home. Similarly, youth are supposed to be assigned a Permanency and Planning Specialist upon placement in a Close to Home facility. The specialist is required to follow them throughout their placement and throughout aftercare. However, it appears aftercare work has been allocated to a Community Support Worker, again creating unnecessary transitions and undermining the goals of Close to Home.

In addition, although youth may be eligible for Bridges to Health services, another Bloomberg Administration legacy is that applications are not being prepared immediately upon their entry into Close to Home. As a result, youth in need of these services are discharged and must wait months before the services are able to be put in place, needlessly jeopardizing their reentry.

Conclusion

Thank you for the opportunity to testify about this important topic. We urge the Council to continue its oversight to ensure that mental health services improve in detention and placement settings for our youth.

Contact: Lisa Freeman, Director, Special Litigation and Law Reform Unit
Juvenile Rights Practice
Phone: 212-577-7982; lafreeman@legal-aid.org

Nancy Ginsburg, Director, Adolescent Intervention and
Diversion Project, Criminal Practice
Phone: 212-298-5190; nginsburg@legal-aid.org

NYC™

Administration for Children's Services

The New York City Council,
Committee on Juvenile Justice, Committee on General Welfare, and Committee on Mental Health, Disability, Alcoholism, Drug Abuse, and Disability Services
February 28, 2014

"Oversight – Pre- and Post- Release Mental Health Services for Detained and Placed Youth"
Testimony by
New York City Administration for Children's Services
Charles Barrios, Senior Advisor for Juvenile Justice Clinical Services,
Division of Youth and Family Justice

The New York City Administration for Children's Services
Charles Barrios, Senior Advisor for Juvenile Justice Clinical Services
Testimony to the New York City Council
Committee on Juvenile Justice, Committee on General Welfare, and Committee on Mental Health, Disability, Alcoholism, Drug Abuse, and Disability Services
February 28, 2014

"Oversight – Pre- and Post- Release Mental Health Services for Detained and Placed Youth"

Good morning Chairs Cabrera, Levin and Cohen and members of the Committees on Juvenile Justice, General Welfare, and Mental Health, Disability, Alcoholism, Drug Abuse, and Disability Services. I am Charles Barrios, Senior Advisor for Juvenile Justice Clinical Services with the Division of Youth and Family Justice at the New York City Administration for Children's Services (ACS). With me is Jennifer Romelien, Executive Director for Detention Programs. Thank you for providing us with the opportunity to share our work related to the mental health services provided to youth in ACS' juvenile justice programs.

Overview of Juvenile Justice Programs

The Administration for Children's Services oversees an array of services and programs for youth at every stage of the juvenile justice process. The agency's Division of Youth and Family Justice (DYFJ) works to promote public safety and improve the lives of youth, families, and communities by providing services that are child-centered and family-focused, including therapeutic treatment, safe and secure custodial care, responsive health care, effective re-entry services, and promotion of educational achievement. We, and our contracted partners, provide these services to youth in secure and non-secure detention facilities, non-secure placement residences, and community-based alternative programs.

Each year, the Division provides secure and non-secure detention services to juvenile delinquents and juvenile offenders whose cases are pending adjudication. While in detention,

residents receive a number of services, such as education, health services including mental health services, recreation, and case management. In 2013, DYFJ served approximately 3,300 youth in our 13 non-secure and two secure detention facilities. As of December 2013, 128 youth were in secure detention: 60 youth in Crossroads Juvenile Center and 68 in Horizon Juvenile Center. A total of 92 youth were in the 13 non-secure detention residences.

On September 1, 2012, New York City launched Close to Home, a juvenile justice reform initiative that allows New York City youth who are found by a Family Court Judge to have committed a delinquent act to receive services in or close to the communities where they live, rather than hundreds of miles upstate. Under Close to Home, young people who are adjudicated as juvenile delinquents in New York City Family Court are placed into the custody of ACS and receive rehabilitative and therapeutic services at one of 31 small, resource-rich residential programs in or near the five boroughs. ACS, in partnership with the New York State Office of Children and Family Services (OCFS), has collaborated with nine local non-profit agencies to implement Non-Secure Placement (NSP), Phase I of Close to Home. Since September 2012, ACS has provided NSP services to approximately 750 young people. Of this total, nearly 270 youth have successfully completed their court order, which ACS divides into two components: residential care and aftercare.

ACS also oversees two community-based alternative programs that offer juvenile justice-involved youth the opportunity to receive services while remaining at home with their families. The Juvenile Justice Initiative (JJI) links juvenile justice-involved young people and families with intensive, evidence-based therapeutic interventions aimed at diverting youth from institutional placement. The goals of JJI are to reduce recidivism, improve youth and family functioning and reduce the number of delinquent youth in residential facilities. Treatment is provided as a

preventive service and youth must comply with the program as a condition of probation. JJI is currently serving approximately 180 youth.

The Family Assessment Program (FAP) serves families seeking to file PINS (Person In Need of Supervision) petitions in the New York City Family Courts. PINS youth are those under the age of 18 who are charged with offenses unique to their status as juveniles, including truancy, ungovernability and running away from home. FAP is a court-based effort in which ACS works closely with PINS adolescents and their families to provide a continuum of services within their community. In 2013, FAP served more than 6,700 youth.

Mental Health Service Needs in Detention

Young people in detention facilities receive preliminary mental health intake and screenings upon admission. Around-the-clock mental health services are provided to young people in both secure and non-secure detention and all youth receive an initial health screening, which includes a brief mental health screening, within 24 hours of admission. A comprehensive health assessment, including a complete health history, physical examination, and laboratory tests, is conducted within 72 hours after a youth arrives. Young people in non-secure detention receive mental health and health services at the secure detention center closest to their group home residence.

The mental health and psychiatric services available to youth in detention are delivered by ACS-contracted providers Addiction Research Treatment Corporation (ARTC), which was renamed START and Charles Jin Medical Service PC, respectively. Mental health services are therapeutic in nature and are provided in both group and individual modalities. Psychiatric services include assessment, evaluation and medication management.

Over the past three years, approximately 40% of the youth population screened by ACS' mental health clinicians in detention were identified as needing additional mental health evaluation

and mental health services onsite. The number of youth referred to psychiatric services increased from an average of 35 per month in 2012 to 48 per month in 2013. Currently, 25% of youth who receive psychiatric services at Crossroads Juvenile Center and 36% of youth who receive psychiatric services at Horizon Juvenile Center are prescribed psychotropic medications to address mental health conditions.

In 2012, ACS set out to explore ways to leverage additional services, components, assessment tools, elements, and staffing that would better inform our intake process, create options for deeper and more clinical assessments of youth when needed, and further and better identify mental health needs while still in detention and in anticipation of placement. That same year, Bellevue Hospital Center and the NYU Langone Medical Center, in partnership with ACS, was awarded a four-year grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its National Traumatic Stress Initiative to create and conduct trauma-informed screening and care in secure detention. Developed to train frontline residential staff in dealing with the various types of trauma that up to 90% of our young people in the juvenile justice system have experienced, the Trauma Informed Care Project strives to: establish evidence-based, trauma-informed mental health screening in ACS' two secure detention facilities; develop evidence-based skills groups to reduce trauma-related problems among youth in detention; train staff about the effects of trauma and how to mitigate them in a juvenile justice population; and build collaborative partnerships in the child-serving systems associated with juvenile detention to increase trauma responsiveness in those systems. ACS, in conjunction with our partners at Bellevue and NYU, is the first secure detention system in the country to implement trauma-informed practices and training, which is complimentary to the work that we are doing to create an integrated intake process for detention and placement and establish a therapeutic milieu to provide targeted re-entry and treatment recommendations for youth as they transition into placement, alternative to placement

programs or back into the community. We are proud to say that our excellent staff in DYFJ is at the forefront of this groundbreaking work.

Beginning last winter, Bellevue's team held a series of trainings with staff at Crossroads Juvenile Center to increase the staff's ability to identify trauma exposure and work effectively with traumatized youth as well as reduce secondary trauma issues among staff. By the end of the four week curriculum, the trauma-informed training was provided to all 200 Crossroads Juvenile Center staff (including housekeeping and kitchen staff). During August 2013, 126 Crossroads residents were screened for trauma history, Post Traumatic Stress Disorder (PTSD), depression, and problematic substance abuse. Of those screened, 107 (85.2%) reported experiencing at least one potentially traumatic event such as sexual abuse, physical abuse, and domestic violence. Overall, residents reported experiencing an average of 3.2 potentially traumatic events and 43 of the 126 screened positive for PTSD and/or depression. According to a sampling conducted by Bellevue in 2013, the predominant psychiatric diagnoses of youth screened in our secure and non-secure detention facilities included Attention Deficit Hyperactive Disorder (ADHD) and impulse control (36%) followed by mood disorders (32%).

ACS is committed to ensuring continuity of care for all young people in our detention settings. Our continuity of care policy reinforces this expectation with respect to a youth's previously provided mental health and psychiatric care, including medications prescribed to a youth prior to their entering detention. In the event that a medication is cost prohibitive, ACS may prescribe a comparable, generic equivalent as is widely practiced in the community.

Mental Health Service Needs in Placement

Non-secure placement providers are responsible for delivering care that meets the full range of mental health needs of youth, either by offering a comprehensive array of mental and behavioral

health services onsite or establishing referral and treatment arrangements with community-based mental health providers. NSP providers that link to community-based mental and behavioral health providers must ensure that services are readily available. All NSP mental health services are delivered by qualified mental health providers who develop and update consistent diagnoses of the young people they treat.

The majority of the NSP providers use the Missouri Approach, a highly regarded therapeutic approach for juvenile justice-involved youth. This unique multi-layered treatment is designed to help young people make lasting behavioral changes that will prepare them for successful transitions back into their home communities. The approach stresses close supervision and features a group treatment process in which each young person is held accountable for his or her actions by the other young people in the group.

New York City's NSP services are divided into general and specialized residential programs. The majority of non-secure placement residences have service-rich programs that are considered appropriate for a "general" population of youth. The non-secure placement system also includes programs designed to serve youth with specific high-level needs (e.g. mental health diagnoses, intellectual and developmental disabilities, fire-setting behaviors, problematic sexual behaviors, history of commercial sexual exploitation, and substance abuse treatment). Of the 31 NSP sites, ten are dedicated to serving youth with specialized needs.

Youth who are placed in Close to Home follow a placement matching process that relies on a careful, synthesized review of their clinical and behavioral needs. Our placement staff incorporate information about the young person from the Department of Probation's Investigation and Report assessment tool, educational records, and Family Court Mental Health Services. ACS Intake and Assessment Specialists update these records by obtaining information about youth from the ACS-contracted medical and mental health staff at our secure detention facilities.

Within 14 days of a young person's arrival at the NSP residence, providers conduct a mental health screening. At minimum, the screening ascertains: the youth's current mental status; history of present illness; current medications and response to them; history of treatment with medications and responses; social history; substance abuse history; interviews of parents or guardians; a review of prior records; and an explanation of how the youth's symptoms meet diagnostic criteria for the proffered diagnosis or diagnoses.

Where the initial screening or history indicates a need for mental health services, the NSP provider ensures that qualified staff or a qualified contracted mental health professional performs a full assessment. Youth who have severe developmental and/or mental health needs may be referred to appropriate New York State Office of Mental Health services or to the Bridges to Health program. The Bridges to Health Program is a home and community-based services Medicaid Waiver program that provides support and health care services for young people with disabilities while they are in and once they are discharged from NSP residences. When assessments indicate a need for mental health services, the staff arranges for the prescribed services. If a psychiatric referral is needed, it is made promptly upon indication.

Similar to youth in detention, young people served in our non-secure placement system have been diagnosed with a host of mental health conditions including conduct disorder, antisocial personality traits, bipolar disorder, depression, and post-traumatic stress disorder. There are currently 140 youth in the entire NSP system who are taking medication for their mental health conditions.

Following six to seven months of residential placement, youth are discharged to their families in the community on aftercare status, the next step in the continuum of care for adjudicated juvenile delinquents, which is a critical component to the successful re-entry of youth. Prior to leaving residential placement, each youth has a structured aftercare service plan in place, which

may include mental health services. Two hundred young people are currently on aftercare status. It is Children's Services' expectation that the majority of youth transitioning out of residential placement will be served by ACS-contracted NSP aftercare services providers through the provision of Functional Family Therapy (FFT), the Boys Town Model, or the Family Connections Model, as well as linkages to local community-based organizations.

Mental Health Service Needs in Community-Based Alternative Programs

The Juvenile Justice Initiative's Alternative to Placement program provides home-based services for youth prosecuted on juvenile delinquency charges in Family Court, and to their families. This program is a condition of probation for youth who would otherwise be placed in institutional settings. Through JJI, therapists provide comprehensive services to all family members in the home to address a range of issues including mental health, substance abuse, peer difficulties, school-related challenges and family troubles. These intensive services usually take place in the home when it is most convenient for the family. Therapists see families many times a week and remain on call 24 hours a day.

Following a court ordered exploration of alternatives, court intake staff assess youth and their and families by using the Department of Probation's Investigation and Report assessment tool or a Mental Health Study. Young people determined to be eligible JJI and their families are directed to one of three evidence-based therapeutic modalities: Blue Sky, a continuum of Functional Family Therapy, Multi-systemic Therapy, and Multidimensional Treatment Foster Care that serves Bronx and Manhattan; Multi-systemic Therapy which serves Brooklyn, Queens, and Staten Island; and Multi-systemic Therapy Psychiatric services which serves Brooklyn and Queens.

In 2012, ACS partnered with the Medical University of South Carolina and New York Foundling to evaluate the Blue Sky modality and compare it to other juvenile justice programs,

including placement and community-based alternatives to placement. The researchers will collect data on the 211 youth participating in the project's randomized clinical trial, and compare recidivism outcomes one year post-treatment between youth who received Blue Sky services and those who participated in other juvenile justice programs. This project marks the first randomized clinical trial conducted in New York City of any evidence-based treatment modality that targets delinquency behavior and prevention.

The Family Assessment Program, ACS' PINS diversion program, is completely voluntary, however a family must participate in FAP before a PINS petition can be filed. In the fall of 2010, FAP launched a new continuum of five service interventions targeted and prioritized for families that access services from FAP. Services range in intensity from in-home therapy to the placement of youth with a specially trained foster family who becomes, alongside a family therapist, part of the youth's therapeutic team. Additionally, ACS has a memorandum of understanding with the New York City Department of Health and Mental Hygiene (DOHMH) which provides funding for two clinical consultants to assess youth in FAP who have serious mental health needs. Last year, the consultants accepted 152 referrals to work with these types of young people.

In 2010, FAP redesigned its approach in order to ensure that staff had the ability to identify and differentiate between low- and high- needs families. With the aid of a new screening instrument, staff are able to direct families and young people who score in the "low" range, to FAP counseling services or neighborhood-based preventive services and to offer those who score in the "high" range a more comprehensive assessment and a referral to partner agencies, many of which specialize in intensive therapeutic approaches to stabilize families in crisis. Although the options vary in scope, duration, and technique, all of these programs are proven to work specifically with young people to promote family cohesion over the long-term.

Closing

Thank you for the opportunity to share with you the important work we are doing to address the mental health needs of youth in our juvenile justice programs. We are grateful for all of the support of the Council as we continue to strive to improve services for the City's most vulnerable young people. I am happy to take any questions you may have.

FOR THE RECORD

WRITTEN TESTIMONY OF
HON. EDWINA G. RICHARDSON-MENDELSON
ADMINISTRATIVE JUDGE, NEW YORK CITY FAMILY COURT
FEBRUARY 28, 2014

TO NEW YORK CITY COUNCIL COMMITTEES ON JUVENILE JUSTICE, GENERAL WELFARE, AND MENTAL HEALTH, DEVELOPMENT DISABILITY, ALCOHOLISM, DRUG ABUSE AND DISABILITY SERVICES
HEARING ON THE PRE-AND POST-RELEASE MENTAL HEALTH SERVICES FOR DETAINED AND PLACED YOUTH

My name is Edwina Richardson-Mendelson and I proudly serve as the Administrative Judge of New York City Family Court. Thank you to the Committees assembled on the topic of Pre- and Post- Release Mental Health Services for Detained and Placed Youth for the opportunity to provide written comments.

The mission of the New York City Family Court is to provide the highest standard of justice, to decide cases as quickly as practicable, to treat court users with courtesy and professionalism, to offer information and assistance, to provide service that is responsive and helpful, and to protect the rights of all litigants appearing in our courts, including those who cannot afford legal representation.

Meeting the mental health needs of the youth who appear in our courts is vitally important. Our judges who preside over juvenile delinquency matters believe it is important to have available comprehensive mental health services for youth in both detention and placement, and, therefore, believe it is necessary to provide adequate funding for these services. Additionally, juvenile justice facilities must ensure that children remain on prescribed medications while in their care. The absence of needed mental health treatment will lead to high rates of recidivism and the unsuccessful transition of youth back to their communities.

As to the current mental health services available to our juvenile justice involved youth, on behalf of the judges who address these matters daily I can report several concerns. The first concern is the dearth of available mental health services in both detention and placement facilities, as well as in alternative to detention and alternative to placement programs. For the youth who are provided with mental health treatment, judges question the credentials and training of the mental health clinicians on staff. Additionally, judges note that the reports submitted to the court regarding the mental health treatment of youth are often not substantive, thorough, or helpful in reflecting the youth's progress and conduct while in detention and placement.

The issue of mental health services and treatment of juvenile justice involved youth is a priority for the Family Court bench. It is the hope of our judiciary that through adequate funding and resources, with better coordination and communication between detention facilities and foster care placement, and increased family engagement, the youth who appear in our courts will have healthy productive futures.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 2/28/14

(PLEASE PRINT)

Name: Charles Barrios

Address: 150 William St NY, NY 10038

I represent: ACS

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/28/14

(PLEASE PRINT)

Name: Dr. John Shaw

Address: 500 Bergen Ave Bx 10455

I represent: Episcopal Social Services

Address: Same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1 Res. No. _____

☐ in favor ☐ in opposition

Date: 2/28/14

(PLEASE PRINT)

Name: CAROL FISLER

Address: 520 Eighth Ave NY NY 10018

I represent: Center for Court Innovation

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Nancy Ginsburg

Address: _____

I represent: Legal Aid Society

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: USA Freeman ~~Nancy Ginsburg~~

Address: _____

I represent: Legal Aid Society

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: Feb 28. 2014

(PLEASE PRINT)

Name: Dr. Jeremy Kohomban

Address: _____

I represent: The Children's Village and Harlem Dowling

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/28/14

(PLEASE PRINT)

Name: Sarah Bass

Address: ~~13~~ 150 William Street

I represent: ACS DYFJ

Address: 150 William Street

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/28/14

(PLEASE PRINT)

Name: Jennifer Romelien

Address: 150 William Street, NY NY 10038

I represent: ACS-DYFJ

Address: 150 William Street NY, NY 10038

Please complete this card and return to the Sergeant-at-Arms