BEHAVIORAL SKIN SHOCK SAVES INDIVIDUALS WITH SEVERE BEHAVIOR DISORDERS FROM A LIFE OF SECLUSION, RESTRAINT AND/OR WAREHOUSING AS WELL AS THE RAVAGES OF PSYCHOTROPIC MEDICATION:

REPLY TO THE MDRI APPEAL TO THE U.N. SPECIAL RAPPORTEUR ON TORTURE

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Introduction

Modern behavioral psychology has developed a number of effective treatments for major problem behaviors of special needs children and young adults. These treatments involve administering rewards for desired behaviors and corrective consequences, also known as *aversives*, for undesired behaviors. Some well-intentioned, but misguided, *anti-aversive advocates* object to the use of certain types of aversives, such as the skin-shock aversive used by the Judge Rotenberg Educational Center ("JRC").

The authors of the Mental Disability Rights International ("MDRI") document "Torture Not Treatment: Electric Shock and Long-Term Restraint in the United States on Children and Adults with Disabilities at the Judge Rotenberg Center" (the "MDRI Report") appear to have bought into the anti-aversive philosophy, without ever visiting JRC or discussing a single concern with any of the current JRC clinicians or parents, or with any of the many current and former students who are supremely grateful for the life saving progress they made at JRC. Apparently, the views of the MDRI Report's authors have been formed solely based on what they have heard from other anti-aversive advocates. Remarkably, while only hearing about JRC second and third hand from those who are already opposed to JRC and/or aversives, they nonetheless have felt qualified to make the judgment that what JRC offers is torture and not treatment, and to produce a report that pretends to document and prove their case.

This document, will respond to the extraordinary amount of false and deceptive information in the MDRI Report. More importantly, it will try to explain why aversive therapy, though controversial in some quarters, is a very safe and important treatment option that should remain an option for parents deciding what treatment to seek for their special needs children. In some cases it may be the *only* means of saving their children from maiming themselves, from killing themselves, or from leading painful and wasted lives filled with catastrophic self-inflicted physical injuries, psychotropic drugs, restraint, isolation, warehousing, and institutionalization.

This document will also explain why aversives are a scientifically proven form of treatment and not a form of torture, and why persons with developmental and psychiatric challenges have a right to have the option to choose aversive therapy to cure or ameliorate their behavior problems.

MDRI's appeal must be rejected by the United Nations because of its obvious false statements, bias, and lack of credible evidence. JRC invites the United Nations Special Rapporteur on Torture to visit JRC and witness first hand the life-saving treatment and ground-breaking education that is being provided to what is probably the highest concentration of difficult-to-treat special needs students in the world.

Executive Summary

Some special needs students with severe behavior disorders show frighteningly dangerous self-abusive behaviors such as: gouging out their eyes, causing near-blindness; smearing feces; head-banging to the point of causing stroke; skin scratching to the point of fatal blood and bone infection; pulling out their own adult teeth; running into a street filled with moving cars; or suicidal actions such as attempting to hang oneself, swallowing razor blades, taking a drug overdose, and jumping out of a moving vehicle or off of a building. Some students have shown violent aggression such as biting, hitting, kicking, punching, and head butting others. Some have pushed a parent down a flight of stairs, raped someone, tried to strangle a parent while the parent was driving, and beat a peer so severely that plastic surgery was required. Some have attempted to injure or kill others by pushing a child into oncoming traffic, smothering a sibling, stabbing a teacher, or slicing a peer's throat. Some have attacked police and therapists. Some have set their homes on fire, lit a fire in school, and lit themselves or family members on fire. Some have engaged in prostitution, been involved in gangs, and assaulted others with weapons such as a machete and chainsaw. ***All of these are behavior problems that students have shown prior to enrolling at JRC and that JRC has undertaken to treat.***[1]

Fortunately, behavioral psychology has developed a treatment for these behaviors called "behavior modification" or "applied behavior analysis." At its simplest and most easily understood level, it involves arranging rewarding consequences for desired behaviors and corrective consequences (consequences designed to decrease problem behaviors, or "aversives") for undesired behaviors.[2]

The use of skin shock as a component of behavior modification treatment is opposed by certain advocates. Because JRC is the leading example of a program willing to supplement positive behavioral supports, such as rewards with skin shock as an aversive, in cases where the person cannot be effectively treated without them, JRC has become the focus of attacks by anti-aversive advocates. Characteristically, these persons are unwilling to rationally weigh the risks or intrusiveness of skin shock aversives against the benefits, and to consider whether using such aversives might be a better choice than the alternatives. They simply ignore the small population of people who cannot be effectively treated with psychotropic drugs and positive behavioral supports alone, and who are being warehoused and drugged into submission.

JRC has been licensed or approved continuously, throughout its 39 year history, by the state education, developmental disabilities and child care departments of Rhode Island and Massachusetts. The Massachusetts Department of Developmental Services ("DDS") has granted and renewed, ever since 1986, JRC's special certification to use aversive

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[1] JRC's website, at www.judgerc.org, contains a wealth of information. Additional information about aversives can be found at www.effectivetreatment.org.

[2] *See* http://judgerc.org/parents_journey.wmv ("Parents' Journey") for film clips showing some of these types of behavior problems, and giving an overview of how JRC uses positive reward and educational procedures, supplemented with aversives when necessary, in treating these behaviors.

behavioral procedures. More than fifteen different judges of the Massachusetts Probate and Family Court have, during the last 25 years, approved individual petitions, by guardians on behalf of incompetent children and adults at JRC, to allow the use of aversive therapy in individual behavior modification treatment programs. Thousands of loving parents—including professors at Harvard and NYU, as well as psychiatrists and pediatricians—have entrusted the care and habilitation of their children to JRC.[3] Former JRC students have voluntarily come before legislative committees to testify that JRC saved their lives.[4]

The use of a skin-shock as a supplementary component of positive behavior modification treatment does not meet any of the requirements in the definition of torture in the UN Convention against Torture. Behavioral skin-shock is applied to "ameliorate a condition or illness," a fact that rules it out as a form of torture. A two-second application of shock to the surface of the skin, typically on an arm or leg, does not inflict "severe pain and suffering." Aversive therapy is not experienced by JRC's students as torture, as witnessed by their own testimony; many students view it as helpful or even life-saving. Aversive therapy is used to *end* pain, as well as to save, extend and enrich lives. There is no discriminatory purpose in how behavioral skin shock is used. Aversive therapy is not administered for the purpose of applying retributive punishment to an individual.

To call aversive therapy "torture" is as inappropriate as calling uncomfortable medical treatments torture or as calling surgery "assault with a deadly weapon." Indeed, if we adopt the reasoning of MDRI Report, both dental surgery and surgery to treat cancer would satisfy the definitional requirements of "torture."

Under state and federal law, non-disabled individuals have the right to choose aversive therapy to treat behavioral problems such as smoking and drinking. Preventing disabled persons from the opportunity to avail themselves of aversive therapy for their own behavior problems, would be an invidious discrimination against disabled persons.

The authors of the MDRI Report have a strong philosophical opposition to aversives. Presumably, even if treatment with behavioral skin-shock were the only treatment that could save a child from maiming or killing himself or herself, they would oppose its use. Indeed, Dr. Fredda Brown, one of the key persons who provided information to the authors of the MDRI Report was involved in just such a case.[5] In that case, a young man

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[3] *See* http://www.judgerc.org/intensivetreatment.html#State_House_Testimonies,_November_2009 and http://www.judgerc.org/Comments/parents_AV.html

[4] *Id.*

[5] Dr. Brown, a zealous advocate of deinstitutionalization and an anti-aversive supporter, was instrumental in the removal from JRC in the late 1990's of a student named James Velez. James suffered from a debilitating compulsion to scratch and gouge his skin with his fingernails—a behavior that caused serious blood and bone infections and caused him to require a wheelchair. At JRC his behavior improved sufficiently to enable him to get out of the wheelchair. His self-mutilation was drastically reduced, his skin bone infections cleared to the point where he could have some skin grafts, and he was even able to attend classes at a local public high school with having to wear his GED skin shock device. Unfortunately the anti-aversive advocates, advised by Dr. Brown

who was maiming himself through self-abusive scratching until he received effective treatment with behavioral skin-shock at JRC. Unfortunately, anti-aversive advocates persuaded his parents that he no longer needed that treatment and could live in a supported apartment where aversives would no longer be available. Without aversives, however, his self-abusive scratching (causing blood and bone infection and eventual paralysis) resumed and caused him a painful and premature death at the age of 25.

Almost all of the persons listed as sources for the information for the MDRI Report have testified in Massachusetts for bills that would, if passed, ban the use of aversives. After trying, unsuccessfully to pass such bills for 24 years, the proponents of these bills now are looking to the United Nations Rapporteur on Torture for help with their political cause.

Because of the authors' strong philosophical opposition to aversives, what they refer to as an "investigation" was simply not that. They never visited JRC, never sought to discuss their concerns with JRC's clinicians or staff, never spoke to the hundreds of parents who

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persuaded James' parents that he no longer needed the behavioral structure or aversives of JRC.

James was then removed from JRC against JRC's advice. The advocates who removed him were so hostile to JRC that they refused to even communicate with JRC's medical director about what James' medical needs were, and refused to discuss with JRC's clinicians what his treatment needs were. JRC was unable to even find out where James was living. The anti-aversive advocates were so eager to remove him from JRC that they removed him even before there was a group home or supported apartment ready for him in New York, his home state. As a result he spent 2 years in a ward for developmentally disabled persons at the Brooklyn Development Center.

Eventually James was moved into a supported apartment in Brooklyn operated by an agency that was opposed to the use of aversives. After moving into his apartment, James was invited by the anti-aversive advocates to tell his story at a Boston conference of TASH, an advocacy organization that is strongly opposed to aversives. (Jan Nisbet, one of the other persons providing information for the MDRI Report is a former President of TASH.) James' life story to this point was chronicled in a manner quite sympathetic to the anti-aversive advocates, in four front page articles that ran in the *New York Times* in June and December 1997. Copies of the four *New York Times* articles, James' obituary, and a proposed OpEd piece about James by Dr. Israel are attached hereto in Appendix J.

At his shared apartment James' behavioral consultant was Dr. Brown. Devoid of the behavioral structure and aversives that had served him at JRC, James resumed his scratching, had to use a wheelchair once again, and within about 13 months was hospitalized and nearly died from a leg infection. By February, 1999 he was paralyzed and by October 1999 he was dead at the age of 25, due to infections of the blood and spine caused by the very behaviors JRC had been able to successfully control through the use of skin-shock. Characteristically, the anti-aversive advocates showed no remorse over his death or second thoughts as to the wisdom of removing from JRC the one program that had gotten him out of a wheel chair, made him healthy again, and kept him alive. The director of the supervised apartment program in which he died is quoted in his obituary as saying, "Things turned out not to be so simple as we first thought. For the last few years, though, I think that James had the best life that he could have. If that's what this experiment proves, that's a lot….He had the life he wanted…James paved the way."

After James' death, when Dr. Brown came to JRC to testify against the use of aversives in the treatment program of another student, Dr. Israel invited her to his office to discuss the case. She refused and marched out of his office when the subject was raised.

are pleased with what JRC has been able to accomplish for their children, never advised JRC of their investigation or invited JRC to respond to their concerns, and never interviewed current or former students who have been pleased with the results of their treatment at JRC, including the use of aversives.

MDRI's "investigation" consisted largely of the following: finding and using unverified negative accusations available on the internet; taking selective quotations from the JRC web site given by parents and students in *support* of JRC's use of aversives, and fraudulently revising those portions to make up false or misleading statements designed to make the authors appear to be *negative* toward JRC's treatment; soliciting information from an individual who, according to an August 29, 2006 police report, claimed to have placed a "whistle blower" inside JRC;[6] soliciting as many negative quotes as possible from persons who are opposed to JRC; accepting and publishing anonymous accusations without researching whether there was any truth to them; taking selective quotations from reports by a state agency that has a philosophical opposition to aversives (and that is currently being sued by a group of JRC parents in the Federal District Court of Northern New York) without any reference to JRC's responses to those accusations, all of which are available on JRC's website; and presenting as facts, outdated, re-hashed, and long-since refuted accusations, some of which are now as much as 30-40 years old.

Particularly disturbing is the authors' willingness to distort testimonial material from JRC's own website. The authors took words out of context, made up statements that were not made by the persons who gave the testimonials, and represented the material to be negative comments about JRC and/or skin-shock aversives. If the authors were so willing to falsify statements that can be so easily checked—just by going to the JRC website—how much have they distorted the many other accusations in the MDRI Report that were made anonymously and whose accuracy cannot be checked?

In summary, the MDRI Report is a false, misleading, sensationalized, and one-sided account of JRC that is worthy only of a tabloid. It is not a serious or accurate piece of reporting or investigation. One fervently hopes that this Report is an aberration, and not representative of the standards used by MDRI for its other work on both the national and international fronts.

[6] A copy of the police report is attached hereto as Appendix A. Note that even a fellow JRC-accuser admitted, "I guess we know the whistle blower is not reliable."

I. JRC PROVIDES LIFE-AND-LIMB-SAVING BEHAVIORAL TREATMENT THAT HAS BEEN FULLY LICENSED OR APPROVED BY STATE AGENCIES, APPROVED IN INDIVIDUAL CASES BY OVER FIFTEEN DIFFERENT JUDGES OF THE MASSACHUSETTS PROBATE COURT SYSTEM, AND APPROVED BY GRATEFUL PARENTS.

JRC is a residential and day educational and treatment program in Canton, Massachusetts that was started in 1971 by Dr. Matthew Israel, a student of B. F. Skinner, the founder of modern behavioral psychology. Currently, JRC's staff of approximately 1000 employees serves 215 special needs children and adults who have a variety of psychiatric diagnoses and educational labels, including developmentally disabled, emotionally disturbed, and conduct disordered. All of the students have at least one thing in common—they suffer from severe behavior disorders that could not be effectively treated by the many previous treatment programs and psychiatric hospitals they had been in prior to coming to JRC. The students attend JRC's school in Canton and live in 33 residences in nearby communities which JRC staffs and operates.

JRC is based on the following basic principles: (1) JRC uses a highly consistent behavioral approach to both the education and treatment of its students; (2) JRC eliminates or minimizes the use of psychotropic drugs; (3) JRC has a zero rejection, zero expulsion policy; (4) JRC's treatment relies almost exclusively on the use of positive rewards and educational procedures; however, if positive procedures alone are insufficiently effective, JRC supplements them with the use of aversives (decelerative procedures).

JRC serves what is probably the highest density of individuals with difficult-to-treat behavior problems in the country. JRC saves children and young adults from crippling disabilities, permanent injuries and even death caused by their treatment-resistant, life-threatening behavior disorders. Before coming to JRC, many students were confined for years in psychiatric facilities or were living on the streets, suffering from the physical, mental and emotional pain caused by their untreatable self-mutilation, aggression, destruction and other harmful behaviors.

JRC's students have engaged in such severe self-abusive behaviors as: continually ruminating and projectile vomiting to the point of nearly starving to death;[7] manually pulling out one's own teeth;[8] scratching oneself so persistently as to be

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[7] *See* Parents' Journey, note 2, *supra*. (Containing films of a student with these behaviors, as well as other students with severely harmful behaviors before and after the receipt of aversive therapy.)

[8] JRC currently has a student who has pulled out all but 14 of his adult teeth. Unfortunately, due to regulations of the New York State Department of Education ("NYSED") that ban the use of aversives (lobbied for by some of the informants who provided information for the MDRI Report), JRC has been unable to provide this student with the treatment he requires to treat this behavior. As a result, JRC has to keep him in tube-like arm restraints to keep him from engaging in further teeth-removals. His parents have joined other similarly situated New York parents in a lawsuit they filed against NYSED in Federal Court in New York State seeking an injunction that would prohibit NYSED from enforcing the NYSED regulatory ban on aversives against their son.

at risk for death through blood and bone infection;[9] violently attacking one's parents and teachers; eye-poking and head-banging with such force as to detach both of one's retinas;[10] and head banging so violent as to cause oneself to have a stroke.[11]

The following letter, which was written by the parents of a student who had detached both of her retinas through self-abusive head-poking, is illustrative of the flavor of such problems. The letter, which was sent to legislators who were considering a proposed bill in the Massachusetts legislature to ban the use of aversives is as follows:

> *To Whom it May Concern:*
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> *We would like to tell you about our daughter, Samantha, and how the Judge Rotenberg School in Canton Massachusetts has saved her life.*
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> *We first discovered Samantha was different when she was about 2 years old. She would not relate well to others, had very little speech, and would stare at her hands or small objects for hours at a time. She also had frequent tantrums, and cried often. She began with early intervention, and over the next ten years, she went to four specialized schools for autistic children. In addition to her schooling, numerous therapists, and teachers came to our house to work with Samantha after hours, most of which was paid for out of our own funds. All these schools worked closely with her in small groups, and on a one to one basis, using learning trials, and positive reinforcement. In addition to this, Samantha was under the care of a psychiatrist, and given several different psychotropic medications.*
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> *Despite, all these well caring professionals working with our daughter, Samantha progressively deteriorated. Over the years, she became more violent. She would attack us, other children, and her teachers. She would bite, scratch,*

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[9] *See* note 5, *supra*.

[10] JRC has such a student who had detached both retinas due to eye-poking. Her previous placement, a program that used positive-only treatment procedures, was unable to stop the behavior. Supplementary skin shock at JRC was successful in treating the behavior and thereby enabling the retinas to be re-attached. The young lady is now thriving. Before and after treatment photos of her are provided in this document at pages 36 and 37.

[11] JRC has a student who is only 16 years old, but who has engaged in head-hitting so forcefully that he has caused himself to have a stroke. His physician has advised JRC that in all probability continued head-banging will cause a fatal brain hemorrhage. Unfortunately, due to NYSED regulations that ban the use of aversives (lobbied for by some of the individuals who provided information for the MDRI Report), JRC has been unable to provide this student with the treatment he requires to treat this behavior. As a result, JRC has to keep him in a helmet and partial mechanical restraints to keep him from engaging in further forceful head-hits. His parents have joined other similarly situated New York parents in a lawsuit they filed against NYSED in Federal Court in New York State seeking an injunction that would prohibit NYSED from enforcing the NYSED regulatory ban on aversives against their son.

kick, hit, pinch, and head-butt. In addition she became more self-abusive. She would throw herself on the floor, hit herself, and throw herself against hard objects. She constantly had marks, and bruises on her from her own self abuse. We were also prisoners in our own home, as we could not take her anywhere, due to her behaviors; this had an impact on our other children as well. The final straw came when she hit herself in her head with such force, that she detached both retinas of her eyes, and was virtually blind. This has subsequently required 6 eye surgeries to repair, and her vision is still far from normal. The Anderson School, where she was at the time, told us they could not handle her, and asked us to find another school. This is when we learned about the Judge Rotenberg School (JRC), and the GED device.

Within several weeks of getting treated with the GED device, a miracle happened; Samantha stopped hitting herself, and stopped her violent behavior. She appeared much happier. She was able to be weaned off all of her psychotropic medications.

There was a period of deterioration. In June 2006, aversive treatment became a big issue in New York State. A law was passed prohibiting the use of the GED for antecedent behaviors, leading up to more aggressive behaviors. Samantha became more aggressive, and angry. Some of her old behaviors returned. An injunction to this law was obtained several months later, and the GED was then able to be applied as indicated in the JRC program. Samantha improved, and was happier, and no longer aggressive towards herself or others. This was proof that she needs an ongoing program that includes the GED.

Recently, Samantha had another challenge. Due to a congenital condition, she had to undergo complex orthopedic surgery on both legs to correct a balance problem, and prevent future arthritis. JRC was absolutely wonderful. They accompanied her to all her appointments at the Boston Children's Hospital. She remained in the hospital for 6 days after her surgery. JRC had staff members in her room 24 hours a day, during her entire stay in the hospital. In her post operative period, the staff was with her in her residence at all times, and met her every need. She had to be non-weight bearing for 6 weeks post op, and the JRC staff helped her and transported her to school, and to all her post operative doctor's appointments. One of the most remarkable things about her surgical experience, is through all her pain and all her frustration of not being able to walk, she remained calm, and pleasant. This proves the durability of this program at JRC. If she was anywhere else, surely her old behaviors would have returned, and may have affected her post operative outcome.

Sometimes, we feel that JRC is the most misunderstood place in the world. Samantha has now been at JRC for over 5 years, and we have seen nothing but love and affection for her on the part of the entire staff. They appear to have the same love for all the students at the school. The GED is given only after the failure of positive reinforcement programs, and only after the approval of a judge.

It is given carefully, and under strict protocols. Everything done at this school and in the residences is video monitored. The program is 100 percent transparent, and has nothing to hide.

The bottom line is that this program helped, and continues to help our daughter where all other programs have failed. Our daughter is a different person than 5 years ago. She is happy, able to concentrate and learn, and fun to be with. She is on no psychotropic medications.

JRC takes only the most difficult kids that have failed at other programs, and make successes of a large number of them. Many of these children have life threatening behaviors, before arriving at JRC. Everything there is done out of love, not cruelty. We believe our daughter would be dead, or in an institution heavily sedated if it were not for this wonderful school, and caring staff. Many other parents feel the same.

Sincerely,
Mitchell Shear, MD, and Marcia Shear[12]

Prior to coming to JRC all forms of counseling, drugs and positive-only behavioral supports had been tried with these children and young adults with no meaningful effect. These children were too sick and too dangerous to be accepted by most residential schools. In many cases, schools that did accept them later expelled them[13] when their behaviors proved to be too severe to respond to the treatment procedures the schools employed. In one case, a well-regarded school (New England Center for Children) that used positive-only procedures (i.e., did not use aversives) admitted in a discharge document for one of its students that its positive-only procedures were inadequate to treat the individual's behaviors successfully and that the child needed aversive procedures instead. The exact quotation is:

> At this point, behavior–control medication and treatment approaches based on positive reinforcement have been generally unsuccessful in producing long-lasting decreases in J.B.'s behavior. This suggests that J.B. may require alternative interventions than those normally used as NECC, for example, mechanical restraint and contingent aversive stimulation.[14]

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[12] This letter may be found on the JRC website at http://www.judgerc.org/parentletters.html#letter66. Photos of this student before and after treatment with behavioral skin shock are found on pages 36 and 37 of this document.

[13] Israel, M.L., Blenkush, N.A., von Heyn, R.E., and Sands, C.C.: Seven Case Studies of Individuals Expelled from Positive-Only Programs (2010). *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention, 2 (1),* 20-36. Full text available at http://www.judgerc.org/SevenCaseStudies.pdf.

[14] This document, attached hereto as Appendix B, is included in a paper entitled, "Positive-only programs expel their difficult-to-treat students, many of whom are then referred to JRC for successful treatment." Full text available at http://www.judgerc.org/posonlyprograms.pdf. This paper gives the names of the programs that expelled students (who were ultimately referred to JRC)

Often the parents of these children had been told by the psychiatrists, psychologists and other doctors treating their children that nothing could be done and that their children would have to continue a life of heavy sedation, confinement, isolation, restraint and no education or hope for their future. In some cases the individuals' behaviors were so violent and intractable that when they were expelled from other schools they could not live at home because that would endanger the lives of their family members. At that point the parents had no place at all for them—a nightmare for any loving parent.

JRC has a 39-year history of freeing hundreds of children and adults from the deadly grip of sedatives, restraint, seclusion and institutional warehousing. JRC's intricate twenty-four hour behavioral system of rewards for desired behaviors, supplemented with aversives when required, works effectively in cases where every other treatment has failed and gives each student a chance to learn positive behaviors such as reading, writing, socializing and living in the community. These learned positive behaviors replace the prior behaviors of self-abuse, aggression and destruction.

JRC has been able to save hundreds of children and has flourished as a fully licensed program because it has proven in courts of law time after time that: (1) the failed drug regimes, the other unsuccessful treatments, and the resulting warehousing of these students, were physically and emotionally harmful to the students; and (2) JRC was able to free these students from restraint, drugs, self-abuse, and all the severe pain it was causing them, through the use of safe, effective behavioral treatment. JRC's treatment has helped many JRC students go on to higher education, jobs and successful careers. There is no credible evidence that for these most severe forms of behavior disorders, there is any other pharmacological or psychological treatment that can treat these students as effectively as JRC's treatment, or even, in certain cases, keep the students safe. JRC is the only program willing to address the reality of these children's disorders and to endure the political firestorm that the use of aversives inevitably entails in order to save these children and give them an education and a future.

JRC's program is approved or licensed by every Massachusetts agency that has jurisdiction over it. JRC's education program is certified by the Massachusetts Department of Elementary and Secondary Education ("DESE"). JRC's residential program for children under the age of 22 is licensed by the Massachusetts Department of Early Education and Care ("EEC"). JRC's treatment program for adults over the age of 22 is licensed by the Massachusetts Department of Developmental Services ("DDS"). JRC has a special certification, issued by the MA DDS, to use aversive therapy. In addition, since 1986, every single treatment program that involves the use of aversive therapy has been approved, on an individualized basis, by a judge in the Massachusetts Probate Court, and is reviewed on a yearly basis after its initial approval. Over 15 different judges have been involved in these "substituted judgment" cases since 1986.

Hundreds of loving parents —including distinguished professors at Harvard University and NYU, as well as several psychiatrists, pediatricians, attorneys, social workers and

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because their procedures were unable to handle them. It also presents the actual documents from JRC files (with permission) that prove this statement.

teachers—have entrusted the care and habilitation of their children to JRC.[15] Copies of moving letters and statements JRC has received from parents are attached hereto as Appendix C. JRC has also received grateful thanks from many of its current and former students. Some have even testified at public legislative hearings that the treatment has saved their lives.[16] A copy of a letter that JRC received from a former student is attached hereto as Appendix D.

School administrators who claim to be able to successfully treat all forms of disorders without aversives simply expel the children they cannot treat. Some of these children and their parents ultimately find JRC and are astounded to see the miraculous improvements in behaviors, education and health that are possible when just a very small amount of aversive interventions are added, if required, as a supplement to an intensive behavioral and educational program based almost exclusively on rewards and other positive procedures. Parents are ecstatic to see their children removed from the devastating side effects of drugs and to see their children receive an education as well as effective treatment for their behavior disorders.

JRC is a successful educational and treatment program because it focuses on treatment safety and effectiveness and not on what is politically expedient. JRC designs behavioral treatment plans based on the individual needs of the student. More than half the JRC students never receive supplemental aversives because they can be effectively treated by the positive programming that is the basic component of JRC's unique 24/7 intensive behavioral program. Unlike the stories about what is happening in public schools to disabled children behind closed doors, all of JRC's treatment is disclosed, court approved, and monitored. Immediate and dramatic results must be obtained or the treatment is terminated. No other treatment program in the nation is scrutinized as closely as is JRC and this, along with JRC's unparalleled record of success with the toughest cases in the nation, is why parents trust and believe in the school.

[15] *See* note 3, *supra.*

[16] *Id.*

II. THE MDRI REPORT FAILS TO PRESENT THE BIG PICTURE. THERE IS A SMALL GROUP OF SPECIAL NEEDS INDIVIDUALS WITH SUCH SEVERE BEHAVIOR PROBLEMS THAT THEY ARE IN DANGER OF HURTING, MAIMING OR KILLING THEMSELVES OR OTHERS. FOR THESE INDIVIDUALS, BEHAVIOR MODIFICATION TREATMENT, INCLUDING THE USE OF SUPPLEMENTARY AVERSIVES WHEN NECESSARY IS—FAR FROM REPRESENTING A FORM OF TORTURE—A HUMANE, LIFE-SAVING FORM OF TREATMENT. IT IS FAR MORE EFFECTIVE THAN THE ALTERNATIVES (TAKE-DOWNS, MANUAL AND MECHANICAL RESTRAINTS, PSYCHOTROPIC DRUGS, ISOLATION, TIME OUT ROOMS AND WAREHOUSING), HAS NO SIGNIFICANT ADVERSE SIDE EFFECTS, AND HAS MANY POSITIVE SIDE EFFECTS.

A. Certain individuals who have developmentally disabilities or psychiatric challenges can display severe behavior problems that are extremely dangerous. If these are left untreated, the individual will be either maimed or killed or will harm others.

Most people do not encounter, on a regular basis, individuals with severe autism or severe psychiatric challenges. Therefore most people are not aware of how dangerous and self-abusive the behaviors are that such persons may display.

Some examples are these: gouging out one's eyes, causing near-blindness; smearing feces; head-banging to the point of detaching both retinas or of causing a stroke; skin-scratching to the point of fatal blood and bone infection; pulling out one's own adult teeth; running into a street filled with moving cars; exhibiting suicidal behaviors such as attempting to hang oneself, swallowing razor blades, taking a drug overdose, and jumping out of a moving vehicle or off of a building. Some students have shown violent aggression such as biting, hitting, kicking, punching and head butting others. Some have pushed a parent down a flight of stairs, raped others, tried to strangle a parent while the parent was driving, and beat a peer so severely that plastic surgery was required. Some have attempted to injure or kill others by pushing a child into oncoming traffic, attempting to smother a sibling, stab a teacher, or slice a peer's throat. Some have attacked police and therapists. Some have set their homes on fire, lit a fire in school, and lit themselves or family members on fire. Some have engaged in prostitution, been involved in gangs, and assaulted others with weapons, including a machete and chainsaw. ***All of these are behavior problems that students have shown prior to enrolling in JRC and that JRC has undertaken to treat during the past 39 years.***[17]

Behaviors such as these make such students extremely dangerous to themselves and others. The behaviors can be so disruptive that their parents cannot keep the students safe at home; teachers may refuse to serve them in a

[17] *See* Parents' Journey, note 1, *supra*. (Video showing some of these behaviors).

public or private school environment, and physicians, dentists and surgeons may be unwilling to provide them with urgently needed medical or dental services.

B. Modern behavioral psychology has developed effective treatments for many of these behavior problems.

Modern behavioral psychology, beginning largely with the work of B. F. Skinner, has developed a treatment for these behaviors that is called "behavior modification" or "applied behavior analysis." At its simplest and most easily understood level, it involves arranging rewards for desired behaviors and decelerative (aversive) consequences whenever undesired behaviors are shown. Using this approach, new treatments have been developed for a variety of behavior problems. Probably the most widely known applied behavioral treatment is that which is offered to young autistic children. When provided in sufficient intensity and consistency, some behavioral psychologists claim to have been able to reverse autism and return young autistic children to near-normal functioning.[18]

Behavioral treatment has also proven to be able to do the following, without requiring use of psychotropic drugs: save children from maiming themselves through self-abuse; keep them from injuring others through aggression; prevent them from destroying their own homes; enable them to receive an education in a school environment; re-unite them with their families; and enable them to enjoy desperately needed medical treatment that would otherwise be impossible for them to obtain.

Needless to say, when such changes are made, the parents are ecstatic. Their children's problem behaviors have been eliminated. New and better behaviors have been taught. Their children no longer have to take the psychotropic medications that have horrific side effects, can sedate them into a state of continual drowsiness or sleep, and can shorten their lives. Their children now have a chance for a better future. The children themselves see that they are now able to enjoy things they never were able to enjoy previously. Those that can speak can tell others how pleased they are to see themselves improve and to have some hope for the future for the first time in a long time. Those that cannot speak are clearly happier based upon their smiles and their new enthusiasm for education and social interaction.

In the behavioral treatment of severe problem behaviors—such as violent aggression or dangerous self-abusive actions—the following are the types of procedures that are normally employed:

(1) *Perform a functional assessment* to determine what events may be strengthening the inappropriate behaviors that are to be treated, what events may be triggering the behaviors, what events are rewarding to the individual, etc.

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[18] Lovaas, O.I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology, 55*, 3-9.

(2) *use counseling* to make use of the student's language abilities and reasoning abilities to persuade him/her to change the behavior.

(3) *eliminate any events that appear to be rewarding the problem behavior*;

(4) *eliminate any events that tend to "trigger" the occurrence of the inappropriate behavior*;

(5) *use rewards for desired behaviors* to increase the frequency of those behaviors. Examples are money, points, special privileges, field trips, etc. The rewards are used not only as immediate consequences for desired behaviors, but also as things to be earned through "behavioral contracts," in which the student enters a contract to display certain desired behaviors, and to refrain from certain inappropriate behaviors, in order to earn a reward.

(6) *use corrective procedures ("aversives")* as consequences for the inappropriate behaviors in order to decrease the frequency of those behaviors. Examples are as ignoring, reprimands, privilege-losses, requiring the individual to spend time in a time-out room, restraining the student for a brief period (e.g. 30 seconds), and administering token or money fines, to decrease problem behaviors.

(7) *use educational procedures* to teach alternative and replacement behaviors;

(8) *add psychotropic medications*.[19] If steps (1) through (7) are not sufficiently effective, psychotropic medication is likely to be tried. These medications often have extremely dangerous side effects, can make the student so sleepy that he/she exists in a sedated stupor all day, and can cause premature death. Worse still, the evidence is that individuals who do not take psychotropic medications are better off in the long run than those who do. More information on this topic is provided below.

(9) *physically prevent the behavior through "emergency" takedowns, "emergency" manual restraint, and mechanical restraint.* If all the above steps do not work, then the usual approach is to try to physically stop the problem behavior, or prevent it from occurring, by “taking down” the student to the floor and holding him/her there until he/she stops struggling, or by restraining the student's arms, legs or torso with the use of manual or mechanical restraint. Unfortunately, these procedures have their own problems. They may only stop the behavior temporarily. Some behaviors (such as biting a hole in the inside of one's cheek) cannot be stopped through such restraint. And some children with autism who have self-abusive behaviors actually find restraint a rewarding (desirable) condition.

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[19] For an explanation of psychotropic drugs—what they are, what effects they have, etc., *see* Israel, M. L. (2009) *Primer on Psychotropic Drugs.* Full text available at http://www.judgerc.org/DrugPrimer.pdf. For two articles summarizing the history of antipsychotic medications and their negative side effects, *see* Levitas, A. S. & Hurley, A. D. (2006a). The history behind the use of anti-psychotic medications in persons with intellectual disability: Part I. *Mental Health Aspects of Developmental Disabilities*, 9, (26-32).; Levitas, A. S. & Hurley, A. D. (2006b). The history behind the use of anti-psychotic medications in persons with intellectual disability: Part II. *Mental Health Aspects of Developmental Disabilities*, 9, (93-98). Full text of these articles available at http://www.judgerc.org/LevitasAntipsychoitc.pdf.

(10) *warehousing.* This refers to simply allowing the problematic behaviors to occur and not making a major effort to change them. If taken to the extreme this means simply providing food, clothing, shelter and warmth, and allowing the individual to continue his/her destructive behaviors unabated and without treatment.

(11) *isolation*. The individual may be placed in a bare room, alone, for long periods of time. If an individual in such an isolation room is not watched carefully, he or she could commit suicide.

(12) *expulsion.*[20] If the program simply cannot handle the student it may expel him or her and attempt to deliver the student back to the parent. Sometimes, however, the student is too violent to be able to return to his/her home and the parent is left with no alternatives at all. Most people are unaware of the fact that many if not most programs that foreswear the use of aversives do resort to this somewhat shameful practice.

In the parlance of current behavioral treatment, procedures numbered (1) through (9) are generally accepted procedures, all of which would fit within the rubric of Positive Behavior Support. This document will refer to them as "positive-only" procedures. Unfortunately, these procedures have proved effective in treating problem behaviors in only 50-60% of the cases.[21,22,23] ***This well-proven failure of positive only programs to be***

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[20] Israel et al. (2010), note 13, *supra*; *see also* http://www.judgerc.org/posonlyprograms.pdf (documentary proof of the assertion that well-known positive only programs expel students whose behaviors prove to be too severe to be treated with positive-only treatment procedures. Proof is provided for the seven cases covered in the Israel et al. (2010), plus three additional cases).

[21] Carr, E. G., Robinson, F., Taylor, J. & Carlson, J. (1990). Positive approaches to the treatment of severe behavior problems in persons with developmental disabilities. In: *National Institutes of Mental Health Consensus Development Conference*,(pp. 231-341). NIH Publication No. 91-2410. In this review of 95 published papers in 21 journals covering the period 1969-1988, Carr and associates found that positive-only procedures were effective in only 37% of the cases where self-abuse was involved and in only 35% of the cases of aggression.

[22] Carr, E.G., Horner, R.H., Turnbull, A.P., Marquis, J.G., Magito McLaughlin, D., McAtee, M.L., Smith, C.E., Anderson Ryan, K., Ruef, M.B., & Doolabh, A. (1999). *Positive behavior support for people with developmental disabilities: A research synthesis*. Washington, D.C.: American Association of Mental Retardation. This is the most comprehensive review of the literature on Positive Behavior Supports that has ever been done. The authors, whose names are among the most distinguished names in the field of positive programming, reviewed 216 published studies from 36 journals, covering the period 1985-1996 and selected 109 articles that met their review standards. Their conclusion was that positive programming was effective in only 51.5% of the cases (see page 45). Full text available at http://www.judgerc.org/PositiveBehaviorSupport.pdf

[23] Horner, R. H., Carr, E. G., Strain, P. S., Todd, A .W. and Reed, H. K. (2002). Problem behavior interventions for young children with autism: A research synthesis. *Journal of Autism and Developmental Disorders*, 32, 423-445. This study looked at peer-reviewed studies involving young autistic children during the period 1996-2000. Nine studies met the criteria for review. These involved 24 participants and 37 before-and-after treatment comparisons. Although punishment (not involving skin-shock) was employed in 12 (32%) of the comparisons, the remaining 25 (68%) of the comparisons involved positive-only procedures. Using the same standard of achieving a 90% reduction from baseline that was used in the two earlier Carr et al. studies, only 60% of the comparisons showed effective treatment. (Horner et al. at p. 434).

effective in all cases, is the single most important scientific justification for keeping available the use of aversives.

There is general agreement that procedures (8) through (12) above are undesirable practices and would best be avoided. One way to do this is to make step (6) more effective by using a more effective corrective (aversive) consequence. JRC has chosen to do this. The aversive that is used at JRC is a two second shock to the surface of the skin, typically on an arm or leg. This is a procedure that: (a) has no significant adverse side effects;[24] (b) can make the difference between maiming or killing oneself or not; (c) has a proven record of effectiveness[25] when it is used, as it is at JRC, as a supplement to a program that is overwhelmingly based on positive rewards[26] and educational procedures; (d) is employed only after trying positive-only treatment procedures for an average of 11 months; (e) can be dispensed with in most cases as the student's behavior improves; and (f) is employed at JRC with only the most case-hardened problem behaviors (23% of the school age students, and 43% of all JRC residents); and that is used, even with those students, very infrequently (the median is 0 per week; the mean is 3 per week).

C. Behavioral treatment at JRC has drawn fire from certain quarters because it has chosen to use skin-shock as an aversive in preference to the use of psychotropic drugs, and in preference to the aversives used in other positive-only (Positive Behavior Support) programs–procedures such as time-out rooms, physically restraining the student in a hold for a period of time; "emergency" takedowns; "emergency" manual or mechanical restraint; electroconvulsive shock therapy (ECT)[27], warehousing, and expulsion.

Behavioral treatment that includes the use of skin shock is very effective; however it has drawn fire from certain advocates. Many of these persons believe that anything unpleasant should never be used when educating and caring for children—particularly children with mental and behavioral disabilities. Although such persons accept many types of aversives (see item 6 in section B above), and oppose only *certain* aversives such as skin shock, they have come to be referred to as "anti-aversive advocates" and that is how they will be referred to in this document. Similarly, although the term *aversive* means any consequence that decreases the frequency of a behavior, the term is used by the anti-aversives advocates to refer only to a small subclass of aversives, such as skin shock, spanks or water sprays to the cheek.

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[24] van Oorsouw, W. M. W. J., Israel, M. L., von Heyn, R. E., & Duker, P. C. (2008). Side effects of contingent shock treatment. *Research in Developmental Disabilities, 29,* 513-523. Full text available at http://www.judgerc.org/SideEffectsContingent.pdf..

[25] Israel, M.L., Blenkush, N.A., von Heyn, R.E., & Rivera, P.M. (2008). Treatment of aggression with behavioral programming that includes supplementary skin-shock. *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention, 1 (4),* 119-166. Full text available at http://www.judgerc.org/AggressionPaper.pdf.

[26] *See* http://www.judgerc.org/yellowbrickroad.html.

[27] Wachtel, L.E., Contrucci-Kuhn, S.A., Griffin, M., Thompson, A, Dhossche, D.M., & Reti, IM. (2009). ECT for self-injury in an autistic boy. *European Child & Adolescent Psychiatry, 18 (7),* 458-63.

Anti-aversive advocates are often well-intentioned. They believe that in advocating against aversives, they are in some sense fighting to help children with disabilities and even to "liberate" them from onerous and misguided treatment. Typically, those who advocate against aversives are not the parents of children who have very severe behavior disorders that threaten to maim or kill the children themselves or others. Nevertheless, they feel impelled to insist that their perception of aversives is the only correct one, and that all parents—even those whose children have self-maiming or potentially self-killing behaviors—should be deprived of the option to choose aversive therapy for their own children.

A prime characteristic of such anti-aversive advocates is that their beliefs about aversives are not open to rational discussion. For example, most persons, when asked whether they would like to try some new or unusual medical or dental procedure, would ask, "What are the risks, what are the benefits, and what are the alternatives?" They would weigh whether the benefits seem to outweigh the risks and would compare this with the risks and benefits of the alternatives. It is characteristic of the anti-aversive advocates that they are unwilling to engage in this rational risk/benefit analysis. Their attitude is that aversives are wrong and must be stopped—even if their availability could save a child's life.

D. The Judge Rotenberg Educational Center (JRC), as the leading proponent of the use of behavioral treatment that includes skin-shock aversives when necessary, has become the lightning rod, and the prime target, for the attacks of the anti-aversives advocates. MDRI has now joined in those attacks.

The Judge Rotenberg Educational Center (JRC) is the leading proponent of an active, drug-free, form of behavioral treatment that is composed almost exclusively of rewards and positive procedures, but which openly supplements those procedures with skin-shock aversives when necessary.[28] JRC applies these procedures to the problem of treating severe behavior problems in children and adults with developmental disabilities,

[28] JRC is not the only program using aversives. All programs that work with children with difficult behaviors use aversives but either hide them or do not call them aversives. For example, if a program administers a "take-down" every time that a child is aggressive, this procedure may, depending on a number of factors, function as an aversive. The same applies to "time-out" procedures or seclusion procedures that are administered as consistent consequences for certain behaviors. Holding a young autistic child still for 30-60 seconds against his/her will is a frequently used procedure that can function as an aversive; some clinicians even consider it to be a procedure that is consistent with the "Positive Behavior Support" approach. Physical "redirection" procedures or physical "prompts" that are accompanied with a hard squeeze on the shoulder or arm often can functions as "hidden" aversives. A loud shouted "NO!" can, depending on how it is administered, be a terrifying aversive for young child. A spank on the buttocks is a common aversive that parents sometimes use. Monetary fines, bad grades, point losses, losses of privileges, ignoring, and signs of disapproval can also function as aversives. Therefore it is not the case that JRC uses aversives and other programs do not. Rather, JRC chooses to use a safer and more effective aversive (skin shock) than these other procedures, and is willing to label it for what it really is—an aversive. For an explanation of what aversives are, how and why they are used and the reasons why skin shock is so much more effective and preferable than other aversives., *see* Israel, M.L. (2008). *Primer on Aversives*. Full text available at www.judgerc.org/aversivesprimer.pdf.

psychiatric problems, conduct disorders, emotional disturbance, etc. JRC currently serves 215 such individuals, and provides its treatment—without using psychotropic drugs, without ever rejecting or expelling the difficult cases, and with a remarkable record of effectiveness. JRC probably serves the largest concentration of individuals with severe behavior disorders in the country.

The authors of the MDRI Report appear to have bought into the anti-aversive philosophy, even without ever visiting JRC or discussing a single concern with any of the current JRC clinicians or parents, or with any of the many current and former students who are supremely grateful for the treatment they received and the life-saving progress they made at JRC. Apparently, the views of the MDRI Report's authors have been formed solely based on what they have heard from other anti-aversive advocates. Remarkably, while only hearing about JRC second and third-hand from those who are already opposed to JRC and aversives, they nonetheless have felt qualified to make the judgment that what JRC offers is torture and not treatment, and to put out an official-looking report that pretends to document and prove their case.

Later, this document will respond to the information in the MDRI Report that is false and/or misleading, and will explain not only why aversives are not a form of torture, but also why persons with developmental and psychiatric challenges ***have a right to have the option to choose aversive therapy*** to cure or ameliorate their behavior problems. Before doing so, however, it is important to do what the anti-aversive advocates, as well as the MDRI Report authors, are so reluctant to do—to examine the alternatives—i.e., to examine what practices are followed when aversives are not available.

E. When aversives are *not* used, all of the following practices are found, each of which is less desirable than a brief 2-second skin-shock: (1) use of ineffective, positive-only procedures; (2) use of psychotropic drugs; (3) use of take-downs; (4) use of manual and mechanical restraint; (5) use of warehousing; (6) use of time-out or seclusion rooms; and (7) expulsion. In the treatment of individuals with severe behavior disorders, these are the real alternatives to the use of aversives.

1. Ineffectual Treatment with Positive-only Procedures.

Those who oppose the use of aversives in behavioral treatment assert that difficult behavior problems can be treated without the need for using aversives. The philosophy of those who take this approach is often called Positive Behavior Support. Drs. James Mulick and Eric Butter have written an excellent explanation of the Positive Behavior Support movement.[29]

All persons of good will, including all clinicians at JRC, wish that positive-only procedures would be robust enough by themselves to treat the most severe behavior

[29] Mulick, J. A. & Butter, E .M. (2004). Positive behavior support: a paternalistic utopian delusion. In J. W. Jacobson, R.M. Foxx, & J. A. Mulick (Eds.), *Controversial therapies for developmental disabilities* (pp. 385-404). Lawrence Erlbaum Associates.

disorders. If this were true, there would be no need for JRC to use aversives, and JRC would immediately stop using them.

The evidence from the research literature is quite clear, however: positive only procedures are effective (where *effective* means reducing the problem behavior by 90% from its pre-treatment level) with only 50-60% of the cases—a fact that has been demonstrated in three major review articles written by key proponents of positive-only procedures.[30, 31, 32] The MDRI report is silent on this important fact and the key anti-aversive advocates never seem to be willing to discuss the implications of those studies.

Actually, even the 50-60% figure given in those studies may be overstating the effectiveness of positive-only procedures. As Richard Foxx has pointed out, the studies published by those who support the positive-only philosophy tend to be done on behaviors that are not really severe at all. [33]

Proponents of positive-only procedures sometimes argue that programs other than JRC have successfully served students who were transferred from JRC to their programs. Those who make such assertions often do not reveal the full information about the former students' current condition or make known the facts about those students who have done remarkably worse when transferred to positive-only programs. When such assertions are made, therefore, one or more of the following facts and possibilities should be considered:

(1) At least two former JRC students have died after leaving JRC—due either to the removal of the use of aversives, or to the removal of careful and strict oversight of their treatment programs.

(2) The post-JRC program may be able to serve the student without aversives, but only because the major job in reducing the student's problem behaviors was done at JRC, through the use of aversives. In other words, when the student improved enough, as a result of the use of aversives at JRC, the student became capable of transitioning to a positive-only program.

(3) The post-JRC program may be "serving" the student by adding the use of psychotropic medications to the student's program–exposing the student to the dangers of such medication.

(4) The post-JRC program may be just warehousing the student. It may be just feeding, clothing and housing the student and not trying to actively treat his/her

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[30] *See* note 21, *supra.*

[31] *See* note 22, *supra*.

[32] *See* note 23, *supra*.

[33] Foxx, R. M. (2004a). Severe aggressive and self-destructive behavior: The myth of the nonaversive treatment of severe behavior In J. W. Jacobson, R.M. Foxx, & J. A. Mulick (Eds.), *Controversial Therapies for Developmental Disabilities* (pp. 295-313). Lawrence Erlbaum Associates. Full text available at http://www.judgerc.org/SevereAggressive.pdf

problem behaviors. For example, the program may be allowing the student to wander around or even sleep much of the day, without placing any education- or treatment-related demands on him/her.

(5) The post-JRC program may be confining or restraining the student.

There are at least five cases in which the claim that positive-only programs could handle JRC's students was put to the test and failed.

- In 1981 Student 1 was removed from JRC and placed in a positive-only program (the Elizabeth O'Hara Walsh School) in his home state of Connecticut. His aggression was too much for that school to handle. Within 36 months he had to be readmitted to JRC.
- Student 2, a young man from Massachusetts, was removed from JRC twice (in 1982 and 1987) to positive-only programs, one of which was the May Institute in Massachusetts, and had to be readmitted twice back to JRC. Interestingly, the MDRI Report cites a paper that prematurely claimed his case as an example of how someone can be removed from JRC and moved into Positive Behavior Support Procedures without harm.[34]
- Student 3 was transferred in 1996 to a positive-only program run by Brooklyn Developmental Disabilities Service Organization in New York. Within two years he was transferred back to JRC.
- Student 4 was removed from JRC by anti-aversives advocates in 1994 and ultimately placed in a supervised apartment in New York in 1996 run by an agency (Job Path) opposed to the use of aversives. Within two years he died of self-inflicted scratching that had been well-controlled at JRC.[35]
- Student 5 was transferred from JRC to the May Institute in August 1994. While there he set fire to and burned down one of the May Institute's residences and was subsequently transferred to a Florida program. He is another student who was prematurely claimed as an example of how a student can be removed from JRC and transferred to a Positive Behavior Support program without harm.[36]

Although JRC uses aversives with a minority of its students, the primary procedures relied upon at JRC are the use of positive rewards and educational procedures. JRC has gone to extraordinary lengths to have a rich and powerful program of positive rewards and educational procedures available to motivate students to improve their behaviors. Currently, JRC's powerful and varied reward program is, to our knowledge, unequalled in any other residential or day program. Among the rewards and reward facilities that JRC makes available are these:

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[34] Bird, F.L. & Luiselli, J.K. (2000). Positive behavioral support of adults with developmental disabilities: assessment of long-term adjustment and habilitation following restrictive treatment histories.: 31 *Journal of Behavior Therapy and Experimental Psychiatry* 5, 7. (Student 2 is "Mike" in Section VI at Item 27, *infra*.)

[35] *See* note 5, *supra*; Appendix J.

[36] *See* Section VI at Item 28, *infra.*

- JRC has created a Yellow Brick Road Reward Area with a Wizard of Oz theme that contains the following reward opportunities: a large arcade-type "Big Reward Store" with amusements designed to appeal to students with developmental disabilities; a teen lounge with video games, pool table, etc., designed to appeal to students with emotional disturbance and psychiatric issues who function at normal cognitive levels; an internet lounge; a hair salon; a retail store where students can purchase items of their choice (gift items, t-shirts, model kits, jewelry, etc.); a movie theatre; a snack bar; a library, a fitness gym; and an indoor basketball court.[37]
- In each of JRC's classrooms for students with developmental disabilities, there is a reward corner that contains couches, TVs, music listening devices, games, etc. Those classrooms also contain reward boxes filled with desirable items that the students can earn.
- Students can earn spending money by acquiring academic skills. They can also earn field trips. Students can advance in a hierarchical system in which they earn increasing privileges and independence as their behaviors improve.
- All students can earn the opportunity to enjoy a weekly outdoor barbecue/reward afternoon that is filled with fun activities. JRC has an outside recreational area with a basketball court, a picnic grove, and walking trails through seven acres of wooded land on the school's property.

JRC always starts treatment with positive- only behavioral supports and this treatment is successful with more than half of its students. Aversives are introduced as a supplement to the positive behavior support program, with prior parental and court approval, only if the latter program is insufficiently effective after having been tried for a substantial period of time (the average time is 11 months).

A key procedure in treating problem behaviors at JRC is to make behavioral contracts with those students who are capable of benefiting from them. These contracts involve the student's showing certain positive behaviors, as well as the absence of certain negative behaviors, for a certain period of time, in order to earn a reward. At first, a proportionately large reward may be given for a small improvement in behavior. If the student succeeds, the amount of improvement called for in the next contract will be increased slightly. The process continues until the student is showing large improvement in order to receive the rewards. Each student at JRC has many of these contracts going concurrently, covering many aspects of their day and many behaviors. This behavioral contract system is extraordinarily effective at JRC because of its individualized design and the wide range of rewards made available to the students.

On the educational side, JRC employs both computerized self-instruction as well as group instruction. The former enables each student to learn at his/her own pace, to receive immediately feedback from the computer as to whether he/she is right or wrong, and to avoid the frustration that many of our students have experienced when they have

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[37] *See* note 26, *supra*.

fallen behind in the traditional group instruction process that was provided in their previous schools.

2. Psychotropic Drugs.

If positive-only procedures are insufficiently effective, the most common strategy in other programs is the use of psychotropic drugs. Most programs place students with severe behavior problems on a cocktail of dangerous and sedating psychotropic drugs.[38]

A recent comprehensive study analyzing the treatment of children and adolescents with antipsychotic medications showed a 6-fold national increase in the use of such drugs between 1993 and 2002.[39] Although there is no authoritative or official count of the number of youth using psychotropic drugs in the United States, the New York Times reported in 2006 that approximately "1.6 million children and teenagers—280,000 of them under age 10—were given at least two psychiatric drugs in combination."[40] The critically acclaimed PBS documentary series *Frontline*, in its series entitled "The Medicated Child," asserts that the total number of children taking psychiatric drugs is much higher, putting it at 6 million.[41]

Unfortunately, all of these drugs have negative (and sometimes permanent) side effects which can include: liver damage, which can cause premature death; hyperglycemia; tardive dyskinesia (a disfiguring condition in which the muscles twitch constantly and for which there is no cure; tremors; headaches; fatigue; tachycardia (rapid heart rate); blurred vision; sedation to the point of constantly being in a stupor, being unable to stay awake in school and sleeping all day; massive weight gain, leading to diabetes; and shortened lifespan (premature death). Consider, for example, the two atypical antipsychotic drugs Seroquel and Zyprexa. During 2006-2008, there were 2,742 deaths reported to the FDA in which these two drugs alone were reported to be the primary suspected cause.[42]

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[38] *See* note 19, *supra.*

[39] Olfson, M., Blanco, C., Liu, L., Moreno C. & Laje, G. (2006). National Trends in the Outpatient Treatment of Children and Adolescents With Antipsychotic Drugs. Archives of General Psychiatry, v. 63, pp. 679 – 685.

[40] "Proof is Scant on Psychiatric Drug Mix for Young." New York Times (November 23, 2006) (citing analysis performed by Medco Health Solutions at the request of the New York Times).

[41] *See* http://www.pbs.org/wgbh/pages/frontline/medicatedchild/ (accessed May 6, 2010).

[42] The Food & Drug Administration (FDA) maintains a database of information obtained through its Adverse Event Reporting System (AERS) for all approved drug and therapeutic biologic products. The FDA uses AERS to monitor for new adverse events and medication errors with these marketed products. This information is compiled, on a quarterly basis, into reports available to the public at http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Surveillance/AdverseDrugEffects/ucm082193.htm. Although the FDA makes this information available on its web site, the data files are not presented in an easily accessible form. JRC has used the FDA data submitted for 2007 and 2008 to create a table for each drug that shows the top 20 reported adverse events for which that drug was the primary suspected cause. JRC compiled this information for the 82 most frequently

Regarding the antipsychotic drugs which are now increasingly being prescribed for children, psychiatrist Grace Jackson, M.D. has this to say about their toxicity:

> With the possible exception of the chemotherapies used in the treatment of cancer, it would be difficult to identify a class of medications as toxic as the antipsychotics. Whether one considers the effects of dopamine antagonists upon the central nervous system or beyond, their proven harmfulness has been an iatrogenic tragedy too often minimized or denied.[43]

Speaking about the same drugs, psychiatrist Peter Breggin, M.D. has this to say:

> … prescribing physicians cannot fully inform patients about the risks associated with neuroleptics because no one except the most self-destructive patient would knowingly take such toxic drugs**.** Doctors have to hide the mountain of risks associated with these drugs in order to get their patients to take them. In this sense, informed consent is largely a sham in regard to antipsychotic drug administration.[44]

Most people are not aware that a widespread misconception in the use of psychotropic drugs—that there is a "chemical imbalance" in the brain that is corrected by psychotropic drugs (much like insulin is used for diabetes)—has no scientific support and is basically a marketing ploy of the drug companies.[45] Most people are also not aware that the medical journals have largely been transformed into what a former editor of the *British Medical Journal* referred to as information laundering operations for the drug companies.[46] For that reason they cannot be relied upon, even by doctors, for authoritative information about psychotropic drugs.[47]

This would not be so important if the drugs showed effectiveness in treating behavior problems. Unfortunately, this has not been shown. The best understanding is that, with respect to adults, psychotropic drugs may improve certain symptoms in the short run and even in the long run for certain individuals. However in the long run the evidence is that most individuals will have a better chance of recovery from mental illness if they never

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used psychotropic drugs. These tables are presented in Appendix B of Israel, M.L. (2009) *Primer on Psychotropic Drugs*, v. 42, available at www.judgerc.org/DrugPrimer.pdf .

[43] Jackson, G.E. (2005). *Rethinking Psychiatric Drugs*. Bloomington, IN, Authorhouse, p. 14.

[44] Breggin, P. R. (2008). *Brain Disabling Effects of Psychiatric Drugs.* New York: Springer Publishing Company, p. 112

[45] Valenstein, E. S. (1988). *Blaming the Brain: The Truth about Drugs and Mental Health*.. New York: The Free Press.

[46] This change in medical journals is covered in Abramson, J. (2008). *Overdosed America: The Broken Promise of American Medicine*. Harper Perennial.

[47] *Id*.

take psychotropic drugs to begin with than if they take them.[48] Unfortunately, once a person starts to take certain types of psychotropic drugs (such as a benzodiazepine), it is often very difficult to stop because of extremely aversive withdrawal effects.[49]

As applied to the psychiatric problems of children and adolescents, evidence of effectiveness of psychotropic drugs in treating depression, anxiety, or manic-depressive disorder is largely lacking.[50] The same applies to the SSRI drugs such as Prozac.[51] Many of the prescriptions that are given by physicians are for uses ("indications") that have not been approved by the FDA—i.e., they are said to be "off label." Although this is not illegal, whenever this is done even the limited protections that the FDA oversight process provides are not being taken advantage of. Of course, if one gives an aggressive individual so much psychotropic medication that he/she sleeps all day, one may be able to avoid much of the individual's aggression; however, this is not treatment, this is chemical restraint. The price that is paid for doing that is that the individual is not really alive and will suffer the horrendous medical consequence of the side effects of the drugs.

It is quite important, therefore, that society develop alternative treatments to the use of psychotropic drugs. ***Any competent evaluation of the aversives controversy, as well as of the MDRI Report, should keep this fact in mind***.

3. "Emergency" Take-downs.

These involve from 2-7 staff members grabbing the individual and forcing him/her to the floor, holding him/her there until the struggling stops. Bruises, sprains, rug burns, etc. are typical side effects. If the take-down and the subsequent manual restraint that typically follows it are not done carefully, serious injuries or even death can result.

Although take-downs are often called "emergency" procedures, if they are used consistently, each time the individual is, for example, aggressive, they function as

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[48] *See* Whitaker, R. (2010). *Anatomy of an Epidemic: Magic Bullets, and the Astonishing Rise of Mental Illness in America*. New York: Crown Publishers. A summary of the studies supporting this statement is given on pages 307-309.

[49] *Id*. at 126-147.

[50] Fisher, R.L. & Fisher, S. 1997. Are we justified in treating children with psychotropic drugs? In Fisher, S. & Greenberg, R.P., (Eds.) *From Placebo to Panacea:Putting Psychiatric Drugs to the Test.* New York: Wiley. p. 317. ("Our explorations of a number of the major uses of psychotropic drugs for psychologically distressed children and adolescents have brought into view a wasteland. There is no consistent scientific evidence that the major drugs widely prescribed for depressive, manic-depressive, and anxiety symptoms are superior to placebos.")

[51] *See* Whitaker (2010), note 48, *supra* at 229 – 230. ("Presumably these drugs [Prozac and other SSRIs] provide a short –term benefit to children and adolescents that the tricyclics [the drugs often prescribed for depression prior to the arrival of the SSRIs] fail to provide, but unfortunately, we can't review the scientific literature to see if that is true because, as is widely acknowledged today, the literature is hopelessly poisoned. The trials [the drug trials that the manufacturers did to get the drugs approved] were biased by design; the results that were published in the scientific journals didn't square with the actual data; adverse events were downplayed or omitted; and negative studies went unpublished or were spun into positive ones."[bracketed material supplied])

aversives. This type of aversive is used in Positive Behavior Support programs and is not objected to by the anti-aversive advocates.

4. "Emergency" Manual Restraint and Programmed Manual Restraint

It has been estimated that between 50 and 150 deaths occur annually as a result of either restraint or seclusion, and that approximately one-fourth of those deaths are children.[52] The number of injuries is much higher. In addition, based on California data, there is a 25% chance that a person restrained (manually or mechanically) will be given emergency antipsychotic medication.[53]

Programmed (planned) manual restraint—for example, putting the student into a basket hold and maintaining the hold for a period of time—is an aversive that is commonly employed in positive-only programs. Its use is not objected to by the anti-aversive advocates.

In some cases manual restraint may be counterproductive. For some students the chance to wrestle with a staff member who is trying to restrain him or her manually can actually be rewarding. When this is the case, the restraint may prove to be iatrogenic—i.e., it will serve to increase, rather than decrease, the frequency with which the problem behavior is displayed on future occasions. In addition, for some self-abusive students with autism, being restrained may be a rewarding condition. When that is the case, such students will act in ways to cause staff members or parents to restrain them, and the restraint, when applied will in such cases actually strengthen (rather than weaken) the problematic behavior.

Finally, there are certain forms of self-abusive behaviors that cannot easily be prevented through the use of restraint. Examples are: biting a hole in one's cheek; rubbing one's skin against the inside of a cast for a broken arm or leg; refusing to swallow food, and constantly ruminating and the projectile vomiting of food against others.[54]

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[52] Weiss, E., et al., Deadly Restraint: A Nationwide Pattern of Death, Hartford Courant (Oct. 11 -15 1998). as cited in United States General Accounting Office Report to Congressional Requesters, Mental Health: Improper Restraint or Seclusion Use Places People at Risk (September 1999). See also Nunno, M.A., Holden, M.J. & Tollar, A. (2006) Learning from tragedy: A survey of child and adolescent restraint fatalities. Child Abuse & Neglect, 30, 1333-1342 (examining 35 child and adolescent fatalities related to restraints in residential (institutional) placements in the United States from 1993 – 2003).

[53] California Department of Developmental Services. (n.d.) Restraint Statistics January 1, 2007- March 31, 2007; April 1, 2007 – June 30, 2007; July 1, 2007 – September 30, 2007; October 1, 2007 – December 31, 2007. Accessed May 27, 2010 at http://www.dds.ca.gov/restraint/home.cfm.

[54] JRC's GED device was invented in order to save the life of the student who had this problem. .He had dropped to a weight of 56 pounds because of his constant ruminating and refusal to swallow food and was in real danger of starving to death. No medical cause for this behavior could be found after examination at Boston Children's Hospital and no medical solution was available. Fortunately, Judge Ernest I. Rotenberg (after whom the school was renamed in 1996) approved a treatment plan for the use of the GED behavioral skin shock procedure to treat this student's behaviors, and the treatment was successful. *See* Parents' Journey, note 2, *supra*. (Showing the problem behaviors and the improvement.)

5. Mechanical Restraint.

When programs are unable to stop a child from dangerous self-abusive or aggressive behaviors, they may resort to the use of mechanical restraint. For example, if a child engages in constant eye-poking, the program may have to resort to putting stiff tubes on the individual's arms to prevent the arms from bending and may have to restrain the student to his/her bed at night with a restraining apparatus or sheet to keep the arms and or legs from engaging in self-abuse. Mechanical restraint has many of the same problems as manual restraint.

Such restrictive procedures are routinely used when necessary in positive-only programs and are not objected to by the anti-aversive advocates.

5. Warehousing.

This is a situation in which no serious attempts are made to treat the student's problematic behaviors or provide an education. When taken to the extreme, warehousing means that the agency merely provides food, clothing and shelter. The individual is more or less allowed to do what he/she wants to do. Warehousing is often combined with psychotropic medication and restraint.

6. Placement in aTime-out or Seclusion Room

A common aversive that is often employed in "positive-only" treatment programs is the "time-out" procedure. This involves requiring the individual to be in a bare room, alone, from which he/she cannot escape, for some pre-determined amount of time. This is procedure is problematic because: (a) valuable time that otherwise might be spent learning new skills is wasted in a barren room; (b) individuals can continue to engage in self-abuse when in time-out or isolation rooms (c) some individuals may attempt to destroy the room by, for example, urinating, defecating, punching holes in walls, ripping out light fixtures, etc.; (d) the staff of some programs may use time-out rooms as a convenient way to get rid of the individual for a period of time; (e) some individuals may commit suicide while in time-out or isolation rooms unless staff are keeping close eye on them; and (f) some individuals may find this procedure rewarding (because it is way of escaping demands placed on them in the normal environment, because they want to be alone, or for other reasons). As a result, using a time-out or seclusion room procedure as a consequence for an individual for whom escape-from-demands is rewarding can cause the problem behavior to *increase* in its future frequency of occurrence, rather than decrease.

7. Expulsion

When programs that use positive-only treatment procedures encounter a student with really severe problem behaviors that do not respond to their procedures, they simply expel the student and attempt to hand the child back to the parents. Evidence of this little-known, but critically important fact is found in a paper recently published in *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention* by Israel

et al.[55] This paper describes seven cases studies of students who were expelled from positive-only programs because their behavior problems were too severe to be treatable by positive-only programming and who were eventually referred to JRC. In one case a well-known program that uses positive-only procedures expelled a student and stated in its Discharge Summary that the program's positive procedures had not been effective and the student needed aversives.[56] Sometimes the parent may not be able to allow the child back into the home because of the danger of violence against his/her siblings and/or the parents. In that case, the only alternative is jail or an institution or living on the streets.

These alternatives (Sections E. 1 through E. 7 above) are not satisfactory and not curative. Their net effect is to leave the individual imprisoned in a non-functional repertoire of behaviors that lead to a life of drugging, institutionalization, premature death or some combination of the three.

F. When positive-only procedures prove to be insufficiently effective, a preferable alternative to any of the other alternatives listed in Section E. above is to arrange a brief aversive consequence (such as JRC's behavioral skin shock) after each instance of the target inappropriate behavior.

JRC's basic approach is described as follows:

(1) following the advice of a psychiatrist, eliminate or minimize the use of psychotropic medications;

(2) provide a highly consistent, individualized behavior modification program on a 24/7 basis, featuring positive reward and educational procedures to teach new skills and replacement behaviors;

(3) try this for an adequate period to find out if this alone will be sufficiently effective (at JRC this is tried for an average of 11 months and are successful for more than half the students).

(4) if this proves to be insufficiently effective, supplement with the use of a brief decelerative consequence (an "aversive") each time the behavior occurs.

When these procedures are followed, the behavior is eliminated or dramatically reduced, the individual's mental faculties are left intact, the need for seclusion and time-out rooms is eliminated, and the need for take-downs, manual restraint, mechanical restraint, and drugs is either eliminated or minimized**.** The student is then able to receive education, live in and enjoy the community and acquire other skills and positive behaviors to replace the problematic behaviors. None of this is possible when the alternatives such as sedating drugs and restraints are used.

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[55] *See* note 13, *supra*.

[56] *See* note 14, *supra.*

The aversive that JRC employs is a brief 2-second shock that is administered to the surface of the skin, typically on an arm or leg, immediately after a problem behavior has occurred, by remote-controlled device called the GED.[57] An aversive is a consequence which, when it is arranged consistently for a severely problematic behavior, decreases the future frequency of (i.e., "decelerates") that behavior. JRC's skin shock procedure, although moderately painful for the very brief two second period of its application, is extremely effective[58] and has no significant side effects.[59] In many cases aversives are required only during the initial phases of treatment and can be phased out as the student's behavior improves. When aversives are introduced they are used as a supplement to, and not as a replacement for, the ongoing positive programming. Currently only a minority of JRC's students—43% of JRC's total population, and less than 23% of the JRC's school-age population—require supplementation with aversives. For those students who do have aversives in their programs, the use is infrequent.

Recognition that behavioral skin shock can be an effective decelerative consequence can be found, surprisingly, even among proponents of positive-only treatment procedures. For example, a 2005 paper (co-authored by Dr. Fredda Brown, one of the persons cited as contributing information for the MDRI Report) reported that as many as 10% of a group of 73 well-respected proponents of positive-only treatment procedures admitted, when given the chance to respond by confidential questionnaire, that they would use skin shock in certain circumstances.[60]

For a small number of individuals with severe behavior problems, the availability of aversives may be needed on a long-term, prosthetic basis. When used in this way, aversives function like eyeglasses, hearing aids or prosthetic limbs. When they are available to the individual, his/her quality of

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[57] *See* Israel, M.L. (2008), *Primer on Aversives*, at 5 – 12 (describing the advantages that skin shock possesses over alternative forms of behavioral consequences used to decelerate problematic behaviors). Full text available at http://www.judgerc.org/aversivesprimer.pdf.

[58] *See* Israel et al. (2008),note 25, *supra*.

[59] *See* van Oorsouw et al. (2008), note 24, *supra*.

[60] *See* Michaels, C., Brown, F. & Mirabella (2005). Personal paradigm shifts in PBS experts: perceptions of treatment acceptability of decelerative consequence-based behavioral procedures. *Journal of Positive Behavioral Interventions*, 7, 93-108. Full text available at http://judgerc.org/PersonalParadigmShifts.pdf. Michaels, Brown and Mirabella conducted a survey of 73 experts in the field of Positive Behavior Supports, guaranteeing anonymity for their responses. They asked these experts to say what decelerative treatment procedures, if any, they would consider using in certain circumstances. Ten percent of these experts said that they would use contingent electric shock "under certain circumstances or conditions." Of those who said they would use skin shock, 100% said it was effective and 83% said it was supported in the literature. Of the same group, 100% said they would use behavioral skin shock if there was "risk for harm, 57% said they would use it if other procedures were ineffective, 28% would use it for a behavior that "interferes with learning," and 28% would use it for behavior that is "socially stigmatizing, preventing inclusion."

life is vastly better than when they are not available.

JRC's use of the skin shock aversive enables it to avoid the use of psychotropic drugs, time out or seclusion rooms, or warehousing, and allows JRC to successfully treat the most severe forms of behavior disorders. It also enables JRC to eliminate or minimize the need for manual and mechanical restraint and take-downs.[61]

Sometimes students welcome the skin-shock procedure, recognizing that it helps them to control behaviors that are otherwise out of control and/or to make educational or treatment progress that they cannot make without its help.

G. Behavioral skin shock is an extremely effective treatment procedure with no significant adverse side effects

Behavioral skin shock is one of the most extensively-published procedures in the scientific literature. There are over 113 peer reviewed papers dating back to the 1960's that document its effectiveness in treating a wide variety of behavior problems.[62]

Three recent papers document the effectiveness of JRC's particular behavioral skin shock procedure, the GED.

(1) In 2007, *Research in Developmental Disabilities* published an article by Drs. van Oorsouw, Israel, von Heyn, and Duker entitled, "Side Effects of Contingent Shock Treatment."[63]

The abstract is as follows:

> In this study, the side effects of contingent shock (CS) treatment were addressed with a group of nine individuals, who showed severe forms of self-injurious behavior (SIB) and aggressive behavior. Side effects were assigned to one of the following four behavior categories: (a) positive verbal and nonverbal utterances, (b) negative verbal and nonverbal utterances, (c) socially appropriate behaviors, and (d) time off work. When treatment was compared to baseline measures, results showed that with all behavior categories, individuals either significantly improved, or did not show any change. Negative side effects failed to be found in this study.

(2) In 2008 *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention* published an article by Drs. Israel,

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[61] For a comparison of the relative advantages of using skin shock as compared with using drugs, restraint, etc., please see www.judgerc.org/advantagesofAversiveTherapy.pdf.

[62] *See* Appendix E.

[63] *See* van Oorsouw et al. (2008), note 24, *supra.*

> Blenkush, von Heyn, and Rivera on the effectiveness of the GED skin shock procedure in the treatment of aggression, entitled, "Treatment of aggression with behavioral programming that includes supplementary skin-shock.[64]

The abstract is as follows:

> Behavioral treatment of aggression with contingent skin shock (CSS) has been investigated in relatively few studies and never with cognitively typical individuals. We evaluated CSS during a 3-year period with 60 participants, half to two-thirds of whom functioned at normal or near-normal cognitive levels. Sixty individual charts, arranged in a multiple baseline across participants display, reveal clearly the effectiveness of the treatment. When end-of-baseline data were compared with end-of-treatment data, CSS, as a supplement to positive programming, showed effectiveness (defined as a 90% or greater reduction from baseline) with 100% of the participants. This compares favorably with positive behavior support procedures, which, according to the 1999 treatment outcome review by Carr at al., achieved that effectiveness standard with only 55.5% of the cases (Carr et al., 1999). Higher functioning participants showed from 2 to 6 times more reduction than did lower functioning participants. Psychotropic medications were reduced by 98%, emergency takedown restraints were reduced by 100%, and aggression-caused staff injuries were reduced by 96%. As a result of the treatment, 38% of participants no longer required CSS and some returned to a normal living pattern.

The following 36 charts show how effective JRC's behavioral skin shock has been in the treatment of aggression for all students who were started on the use of skin shock during the 2 year period 2003-2005. Charts for *all* these students are shown—not just selected charts that show favorable results. Each chart is for a single student and each dot represents the total number of aggressive behaviors shown during one week. The charts are arranged in chronological order according to when, within the 2 year period covered by the report, the student was started on the skin shock. The red vertical line shows where the skin shock was introduced as a supplement to the ongoing positive programming. In each case the frequency drops (in most cases to zero or near-zero) as soon as the skin shock is introduced. The drop is even greater than it may seem to the eye because the vertical scale is a "multiply/divide scale" (the heavy blue horizontal lines, starting from the bottom and reading up, are for 1, 10, 100, 1000, etc. per week) instead of the more typical "addition/subtraction scale." The charts below are for 36 students and cover the period May 2003 - May 2005.

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[64] See Israel et al. (2008) note 25, *supra.*

EXHIBIT 1

Aggression Behaviors for all 36 Students Admitted May 2003- May 2005 and Treated with GED Skin Shock

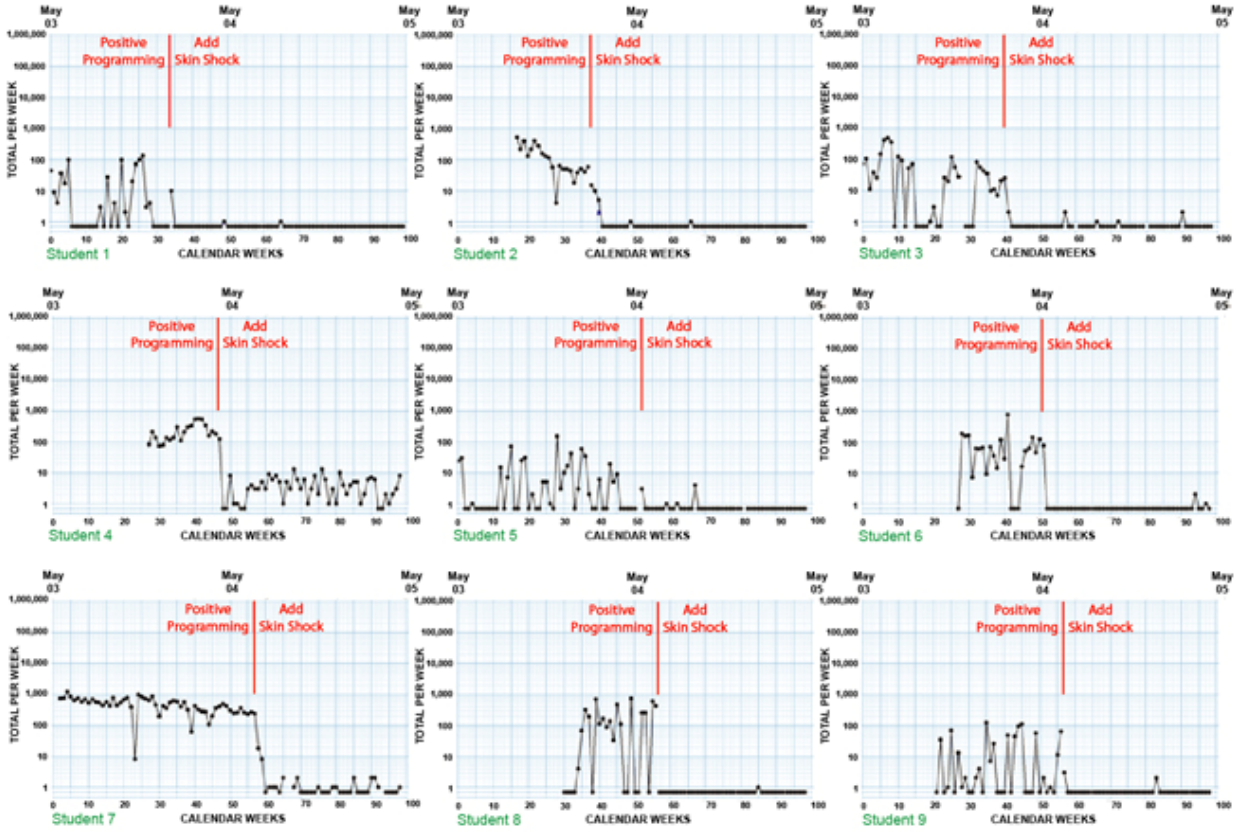


EXHIBIT 2

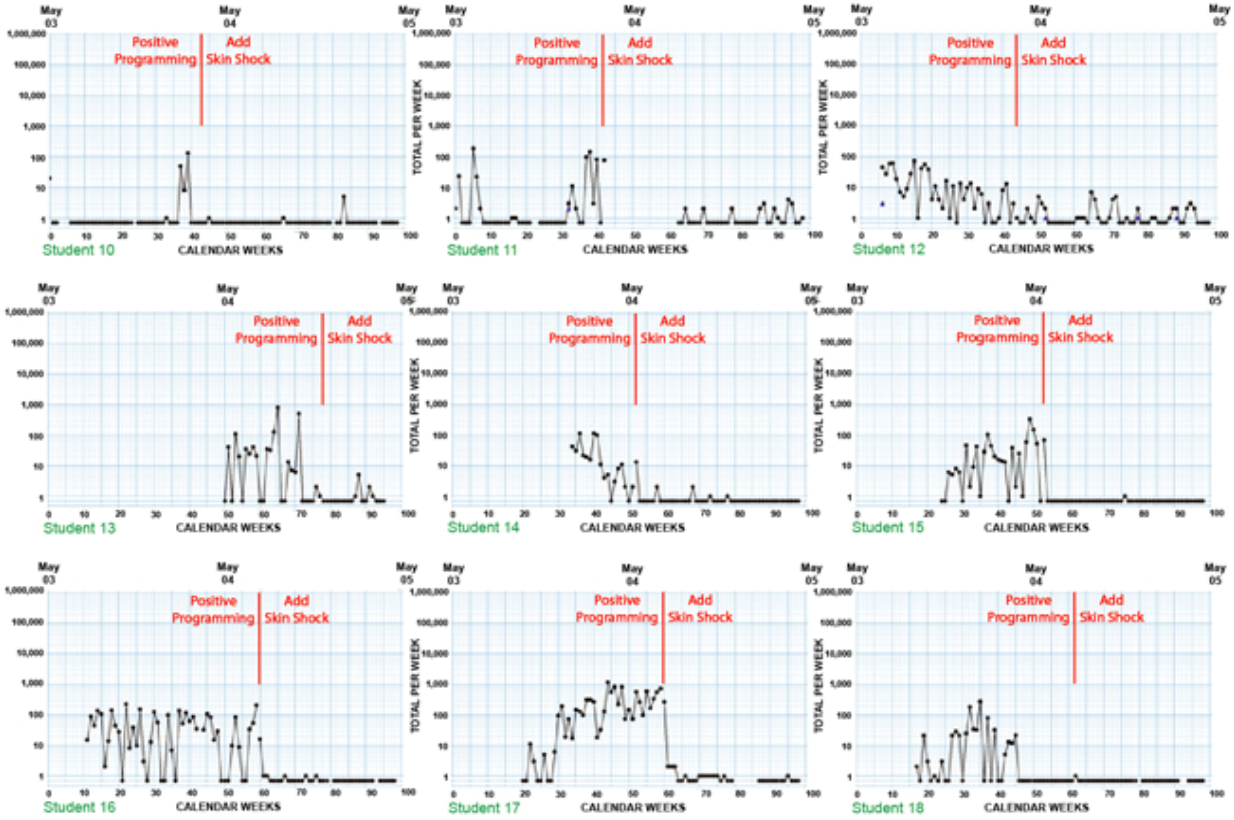

Positive Programming
Add Skin Shock
TOTAL PER WEEK
CALENDAR WEEKS
Student 10
Student 11
Student 12
Student 13
Student 14
Student 15
Student 16
Student 17
Student 18

EXHIBIT 3

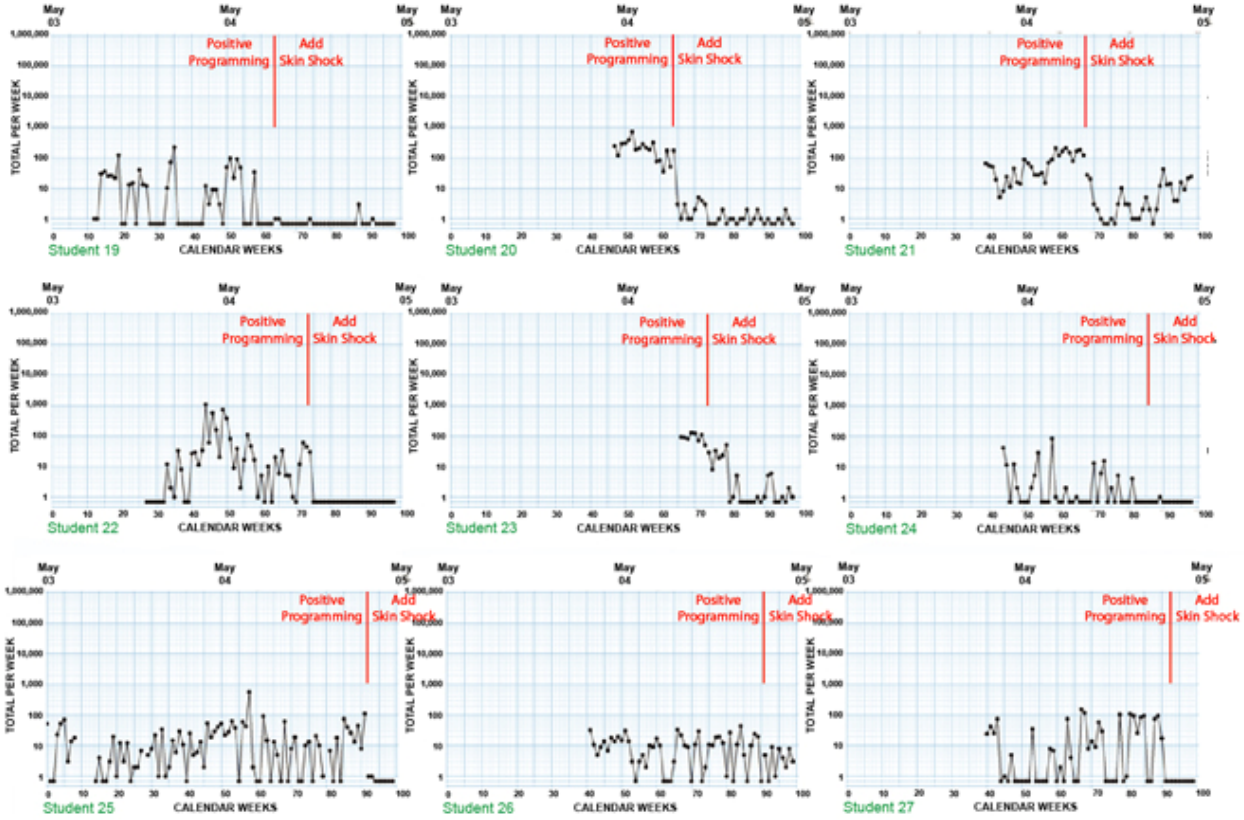
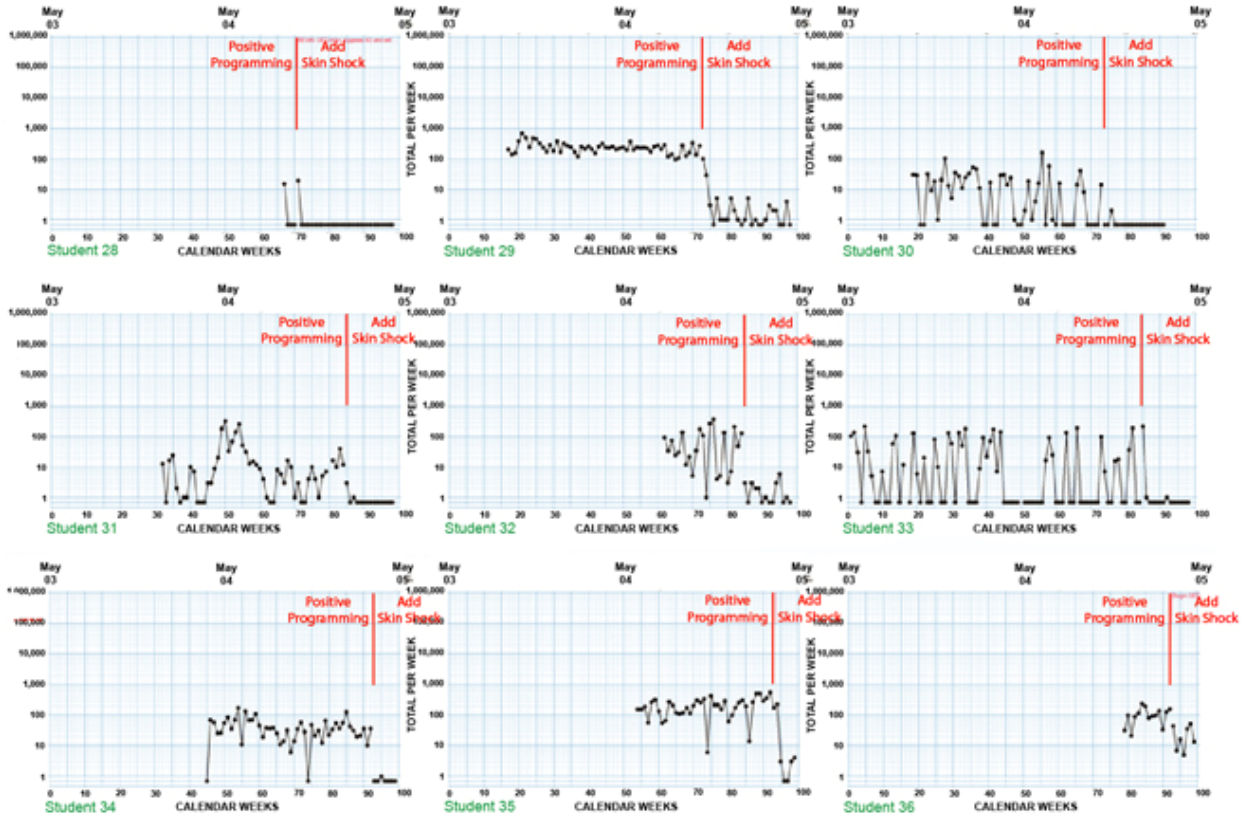

Positive Programming
Add Skin Shock
TOTAL PER WEEK
CALENDAR WEEKS
Student 19
Student 20
Student 21
Student 22
Student 23
Student 24
Student 25
Student 26
Student 27

EXHIBIT 4



The Israel et al (2008) paper on aggression includes data for an even greater number of students (60) and for a longer period (3 years).[65]

(3) In 2010, *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention* published an article by Drs. Israel, Blenkush, von Heyn, and Sands documenting the fact that programs using positive only treatment procedures were unable to treat the really difficult behavior problems and simply expelled those students when that happened. The paper shows how the students fared when they came to JRC.[66]

The abstract of this paper is as follows:

> In the debate over aversives a little-known but significant fact is often overlooked: programs that restrict themselves to positive-only treatment procedures sometimes expel individuals with severe behaviors when their behaviors become too difficult to handle. We review seven such cases of individuals with severe behavior problems who were expelled from state-

[65] *See* Israel et al. (2008), note 25, *supra*.

[66] *See* Israel et al. (2010), note 13, *supra.*

of-the-art, positive-only programs and describe what happened to them when they were enrolled in a program that was able to supplement its positive-only procedures with contingent skin-shock when necessary.

H. Behavioral skin shock makes medical and surgical treatment possible that would be impossible otherwise.

A major benefit of JRC's treatment is individuals can enjoy the benefits of badly needed medical and surgical treatments that were previously impossible to obtain because the person's behaviors were too violent. Here are a few case examples.

(1) A twelve year-old girl engaged in eye poking and head-hitting with such force and to such an extent that she had detached both retinas and was on her way to becoming blind. The retinas could not be re-attached because her eye-poking would continually cause them to detach. Through JRC's use of aversives (including the use of holsters which the MDRI Report objects to), her eye-poking was successfully treated, her retinas were re-attached and her sight restored. She is now thriving. Here is a photo before GED treatment:

Here is a picture after her treatment with the GED (shown with her father on a home visit):

(2) A young man had scoliosis so severe that he required surgery on his spine. The surgery was delayed for several years because of the severity of his aggressive behaviors. Only after the implementation of the GED was the surgery allowed. With aversives, his aggressive behaviors reduced to near zero levels, and the surgery was a success.

(3) A man from Massachusetts, aged 47, who exhibited such disruptive and self abusive behaviors that he had been in and out of psychiatric hospitals for most of his life was able, as a result of successful treatment with the GED, to have hip replacement surgery.

(4) A nineteen year old girl from New York with severe aggressive behaviors required surgery on both of her knees due to injuries sustained in physical restraints which occurred prior to attending JRC. After treatment began with the GED, her aggressive behaviors dropped to zero and she was able to have two successful surgeries. She continually asks her mother what took so long for her to get this GED treatment.

I. Behavioral skin shock makes it possible for students to leave institutional settings and to receive residential treatment. These are students who otherwise would be refused treatment anywhere.

Here are some sample cases.

(1) A boy with a serious heart condition and severe self-abusive and aggressive behaviors was refused admission to all the programs he was considered for in the United States. He would head bang so severely a helmet was required. He was not allowed around other children for fear of harming them. His condition was such that if one restrained him there was a danger of a major heart failure. Roland Smiley, of the New York State Education Department personally asked Dr. Israel to accept the boy and provide aversive treatment. JRC was able to accept him because it was confident that with its intensive behavioral program and, if necessary, use of the GED, restraint would not be required in his treatment. This proved to be correct. The boy is thriving and his parents are very happy. An admission such as this from New York could not happen today because of the current NYSED regulations banning aversives to newly admitted students at JRC subsequent to July 1, 2009. These regulations are being challenged in federal district court by a group of New York parents. The judge has ruled that the parents may have the right to obtain exceptions to the ban if the ban interferes with their right to a free and appropriate public education ("FAPE"), which is guaranteed under the federal education law.

(2) A teenage girl had made numerous homicidal attempts, targeting both staff members and other students. She was so feared that no program in Massachusetts or anywhere else in the country was willing to accept her and provide treatment. The severity and dangerousness of her case was so well known among professionals

that psychologists and psychiatrists were unwilling to be involved in her case. JRC was willing to provide treatment to this young woman because it was confident that with its intensive behavioral program and, if necessary, use of the GED and any other needed procedures (including behavioral rehearsal lessons which the MDRI Report objects to), it could succeed in this young woman's treatment. JRC succeeded so well that the young woman was able to graduate from JRC to a less structured program and now attends a local college.

J. The use of behavioral skin shock at JRC is accompanied by numerous safeguards such as the following:

(1) It is included in the student's Individual Education Plan created by his/her school district.

(2) It is authorized on an individual, case-by-case basis by a Massachusetts Probate Court judge, who appoints an attorney to represent the student's interests.

(3) It is approved by the student's parent who can withdraw approval at any time.

(4) It is approved by a physician on an individual basis, in terms of verifying that there are no medical contraindications.

(5) It is approved on an individual basis, also in terms of verifying that there are no contra-indications, by a psychiatrist, neurologist or other medical specialist for students with any prior diagnoses in those areas.

(6) It is approved on an individual basis by a Human Rights Committee.

(7) It is approved on an individual basis by a Peer Review Committee.

(8) It is overseen by qualified clinician with doctoral degree in psychology.

(9) JRC's treatment is maximally transparent. JRC maintains a secure Parent/Agency website where parents and school district representatives can review, on a daily basis, the number of skin shock applications, if any, that their student has received, the effects on the student's problem behavior(s), the number of restraints or other intrusive procedures that the students have received, etc.

(10) Parents are welcome to visit their child at any time, with or without notice.[67]

K. Behavioral skin shock treatment is well supported in the professional behavior modification literature, by authors of psychology and psychiatry textbooks, and by national professional organizations.

The professional literature in the field of behavior modification contains 113 studies in which behavioral skin shock has been used.[68]

[67] For a complete list of the safeguards that surround JRC's use of aversives, *see* Appendix F.
[68] *See* Appendix E.

The following national organizations have issued statements recognizing the professional basis of the use of behavioral skin shock, the use of aversives in general, or the right of parents of special needs children to choose the form of therapy best suited to their own child's needs:

- The Association for Behavioral and Cognitive Therapies (1982). *The Treatment of Self-Injurious Behavior.* This position paper, by the leading association of behavioral therapists in the world, supports the use of skin shock aversives to decelerate self-abusive behaviors.[69]
- International Association for Behavior Analysis. *The Right to Effective Behavioral Treatment* (1988). This statement, by the leading association of behavioral psychologists in the world, supports a parent's right to obtain effective behavioral treatment, including the right to use of aversives when necessary.[70]
- The National Institute of Health 1989. Consensus Conference on Destructive Behaviors. The report of this Conference specifically recognized skin shock as a decelerative procedure that has support in the professional literature.[71]
- Division 33 of the American Psychological Association (1989). Position paper, "Guidelines for Effective Behavioral Treatment for Persons with Mental Retardation or Developmental Disabilities." In this document Division 33 (the division for developmental disabilities) supports the use of aversives when necessary.[72]
- Autism Society of America (1995). Options Policy. In the context of a debate over the use of aversives, the Autism Society of America, which is the largest advocacy organization for autistic persons in the country, adopted a policy that supports the right of parents to select the option for the treatment of their

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[69] Full text available at http://www.judgerc.org/TheTreatmentofSelf-InjuriousBehavior.pdf.

[70] Full text available at http://www.judgerc.org/TheRighttoEffectiveBehavioralTreatment.pdf.

[71] Full text available at http://www.effectivetreatment.org/nih.html. The anti-aversive advocates were very upset at this Consensus Conference Report because it supported the scientific legitimacy of skin shock as one form of behavioral treatment—so much so that through their lobbying efforts they managed to delay the publication of the official report for a considerable amount of time. Subsequent to the publication of the official statement of this conference, the anti-aversive advocates persuaded government officials to add a qualification to the report, asserting that the report was no longer recommended for clinical practice. (The report itself was never intended to be a recommendation to clinicians as to what to use in clinical practice.) The story of the considerable clout of the anti-aversives advocates in delaying the publication of the report is told in a chapter by Dr. Richard Foxx in the book *Controversial Therapies for Developmental Disabilities. See* Foxx, R. M. (2004). The National Institutes of Health Consensus Development Conference on the Treatment of Destructive Behaviors: A study in professional politics. In J. W. Jacobson, R.M. Foxx, & J. A. Mulick (Eds.), *Controversial Therapies for Developmental Disabilities* (pp. 461-476). Lawrence Erlbaum Associates. Full text available at http://www.judgerc.org/NIHConsensus.pdf.

[72] Full text available at http://www.judgerc.org/GuidelinesforEffectiveBehavioralTreatment.pdf.

> autistic child that is best suited to his or her needs.[73]

A prominent and widely used textbook in behavior modification has this to say:

> Contingent electric stimulation as punishment involves the presentation of a brief electrical stimulus immediately following an occurrence of the problem behavior. Although the use of electrical stimulation is controversial and evokes strong opinions, Duker and Seys (1996) report that 46 studies have demonstrated that contingent electric stimulation can be a safe and highly effective method for suppressing chronic and life-threatening self-injurious behavior (SIB). One of the most rigorously researched and carefully applied procedures for implementing punishment by electric stimulation for self-inflicted blows to the head or face is the Self-Injurious Behavior Inhibiting System (SIBIS) (Linscheid, Iwata, Ricketts, Williams, & Griffin, 1990; Linscheid, Pejeau, Cohen, & Footo-Lenz, 1994; Linscheid & Reichenback, 2002).[74]

JRC's skin-shock device is similar to the SIBIS device described above.[75]

A widely used psychiatry textbook has this to say:

> *Aversion therapy*. While behavioral interventions typically employ positive rewards to obtain the desired responses, the effects may take weeks and months of training. Self-injurious behaviors may be refractory to the usual behavioral interventions, physical restraints and pharmacotherapy. In such situations, applications of aversive techniques may result in cessation of behavior that could injure the person. Although unavailable at the Kennedy-Krieger

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[73] Full text available at http://www.autism-society.org/site/PageServer?pagename=optionspolicy.

[74] Cooper, J. O., Heron, T. E., & Heward, W. L. (2007). *Applied Behavior Analysis.*(p. 344) Saddle River, N.J.: Pearson Education, Inc.

[75] *See* the following seven published articles describing the SIBIS:

Salvy, S., Mulick, J.A, Butter, E., Bartlett, R.K. & Linscheid, T.R. (2004) Contingent electric shock (SIBIS) and a conditioned punisher eliminate severe head banging in a preschool child. *Behavioral Interventions*, 19, 59-72; Linscheid, T.R. & Reichenbach, H. (2002). Multiple factors in the long-term effectiveness of contingent electric shock treatment for self-injurious behavior: a case example. *Research in Developmental Disabilities*, 23, 161-177; Linscheid, T. R., Pejeau, C., Cohen, S., & Footo-Lenz, M. (1994). Positive side effects in the treatment of SIB using the Self-Injurious Behavior Inhibiting System (SIBIS): Implications for operant and biochemical explanations of SIB. *Research in Developmental Disabilities*, 15(1), 81-90; Linscheid, T., Hartel, F., & Cooley, N. (1993). Are aversives durable? A five year follow-up of three individuals treated with contingent electric shock. *Child and Adolescent Mental Health Care*, 3(2), 67-76; Williams, D. E., Kirkpatrick-Sanchez, S., & Iwata, B. A. (1993). A comparison of shock intensity in the treatment of longstanding and severe self-injurious behavior. Research in Developmental Disabilities, 14, 207-219; Ricketts, R., Goza, A., & Matese, M. (1992). Case study: Effects of Naltrexone and SIBIS on self-injury. *Behavioral Residential Treatment*, 7(4), 315-326; Linscheid, T. R., Iwata, B., Ricketts, R., Williams, D., & Griffen, J. (1990). Clinical evaluation of the Self-Injurious Behavior Inhibiting System (SIBIS). *Journal of Applied Behavior Analysis*, 23, 53-78.

Full text of all of these articles is available at http://www.judgerc.org/15_papers.pdf .

> Institute, the Johns Hopkins Hospital, the Johns Hopkins Medical Institutions, the Johns Hopkins University, Bellevue Hospital Center, and New York University, aversive therapy is reported to be an effective intervention for challenging behaviors including self-injurious behaviors. While aversive therapy is illegal in some locations and controversial in others, a comprehensive discussion of self-injurious behavior includes mention of this disputatious technique.
>
> Punishment - the application of a noxious stimulus, such as an electric shock, immediately after self-injury - is a quick, effective method of eliminating the behavior. One aversive approach is the administration of a spray of water from a water pistol to the nose or face. Other aversive techniques include the application of a small current of electricity to the skin, resulting in a small electric shock. Loud bursts of noise have also been employed as an aversive stimulus.
>
> Aversive techniques are illegal in some locations and clinicians must know and follow local laws. While there is potential for abuse and misuse by untrained individuals, aversive approaches, as noted above, are sometimes effective (205). Referral of subjects to inpatient facilities experienced in the practice of aversive therapy may be appropriate for people with autism who exhibit self-injurious behaviors unresponsive to alternative treatments.[76]

L. The sensible approach to evaluating whether or not to use behavioral skin shock is to weigh the intrusiveness of the procedure against its benefits. The authors of the MDRI Report refuse to consider this.

The MDRI authors appear to be so blinded by their philosophical or advocacy predilections against the use of aversives that they are unwilling to consider the plight of people with the severest forms of behavior disorders and weigh the advantages of skin shock against its benefits and to consider how it compares with the available alternatives. The MDRI authors also appear determined to make it impossible for any parents of an individual with behavioral disabilities to have the right to do a risk/benefit analysis of their own to determine if aversives could help their child, and to deny that right also to the child him/herself. Instead, the MDRI position appears to be to ban aversives, and particularly skin shock, regardless of what benefits aversives might have. The MDRI position seems to be that even if aversives were necessary to save a child's life, the MDRI authors would to prefer that the child be allowed to die or suffer a life of severe

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[76] Brasic, J.R. (2003). Treatment of Movement Disorders in Autism Spectrum Disorders. In Hollander, E. (Ed.), *Autism Spectrum Disorders*. (p. 292). New York: Marcel Dekker. (internal citations omitted).

pain and institutionalization rather than allow aversives to be used to save his/her life. This approach makes no sense to most rational persons.

Indeed, one of the key persons (Dr. Fredda Brown) who provided information to the authors of the MDRI Report was involved in just such an unfortunate case where a young man was put at risk of dying—and ultimately died—because of a philosophical objection to aversives.[77]

[77] *See* note 5, *supra*; *see also Appendix* J.

III. AVERSIVE THERAPY IN THE FORM OF BEHAVIORAL SKIN SHOCK IS THERAPEUTIC TREATMENT AND DOES NOT MEET THE DEFINITION OF TORTURE IN THE U.N. CONVENTION AGAINST TORTURE.

A. Aversive therapy does not even meet the definition of torture used by MDRI.

MDRI admits in its appeal that procedures cannot be defined as torture if "the stated purpose is to ameliorate a condition or illness." Accordingly, JRC's use of aversive interventions to supplement the behavioral treatment plans for only its most difficult cases after it has proven in an court of law that none of the non-aversive treatments can effectively treat a student's severe behavior disorder, does not meet the definition of torture used by MDRI or any other reasonable definition of torture. As mentioned above, there are 113 peer-reviewed journal articles which find that aversive interventions are a safe and effective treatment for severe behavior disorders – including articles on skin-shock devices, such as the GED and SIBIS, and articles on the use of aversives and skin-shock in other countries such as Canada and the Netherlands.[78]

B. Aversive therapy does not involve the infliction of severe pain or suffering.

Under Article 1-1 in the UN Convention Against Torture, torture is defined as follows:

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

This definition requires that the action in question inflict "severe pain or suffering." JRC's use of skin shock does not do this. In JRC's treatment, the average student being treated with supplementary skin shock receives very few applications—currently the average student receives a median of 0 per week and a mean of 3 per week. The degree of discomfort that is caused by the stimulus is far less than the discomfort caused by untreated self-mutilation and other severe behaviors, by restraint, by seclusion or by ineffective drug treatments. JRC's clinicians and admissions staff routinely demonstrate the skin shock stimulus on themselves to parents/guardians to show how tolerable it is. Most medical surgeries and many dental procedures would meet the definition of causing "severe pain or suffering."

C. Aversive therapy is not experienced by JRC's students as torture, as witnessed by their own testimony. Many view it as extremely helpful or even life-saving treatment.

Current and former students at JRC have never made a single complaint to state agencies that they have been subjected to "torture" or to abusive treatment involving the GED skin

[78] *See* Appendix E.

shock, despite the fact that a great many of the students who have received this treatment are fully capable of expressing their thoughts and feelings to others, and of making a complaint to a state agency.

To the contrary, many current and former students have expressed their gratitude for the successful treatment they received at JRC, including the use of aversives. In many cases the treatment enabled them to come off of the psychotropic medication, to change their previously anti-social or otherwise problematic behaviors, and as a result to turn their lives around. Where previously they were headed for a depressing life of being drugged, restrained and warehoused in a psychiatric hospital, jail or other institution, or being left to live on the streets, in homeless shelters, etc., they now for the first time in their memory had some self-respect, and some hope, optimism and prospects for a better future.[79] In sum, they had an illness which the aversive therapy helped to cure.

One female former student says:

> Before coming to the Judge Rotenberg Center, I was very aggressive. I used to hit my mother. I used to grab knives. I used to cut myself. I used to manipulate by getting—I used to try to manipulate to get my way by banging my head or threatening to cut myself or threatening to commit suicide. I voluntarily asked if I could go on the GED. I'm currently not on any medications and my relationship with my mother now is wonderful.

Another female former student says:

> I probably received about 11 applications in total. The GED program—I think that was the best thing. I can't thank JRC enough for all the help they did for me. You know, without them I don't know where I'd be today—It's either jail, state-instituted, or dead. Who knows?

Brian Avery, a former JRC student, recently wrote an unsolicited letter to JRC.[80] The last two paragraphs of this letter are as follows:

> *About the GED, it saved my life. There are lots of opponents to this controversial, yet potentially life-saving treatment, and understandably so. For someone who has never had the kind of problems I had nor has dealt with anyone who has my kind of problems, when hearing about the GED for the first time, it is only natural to cry torture. However, in reality, being on the GED is a much nicer alternative than being warehoused in a hospital, incarcerated, or being doped up on psychotropic drugs to the point of oblivion. A brief 2-second shock to the surface of the skin sure beats out spending my days restrained and drugged up on drugs and not making any academic progress. I did not like being on the GED when I felt like acting up because it prevented me from being able to do so. But in*

[79] *See* Parents' Journey, note 2, *supra*. (Containing video interviews in which students comment on their experience with the GED).
[80] *See* Appendix D for the full text of this letter.

the end, I'm thankful for the GED because of the enormous progress I made with it and have continued to make once I no longer needed it.

Some people may wind up spending the majority of their life at JRC while being able to enjoy the benefits and privileges the program has while others, like myself, are able to go on to live an independent life. The bottom line is, if those who opposed the GED had their way, I would currently be locked up and heavily medicated at a hospital or in jail or possibly even dead. So for those who have set out to ban the GED please don't.

D. Aversive therapy is often used to *end* pain, as well as to save, extend and enrich patients' lives.

When skin shock is used to treat self-abuse and other violent behaviors, the net effect is to dramatically decrease the pain and discomfort that the individual is inflicting on him/herself. For example, a student who picks at open and infected skin sores down to the bone, who pulls out his own teeth, who bites a hole in his cheek, or who bites off his own fingertips or tongue, is inflicting considerable pain on his own body. If a few skin shocks that have no significant side effects can end such behaviors, they may be saving the student from what otherwise would be massive amounts of self-inflicted pain and injuries that could lead to death.

E. Aversive therapy is not utilized with any individual at JRC for the purpose of "intimidating or coercing him or a third person, or for any reason based on discrimination of any kind."

The fact that aversive therapy is applied to persons with behavior problems is no more discriminatory that the fact that radical surgery and chemotherapy are applied to persons with cancer or that an arm cast is used only with persons who have broken their arms. Treatment is always applied only to those whose medical or behavioral conditions require such treatment in order to achieve a cure or an amelioration of the condition.

F. Aversive therapy is not utilized with any individual at JRC for the purpose of "punishing him for an act he or a third person has committed or is suspected of having committed."

There is a fundamental difference between "punishment" or "corporal punishment" and aversive therapy. Punishment is generally done with a purpose of retribution for an action that the individual has willfully chosen to do. The individual is thought to have behaved badly and is thought to deserve pain or other loss of freedom in retribution. By contrast, aversive therapy is never performed with this thought or intention. An autistic child who is whacking her head to the point of detaching her retinas and near-blinding herself, is not considered to have "behaved badly" and therefore to deserve pain or loss of freedom in retribution. Instead, the child is considered to be exhibiting behavior that is out of his/her control because of his/her illness. Such a behavior is in need of curative treatment and not the retributional infliction of pain or loss of freedom. In a similar way, a person who has a cancerous growth that requires surgery is not in need of the retributional infliction of pain; instead, such a patient is in need of surgery.

In the practice of behavior modification, the individual who receives the treatment is not considered to be "problematic," "bad" or "evil." Behavior modification largely rests on the assumption that behavior is lawfully determined by one's genetics and previous environmental conditioning.[81] Effective treatment can often be achieved by providing a highly specialized environment in which the causes of the problem behaviors are assessed, in which positive behaviors are taught and rewarded and in which, if necessary, problematic behaviors are decelerated through the systematic application of aversive stimuli as consequences, when positive procedures alone are not effective.

G. To call such a remarkably effective and harmless therapeutic procedure "torture" is as inappropriate as calling therapeutic medical treatments torture.

If we were to accept the reasoning of the authors of the MDRI Report, dental surgery and cancer surgery—to take just two examples—would each satisfy the definitional requirements of "torture." To equate with torture the systematic use of an aversive stimulus that is employed to decelerate extremely painful and dangerous behavior, as part of a fully approved behavior modification treatment program that includes individual court pre-approval and subsequent periodic review by a court, is to make the same mistake that one would make if one called a surgeon's use of a knife a "stabbing," or an "assault with a deadly weapon."

[81] *See* Skinner, B.F. (1953). *Science and Human Behavior*. New York: Macmillan.

IV. PERSONS WITHOUT DISABILITIES HAVE THE RIGHT TO AVAIL THEMSEIVES OF AVERSIVE THERAPY IN ORDER TO TREAT PROBLEMATIC BEHAVIORS. IF WE WERE TO DENY PERSONS WITH DISABILITIES THE SAME RIGHT, THIS WOULD CONSTITUTE INVIDIOUS DISCRIMINATION AGAINST INDIVIDUALS ON THE BASIS OF DISABILITY.

A non-disabled individual seeking to control or eliminate problematic or dangerous behaviors possesses the right to seek out—and consent to—treatment of any type. For example, an individual who is addicted to cigarette smoking, and subject to its dangerous side effects, may seek out aversive therapy as a means of cessation.[82] Similarly, aversive therapy—specifically the use of contingent electric shock—has long been recognized as a safe and effective method of treating alcoholism.[83] If a nicotine addict can utilize aversive therapy to avoid death by cancer, if an alcoholic can avail him or herself of aversives to evade death due to liver disease, and if other persons can avail themselves of aversive therapy to avoid death caused by any of their other dangerous behaviors, so too must any person with behavior disorders, whether otherwise disabled or not, be permitted to take advantage of a full range of treatments—including aversive therapies, if necessary—to address his or her own uncontrolled life-threatening behaviors. Any other approach would be a clear and unabashed violation of Massachusetts law and the Americans with Disabilities Act (the "ADA"), 42 U.S.C. §§ 12101 *et seq.*

Regulations promulgated by the Massachusetts DDS pertaining to behavior modification expressly provide that a competent individual may elect treatment which includes aversive therapy, or Level III interventions, as they are referred to in the regulations.[84] Specifically, the regulations provide that, for treatment plans that include aversive interventions:

> Where the individual is 18 years of age or older, or is deemed a mature minor under the applicable law, and is able to provide informed consent to a plan of treatment, the plan may be implemented upon his/her acceptance of its provisions.[85]

Further, as noted above, in addition to JRC's obligations under the DDS regulations, JRC itself is a party to a settlement agreement with the Commonwealth of Massachusetts (the

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[82] *See e.g.* Lancaster, T., Stead, L., Silagy, C. & Sowden, A. (2000). Effectiveness of interventions to help people stop smoking: findings from the Cochrane Library. *British Medical Journal*, 321(7257): 355–358. (Reviewing multiple methods of smoking cessation including counseling, nicotine replacement therapy, medication, acupuncture, hypnotherapy and aversion therapy).

[83] *See e.g.* Wilson, G.T., Leaf, R.C. & Nathan, P.E. (1975). The Aversive Control of Excessive Alcohol Consumption by Chronic Alcoholics in the Laboratory Setting. *Journal of Applied Behavior Analysis*, 83 (1), 13-26.

[84] *See* 115 CODE MASS. REGS. § 5.14(e)(1).

[85] *See* 115 C.M.R. § 5.14(e)(1).

"Settlement Agreement"), which was adopted as an order of the Court on January 7, 1987 and remains in effect to this day, having been upheld and enforced by Massachusetts courts in 1995 and affirmed by the Supreme Judicial Court of Massachusetts in 1997.[86] The Settlement Agreement also provides that "where the client is an adult and able to provide informed consent" to a treatment plan which includes aversive procedures "the plan may be implemented upon his/her acceptance of its provisions."[87] Where an individual is a minor or an incompetent adult unable to provide informed consent, both the regulations and the Settlement Agreement provide for the authorization of treatment with aversive therapies through a court order based on substituted judgment criteria.[88] Thus, under the laws of Massachusetts it is clear that both competent and incompetent individuals have the right to consent to aversive treatment. A denial of this right to a disabled person would be a violation of the substituted judgment mechanism provided for under the DDS regulations, as well as a violation of the ADA.

Title III of the ADA prohibits discrimination on the basis of disability in "places of public accommodation," such as businesses and non-profit agencies that serve the public. Specifically Title III commands that:

> [n]o individual shall be discriminated against on the basis of a disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by a person who owns, leases (or leases to), or operates a place of public accommodation.[89]

Elementary or secondary private schools are considered public accommodations.[90] A school such as JRC qualifies as a person for the purposes of the statute.[91]

Under the ADA, a disability is defined as a "physical or mental impairment that substantially limits one or more major life activities" and a physical or mental impairment includes "[a]ny mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities."[92] Major life activities include "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."[93] Clearly,

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[86] *See* Appendix I. *See also Judge Rotenberg Educational Center, Inc. v. Comm'r of the Dep't of Mental Retardation*, 422 Mass. 430, 677 N.E.2d 127 (1997).

[87] *See* Appendix I, *Settlement Agreement* at ¶¶ A-4(a), A-5(a).

[88] *See* 115 C.M.R. § 5.14(e)(2),(3); Appendix I, *Settlement Agreement* at ¶¶ A-4(b),(c), A-5(b)(c).

[89] *See* 42 U.S.C. § 12182(a).

[90] *See* 42 U.S.C. § 12181(J).

[91] *See* 28 C.F.R. § 36.201(a).

[92] *See* 28 C.F.R. § 36.104.

[93] *Id*.

the students at JRC who stand to benefit from aversive therapy qualify as individuals with disabilities.

In order to comply with the dictates of Title III, a public accommodation, such as JRC, cannot discriminatorily deny an individual with a disability the services or benefits offered by the public accommodation because she or he has a disability.[94] In addition, a public accommodation cannot deny an individual with a disability an equal opportunity to participate in or benefit from the goods or services offered by the public accommodation based on his or her disability.[95] Yet, this is precisely what MDRI submits should occur. JRC offers unique "services or benefits" which include life-saving treatment with aversive interventions. This therapy should be available to any individual—disabled or non-disabled—who could benefit from its efficacy at reducing or eliminating dangerous and problematic behaviors. Despite the documented effectiveness of aversive therapy, MDRI in its appeal unreasonably asks the United Nations to disregard the mandate of the ADA and impose a policy that systematically and invidiously discriminates against persons with disabilities by denying them treatment without any consideration for their individual needs. Such a blatant flouting of the anti-discrimination purposes and ideals behind the ADA represents a significant step backwards in the realm of disability rights in the United States.

[94] *See* 42 U.S.C. § 12182(b)(1)(A)(i).

[95] *See* 42 U.S.C. § 12182(b)(1)(A)(ii).

V. THE MDRI REPORT WAS PREPARED BY PERSONS WITH A PRE-EXISTING PHILOSOPHICAL OPPOSITION TO THE USE OF AVERSIVES. AS A RESULT, WHAT WAS REPRESENTED TO THE U.N. RAPPORTEUR TO BE AN "INVESTIGATION" WAS NOT ONE. THE MDRI AUTHORS SOUGHT OUT AND PRINTED A COLLECTION OF FALSE ACCUSATIONS WITH NO SUPPORTING FACTS AND MANY ANONYMOUS SOURCES AND MADE NO EFFORT TO INVESTIGATE OR EVEN CONSIDER ANY OF THE EVIDENCE IN SUPPORT OF THE EFFICACY OF AVERSIVE PROCEDURES.

A. The Board President of MDRI, as well as most of the persons who were sources of information for the Report, have had a pre-existing bias against the use of aversives and/or JRC.

An examination of the sources that are cited as the basis for much of the information in this report, as well as of the staff and leadership of MDRI, demonstrates that the authors of this report started with a pre-existing bias against the use of aversives and that the "investigation" was essentially a process of looking only for negative information about JRC and aversives, regardless of the credibility of the sources of information, and only interviewing people that they knew would make negative accusations. Here is some of the evidence:

(1) Several years ago the President of the Board of Directors of MDRI, Clarence Sundrum, J.D., came to Boston and testified in favor of a bill in the Massachusetts legislature that would have banned the use of aversives. In 2006, Dr. Sundrum wrote an op ed piece in the *Albany Times Union* that foreshadowed the MDRI report, mentioning torture three times in connection with the use of aversives. A few paragraphs of this op ed piece are reprinted below. It appears that MDRI had concluded that aversives were a form of torture long before they conducted their "investigation."

> Some psychiatric hospitals make heavy use of mechanical restraints and defend them as absolutely necessary; others serving a similar patient population hardly use them at all. Some have a high rate of seclusion; others don't even have seclusion rooms. When questioned, clinical professionals explain this diversity as flowing out of their own values about how people should be treated.
>
> The same is true of the use of painful and humiliating aversives. While there are tens of thousands of people with mental disabilities in institutions across America, and many hundreds, if not thousands, have severe maladaptive behaviors, only a small

handful of programs subject their residents to sanctioned abuse in the name of treatment.[96]

(2) One of the co-chairs of the Coalition for the Legal Rights of People with Disabilities is Polyxane Cobb. She testifies for the same Massachusetts bill (to ban aversives) every single year. She is credited with having "provided MDRI with historical data, research and interviews."

(3) Matthew Engel, an attorney with the Massachusetts Disability Law Center, also testifies each year in favor of the same bill to ban aversives. He has represented several JRC students in the substituted judgment hearings in which JRC seeks to obtain approval of the treatment plans for its students that involve aversives. Mr. Engel is also a source of information for the MDRI Report.

(4) Ken Mollins is an attorney who represents Evelyn Nicholson. Her son Antwone was a student from New York who attended JRC and whose aggressive behaviors responded very well to JRC's skin shock treatment procedures. On February 15, 2006 Evelyn Nicholson suddenly withdrew her consent to the use of the skin shock device for Antwone, a request that JRC immediately complied with. Her attorney, Mr. Mollins, then started a media campaign and a lawsuit against JRC demanding money from JRC, as well as from her school district and the New York State Education Department. One of Evelyn Nicholson's lawsuits has already been dismissed. The first time Mr. Mollins visited JRC, he brought with him a reporter from WNBCTV Channel 4 in New York but introduced the reporter only as his "associate." The TV reporter, Tim Minton, did not reveal his true identity and subsequently aired several unfair and sensationalized news stories about JRC which put JRC in a very negative light. Mr. Mollins' suits against JRC and against the school district are still pending. He has something to gain, both financially and in terms of publicity in that lawsuit. A negative report on JRC by MDRI, therefore, would be very helpful to Mr. Mollins, who was also a source of information for the report

Attorney Mollins has previously been involved in making false accusations against JRC. One notable case is described below in Item 38 of Section VI of this report. Attorney Mollins claimed he had a "whistleblower" within JRC's staff who supposedly relayed some complaint about abuse he/she was aware of at JRC to Mollins (and not to either JRC or to state authorities). The police report documenting this incident, attached hereto as Appendix A, shows that Mollins, unwilling to reveal himself as the source of the complaint, apparently persuaded a Kevin Hall, a scientologist and an anti-aversive advocate in Massachusetts, to file the complaint. A policeman immediately visited JRC to investigate and found that "Neither juvenile had any bruising nor any burns on the areas inspected. The juveniles were clean and well dressed. There were no signs of any abuse or neglect." As the police report shows, Hall then admitted to the policeman who filed the report, "I guess we know the whistle blower is not reliable."

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[96] Sundram, Clarence J., *Unlearn Shocking Behaviors*, ALBANY TIMES UNION, July 16, 2006, at B1.

(5) Jan Nisbet, who also provided information for the report, is a past president of TASH, an organization that is publicly opposed to the use of aversives. Ms. Nisbet has testified for the Massachusetts bill to ban the use of aversives.

(6) Dr. Fredda Brown is also named as a source of information for the Report. As noted earlier, she was involved in convincing James Velez' mother to remove him from JRC and place him in a supported apartment in New York City where no aversives would be used and where he would be cared for with only "positive-only" treatment procedures—a step that led to his premature death through self-abusive behaviors.[97] Dr. Brown's strong anti-aversive predilections were so obvious that the reporter from the *New York Times* who chronicled the story of James Velez for the paper, wrote the following: "Ms. Brown had ill disguised contempt for aversives, and after visiting Mr. Velez [at JRC], she concluded he would blossom in the outside world."[98] She has also testified against the use of aversives at JRC in one or more substituted judgment hearings (the hearings where JRC seeks judicial permission, on a case by case basis, to employ aversives in the treatment programs of certain students). Dr. Brown has also testified in favor of the Massachusetts bill to ban the use of aversives.

So many of the above people have testified in favor of the Massachusetts bill to ban the use of aversives, that it appears that having failed to pass that bill, despite trying unsuccessfully for 24 years to do so, they have turned to the UN Special Rapporteur on Torture to do for them (interfere with JRC's ability to offer aversive therapy) what they have been unable to do in the Massachusetts legislature because the safety and benefits of the use of aversives have been so clearly demonstrated to the legislature and the courts.

B. Because of the authors' strong philosophical opposition to aversives, what they refer to as an "investigation" was not an investigation. They started with the judgment that aversive therapy is torture and then sought out whatever "evidence" they could find—no matter how unproven , misleading or anonymous it might be.

The authors never took a single step to research any of the evidence supporting the use of aversives and made no attempt to interview anyone that might speak in support of aversives or JRC. They never visited JRC, never interviewed JRC's clinicians or staff, never spoke to the hundreds of parents who are pleased what JRC has been able to accomplish for their children, never advised JRC of their investigation, never invited JRC to respond to their concerns, and never interviewed current or former students who have been pleased with the results of their treatment at JRC, including the use of aversives.

The MDRI authors report that they spoke to only three former JRC employees and all three refused to be identified. These three appear to be the same three disgruntled former employees who have been telling the same lies about JRC for years. One of these resigned from JRC after being transferred, due to poor performance, from work in classroom to a residential assignment that he did not want to perform. He worked for

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[97] *See* note 5 *supra*; Appendix J.

[98] Kleinfield, N.R. *Institutions, Electric Shocks, and Now a Glimmer of Hope*, NEW YORK TIMES, June 23, 1997, at Page 3. *See* note 5, *supra*; Appendix J.

JRC for over three years, during which he never raised a single complaint about any procedure, despite being a mandated reporter who had obligation to report any suspected abuse. JRC has had more than 10,000 employees working for it since 1996 alone. To give credence to the word of a few disgruntled ex-employees without seeking the other side of their allegations, and without seeking to speak with any of the many current and former employees who are supportive of JRC, speaks volumes about the lack of credibility of the MDRI report.

What is referred to as an "investigation" consisted largely of the following: finding and using unverified negative accusations taken from the internet; taking selected quotations from the JRC web site out of context, even going so far as to take portions of testimony given by parents in *support* of the use of aversives, and changing the testimony to make the program look abusive; soliciting as many negative quotes as possible from persons who are opposed to JRC; accepting and publishing anonymous accusations without researching whether there was any truth in them; taking selected quotations from reports by a state agency that has a philosophical opposition to aversives (and that is currently being sued by a group of JRC parents in Federal District Court of Northern New York) without any reference to JRC's responses to those accusations, all of which are available on JRC's website; and presenting as facts outdated, re-hashed, and long-since refuted accusations, some of which are now as much as 30-40 years old.

The charges contained in the MDRI Report, for the most part, were made by persons who fall into the following categories: (1) persons who are philosophically opposed to the use of aversives and who have been trying without success for 25 years to get bills passed in Massachusetts that would ban the use of aversives; (2) three disgruntled former employees, none of whom ever claimed that there was torture at JRC while they worked there; (3) an attorney and a parent who is suing JRC and who would financially benefit from negative publicity about JRC; (4) persons from other residential programs who compete with JRC for clients; (5) psychologists who are not behavioral psychologists; and, (6) persons associated with the NYSED who were paid by NYSED as part of its efforts to ban the use of aversives.

The next section of this document contains answers and refutations to allegations contained in the MDRI Report.

VI. RESPONSES TO THE SPECIFIC ACCUSATIONS IN THE REPORT

(1) Title Page: "…electric shock…" At no point does the Report distinguish between the use of electroconvulsive shock therapy (ECT) and the skin shock that is used at JRC as a part of behavior modification treatment. Many readers will suspect, therefore, that JRC is using ECT. ECT is a psychiatric procedure, often done in a hospital setting that is entirely different from behavioral skin shock. In ECT electricity is passed through the brain, causing a seizure. That procedure can have serious effects on a person's memory and other functions. By contrast, in the skin shock used at JRC a small electric current crosses the surface of a small area of the skin, typically of an arm or a leg, for a brief period of 2 seconds. No medical conditions are caused and there are no serious side effects.

(2) Title Page: "…and long term restraint…" JRC's treatment procedures enable students to *avoid,* rather than require, mechanical or manual restraint (data is shown below).

If mechanical restraint is used at JRC, it is used only on a partial basis and is designed and implemented in such a way that, although there is enough restraint to keep the individual from hurting him/herself or others, he/she can still ambulate, sit at his/her desk, do his/her academic work, use the computer, etc. Partial mechanical restraint is needed only: (1) when a student is so self-abusive that it is necessary to prevent severe self-abuse that could maim the student (see cases described in next two paragraphs); or (2) when the student is so unusually violent, dangerous, and strong that it is required in order to keep other students or staff safe (the case in the cover photo). When the student's behaviors improve, the restraint is gradually removed until it is faded away completely.

Currently at JRC only 2 (out of 217 students) require partial mechanical restraint. One is a student whose head-banging is so violent that (prior to enrolling in JRC) he caused himself to suffer a stroke. His physician has warned JRC that one more severe head-bang could be fatal. The only reason that restraint is required in his case is that the student is from New York State, and NYSED regulations forbid its use for school-age students from New York. His parents are participating in a lawsuit in Federal District Court, however, asking that those regulations not apply in his case.

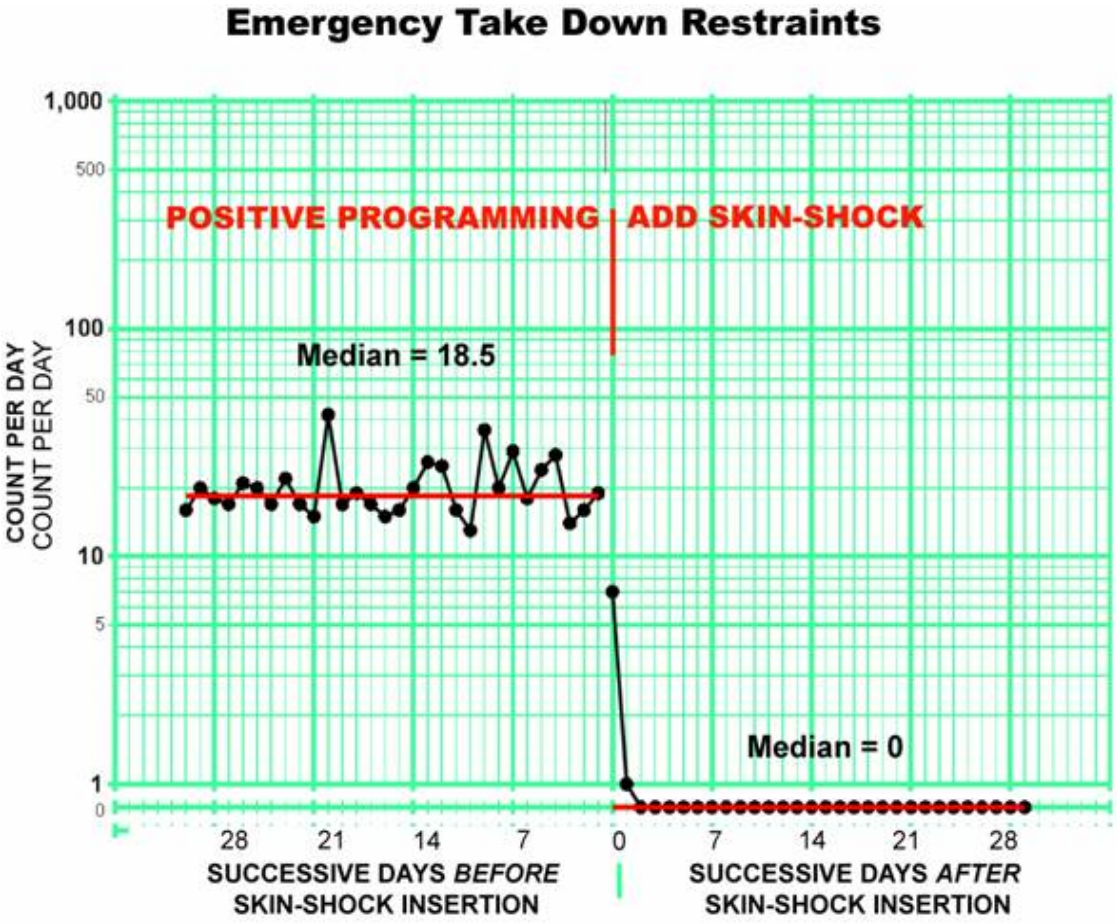
The only other student in partial mechanical restraint wears arm tubes to prevent him from pulling out his teeth. Prior to coming to JRC, he had pulled out all but 14 of his adult teeth. He is danger of pulling the rest of them out. The stiff arm tubes that are used with him are not considered to be a "restraint" under NYSED regulations; instead, they are classified as a "health related support." In his case the only reason he needs the arm tubes is that JRC is unable to use skin shock because of the current NYSED regulations. His parents are also

participating in a suit in Federal District Court asking the judge to allow aversives so that his self-abusive behavior can be treated.

At JRC, manual restraint is needed only where it is required in order to keep everyone safe from the effects of a student's dangerous behaviors. This occurs when the student's behaviors have not yet been adequately treated—usually because JRC lacks authorization to use its skin shock procedures. The latter occurs for reasons such as these: (1) the student is from New York (which has adopted regulations that ban aversives for school-age students); (2) a parent has decided not to give permission for the use of aversives; or (3) court authorization for aversives has not yet been requested or granted.

In almost every case, the use of behavioral procedures, including skin shock if necessary, enables students to *end* the need for any restraints, whether manual or mechanical. JRC has published data on 60 students who had major aggressive behaviors before receiving behavioral skin shock treatment at JRC.[99] On the average, those students had to be restrained almost 20 times per week prior to the use of behavioral skin shock. After the skin shock treatment was introduced, however, this frequency dropped to zero. Here is the graph that shows this data:

[99] *See* Israel et al. (2008), note 25, *supra.*



Prior to their admission to JRC, many of these students had been isolated and restrained in psychiatric hospitals with no freedom or education. After they received skin shock aversives, they became free of restraint, were able to learn in a classroom, and were able to enjoy home visits with their families and participate in community activities.

(3) "At JRC pain is the treatment…The treatment at JRC is punishment." (p.1)
The method of treatment at JRC is almost exclusively the use of powerful rewards and educational systems. More information about the reward and educational systems provided by JRC, is provided herein at section II.E.1. The frequency of the use of aversive interventions at JRC is a tiny fraction of one percent when compared to all of the rewards and educational systems used at JRC every day.[100] Skin shock aversives are used with less than 23% of JRC's school-age population and with less than 43% of JRC's overall population. For those students whose programs do require skin shock aversives, they receive a median of of 0 applications per week and a mean of 3 per week. The vast majority of this group receives fewer than 1 application per week. Each application lasts 2 seconds.

[100] *See* note 26, *supra.*

(4) "The shocks… are so strong as to cause red spots or blisters to the skin." (p. 1) The GED device has been cleared with the FDA and JRC has been registered with the FDA as its manufacturer. The GED has been used safely at JRC for over eighteen years. It has been proven beyond any doubt that the GED causes no harm to the student. Normally the skin shock leaves no mark. Occasionally there is a temporary and harmless reddening of the skin. The GED device does not cause burns. Any marks left by the GED device disappear within a few days. False allegations were made by the anti-aversive advocates that the GED device was causing burns. These allegations were thoroughly investigated by the Massachusetts Disabled Persons Protection Commission in 2006 and found to be unsubstantiated.

(5) "The level of shock is unbelievable, very painful…" (p.1) This statement is attributed to a "psychologist who visited JRC on behalf of the New York State Department of Education." NYSED, which continues to approve JRC as one of its out of state placement options for special needs children and adolescents from New York State, made a decision in 2006 to try to ban aversives as applied to any New York school-age student. As part of its campaign to accomplish this, NYSED selected a group of consultants who were firmly opposed to the use of aversives and asked that group to visit JRC in the spring of 2006 and write a report on JRC. As expected, the report was quite critical of JRC and was replete with false and misleading information. JRC has responded to all aspects of the report.[101] NYSED then used the report to support its proposed regulations which called for restricting and eventually banning the use of aversives. In 2006, the parents of the New York students receiving aversives at JRC filed a lawsuit against NYSED seeking to block NYSED from enforcing those regulations against their children.[102] The parents argued that implementation of the regulations would deny their children access to the federally-mandated free and appropriate public education ("FAPE") that every special needs child is entitled to. The Judge presiding over the case issued two injunctions prohibiting NYSED from enforcing certain aspects of the regulations, which injunctions remain in place.[103] As a result, the children of the plaintiffs in that case continue to thrive at JRC with continued access, when needed, to aversive interventions.

(6) "Children are…secluded for months at a time." (p. 2) This is completely false. Unlike most other schools, JRC makes no use of seclusion or time-out rooms. If a student ever has to be removed from his/her classroom to a different room for reasons of safety, a staff member always accompanies the student and continues the student's program in that room. The student is given academic or other tasks

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[101] *See* JRC Responses to Allegations in NYSED June 9, 2006 Report ("JRC Response"). Full text available at http://www.judgerc.org/ReplytoJuneReport.pdf.

[102] *Alleyne, et al. v. New York State Education Department, et al.*, N.D.N.Y. 1:06-CV-994 (GLS).

[103] *Alleyne et al. v. New York State Education Department et al.*, September 8, 2006 and October 2, 2006 Preliminary Injunction Orders (GLS).

designed by the teacher, is prompted and rewarded for doing them, and is never allowed to be alone.

(7) Mock and threatened stabbings – to forcibly elicit unacceptable behaviors which then result in electric shock punishment…have been reported…"(p. 2) No student at JRC has ever been threatened with violence or anything of the sort in order to elicit an unacceptable behavior, as is falsely claimed in the MDRI report). Over the almost four decades of JRC's existence there have been a few extremely dangerous students who required the use of a preventive form of behavior therapy known as "behavior rehearsal lessons" which are recognized and supported in peer reviewed scientific journals.

This therapy is needed when the behavior to be treated occurs very infrequently but is so dangerous and threatening to the students themselves or others that the students are at risk of ending their own lives or those of others, or of maiming themselves or others, even if only one instance of the behavior is allowed to occur. The combination of these two factors—extremely dangerous behaviors that occur only rarely—means that it is not prudent to wait for the behavior to occur, and rely on the use of decelerating (aversive) consequences alone to change the behavior. In other words, it would be unsafe—and perhaps even unethical—to permit the problem behavior to occur and then "consequate" (meaning arrange a consequence for) it after the fact with an aversive if even one instance can have disastrous results.

Some examples of this type of behavior are these: (1) swallowing razor blades; (2) attempting to cut one's skin with a knife under conditions where the skin is too scarred to be able to be sutured due to repeated occurrences of the behavior; (3) stabbing or suffocating others, or otherwise engaging in a homicidal action; (4) jumping out of a moving vehicle; and (5) setting fire to a house. The goal of the behavior rehearsal procedure is to make even the beginning phases of the behavior generate conditioned aversive stimulation which the student will then act to avoid in the future. For the few students with whom this procedure has been used, the procedure has proven very effective.

Here is an account of one of its few uses at JRC, taken from the JRC website:

Preventive treatment: behavior rehearsal lessons

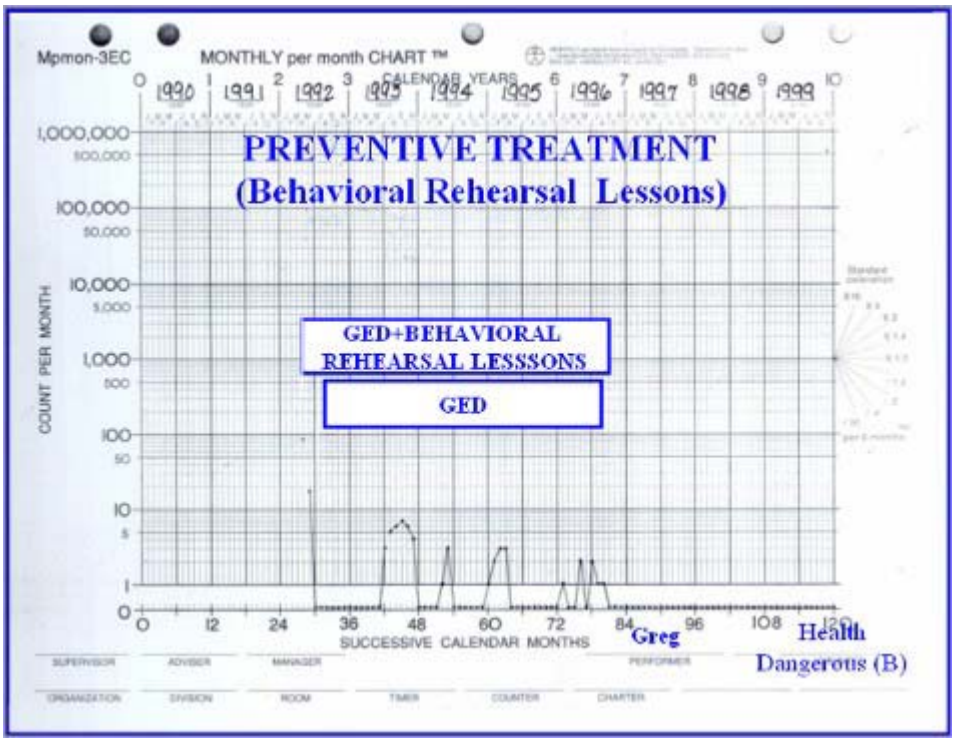

Exhibit 226

Exhibit 226 shows the use of the GED in preventive treatment. G.M. is a student who had life-threatening self-injurious behaviors, including gouging his body with knives. G.M had already lost much of the sight in one eye through self-abuse before being admitted to JRC. In his most recent placement [before he enrolled at JRC], he had suffered a life-threatening pulmonary embolism due to the continuous periods of mechanical restraint he was subjected to in order to prevent further self-abuse. His most recent placement had referred him to the Mass General Hospital for a cingulotomy (surgical cutting of pathways of the brain) in order to try to stop his self-abusive behaviors. The neurosurgeon advised trying behavioral treatment first, and that is how he was referred to JRC. (bracketed material supplied)

In G.M.'s case, it was decided that even one instance of further self-abuse was too many. To prevent or minimize occurrences of the behavior, G.M. was given a course of preventive treatment over a period of approximately 10 months. JRC called this treatment "behavioral rehearsal lessons." In each lesson, G.M. was required to engage in the beginning phase of one of the self-abusive actions in which he had previously engaged. At first G.M. was given four such lessons a

day, separated by three or four hours. After a few months, JRC made contracts with him that enabled him to reduce the number down to three per day if he avoided any problem behaviors. This number was then reduced to two per day, then to one per day and, after ten months, we dropped the lessons entirely."

Exhibit 226 shows that during the entire ten months of these lessons, G.M. did not show the targeted behavior even one time. After the lessons stopped, G.M. has continued to do well. He did show a few instances of the beginning phase of the behavior, and these were treated with the GED. He did not, however, ever show a full blown self-abusive action. G.M. continues to do extremely well. He recently testified before a joint committee of the Massachusetts legislature about how the JRC program, including the use of aversive interventions, saved and dramatically improved his life.[104] G.M. is enjoying significant independence, including paid employment at JRC.

(8) "Behaviors deemed "aggressive" –getting out of a chair without permission – and behaviors referred to as "minor" and "non-compliant" behaviors – raising your hand without permission – are all punishable by electric shocks, restraints and other punishments." (p. 2) JRC does not treat "minor" behaviors with aversives. JRC treats with aversives major behaviors when: (1) the behaviors seriously harm the health, safety or effective habilitation of students; and (2) JRC finds that it is unable to treat the behaviors effectively with positive-only procedures. These behaviors might include self-mutilation, violent physical attacks, destructive behaviors such as throwing furniture and computer equipment around a classroom or residence, and disrobing or masturbating in public.

Safe and effective behavioral therapy requires that the beginning phases of a problematic behavior be treated, and that the clinician should not wait for the student to do damage to himself or others before treating the behavior. For example, in treating the behavior of jumping out of one's chair to attack a staff member or other student, it is important to treat the earliest phase of that behavior—i.e., jumping out of one's seat—as soon as possible, and not to wait until the violence has already occurred. That way the violence can be prevented and the aggressive behavior can be effectively treated.[105]

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[104] Video of G.M.'s testimony can be viewed in full on JRC's website at http://www.judgerc.org, by clicking on the link for "Optional intensive treatment if rewards alone are insufficiently effective" on the home page and then selecting "3. Films" and clicking on the link at 3(a)(i)(3) "3 former and current JRC students explain why treatment worked."

[105] *See* Israel et al. (2008), note 25, *supra.*

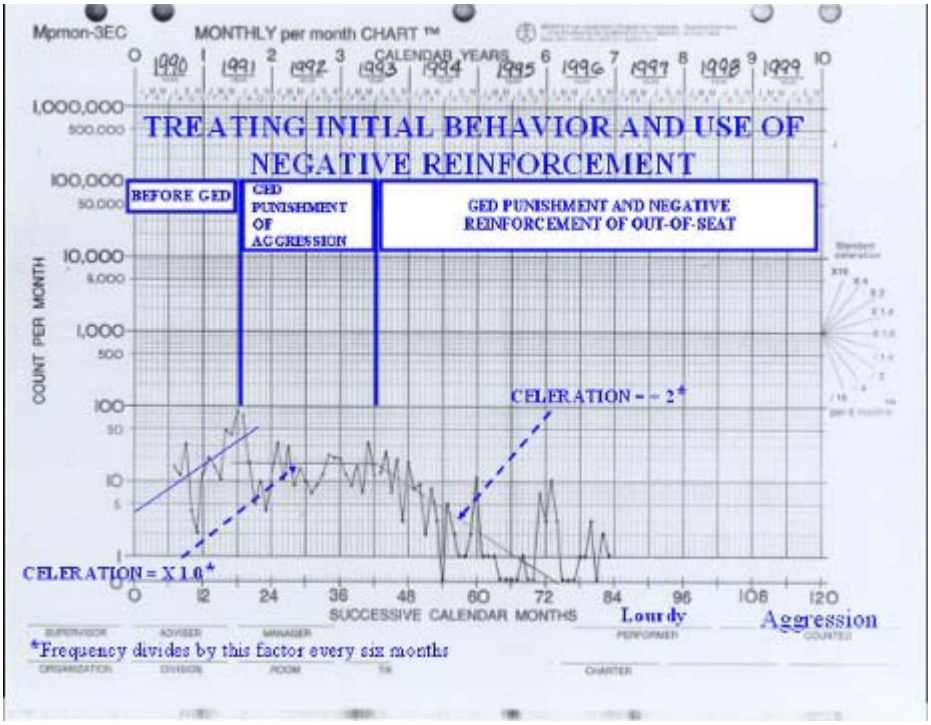

Exhibit 227

Here is a section of a paper on the JRC website which explains this and gives an example of its effectiveness:

> Exhibit 227 illustrates a case where the treatment of aggression did not become effective until we changed from consequating the full occurrence of the aggressive behavior to consequating the beginning phase of a chain of behaviors that typically ended in aggression. The chart shows the treatment of L.L.'s aggression over the course of nine years. The chart shows monthly totals of L.L.'s aggressive behavior during the years 1990 through 1996.
>
> As Exhibit 227 shows, during the 12 months prior to the introduction of the GED, L.L.'s aggressive behaviors were showing an alarming increase in frequency and by June 1991 had reached a level of 100 acts of aggression per month. The GED treatment was started that June, and caused an immediate drop to a level of approximately 20 per month. However, after that drop, the frequency showed no improvement after that, remaining at about 20 dangerous occurrences per month throughout the entire next two years.
>
> In June of 1993 JRC began treating the beginning phases of the behavior being treated. Most of the aggressive behaviors started with L.L.'s bolting out of his seat in the classroom and attacking another student or staff member. Prior to June of 1993 JRC had arranged the GED

consequence as soon as he attacked the student or staff member. In June of 1993, JRC devised a scheme that would punish the very first member of the chain of behaviors that led to the aggression- which was bolting from his seat.

L.L. was also taught that if he had a legitimate need to get out of his seat, for reasons other than to be aggressive, he would be able to do so by raising his hand to ask to get up. Exhibit 227 shows that as soon as JRC started treating the out-of-seat behaviors (in June, 1993), (instead of waiting for the full-blown aggression to occur), aggression began to decrease. As the chart shows, the behavior decelerated over the course of the next three and half years to minimal or zero levels each month.

JRC's behavioral treatment program is designed to eliminate the problematic behaviors that physically harm the student and prevent the student from learning new skills and replacing those problematic behaviors with positive behaviors such as reading, writing, class participation, self-care, independence and social interaction. Harmless behaviors such as raising one's hand without permission have never been treated with skin shock at JRC.

(9) "it is imperative that JRC devise a protocol for reassessing the effectiveness of aversive interventions [shock] once they have been tried for 5 years with only limited effectiveness… - April 2009 report Massachusetts Department of Mental Retardation." (p. 28) JRC has always worked closely and cooperatively with the Massachusetts Department of Mental Retardation, now called the Massachusetts Department of Developmental Services (DDS), in order to satisfy the requirements of the Department and to maintain JRC's special certification to employ aversives, which under DDS regulations, are called Level III interventions.[106] JRC has been and continues to be fully certified by DDS to use aversive interventions. JRC is re-evaluated every two years by DDS as part of the DDS recertification process. The above-referenced quotation is from the April 2009 Report of the Certification Team on the Application of the Judge Rotenberg Educational Center for Level III Behavior Modification Re-Certification, in which DDS granted a 6 month recertification to JRC, subject to certain conditions. One of those conditions, as cited above, required further documentation and analysis of the situations in which aversives are used with individuals for longer periods of time. What the MDRI report fails to note is that, subsequent to the comment quoted above, in a report dated September 27, 2009, the DDS Certification Team determined that JRC had reached "substantial compliance" with this condition. The report noted that:

while 63 students have been approved for Level III interventions for more than five years, the average frequency of applications among this group is 1.28 per week. Eight of these students have a

[106] 115 C.M.R. § 5.14(4)(f).

weekly mean of 0 applications. With the exception of one outlier [BS], whole school data in 2009 showed that the number of applications of Level III interventions, whether students recently started on Level III or who had been on it for several years, indicates that fewer than seven students receive more than one application per day and the vast majority are receiving less than one application per week. In fact the modal number of weekly GED applications for GED approved students was zero. Special attention was paid to a review of GM who is approved for Level III for what appears to be a prophylactic deterrent for seriously harmful behavior. The Certification Team was impressed by JRC staff's thorough rationale for this strategy as it is integrated into a diligent discharge planning effort. The student's targeted behaviors, now in remission, are so dangerous that his treatment team feels the need to have the device available to use in case of relapse. While Level III interventions remain a part of his treatment plan, he has not received an application in over two years. The student himself supports this approach.[107]

(10) "the pain and suffering is severe;" (p. 3) There is brief discomfort that lasts only for the two seconds during which the shock is applied. There is nothing that would merit the phrase "pain and suffering." Many JRC staff members routinely demonstrate the GED stimulus on themselves when requested to do so by visitors or parents and none of them describe the pain as severe. The students in question do, however, suffer or cause severe pain when they cause grievous injury to themselves through self-mutilation or to others through violent aggression. In addition, the massive dosages of medication that many of them were on prior to coming to JRC often caused them unrelenting discomfort and despair.

(11) "the infliction of pain is for a purpose that is coercive or discriminatory." (p. 3) The purpose is not coercive or discriminatory. Behavioral skin shock is applied as a contingent consequence in order to decelerate a specifically targeted behavior such as head-banging. That is, it is applied in order to decrease the future frequency of the inappropriate behavior that has just occurred, so that the student can be taught new and positive behaviors that will take the place of the problem behavior. The reason that a student receives the treatment is that he/she has been diagnosed with a major clinical and/or behavioral disorder(s) that is in need of treatment.

(12) "One girl who was blind, deaf and non-verbal…" (p. 3) This is a false claim. JRC has never even had a student who was both blind and deaf. Like many of

[107] *See* Report of the Certification Team on the Ninety Day Monitoring of the Judge Rotenberg Educational Center Pursuant to the April 27, 2009 Level III Behavior Modification Certification Report, at 14 – 15 (attached hereto at Appendix G).

the other false statements in the MDRI Report, this is an anonymous accusation in which the accuser and the allegedly abused student are both unidentified.

(13) "I was kept in a small room, isolated. One staff and me for a year and a half." (p. 3) MDRI fraudulently takes words out of a testimonial statement by a JRC student that was entirely favorable to JRC and in support of the GED skin shock procedure, and uses those words to deceptively create a statement that the student never made and that appears to be negative toward JRC. Notice that the false quotation asserts that the student was "kept in a small room isolated" with only "one staff and me for a year and a half." Yet the original testimonial statement (shown below) reveals that the student never made such a statement. The student never stated that he was "isolated," only that the room he was in with a staff member, was isolated. He notes that he was kept in that room with a staff member in order to prevent himself from hurting people and trying to stab people. He also never states that he was in that condition ("in a small room, isolated") for a year and a half. He only states that after a year and a half he was approved for the GED skin shock treatment. An accurate account of the February 16, 2006 testimonial statement of Chris Adonetto, as it has always appeared on the JRC website, is as follows (the words that were taken out of context by the MDRI authors, and inappropriately used to create statements the student never made, are shown in bold font.):

> *Hi my name is Chris Adonetto. I am 21 years old. Before I came to JRC I was in jail for three years for the illegal substance of marijuana and possession of a weapon. I was very aggressive. I used to fight, not listen. I used to just do what I wanted. And prior of me coming to JRC I was still aggressive during them times and I used to hurt people and try to hide objects, try to stab people and whoever was around me. To prevent from all that happening* ***I was in a small, isolated room*** *with* ***one staff and me****, try to do my academics, I didn't do it. And after* ***a year and a half*** *I was approved for electro shock treatment and when I went on I received a couple, like most likely twenty, once a week and after you know, I started realizing, you know, I wasn't hurting no one else but myself, I took the priority of, you know, the GEDs came a long way, cause I went almost 10 months already without aggression and prior to that when I was in the conference room I used to have over 2000, 2098 behaviors, problem behaviors and the GED has helped me because now I have zero, flat. I am a flat line. And, you know, and I felt that it helped and right now I have a job, I am faded, I don't wear them completely no more. Unless I exhibit a behavior that I would get a consequence for. And, you know, my goals are to become a chef and to receive my high school diploma, which I am going to be receiving in four months. And to*

show the people that I hurt in the past how much I came afar, a long way, you know. And that's pretty much about it.[108]

It is important to note that JRC does not use isolation rooms. If a student's behavior is too violent to enable the student to be in a normal classroom with other students, he/she may be given his or her own "mini-classroom." A staff member is always in the room with the student and the student is given educational tasks to do under the guidance and supervision of the student's teacher and earns rewards for doing them. The student is also visited and evaluated during the day by several other JRC staff and administrators.

(14) "I was in restraints constantly… I was in an isolated room. Then I went on the GED. (p. 3). Once again, the MDRI authors fraudulently misrepresent what this student said by taking words out of context. The testimonial statement was entirely favorable to JRC and supported the use of behavioral skin shock aversive treatment. However, the MDRI authors fraudulently changed certain words, and made up a statement that the student never made, that asserts facts that the student never asserted, and that is made to appear negative toward JRC. The full text of this student's testimonial statement as it has always appeared on JRC's website is given below:

*Hi, my name is Ed Ferri, I'm 26 years old. Prior to coming to JRC I was in many psychiatric hospitals and other programs, on a lot of medications that didn't work for me. I used to get, I used to open doors in moving vehicles, get out of my seat during moving vehicles, I used to aggress, I used to bite myself, I used to hit others, I used to head, bang my head, I used to do many inj-, things to hurt myself, like, but…. I came to JRC in December of 1997. Since coming to JRC…. When I came to JRC, in December of 1997, I was in an isolated room due to my behaviors because I was unsafe to be around other people. I was in a restricted residence with numerous staff**. *I was still getting restrained constantly and I went on the skin shock treatment, also known as the GED. And I, I, my behaviors started to decrease over time. And my life changed dramatically. I am able to do a lot of things now. That I weren't able to do before. Last year I went to Florida, and I'm planning the same thing this year, by plane and that wouldn't have been possible if, if, I didn't have the help from the skin shock treatment. I don't, no longer wear the skin shock device, also known as the GED. I, I'm, I have independence now, and I have an in school job, where I work in the Big Reward Store which is a rewarding environment where students can come into, and they have games in there and a pool table, a popcorn machine. And…. So… but… and in the last 12 months I have had zero major behaviors. That's a big change from me having, like, countless behaviors, aggressions, getting restrained frequently, like almost every, almost every day. Or like, you know, now, like I'm actually much better and it's a pleasure for me to go on home visits with my dad and I'm just very satisfied with the improvement I have accomplished since going*

[108] Testimonial statement of JRC Student Chris Adonetto, February 16, 2006. Retrieved May 26, 2010, from http://www.judgerc.org/Key_Features/GEDvideotestimonialsSTU.html.

on the GED device and I appreciate all the help JRC's given me. And I, I feel that if you take this, this option of the skin shock device away, then you, you're not going to give people the choice and a lot of lives won't be changed the way my life has changed. Because it's a great, great treatment.[109]

If the MDRI authors were willing to falsify quotations taken from the JRC website, which can so easily be checked, one wonders what kind of liberties they took with the material that they collected from the persons who made anonymous allegations whose accuracy cannot be checked.

(15) "Long-term effects from electric shock can reportedly include muscle stiffness, impotence, damage to teeth, scarring of skin, hair loss, post-traumatic stress disorder, severe depression, chronic anxiety, memory loss and sleep disturbance." (p. 3) The GED devices used at JRC now for over 19 years have never produced any of these side-effects. There are no harmful side effects of the GED and minor side effects may consist of reddening of the skin and, on very rare occasions, the appearance of a small blister, both of which are temporary. This has been confirmed by nineteen years of intensive observation of hundreds of JRC students receiving the treatment. All of the side effects of JRC's behavioral skin shock procedure are either positive or neutral.[110] The list of side effects in the MDRI Report is completely false and MDRI cites no source, nor does it provide any other indicia of credibility for this claim. MDRI may be referring to effects of procedures such as electro-convulsive shock therapy, or of commercially available law enforcement devices used to incapacitate criminals. The failure to distinguish behavioral skin shock delivered by JRC's GED device, on the one hand, from ECT or law enforcement devices such as the Taser on the other hand, is another major deceptive facet of the MDRI Report.

(16) "One mother reported to MDRI that her child was held in restraints for two years." (p. 3) This is another anonymous and unsupported false allegation. For accurate information of JRC's use of restraint, see the response to Item (2) above in this section.

(17) "If students are non –compliant or aggressive, 4 or 5 staff will wrestle kids to the floor and strap them to a board face down and then shock them…they could be like that for 12 hours or more until they "complied." (p. 3) Students are not kept on a restraint board for 12 hours. This is another anonymous unsupported accusation. DDS regulations require that an observer who is not part of the restraining staff must be present at every restraint procedure, to insure that the restraint procedure is carried out safely, correctly, and according to DDS regulations.

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[109] Testimonial statement of JRC Student Edward Ferri, February 17, 2006. Retrieved May 26, 2010 from http://www.judgerc.org/Key_Features/GEDvideotestimonialsSTU.html.

[110] *See* van Oorsouw et al. (2008), note 24, *supra.*

Intrusive restraint is common in other programs, but JRC's safe and effective treatment program eliminates much of the need for restraint. All of JRC's use of restraint is conducted in compliance with state regulations and treatment plans approved by a court on an individual basis.

(18) "The Judge Rotenberg Center (JRC) was founded …in California…was then moved to Rhode Island." (p. 6) This is an example of the shoddiness of the MDRI authors' research, even in simply reporting what they found in JRC's publicly available website. JRC's website clearly states that JRC was started in Cranston, Rhode Island. [111]

(19) "in 1981 [in California], a 14 year-old boy died face down…" [bracketed material supplied] (p.6) JRC was not operating a program in California in 1981 and was not responsible for this boy's care and treatment.

(20) "JRC is not an open facility but a closed institution where children are transported from the JRC owned and operated residences to the JRC school in shackles. Students were observed as they arrived and departed from school. Almost all were restrained in some manner." (p. 9) JRC is not a locked facility. The students live in beautiful single-family residences or apartments located in several towns in southeastern Massachusetts. Some (not all) students, at the direction of their clinicians, in accordance with their IEP, and with the permission of the state agencies sponsoring the students, are transported to and from JRC in transportation restraints for reasons of safety only. Massachusetts state regulations provide for the use of transportation restraint for students who are at risk of engaging in behaviors during transport that could endanger the lives of the passengers and others on the road. JRC uses transportation restraint for only those students who meet the criteria of the regulations.[112] Many forms of transportation restraint are commercially available and are used by special education programs across the country to help keep special needs students safe during transport. This is an accusation that originated in a report on June 9, 2006 prepared by the New York State Education Department (NYSED).[113]

(21) "What's wrong with punishments is that they work immediately, but give no long-term results…" B.F. Skinner interview The New York Times, 1987. (p. 10) This is another example of MDRI's misleading the reader by providing incomplete misinformation. Subsequent to the interview referred to, Skinner issued a statement on punishment that clarified his position regarding the usefulness of punishment in the treatment of certain behaviors. In this statement he wrote:

> [s]ome autistic children, for example, will seriously injure themselves or engage in other excessive behavior unless drugged or restrained, and other treatment is then virtually impossible. If brief and harmless aversive

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[111] *See* http://judgerc.org/history.html.

[112] *See* 115 C.M.R. § 5.13.

[113] *See* JRC Response, note 101, *supra*, at 62.

stimuli, made precisely contingent on self-destructive or other excessive behavior, suppress the behavior and leave the children free to develop in other ways, I believe it can be justified.[114]

(22) "…it is important to recognize that the use of electric shock and restraints as treatment, as practiced at JRC lacks evidenced-based proof of long-term efficacy or safety." (p. 10) This is false. Citations to 113 peer-reviewed articles providing evidence-based proof of the benefits and safety of skin-shock as part of a behavioral treatment plan are attached hereto at Appendix E. JRC does not make its GED device available for use in any other programs, despite receiving requests to do so over the years. The first three citations contained in Appendix E deal specifically with JRC's GED skin shock device.

(23) "There are non-dangerous approaches to the management of dangerous or disruptive behaviors that do not involve the infliction of pain." (p. 10) There are such approaches; however, they are not always sufficiently effective in treating the severest cases of behavior disorders. Two major reviews have shown that they are effective in at most 60% of the cases, leaving 40% with ineffective treatment.[115] Studies that claim effectiveness in treating these procedures are generally not performed on students who have severe problem behaviors.[116] These issues have been addressed at length in Dr. Israel's *Primer on Aversives.*[117]

(24) "Professional disability organizations like TASH…have come out against *any* use of aversives." (p.10) TASH is an advocacy organization. There are many professional organizations that support the use of aversives, as noted in Section II K of this document, above.

(25) "The NY Psychological Association Task Force, which reviewed NYSED's report, raised particular concerns about the use of aversives at JRC without careful attention to the patient's diagnosis." (p. 10) JRC thoroughly diagnoses every student that is recommended for supplemental aversive interventions and those diagnoses are submitted to the court as part of the proposed treatment plan. The JRC students receive a number of different services depending on their diagnosis, including all of the services requested by their school district and set forth in their Individual Education Plans. Most JRC students are diagnosed with multiple disorders before arriving at JRC, but typically, their most urgent and health-threatening diagnosis is a severe behavior disorder that had been resistant to all other forms of treatment, including drugs and positive-only procedures. JRC also employs psychiatrists, school psychologists, physicians, speech therapists, and other medical and rehabilitative professionals to address all diagnostic and treatment needs. The

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[114] Skinner, B.F., A Statement on Punishment, *APA Monitor*, June 1988, p.22. Full text available at http://www.judgerc.org/Griffin1988SkinnerpunishmentstatementAJMR.pdf.

[115] Carr et al. (1990), note 21, *supra*; Carr et al. (1999), note 22, *supra*.

[116] Foxx (2004a), note 33, supra; Mulick & Butter (2004), note 29, *supra.*

[117] Israel (2008), note 28, *supra.*

Task Force referred to above may not have had any behavioral psychologists on it who were familiar with the uses and benefits of aversives or behavioral skin-shock. The NY Psychological Association Task Force has never visited JRC or directed any questions to any of JRC's clinicians. It appears that this Task Force formed its opinions by doing nothing more than reading the false and biased NYSED report of 2006.[118]

(26) One study examined a sample of five adults with developmental disabilities who had been subjected to an aversive program of electric shock, mechanical restraints, and food deprivation. This study showed that the same individuals could be served in the community with the same alleviation of symptoms, using only positive behavior supports. (p. 11) The use, by the MDRI authors, of this study, which was written by clinicians from a program that is a competitor of JRC, is another example of presenting misleading information. Two of the five students reported on in this study—who had been transferred from JRC to the May Institute—later returned to JRC because the May Institute could not effectively treat them or keep them safe. One of the five students (Mike) proved to be so unmanageable that the May Institute had to expel him. Subsequently he was referred back to JRC where he currently resides. A second student set fire to, and burned down one of the May Institute's residences, after which he was transferred to a program in Florida. As for the remaining three, JRC does not have data on them subsequent to their discharge from JRC; however, given the outcome with respect to the first two students, the study as a whole cannot be trusted

The paper itself acknowledges that aversives can be therapeutically effective and can have long term benefits, stating: (1) "..the low-frequency challenging behaviors displayed by the participants in their former setting [JRC] suggests that a therapeutic effect had been produced by such treatment;" and (2)"It is possible, of course, that the prior invasive treatment [referring to JRC] contributed to the long-term outcomes presented in this report" (bracketed material supplied).

Even if the authors were correct in stating that the students continued to do well after leaving JRC and going to the May Institute—clearly not the case for at least two of them—this would speak well for JRC and aversive interventions. JRC's goal is to bring students to a point where they do not need to have a continuation of such intensive procedures.

(27) "MDRI has interviewed providers who serve individuals once detained at JRC…" (p. 11) JRC is not a correctional facility. Students are placed at JRC by their school districts and parents to receive an education and effective treatment. The "providers who serve individuals once detained at JRC" are actually competitors of JRC who would benefit from a negative MDRI report on JRC. It is true, however, that many students leave JRC after successful behavioral treatment for their severe behavior disorders and then do very well at their next placement, which is usually a

[118] *See* JRC Response, note 101, *supra.*

much less structured program.

(28) "Contrary to the notion that only JRC can serve the most disabled individuals, other programs are able to serve the same persons without aversives." (p. 11) There is no dispute that some students with behavior disorders can be safely and effectively treated with behavioral treatment that does not include aversives. Indeed, JRC safely and effectively treats and educates more than three quarters of its school-age students without aversives. As noted earlier, comprehensive reviews have shown that positive-only treatment procedures are effective in 50-60% of the cases[119] It is the remaining 40-50% of the cases that may require the addition of aversives.

As noted earlier in this paper, to evaluate properly claims by a positive-only programs that they are able to treat individuals with equally severe behaviors disorders as those treated at JRC, one needs to take into account factors such as: (1) how severe are the behaviors currently; (2) if the student attended JRC earlier in his career, whether JRC's intensive treatment responsible for why it is now possible to treat the individual with positive-only procedures; (3) whether psychotropic drugs being used; (4) whether the program putting the same level of treatment and educational demands that JRC places; (5) whether the program simply warehousing the individual; and (6) to what extent restraint, time-outs and/or isolation procedures are being used.[120]

(29) "The concept of Positive Behavioral Intervention Support (PBIS) was developed in the 1990's and has gained wide acceptance as the preferred approach to helping individuals with behavior problems." (p. 12) JRC has been a pioneer in using positive behavioral procedures since it was founded in 1971 and continues to develop innovative and effective positive behavioral procedures.[121]

(30) "The National Disability Rights Network and TASH have outlined a wide variety of best practices used throughout the United States, demonstrating that realistic options exist for the treatment of the most severe disabilities. Serious deficiencies may exist in the United States regarding the availability of these services, and parents may rightfully be desperate to find appropriate treatment for children. The lack of services, however, is a product of a lack of funding and planning – not because such alternative are impossible to provide." (p. 12) This statement acknowledges the fact that there is a "lack of" effective services for some students, but incorrectly attributes all cases to a lack of funding and planning, and most importantly suggests no solution. The JRC parents come to JRC for help because they are tired of being told that nothing can be done to save their child. Hypothetical positive-only treatment procedures, that are argued to be effective for students with severe behavior disabilities, and that admittedly do not in reality exist at the present time, will do nothing to help a parent whose child, for example, is pulling

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[119] *See* Carr et al. (1990), Carr et al. (1999) & Horner et al. (2002), notes 21 - 23, *supra.*
[120] *See* Section II E.1, *supra*.
[121] *Id.*

out all of his adult teeth--regardless of whether or not those procedures are characterized as "best practices" or as "realistic options."

(31) "Children and adults at JRC are routinely subject to electric shock…" (p. 12) This is not true. Item (3) above in this section provides data on how infrequently skin shock is used at JRC.

(32) "…for behaviors such as getting out of their seats, making noises, swearing or not following staff directions." (p. 12) The behavior of getting out of one's seat has been treated with the GED at JRC only if bolting out of one's seat is a consistent antecedent to violent aggression, and only if positive procedures alone have been insufficiently effective in treating the behavior. A specific example with data is described in Item (8) above in this section. Ordinary noises are never treated with skin-shock. However, extremely disruptive loud yelling or screaming that is not responsive to positive-only procedures and causing harm to the student and preventing educational activities may be treated with skin-shock. Ordinary swearing is not treated with the GED skin shock; however, if swearing in a particular individual's case is an antecedent to aggression, and if it cannot be treated effectively with positive-only procedures alone, those positive procedures may be supplemented with a behavioral skin-shock aversive.

There are four cases where it may be necessary to use skin shock or some other effective aversive to treat a behavior which, on its face and when not considered in its full context, might, to the casual observer, not seem to be important enough to need to receive the application of a skin-shock aversive:

(1) The behavior in question seems minor on its face, but in actuality is an antecedent to some aggressive, self-abusive or other major problematic behavior.

(2) The behavior in question seems minor on its face, but actually is an altered form of a self-abusive or other problem behavior that is in the process of being decelerated through the use of an aversive. For example, in treating the behavior of pulling out one's hair, as the behavior decreases in frequency (in response to the aversive) it also sometimes changes its form. For example, the behavior starts out as the full-blown pulling-out-the-hair. Then, as it decreases in frequency in response to the aversive, it may also change its form first to firm tugging on the hair, then to merely grabbing the hair, then to merely reaching for the hair, then to merely lifting the hand toward the hair. To treat the full-blown behavior of pulling-out-the-hair it is necessary to treat all of these modified forms of the behavior with an effective aversive if positive-only procedures are not effective. If they are not treated, the behavior is likely to quickly grow back to the full-blown pulling-out-one's-hair.

Similarly, in treating the behavior of punching others, as the frequency of punching decreases due to the aversive, it also may change its form. It starts as a hard punch, and then changes to a softer punch, then to just tapping the

person with the fist, etc. Again, for successful treatment of the full-blown punching, the altered forms must also be treated with an effective aversive if positive-only procedures are not effective.

(3) The behavior in question is first member of a chain (closely linked sequence) of behaviors that terminates in a major aggressive, self-abusive, or otherwise seriously problematic behavior. A discussion of the treatment of bolting out of one's seat is included in Item (8) above in this section.

(4) The behavior in question seems minor on its face, and when considered out of its full context; however, when carried to extremes, it is actually quite dangerous or harmful. An example is the behavior of closing one's eyes. If one keeps them closed all day, one can fall down a flight of stairs and be seriously injured. Another example is scratching the skin. If carried to excess, it can lead to blood and bone infection and ultimately to paralysis and death.

(33) "The homemade shock devices, invented by the school's founder, Matthew Israel, and manufactured at the school…" (p. 12) The GED skin shock device is similar, but with better design, function, and safety, to other skin shock devices that have been used in other programs, including the SIBIS device, which was first used at JRC in 1990. In developing the GED, JRC retained electrical engineers to follow the FDA's Quality System Requirements to design a safe and effective skin shock device. The component parts of the GED are largely manufactured and assembled by companies outside of JRC with final assembly and testing performed by JRC's electronics Department. JRC and those outside companies adhere to the FDA's Good Manufacturing Practices. The assembly and testing of the GED that occurs at JRC is modeled after and follows the requirements of the FDA's Quality System Regulation.[122] The GED device has been cleared by the FDA for the past 12 years. Since the GED's initial clearance, JRC has never been found to deviate from the FDA Good Manufacturing Practices. JRC is an FDA registered manufacturer of the GED device.

(34) "The shock is administered remotely by minimally trained staff—some with only two weeks of training." (p. 12-13). This statement is not true. JRC requires passage of a rigorous training and apprenticeship program, over a minimum of 3 months, before a staff member is allowed to use the skin-shock device. A brief description of the initial training required before a staff member is qualified to use the GED device is as follows:

- 3 Weeks Pre-service Training. Each trainee undergoes 3 weeks of paid pre-service training which includes training in the use of the GED, and the trainee must pass a test on GED use with 100% accuracy on certain questions and

[122] *See* 21 C.F.R. § 820.

with 80% accuracy overall. If the trainee fails the test s/he is dropped from training. Despite the inclusion of this training in the GED, the trainee is not allowed to use the GED with any student until he/she has undergone the further training explained below.

- 3 Months Training without Authorization to Use GED. If the trainee passes the first 3 weeks of training, s/he must then work for an additional three months (and a minimum of 36 shifts) with students whose program does not include the GED before s/he can be considered for further special training in the GED use.

- Special GED Training & Testing. After 3 months, (and a minimum of at least 36 shifts) of working with students whose programs do not include the GED, the staff member is sent back to the Training Department to receive further special training on GED use. At the end of that special training the staff member must pass a competency test at a 100% level. The test has two parts: (1) a practical evaluation of the trainee's actual hands-on skills; and (2) a written examination. If the staff member fails this test, the staff member must go back and spend another month working with students whose programs do not include the GED, after which s/he is sent once again to undergo the special GED training and take the GED competency test. If the staff member fails for a second time to pass the GED competency test at the 100% level, the person's employment at JRC is terminated.

- 1 Month Apprenticeship. After a staff member passes both parts of the GED competency examination s/he is then eligible and required to work as an apprentice to a GED-qualified staff member for an additional period of 1 month.

- Qualification to Use the GED. At the end of the 1 month apprenticeship period, supervisors of the staff member are asked to evaluate whether the staff member is qualified to use the GED. If there are positive responses, from these supervisors, the staff member is then allowed to work with students who have the GED in their programs.

All GED-qualified staff are required to undergo an annual "Level III re-certification training." This is a training period in GED use and includes the same GED competency examination described above. In addition, all staff members receive continual on the job training, daily feedback, and Quarterly Evaluations. At the end of each shift each staff member receives a numerical evaluation (a rating from 0-5) on his/her performance on that shift. Any score below 5 must be accompanied with a written comment by the supervisor who gave the score. At the end of each quarter, each staff member receives a written evaluation. All staff members are also subject to a demerit point disciplinary scheme.

(35) "Students never know when they will receive a jolt…" (p. 13) This is not true. Trained, doctoral level clinicians decide which specific inappropriate behaviors are causing serious harm to a student. The specific aversive that each student receives for each inappropriate behavior is listed on the Daily Recording Sheet which accompanies the student at all times. The student is given rewards for displaying behaviors that are the opposite of, or that are designed to replace, the inappropriate behavior(s) being treated. If rewards and educational procedures alone are insufficiently effective, aversives are added as a supplement to the student's positive reward program to treat only those specific behaviors that have been designated by the assigned clinicians. The student is informed orally what inappropriate behavior has occasioned each application of an aversive. Students who function at a cognitive level where they can discuss their program with their clinician are able to discuss with the clinician what behaviors are consequated with aversives and what specific aversives will be used to consequate what behavior(s). As a result of these procedures, the student knows exactly which behaviors will result in receipt of the skin shock and which will not.

The student is also trained in behavioral strategies for avoiding the problematic behavior(s) altogether. The students receive at least weekly consults with their assigned clinician to review and discuss their treatment program, their progress, and/or their need for treatment changes, etc.

(36) "For 16 years, nearly half her life, Janine has been hooked up to Israel's device. A couple of years ago, when the shocks began to lose their effect, the staff switched the devices inside her backpack to the much more painful GED-4." (p. 13) Direct care staff members have no authority to make such a change in a student's treatment. Only the doctoral level clinician can do this and even then, only if the procedure is included in a court-authorized treatment plan for that individual student. The material is quoted from an article written by Jennifer Gonnerman, and is only one of several false or misleading accusations that are derived from that article. The Gonnerman article was originally planned for submission to *New York Times Sunday Magazine* which sent photographers all the way from the west coast to JRC to do the associated photographs. However, when the *Times* editors read the article they rejected it because it was as too obviously a one-sided, sensationalized hatchet job on JRC. *Mother Jones Magazine* then purchased the article and published it. All of the false or misleading accusations that appeared in the Jennifer Gonnerman article have been fully responded to and are available on JRC's website.[123] As to Janine, she has been a success story. Her life and health have been saved by JRC.

(37) "…48 [students] had been receiving the shocks for 5 years or more." (p. 13) All of the students at JRC who have received aversive interventions have done extremely well. Most of the students who have received aversive interventions at

[123] *See* http://www.judgerc.org/SummResponsetoGonnermanArticle.pdf; *see also* http://www.judgerc.org/ResponsetoGonnermanArticle.pdf.

JRC no longer need aversive interventions and are either still at JRC receiving only positive behavioral supports or have graduated to other programs or have moved on to higher education or a career. There is a small group of adults, however, typically with moderate to severe mental retardation, who will need residential care for the rest of their lives and who may also occasionally suffer a relapse in their severe behavioral disorder. They need to have aversive interventions available to quickly and effectively address the reoccurrence of severe behaviors such as self-mutilation or aggression. This is no different than what is the case with other ailments that are suffered by people with lifelong disabilities. In this respect the use of skin-shock is similar to the use of some medical drugs which also may be needed to be used on a long term basis. In such cases, the frequency with which behavioral skin-shock is required is much, much lower than it was when treatment was first instituted, and the continued availability of the treatment makes possible a quality of life that could never have been enjoyed if the skin shock had not been provided.

(38) "One kid, you could smell the flesh burning, he had so many shocks." (p. 13) This is not true. GED treatment does not cause burns. A similar allegation was made in 2005 and a school-wide investigation was conducted by the Massachusetts Disabled Persons Protection Commission in 2006 and the allegation was found to be unsubstantiated. JRC's use of the GED device is under constant supervision by the Massachusetts DDS, Department of Early Education and Care (EEC) and the Massachusetts Probate and Family Court and has always been found to be safe and effective.

This accusation is said to have been made by an anonymous "former teacher," probably Greg Miller. Miller is a disgruntled former JRC employee who worked at JRC for over 3 years. After he was demoted from working in the classroom to working in a residence, due to inadequate performance, he quit JRC and began providing false information to anti-aversives advocates who have been trying to bring JRC down. If Mr. Miller really felt that he was witnessing something abusive while working at JRC, all he had to do (and was legally required to do as a mandated reporter) was to pick up the phone and call the state agency that investigates child abuse. The telephone number, how to make the complaint, and his *duty* (as a mandated reporter) to make such a complaint if he saw something abusive, were all taught to him in JRC's training course. The fact that he worked for over three years at JRC and never made a single complaint either to JRC staff or to the state agency shows that he is now just engaging in some retaliation to JRC for demoting him—the act that caused him to resign.

The accusation in question was filed with the Disabled Persons Protection Commission and the Massachusetts State Police. A State Police officer appeared immediately at JRC, unannounced, to investigate. The police report, attached hereto at Appendix A, found the claim to be false, stating:

> *I went to the room [at JRC] where both juveniles were. The staff was cooperative with allowing me to inspect the arms, neck and head of both juveniles. Neither juvenile had any bruising nor any*

> *burns on the areas inspected. The juveniles were clean and well dressed. There were no signs of any abuse or neglect…Hall told me he received the information from Kevin Mollins. He told me Mollins is an attorney in New York. Mollins is an attorney who has filed a law suit against the Judge Rotenberg Center. Hall told me Mollins has a whistle blower inside the school. He told me "I guess we know the whistle blower is not reliable.* (bracketed material supplied)

(39) "**It made me sick and I could not sleep. I prayed to God someone would help these kids."** This is part of the same allegation (addressed in the previous item) that JRC believes was made by Greg Miller, the disgruntled former employee.

(40) "The shock is …dangerous." In over 19 years of using the GED, no student has sustained any injury from JRC's treatment with the skin-shock device.

(41) "A stun gun [used by police] is a legal electrical self-defense device that puts out a high voltage and low amperage shock. To put things in perspective, one amp will kill a person. Our stun gun will deliver 3-4 milliamps. However most stun guns on the market are only 1-2 milliamps." (p. 14) The authors of the MDRI Report here attempt to draw an incorrect parallel between a stun gun and the GED. The devices are not technologically or functionally comparable and are used for markedly different purposes. Stun guns are designed to aid law enforcement in safely incapacitating violent criminals. In order to achieve incapacitation, they use high voltage and low amperage electricity that passes through the subject's entire body, causing the person to lose voluntary control of their muscles and fall to the ground. The GED on the other hand is not designed to incapacitate an individual. Quite the opposite, the GED emits a completely different and safe electrical wave form and causes a mere 2 seconds of discomfort that is limited to a small area of the surface of the skin, typically on an arm or leg, for the purpose of assisting an individual to control dangerous behaviors.

(42) "You could not do this to a convicted felon." (p. 14) This assertion incorrectly mixes treatment with criminal justice. The status of a person who is a felon and the status of a person who is a patient in need of therapeutic treatment for a behavior disorder are entirely different cases. It is to be expected, therefore, that what are appropriate actions are very different in the two cases. One would not provide cancer surgery or radiation treatment to a convicted felon just because of his/her status as a felon. One would not provide jail incarceration to a cancer patient because of his/her status as a cancer patient. Similarly, one would not provide behavioral skin shock to a convicted felon just because of his/her status as a convicted felon. One would not provide incarceration in a jail as to an autistic person who is in need of behavior therapy to remove a seriously problematic behavior.

The type of medical, psychiatric or behavioral treatment that is provided to an individual is always specific and individualized to the person and to the presenting problem. One would not do surgery on a person who does not have a need for

surgical treatment. One would not administer medical drugs to persons who have no need for them.

The quoted statement assumes that behavioral skin shock is applied as a way to deliver retributive punishment to an individual for some behavior that the student has engaged in, just as society provides incarceration as a retributive punishment for an offense committed by a convicted felon. That however, is not the case. The individual who needs aversive therapy is not considered to have done anything "wrong" or "criminal" that requires society to impose some retributive punishment. Instead, the individual is considered to be in need of therapy to remove or diminish a behavior that is extremely harmful to him/herself. Skin-shock aversives are administered for the limited purpose of decelerating the future frequency of a specific pre-designated problem behavior that has just occurred, which is severely harmful to the individual.

The JRC treatment program, including any supplemental use of aversive interventions, is only used when approved on an individual basis by a physician, a court, and the individual's parents. In the case of school age children a further requirement is that the use of aversives be added to the student's Individualized Education Plan.

(43) "I had a tingling up to my elbow on the inner part of my arm I would say for four hours." (p. 14) This accusation (now almost 20 years old) was made by two disgruntled employees and it is not possible because of the design of the GED device. After the 2 second application of the GED, the electrical stimulus is terminated by the GED device and could not possibly cause a tingling for four hours. There is no residual stimulation of the body's sensors and therefore there is no continuing physiological effect on the body. Anti-aversive advocates who have tried the GED skin shock on themselves in public situations where there is an audience, have been known to dramatically exaggerate the apparent painfulness of the skin shock, or to give a false report, in order to support their argument that skin shock aversives should be banned.

(44) JRC refers to physical restraints as "limitation of movement" (LOM) and this is a core part of its aversive treatment program. (p. 15). Item (2) above, in this section contains accurate information about JRC's use of restraint.

(45) "Students may be restrained for extensive periods of time (e.g. hours or intermittently for days) [emphasis added] when restraint is used as a punishing consequence." (p. 15) "one boy spent two years almost continually strapped to a chair. from 2007 to 2009, when the mother refused the use of the GED with her child, he was almost continually strapped to a chair, until she was finally able to find another placement…" (p. 16) "He has been strapped to a chair for 2 years." (p. 16) This is another false allegation. See item (2) above, in this section, for accurate information about JRC's use of restraint..

(46) "Staff will wrestle the student to the floor and strap them to a board face down and then shock them…they could be there for 12 hours or more until they "complied." (p. 16) This is another false allegation. Item (2) above, in this section, contains accurate information about JRC's use of restraint.

(47) "Mechanical restraints on both arms and legs face down and just left there… I was put in a room by myself and put in a 4-point chair." (p. 16) This is false. All use of restraint at JRC is conducted in compliance with state regulations and court-approved treatment plans. As explained earlier, students are never left alone in a room. Item (2) above, in this section, contains accurate information about JRC's use of restraint.

(48) "and would shock her and shock her…" (p. 16) This is another false statement from an anonymous source. The particular behaviors to be treated with aversives are designated in writing by the student's treating, doctoral-level clinician and all applications of the GED device are controlled and monitored by JRC's doctoral-level clinicians and other supervisory staff. No one is allowed to do anything that could be accurately described with a phrase such as "and would shock her and shock her."

(49) "an automatic holster-like device, attached to a chair, in which children are made to keep their hands. Removal of the hands from the holster triggers an automatic shock." (p. 16) JRC receives students that forcefully hit themselves in the head literally thousands of times per day and violently attack other people at a high daily frequency. JRC has successfully treated hundreds of students with this type of intense head-hitting, eye-gouging, or assault and battery. In the case of a few of the students, a holster was developed for students to wear on their belt (not attached to a chair) so that they could learn how to be around other people without attacking themselves or others. The procedure has been extremely successful, is safe, and is only done with court approval and under the direct supervision of experienced staff. With students who engage in self-abusive behaviors such as eye-poking, this has proven to be a very effective treatment procedure. The procedure has helped one child regain her eyesight after having detaching both retinas at her previous placement where aversive therapy was not available. Photos of this student appear in section II. H., above.

(50) "he was never in diapers before and he always used a toilet." "But they didn't want to untie him and let him use the bathroom." (p. 17) This is false. JRC has always provided bathroom breaks and schedules regular bathroom visits for all of its students. JRC has also successfully treated adolescent students and adults who came to JRC wearing diapers twenty-four hours a day because they purposely urinated or defecated in their clothes, or because their behaviors were so violent that no one had ever felt safe enough to try to toilet-train them.

(51) "MDRI interviews indicate that students are likely to be restrained after they are admitted and before they go before a court to determine whether they

can be subject to Level III aversive treatment…These findings raise concern that restraints may be used to pressure or coerce individuals into consenting." (p. 17) When a student is first admitted, he/she is likely to engage in the same dangerous behaviors that had caused him/her to be rejected or expelled from prior placements, to be confined to psychiatric hospitals or correctional institutions, to be mechanically and physically restrained or isolated at previous placements, etc. Consequently, restraint is more likely to be required shortly after the student is admitted than it is at later points after JRC's treatment program has begun to change the student's behaviors for the better.

Similarly, the reason that some students may have to be restrained "before they go before a court" is that the only students who go before a court are those whose behaviors are so severe that they could not be treated successfully with positive behavioral supports alone. Such students need to be restrained in order to avoid serious harm to themselves until their behavior can be adequately treated and improved through the addition of court-authorized aversives to their ongoing program of positive rewards and educational procedures. JRC's effective treatment will then quickly eliminate the need for future restraint.

(52) "When I started off in the Judge Rotenberg Center, I was in restraint at least fifteen times a day." (p.17) This sentence is taken from a testimonial statement by a student named Jennel.[124] MDRI has taken this statement out of context in order to make it appear as though Jennel was making a statement that was negative toward JRC. The full statement is re-printed below and the sentence that was taken out of context has been placed in bold font. Notably absent from the material that the MDRI authors chose to quote were statements such as this: "*I feel that this program has done an awful lot to help me.*"

> *To whom it may concern:*
>
> *I would like to give everyone in the Judge Rotenberg Educational center a great big thank you for everything that have done for me. If it weren't for some of the staff I probably wouldn't have been able to get here at the Turnpike residence but most of the staff has been an excellent success in my life. I entered the Judge Rotenberg Center Wednesday, August 23, 2000. I came in this program on seventeen different types of meds and the nurses had a doctor come and talk to me to see if they were doing anything or even they were needed. When the doctor came he had said that there was no need for me to be on so much medication. Most of the meds were supposed to relax me, but they made me tired instead of relaxed. I used to want to sleep all day and do nothing. But right now all I*

[124] Testimonial statement of JRC Student Jennel Chisholm, November 17, 2001. Retrieved June 8, 2010, from http://www.judgerc.org/Comments/stultr11.html.

really want to do is things such as academics and extra chores. When I first came here I didn't want to do any of these things. But now that I am on no meds at all I am finely able to do things for my self instead of staff or anyone else doing the things that I am supposed to do for my self. ***When I started off in the Judge Rotenberg Center I was in restraint at least fifteen times a day.*** *Before I started my treatment at JRC I had fourteen hundred aggressions and a lot of HDB's (Health Dangerous Behaviors). Now that I had something that will help me control my aggressions I am able to either use my words and my actions. My actions used to speak louder than my words can. But since I have been on my treatment there has been a serious decrease in all my behaviors. But when I first entered this program I was at a higher crisis house due to my behaviors. I had tried my best to not have behaviors. I feel that this program has done an awful lot to help me. I have been through a lot and I have been trying to deal with all my anger in an appropriate manner not a negative manner. I have had to deal with a lot of changes made in either the residence or the school. I have had at least five different case managers and they have all helped me in the same way and the same manner. I feel that all of the higher up staff are also a great big success in my time at the Judge Rotenberg Education Center. I have also had two great clinicians in my time so far here at the Judge Rotenberg Center. I have really appreciated everything that has been done for me here at the Judge Rotenberg Educational Center. Thank you very much for all the help and the patience that all of the staff has had with me.*

(53) "It is during this initial restrictive placement at JRC that the frequency of behaviors is documented for purposes of obtaining a substituted judgment for the use of Level III procedures." (p. 17) It is a requirement of behavioral clinical practice to record a baseline frequency of problematic behaviors as part of designing an effective behavioral program. All good behavioral programs do this, starting on the date of admission including JRC, and would be rightly criticized if they did not. JRC also receives many of the treatment records from the student's placements prior to JRC and those records are always replete with countless acts of violent and dangerous behaviors. JRC uses the baseline data, prior treatment records, its own observations of the student, and additional information to design, first of all, a positive-only treatment plan that meets the individual needs for the student. In those cases where JRC's positive-only procedures prove insufficiently effective when used by themselves, there is always significant incontrovertible evidence for the need to add supplemental aversives to the student's program.[125]

[125] *See* JRC Response, note 101, *supra*, at 8 – 9.

(54) "I would be frequently restrained and placed in a small room…" (p. 17)
Again, MDRI has fraudulently taken out of context a small part of a longer statement that is very supportive toward JRC and toward the use of the GED skin shock.[126] By selecting and rearranging words, MDRI makes it seem like a critical statement. The words as quoted were not what the student actually said. Notably absent from the words that MDRI chose to quote are the following words, "*About the GED, it saved my life,*" which appear as the first sentence in the final paragraph of the letter. The full statement, a letter from a former JRC student, Brian Avery, is re-printed below. The words taken out of context are indicated by bold font.

> *My name is Brian Avery and I was a student at JRC from September 1998 to January 2004. Prior to me entering JRC at age 12, I was in and out of several psychiatric hospitals and failed in two alternative educational settings.*
>
> *My behavioral problems really began to escalate when I was 8 or 9 years old. I was on several medications including Tegretol, Haldol, Ritalin, Risperdal, Depekote, Prozac and Paxil. At age 10, my behavior become dangerously out of control. While in school, I would climb on furniture, climb under furniture, mouth off at the teacher, run out of the classroom and would have to be chased down by school staff. I would disrespect authority figures, yell, swear, exhibit inappropriate sexual behaviors in school. I would even try to stab myself with a pencil. I would become physically aggressive with my teachers and would have to be confined in a small padded room. In December of 1996 I was moved from a co-ed class with a 10:2 student/teacher ratio to another elementary school a few towns over and placed in a all male class with a 6:2 student/teacher ratio. That changed delivered little improvement in my behavior and academic progress. At home, I spent most of my time sleeping or being a couch potato, a debilitating side effect of all the medication I was taking. During the time that I was awake, I would disrespect my parents, be aggressive towards my parents and siblings, throw tantrums, destroy property, and would spend hours on end crying. In November of 1996, I spend three weeks in a psychiatric hospital. In February of 1998, and also in May of that year, I spent another three weeks in a psychiatric hospital. After my third hospitalization, my parents and school district finally came to the conclusion that I needed to be placed in a residential school. After visiting numerous schools in New York, Pennsylvania, New Jersey, and Massachusetts, my parents chose JRC.*
>
> *In September of 1998, I was placed at JRC. Within three months of being at JRC, I was taken off all of my medication. My first few months at JRC were very depressing. For the first month or so of being at JRC, my behavior was much more under control that it had been for a very long*

[126] Letter from former JRC Student Brian Avery, received June 7, 2009. This statement in its entirety appears on JRC's website at http://judgerc.org/Comments/stultr15.html.

time. However, once I became acclimated to the program, my behavior began to deteriorate. I would once again display the same inappropriate behaviors that I did in public school. ***I would be*** *frequently* ***restrained and placed in a small room****. JRC would employ an elaborate scheme of behavior contracts and punishments (not the temporary skin shock). Such contracts included earning a small snack and 10 minutes of free time for going an hour without exhibiting inappropriate behaviors, earning a preferred breakfast for completing my morning routine without incident, being able to order take out for going a full day without displaying inappropriate behavior, being able to attend the weekly BBQ and go on field trips for going a week without displaying inappropriate behavior, and so on. Punishments that JRC would employ involve me spending the day in a small room with a staff person whom I was forbidden from socializing with, going to bed at 7pm, having to do schoolwork or chores on the weekend without being able to socialize with my housemates. Other punishments included being deprived of foods that were rewards. For example, if everyone else were having pizza, I would be served peanut butter and jelly. I would also be put through a ball task, which involved me needing to place 250 foam balls, one at a time, into a trash can while wearing mitts, a task that is very unpleasant. Although I would have occasional bouts of progress (staying on contract for two months at one point), I made no sustainable progress in 1998 through most of 1999. In the fall of 1999, JRC and my parents had decided that it was time to give the GED a try. I reluctantly agreed to the GED and decided not to fight JRC's attempt to place me on the device. I figured that although unpleasant, the GED would deter me from displaying behaviors that would result in me being restrained and losing out on the rewards that came with the program.*

In December of 1999, I was placed on the GED. For the first month or so that I was on the GED, I displayed few inappropriate behaviors, however, once I became acclimated to the fact that I was on the device and was aware of what the GED felt like, I would start displaying lots of more minor behaviors that were not treated with the GED. Once on the GED, instances of me acting out became fewer and more far in between. Although when my contract was broken, I would display lots of inappropriate behaviors, but I would be selective as to not exhibit GED behaviors, although I would occasionally slip up and receive a GED application. By the spring of 2001, it had been several months since my previous major behavioral incident. JRC then began to rapidly fade me off the GED (although the fading process started nearly a year prior, bouts of behavioral episodes impeded the fading process). In July of 2001, I was completely faded from the GED and was moved into a less restrictive residence (apartment), with a student/staff ratio of 4:1. In the apartment, I enjoyed many privileges, such as grocery shopping, going on weekly field trips to the movies, to the arcade, YMCA, local parks etc. I even attended

a few sporting events, including the Providence Bruins, Harlem Globetrotters, and even a Red Sox-Yankees game at Fenway Park. I was also given independence to move about the residence and school unsupervised. All of these were privileges I could not even dream of prior to being placed on the GED. From September 2001-September 2002, I would have a few bouts of behavioral incidents and was placed on and off the GED. However, in October of 2002, I was faded from the GED for good. In the fall of 2002, I attended a culinary class at Blue Hills Technical school, and in November I worked in the computer department as an in school job. Also, I began preparing for the New York Regents exams, and in 2003 I began taking the Regents exams. In the fall of 2003, it became clear to JRC, my parents, and school district that I had accomplished all I could while at JRC and in January 2004 I was transitioned back to public school in New York and mainstreamed.
I moved to Florida in August of 2004 and graduated from high school with honors in May 2005. Since then, I took and passed a couple of college courses and had a few jobs, including a seasonal position working for a bank as a data capture specialist, a job that I obtained because of my quick typing skills that I acquired while at JRC.

About the GED, it saved my life. There are lots of opponents to this controversial, yet potentially life-saving treatment, and understandably so. For someone who has never had the kind of problems I had nor has dealt with anyone who has my kind of problems, when hearing about the GED for the first time, it is only natural to cry torture. However, in reality, being on the GED is a much nicer alternative than being warehoused in a hospital, incarcerated, or being doped up on psychotropic drugs to the point of oblivion. A brief 2-second shock to the surface of the skin sure beats out spending my days restrained and drugged up on drugs and not making any academic progress. I did not like being on the GED when I felt like acting up because it prevented me from being able to do so. But in the end, I'm thankful for the GED because of the enormous progress I made with it and have continued to make once I no longer needed it.

Some people may wind up spending the majority of their life at JRC while being able to enjoy the benefits and privileges the program has while others, like myself, are able to go on to live an independent life. The bottom line is, if those who opposed the GED had their way, I would currently be locked up and heavily medicate at a hospital or in jail or possibly even dead. So for those who have set out to ban the GED please don't.

Thank you very much

Sincerely,

(55) "I refused to allow the GED…" (p. 18) This is another example of MDRI fraudulently taking a very positive and supportive statement off of JRC's website and editing it to make it appear to be saying something negative about JRC. This statement comes from the testimony of Ricardo Mesa, the father of a current JRC student. Mr. Mesa's full testimony is given below.[127] To illustrate how blatantly out of context this quote is, the full testimony is reproduced here and the words taken out of context are shown in bold font. Notably absent from the words that the MDRI Report chose to quote are the words, "*What means something is that I have a daughter who has a life now…and is happy."*

> *I have a daughter, Nicole, who went to JRC in 2004. She's still at JRC in the adult services and she was diagnosed with autism and later Landau-Kleffner Syndrom. As the years went by she got progressively worse. She had brain surgery to remove the epilepsy, which helped with her receptive language. But her behavior continued to be extremely severe. To the point that she would constantly punch her eyes like this {demonstrates} constantly. And I used to be a martial Arts instructor and I used to block and there was no way you could block those punches. Those were hard punches to the eyes. She was doing about a thousand a week. We had to pad the entire room, in her bedroom, she lived with us, she still lives with us. We had to, um, we couldn't go anywhere, we couldn't go on vacation, we couldn't …. At nights we would hear her banging her head constantly, all night long. She would run out, pinching constantly, her face, her body her breasts, black and blue. You get the picture. She went to the May Center, she went to the LCDC Center, she went to Lighthouse, she went to Perkins School for the Blind, she went to the behavioral program, the neuro-behavioral program at the May Center. These are all excellent programs with very devoted teachers and excellent staff. They couldn't help her. They couldn't stop her. Finally, the Boston School District, the ETL suggested JRC because of some of the progress she had seen from some of the children and I went to see it. We decided to send her over there. And I refused to allow the GED. Because it just, it's so counter-intuitive, I love my daughter, so* ***I refused to allow it****. And they were fine with it. They allowed me to keep her in the school. They used other methods to try to keep her safe, the restraints, the arm splints and so forth. But Nicole was not making any progress. When she'd come home it was the same story. I agreed after a long time and the hardest day of my life was going before Judge Souten (sp) and asking for them to allow her to use the GED. I told my wife, "We will give them one month. If I don't see immediate progress, she's off it." They put her on the GED, she had a few*

[127] Testimony of Father of a JRC Student to Massachusetts Legislative Committee, October 27, 2009. Available in its entirety testimony at: http://judgerc.org/StateHouseTestimonies/42.%20Ricardo%20Mesa%20State%20House%20Testimony%2011.4.09.wmv

applications the first day. A few days went by and she had one more. And from that point on she's had an application once every three months, two months and they were usually for very severe behaviors. I don't allow them to use it for any other type of behavior. That contradicts prior testimony {gesturing about someone behind him.} They are fine with it. They have not asked me to take her out of there. Because of that, now she gets one maybe once every year, six months. I mean it's been a long, long time. I can't even recall. She lives at home with us. At home she doesn't wear the GED. It's there in the house and I remind her, that if I see the antecedents, I tell her, "You're going to have to wear the GED." She's fine with it. She has to dress well to go to school. She takes really good care of herself. The staff is extremely loving to her. Always has been, that's one of the things I love. I know them well. My wife knows them very well. We've been able to go to a vacation to Florida every year and Virginia Beach, we are able to go to the movies, we are able to go to dinner together, we have a life. And she lives with us. And that's the way I want it. My biggest fear is that we'll lose all of this ground we've made. That she might return to those horrible days, when she was hurting herself so badly. She knocked out my wife a couple of times with headbutts, this was before the GED. And if she were to go back to that stage, it would be just a matter of time before we would have to put her in an institution, or, she wouldn't be able to live with us. So, you know, I really, I know there's a lot of emotion in all of this. A lot of these are articles that have been written, I spoke one time to a reporter all about my daughter and the Boston Globe and the only thing they did, was post "Torture Versus Love." Not one word about what I told them about my daughter was in that article. You can't believe everything you read. And there's a public outcry, against this and exaggerations about what they are doing at the school. I can't speak for anybody else, but I can speak for my daughter and for my life. And I am not a crazy person, or an uninformed person. I am an accountant and I am also an ordained permanent Deacon with the Archdiocese of Boston. I work very closely with Cardinal Law, I mean Cardinal Sean O'Malley. I studied psychology when I was in school. All of that doesn't mean anything. What means something is that I have a daughter who has a life now. I taught her how to ride a bicycle, who can go swimming, who can go on vacation, who goes to school and comes home and is happy.

(56) "Provocation of bad behavior" (p. 18) This is not true. Item (7) above, in this section, addresses this issue.

(57) "Food Deprivation" (p. 19) For some developmentally disabled students with severe behavior disorders, food may be the only motivational item that will work as an effective reward in order to teach the student such skills as: how to imitate; how to communicate in order to ask for things; how to urinate or defecate into a toilet; how to dress and undress; how to pass behavioral contracts; how to stop engaging in

dangerous behaviors; etc. JRC uses two types of food programs as motivational procedures. Both food programs are safe, must be court-approved, and are supervised by JRC's nursing and physician staff. No JRC student has ever been harmed by one JRC's food programs. These programs are very effective.

(58) "The Contingent Food Program and Specialized Food Program may impose unnecessary risks affecting the normal growth and development overall nutritional/health status of students subjected to this aversive behavior intervention." **(p. 19).** This criticism, raised in the NYSED June 9, 2006 report, was answered in JRC's response to the NYSED report.[128]

(59) "Creating social isolation. To further maintain strict control, socialization among students, between students and staff, and among staff is also extremely limited." (p. 20) There is no social isolation at JRC. The students are never alone and they have daily ongoing interaction with a number of JRC staff members and other students. This includes significant interactions with their teacher, classmates, and housemates, and at least weekly interaction with their treating clinical and other school administrators. Because some of the JRC students have a history of criminal activity and/or gang involvement, JRC does closely monitor discussion and interactions between certain students and will include proper social interactions as a target behavior in certain students' behavior modification plans. Some students are able to earn additional time with other students as a programmed reward for not engaging in harmful behaviors such as not plotting to disrupt class, or plotting to harm other students or staff. This behavioral treatment has been very effective in eliminating destructive behavior and accelerating positive behaviors such as proper classroom and other social behaviors. JRC has a level system in which, as the student's behavior improves, his/her privileges and opportunities improve.

Certain socializing between staff and students is discouraged because we want our teachers and direct care staff members to maintain proper boundaries between themselves and the students. Socializing between staff members on duty is also discouraged because the staff members should be concentrating their attention, during their working time, on their teaching, behavior modification, and child care duties.

(60) "Aversives for harmless behavior" (p. 20) Items (8) and (32) above, in this section address this issue.

(61) "One student stated she felt depressed and fearful…she is not permitted to initiate conversation with any member of the staff. Her greatest fear is that she would remain at JRC beyond her 21st birthday. This criticism, raised in the NYSED June 9, 2006 report, was answered in JRC's response to the NYSED report.[129]

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[128] *See* JRC Response, note 101, *supra*, at 29.

[129] *See* JRC Response, note 101, *supra.*

(62) "I was always in restraint when I came to JRC…Being in restraints wasn't helping me so I wanted GED…I had 20,813 problem behaviors in 5 months before the GED." (p. 32) Once again MDRI takes a testimonial that is favorable to JRC appearing on JRC's website and alters it to make it appear to contain negative comments about JRC. The complete statement that Jennel made is shown below.[130] The phrases that the MDRI authors have used in putting together the above false quotation are shown in bold font.

Conveniently omitted are words such as these: (1) *"and I am able to be in a classroom. I passed the math MCAS. I am taking classes out in the community. And I am able to go on home visits and I have a better relationship now with my mother"* and (2) *"and if you take the GEDs away, you are putting many lives in jeopardy."*

> *Hi, my name is Jennel Chisolm, I am twenty years old, I entered the Judge Rotenberg Center in August of 2000. I come from Charlton, Massachusetts. Before coming to JRC I was in several different hospitals and programs. I was on six different types of, eight different types of psychotropic medication. And no other programs out there would accept me, because I would always head bang. One time when I was four, my mother said "No," so I threw myself down a flight of metal stairs. I was picking at myself; I threw my mother into a refrigerator and my sister into a wall one time. When I first came to JRC, before the GED devices that became part of my program**, I had 20, 813 problem behaviors**. And that was in the course of **5 months**. **I was always in a restraint when I came to JRC**. I was unable to be in a regular classroom. Sometimes I was unable to come to school because of my behaviors. If, if it wasn't for the GED I probably wouldn't sit here to this day, because I have a shunt which flows the fluid from my brain, and I used to head bang. And through the head banging that I did, I could've misplaced that shunt and that could have resulted in me dying, then and there. It was my choice to go on the GED. I had spoken with my psychologist and case manager and I said that I need something else to help me. **Cause being restrained wasn't helping me**, staff telling me "No" wasn't helping me and medications weren't helping me. I came to JRC on six different types of medications and in four and a half months I was off. And since being on the GED I have only had 13 problem behaviors in the last seventeen months. And I am able to be in a classroom. I passed the math MCAS. I am taking classes out in the community. And I am able to go on home visits and I have a better relationship now with my mother. I don't go home and hurt her. I don't hurt myself. If, and my future goal is to graduate, get a job, earn coming off of the skin shock treatment and earn independence. And if you take the GEDs away, you are putting many lives in jeopardy.*

[130] Testimonial statement of JRC Student Jennel Chisholm, February 17, 2006. Retrieved May 26, 2010, from http://www.judgerc.org/Key_Features/GEDvideotestimonialsSTU.html.

(63) "…The NYSED review team found a litany of abuses involving the most painful of punishments used by JRC." (pp. 37-38) The NYSED review team has been completely discredited by their obvious bias and lack of qualifications. First, NYSED assembled the review team without consulting or involving in any way the NYSED Regional Associates who had been specifically assigned to JRC and whose duties were, *inter alia*, to review the program. The probable reason for this was the fact that the NYSED Regional Associate had just evaluated JRC five months earlier and found JRC to be in compliance with all NYSED regulations.[131]

NYSED made no credible effort to ensure that the review team members were unbiased concerning aversive interventions and some review team members later made no secret of their virulent opposition to the use of aversives. Such attitudes were pervasive among the NYSED personnel who supervised or oversaw the review team's efforts. Furthermore, the outside consultants lacked sufficient knowledge or experience to conduct an informed review of JRC. None of the consultants had any direct experience with aversive interventions. None had ever evaluated a program's use of aversive interventions. None had any prior experience with some of the aversive interventions used at JRC.

Finally, NYSED ignored basic procedural requirements of fairness before and after the review team visits occurred. They refused to allow JRC staff to explain to JRC's complex and intricate treatment program to the review team. The NYSED review team refused to ask questions or seek explanations for anything they saw in the program. JRC has responded in great detail to every false accusation made in the report produced by this review team in 2006.[132]

[131] *See* Appendix H.

[132] *See* JRC Response, note 101, *supra*.

Summary

The "investigation" that MDRI asserts they conducted was not an investigation, but rather a kind of witch hunt, using biased and often-anonymous sources, whose purpose was to find and generate negative allegations about JRC. No effort whatsoever was made to look at both sides of the issues or to interview any persons supportive of aversives. As a result, the allegations that were generated by this report are unproved, highly biased, false and/or misleading.

Particularly disturbing was the authors' willingness to distort testimonial material from JRC's own website. The authors took words out of context, made up statements that were not made by the persons who gave the testimonials, and represented the material to be negative comments about JRC and/or skin-shock aversives. If the authors were so willing to falsify statements that can be so easily checked—just by going to the JRC website—how much have they distorted the many other accusations in the Report that were made anonymously in the course of their one-sided research and whose accuracy cannot be checked?

The MDRI Report is so full of obviously biased and falsified information that it is much too weak a platform to support a serious request to consider JRC's aversive therapy to be a form of torture. This one-sided account may be welcomed by those who are philosophically and dogmatically opposed to the use of aversives in behavioral treatment. The Report may also help MDRI raise funds from persons who will not take the time to hear the other side of the story. However, the MDRI Report is seriously flawed and casts doubt on the other national and international work of MDRI which, one fervently hopes, has been done with less obvious bias and falsification.

MDRI's appeal must be rejected. There is overwhelming evidence of the safety and effectiveness of aversive interventions and their use at JRC, including over 113 scientific peer-reviewed journal articles, judicial findings in hundreds of court cases, eye-witness testimonials from present and former JRC students and parents, and the successful licensing and supervision of JRC by numerous state agencies. All of this highly credible evidence stands in sharp contrast to the MRDI report which is clearly just a collection of unproven false allegations. Accordingly, the United Nations High Commissioner for Human Rights, the United Nations Special Rapporteur on Torture, the Obama Administration and the U.S. Department of Justice should reject MDRI's appeal and decline to take any action.

Appendix A

CANTON POLICE REPORT REFERENCING FALSE ALLEGATIONS MADE BY ATTORNEY KEN MOLLINS

Canton Police Report 9.11.2006.pdf

Click here: http://www.judgerc.org/CantonPoliceReport91106.pdf

Appendix B

DISCHARGE SUMMARY FOR STUDENT EXPELLED FROM SCHOOL
THAT USES POSITIVE-ONLY TREATMENT PROCEDURES

Discharge Summary DRAFT

Name: **J.B.**
Birth Date: 4/10/90
Entry Date: 10/29/97
Discharge Date: March 2005

J.B. is a 14-year old boy diagnosed with Autism **J.B.** is a strong, well-developed boy who enjoys participating in outdoor activities such as swimming or rollerblading. One of **J.B.**'s strengths is in the area of sorting, assembling and organizing materials neatly. He also enjoys participating in domestic chores. **J.B.** has made tremendous progress over the past few years on using language to communicate his needs and to express his preferences. However, at times, **J.B.** becomes agitated and he exhibits severe forms of self-injurious, aggressive, and destructive behaviors. Self-injurious topographies currently observed include body hits to the environment, head hits to wall and floor, body punches, face or head hits, and self bites. Aggressive behaviors, which can be quite intense and non-redirectable, include head directed punches, head butts, hair pulling, kicking, grabbing, and biting. Environmental episodes include minor forms such as throwing small objects and ripping materials, or major forms such as turning over furniture or throwing heavy large objects.

J.B.'s rates of Major Aggressive episodes reached levels as high as 10.4 episodes per day as measured across the twelve-week period ending on 6/2/2002, and levels as low as 0.6 episodes per day as observed during the twelve-week period ending on 2/8/2003. Rates of self-injurious behaviors reached levels as high as 10.8 episodes per day as measured across the twelve-week period ending on 5/25/2003, and levels as low as 3.8 episodes per day as observed during the twelve-week period ending on 9/7/2003. For property destruction, **J.B.**'s rates of behaviors were as high as 14.2 episodes per day during the twelve week period ending on 6/30/2002; and as low as 0.8 episodes per day during the twelve week period ending on 8/3/2003.

J.B.'s challenging behaviors seem to occur in a cyclic manner. Several functional assessments and functional analyses were carried out over the past three years as part of the effort of identifying the conditions in which **J.B.**'s target behaviors are more likely to occur. These assessments, however, have shown no conclusive results, as **J.B.**'s behaviors appear to be multi determined (i.e., serve multiple functions). A neurological evaluation was carried out in 2003 to assess any possible correlation between his behaviors and brain functioning abnormalities that were previously identified. Once again, no conclusive results were obtained. Current efforts to decrease the frequency of **J.B.**'s challenging behaviors include a combination of several positive reinforcement techniques **J.B.** gains access to small preferred snacks throughout the day that are delivered contingently upon appropriate behaviors. In addition, he gains access to breaks and preferred activities contingently upon the completion of structured activities. De-escalation techniques that have proved effective for **J.B.** include the use of Functional Communication Responses (FCR) **J.B.** is continuously encouraged to use appropriate language to escape from demand, gain access to time alone, or gain access to teacher's attention. At times, when **J.B.**'s behaviors are not successfully de-escalated, there is an eminent risk of serious injury to both the staff and **J.B.** When the situation becomes unsafe and all other de-escalation techniques were already attempted, it becomes necessary for the staff to physically manage the situation so that **J.B.** the staff and other students are kept safe.

The frequency of behavior episodes (SIB or aggression) that require the use of physical intervention (particularly floor holds) is highly variable, ranging from a weekly total of zero to more than 70. Each protective hold requires a minimum of two teachers; the majority require three or four teachers; and occasionally as many as five teachers are needed to safely manage

J.B.'s behavior outbursts. Despite these precautions, over the past year **J.B.** has caused significant injuries to himself and to staff.

As a result of **J.B.**'s self injurious behaviors, bruises, scratches, and swelling of joints are often observed. In addition to these minor injuries, **J.B.** has suffered several significant injuries that resulted from SIB. In April of 2003, **J.B.** had to have stitches in his forehead due to a cut caused by intense head to floor hits (while wearing a protective helmet). **J.B.** also fractured bones in his hands on two occasions, once as a result of one very intense instance of "hand to object" hit, and a second time from repeated body punches, hand-to-object hits and/or hand contortions (intense "wringing" of hands and fingers). He showed little to no discomfort after breaking his hand.

J.B. has also caused numerous serious staff injuries. Over the past twelve months, there have been several staff injuries that resulted in visits to the Emergency Room. Frequent instances of back and neck injuries occur during the implementation of protective measures. More recently (mid-September through early December, 2004) the injuries to staff have been more severe, including two instances of concussions, four head and facial contusions, and one twisted ankle. Each of these injuries has resulted in staff visits to the Emergency Room and lost work time.

Clinical resources addressing **J.B.**'s case have included Staff Intensive Unit clinicians, the NECC Peer Review system, and internationally-recognized behavior experts. Numerous reinforcement-based behavioral treatment strategies have been attempted in the time **J.B.** has been a student at NECC. These have included high-density positive reinforcement for appropriate behavior; periods of no demands; periods of consistent high-rate demands; functional communication response training; and even attempts to use physical restraint as a positive reinforcer. While most interventions have resulted in brief improvement in **J.B.**'s behavior, none has resulted in long-lasting change.

In addition to behavioral programming, **J.B.** takes Risperdal and Trileptal for behavioral control and to prevent possible seizure activity. Other behavior-control medications (e.g., Seroquel) have not been found effective. The current regimen has had some effect on **J.B.**'s aggressive behaviors, which decreased slightly following the most recent Risperdal increase.

Despite the programmatic efforts that have been made over the past several years to reduce **J.B.**'s rates of maladaptive behaviors, there has been no significant and persistent decrease in levels of challenging behaviors. **J.B.**'s rates of aggressive and self-injurious behaviors have varied with no noticeable regularity. Data collected over the past two years indicate that even though **J.B.**'s behaviors have responded to medication and program manipulations, changes are temporary and rates of maladaptive behaviors tend to accelerate again after a period of deceleration.

At this point, behavior-control medication and treatment approaches based on positive reinforcement have been generally unsuccessful in producing long-lasting decreases in **J.B.**'s behavior. This suggests that **J.B.** may require alternative interventions than those normally used at NECC, for example, mechanical restraint or contingent aversive stimulation.

Because of the significant challenges presented by **J.B.**'s behavior, it has been necessary to assign additional teaching staff resources to maintain **J.B.**'s, and the staff's, safety. The additional staff has been scheduled at times of day when **J.B.**'s behaviors are most likely to present significant challenges.

In spite of **J.B.**'s challenging behavior, he has made considerable progress in English Language Arts, Mathematics, Domestic, Speech and Language, and Adaptive Physical Education domains. His most recent IEP Progress Report (March 2005) contains up-to-date information on these domains. His challenging behaviors have been most interfering with Community and Vocational activities, and thus his progress in these domains has been more limited.

Summary

J.B. is a fourteen-year-old boy diagnosed with Pervasive Developmental Disorder. He entered the staff intensive unit of the New England Center for Children in October of 1997. He receives 1:1 staff -student ratio during all of his waking hours.

During the time that **J.B.** has been a student on the Staff Intensive Unit, numerous positive-reinforcement based interventions have been successfully utilized to establish a repertoire of appropriate functional skills, including communication skills. **J.B.** is able to request most of his everyday wants and needs, and in fact frequently does so. In spite of his repertoire of appropriate behaviors, **J.B.** continues to engage in severe maladaptive behaviors, and these behaviors have caused numerous significant injuries to **J.B.** and his teachers. Positive programming has not been consistently successful over long periods.

Despite the frequency and severity of **J.B.**'s challenging behaviors, he continues to make substantial progress across several domains.

Appendix C

LETTERS OR TESTIMONY FROM PARENTS

Parent Letters.pdf

Click here: http://www.judgerc.org/ParentLetters.pdf

Appendix D

LETTER FROM FORMER STUDENT BRIAN AVERY

Avery Letter.pdf

Click here: http://www.judgerc.org/Comments/stultr15.html

Appendix E

BIBLIOGRAPHY OF PEER REVIEWED PAPERS SUPPORTING THE USE OF BEHAVIORAL SKIN SHOCK

1. Israel, M.L., Blenkush, N.A., von Heyn, R.E., and Sands, C.C.: Seven Case Studies of Individuals Expelled from Positive-Only Programs (2010). *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention, 2 (1),* 20-36.

2. Israel, M.L., Blenkush, N.A., von Heyn, R.E., & Rivera, P.M. (2008). Treatment of aggression with behavioral programming that includes supplementary skin-shock. *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention, 1 (4),* 119-166

3. Van Oorsouw, W.M.W.J., Israel, M.L., von Heyn, R.E., and Duker, P.C., (2008). Side Effects of Contingent Shock Treatment. *Research in Developmental Disabilities, 29(6),* 513-523.

4. Salvy, S., Mulick, J.A, Butter, E., Bartlett, R.K. & Linscheid, T.R. (2004) Contingent electric shock (SIBIS) and a conditioned punisher eliminate severe head banging in a preschool child. Behavioral Interventions, 19, 59-72.

5. Foxx, R.M. (2003). Treatment of dangerous behavior. Behavioral Interventions, 18, 1-21.

6. Lerman, D.C. & Vorndran, C.M. (2002). On the status of knowledge for using punishment: Implications for treating behavior disorders. Journal of Applied Behavior Analysis, 35, 431-464.

7. Linscheid, T.R. & Reichenbach, H. (2002). Multiple factors in the long-term effectiveness of contingent electric shock treatment for self-injurious behavior: a case example. Research in Developmental Disabilities, 23, 161-177.

8. Duker, P.C. & Seys, D.M. (2000). A quasi-experimental study on the effect of electrical aversion treatment on imposed mechanical restraint for severe self-injurious behavior. Research in Developmental disabilities, 21, 235-242.

9. Duker, P.C. & Seys, D.M. (1996). Long-term use of electrical aversion treatment with self-injurious behaviors. Research in Developmental Disabilities, 17, 293-301.

10. Mudford, O. C., Boundy, K., & Murray, A. D. (1995). Therapeutic Shock Device (TSD): Clinical Evaluation with Self-Injurious Behaviors. Research in Devleopmental Disabilities, 16 (4), 253-267.

11. Linscheid, T. R., Pejeau, C., Cohen, S., & Footo-Lenz, M. (1994). Positive side effects in the treatment of SIB using the Self-Injurious Behavior Inhibiting System (SIBIS): Implications for operant and biochemical explanations of SIB. Research in Developmental Disabilities, 15(1), 81-90.

12. Williams, D.E., Kirkpatrick-Sanchez, S. & Crocker, W.T. (1994). A long-term follow-up of treatment for severe self-injury. Research in Developmental Disabilities, 15(6), 487-501.

13. Linscheid, T., Hartel, F., & Cooley, N. (1993). Are aversives durable? A five year follow-up of three individuals treated with contingent electric shock. Child and Adolescent Mental Health Care, 3(2), 67-76.

14. Matson, J., & Farrar-Schneider, D. (1993). Common behavioral decelerators (Aversives) and their efficacy. Child and Adolescent Mental Health Care, 3(1), 49-64.

15. Ricketts, R.W., Goza A.B. & Matese, M., (1993). A 4-year follow-up on treatment of self-injury. Journal of Behavior Therapy and Experimental Psychiatry, 24, 57-62.

16. Williams, D. E., Kirkpatrick-Sanchez, S., & Iwata, B. A. (1993). A comparison of shock intensity in the treatment of longstanding and severe self-injurious behavior. Research in Developmental Disabilities, 14, 207-219.

17. Mudford, O. C., Barrera, F. J., Murray, A., & Boundy, K. (1992). Remote and Handheld Delivery of Contingent Shock: Effects and Side Effects, Unpublished manuscript.

18. Ricketts, R., Goza, A., & Matese, M. (1992). Case study: Effects of Naltrexone and SIBIS on self-injury. Behavioral Residential Treatment, 7(4), 315-326.

19. Barrera, F., Teodoro, J. M., & Goldberg, B. (1991). Pharmacological and behavioral treatment of a dually-diagnosed (Tourette Syndrome) person Paper presented at Invited Symposium (Division 25) on Recent Studies in the Psychopharmacology of the Developmental Disabilities, San Francisco, CA.

20. Gerhardt, P., Holmes, D. L., Alessandri, M., & Goodman, M. (1991). Social policy on the use of aversive interventions: Empirical, ethical, and legal considerations. Journal of Autism and Developmental Disabilities, 21(3), 265-280.

21. Harris, S. L., Handleman, J. S., Gill, M. J., & Fong, P. L. (1991). Does punishment hurt? The impact of aversives on the clinician. Research in Developmental Disabilities, 12, 17-24.

22. Shrader, C., & Gaylord-Ross, R. (1991). The Eclipse Of Aversive Technology: A Triadic Approach To Assessment And Treatment. In A. C. Repp & N. N. Singh (Eds.). Perspective On The Use Of Nonaversive And Aversive Interventions For Persons With Developmental Disabilities, (pp. 403-417). Sycamore, Il: Sycamore Publishing Company.

23. Linscheid, T. R., Iwata, B., Ricketts, R., Williams, D., & Griffen, J. (1990). Clinical evaluation of the Self-Injurious Behavior Inhibiting System (SIBIS). Journal of Applied Behavior Analysis, 23, 53-78.

24. Barrera, F. J., Teotoro, G. M., & Labadie, B. D. (1989). 'Social bonding' outcomes in a clinical trial of SIBIS Invited address at the 15th Annual International Convention of the Association for Behaviour Analysis, Milwaukee, WI.

25. Foxx, R., Bittle, R., & Faw, G. (1989). A maintenance strategy for discontinuing aversive procedures: A 52-month follow-up of the treatment of aggression. American Journal of Mental Retardation, 94(1), 27-36.

26. Matson, J., & Taras, M. (1989). A 20 year review of punishment and alternative methods to treat problem behaviors in developmentally delayed persons. Research in Developmental Disabilities, 10, 85-104.

27. Spreat, S., Lipinski, D., Dickerson, R., Nass, R., & Dorsey, M. (1989). The acceptability of electric shock programs. Behavior Modification, 13(2), 245-256.

28. Iwata, B. A. (1988). The development and adoption of controversial default technologies. Behavior Analyst, 11 (2), 149-157.

29. Council on Scientific Affairs. (1987). Aversion Therapy. Journal of the American Medical Association, 258(18), 2562-2566.

30. Bernstein v. Department of Mental Health and Developmental Disabilities Il, & Ann Kiley. (1986). No. 79-p-2138. Mass. Probate Court Order, Bristol Co. (May 30, 1986).

31. Foxx, R. M., McMorrow, M. J., & Bittle, R. G. (1986). Increasing staff accountability in shock programs: simple and inexpensive shock device modifications. Behavior Therapy, 17, 187-189.

32. Foxx, R. M., McMorrow, M. J., Bittle, R. G., & Bechtel, D. R. (1986). The successful treatment of a dually-diagnosed deaf man's aggression with a program that included contingent electric shock. Behavior Therapy, 17, 170-186.

33. Foxx, R., Plaska, T., & Bittle, R. (1986). Guidelines for the Use of Contingent Electric Shock to Treat Abberant Behavior. Progress in Behavior Modification,

20, 129-140.

34. Matson, J. L., & DiLorenzo, T. (1984). Punishment and its Alternatives. New York: Springer.

35. Sherman, J. S., Swinson, R. P., & Lorimer, W. P. (1984). On the importance of reliable equipment in the shock punishment of self-injurious behavior. Analysis & Intervention in Developmental Disabilities, 4(1), 81-84.

36. Carr, E. G., & Lovaas, O. I. (1983). Contingent electric shock as a treatment for severe behavior problems In S. Axelrod & J. Apsche (Eds.) . The Effects of Punishment on Human Behavior, (pp. 221-245). New York, Acedemic Press.

37. Barrera, F. J., Bucher, B., & Boundy, G. (1982). Dependence on shock-producing stimuli: A documented case study Presented at the World Conference of the International Association for the Scientific Study of Mental Deficiency, Toronto.

38. Favell, J. E., Azrin, N. H., Baumeister, A. A., Carr, E. G., Dorsey, M. F., Forehand, R., Foxx. R. M., Lovaas, O. I., & Romanczyk, R. G. (1982). The treatment of self-injurious behavior. Behavior Therapy, 13, 529-554. Association for Advancement of Behavior Therapy Task Force Report).

39. Trudel, G., Beaupre, M., & Maurice, P. (1981). The effect of the intensity of an aversive stimulus on self-injurious behaviors. Poster Presentation at the Association for the Advancement of Behavior Therapy Convention.

40. Beck, G. R., Sulzbacher, S. I., Kawabori, I., Stevenson, J. G., Guntheroth, W. G., & Spelman, F. A. (1980). Conditioned avoidance of hypoxemia in an infant with central hypoventilation. Behavior Research of Severe Developmental Disabilities, 1, 21-29.

41. Gomes-Schwartz, B. (1979). The modification of schizophrenic behavior. Behavior Modification, 3(4), 439-468.

42. Anderson, L., Dancis, J., & Alpert, M. (1978). Behavioral contingencies and self-mutilation in Lesch-Nyhan disease. Journal of Consulting and Clinical Psychology, 46(3), 529-536.

43. Harris, S. L., & Ersner-Hershfield, R. (1978). Behavioral suppression of seriously disruptive behavior in psychotic and retarded patients: A review of punishment and its alternatives. Psychological Bulletin, 85(6), 1352-1375.

44. Johnson, W. L., & Baumeister, A. A. (1978). Self-injurious behavior: A review and analysis of methodological details of published studies. Behavior Modification, 2, 465-487.

45. Wright, D., Brown, R., & Andrews, M. (1978). Remission of chronic ruminative vomiting through a reversal of social contingencies. Behavior Research & Therapy, 16, 134-136.

46. Linscheid, T. R., & Cunningham, C. E. (1977). A controlled demonstration of the effectiveness of electric shock in the elimination of chronic infant rumination. Journal of Applied Behavior Analysis, 10(3), 500.

47. Richmond, G., & Martin, P. (1977). Punishment as a therapuetic method with institutionalized retarded persons. In Thompson & Grabowski (Eds.). Behavior Modification of the Mentally Retarded, (pp. 467-494).

48. Turner, S., Hersen, M., & Bellack, A. S. (1977). Effects of social disruption, stimulus interference, and aversive conditioning on auditory hallucinations. Behavior Modification, 1, 249-258.

49. Akerly, M., Creedon, M. P., Opppenheim, R. C., Shea, J., & Shea, N. (1976). Reactions to "Employing Electric Shock with Autistic Children". Journal of Autism and Childhood Schizophrenia, 6(3), 289-294.

50. Alford, G. S., & Turner, S. M. (1976). Stimulus interference and conditioned inhibition of auditory hallucinations. Journal of Behaviour Therapy and Experimental Psychiatry, 7, 155-160.

51. Cohen, R. (1976). Comments on the "Cattle-prod Controversy". Perceptual and Motor Skills, 42, 146.

52. Cunningham, C. E., & Linscheid, T. R. (1976). Elimination of chronic infant ruminating by electric shock. Behavior Therapy, 7, 231-234.

53. Duker, P. C. (1976). Remotely applied punishment versus avoidance conditioning in the treatment of self-injurious behaviours. European Journal of Behavioural Analysis and Modification, 3 (3), 179-185.

54. Gathercole, C. E. (1976). Comment to P. C. Duker: Remotely applied punishment versus avoidance conditioning in the treatment of self-injurious behaviours. European Journal of Behavioural Analysis and Modification, 3(3), 186-187.

55. Lichstein, K. l., & Schreibman, L. (1976). Employing electric shock with autistic children. A review of the side effects. Journal of Autism and Childhood Schizophrenia, 6, 163-173.

56. Masterton, B. A., & Biederman, G. B. (1976). Aversive control by an electrostatic shock source: An unmodifiable, humane preparation. Journal of the Experimental Analysis of Behavior, 26, 523-526.

57. Munford, P. R., Reardon, D., Liberman, R. P., & Allen, L. (1976). Behavioral treatment of hysterical coughing and mutism: a case study. Journal of Consulting and Clinical Psychology, 44(6), 1008-1014.

58. Ball, T., Sibbach, L., Jones, R., Steele, B., & Frazier, L. (1975). An accelerometer-activated device to control assaultive and self-destructive behaviors in retardates. Behavior Therapy and Experimental Psychiatry, 6, 223-228.

59. Griffin, J. C., Locke, B. J., & Landers, W. F. (1975). Systematic manipulation of potential punishment parameters in the treatment of self-injury. Journal of Applied Behavior Analysis, 8(4), 458-468.

60. McFarlain, R., Scott, J., & Wheatley, M. (1975). Suppression of headbanging on the ward. Psychological Reports, 36, 315-321.

61. Romanczyk, R. G., & Goren, E. R. (1975). Severe self-injurious behavior: The problem of clinical control. Journal of Consulting and Clinical Psychology, 43(5), 730-739.

62. Toister, R., Condron, C., Worley, L., & Arthur, D. (1975). Faradic therapy of chronic vomiting in infancy: A case study. Journal of Behavior Therapy and Experimental Psychiatry, 6, 55-59.

63. Anderson, L., & Alpert, M. (1974). Operant analysis of hallucination frequency in a hospitalized schizophrenic. Journal of Behavior Therapy and Experimental Psychiatry, 5, 13-18.

64. Ausman, J., Ball, T. S., & Alexander, D. (1974). Behavior therapy of pica with a profoundly retarded adolescent. Mental Retardation, 12(6), 16-18.

65. Jones, F. H., Simmons, J. Q., & Frankel, F. (1974). An extinction procedure for eliminating self-destructive behavior in a 9-year-old autistic girl. Journal of Autism and Childhood Schizophrenia, 4(3), 241-250.

66. Prochaska, J., Smith, N., Marzilli, R., Colby, J., & Donovan, W. (1974). Remote-control aversive stimulation in the treatment of head-banging in a retarded child. Journal of Behavior Therapy and Experimental Psychiatry, 5, 285-289.

67. Ramey, G. (1974). Use of electric shock in the classroom: The remediation of self abusive behavior in a retarded child. Behavioral Engineering, 1(2), 4-9.

68. Rechter, E., & Vrablic, M. (1974). The right to aversive treatment including aversive stimuli. Psychiatric Quarterly, 48(3), 445-449.

69. Ribes-Inesta, E., & Guzman, E. (1974). Effectiveness of several suppression procedures in eliminating a high-probability response in a severly brain-damaged

child. Interamerican Journal of Psychology, 8, 1-2.

70. Wilbur, R. L., Chandler, P. J., & Carpenter, B. L. (1974). Modification of self-mutilative behavior by aversive conditioning. Behavioral Engineering, 1(3), 14-25.

71. Young, J. A., & Wincze, J. P. (1974). The effects of the reinforcement of compatible and incompatible alternative behaviors on the self-injurious and related behaviors of a profoundly retarded female adult. Behavior Therapy, 5, 614-623.

72. Alexander, A., Chai, H., Creer, T., Miklich, D., Renne, C., & Cardoso, R. (1973). The Elimination of Chronic Cough by Response Suppression Shaping. Journal of Behavior Therapy and Experimental Psychiatry, 4, 75-80.

73. Brandsma, J. M., & Stein, L. I. (1973). The use of punishment as a treatment modality: A case report. The Journal of Nervous and Mental Disease, 156(1), 30-37.

74. Hall, H., Thorne, E., Shinedling, M., & Sagers, P. (1973). Overcoming situation-specific problems associated with typical institutional attempts to suppress self-mutilative behavior. Training School Bulletin, 70(2), 111-114.

75. Kohlenberg, R. J., Livin, M., & Belcher, S. (1973). Skin conductance changes and the punishment of self-destructive behavior. Mental Retardation, 11(5), 11-13.

76. Lovaas, O. I., Koegel, R., Simmons, J. Q., & Long, J. S. (1973). Some generalization and follow-up measures on autistic children in behavior therapy. Journal of Applied Behavior Analysis, 6 (1), 131-166.

77. Merbaum, M. (1973). The modification of self-destructive behavior by a mother-therapist using aversive stimulation. Behavior Therapy, 4, 442-447.

78. Tanner, B. A. (1973). Aversive shock issues: Physical danger, emotional harm, effectiveness and "dehumanization". Journal of Behavior Therapy and Experimental Psychiatry, 4, 113-115.

79. Wright, L. (1973). Aversive conditioning of self-induced seizures. Behavior Therapy, 4, 712-713.

80. Bachman, J. A. (1972). Self-injurious behavior: A behavioral analysis. Journal of Abnormal Psychology, 80(3), 211-224.

81. Baumeister, A. A., & Forehand, R. (1972). Effects of contingent shock and verbal command on body rocking of retardates. Journal of Clinical Psychology, 28, 586-

590.

82. Tate, B. G. (1972). Case study: Control of chronic self-injurious behavior by conditioning procedures. Behavior Therapy, 72-83.

83. Watkins, J. (1972). Treatment of chronic vomiting and extreme emaciation by an aversive stimulus: Case study. Psychological Reports, 31, 803-805.

84. Browning, R. M. (1971). Treatment effects of a total behavior modification program with five autistic children. Behaviour Research and Therapy, 9, 319-327.

85. Bucher, B., & King, L. W. (1971). Generalization of punishment effects in the deviant behavior of a psychotic child. Behavior Therapy, 2, 68-77.

86. Corte, H. E., Wolf, M. M., & Locke, B. J. (1971). A comparison of procedures for eliminating self-injurious behavior of retarded adolescents. Journal of Applied Behavior Analysis, 4(3), 201-213.

87. Kircher, A. S., Pear, J. J., & Martin, G. L. (1971). Shock as punishment in a picture-naming task with retarded children. Journal of Applied Behavior Analysis, 4(3), 227-233.

88. Bucher, B., & Fabricatore, J. (1970). Use of patient-administered shock to suppress hallucinations. Behavior Therapy, 1, 382-385.

89. Galbraith, D. A., Byrick, R. J., & Rutledge, J. T. (1970). An aversive conditioning approach to the inhibition of chronic vomiting. Canadian Psychiatry Association Journal, 15, 311-313.

90. Kohlenberg, R. J. (1970). The punishment of persistent vomiting: A case study. Journal of Applied Behavior Analysis, 3(4), 241-245.

91. Lebow, M. D., Gelfand, S., & Dobson, W. R. (1970). Aversive conditioning of a phenothiazine-induced respiratory stridor. Behavior Therapy, 1, 222-227.

92. Yeakel, M. H., Salisbury, L. L., Greer, S. L., & Marcus, L. F. (1970). An appliance for autoinduced adverse control of self-injurious behavior. Jornal of Experimental Child Psychology, 10, 159-169.

93. Gardner, W. (1969). Use of punishment procedures with the severely retarded: A review. American Journal of Mental Deficiency, 74(1), 86-103.

94. Hamilton, J., & Standahl, J. (1969). Suppression of stereotyped screaming behavior in a profoundly retarded institutionalized female. Journal of Experimental Child Psychology, 7, 114-121.

95. Kushner, M. (1969). Faradic Aversive Controls in Clinical Practice. Behavior Modification in Clinical Psychology (Nueringer & Michael, Eds.), 26-51.

96. Lang, P. J., & Melamed, B. G. (1969). Avoidance conditioning therapy of an infant with chronic ruminative vomiting. Journal of Abnormal Psychology, 74(1), 1-8.

97. Lovaas, O. I., & Simmons, J. Q. (1969). Manipulation of self-destruction in three retarded children. Journal of Applied Behavior Analysis, 2, 143-157.

98. Simmons, J., & Lovaas, I. O. (1969). Use of pain and punishment as treatment techniques with childhood schizophrenics. American Journal of Psychotherapy, 23, 23-36.

99. Simmons, J., & Reed, B. (1969). Therapuetic punishment in severely disturbed children. Current Psychiatric Therapies, 9, 11-18.

100. Birnbrauer, J. S. (1968). Generalization of punishment effects--a case study. Journal of Applied Behavior Analysis, 1, 201-211.

101. Luckey, R. E., Watson, C. M., & Musick, J. K. (1968). Aversive conditioning as a means of inhibiting vomiting and rumination. American Journal of Mental Deficiency, 73(1), 139-142.

102. Miron, N. B. (1968). Issues and implications of operant conditioning--The primary ethical consideration. Hospital and Community Psychiatry, 50-52.

103. Risley, T. R. (1968). The effects and side effects of punishing the autistic behaviors of a deviant child. Journal of Applied Behavior Analysis, 1(1), 21-34.

104. Whaley, D., & Tough, J. (1968). Treatment of a self-injuring mongoloid with shock-induced suppression and avoidance. Michigan Mental Health Research Bulletin, 2(1), 33-35.

105. Agras, W. S. (1967). Behavior therapy in the management of chronic schizophrenia. American Journal of Psychiatry, 124(2), 240-243.

106. Bucher, B. D., & Lovaas, O. I. (1967). Use of adversive stimulation in behavior modification. In M.R. Jones (Ed.) Miami Symposium on the Prediction of Behavior 1967: Aversive Stimulation., 77-145.

107. Lovaas, O. I. (1967). A behavior therapy approach to the treatment of childhood schizophrenia. Minnesota Symposia on Child Psychology, 1, 108-159.

108. White, J. C., & Taylor, D. J. (1967). Noxious conditioning as a treatment for rumination. Mental Retardation, 5, 30-33.

109. Barnard, G. W., Flesher, C. K., & Steinbook, R. M. (1966). The treatment of urinary retention by aversive stimulus cessation and assertive training. Behaviour Research and Therapy, 4, 232-236.

110. Tate, B. G., & Baroff, G. S. (1966). Aversive control of self-injurious behavior in a psychotic boy. Behaviour Research and Therapy, 4, 281-287.

111. Breger, L. (1965). Comments on "Building social behavior in autistic children by use of electric shock". Journal of Experimental Research in Personality, 1, 110-113.

112. Johnson, B. G., Williams, A., & Landrum, J. L. (1965). The use of the superheterodyne as a means of behavior control--a note of caution. American Journal of Mental Deficiency, 70, 148.

113. Lovaas, O. I., Schaeffer, B., & Simmons, J. Q. (1965). Building social behavior in autistic children by use of electric shock. Journal of Experimental Research in Personality, 1, 99-109.

Appendix F

SAFEGUARDS FOR THE USE OF AVERSIVES WITH STUDENTS AT JRC

A. Safeguards Before Aversives are Considered

1. **Trial of powerful positive-only procedures prior to considering aversives.** JRC uses positive-only educational and treatment procedures first, for a period averaging 11 months, before considering the use of aversives. JRC's facilities and program of 24 hour/7 days per week positive reward programming is unparalleled. For example, no program in the country offers as powerful and as wide a set of reward opportunities as are provided in JRC's Yellow Brick Road Reward Facilities (see notebook of photos of JRC's facilities and program).

2. **Unique educational system in which the majority of the instruction is provided through self-instructional software delivered on a personal computer provided for each student.** This type of teaching allows students to catch up with their peers in academic and other skill areas, thus eliminating a source of frustration for many students that otherwise might make aggressive and other problematic behaviors more likely to occur.

B. Safeguards when Aversives are Used in a Student's Program at JRC

If the student's clinician believes that aversives as a supplementary treatment option should be added to his or her treatment program, the following safeguards are in effect.

1. **Parental Consent**. The student's clinician will request an in-person meeting with the parent or guardian to discuss the possible addition of supplementary aversives to the student's treatment program.. No aversive is employed without prior, written informed consent from the parent or guardian. Consent forms are reviewed and re-signed every year. Consent may be revoked by the parent at any time.

2. **IEP Meeting**. The local school district will hold an IEP meeting to discuss what the student needs in order to obtain a Free Appropriate Publicly Supported Education (FAPE). The parent is a member of the CSE team. At that meeting, the team will discuss the potential benefits of adding an aversive intervention to the student's Individualized Educational Plan (IEP). Aversives cannot be used unless they included in the student's IEP.

3. **Court Appointed Attorney**. Once the use of aversive interventions is added to the student's IEP, the individual court process in Massachusetts can then be started. Typically, JRC initiates the process by filing a guardianship petition and proposed treatment plan with a Massachusetts Probate Court, and a request for a hearing. The Court appoints an attorney to represent the interests of the student, which are separate and apart from those of JRC or of the parent. The attorney hires his/her own expert psychologist, at state expense, to evaluate the student and advise the attorney as to what position the attorney should take on the proposed treatment plan, including the use of aversives, with the student in question.

4. **Court Hearing**. JRC submits a detailed proposed treatment plan to the Court. The Court must decide: (1) whether or not the student is competent to make his/her own treatment decisions; and (2) if competent, would he or she have chosen the treatment? The Judge makes the ultimate determination whether or not aversives will be approved for the individual's treatment plan.

5. **Reports to the Court**. An individualized quarterly report on the use of the aversives for each student is sent to the court, parent, and sending agency. The report includes the number of applications given, the behaviors for which the aversives were used, the progress the student is making behaviorally and academically, and the plan to fade the individual from the aversives.

6. **Opportunity for Opposing Counsel to Object to the use of Aversives at any Time**. The opposing counsel can object to the treatment plan and seek to change or remove the plan at any time.

7. **Opportunity for Parent to Withdraw Permission for Aversives at any Time**. If a parent or legal guardian withdraws his/her consent, JRC ceases use of the aversive immediately, whether or not JRC still has a court authorization to use aversives with that student or not.

8. **Treatment Plan Reviews**. The treatment plan is reviewed by the Probate Court on a yearly or more frequent basis.

9. **Annual IEP Meetings**. The local school district holds an IEP meeting each year to review the student's progress. At that meeting, the Team will discuss the need for continuing the aversive intervention.

10. **Case Conferences**. For students who have had a treatment plan that includes aversive interventions for three years, the case is reviewed by independent MA clinicians, appointed by MA DMR, to determine the need for continued treatment.

11. **Parent Agency Website**. The parents and the sending agency (school district) have the ability to monitor the student's treatment through a secure website as frequently as they wish. This means that the parent can see the number of

aversives administered each day, what behaviors they were administered for, and the progress the student is making.

12. **Certification of JRC by the Massachusetts Department of Mental Retardation to use Level III aversives**. JRC goes through periodic rigorous reviews (at least every two years) by the Department of Mental Retardation to remain certified to use "Level 3" procedures. Level 3 procedures include the use of aversives.

13. **Medical Approval**. A physician examines each student whose treatment plan includes supplementary aversives. The Physician must sign an approval indicating that the treatment is not contraindicated by the student's medical condition if aversives are to be employed. Depending on the student's medical history and condition, the student may also be examined for any contraindications by a psychiatrist, neurologist, and/or cardiologist.

14. **The Human Right Committee.** This committee, which is composed of volunteer members from the community, JRC parents and others, must approve the use of aversives on an individualized basis for the student in question prior to their use. Both MA DMR and NYSED place a member of their choice on this committee.

15. **The Peer Review Committee.** This committee, which is composed of clinicians other than the student's own clinician, must also approve of the use of aversives on an individualized basis for each individual student prior to their use. MA DMR places a member of its choice on this committee.

16. **Design and Oversight of each Student's Program by a Qualified Clinician**. A qualified clinician with doctoral level training in psychology designs each treatment plan based on the individual needs of the student, designates which behaviors will be selected for treatment with aversive interventions, and oversees the implementation of the plan. The clinician must authorize any change in treatment. The clinician sets limits on the number of aversives that can be used before the clinician is notified. The clinician observes and meets with the student at least weekly and more frequently at the start of the treatment plan and at any time treatment is not progressing well.

17. **Weekly Communication Between the Case Manager and Parents** on all aspects of the student's program.

18. **Nursing and Medical**.
    a. Direct care staff do body checks on all students each morning and evening.
    b. All applications of the aversive are reported to nursing staff who do a body check on the student within 24 hours.
    c. The electrode site is checked each hour, when the electrode is rotated, and also after each application.

d. Each student receives a complete medical examination at least annually, and is referred to a medical specialist if needed.
e. Nursing care is provided on a 24/7, round-the-clock basis.

19. **All classrooms and residences are monitored on a 24/7 basis from a central location by means of a digital video monitoring system.** All classrooms and residence areas are covered by video cameras and microphones. Experienced staff members monitor activities in both the school and residences, from a central location at the JRC administration building, using the internet.

20. **Tight Control over the Number of Applications.** The number of applications of the skin shock that are used with any student who has skin shock in his/her treatment plan is kept low. The average student receives less than one application per week. If more than 1 application in any 24 hour period is required, the student's clinician sets the number which may be administered before he or she is notified and gives further approval. This number can be no greater than 10.

21. **Data Collection and Review by Clinicians and Parents.** Every application of an aversive is documented on the student's daily recording sheet and transferred to daily, weekly and monthly charts which are immediately available to the student's clinician (through a database that is available through networked software) and to the parents and placing agency (through a Parent/Agency Website), enabling clinicians, parents and agency officials to know exactly how many applications are made, for what behaviors, and with what results.

Appendix G

MASSACHUSETTS DEPARTMENT OF DEVELOPMENTAL SERVICES 90-DAY MONITORING REPORT

90 Day Monitoring Report.pdf

Click here: http://www.judgerc.org/90DayMonitoringReport.pdf

Appendix H

NYSED NOVEMBER 2005 FAVORABLE REPORT ON JRC

Nov 2005 NYSED Report.pdf

Click here: http://www.judgerc.org/Nov05NYSEDReport.pdf

Appendix I

JRC-DDS SETTLEMENT AGREEMENT. 1986

Settlement Agreement.pdf

Click here: http://www.judgerc.org/SettlementAgreement.pdf

Appendix J

JAMES VELEZ DOCUMENTS

James Velez Documents.pdf

Click here: http://www.judgerc.org/JamesVelezDocuments.pdf