The New York City Administration for Children's Services
Commissioner Gladys Carrión
Testimony to the New York City Council
Committee on Juvenile Justice
December 2, 2014

"Oversight – Examining DYFJ's Juvenile Justice Oversight Board"

Good afternoon Chair Cabrera and members of the Juvenile Justice Committee. I am Gladys Carrión, Commissioner of the Administration for Children's Services. Joining me today is Felipe Franco, Deputy Commissioner of the Division of Youth and Family Justice. I would like to thank the Council for the opportunity to update you on the Juvenile Justice Oversight Board. But, before I do, I would like to provide an overview of our system, as well as background on the Board, and then discuss the changes I have made recently.

Overview of Juvenile Justice Programs

The Administration for Children's Services offers a continuum of services and programs for justice-involved youth. Our 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. Services include therapeutic treatment, safe and secure custodial care, responsive health care, re-entry services, and promotion of educational achievement. Together with our contracted partners, ACS provides these services to youth in community-based programs, as well as in secure and non-secure detention facilities and non-secure placement residences.

Over and over, we see that when young people who have gotten into trouble are allowed to remain in the community and receive intensive services, they achieve better outcomes than those sent to out-of-home placements. And so, whenever possible, ACS advocates for young people to remain at home in their communities, while addressing the concerns that brought them to the attention of the juvenile justice system.

We oversee two community-based programs with this goal in mind. The Juvenile Justice Initiative (JJI) works to reduce recidivism, improve youth and family functioning and reduce the number of youth in residential facilities. These young people must comply with the program as a condition of probation and treatment is provided to help them stay out of the justice system. JJI currently serves approximately 180 youth. The second program, called the Family Assessment Program (FAP), serves families seeking to file Person In Need of Supervision (PINS) petitions in the

New York City Family Courts. PINS are young people under the age of 18 who are charged with offenses unique to their status as juveniles, such as not going to school or running away from home. In 2013, FAP served more than 6,700 youth and the program is on track to serve the same number of families in 2014.

Where treatment and services in the community is not an option, young people may also be served in our secure or non-secure detention facilities services while their cases are pending adjudication. While in detention, residents receive a number of services—education, health services including mental health, recreation, and case management. In 2013, DYFJ served approximately 3,300 youth in our 13 non-secure and two secure detention facilities. As of October 2014, approximately 99 youth were in secure detention and 73 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 need residential rehabilitation to receive services in or close to the communities where they are from, rather than hundreds of miles upstate. Under Close to Home, young people are placed in the custody of ACS and receive rehabilitative and therapeutic services at one of 30 small, resource-rich residential programs in or near the five boroughs. In partnership with the New York State Office of Children and Family Services (OCFS), ACS has collaborated with nine local non-profit agencies to implement Non-Secure Placement (NSP), Phase I of Close to Home. Approximately 180 young people are currently receiving residential services and another 100 have transitioned back to their families and are receiving aftercare services. In March of 2015, ACS will launch Limited Secure Placement; three providers will operate facilities at six sites in and near New York City, serving approximately 120 young people in need of a higher level of care and structure.

Oversight of ACS' Juvenile Justice Programs

Multiple layers of oversight and quality assurance mechanisms promote public safety and high quality services for young people in our juvenile justice programs. The New York State Office of Children and Family Services (OCFS) sets and enforces regulations for all detention and placement related services for youth in New York State and City. OCFS has a total of 13 state employees responsible for the oversight of NYC detention facilities; at least 5 of those employees are stationed in New York City and they have an office within each of our secure facilities. In

addition to oversight of New York City's detention programs, OCFS also created an Office of Close to Home Oversight and System Improvement, an entire unit of 21 state employees dedicated to limited and non-secure placement planning, implementation and operations in New York City. Oversight activities include a minimum of quarterly official inspections of all 30 placement residences to review safety, security, procedures, and programs. This office works in partnership with the OCFS regional child welfare office that oversees the child welfare agencies that are operating non-secure Close to Home facilities. There is a constant exchange between OCFS and ACS including frequent meetings and the sharing of information to address any concerns or issues that arise.

In addition to programmatic oversight from the State, OCFS also has an Office of the Ombudsman that advocates on behalf of youth in residential care. That Office, which reports directly to the OCFS Commissioner, ensures that the rights of residents of juvenile justice residences are protected and the concerns of the young people are addressed. OCFS has designated 3 staff members to conduct visits to Close to Home residences during the late afternoon, evening and weekend hours when youth are most available and are not typically participating in school and other programs. Since April 2013, the NYC OCFS Ombudspersons have conducted 499 visits to the 30 residential settings operated by the nine non-secure placement providers. OCFS ombudspersons also monitor a 24-hour youth hotline, seven days a week. Every visit generates a report that is part of the OCFS oversight review. Their regular visits and engagement with youth and provider agencies allow the OCFS ombudspersons unfettered insight into any areas of concern, which they share with the OCFS' Close to Home Oversight and System Improvement Office and, ultimately, with ACS. Once a week, ACS and the State Office of Children and Family Services discuss the OCFS ombudsman's findings for the previous week to determine the needs of the youth in ACS' care and any issues they have encountered with the provider agencies' delivery of services.

Monitoring the juvenile justice system is both a local and state responsibility. As the licensing agency for the provider agencies, OCFS retains oversight responsibility over the Close to Home provider agencies. ACS also oversees the individual programs and agencies that make up the Close to Home system of care. The shared oversight responsibility ensures a robust system of accountability.

ACS also maintains an Ombudsman program, the Resident Advocacy Program (RAP), to advocate for the rights of detained youth, enhance accountability, and strengthen services while

monitoring the living conditions within the City's juvenile detention facilities. The Resident Advocacy Program achieves its mission through ombudspersons operating in our secure and non-secure detention facilities. The ACS ombudspersons ensure that all youth understand their right to report and pursue a grievance and the process for doing so. ACS ombudspersons preserve the confidentially of all young people's identities while investigating and working to resolve and address the concern. Ombudspersons respond promptly to the youth, acknowledge receipt of their complaint, and initiate an investigation within 24 hours of speaking with the youth. As per the Resident Advocacy Program directive, residents, parents, legal guardians, and other relevant parties may contact the facility ombudsperson to request services.

Over the years, ACS has broadened the role of the ombudspersons, encouraging them not only to address the concerns raised by others but also to take a proactive approach to youth advocacy. In addition to fielding concerns, ombudspersons themselves also investigate and assess the quality of services and living conditions. Ombudspersons attend the Group Oriented Analysis of Leadership Strategy (GOALS), which is the Division of Youth and Family Justice's monthly performance management meeting, to better understand issues that may impact our ability to serve youth. Attending GOALS provides yet another route to advocate for youth, and offers an opportunity to meet with senior leadership, enabling ombudspersons to provide input on broader ACS policies.

To enhance the independence of the Resident Advocacy Program, I recently changed the reporting structure and transferred the reporting, supervision and support of the Ombudspersons to my First Executive Deputy Commissioner; formerly they reported to the executive directors of the secure detention facilities. In addition, we hired two Residential Care Advocates who had prior justice system involvement, to work both in our detention and Close to Home sites and liaise with the NYC OCFS ombudspersons. The Residential Care Advocates also report to the First Deputy Commissioner and are responsible for ensuring that ACS is being responsible to the concerns expressed by the youth in care. They are out visiting programs, conducting workshops and engaging with the youth. They recently organized a youth speak out for me and some members of my senior staff, COFCCA and other partners to hear directly from youth about their experiences in both the foster care and juvenile justice systems.

There are several other external NYC oversight entities such as the NYC Comptroller's Office, who is currently conducting an audit of the Close to Home initiative, and the NYC Office of

the Inspector General who has oversight responsibility of all city agencies including ACS and has staff dedicated to ACS oversight. The Public Advocate has an ombudsman function that provides oversight over city agencies. The five NYC District Attorneys have the authority to investigate city agencies when they suspect wrong doing and empanel grand juries to investigate and issue their findings. And most importantly, the City Council has oversight responsibilities over the work of city agencies and regularly conducts oversight hearings such as this one.

As many of you are aware, the New York State Justice Center has investigatory oversight over both detention and Close to Home facilities. They investigate all allegations of abuse, monitor outcomes of significant incident reviews and corrective action plans undertaken by providers and perform post audit activities regarding the implementation of corrective action plans by facilities and providers. In addition, the New York State Comptroller's Office also has the authority to investigate and audit city programs funded with state dollars. As you can see, there are many layers of oversight.

Juvenile Justice Oversight Board

The Juvenile Justice Oversight Board (JJOB) was established in the Close To Home Non-Secure Plan approved by OCFS. In the plan, ACS indicated it would "... develop an Independent Oversight Board, comprised of individuals from a range of backgrounds who are knowledgeable in the issues facing young people in residential care in connection with juvenile delinquency proceedings and committed to improved outcomes for youth, families, and communities. The Independent Oversight Board will be responsible for reviewing and reporting on conditions throughout the residential placement system". There is no other reference to the Juvenile Justice Oversight Board in the Plan. The prior administration appointed most of the members and had convened one meeting in September 2013. I first met with the Board on March 31, 2014. At that time, I shared my vision for our juvenile justice system and discussed the role that would be most helpful to me in advancing our work. Additionally, I informed them that I would be reviewing the Board composition and the role of the Board to better serve the priorities of this administration.

Given the robust oversight from the state and the structure for advocacy on behalf of youth at both the state and city levels, I began to examine the function and objectives of the Board and to better define the scope of responsibilities of a board comprised of individuals independent of ACS but who function in an advisory role to the Commissioner.

The welfare of justice involved young people will be better served by a Juvenile Justice Independent Oversight Board that will review and advise on the entire spectrum of the juvenile justice in New York City, including alternatives to placement, respite care, secure and non-secure detention and non-secure and limited secure placement. This expands the Board's ability to look at the functioning of the entire system. Specifically, the Board will undertake the following roles:

- Review operations and services offered of ACS-run and ACS-contracted facilities;
- Review and analysis data, provide feedback and recommendation;
- Assist with non- secure program advisory boards, community outreach and stakeholder-messaging;
- Advise the Commissioner on policy and program challenges and changes, new projects and future goals;
- Provide juvenile justice specific content expertise; and
- Assist in the identification and brokering of resources.

The Board will meet quarterly at juvenile justice detention and placement residences throughout the City and in collaboration with ACS will issue an annual report that summarizes its work, the system challenges and accomplishments to serve our justice involved youth and their families. Also, the membership requirements will change slightly, to ensure city wide representation in the composition and experiences of Board members. Juvenile justice-involved youth are best served by engaged members who are active in the juvenile justice field and vested in our communities. Therefore, community connection is a central attribute of board membership. As such, I have modified the Board's membership criteria to solely allow residents of New York City to participate and feel strongly that all five boroughs must be represented. Unfortunately, this new residency requirement will preclude three current members from serving on the Board. We sincerely thank them for their commitment to youth and hope to engage them in other aspects of our work.

In addition to requiring New York City residency for Board members, going forward, the Board will include at least one parent of a justice-involved youth, an adult who was justice-involved as a young person, as well as representative from the fields of education, mental health, Judiciary, legal community and a member of the philanthropic community. The vision is that stakeholder interests are adequately represented, particularly with respect to community connections and

investment. Members are expected to attend all Board meetings as well as engage with and advise our other juvenile justice groups, specifically the community advisory boards that each of our NSP providers are required to convene.

Ultimately, the full Board will have between nine and fifteen members, including a Chair that I will appoint. I invite the Council to recommend qualified candidates for consideration. I shared this new, expanded vision for the Board during our second meeting on October 28th. The Board will hold its next meeting on January 28th at an ACS juvenile justice residence.

Closing

Thank you for the opportunity to share with you the important work we are doing to address the 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.

New York City Council Oversight Hearing:
Testimony of Gabrielle Horowitz-Prisco, M.A., Esq.
Director, Juvenile Justice Project
The Correctional Association of New York

Re: Oversight: Examining DYFJ's Juvenile Justice Oversight Board

Submitted to the
Juvenile Justice Committee
December 2, 2014

The Correctional Association of New York
Re: Oversight: Examining DYFJ's Juvenile Justice Oversight Board
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My name is Gabrielle Horowitz-Prisco. I am the Director of the Juvenile Justice Project of the Correctional Association of New York and an attorney who has previously represented children in New York City's Family Court. The Correctional Association of New York is an independent, non-profit organization founded by concerned citizens in 1844 and granted unique authority by the New York State Legislature to inspect prisons and report its findings and recommendations to the legislature, the public and the press. Through monitoring, research, public education and policy recommendations, the Correctional Association strives to make the administration of justice in New York State more fair, efficient and humane. The Correctional Association does not provide direct services other than leadership training programs and does not engage in litigation or represent a sector or workforce. The Juvenile Justice Project is committed to working toward a youth justice system that is transparent and accountable to children and their families and communities, legislators and policy-makers and the public. The system we envision and work toward is one in which children are given the tools and skills they need to succeed and where positive youth development principles translate into increased public safety outcomes.

Thank you to the Juvenile Justice Committee Chair and members for this opportunity to testify.

Background
On January 1, 2013 the Administration for Children's Services' (ACS) then Commissioner Ronald Richter issued a draft policy entitled "Juvenile Justice Oversight Board" (Policy #2012/02). This draft policy outlined the purpose, scope and basic parameters of a new Juvenile Justice Oversight Board (JJOB). The JJOB replaced the Resident Advocacy Committee Resident Advocacy Program Committee (RAPC), which had been in operation since 2008 (after replacing the Ombudsman Review Board). To the best of our understanding, there was a JJOB application process, which we believe was open to the public. JJOB members were selected and began meeting. It is our understanding that then Commissioner Richter never issued a final JJOB policy. It is also our understanding that the present Commissioner Gladys Carrión disbanded the JJOB, replacing it with a Juvenile Justice Advisory Board (JJAB). It is our further understanding that the purpose of the JJAB is to serve as advisors to the Commissioner and the agency, and that the JJAB does not serve an oversight role.

The need for robust independent and external system oversight and public transparency
In the words of Patricia Wald (who later became a federal circuit judge) in 1975, juvenile detention is the "hidden closet for the skeletons of the rest of the system." These words have, sadly, held their truth to date, and they may be applied to juvenile detention and placement institutions across the nation. As an organization that has served as an independent outside monitor of New York's adult prison system for over 166 years, the Correctional Association is well aware of the myriad risks faced by individuals in custody. Children in residential facilities are uniquely susceptible to abuse and mistreatment by virtue of the combination of their age, their isolation from the public, and the generally closed nature of such facilities.

As the City Council is well aware, New York's children have not been immune to abuse. The federal Department of Justice has investigated conditions in both the New York State Office of Children and Family Services (findings issued on August 14, 2009) and in Rikers Island (findings released on August 4, 2014).

But these risks are not limited to New York's children. Instead, they are endemic to our current justice system of locked residential facilities with little public transparency. For example, the Department of Justice has documented constitutional violations including the excessive use of force in residential youth placements across the nation, including in both state and locally operated facilities.[1]

ACS' current leaders have expressed a firm and public commitment to principles of positive youth development and best practices. Commissioner Carrión is a nationally recognized leader, whose previous work as Commissioner of the NYS Office of Children and Family Services led to many important and transformational system reforms, including the closing of many youth facilities. We are confident that Commissioner Carrión brings to ACS and the city's children the same intelligence, vision, and skill she brought to the state. We also recognize and encourage ACS' commitment to improving its own system. .

And we are simultaneously mindful of the tensions inherent to *any* agency or body tasked with its own oversight. These tensions are what drive independent inspections and oversight of many private and public spheres where the well being of the public is at stake, including, for example, the New York City Department of Health and Mental Hygiene's *unannounced* and *independent* inspections and grading of food establishments.[2] The city would never say that a restaurant owner could inspect his or her own food handling and kitchen practices, and both determine and monitor their own compliance with relevant regulations. In a similar vein, just as we do not allow restaurants to be solely responsible for their own oversight, the safe operation of the youth justice system requires a system of both internal and external review and checks and balances.

There are currently multiple agencies serving an oversight role over ACS. The New York State Office of Children and Family Services (OCFS) has both 33 Close to Home oversight staff and 3 New York City Ombudspeople. The New York City Comptroller can audit and review the city's system. There is also the New York City Inspector General, the New York State Justice Center, the Public Advocate, and the city's District Attorneys, each of which has some oversight ability. The challenges, however, are that these powers are diffuse, not fully independent from the city, and not

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[1] In August 2009, the federal Department of Justice concluded a two-year investigation of four New York State-operated juvenile prisons, finding routine incidents of physical abuse and excessive use of force, a complete lack of staff accountability, and woefully inadequate mental health services. *Investigation of the Lansing Residential Center, Louis Gossett, Jr. Residential Center, Tryon Residential Center, and Tryon Girls Center,* U.S. Dept. of Justice, August 2009. The DOJ has similarly investigated and made findings against a host of jurisdictions. See Mendel, Richard A., No Place For Kids, p.5; U.S. Dept. of Justice Investigation on the Walnut Grove Youth Correctional Facility in Mississippi, March 2012: http://www.justice.gov/opa/pr/2012/March/12-crt-352.html; U.S. Dept. of Justice Investigation Report of Arthur G. Dozier School for Boys and the Jackson Juvenile Offender Center, Marianna, Florida, December 2011: http://www.justice.gov/crt/about/spl/documents/dozier_findltr_12-1-11.pdf; U.S. Dept. of Justice Investigation of Terrebonne Parish Juvenile Detention Center, Houma, Louisiana, January 2011: http://www.justice.gov/crt/about/spl/documents/TerrebonneJDC_findlet_01-18-11.pdf; U.S. Dept. of Justice Investigation of the Los Angeles County Probation Camps, October 2008: http://www.justice.gov/crt/about/spl/documents/lacamps_findings_10-31-08.pdf; U.S. Dept. of Justice Investigation of Marion County Juvenile Detention Center, Indianapolis, Indiana, August 2007: http://www.justice.gov/crt/about/spl/documents/marion_juve_ind_findlet_8-6-07.pdf; For more examples please see: http://www.justice.gov/crt/about/spl/findsettle.php#Juveniles%20Findings%20Letters.

[2] *See* http://www.nyc.gov/html/doh/html/rii/index.shtml.

totally working. None of these agencies satisfies the standards (discussed in more detail later in this testimony) set out by the American Bar Association and other experts on facility oversight.

The failure of these agencies to fully meet their oversight responsibilities is evidenced by the following: 1) ACS is currently under a Corrective Action Plan from NYS OCFS regarding the excessive use of restraints and room confinement in its detention facilities; 2) publicly available data revealed an alarming use of restraints and room confinement for a full two years before OCFS issued its investigative findings; 3) no other oversight agency took action on this issue during that time; 4) another two years has passed since OCFS' investigation and the rate of restraints in ACS detention remains extremely high and dangerous; and 5) no documents related to the OCFS investigation, including ACS' Corrective Action Plan have been publicly released.
Publicly available data indicates alarming restraint practices dating back to at least October 2010, and OCFS' Secure Detention Focused Review (highlighting these practices and requiring ACS to respond to them) was not issued until October 18, 2012. ACS' written response to OCFS is dated January 8, 2013.

Despite the passage of three full years since OCFS issued its Secure Detention Focused Review and laudably appearing to make great reductions in the use of room confinement, ACS continues to experience extremely troubling rates of restraints. For example, and as detailed below, there were 630 physical or mechanical restraints of children in detention reported during the fourth quarter of 2014 (among an average daily population of only 234 youth).

Finally, we understand that the operation of the city's youth justice system will, as a matter of course, exceed the terms of its current leaders. It is, therefore, our overarching recommendation that the commitment to self-evaluation that ACS has demonstrated be coupled with the creation of durable mechanisms for independent and external oversight[3] and public transparency- mechanisms capable of transcending the tenure of any particular agency administration.

In sum, it is our conviction, grounded in a strong body of literature and national best practice standards, that the combination of independent external oversight and increased public transparency will better protect vulnerable children while enhancing the system's performance. This approach additionally helps ensure that the city's significant fiscal incentive in the youth justice system translates into positive outcomes and may assist in insulating the city from potential liability.

Current data from ACS' detention facilities underscores the need for independent oversight and public transparency

[3] For more information on effective oversight, *see*: Deitch, Michele, *Opening Up a Closed World: What Constitutes Effective Prison Oversight?* Pace Law Review, Volume 30, Number 5, p. 1397-1410, Fall 2010 and Michele Deitch, *Distinguishing the Various Functions of Effective Prison Oversight*, Pace Law Review, Volume 30, Number 5, Fall 2010. Additionally, Governor Paterson's Task Force on Transforming Juvenile Justice made a number of key recommendations for youth justice reform in New York State including the need to "(e)stablish and fund an independent, external oversight body to monitor and report on OCFS' juvenile justice policies and practices." The Task Force was charged with looking at the OCFS state-system although their analysis and conclusions regarding the need for an independent, oversight body are applicable to a city-run system and to private agencies. The Task Force report is available at: http://www.vera.org/download?file=2944/Charting-a-new-course-A-blueprint-for-transforming-juvenile-justice-in-New-York-State.pdf.

There is a tremendous need for increased oversight and public transparency over the city's detention facilities.

Introduction 153-A and 37-A passed by the New York City Council requires ACS to post a quarterly Incident Report, an annual demographic report and an annual report of child abuse allegations with regard to the its secure and non-secure detention operations. There is currently no such law with regard the operation of Close to Home facilities. This information is publicly available via ACS' website: http://www.nyc.gov/html/acs/html/statistics/statistics_links.shtml

According to the most recent publicly available data, during the fourth quarter of FY 2014 (April 1, 2014 - June 30th, 2014) –there were:

- 630 physical or mechanical restraints of children reported (in a three month period)
- 481 of the restraints were physical
- 160 physical restraints per month[4]
- 37 physical restraints per week[5]
- more than 5 physical restraints per day[6]
- 1 physical restraint approximately every 4.4 hours[7]
- 22 reported injuries to children as the result of a physical restraint
- Injury rate of 4.57%, meaning that approximately 1 in every 2 physical restraints resulted in an injury to a child[8]
- Injuries may be serious and require professional medical care. Of the 22 injuries reported during this 3-month timeframe, 3 were classified as "Injury A," which is defined as "injuries requiring clinical treatment beyond what could be provided by a layperson with over-the-counter products."[9]
- Note that for FY 2014 (the most recent publicly available data), the average daily population was 234.1 across all detention (secure and non-secure facilities)[10], meaning that an average of 160 restraints a month are amongst a population of only about 234 children.

[4] Calculated as follows: 481 reported restraints divided by the 3 months between 4/1/14 and 6/30/2014 = 160.33 restraints per month.
[5]Calculated as follows: 481 reported restraints divided by the 12.85 weeks between 4/1/14 and 9/30/2014 = 37.43 restraints per week.
[6] Calculated as follows: 481 reported restraints divided by the 90 days between 4/1/14 and 9/30/2014 = 5.34 restraints per day.
[7] Calculated as follows: 90 days between 4/1/14 and 9/30/2014 multiplied by 24 hours in a day = 2,160 hours. 481 reported restraints divided by 2160 hours = .227 restraints per hour, and 1 divided by .227 = 4.4.
[8] Calculated as follows: 22 reported physical injuries divided by 481 reported restraints = .046 multiplied by 100 = 4.57%.
[9] Available at: http://www.nyc.gov/html/acs/html/statistics/statistics_links.shtml (scroll down to "Youth and Family Justice Reports). According to the Administration for Children's Services, this data includes restraints within non-secure detention facilities, secure detention facilities, "transportation" and "court services." Definition of "Injury A" provided on data reports.
[10] NYC ACS Detention Demographic Data Fiscal Year Report, Fiscal Year 2014, available at: http://www.nyc.gov/html/acs/html/statistics/statistics_links.shtml.

This data is not an anomaly and instead is part of a pattern that has persisted over time. In the fourth quarter of 2011 (April 1st , 2011-June 30th, 2011) there were:

- 944 total restraints reported
- 721 physical restraints which was approximately 240 physical restraints a month
- 8 restraints per day[11]
- 1 restraint every 3 hours[12]
- In 90 days, there were 168 injuries due to restraint and 17.8% of the restraints led to injury[13]
- Physical restraints that led to injury = 15.26%[14]
- Mechanical restraints that led to injury = 26%[15]
- 4 injuries requiring clinical treatment (Injury As) per month on average [16]
  Note that in the fourth quarter of FY 2011, the average daily population was 337.4 across all detention (secure and non-secure facilities)[17], which is about 100 more than in the comparable quarter in FY 2014. The monthly average of 240 physical restraints happened amongst a population of 337 children.

The progress that has been made in terms of reducing restraints over the past three years has been minimal, even as the city has been under Corrective Action.

Restraints can be fatal, and their dangers are not confined to ACS. Within the past eight years, restraint practice has resulted in the death of three young men in residential care outside of ACS' custody. In 2006, Darryl Thompson, a 15 year old confined in a NYS Office of Children and Families facility, died after being restrained after asking repeatedly for recreation time.[18] In 2010, Alexis Cirino-Rodriguez, 20 years old, died in an upstate privately run foster care placement after a restraint by staff.[19] Alexis was placed in the William George Agency, a private residential facility near Ithaca. Although we believe the William George agency does not currently serve youth from New York City, Alexis's death highlights that the risks to children in custody are not limited to OCFS-operated facilities and extend to privately operated agencies (the city contracts with private agencies for the operation of placements under the Close to Home Initiative). In 2012, Corey Foster, 16

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[11] Calculated as follows: 721 total restraints divided by 90 days= 8.011.
[12] Calculated as follows: 90 days x 24 hours in a day = 2160; 2160/721 total restraints = 3.
[13] Calculated as follows: 168 total injuries/944 total restraints x 100 = 17.79.
[14] Calculated as follows: 110 total physical injuries / 721 total physical restraints=.1526 x 100
[15] Calculated as follows: 58 total mechanical injuries/223 total mechanical restraints =.26 x 100
[16] Calculated as follows: 6 "Injury A" injuries from this quarter (two Injury A's resulting from physical restraint and two Injury A's resulting from mechanical restraints)/3 months in one quarter=an average of two Injury A's per month.
[17] NYC ACS Detention Demographic Data Fiscal Year Report, Fiscal Year 2014, available at: http://www.nyc.gov/html/acs/html/statistics/statistics_links.shtml.
[18] *See* Trina Darling, *OCFS Bans Shackling of Youth*, Examiner.com, http://www.examiner.com/article/ocfs-bans-shackling-of-youth, and Rick Karlin, *New York state pays $3.5M to settle death case at youth prison*, Times Union, (Dec. 6, 2011), http://www.timesunion.com/local/article/New-York-state-pays-3-5M-to-settle-death-case-at-2353770.php.
[19] *See* Editorial, *Prone Restraint: Why is this risky technique still used at juvenile facility?*, The Post-Standard (November 10, 20120), http://blog.syracuse.com/opinion/2010/11/prone_restraint_why_is_this_ri.html.

Years old, died after being restrained by school staff members for allegedly refusing to leave a basketball court at a Leake and Watts school for students with special needs.[20]

Child Abuse Data

Further, in Fiscal Year 2014, there were 103 child abuse allegations regarding children in the city's secure detention facilities, non-secure group homes, and in "court services/transportation." 8 of these child abuse allegations were indicated.[21]

It is important to note that the chilling data about the reported use of restraints and child abuse documented above all exists in the context of a system that was subject to oversight by the DAs, the Inspector General, OCFS, the Comptroller, the City Council, the Justice Center, and the Public Advocate. To the best of our knowledge, the only oversight body that took any action on this was OCFS, and as detailed above, despite years of Corrective Action and oversight, the restraint numbers remain startling and dangerous.

The Juvenile Justice Advisory Board lacks necessary independence and public transparency mechanisms

The Juvenile Justice Advisory Board is, to the best of our understanding, an internal advisory board with no independence from ACS and no mechanisms for public transparency. The Juvenile Justice Oversight Board, which it replaces, also lacked independence and robust public transparency mechanisms. It is worth noting, however, that the previous Juvenile Justice Oversight Board did at least require one annual public forum a year (as required by the Draft Policy). Additionally, the application for the previous Juvenile Justice Advisory Board stated that the Board would issue at least one public report a year (although this requirement was not codified in the Draft Policy establishing the Board).

It is appropriate and useful for ACS to establish and work with an internal advisory body, such as the Juvenile Justice Advisory Board. It is, however, crucial to bear in mind that such a body is uniquely different than an independent and external body, and that the safety of children depends also on the establishment of the later. The distinction between an internal review body and independent oversight is highlighted in national research on this issue. Professor Michele Deitch is widely regarded as a national expert on oversight of confinement facilities. She served as a consultant to the American Bar Association as they developed their recommended standards for

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[20] *See* Angela Hill, Brian Ross and Matthew Mosk, ABC News (Nov. 30, 2012) Death at School: Parents Fight Back Against Deadly Discipline, http://abcnews.go.com/Blotter/death-school-autism-parents-fight-back-deadly-discipline/story?id=17841322.

[21] For information on how an alleged child abuse or neglect case is determined to be "indicated," *see* A Guide to New York's Child Protective Services System, 2001 Revised Addition, available at: http://assembly.state.ny.us/comm/Children/20011016/htmldoc.html#fn32 (last accessed 2/9/2012). "By evaluating information gathered during the investigation, the protective caseworker determines whether there is some credible evidence to indicate the report of abuse or maltreatment. This determination is based on certain signs or indicators...Credible evidence is evidence that is 'worthy of belief.' If the protective caseworker does not find some credible evidence substantiating the report, the report is considered unfounded." *Id.*

residential oversight. In "Distinguishing the Various Functions of Effective Prison Oversight," Professor Deitch directly addresses this distinction:

> I should mention at the outset that I am referring to external oversight mechanisms, that is, to entities that exist outside the correctional agency. While it is critical that prisons and jail systems have their own internal accountability mechanisms—for identifying problems, informing management about these concerns, and addressing wrongdoing—such internal measures do not provide public accountability. Moreover, most internal review processes are designed to remain confidential. They support the needs of management for information and accountability without being designed to further the additional goal of public transparency.[22]

Additional Recommendations on Independent External Oversight Mechanisms

According to the American Bar Association and national experts on oversight, residential facilities for children are in need of *independent* oversight.[23] The American Bar Association (ABA) outlined twenty standards for effective youth and adult prison oversight including the following essential points. These points include that the overseeing entity must be:

1) Independent, specifically meaning that it must not be located within the agency it oversees and it must operate from a separate budget;
2) Statutorily guaranteed the right to conduct unannounced and unfettered visits including the ability to have confidential conversations with youth in the facilities and programs;
3) Granted the power to subpoena witnesses and documents and have the power to file suit against the agency operating a facility(ies);
4) Assigned the power and duty to report its findings to the executive, legislative, and judicial branches, and also to the public;
5) Allocated adequate funding and appropriate staffing levels necessary for effectiveness; *and*
6) Facility administrators must be required to respond publicly to monitoring reports.[24]

All agencies and facilities that, by design, isolate children from the general public are in need of well-funded, robust, and independent external oversight, regardless of how close to home children are placed. Robust external oversight can play a role in improving conditions of confinement as well as

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[22] Michele Deitch, *Distinguishing the Various Functions of Effective Prison Oversight*, Pace Law Review, Volume 30, Number 5, Fall 2010, p. 1439.

[23] For more information on effective oversight, *see*: Deitch, Michele, *Opening Up a Closed World: What Constitutes Effective Prison Oversight?* Pace Law Review, Volume 30, Number 5, p. 1397-1410, Fall 2010 and Michele Deitch, *Distinguishing the Various Functions of Effective Prison Oversight*, Pace Law Review, Volume 30, Number 5, Fall 2010. Additionally, Governor Paterson's Task Force on Transforming Juvenile Justice made a number of key recommendations for youth justice reform in New York State including the need to "(e)stablish and fund an independent, external oversight body to monitor and report on OCFS' juvenile justice policies and practices." The Task Force was charged with looking at the OCFS state-system although their analysis and conclusions regarding the need for an independent, oversight body are applicable to a city-run system and to private agencies. The Task Force report is available at: http://www.vera.org/download?file=2944/Charting-a-new-course-A-blueprint-for-transforming-juvenile-justice-in-New-York-State.pdf.

[24] The American Bar Association Criminal Justice Committee, Report to the House of Delegates (2008).

facilitating systemic change. Effective and consistent monitoring and inspection empowers an agency to immediately address problems as they arise. This process can help to highlight the good work that is being done in institutions and ensure its sustainability. Instead of presuming wrongdoing, a strong oversight body can create a proactive mechanism that ensures quality services and objective evaluation through regular facility inspections the consistent review of policies, programs, and services, and regular reporting.[25] Independent oversight can also play a strong role in securing public accountability for systems of confinement.

- We encourage ACS and members of the Council to measure the proposed scope and function of the new Advisory Board as well as the oversight mechanisms of OCFS and the other oversight agencies against the ABA standards and other national best-practice standards.

- We urge the city to develop and implement an independent oversight body consistent with the ABA standards and other national best-practice standards for youth justice oversight. This body should have oversight over both detention and Close to Home facilities. Parents, family members, and community members should be empowered to participate in this body's monitoring visits.

- The Correctional Association recommends that NYC undergo Juvenile Detention Alternatives Initiative (JDAI) training on facility inspections and begins conducting such inspections in a timely manner. As mentioned above, the national JDAI approach is widely recognized as a model for creating safe and effective detention systems. This proven, effective approach has been around since 1992 and is used in approximately 100 sites in 24 states. The JDAI core strategies speak directly to the issue of detention oversight and are based on an understanding that the routine inspection of detention facilities by knowledgeable individuals applying rigorous protocols and ambitious standards is crucial to safe and effective detention systems.[26] Absent of this kind of consistent scrutiny, conditions in are unlikely to improve and often will deteriorate. Six of the largest jurisdictions outside of NYC are currently pilot JDAI sites, and there is a vision and plan for expansion of JDAI across the state. JDAI offers training to jurisdictions in their model of facility inspections.

- As the literature on national best practices for oversight makes clear, unannounced visits are a crucial component of oversight. There should also be clear guidelines mandating the baseline privacy provided to youth for conversations with oversight agency members. In the

[25] This section of testimony on independent oversight and monitoring draws heavily from a one-page memorandum that this group wrote and distributed to Department of Probation Commissioner Vincent Schiraldi, and, in slightly revised forms, to ACS Commissioner John Mattingly, Division of Youth and Family Justice Executive Deputy Commissioner Larry Busching, and the State Strategic Plan Steering Committee (the author of this testimony sat on this Steering Committee). This memorandum was signed by Community Connections for Youth, the Correctional Association of New York, the Children's Defense Fund New York, the Institute for Juvenile Justice Reform and Advocacy, a project of the Center for NuLeadership. Riverside Church Prison Ministry later joined as a signatory.

[26] See, e.g. Pathways to Juvenile Detention Reform #6: Improving Conditions of Confinement in Secure Juvenile Detention Centers and JDAI Detention Facility Self-Assessment Practice Guide, available at the Annie E. Casey Foundation's website: www.aecf.org.

Correctional Association's experience, privacy within the context of residential placements is not uniformly defined or understood. There should be clear protections and mechanisms for youth and their families to speak solely to oversight agency members, out of complete earshot of any ACS staff and/or provider staff.

- Children's Services should develop an independent Ombudsperson mechanism or some other mechanism to ensure that children and their families can confidentially report complaints and grievances to a body other than the agency that houses them. Ombudspeople should not be employees of Children's Services and should be wholly independent of both the Close to Home and Non-Secure Detention private providers and Children's Services.

- Detailed procedures should be designed by Children's Services to ensure that children and families understand the mechanisms for complaint/grievance and have on-going and easy access to information about how to make a complaint/file a grievance (such as posters hung in very visible places throughout a facility including a toll-free number to a confidential hotline to speak to an Ombudsperson).

- It is our understanding that youth in residential care and their families are often reluctant to report serious incidents, particularly those involving staff, and that oversight bodies may be more likely to receive "quality of life" complaints such as those regarding food, personal care products such as soap and other relatively minor (although very real) issues. Given this reality, we recommend that ACS and all oversight agencies analyze how they might best separate out "quality of life" issues from more serious issues, developing mechanisms that address both.
    - ACS and its oversight bodies should develop pro-active mechanisms for gathering information from youth about more serious and even life-threatening issues, such as the uses of restraints and force.
    - ACS and its oversight bodies should not rely solely on grievances and other reported information in order to analyze issues like restraints and use of force.
    - Given the large number of facilities (Close to Home and detention), particular attention should be paid to ensuring that mechanisms exist for the routine and regular inspection of all facilities. Large numbers of youth, not just those who have registered complaints, should have on-going, regular, and confidential access to oversight agents.
    - There should also be clear guidelines mandating the baseline privacy provided to youth for conversations with oversight agents. In the Correctional Association's experience, privacy within the context of residential placements is not uniformly defined or understood. There should be clear protections and mechanisms for youth and their families to speak solely to oversight agents, out of complete earshot of any ACS staff and/or provider staff.

- ACS should develop a basic standard/a report card for conditions inside facilities, and facilities should be regularly scored, with the results made public. The aforementioned nationally recognized Juvenile Detention Alternatives Initiative model might provide relevant guidance on this point.

- ACS should develop clear protocols and guidelines aimed at shielding youth and families from retaliation, and at monitoring outcomes to ensure that no such retaliation occurs. These mechanisms should be clearly explained to youth, family members and community members. In addition to substantively protecting youth from retaliation, this process may very well serve to increase the trust youth and family and community members have in the system, thereby increasing the reliability and thoroughness of the information received by ACS and its oversight agents.

- As discussed elsewhere in this testimony ACS and its oversight agents should be required to routinely and regularly report to the public, including the City Council, on a diverse and rich set of performance measures and other data points. This issue will be discussed in more detail later in the next section of testimony.

Additional Recommendations on public transparency over data and performance measures
Comprehensive public transparency over system outcomes and operations is also essential to the protection of children and to positive system outcomes. Members of the public and legislators, including City Council members, should have easy access to aggregated (de-identified) data about the youth in the system.[27] Public transparency helps ensure that the public is aware of what is happening to its children so that the public can effectively and appropriately respond when children are being harmed. Additionally, the public transparency of data, including fiscal data, increases the likelihood that public finances are used effectively and responsibly. Finally, the more educated policymakers and citizens are, the more likely it will be that youth justice policy will be made on facts and not on biases, stereotypes, or myths.

The City Council has a strong history of requiring the public release of important data including Introduction 153-A and 37-A referenced earlier in this testimony and a newer bill requiring the release of some Close to Home data. Also, pursuant to New York City Local Law 29 of 2009, the New York City Department of Correction "NYC-DOC") provides "Adolescent Census Data and Security Indicators" on a quarterly basis. Both data sets have provided stakeholders, including City Council members, advocates, and other stakeholders, with important information about the safety of children and adolescents in the custody of ACS and NYC-DOC, including information about injuries to children in custody.

[27] Concerns about the confidentiality of records may be raised when the public dissemination of data is discussed. These recommendations are specifically limited to aggregate data where the names and identifying information of young people, complaining witnesses, and others are removed.

- We also urge the Council to increase its own scrutiny over the use of restraints, use of force, and use of room confinement in the youth justice system.

- ACS should routinely release to the Council and the public additional detailed information with regard to the use of restraints, use of force, and use of room confinements in both secure and non-secure detention and Close to Home facilities. This data should include but not be limited to: frequency of use of restraints; frequency of injuries to youth and staff; details about the nature of any injuries to youth and staff; what if any measures and mechanisms are there for staff accountability with regard to inappropriate restraints and information about how these measures/mechanisms are communicated to staff; how many restraints result in a State Central Registry report for suspected abuse and neglect; how many restraints result in an internal investigation within a provider agency or ACS; de-identified outcomes of investigations with regard to staff with regard to the use of restraints; and, if there is a collective bargaining agreement in place at any ACS or NSP provider agency, what, if anything, does that agreement state with regard to the employment of staff who have been found to have engaged in inappropriate use of force or restraint. This information should be de-identified to protect staff and children's identities, but should be aggregated by key variables including by provider agency and by children's race, ethnicity, age, sex and, when possible and appropriate, LGBTQ status.

Conclusion

The hidden closet phenomenon that characterizes residential youth facilities is real and transcends any particular agency or its administration. By nature, youth justice facilities are currently designed to keep youth in custody separate from the general public. As a result, youth justice residential facilities are generally very shrouded from public view. A strong body of evidence suggests that one of the very best ways to make youth justice facilities safer is to deliberately make them more transparent. There should be no secrets inside a youth justice facility, and their operations including both day-to-day concerns and more serious matters should be apparent to parents, community members, legislators and the public.

Current youth justice reforms within New York City, including the Close to Home Initiative, present the City Council and other system stakeholders with a unique and important opportunity to create a new youth justice system from the ground up. New York City currently has rich potential to serve as a model both state- and nation-wide. The Correctional Association welcomes the opportunity to work together with Children's Services, the City Council, impacted youth, family, and community members and other stakeholders to build a sustainable and transparent justice system that ensures robust protections for children, communities, and the city. Increasing system oversight and public transparency will only strengthen New York City's system and its potential to be a national leader.

FOR THE RECORD

TESTIMONY

The Council of the City of New York
Committee on Juvenile Justice

Oversight: Examining DYFJ's Juvenile Justice Oversight Board

December 2, 2014

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The Legal Aid Society Juvenile Rights Practice is pleased to submit this testimony. We thank the Committee on Juvenile Justice and Chairperson Cabrera for allowing us the opportunity to submit our testimony on the important topic of oversight.

The Legal Aid Society's Experience and Perspective

The Legal Aid Society, the nation's oldest and largest not-for-profit legal services organization, is more than a law firm for clients who cannot afford to pay for counsel. It is an indispensable component of the legal, social, and economic fabric of New York City, passionately advocating for low-income individuals and families across a variety of civil, criminal and juvenile rights matters, while also fighting for legal reform. Through a network of borough, neighborhood, and courthouse offices in 25 locations in New York City, the Society provides comprehensive legal services in all five boroughs of the City. With its annual caseload of more than 300,000 legal matters, The Legal Aid Society takes on more cases for more clients than any other legal services organization in the United States.

The Legal Aid Society's Juvenile Rights Practice provides comprehensive representation as attorneys for children who appear before the New York City Family Court 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 Administration for Children's Services' (ACS) Division for Youth and Family Justice (DYFJ). During the last year, our Criminal Practice handled over 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. Many of

these youth are held in secure detention operated by ACS' DYFJ. In addition to representing many thousands of children, youth, and adults each year in trial and appellate courts, we also pursue impact litigation and other law reform initiatives on behalf of our clients.

Our perspective comes from our contacts with thousands of individuals many of whom have been confined in facilities, and also from our frequent interactions with the courts, the schools, community-based programs, the New York City detention and placement facilities, the New York State Office of Children and Family Services (OCFS) facilities, as well as jails and prisons throughout the City and State.

Incarcerated Youth are Vulnerable Youth in Need of Protection

An independent oversight body is required to ensure the safety of all people held in custody, as the American Bar Association itself has recognized.[1] However, the need for an independent oversight body to ensure the safety of children is particularly acute. Children are particularly vulnerable and least likely to effectively complain of abuse.

The extent of mental health problems among youth in the juvenile systems is staggering. A multi-state study found that 70 percent of youth in the juvenile justice system suffer from mental health disorders and that 27 percent of youth are experiencing disorders so severe that their ability to function is significantly impaired.[2] Indeed in New York City, 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.[3] In Fiscal Year 2013, ACS reported that 58 percent of youth in detention and placement were referred for and

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[1] *Monitoring Conditions from the Inside and Out: Developing Comprehensive Quality Assurance and External Oversight Systems*, May 22, 2013, p.10. www.nc4yc.org (citing ABA Resolution 104b (2008)).

[2] *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*, Jennie L. Shufelt, M.S. and Joseph J. Cocozza, PhD, (June 2006) National Center for Mental Health and Juvenile Justice. http://www.unicef.org/tdad/usmentalhealthprevalence06(3).pdf .

[3] *Innovations in NYC Health and Human Services Policy*, Jennifer Fratello, et al. Vera Institute of Justice (2014) http://www.vera.org/sites/default/files/transition-brief-juvenile-detention-reform.pdf at 12.

received mental health services.[4] Also the prevalence of cross-over youth--those who have had child welfare involvement and juvenile justice involvement is high. In fiscal year 2010, 48.2 percent of the detention admissions had current or past histories of child welfare involvement. Many incarcerated youth lack strong familial support, suffer from a multitude of disabilities, including mental illness,[5] cognitive and educational delays,[6] and trauma histories.[7] Such vulnerabilities, among other factors, make it difficult, if not impossible, for youth to access the help they need to hold facilities, agencies, and staff accountable. The job of protecting youth from harm falls squarely on all of us; it is the role of legislators, facility administration, stakeholders, community members, staff and parents alike to ensure the safety and well-being of incarcerated youth, in keeping with both the spirit and letter of the law.

Conditions of Confinement

Independent oversight is also vital because incarcerated youth face serious challenges that may be unnoticed by their families or the public-at-large. For example, incarcerated youth are exposed to risks related to the use of physical restraints,[8] staff-on-youth violence or force,[9] youth-on-youth violence, and isolation (also known as room confinement). They are also more likely to engage in self-harming and suicidal behavior.[10] In fact here in New York City, in

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[4] http://www.nyc.gov/html/ops/downloads/pdf/pmmr2014/acs.pdf.
[5] Thomas Grisso, speaking at the "Intersection of Mental Health and Juvenile Justice for New York City Youth," Where We Are and Where We're Going in Policy and Practice, October 19, 2012.
[6] Mary M. Quinn, *Youth with Disabilities in Juvenile Corrections: A National Survey*, 71EXCEPTIONAL CHILDREN 339, 340 (2005), *available at* http://www.helpinggangyouth.com/disability-best_corrections_survey.pdf.
[7] "Studies from a number of psychological journals report that between 75-93 percent of youth entering the juvenile justice system annually are estimated to have experienced some degree of traumatic victimization." JUSTICE POLICY INSTITUTE, HEALING INVISIBLE WOUNDS: WHY INVESTING IN TRAUMA-INFORMED CARE FOR CHILDREN MAKES SENSE 5 (2010).
[8] The use of physical restraints is recognized as "an intervention of last resort" due to the high-risk outcomes associated with it, which include trauma, injury, and even death. Michael A. Nunno, Martha J. Holden, & Amanda Tollar, *Learning From Tragedy: A Survey of Child and Adolescent Fatalities*, 30 CHILD ABUSE & NEGLECT 1333, 1337 (2006).
[9] *See* RICHARD A. MENDEL, NO PLACE FOR KIDS: THE CASE FOR REDUCING JUVENILE INCARCERATION 5 (2011).
[10] The Office of Juvenile Justice and Delinquency Prevention reports that 11,000 youth engage in more than 17,000 acts of suicidal behavior in the juvenile justice system annually. BARRY HOLMAN & JASON ZIEDENBERG, THE

October 2012, OCFS (in its oversight capacity) placed ACS under a corrective action plan due to the frequent use of physical restraints and high rate of room confinement imposed in ACS DYFJ's secure detention facilities. We know that physical interventions can have harmful and even fatal effects on youth and should be used only as an absolute last resort, in a manner consistent with the youth's mental health and medical treatment needs.

Robust oversight provides protection to incarcerated youth who are often socially isolated, unaware of their rights and unable to effectively assert them. Incarcerated youth may accept abusive treatment as the norm in a particular facility. Even if these youth seek to complain, they live in a rigidly controlled environment that allows only limited and highly supervised contact with the outside world, family members included. Even where family members or advocates are aware of harmful situations, they do not always know where to turn for relief and often fear retaliation for the young person if they make their concerns known.

The Role for Independent External Oversight

The more eyes the better. While we know that the City has developed a more therapeutic approach, no system is immune from problems, no matter how well-intentioned. We cannot simply trust in the rhetoric of reform as an antidote to past abuses and failures. Certainly placing children close to home is critical to meaningful oversight and a welcome step in the right direction. We look forward to ACS' implementation of the next phase of the Close to Home Initiative which will bring youth placed limited secure closer to their homes, families, communities and attorneys. Having youth placed close to home allows family members and attorneys to visit and keep an ever-watchful eye on the conditions in the DYFJ facilities. Even with the access that having youth close to home allows, as well as ACS' and OCFS' internal

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DANGERS OF DETENTION: THE IMPACT OF INCARCERATING YOUTH IN DETENTION AND OTHER SECURE FACILITIES 9 (2006).

oversight mechanisms, there is still a need for comprehensive, independent oversight. Such independent oversight should include perspectives from youth and families affected by the juvenile justice system as well as stakeholders who can provide a wealth of experience and knowledge.

Oversight is generally characterized as governmental or internal as distinct from independent or external oversight. No one entity can meaningfully serve every oversight function, which is why both internal and external oversight is needed. Presently, ACS largely polices itself, with some oversight by other governmental agencies such as OCFS and the City Council. However, the mandate and resources of these organizations are limited and they are subject to political pressures. Independent, external oversight with a monitoring[11] component is critical for ensuring a credible assessment of what is happening inside facilities. Such external oversight would allow administrators and the public-at-large to properly evaluate facility programs and the needs of both staff and incarcerated youth. Furthermore, such oversight is a prerequisite for the creation of policies and practices that are both effective to support staff and ensure humane treatment.

The essential elements of an effective oversight system include: (1) It must be *independent* of the governmental agency, and able to do their work without interference or pressure from the agency or any other body; (2) It must have unfettered and confidential access to facilities, prisoners, staff, documents, and materials, and it's staff should have the ability to visit at anytime of day without prior notice; (3) It must be adequately resourced, with sufficient staffing, office space, and funding to carry out their monitoring responsibilities, and the budget must be controlled by the monitoring entity; (4) It must have the power and the duty to report

[11] Monitoring involves an entity outside of the corrections/detention agency with the power and the mandate to routinely inspect institutions and to report on how people within that facility are treated. Id. at 9.

their findings and recommendations, in order to fulfill the objective of transparency, and they should control the release of their reports; and (5) It must take a multi-faceted approach to evaluating the treatment of youth, relying on observations, interviews, surveys, and other methods of gathering information from youth and families as well as on data and performance-based outcome measures.

The goal of external oversight is not to lay blame for past mistakes, but rather to improve practices and prevent occurrences in the future. It is about finding ways to meet agreed-upon goals and to ensure quality services and humane treatment. External oversight can also provide many other benefits. It can provide needed continuity between City administrations and their differing policies. It challenges detention administrators, and helps them avoid complacency. An outside monitor can provide administrators with leverage when it comes to securing resources and programming in their facilities. External scrutiny of this type helps reassure citizens that conditions for incarcerated youth are appropriate and consistent with constitutional requirements, thereby enhancing public trust. Regardless of the quality of internal forms of operational review, the public will always remain skeptical that self-regulation is sufficiently objective or rigorous. In addition, most internal processes are designed to remain confidential. They support the needs of management for information and accountability without furthering the goal of public transparency.

In addition, routine and regular inspections ensure that this form of oversight applies equally to all facilities within the jurisdiction of the monitor, not just those with publicized problems. Regular monitoring helps keep the quality of services high, because the staff's knowledge that an inspector could arrive at any time not only keeps staff on their toes, it also allows staff to have a voice in their own governance. Finally, monitoring is the one avenue that

proactively examines operations from the youth's standpoint. For all of these reasons, we encourage the City Council to ensure that an effective oversight structure be established for youth in ACS DYFJ custody.

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: Gabrielle Horowitz - Prisco

Address: Director, Juvenile Justice Project

I represent: Correctional Association of NY

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: 12/2/14

(PLEASE PRINT)

Name: Gladys Carrion & Elipi Franco

Address: 150 William Street, NY, NY 10038

I represent: ACS

Address: _____

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