Legislative Document (1976) No. 92

EIGHTEENTH ANNUAL REPORT

OF THE

TEMPORARY COMMISSION OF INVESTIGATION OF THE STATE OF NEW YORK

TO

THE GOVERNOR AND THE LEGISLATURE

OF THE

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THE TEMPORARY COMMISSION OF INVESTIGATION OF THE STATE OF NEW YORK

Commissioners

DAVID W. BROWN,* *Chairman*

EARL W. BRYDGES, JR.

FERDINAND J. MONDELLO

ROBERT K. RUSKIN*

ERIC A. SEIFF**
First Deputy Commissioner

JOSEPH FISCH
Deputy Commissioner and Counsel

ALBERT SOHN
Chief Accountant

EDWARD J. KIRK
Chief Investigator

WARREN E. DOWNING
Executive Assistant

EILEEN M. BARRETT
Assistant to the Chairman

*Attorneys****

LESLIE TRAGER
First Assistant Counsel

JAMES R. SLATER
Assistant Counsel

JOHN G. GUYET
Assistant Counsel

THEODORE S. ORLIN
Assistant Counsel

CHARLES L. JONES
Assistant Counsel

BARBARA T. DIXON
Assistant Counsel

MEREDITH ANNE FEINMAN
Assistant Counsel

Accountants

RICHARD E. ALLEYNE

MURRAY S. REICH

JULIUS H. BEIM

SIDNEY BLOOM

GERARD J. WEINGARTNER

(over)

* Commissioners Brown and Ruskin succeeded Howard Shapiro and Arnold D. Roseman whose terms expired April 30, 1975.

** Succeeded Deputy Commissioner Nathan Skolnik who retired on September 30, 1975.

*** Resignations during 1975: Andrew P. Donlevy, Stephen D. Kramer, Stephen B. Shiffrin.

*Special Investigators**

JOHN E. GALLAGHER, JR.
DANIEL D. MOYNIHAN
RAYMOND C. RUDDEN
HERBERT H. RAYMONDE
RICHARD J. DOYLE
MAX W. RENNER
WILLIAM E. GRAFF
EDMUND J. LEARY

Support Staff

BARBARA O. FLORIA
ROSE F. ANTONIO
SYLVIA STEIN
GERTRUDE C. BIEGELSON
MINNIE M. BUSCH
MARY ANN LINDE
PATRICK W. GUY
MARIE BRUCAS
NORA O'CONNELL
CONCETTA F. FASANO

* Resignation during 1975: Walter J. Maxwell

LETTER OF TRANSMITTAL

To the Governor and the Legislature of the State of New York:

Pursuant to Section 2 (9), Chapter 989 of the Laws of 1958, as last amended by Chapter 97 of the Laws of 1974, the Temporary Commission of Investigation respectfully submits this report of its activities during the year 1975.

Respectfully submitted,

DAVID W. BROWN, *Chairman*
EARL W. BRYDGES, JR.
FERDINAND J. MONDELLO
ROBERT K. RUSKIN
Commissioners

April 1976

THE RETIREMENT OF DEPUTY COMMISSIONER NATHAN SKOLNIK

On September 30, 1975, Nathan Skolnik, who had been with the Commission since 1958, retired. Deputy Commissioner Skolnik served the Commission for seventeen years with ability, loyalty and dedication. His retirement from this agency represents a loss not only to us but also to the public which he served so well.

TABLE OF CONTENTS

INTRODUCTION

This is the State Investigation Commission's (SIC) Eighteenth Annual Report. It furnishes an account of the operations and activities of the SIC, and the results, for the calendar year of 1975.

During this past year, the SIC conducted a number of important investigations, including probes into the State Commission of Correction, the New York City Board of Education and the Office of Drug Abuse Services.

Following the SIC report and recommendations concerning the inadequacies of the State Commission of Correction, the powers and duties of that Commission were strengthened by the Legislature, and an entirely new Commission was appointed by the Governor.

The Commission's report on certain contracts between the New York City Board of Education and private concerns revealed proven waste of over $1 million because the Board of Education failed to comply with both the State law and also with its own regulations relating to bidding. As a result of this investigation, the City of New York has indicated to us that it is in a position to litigate for the recovery of the money wasted. Additionally, one employee of the Board of Education has been convicted for perjury, a second indicted and three more disciplined by the Board. Additional material furnished to various district attorneys has already resulted in two major indictments.

After a six-month investigation, the Commission held public hearings, in November 1975, into the operation and management of certain residential treatment centers under the control of the New York State Office of Drug Addiction Services. At the conclusion of the hearings, the Commission recommended that certain treatment centers be closed and that those running ODAS should be held accountable for their agency's performance. Since the conclusion of these hearings, ODAS Commissioner Anthony Cagliostro has resigned. On January 20, 1976, Governor Carey stated in his "Budget Message" that:

> "Previous rehabilitation efforts for drug abusers have not been successful. Our State-funded residential programs have been legitimately criticized. Many beds have remained vacant and too few clients are being served in enormously expensive facilities. A major

> overhaul of these facilities is clearly required and I have begun this process by recommending the closing of four residential facilities. We will redirect the remaining resources toward more efficient, appropriate and less costly community-based programs."

These three major investigations were completed in 1975, and at the close of the year, the Commission took on a number of new inquiries. These included a review of the operation of the office of the Dutchess County Sheriff; the improper disclosure of information relating to Grand Jury investigations; alleged improprieties relating to sanitary landfill and resource recovery in Putnam County; and an examination of the State Racing and Wagering Board and the financial condition and operations of the Yonkers and Roosevelt Raceways. The latter investigation was begun in response to a directive from the Governor dated December 16, 1975.

Any inventory of results must also note an action by the State Charter Revision Commission and its approval by the voters at the polls. In November 1975, six proposals advanced unanimously by the Charter Revision Commission were adopted by the voters of New York City. One of these proposals calls for the establishment of a coordinator's office for the criminal justice system in New York City. This proposal was first advanced by the SIC back in 1974, and should further significantly the opportunity for a unified approach to New York's criminal justice problems.

It should also be pointed out that in addition to the above mentioned major investigations conducted or begun during the past year, the Commission considered hundreds of complaints which it received from persons across the State, pertaining to a wide range of matters. And finally, it should be noted that a significant SIC function was its monitoring the activities of certain State agencies.

Those of us serving on the Commission wish at this time to acknowledge the professional and personal contributions that have been made by this agency's able staff members.

BACKGROUND OF THE COMMISSION

From time to time, over a period of many years, this State and others have found it necessary to create temporary crime commissions to conduct investigations into racketeering and corrruption. The most recent such crime commission in this State was established by Executive Order of Governor Thomas E. Dewey, dated May 14, 1951. That Commission, known as the State Crime Commission, was directed, among other things, to "investigate generally the relationship between the government of the State and local criminal law enforcement."

The State Crime Commission recognized the failure of law enforcement under certain conditions to cope with organized crime and corrupt officials. It also deplored the necessity of creating new temporary investigating bodies, with the all too frequent return of the unlawful or unsatisfactory conditions when the investigating body's term expired. In recommending the establishment of a permanent Commission of Investigation, it stated as follows:

> "It is the strong view of this Commission that the creation of such a permanent Commission of Investigation, having members, counsel and staff of the highest calibre, would be a long step forward in destroying the stranglehold which organized crime has had in various areas upon the administration of the criminal laws in this State."

On the basis of this strong recommendation, Section 11 of the Executive Law was enacted in 1953 to establish the Office of the Commissioner of Investigation in the Executive Department headed by a single Commissioner (Chapter 887, Laws of 1953). Governor Thomas E. Dewey appointed the first of such Commissioners whose powers and functions were confined to the provisions of former Section 11.

Establishment of the Commission

To improve and strengthen State investigative activity, as well as eliminate all charges of political motivation, the Legislature in 1958 passed the statute establishing the present Commission. Governor Averell Harriman signed this bill on April 25, 1958, as Chapter 989 of the Laws of 1958, Section 7501,

et seq. Unconsolidated Laws. The Act became effective May 1, 1958, and on that date the first Commissioners took office.

The Commission is comprised of four Commissioners. Two are appointed by the Governor, one by the Speaker of the Assembly and one by the President *pro tem* of the Senate. The Governor designates one of the Commissioners as Chairman. Under the statute, no more than two of the four Commissioners may be members of the same political party. While bipartisan in organization by law, the Commission is nonpartisan in operation.

Jurisdiction of the Commission

The basic jurisdiction of the Commission is set forth in Section 2 of Chapter 989, Laws of 1958, Section 7502, Unconsolidated Laws. The Act provides:

> "(1) The Commission shall have the duty and power to conduct investigations in connection with:
>
> a. The faithful execution and effective enforcement of the laws of the state, with particular reference but not limited to organized crime and racketeering;
>
> b. The conduct of public officers and public employees, and of officers and employees of public corporations and authorities;
>
> c. Any matter concerning the public peace, public safety and public justice."

Pursuant to Section 2(2), at the direction of the Governor, the Commission shall conduct investigations and otherwise assist the Governor in connection with: (a) the removal of public officers; (b) the making of recommendations by the Governor to any person or body with respect to the removal of public officers; (c) the making of recommendations to the Legislature with respect to changes in or additions to existing provisions of law required for the more effective enforcement of the law.

The Act then sets forth these additional functions:

> "(3) The Commission is required to investigate the management or affairs of any department, board, bureau, commission or other agency of the state, upon request of the Governor or the head of any such body;
>
> (4) Upon the request of district attorneys and other law enforcement officers, the Commission is to cooperate with, advise and assist them in the performance of their official powers and duties;
>
> (5) The Commission is directed to cooperate with departments and officers of the United States Government in the investigation of violations of federal laws within the state;
>
> (6) The Commission is requested to examine into matters relating to law enforcement extending across the boundaries of the state into other states;
>
> (7) Whenever it shall appear to the Commission that there is cause for the prosecution of a crime or for the removal of a public officer for misconduct, the Commission is required to refer the evidence to the official authorized to conduct the prosecution or remove the public officer."

Thus, it can be seen that the Commission, as an investigative, fact-finding body, has a wide range of statutory responsibilities. It is highly mobile, may compel testimony and production of documents throughout the State, and is authorized to confer immunity upon witnesses. However, the Commission does not have, nor does it exercise any prosecutorial, quasi-judicial, or administrative functions.

One of the Commission's important duties, when it uncovers irregularities, improprieties, official misconduct or corruption, is to bring the facts to public attention. The objective of this policy is to ensure corrective action. Indeed, the record of the Commission's activities has illustrated that the public hearing, as authorized by statute, has been a most effective weapon in combatting official misconduct, corruption and organized crime. Public exposure of deeply entrenched conditions which are detrimental to the public welfare is a most salutary and worthwhile accomplishment. It has proven a sure stimulus to correction of the wrongs.

SUMMARY OF REPORT CONCERNING THE STATE COMMISSION OF CORRECTION

On April 23, 1975, Governor Hugh L. Carey directed the SIC to investigate the management and affairs of the State Commission of Correction (SCC) and certain allegations concerning the Dutchess County Jail. In compliance with this direction, the SIC reviewed pertinent records, interviewed the Chairman, Commissioners and staff members of the SCC, and other individuals having information relative to this investigation.

The administrator of the Commission of Correction testified before the SIC that it was his policy that investigations of alleged wrongdoing by persons in a Sheriff's Department should be left "to the sheriff's own men." Minutes of State Commission of Correction meetings reflected the passive attitude of the Commissioners and their constant postponement of matters from one meeting to the next with the final result often being "no action" at all. The seven Commissioners of the Correction Commission met only once a month, and with the exception of one Commissioner, rarely visited the institutions over which they had jurisdiction. In general, the Commissioners appeared to take little interest or to devote much time to improving conditions in the penal system.

It was clear the Commissioners, as a body, were unfamiliar with their own statute. At one meeting with a local group which was complaining about conditions at their jail, the Chairman and Vice-Chairman of the State Commission of Correction, who were lawyers, asked these visitors to research the statute under which it, the State Commission of Correction, operated, to determine what power the Commission possessed which might be utilized against the local Sheriff.

The results of the SIC investigation, together with its recommendations for positive corrective action, were forwarded to the Governor on June 16, 1975. After reviewing this report, the Governor determined that it was in the public interest to make the report public, and in releasing it, stated:

> "This report has effectively pinpointed the policies and procedures which have produced the dismal record of the present Commission. In my view, it would be imperative that any new members appointed to serve on the Commission review and discuss the

> SIC report and recommendations with Chairman Brown and his colleagues so that such errors will be avoided in the future.
>
> The thorough report that I have received from the SIC fulfills my expectations in its capacity to undertake major investigatory responsibilities during my administration."

Subsequent to the conclusion of the Commission's investigation and the public release of its report, new legislation was enacted restructuring the Commission of Correction, and new Commissioners were appointed by the Governor. The full report commences at page 19.

SUMMARY OF REPORT CONCERNING THE NEW YORK CITY BOARD OF EDUCATION

On October 31, 1975, the SIC released the report of its investigation into the relationship between the New York City Board of Education and a computer firm named Computer Specifics Corporation which had received approximately two and a half million dollars from the Board of Education for payroll processing.

The report disclosed that this large sum of money had been paid to Computer Specifics even though no contract existed. In order to do this, the Board of Education used imprest funds (funds designed essentially for petty cash items in the amounts of $5,000 or under). This procedure not only violated the Board of Education's own by-laws requiring contracts in excess of $5,000 to be approved by the members of the Board of Education, but also violated State law relating to bidding requirements.

The Commission's investigation further revealed that a number of Board of Education employees received various gifts from Computer Specifics. In addition, a then recent employee of the Board of Education was one of two principals of this company. The Administrative Code of the City of New York explicitly prohibits former City employees from receiving remuneration for matters with which they had been involved during their City employment, for the two years subsequent to such City employment.

Moreover, although the impropriety of the Board doing business with a former employee was pointed out to the Board of Education in October 1972, by the State Department of Audit and Control, this illegal arrangement was continued for another two years thereafter. Indeed, it was not until after the SIC's investigation had become publicly known that the Board finally terminated the arrangement in November 1974.

Following our investigation, SIC staff members held a number of conferences with top personnel of the Corporation Counsel's Office of the City of New York and made available to that office the testimony, materials and other information gathered by the Commission during its investigation. Subsequent to these conferences, the Corporation Counsel advised us that the material furnished by the SIC affords a basis for a civil damages action by the City of New York. The complete report commences at page 43.

SUMMARY OF REPORT CONCERNING THE OFFICE OF DRUG ABUSE SERVICES (ODAS)

In April of 1975, the Governor directed this Commission to undertake an investigation into "possible criminal conduct" at the Otisville Rehabilitation Center, a drug treatment facility operated by the New York State Office of Drug Abuse Services. The SIC's inquiry into these and related allegations disclosed the existence of serious problems not only at Otisville, but at other ODAS residential facilities as well. Accordingly, the Commission undertook an investigation into the operation and management of State-run residential drug treatment facilities.

The SIC's investigation, which was the "first hard look" at the program, uncovered a shocking series of supervisory and fiscal abuses.

Operational costs at the various facilities examined by the SIC for the 1974-1975 fiscal year ranged from $24,059 per year per resident to $45,110 at Otisville. The per patient costs during the initial nine months of Otisville's operation were $118,253 per year. During that time, a staff of 160 was serving an average of 14 residents.

The excessively high cost of residential treatment was compounded by an apparent lack of planning and coordination, inadequate supervision and staff training. Deficiencies were found in medical care, educational, vocational, counseling and recreation components. The Commission's investigation also uncovered the presence of contraband, including drugs, in some facilities, as well as a history of violence and sexual abuses of residents. These problems indicated an apparent inability by Central Office personnel properly to supervise staff or implement existing policies and procedures. The same lack of planning and coordination was found in their methods of referral, release and after-care. The SIC also inquired into ODAS's relationship with a not-for-profit corporation known as Narcotics and Drug Research, Inc. Public hearings were held in New York City in late November of 1975. At the conclusion of those hearings, the Commission issued its interim recommendations and observations.

Since the Commission's public hearings, disciplinary charges have been brought against a number of ODAS employees. In addition to the closing of some residential centers, certain others have been turned over to the New York State Department of

Correctional Services. In addition, administrators have been reassigned, and the Governor has appointed an Executive Deputy Commissioner to bring about administrative improvements within the agency.

The final report on this investigation will be found on page 71.

ORGANIZED CRIME SEMINARS

Pursuant to a grant from the Division of Criminal Justice Services, the SIC conducted nine two-week seminars during 1975 on organized crime and criminal intelligence. These sessions were designed to offer advanced instruction to law enforcement personnel concerned with organized crime and criminal intelligence.

By the conclusion of 1975, over 200 persons in law enforcement agencies throughout the State had attended. The Division of Criminal Justice Services has agreed to fund this seminar for a second year.

REPORT CONCERNING THE STATE COMMISSION OF CORRECTION

INTRODUCTION

On April 23, 1975, pursuant to his statutory authority, Governor Hugh L. Carey directed this Commission "to investigate the affairs of the State Commission of Correction." Included in this directive was the request that this Commission inquire into the conduct of the State Correction Commissioners and staff in relation to the performance of their official duties for the purpose of assisting the Governor in the exercise of his statutory responsibilities. The Governor also requested that this Commission inquire into the acts or omissions of such officers and employees concerning information communicated to them regarding the Dutchess County Jail since January 1, 1974.

This Commission, in response to the Governor's directive, undertook the investigation expeditiously. All pertinent books, records, minutes, reports and documents of the State Commission of Correction (hereinafter referred to as "SCC") were examined. The SCC Commissioners, a former Commissioner, the Administrator, and key members of its staff were examined at private hearings and at conferences in New York City and Albany; persons having material information regarding this matter were interviewed in the field, including the Dutchess County Jail, and at this Commission's offices. In addition, the transcripts of the public hearings on the SCC conducted in Albany on April 21 and April 28, 1975, by the New York State Senate Standing Committee on Crime and Correction, of which Senator Ralph J. Marino is Chairman ("Marino Committee"), were studied. Conferences were also held with Senator Marino and his staff, as well as with Assemblyman Stanley Fink, Chairman of the Assembly Committee on Codes, and with members of his staff.

In view of the fact that the Marino Committee has issued a report of its inquiry and remedial legislation is pending, this Commission had decided that it should inform the Governor as soon as possible what its investigation has disclosed.

CONCLUSIONS

The powerful provisions of the statute which restructured the SCC in 1974 and gave it independence were not self-executing.

They required dynamic implementation and imaginative appreciation of the opportunity they provided the SCC to do something meaningful in the correctional institutions of the state. Receiving neither, the statute became nothing more than a meaningless and ignored document.

It is quite apparent from this Commission's investigation that the incumbent State Correction Commissioners failed to fulfill their statutory obligations. They have attempted to explain away this failure by claiming their role was only as a citizens board —despite statutory language to the contrary. It would appear to this Commission that such a misconception of their role arose for reasons of convenience rather than conviction. Furthermore, using their own standard of acting as a citizens board, the incumbent Commissioners even failed to satisfy the lesser demands of this more modest role. Whether or not new legislation is enacted, clearly the circumstances require that the remaining incumbent Commissioners be asked to resign.

It is true we are a government of laws, not men, but we should not lose sight of the fact that men and women holding positions of grave responsibility must be held accountable for the faithful execution of those laws.

HISTORY AND BACKGROUND

The State Commission of Correction is the statutory successor to the Commission of Prisons which was created in 1907 as an independent body charged with visiting and inspecting institutions for the detention of sane adults and authorized to investigate the management of such institutions to ensure their efficient and humane operation.

The Commmission of Prisons comprised seven Commissioners, appointed by the Governor with the advice and consent of the Senate. Meetings were to be held at least once a month and a Commissioner's absence from three consecutive meetings, unless excused, constituted a resignation. The Commission was granted power to subpoena, to examine persons under oath, and power to obtain a Supreme Court order to compel compliance with the Commission's directives to prison officials.

In 1929, New York's Correction Law was enacted and incorporated therein as Article 3 were the 1907 provisions regarding the Commission of Prisons, its name now changed to the State Commission of Correction, and the Commissioner of Correction becoming its *ex officio* Chairman. The Commission was

also given a new weapon: the power to close any of the local correctional institutions* found to be unsafe, unsanitary, or inadequate to provide for the separation and classification of prisoners as required by law.

In 1965, the Commission was granted a new and significant duty: to promulgate rules and regulations establishing minimum standards for the care, custody and treatment of all inmates of local correctional facilities. It was also authorized to close any local correctional institution which did not adhere to the Commission's rules and regulations. 1970 witnessed the enactment of the last major amendment to the 1929 provisions, a measure which established a basic correctional training program for local correctional personnel to be operated by the Commission with certain powers of exemption.

Article 3 of the Correction Law was redrafted in 1973, and as the result of a 1973 constitutional amendment which became effective on January 1, 1974, the Commission of Correction was once again made independent of the Commissioner of Correctional Services, and one of the Commission's own seven members was to be designated Chairman by the Governor. The resignation-by-absence feature of the old law was eliminated.

The powers, functions and duties of the Commission were expanded in several respects. The Commission was given an advisory role with respect to the Governor (to aid in developing plans, policies and programs to improve the administration, effectiveness, etc. of correctional facilities), and directed to make similiar recommendations to the administrators of correctional facilities. Also added was a direction to establish effective inmate grievance procedures in local institutions and the duty to issue an Annual Report and special reports, as necessary. The statute retained the Commission's important duties with regard to promulgating minimum standards, the training of correctional employees and the SCC's power to close local facilities. The additional resort to court order was now made available to remedy violations of the SCC's minimum standards in addition to violations of law in the care and custody of inmates.

This statutory history of the SCC evidences the Legislature's intention that it be an active Commission. Its history, however, has proven otherwise.

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* Local correctional institutions are those operated by a County or other local governmental unit as distinguished from State facilities.

THE COMMISSIONERS

The SCC consists of seven Commissioners charged by statute with meeting "*at least* once a month,"* a full-time Administrator, appointed by the Commissioners, and staff. At the time of the SIC's investigation, the seven Commissioners included three attorneys, one businessman, one union official, one school superintendent and a retired penologist. This Commission interviewed, or examined under oath, five of these seven Commissioners,** all of whom had held office at the time of the restructuring of the SCC in 1973.

One Commissioner, appointed by Governor Dewey in 1950, was told that the position would not take him away from his job and he was expected to visit institutions only when it did not conflict with his job. Another Commissioner stated that his County Chairman had contacted him in 1968 when a vacancy occurred on the Commission because of a death, and asked him to take the position because he felt it "belonged" to his County. No one said "here's the law" or told him "anything," and his SCC indoctrination was a "do it yourself program." He thought the job was akin to being a member of a Board of Directors. The Chairman, appointed in 1972, stated that when he agreed to take the position, it was his understanding that the SCC was to function as "a citizen's commission."

All the Commissioners interviewed by this Commission stated that they expected that the actual operation of the Commission would be handled by staff. The Commissioners were to meet once a month, visit institutions when they had time, act upon decisions as they were presented to them, and read reports. A number of the Commissioners stated that they would not have accepted their positions had they been informed that more time was necessary. However, when the SCC was restructured in 1973, they realized that their agency was supposed to do more, and as one Commissioner put it, "it was like going from a corner store to running a supermarket." One Commissioner stated that there were usually about 50 matters from different

* Section 42 (6) *Correction Law*. This section also authorized payment to the Commissioners of $100 for each day's attendance at meetings or while engaged in any other SCC business, with an annnual maximum of $5,000. (§42 (5)). Thus it was contemplated that a Commissioner could have devoted almost one day a week to SCC business and be compensated by the State.

** One had retired and declined to meet with the Commission. The other resigned on the day she was to appear before the Commission. One of the Commissioners who did appear and who testified under oath has also submitted his resignation.

institutions which they had to consider at their monthly meeting. Nevertheless, they still adhered to their "Board of Directors" concept, remained in their posts, and continued to meet only once a month for three hours or so. Although they claimed that there were inadequate funds to hire more staff, they made little effort themselves to obtain such funds but simply delegated to their Administrator the task of negotiating with Budget and Civil Service.

The SCC office is in the Alfred E. Smith Building in Albany. Its staff operates out of that office and all its files and records are there. In 1974, two of the Commissioners asked to "kill" the Albany meetings because it was "inconvenient" and an "imposition" to travel there. The other Commissioners agreed. Accordingly, there were only four meetings in their office in Albany in 1974 and the remaining eight were held at various meeting locations in New York City.* When this Commission asked about their Albany office, one Commissioner was uncertain on what floor of the Alfred E. Smith Building it was located. The Commissioners delegated to their Administrator all aspects of hiring staff personnel and never interviewed or met new members of the staff. The Commissioners rarely called their professional people to meetings for advice or to discuss matters on which they were working and on which the Commission was asked to act. Indeed, the Chairman conceded the following point during his private hearing examination:

> "Q Would it be fair to say that you probably have a good percentage of your professional staff there who would not even recognize what the Commissioners looked like?
>
> A Definitely so. There is no question about it." (237)**

An examination of the verbatim minutes of Commission meetings reveals an indifference toward their jobs and responsibilities. During 1974, when one would have expected the SCC to be working diligently in response to their new mandate, the meetings were not well attended. At one meeting, a Commissioner conceding that "I do not know what these projects are all about" then moved to approve them. On another occasion, they

* All the 1975 monthly meetings have been held in New York City.

** Page reference to Private Hearing testimony.

discussed a request they had received from the New York City Board of Corrections, suggesting a meeting. When the Chairman asked his fellow Commissioners how he should respond to this request for a meeting, one Commissioner stated "Tell them they can't add a blessed thing to our problems," and another suggested "Let them drift."

Their record of visits and inspections of correctional institutions left much to be desired. This Commission asked the SCC to compile a list of such visits and inspections by Commissioners for the years 1973 and 1974. This compilation, based upon their own records,* reveals the following number of such visits and inspections:

Chairman Albert Berkowitz — 2 (1 in 1973 and 1 in 1974)

Vice-Chairman James J. Beha — 10 (3 in 1973; 7 in 1974)

Commissioner Thomas G. Young — 2 (1974)

Commissioner Marguerite N. Stumpf — 2 (1974)

Commissioner John F. Karl — 5 (1974)

Commissioner Carmen Rodriguez — 2 (1974)

Commissioner Edward Cass — 32 (7 in 1973; 25 in 1974)

Thus, it appears that the only Commissioner who actively pursued the SCC's statutory obligation to "visit and inspect" correctional facilities was Commissioner Cass, a retired penologist.

Although three of the seven Commissioners, including the Chairman and Vice-Chairman were attorneys, they had obviously not familiarized themselves with their own statute and did not appreciate their powers and duties. In October 1974, the SCC met with the Ulster County Jail Citizen's Committee concerning problems at the Ulster County Jail. The spokesman for the citizen's group asked that the SCC consider going to the Supreme Court to seek a court order directing the jail administration to comply with the SCC's regulations. The spokesman for the citizen's group correctly cited the appropriate section of

* Based upon vouchers submitted by the Commissioners.

the SCC statute (§ 50 (4) of the Correction Law) which authorizes such action. The Commissioners did not realize the SCC had the authority to do this, and spoke only of its authority to close a jail. The meeting concluded with the Vice-Chairman—who was a lawyer—asking that one of the members of this private citizen's group familiarize himself with the law during the next few days and "to tell us what he thinks we can do under the Correction Law."

The Chairman was asked about this at his private hearing before the State Commission of Investigation:

> "Q Do you think that your agency should be asking citizens to research your power and to tell you what you can do?
>
> A You have answered the question by asking it." (254)

During the same meeting with the Ulster County citizen's group referred to above, a clergyman asked whether the SCC had the power "to remove or recommend the removal of the sheriff" and the Chairman of the SCC (an attorney), replied: "It is beyond our power to recommend his removal." When the Chairman was questioned about this during his private hearing before the Commission on June 9, 1975, he conceded that his agency probably had the inherent power to make such a recommendation to the Governor, and perhaps should have exercised it, but never did (248).

The Administrator, who is not a lawyer, testified that when his agency issued citations to close a jail, he personally researched the law and drew up the citation "from an old one that somebody thought up twenty years ago." He did this himself because his agency did not have a staff attorney. When asked why he did not seek help from any of the three Commissioners who were attorneys, he stated "they are not conversant with Correction Law too much" and also conceded that he felt they would have been unwilling to devote the time to doing the work because they were part-time (212-13).

The statute creating the SCC invests that agency with broad powers over correctional institutions.* A very important power granted to the Commission, referred to earlier, is the power under §50 (4) to obtain a Supreme Court order compelling a

* Section 48 (3), *Correction Law.*

sheriff or other jail administrator to comply with the regulations of the SCC. This power has never been utilized. It is appropriate to emphasize that the seven-member SCC consists of members who had served on the Commission for many years,* three of whom are practicing attorneys. It is also appropriate to point out that in October 1974 private citizens had specifically directed the SCC's attention to this provision of their own statute. Still, the SCC operated on the mistaken assumption that all they could do was close a jail. Not only private citizens, but even inmates, apparently knew more about legal opportunities than did the SCC. In the Dutchess County Jail, the inmates brought a class action in Federal Court in 1973 to compel the Sheriff to abide by the SCC's regulations.

The Commission also failed to exercise the power to promulgate minimum standards for correctional personnel.** The SCC has had evidence for a number of years that there were individuals working in correctional institutions who were not qualified. In one institution, the SCC received a report from their inspectors that there were individuals working in the local jail with criminal records, including assault, indecent exposure, driving while intoxicated and alleged illicit involvement with a minor. The Commission's response to this revelation was to issue a public statement that the SCC had received evidence of "mismanagement by the jail administration," that the SCC's regulations had been violated and many of its recommendations ignored by the Sheriff, and that "The Commission will give further consideration to the matter and will take such steps as it deems necessary to correct the situation." The "steps" taken by the SCC were to wait. This pattern of deferring decisions from one monthly meeting to the next, and of finally apparently doing nothing, was characteristic of the SCC.

If matters were not postponed, they were often just not acted upon. The verbatim minutes of the SCC's monthly meetings contain references to reports of unusual incidents which include deaths, assaults, suicides, escapes, etc. In many such instances, the report concludes with the notation "no action." For example, at the March 1974 meeting referred to above, the Commission reviewed reports from various institutions showing five attempted hangings, three assaults, eight cases of self-inflicted injuries by inmates, five escapes, two inmates observed under

* One was appointed in 1936, another in 1950 and a third in 1955.

** §48 (6).

the influence of drugs, marijuana found in possession of the same inmate on two different occasions and in the pipe of another at another time, one fraudulent release from a state institution and two suicides. Except for the two deaths which were referred to the Medical Review Board,* the SCC's own minutes report the Commission's decision on each of the other incidents: "No action."

The SCC's failure to exercise its statutory duties, as for example, by not prescribing minimum standards for correctional personnel, may have had tragic consequences. In one institution, an inmate committed suicide by hanging himself. Upon investigation, it was discovered that the jailer on duty in that tier that evening, had corrected vision of 20/150 in one eye and 20/200 in the other. The Administrator of the SCC, when questioned about this at the Commission's private hearing of June 3, 1975, said "This man should never have been on this job" and conceded that the SCC "certainly" has a responsibility to see that such an individual is not employed in a correctional institution. The Administrator was asked whether the SCC had ever done anything to establish such minimum standards for employment in jails:

"A We have not established it.

Q Not yet, in all this time, Mr. Van Hoesen?

A In all this time—in one year.

Q Did you have the authority to set those standards prior to 1974?

A They may have had the authority but they never established them." (28)

It is interesting to note that when the State Commission of Investigation questioned SCC Commissioners about this on June 9 and 10 of this year, some still were not sure they had this authority, thanked the Commission for bringing it to their attention, and said it was something to think about.

Another statutory power which the SCC had previously not utilized is the power of subpoena.** A few weeks prior to his

* The Medical Review Board is a unit within the SCC charged with investigating inmate deaths.

** §50 (2).

private hearing before the Commission, an SCC Commissioner was advised by members of one Sheriff's Department that if served with subpoenas compelling them to testify, they would have much to say concerning the administration of a county jail. The Commissioner told them to see their County Attorney. This information was brought to our attention and the SCC Commissioner was questioned about this at his private hearing on June 9. The very next day, the SCC served subpoenas on five members of that Sheriff's department.

A major failure of the SCC is that it does not investigate inmate grievances. Although the statute clearly and specifically mandates that the SCC "establish procedures to assure effective investigation" of grievances of inmates of local correctional facilities,* the SCC has not done so.

The SCC is also charged by statute** with the duty of advising and assisting the Governor in developing plans and programs to improve the administration and effectiveness of correctional facilities, but it has never done so. No research work has been undertaken, and no program has been devised for the improvement of medical care in correctional institutions, although SCC files contain sufficient indications of medical deficiencies. In this connection, the Administrator of the SCC, in testifying before this Commission on June 3, 1975, conceded that it was his impression that the SCC, even after it was restructured in 1974, "was designed to be a low keyed Commission which was not supposed to rock the boat and not to make waves" (121).

A notable exception to this indifference and lack of appreciation of the duties and responsibilities of being a Commissioner, was Burton Schoenbach. Mr. Schoenbach was appointed as a Commissioner of the SCC in January 1973 and immediately went to work. He inspected institutions, met and talked to staff personnel, went into the commmunities seeking their participation, worked towards improving medical care in correctional facilities and attempted to correct inmate grievances and improve conditions in the institutions. It was his position that the SCC had an important ombudsman role to fulfill and he did not regard his position on the SCC as merely membership in a "prestigious club." Mr. Schoenbach began to make waves. On September 1, 1973, when the SCC was restructured by statute,

* §48 (4) of the Correction Law.
** §48 (1).

Mr. Schoenbach was the only one of the seven Commissioners who was not reappointed.

THE ADMINISTRATOR

Because the Commissioners were part-time, met only once a month, and took little interest in the SCC's routine operations, the burden of running the State Commission of Correction fell upon the Administrator.

The Administrator came to the old SCC as a Correction Specialist in 1967, became its secretary in December 1971, and assumed the title of Administrator when the SCC was restructured in September 1973. His background was in Corrections work, and he knew many of the Sheriffs as a result of his many years of experience in the field, and his activities with the SCC.

It is significant in understanding the operations of the SCC, to refer to a meeting of the Sheriffs Association which the Administrator attended in early 1975. At that meeting, he made a "commitment" to the Sheriffs that his office would conduct no investigations of jails without first advising them.* It was the Administrator's position, candidly acknowledged when he appeared before this Commission at a private hearing on June 3, 1975, that the Sheriffs should run their own show. This deference to the Sheriffs by the Administrator and the SCC resulted in some questionable concessions. In one institution, the SCC had information alleging that one or two officers working in the jail were involved in bringing contraband into the jail. The SCC did some preliminary investigation, and had given the District Attorney of that County some of its information. At one point however, the SCC decided to terminate its investigation and met with the Sheriff. The Administrator then turned over to the Sheriff all the information it had, including the names of the officers allegedly involved. The Administrator emphasized to the Sheriff that the SCC had not initiated the investigation but had responded to allegations it had received, and then informed the Sheriff that the SCC was terminating its investigation. In others words, the Sheriff was permitted to investigate his own jail and his own men. This information was given to the Sheriff apparently without advising the District Attorney, and with no directive to the Sheriff that he advise the SCC of the results of his investigation and the action he was taking.

* The Administrator reported this to the SCC at their monthly meeting of February 11, 1975, and it is reported in the Verbatim Minutes of that meeting.

Subsequently the Sheriff informed the SCC that the allegations were unfounded but that he had discharged one of the officers allegedly involved, a contradiction at least on its face, which neither the Administrator nor the SCC elected to pursue. The Administrator testified before the Commission on June 3, 1975 that he did not get a report from the Sheriff about these allegations of possible involvement by officers in drug traffic and never asked for one (81-2). The Administrator also acknowledged that he did not know why one of the officers allegedly involved was discharged, nor did he know whether he was working in another County institution (82). The Administrator was asked what his policy was where the SCC had information of possible wrongdoing by a Sheriff's own men:

"A It's up to the Sheriff.

Q The Sheriff should investigate whether anyone in his jail is bringing in contraband?

A Who else would? I definitely think it is the Sheriff's responsibility.

Q To have an investigation of his own men?

A Why certainly. It's his department. He is the law enforcement agency . . . ." (67-8)

* * *

COMMISSIONER RUSKIN: . . .
Are you suggesting that in every instance where you were to get allegations that contraband was being brought into a jail by officers within that jail, that it would be the proper role of the Sheriff, the boss of those officers, to conduct an investigation to see if his men were engaged in that sort of misconduct?

THE WITNESS: Yes, sir." (70-71)

The Administrator explained that in his opinion there is no Sheriff anywhere in the State "who countenances corruption or criminal activity" in his jail and therefore he felt they would always conduct a fair investigation even if it means investigating his own prison (71; 75).

This policy of permitting the Sheriff to run his own show, and of the SCC looking the other way, was seen in other cases. The Administrator admitted that he had heard an allegation

that a correction officer was discharged from a state institution because of misappropriation of funds and was now working at a local jail. He never bothered to check (although it merely required a telephone call or two) and he was not particularly interested, and did not regard that as a violation of the SCC's minimum standards (84-5; 134).

An extremely important responsibility of the SCC is its training programs which are mandated for corrections personnel. The Administrator admitted receiving allegations from his training staff that officers had advised them that they had been instructed by their Sheriffs to ignore this training upon their return to the jails. The Administrator never bothered to investigate those charges (207).

The eagerness to accommodate Sheriffs took many other forms. Where there was an allegation of narcotics in one jail, the Administrator's decision was to permit the Sheriff to make the search (53). Sheriffs were asked for reports of certain unusual incidents, but the Administrator could not say, when questioned by this Commission, whether the Sheriffs complied (15). Where the SCC made certain recommendations to the Sheriff, the Administrator was satisfied to rely upon the Sheriff advising the SCC whether he had complied rather than having SCC inspectors confirm compliance (53). In one institution, the Administrator apparently notified the jail personnel in advance on what day an investigation was to be made and acceded to the Sheriff's request that certain SCC inspectors not be given that assignment. On more than one occasion the SCC learned of unusual incidents in a jail through newspaper accounts and it was obvious that the Sheriff involved was defying the SCC's reporting requirements. Nevertheless, the Administrator readily accepted the explanation that the Sheriff forgot to report or did not have sufficient time to do so.

With regard to state institutions, the SCC apparently refused to exert its authority at all, and merely accepted whatever information the state institution was willing to report to it, or else hoped that a friend inside the institution would report. The Administrator acknowledged this when questioned by this Commission on June 3, 1975:

"Q You are saying you had to rely on someone friendly to you tipping you off, isn't that right?

A Exactly right; or the newspapers." (16)

THE PROFESSIONAL STAFF

The professional staff of the SCC performs the agency's functions of inspections, training of corrections personnel, and related matters.* These professionals include a number of persons with prior experience in the corrections field as well as other individuals with less traditional ties and thinking.

This Commission interviewed present and past members of the professional staff and reviewed their reports, memoranda and other SCC records. It is clear that many of the SCC's professionals were dissatisfied with their agency's passive role, and communicated this dissatisfaction to their superiors and to the Administrator.

One inspector, interviewed by this Commission on June 12, 1975, stated that he felt so frustrated and ineffective as an inspector because his recommmendations were not followed, that he requested transfer to the Training Academy. Other inspectors also complained to this Commission that the recommendations they made upon completion of their inspections of correctional institutions, and which were included in their inspectional reports, were not implemented by their agency. These inspectors described their agency's reluctance to take affirmative action which might embarrass or antagonize sheriffs, or otherwise cause a confrontation, and most agreed that the SCC just did not want to "rock the boat." Interestingly, such criticism of their agency's complacency was not limited to the new employees, but was expressed by other staff members as well. Thus, one inspector, who had worked as a Correctional Officer before coming up to the SCC in 1972, testified at a hearing before this Commission on June 9, 1975, that it was understood among the staff that the Commissioners wanted to maintain the "status quo" and the "consensus" among the inspectors was that "unless the Commission moves, we are not going to move" (354; 356-7).

The professional staff criticized many of its agency's operating procedures. For example, inspectors were told to "stick to the minimum standards"** in inspecting a jail although it was obvious that these standards were outdated and woefully deficient, and that conformance by an institution to these standards meant nothing. One experienced inspector, who had many years in the correctional field before joining the SCC pointed out that his agency's minimum standards for supervision merely requires at least two jailers inside the institution:

> "A . . . at least two jailers inside the institution at all times and this doesn't say whether there are two jailers for every 20 men or two jailers for 200 inmates.
>
> Q That's just two jailers per jail, regardless of the size of the institution?
>
> A Right.
> I mean, this just isn't supervision. I can go through the minimum standards and if you are familiar with any kind of correction work, it can make you sick to your stomach.
> I know why there is suicide. I know why there is attempted suicide. I know why suicides are successful.
>
> Q Why?
>
> A Because of lack of supervision . . . lack of psychiatric care." (382)

This inspector also criticized the fact that inspections are normally made between 8 A.M. to 4 P.M., rather than at surprise off-hour times and that most institutions seem to know when an inspector is coming. He stated that, as an experienced correction officer, he knew that jailers sleep on duty and otherwise do not perform their job and that suicides often occur at such times when supervision is lax. He stated "anybody can walk in and catch them" and described what he found when he made a surprise visit to a county jail:

> ". . . I did walk in and they were all playing cards, drinking, drinking coffee and they were supposed to be on the job." (369)

When asked his opinion of his agency, he stated that the Commissioners "didn't care [and] weren't interested," that he had seen his own recommendations repeated "four or five years in a row" with "nothing . . . being done" (375; 379). He felt

* There is also the Medical Review Board which investigates inmate deaths.

** These minimum standards covered the physical facilities, extent of supervision over inmates and other jail procedures. As previously noted there were no minimum standards covering qualifications for personnnel working in such institutions.

that if his agency were only willing to "push" and exert the authority it possessed under the law, many of the problems in the jails would be corrected:

> ". . . if it was enforced a couple of times on a couple of occasions, you would see these people in these jails squared away . . . ." (379)

The criticism expressed by the SCC's professional staff about the ineffectiveness of their agency was brought directly to the attention of the Administrator and the Commissioners. This Commission's investigation disclosed a memorandum from the Administrator to the SCC Commissioners, dated August 8, 1974, reporting his discussions with staff. As a result of these discussions, the Administrator advised the Commissioners that the following should be the first objective of the SCC:

> "(1) The Commission of Correction must take a more active role in the improvement of the operations of correctional facilities."

Again, a December 27, 1974 memo from the Assistant Administrator to the Administrator, listed "issues [which] have surfaced from within the agency and from without the agency." These included, among other things,

(a) The SCC Commissioners should be full-time and should visit correctional facilities;

(b) the reports released by the SCC do not evaluate the administration of correctional facilities;

(c) the failure of the agency to conduct research;

(d) the failure of the agency to investigate inmate grievances;

(e) the standards for the operation of local correctional institutions are outmoded.

As this report indicates, such warnings went unheeded.

The diversity of background of the professional staff produced certain philosophical and practical divisions, which is unfortunate, for there undoubtedly is a good deal of talent and dedication among these professionals. It is essential that the energies, talents and experience of these people be properly utilized.

In this connection it is appropriate to note that the Vice-Chairman of the SCC, on two occasions, utilized the professional staff for personal reasons. It should also be noted that the SCC devoted a disproportionate amount of time and staff in an effort to determine how certain SCC reports were being disseminated to the press.

DUTCHESS COUNTY JAIL

Documents contained in the files of the SCC reflect repeated reminders over the years that serious problems existed in the Dutchess County Jail and that the Sheriff was making no sincere effort to improve matters. There have been Grand Jury investigations and reports, Citizen's Committee reports, special and regular Inspection Reports by SCC staff, complaint letters by inmates, unusual incident reports, newspaper articles, meetings, and in July 1974—a Federal Court stipulation following a class action by inmates against the Sheriff. Throughout this entire period the SCC believed itself impotent to do anything forceful or constructive, convinced that the only power it could exercise was to close the jail.

On May 25, 1972, an inmate pried open a skylight window and "escaped" by just walking away in what several SCC Commissioners subsequently described as a "ridiculous" caper. The SCC wrote a letter to the Sheriff on June 1 reminding him of the need for "constant and proper supervision of jail inmates." The effect of the letter was evidenced on June 23—just three weeks later—when another inmate apparently decided he, too, had had enough and also walked away. The inmate surrendered himself on September 6th. One SCC Commissioner recalled that on one occasion when she visited the institution several years earlier, she discovered that the guards had forgotten to close the gate.

Not all "unusual incidents" at Dutchess County Jail however were of this nature. On July 12, 1972, an inmate died suddenly following minor surgery. Since then the following incidents were reported, or came to the attention of the SCC: two suicides by hanging; three attempted suicides; seven cases of self-inflicted inmate injuries requiring hospitalization; three cases (involving four inmates) of drug overdoses requiring hospitalization; nine additional inmate escapes; five cell fires and mattress burnings, some of which required hospitalization of inmates and officers; four assaults of officers by inmates; three

assaults of inmates by other inmates; four alleged homosexual assaults upon inmates; four instances of contraband being discovered in the jail; and eight separate inmate disturbances involving revolts, guards held hostage, possible riots, etc.

In one of the incidents cited above, seven inmates with hand-fashioned weapons stormed the gate, took two guards as hostage and injured three officers. This incident was not reported by the Sheriff to the SCC which learned of the incident by reading about it in the newspapers several days later.

Medical deficiencies at Dutchess County Jail were reported to the SCC over a period of years by their own inspectors, by inmates in letters of complaint, and in other forms. A July-August 1973 Grand Jury Report commented on medical deficiencies at the jail, as did a report in November 1973 by a Citizen's Committee.*

The Administrator of the SCC was asked about these Grand Jury and Citizen's Committee Reports when he appeared before this Commission on June 3, 1975. He remembered "reading a Grand Jury report" but could not recall its content. He was then asked:

"Q Did you do anything after having read the report?

A In what respect?

Q Seeing that these problems were corrected in the jail?

A Not that I know of." (151-2)

With regard to the Citizen's Committee Report, the SCC Administrator recalled reading it, and believed he sent it to the staff to review:

"Q What about the Commission?

A I don't remember whether it was sent to the Commission or not.

Q Did you basically ignore it?

A Yes, I would say so." (159)

* Report of the Citizen's Committee to Study the Feasibility of Establishing a Department of Correction in Dutchess County.

On November 25, 1973, an inmate wrote a letter to the SCC complaining, among other things, of inadequate medical attention. The SCC replied on December 4, 1973, informing the inmate that it was the Sheriff's responsibility to provide medical care as per the jail physician.

On March 18, 1974, a highly critical *Special Report* on Dutchess County Jail was submitted to the SCC by two of its new investigators. This *Special Report* was much more extensive than the routine SCC Inspection Report, which generally is limited to a check-list review of an institution's physical plant and procedures. The *Special Report* charged, among other things, inadequate medical care, lack of supervision and discipline, a loss of control, an alleged drug traffic and many other deficiencies. The allegations of inadequate medical care were based on statements by jail personnel and by the jail physician himself, and not merely the complaints of inmates. For example, it was learned that the jail doctor did not examine every inmate claiming to be sick but spoke to them through the bars and then prescribed medication. Both the doctor and the Sergeant in charge of the jail agreed that about 85% of the inmates were on some type of drug.

The charge of lack of supervision, discipline and control were based on statements by several jail officers and guards, actual observations by the SCC officers conducting the inspection and by the Sheriff himself who was quoted in the report as saying "we're sitting on a powder keg and I don't know what to do about it." Jail personnel told the SCC inspectors that the jail "was going to blow," and that they had "lost control" over the running of the jail and the inmate population. One officer stated he knew of no emergency plans of any type and had never been instructed on what to do in case of emergency except "yell." If an unusual incident occurred, the procedure was to summon the Sergeant from his home, 25 miles away. There were other allegations by officers identified by name in the report, that certain jail personnel gamble with inmates, that corrections officers returning from the SCC's training courses were not allowed to apply their training, etc.

This *Special Report* was reviewed by the SCC Commissioners at their monthly meetings of March 19 and April 9, 1974. At the March 19th meeting, the Administrator stated:

"We feel that the whole situation is very explosive and we also are quite sure that the only thing that is pre-

venting violent reaction on the part of the inmates is that they anticipate some form of relief to rectify the situation."*

He further stated, "I don't think this is something that can be delayed at all because at any minute, it can blow up." After reviewing the *Special Report*, the SCC decided to bring these matters to the Sheriff's attention and permit him an opportunity to correct things. Failing that the SCC would institute proceedings to close the jail.

On April 16, 1974, an SCC inspector was approached by an inmate at Dutchess County Jail who asked to speak with him privately. The inmate then turned over to the inspector an envelope containing approximately 50 assorted pills and stated that other inmates also had such drugs.

On April 17, the Administrator and other SCC staff personnel met with the Sheriff and turned over to him its information concerning the alleged involvement by two of his men in smuggling drugs and other contraband into the jail.

The wisdom of entrusting to the Sheriff the responsibility of doing something about drugs in his jail was evidenced on May 4 when an inmate was taken to the hospital to have his stomach pumped out after ingesting approximately eight tranquilizers. Further evidence of the Sheriff's laxity in operating his jail properly was seen on May 9 with the escape of two inmates who somehow were able to obtain a saw blade. After this happened, the Sheriff stated he was going to institute new search procedures. On May 14 the Sheriff appeared before the SCC in Albany. The Sheriff stated that he had investigated the allegations of improper conduct by his officers and they were "unfounded." He claimed that a search of his jail had disclosed no drugs; denied other charges made by SCC inspectors; and claimed that all SCC rules and regulations were being followed. The SCC then met in executive session and decided to "let the matter rest for another month" and reinspect the facility in June.

On June 13, a different SCC inspector was sent to the Dutchess County Jail. According to his own testimony before this Commission on June 9, 1975, his instructions were "very narrow and very limited" (360). He was not given, nor did he

* According to the records of the SCC covering the period of 1973 and 1974, not one of the seven Commissioners ever visited Dutchess County Jail during those two years.

see, the *Special Report* of March 18 described above, which was the subject of discussion at the SCC's monthly meetings of March and April and which the SCC discussed with the Sheriff on May 14. The inspector sent to the Dutchess County Jail on June 13 went there to reinspect the facility in order to determine whether the recommendations contained in a different SCC Regular Report were being complied with. The inspector visited the jail and also inspected Ulster County Jail on the same day. Based upon this brief and routine inspection, which did not address itself to the conditions reported in the March 18 *Special Report*, the SCC decided to give the Dutchess County Jail another reprieve.

Unfortunately, history repeated itself, and the complaints by inmates which the SCC never investigated, plus the warnings which it had received over the years from its own inspectors and other sources concerning, among other things, inadequate supervision, deficient medical care, and ignorance by jail personnel of how to handle emergency situations, resulted in tragic consequences.

The events which took place at Dutchess County Jail subsequent to the SCC's decision to rely, once again, on the Sheriff's willingness to clean his own house, reveal the SCC's persistent and adamant refusal to act affirmatively and the cost of such refusal.

On August 19, 1974, the SCC received a letter from Senator Jacob Javits forwarding a letter signed by 12 inmates of Dutchess County Jail, complaining of their treatment and alleging that the jail officials were denying them certain basic needs. (The files of the SCC reveal that inmates had previously complained to SCC inspectors about the same matters.) The SCC did not investigate this letter, but merely forwarded it to the Sheriff for comment. The Sheriff responded by saying the complaints were unfounded, and the SCC accepted this response without question.

On December 30, 1974, there was an evaluation of medical procedures at the jail by the Dutchess County Commissioner of Health. Many deficiencies were reported and a number of recommendations were made, none of which were being implemented by jail officials as of that date.

On January 15, 1975, a Dutchess County Jail inmate died, and a subsequent investigation into the circumstances of his death and the medical care he received while at the jail re-

vealed the following facts. The inmate had a diseased liver and two duodenal ulcers. According to the SCC's records, despite his serious medical condition and his history of poor health, he received no special diet. Although this inmate repeatedly coughed up blood, he was afforded no special attention by the jail physician. It was not until he showed jail personnel a sample of his stool laced with blood that he was finally hospitalized. On one occasion when he was brought from the hospital to court, he was clothed only in prison denims and a shirt, without any underwear, and the transporting officers refused to accept a coat and warm clothing which his mother and brother had tried to give him as he was being led down the hospital corridor. The investigation of this case by the SCC indicated that the lack of care he received at the jail may have hastened his death.

On March 19, 1975, an inmate who had previously written the SCC to complain about conditions at Dutchess County Jail committed suicide by hanging. One letter from this inmate had been received by the SCC on March 7, 1975, and on March 13 the SCC replied to him that an inspection of the jail by SCC staff had revealed conditions at the jail were not as alleged by the inmate and that his complaints, generally, did not appear valid. The letter concluded by advising the inmate that another inspector would shortly visit the jail "and if you are still there he will be talking to you." The inmate committed suicide within days after this letter was sent.

On March 21, 1975, a 19-year old inmate committed suicide in Dutchess County Jail. The guard on duty had corrected vision of 20/150 in one eye and 20/200 in the other eye and was unable to read a sign 10 feet away from him. When the suspended body was discovered, prison officers insisted it be left hanging until the doctor arrived.

On March 22, another inmate attempted suicide by hanging himself with a bed sheet but was saved by fellow inmates who cut him down.

A few days later, there was another attempted suicide by a different inmate, followed, over the next several days by inmate disturbances and the taking of a guard as hostage. It was not until April of 1975, after a series of newspaper articles critical of the SCC appeared in the Albany press and the initiation of official investigations of the SCC by other governmental agencies that the SCC took some affirmative action. The SCC finally assigned members of its staff to monitor all procedures at the jail, and held a special meeting to review the situation at that institution.

The Dutchess County Jail is but one example of the SCC's failure. It also underscores the principle that the acceptance of public office is the inseparable companion of public responsibility. Undoubtedly the Commissioners of the SCC are decent men and women, but more was required.

RECOMMENDATIONS

The administration of correctional institutions is one of the most difficult tasks facing government. For this challenge to be met there must be a commitment at all levels of government by those having the responsibility to see to it that correctional institutions are properly administered with due regard for the interests of prisoners, correction staffs and the public.

The role of the Commission of Correction is an extremely important one for it has the responsibility to oversee correctional institutions, develop methods for improving these institutions and take appropriate actions, where necessary, to enforce compliance with SCC standards. Such vast responsibilities suggest that the persons selected as commissioners be persons who have expressed interest in the humane administration of correctional institutions. They should serve on a full-time basis, at a compensation designed to attract the best persons available, and capable of acting independently with full appreciation of their responsibilities and authority. These commissioners, in turn, must select a staff capable of investigating incidents and recognizing potentially troublesome situations which require correction before they become incidents. For the commissioners and their staff to function effectively they must, of course, be given adequate budgetary support.

The SCC should establish an effective method for receiving and acting upon allegations of improper administration. In addition, surprise, unannounced inspections at any hour, should be instituted by the SCC. With respect to State institutions, the SCC's role should be clarified so that both those responsible for State institutions and the Commission know what is required of them.

The SCC should revise and update its minimum standards so that they are suitable to today's needs and environment. Such

standards should include not only the physical conditions of the jails, but qualifications and training for personnel employed in these jails. Furthermore, the SCC should develop programs and research with respect to improving medical and psychiatric treatment, recreation and vocational rehabilitation.

Given the wide geographical distribution of correctional facilities, consideration should be given to the need for regional offices of the SCC.

The Commission should not be afraid of using all of its power to compel those responsible for local institutions to administer them in a lawful and proper manner. In appropriate cases, the SCC should not hesitate to recommend to the Governor the removal of a sheriff who has demonstrated his refusal or inability to discharge his responsibilities.

In addition, the SCC should develop an effective liaison with the Governor's office and the Legislature. Maintaining these relationships will keep the Executive Chamber and the Legislature well informed about the SCC's problems and will be critical to the implementation of programs considered desirable by the SCC.

The SCC should make greater use of public hearings and the issuance of public reports to enlist public support for needed changes and improvement of conditions in correctional institutions.

Finally, it is suggested that a serious study be undertaken of the current system of county correctional institutions. This study should review the desirability of continuing to entrust to the sheriff the administration of such facilities.

Respectfully submitted,

DAVID W. BROWN, *Chairman*

EARL W. BRYDGES, JR.
FERDINAND J. MONDELLO
ROBERT K. RUSKIN

June 16, 1975

REPORT OF AN INVESTIGATION OF CERTAIN CONTRACTING PRACTICES AND PROCEDURES OF THE NEW YORK CITY BOARD OF EDUCATION AND RELATED MATTERS

INTRODUCTION

This investigation resulted from complaints which the Commission originally received in 1973 concerning certain contracting practices and procedures of the New York City Board of Education. Inquiry was subsequently undertaken with particular reference to the awarding of work by the Board of Education to a computer firm known as Computer Specifics Corporation (Computer Specifics) for processing payrolls for paraprofessional employees and evaluation of educational programs. This investigation led the Commission to review certain matters involving the State Department of Education and the State Department of Audit and Control.

During the course of the investigation, numerous witnesses were interviewed and examined under oath, and the books and records of a number of corporations were audited. Certain key witnesses attempted to thwart and delay the Commission's investigation by refusing to make records available for examination by the Commission's accountants and by refusing to testify personally on a number of grounds. These tactics resulted in time-consuming litigation in which the Commission's right to the books and records was upheld.

I

THE NEW YORK CITY BOARD OF EDUCATION AND COMPUTER SPECIFICS CORPORATION

Between November 1969 and November 1974, the Board of Education engaged a corporation known as Computer Specifics to perform certain payroll accounting tasks and other computer functions. Computer Specifics received over two million dollars from the Board of Education during this five-year period for these services.

Investigation by this Commission reveals that the transactions between Computer Specifics and the Board of Education involved conflicts of interest between employees of the Board and Computer Specifics, the payment of money and gifts to employees of the Board, the failure of the Board to properly con-

tract with Computer Specifics and the misuse of the imprest fund* available to the Board. This Commission estimates that if the Board of Education had, instead, followed proper procedures it could have saved the City of New York approximately one-half of what it spent on this project. It could have saved approximately one million dollars.

A Board of Education Employee Enters the Computer Field

From June 1968 until October 1969, Mr. Seymour Sayetta was employed as an accountant by the Board of Education. In this capacity he worked on the "E-Bank payroll"—the payroll for paraprofessional employees of the Board of Education. During 1968 and 1969, the Board of Education had experienced difficulties in processing this payroll.

Sometime during the first quarter of 1969 (and prior to the formation of Computer Specifics) Mr. Seymour Sayetta and Mr. Joseph Pape, at that time a Deputy Clerk, Supreme Court, New York County, approached E.P.G. Computer Services, Inc. (E.P.G.) with a proposal. Under this proposal, E.P.G. would receive computer work from the Board of Education in return for which Messrs. Pape and Sayetta would receive an interest in E.P.G. On the advice of counsel, E.P.G. declined this offer on the ground that it would be improper in light of the governmental positions held by Messrs. Pape and Sayetta.**

Subsequently, Mr. Sayetta and Mr. Pape formed a company to computerize the production of the "E-Bank payroll." In April 1969, Computer Specifics was incorporated.

As of the Spring of 1969, the paraprofessional employees on the "E-Bank payroll" were being paid in large part by emergency checks issued from the imprest fund. At the same time a corporation known as Specialized Data Services Corporation (SDS) was hired by the Board to develop a program for the computerization of this payroll. Employees at the Board of Education under the direction of Lawrence Berke and Edgar Noguarola were also attempting to develop a computer program. During the Summer of 1969, SDS produced payrolls but in the Fall of that year stopped because of a contract dispute. At a

* An imprest fund is designed for advancing funds which, for one reason or another, cannot be disbursed through the usual payment method and are generally for small amounts.

** Section 801 of the General Municipal Law prohibits a municipal employee from having an interest in municipal contracts and a violation of this law is a Class A misdemeanor.

meeting to discuss this problem, Noguarola and Sayetta recommended that SDS not be paid additional monies and that the services of SDS be terminated (2905).* Berke, who was also at that meeting, recommended paying the additional amount. As noted, Mr. Sayetta at that time was involved with a corporation which was to become a competitor of SDS. It further appears that Mr. Noguarola had some financial involvement with Computer Specifics.**

Although Computer Specifics was not to be given any Board of Education authorization to proceed with developing a computerized payroll until November 1969, Computer Specifics wrote checks payable to cash totaling $8310 between May 9 and August 24, 1969. Included in this total was a check for cash in the amount of $4,500 dated August 24, 1969. While the Commission was unable to determine the use made of this extensive amount of cash proceeds, a witness before the Commission testified that Mr. Sayetta had told him that he had paid "several thousand dollars" to a high-ranking Board employee (4741).

The two principals of Computer Specifics refused to testify before the Commission—Mr. Sayetta, after one appearance, on the ground that he was too ill, and Mr. Pape, on the ground that his answers might tend to incriminate him.

In October 1969, Mr. Sayetta resigned his employment with the Board of Education. On November 26, 1969, Deputy Superintendent of Schools, Benjamin Gamsu, wrote a letter to Computer Specifics authorizing it to proceed with test payrolls. This letter said in part:

> "It is the intent that the Computer Specifics will do the two payrolls indicated above until such time as the decentralization of the Board of Education becomes effective. A contract will be formalized after we know the price, what specific information, completely detailed, will be furnished by Computer Specifics, all such documents to be reviewed by and approved by PPB and MIDP. In addition, it is the intent of the Board of Education to purchase the software*** which is used to process the payrolls.

* References in parenthesis are to page numbers of testimony.

** In July 1969, Mr. Noguarola received a check for $25 for "consultation on P/R" (4711) and in December 1970, he received $200-300 in cash as a Christmas gift (4689).

*** "Software" refers to the programming and processing materials used in the computers such as tapes and keypunch cards.

> We anticipate that if the payroll system and procedures are successful, we will ask Computer Specifics to work with MIDP in developing systems for other payrolls."

Upon receiving this letter, Messrs. Sayetta and Pape, on behalf of Computer Specifics, again contacted E.P.G. They informed E.P.G. that they were no longer employed by any governmental agency and now headed a company known as Computer Specifics. After a series of negotiations, E.P.G. agreed to develop a payroll system, including the software, for the "E-Bank payrolls" for $45,000. Subsequently, Computer Specifics charged the Board of Education $180,000 for the same work.

Mr. Sayetta's activities in securing this work should be viewed in light of Section 1106-3.0 of the Administrative Code of the City of New York. This section makes it a misdemeanor for a former employee of the City, within two years after the termination of his employment, to receive compensation "in relation to any case, proceeding or application with respect to which such person was directly concerned or in which he personally participated during the period of his service or employment, or which was under his active consideration or with respect to which knowledge or information was made available to him" during the period of his employment with the City.

On February 11, 1970, Mr. Gamsu stated in a letter to Computer Specifics that the processing of payrolls E-743 and E-744 had been substantially accomplished and performed in a satisfactory manner. This letter further stated:

> "Pending the negotiation of a formal contract between the Board of Education and Computer Specifics Corporation, such processing will be paid on a week to week basis."

As a result of the November 1969 and February 1970 letters to Computer Specifics, a Deputy Superintendent of Schools engaged a firm to do computer work without any competitive bidding, written contract, or agreement as to the price to be charged for such services. Moreover, although Board of Education by-laws require the members of the Board to approve contracts above $5,000, they did not approve and apparently, at this time, did not even know of the transaction.

Misuse of the Imprest Fund

Since no formal contract existed, Computer Specifics could not be paid in the normal manner by the City Comptroller. Instead, Computer Specifics submitted a series of bills, each for less than $5,000 which were paid out of an imprest fund. Each bill was for less than $5,000 because Board of Education regulations prohibited payments in excess of this sum out of imprest funds. Yet, by February 11, 1970, bills submitted by Computer Specifics already totalled over $20,000.

This misuse of the imprest fund was noted by the Board of Education's audit department. On February 20, 1970, Leon Marlowe, then director of this bureau, wrote to Dr. Nathan Brown, then Superintendent of Schools. This letter referred to the use of the imprest fund as "an obvious attempt to circumvent the Board of Education by-laws." It went on to characterize the bills submitted by Computer Specifics as "meager and in some cases misleading." According to this letter, the lack of detail together with "the fact that no contract has ever been negotiated with the firm detailing processing charges makes it impossible . . . to audit the accuracy of the amounts claimed."

Despite this letter, payments continued to be made from the imprest fund. On July 20, 1971, (18 months later) Helene M. Lloyd, Assistant Superintendent, wrote to Joseph Kratovil, who had become Executive Director for Business and Administration, that "if it is possible, no further work should be contracted with this corporation without a Board resolution." Mr. Kratovil, who socialized with Mr. Sayetta and had obtained an apartment through him, did not follow this suggestion and payments to Computer Specifics from the imprest fund continued until November 1974—after this Commission's investigation had become publicly known.* The total amount paid to Computer Specifics was $2,488,192.03.

The Payment for Development Costs

The November 26, 1969 letter from Benjamin Gamsu stated that "it is the intent of the Board of Education to purchase the software which is used to process the payrolls." Yet no written agreement was ever entered into regarding the purchase of the software from Computer Specifics.

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* As the result of litigation, the Commission's investigation was first reported in the press on June 18, 1974.

Instead, in November 1970, Computer Specifics commenced to bill $3,000 a week for software. Apparently, sometime prior to that time a verbal agreement had been entered into by Mr. Gamsu on behalf of the Board of Education to pay Computer Specifics a total of $180,000 for the software in 60 payments of $3,000 each (5405). This verbal agreement was never confirmed or acknowledged in writing. Under the terms of this verbal agreement, the Board of Education was to receive the software so it could thereafter process the material on its own computer, if it chose, upon payment of this $180,000.

By the end of January 1972, Computer Specifics had billed for 59 payments and had received a total of $177,000. Computer Specifics never sent the final bill for the last $3,000 and the Board of Education has never received the software to which the Board of Education was presumably entitled under this verbal agreement. As previously noted, the cost to Computer Specifics for developing this software initially was only $45,000. Thus, on this one phase alone, Computer Specifics not only made a profit of $132,000 but retained possession of the software.

Computer Specifics as a Broker

Until early 1972 when E.P.G. went into bankruptcy, Computer Specifics relied primarily on E.P.G. for the computer work on the payrolls. The entire computer program was written by personnel at E.P.G. Modifications were made to it by E.P.G. personnel and the data was processed on E.P.G. computers. E.P.G. billed Computer Specifics for its work and Computer Specifics, after approximately doubling and tripling the bills, billed the Board of Education for the same work. (See Appendix A) Indeed, Computer Specifics, prior to 1972, consisted only of Mr. Sayetta, a former Board of Education accountant; Mr. Pape, a former Supreme Court clerk; and a secretary.

After June 1972, Computer Specifics employed some persons with experience in computer work—mostly former E.P.G. employees—and farmed out to various other companies the mechanical operations such as key punching and processing.

The status of broker, of course, would clearly indicate to the Board of Education that it was paying more to Computer Specifics than it would have had to pay had it gone directly to the computer company involved. Apparently for this reason Computer Specifics concealed its status as a broker.

Thus, Computer Specifics informed people at the Board of Education that some of the key personnel at E.P.G. were in fact employees of Computer Specifics (3048). Furthermore, Computer Specifics had E.P.G. place Computer Specifics' name on the door to E.P.G.'s offices (3055). Computer Specifics took people from the Board of Education to E.P.G.'s offices and plant in order to impress upon them Computer Specifics' resources when in fact the visitors were viewing E.P.G.'s equipment.

The audit by the Commission indicates that if the Board of Education had used a computing firm and not a broker, it could have saved over one million dollars during the course of this arrangement. (See Appendix B for analysis.)

The Department of Audit and Control Report

On October 13, 1972, the Department of Audit and Control filed a report with respect to the transactions between the Board of Education and Computer Specifics. This report disclosed that as of that time, $1.2 million had been spent by the Board of Education "over three years without a formal contract or any known board resolution." The report found Computer Specifics was splitting invoices in order to circumvent both the City Comptroller's and the Board of Education's own regulations regarding the use of imprest funds, had not obtained the business by bidding and had not supplied any data to support the reasonableness of its charges.*

In addition, the report also noted that Section 1106-3.0 of the Administrative Code of the City of New York, which prohibits a former New York City employee from being employed for two years following his employment by a corporation doing business with the Board of Education in a capacity relating to the prior employment, appeared to have been violated. The report went on to say in this regard that the Board of Education's business administrator and assistant administrator "at the time were aware of or should have been aware of this relationship as correspondence from them discussing the assignment of this work to COMSPEC** . . . was addressed specifically to this individual, and former employee." (P. 4 of Audit)

* Board of Education By-Law Section 71.1 requires public advertisement for all contracts where "the cost . . . may exceed five thousand dollars . . . ." The explanation in the resolution states that the Board will remain "more protective of the bid process than the Education law requires" and will dispense with it even for lesser amounts only where "immediately required."

** Computer Specifics was sometimes referred to as COMSPEC.

On October 24, 1972, Acting Director of the Bureau of Audit of the Board of Education, Mr. Harry B. Newman, in a memorandum to Mr. Irving Anker, then Deputy Chancellor for the Board of Education, stated:

> "The State, in its report, appears to be generally correct in their findings and we are in agreement with their recommendations."

This memorandum went on to state:

> "Regrettably, it appears that the improper procedures involved in the processing of payments to COMSPEC have been continued for too long a period beyond the time and the urgency and need of their services could possibly justify the unusual method of payment to them."

This memorandum suggested that a task force be created under Mr. Kratovil's direction to resolve this matter without delay.

On December 11, 1972, a story appeared in the *New York Times* based upon the State Comptroller's report. On December 15, 1972, the then Chancellor of the Board of Education, Harvey B. Scribner, sent a memorandum to all members of the Board of Education requesting that the item regarding Computer Specifics be discussed "at the next informal meeting of the Board of Education." (Informal discussions by the Board are not open to the public.)

Attached to Mr. Scribner's memorandum was a memorandum from Mr. Kratovil to Mr. Scribner of that same date giving a history and status of the Computer Specifics transactions. Mr. Kratovil's report noted that the City Comptroller had, after the report of the State Comptroller, refused to process and pay the monies expended by the Board of Education from the imprest fund for the services of Computer Specifics. Mr. Kratovil recommended that a non-competitive contract be negotiated with Computer Specifics.

The Failure of the Board of Education to Correct the Situation

Despite the report of the Department of Audit and Control and the report to the members of the Board of Education, the Board of Education continued to pay Computer Specifics through funds available from the imprest fund until November 1974. Between January 1, 1973 and November of 1974, Computer Specifics was paid $1,074,044.73 by the Board of Education from imprest funds. Apparently, even though the City Comptroller continued to refuse to reimburse the Board of Education for these imprest funds, the Board of Education had sufficient extra funds to continue to operate its imprest system despite the lack of reimbursement by the City Comptroller.*

Although the record indicates that Board of Education employees ostensibly attempted to enter into a contract with Computer Specifics and Computer Specifics ostensibly wanted to enter into a formal contract with the Board, nevertheless, no such contract was consummated. The Board of Education's position was that before it could enter into a non-competitive contract with Computer Specifics, it had to audit Computer Specifics to determine what a reasonable price for the contract should be. According to Mr. Harry B. Newman, Director of the Bureau of Audit for the Board of Education, Computer Specifics agreed to allow the Bureau of Audit to commence their audit on June 11, 1973. However, on June 7, 1973, Mr. Sayetta claimed that he had to be personally present at all audits, even though the Bureau of Audit did not find his presence necessary, and that he could not work full-time because of a heart condition. He also claimed that items relating to overhead and other types of expenditures not directly chargeable to the Board of Education could not be audited. As a result, Mr. Newman concluded in a memorandum dated June 11, 1973 to Acting Chancellor Irving Anker, that the audit, as limited by Mr. Sayetta, "could not possibly enable us to determine the reasonableness of the company's charges or the presence of any irregularities in its operations."

On August 23, 1973, Mr. Anker in a memorandum to Mr. Kratovil directed him to proceed with dispatch in this matter and stated that "there will be no waiving of audit requirements from any source."

Despite this directive, a meeting was held on October 16, 1973, between the Chancellor and the president of Computer Specifics, wherein it was agreed that a meeting would be held between representatives of the Board of Education and Computer Specifics on October 19 with respect to the audit materials. But this meeting was postponed by Computer Specifics until October 30. A meeting was held on October 30, 1973, but this

* On May 12, 1975, the City Comptroller reimbursed the Board of Education for these funds.

also proved to be unsuccessful for no agreement was arrived at with respect to the audit materials.

In the first quarter of 1974, the State Comptroller reported that:

> "Our current review indicated that no corrective action had been taken between the time we issued our last report in November 1972 and the end of January 1974 to remedy this situation."

Indeed, despite these memoranda and letters, the Board of Education failed to correct the situation until after this Commission's investigation became known to the Board and the public.

Representatives from the Board of Education claimed that the Board could not precipitously terminate Computer Specifics' services out of fear that the paraprofessionals on the payroll being administered by Computer Specifics might not get paid (5408-9). Nevertheless, in November 1974, after this Commission's investigation was publicly disclosed, the Board of Education stopped using Computer Specifics and found that it was able to process the payrolls without Computer Specifics.

The Board of Education, however, had to develop its own program for the payroll because the software developed by Computer Specifics for the Board of Education had, as noted, never been delivered to the Board. In an attempt to obtain the software, the Board of Education, under the direction of Deputy Chancellor Bernard Gifford, conducted a "raid" on November 15, 1974 on the offices of Computer Specifics in an attempt to seize this material by force. It appears, however, that this raid was unsuccessful in that the material recovered did not include the software for which the Board of Education paid.

Gifts to Employees of the Board of Education

The investigation by this Commission determined that Computer Specifics made a practice of giving gifts, large and small, to employees of the Board of Education.

As previously noted, between May and August, 1969, when the company was established, cash in the amount of $8,310 was raised and disbursed. According to sworn testimony by a witness before this Commission, Mr. Sayetta told him that he had paid a high ranking employee of the Board of Education "several thousand dollars" and that he had supplied this same high ranking employee with the services of prostitutes (4741).

The Commission also found that during the period 1970 through November 1974, Computer Specifics raised a cash fund of approximately $55,000 by surreptitious means. For example, checks totaling $18,000 were written by Computer Specifics and made payable to a restaurant supply company, an interior design firm and a liquor store. However, the Commission's investigation revealed that these concerns did not supply any goods or services to Computer Specifics, but merely cashed the checks made payable to them and delivered the cash to Joseph Pape (4583-8; 5260-5). In addition, checks totaling $32,000, payable to Mr. Pape's sisters, were generally endorsed and cashed by employees of Computer Specifics and given to Mr. Pape (3872; 3878). Between July 1973 and February 1974, checks totaling over $3,000 were also written for a consultant whose services had terminated in mid-1970 and were cashed without this consultant's knowledge. Finally, checks totaling $1,730 were found payable to such apparently fictitious characters as "Ralph Blintzer" and "Sidney Bagle."

Mr. Joseph Kratovil, who was employed in February 1971 by the Board of Education as Executive Director for Business and Administration, was introduced to Mr. Sayetta by another Board employee. In turn, Mr. Sayetta arranged to have Mr. Kratovil occupy an apartment in the Hampshire House owned by Computer Specifics' accountant at a rental of $400 per month, when the maintenance on the apartment cost $460 per month (Mr. Kratovil did not live in the New York area prior to his employment by the Board of Education). In addition, Mr. Kratovil socialized with Mr. Sayetta and was introduced by him to a woman who, it subsequently developed, turned out to be a prostitute in Computer Specifics' employ.

After these facts were developed by this Commission's investigation, Mr. Kratovil informed Chancellor Irving Anker that he had dated a woman whom he had met through Mr. Sayetta. On December 2, 1974, Mr. Anker sent a letter to Mr. Kratovil reprimanding him for his conduct. This letter concluded:

> "Without attempting to prejudge matters which are presently under inquiry both within and outside of the Board of Education, I am sending this letter as a reprimand based on my judgment that your relationships with officials of Computer Specifics Corporation involved indiscretion on your part in accepting special

favors from officials of the Corporation. As Executive Director, your conduct must be above reproach or suspicion so that the public can be assured that our employees work in the interest of the public. I have no reason to doubt that you have acted on any basis other than the public interest. Nevertheless, I believe that you showed lack of discretion in your past dealings with the officers of this Corporation and that this letter is appropriate under the circumstances."

Mr. Clifford Goodman, an associate accountant at the Board of Education, was indicted by the Manhattan District Attorney's Office for perjury first degree before this Commission and pleaded guilty to the charge of perjury third degree. This Commission's investigation revealed that he received payments from Computer Specifics. The total paid to either Mr. Goodman or his family during the period January 1969 through March 1974 was $6,118.24. Payments were made either by cash or by check payable to Mr. Goodman, members of his family or other persons. During the relevant periods of time, Mr. Goodman worked closely with Computer Specifics in transmitting information from the Board of Education to Computer Specifics in order to help Computer Specifics develop and maintain the payroll programs.

Mr. Lawrence Berke was employed by the Board of Education in 1967 as a management analyst trainee and by 1969 had been promoted to assistant methods analyst. As such he was given the task with others of reorganizing the paraprofessional payroll and developing basic data requirements for computerizing this payroll. At his first hearing before this Commission, Mr. Berke denied ever receiving any money from Computer Specifics (2945). Subsequently, Mr. Berke requested an opportunity to return for the purpose of correcting his testimony. He then admitted that he had received two Christmas gifts in 1969 and 1970 of $30 each in cash, $50 in cash in January 1971 as a housewarming gift, and a check in December 1970 in the amount of $224.53 payable to Ingrid Groman. Mr. Berke claimed this check represented "reimbursement for dinner expenses" on occasions when he was working overtime for the Board of Education at the offices of Computer Specifics (4727). Ingrid Groman was the maiden name of the wife of another Board of Education employee, but the check was in fact endorsed in her name by Clifford Goodman—another Board of Education employee. According to Mr. Berke, Mr. Sayetta stated that the reason for the use of Ingrid Groman's name was that "he did not want it to look like (Berke) was in the employ" of Computer Specifics (4746). Mr. Berke also admitted receiving a digital clock-radio and a 14k gold pen. As to the clock-radio, Mr. Berke testified that these gifts were "all over the Board" (4743). Mr. Berke testified that he was also offered the services of a prostitute by Mr. Sayetta "on several occasions" and that at least one other Board of Education employee was present during the time of these offers (4734). Mr. Berke stated he declined these offers (4737).

Another employee to whom gifts were given was Norton Morgenthal, Director of Management Information Planning in the office of Programming, Planning and Budgeting. Mr. Morgenthal had been involved in the original meeting of November 26, 1969 which resulted in the engagement of Computer Specifics to provide payroll services. Mr. Morgenthal also apparently drafted a report for Computer Specifics which Computer Specifics forwarded to the Board of Education as its own program and which resulted in a separate $20,000 contract between the Board of Education and Computer Specifics for the computerization of textbook procurement.

Finally, Mr. Morgenthal was also involved in awarding a contract for $175,000 to a company called Anathon Corporation which at the time was in the process of merging with Computer Specifics. It appeared that Mr. Morgenthal and Mr. Victor Facio, who had known Mr. Pape for many years, were responsible for this award.* Moreover, although this was a bid contract, Computer Specifics' books, when the merger subsequently failed, indicated an account receivable from Anathon of five percent of $175,000 ($8,750). Computer Specifics claimed this fee on the ground that they had helped secure this contract.

Investigation by this Commission disclosed that Computer Specifics paid $1,437.30 for a Florida vacation in April 1973 for Mr. Morgenthal, his wife and two children. This case has been referred to the Kings County District Attorney's Office.

* Mr. Facio, a Board of Education employee, was subsequently discharged by the Board and re-hired by Mr. Morgenthal as a consultant. Mr. Facio admitted that he performed little work as a consultant for which he was paid $14,920, but spent most of his time looking for a new job (8923-25).

A Board of Education employee (Edgar Noguarola) assigned to the Board of Education computer center to help process and correct the errors found in the program of Computer Specifics, stated that at one time during the Christmas season, he received from Mr. Sayetta personally $200 to $300 in cash (4689).

Mr. Pape also attempted to pay the hotel bill of Elizabeth Cagan, Director of Reimbursable Programs at the Division of Business and Administration at the Board of Education when she was vacationing in Mexico. Mr. Pape's efforts, of which Ms. Cagan was not aware, were thwarted by the fact that she had paid for her vacation in advance. Ms. Cagan had the responsibility of approving many of the vouchers from Computer Specifics for payment under the imprest fund.

In addition to the foregoing items, the Commission also found indications of numerous small gifts made to various Board of Education employees.

Finally, the Commission discovered that Mr. Sayetta had apparently obtained certain Board of Education records relating to Board employees who may have committed certain improprieties. Mr. Berke testified that Mr. Sayetta obtained copies of the time sheets of certain Board of Education employees which would tend to show that these employees had billed the Board of Education for overtime even though they had not in fact worked that overtime. According to Mr. Berke, Mr. Sayetta told him that

> "If these guys give me any trouble, I will have their time records." (4748)

In short, the record demonstrates that Computer Specifics carried on a program of ingratiating itself with Board of Education employees and, to whatever extent it could, undermining their impartiality and judgment.

II

THE NEW YORK STATE DEPARTMENT OF AUDIT AND CONTROL AND COMPUTER SPECIFICS

Although the Department of Audit and Control criticized the relationship between the New York City Board of Education and Computer Specifics, this Commission found that certain branches of that Department were also involved with Computer

Specifics in questionable ways. Specifically, the Commission found that Computer Specifics obtained a contract for reprogramming certain data at the Department of Audit and Control for $88,000, even though the reprogramming seemed unnecessary and was never used. In addition, Computer Specifics obtained a letter from the Department of Audit and Control indicating that no conflict of interest existed between an officer of Computer Specifics and the Board of Education, despite an earlier finding by the auditors from the Department of Audit and Control that:

> ". . . it appears that the [Board of Education] violated the City Administrative Code, the City Charter, and its own policies relating to conflicts of interest."

The Reprogramming Contract

Because the programs for the Department of Audit and Control were written in a language called Autocoder, an obsolete language used for second generation computer equipment, the Department entered into a contract with IT&T to reprogram its data for the more modern computers. This would include reprogramming with the computer language COBOL.

Despite this contract, in February or March 1972, Deputy Comptroller for Administration Maurice Fleischman decided to translate some of the Retirement System programs from Autocoder to COBOL with another company (6862). He claimed this decision was based on the unduly long processing time required to run the Autocoder programs in simulation* and the uncertainty as to when, if ever, IT&T would complete its work (6775). While Mr. Fleischman had control and responsibility for the operation of the computer center, he did not have authority or responsibility for the computer programs of the Retirement System which were under the authority of a different deputy commissioner. The programming staff of the Retirement System, who were responsible for the computer programs, were opposed to any such translation effort, but were not informed of it until the decision had already been made.

According to Mr. Fleischman, he asked his director of Electronic Data Processing, Mr. John L. Dorman, to check with IT&T and secure the names of companies that might be able to

* A process in which modern computers were operated to simulate the old ones, thus allowing the older programs to be used on the modern machines.

translate Autocoder programs into COBOL with a minimum of manual intervention (6789). IBM had already informed Mr. Dorman (and through Mr. Dorman, Mr. Fleischman) that they deemed such a translation impossible and could not themselves do it. According to the testimony of Mr. Fleischman, Mr. Dorman, after checking with IT&T, received the names of several computer companies and after checking with these companies found only one, Computer Specifics, which said it was able and willing to do the work (6871 and 6894).

Although Mr. Dorman initially confirmed Mr. Fleischman's testimony, Mr. Dorman subsequently recanted this testimony and in a signed statement submitted to the Commission, Mr. Dorman stated that he had not received the name Computer Specifics from IT&T but from Mr. Fleischman. In a subsequent interview with the Commission, Mr. Dorman stated that he had the distinct impression that Mr. Fleischman gave him the name Computer Specifics, not as a possible vendor but as *the* vendor who would do the work.* Indeed, when the representative of IT&T who had spoken with Mr. Dorman was questioned, he stated that he had supplied names of some companies to Mr. Dorman but he had never heard of Computer Specifics.

In any event, in March 1972, Computer Specifics entered into an agreement with the Department of Audit and Control to reprogram 22 programs at a cost of $4,000 per program. Mr. Dorman testified that when he told Mr. Fleischman that the price was too high, Mr. Fleischman stated, "He respected my opinion, but that we had to go ahead with it." (6839)

Another unusual circumstance concerning this contract was the manner in which the contract was drafted. The contract was drafted by Finance Officer Daniel Pagano, per Mr. Fleischman's instructions, without any review by any member of the Legal Division of the Department of Audit and Control. Mr. Pagano conceded in testimony before this Commission that this was the only contract that he had ever drafted by himself during his many years in that Department.

During July, August and September 1972, Computer Specifics submitted allegedly translated programs to the Department of Audit and Control. Promptly upon receipt of "translated programs," Mr. Dorman authorized payment of the agreed

*Mr. Fleischman had previously met Mr. Pape. The Commission received testimony that on one occasion a case of wine purchased by Computer Specifics was delivered to Mr. Fleischman's home in Albany (6959-62).

upon price to Computer Specifics. The only exception was on September 15, 1972. On that date, Mr. Dorman sent the last voucher from Computer Specifics to Mr. Pagano with the direction that the check be drawn but not delivered until the final tests were completed. Nonetheless, the check was issued and delivered and was deposited by Computer Specifics into its account on September 20, 1972. The Commission's investigation disclosed that as of September 20, 1972, not one of the 22 programs allegedly translated by Computer Specifics was in a workable, functioning state; yet, the entire $88,000 had been paid.

For the next several months, efforts were made by Computer Specifics and technicians from both the Retirement and Administrative Divisions of the Department of Audit and Control to modify, repair, and correct the translated programs so as to make them workable. One programmer from the Retirement Division advised this Commission that for six months he devoted approximately half of his time to this project. It was during this period that the Department of Audit and Control learned that Computer Specifics was basically "brokering" this project, in that the actual translation program had been written and developed by a company near Buffalo.

Eventually, a decision was made to concentrate the repair efforts on two of the 22 programs—the Post and Update Programs. After considerable effort, the Post Program was successfully tested in the early Spring of 1973. According to information received by this Commission, the Update Program may have also tested successfully on or about this date.

During this testing period, representatives of the Retirement Division complained of the amount of work that was required of them. In the Fall of 1972, at a meeting on the Retirement System, Mr. Seymour Peltin, Chief State Accounts Auditor, voiced some of these objections to Comptroller Arthur Levitt. Mr. Levitt then directed his Deputy Comptroller for Audits and Accounts, Martin Ives, to conduct an inquiry into this matter. Mr. Ives assigned his Administrative Systems manager and former Chief Auditor, Raymond J. Ippolite, to review the contract. Mr. Ippolite concluded his review with a memorandum dated November 20, 1972. This report concluded that there was little justification in terms of costs or operations for this agreement in the first place, and that as of November 20, 1972, none of the programs was operable.

Of the 22 programs, 20 never worked.* Moreover, as to the two programs developed by Computer Specifics which may have worked, these programs were never used. Rather, the IT&T programs which had been contracted for prior to the Computer Specifics contract constitute the present operating system.

The Conflict of Interest Letter

As noted, the report of the Department of Audit and Control in November 1972 stated that there appeared to be a conflict of interest because Mr. Sayetta was formerly employed by the Board of Education in a capacity dealing with the very subject for which Computer Specifics was subsequently engaged as a contractor. According to Mr. William Volet, Executive Assistant to Comptroller Arthur Levitt, Mr. Volet received a call in March or April 1973 from Mr. Pape, whom he had known for 25 years, asking for an opinion letter from the Comptroller to the effect that there was no conflict of interest. Mr. Volet suggested that Mr. Pape put his request in writing. Mr. Pape subsequently visited Mr. Volet at his Albany office and brought with him a letter dated April 4, 1973 addressed to Comptroller Arthur Levitt, containing statements purporting to show that there was no conflict of interest and asking for a letter to this effect.

Associate Counsel Theodore Holmes testified before the Commission that it was the policy of the Comptroller's Office not to render opinions to private individuals but only at the request of public officials (5012). Mr. Holmes testified he raised this issue with Mr. Volet and Mr. Volet did not disagree such had been the policy of the Department of Audit and Control. Nevertheless, Mr. Volet directed Mr. Holmes to prepare a letter-opinion (5011-5014). Accordingly Mr. Holmes prepared and signed a letter on behalf of Comptroller Arthur Levitt dated April 5, 1973. This letter was addressed to Mr. Kratovil, even though Mr. Kratovil did not ask for the opinion. Mr. Holmes testified that Mr. Volet gave him Mr. Kratovil's name (5014). The letter stated in part:

> "We are aware of no provision of law or ruling which would prohibit the Board of Education from entering into a contract with a firm where it appears that an official of the firm had been employed by the Board of Education during a period that ended some four years ago."

* Written statement dated July 20, 1975 submitted to the Commmission by John L. Dorman.

This letter made no reference to the fact that the initial transaction was entered into immediately after Mr. Sayetta's employment with the Board of Education terminated in October 1969, and that the proposed contract four years later was the direct result of the first transaction. Mr. Holmes further stated that he had little more than read the applicable provision of the Administrative Code and had relied on Mr. Pape's letter for the facts even though these assertions offered as facts were not only inaccurate but contrary to what had been found by the Department's prior audit. Mr. Holmes conceded he knew of no instance, aside from this one, where a finding made in a prior audit was contradicted without first checking with the person who had done the audit (5014-42).

III

COST PLUS EVALUATION CONTRACTS

During the past five years and particularly in the early 70's, many new programs were developed in an attempt to deal with problems in urban education. Because evaluation of these programs was required, particularly under such acts as the State Education Program (Sec. 3602, New York State Education Law), the Board of Education and, after decentralization, the local school boards engaged persons and corporations for the purpose of evaluating the various programs.

The standard contract for evaluation provided reimbursement to the contractor of his cost plus overhead and profit up to a fixed amount.

While reviewing a number of these evaluation contracts entered into between the Board of Education and various contractors, on the basis of complaints received, the Commission had occasion to examine two such contracts involving Computer Specifics Corporation.

The first contract was for the school year 1970-71 for a sum not to exceed $6,500. On March 27, 1972, Computer Specifics submitted a bill totaling $6,350. This total included, according to the bill, payment for three consultants at the rates of $1,450,

$1,215, and $500. Although the evaluation contract was to evaluate English as a second language program, investigation by this Commission found no records indicating the hiring of any consultant with any expertise in this area.

Rather, the Commission's audit disclosed that the City Comptroller had allowed payment for three consultants in the following amounts: $1,189.19, $433.00, and $1,326.00. Based upon this information the Commission attempted to determine the identity of the persons receiving this money. The Commission found that checks payable to Theresa Roland, one of Mr. Pape's sisters, totaling precisely $1,189.19 were made out during October and November 1971 and presumably she was one of the "consultants." Mr. Spiewak, a vice president of Computer Specifics, testified that he had never seen Theresa Roland perform any services for Computer Specifics (3340-41).

As to the remaining two payments for "consultants," the Commission found that Mr. Spiewak, who had done some work for Computer Specifics, received $500 via a check payable in the name of his son. With respect to the third payment for a consultant, the Commission was unable to determine who in fact this person was. The books and records of Computer Specifics for this period disclosed numerous payments charged to "consultants' expenses" including payments of $1,805 to a prostitute,* approximately $4000 to Anna DeClara—another sister of Mr. Pape's—and approximately $2,400 to "Charles Pape."

The second contract secured by Computer Specifics was for a report on English as a second language program for the school year 1971-72 at a cost not to exceed $15,000. On July 26, 1972, Computer Specifics submitted a bill for $15,000. This bill listed $4,205 for supervisory personnel and $4,035 for two consultants.

Investigation by this Commission disclosed that included within these items were Mr. Pape's two sisters at a total of $3,800. Neither Anna DeClara nor Theresa Roland performed any consulting work at Computer Specifics. Hospital records indicate that during the relevant period, Theresa Roland was

* Another prostitute testifying before this Commission stated that Mr. Pape had said to her that "He had certain people, clients that would not accept, you know, money because they had money, but they'd like to meet a nice girl." (5110) It is appropriate to note that over 90 percent of Computer Specifics' income from computer services was derived from governmental clients.

very ill and in the hospital part of the time during which she was supposed to be working. Theresa Roland, who was born on January 24, 1898, died on June 21, 1973. Anna DeClara, in testimony before this Commission, admitted that she did not work on this evaluation project (6086-87; 6107-08).

Not only did Computer Specifics submit an invoice containing almost $4,000 for fees of non-existent consultants, but the report itself was sharply criticized and rejected by the Bureau of Education Research of the Board of Education. One reviewer described the report as follows:

> "Comparing the proposed and implemented evaluation objectives and methods reveals gross discrepancy. Cursory examination of a sample of components finds minimal resemblance between design and execution. The sections are characterized by loose description, missing information, overstatement and failure to provide data for the judgments and affirmations which are made. These inadequacies seem generalizable to the entire report."

Despite this negative report, the report was accepted on behalf of the Board of Education by the Administrator of this program, Miss Susan Friedwald, and paid for by the City Comptroller.

IV

THE STATE DEPARTMENT OF EDUCATION AND MIND, INC.

During the course of its investigation, the Commission learned that the Welfare Education Plan (WEP)* of the New York City Board of Education had purchased two mobile vans at an approximate cost of $200,000 at the direction of a member of the staff of the State Department of Education.

The Commission's investigation revealed that Monroe C. Neff, Director of the Division of Continuing Education of New York, had written a letter to the New York City Board of Education's coordinator of federally funded programs, who is the overall

* WEP is a program designed to furnish basic educational skills to welfare recipients.

supervisor of programs including the WEP program. In his letter, dated October 29, 1971, Mr. Neff stated:

> "Your welfare education funds were increased from $1.7 million to $3.5 million for this current year. I know with this great increase we will not be able to show the proper percentage increase in increased enrollments. Due to this, we need to try innovative pilot projects to see how we can better serve the welfare adults in basic education programs. This project that I am requesting you undertake immediately will be documentation that can be used with the Legislature during the next session."

The letter went on to say that "this pilot special project is to be contracted with Mind, Inc."

Since this letter came from the official at the State Department of Education who controlled the funding for the State and Federally supported programs, it is not surprising that a mobile unit was purchased from Mind, Inc. in 1972. The cost of this unit was $104,881.19.

Unknown, however, to the Board of Education and, at that time, to the State Department of Education was the fact that commencing in September of 1971 (one month before he wrote the letter referred to above), Mr. Neff was retained as a consultant to Mind, Inc. at a monthly retainer of $750. Although the agreement purported to be limited to services performed outside the State of New York, not only did Mr. Neff use his position within this State to further the fortunes of Mind, Inc., but he used his authority and position with the State Education Department as a basis for recommending the products of Mind, Inc. to other states. For example, in a letter on State Education Department letterhead dated September 28, 1971, Mr. Neff stated:

> "I have become familiar with what I think is an extremely valuable system of instruction for continuing education. . . . I feel that it could be used very successfully in your Adult Basic Education Programs. . . . We have had our staff at the New York State Education Department look at these materials, and they have a high regard for them. We are using them in our state.

> I am speaking of the materials system and programs that are offered by Mind, Inc. . . . As you see, I am very much impressed with their learning system."

Similarly, in March of 1972, in a letter sent to an official in Texas, he stated:

> "After seeing the program, it occurred to me that you might be interested in something that we are finding very successful in New York State and especially New York City. We have found that the instructional programs offered by Mind, Inc. are helping so greatly in continuing education. . . . We have found them very successful in New York State. . . ."

Nothing in these letters, of course, indicated that Mr. Neff was a paid consultant, or that he was acting in any capacity other than a disinterested official employed by the State of New York.

In December 1972, Mr. Neff again wrote to the New York City Board of Education's officer in charge of federally funded programs, in which he stated that $100,000 was included in the budget for expanding the mobile project. As a result of that letter in April 1973, another van was purchased from Mind, Inc., at a cost of $96,000.

In addition, Mr. Neff also secured material which would not otherwise have been available to Mind, Inc. Thus, Mr. Neff wrote to the Children's Television Workshop in November of 1971 (the producers of "Sesame Street"), and asked for data to help the Department of Education develop a program to reach adults, sixteen years and over. On December 15, 1971, Mr. Neff received a confidential research report used in developing "Sesame Street." This report, together with other information received from Children's Television Workshop, was turned over two days later to Mind, Inc., without Mr. Neff even keeping a copy of the material in the State Education Department's files.

In April 1973, Mr. Neff was suspended without pay by the Department of Education and charged with misconduct under Section 74, Public Officers Law. These charges alleged that Mr. Neff had violated this Section by receiving a fee of $750 a month, and using his position with the State Education Department to assist Mind, Inc. in obtaining a contract with the New York City Board of Education.

Before a hearing could be held, Mr. Neff resigned. In spite of Mr. Neff's conduct, a letter was written to him by a Deputy Commissioner in the Department of Education stating in part:

> "I'm sorry we'll be losing your services for it is easy to identify many very fine contributions you have made to the work of the State Education Department, and more importantly to the cause of continuing education in our State."

With that letter the State Education Department terminated this matter. Although the facts disclosed may have constituted violations of the criminal statutes of this State, the State Department of Education did not refer this matter to any prosecutorial authority or law enforcement agency.

CONCLUSION

It is hoped that this Commission's disclosures will provoke the governmental bodies involved to examine and improve their operations and procedures.

Corruption and favoritism must be erased from the governmental process and a greater concern shown by people in government for the public funds with which they are entrusted and for which they are accountable.

Toward these ends, the information and evidence collected by the Commission during this investigation is being referred to law enforcement and governmental bodies for consideration and appropriate action.

Respectfully submitted,

DAVID W. BROWN, *Chairman*
EARL W. BRYDGES, JR.
FERDINAND J. MONDELLO
ROBERT K. RUSKIN
Commissioners

October 31, 1975

APPENDIX A

Sample of Comparisons Between Computer Specifics' Cost from E.P.G. and Computer Specifics' Bills to The Board of Education

Payroll Period Ended	Payroll Banks	Computer Specifics' Billing to NYC Board of Education		E.P.G. Billings to Computer Specifics	Difference
12/3/69	E-743	3,900			
	E-744	4,000	7,900	5,700.00	2,200.00
12/17/69	E-743	2,500			
	E-744	3,200	5,700	3,800.00	1,900.00
7/8/70	E-743	2,300			
	E-744	2,900	5,200	3,800.00	1,400.00
8/5/70	E-743	2,500			
	E-744	3,200	5,700	3,300.00	2,400.00
9/23/70	E-743	2,500			
	E-744	3,200	5,700	2,722.93	2,977.07
8/10/71	E-741	3,750			
	E-743	2,700			
	E-744	3,500	9,950	2,486.11	7,463.89
11/2/71	E-741	3,750			
	E-743	2,700			
	E-744	3,500	9,950	4,193.69	5,756.31
5/16/72	E-741	4,350			
	E-743	3,975			
	E-744	3,950	12,275	4,448.68	7,826.32
5/30/72	E-741	4,350			
	E-743	3,975			
	E-744	3,950	12,275	4,159.84	8,115.16
6/13/72	E-741	4,350			
	E-743	3,975			
	E-744	3,950	12,275	4,324.28	7,950.72

APPENDIX B

Analysis of Excess Costs to the NYC Board of Education for Services Rendered by Computer Specifics

(Source: Records of Computer Specifics Corporation)

Description	F/Y/E* 4/30/70	F/Y/E 4/30/71	F/Y/E 4/30/72	F/Y/E 4/30/73	F/Y/E 4/30/74	Totals
Computer Specifics' Total Income from Computer Services	$87,622	$402,996	$586,662	$727,781	$558,139	$2,363,200
Income from NYC Board of Education for Computer Services	87,622	402,996	578,917	592,160	558,139	2,219,834
Less: Amounts that the Board of Education Would Have Paid for Computer Services if They Employed a Fully Integrated Computer Firm**	89,182	238,718	181,118	254,800	312,232	1,076,050
Excess Cost to NYC Board of Education	$(1,560)	$164,278	$397,799	$337,360	$245,907	$1,143,784

* Reference is to fiscal year of Computer Specifics.

** See Page 2 of this Appendix for explanation of these figures.

APPENDIX B

Analysis of Expenses Applicable to all Computer Services Rendered by Computer Specifics to NYC Board of Education

(Source: Records of Computer Specifics Corporation)

	F/Y/E 4/30/70		F/Y/E 4/30/71		F/Y/E 4/30/72		F/Y/E 4/30/73		F/Y/E 4/30/74		Total
Description	Total	Amount Applicable to NYC Bd. of Educ.	Total	Amount Applicable to NYC Bd. of Educ.	Total	Amount Applicable to NYC Bd. of Educ.	Total	Amount Applicable to NYC Bd. of Educ.	Total	Amount Applicable to NYC Bd. of Educ.	Amount Applicable to Board of Educ.
Outside Computer Contractors	51,400	51,400	176,600	176,600	130,667	130,667	130,964	107,390	115,956	115,956	582,013
Direct Labor	–	–	–	–	–	–	77,500	63,550	86,764	86,764	150,314
Add: Payroll Taxes & Payroll Insurance Costs (15%)	–	–	–	–	–	–	11,625	9,532	13,015	13,015	22,547
Officers Salary—One Officer (Note 1)	15,369	15,369	25,000	25,000	25,000	25,000	30,000	24,600	30,000	30,000	119,969
Add: Payroll Taxes & Payroll Insurance Costs (15%)	2,305	2,305	3,750	3,750	3,750	3,750	4,500	3,690	4,500	4,500	17,995
Consultants	10,037	10,037	5,490	5,490	–	–	–	–	–	–	15,527
Entertainment (20% of Total Entertainment Costs) (Note 2)	1,193	1,193	4,061	4,061	4,773	4,773	5,373	5,373	7,591	7,591	22,991
Goodman Family Expenses	771	771	2,115	2,115	463	463	22	22	2,748	2,748	6,119
Overhead (10% of All Costs)	8,107	8,107	21,702	21,702	16,465	16,465	25,998	21,416	26,057	26,057	93,747
Profit Allowable (15% for F/Y/E 4/30/73 & 4/30/74 only) (Note 3)	–	–	–	–	–	–	23,253	19,227	25,601	25,601	44,828
Totals	89,182	89,182	238,718	238,718	181,118	181,118	309,235	254,800	312,232	312,232	1,076,050

APPENDIX B

Notes to Statement

1 There were two paid corporate officers. Neither one devoted full-time to the efforts involved in the processing of the paraprofessional payroll. Accordingly, the allowance is made for one full-time salary for a corporate officer.

2 Allowance of 20% for entertainment costs results from an analysis of these expenses which discloses that the bulk of it relates to personal entertainment, and costs incurred in attempts to acquire new business.

3 A profit allowance of 15% of all costs except costs incurred for outside computer services was allowed for the years ended 4/30/73 and 4/30/74. During these two years Computer Specifics had in its employ computer personnel although the functions of key punching and computer processing was still performed by outside contractors. In the earlier years Computer Specifics acted entirely as a broker and therefore no allowance is made for a profit as part of realistic costs.

REPORT ON THE OPERATION AND MANAGEMENT OF REHABILITATION AND AFTER-CARE FACILITIES OPERATED BY THE NEW YORK STATE OFFICE OF DRUG ABUSE SERVICES

TABLE OF CONTENTS

REPORT ON THE OPERATION AND MANAGEMENT OF REHABILITATION AND AFTER-CARE FACILITIES OPERATED BY THE NEW YORK STATE OFFICE OF DRUG ABUSE SERVICES

INTRODUCTION

In late April 1975, the Governor directed this Commission to undertake an investigation into allegations concerning "possible criminal conduct" at the Otisville Rehabilitation Center of the New York State Office of Drug Abuse Services (hereinafter referred to as ODAS), located in Orange County, New York. The initial complaint was originally brought to the attention of the President Pro Tem of the State Senate, who in turn, forwarded this matter to Governor Carey's office. After reviewing the documents accompanying the Governor's letter, the Commission initiated an investigation which led to an intensive review of four residential treatment centers operated by ODAS. These were Otisville, Ray Brook, Masten Park and Iroquois.

Commission accountants examined the capital expenditures and operating costs involved in the opening of Otisville, Ray Brook and other NACC-DACC-ODAS facilities.* The Ray Brook Rehabilitation Center, located near Saranac Lake, New York, was taken over by NACC in 1971, in the very same year that, due to legislative budgetary restriction, the agency was required to close five existing facilities. Large sums had already been expended to renovate these four centers. Ray Brook required and still requires large capital expenditures in order to provide an adequate setting for a rehabilitation program.

Otisville, situated near Middletown, New York, was taken over by NACC from the Division for Youth in 1973. Apparently, there was no effort made to evaluate the staffing pattern necessary for this allegedly unique facility. NACC merely as-

*From 1966 (L.1966, c. 192, §5) until 1973, New York State drug abuse agency was known as the Narcotic Addiction Control Commission or NACC. In 1973, the agency was given the expanded responsibility of treating non-narcotic drug abusers and the name of the agency was changed to the Drug Abuse Control Commission or DACC (L.1973, c. 676). In April 1975, the Commission structure was changed to an agency headed by a single Commissioner, and its name was changed to the Office of Drug Abuse Services or ODAS (L.1975, c. 667). Reference will be made throughout this report to NACC, DACC or ODAS, depending upon the time span in question.

sumed an existing staff of 160 individuals, a staff which had no prior training in dealing with drug abusers, a staff which often lacked NACC's own minimum qualifications for employment and which ended up costing $118,000 per resident for the first nine months and over $40,000 per resident for the ensuing year.

Common to both these facilities, the Commission's investigators found inadequate medical care and staff members often untrained in basic rehabilitative, safety, custodial, and security skills.

This Commission held public hearings* which revealed that ODAS staff members were at times suppliers of contraband to residents of some ODAS treatment facilities and were on occasion sexual partners to such residents. Former residents testified during public hearings and at private proceedings of their access to drugs and alcohol and the ease with which they could leave the facility and return with contraband. In the course of its investigation and public hearings, the SIC has attempted to focus on what the drug abuse agency's Central Office staff has done or has not done about fiscal waste, program deficiencies and personnel problems.

Despite the long history of public concern about drugs and their abuse, the public remains generally uninformed about the manner in which this serious problem is being handled by our governmental agencies and officials. It was with this thought in mind that the Commission decided that it would be in the public interest to pursue this investigation and to present the facts at a public hearing and in this report.

The State's residential treatment program has been a major part of the State's overall effort to combat the ravages of drug abuse. This segment of the program has received the single largest appropriation of funds earmarked for narcotic and drug abuse treatment and yet has been plagued with serious problems since its inception. The Commission's investigation and recent public hearings have been an attempt to expose these problems to public view.

The investigation, subsequent public hearings, and this report comprise the first hard look at the State's residential treatment program for narcotic and drug addicted and dependent

* The SIC held public hearings on the operation and management of residential treatment facilities of the New York State Office of Drug Abuse Services, in New York City on November 17, 18, 19, 20 and 25, 1975.

individuals. On the basis of evidence collected by the SIC during the course of its investigation, the residential aspect of New York State's response to the drug problem appears to have been uncertain, uncoordinated and immensely expensive.

As was stated at the close of the Commission's hearings:

> "Although this Commission does not presume to define the manner in which drug addicted and drug dependent individuals are to be treated by the State, it is our duty and our mandate to bring the public attention to the manner in which they may have been mistreated, the manner in which dollars may have been misspent, and to draw attention to those ODAS officials who have allowed these conditions to exist and have failed to respond in an immediate and responsible manner." (Pub. H. 833-4)*

THE NEW YORK STATE OFFICE OF DRUG ABUSE SERVICES

History of New York State's Response to Drug Abuse

Although throughout the century, the State of New York had provided some response to the problems of drug abuse, in reality it was not until 1962 and the passage of the Metcalf-Volker Act (L.1962, c. 204) that the first comprehensive statutory effort was made.

The Metcalf-Volker Act was an attempt to deal with the "human suffering, social and economic loss" caused by narcotic abuse and addiction. The intent of the legislation was to provide quick, fair and effective in-patient and after-care treatment for narcotic addicts.

The Commissioner of Mental Hygiene was empowered to coordinate research and training, foster prevention and public education programs and establish special facilities for drug addicts under 21 years of age. Entrance into these facilities was effected by voluntary admission, or by court certification. Rehabilitation facilities were located in existing hospital wards which were then formally designated as special facilities by the Commissioner of Mental Hygiene. The end results of the Metcalf-Volker Act's efforts were negligible.

* Reference is to the pages of the transcript of the testimony at the Commission's Public Hearings or where introduced by "Q&A", to non-public question and answer sessions.

The first major change in New York's approach to drug abuse occurred in 1966 with the creation of the Narcotic Addiction Control Commission, more commonly known as NACC. The five-man Commission was designated by the Legislature as the State's agent in the effort against drug abuse. A major thrust of the State's new program was to establish and operate rehabilitation and after-care centers throughout the State. In addition, NACC was given the responsibility to approve and oversee the State's private and locally run narcotic addict treatment facilities.

Initially, in 1967, NACC opened eight facilities. In 1968, five more were opened and in subsequent years, another eleven were made operational, although ten were ultimately closed.

With the passage by Congress of Public Law 92-255 in March 1972, the Federal Government committed itself to large grant appropriations for drug abuse treatment and prevention. As a result of the new Federal plan, NACC became New York's "single state agency responsible for development and preparation of" the State's drug abuse treatment plan and the ultimate voice in determining how Federal drug monies would be used in New York State. It is fair to conclude that by 1970 NACC, with the exception of HEW, had become the largest agency in the nation dealing with the problems of drug abuse.

It became evident by the early 1970's that despite massive amounts of Federal, State and local monies, the efforts of this State's drug abuse program, as coordinated and led by NACC, were ineffective. The addict population increased as did the criminal problems normally associated with drug abuse.

In 1973, Governor Rockefeller acknowledged the failure of the State's effort to curb drug abuse. He stated:

> "This is the time for brutal honesty regarding narcotics addiction. In this State, we have tried every possible approach to stop addiction and save the addict through education and treatment—hoping that we could rid society of this disease and drastically reduce mugging on the streets and robbing in the homes.
>
> We have allocated over $1 billion dollars to every form of education against drugs and treatment of the addict through commitment, therapy, and rehabilitation.

> But let's be frank—let's 'tell it like it is':
> We have achieved very little permanent rehabilitation —and have found no cure."*

In a dramatic shift in the State's drug policy, Governor Rockefeller called for increased penal sanctions for drug related crime. To enact his new policy, the then-Governor sought approval of the Emergency Drug Abuse Control Act of 1973. This Act called for the amending of the Penal Law, Mental Hygiene Law, Correction Law, Criminal Procedure Law, Executive Law and the Family Court Act in order to:

(1) Drastically increase the penalty for all illegal trafficking.

(2) Forbid probation, parole and suspension of sentences for certain drug-related crimes.

(3) Remove the protections of the Youthful Offender Law for persons charged with illegal trafficking in hard drugs.

(4) Expand the court system to handle narcotic cases thereby attempting to end the delays caused by the overcrowded courts.

As part of the Emergency Dangerous Drug Control Act of 1973 and in response to the ever-increasing trend towards poly-drug abuse by a younger population, NACC was redesignated as DACC and its rehabilitative responsibilities were enlarged to include "the drug dependent person." A "drug dependent person" was defined as a "narcotic addict or a person who at the time of examination was dependent on a controlled substance . . . or, who by reason of the repeated use of any such substance, is in imminent danger of becoming dependent on such substance" (Mental Hygiene Law §81.03(b)4).

Despite the policy changes wrought by this drastic legislation, the pessimism expressed by the then-Governor continues to persist. In a recent Court of Appeals opinion upholding the severe sanctions of the Emergency Drug Abuse Control Act, Chief Judge Breitel stated:

> "The Court does not necessarily approve or concur in the Legislature's judgment in adopting these sanctions. Their pragmatic value might well be ques-

* Annual message to a joint session of the 196th Legislature, January 3, 1973.

tioned, since more than a half century of increasingly severe sanctions has failed to stem, if indeed has not caused, a parallel crescendo of drug abuse." *(People v. Broadie,* 37 N.Y. 2d 100 [1975])

ODAS

In 1975, the Legislature once again changed the drug agency's designation by abolishing the Commission structure and adopting the name ODAS. ODAS is now run by a single Commissioner appointed by the Governor with the advice and consent of the Senate.

It is interesting to note that objections were raised to the prior Commission structure of NACC by the Bureau of the Budget in 1972. A study conducted by that agency suggested that the Commission structure originally created in 1966 was unnecessary and wasteful. A former Chairman of the agency had privately expressed fears that NACC would become a political "dumping ground."

Although the State's drug abuse agency has had a variety of names since 1966, its powers and duties have remained essentially unchanged. The present statutory description of the agency's powers and responsibilities are found in Section 81.09 of the New York State Mental Hygiene Law.

ODAS is empowered and directed to:

Survey and analyze the State's need in terms of the prevention and control of drug abuse and the treatment of drug dependent persons.

To conduct and promote education, prevention, diagnosis, treatment, after-care, community referral, rehabilitation and control of drug abuse.

To conduct research in the various disciplines.

To provide education and training for health professionals.

To gather and maintain pertinent information on drug abuse.

To regulate private facilities within the State dealing with drug abuse.

To establish and operate rehabilitation centers and such other facilities as was deemed necessary.

At the time of the SIC's public hearings, in November of 1975, ODAS was operating twelve residential facilities housing approximately 2,000 residents, as well as regulating and funding approximately 400 local drug abuse programs located throughout the State.

As of January 10, 1976, ODAS is operating ten residential facilities. As of December 31, 1975, these facilities housed 1,746 residents. The agency budget for the 1975-76 fiscal year calls for expenditures of $155,846,494 with $57,760,000 to be spent for the residential treatment program.

ODAS operates residential treatment centers for those rehabilitants "considered to be in need of close supervision in a structured treatment setting." In addition to a non-psychiatric counseling program, ODAS envisions its centers furnishing rehabilitants with vocational and academic education, a therapeutic recreation program and, where necessary, supplemental psychological and psychiatric services. Medical services are offered, with infirmaries staffed by nurses and physicians.*

Admission to an ODAS facility is either by civil or criminal court certification, or on a voluntary basis.

Civil certification is initiated by a voluntary petition of the drug dependent person or upon the application of a relative or any other person having knowledge of an individual's drug addiction. Thereafter, a hearing and medical examination are conducted to substantiate the fact of drug dependency (Mental Hygiene Law, Section 81.13).

A narcotic addict who is convicted of a crime may be admitted to an ODAS center only upon approval of ODAS and upon the imposition of a provisional sentence conditioned upon in-patient treatment. The duration of such treatment is determined by ODAS but may not exceed one year (Mental Hygiene Law, Sections 81.19, 81.21; Penal Law, Sections 60.03, 65.00). An alternative is available to a defendant facing criminal charges who is also an addict. Under Section 81.25 of the Mental Hygiene Law, he or she may apply for civil certification to ODAS by filing a petition in the court in which the criminal action is pending. Upon a determination of eligibility and a grant of the application, the defendant is certified and the criminal charges are adjourned in contemplation of dismissal of the accusatory instrument.**

* The physicians in most facilities serve on a part-time basis.

** Criminal Procedure Law §170.55.

Although the staffing patterns may differ slightly according to unique needs, the agency has developed a basic staffing pattern for residential facilities. In addition to the administrative staff consisting of a director and assistant director and business manager or steward, there are counselors, teachers, vocational instructors, medical personnel and a security or ward services staff. The usual staffing pattern also includes a psychologist and a part-time psychiatrist. In some facilities there are also trained recreation personnel on staff.

Facilities Examined

Of the ten residential facilities presently run by ODAS, our investigation dealt primarily with Otisville and Ray Brook, and to a lesser extent with Masten Park and Iroquois Rehabilitation Centers.

Ray Brook Rehabilitation Center is located in Essex County, not far from Saranac Lake. The rehabilitation center is a single modality treatment center for females and was formerly a New York State Department of Health T.B. hospital. The hospital, opened in 1911, discontinued its activities in 1971 when the facility was taken over by DACC, ODAS's predecessor. The facility, comprised of a number of large buildings with smaller cottages formerly used as staff housing, is situated on a beautiful 530 acre tract of land with rolling lawns and well designed landscape. It is an open facility with no apparent security provisions.

The Otisville Rehabilitation Center in Middletown, New York, was previously operated as a Division for Youth Training School, and transferred to NACC in the summer of 1973. Otisville is a co-educational facility that sits on 1,300 acres. Its buildings are modern and the facility is well-suited for use as a school or youth service setting. There are no fences or gates at Otisville, and although there is a check point at the main entrance, no systematic effort has been made to create a secured setting.

Masten Park Community Rehabilitation Center in Buffalo is a multi-modality setting offering in-patient detoxification services and methadone administration, out-patient methadone maintenance and field services and community care, as well as drug free residential treatment. Iroquois, located on a Federal bird sanctuary, has developed a drug free residential treatment program which is closely involved with its particular setting.

In addition to visiting these four facilities, Commission representatives reviewed numerous patient records and conducted interviews around the state.

It soon became apparent that although each facility is in part a unique entity, many of the problems uncovered during the SIC investigation were common to several and were directly related to the manner in which ODAS and its high-ranking administrative staff defined and implemented agency policy. Many of the severe shortcomings to be discussed throughout this report were the product of a lack of supervision, lack of essential support services and improper or, at times, non-existent professional supervision. The Deputy Commissioner directly charged with the supervision of Ray Brook and several other upstate residential treatment centers visited Ray Brook on the average of only once a year "because," he stated "of the inacessibility [of Ray Brook] from the city."

As stated by SIC Chairman David W. Brown at the beginning of five days of public hearings:

> "None of us can be let off the hook by blaming the 'system'—budgets, bureaucracy and baloney. Public servants are the system and their accountability must not be lost in a sea of jargon about resources, regulations, etc." (12)

The High Cost of Residential Treatment Programs

The SIC's accountants carried out a careful study of ODAS expenditures for residential treatment. Operating and capital costs were examined and reviewed. It soon became apparent that since the 1966 inception of ODAS's predecessor agency, NACC, New York State has expended $833.3 million for prevention, rehabilitation and treatment of drug abusers. Of this amount, $134.6 million was used for capital expenditures and $698.7 million went to operating expenses. Of this latter amount, $228.9 million was spent to operate residential treatment facilities. As noted above, ODAS, which is an independent agency within the Department of Mental Hygiene, presented an annual budget of $155,846,494 for the fiscal year 1975-6. Of this amount, $57,760,000 was spent directly by ODAS for treatment and rehabilitation. Approximately 80% of this sum or

$46,208,000 was spent for the operation of ODAS's residential treatment centers. The State also receives approximately $15 million from the Federal Government through various sources of Federal aid. Other Federal funds are received by a separate not-for-profit corporation called Narcotics and Drug Research, Inc. which will be discussed in greater detail later in this report.

During the course of its investigation, the SIC documented numerous examples of mismanagement, patient abuse and shoddy treatment which will be spelled out further on in this report. In the wake of these observations, the revelation of exorbitant dollar costs to the State for residential care almost defies explanation.

Audits conducted by the Commission and testimony adduced at public hearings and private question and answer sessions have revealed that the average annual cost of maintaining a residential patient at the Ray Brook Rehabilitation Center came to $43,643 for the 1974-75 fiscal year. The average annual cost of maintaining a residential patient at Otisville for that same year came to $45,110. It was at Otisville during its first nine months of operation, in the 1973-74 fiscal year, that the average per resident cost came to $118,253.

Costs at other rehabilitation centers operated by the New York State Office of Drug Abuse Services were also high. At Iroquois, for the 1974-75 fiscal year, the per patient cost was $24,059 and $25,820 at Masten Park. The average annual cost of maintaining a resident at the State's other eight residential drug abuse treatment centers in fiscal 1974-75 was determined to be $26,160.*

It has become apparent that the New York State Office of Drug Abuse Services engaged in little, if any, fiscal control and, in fact, for most of its life had no functioning system of utilization review or cost effectiveness studies.

When asked if ODAS had any cost guidelines for operating residential treatment centers, Commissioner Anthony Cagliostro, then head of the agency, replied:

> "There are no cost guidelines. I have said that repeatedly and you keep coming back to this question. The cost guidelines come from the fact that you have a reality. You are operating a facility.

* As of July 1975, fourteen centers were in operation.

> The mission of the facility is to have a residential component; to have an aftercare component. What staff do you need, what is their current salary, what is the projection for next year's salary, if any increase that might be, what is the projection for cost of living increases, what are your projections for utilization. You take these factors into account. You develop a budget. That's your cost guideline for that facility." (695-6)

The expenses noted above, as outlandish as they may seem, do not include capital costs for the acquisition, renovation and maintenance of residential facilities. In 1971, ODAS, due to budgetary restrictions, closed five residential treatment centers. One of these, Cross Bay located in Queens County, had cost $7,400,000 for acquisition and renovation and was open for only about fifteen months. An additional $5,320,000 had been spent on renovation and improvements of four other facilities closed in 1971.

At the same time that the State was cutting costs by closing already renovated and expensively acquired facilities, ODAS assumed the operation of Ray Brook Rehabilitation Center near Saranac Lake, a facility which had been surplussed and was being closed by the New York State Department of Health. Ray Brook, which was in dilapidated condition, required and still requires extensive renovation and repair. Ray Brook is a facility for females. Albion Rehabilitation Center, also a women's facility, was one of the centers closed by NACC in 1971, even though some money had already been spent on the renovation of this facility.

The high costs incurred for the acquisition and renovation of facilities seems to be directly related to the poor administration of the agency as manifested in inadequate planning and poor coordination. It should be noted that throughout all of the SIC's private proceedings and the public hearings, high ranking ODAS personnel, both past and present, continually referred to forces and orders operating from outside of the agency.

ODAS's Powers and Duties

The powers and duties of the Office of Drug Abuse Services and its predecessor agencies are outlined in Section 81.09 of the New York State Mental Hygiene Law. Sub-section k refers

to the office's powers and duty "to establish and operate rehabilitation centers and such other facilities as the office may deem necessary or desirable for the care, custody, treatment, aftercare and rehabilitation of drug dependent persons certified to the care and custody of the office pursuant to provisions of this article." The statute under which ODAS operates gives full and exclusive power, duty and responsibility to that agency to select institutions and sites for residential facilities. SIC Commissioner Earl W. Brydges, Jr. pointed out to Commissioner Cagliostro that nowhere is this statute modified to the extent that it adds "with the advice and consent of the Governor, with the advice and consent of the Legislature, with the advice and consent of [the Division of the] budget." (716)

The Absence of Planning

The Department of Health section of the 1971 Executive Budget noted the closing of Ray Brook as a T.B. hospital. Nowhere in the NACC section of this same document was there any mention of the acquisition of Ray Brook by that agency. The absence of systematic planning becomes more apparent, and lends itself to harsher questioning, upon the discovery that as early as December 1970, NACC personnel had inspected this multi-building facility and determined the eventual need to replace the entire heating plant, which at the time burned coal.

Furthermore, agency personnel familiar with Ray Brook from the time of its acquisition have consistently noted Ray Brook's dilapidated condition at the time of its acquisition by NACC.

Numerous questions begin to present themselves when this sequence of events is examined. Why was Ray Brook opened and maintained in the same year that five existing facilities were closed? Why did the preliminary reports on Ray Brook fail to mention its dilapidated state? Why do present and former NACC, DACC and ODAS officials fail to be able to document the reasoning which went into its opening. Drug agency officials again point to "the second floor"* and political pressure to maintain employment in the community. As will be seen later in this report, this same lack of planning was a major factor contributing to excessive costs and poor programming at Ray Brook.

* State jargon standing for the Executive Branch.

Otisville Rehabilitation Center, in Orange County, was opened as a DACC facility in the summer of 1973. It is notable that at the time Otisville was transferred from the Division for Youth to DACC, the drug agency had approximately 1,000 empty patient beds in already existing facilities.

Both Anthony Cagliostro and First Deputy Commissioner John W. Randall conceded that they saw no need for Otisville. Neither could justify its opening other than by attributing its origin to the desire of the executive branch.

Ray Brook

In reviewing the cost of operating the Ray Brook Rehabilitation Center, it was determined that in the last four years $9,594,000 was spent to operate the facility as a drug abuse treatment center. In the 1975 fiscal year the average per patient cost for maintaining a resident at Ray Brook for one year was $43,653.

Once again, high operating costs seem to be a direct function of under-utilization and poor planning. Not only was Ray Brook opened at a time when NACC was closing other facilities, but it was also apparently a poor choice for a facility by almost every significant indication.

The physical plant was in a dilapidated state and the location itself led to numerous problems related to staffing and poor program quality. A senior staff member stated, in explaining the condition of Ray Brook at the time of its opening, that:

> "We didn't have a school area, we didn't have a recreation area, we didn't have adequate office areas. I mean, we had space, but they (sic) were really dilapidated. Everything was located in a building that I believe was constructed in 1905. . . ." (Q&A 488)

The excessive costs at Ray Brook also directly relate to under-utilization of the facility. Fewer than 100 women are housed and treated on 530 acres with numerous buildings in use. One cannot lose sight of the necessary fixed costs encountered in the running of any institution. Administrative personnel, maintenance personnel, and a basic medical staff are necessary where only one resident is treated, as was the case at Otisville during its first months of operation, or where several hundred are in treatment. The use of a facility such as Ray Brook for the treat-

ment of 60 to 100 women necessitated the incurring of many costs which would have been no greater for a facility treating many, many more patients. Obviously, utilization review was totally absent within the agency's planning structure.

It is ironic that although the state spent in excess of $43,000 per patient per year at Ray Brook, psychiatric care was lacking as were the services of a full-time staff psychologist. Medical care at Ray Brook was below standard, and the New York State Department of Health was severely critical of the food served to residents.

Otisville

The direct cost of operating Otisville, from the time it first became an ODAS facility in 1973, totalled $4,354,000. In the first nine months of operation the average per patient cost of maintaining a resident at Otisville was $118,253. During the last year that it operated Otisville, the New York State Division for Youth spent an average of $14,663 per resident. The tremendous increase in per resident cost is directly attributable to gross under-utilization of the facility by DACC. It is ironic to note that DFY had given up the facility due to under-utilization by that agency.

When the Drug Abuse agency assumed the operation of the Otisville facility, they accepted the entire existing staff of 160 people. This led to a situation in which during the first nine months of operation, these 160 people were responsible for the care and supervision of an average of only 14.01 residents. This was one of the major factors contributing to the excessive costs.

Some ODAS officials have said that the assumption of these employees was mandated by Section 70.2 of the New York State Civil Service Law, while others have pointed to an "understanding" that no one was to be fired or forced to transfer. While there appears to be some confusion as to the meaning and operation of this section, the law does allow the accepting agency in such a transfer, e.g., DACC, discretion in determining which staff members will be retained. In the Otisville situation DACC did not exercise this discretion and merely took on the entire DFY staff. In fact, agency administrators have stated that for the first two years of Otisville's operation as a residential treatment center, they made no effort to abolish positions or lay off employees. Again they explained this lack of action with

vague references to "the second floor" and "directions from above" and "understandings."

The present First Deputy Commissioner of ODAS, John W. Randall, testified that when ODAS assumed Ray Brook from the State Department of Health, negotiations were carried on so that the entire staff at the T.B. hospital was not absorbed by the then Narcotic Addiction Control Commission. It is obvious that there was no necessity to absorb the entire staff at Otisville and that ODAS's acquiescence in this matter led to the outlandish costs encountered at Otisville.

Oddly enough, ODAS also assumed the total responsibility for the maintenance of a reservoir and the operation of a laundry situated on the Otisville site. Both the laundry and the reservoir were in no way related to the operation of a facility for the treatment of drug addicted persons. They provided no direct service to the facility and in no way enriched the program.

In the second year of ODAS's operation of Otisville, the per patient cost for maintaining a resident improved somewhat but was still appallingly high at $45,110 per patient.

It has become apparent that the exorbitant costs incurred at Otisville are mainly attributable to a lack of administrative planning and appropriate utilization review.

Although Otisville was to be a unique facility with special criteria, agency officials realized within months of its opening that these criteria were not realistic and that Otisville was seriously under-utilized. Efforts were made to increase the resident census, and during the Spring and Summer of 1974 many new residents were transferred in from other DACC facilities. Concomitantly, an analysis of Otisville's census statistics for that period reveals an inordinately large number of escapes.

Comparative Costs

Cost figures of comparable facilities were also reviewed. The New York City Addiction Services Agency uses a $5,000 per year resident figure as a guideline for the residential treatment programs it funds.

The cost of maintaining an inmate at a State correctional facility is in the neighborhood of $15,000 per inmate per year. The State of Illinois maintains a resident for a year at a residential treatment program for $7,700.

In reviewing two other facilities that the Commission examined, it was revealed that the total annual average cost for main-

taining a resident at Masten Park was $25,820. At Iroquois Rehabilitation Center, the total annual average cost per resident for fiscal year 1973-74 was $18,326 and $24,059 for fiscal year 1974-75.

During the 1974-75 fiscal year, Ray Brook had 2.38 employees per resident. Masten Park had 2.08 employees per resident, and Otisville had 2.53 employees per resident. Of the four institutions reviewed by our accountants, only Iroquois had an employee to resident ratio of less than 2:1, and there the ratio was 1.43:1. During the first nine months of Otisville's operation by DACC, the ratio of employees to residents was 11.7 to 1.

SIC accountants determined that the overall cost of maintaining residents in the other ten ODAS run treatment facilities was $26,900 based on per diem Medicaid rates for the year ending March 31, 1974.

As a treatment provider, ODAS participates in the Federal Medicaid program. From July 1969 to July 1975, ODAS generated approximately $85 million in the form of Medicaid reimbursements to the State.

SIC Chief Accountant Albert Sohn testified at the public hearings as to the disparity in Medicaid applications by the various facilities. He stated:

> "Some facilities apply for as few as 25 percent of their residents for Medicaid reimbursement and others apply for, perhaps, eighty or eighty-five percent of their residents for Medicaid reimbursement." (32)

ODAS officials were unable to explain this disparity.

It is interesting to note that the Medicaid reimbursement does not go directly to ODAS. Medicaid monies received for services rendered by ODAS are immediately transmitted to the New York State Facilities Development Corporation (FDC). The FDC uses these funds to offset construction costs of various mental hygiene facilities and has played a part in the financing of ODAS's major construction projects. Since the FDC is responsible for the development of all mental hygiene facilities, only a portion of the Medicaid money generated by ODAS actually goes back to offset the expenses of the agency.

Calculation of Costs and Fiscal Control

Throughout the course of our investigation and public hearings, it was difficult to find a clear pattern of administrative responsibility within ODAS. Commissioners and Deputy Commissioners talked of "non-conforming" facilities and "modular staffing patterns" and yet were unable to provide this Commission with specifically established guidelines which the agency might use to keep its cost base at a minimum.

The approach used by the drug agency seemed to require increasing to its highest believable point the number of individuals assisted by the agency and dividing that into the total number of dollars spent by the agency for treatment.

Top agency officials were unable to give an adequate picture of the manner in which public funds were spent. Commissioner Cagliostro, who previously served as Chairman, Vice Chairman, First Deputy Commissioner and Counsel, was unable to state unequivocally what portion of the agency's budget was spent for the operation of State services, other than to conclude eventually that a major portion of approximately $69,000,000 was spent for this purpose.

Furthermore, ODAS had no mechanism for dealing with problems of cost effectiveness. Cagliostro was vague and indeed, evasive, when questioned not only about cost effectiveness standards applied to his own agency, but also about those standards applied to local agencies receiving State funds through ODAS. He consistently refused to explain the manner in which judgments about local programming are made. Cagliostro insisted that:

> "Given the state of the art, . . . it's impossible to reduce to writing or to develop criteria that will permit the assessment of the quality of treatment." (687)

ODAS also had no identifiable guidelines for determining the effectiveness of its own intramural or residential programs.

"BY MR. SLATER:

Q In other words, could one draw the inference that there is no way to determine the quality of treatment given? No way that would be reducible to some type of—

A That's correct.

Q I see. There is no way. Then how does the agency do it?

A You have a mission. You have established the means to accomplish that mission.
. . . ." (691)

This lack of specific criteria seemed to be closely related to the manner in which the agency, through Commissioner Cagliostro, chose to deal with the cost of treatment in response to SIC questioning. Cagliostro refused to break down the various components of the agency's structure and deal with their cost. He merely stated that:

"You would find that for 1974-75 our composite annual average cost per client was $8,544.46, including fringe benefits and the high cost facilities you have made the focus of your inquiry." (781)

This figure is totally valueless for the purpose of determining treatment costs. It is arrived at by lumping together the cost of residential treatment and such inexpensive services as the administration of methadone on an outpatient basis. It is the proverbial mixing of apples and pears. Nor is this process a sound accounting basis on which to proceed. It has been pointed out that:

". . . [F]or management purposes it would be of the utmost importance to break down the costs by your different services so you know where you are incurring overruns or where you are just running too high." (792)

Civil Service Law

In studying the manner in which DACC accepted the entire existing staff at the Otisville facility, it would appear that the agency totally disregarded the existing applicable statutory mechanism. Section 70.2 of the New York State Civil Service Law provides the statutory framework for handling such a transfer in function.

Section 70.2 of the New York State Civil Service Law reads in pertinent part:

". . . Upon the transfer of a function (a) from one department or agency of the state to another department or agency of the state, . . . provision shall be made for the transfer of necessary officers and employees who

are substantially engaged in the performance of the function to be transferred. . . ."

Representatives of the New York State Department of Civil Service, when questioned by SIC staff as to the implementation of this statute, stated that in a transfer of facility, responsibility for the employees is shared by the gaining agency and the agency giving up the facility. In a private question and answer session conducted prior to the SIC's public hearings, a Civil Service Department representative gave the following responses:

"A [The] losing [sending] agency could determine to transfer someone in advance of the date to some other facility they operate.
That would be their decision, I guess. If the receiving agency didn't want certain employees, they would have the responsibility, I guess, of talking about it in advance in making some arrangements with the losing agency that they wouldn't accept those employees. . . .

* * *

BY MR. ORLIN:

Q In the operation of that section, what is the losing agency's responsibility?

A They have to notify the employees. That's part of their responsibility and, of course, if some of those employees were not going to transfer, their positions were going to be abolished, they would then also have to tell the employees this and get the forms for putting them on preferred lists or arrange for which employees get laid off if there was a question of lay-offs involved.

Q It would be the losing agency who determines initially which—what employees are to be transferred within their own structure, is that correct?

A Yes." (Q&A 1370-2)

This witness further points out that the gaining agency need not accept all of the persons on the list.

"Q Once this list is prepared by the losing agency, what is the gaining agency's responsibility?

A Of course, they get a copy of the list, too and if they feel that some people on the list are not appropriate for their operations, presumably they would speak up and say they did not wish these employees.

They would ask the losing agency to make other provisions to transfer them within their own internal structure before the transfer took place.

Q Would it be correct to say they are not obligated by the law to assume all those people on the list?

A They are not obligated to assume all those people. Yes, that's correct." (Q&A 1376-7)

When taking over Ray Brook, NACC engaged in negotiations with the Health Department which, at the time, was the losing agency. In that transfer of facility, only a small portion of the former Health Department staff was transferred to NACC.

This total acceptance of an existing staff caused numerous problems. Of course, the most glaring difficulty came to light when a calculation of resident census developed the fact that so swollen was the staffing for the first nine months of Otisville's operation, that the per resident cost reached the astronomical proportions of over $118,000 per resident. Secondly, many of the staff members did not meet the basic criteria which ODAS itself had established for employment. The present director of the Otisville facility testified that some members of his staff with responsibility for resident care were functionally illiterate. Unbeknown to ODAS administrators, other staff members had criminal records or histories of psychiatric disturbance.

The staff accepted by ODAS at Otisville was not complimentary to the agency's staffing pattern. As an example, teachers were in great excess at Otisville in 1973 and '74 while Masten Park Rehabilitation Center in Buffalo was seriously lacking trained educators. John W. Randall, who was then director of employee relations, testified as follows:

"BY MR. SLATER:

Q In opening that facility and in bringing in that staff of 160 people, was that the type of staff that

you would have chosen for that facility, looking at staffing patterns, the type of professionals included and backgrounds, professional employment and training backgrounds of the majority of the staff?

A I don't think so.

Q Do you think it was below the caliber in general that you would normally hire?

A Well, there is a different staffing mix, because, as I recall it, the Division for Youth programs was (sic) heavy on school academic type operations, and there were several more teachers on staff than we would have used, there were fewer counselors than we would have used; those sorts of things.

Q Weren't there fourteen teachers when you only felt you needed two or three?

A No, I wouldn't say that.

Q How many teachers were there?

A I think there were probably about in the high twenties altogether, teachers, vocational instructors and supervisors.

Q Weren't you quite concerned about this number of teachers?

A Yes.

Q Did you ever do anything to remove them from the payroll?

A Yes.

* * *

A We reduced the number of teachers—let's see, now—this fiscal year.

Q This fiscal year?

A Yes.

Q Starting when would that be?

A This fiscal year began April 1, 1975." (91-2)

CONTINUED

1 OF 2

Not a single one of the high ranking administrators of ODAS questioned by this Commission would admit responsibility for maintaining this obviously excessive staff.

Randall's further testimony is also instructive:

"BY MR. SLATER:

Q When you took over the Otisville facility from the Division for Youth, did you go through the same type of discussions that you did with the Health Department; in other words, selectively picking those staff members which you would take on as ODAS or DACC employees?

A Well, as I recall, we took just about every employee there, with the exception of perhaps the Director, and he did stay for awhile.

Q In other words, you took over the entire existing staff of the facility?

A Pretty much. I think—I would have to take a look at their records, but I think that's reasonably accurate.

Q Do you know how large that staff was?

A I think around 160 or so. I don't know for sure. I'd have to look at the record again.

Q Well, you have discussed fixed, invariably fixed, non-fixed and variable costs before.
Is it the policy of your agency to open a facility with a full-blown staff?

A That isn't the way we opened other facilities such as Sheridan and Gross Bay that we opened on our own, no.

Q Then why did you keep the entire staff at Otisville?

A I think to get a good answer you are going to have to ask somebody else, but the impression that I received is that our agency was told we should take all the staff there." (86-8)

Program Deficiencies

A consistent lack of planning and apparent abdication of Central Office administrative responsibility has caused serious program deficiencies in the operation and management of residential treatment facilities which the SIC scrutinized during its investigation. Educational and counseling programs seemed to lack concrete goals and plans and often had no exposure to agency-wide policy or evaluation. Recreation, an admittedly important segment of residential programming, often operated on a hit-or-miss basis. The various medical components explored were often inadequately staffed and the delivery of medical care was not uniformly supervised.

The Commission's investigation revealed that almost every program component at Otisville and Ray Brook suffered from program deficiencies that hindered the successful rehabilitation of residents. Some of these program failures were of such a significant nature that they often endangered the very health and well-being of the centers' residents.

The Commission is well aware that ODAS has many fine and dedicated employees. However, we have found that such employees have received inadequate supervision and support from both their superiors and the specialized units within ODAS.

Failings of the Medical Component

Medical personnel rarely received necessary support services. Medical records were slow in arriving, and the operation of health care facilities often lacked professional direction and review.

An examination of the Medical Department at Ray Brook Rehabilitation Center revealed a lack of supervision, orientation and in-service training, as well as insufficient and unlicensed treatment personnel. The transition from a tuberculosis hospital to a drug abuse treatment center was apparently carried out without thought being given to the necessary training and orientation for the unique medical and psychological problems of drug abusers.

The Nurse Administrator at Ray Brook, who was, for many years, employed at the T.B. hospital, related to this Commission the sudden manner in which he was informed that he was immediately to take charge of the medical department and develop policies and procedures for the treatment of ODAS residents. He received no initial orientation as to the workings of

ODAS or its program goals. His duties and responsibilities were not outlined in any detail. At the time of his appointment as Nurse Administrator, he had no prior experience in dealing with drug abusers and admits that he was unprepared to handle their specific medical problems. Since Ray Brook was taken over by the drug abuse agency, little in-service training has been received by the medical staff and little supervision or assistance has been received from Central Office personnel.

At the time that ODAS took over the facility, both the Nurse Administrator and the primary physician were unfamiliar with ODAS regulations or administration. They were not informed as to how to request or order medical supplies from the Central Pharmacy and were eventually supplied with a large number of pharmaceuticals on which the expiration date could not be determined. The ODAS Central Pharmacy offered no assistance and, in fact, no agency pharmacist visited the facility for the first year of its operation as a drug abuse center.

The obvious confusion was added to by the fact that no policy or procedure manual was made available to the medical staff, and it was only later that one was prepared for Ray Brook by the Nurse Administrator.

Significant problems were evident in the transmission of medical records and in the return of results from various tests and procedures ordered by physicians. Often reports of gynecological examinations and blood tests arrived weeks and, indeed, months after the patient had arrived at the facility. In one instance, it took an entire year for a record to be sent to Ray Brook from the Manhattan Rehabilitation Center. These delays resulted in numerous repetitions of previously administered examinations and tests.

In the course of its investigation, the SIC discovered that Ray Brook's primary physician was not licensed to practice in New York. It soon became apparent that the agency hierarchy was totally unaware of this situation. Although Ray Brook was taken over by the then Narcotic Addiction Control Commission in 1971, it was not until this Commission initiated its investigation in 1975 that ODAS administrators became aware of the lack of a licensed physician at Ray Brook.

This primary physician, the only physician at the Ray Brook Rehabilitation Center, did not have admitting privileges at Saranac Lake General Hospital, the local hospital to which residents requiring hospitalization are sent. Therefore, there could

never be continuity of care since a new physician must always arrange admittance of the patient to the hospital and supervise in-patient treatment.

Otisville

The Nurse Administrator at Otisville Rehabilitation Center was a nurse at Otisville prior to its becoming an ODAS facility. She, as her Ray Brook counterpart, encountered numerous problems during the transfer of the facility to ODAS. Many of the problems encountered in the delivery of services that existed in 1973 at the time of the transfer still existed at the time of the Commission's investigation in 1975.

During SIC public hearings, Mrs. Weeden described the type of orientation she received from ODAS.

> "MRS. WEEDEN: The Director of Medical Services, the Director of Nutritional Services, the Director of Transportation and so on came to Otisville. They told us how all the different departments were supposed to work.
>
> They told us some—they mentioned what the drug abusers were like, hypochondriacs, and so on. That was just about it.
>
> MR. ORLIN: Prior to this, did you have any experience with drug abusers or narcotic addicted people?
>
> MRS. WEEDEN: None. . . .
>
> MR. ORLIN: How long was this training session?
>
> MRS. WEEDEN: I would say a week, possibly two weeks. I don't recall.
>
> But, it seemed like forever, because they were very boring and we really weren't learning much about drug addicts." (618-9)

Nurse Weeden also described the insufficient nursing coverage at the Otisville Rehabilitation Center, and the problems thereby caused. That lack of nurses continued to exist right up to the time of the Commission's hearings. It should be kept in mind that this critical shortage existed during the time when Otisville was overstaffed and probably had more teachers than clients. Yet DACC's personnel office did nothing.

This shortage of nursing staff existed at a facility which was designed to cater to polydrug abusers. These young people often

abused barbiturates prior to and even during their stay at Otisville. Dr. Howard Meiselas, Chief of Program Planning and Research for ODAS, a psychiatrist and veteran of many years in the field of drug abuse treatment stated:

> ". . . I would be less concerned about someone withdrawing from narcotics than someone who was withdrawing from barbiturates. . . . The barbiturate withdrawal syndrome, on the other hand, does involve the possibility of convulsions, does involve the possibility of a severely compromised central nervous system, has been associated with death. . . ." (Q&A 1126-7)

Although the primary physician at the Otisville Rehabilitation Center did hold a valid state license, evidence disclosed that he was semi-retired and maintained no regular hours at the facility. From August 16, 1973, when Otisville became a NACC facility, until mid 1975 he was on a regular salary but came to the facility only when summoned. At times, residents were transported to his office. Also, as noted at Ray Brook, this physician did not admit patients to the hospital.

> "MR. ORLIN: Let's ask another question: Did he have admitting privileges at the local hospital?
>
> MRS. WEEDEN: I'm not sure. I don't believe so. He had a heart attack and he more or less restricted his practice and I think he gave up hospital work.
>
> MR. ORLIN: Did he ever admit a patient to the hospital?
>
> MRS. WEEDEN: No, he referred them to a consultant." (625-6)

These consultants were then paid in addition to the salary being paid to the physician. At times, difficulty was encountered in finding a physician to admit a patient to the hospital.

The SIC also discovered that Otisville did not abide by ODAS's own regulations which require that a facility should have a written letter of understanding, relating to admissions, with a local hospital. The Commission's investigators discovered that up until the time of our investigation in the spring of 1975, Otisville had no such written agreement with the hospital to which its residents were sent.

Since Otisville's opening, its infirmary had been located in a building that the New York State Department of Health eventually found to be a fire hazard. This was determined by a New York State Health Department survey team in the spring of 1975. The infirmary has since been moved to another building on the Otisville grounds which required some renovation.

SIC made a detailed review of the comprehensive surveys conducted by the New York State Department of Health. The survey teams, which consisted of nurses, nutritionists, sanitarians and social workers detailed many other problems with ODAS's medical program. Their findings will be discussed in further detail later in this report.

Both Otisville and Ray Brook lacked sufficient psychiatric expertise. In such a facility, a psychiatrist is important not only for patient care but can be of immeasureable assistance in staff training.

Education Program—Academic, Vocational

Academic and vocational training is an integral part of what ODAS officials termed their multi-disciplinary approach to the programming of residential treatment facilities. Interviews with many present and former residents revealed their lack of respect for the program. In visits to various ODAS facilities, Commission investigators observed an uneven approach to the development of both academic and vocational training programs. Assignment of residents to various segments of the program appeared to be on an essentially hit-or-miss basis.

As in many other aspects of the ODAS operation, there seemed to be little input from central headquarters. Some facilities had staff members skilled in vocational rehabilitation while others did not. Little thought seemed to have been given to cooperative effort with the New York State Division of Vocational Rehabilitation.

The Director of the Ray Brook Rehabilitation Center was asked:

> "Q Who from Central Office comes to Ray Brook [sic] to determine . . . the quality of the educational program offered and to supervise and professionally assist the education director?
>
> A In that context it doesn't happen, sir." (450-1)

The problem of excess teachers at Otisville has already been mentioned. Serious morale problems arose not only from the fact that there were too many teachers, but also from the apparent lack of any clearly designed education program. No central plan seemed to be available to assist in settling their almost constant fighting with the Director in charge of Otisville during the first eighteen months of its operation as a DACC facility.

Furthermore, when Otisville was turned over to ODAS, many of the teachers missed a good deal of the limited training which the agency offered since they were away on summer vacation.

Although ODAS officials consistently mentioned that Otisville was to be a unique facility, little thought seems to have been given to creating a unique educational program there. One Otisville staff supervisor with twenty years' experience in youth work testified as follows:

"THE WITNESS: Educationally, I think there was a lag. True, we had the educational staff, the teaching staff, but I don't know. Their qualifications for teaching this type of resident was in question and there was a feud between education and our former director, Mr. Kaufman, at that time. So I think there was a lag there.

COMMISSIONER RUSKIN: You mean in terms of their being able to establish any kind of rapport with the residents to be able to rap with them or talk to them or reach them?

THE WITNESS: No. I am talking as far as their teaching skills and ability to teach. Again, education wasn't my end of it, but from my own assessment of it, I think that these residents that we were getting—let me go back.

The clientele we had before were, more or less, in the remedial type of education and most of them had—if they were tenth grade, they were lucky.

The clientele that we received were high school graduates, some were two years college. So I think —I don't know whether it offered a threat or what, but there was some kind of a turmoil there where they just couldn't get into the swing of things." (363-4)

Otisville was supposed to have been designed to meet the needs of a more sophisticated client population; the type of population that would be well-suited for some form of higher education. DACC not only did not provide a teaching staff qualified to meet the needs of this type of clientele, but failed to develop a program which would be valuable in light of their identified needs and shorter stays at the facility. By not providing Otisville's teachers with specialized training to meet the demands of a somewhat sophisticated polydrug clientele, DACC compounded its failure.

Another example of inadequacy was found in the vocational education program. Those programs offered to residents were not planned so that the resident leaving the facility had completed a training program. A former Otisville resident explained his experiences with the Otisville program.

"Q When you returned there, what happened? Were you assigned to your regular program?

A Yes. I was assigned to my regular program that I had before I left.

Q What was that program?

A Well, I was going to school and I was a school janitor.

Q And you spent your day cleaning the schoolroom?

A Yes. In the afternoon.

Q And did you receive some studies?

A Yes.

Q In what field, sir?

A Well, I took auto body shop for about a period of three and a half months, and I also, I worked in, I worked in the school area also in the afternoon.

Q All right. You say that you studied in the auto body shop.

Now, when you left DACC were you able to get a job in the auto body and repair business?

A No, I wasn't.

Q Why not, sir?

A Because jobs that I went to, they said I have to have at least six months' training.

Q All you had, sir, was three months' training?

A Yes." (326-7)

Vocational programs should be tailored to projected length of stay at the facility as well as the overall program goals.

This situation was not peculiar to Otisville alone. In testimony given by Robert Eisenberg, Assistant Director of the Ray Brook Rehabilitation Center, it was explained that Ray Brook's vocational program is not geared to teach a resident the type of skill that would lead to a job at the time of the resident's release. Mr. Eisenberg, in describing the educational program, explained that there is a cosmetologist at Ray Brook, but that the cosmetology course is designed only to teach a resident personal skills needed to groom herself. It was further explained that this course does not lead to licensing which would permit a former resident to work as a cosmetologist.

Although DACC and ODAS intended Ray Brook to have a sewing program, when the facility was opened, it was discovered that there were too few 220 volts outlets to operate sewing machines, and that as a result, this program suffered.

Ray Brook's Director, Joseph P. Daly, made these comments in regard to his facility's vocational program.

"Q What is a vocational program, Mr. Daly, what is it supposed to do?

A I would have to qualify it. It is somewhat of a misnomer.
In our center, as it is in most centers, we do not train for a specific vocation. Ideally you would think of a vocational program as a program that would actually prepare a person for a specific vocation.
Because of the relatively short length of stay, and what have you, this is—it's not a viable thing." (452)

Mr. Daly went on to point out that the program does not prepare a resident for a vocation. Such a course as sewing prepared a resident to mend her own clothes but not to work in the needle trades. The cosmetology course also was only for home use. Ray Brook did not have a trained vocational rehabilitation counselor.

Not only did Ray Brook and Otisville lack trained vocational rehabilitation personnel but they also suffered from inconsistent and poorly planned work release programs. ODAS has no centrally defined guidelines for the establishment of such programs. The quality or lack of quality of such programs seemed to be dependent upon the personal whims of the center director and counseling staff.

The location of some centers in small rural communities not only presented limited outside educational resources but also poor job availability. With the exception of the North Country Community College, Ray Brook has few outside resources which can be called on to enrich program offerings. Most of the women on work release from Ray Brook worked as chambermaids in local resorts.

Finally, it should be noted that in the regional Health Department survey reports on all ODAS rehabilitation centers, there was consistent criticism of the curriculum offered to residents. An often cited criticism of ODAS's educational program is the lack of health-oriented courses. Both Ray Brook and Otisville did not provide their residents with either nutrition or sex education courses. Not only should it be the responsibility of a rehabilitation program to provide quality foods, but also to acquaint residents with an understanding of how to maintain their emotional and physical health. Young men and women coming to ODAS rehabilitation centers often lack the knowledge basic to the maintenance of good health, particularly the avoidance of venereal diseases and the maintaining of proper sexual hygiene.

The Counseling Program

Individual and group counseling is the major program component offered at ODAS residential treatment centers. Each residential treatment center has a staff of counselors assigned to perform this task. These counselors are supervised by a Senior Counselor and Associate Counselor. The counseling staff, in turn, reports to the Assistant Director of the facility. In addition, ODAS staffing patterns call for a psychologist as well as the input of a trained psychiatrist. The SIC found that there

is little uniformity in the supervision of counselors by psychologists and psychiatrists. In addition, there appeared to be no criteria for screening of patients by trained mental health professionals prior to their involvement in the counseling program.

ODAS insists that its counselors have a B.A. Degree. Interestingly, it is not necessary that the degree be in psychology, counseling or related fields of study. These counselors receive little in-service training and, at times, no professional supervision from trained mental health workers. It is reasonable to assume that some ODAS counselors begin their careers and assume active caseloads with no experience or training in counseling. Since there is no formal training, they must rely on an uneven pool of colleague skill and supervisory knowhow. The combined lack of professional preparation, orientation courses and in-service training has resulted in less than satisfactory performance.

A basic tenet of counseling and professional social work is that a practitioner report and discuss his or her treatment process with a qualified supervisor. The nature of this supervision and the quality of Ray Brook's counseling program was explored with Director Joseph P. Daly at the Commission's public hearings.

"BY MR. SLATER:

Q Are you aware of whether or not an individual who is not properly screened for a group session could be damaged by their attendance in that group?

A That can happen, yes, sir.

Q For instance, if an undiagnosed schizophrenic was placed in a group session, could he come out of it being harmed?

A I am not an expert on that, but—

Q Have you ever heard that kind of statement from anyone?

A Yes, sir.

Q Who is there at Ray Brook who sees each and every resident to determine whether or not they

are fit to be involved in a group counseling session?

A That determination is made by dealing with the record, the background—

Q By whom?

A The Associate Counselor, Senior Counselor, no one person.

Q No one person had the responsibility?

A Puts a stamp on it, no.

Q There is no one you can point to who determines whether a person should go into the group or not.

A It is a team basically.

Q Who is in charge of the team?

A Associate counselor.

Q Is he a certified psychologist?

A No, sir, he is not.

Q Is he a trained social worker and has a Masters in Social Work and a CSW certification?

A No, sir.

Q Does he have any training in identifying mentally sick, ill people who might be damaged by a group session?

A Not to my knowledge.

Q But he is the captain of that team?

A Yes, sir.

* * *

Q Who from the central office staff gives any constant or on-going supervision to this counseling program?

A At this time, no one." (442-4)

When questioned as to whether or not Ray Brook was providing the "best treatment" ODAS could offer, Mr. Daly replied that it did not.

Former residents of ODAS facilities consistently stated that they felt they had received little, if any, help from the counseling program which took place in the facility. One former Otisville resident claimed that with no prior screening, he attended a group therapy session at which the counselor related his own experiences with homosexuality and bestiality. The resident was totally unprepared for such a stark introduction to group therapy. This allegation was well corroborated in the course of the SIC's investigation. What was even less explicable was the lack of any mechanism by which those professionals in the Central Office could have some input into the substance of group sessions.

Representatives of the Broome County Drug Awareness Center testified that after referring a young man to Otisville and informing the Otisville staff of his habituation to inhaled substances (glue sniffing), he was assigned to paneling walls with highly volatile glue.

Other former residents revealed to the Commission that their involvement with the counseling program was extremely limited. One resident stated she did "nothing" during the first part of her stay at Ray Brook. Another resident testified that he only saw his counselor two or three times in the three months that he was in Otisville. These statements, plus the other information gathered from residents and former residents indicate to the Commission that if counseling is indeed the essential and primary treatment discipline, much must be done to improve the quality of counseling offered at the residential treatment centers.

Another problem disclosed is the failure by counseling personnel to maintain a "treatment plan." It is an accepted social work and counseling practice to prepare a written plan of care for a client. This plan is maintained and updated by counselors and other members of the treatment team in order to track, systematically, the progress of a client. In addition, the plan permits a counselor, by referring back to the history of a client, to deal more effectively with a client's problems. No such plans were to be found at Ray Brook or Otisville until Health Department survey teams noted this deficiency.

Inadequacy of the Recreational Component

Part of ODAS's multi-disciplinary treatment approach is a therapeutic recreational component. Here, too, the Commission found inconsistencies in ODAS's ability to provide quality programming to residents, and little, if any, input from Central Office personnel.

Since its opening in 1971, Ray Brook has not had a gymnasium; as a result the recreation program has been severely limited during the severe north country winters. During the winter months, residents are confined to passive indoor activities such as arts and crafts. Ray Brook's staff members have told the Commission that the inability to have such physically oriented activities such as basketball and handball in the winter months, severely hampers their attempts to create a successful recreation program, which ODAS officials claimed was an important facet of residential treatment.

Otisville, on the other hand, does have a fine fully equipped gymnasium. In fact, Otisville even has an outdoor swimming pool. Yet, here too, residents have suffered from a poor recreation program. The Commission's investigation disclosed that Otisville's facilities are severely under-utilized. When the Commission staff visited this facility, they often saw the gym unused for lengthy periods while residents seemingly lingered around the facility with nothing to do. No indication of a planned recreational program was evident.

In questioning Otisville's staff, it became apparent that, despite the excellent facilities and equipment, there were no intramural sports tournaments, gym classes, or any other planned recreational activity. Thomas Wills, the present Director of Otisville, stated that when he came to the facility there was no recreation staff able to supervise the gymnasium. In addition, the Commission also discovered that the swimming pool went unused last summer for lack of a trained lifeguard.

A Health Department survey team leader faulted Otisville for not having a physical education program specifically designed for women. It was her contention that women residents rarely enjoyed therapeutic recreation. The survey team was also critical of the library, citing the fact that many of the books were meant for the age group DFY dealt with and not the age clientele of an ODAS rehabilitation center. Also absent in the library were those newspapers and periodicals which would be of specific interest to the resident population.

Throughout the course of our investigation, Commission staff members visited several ODAS residential treatment centers numerous times. One observation appeared to be universal at

those facilities visited. Regardless of the time of day or season of the year, numbers of young people were aimlessly milling around or sleeping, On one lovely summer day, 12 female residents at Otisville (their cottage had approximately 20 residents) were found in the recreation room of the cottage either sleeping or watching TV. Although it was the middle of the afternoon, they all stated that they had no program to go to.

Sex, Drugs and Violence

The presence of sexual abuse, violence and contraband in any closed facility is, unfortunately, an almost universally accepted reality. At both Otisville and Ray Brook, and to a lesser extent at the other ODAS residential facilities reviewed, the severity of the contraband problem was for the most part directly related to a lack of definitive action and planning aimed at its eradication. Those facilities which adhered to existing agency policy concerning searches had less of a contraband problem than those facilities which did not enforce a uniform search procedure. The SIC determined that in facilities with an acknowledged contraband problem, Central Office administrators took few, if any, steps to ascertain whether agency policy was strictly adhered to, or even if policy was adequate to deal with present problems.

The head of security at one facility testified under oath that when he was appointed to that position, he knew nothing about the identification of contraband substance and could not "tell a hard drug from a soft drug."

Violence and sexual involvement between staff members and residents in most cases investigated by the SIC was directly attributable to a lack of supervision by line personnel and Center directors and an apparent inability on the part of agency administrators to recognize potentially dangerous or improper situations.

In the course of the investigation, allegations of sexual misconduct by staff members and residents were repeated on several occasions. Commission investigators spoke to many former residents around the state in order to develop a more complete picture of the problems involved. Present and former staff members were also interviewed, and some openly admitted their prior sexual experiences with residents. A Narcotic Correction Officer, formerly assigned to Ray Brook, corroborated the separate allegations of two former Ray Brook residents by telling

representatives of this Commission that around Christmas, 1974, while on duty in the Ray Brook infirmary, and assigned to watch the two women patients, he exposed his private parts to them, fondled them, and was fondled by them. In his opinion, it was considered standard procedure to fondle female residents while on duty in the living areas at Ray Brook. He further acknowledged the validity of complaints that he had kicked a resident.*

On another occasion, a Narcotic Correction Charge Officer, a first line supervisor, celebrated New Year's Eve with a resident, supplying the liquor and an empty, locked room in the facility. When they got there, they found another staff-resident couple had already settled in that area. This same supervisor appeared on the facility while off duty in June of 1975 and forced "Miss X" to accompanying him to town.**

The young woman, dubbed "Miss X", in order to maintain her privacy, testified before the SIC in public hearings and related numerous incidents of her own sexual involvement with staff members. She also discussed the use of contraband within the facility and the atmosphere of violence which often prevailed. Staff attorneys and investigators corroborated each incident mentioned at the public hearings.

"Miss X" testified that upon requesting a transfer to the cottage program at Ray Brook, this counselor directed her to perform an act of fellatio on him as a *quid pro quo*. She stated that she refused, but some time later went back to the counselor in order once again to request a transfer. On that occasion, she and the counselor engaged in oral sex.

"BY MR. SLATER:

Q Did you proposition him?

A No. He more or less put it to me that, you know, to be nice to him.

Q What do you mean? Did you go and ask him for a transfer to the cottages?

A Yes, I did.

---

* This information was subsequently turned over to ODAS officials. At the time of the preparation of this report, the NCO in question is the subject of disciplinary proceedings.

** Disciplinary proceedings have finally been brought against the staff member.

Q And what did he say to you?

A Well, he really didn't say too much. He just opened his zipper up.

Q Had you said anything to him other than the fact that you would like to go to the cottages?

A No.

Q After you were with him and engaged in this act of fellatio, did there come a time when you had to see this person again to make another request of him?

A Yes, I did. For work release. . . .

Q And what did he say to you then?

A He told me I could forget about making work release, and that there were too many people, you know, against it, and again we engaged in—in other words, if he was on my side [,] I would be able to make work release.

Q He told you that—what did he say to you exactly?

A Well, he said being that most of the people were against it, that if he spoke up for me that I would make work release.

Q And what happened next?

A We engaged again in oral sex.

Q Did you then get the pass to go on work release?

A Yes." (299-300)

When asked to characterize her experiences at Ray Brook, "Miss X" testified as follows:

"Q Did you ever compare the difference, . . . between being on the streets and being in the rehabilitation facility?

A Yes.

Q And what is the difference?

A There isn't.

Q There isn't? What do you mean by that?

A You can get drugs. You could have sexual relations. You could get drunk. You could do everything there, really, so there was really no difference." (306)

Several residents and former residents of Ray Brook discussed the homosexual experiences they encountered while at the facility. It was apparently common knowledge among the residents that upon being transferred to the cottage program, the more desirable living situation at the facility, a woman was often forced to have homosexual relations with the other cottage residents.

Ray Brook Assistant Director Robert Eisenberg stated that homosexuality was a problem and further commented that he did not feel that staff members properly handled such problems. He pointed out that incidents of violence at the facility are often directly attributable to the jealousy engendered by homosexual triangles.

Contraband, in the form of alcohol, pills, marijuana and excessive quantities of the spice mace was easily available. Residents on work release were able to bring it back to the facility with them as were residents who had been out on pass. Visitors were another source of contraband. One resident, now deceased, was known to have been "high" for several weeks while at the facility. Apparently, some staff members were aware that her common-law husband was smuggling pills and illicit methadone.

Portions of this resident's case record were read into the record by Commission Special Agent Raymond C. Rudden during the course of public hearings.

". . . Refused her assignment. Believes she was high last night. Extremely groggy this A.M. . . . [resident's name omitted] did her thing— . . . She will continue to do so wherever she goes until she makes up her mind to stop. What a beautiful person to waste a life. . . ." (315-6)

Another case record entry also uncovered by Commission investigators discusses one way in which contraband was brought into the facility.

". . . [R]esident was leaning out window of resident [resident's name omitted] room, when I came past

the room. I looked out and saw her visitor. There was a crocheted bag with a drawstring on it. He pulled at it and ran towards the woods. She left the room and unit. . . ." (316)

In discussing this same resident's abuse of drugs in the facility, a Narcotic Correction Officer also noted in her case record:

". . . Every resident on this floor has lost respect for her and I can see it plain as day. Maybe this all happened for the good or best as long as she doesn't OD or anything . . . ." (316)

This resident was admitted to Ray Brook on three separate occasions. Each time she was to be released few, if any, plans were made with her family. Each time she was released from Ray Brook, she was abusing drugs within days if not immediately upon her release. Several weeks after her last release, this 23-year-old woman was found dead in a shower. She apparently drowned while under the influence of an excessive amount of barbiturates.

Residents at Otisville would often draw lots to see who would make a "liquor run" to the nearby town. In one instance, an argument over who would bring back liquor led to a serious fight. As a result of this altercation, one resident suffered serious injuries necessitating the eventual removal of his spleen.

In discussing outbreaks of violence at Otisville, a witness described the manner in which residents would break pool cues in the recreation area, and fashion them into weapons using the facilities of the Otisville wood shop. He noted that these pool cues were brought back to the living quarters and hidden there for possible use at a later time. It is believed that a beating with these instruments caused the serious injury which resulted in the spleenectomy mentioned above.

Staff members at Masten Park and Iroquois also acknowledged the presence of contraband on the facility. Iroquois seemed to have much less of a contraband problem than Otisville even though it, too, is an open facility. This is probably attributable to stricter enforcement of search regulations and its greater distance from town. There seemed to be a direct correlation between stricter supervision and less contraband, violence, and involuntary sexual activity.

Throughout the SIC's inquiry into the problems of contraband, violence and sexual acting out at ODAS residential facilities, supervision or lack of it seemed to be the prime area of neglect. Serious allegations of sexual misconduct by certain Narcotic Correction Officers at Ray Brook were received by the Director of the facility and discussed with Central Office personnel months before disciplinary action was taken.

Referrals, Release and After-Care

Multi-Purpose Outreach Units—ODAS's Referral System

The Office of Drug Abuse Services maintains a state-wide system of Multi-Purpose Outreach Units (MOU's) designed to act as central intake units for communities and in conjunction with the criminal justice system throughout the State. Their stated objective is to assure that drug abusers who appear voluntarily or under judicial mandate are properly screened, diagnosed and referred to the appropriate local or state-run treatment program.* This segment of the ODAS program is partially supported through Federal funds received under a contract with the National Institute on Drug Abuse.

A review of referral procedures and criteria has shown that screening is not always carefully done, and the choice of facility appears to be often a random selection, at times based more upon bed availability than treatment criteria. Staff members at residential treatment centers have testified that at times they are faced with the problem of properly programming residents who are not drug abusers or who have only a minimal history of drug abuse. Whether this type of referral reflects poor screening or unnecessary judicial pressure upon the referral unit is a problem which must be examined by both the courts and the treatment agency.

Employees of locally operated treatment and referral agencies have expressed the feeling that MOU staff members are more concerned with keeping ODAS facilities at a high census level than with appropriate referral technique.

One counselor from a county-wide referral agency related an incident in which her agency had maintained ongoing contact with a client for several months. During that period of time, seeking an independent evaluaton of the client's problems,

* 1975 Executive Budget, Page 126.

she referred him to the local MOU. She related the client's history to the worker, and the worker agreed to interview the client and share her findings with the counselor. The client spent several hours at various times with the MOU worker. Nothing was heard from the ODAS program for many weeks. During that time, the local referral agency had succeeded in placing the client in a county-run residential facility.

After the client was placed in that facility and showing some signs of positive adjustment, the MOU recommended to the court that his probation be contingent upon a transfer to Otisville. The client was removed from the local facility and sent to Otisville against the recommendations of the local counselor.

A former resident of the Ray Brook Rehabilitation Center, in describing her program there, related the following situation:

"Q Did part of that [program] include any classes, any schooling?

A Sewing....

Q What about academic subjects?

A No, I didn't have any, because I had my high school diploma when I got there; so I did work details." (816)

Local program workers have also stated that they have found that they cannot rely upon program representations made by MOU representatives. For example, MOU representatives advised local agency counselors that clients would be sent to a particular facility. On the basis of such statements, these counselors have convinced their clients to enter the ODAS program. Subsequently, the client was sent to another facility; in one case, a facility which a client had specifically stated she was afraid to go to due to its reputation for excessive homosexual activity.

In referring clients to various facilities, the SIC has also found that ODAS often agrees to send a particular individual to a particular facility but does not do so upon his commitment to the agency by a court. Often, clients must spend several days or weeks in a different facility where they are not included in active rehabilitative programming.

A former resident, who had agreed to a commitment to Ray Brook in lieu of incarceration on criminal charges, testified concerning her experiences prior to arriving at Ray Brook:

"Q Were you a resident at any other [than Ray Brook] rehabilitation center?

A Manhattan.

Q How long were you at Manhattan Rehabilitation Center?

A A month.

Q How did you get there?

A From jail....

Q While you were at Manhattan Rehabilitation Center for that month, what kind of programming were you put through?

A I really didn't have a program, because I was waiting to be shipped to Ray Brook.

Q What did you do for that month?

A Laid there.

Q Laid there?

A Nothing.

Q What happened? What went on during the day? What did you do?

A I got up in the morning—that's it. Watched TV all day." (814-5)

24-Hour Hot Line

A good deal of publicity was at one time given to ODAS's 24-hour Hot Line. Apparently, in some portions of the state, this line was anything but hot. A counselor from the Broome County Drug Awareness Center testified before the SIC concerning her clients' experiences with this telephone number. She recalled one client who had called the advertised telephone number and received a tape recording telling him to call another number. He had already overdosed and was in a "medically dangerous condition."

". . . He called the other number and the person at the other end of the line identified themselves as Officer so and so at one of the DACC facilities.

He told the Officer the problem, requested help. He was told to go to the hospital.

The client replied he couldn't make it to the hospital; he was too sick and they just continued to tell him to go to the hospital." (272)

After receiving other complaints, the counselor went to a DACC employee and inquired about the Hot Line:

". . . This employee of DACC called the Hot Line himself indicating that he had a problem. He too, received a tape recording; had to call another number and received an officer at one of the facilities.

And he explained he had a drug problem and wanted help. This was on Friday night again.

He was referred back to his own office for the following Monday morning which would leave him nothing for the weekend. . . ." (272-3)

Planning for Release

Deficiencies in screening and referral are mirrored by similar deficiencies found in the planning for a patient's release from a residential facility. Criteria for release seems to be as vague as ODAS's definition of the problem which they are allegedly treating. It is apparent that ODAS does not seek a definitive cure but consistently refers to drug abuse as a "constant recurring condition." The SIC's examination of release procedures has revealed insufficient planning for the resident's proper reintegration into society as well as inadequate support services for former residents during the all-important transitional period. True job development is unavailable, as are the appropriate social services necessary for establishing one's self in a community if one does not return to a readily accepting family or spouse.

The family of the now deceased young woman mentioned in a prior section of this report* told SIC investigators that home visits or contacts were not made by after-care personnel prior to this young woman's first two releases from Ray Brook. On the other hand, agency personnel have stated that agency policy requires the after-care officer nearest to the resident's home to prepare a pre-release report which would in part be addressed to the problems which the resident would face upon release.

* See pages 111-12, *supra.*

Another young woman told Commission investigators that she had been approved for release from Ray Brook after four months. She stayed for three additional months because she simply had no place to go. Her initial drug involvement was minimal. She was eventually released, with no additional planning, about two weeks before Labor Day, while holding a job which was known to be purely seasonal. Within two weeks after her release, she was unemployed and without funds.

A number of women released from Ray Brook were able to achieve only seasonal employment and soon after their release, returned to the public welfare rolls.

Where a former rehabilitant will reside upon leaving a residential treatment facility is one of the most significant problem areas to be faced in planning for release. Not only should employment and housing considerations be taken into account, but also the proximity of an after-care facility. Upon release from an ODAS facility, unless that particular facility has an after-care staff, former residents may not look to it for help and support but must turn to the after-care officer. The several young women who settled in Saranac Lake with seasonal employment, after their release from Ray Brook, were the responsibility of an after-care officer who was stationed in Albany over 150 miles away. Although an extremely conscientious employee, she was able to make only bi-weekly trips to the Saranac Lake area. When former residents encountered serious problems, they either had to attempt to reach her by phone or wait until her next visit.

After-Care

During SIC public hearings, it became apparent that difficulties in the delivery of after-care services were not limited to Ray Brook and its former residents. Robert Bridges, Senior Staff Counselor for the Broome County Drug Awareness Center, testified that his agency had encountered numerous problems in assisting their clients in maintaining consistent ongoing relationships with after-care officers. After-care officers often lost contact with clients even though the clients were willing to maintain contact. Further, counselors were unnecessarily shifted between various after-care officers necessitating the establishment of new relationships and familiarities with case records.

The role of an after-care officer is indeed difficult to define.* One NPO who testified before this Commission summed up her duties as follows:

> "Well, they involved, I guess a combination of being both policewoman or policeman and social worker at the same time.
>
> You are responsible for making sure that those on your caseload are drug free and you can get involved in family counseling, helping them find employment, helping them find homes, helping them get training, anything that is necessary toward the rehabilitation [sic] goal." (799-800)

This dual role seemed to create additional problems in the delivery of services. The NPO is forced to wear "two hats." On one hand the NPO tells his/her counselees to be honest in confiding their problems. On the other hand, if they are doing something wrong, he/she might send them back to what many of the young people consider to be a jail.

In addition to their other duties, NPO's also must work in conjunction with various probation departments and, at times, serve in lieu of probation officers pursuant to a prior agreement between the particular probation department, ODAS and the courts.

The agency gave the new NPO no formal training. After some conferences with her supervisor, the after-care officer who testified before the SIC merely spent 3 days at Manhattan Rehabilitation Center getting to know other counselors.

When this particular NPO finally assumed her entire caseload, she was responsible for a geographic area covering 26 counties in the Northeast portion of New York State.

She pointed out that having lived in Albany all her life, she was well-acquainted with other social agencies in that area but that—

> ". . . [I]f I had to do the same thing in every city that I had somebody located at, it would be very time consuming because I wouldn't necessarily know who to go to, and it would take me time to find out and make the contacts that I already have established for myself in Albany.

* After-care officers are officially known as Narcotic Parole Officers or NPO's.

> Q Is it absolutely necessary in rendering the type of service which you feel you should be rendering and which your agency, I assume, directs you to render, that you are familiar with the offering of services by other agencies, agencies other than the Office of Drug Abuse Services?
>
> A Yes.
>
> Q Is the after-care program designed, as you understand it, in such a manner that the after-care officer is supposed to seek out these community resources so that they can be made readily available to the client?
>
> A Absolutely." (804-5)

Abscondences

An examination of statistics supplied to the SIC by the ODAS indicates that for the last two years reviewed, the abscondence rate from residential facilities has been well in excess of 30%. Thomas Wills, the present Director of Otisville, when questioned about the high number of abscondences stated: ". . . [Y]ou keep residents there by providing a climate where they are willing to stay." It was apparent to this Commission that in many cases the facilities studied did not provide that type of climate.

In some facilities, abscondence frequently meant nothing more than walking away, there being no need to hide or disguise one's intention. This arose from the combination of physical openness of a facility, together with a dearth of security personnel.

In an analysis of abscondence statistics from various facilities, it has become evident that the openness of a facility is not the sole cause of abscondences, and conversely, that the amount of security present is not always a deterrent. Otisville and Iroquois have essentially comparable physical settings, yet the number of abscondences from Iroquois was substantially lower than from Otisville.

While examining the admission and abscondence statistics at Otisville, Commission representatives noted that when DACC became aware of a need to fill Otisville immediately and began to transfer residents in from more secure facilities, the number

of abscondences skyrocketed. More careful screening of residents and more particular care in assigning them to specific facilities might lessen the total number of abscondences.

Warrant Squad

Section 81.29 of the New York State Mental Hygiene Law invests in ODAS the power to issue a warrant for the arrest of a person who, after having been certified to its care and custody, is declared delinquent due to either having absconded from a facility or after-care supervision, or fails to report as required. The statute in question further states:

> ". . . [A] copy of the warrant shall be sent to the State Police for execution. The State Police may request any Peace Officer in the State to assist in the execution of such warrant. Such warrant shall constitute sufficient authority to hold in temporary custody the person retaken pursuant thereto until such time as he can be returned to the Office [of Drug Abuse Services], and no order or commitment shall be necessary therefore." (Mental Hygiene Law, Section 81.29 (c))

As of September 1975, ODAS maintained four Warrant Squad locations throughout the State. Ten Warrant Officers were assigned to the New York City office. The Buffalo office had three officers with one officer being stationed in Albany and one in Newburgh.*

A residential treatment facility or other ODAS facility normally notifies the Warrant Squad upon the resident's abscondence from a facility or from after-care. The Warrant Squad officers are supplied with a physical description of the escapee and other pertinent information. It became apparent in the course of the SIC's investigation that the warrant procedure, as many other ODAS procedures, was not a uniform one throughout the agency. A supervisor in ODAS's Warrant Squad told this Commission that only his office had the power to issue a warrant upon the notification of abscondence. On the other hand, a facility director stated that a warrant is initially issued from the facility.

* Warrant and Transfer Officers of the New York State Office of Drug Abuse Services are designated Peace Officers pursuant to Section 1.20, Subdivision 33(v) of the Criminal Procedure Law.

Once a warrant is issued, a copy is forwarded to the New York State Police, to appropriate local law enforcement agencies and the New York State Identification and Intelligence System.

Unless the escapee is recaptured in the immediate vicinity of the facility from which he has escaped, he is usually only apprehended as a result of either a subsequent arrest or a "tip" being received by the Warrant Squad. If he is subsequently arrested and charged with a crime, routine post-arrest fingerprint check will reveal the presence of the outstanding warrant.

Commission investigators reviewed Warrant Squad files after studying Escape and Unusual Incident Reports from Otisville, Ray Brook, Masten Park and Iroquois in an attempt to determine the effectiveness of ODAS's Warrant Squad. As a result of this statistical analysis, it was discovered that notice of an escapee very rarely gets to the Warrant Squad. Once the Warrant Squad receives these files, little active investigation is carried out.

Of 77 known escapees from Otisville, only 17 were on record at the Warrant Squad office in New York City, which is supposed to have a record of all escapees. Of those 17, 11 files indicated either investigation or apprehension. Of 25 escapees from Ray Brook, warrant records existed in the New York office for only 4, and only one of the files indicated investigation or apprehension. Five of 23 escapees from Iroquois were on record in the Warrant Squad office, and further record of investigation or apprehension was unavailable. Of 18 escapees from Masten Park, the Warrant Squad had investigation or apprehension reports on 7. Little field investigation is done by the Warrant Officers. No officer goes more than 50 miles from his home office.

Ineffective Supervision—Lack of Training

Each problem examined, each inadequacy identified and each complaint considered during the course of this investigation was investigated and analyzed by the SIC from several sides. Not only did the SIC attempt to identify immediate problems and to isolate the deficiencies which caused them, but we also sought to learn and understand the manner in which top-level administrators responded to problems existing within individual treatment centers. In almost every case explored, a lack of adequate supervision or proper training often coupled

with ineffective communication within the agency was responsible for high costs, patient abuses and inefficient and ineffective programming.

While investigating sexual misconduct on the part of Ray Brook staff members, the SIC determined that although the Director of Ray Brook notified his superiors of these serious allegations in the late winter or early spring of 1975, formal intensive attempts at investigation were not initiated by ODAS supervisory personnel until late in the day on Friday, October 10, 1975. ODAS's first Deputy Commissioner was questioned by the SIC on October 9, 1975, and the Associate Commissioner in charge of the upstate facilities was questioned on the morning and early afternoon of Friday, October 10, 1975.

The Director of Ray Brook was informed by a resident in June of 1975 that she had had intercourse with a male staff member and that another male staff member had forced her to accompany him off the grounds of the facility late one night that same month. Disciplinary proceedings were not initiated against these two employees until October 1975.

Ray Brook's Director also acknowledged that he had heard a "buzzing" about the incident which took place in Ray Brook's infirmary on Christmas 1974. These actions by a male NCO are also discussed above.* No direct action was taken in that case. Disciplinary proceedings were brought after the SIC's public hearings.

Although the agency moved quite slowly in bringing charges against employees at Ray Brook, the first director assigned to Otisville at one time had 35 disciplinary proceedings instituted against staff members at the same time. ODAS administrators have pointed to this as one of his shortcomings.

During his appearance before the SIC, then-Commissioner Anthony Cagliostro was questioned about his personal efforts to improve agency management and supervision. He stated that it was his opinion that he should be aware of problems within facilities only in "broad terms." He stated:

> ". . . That's all I should be made aware of, in broad terms, because if I am supposed to supervise every individual action, then it is an impossibility.
> We have a hierarchy and the system provides for a hierarchy because you are presumed to be able to rely upon your subordinates to do the job and their subordinates and so on down the line. . . ." (739-40)

* See pages 108-9, *supra*.

Not only did agency administrators apparently fail to implement a uniform policy for the initiation of employee disciplinary proceedings, but they also failed to give facility directors sufficient support and guidance generally. During his testimony before the SIC, Joseph Daly, Director of Ray Brook, was asked:

> "Q Do you believe that if you were visited more frequently and had an opportunity for you and your staff to discuss with central staff personnel policy goals and aims your program could be improved?
>
> A I believe such visits would be beneficial. I believe they would have to have a beneficial effect, yes, sir.
>
> Q Have you related this to the Central Office?
>
> A Yes, sir.
>
> Q What has been the response?
>
> A Very often the response is as simple as the fact, well, it is an awfully long way to go. It is difficult to get to Ray Brook." (Q&A 402-3)

Thomas Wills, present Director of the Otisville Rehabilitation Center, also testified that he felt that at times his immediate superiors were not aware of instructions that he, Wills, had received from other agency administrators. Wills pointed out that prior to his assignment to Otisville, he had discussed certain treatment modalities and staffing patterns, particularly the "team treatment approach", with Dr. Harold Meiselas, Chief of Program Planning and Research. He had been sent to Otisville with what he perceived to be specific instructions to implement these ideas, and yet four or five months after he arrived at Otisville, his immediate superior, Associate Commissioner Meyer Diskind, was aware of the concepts but was not aware of agency plans to implement them at Otisville.

The SIC also found that there was little effective communication amongst and between agency-wide administrators. A cogent example of this was a memorandum from the Deputy Commissioner for Local Services to the First Deputy Commissioner

outlining numerous faults which representatives of outside agencies found at Otisville. Although this memorandum was prepared in June of 1974, the Deputy Commissioner directly responsible for Otisville's operation was unaware of its existence as late as October of 1975. This lack of communication was made more serious by apparent jealousies and rivalries at the Deputy Commissioner and Associate Commissioner level.

Effective management was obviated through a system which seemed to leave rehabilitation center directors pretty much on their own while Central Office personnel met with each other and apparently failed to communicate the developed policy to those entrusted with carrying it out.

A psychiatrist assigned to one of the ODAS treatment facilities observed that the most serious weakness in their programming was, in his opinion, a lack of training for staff. The SIC's examination of program failures has reinforced this observation.

A former Narcotic Correction Officer at the Ray Brook Rehabilitation Center testified at public hearings. This woman, who had spent many years as a supermarket employee, received no formal training prior to being assigned to her resident care duties at Ray Brook. She received no manual or other training materials and merely went along with more senior NCO's for the first days of her employment.

She subsequently became intimately involved with a female resident and eventually was convinced by the resident to aid in her escape from the facility. She and the resident drove to California and eventually returned to New York.

Upon her return to the community, she contacted the facility and informed them that she was back. She was subsequently placed under arrest by the New York State Police and pleaded guilty to the crime of custodial interference.* At no time since her return had any ODAS staff member or official contacted her either to determine how or why such a situation arose or, in fact, to ask about the whereabouts or well-being of the former resident.

Throughout this woman's tenure as an employee of ODAS all of her employee evaluations were at least average, and in most cases better than average. One evaluation discussed her potential for advancement to a supervisory position.

* Penal Law Section §135.45.

Although she admitted in her testimony before the SIC that she spent an inordinate amount of time in the company of this resident while on duty, none of her superiors ever inquired about her conduct with the resident. They did not even discuss the potential for a problem with her when they received a letter from another former resident which directly referred to the possibility of an improper relationship between the NCO and resident. In fact, her dismissal from employment was based on non-attendance and did not mention the escape.

This witness pointed to what appears to be an abdication by ODAS of their responsibility to train employees and properly prepare them for the duties they are to assume. She stated:

> "As far as responsibility for my experience, I'm aware of my own responsibility. I, however, hope that the Commission [ODAS] would be made aware through this hearing of their responsibility to people like me in the future." (411)

In exploring the manner in which the staff at Otisville was prepared for new assignments upon the transfer from DFY to ODAS, it was discovered by this Commission that little, if any, thought seemed to have been given to a definition of new roles or appropriate training. When the drug agency took over Otisville in the summer of 1973, an initial attempt was made to present some kind of training program. This program has been described by one experienced youth worker at Otisville as having been "half-assed." He went on to say, "We had a lot of idle time on our hands. . . ." (345)

Not only was training inadequate, but employees were not told what their new responsibilities would be. When the first resident arrived at Otisville, and for some time thereafter, there was no difference between the former DFY Program and what was being carried on under ODAS. No program planning had been done for the new residents nor had new program goals been clearly explained. All that was said was that Otisville was to be experimental.

Wesley Hunter, the present Security Director of Otisville, and a highly experienced youth worker, testified at SIC public hearings:

> "Q Did anyone tell you before those residents came, [that] there would be a new or unique program?

A They explained to us, it was to be an experimental program. This was a new and experimental program.

Q When you do have an experiment, you have to know what to do with the things you are experimenting with.
Did anybody tell you what to do with those people?

A No. We followed pretty much the same trend as we did with the boys' training school to start with." (348-9)

Proper professional supervision is closely related to an efficient dissemination of agency policy. Not only must there be a uniform policy and procedure manual for the entire agency, but this must be made available to and understood by all personnel. In addition, since each facility is faced with situations and plans unique to that facility, personnel should be able to turn to an individual collection of policies and procedures created for the individual institution.

Manuals, books, lectures and supervisory conferences are ineffective if not consistently reviewed as to their implementation and appropriateness. ODAS has apparently been unable to insure that its own policies and procedures were uniformly carried out.

Although ODAS's policy and procedure manual calls for the use of isolation only when a resident is a danger to himself/herself or others, at the time of SIC visits to Otisville, isolation was being used as punishment in direct contravention of stated policies and procedures. The written policies of the agency call for a standing letter of agreement between a facility and the local hospital. None existed at Otisville.

When questioned about the apparent disregard for the uniform enforcement of policies and procedures at the institutions under his direct supervision, particularly Otisville, Associate Commissioner Meyer Diskind stated:

"I say that comes to me as a complete surprise . . ." (553)

He further stated that the purpose of his visits to facilities was to evaluate them in depth.

Findings of the New York State Department of Health

Recent Federal legislation and rules enacted thereunder* require that ODAS's residential treatment centers be subject to inspection by the State Health Department as Intermediate Care Facilities, just as nursing homes are. Although some Health Department and ODAS officials have pointed out that many of the criteria applied to nursing homes need not be applied to facilities housing young, active patients, failure by ODAS to conform to the published rules could have resulted in a potential loss of $21 million dollars to the State of New York during the present fiscal year. This would have occurred if the residential treatment facilities operated by ODAS failed to receive certification from the State Health Department and lost Medicaid reimbursement.

ODAS's response to the imposition of these additional, stringent requirements was another example of the agency's administrative ineffectiveness, poor planning and imprudent fiscal management. While testifying before the SIC, ODAS's First Deputy Commissioner John W. Randall discussed the agency's lack of preparation for these inspections:

"Q Was anyone in the agency aware that these Federal regulations, whether or not they were in your feeling or anyone's feeling germane to narcotic rehabilitation centers, was anyone aware they were going to come into effect and [that] the Health Department would be investigating and examining your facilities?

A Yes.

Q Was any action taken prior to these actual visits by the Health Department?

A Well, we knew that the Health Department was coming. They had spoken with, I believe, Mr. Shattenkir and told him that they were coming. We told each facility to expect the visits and be cooperative.

Q Were you aware of the type of criteria they would be applying when they visited?

* See Public Law 92-223; 85 Statutes at Large 810; also 38 Federal Register 5974 and 39 Federal Register 2220.

A Well, we were aware that it would be criteria applied primarily to nursing home type operations, and we didn't feel were appropriate to the type of program we operated.

Q Even though you didn't feel they were appropriate, Commissioner, you are aware that these standards were to be, at least for the immediate future, applied to your facilities?

A Yes.

Q Did you make any efforts—when I say 'you,' I mean the agency—to do a pre-investigation of the facilities to determine whether you would have any problems with the Health Department's visits.

A Well, we didn't do any organized visit to each facility to apply our knowledge of those to each facility. No, we didn't do that." (72-4)

Health Department inspection teams from the various regional offices visited ODAS facilities throughout the State. Deficiencies were noted in most of the facilities. These deficiencies reflected structural inadequacies, poor program planning, inadequate medical care, often poorly prepared food with poor nutritional value and other failings which, in at least one instance, could have been life-threatening.

Initially, the certification of most facilities was in question; that very certification necessary to continue the inflow of Federal dollars. Although the State Health Department has issued waivers as to many deficiencies cited in their initial reports, many of the problems and inadequacies to be discussed below still existed.

A brief review of the Health Department's findings indicate that at the time of their inspection of various ODAS facilities in 1975, Otisville lacked proper nursing coverage as well as written policies for the administering, dispensing, controlling and recording of all medications. In addition, surgical and biological wastes, as well as infectious materials and disposable syringes and needles were not being destroyed by incineration, but being thrown out with the rest of the garbage and dumped in the town landfill causing the potential threat of the spreading of infectious diseases. In addition, the infirmary was located in a non-fire resistant building.

The Health Department noted that at Ray Brook the staff had not been given the required tubercular Tyne tests to determine a potential for developing tuberculosis. The infirmary at Ray Brook had inadequate fire escapes as noted by DACC's own safety inspector in 1973. This situation still existed in 1975.

Masten Park also suffered from inadequate nursing coverage. The interiors of the buildings were constructed of non-fire resistant materials and numerous fire escapes led to areas considered "non-safe" in the event of a fire.

Several years ago, a serious fire developed at Masten Park. The Fire Department was not called immediately and upon their arrival were not able to gain access to the facility since the gates were not functioning. Security personnel did not cooperate with the Buffalo Fire Department and fire officials had difficulty in gaining access to portions of the building since keys could not be located.

Deficiencies were also noted at Ridge Hill, Bushwick, Queensboro and Iroquois.

All of the facilities mentioned above were cited by the Health Department for a lack of annual physical examinations of staff, a serious lack of input from licensed pharmacists and inadequate supervision of food services personnel as well as a properly trained dietary staff.

Narcotics and Drug Research, Inc.

In 1967, Commissioners and other administrative personnel of NACC, on their own, formed a not-for-profit corporation known as Narcotic and Drug Research, Inc. Its stated purposes were:

> "To assist in developing, expanding and augmenting the efficiency of the facilities of the New York State Narcotic Addiction Control Commission, and the institutions and agencies established within such commission or supervised by or related to it; to conduct studies and research with respect to the causes, nature, prevention, control, treatment, cure and aftercare of narcotic addiction and drug abuse, and all such physical, medical, familial, and societal phenomena as may be characteristic thereof; to promote but not to conduct programs concerning narcotic addiction and drug abuse, its causes, nature, prevention,

control, treatment, cure and after-care; to encourage gifts, grants, bequests, devises, contributions and donations of real and personal property to the corporation for such purposes."*

The corporation received its first grant in 1970, and presently handles over one million dollars in Federal funds.

The State of New York has no direct control over the actions and policy of this corporation other than those controls it would have over any other corporation. In other words, even though all corporate officers and directors are employees of the State, and the stated purpose of the corporation is to assist in the development and operation of a state agency, neither the legislative or the executive branch presently control its policy or procedures.

Investigation by SIC personnel and the testimony of former Commissioner Anthony Cagliostro at SIC public hearings have caused this Commission to question the propriety of such a situation.

Commissioner Cagliostro stated that:

". . . [T]here would be an identity of control between the agency and the corporation so that there couldn't be any chance that the corporation organized to assist the agency would ever go its own way and conflict with the agency, and that the officials of the agency, who were also officers of the corporation, would know what were the policies of the agency, and, therefore, made sure that the policies of the corporation would not be contrary, inimical or in contradistinction to those of the agency." (754)

This very situation could also insure that no researcher or other professional whose views differed from those in control of the agency would receive financial support for his or her research. Although the Division of the Budget might be able to review grant applications to assure that those "inimical to the interest of the State" would not be funded, the State Government would have no way of knowing of the existence of those ideas, possibly valid, which did not receive ODAS's support solely because of philosophical opposition by ODAS officers

* Certificate of Incorporation filed June, 1967.

wearing two hats. The Board of Directors of the corporation is composed only of high ranking officials of ODAS and the corporation is run by an Executive Committee who are, in fact, ODAS's highest ranking officials.

Therefore, opposition to its actions, even by middle management bureaucrats within the drug agency, is next to impossible.

In addition to dealing with research funds, the drug agency contracts exclusively with the corporation for the development of planning, training and evaluation activities funded through Federal formula grants. This, too, denies access to planning and review functions to those individuals and research institutions not directly affiliated with ODAS or friendly to its highest ranking officials.

It is also possible for a former employee of the agency to be employed by the corporation. This fact, coupled with the present situation in which the Division of the Budget and the Comptroller's office have no direct control over the corporation, creates a situation which allows for the possibility of abuse.

RECOMMENDATIONS

The SIC has already stated that it is

". . . [W]ell aware that the Office of Drug Abuse Services has many fine and dedicated employees. However, we have found that such employees have received inadequate supervision and support from both their superiors and specialized units within ODAS . . .

Although this Commission does not presume to define the manner in which drug addicted and drug dependent individuals are to be treated by the State, it is our duty and our mandate to bring the public attention to the manner in which they have been mistreated, the manner in which dollars may have been misspent and to draw attention to those ODAS officials who have allowed these conditions to exist and have failed to respond in an immediate and responsible manner." (833-4)

The following recommendations are made with the hope that their implementation will assist the State in meeting its ac-

knowledged obligation to those individuals in need of residential treatment and to the community at large.

1. There should be a sweeping top-to-bottom review of the State's residential treatment program for drug abusers with the view towards strengthening administrative procedures, the setting of understandable criteria and standards for programs and facilities and the identification of specific supervisory personnel responsible for monitoring the effectiveness of these programs.

2. ODAS's budgetary and planning mechanisms should include a more comprehensive method of cost effectiveness control and facility utilization review.

3. A written policy and procedure manual and treatment plan should be developed for each residential treatment center in addition to those agency-wide policies and procedures already in existence. This would facilitate continuity of treatment, improve supervision and assist in the professional development of staff members as well as aiding in the delivery of services.

4. Formal pre-employment and in-service training curricula must be developed and implemented. An increase in the quality of training given to staff would definitely aid in improving the quality of services delivered and the continuity of treatment rendered. It would also assist in developing uniform criteria for assessing the operations of individual facilities and the functioning of particular staff members.

5. Greater attention should be given to planning for a resident's release. The transition from institutional regimentation to independent living in a community require increased cooperation between the resident, institutional counselor and after-care officer. The resident should be developing post release plans in conjunction with the assigned after-care worker prior to his or her returning to

the community. ODAS should more clearly define the worker's role for the benefit of both the resident and staff.

6. Great emphasis should be placed on designing effective security arrangements and properly implementing those security procedures already established for the control of contraband as well as other institutional problems.

7. State policy with regard to the implementation of existing Civil Service Laws, particularly Section 70 of the New York State Civil Service Law, should be reviewed. The spirit of reform which led to the adoption of these very laws should not be perverted so that a State Agency is required to assume an entire existing staff based on considerations other than the effective operation of their agency and the efficient delivery of the services they are mandated to give. If necessary, we respectfully suggest that the Legislature consider clarifying existing statutes.

8. ODAS's Warrant Squad operation should be abolished. Any probationer who absconds would be in violation of probation and voluntary admissions who choose to leave do not require Warrant Squad action. This would reduce the personnel budget and incidentally do away with the necessity for an additional class of persons who are presently granted Peace Officer status and therefore the concomitant right to bear arms.

9. The existence of Narcotic and Drug Research, Inc. as a separate not-for-profit corporation leads this Commission to question the operation of such a private entity not under State control when such a corporation is controlled by the same people who control a State agency. The SIC feels that the quality and effectiveness of research might suffer if there is control of this corporation by the same group who control research and the general policy of ODAS. There is at least the appearance of a conflict of interest. The SIC recommends that the

State seek to determine whether changes should be made in the corporation's management, operation and accountability.

Respectfully submitted,

DAVID W. BROWN, *Chairman*

EARL W. BRYDGES, JR.

FERDINAND J. MONDELLO

ROBERT K. RUSKIN
Commissioners

END