POSITIVE-ONLY PROGRAMS EXPEL THEIR DIFFICULT-TO-TREAT STUDENTS, MANY OF WHOM ARE THEN REFERRED TO JRC FOR SUCCESSFUL TREATMENT

Executive Summary

Those who oppose the use of supplementary aversives in behavior modification treatment programs often assert that students with difficult behaviors can be successfully treated in programs that do not use aversives. The implication is that JRC uses aversives unnecessarily. The truth is that students with extremely difficult-to-treat behaviors are either expelled from, or rejected for admission to, schools that use positive-only procedures. Such children often are subsequently referred to JRC, either immediately or, in some cases, after intervening stays in psychiatric hospitals.

In at least one case the discharge papers from one such positive-only program, The New England Center for Children (NECC) even acknowledged the student's need for aversives. (See J.B.'s Discharge Summary on page 7 below.) In another case, the May Institute frankly acknowledged that all of its positive-only treatment procedures had to be suspended because the student was too big, strong, and property destructive. (See document labeled "Summary" on page 37 below.)

In this paper we summarize the experience of ten difficult-to-treat students who at one point were treated at the following programs, each of which would be considered to be a respected program that uses state-of-the-art "positive-only " procedures: New England Center for Children (Southboro, MA), the May Institute (Randolph, MA), the Anderson School (Staatsville, NY), the Kennedy Krieger Institute (Baltimore, MD), the Higashi School (Randolph, MA) and the League School (Walpole, MA). This pattern– unsuccessful treatment at a positive-only program and then subsequent referral to JRC – is a pattern that we see in almost every single one of our students.

Exhibit 1 (at the end of this document) is a table that shows, for each current JRC student, the number of previous placements in positive-only programs her or she has had, (as of December 7, 2006). **The average student at JRC has failed in approximately four positive-only treatment programs before coming to JRC**. In most of these cases, the reason the student did not remain in that program is that the program failed to provide effective treatment. Exhibit 2 shows, for each positive-only program, the number of JRC students who attended that program prior to coming to JRC.

The major point made by this paper is that programs that restrict themselves to using nonaversive procedures send their difficult cases to JRC.
However in preparing this paper we noted these additional points:

(1) Some programs that have a reputation for employing positive-only treatment procedures also use procedures that are clearly aversive.

(2) The use of the procedure called “functional analysis” has not enabled “positive – only” programs to provide effective treatment to their difficult cases without using aversives.

(3) JRC’s own positive-only, nonaversive programming is so powerful that it has enabled JRC to succeed, without employing any aversives, with several students who had failed in other positive-only programs.

(4) Most of the students covered in this paper all had to have less 1-1 staffing, and less psychotropic medication and fewer restraints during their stay at JRC than they experienced at the previous non-aversive program.

The facts presented in this paper are supported by referral documents on file at JRC. We have included with this paper, however, one or two documents which show that each student attended one of these positive-only programs and then was referred to JRC. In each case we use the student’s initials instead of name for privacy reasons. In a few cases, parents have written letters about their child’s experiences and given us permission to make them public. Each of the parents or guardians of the students whose case histories are reported in this paper has granted JRC permission to use the information concerning his or her child in this document.

Summary of Cases Presented in this Paper

Students who Attended the New England Center For Children (NECC), Southboro, MA.

1. **J.B.** attended NECC between 1997 and 2005, between the ages of 7 and 15. In March 2005, NECC referred him to JRC. His Discharge Summary explained the reason: "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." He enrolled in JRC, directly from NECC, in April 2005 where he has been successfully treated ever since. Skip to the complete account.

2. **C.M.** attended NECC between 1997 and 2001, between the ages of 10 and 14. On October 25, 2001 he was referred by NECC to JRC because, as one of his IEP documents states, "his behavioral issues are becoming more significant and putting his safety at risk…NECC have given the district until Feb 1, 2002 to transition C.M. to another placement." Another IEP document records the fact that **"**NECC has requested that C.M. transition to another program that can better address his significant behaviors." He entered JRC in 2001 and has been treated successfully there ever since. Skip to the complete account

3. **A.M.** attended NECC between 2000 and 2003 when he was 14-17 years old. A referral letter to JRC from the Boston Public Schools says. "A.M. currently attends the New England Center for Children. As a result of his last IEP meeting it was decided that a more appropriate residential placement be found to address A.M.'s complex needs." A.M. enrolled in JRC in 2003 has been successfully treated there ever since. Skip to the complete account.

Students who Attended the May Institute, Randolph, MA

4. **A.P.** enrolled in the May Institute's day program in Arlington, MA in June 2003 when he was 11 years old. By June of 2005, when he was 13, his aggression and self-abuse had become too difficult for the May Institute to handle. A referral letter from the Revere, Massachusetts Public Schools on June 23, 2005 stated, "A.P.'s needs were not being adequately accommodated" at the May Institute and urged JRC to admit him "as soon as possible." He enrolled in JRC's day program on September 2, 2005 and has been doing well ever since *without any use of aversives.* Skip to the complete account.

5. **N.M.** was a day student at the May Institute for Education and Neurorehabilitation in Brockton, MA between 1998 and 2003, between the ages of 13 and 18. By 2003 her parents concluded that May Institute was unable to control N.M.'s self-injurious behaviors such as head-banging and punching her

face and eyes, and were concerned with N.M.'s lack of progress in communication skills. On January 12, 2004 the Boston Public Schools informed JRC that her parents "are concerned with the increase in her self-injurious behaviors as well as her behaviors at home" and referred N.M. to JRC. N.M. enrolled in JRC's day program on March 17, 2004 and has done remarkably well ever since supplementary aversives were added to her program. Skip to the complete account.

6. **D.R.** enrolled as a day student at the May Center in Randolph, MA at the age of 14; however, after 5 months of positive only-treatment his aggressive and destructive behaviors became too difficult and dangerous to be controlled at the May Center, despite the fact that the May Center provided him with 1:1 staffing. A referral letter from the Boston Public Schools to JRC dated April 12, 2006 stated that "…The May Center in Randolph…have determined that they are unable to meet his needs any longer. They are seeking to have him transfer just as soon as possible to another day school." D.R. enrolled in JRC's day program in June 13, 2006 and has done well ever since *without the need for any aversives* and without the need for 1-1 coverage. Skip to the complete account.

Students who Attended the Anderson School, Stattsville, NY

7. **S.S.** was enrolled at the Anderson School in Staatsville, N.Y. at the age of 11 in January of 2004. After one year of Anderson School's positive-only treatment procedures, S.S.'s self-injurious and aggressive had became so intense and unmanageable that she had fully detached both of her retinas. In 2005 the Anderson School acknowledged that positive-only procedures were insufficient, that S.S. needed procedures such as aversives that the Anderson School did not offer and referred S.S. to JRC. S.S. enrolled in JRC in March, 2005. Aversives were added to her program in mid-May. Immediately after that her aggression and self-abuse showed a marked deceleration, a trend that has continued to date. While at JRC, S.S. has been able to have her retinas re-attached and she has not detached them while at JRC. Skip to the complete account.

8. **M.D.** was enrolled at the Anderson School in Staatsville, N.Y. at the age of 5 in September of 1991. After many years of Anderson School's positive-only treatment procedures, M.D.'s aggressive behaviors had became so intense and unmanageable that he had injured several staff, required frequent chemical restraint and several psychiatric hospitals. For a six month period M.D. was sending staff members to the hospital weekly. He would violently attack them, pulling their hair and choking them. In August of 2004 the Anderson School acknowledged that positive-only procedures were insufficient, that M.D. needed additional interventions. M.D. enrolled in JRC in December, 2004. During his first day at JRC he went into a coma and was diagnosed with Neuroleptic Malignant Syndrome as a result of being on so many psychotropic medications. M.D. spent 8 days in a coma and according to his parents, almost died. Upon

returning to JRC from the hospital M.D. was treated with JRC's positive-only program until aversives were added to his program in January of 2005. Immediately after M.D.'s program was supplemented with Level III aversives his aggression and self-abuse showed a marked deceleration, a trend that has continued to date. Skip to the complete account.

Students who Attended the Kennedy Krieger Institute, Baltimore, MD

9. **S.S.** was treated in numerous facilities prior to a 3 month evaluation at the Kennedy Krieger Institute beginning December 1999. At Kennedy they developed special arm splints to be worn during the day, and a full bed restraint which fully immobilized him during the nightime. He was discharged back to Cumberland Hospital with a reported lower rate of self-injurious behavior but that was apparently due to his being mechanically prevented from exhibiting the behavior. Cumberland Hospital attempted to maintain the Kennedy Krieger program but even the first day back S.S. averaged 25 aggressive and self-injurious an hour. S.S. entered JRC in October 2000 and has made remarkable progress with the contingent skin shock supplementing a powerful positive program that includes a dense system of rewards. S.S. is now free of all restraint and medication and lives in a community based home. The rate of his self-injurious behavior currently averages only one per week and he now is a happy, smiling young man, free of any injuries**.** Skip to the complete account.

A student who Attended the Higashi School, Randolph, MA and the League School, Walpole, MA

10. B.C. was enrolled in several programs prior to coming to JRC. These program included the Kennedy-Donovan Center, New England Center for Children, the Higashi School, and the League School. All of these programs utilized positive-only treatment procedures, none of which were successful in decreasing B.C.'s dangerous behaviors to acceptable levels. When B.C. was admitted to JRC he was treated with JRC's positive-only program for over seven months until aversives were added to his program in October of 2003. Immediately after B.C.'s program was supplemented with Level III aversives his aggression and self-abuse showed a marked deceleration, a trend that has continued to date. Skip to the complete account.

New England Center for Children, Southboro, MA

Difficult-to-Treat Students whom New England Center for Children (NECC) Expelled and Who Were Subsequently Referred to JRC

1. Student J.B.

Summary: J.B. attended NECC between 1997 and 2005, between the ages of 7 and 15. In March 2005, NECC referred him to JRC. His Discharge Summary explained the reason: "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." He enrolled in JRC, directly from NECC, in April 2005 where he has been successfully treated ever since.

J.B's NECC discharge summary (see end of this section on J.B.) contains the following information. J.B.'s aggressive behaviors were "quite intense and non-redirectable," and included "head directed punches, head butts, hair pulling, kicking, grabbing and biting." J.B.'s aggression and self-abuse was so frequent that he had to be restrained "more than 70" times per week, with each restraint requiring up to five teachers. His self-injurious behaviors included "body hits to the environment, head hits to wall and floor, body punches, face or head hits, self-bites" and hand contortions (intense wringing of hands and fingers). These behaviors caused "bruises, scratches, swelling of joints, cuts to forehead caused by intense head-to-floors (while wearing a protective helmet)...[and] fractured bones in his hands on two occasions." Property destruction included throwing objects, ripping materials, turning over furniture and throwing large heavy objects.

These behaviors caused numerous staff injuries requiring Emergency Room visits and lost work time, including back and neck injuries, two instances of concussions, four head and facial contusions and one twisted ankle. To try to control J.B.'s behaviors, NECC conducted functional analyses to determine what events were rewarding J.B.'s behaviors. Such analyses are said by some to obviate the need for aversives. The discharge summary states, "Several functional assessments and functional analyses were carried out over the past three years…These assessments, however, have shown no conclusive results, as J.B.'s behaviors appear to be multi-determined (i.e., serve multiple functions)."

NECC also tried the following "positive-only" treatment approaches: giving J.B. rewards of small snacks, breaks and preferred activities throughout the day contingent on appropriate behaviors or on the completion of certain tasks; teaching J.B. functional communication responses, in which he used language to request being alone, to get teacher attention, or to escape demands; attempts to use restraint as a positive reinforcer;

periods of no demands; periods of high-rate demands; and 1-1 staffing. At one point he received 1-1 staffing during all waking hours. In designing their positive-only procedures for J.B., NECC made use of "internationally-recognized behavior experts."

In addition, NECC gave J.B. psychotropic medications such as Risperdal, Trileptal and Seroquel, none of which were sufficiently effective.

In summary, despite 1-1 staffing, sophisticated positive programming, functional analyses, psychotropic drugs, and consultation from experts, NECC was unsuccessful in treating J.B.'s major problem behaviors. The NECC discharge summary, (see next two pages) states:

> "While most interventions have resulted in brief improvement…none has resulted in long-lasting change…Despite 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 aggressive and self-injurious behaviors have varied with no noticeable regularity…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 NEDD, for example, mechanical restraint or contingent aversive stimulation."[underlining added]

The following is the discharge summary for J.B. that NECC sent to JRC:

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.

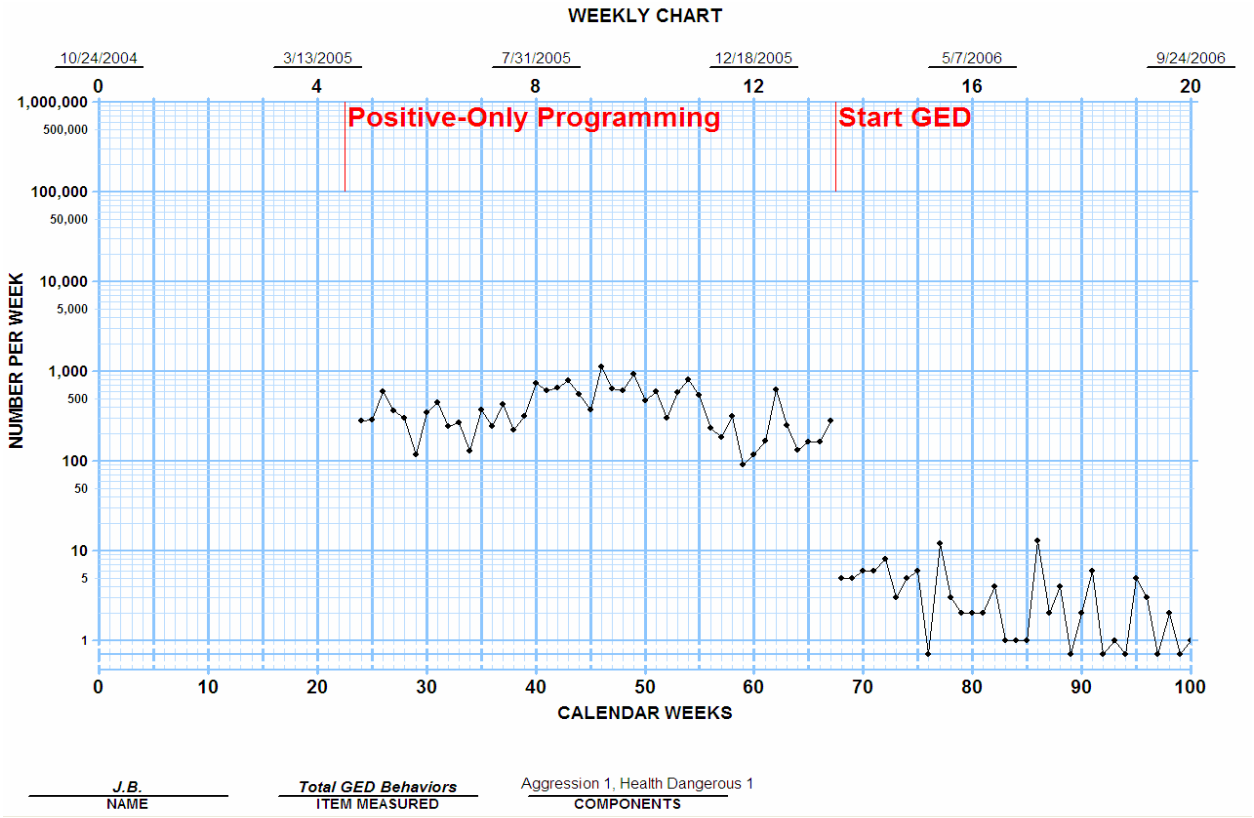
Summary

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.

In March 2005, NECC referred J.B. to JRC. During the first eleven months at JRC, JRC removed his psychotropic medication and applied positive-only programming. This was not successful in decreasing his problem behaviors. After 11 months, the GED was added to his program. The following graph tells the story.



The graph shows that during the 11 months of positive-only treatment, J.B. showed approximately 500 aggressive and health dangerous problem behaviors per week. Once the GED was added to his program, however, it resulted in an immediate 100-fold decrease in these behaviors.

J.B.'s mother described the changes in J.B., once the GED was added to his program as follows:

> "…within a couple of weeks of using the temporary skin shock therapy on J.B., J.B. was like a new person. Gone were the bruises, cuts and swelled skin on his body from where he used to pound himself and bite himself; gone was the tensing up of his face that almost always signaled he was about to try to hurt himself; and gone was the constant wearing of a protective helmet for his head—he didn't need it as much anymore."

The following is a description by J.B's clinician at JRC of J.B.'s current status:

"The GED was started with J.B. in February 2006. Since that time, he has averaged a daily median of 1 application, has never had to be restrained since being on the devices, is totally off psychotropic medication, does not require any 1:1 coverage and works independently daily on a computer doing his academic work. J.B. has made significant progress at JRC and spends his time now progressing socially and educationally. He attends field trips and all school activities. He has not injured one staff member, himself or student since being on the GED.

While J.B. requires supervision, he does not require the high crisis staff or the staff-to-student ratio that he did when he was at the New England Center. Medication, positive programming alone and all the behavioral techniques used by the New England Center were not effective in preventing J.B. from hurting himself and others. JRC's positive programming combined with the supplemental use of the GED was successful in reducing those rates to near zero frequency in just 5 months."

The following is letter which J.B.'s mother wrote in 2006 to some New York legislators, urging them to oppose a bill that would have banned the use of aversives with New York students

TRISHA M _____
____ _____ Street
_____, New York xxxxx
Home Phone: (xxx) (xxxx)
Cell Phone: (xxx) (xxxx)
E-Mail Address: xxxxxt@netscape.com

As the mother of a child who will be directly affected should a bill or policy that bans the use of aversive therapy, ultimately become law, I am writing to express my opposition to said bill/policy and implore you to also oppose the bill/policy.

As you are probably already aware, there are proposed bills/policies that would prohibit the use of aversive therapies, such as the temporary skin shock therapy that my son currently receives, in programs that serve children under the auspices of the New York State Department of Education, OMRDD, and certain other agencies. Let me come directly to the point and tell you that if my son could no longer receive the temporary skin shock therapy, he may severely injure himself or even, God forbid, accidentally kill himself due to the likely escalation of his severe self-abusive behaviors that would most likely accompany the discontinuance of the temporary skin shock therapy.

My sixteen year-old severely autistic son, J.B., is a full-time residential student at the Judge Rotenberg Educational Center in Canton, Massachusetts, and has been such since March 2005. From October of 1997 through March of 2005 J.B. was a full-time residential student at the New England Center for Children in

Southborough, Massachusetts. **In early 2005 the faculty of the New England Center for Children informed me that my son's self-abusive and aggressive behaviors had become so severe that faculty and staff at the school were no longer able to treat him through the use of traditional "positive reinforcement" therapy, and they stated that the use of aversive therapy might be the only thing that could help my son**. Since the New England Center for Children did not use aversive therapy, they suggested transferring J.B. to The Judge Rotenberg Educational Center. Of course, since I am a New York State resident, this new placement had to be approved by my local school district (Schenectady City School District) and, ultimately, the New York State Department of Education. So, the Special Education Department representative at the Schenectady City School District first looked for in-State facilities that might be appropriate for J.B. and that would take him. No in-State facilities would take him. Then out-of-State facilities were investigated. The only facility that was appropriate and that would take him was the Judge Rotenberg Education Center.

In March of 2005 J.B. started at the Judge Rotenberg Educational Center, with only the traditional "positive reinforcement" therapy being used for many months. J.B.'s self-abusive and aggressive behaviors continued to escalate. In the Fall of 2005, with my written consent and authorization as J.B.'s sole legal custodial parent the Judge Rotenberg Educational Center filed a Petition with the local courts seeking approval to use aversive therapy, specifically temporary skin shock therapy, on J.B. Upon filing the petition, J.B. was given his own lawyer in Massachusetts in order to independently protect J.B.'s rights, and the process went forward. After several months, the court approved the use of aversive therapy on J.B. So, in early 2006, the use of aversive therapy was started on J.B. As I visit J.B. quite frequently, I can say with all honesty that within a couple of weeks of using the temporary skin shock therapy on J.B., he was like a new person. Gone were the bruises, cuts and swelled skin on his body from where he used to pound himself and bite himself; gone was the tensing up of his face that almost always signaled he was about to try to hurt himself; and gone was the constant wearing of a protective helmet for his head — he didn't need it as much anymore.

Although certainly not a person who could engage in a normal conversation like you or I, J.B. is now able to verbally communicate his needs while remaining calm. He is able to go outside in the sun and enjoy being around other people, and other people enjoy being around him. He even smiles now, which is just great for a mom to see. The faculty tells me that pretty soon he will no longer require the helmet at all. So, while J.B. will always need to be under constant supervision his entire life, it seems that his life may now be happier for him because he is able to havethe temporary skin shock therapy. Please don't take this therapy option away from him and other children like him.

Lastly, let me just say that the temporary skin shock therapy is not some horrific electro shock therapy that goes into a person's brain. That is a very common misconception. Until staff at the Judge Rotenberg Educational Center showed me

the temporary skin shock device and how it worked, I had that misconception. One of the best things about the device is that no matter how long a staff member pushes on the button that triggers the temporary skin shock, the temporary skin shock only lasts a few seconds, as the length of time of the skin shock is controlled by a computer within the device. That really gives me peace of mind. There are digital monitors all over the school and at the residences, so any misuse of the device by a staff member can be caught, although I have never seen a staff member, in my opinion, misuse the device or mistreat any student. And believe me, if I thought for one second that my son was being abused or mistreated in any way, I would first call the police and Child Protective Services, and then I would

Personally go to the school and retrieve my son. But, to date, all is well and the Judge Rotenberg Center has thus far, treated by son very well, and the school itself has a very pleasant atmosphere, as do the residences. Please feel free to contact me via my cell phone number or e-mail address listed above should you wish to set up a up a time to meet with me in person to discuss this matter further.

Thank you for your time and attention in this matter.

Respectfully,

T.M.

2. Student C.M.

Summary: C.M. attended NECC between 1997 and 2001, between the ages of 10 and 14. On October 25, 2001 he was referred by NECC to JRC because, as one of his IEP documents states, "his behavioral issues are becoming more significant and putting his safety at risk…NECC have given the district until Feb 1, 2002 to transition C.M. to another placement." Another IEP document records the fact that "NECC has requested that C.M. transition to another program that can better address his significant behaviors." He entered JRC in 2001 and has been treated successfully there ever since.

At NECC, C.M. engaged in severe aggression which included "head-directed punches, kicking, biting, spitting and throwing feces at others." He fractured a staff member's nose. His severe self-injury included head banging (against walls and objects) that required emergency sutures, "punching his eyes, hitting his head against objects, pulling his teeth out, biting himself, etc.". He also engaged in "property destruction, disrobing, clothes ripping, fecal smearing…elopement as well as other disruptive behaviors such as swearing, teasing and banging walls and objects." On "two occasions he eloped during overnight hours when staffing was reduced." He also ingested inedible items, inserted objects into body orifices, showed noncompliance and engaged in tantrums.

Because of these problems, C.M. required 3-person restraints for at least 10 minutes as

many as 10-15 times per day. He spent most of his time in his bedroom or classroom. His bedroom was devoid of furniture and contained only his bed and a few decorations placed out of reach because of his destructive behaviors. He was unable to enjoy gym lessons or community activities and required 2:1 staffing during all waking hours.

C.M. was given the psychotropic medications Risperdal, Tegretol, Trazodone and Benadryl. They were not effective.

NECC tried a variety of positive-only behavioral strategies. These included "positive reinforcement contracts," as well as "antecedent-based" [nonaversive] types of interventions. At one point, after receiving expert behavioral consultation from Dr. Richard Foxx, NECC implemented new reward procedures as well as punishments. Contingent upon good behavior, C.M was allowed to a) select who would work with him on an hourly basis b) choose from any preferred item or activity and c) request breaks and conversations at any time. In addition, surprise rewards were delivered on a variable-time schedule. Following certain maladaptive behaviors, C.M. was punished by being given complete (but non-preferred meals) and denied any form of social attention until he exhibited 8 consecutive hours of appropriate behavior. This social isolation procedure was not effective.

C.M.'s Referral Summary reports that although NECC's treatment procedures often showed promise at first, "these positive effects do not seem to maintain, and CM's aberrant behavior re-emerges…This has produced minimal positive change in Chris' behavior." Decreases in target behaviors "haven't lasted more than one or two weeks."

The NECC Referral Summary states:

> "On two occasions C.M. has eloped from the program during overnight hours when staffing is reduced, demonstrating his ability to plan in advance and take advantage of situations. This type of behavior (i.e., willful, premeditated) is not typical of the autistic and developmentally delayed population served by NECC and is a primary reason for C.M.'s referral to other programs." Handwritten notes on IEP documents (see end of this section on C.M.) indicate that "his behavioral issues are becoming more significant and putting his safety at risk…NECC have given the district until Feb 1, 2002 to transition C.M. to another placement." And **"NECC has requested that C.M. transition to another program that can better address his significant behaviors."**

The following are the Referral Summary and IEP documents from which the above quotations are taken:

The New England Center
FOR CHILDREN
Independence through Educational Excellence

33 Turnpike Road
Southborough, Massachusetts 01772-2108

508-481-1015
fax: 508-485-3421
internet: http://www.NECC.org

(12)

Rec'd 10-29-01

October 25, 2001

DV

Admissions Department
Judge Rotenberg Educational Center
240 Turnpike Street
Canton, MA 02021

RE: Referral packet for [redacted].
D.O.B. 11-30-87

Dear Colleague:

Enclosed please find a referral summary and assessments regarding [redacted], a student in our Staff Intensive Unit Program. We are forwarding this information on behalf of Chris with permission of his parents [redacted] and [redacted].

I would appreciate your review of this material. I will contact the Judge Rotenberg Educational Center in the near future to discuss the possibility of setting up an intake for [redacted].

In the meantime, if you have any questions please don't hesitate to contact me.

Yours Truly,

Richard W. Martin, LICSW
Director of Outreach Services

[redacted] Notice Date: 12/11/01

Student

Directions to School Staff:

This notice must be sent to parents in their native language or other mode of communication used by the parent. School district must ensure that parents understand the content of this notice. (Federal regulation 300.503)

Answer the following questions:

1. What action is the school district proposing to take?
2. Why is the school district proposing this action?
3. What rejected options were considered and why was each option rejected?
4. What evaluation procedure, test, record or report was used as a basis for this action?
5. What other factors were relevant to the school district's decision?
6. What next steps, if any, are recommended?

Narrative Description of School District Proposal

(1.) The WPS and CPS are proposing an amendment to [redacted] IEP.

(2.) The districts are proposing this, because his behavioral issues are becoming more significant and putting his safety at risk. Also NEC have given the districts until Feb. 1st. 2002 to transition [redacted] to another placement.

(3.) No rejected options were discussed at this time.

(4) Data collection from NEC behavioral programs were used as basis of the amendment.

(5.) No other factors were relevant.

(6.) Next steps include:
- implement amendment
- contact alternative programs
- (follow-up as needed)

School District Name: Worcester / Clinton

School District Address:

School District Contact Person/Phone #: Pat George / Kathy McGrail

Individualized Education Program (IEP) Amendment

Amendment will be attached to IEP dated: from 9/1/01 to 9/2/02

Student Name: [redacted] DOB: 11/30/87 ID#: 73602 Grade/Level: _____

What change(s) will be made to the existing IEP?	Why?
[redacted] requires a 2 staff : 1 student ratio from 8AM-10pm daily in order to address his significant behavioral issues.	A Specialized behavior program has been initiated in order to reduce [redacted] significant aggressive behaviors (toward self and others).

Use only for minor changes that do not change type of placement.

Individualized Education Program Amendment

Student Name: [redacted] to DOB: 11/30/87 ID#: 73602

Additional Information

* NEC has requested that [redacted]' transition to another program that can better address his significant behaviors. NEC has stated that this transition occurs prior to Feb. 1st 2002.
* WPS and CPS have sent 9 packets to alternative placements.

Response Section

School Assurance

I certify that the changes in this amendment are those recommended by the Team and that the indicated services will be provided.

Signature and Role of LEA Representative: [redacted] Director 12/11/01
Date

Parent Options / Responses

It is important that the district knows your decision as soon as possible. Please indicate your response by checking at least one (1) box and returning a signed copy to the district. Thank you.

☑ I accept the IEP amendment. ☐ I reject the IEP amendment.

☐ I reject the following portions of the IEP amendment with the understanding that any portion(s) that I do not reject will be considered accepted and implemented immediately. Rejected portions are as follows:

☐ I request a meeting to discuss the rejected IEP amendment or rejected portion(s).

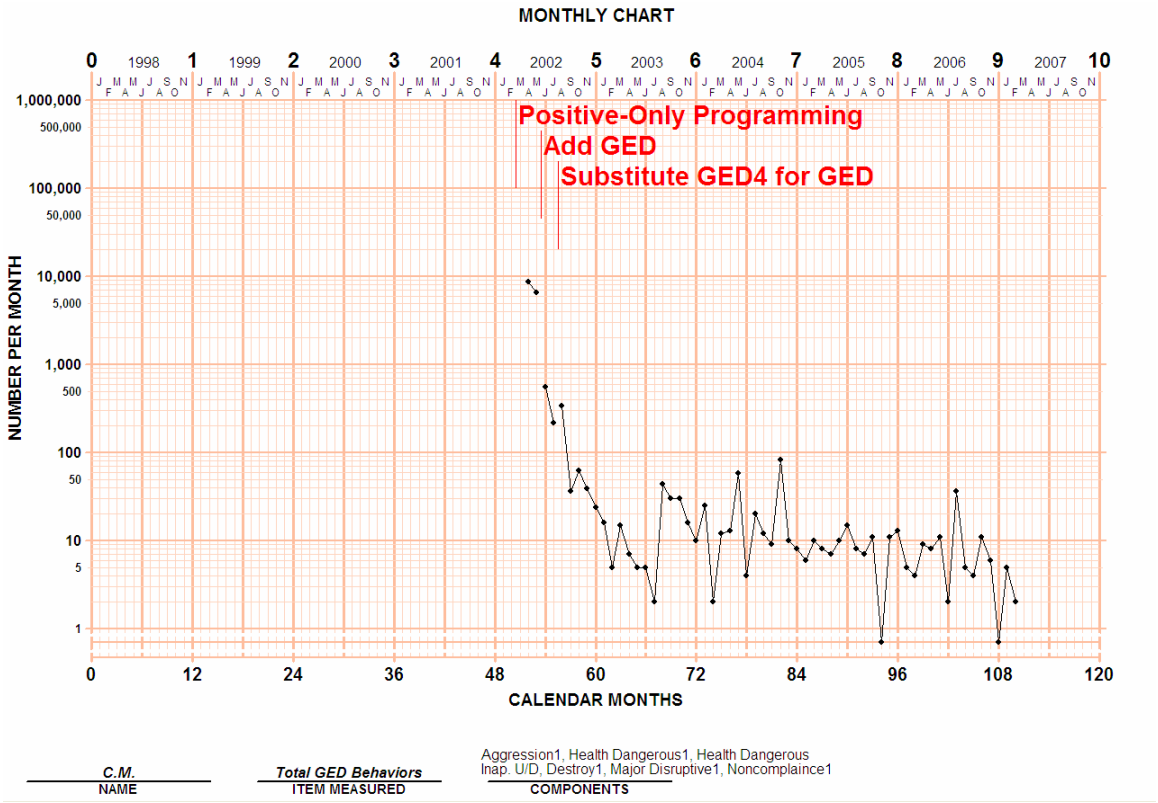
X [redacted] 12-11-01
Signature of Parent, Guardian, Educational Surrogate Parent, Student 18 and Over* Date

**Required signature once a student reaches 18 unless there is a court appointed guardian.*

Parent Comment: I would like to make the following comment(s) but realize any comment(s) made that suggest changes to the proposed IEP amendment will not be implemented unless the IEP or IEP amendment is changed.

During the referral process, JRC's Director of Clinical Services, Dr. Robert Von Heyn, had occasion to visit C.M. at NECC and discuss his case with **Vince Strully, executive director of NECC. On that occasion Mr. Strully stated to Dr. Von Heyn that C.M. needed aversives**.

On October 25, 2001, NECC referred C.M. to JRC. C.M enrolled in JRC in Feb. 2002. C.M.'s progress at JRC is summarized in the following graph. On this graph each dot represents the total number of major problem behaviors C.M. showed each month.



The chart shows that during the two months prior to the start of the GED, C.M. displayed 8,000 to 10,000 problem behaviors per month. After the GED and GED-4 were introduced C.M.'s problem behaviors decelerated over the next year to only about 10 per month. This is a decrease by a factor of about 10,000.

The following is an account, prepared by C.M.'s clinician, of his progress at JRC.

> Upon admission to JRC, C.M. engaged in thousands of aggressive, self-injurious, destructive and major disruptive behaviors over 3 months while JRC attempted to reduce his severe problem behaviors using positive only programming. JRC then sought and received approval to use Level III aversive procedures. To date, C.M.'s behavior has improved dramatically. He engages in 0-10 major behavior per month, rarely requires physical restraint and consistently masters academic lessons in reading, math, phonics and spelling. He lives in a beautifully decorated room with

> another student. He attends field trips (educational and recreational) and no longer has difficulties with transitions. All of C.M.'s psychotropic medications have been discontinued. C.M. continues to learn new and appropriate social behaviors that have allowed him to form relationships and interact appropriately with his support staff, family and other students.

The following is a letter from C.M.'s mother written in the spring of 2006:

> "Before my son C.M. went to the Judge Rotenberg Center, he could not control his behavior. He was unable to come home because it was not safe to transport him in the car. C.M. would become aggressive toward family members and staff. He was taking two different medications in an effort to control his behavior. The medication didn't seem to work. He was still being aggressive.
>
> While taking these medications, C.M. was kicked out of five treatment centers because they could not handle his dangerous behaviors or provide him with an education. C.M. has been at the Judge Rotenberg Center for five years and in that time he has been able to come off all medications and is now able to come home weekends to spend time with family. C.M. is doing well in his academically and has made tremendous gains socially. C.M. now loves to talk to people and help out in the class room. This is something he could not do five years ago due to his aggressive behaviors. C.M.'s dangerous behaviors have dropped considerably and I don't have to worry half as much as I used to. JRC has helped my son C.M. grow and develop beyond any other school or treatment center could do it is a comfort to know my son is getting the help he needs to become a productive person.
>
> Sincerely,
>
> Bonnie"

The following are a few referral documents that show that CM was referred to JRC after failing to be effectively treated at NECC.

3. Student A.M.

Summary: A.M. attended NECC between 2000 and 2003 when he was 14-17 years old. A referral letter to JRC from the Boston Public Schools says. "A.M. currently attends the New England Center for Children. As a result of his last IEP meeting it was decided that a more appropriate residential placement be found to address A.M.'s complex needs." A.M. enrolled in JRC in 2003 has been successfully treated there ever since."

A.M. was admitted to NECC on June 29, 2000 after numerous psychiatric hospitalizations. His diagnoses have included PTSD, Bipolar Disorder NOS, Oppositional Defiant Disorder, Borderline Intellectual Functioning, and Psychotic Disorder-NOS. He also meets the criteria for a diagnosis of Mild Mental Retardation.

A.M.'s discharge summary (see referral materials at end of this section on A.M.) reports that while at NECC he displayed "noncompliance, aggression to others, sexualized behavior, self-injury and property destruction," behaviors that occurred "across the day at the school and residential settings…". He often required 3:1 or 4:1 staffing and was often restricted to the Staff Intensive Unit where students would receive 24-hour 1:1 staffing. During his stay at NECC there were numerous documented incidents in which he required medical attention as a result of self-injurious behaviors or fighting with his peers. He exhibited severe aggressive behaviors, including physical altercations with his peers, as well as self-injurious behaviors such as, punching his head, running away and cutting into his right arm. In addition, A.M. was prone to displaying sexualized behaviors and swearing at staff.

He also exhibited very dangerous behaviors while on home visits with his family. During multiple visits, A.M. either ran away or would engage in physical altercations with his family members. After one of his fights with his father, A.M. had to be placed into handcuffs and taken to the emergency room.

His discharge summary reports that when A.M. exhibited problematic behavior, the primary techniques that NECC staff used were "physical intervention," placing him in "exclusionary time out" [seclusion] and restricting him from "community and vocational environments for varying amounts of time depending on the topography of the behavior."

NECC placed A.M. on multiple psychotropic medications including Risperdal, Trazadone, Depakote, Neurontin, and Cogentin (he had previously been prescribed Ritalin, Dexadrine, clonidine, Tenex, and Thorazine).

Due to the frequency and intensity of A.M.'s aggressive and health dangerous behaviors he was discharged from the New England Center for Children and referred to JRC. A letter to JRC on October 20, 2003 from the Boston Public School system stated:

> "A.M. currently attends the New England Center for Children. As a result of his last IEP meeting it was decided that a more appropriate residential placement be found to address A.M.'s complex needs."

The following is the letter that NECC sent to JRC when NECC referred A.M. to JRC.

CAROLYN RILEY
SENIOR DIRECTOR

Jane Sullivan
Director

Campbell Resource Center
1216 Dorchester Avenue
Dorchester, MA 02125
617-635-8599 Voice
617-635-8014 Fax

BOSTON PUBLIC SCHOOLS

UNIFIED STUDENT SERVICES

William Kelley
Director

Boston Latin Academy
443 Warren Street
Dorchester, MA 02121
617-635-8030 Voice
617-635-8033 Fax

1A

Rec'd 10/22/03
Km

October 20, 2003

Ms. Karen LaChance
Judge Rotenberg Educational Center
240 Turnpike Street
Canton, Massachusetts 02021

RE: [redacted]

Dear Karen:

[redacted] currently attends the New England Center for Children. As a result of his last IEP meeting it was decided that a more appropriate residential placement be found to address [redacted]'s complex needs.

Please review the enclosed records, which include an updated IEP and assessements, and determine whether or not [redacted] is appropriate for your program. If you are able to provide services to [redacted], please contact Ms. [redacted], [redacted]'s mother, at [redacted] and Fran Tobin, the Evaluation Team Facilitator at 617.635.8282.

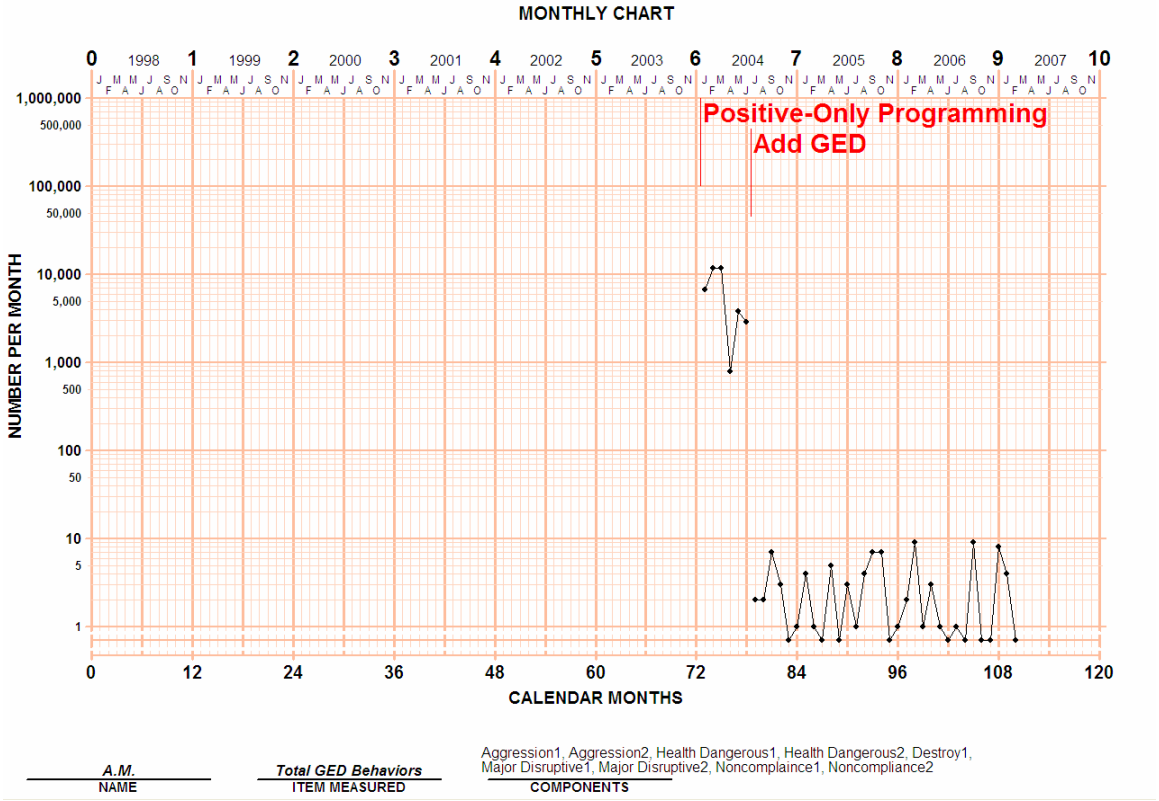
Thank you for your assistance in helping to provide the quality educational services to Anderson.

Sincerely,

Lisa J. Martiesian

Lisa J. Martiesian
Assistant Program Director
Out-of-District Placements

A.M. was admitted to JRC on December 22, 2003. The following chart shows his progress:



On this chart each dot shows the monthly total of A.M.'s major problem behaviors. During the first six months, A.M. received positive-only programming in the form of various behavior contracts targeting the absence of inappropriate behaviors with the opportunity for him to earn various rewards throughout the day. During this period he was also slowly weaned off all of his medication. A.M.'s problematic behaviors showed substantial improvement during the first six months; however, he was still exhibiting a very high level of dangerous and disruptive behaviors, averaging 7,300 a month. There were days where A.M. would exhibit over 2000 dangerous behaviors including aggression and sexually inappropriate behaviors. He required placement in an individual conference room with 1:1 staff. He lived at a highly staffed residence and did not earn the opportunity to attend any field trips or home visits. He was not able to make any significant progress towards his educational or social emotional goals as descri bed in his IEP.

With permission from his guardian and the school district JRC received the authority from the Bristol County Family Probate court to begin supplementing A.M.'s positive programming with Level III aversive interventions including the Graduated Electronic Decelerator (GED). As soon as the supplemental skin shock treatment was added to his program, A.M. showed immediate and dramatic improvement. His problem behaviors dropped immediately from 3,000 per month to about 3 per month, a 1000-fold improvement.

A.M. is currently in a classroom with his peers and is able to engage in daily academics. He has now exhibits an average of only 3 dangerous inappropriate behaviors a month and

has been able to go almost 9 weeks without exhibiting any dangerous behaviors. Not only is he not hurting himself or others, but he is able to engage in academics throughout the day, live in an apartment with peers/minimal staffing and learn vocational skills. A.M. has also been on several successful home visits. Although recently he ran away from a home visit, we continue to work with him and his family and are hopeful he will be able to successfully resume these visits. As A.M. continues to show sustained behavioral improvement, we foresee him eventually leaving JRC and living in a transitional residence with a job in the community. Previously, this would not have been an option due to the severity of his aggressive, disruptive and dangerous behaviors.

The May Institute, Randolph, MA

Difficult-to-Treat Students whom The May Institute Expelled and Who Were Subsequently Referred to JRC

4. Student A.P.

Summary: enrolled in the May Institute's day program in Arlington, MA in June 2003 when he was 11 years old. By June of 2005, when he was 13, his aggression and self-abuse had become too difficult for the May Institute to handle. A referral letter from the Revere, Massachusetts Public Schools on June 23, 2005 stated, "A.P.'s needs were not being adequately accommodated" at the May Institute and urged JRC to admit him "as soon as possible." He enrolled in JRC's day program on September 2, 2005 and has been doing well ever since *without any use of aversives.*

A.P. was eleven when he enrolled at the May Institute in 2003. While there, he engaged in self-abusive behaviors that, in 2004, occurred as frequently as 202 times per week. These behaviors included: hitting his head, banging head against objects (including breaking windows with his forehead), hitting his head or body with his hand, biting his wrist to the point of breaking the skin (leaving multiple scars). His aggression, which occurred as frequently as 247 times per school day consisted of hitting, pinching, scratching, kicking, pushing, biting, pulling the hair of staff or peers or head butting. He also engaged in spitting (as often as 116 times per week) and property destruction.

Elaborate and varied functional analyses (procedures that are designed to find out what events are functioning as the rewarding causes of the problem behaviors and that are often claimed to avoid the need for aversives) were performed at the May Institute on A.P.'s behaviors; however, they proved to be of no value in his treatment because the rewarding causes were usually found to be either unknown or multiple. The functional analyses failed to lead to effective treatment procedures.

The May Institute's "positive-only" methods for dealing with A.P.'s aggression, self abuse and spitting included the following: blocking his attempts at self-injury with pads; moving his chair back from the table to prevent head hits to the table; padding the walls to block head hits to the wall; partitioning off a special portion of the classroom just for A.P.; giving no eye contact or verbal communication to him when he displayed these behaviors while maintaining any ongoing demands (i.e., not lessening the demands when aggression occurred); giving contingent verbal feedback; giving social praise for appropriate behavior; providing frequent breaks on a schedule; having staff stand back when out-of-seat occurred; arranging behavioral contracts for not showing the behaviors; and ignoring the spitting behaviors.

Because A.P.'s behaviors were not sufficiently safe or appropriate, he was unable to

participate in any community field trips. When JRC staff visited A.P. at the May Institute in the summer of 2005, prior to JRC's accepting him as a student, the JRC staff noted considerable bruising on his arms and on the teacher's arms that had evidently resulted from his aggression and self-abuse and possibly from the May Institutes procedures in coping with his behaviors. JRC staff members also noted the great difficulty May Institute staff had in keeping him in his seat.

While attending May Institute, A.P. was given four psychotropic medications at the same time, including Zoloft, Buspar, Abilify and Trazadone.

By 2005 it was clear that the May Institute program was unable to treating A.P.'s problem behaviors successfully. On June 23, 2005, the Revere, MA public schools sent the following letter to JRC, **requesting that JRC "consider him for admission to your program as soon as possible" and noted that A.P.'s "needs were not being adequately accommodated" at the May Institute**.

REC'D
7-1-05
CM

REVERE PUBLIC SCHOOLS

Maureen McCarthy, M.Ed., CAGS
Administrator of Special Education
Special Education Department
101 School Street
Revere, MA 02151

Telephone 781-286-8240
Fax 781-485-8402
E-mail: mmccarthy@revere.mec.edu

June 23, 2005

Judge Rotenberg Educational Center
240 Turnpike Street
Canton, MA 02021

Dear Ms. LaChance,

Enclosed please find information regarding A.P. . The Revere Public Schools is requesting that you consider him for admission to your program as soon as possible.

A.P. is currently attending The May Institute in Arlington, Massachusetts. The team has reconvened and determined that A.P. needs were not being adequately accommodated.

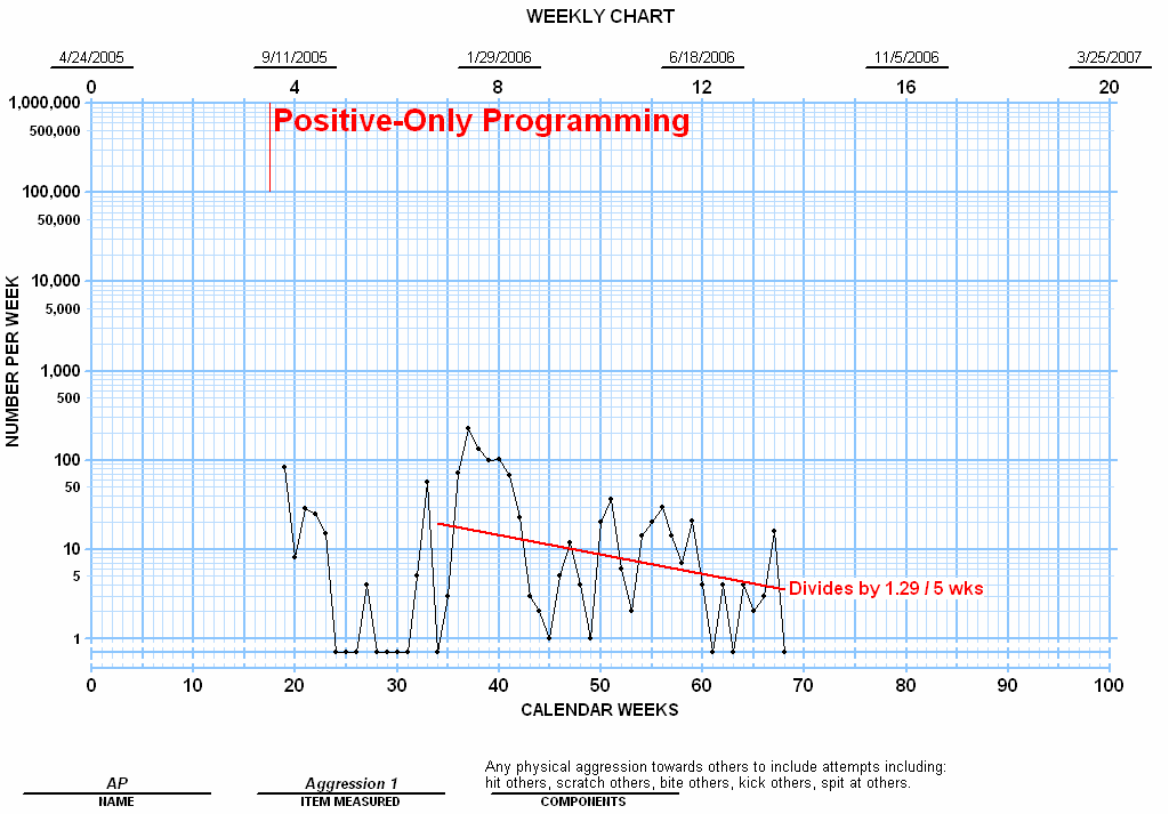
Please review the enclosed information and notify me of the appropriateness of A.P. for you program. If you are unable to accept A.P. into your program, I would appreciate a letter stating the reason.

I look forward to your response.

Sincerely,

Stacy A. Grillo
Special Education Chairperson
Revere High School/Out of District Students
101 School Street
Revere, MA 02151
phone (781) 286-8240
fax (781) 485-8402

A.P. enrolled in JRC in September 2005 as a day student, attending 6 days per week, from 9:00am to 4:00pm. **To date, A.P. has received only positive programming at JRC and has received no aversives**. On the following chart each dot shows the weekly total of A.P.'s aggressive behaviors since he enrolled in JRC.



This chart shows that A.P. has made steady improvement during the past 32 weeks. During that time his aggression has decreased from a high 200 per week to approximately 4-5 per week during the past two months.

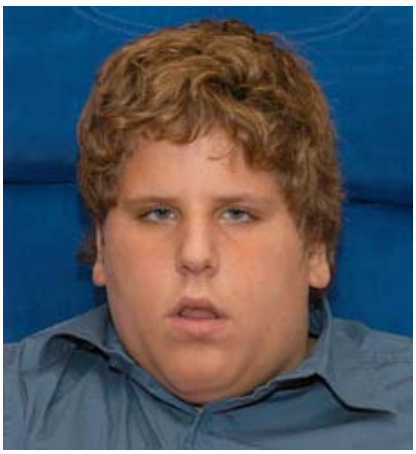
A.P.'s mother recently spoke with her son's clinician, Nick Lowther. Her comments on his progress were summarized by him as follows:

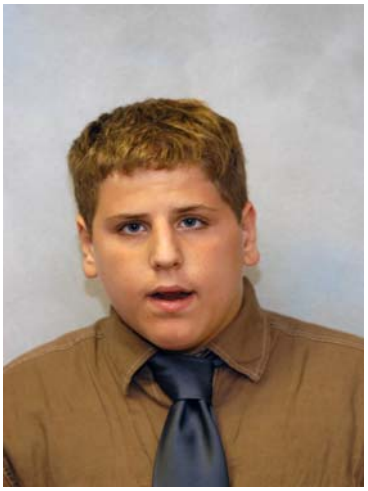
> She is pleased with his behavioral progress and his academic progress. She notes that he had not shown behavioral progress at the May Institute and little academic progress. She is also pleased with the level of monitoring (including digital video recording) at JRC and with the close involvement of AP's JRC treatment team with his daily progress. She commented that she has been impressed with the number of varied 'positive-only' programmatic interventions and with the treatment team's subsequent level of scrutiny as to the effectiveness of the program. AP's mother further commented as follows: that AP could not go on field trips while he was enrolled at the May Institute, yet, he has been able to do so while at JRC (to Boston Children's Museum, Edaville Railroad, New England Aquarium, etc.); that AP is more often able to play in the family's yard and pool at home (i.e. that his behavioral progress has generalized to his home environment); that AP's wrists and arms are healing due to the reduction in

arm/wrist biting; and that AP now sits at his desk and engages in academic work, which he was not doing prior to his admission to JRC. She also noted that AP now receives only two psychotropic medications (Abilify and Trazadone) as compared to four at once (Zoloft, Buspar, Abilify and Trazadone) that had received at one point during his stay at the May Institute.

A.P.'s clinician at JRC summarizes A.P.'s current progress at JRC as follows:

> "A.P.'s aggressive behaviors are of such low intensity and frequency that A.P. does not require emergency physical intervention at all during most weeks. A.P.'s on-task behavior is much improved as compared with the same behavior at the May Institute in that A.P. remains in his seat when it is time for him to work. Especially exciting are A.P.'s behavioral frequency data during the past three weeks, which have shown a significant decrease in response to some recent "DRO" behavioral contract modifications. A.P. enjoys frequent, contingent exercise (walks) as a reward for refraining from health dangerous behavior for short periods of time while he completes his academic work. Assuming that A.P.'s present behavioral data trends are sustained, I am optimistic that we may be able to attempt fading of his 1:1 staffing as well as a minimization of his medication dosages.
>
> Also greatly beneficial to A.P.'s physical health is his weight loss since his admission to JRC's program. This is probably due to a decrease in the overall amount of psychotropic medication A.P. has received at JRC, as compared with what he received at the May Institute, plus the increase in his exercise both at JRC and at home. Whereas A.P. weighed 194 pounds upon admission, his most recent weight data point was 175 pounds, an important improvement for a 14-year-old who is categorized as obese, per the body mass index (BMI) system. The following photos of A.P. (used with permission of his parents) show the weight loss that has occurred."





5. Student N.M.

Summary: N.M. was a day student at the May Institute for Education and Neurorehabilitation in Brockton, MA between 1998 and 2003, between the ages of 13 and 18. By 2003 her parents concluded that May Institute was unable to control N.M.'s self-injurious behaviors such as head-banging and punching her face and eyes, and were concerned with N.M.'s lack of progress in communication skills. On January 12, 2004 the Boston Public Schools informed JRC that her parents "are concerned with the increase in her self-injurious behaviors as well as her behaviors at home" and referred N.M. to JRC. N.M. enrolled in JRC's day program on March 17, 2004 and has done remarkably well ever since supplementary aversives were added to her program.

N.M. enrolled at May Institute in 1998. She engaged in head-banging to the point of causing pain, redness, bruising and tissue damage. She did this by either hitting her head against an object or by punching her head or face with her fist. She averaged 15-23 occurrences of this per day. Punching her own eyes has caused permanent impairment of her vision. She also flopped on the floor from a standing or seated position and aggressed against other students as well as staff members. Her aggressive behaviors included grabbing, pinching, scratching and pushing others.

May Institute staff members treated these behaviors without aversives, using the following procedures: they tried to block all of her self-injurious behaviors; they prompted her to put her hands down if necessary; they stopped interacting with her until she remained calm for ten seconds; they encouraged her to use her "words" when she exhibited her behaviors; they granted any request during times she was not exhibiting her behaviors; they gave her a functional communication book and they also used manual restraint in the form of certain "protective holds." On the school bus they kept a row of empty seats as well as an aisle between Nicole and the nearest other person.

While attending the May Institute, N.M. was treated with the following medications: Depakote for her seizures; and the psychotropic medications Buspar, Prednisone and Risperidone for her behaviors.

Despite the procedures and medications that N.M. received while at the May Institute, N.M.'s parents became dissatisfied with her progress.. N.M.'s last IEP from the May Institute shows that her self-injurious behaviors, even after 5 years of positive-only treatment, were occurring approximately 23 times per day.
On January 12, 2004, we received the following letter from the Boston Public Schools:

(1) Rec'd

AROLYN RILEY
ENIOR DIRECTOR

Jane Sullivan
Director

Campbell Resource Center
1216 Dorchester Avenue
Dorchester, MA 02125
617-635-8599 Voice
617-635-8014 Fax

BOSTON PUBLIC SCHOOLS

UNIFIED STUDENT SERVICES

Willi
Di

Boston
443 W
Dorch
617-6
617-6

January 12, 2004

Ms. Sherry Rotenberg
Judge Rotenberg Center
240 Turnpike Street
Canton, MA 02021

RE: N.M.

Dear Ms. Rotenberg:

N.M. is currently a student attending the May Institute in Brockton. At this time, N.M.'s parents are concerned with the increase of her self-injurious behaviors as well as her behaviors at home. Mr. and Mrs. M. are interested in exploring other programs for N.M. at this time. It is also my understanding that staff from JRC have already spoken to the M.'s regarding N.M. attendance at your program.

Please review the enclosed records and determine whether or not N.M. is appropriate for your program. If you are able to provide services to N.M. please contact her parents, Mr. and Mrs. M. at . If you would like additional information, please contact me at 617.635.8282.

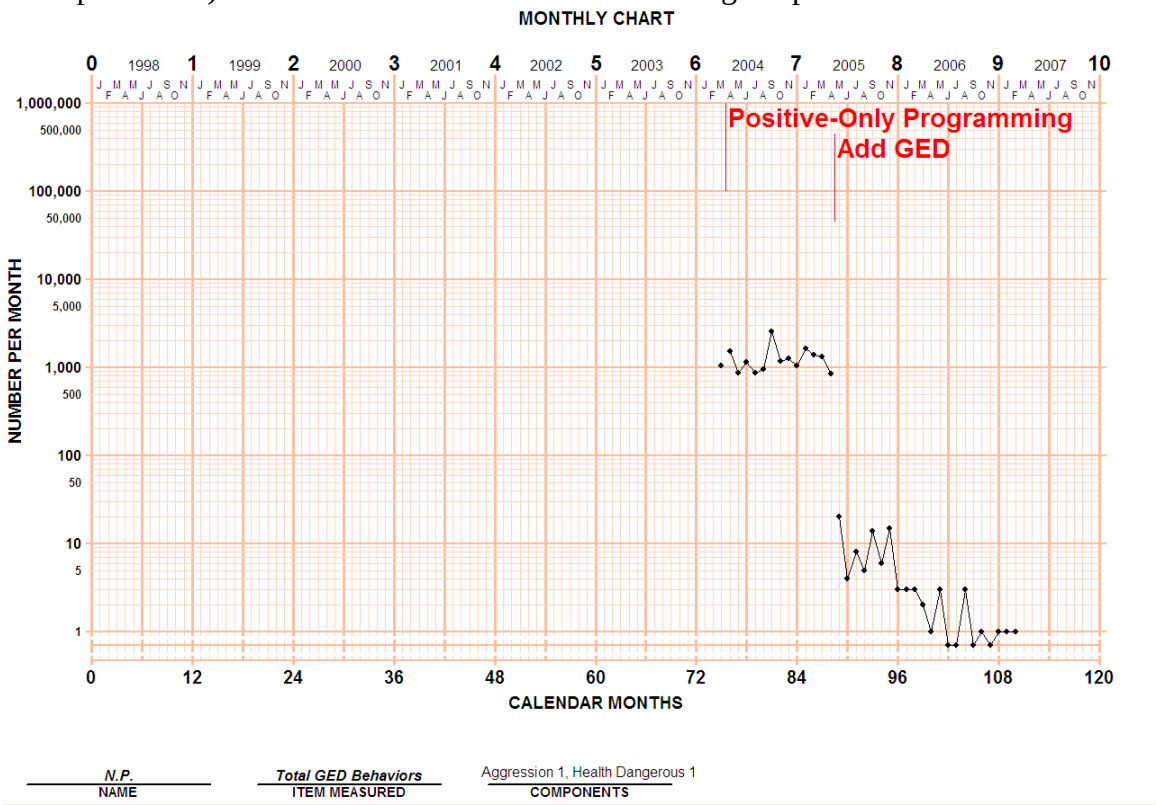
8030 - secretary

Thank you for your assistance in helping to provide the quality educational services for

Sincerely,

Lisa J. Martiesian
Assistant Program Director

N.M. was admitted to JRC in April 2004. During her first 13 months at JRC N.M. was treated with positive-only programming and this was not effective in decreasing her major problem behaviors. Beginning in May 2005, JRC added the GED skin-shock to N.M.'s positive programming to treat her aggressive and health dangerous behaviors. Below is a chart that shows the monthly totals of these behaviors throughout N.M.'s enrollment at JRC. The chart shows that once the supplemental aversives were added, her aggression and self-abuse dropped immediately by a factor of 100 (from 1000 per month to 10 per month) and has decreased to a zero level during the past six months.



The following is a summary of N.M.'s current progress at JRC prepared by her clinician:

> "N.M. now engages in academics for extended periods of the day and is able to transition from one area of the building to another without problems. She works on academic programs teaching her to count and is making significant progress in her communication skills. All of this would be impossible to learn if the frequency of her dangerous and self-injurious behaviors had remained at frequencies similar to those she exhibited at the May Institute and during her first 13 months of positive-only programming at JRC. She continues to receive anti-seizure medication but she no longer receives any psychotropic medication."

The following is a letter N.M.'s father sent to the Boston Globe:

A parent's view of treatment

May 29, 2006

"A QUESTION OF `tough love' vs. torture" was the headline of a story by Scott Allen (City & Region, May 22 [*Boston Globe*]*). Surprisingly, a picture of me with my daughter N.M. appeared underneath -- but nothing from my interview with Mr. Allen. Printing my story would have let readers know that N.M. suffers from Landau-Kleffner syndrome, a rare epilepsy often misdiagnosed as autism. The epilepsy impaired her communication and led to increasing frustration and extreme self-abusive behavior.

N. M. attended top behavioral schools and was treated with drug and behavioral therapy without success. After consultation with our neurologist and judicial approval, she began skin shock therapy at the Judge Rotenberg Center. After two days, there was a reduction of self-inflicted punches to her eyes and head from 1,400 per week to one every three to five weeks. She is improving and spends her days learning, communicating, and developing healthier behaviors.

Our kids are one punch away from going blind or killing themselves, and we need effective treatments that work quickly with minimal side effects. It would be a terrible injustice to deprive a child of such an effective treatment, simply because it makes some adults feel more comfortable.

THE REV. DEACON R.M.
West Roxbury

* Bracketed Material inserted by JRC

Here is a veru recent letter from N.M.’s father in which he compares the results of N.M.’s nonaversive treatment at the May Institute and her treatment at JRC:

August 31, 2006

Matthew L. Israel, Ph.D.
Executive Director
Judge Rotenberg Educational Center
240 Turnpike Street
Canton, MA 02021

Dear Dr. Israel,

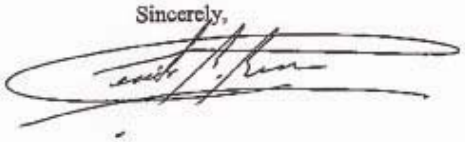
N.M. was seen by Dr. James Riviello, Neurologist, at Children's Hospital in Boston this afternoon for her semi annual follow up visit. Dr. Riviello has been following Nicole for the past ten years. He commented to us that N.M. is doing remarkably well. He is especially pleased that her extreme self abusive / aggressive behaviors have virtually disappeared during her attendance at the Judge Rotenberg Center.

N.M. had previously attended the May Center for Neurorehabilitation, which is an excellent behavioral school. However, during the five years she attended the May Center, her extreme self abusive / aggressive behaviors escalated in frequency (over one thousand incidents per week) and intensity. She came home every day from school with self inflicted bruises on her eyes, face, head, torso, arms and legs. She would bang her head against walls, desks, file cabinets and windows. N.M. would pick up objects and hit her face and head with them. She was constantly pinching her face and body. The wall in her bed room at home had many patched areas where she had banged her head right through the wall. Nicole would attack (pinch, scratch, and head butt) staff and other students at school. At home, she would attack her sister, Danielle, and Elizabeth and I. If we visited someone she would often aggress towards them making it impossible to go out with N.M. to social events. After five years and numerous meetings with the school psychologist and staff, it became obvious that the May Center could not control extreme behaviors. We looked at other behavioral schools, however, she was not a candidate for any other program due to the severity of her behaviors. Therefore, we transferred her, with the help of the Boston School District, to the Judge Rotenberg Center.

Today N.M. spends her time learning as opposed to being restrained all day long. Many weeks often elapse before she exhibits an aggressive of self abusive behavior. As a result of her progress, we have been able to enjoy family vacations with N.M. in Florida, visiting family and friends. N.M. is now a happy young lady that enjoys new experiences and is continually improving in all aspects of her life - health, educational and social.

E.M. and I are very grateful to you and your staff for helping **N.M.** to have a realistic chance at a happy life and a promising future.

Sincerely,



6. Student D.R.

Summary: D.R. enrolled as a day student at the May Center in Randolph, MA at

the age of 14; however, after 5 months of positive only-treatment his aggressive and destructive behaviors became too difficult and dangerous to be controlled at the May Center, despite the fact that the May Center provided him with 1:1 staffing. A referral letter from the Boston Public Schools to JRC dated April 12, 2006 stated that "…The May Center in Randolph…have determined that they are unable to meet his needs any longer. They are seeking to have him transfer just as soon as possible to another day school." D.R. enrolled in JRC's day program in June 13, 2006 and has done well ever since *without the need for any aversives* and without the need for 1-1 coverage.

At the May center, D.R. engaged in severe aggression which included "grabbing, hitting, hair pulling, pushing, grabbing clothing, biting and scratching". He engaged in an average of 17 major aggressive incidents per day. His destructive behaviors included "throwing objects to include computers and chairs, clearing tables, breaking objects, stomping on objects, and tearing objects" with 117 episodes observed in March 2005. In addition, he averaged 22 minutes of non compliant behaviors per day and had several incidents of feces smearing and disrobing behaviors. Because of these problematic behaviors D.R. required a 1:1 staffing ratio throughout the day and had 3:1 staffing when he displayed problem behaviors.

The May center tried a variety of positive-only behavior strategies and at least one aversive strategy. When D.R. was aggressive May staff were directed to "escort him to a seated position on the floor and back away out of his reach" and to "not interact further until he stands up on his own," at which point they were to "verbally cue him back to the activity and provide a gestural prompt." When he disrobed he was to be escorted to the seclusion time out room and asked to get dressed every 30 seconds until he did so. Other procedures tried included verbal and physical prompting, redirection, programmed ignoring procedures, loss of tokens and even seclusion time out, which is an aversive intervention. His mother reports that one of D.R.'s smearing episodes resulted in his being placed in a small room the size of walk-in closet.

Unfortunately, D.R. was so big, strong, aggressive and property destructive that these positive procedures were impractical to use with him and had to be abandoned. The following discharge summary, prepared by the clinical director of May Institute, recommends his immediate discharge. The circled material summarizes the entire document.

MayInstitute
May Center for Child Development
41 Pacella Park Drive • Randolph, Massachusetts 02368 • Tel: 781.437.1300 • Fax: 781.437.1301 • www.mayinstitute.org

Discharge Summary

Student: D.R.
Date of Birth: 12/4/91
Date of Admission: 11/17/05
Date of Discharge: 4/12/06

Background information

D.R. is a 15 year old boy with a diagnosis of autism. He has been attending the May Center for Child Development in Randolph since November, 2005. Prior to that, D.R. attended a specialized program in Boston Public Schools. D.R. currently participates in a self-contained classroom with 5 other students. This classroom is specifically designed to manage students with significant problem behavior. D.R. currently receives 1:1 staffing throughout the day and requires up to 5 additional staff to manage aggressive episodes. Very recently, D.R. has been moved to a classroom by himself because of the significant risk that his problem behavior was posing to staff and other students. D.R. is currently staffed 1:1 in this room but additional staff are required any time he travels outside of the room (ex., to the bathroom) and during episodes of problem behavior in the room.

Summary of Significant Problem Behavior

D.R. currently displays high rates of problem behavior that interfere with his ability to participate in educational activities and pose a significant risk to himself, staff, and other students in the environment. Rates of problem behavior displayed during the month of March are listed below.

Behavior	Average Frequency per Day
Aggressive Episodes	17
Property Destruction	5.85
Non-compliance	22 minutes

The most significant of D.R. 's problem behaviors are the aggressive episodes and the property destruction.. Aggressive episodes are defined as any episode in which two of the following behaviors (in any combination) occur within a 10 second period; grabbing, biting, hitting, grabbing others clothing, scratching, hair pulling, pushing or pursuing an individual to aggress. Aggressive episodes can last from one minute to two hours in length and often require two to six staff members to manage.

D.R. is a large, very strong teenager who will repeatedly hit, scratch, push, and pull hair of staff during an episode. Interventions that have been unsuccessful include DRO, redirection, seclusion time-out, and protective holding. Several staff injuries have occurred during these episodes ranging from bleeding scratches and lost clumps of hair to a sprained knee requiring restricted duty for the injured staff person. Despite the intensive intervention directed to this problem behavior, rates continue to escalate and compromise the safety of D.R. and others in his environment.

Episodes of property destruction are of equal concern. These episodes include tearing, throwing, and kicking objects and can last from a few seconds to an hour or more in duration. D.R. has thrown chairs, thrown and broken two classroom computers, destroyed other student's task materials and tipped over a filing cabinet. During these episodes, he will sometimes bolt into other classrooms and destroy the environment. Multiple intervention attempts have been unsuccessful in reducing the frequency of these episodes.

Functional assessment information reveals that most aggressive and destructive episodes serve the initial function of escape from task demands. Once an episode has begun, it quickly shifts to attention-seeking motivation and D.R. actively attempts to keep staff engaged in physical struggle by displaying increasingly dangerous behavior. He has recently been moved to a classroom by himself in an attempt to reduce the attention that must be directed toward the problem. D.R. is keenly aware of his environment and has been able to quickly determine the environments in which he can display problem behavior (ex., in the hallway on the way to the bathroom)that will require intensive staff intervention.

At present, D.R. does not comply with instructions to complete classwork and repeated demands will frequently result in episodes of aggression and property destruction.

Language/communication

D.R. is primarily a verbal communicator and currently uses one word utterances to meet basic wants and needs. With some prompting, he is able to use simple sentences to make requests. His conversational speech is limited to echolalic responses. He will at times, grab a staff person's arm to indicate a need. He does not currently use an augmentative communication system

Social Interaction

D.R. seems to enjoy staff attention but, at present, does not have an appropriate means for gaining attention. He will frequently engage in problem behavior to maintain staff interaction. D.R. does not show an interest in his peers and, because of his high rates of problem behavior, is not able to participate in any group activities.

Academic Skills

D.R. can follow two-step related directions in the classroom. He can identify pictures, verbs, colors, and other modifiers in a field of three by pointing to the target. He responds to his name when called and he can make eye contact (although this is not consistent). He is able to write a variety of words including his name, Boston, and the months of the year. He is able to read simple short stories and to recognize a large number of sight words when presented with a list. D.R. enjoys reading Dr. Seuss books with staff. At present D.R. is not able to participate in ongoing educational activities because of the significant levels of problem behavior he displays. Thus, he is not receiving educational benefit from his current placement.

Summary

D.R. is a large, very strong teenager who displays high rates of significant problem behavior including aggressive episodes and property destruction. These episodes of problem behavior often require from wo to six staff to manage and pose a significant risk to D.R., staff, and other students in the environment. He has thrown chairs, task materials, tables, and computers and aggression has resulted in staff injury. Interventions attempted to date include the following:

Block and redirect- suspended because episodes resulted in hours long physical struggles involving up to six staff.

Exclusionary time out- suspended because of significant damage to the environment including breaking a doors hinges and cracking a wall.

Seclusion time out- suspended because episodes frequently occurred in areas some distance from the STO room requiring a prolonged physical struggle to get D.R. to the time out.

Protective holding (floor control)- suspended because episodes of aggression and destruction required multiple applications of holds 9up to 25 per episode) posing unacceptable risk tc D.R. and staff.

D.R. continues to pose a serious risk to himself and others in his environment as a result of the high rates of problem behavior he displays on a daily basis. At present, D.R. is extremely limited in his ability to participate in educational programming.

It is recommended that D.R. be discharged from the program immediately.

Jane I. Carlson, PhD, BCBA
Clinical Director

It is notable that although the May Institute (like so many other programs) enjoys a reputation for not using aversives, several of the procedures that were tried with N.M., and which are in the circled material, are obviously quite aversive such as:

1. "Block and redirect." This sounds innocuous, but in reality it led to "hours long physical struggles of D.R. with up to 6 staff members.
2. "Exclusion time out." This usually means putting the student in a small room with the door unlocked. It was suspended because of damages to doors and walls.
3. Seclusion time out." This usually means putting the student in a small room alone and locking the door or otherwise mechanically preventing escape from the room. It was suspended because of the struggles to move the student from wherever he was when he engaged in the problem behavior to the seclusion time out room.
4. Protective holding (floor control). This seems to be a euphemism for taking a student down to the floor and holding him there until he stops struggling. May Institute suspended this procedure because up to 25 of these "take-downs" were necessary during a single episode of problem behavior.

On the very same day (April 12, 2006) the Boston Public Schools sent the following referral letter to JRC . In it they report that the May Center "has determined that they are unable to meet his needs any longer. They are seeking to have him transferred just as soon as possible to another day
school".

Rec'd 4

CAROLYN RILEY
SENIOR DIRECTOR

Jane Sullivan
Director

Campbell Resource Center
1216 Dorchester Avenue
Dorchester, MA 02125
617-635-8599 Voice
617-635-8014 Fax

BOSTON PUBLIC SCHOOLS

UNIFIED STUDENT SERVICES

William
Direc

Boston La
443 Warre
Dorcheste
617-635-8
617 635-8

To: Day School
From: Paul Howe
Date: April 12, 2006
Re: D.R.

He is currently a day student at The May Center in Randolph. They have determined that they are unable to meet his needs any longer. They are seeking to have him transfer just as soon as possible to another day school.

Please contact his parents, Mr. & Mrs. C. at to arrange an intake. I am hopeful we can avoid having to place him on interim home instruction.

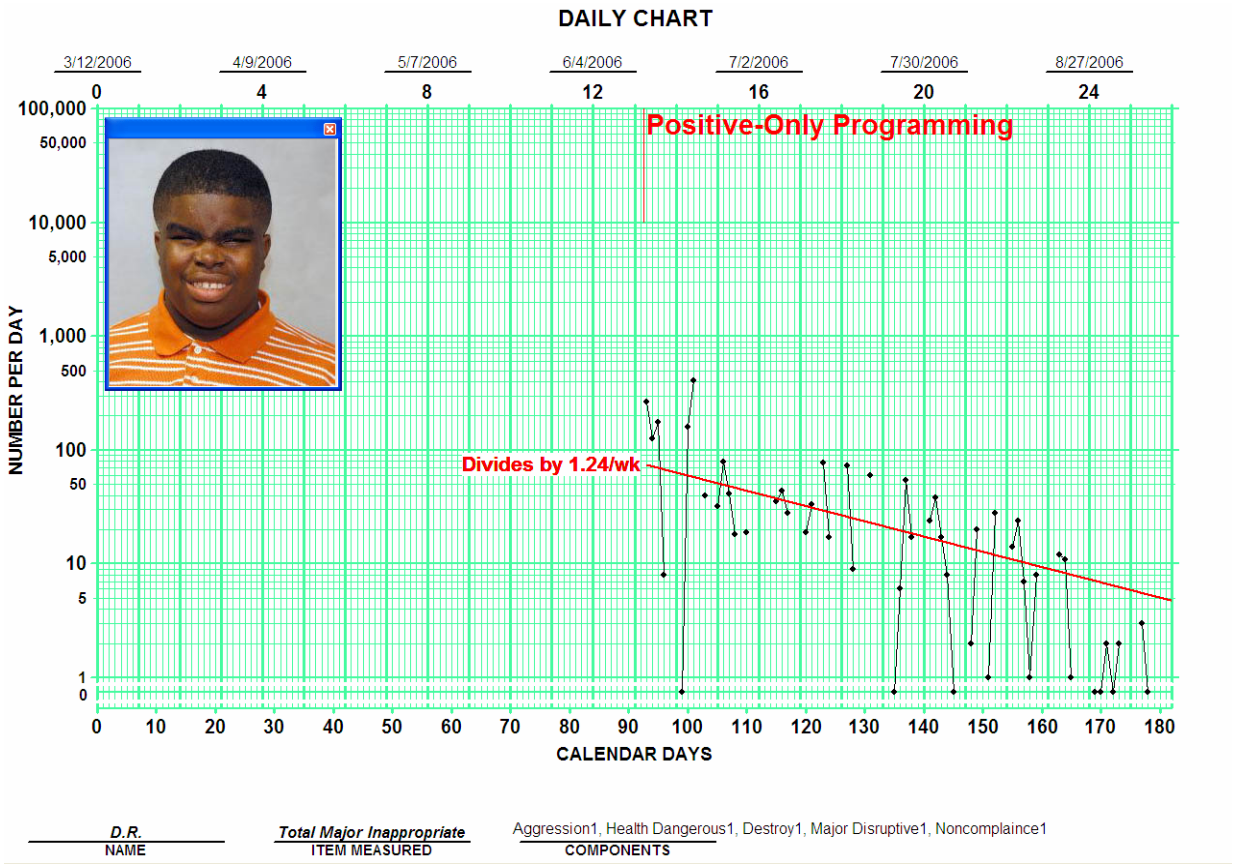
Please call me at 617-635-8030 if you can meet his needs.

Thank you

Paul V. Howe
Unified Student Services
443 Warren Street ~ Suite 3
Dorchester, Massachusetts 02121

D.R. enrolled in JRC in June 2006. His behaviors responded immediately and steadily to JRC's positive-only treatment procedures. After only two months he was doing so well that JRC was able to remove his 1:1 staffing. Although May Institute had employed a seclusion time-out procedure (an aversive procedure) with D.R., **JRC has not needed to use any aversives in its treatment of D.R.**.

The following chart shows the steady progress that D.R. has made at JRC. It is a daily chart on which each dot represents the total number of aggressive, health dangerous, disruptive and non-compliant behaviors he displayed each day. It shows these behaviors decreasing by a factor of 1.30 from week to week.



The following is a letter written by his parents, describing his experiences at May Institute and at JRC.

[Letter from D.R.'s parents will be inserted here.]

D.R.'s clinician has summarized his progress at JRC as follows;.:

> Upon admission to JRC, D.R. engaged in hundreds of aggressive, destructive, major disruptive and non complaint behaviors per day. His treatment team, which consists of a clinician trained in behavioral principles, a case manager, a special education teacher, and parents, worked diligently to provide him with a

salient behavioral intervention program. Using JRC's dense reward systems which include behavioral contracts and token economies that make use of the reward features available in JRC's beautifully decorated facilities, playground, classroom reward store, contract store and other reward items and activities, we have been able to decrease D.R..'s problematic behaviors in all environments to a median of 9 per day, decrease the need for emergency restraint while increasing his on-task behavior and completion of academic assignments. He is able to attend field trips (educational and recreational) and is remains free of any psychotropic medications. D. R. continues to learn new and appropriate social and communication skills that have enabled him to interact appropriately with his treatment team, support staff, family members, and other students.

The Anderson School, Staatsville, NY

Difficult-to-Treat Students whom The Anderson School Expelled and Who Were Subsequently Referred to JRC

7. Student S.S.

Summary: S.S. was enrolled at the Anderson School in Staatsville, N.Y. at the age of 11 in January of 2004. After one year of Anderson School's positive-only treatment procedures, S.S.'s self-injurious and aggressive had became so intense and unmanageable that she had fully detached both of her retinas. In 2005 the Anderson School acknowledged that positive-only procedures were insufficient, that S.S. needed procedures such as aversives that the Anderson School did not offer and referred S.S. to JRC. S.S. enrolled in JRC in March, 2005. Aversives were added to her program in mid-May. Immediately after that her aggression and self-abuse showed a marked deceleration, a trend that has continued to date. While at JRC, S.S. has been able to have her retinas re-attached and she has not detached them while at JRC.

S.S. enrolled at the Anderson School in Staatsville, N.Y. at the age of 11 in January, 2004. The Anderson School specializes in the treatment of autistic children. During the years of 2003 to 2005 Dr. Carol Magyar was brought into Anderson School as a consultant by the State Education Department to train it's staff in the nonaversive procedures known as Positive Behavior Support. Dr. Magyar is one of three outside consultants who participated in the June 9, 2006 review of JRC that was conducted by NYSED and that found fault with many of JRC's procedures including its use of aversives.

The Anderson School tried to treat S.S. with the following "positive-only" treatment approaches which were stated in her Anderson School Behavior Support Plan dated 9/17/04:

1. S.S should follow a picture schedule both in school and in the residence;
2. staff should also use "first….then" sequence cards with her so that she can anticipate reinforcement;
3. staff should use a timer so she can recognize the beginning and end of activities; she should be given a sensory diet;
4. staff should give instructions to her that are short, direct and brief;
5. a penny board should be implemented;
6. she should use a "break card" so that she can request a break at any time;
7. she should also use of communication book and receive Functional Communication Training.

During her stay at Anderson School S.S. received 1-1 staffing during all school hours.

In addition, Anderson School gave S.S. psychotropic medications such as Risperdal, Prozac, Depakote and Abilify, none of which were sufficiently effective.

Unfortunately, despite one year of these positive-only treatment procedures plus psychotropic medications at the Anderson School, and 1-1 coverage at all times, S.S.'s self-injurious and aggressive behaviors eventually became so intense and unmanageable that she fully detached both of her retinas.

When S.S.'s behaviors did not respond after 10 months to any of the positive-only Behavior Support Plans that were implemented, a full Functional Analysis of Behavior (Analog Assessment) was conducted. This was a modified version of Dr. Brian Iwata's protocol for conducting a Functional Analysis of Self-Injurious Behavior (SIB). During this analysis S.S. was placed in 10 separate conditions across 5 consecutive days to help determine the functions of her behaviors. The results indicated that her problem behaviors had multiple determinants. Unfortunately, this was of no help to S.S., because all of the possible interventions suggested by the behavioral literature for those multiple determinants that had been found in the functional analysis had already been tried unsuccessfully at the Anderson School. It was after the completion of this functional analysis that the Anderson School acknowledged that their positive-only procedures were insufficient and that S.S. needed procedures such as aversives that the Anderson School did not offer. At that point the Anderson School referred S.S. back to her district and referred S.S. to JRC. In summary, despite 1-1 staffing, sophisticated positive programming by a staff trained by a positives-only consultant held in high regard by NYSED, a full functional analysis and psychotropic drugs, Anderson School was unsuccessful in treating S.S.'s major problem behaviors.

The letter in which S.S.'s home district referred her to JRC states that her "behavior has deteriorated over the past few months and the Anderson School feels it is no longer able to meet S.S.'s needs" It further states that she "displays self-injurious behaviors such as gouging at her face and slapping herself in the head and face. These occurrences take place at frequency of 700-800 incidences within an eight hour period. S.S. currently wears protective head gear as a means of protection." This referral letter to JRC is shown below:

(1.)

EAST WILLISTON UNION FREE SCHOOL DISTRICT

11 Bacon Road
Old Westbury, New York 11568
(516) 333-5690
Fax (516) 333-5973

Rec'd 1.13.05

Susan Miller
Administrator of Special Education
And Related Services

Dr. Carolyn Harris
Superintendent of Schools

Dawn Muscarnera
CPSE/CSE Chairperson

SR

January 10, 2005

Dear Director,

The East Williston CSE is seeking placement for S.S. (DOB). S.S. is an eleven-year-old girl who is classified as autistic. She currently attends the Anderson School, which is a residential placement in upstate New York. S.S. 's behavior has deteriorated over the past few months and the Anderson School feels it is no longer able to meet S.S. 's needs. S.S. displays self-injurious behaviors such as gouging at her face and slapping herself in the head and face. These occurrences take place at frequency of 700-800 incidences within an eight hour period. S.S. currently wears protective head gear as a means of protection. S.S. requires placement in a small, highly structured, residential program that specializes in dealing with students with autism and aggressive behaviors. Enclosed with this letter are S.S. 's most current IEP, evaluations, behavior plan and medical records. We are hoping you will be able to service this student's needs and we look forward to hearing from you.

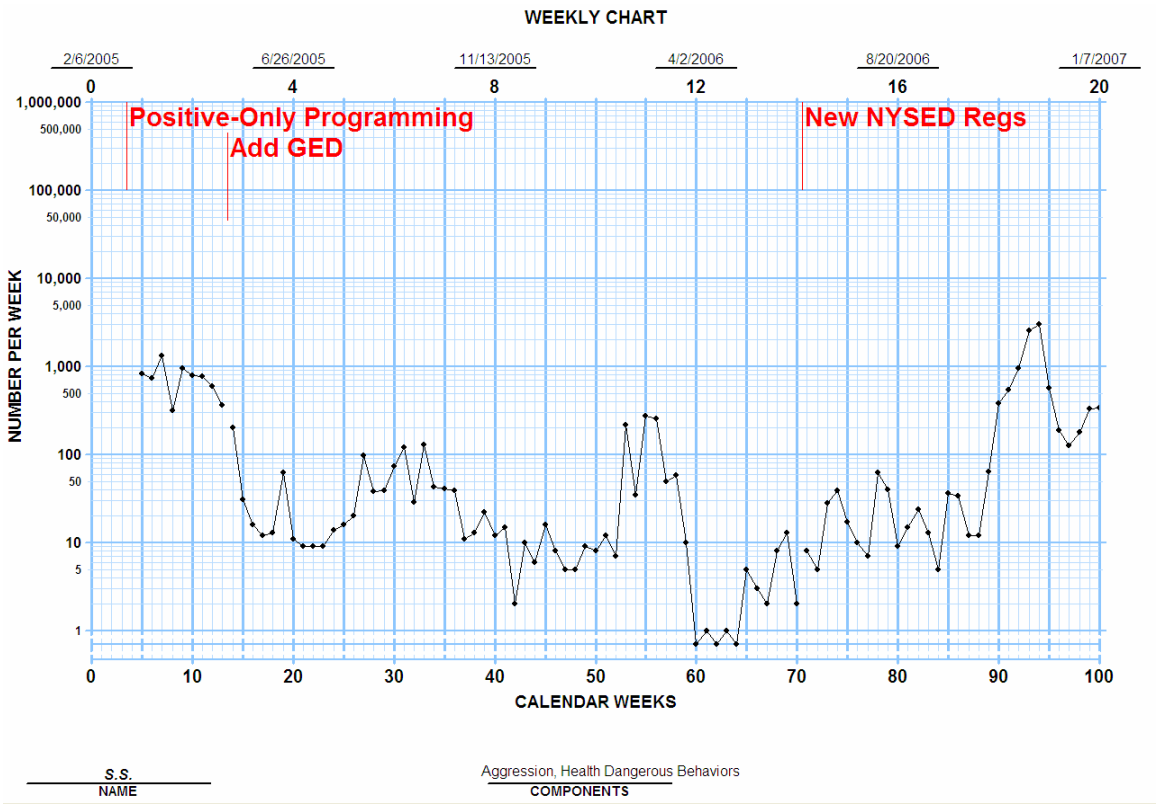
If you require any additional information or if I can be of any help, please feel free to contact me at (516) 333- 5690.

Sincerely,

Dawn Muscarnera

Dawn Muscarnera
CSE Chairperson

In January 2005, Anderson School referred S.S. to JRC. The following is a chart showing the frequency of her aggressive and health dangerous behaviors. Each dot represents the total number of aggressive and health dangerous behaviors shown on each week.



During S.S.'s first 9 weeks at JRC, JRC removed her psychotropic medication and applied positive-only programming. This was not very successful in decreasing her problem behaviors. During these 9 weeks of positive-only treatment, S.S. showed approximately 776 aggressive and health dangerous problem behaviors per week even while wearing arm splints all day and night, and a neck brace for her safety. In addition, during this time had S.S. had had the first of four major eye surgeries. After 9 weeks, the GED was added to her program. Once it was added, S.S.'s aggressive and health dangerous behaviors showed an immediate jump-down (an immediate 64-fold decrease) and subsequent deceleration, as can be seen in following graph.

On June 23, 2006 new regulations of the New York State Education Department prevented JRC from using the GED for S.S.'s noncompliance, major disruptive and property destructive behaviors. This prohibition caused some regression for S.S. This effect is seen in the last 10 dots on the chart (the 10 weeks immediately subsequent to the change in the NYSED regulations on aversives). This occurred because JRC was, starting on June 23, 2006, prevented from treating behaviors that were frequent antecedents to her self-abusive and aggressive actions.

S.S.'s mother described the changes in S.S., once the GED was added to her program as follows:

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

The following is a description by S.S.'s clinician, Dr. Christine Chiudina, at JRC of S.S.'s current status:

> "The GED was started with S.S. in May 2005. Since that time, she has averaged a daily median of 2 applications, has never had to be restrained since being on the devices, is totally off psychotropic medication, no longer wears protective equipment and works daily on a computer doing her academic work. S.S. has made significant progress at JRC and spends her time now progressing socially and educationally. She attends field trips and all school activities."

The following is letter which S.S.'s parent wrote in 2006 to some New York legislators, urging them to oppose a bill that would have banned the use of aversives with New York students:

> "April 2006:
>
> To whom this may concern:
>
> We would like to tell you about our daughter, S.S., and how the Judge Rotenberg School in Canton Massachusetts has saved her life.
>
> We first discovered S.S. 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. (Variety Pre-schoolers Workshop, The Young Autism Program at DDI, AHRC, and finally The Anderson School in Staatsburg, NY) In addition to her schooling, numerous therapists, and teachers came to our house to work with S.S. 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, S.S. was under the care of a psychiatrist, and given several different psychotropic medications.
>
> Despite, all these well-caring professionals working with our daughter, S.S. progressively deteriorated. Over the years, she became more violent. She would attack us, other children, and her teachers. She would bite, scratch, 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, and the GED device.

Within several weeks of getting treated with the GED device, a miracle happened; S.S. stopped hitting herself, and stopped her violent behavior. She appeared much happier. She was able to be weaned off all of her psychotropic medications. She continues to do well, and only requires 1 or 2 GED applications per week.

Clearly, we tried positive reinforcement, and psychotropic medications, for over 10 years, and the GED device accomplished more in just a few short weeks, then the treatments of the previous 10 years. There are a number of children with similar stories of severe behavioral problems that have benefited by this treatment, as well as the story of their poor desperate parents who have exhausted all other options. There are numerous scientific papers attesting to the effectiveness, and safety of skin shock therapy. There was also a paper published in 1999, by the American Association of Mental Retardation, finding that positive programming is effective in 50% of the cases. What about the other 50%?

Sincerely,

M.S and M.S."

8. Student M.D.

Summary: M.D. was enrolled at the Anderson School in Staatsville, N.Y. at the age of 5 in September of 1991. After many years of Anderson School's positive-only treatment procedures, M.D.'s aggressive behaviors had became so intense and unmanageable that he had injured several staff, required frequent chemical restraint and several psychiatric hospitals. For a six month period M.D. was sending staff members to the hospital weekly. He would violently attack them, pulling their hair and choking them. In August of 2004 the Anderson School acknowledged that positive-only procedures were insufficient, that M.D. needed additional interventions. M.D. enrolled in JRC in December, 2004. During his first day at JRC he went into a coma and was diagnosed with Neuroleptic Malignant Syndrome as a result of being on so many psychotropic medications. M.D. spent 8 days in a coma and according to his parents, almost died. Upon returning to JRC from the hospital M.D. was treated with JRC's positive-only program until aversives were added to his program in January of 2005. Immediately after M.D.'s program was supplemented with Level III aversives his aggression and self-abuse showed a marked deceleration, a trend that has continued to date.

M.D. enrolled at the Anderson School in Staatsville, N.Y. at the age of 5 in September of 1991. The Anderson School specializes in the treatment of autistic children. During the years of 2003 to 2005 Dr. Carol Magyar was brought into Anderson School as a consultant by the State Education Department to train it's staff in the nonaversive procedures known as Positive Behavior Support. Dr. Magyar is one of three outside consultants who participated in the June 9, 2006 review of JRC that was conducted by NYSED and that found fault with many of JRC's procedures including its use of aversives. Dr. Magyar is referenced in the letter below as the "…expert in autism from the University of Rochester."

The Anderson School tried to treat M.D. with the following "positive-only" treatment approaches which were stated in his Anderson School Behavior Support Plan:

8 M.D. should follow a picture schedule both in school and in the residence;
9 staff should also use "first….then" sequence cards with him so that he can anticipate reinforcement;
10 staff should use a timer so he can recognize the beginning and end of activities;
11 a penny board should be implemented;
12 he should use a "break card" so that he can request a break at any time;
13 he should also use of communication book and receive Functional Communication Training.

During the crisis the period just prior to M.D. being discharged the Anderson School the school sites various interventions which were utilized. They include the following:

1 modification to his behavior plan
2 retraining staff
3 providing M.D. with a 1:1 staff during all hours

4 psychiatric consultation
5 consultation with an expert in autism from the University of Rochester
6 classroom changes
7 hospital outpatient psychiatric services
8 PRN medications

In addition, the Anderson School gave M.D. medications such as Haldol, Dexedrine, Orap, Thorazine, Risperdal, Depakote, Clonidine, Cogentin, Benydryl, Zoloft and Luvox. In addition, Thorazine was also prescribed as a PRN and if his behaviors failed to respond to the Thorazine another PRN of Trazodone was administered. None of these medications were effective in controlling M.D.'s behaviors. His parents report that at one point he was on 12 psychotropic medications at the same time. While on these medications M.D. suffered from lethargy, excessive drooling and neuroleptic malignant syndrome.

Unfortunately, despite ten plus years of these positive-only treatment procedures plus psychotropic medications at the Anderson School, M.D.'s self-injurious and aggressive behaviors eventually became so intense and unmanageable that he nor those around him were safe. The Anderson School requested another placement as they were no longer able to safely manage M.D. The Anderson School acknowledged its inability to manage M.D. in the following letters:

Anderson School

Reaching new heights in a tradition of caring for children and adults with special needs.

August 20th, 2004

Deborah Vertovez
CSE Chairperson
West Islip Public Schools
100 Sherman Avenue
West Islip, NY 11795

RE: Marc Doherty

Dear Ms. Vertovez:

As a follow up to our initial phone conversation on 07/19/04 (and subsequent phone conversations, emails and written correspondence regarding Marc Doherty) the Anderson School CSE is recommending that Marc be referred to an alternate placement. As I described to you on the phone and in email correspondence, Marc's behaviors of intense aggression, self injury and obsessive compulsion, which quickly escalate to aggression, have increased in intensity and duration. Over the past 4 to 6 weeks Marc's team has attempted various interventions including; modifying Marc's behavior plan, retraining staff, providing Marc with a 1:1 staff, psychiatric consultations to address medication adjustments, consulting with a psychologist, consultations with an expert in autism from the University of Rochester, changing Marc's classroom, hospital out patient psychiatric services and using PRN medications to address Marc's behaviors. Unfortunately we have not seen a change in Marc's overall behavioral status to date. Currently Anderson School does not have the support system to manage behaviors of such high intensity which have put Marc and staff at great risk. It is critical that an alternate placement be pursued with urgency so that Marc's behavioral needs are met, and the safety of others at Anderson School and students is assured.

During yesterday's phone conversation with you I was encouraged to hear that the West Islip school district CSE is already aggressively pursuing alternate placement options to ensure an appropriate placement for Marc is secured as soon as possible.

This notice is in keeping with the CRP 200.5 (a)(1) regulations' regarding the student's right of pendency to remain at the Anderson School. Upon receipt of this referral we will expect that within 60 days of the date of the referral the CSE will arrive at a recommendation for an alternate placement. Please be assured that the Anderson staff will work with your school district in ensuring compliance with these timelines in accordance with NYS 8CRR 200.4(d).

If you have any questions or need further assistance, please do not hesitate to call me at (845) 889 – 4034 ext. 556 or Kathleen Marshall (Director of Education) at ext. 533.

Sincerely,

Ashok Ramesh
IEP Coordinator

Another letter sent, seen below, to the district by Anderson School's Executive Director and CEO states " …I believe that we have reached a serious point where we can longer assure his safety, that of other children around him, and that includes staff."

Anderson School

Reaching new heights in a tradition of caring for children and adults with special needs.

August 20, 2004

Deborah Vertovez
CSE Chairperson
West Islip Public Schools
100 Sherman Avenue
West Islip, NY 11795

Re: Marc Doherty

Dear Ms. Vertovez:

This letter updates a letter you received from Ashok Ramesh yesterday. I know you are working very hard for alternate placement.

I have been intricately involved with Marc's case throughout the past two weeks working hard for short-term psychiatric intervention. Unfortunately, there is a bottleneck for beds in the system and no help seems to be within reach.

What prompts my letter is that Marc had another major uncontrollable episode last night whereby I had to authorize sending him to the Emergency Room by ambulance with police involvement using restraints. As hard as it is for us to reach this point with Marc, I believe that we have reached a serious point where we can no longer assure his safety, that of other children around him, and that includes staff. That makes this volatile situation an utmost urgent matter and, in that regard, we seek whatever can be done to facilitate an emergency placement into a more equipped residential school or other setting you deem appropriate.

I stand ready to use my full agency supports to assist you as you may wish. That being said, I ask that you treat this matter with the same sense of urgency I employ upon you through this letter. Patrick Paul, our Chief Operating Officer will be calling simultaneously to my sending this letter to offer his services and answer any questions.

Thank you for your anticipated understanding and assistance. Feel free to call upon me directly on my cell phone at (845) 546-5700.

I remain,

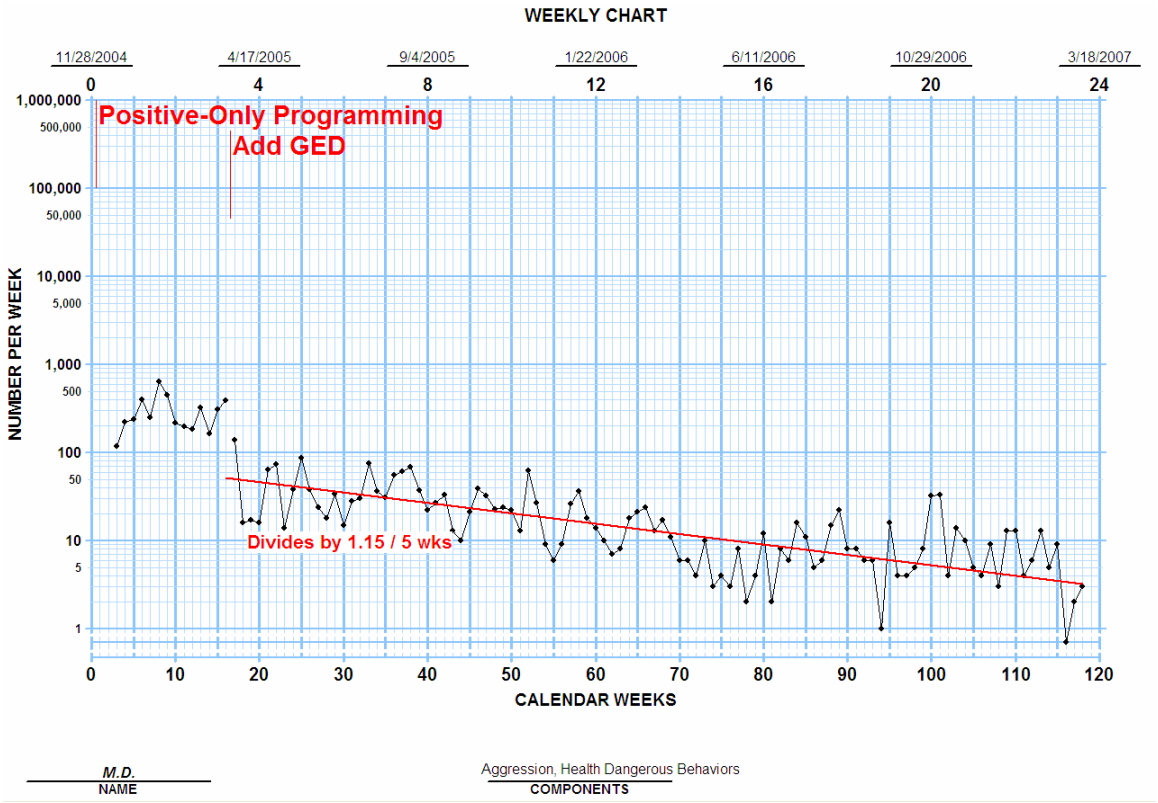
Sincerely yours,

Neil J. Pollack, M.H.S.A.
Executive Director/C.E.O.
Anderson School & The Anderson Education Foundation, Inc.
Phone: (845) 889-4034 x 203
Fax: (845) 889-3104
Serving Children & Adults With Autism
www.andersonschool.org

Every appropriate New York State placement turned M.D. down after reading his history. His information was sent to eighteen schools from Maine to Virginia. Only four of them called for interviews and he was rejected by all of them due to the intensity of his

aggression.

In August 2004, NY CBST referred M.D. to JRC. He was admitted in December 2004 and after going into a coma on the first day due to psychotropic medication overdose M.D. was removed from all of his medications. Positive-only programming was utilized for 2 weeks following his 8 day coma.



The chart shown above is a weekly graph in which each dot shows the total number of aggressive and self-abusive behaviors he showed each week. The chart shows that during the 2 weeks of positive-only treatment, M.D. showed approximately 239 aggressive and health dangerous problem behaviors per week. Once the GED was added to his program it resulted in an immediate decrease in these behaviors to a median of 16 per week.

The chart also shows that when the new NYSED regulations on aversives were adopted on June 23, 2006, M.D. began to display some regression. This is seen in the last 12 dots on the chart (the 12 weeks immediately subsequent to the change in the NYSED regulations on aversives). This occurred because JRC was, starting on that date, prevented from treating behaviors that were frequent antecedents to the self-abusive and aggressive actions.

M.D.'s parents described the changes in M.D., once the GED was added to his program as follows:

> "This school has saved my son's life. … [he now] receives about three GED applications a week. The Judge Rotenberg

> Center does not believe in psychotropic medication and M.D. is now medication free. His behavior and quality of life has improved tremendously, along with his health. He is starting to work on the computer and can work consistently on a regular basis..”

The following is a description by M.D.'s clinician, Dr. Christine Chiudina, at JRC of M.D’s current status:

> “The GED was started with M.D. in January 2005. Since that time, he has averaged a daily median of 1 GED application over the past 6 months, is completely off psychotropic medication and works daily on a computer doing his academic work. M.D. has made significant progress at JRC and spends his time now progressing socially and educationally. He is able to participate in field trips and attends all school activities.”

The following is letter which M.D.’s parent wrote in 2006 to some New York legislators, urging them to oppose a bill that would have banned the use of aversives with New York students:

> “April 2006:
>
> To Whom It May Concern:
>
> There is a positive place for aversive interventions and I feel more information is needed before any actions are taken. At this time, there are one hundred eleven scientific research articles that have been peer reviewed and published in scientific journals that establishes that the use of aversives, specifically, behavior skin shock, is effective treatment. Please don't let the recent media hype cloud your good judgment. It’s imperative that both sides of the story be told.
>
> I am the parent of an autistic child who is a student at The Judge Rotenberg Center (JRC) in Canton, Massachusetts. This school has saved my son's life. Prior to being enrolled at JRC, my son M.D. was on a variety of psychotropic drugs. This had been going on for nine years. My family and I struggled with M.D. while working with various professionals including psychologists/psychiatrists specializing in behavior modification techniques. M.D.’s self injurious behavior grew worse of the years. In 2003 M.D.’s behavior changed, though not for the better. In addition to his self destructive behavior, he had become increasingly aggressive. For a six month period M.D. was sending staff members to the hospital weekly. He would violently attack them, pulling their hair and choking them. His needs were so intense that he required a 1:1 paraprofessional. The doctors on staff at his school, The Anderson School for Autism, had altered his medication regime on several

occasions. This often included increasing/decreasing and starting/stopping multiple medications. At one time, M.D. was taking as many as twelve different medications. M.D.'s response to being medicated was far from positive. A good portion of the time he was lethargic with drool running down his face. Any energy M.D. did have was used during his violent outbursts. In December of 2004, M.D. was admitted to the hospital. He had become lethargic and disoriented. M.D. was diagnosed with Neuroleptic Malignant Syndrome (NMS), which was the direct result of being over medicated with Thorazine. M.D. remained in a coma for eight days and almost died.

The Anderson School for Autism requested that we find another placement as they were no longer able to safely manage M.D.. Every appropriate New York State placement had turned us down after reading M.D.'s history. His information was sent to eighteen schools from Maine to Virginia. Only four of them called us for interviews. We went to screen these schools, looking to see what they had to offer. After various interviews and meetings, three of the schools sent representatives to the Anderson School to observe M.D.. The administrators from one school in Delaware had told us they had never turned away an admission. After observing my son and talking to the Anderson School staff, we were told they could not afford the additional staff needed to serve M.D. and he was subsequently not accepted.

The use of aversives are a last resort, however, in extreme circumstances they can be a life saver. JRC has multiple safeguards in place to monitor the treatment of their students as well as their staff performance. My son now receives about three GED applications a week. The Judge Rotenberg Center does not believe in psychotropic medication and M.D. is now medication free. His behavior and quality of life has improved tremendously, along with his health. He is starting to work on the computer and can work consistently on a regular basis. M.D. is classically autistic with a full scale IQ of 41. He is non verbal and will most likely require residential placement for the rest of his life. He may need the use of the GED as well. Would you deny a diabetic their insulin? Why would you want to deny treatment to a thriving autistic child who has made so much progress?

I feel it is important to understand the treatment offered at JRC. If you would like to speak to me, I would love to tell you my story and the story of countless other parents in detail. I would be more than happy to send you any information regarding skin shock therapy (which is vastly different from the "shock therapy" depicted in the media and in movies). I'm certain it would give you a better understanding of the situation.

Thank you for your time.

RD & LD
West Islip, NY"

Kennedy Krieger Institute, Baltimore, MD

Difficult-to-Treat Students whom the Kennedy Krieger Institute Failed to Treat Effectively and Who Were Subsequently Referred to JRC

9. Student S.S

Summary: S.S. was treated in numerous facilities prior to a 3 month evaluation at the Kennedy Krieger Institute beginning December 1999. At Kennedy they developed special arm splints to be worn during the day, and a full bed restraint which fully immobilized him during the nightime. He was discharged back to Cumberland Hospital with a reported lower rate of self-injurious behavior but that was apparently due to his being mechanically prevented from exhibiting the behavior. Cumberland Hospital attempted to maintain the Kennedy Krieger program but even the first day back S.S. averaged 25 aggressive and self-injurious an hour. S.S. entered JRC in October 2000 and has made remarkable progress with the contingent skin shock supplementing a powerful positive program that includes a dense system of rewards. S.S. is now free of all restraint and medication and lives in a community based home. The rate of his self-injurious behavior currently averages only one per week and he now is a happy, smiling young man, free of any injuries.

S.S. was admitted to the Kennedy Krieger Institute on December 8, 1999. JRC's records contain no documentation from Kennedy Krieger and the following information was reported by Cumberland Hospital where S.S. was treated both before and after his stay at Kennedy Krieger. Upon S.S.'s placement at the Kennedy Krieger Institute, the frequency of S.S.'s self-abuse and aggression were very high. His self-abusive behaviors included scratching himself, rubbing his body parts together to cause injury, biting himself, pinching himself, and hitting/banging his head.

Due to his self-abuse, S.S. had numerous scars on his body and had required surgery on his left ear. Steven would become aggressive if staff prevented him from injuring himself. During his stay at Kennedy Krieger, the Institute implemented special arm restraints to be worn at all times and the use of a specialized restraint system (Hooper) to be worn at night. The special arm restraints consisted of a cloth sleeve with four pockets in which stays of varying degrees of flexibility could be inserted or removed. Reports indicated a decelerative effect in frequency and his sleeping pattern improved following the onset of these protective restraints.

In essence the Kennedy Krieger evaluation led to mechanical restraint for almost the entire day and immobilization at night. S.S.'s dangerous behaviors decreased because he had less opportunity to engage in these behaviors and he was prevented from even

moving in bed so he likely slept better. Even with all this mechanical restraint S.S. continued to engage in self-abusive and aggressive behavior. His mother reported that he came out worse than when he went in. His mother wrote that the case manager told him on the day of his discharge that “We have never met anyone like S.S. before, and hope we never do again.”

S.S. was discharged back to Cumberland Hospital in New Kent, Virginia on March 23, 2000 following his evaluation. According to the hospital’s behavior charts S.S. averaged over 25 aggressive and self-injurious behaviors an hour on his first day back. Clearly, the procedures that had been developed at Kennedy Krieger were not effective. Over the next 6 months his aggressive and self-injurious behaviors were quite variable and averaged 6.63 per hour despite using the restraint procedures developed at Kenney Krieger.

Cumberland Hospital added a contingent basket hold restraint following any aggressive or self-injurious behavior and the medications Droperidol and Cogentin. Droperidol is used in conjunction with anesthesia to reduce vomiting and nausea and also as an antipsychotic. (S.S. did receive these medications for a short while when he entered JRC and they quickly put him to sleep for hours).Despite the use of restraint, medications, one to one staffing and an enriched environment where S.S. had access to his preferred items, Cumberland Hospital staff were unable to significantly reduce his aggressive and self-injurious behavior and he was discharged by ambulance to the Judge Rotenberg Center (JRC) on October 12, 2000.

S.S. has made tremendous progress at JRC. Initially the arm splints use was continued but not the Hopper restraint at night. His medication continued for a short while and did nothing more than put him to sleep. Since JRC could not find anyone in the area that made liquid Droperidol for oral ingestion, and the fact that it made him unable to learn, it was discontinued. Initially S.S. did have high rates of dangerous behaviors. Besides the use of the arm splints he did require mechanical restraint including a four point chair. A soft karate helmet was also used to keep him from head banging and biting himself.

S.S. started on court approved GED in October 2000 because he had continued to cause severe damage to his face even with arm splints and a helmet. A lot of his self-injury occurred while he was in bed. S.S. would repeatedly rub his face and other body parts against his sheets with sufficient frequency and intensity to produce large open sores. Within one week of GED treatment JRC had successfully faded his helmet and began fading the stays out of splints. S.S. still had a few rough periods when the GED treatment program was halted and mechanical restraint was required to keep him safe.

Since starting on contingent skin shock S.S.’s maladaptive behaviors have continued to decelerate and he has flourish academically and socially. Currently S.S.’s health dangerous behaviors average only once per week as compared to hundreds a week prior to the use of the GED treatment. No restraint or medications are necessary and he participates in a full schedule of academics, habilitative skill development and vocational training. He is able to frequently access his community and enjoys frequent visits from his mother.

Higashi School, Randolph, MA and League School, MA

A Difficult-to-Treat Student whom the Higashi School and League School Failed to Treat Effectively and Who Was Subsequently Referred to JRC

10. Student B.C.

Summary: B.C was enrolled in several programs prior to coming to JRC. These program included the Kennedy-Donovan Center, New England Center for Children, the Higashi School, and the League School. All of these programs utilized positive-only treatment procedures, none of which were successful in decreasing B.C.'s dangerous behaviors to acceptable levels. When B.C. was admitted to JRC he was treated with JRC's positive-only program for over seven months until aversives were added to his program in October of 2003. Immediately after B.C.'s program was supplemented with Level III aversives his aggression and self-abuse showed a marked deceleration, a trend that has continued to date.

When B.C. was 5 years old he attended a day program at the Kennedy-Donovan Center School in Foxboro, Massachusetts. The program was a full-time, 12 month, day school program, which provided education, therapy and support for children with multiple developmental disabilities. B.C.'s mother reports that this placement was not appropriate for him as he was not physically challenged like the rest of the students. She indicated that he was out of control while there and frequently ran around the classroom nonstop. During a weekend respite stay at the Center, B.C. opened a bottle of liquid Melleril and drank the entire bottle. He ended up in the emergency room and on the pediatric unit for three days. B.C. was discharged from the Center after 1 year as he was not making any progress and his behaviors were increasing.

B.C was then admitted to the New England Center for Children (NECC) in Southborough, Massachusetts. NECC is described as a full range of educational, residential and treatment programs designed to help children with autism and other developmental disabilities reach their full potential. Their goal is to provide Applied Behavior Analysis when teaching children with autism, thereby increasing their abilities to function and communicate successfully with as much independence as possible. B.C.'s mother stated that he did not make any progress there. He was engaging in 70-80 aggressive and self-injurious behaviors per day. His most severe behaviors included biting himself and others, bolting from staff, pinching himself and others, and PICA. He was discharged after 1 year as he was not making progress and his behaviors were increasing.

B.C. then spent 7 years at the Boston Higashi School located in Randolph, Massachusetts. The Higashi School is based on a methodology of group dynamics which incorporates physical education, art, music, academics, the acquisition and development

of communication and daily living skills to promote social independence. The focus is to establish stability of emotions gained through the pursuit of independent living and the development of self-esteem. Extensive physical exercise is used to establish a rhythm of life. The school does not support or use aversives, punishment, medication, Applied Behavior Analysis or time-out procedures to change behavior. During this time, it is noted that B.C. made significant progress in learning daily living skills but his severe maladaptive behaviors impeded continuous growth in all other areas. He would often have tantrums involving violently aggressive outbursts and health dangerous behaviors such as frequently bolting from teachers and engaging in PICA. B.C. was unable to maintain his residency there due to the extended vacations the school provided in which the students went home to their parents. B.C.'s mother indicated that during these vacation periods she was unable to control him at home as he frequently engaged in severe dangerous behaviors. He would stay awake during the night hours and engage in PICA, ingesting household items such as motor oil, detergents, bleach, plants, lead paint, and deodorant. On one occasion, B.C. assaulted his brother while his bother was driving a moving vehicle. During this time B.C. also repeatedly chewed on the woodwork in his mother's house

Upon discharge from the Higashi School, B.C. was enrolled in the League School of Greater Boston, in Walpole, Massachusetts. He attended the day school program 216 days a year and resided at a group home in Sharon, Massachusetts. The League School employs a psycho-educational treatment approach in which teachers and staff focus attention on areas of a student's social, cognitive, emotional and behavioral development. Though B.C. had made some progress there, the frequency and intensity of his dangerous behaviors began to increase. He recurrently targeted younger children and females with intense aggression, often biting and scratching them. These outbursts were sometimes without antecedents and were premeditated, as he would wait for the staff or peer to turn their back to him. At other times, direct antecedents or situations likely to bring about behavioral outbursts included placing demands on him, telling him "no", and denying him a food item that he desired. While attending the League School, B.C. would be escorted to a secluded area subsequent to an aggressive or health dangerous episode and be prompted into a seated position. In this area he quite often would bite his hand or bang his head while moaning; several instances required additional staff support to contain him in the area while he attempted to assault the staff. If these episodes occurred while at the group home, B.C. would be escorted to an empty room and be left unattended. Once there, he often destroyed the blinds in the room, bit himself, and continually got out of his seat. Moreover, B.C. engaged in frequent disruptive and non-compliant behavior such as screaming, refusing to follow directions or physical prompts, disrobing, and masturbating in public. While at the League School B.C. was prescribed Risperdal, which was also unsuccessful in treating his behaviors.

Since B.C. was admitted to JRC in 2003 he has made a tremendous amount of progress. His mother has stated that "behavioral he has improved 100% and the PICA is completely gone." Below is B.C.'s behavioral chart which clearly depicts his great progress. When B.C. was admitted to JRC he was treated with Positive-only Programming for over seven months. During this time period there was no deceleration in

his behaviors and he was engaging in a median of 1,720 dangerous and disruptive behaviors per month. Once the GED was introduced B.C.'s dangerous and disruptive behaviors decreased significantly. Since the GED has been added to his behavioral program in conjunction with positive programming, B.C.'s has exhibited a median of 6 dangerous and disruptive behaviors per month. In addition, to behavioral improvements, B.C. has advanced academically and socially. He participates in community outings and field trips on a weekly basis.

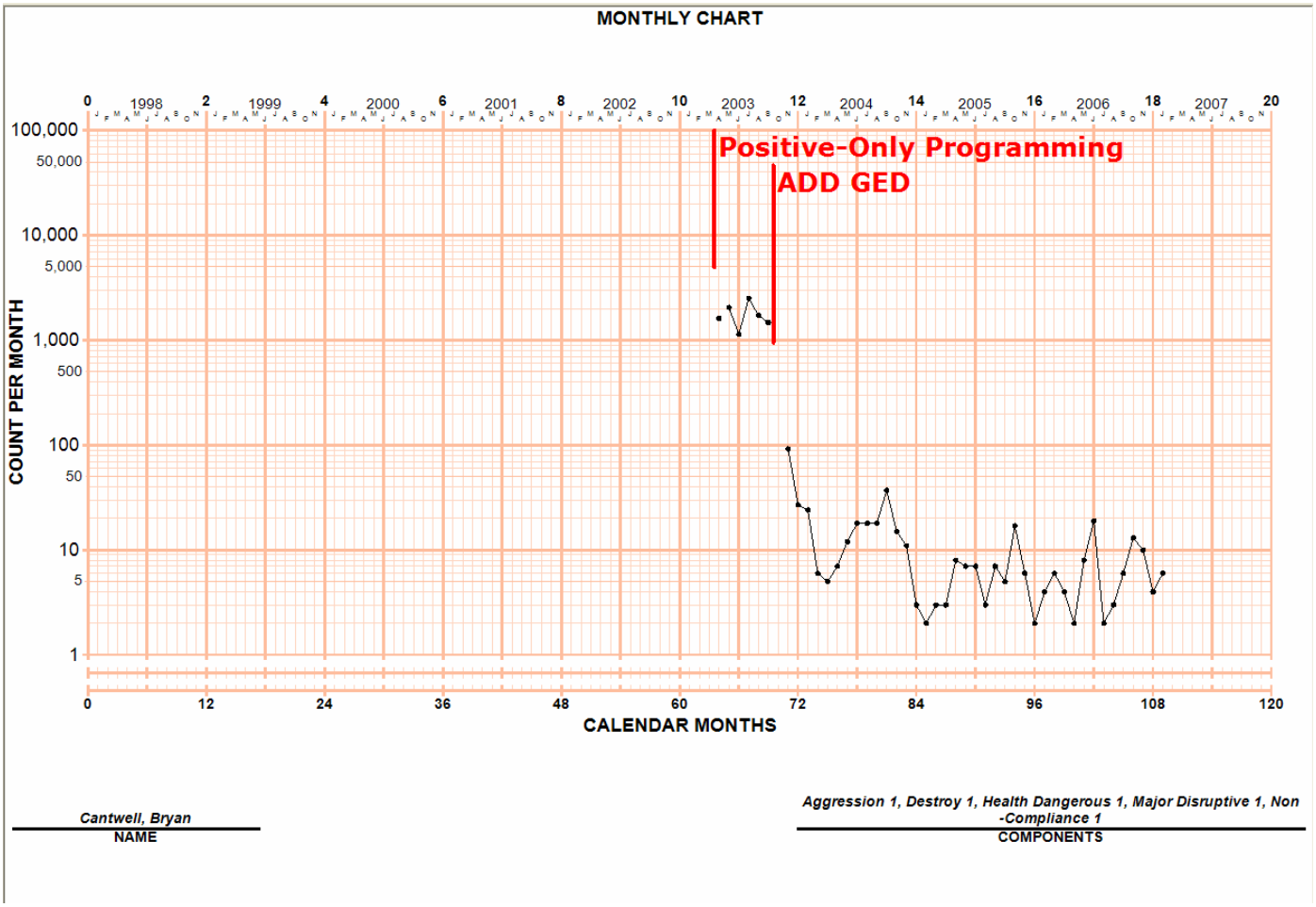


Exhibit 1.

Current JRC Students and their Former Positive-Only Residential Programs

Student No.	Prior Residential Placement	Number of Placements
1	Long Island Jewish Medical Center (Zucker Hillside Hospital) (NY)	3
	Queens Children's Psychiatric Center (NY) **2 admissions**	
2	Anderson School (NY)	1
3	Kings County Psychiatric Center (NY) **2 admissions**	3
	Woodhull Medical and Mental Health Center (NY)	
4	Franciscan Hospital for Children (Kennedy Hope Academy) (MA)	1
5	Bellevue Hospital (NY) **2 admissions**	5
	Queens Children's Psychiatric Center (NY)	
	Saint Vincent Catholic Medical Centers (NY)	
	Woods Services (PA)	
6	Children's Village (NY)	2
	Stony Lodge Hospital (NY)	
7	Anderson School (NY)	2
8	Devereux (CT)	4
	Dynamite Youth Center (NY)	
	Hospitality House (NY)	
	Orange County Jail (NY)	
9	Saint Vincent Catholic Medical Centers (NY)	1
10	New England Center for Children (MA)	1
11	Bronx Children's Psychiatric Hospital (NY)	1
12	Rose F. Kennedy Center for Developmental Disabilities (NY)	2
	Shield of David Institute (NY)	
13	Children's Own School (MA)	3
	Lakeside School (MA)	

	Tri-City Mental Health Center Summer Day Camp (MA)	
14	Barley School (PA)	3
	Princeton Child Development Institute (NJ)	
	Trenton Children's Hospital (NJ)	
15	Dominion Psychiatric Hospital (VA)	2
	KidsPeace (PA)	
16	Bronx Children's Psychiatric Hospital (NY)	1
17	Four Winds Hospital-Katonah (NY) **2 admissions**	2
18	Cumberland Hospital (VA)	2
	Snowden at Fredricksburg (VA)	
19	Champlain Valley Hospital (NY)	1
20	Astor Learning Center (NY)	9
	Four Winds Hospital-Katonah (NY)	
	KidsPeace (PA)	
	Leake & Watts (NY)	
	Mount Sinai Hospital (NY)	
	New York-Presbyterian Hospital (NY)	
	Rockland Children's Psychiatric Center (NY) **2 admissions**	
	Samuel Ittelson Day Treatment Center (NY)	
20	Holliswood Hospital (NY)	5
	Huntington Hospital (NY)	
	Kings County Psychiatric Center (NY)	
	Lake Grove School (NY)	
	South Beach Psychiatric Center (NY)	
21	Kings County Psychiatric Hospital (NY)	1
22	Community Medical Center (NJ)	1
23	Boston Higashi School (MA)	3
	League School (MA)	
	New England Center for Children (MA)	
24	Queen's Children's Psychiatric Center (NY)	1
25	Anderson School (NY)	1

26	May Institute (MA)	3
	South Shore Collaborative (Collaborative Mini School) (MA)	
	St. Elizabeth's Medical Center (MA)	
27	Psychiatric Institute of Washington (DC)	2
	Riverside Hospital (DC)	
28	Bournewood Hospital (MA)	12
	Cambridge Hospital (MA)	
	Charles River Hospital (MA) **2 admissions**	
	Charter Brookside (MA)	
	Early Learning Center (MA)	
	G. Stanley Hall School (MA)	
	Latham School (MA)	
	Providence Behavioral Health Hospital (MA)	
	Three Rivers (MA)	
	Westborough State Hospital (MA)	
	Westwood Lodge (MA)	
29	Bay State Medical Center (MA)	3
	Brightside ART (MA)	
	Eagleton School (MA)	
30	Devereux (PA)	2
	Elmhurst Hospital Center (NY)	
31	Braintree Mini-School (MA)	6
	Dally's Nursing School (MA)	
	Lakeside School (MA)	
	Protestant Guild for the Blind (MA)	
	South Shore Mental Health Center (MA)	
	Spear Educational Center (MA)	
32	Boston Children's Hospital (MA)	21
	Devereux (FL)	
	DYS Girls Secure Unit at Brockton Y (MA) **2 Admissions**	
	Franciscan Children's Hospital (MA) **4 Admissions**	
	Germaine Lawrence, Inc. (MA)	
	Gifford School (MA)	
	Hunt Center (MA)	
	Somerville Hospital (MA)	
	Taunton State Hospital (MA)	
	McLean Hospital (MA)	
	North Crossing Program (MA)	
	Carney Hospital (MA)	

	Westborough State Hospital (MA) **3 Admissions**	
	DYS Detention-Dorchester (MA)	
	Juvenile Detention-unspecified (FL)	
33	Four Winds Hospital-Katonah (NY)	3
	Woodhull Medical and Mental Health Center (NY)	
	Wright Hospital (NY)	
34	Butler Hospital (RI)	5
	Floating Hospital for Children-Pediatric Neurology (MA)	
	Franciscan Children's Hospital (MA)	
	Massachusetts General Hospital (MA)	
	New England Medical Center (MA)	
35	Bellevue Hospital (NY)	1
36	Benedictine Hospital (NY)	2
	Devereux (NY)	
37	Bellevue Hospital (NY)	2
	Queens Children's Psychiatric Center (NY)	
38	New England Center for Children (MA)	2
	Protestant Guild for Human Services, Inc. (MA)	
39	Mount Sinai Hospital (NY)	2
	Saint Vincent Catholic Medical Centers (NY)	
40	Brunswick Hospital-Brunswick Hall (NY)	12
	Elmhurst Hospital Center (NY)	
	Holliswood Hospital (NY)	
	Kings County Psychiatric Center (NY)	
	Long Island Jewish Medical Center (Zucker Hillside Hospital) (NY)	
	North Shore University Hospital (NY)	
	Queens Children's Psychiatric Center (NY)	
	Saint Christopher Ottile Family of Services (NY)	
	Saint Vincent Catholic Medical Centers (NY)	
	South Oaks Hospital (NY)	
	St. Mary's Hospital for Children (NY)	
	Woodhull Medical and Mental Health Center (NY)	
41	Benhaven (CT)	6
	Elizabeth O'Hara Walsh School (CT)	
	Ives School (CT)	

	Montanari School (FL)	
	Woods Services (PA)	
	Yale Child Study Center (CT)	
42	EL Bajo De Haina, Dominican Republic	4
	Private Boarding School in Dominican Republic	
	Westchester Medical Center (NY)	
	Yonkers Public Schools (NY)	
43	Holliswood Hospital (NY)	2
	Maryhaven Center of Hope (NY)	
44	Brandon School (MA)	4
	Carney Hospital (MA)	
	Harbor School (MA)	
	Saint Vincent's Home (MA)	
45	Baldpate Hospital (MA)	5
	League School (MA)	
	May Institute (MA)	
	New England Center for Children (MA)	
	Shore Educational Collaborative (MA)	
46	Anderson School (NY)	1
47	New York-Presbyterian Hospital (NY)	2
	Saint Christopher Ottile Family of Services (NY)	
48	Bridges Residential Treatment Center (VA)	19
	Commonwealth Center for Children and Adolescents (VA) **2 admissions**	
	Dominion Psychiatric Hospital (VA) **5 Admissions**	
	For Child's Sake (VA)	
	Grafton School (VA) **2 Admissions**	
	Loudon Youth Shelter (VA)	
	My Friend's Place Group Home (VA) **2 Admissions**	
	Respite Care	
	Virginia Home for Boys and Girls (VA) **2 Admissions**	
	Virginia Treatment Center for Children (VA) **2 Admissions**	
49	Arbour Hospital (MA) **4 Admissions**	39
	Bay Cove Human Service Agency Residential Program (MA)	
	Bournewood Hospital (MA)	
	Bridgewater State Jail (MA)	
	Dr. Solomon Carter Fuller Mental Health Center (DSCFMHC) (MA) **7 Admissions**	

	Eric Lindemann Mental Health Center (MA) **2 Admissions**	
	Kolburne School (MA)	
	Lakeview Neurobehavioral Center (NH)	
	Malden Hospital (MA)	
	Medfield State Hospital (MA) **7 Admissions**	
	Metro Residential Services (MA) **3 Admissions**	
	Metropolitan State Hospital-Gaebler Children's Center (MA) **2 Admissions**	
	North Shore Medical Center Salem Hospital (MA)	
	Residential Program (Not otherwise specified: pg 2)	
	Springside Manor Residential School (MA)	
	Suffolk County Jail (MA)	
	Taunton State Hospital (MA) **2 Admissions**	
	Westborough State Hospital (MA)	
	Winthrop Hospital (MA)	
50	Attleboro Center (MA)	8
	Brandon School (MA)	
	Mount Prospect (NH)	
	New Hampshire Youth Detention Services (NH)	
	New Hope (SC)	
	Pennsylvania Clinical Schools (PA)	
	Top East/Time Out Program	
	Westwood Lodge Hospital	
51	Cabaniss Residential Services (VA)	8
	Central State Hospital (VA)	
	Dejarnette Center (VA)	
	Dominion Psychiatric Hospital (VA)	
	Fairfax County Adult Detention Center (VA)	
	Southern Virginia Mental Health Institute (VA)	
	Wall Residences (VA)	
	Woods Services (PA)	
52	Saint Vincent Catholic Medical Centers (NY)	1
53	Riverhead Jail (NY)	3
	Sagamore Children's Psychiatric Center (NY)	
	Woodward School (NY)	
54	KidsPeace (PA)	1
55	Four Winds Hospital-Katonah (NY)	3
	Saint Vincent Catholic Medical Centers (NY)	
	Stony Lodge Hospital (NY)	

56	Miami Children's Hospital (FL)	1
57	Avalon School (MA)	6
	Dorchester Community Mental Health Center (MA)	
	Eric Lindemann Mental Health Center (MA)	
	Fine House (MA)	
	League School (MA)	
	New England Medical Center (MA)	
58	Crotched Mountain Rehabilitation Center (NH)	7
	Harbinger House (MA) Harbinger House (MA)	
	McLean Hospital (MA) **3 Admissions**	
	Wayside Youth & Family Support Network (MA)	
	Westwood Lodge (MA)	
59	Dominion Psychiatric Hospital (VA)	4
	For Child's Sake (VA) **3 Admissions**	
60	Devereux (NY)	2
	Long Island Jewish Medical Center (Zucker Hillside Hospital) (NY)	
61	Baldpate Hospital (MA)	3
	Hampstead Hospital (MA)	
	JRC Respite (MA)	
62	Holliswood Hospital (NY) **2 Admissions**	4
	Kings County Psychiatric Center (NY)	
	Rye Hospital Center (NY)	
63	Family Foundation School (NY)	3
	Hawthorne Cedar Knolls Treatment Center (NY)	
	St. Dominic's House (NY)	
64	Florida Institute of Neurological Rehabilitation, Inc. (FL)	3
	Suncoast New Options-Community Based Residential (FL)	
	Winter Haven Hospital (Mary Strang Children's Treatment Unit) (FL)	
65	Holliswood Hospital (NY)	1
66	Crotched Mountain Rehabilitation Center (NH)	1

67	Evergreen Center (MA)	6
	Franciscan Children's Hospital (MA) **2 Admissions**	
	Holyoke Hospital (MA)	
	Maplegate Program (MA)	
	Providence Behavioral Health Hospital (MA)	
68	Berkshire Meadows (MA)	4
	Lowell School (NY)	
	North Shore University Hospital (NY)	
	Summit School (NY)	
69	Bellevue Hospital (NY)	1
70	Day Top Out Care Residential (NY)	2
	St. John's Residence for Boys (NY)	
71	Barry Robinson Center (VA)	3
	Commonwealth Center for Children and Adolescents (VA)	
	Grafton School (VA)	
72	Bellevue Hospital (NY) **2 Admissions**	2
73	Alternatives (MA)	4
	Arbour Fuller Hospital (MA)	
	Fuller Memorial Hospital (MA) **2 Admissions**	
74	Center for Autistic Children (PA)	3
	Devereux (PA)	
	Pathway School (PA)	
75	Four Winds Hospital-Saratoga (NY)	1
76	Protestant Guild for Human Services, Inc. (MA)	1
77	Cornell Medical Center (NY)	3
	Devereux (PA)	
	Queens Children's Psychiatric Center (NY)	
78	Four Winds Hospital-Saratoga (NY)	3
	St. Coleman's Home (NY)	
	Vanderhyden Hall (NY)	
79	The Center for Developmental Disabilities, Inc. (NY)	1
80	South Oaks Hospital (NY)	1

81	Metropolitan Hospital Center (NY) **2 Admissions**	5
	Mount Sinai Hospital (NY)	
	Saint Vincent Catholic Medical Centers (NY) **2 Admissions**	
82	Rockland Children's Psychiatric Center (NY)	3
	Saint Vincent Catholic Medical Centers (NY)	
	Stony Lodge Hospital (NY)	
83	Bronx Children's Psychiatric Hospital (NY)	3
	Devereux (PA)	
	Westchester Medical Center (NY)	
		15
84	Arbour Fuller Hospital (MA)	
	Arbour Hospital (MA)	
	Boston Children's Hospital (MA)	
	Charles River Hospital (MA) **3 Admissions**	
	Dr. Solomon Carter Fuller Mental Health Center (DSCFMHC) (MA)	
	Harbinger House (MA)	
	Home for Little Wanderers Program (Taunton Intensive Residential Treatment Program) (MA)	
	Lighthouse School (MA)	
	Lowell Youth Treatment Center (MA)	
	Pembroke Hospital (MA)	
	Westborough State Hospital (MA) **2 Admissions**	
	Westwood Lodge (MA)	
85	Downstate Hospital (NY)	2
	Long Island Jewish Medical Center (Zucker Hillside Hospital) (NY)	
86	Lake Grove School (NY)	2
	McQuade Children's Services (NY)	
87	Devereux (MA)	3
	Protestant Guild for Human Services, Inc. (MA)	
	Somerville Hospital (MA)	
88	Kolburne School (MA)	3
	New England Center for Children (MA)	
	Taunton State Hospital (MA)	
89	Arbour Hospital (MA)	12
	Bridgewater State Jail (MA)	
	Brown and Sullivan (MA)	

	Danvers State Hospital (MA) **2 Admissions**	
	May Institute (MA)	
	McLean Hospital (MA)	
	Metropolitan State Hospital (MA)	
	Metropolitan State Hospital-Gaebler Children's Center (MA)	
	Spaulding Youth Center (NH)	
	Tewksbury Hospital (MA)	
	VinFen (MA)	
90	Fine House (MA) **2 Admissions**	5
	Somerville Hospital (MA)	
	Somerville Hospital (MA)	
	Westwood Lodge (MA)	
91	Devereux (PA)	3
	Hillcrest Educational Center (MA)	
	School for Contemporary Educ.(VA)	
92	Bayley Seton Hospital (NY)	7
	Saint Vincent Catholic Medical Centers (NY) **6 Admissions**	
93	Bellevue Hospital (NY)	7
	Children's Village (NY)	
	Elmhurst Hospital Center (NY)	
	New York-Presbyterian Hospital (NY)	
	Rockland Children's Psychiatric Center (NY)	
	Saint Vincent Catholic Medical Centers (NY)	
	Stony Lodge Hospital (NY)	
94	Brunswick Hospital-Brunswick Hall (NY)	2
	Long Island Jewish Medical Center (Schneider Children's Hospital) (NY)	
95	Bronx Lebanon Hospital Center (NY)	4
	New York- Presbyterian Hospital (NY)	
	St. John's Residence for Boys (NY)	
	The Children's Cottage (NY)	
96	Whiting Forensic Division of Connecticut Valley Hospital (CT) **2 Admissions**	10
	Bridgeport Community Mental Health Center (CT)	
	Silver Hills (CT)	
	St. Vincent's Hospital (CT)	
	Yale New Haven Hospital (CT)	
	Hallbrooke Hospital (CT)	
	Park City Hospital (CT)	

	Fairfield Hills Hospital (CT)	
	Yale Psychiatric Institute (CT)	
97	Evelyn Doughlin Center (NY)	2
	Saint Agatha Home Residential Treatment Center (NY)	
98	Dr. Franklin Perkins School (MA)	4
	McAuley Nazareth Home for Boys (MA)	
	New England Center for Children (MA)	
	University of Massachusetts Medical Center (MA)	
99	Lighthouse School (MA)	2
	New England Center for Children (MA)	
100	Sagamore Children's Psychiatric Center (NY)	1
101	A.J. Woods School (WY)	5
	Devereux (AZ)	
	Old Dominion University Exceptional Child Center (VA)	
	Onslow County Association for Retarded Citizens (NC)	
	Tidewater Association for Retarded Citizens (VA)	
102	Danville City Jail (VA)	4
	Hillsville Training Center (VA)	
	Southern Virginia Mental Health Institute (VA)	
	Wall Residences (VA)	
103	Franciscan Children's Hospital (MA) **2 Admissions**	3
	University of Nebraska Medical Center (NB)	
104	Berkshire Meadows (MA)	1
105	Four Winds Hospital-Katonah (NY)	3
	Rockland Children's Psychiatric Center (NY)	
	Stony Lodge Hospital (NY)	
106	Greenburgh North Castle (NY)	1
107	Copper Hills Youth Center (UT)	5
	Manatee Palms Youth Services (FL) **2 Admissions**	
	Pines Residential Treatment Center (VA)	
	Whisper Ridge Behavioral Health System (VA)	
108	AMIC (MA) **2 Admissions**	3
	Wrentham Developmental Center (MA)	

109	Carelton Street Residential (May Institute) (MA)	5
	Carelton Street Residential (Vinfen) (MA)	
	Coolidge Street (DMH residential) (MA)	
	Germaine Lawrence, Inc. (MA)	
	Tewksbury Hospital (MA)	
110	Boston Children's Hospital (MA)	4
	Devereux (MA)	
	Franciscan Hospital for Children (Kennedy Hope Academy) (MA)	
	Somerville Hospital (MA)	
111	Dr. Solomon Carter Fuller Mental Health Center (DSCFMHC) (MA)	4
	Little People School (MA)	
	New England Center for Children (MA)	
	William Ohrenberger Elementary School (MA)	
112	Long Island Jewish Medical Center (Schneider Children's Hospital) (NY)	2
	New York-Presbyterian Hospital (NY)	
113	Long Island Jewish Medical Center (Schneider Children's Hospital) (NY)	2
	Rosemary Kennedy School (NY)	
114	Greenburgh North Castle (NY)	5
	Holliswood Hospital (NY) **2 Admissions**	
	Kings County Psychiatric Center (NY)	
	Mount Sinai Hospital (NY)	
115	Brunswick Hospital-Brunswick Hall (NY)	2
	Metropolitan Hospital Center (NY)	
116	Jewish Board of Family & Children's Services-Mishkon (NY)	3
	Unknown-Romania	
	Unknown-Israel	
117	Bancroft NeuroHealth (NJ)	2
	Delaware Autism Program (DE)	
118	Herbert Birch School (NY)	1
119	Margaret Chapman School (NY)	1

120	Piedmont Behavioral Health Center (VA)	3
	Riverside Hospital (DC)	
	Whisper Ridge Behavioral Health System (VA)	
121	Belmont Comprehensive Center (PA)	3
	Easter Seals (NH)	
	Pathway School (PA)	
122	Devereux (PA)	1
123	Cupertino School (CA)	6
	Devereux (PA)	
	Dysfunctioning Child Center/Dame Evelyn Fox School/Step School (England)	
	Esperanza School (IL)	
	Kennedy Krieger Institute (MD)	
	Michael Reese Hospital and Medical Center (IL)	
	St. John's Child Development Center (DC)	
124	May Institute (MA)	1
125	Bellevue Hospital (NY)	1
126	Ancora Psychiatric Center (NJ)	11
	Bancroft NeuroHealth (NJ)	
	Central State Psychiatric Hospital (WI)	
	Eastern State Psychiatric Hospital (WI)	
	Georgia Regional Hospital (GA)	
	Grafton Hospital, Winnipeg Institute (WI)	
	Little Red School House (VA)	
	Pegotta Institute (WI)	
	Southern Wisconsin Center for the Developmentally Disabled (WI)	
	Underwood Memorial Hospital (NJ)	
	Winnebago Mental Health Institute (WI)	
127	Saint Vincent Catholic Medical Centers (NY)	1
127	Leake & Watts (NY)	3
	Stony Lodge Hospital (NY)	
	University Behavioral Associates (NY)	
129	Mount Sinai Hospital (NY)	1
130	Ashford Group Home (NY)	4
	Bellevue Hospital (NY)	

	Devereux (PA)	
	Mission of the Immaculate Virgin Mount Loretto (NY)	
131	May Institute (MA)	2
	New Boston Middle School (MA)	
132	Horsham Clinic (PA)	1
133	Cornell Medical Center (NY)	1
134	Barbara Blum Residence (NY)	8
	Bridge Group Home (NY)	
	Episcopal Mission Group Home (NY)	
	Kings County Psychiatric Center (NY)	
	Saint Vincent Catholic Medical Centers (NY)	
	Stony Lodge Hospital (NY) **2 Admissions**	
	Westgate Psychiatric Hospital (NY)	
135	Arbour Fuller Hospital (MA) **2 Admissions**	4
	Jewish Memorial Hospital (MA)	
	JRC Respite (MA)	
136	Lemuel Shattuck Hospital (MA)	3
	Massachusetts General Hospital (MA)	
	Pembroke Hospital (MA)	
137	Somerville Hospital (MA)	1
138	Shield Institute (NY)	
139	Brookdale Hospital (NY)	3
	Leake & Watts (NY)	
	South Beach Psychiatric Center (NY)	
140	Sagamore Children's Psychiatric Center (NY)	2
	United Cerebral Palsy (NY)	
141	Bergen Pines (NJ)	4
	Forum School (NJ) **2 Admissions**	
	Mt. Carmel Guild Day Care Center (NJ)	
142	Four Winds Hospital-Katonah (NY) **2 Admissions**	2
143	Four Winds Hospital-Katonah (NY)	6
	Jacobi Hospital (NY)	

	New York-Presbyterian Hospital (NY) **2 Admissions**	
	North Central Bronx Hospital (NY)	
	Stony Lodge Hospital (NY)	
144	KidsPeace (PA)	2
	Saint Christopher Ottile Family of Services (NY)	
145	Rock Creek Academy (DC)	1
146	Anderson School (NY)	1
147	AMIC (MA)	4
	Fernald School (MA)	
	May Institute (MA)	
	Telesis Academy (MA)	
148	Melmark (PA)	1
149	Shield Institute (NY)	1
150	Barry Robinson Center (VA) **3 Admissions**	11
	Bon Secours Maryview Medical Center (Behavioral Medicine Center) (VA)	
	Coyner Springs Detention Center (VA)	
	Hope Haven Family Services (VA)	
	New Hope (SC)	
	Somerville Hospital (MA) **2 Admissions**	
	Virginia Beach Psychiatric Center (VA)	
	Whitney Academy (MA)	
151	Cumberland Hospital (VA) **2 Admissions**	4
	Grafton School (VA)	
	Kennedy Krieger Institute (MD)	
152	Riker's Island Correctional Facility (NY)	1
153	Bellevue Hospital (NY) **4 Admissions**	5
	Bronx Children's Psychiatric Center (NY)	
154	Metropolitan Hospital Center (NY)	2
	Mt. Sinai Hospital (NY)	
155	Clearview School (NY)	4
	Lenox Hill Hospital (NY)	
	May Institute (MA)	

	Thorndike Hall (NY)	
156	Efficacy Research Institute (MA)	3
	May Institute (MA)	
	Spear Educational Center (MA)	
157	League School (NY)	3
	Mount Sinai Hospital (NY) **2 Admissions**	
158	Greenshire School (VT)	3
	Leslie Cutler Guidance Nursery School (MA)	
	May Institute (MA)	
159	Alternative Solutions for Youth (Step-Down Residential) (DC)	4
	Devereux (GA)	
	Psychiatric Institute of Washington (DC) **2 Admissions**	
160	Devereux (PA)	4
	Kings County Psychiatric Center (NY) **2 Admissions**	
	League School (NY)	
161	AuClair Treatment Center (DE)	3
	Cumberland Hospital (VA)	
	Virginia Treatment Center for Children (VA)	
162	Elmhurst Hospital Center (NY) **2 Admissions**	6
	Holliswood Hospital (NY)	
	Queens Children's Psychiatric Center (NY) **3 Admissions**	
163	Devereux (MA)	2
	Westfield Public Schools (MA)	
164	Bancroft NeuroHealth (NJ)	2
	Margaret Chapman School (NY)	
165	Andrus Dyckman Memorial Center (NY)	2
	Summitt School (NY)	
166	Cobb Memorial School (NY)	2
	The Center for Discovery (NY)	
167	Metropolitan Hospital Center (NY)	3
	Mount Sinai Hospital (NY)	
	New York-Presbyterian Hospital (NY)	

168	Avalon School (MA)	6
	Beverly School for the Deaf (MA)	
	Bradley Hospital (RI)	
	Faircrest School (WA)	
	Nebraska School for the Deaf (NB)	
	New Bedford School for Retarded Children (MA)	
169	Brooklyn Temple Seventh Day Adventist (NY)	4
	Miracle Meadows (WV) **2 Admissions**	
	Shenandoah Valley Christian Academy (VA)	
170	Children's Medical Center (DC)	3
	Riverside Hospital (DC)	
	Rock Creek Academy (DC)	
171	Monmouth County Day Training Center (NJ)	3
	New Jersey Regional Day School at Jackson (NJ)	
	United Cerebral Palsy Association of Middlesex County (NJ)	
172	Mount Sinai Hospital (NY)	2
	Saint Vincent Catholic Medical Centers (NY)	
173	Devereux (FL)	4
	Foundations School (VA)	
	Hallmark Youthcare (VA)	
	Riverside Hospital (DC)	
174	Mount Pleasant Cottage School (NY)	2
	New York Institute for Special Education (NY)	
175	Juvenile Detention-unspecified (NY)	1
176	Kolburne School (MA)	1
177	Alexandria Mental Health Center (VA)	4
	Commonwealth Center for Children and Adolescents (VA)	
	Graydon Manor (VA)	
	Leahy Center (VA)	
	Stetson School (MA)	
178	Elmhurst Hospital Center (NY) **3 Admissions**	3
179	Anderson School (NY)	1
180	Four Winds Hospital-Katonah (NY)	3

	Jewish Board of Family & Children's Services (NY)	
	Saint Vincent Catholic Medical Centers (NY)	
181	Avalon School (MA)	4
	Devereux (MA)	
	Metropolitan State Hospital (MA)	
	Metropolitan State Hospital-Gaebler Children's Center (MA)	
182	Bancroft NeuroHealth (NJ)	4
	Heartspring (KS)	
	TERI (Training Education Research Institute) (CA)	
	University of California at Los Angeles Hospital (CA)	
183	Anderson School (NY)	3
	Rose F. Kennedy Center for Developmental Disabilities (NY)	
	Shield Institute (NY)	
184	Samuel Field School (NY)	2
	Shield Institute (NY)	
185	Boston Children's Hospital (MA)	13
	Brattleboro Retreat (VT)	
	Dr. Solomon Carter Fuller Mental Health Center (DSCFMHC) (MA)	
	Germaine Lawrence, Inc. (MA)	
	Gorham Street High Intensity Residence (MA)	
	HRI (Human Resource Institute) (MA)	
	Lowell General Hospital (MA)	
	McLean Hospital (MA) **2 Admissions**	
	Metropolitan State Hospital-Gaebler Children's Center (MA)	
	North Shore Medical Center Salem Hospital (MA)	
	Tewksbury Hospital (MA) **2 Admissions**	
186	Cardinal Cushing School and Training Center (MA)	1
187	Elmhurst Hospital Center (NY) **2 Admissions**	2
188	Crestwood Hospital (NY)	3
	Holliswood Hospital (NY)	
	Riker's Island Correctional Facility (NY)	
189	KidsPeace (PA)	1
190	Bronx Children's Psychiatric Center (NY)	2
	Holliswood Hospital (NY)	

191	Bellevue Hospital (NY)	5
	Children's Village (NY)	
	Queens Children's Psychiatric Center (NY)	
	Saint Christopher Ottile Family of Services (NY)	
	Shield Institute (NY)	
192	Holliswood Hospital (NY)	1
	Mean Number of Prior Positive-Only Placements per Student	3.59375

Exhibit 2.

Positive-Only Residential Programs and the Number of Current JRC Students who Attended Each Prior to Entering JRC

Prior Placement	Location	Number of students placed here prior to attending JRC
Saint Vincent Catholic Medical Centers (NY)	NY	14
Bellevue Hospital (NY)	NY	10
Holliswood Hospital (NY)	NY	10
May Institute (MA)	MA	10
New England Center for Children (MA)	MA	10
Devereux (PA)	PA	9
Mount Sinai Hospital (NY)	NY	9
Four Winds Hospital-Katonah	NY	8
Kings County Psychiatric Center	NY	8
Queens Children's Psychiatric Center	NY	8
Stony Lodge Hospital	NY	8
Anderson School	NY	7
Long Island Jewish Medical Center (Schneider Children's and Zucker Hillside Hospitals)	NY	7
New York- Presbyterian Hospital	NY	7
Somerville Hospital	MA	7
Elmhurst Hospital Center	NY	6
Bronx Children's Psychiatric Hospital	NY	5
KidsPeace	PA	5
Shield Institute	NY	5
Westwood Lodge	MA	5
Arbour Fuller Hospital	MA	4
Bancroft NeuroHealth	NJ	4
Boston Children's Hospital	MA	4
Devereux (MA)	MA	4
Dominion Psychiatric Hospital	VA	4
Dr. Solomon Carter Fuller Mental Health Center (DSCFMHC)	MA	4
Franciscan Children's Hospital	MA	4

McLean Hospital	MA	4
Metropolitan Hospital Center	NY	4
Metropolitan State Hospital-Gaebler Children's Center	MA	4
Riverside Hospital	DC	4
Rockland Children's Psychiatric Center	NY	4
Saint Christopher Ottile Family of Services	NY	4
Westborough State Hospital	MA	4
Arbour Hospital	MA	3
Avalon School	MA	3
Brunswick Hospital-Brunswick Hall	NY	3
Children's Village	NY	3
Commonwealth Center for Children and Adolescents	VA	3
Cumberland Hospital	VA	3
Germaine Lawrence, Inc.	MA	3
Grafton School	VA	3
Kolburne School	MA	3
League School	MA	3
Leake & Watts	NY	3
Protestant Guild for Human Services, Inc.	MA	3
Sagamore Children's Psychiatric Center	NY	3
Taunton State Hospital	MA	3
Tewksbury Hospital	MA	3
Woodhull Medical and Mental Health Center	NY	3
Woods Services	PA	3
AMIC	MA	2
Baldpate Hospital	MA	2
Barry Robinson Center	VA	2
Berkshire Meadows	MA	2
Bournewood Hospital	MA	2
Brandon School	MA	2
Bridgewater State Jail	MA	2
Carney Hospital	MA	2
Charles River Hospital	MA	2
Cornell Medical Center	NY	2
Crotched Mountain Rehabilitation Center	NH	2
Devereux	FL	2
Devereux	NY	2
Eric Lindemann Mental Health Center	MA	2
Fine House	MA	2
For Child's Sake	VA	2
Four Winds Hospital-Saratoga	NY	2
Franciscan Hospital for Children (Kennedy Hope Academy)	MA	2

Greenburgh North Castle	NY	2
Harbinger House	MA	2
JRC Respite	MA	2
Kennedy Krieger Institute	MD	2
Lake Grove School	NY	2
Lakeside School	MA	2
League School	NY	2
Lighthouse School	MA	2
Margaret Chapman School	NY	2
Massachusetts General Hospital	MA	2
Metropolitan State Hospital	MA	2
New England Medical Center	MA	2
New Hope	SC	2
North Shore Medical Center Salem Hospital	MA	2
North Shore University Hospital	NY	2
Pathway School	PA	2
Pembroke Hospital	MA	2
Providence Behavioral Health Hospital	MA	2
Psychiatric Institute of Washington	DC	2
Riker's Island Correctional Facility	NY	2
Rock Creek Academy	DC	2
Rose F. Kennedy Center for Developmental Disabilities	NY	2
South Beach Psychiatric Center	NY	2
South Oaks Hospital	NY	2
St. John's Residence for Boys	NY	2
Southern Virginia Mental Health Institute	VA	2
Summit School	NY	2
VinFen	MA	2
Virginia Treatment Center for Children	VA	2
Wall Residences	VA	2
Westchester Medical Center	NY	2
Whisper Ridge Behavioral Health System	VA	2
A.J. Woods School	WY	1
Alexandria Mental Health Center	VA	1
Alternative Solutions for Youth (Step-Down Residential)	DC	1
Alternatives	MA	1
Ancora Psychiatric Center	NJ	1
Andrus Dyckman Memorial Center	NY	1
Ashford Group Home	NY	1
Astor Learning Center	NY	1
Attleboro Center	MA	1
AuClair Treatment Center	DE	1
Barbara Blum Residence	NY	1
Barley School	PA	1

Bay Cove Human Service Agency Residential Program	MA	1
Bay State Medical Center	MA	1
Bayley Seton Hospital	NY	1
Belmont Comprehensive Center	PA	1
Benedictine Hospital	NY	1
Benhaven	CT	1
Bergen Pines	NJ	1
Beverly School for the Deaf	MA	1
Bon Secours Maryview Medical Center (Behavioral Medicine Center)	VA	1
Boston Higashi School	MA	1
Bradley Hospital	RI	1
Braintree Mini-School	MA	1
Brattleboro Retreat	VT	1
Bridge Group Home	NY	1
Bridgeport Community Mental Health Center	CT	1
Bridges Residential Treatment Center	VA	1
Brightside ART	MA	1
Bronx Lebanon Hospital Center	NY	1
Brookdale Hospital	NY	1
Brooklyn Temple Seventh Day Adventist	NY	1
Brown and Sullivan	MA	1
Butler Hospital	RI	1
Cabaniss Residential Services	VA	1
Cambridge Hospital	MA	1
Cardinal Cushing School and Training Center	MA	1
Center for Autistic Children	PA	1
Central State Hospital	VA	1
Central State Psychiatric Hospital	WI	1
Champlain Valley Hospital	NY	1
Charter Brookside	MA	1
Children's Medical Center	DC	1
Children's Own School	MA	1
Clearview School	NY	1
Cobb Memorial School	NY	1
Community Medical Center	NJ	1
Coolidge Street (DMH residential)	MA	1
Copper Hills Youth Center	UT	1
Coyner Springs Detention Center	VA	1
Crestwood Hospital	NY	1
Cupertino School	CA	1
Dally's Nursing School	MA	1
Danvers State Hospital	MA	1
Danville City Jail	VA	1
Day Top Out Care Residential	NY	1

Dejarnette Center	VA	1
Delaware Autism Program	DE	1
Delaware County Jail	NY	1
Devereux (AZ)	AZ	1
Devereux (CT)	CT	1
Devereux (GA)	GA	1
Dorchester Community Mental Health Center	MA	1
Downstate Hospital	NY	1
Dr. Franklin Perkins School	MA	1
Dynamite Youth Center	NY	1
DYS Detention-Dorchester	MA	1
DYS Girls Secure Unit at Brockton Y	MA	1
Dysfunctioning Child Center/Dame Evelyn Fox School/Step School (England)	England	1
Eagleton School	MA	1
Early Learning Center	MA	1
Easter Seals	NH	1
Eastern State Psychiatric Hospital	WI	1
Efficacy Research Institute	MA	1
EL Bajo De Haina, Dominican Republic	Dominican Republic	1
Elizabeth O'Hara Walsh School	CT	1
Episcopal Mission Group Home	NY	1
Esperanza School	IL	1
Evelyn Doughlin Center	NY	1
Evergreen Center	MA	1
Faircrest School	WA	1
Fairfax County Adult Detention Center	VA	1
Fairfield Hills Hospital	CT	1
Family Foundation School	NY	1
Fernald School	MA	1
Floating Hospital for Children-Pediatric Neurology	MA	1
Florida Institute of Neurological Rehabilitation, Inc.	FL	1
Forum School	NJ	1
Foundations School	VA	1
Fuller Memorial Hospital	MA	1
G. Stanley Hall School	MA	1
Georgia Regional Hospital	GA	1
Gifford School	MA	1
Gorham Street High Intensity Residence	MA	1
Grafton Hospital, Winnipeg Institute	WI	1
Graydon Manor	VA	1
Greenshire School	VT	1
Hallbrooke Hospital	CT	1
Hallmark Youthcare	VA	1
Hampstead Hospital	MA	1

Harbor School	MA	1
Hawthorne Cedar Knolls Treatment Center	NY	1
Heartspring	KS	1
Herbert Birch School	NY	1
Hillcrest Educational Center	MA	1
Hillsville Training Center	VA	1
Holyoke Hospital	MA	1
Home for Little Wanderers Program (Taunton Intensive Residential Treatment Program)	MA	1
Hope Haven Family Services	VA	1
Horsham Clinic	PA	1
Hospitality House	NY	1
HRI (Human Resource Institute)	MA	1
Hunt Center	MA	1
Huntington Hospital	NY	1
Ives School	CT	1
Jacobi Hospital	NY	1
Jewish Board of Family & Children's Services	NY	1
Jewish Board of Family & Children's Services-Mishkon	NY	1
Jewish Memorial Hospital	MA	1
Juvenile Detention-unspecified	FL	1
Juvenile Detention-unspecified	NY	1
Lakeview Neurobehavioral Center	NH	1
Latham School	MA	1
Leahy Center	VA	1
Lemuel Shattuck Hospital	MA	1
Lenox Hill Hospital	NY	1
Little People School	MA	1
Little Red School House	VA	1
Loudon Youth Shelter	VA	1
Lowell Youth Treatment Center	MA	1
Lowell General Hospital	MA	1
Lowell School	NY	1
Malden Hospital	MA	1
Manatee Palms Youth Services	FL	1
Maplegate Program	MA	1
Maryhaven Center of Hope	NY	1
McAuley Nazareth Home for Boys	MA	1
McQuade Children's Services	NY	1
Medfield State Hospital	MA	1
Melmark	PA	1
Metro Residential Services	MA	1
Miami Children's Hospital	FL	1
Michael Reese Hospital and Medical Center	IL	1
Miracle Meadows	WV	1

Mission of the Immaculate Virgin Mount Loretto	NY	1
Monmouth County Day Training Center	NJ	1
Montanari School	FL	1
Mount Pleasant Cottage School	NY	1
Mount Prospect	NH	1
My Friend's Place Group Home	VA	1
Nebraska School for the Deaf	NB	1
New Bedford School for Retarded Children	MA	1
New Hampshire Youth Detention Services	NH	1
New York Institute for Special Education	NY	1
North Central Bronx Hospital	NY	1
North Crossing Program	MA	1
Old Dominion University Exceptional Child Center	VA	1
Onslow County Association for Retarded Citizens	NC	1
Orange County Jail	NY	1
Park City Hospital	CT	1
Pegotta Institute	WI	1
Pennsylvania Clinical Schools	PA	1
Piedmont Behavioral Health Center	VA	1
Pines Residential Treatment Center	VA	1
Princeton Child Development Institute	NJ	1
Private Boarding School in Dominican Republic	Dominican Republic	1
Protestant Guild for the Blind (MA)	MA	1
Residential Program (Not otherwise specified: pg 2)	MA	1
Respite Care	VA	1
Riverhead Jail	NY	1
Rosemary Kennedy School	NY	1
Rye Hospital Center	NY	1
Saint Agatha Home Residential Treatment Center	NY	1
Saint Vincent's Home	MA	1
Samuel Field School	NY	1
Samuel Ittelson Day Treatment Center	NY	1
School for Contemporary Education	VA	1
Shenandoah Valley Christian Academy	VA	1
Shield of David Institute	NY	1
Shore Educational Collaborative	MA	1
Silver Hills	CT	1
Snowden at Fredricksburg	VA	1
South Shore Collaborative (Collaborative Mini School)	MA	1
Southern Wisconsin Center for the Developmentally Disabled	WI	1
Spaulding Youth Center	NH	1
Springside Manor Residential School	MA	1
St. Coleman's Home	NY	1
St. Dominic's House	NY	1

St. Elizabeth's Medical Center	MA	1
St. John's Child Development Center	DC	1
St. Mary's Hospital for Children	NY	1
St. Vincent's Hospital	CT	1
Stetson School	MA	1
Suffolk County Jail	MA	1
Suncoast New Options-Community Based Residential	FL	1
Telesis Academy	MA	1
TERI (Training Education Research Institute)	CA	1
The Center for Developmental Disabilities, Inc.	NY	1
The Center for Discovery	NY	1
The Children's Cottage	NY	1
Thorndike Hall	NY	1
Three Rivers	MA	1
Tidewater Association for Retarded Citizens	VA	1
Top East/Time Out Program	MA	1
Trenton Children's Hospital	NJ	1
Tri-City Mental Health Center Summer Day Camp	MA	1
Underwood Memorial Hospital	NJ	1
United Cerebral Palsy	NY	1
United Cerebral Palsy Association of Middlesex County	NJ	1
University Behavioral Associates	NY	1
University of California at Los Angeles Hospital	CA	1
University of Massachusetts Medical Center	MA	1
University of Nebraska Medical Center	NB	1
Unknown-Israel	Israel	1
Unknown-Romania	Romania	1
Vanderhyden Hall	NY	1
Virginia Beach Psychiatric Center	VA	1
Virginia Home for Boys and Girls	VA	1
Wayside Youth & Family Support Network	MA	1
Westgate Psychiatric Hospital	NY	1
Whiting Forensic Division of Connecticut Valley Hospital	CT	1
Whitney Academy	MA	1
William Ohrenberger Elementary School	MA	1
Winnebago Mental Health Institute	WI	1
Winter Haven Hospital (Mary Strang Children's Treatment Unit)	FL	1
Winthrop Hospital	MA	1
Woodward School	NY	1
Wrentham Developmental Center	MA	1
Wright Hospital	NY	1
Yale Child Study Center	CT	1
Yale New Haven Hospital	CT	1
Yale Psychiatric Institute	CT	1