JRC RESPONSES TO ALLEGATIONS IN NYSED JUNE 9, 2006 REPORT

General Comments

JRC has been an NYSED approved special education school since the 1970's. Starting in the '70's and continuing through today, JRC has successfully educated and treated the most dangerous and difficult to treat school-aged students from the state of New York. JRC receives referrals of students from local New York school districts and on occasion directly from NYSED. As recently as May of last year, JRC received an urgent request from NYSED to accept a severely disabled nine year old child with a heart condition who was also extremely self-abusive and had been resistant to all forms of treatment. This child was receiving no education and causing life-threatening injuries to himself despite receiving heavy dosages of anti-psychotic and other potent medications. Not one program in New York would accept him and the program where he was enrolled demanded that he be discharged immediately. Roland Smiley, Associate with the VESID Central Office Administrative Services Support Team at NYSED, made a personal request to JRC in May 2005 that it accept this child and provide him with JRC's intensive behavioral treatment, including supplemental aversives. JRC accepted this child, provided him with intensive behavioral treatment, including JRC's skin shock device as a supplemental aversive, and succeeded in eliminating his dangerous and other problematic behavior. He is now free from self-abuse, drug-free, and receiving at JRC, for the first time in his life, a free and appropriate education as mandated by federal law. This and a host of other similar success stories contributed to JRC receiving from NYSED on November 17, 2005 an excellent evaluation after a team of NYSED special education officials visited JRC in September of 2005 to conduct one of NYSED's periodic reviews of the entire JRC program.

However, sometime between the time of the November 17, 2005 report and March 2006, and without warning or even a discussion with JRC or the over 250 JRC parents, NYSED officials decided to try to ban the use of aversives and remove JRC from its list of approved schools. This act by NYSED was most likely a response to a well publicized but frivolous complaint by one New York parent. After making her frivolous claims public, this parent left her child at JRC for two months, never visited him, but sent every manner of print and television media to publicize and exploit him as part of an effort to promote her lawsuit for money damages against her local New York school district, NYSED and JRC. This child had done very well at JRC but his mother and his lawyer sacrificed his progress as well as his privacy for the sake of seeking money damages.

It remains a mystery to JRC and the parents of the over 150 students from NY attending JRC, as to why NYSED responded this way rather than at least consulting with JRC and the Parents and defending the treatment program that has provided excellent care and treatment to New York students for over thirty years. To date, NYSED has refused all of JRC's and the JRC parents' many requests to meet and resolve NYSED's concerns. NYSED's June 9, 2006 negative report about JRC is completely false. It was created by

NYSED to support its newly stated position on aversives and to refute NYSED's own laudatory review of JRC conducted in September, 2005. NYSED's only legitimate and thorough evaluation of JRC dated November 17, 2005 found that JRC was meeting all of the special education requirements for the New York students and also found that JRC was meeting all of NYSED's health and safety requirements. This favorable report on JRC is now an embarrassment to NYSED because it was so positive with respect to JRC. What was needed, if aversives were to be banned, and if JRC was to be removed from the list of approved schools, was a new report that was as negative as possible.

NYSED sent a team of reviewers to JRC in April and May 2006, for parts of only five days, and a new report on JRC was issued on June 9, 2006 (the "June Report"). The following facts demonstrate that neither the site visits of April and May, 2006, nor the June Report, were done in a good faith effort to present an accurate appraisal of the JRC program. They are these:

- The NYSED officials brought in three psychologists, none of whom have had any experience in the use of aversives, and none of whom supported their use. Two of the three psychologists have been active participants in the anti-aversives, pro-"Positive Behavior Support" philosophy. The third supports approaches to the care of the developmentally disabled that are antithetical to the use of aversives.
- NYSED officials were reluctant to tell JRC what officials were coming to visit. One of the three psychologists was incorrectly represented to JRC to be a Regional Associate, thus hiding the fact that she was a psychologist.
- During the April and May visits, the NYSED visitors refused several offers by JRC staff to give them a guided tour and explanation of the JRC program—something that is essential if one is to understand any program designed to treat dangerous and life-threatening behavior disorders. NYSED visitors also refused JRC's many offers to provide a group of Department heads to explain the JRC program and answer any questions the visitors might have.
- It is impossible to develop a clear understanding of what the JRC program entails without open communication between the reviewers and JRC administration and staff. JRC is licensed and approved by a host of state agencies that constantly conduct annual and biannual reviews of the JRC program. JRC staff has never witnessed a state evaluation of the JRC program where the reviewers refused to hear any explanation of the program. These reviewers clearly left JRC with no understanding of how the program works, with no understanding of the disorders and the treatment histories of the NY students that JRC serves, and no understanding of the unprecedented treatment success that JRC has been able to achieve with the most difficult to treat population in the nation. Their lack of understanding was magnified by the fact that none of these reviewers had experience with aversive treatment.

- During the April and May 2006 visits, NYSED visitors also refused to watch a brief film that depicts the dramatic progress that a number of JRC students have made with the benefit of supplemental aversives.
- They did not ask JRC for information about the procedures that they eventually criticized in their report. During their visit they did not suggest that JRC should make some change in its procedures. One member of the Review Team complimented Dr. Israel on the fact that the JRC staff treated the students with so much respect.
- NYSED had no real communication with JRC during the April and May, 2006 visits and at other times between November 2005 and the time of this report. As a result NYSED made some major mistakes in this June Report. Two examples were: (1) the assertion that JRC was not in compliance with FDA regulations; and (2) the assertion that JRC was not in compliance with the federal school lunch and school breakfast regulations.
- When the report was complete, NYSED released the June Report to the press and to the New York Board of Regents before JRC had had any chance to respond to it.
- Based on observations made by their review teams during their April and May visits, NYSED then sent complaints to a variety of state and federal agencies, apparently seeking to have those agencies take adverse action with respect to JRC, again without notifying or discussing the issues with JRC. The agencies included the Massachusetts Probate Court, the Food and Drug Administration, the Federal School Lunch Program, the Massachusetts Department of Education and the Massachusetts Department of Early Education and Care.

It is also clear that the authors of the June Report began with an anti-aversives bias and they wrote the June Report in a manner designed to try to prove their pre-existing biases against JRC. These biases included the following:

- The authors were opposed to the use of aversives and supported the anti-aversives position called “Positive Behavior Support.”
- The authors also appear to be uncomfortable with a highly consistent behavioral program in which every possible event and activity is used as a reward for desired behavior. For example, at JRC opportunities to socialize with other students are used as rewards. The visiting team found this offensive.

Some additional points that the reader of the June Report should consider are these:

- None of the authors appear to have had any experience in working with students whose behaviors were as difficult-to-treat or as severe as those at JRC.
- Nowhere in the June Report is there any mention or appreciation of some of the major accomplishments of JRC, such as the fact that our program is demonstrably

effective in producing rapid and effective changes in the behaviors of our students and dramatic growth in their academic and social skills.

- Nowhere is there any recognition that our behavioral treatment environment, however different it may be from that of other schools, has helped children to turn their lives around in positive directions.

- Nowhere is it mentioned that we have enabled youngsters to be taken off of the heavy doses of psychotropic medication that they were on when they came to JRC.

- Many of the criticisms that the authors make are simply the choices that they would have made in how to design treatment procedures if they had been designing the JRC treatment program without seeking any detailed information about the true severity of the students' disorders.

- The June Report is so unremittingly negative about JRC, one is left to wonder, "Why have so many parents placed their children in JRC?" "Why are they so passionate in their defense of JRC?" "Why has JRC grown so quickly to be one of the largest and most successful programs in its field?" "Why has NYSED placed over 456 children at JRC since 1976?" "Why were these terrible findings never mentioned in any prior NYSED site visits in the past 25 or so years?"

1. **The June Report characterizes Dr. Caroline Magyar as one of three "independent psychologists" (see p. 1) who visited JRC during the April 2006 visit. Yet prior to the visit she was identified as a "Regional Associate."** Although NYSED gave JRC 2 business days notice of the April 2006 visit, there were several strange things about the composition of the group who would be visiting. First, our own regional associate, Margaret Schepp was not among those scheduled for the visit.

Second, Dan Johnson, Director of Quality Assurance for VESID, was oddly reluctant to disclose who would be visiting. Ms. Crookes had to call back three times, asking for the names of the planned visitors. At one point Ms. Crookes was told, "What does it matter who is coming. Names mean nothing." Finally, when Mr. Johnson was told that we needed the information for security badge purposes, we were told that there would be four Regional Associates visiting us. When the four came, Dr. Magyar was introduced as a Regional Associate. Why the secrecy? Did NYSED believe that if they disclosed her name we would discover her anti-aversives bias and realize that the visit had a hostile intent?

2. The June Report suggests (p. 2) that the September 2005 visit, which was a site visit that focused on health and safety, had raised some "concerns" relating to the use of aversives. This is not true. No concerns about aversives were mentioned either

during the visit itself or in any aspect of the report. If there really had been any concerns they should have been listed in the report of that visit and brought to the attention of JRC so these concerns could be resolved immediately instead of waiting an additional seven months. The November 17, 2005 "Final Report" detailing the findings of the September, 2005 visit was considered complete by NYSED and circulated by NYSED to JRC's Massachusetts regulators.

3. The June Report asserts that the April and May visits were partly in response to documentation provided by JRC prior to the April Visit (p. 1 par. 2). The June Report also asserts that the April and May visits were partly due to "recent questions from legislators, the Board of Regents and others." No documents specifically dealing with aversives were submitted by JRC to NYSED after the September 2005 visit and prior to the April 3, 2006 letter from NYSED notifying JRC of NYSED's plans to conduct a site visit. The assertion that documentation provided by JRC before the April visit explains the April and May visits is false because JRC never provided such documentation.

What really happened was this. In February JRC was the subject of negative local and national publicity generated by the attorney for one disgruntled parent who is seeking money damages in a bogus lawsuit against JRC, her school district and NYSED. When this negative publicity appeared, NYSED panicked. Rather than defend the parents' right to have their children benefit from aversives—a practice that NYSED had supported for 30 years—NYSED chose to try to escape from the negative publicity by removing JRC from its list of approved schools and ban aversives totally.

To accomplish this, NYSED needed a negative report on JRC. To obtain such a negative report, NYSED appointed a Review Team to visit JRC in April that contained a psychologist who supports the anti-aversive philosophy of Positive Behavior Support. NYSED tried to hide the identity of this psychologist, representing her to be a Regional Associate and refusing to give her name to JRC. In March a second NYSED group visited JRC, this time containing two different psychologists, both of whom where hostile to the use of aversives and one of whom was also a prominent supporter of the anti-aversive philosophy called Positive Behavior Support.

4. The June Report incorrectly characterizes the three psychologists as "independent consultants" (p.1 par. 2). They were not independent, because they were paid consultants to NYSED. They also were not impartial. Dr. Caroline Magyar, the only psychologist who participated in the April visit, is an advocate of Positive Behavior Support. A few years ago she was asked by NYSED to give consulting direction to help change the Anderson School (a residential school in New York State for autistic children) toward a Positive Behavior Support approach.

Dr. Daniel Crimmins and Dr. David Roll, both of whom came in the May visit, were also not impartial. Dr. Crimmins is a prominent advocate for nonaversive treatment. As his

biographical squib on the website for the Motivation Assessment Scale that he co-authored says, "Dr. Crimmins has a long term interest in developing nonaversive interventions for persons with challenging behaviors." Dr. Crimmins told Dr. Israel that his only experience with aversives was in graduate school. However, when asked the same question by the Board of Regents on Monday, June 19, 2006 he said he had never used aversives. He has co-authored a book entitled, Positive Strategies: Training Teams in Positive Behavior Support (published by Westchester Institute for Human Development, 1997.

Dr. Roll teaches a course that includes the philosophies of "Person Centered Planning, Normalization and [Social Role] Valorization" – all approaches that are antithetical to the use of aversives. Dr. Roll admitted to both Dr. Israel during the April visit, and to the Board of Regents at its June 19, 2006 meeting, that he has had no experience at all with aversives.

5. The June Report states that the NYSED reviewers reviewed the records of 12 of the approximately 150 New York students at JRC (p.1 par. 4). In fact, given the extensive treatment histories of the JRC students, a comprehensive review of even 12 students' records would take days if not a week. The two behavioral psychologists on the review team were each at JRC for a day and a half and during which time they alleged to have completed a record review of each of the twelve students and school observation. The review of records and observations of JRC were clearly nothing beyond cursory. The reviewers were told on several occasions that if they could not find anything in the paper files to please ask because many items were located in the computer database or elsewhere. Despite this, they looked only at the paper files and made no request to see information in the computer database which contains the students' behavior charts that are essential in order to understand the progress the students have made and the interventions that have been employed. The only two requests the reviewers made were: (1) to help them understand the court files; and (2) to view the Parent Agency website, where they looked at clinical notes and behavior charts for only two of the twelve students they were allegedly reviewing.

6. Throughout the June Report, NYSED confused emergency restraint, applied solely for the purpose of keeping the student and staff members safe, with level III restraint applied as part of a treatment plan. (p. 1 par. 4) For example, in the following quotation from the June Report, the review team described a procedure as if the procedure was an example of the aversive that is known as *movement limitation*. In fact the procedure they describe is really just a safety emergency restraint procedure.

> "the student is strapped into/onto some form of physical apparatus. For example, a four-point platform board designed specifically for this purpose; or a helmet with thick padding and narrow facial grid that reduces sensory stimuli to the ears and eyes. Another form of mechanical restraint occurs when the student is in a five-point restraint in a chair." (page 8)

Although a four point board, chair or helmet may be used as part of Movement Limitation it typically is not. The helmet is most frequently used as a health related support and is prescribed by a physician. The restraints that the NYSED team witnessed during their visit were most likely emergency restraint, with the student placed on a device with Velcro cuffs or in Mitts. Students are placed in an Emergency restraint to protect the safety of students and staff and not as an aversive consequence for behavior.

7. The June Report states that NYSED observed the residence environments. (p. 2, 3rd. bullet) The visitors spent only 20 minutes in one residence and 5 minutes in another. Both residential visits occurred as the students were either arriving home from school in the evening, or departing for school in the morning.

8. The June Report states that "Psychotropic medication is discouraged at JRC" (p.4 par. 3). Many agencies and parents seek out treatment at JRC because of this policy. Many of our students arrive at JRC very heavily medicated for sedative purposes only, and are carefully weaned from the highly health-dangerous drug treatments they have been forced to endure. This humane and health-preserving step of removing the student from psychotropic medication is only possible because we have in place a very effective behavioral treatment system which the June Report attempts to denigrate.

9. The June Report states that "One school district informed NYSED that JRC did not inform or seek approval of the CSE prior to initiating such interventions with the student" (pg. 5, 3rd bullet). This is a false statement and it should be disregarded since the reviewers conveniently left out the name of this alleged school district. JRC has not implemented any level III interventions without the CSE's knowledge and maintains all of the paperwork to demonstrate this. The reviewers never mentioned this allegation to JRC and never sought to review JRC's files in order to properly and fairly investigate this claim.

10. "The school district and parents are informed that the use of aversive interventions may be a condition of the student's acceptance and continued enrollment in the program." (p. 5, par. 4) This is not JRC's policy. We do not require approval of aversives by a parent prior to admission unless it is very clear that the student will require them at the very start of his/her enrollment, and this occurs in less than 25% of the new admissions to JRC. JRC successfully treats approximately half of its students without ever using aversives and without ever asking their parents to approve the use of aversives. If a student is authorized for the use of aversives, and if the parent withdraws his/her permission, JRC simply stops using the aversives. If the student can be maintained safely at JRC after that point, he/she is allowed to remain. If we cannot care for the student safely, JRC calls for a new IEP meeting so that a more appropriate placement can be found for the child.

11. The June Report describes JRC's Alternate Learning Centers as a setting used to "control students who present with current behavioral difficulties which require physical intervention at a high rate, and for whom substituted judgments have not yet been obtained."(p. 5, par. 2).
A large number of JRC's students come to JRC directly from psychiatric hospitals, detention centers or prisons and are capable of severely injuring themselves or others. Nonetheless, all new students are assigned to regular classrooms when they first enroll in JRC and are placed in a more restrictive setting only if they pose a safety risk to themselves or others. The need for a student to be placed in a restrictive classroom setting, such as a Small Conference Room or an Alternate Learning Center, is reviewed daily by members of the student's treatment team. The treatment team for any student with a high frequency of dangerous behaviors is constantly working to make modifications to that student's program to reduce the unsafe behaviors and return the student to a less restrictive setting. Teachers are assigned to each student in a restricted setting and meet with the student daily to go over academics. The student is always presented with his/her academic tasks pursuant to the IEP goals.

12. The June Report states that the majority of staff in the Alternative Learning Centers and small conference rooms are Mental Health Aides (MHAs) and states that JRC employs 640 MHAs, of whom 468 have only a high school education. (p. 5, par. 2) Four hundred sixty eight of the 640 MHAs (i.e., 73%) have a high school education or higher degree. This is a high percentage for direct-care staff, as compared to other comparable programs. JRC pays the highest wage for starting direct care staff persons in our area ($ 11.30-16.50 per hour).

The June Report does not explain that the primary function of these staff members is to follow the students' programs and collect data as prescribed by the students' clinicians and that MHAs are well trained to perform this task. The MHA makes no treatment decisions regarding changing interventions, changing curriculum, etc. The MHAs make no decisions about which behaviors to treat with aversives. A list of behaviors to be treated for the individual student the MHA is working with is generated by the student's clinician and provided to the MHA. The June Report also makes no mention of the many layers of supervision and support that are available to all direct care staff members. Each school-aged student at JRC is assigned a teacher, residential supervisor, case manager and clinician who all actively participate in the treatment and education of the student as well as in the continued supervision and training of the MHAs. NYSED did not request statistics regarding JRC's staff members during either the April or May visit so JRC can only assume that NYSED used the information that JRC had submitted during the September 2005 NYSED visit. If JRC's staffing causes concern or is not on a par with industry standards why would NYSED not have addressed this in September, 2005 and instead bring this to JRC's attention seven months later?

13. The June Report states "It is during this initial restrictive placement at JRC that the frequency of behaviors is documented for purposes of obtaining a substituted

judgment for the use of level III aversive procedures. In this setting, interactions with students involved little to no instruction; staff primarily attended to students' negative behaviors and employed the use of physical and mechanical restraints at a high frequency and for extended periods of time"(p.5, last bullet). This statement is false and a perfect example of how the reviewers intentionally created a negative report by refusing to ask JRC staff and administrators any questions and basing "conclusions" on their cursory and slanted observations in their brief visit to JRC. JRC's treatment and education of each student is designed on an individual basis. Every student at JRC upon admission receives instruction from a teacher and a rich reward program that is designed to make it easy for the student to earn his/her rewards. Restraint is used only when the student engages in aggressive or self-abusive behavior that creates an imminent risk of serious physical harm. Half of the JRC students thrive under this program but some students need a more potent treatment plan requiring court approval and it is those students who typically exhibit a higher frequency of behaviors. All students, however, no matter how frequent or difficult their behaviors, receive instruction and receive access to their rich reward program. This statement also incorrectly suggests that the frequency of behaviors is documented only during the initial period during which the student is enrolled at JRC. JRC documents the frequency of all behaviors from the time a student comes into the program until a student is getting ready to transition out of the program.

Students are not automatically assigned to Alternate Learning Centers and/or to Small Conference Rooms upon admission. Students are only placed in a restrictive setting due to the dangerous nature of the behaviors they are exhibiting and an in effort to keep students and staff safe. While in these rooms, students are provided instruction as outlined in their IEPs. While students are in these settings, rewards such as breaks tend to be longer and are offered more frequently in order to reinforce the students' positive behaviors and reduce the frequency of dangerous behaviors. Restraint in the Alternative Learning Centers or Small Conference Rooms is imposed only in response to a direct threat to the safety of the student or others in the room. The restraint will last as long as the student continues to be a threat to him/herself or others. As soon as the student no longer poses a threat to anyone's safety, he/she is released from the restraint.

14. The data showing an increase in inappropriate behaviors is used to substantiate the need for Level III aversive behavioral interventions…" (p. 6, 1st bullet) This statement is false. It falsely implies that JRC has placed its students in the Alternative Learning Center or Small Conference Rooms to generate problem behaviors so that JRC can justify seeking Level III. A student is placed in the Alternate Learning Center or Small Conference room for reasons of safety and not to artificially cause an increase in inappropriate behaviors. As soon as the student's behaviors improve, he/she is transferred back to a regular classroom. JRC has no reason to want to use Level III procedures except to help the student improve his/her behaviors. Parents and school districts are even more satisfied and effusive about JRC when JRC can achieve treatment and educational success without adding aversives to the student's treatment program. If JRC can avoid having to go to court to request Level III procedures this is a feather in JRC's cap. JRC is

proud of the fact that approximately 50% of its students do not require the use of substituted judgment and aversives.

15. "…not for analysis to determine alternative forms of intervention." (p. 6, 1st bullet) The purpose of placing a student in an Alternate Learning Center or Small Conference Room is not to enable an analysis of the student's behaviors. Our functional analysis relies primarily on an *in vivo ongoing functional analysis* that is continuous throughout the student's enrollment, no matter which JRC setting the student is in. See paragraph 106 below for explanation of how JRC does its functional analysis.

16. "One student's behavior chart documenting total inappropriate behaviors showed an Increase from 800 per week during the first weeks after admission to JRC to average of 12,000 per week." (p. 6, 1st bullet) JRC has a welcome week policy in which no demands are placed on the student or behaviors are pinpointed. This is in place to give the student a chance to learn the rules and program and experience the rewards JRC has to offer. This may be the reason why there was a dramatic increase in behaviors in the record examined. After the first week demands start to be placed on the student, often for the first time in a long time.

17. "Clinician notes only document the number of inappropriate behaviors. They did not denote any positive behaviors or academic progress." (p. 6, 1st bullet) Clinician notes are designed at JRC to briefly document the student's progress, treatment changes, and treatment rationale. The clinician's weekly notes are supplemented by more comprehensive quarterly reports, court affidavits, independent evaluations by outside experts and yearly court reviews. NYSED only requested to view the clinical notes for 2 students. Looking at only the Clinician notes of 2 students out of 148 (1.4%) students is hardly a statistically sufficient sample.

18. The June Report states that Level III procedures are used at JRC upon receipt of parental consent and after approval of a substituted judgment petition to use Level III aversives through a Massachusetts Probate Court. (p.6, par.1) The June Report fails to mention that each level III treatment plan is reviewed by JRC's Human Rights Committee and Peer Review Committee, consisting of at least one licensed psychologist, and that all interventions requested are specific to the student. The June Report also fails to mention the other levels of oversight involved, (independent clinician, court appointed attorney, JRC's Level III Certification from Massachusetts DMR, etc.).

19. The June Report states that the GED receivers range in size. The GED receivers do not range in size; they are all manufactured using the same size parts.

20. "Students wear the GED for the majority of their sleeping and waking hours" (p.7, par. 2). Students whose behaviors improve are gradually "faded" from having to wear the GED. This might start for an hour or two a day and progresses until they do not have to wear the device(s) at all.

21. "… and some students are required to wear it during shower/bath time." (p.7, par. 2) JRC has changed its policy on bathing/showering for the New York school-aged students in response to the new NYSED Emergency Regulations on aversives. Prior to this change in policy, the arm on which the electrode was placed was situated outside the shower or bath and did not get wet. See letter to Commissioner Mills from Mike Flammia, June 16, 2006.

22. The June Report states that the "FDA recommended warnings on the GED device include statements that the device is to be used only by or under the direct supervision of an appropriately licensed professional" (pg. 7, par. 2) The final label that was agreed upon with the FDA states (directly from the device label) "The GED should be used by or under the direct supervision of an authorized professional as part of an overall therapy program." JRC follows this. A clinician directly supervises each student's program.

23. The June Report claims that the NYSED reviewers were told that staff working 1:1 with a GED student do not need to complete the two person pre-verification procedure to give the student a GED application. (p. 7, par. 4) This is another misunderstanding. First, the verification procedure is not a required procedure. It is used as a redundant check to be sure that students are receiving applications only when required by their treatment plans as designed by their assigned clinician. JRC has the option of removing this redundant check whenever it is not necessary or when the student's treatment would benefit from a change. JRC explained to the NYSED visitors that the two person verification procedure is required for most applications of the GED; however, when a student has his/her own 1-1 staff member assigned to him/her, the two person verification procedure is not employed because that 1-1 staff member is well versed on that particular student, who is the only student he/she is looking after. When the incoming 1-1 staff member starts his shift with a student that he/she is watching, he is given a reminder/briefing by the outgoing 1-1 staff member as to what behaviors are being treated with the GED for that student. This reminder/briefing is called the "pre-verification" and it is this that the NYSED reviewers saw and misunderstood. They incorrectly assumed that that brief interaction (the "pre-verification") was the only training that the 1-1 person coming on duty ever received in the use of the GED. This mistake could have been avoided if the NYSED visitors had communicated their questions and concerns to the JRC staff. They did not.

24. "Of these 77 students, 53 were receiving skin shock through the GED that is adjustable…"(page 8, par. 1). The GED and GED-4 devices are not adjustable. Each are set at the specific output designed for the device during the manufacturing process. The GED or GED-4 device would have to be disassembled by an engineer and different parts added in order to change the outputs.

25. The June Report states that 24 NYS students have GED-4 currently in place as part of their treatment at JRC. When NYSED asked for the GED statistics, the number of students approved by the court for possible use of the GED-4 were provided, and not the current number of students actually using GED-4. JRC currently has only 10 NYS students who are actually using the GED-4. The remaining 14 have the device authorized in their court plan, but it is not currently being used with them because the GED device was sufficiently effective.

26. The June Report states that the GED-4 is used when it is determined that the student is not responding to the GED. (p.8, par. 1)
This is not always true. In the case of certain students the GED-4, and not the GED, has been selected to be used because it is judged to be the most effective, least intrusive treatment for those particular individuals.

27. The June Report states that JRC staff members do not operate the automatic negative reinforcement devices. (p. 8, par. 2) This is not true. JRC staff activate the automatic negative reinforcement device and deactivate it with a remote control device. There is also a back-up off switch.

28. The June Report states that FDA regulations prohibit the use of these devices. (p. 8, par. 2) Not true. See JRC letter to Commissioner Mills, 6/15/06 which explains that the GED is exempt from FDA registration.

29. The June Report describes the helmet used by JRC as having "thick padding and narrow facial grid that reduces sensory stimuli to the ears and eyes." (p.8, par.3) The helmet is not designed as an aversive procedure that reduces sensory stimuli to the ears and eyes; instead it is part of a safety procedure. A hockey face guard, designed to give hockey players full peripheral vision is attached to a soft karate helmet. Vision is not occluded any more than it is for a hockey player. Hearing is also not prevented. There are holes cut in the ear padding to facilitate hearing. The purpose of the helmet is simply to protect the safety of staff and students.

30. "Another form of mechanical restraint occurs when the student is in a five-point restraint in a chair. Students may be restrained for extensive periods of time (e.g., hours or intermittently for days) when restraint is used as a punishing consequence." (p.8, par 3). JRC never uses long periods of restraint in a chair or in 4 point restraint as a punishing consequence.

31. The June Report states that the GED causes "burns." The GED device does not cause burns. It has been reported to cause minor discoloration of the skin or redness and at times a scab can occur, and possibly, in case the electrode has not been placed in proper contact with the skin, a harmless blister, but never a burn. Most often, any marks left by the GED device disappear within a few days.

32. The June Report describes an incident in which a student "complained of hand pain and swelling from restraint." (p. 9, 1st bullet) JRC's staff is trained on the state-of- the-art methods of safe restraint and must pass a competency exam before being allowed to work with students as well as complete yearly in-service training. JRC's use of restraint is closely monitored by JRC's on-site nursing staff, as well JRC's consulting physicians, and administrative staff. JRC cannot speak to the circumstance of this allegation because the reviewers again failed to identify which JRC student claimed to have this problem.

33. The June Report indicates that one NY student who was interviewed reported not being able to attend an IEP meeting because she was being restrained and then cried during another IEP meeting. It also states that the CSE recommend the student be faded from the GED. (p. 9, 2nd bullet) The name of this student is not provided so once again it is impossible for JRC to respond with detail. JRC has an excellent record with making so much progress with its students that many students can attend and participate in their own IEP meetings.

34. The June Report incorrectly describes the use of restraint in combination with GED as the definition of Behavior Rehearsal Lessons (BRL). (p. 9, par. 5) JRC does not restrain students when administering the BRL's. There were no Behavioral Rehearsal Lessons conducted while the reviewers were present at JRC so they have no basis to make this false claim.

35. "The Contingent Food Program is widely applied…" (p. 10, par. 2) Only 6% of the NY school aged students have the contingent food program currently in their contracts.

36. The Contingent Food Program is designed to use hunger to motivate students to be compliant. (p. 10, par. 2) This is false. The Contingent Food Program uses "mini-meals" as an effective reward. The mini-meals are used for two purposes: (1) to reward task completion for those students for whom this form of motivation is required or helpful; and (2) to reward the student for behaving appropriately during a period in which he or she has also not shown certain previously exhibited problematic behaviors. The primary difference from a normal eating pattern is that the students eat smaller "mini-meals" throughout the day, contingent on the student's displaying certain behaviors, instead of three full meals at normal mealtimes. No student goes hungry at all. Each is offered his or her full complement of calories each day.

37. The June Report incorrectly states that the make-up food is "mashed food." (p. 10, par. 2) The makeup food consists of mashed potatoes, spinach and chicken which is garnished with liver powder.

38. The June Report states that "the integrity of the behavioral programming at JRC is not sufficiently monitored by appropriate professionals at the school and in many cases the background and preparation of the staff is not sufficient to oversee the intensive treatment of children with challenging emotional and behavioral problems. (p. 2, last bullet) JRC employs 16 clinicians who oversee the programs of 234 students. 13 of these clinicians have a doctorate in Psychology and 3 have a masters degree in Psychology. This represents a high ratio of doctoral-level clinicians to JRC's total of 234 students. Four of JRC's clinicians are licensed Massachusetts psychologists and six are in the process of obtaining their licensure in Massachusetts. Three of the doctoral level clinicians are also Board Certified Behavior Analysts.

JRC's total of 13 clinicians with doctoral level training in psychology compares favorably with that of other programs. For example, in May of 2005 a similar program in New York, with approximately 123 students, did not have any doctoral level clinicians and only five master's level clinicians. The majority of their "behavior specialists" had only a BA.

Many of JRC's clinicians have had experience working in residential settings prior to joining JRC. JRC's Executive Director, who closely supervises the entire program, has over 30 years experience. The Director of Clinical Services has almost 17 years of experience working with this population. 14 of the clinicians are full time, and two work part time. All new clinicians are supervised for at least a year, during which time their supervisor must sign off on all treatment changes, before they can directly oversee their own case loads.

The direct care staff must pass a rigorous two-week training before they are placed on the schedule. Direct care staff members are closely supervised by experienced staff and the state-of-the-art digital video recording of all classroom, residences, buses and vans insures that programs are being followed as written.

39. This June Report misleads the reader by characterizing the 13 clinicians at JRC as having "some doctoral level training." Even a cursory inspection will show that 13 (not 12 as the June Report mistakenly says) out of the 16 clinicians who were in the department at the time of the NYSED visits have doctorates in psychology. Not just "some doctoral level training in psychology" as the June Report misleadingly states. Two of these doctoral-level clinicians also have Board Certification in Behavior Analysis, and one has been teaching applied behavioral psychology at the university-level for over thirty years. Six of the doctoral level clinicians are "license eligible" and either accruing their post-doc hours or studying for the EPPP.

40. "The purpose of the Quality Assurance (QA) department is to monitor the integrity of the treatment broadly… but not to monitor the integrity of student specific behavior plans." (p. 11, par. 4) This is another false statement. That

department was designed primarily to check on the integrity of "staff conducting programs as written." If the staff members are, indeed, conducting programs as written, then the student specific treatment plans are being carried out correctly.

41. "JRC [Quality Control] staff did not record data on student engagement in productive activities and the number of learning opportunities provided by staff" (page 11, par. 4). This quality control function (recording data on student behavior, etc.) is performed on a daily basis by the JRC teachers and direct care staff, and at least a weekly basis by JRC's clinicians and administrators. Recording behavior data is not the primary function of JRC's Quality Control staff, although the Quality Control Staff are trained to immediately respond when teachers and direct care staff are not properly and sufficiently providing the students with programmed productive activities and learning opportunities. The data collection on student behaviors and activities is done by the direct care staff. The NYSED reviewers would have learned all of this information had they not refused all of JRC's requests to provide it to them.

42. "Documentation was difficult to find for evidence of academic progress or development of positive social skills." (page 11, par. 5) Although numerous offers were given by JRC staff, the NY representatives did not ask for information about how JRC documents academic progress and development of positive social skills. JRC collects data on academic and social skills on a daily basis and this was available if the NYSED visitors had just asked to see it. Academic data is charted daily by the teachers at JRC and was readily available to show to the representatives from NY if they had asked for it.

43. "The program descriptions of behavioral interventions are very standardized across students and show a lack of individualization of treatment planning." (page 11, par. 5) JRC has standard treatment systems so that consistent quality treatment is received by every student at all times, but each system is completely individualized for each student. The assertion that our students' programs are not individualized is false as evidenced by the huge variations in the behavior contracts each student has, the differing rewards that they earn, the differing behaviors targeted, the types of rewards that are defined in their program, and the wide range of classroom and group home settings that are available at JRC depending on the students' current behavioral status.

44. "Treatment plans do not always vary for different types of behavioral difficulties exhibited by an individual student even though these behaviors may serve different functions for the student."(page 11, par. 5) This is completely inaccurate. Every treatment plan is different for each student. Every treatment plan addresses the particular behaviors exhibited by that student and each such behavior is first analyzed by the assigned Clinician, including a functional analysis, before a treatment is chosen. The NYSED reviewers may have not examined JRC's "program descriptions" which are further refinements of the court-approved treatment plans and are changed weekly, daily or even hourly when necessary in order to most effectively address the students

behavioral needs. JRC designs and implements each student's behavior modification program in order to increase the frequency of the student's particular appropriate behaviors and decrease the frequency of inappropriate behaviors**.** In section 106 below dealing with functional analysis, we explain how we handle the fact that different behaviors may have different functions (apparent causes).

45. "The average educational attainment of most of the QA personnel is a High School diploma." (page 12, par. 1) The JRC staff consist of hard working and very dedicated people who have been thoroughly trained on how to follow the behavioral treatment plans that have been designed by the JRC Clinicians and approved by JRC's consulting physicians. It is not necessary nor is there any legal requirement that these well trained individuals have advanced degrees. No program anywhere that serves a large group of severely disabled students 24 hours per day requires advanced degrees for their direct care staff.

46. "They are not required to be Board Certified Behavior Analysts or Board Certified Associate Behavior Analysts." (page 12, par. 1) The role of JRC's direct care staff is not to analyze behavior or to design behavior treatment plans. JRC employs Clinicians, including Clinicians with credentials such as licenses in Psychology, Doctorates in Psychology, Board Certified Behavior Analyst designations, and other advanced degrees, who design and monitor the implementation of the treatment plans. You could not have a consistent and effective behavioral treatment plan if you allowed direct care staff to redesign treatment plans, or decide what behaviors to treat and how to treat them on a given shift. No legitimate treatment program would allow such a thing to occur. The staff in the Quality Control ("QC") department have been promoted from within based upon their knowledge of, and experience with, the JRC systems and policies that are used to successfully implement the treatment program. They are not responsible for designing or changing the students' treatment plans, which is done by the clinician. The QC staff do not make treatment decisions. They are simply making sure that staff members follow students' programs as written by their clinicians. The NYSED visitors did not bother to read the job description, or to understand what the QC function is. This observation is evidence of the review team's disregard for facts, and unwillingness to understand JRC's programs and systems. The NYSED consultant, Dr. Roll, who had the most comments in regards to the QC staff at JRC, refused to even go into the room where the live Quality Control was taking place.

47. "A review of the staff development plan indicates minimal, if any, training on student characteristics…" (p. 12, par. 2) This is not true. Staff must successfully complete two weeks (eight hours per day) of training and a comprehensive exam before they are allowed to work with students. A substantial part of the two weeks of training is training on student characteristics. In addition, both during training and on just about every day thereafter, the staff learn more about the characteristics of the students with whom they are working. The JRC staff know the students' characteristics very well, including but not limited to, the students' preferences for rewards, the students'

educational strengths and weaknesses, the students' positive and problematic behaviors, including antecedent behaviors, etc. This is just another unfair criticism of a group of dedicated people at JRC who deserve respect and admiration for working with some of the most dangerous students in the nation.

48. "…functional behavior assessments…" (p. 12, par. 2) See comments (section 106 below) on our handling of the issue of functional behavior assessments.

49. "reinforcement…" (p. 12, par. 2) Accelerating consequences are discussed thoroughly in the training manual, and are a part of JRC's initial training and in-service training. The JRC staff clearly enjoy the major part of their job which requires them to give the students their rewards, and often involves the staff taking the students on field trips such as amusement parks, ball games, etc. The staff are also required to let the Clinicians know when the student expresses an interest in a new reward so that the Clinician can incorporate the new reward into the treatment plan. The JRC staff do a great job with this.

50. "…shaping or other behavioral techniques for increasing positive social behavior." (p. 12, par. 2) One of JRC's major approaches is to develop programmed teaching systems that accomplish the goals of shaping in a series of carefully graded steps, each of which can be measured objectively. This procedure, designed by the JRC clinicians and teachers and carried out by the direct care staff, will teach new skills. A good example of this is our system to teach nonverbal children how to request things by exchanging a photo card for the item, instead of trying to obtain them through aggressive, disruptive or other problematic behaviors. By programming the teaching in a sequence of carefully planned steps, each of which builds on the previous step, we accomplish the change in topography of the behavior.

51. "teachers do not necessarily receive additional training in educational supports." (p. 12, par. 2) If the NYSED visitors had reviewed our training manual or discussed this with our director of training or Director of Education, they would have become aware that we do provide additional training for our teachers and that ongoing training is provided daily by our QC staff. Our training policy clearly states that training is provided to all staff on curriculum frameworks both MA and NY. The teachers provide additional training to the Teacher Assistants in the classrooms. Additional training is provided, typically a month after being on schedule. Teachers have weekly to bi-weekly in-services to review educational policies and procedures and the Education supervisors also work with the teachers for their first three planning days. Additional training is given to staff according to the department they work in. Training consists of workshops, seminars, classes, online tutor training, one-on-one training, behavioral training, etc. Unfortunately, the NYSED officials were not given any of this information since they refused, on several occasions, to receive a tour/explanation from the JRC staff.

52. "QA team members do not necessarily receive training in behavior analysis." (page 12, par 2) They receive substantial and constant ongoing in-service as explained in paragraphs 45 through 51 above and do not need any training in that area. They are very knowledgeable about the JRC treatment systems and how they should be carried out, as designed by the Clinicians.

53. This June Report asserts that families are not trained how to use the GED on home visits and therefore JRC has no idea whether or not the treatment is being implemented correctly or not. (p. 12. par 3). JRC requires all parents/guardians to successfully complete comprehensive training on how to use the GED before they are allowed to take the devices home with them. They bring home recording sheets and return with recorded data, and the JRC Clinicians check the data and review the home visit with the parent to confirm that the device was used properly and consistently. The review team unfortunately did not speak to any parents to elicit their experiences with the success of the program with their child, all the ineffective treatment that their child endured before coming to JRC and their competence and dedication to continuing JRC's treatment program while the student is on home visits.

54. The June Report states that the lack of specific data regarding the home use of the GED suggests that the court mandate for reporting may be compromised (p. 12. par 3). The parent has a recording sheet and marks on the recording sheet the number of applications his or her child receives. At the conclusion of the home visit the recording sheet returns to the school when the visit is over and the parent is contacted in person or via telephone. The parent is given immediate access to the student's JRC Clinician and other JRC administrators who can be called in case a question arises during a home visit. A member of the JRC treatment team checks on them during the home visit to confirm that everything is going well.

55. This June Report suggests that JRC does not sufficiently train JRC parents or new staff on how to use the GED and propose that this is a direct violation of the FDA safety precautions (p.12, par. 4). This is incorrect. JRC's training procedures for new staff are clearly outlined in our training manual, including a description of the comprehensive and ongoing training in the use of the GED. Family training is also a JRC requirement prior to any family member using the GED. Parents who do not successfully complete the training either do not take the student on the home visit, if the student's behaviors are too dangerous to do so without treatment, or take the student home without the device. The NYSED Review Team did not sufficiently review JRC's training procedures for staff or parents and refused to discuss it with JRC staff so they had no basis to make any observations or conclusions about JRC's training for staff or students. JRC's procedures and policies on the use of the GED device do not violate FDA requirements, and, to JRC's knowledge, none of the Review Team Members have any experience or qualifications to make conclusions about compliance with FDA regulations.

56. The June Report states that in one classroom a new staff member was briefly informed that his role in the room was to monitor 1:1 student S and second party verification was not required before administering the GED. The new staff person was handed the sled (GED transmitter) and verbally given directions and instruction in when to administer the GED. (page 12, par. 5) The Review Team completely misrepresents what happened here. This was not a training session but rather a pre-verification exchange by two staff. Some JRC students' programs require that 1:1 staff be pre-verified prior to administering a GED consequence in order to decrease the amount of time between the occurrence of the behavior and the consequence. The staff completing the pre-verification with the other staff, in this exchange, was emphasizing to the other staff that this particular student is deaf which is standard procedure. What was observed was a pre-verification of behaviors for the one to one staff which is a brief review of the behaviors that receive the GED. It is done hourly as a refresher and in no way intended to be pre-service or in-service staff training.

57. The June Report states that "JRC employs a general use of Level III aversive behavioral interventions to students with a broad range of disabilities, many without a clear history of self-injurious behaviors." (p. 13)
Every JRC student has a clear and demonstrated history of dangerous behaviors that have been resistant to all prior treatments. These dangerous behaviors were preventing the student from receiving a free and appropriate education and in most cases causing the student to live in a psychiatric hospital and/or languish under the heavily sedating effects of anti-psychotic and other potent medications. The GED device safely and effectively treats all types of serious problematic behaviors that cannot be brought under control by counseling, medication, positive behavioral supports and hospitalization including, aggressive, self-abusive, destructive, major disruptive, and non-compliant behaviors. JRC has never stated that the sole purpose of the GED was to treat self-injurious behaviors. JRC's mission has never been limited to the treatment of self-injurious behaviors. JRC's court-authorized treatment plans make clear that our treatment procedures are used to treat all of the major problem behaviors of the students in our care. Many of JRC's higher functioning students may not exhibit behaviors such as head banging, hand biting, etc. but are prone to self-dangerous behaviors such as, unprovoked violent attacks, running away, self-mutilation, and refusing required medication/treatment. All students receiving GED treatment exhibit some sort of dangerous or harmful behavior such as self-injury or aggression and have not responded to therapy, medication or other methods of treatment including positive only behavioral programming[1].

58. "The treatment model/program is behavioral and does not offer any other forms of interventions for those students that exhibit psychiatric, developmental and/or dually diagnosed disorders.

[1] Since the recent adoption of the NYSED emergency regulations on aversives, JRC has been using the GED to treat only aggression and self abuse in the case of the New York school-age students

There were no indications that JRC considers whether its behavioral model based primarily on the use of punishment techniques is appropriate for all types of disabilities and no evidence that JRC differentiates between the treatment of students with psychiatric disorders or developmentally related childhood disorders." **(p. 13, par 1)**

JRC is a 24 hour intensive behavioral treatment program and this is how JRC is described to the parents, school districts, and other state agencies that are considering treatment options for the clients in their care. Parents and agencies do not choose JRC as a placement unless they have decided that intensive 24 hour behavioral treatment is the treatment indicated for their client. JRC, like most treatment programs, focuses all of its resources on providing the best possible treatment in its chosen field which for JRC is behavioral psychology. Specializing in one form of treatment is a very common approach among treatment facilities as it improves the quality of care because the staff are highly trained and experienced in that field. Specializing in multiple forms of treatment can dilute the quality of care. While JRC can provide other forms of mental health treatment and does so on a limited basis when necessary, parents and agencies who are looking for primarily psychotherapy or drug treatment for their client are told by JRC to consider other programs that specialize in those fields.

JRC specializes in taking a consistent behavioral approach to treating all types of problem behaviors, when the other forms of treatment have failed. JRC identifies those behaviors that need to be increased and those that need to be decreased, and applies behavioral procedures to accomplish those goals. JRC treats every student individually and focuses on his/her needs specifically. JRC focuses on treating the student's inappropriate behaviors whether a student has been given the MR or the MI label. Different approaches are taken with each individual student and are based primarily on rewards and educational systems. Aversives are only used as a supplement to the positive programming when clinically indicated. JRC does offer psychopharmaceutical treatment as a supplement to JRC's behavioral program to students who clearly require it. Our model is based primarily on rewards, not on aversives. Aversives are used as a supplement to the positive programming only with guardian, court and funding agency approval and only when all positive programming interventions have been tried first. Most students coming to JRC have multiple diagnoses and are usually taking multiple medications. "Treating" the diagnoses with medication was obviously not effective for the students if their behavior supported their being referred to JRC. The medications prescribed by previous placements are usually providing no treatment benefit and are serving only as a chemical restraint.

59. "There is no evidence that JRC considers the potential negative effects, such as depression or anxiety that may result from the use of aversive behavioral strategies with certain individual students. Several students from NYS came to JRC with diagnoses of Post Traumatic Stress Disorder (PTSD) yet their behavior programs call for skin shock. Skin shock has the potential to increase the symptoms associated with PTSD, yet there is no evidence of data measuring these possible side effects or

therapies designed to treat these symptoms", (p. 13, par. 2) infers that there are negative effects of the GED including an increase in PTSD symptoms." This statement is completely false and based on pure speculation. The Review Team fails to mention seeing any evidence of students suffering an increase in PTSD symptoms caused by skin shock. This is a baseless statement designed to cause harm to the JRC treatment program.

Before any student receives aversives at JRC he/she is examined by a psychiatrist to determine whether there are any psychiatric contraindications to the use of aversives with the student. JRC has three consulting psychiatrists who examine the students upon admission and follow the students during their enrollment at JRC. JRC's consulting psychiatrists look for any psychiatric condition that requires a change in treatment or additional treatment. JRC's psychiatrists have examined hundreds of students receiving skin shock treatment and have never found that the skin shock caused an increase in PTSD symptoms.

The Review Team never told JRC that they were concerned about PTSD and never asked JRC for information about this. The primary diagnosis and area of greatest concern for the students admitted to JRC is their untreatable and very dangerous behavior disorders. Typically these students are engaging in life threatening forms of aggression and health dangerous behaviors and all other forms of treatment, (i.e., potent medications, positive behavioral supports, psychotherapy, etc.), have failed to successfully treat the behavior disorder. The greatest need for these students is an effective treatment for their behavior disorders. Almost every student admitted to JRC is admitted with multiple diagnoses, including Intermittent Explosive Disorder, Conduct Disorder, Mental Retardation, Psychosis, Obsessive Compulsive Disorder, PTSD, Depression, Schizophrenia, etc., but their most immediate need is an effective treatment that will stop their aggressive, health-dangerous, destructive and other disruptive behaviors in order to keep them safe and to allow them to get an education.

There are no negative side effects of the GED to consider. Students respond to the GED with a decrease in restraint, and an increase in education gains, social development, positive family/peer interactions and even smiling. The contention that the GED "has the potential to increase the symptoms associated with PTSD" has no basis in fact. It is clearly not supported by research, and is entirely without foundation. The undisputable fact is, based on hundreds of cases at JRC, the GED's ability to eliminate problematic behaviors and thereby allow the student to be educated and engage in family and social activity, causes the students to become happy and productive. Moreover, the footnote, at the bottom of page 13 of the Report is not an acceptable citation. The DSM IV-TR, pp 463-468 provides the diagnostic standard. This issue was discussed at length in a face-to-face interview with two of our clinicians, but the consultant, Dr. David Roll, apparently did not like what he heard, and has continued to make this professionally irresponsible contention.

60. This June Report incorrectly states that JRC disproportionately uses Level III interventions with higher functioning students from NY (p. 13). Currently, of the 161 Students from NY, 44 are lower functioning school aged, 36 are higher functioning school aged and 15 are lower functioning adults. The percentage of GED-treated New York school-age students who are in the higher functioning category is 45%, which is actually lower than the percentage for the same group in 1999 (67%) as the following table shows:

Year	Total Students	Total NY Student	NY Low functioning School age on GED	NY High Functioning School age on GED	NY Adults on GED
2006	245	161	44	36 (45%)	15
1999	118	77	4	8 (67%)	10

61. "One student wearing the GED…showed insight into his behaviors…less aversive and intrusive interventions could be attempted systematically with this student." (page 13, par 4) The visitors evidently did not review this student's records. All students at JRC have received numerous positive-only interventions prior to JRC and during their initial period at JRC. These positive-only interventions and their effectiveness for the student are documented. In this student's case they failed to produce change in the student's dangerous behavior. Also, this student is currently starting the fading process and working toward a less intrusive program. Clinicians work with their students to help teach them appropriate self-management techniques. All students who are capable of doing so attend chart-share meetings to discuss their self-management projects and strategies. Additionally, some students became so proficient at this that they attended the 2004 International Association for Behavior Analysis Conference in Boston MA to show their charts and discuss them with others.

62. The June Report states that "JRC employs a general use of Level III aversive behavioral interventions to students for behaviors that are not aggressive, health dangerous or destructive, such as nagging, swearing and failing to maintain a neat appearance" (p. 13, par. 6) Regarding the three specific behaviors mentioned in the June Report.

1. Swearing is a frequent antecedent to aggression, that is, in some cases the first step in the sequence of behaviors that leads to aggression is swearing. To treat aggression effectively, the most effective procedure is to treat not only the aggressive act itself, but also the first step in the sequence that leads to it. Repeated swearing in a classroom and other disruptive behaviors will likely lead to a student losing his/her opportunity to receive an education. Effective treatment for these types of major disruptive behaviors at JRC usually results in the student having the ability for the first time in his/her life to receive an education, participate in classroom instruction and have a social life.
2. Nagging in one of our students is a severely compulsive behavior that is often an antecedent to self-injurious actions undertaken to obtain health dangerous

substances that he then ingests. See below for further information about this student. Repeated requests for the same item at a rate of tens if not hundreds of times per hour is a major disruptive behavior that will seriously interfere with learning and will likely lead to the student receiving little or no education.

3. Failing to maintain a neat appearance is never punished with a GED. It is treated with a point or token fine. Some students have the behavior of disrobing in public and that behavior, including any beginning phase of that behavior, may be treated with the GED.

Antecedents, Attempts, Initial Stages and Shaped-Down Versions. JRC has court approval, as well as parental approval, to treat not only the full-blown occurrences of problem behaviors but also other behaviors that are so closely related to the problem behavior that they need to be treated also, in order to achieve effective treatment and lasting elimination of the full-blown occurrences. These include antecedent behaviors, attempts to execute the behaviors, beginning stages of the behavior, and "shaped-down" versions of the behavior that the behavior shows as it is being decreased in frequency.

The typical student entering JRC engages in many types of behaviors that are extraordinary difficult and significantly interfere with appropriate behavior or learning and thereby cause serious harm to the student. They also engage in patterns of behaviors that lead to extremely dangerous behaviors. One cannot judge the appropriateness of a given treatment procedure without understanding the entire treatment context. Sometimes something that seems innocuous when looked at in isolation is quite serious if you understand the full context. In such cases, if positive only treatment is unsuccessful by itself in controlling such behaviors, it is wise to consider using the GED procedure, in conjunction with the positive procedures. JRC observes each student carefully and designs an individual treatment plan for each student that targets the problematic behaviors particular to that student.

Here are some examples of behaviors that must be examined in their full context in order to be properly understood.

1. The behavior by itself seems innocuous, but it is an antecedent, an attempt to execute, or threat to execute, some much more serious behavior. Sometimes a behavior, while not dangerous in and of itself, or when looked at without knowing the full context, is the first part of a chain of behaviors that ends in a dangerous behavior. For example:

    a. If reaching for a knife is almost always an "antecedent" to attacking someone with a knife – i.e., then it is wise to treat this antecedent in order to keep the rest of the sequence from occurring.
    b. If swearing in class is the first step in a sequence that almost always leads to the student's attacking someone else with his fists, then it is wise to treat the antecedent swearing behavior.

c. If bolting out of one's seat is the first step in attacking the teacher, it may be necessary to treat the behavior of bolting out of one's seat.

2. <u>The behavior in and of itself seems harmless, but actually is a reduced ("shaped-down") version of some more significant and dangerous behavior that is in the process of being reduced in frequency.</u>

    a. When the frequency of a behavior is decreasing, the form of that behavior may also undergo changes. For example, when one treats punching with an aversive consequence, and when punching begins to decrease in frequency as a result, it also may change its form. The student could, for instance begin to "pull his punches" – i.e., act as though he is punching, but just touch the other person with his fist. We sometimes refer to these as being "shaped-down" versions of the full-scale behavior. When these shaped-down versions are displayed, the proper treatment procedure may be to continue to treat the "pulled" punching with the same aversive that one has been using for the full-fledged punching. If one does not, the "pulled" punches can quickly grow back to become full fledged injurious punches. It should also be noted that a student faces the same serious problems with education and socialization whether he is hitting people or putting people in fear of being hit.
    b. In the effective treatment of hair-pulling (pulling out one's own hair), as the behavior decreases in frequency, it may change its form. The student begins to pull less hard, then to just tug, then just to grasp the hair and then just to touch the hair. Again, in the successful treatment of this problem it would be important to apply the same consequence to the touching of the hair that one has already been applying to pulling out the hair. For most people, touching their hair can be a common and harmless habit; but for someone with a severe behavior disorder that includes hair pulling, the behavior of touching hair can be very dangerous.
    c. Another example could be loud screaming that goes on constantly and which makes it impossible for the student himself, or any other student to work in the classroom. When such loud screams are treated, they may not only decrease in frequency but also in loudness. In such cases, it may be necessary to continue to treat lower level screams with the same treatment consequence that one is employing with the full-blown screams.

The principle that is at work in these examples is similar to the one that causes physicians to tell their patients to take their medication until all symptoms of the medical problem are ended and not just until the major symptoms are reduced.

<u>Compulsive and Excessive Behaviors</u> There are also behaviors which, if displayed only once, are innocuous; however, if the same behavior is displayed continuously and compulsively throughout the day at inappropriate times, it becomes a severe impediment

to a student's academic and social progress. JRC has a student whose nagging is so compulsive and frequent that it once led to caregivers at a previous placement trying to strangle him and lock him in a room. It is also an antecedent to major problematic behaviors. The following is some background on this case.

Nagging may seem like an innocuous behavior and annoying only to those who have to listen to it, and for most persons that is true. However, for some individuals it is a compulsive behavior that significantly interferes with their academic, social and habilitative development and often serves as an antecedent to dangerous behavior. Some individuals seem to get "stuck" and unable to focus on anything other than the item they are obsessing over.

For one individual at JRC, who is treated with the GED for nagging, the behavior became problematic at an early age and has continued for over 30 years despite hundreds of pharmaceutical and behavioral interventions. The behavior, when he was younger, led to caregivers (not JRC) hurting and locking him in a room. Due to his myriad behavioral issues he was admitted for his first psychiatric hospitalization when he was 4 years old and has been in and out of residential placements, jails and hospitals since. When he was younger, often the repetitive asking to do something or get something was done just for the sake of trying to manipulate people. This developed into repetitively asking for mind altering substances such as caffeine, nicotine and alcohol. This individual will do just about anything to get what he is nagging for, including shoving a pencil up his penis and throwing himself onto his newly replaced hip.

Typically he will start by nagging or asking over and over again for the same item or event. When denied, his behavior escalates more and more until he exhibits dangerous behaviors. Many interventions over the years failed to reduce the frequency of this behavior. At one point JRC did try giving him cigarettes, cigar, soda and coffee on a set schedule noncontingently but that merely increased his severe behaviors and led only to more stealing and attempts to injure himself. He even called in a bomb threat to the White House. Making these items accessible contingent upon behaviors was an improvement but the nagging persisted. Dozens and dozens of different positive only and aversive treatment programs were put into place over the years but none produced a clinically significant effect.

Once nagging was treated with skin shock, however, the behavior decelerated. More importantly, the health dangerous behaviors associated with obtaining, or attempting to obtain, mind altering substances decreased and is now at its lowest point in since his return to JRC in 2001. With behaviors that frequently begin with a seemingly minor behavior, and that can escalate into dangerous behaviors, it is important to treat the earliest behavior in the chain. For this individual the earliest observable behavior is nagging.

63. "The review of NYS students' records revealed that Level III interventions are used for behaviors including …'failure to maintain a neat appearance', 'stopping work for more than 10 seconds', 'Interrupting others',… 'whispering and/or moving conversation away from staff, 'slouch in chair… (page 13, par. 7) This is a false statement. In our review of the same records reviewed by NYSED, we could find no case where a student was authorized to receive a GED application for failure to maintain a neat appearance', 'stopping work for more than 10 seconds', 'Interrupting others', or 'whispering and/or moving conversation away from staff.

64. "One record reviewed indicated the student had received 18 GED skin shocks between 4/01/05 and 4/30/05 and the major destruction and aggression behaviors only added up to 10 instances in that timeframe. The additional eight skin shock applications were due to inappropriate verbalizations and interference with education." (page 14, par 2) This statement suggests that this particular student received 8 out of 18 GED applications for IVB (Inappropriate Verbal Behaviors) or Edsoc (Behaviors that interfere with educational or social development). This is not true. JRC does not use the GED device to treat Edsoc or IVB behaviors. The 8 GED applications identified by NYSED were for a court approved treatment of the student's serious major disruptive and non-compliant behaviors. JRC uses the GED device as part of a comprehensive behavior modification treatment plan to treat serious disruptive and non-compliance behaviors that are resistant to all other forms of treatment and are seriously interfering with the student's education and habilitation. The following must be reviewed and confirmed before aversive or restrictive consequences are used for non-aggressive, non-destructive, or non-self-injurious behavior:

a) The behavior significantly interferes with educational development; or
b) The behavior significantly interferes with social development; or
c) The behavior is an antecedent to aggressive, self-injurious or destructive behaviors; or
d) The behavior is a weaker, shaped-down or incipient version of an aggressive, self-injurious or destructive behavior; or
e) The behavior is an attempt to execute an aggressive, self-injurious, or destructive behavior.

65. "One school district CSE chairperson expressed concern that JRC used Level III Interventions for behaviors the district did not consider problematic for a student they had placed at JRC (i.e. getting out of seat, nagging). The chairperson stated that not all the student's identified behaviors in which the student received skin shock were significant to the extent that they interfered with the student's ability to learn". **(page 14, par. 3)** The Review Team gives no information about who this CSE Chairperson is or the student he is referring to, so it is impossible for JRC to respond. The JRC Clinicians and staff will respond to any questions about treatment posed by any school district official or parent. When such questions are posed to JRC the matter is thoroughly reviewed with the school district official(s) and the parent and the matter is resolved to everyone's' satisfaction.

66. "A higher functioning teenage student was observed sneezing in class. She covered her face and called out for a tissue. The teacher then indicated that that "calling out" was a target behavior that would result in her action being pinpointed as inappropriate (i.e., subject to aversive consequence). This example raises concerns that there might be little to no discrimination of acceptable, appropriate behaviors within a targeted behavior category subject to Level III aversive consequences by untrained or poorly supervised staff." (page 14, par. 4) This report incorrectly assumes that JRC staff indiscriminately consequate students with a GED. JRC staff are only allowed to use the GED for targeted behaviors in a particular students' program designed by the student's clinician. These behaviors are clearly defined and staff members are trained thoroughly on how to read the recording sheets and consequate behaviors. A talk out is not normally subject to Level III interventions and this is again another misunderstanding. This statement is false. This student was not given a GED application for asking for a tissue and such a behavior would never be consequated with a GED application at JRC. The JRC students are taught to raise their hands and wait to be acknowledged by the teacher when the student has a request or to answer a question that the teacher has posed to the class, which is the same procedure used in almost every classroom in the nation. JRC's teachers do point out a failure to follow this classroom rule when it is not followed by a student which again is the same procedure used in every classroom in the nation.

67. "One student's record indicated he would receive one GED for aggression (including verbal threats of aggression or aggressive posturing) as well as actual aggression toward others; possession of weapons, destruction of property or threats to destroy property; leaving a supervised area; running away; hurting self, or verbal threats to hurt self, swearing, yelling, screaming or refusal to follow directions. His plan indicates he would receive five GED exposures over a 10-minute period applied to his legs and waist in response to attempts to touch the GED transmitters in an effort to apply the GED shock to another student. This same student reported the last GED shock he received was for an incident of swearing." (page 14, par. 5) This report indicates that different students receive different consequences for different behaviors; this is actually evidence of how individualized our treatment plans are. Students may receive different consequences for different behaviors. If a student does not respond to one application for a particularly dangerous behavior (giving another student a GED application is particularly dangerous) then he/she may benefit from a stronger consequence such as receiving multiple applications over a specified period of time as clinically indicated. In many cases, swearing is a clear antecedent behavior to aggression.

The student we believe the Review Team is referring to is doing extremely well. Since the approval of the GED, he is now able to work on all of his educational, transitional, social and emotional goals as stated in his IEP. Prior to the approval of the GED, he needed to be removed from his educational classroom and be educated in an alternative

environment due to the high frequency of behaviors he was exhibiting. At times, days would go by without any educational work being completed due to refusals to work on academics, refusals to follow any directions, disruptive behaviors such as swearing and instigating others and aggressive behaviors towards others that would at times lead to restraint. Now, he is very focused on his academics and is always very attentive during lessons and is eager to complete his assigned work. Behaviorally, he has made remarkable progress. He is in the process of being faded from the GED and is currently being reviewed by the Transition committee for increased levels of independence and an in-school job.

68. "Massachusetts' regulations authorize Level III interventions only to address extraordinarily difficult or dangerous behavioral problems that significantly interfere with appropriate behavior and/or the learning of appropriate and useful skills and that have seriously harmed or are likely to seriously harm the individual or others. While behaviors such as "refuse to follow staff directions", "failure to maintain a neat appearance", "stopping work for more than 10 seconds", "interrupting others", "nagging", etc., may have been found predictive of more serious behaviors in past instances, they are clearly not extraordinarily difficult or dangerous in their own right. Common behavioral practice is to use these behaviors that have been at the beginning of a chain leading to severe behaviors as a signal to institute preventative measures that would break the previously observed chain." (page 14, par. 6) This report falsely describes the events of "chaining" and suggests that JRC incorrectly uses this procedure by punishing the first link in the chain. The position that the review team describes as "common behavioral practice" on chaining is incorrect. "Common behavioral practice" is to identify the steps or "links" in a behavioral chain, and to eliminate the first link, thereby obviating the entire chain.

It may well be that "common behavioral practice within the field of Positive Behavior Support is different, and is to "use these behaviors as a signal to institute preventative measures that would break the previously identified chain." If so, that indicates a clear difference between Positive Behavior Support (which is really more of an ideology than a science and is based on the avoidance of the use of aversives[2]) and behavioral psychology. A comprehensive review[3] of studies using Positive Behavior Support procedures showed that it is effective in only 50-60% of the cases. JRC tends to serve the students who have not been able to be served effectively with positive-only procedures.

---

[2] See Jim Mulick and Eric Butter's chapter, "Positive Behavior Support: A Paternalistic Utopian Delusion in, Jacobson et al, Controversial Therapies for Developmental Disabilities, Lawrence Erlbaum Associates, 2005, pages 385-405.

[3] Carr, E. G., Horner, R. H., Turnbull, A. P., Marquis, J. G., Magito McLaughlin, D., McAtee, M. L., Smith, C. E., Anderson Ryan, K., Ruef, M. B., & Doolabh, A. (1999). Positive behavior support for people with developmental disabilities: A research synthesis. Washington, DC: American Association on Mental Retardation.

As stated earlier, no student reviewed by NYSED received a GED application for "failure to maintain a neat appearance", "stopping work for more than 10 seconds", or "interrupting others". This is a blatantly incorrect statement. The Review Team also fails to point out that all the students are tried on a positive-only behavior modification treatment plan at JRC and aversives are added to the treatment plan only when the positive only procedures are not sufficiently effective.

69. The June Report states that seventy-one NYS "students were receiving Level III aversives as of the date of the review and JRC was seeking court approval to use Level III aversives with an additional 10 students. Of the IEPs of NYS students that include statements regarding the use of Level III behavioral interventions, all read the same and are written without specificity with regard to how such interventions are to be used with a student:" (p. 15, par. 1) The language used in the IEP is decided upon by the school district. Using general statements to describe procedures/goals in the IEP is common practice across all school districts, and used to describe the different education strategies and treatment options available. The priority for the IEP is to select the most appropriate procedures and goals for the student and not to describe them in great detail. JRC has never been asked to expand upon, or provide clarification of, these general statements either by a CSE or by NYSED. NYSED examined JRC's IEPs as recently as in its September 2005 visit and made no criticism. The June Report neglects to mention that JRC submits to the school district an individualized rationale for the use of level three procedures prepared by the clinician.

70. Eight "students receiving Level III aversive interventions had lEPs that indicated that JRC would be seeking court authorization to use of Level III aversive interventions with no indication on the IEP that JRC had obtained court authorization." (p. 15, par. 4) When the student's behaviors are dangerous and, out-of-control, interfering with education, and resistant to all other forms of treatment, then the IEP team will put aversives in the IEP and JRC will be instructed to seek court-approval. All students, however, are tried on JRC's non-aversive intensive behavior modification treatment program upon admission to see if JRC's brand of very consistent, intensive, 24-hour version of positive-only behavior modification treatment will be effective without the need for adding aversives upon court approval. In many of these cases, the student's behaviors do show sufficient improvement simply by being exposed to JRC's very consistent positive-only procedures and in those cases it is not necessary to seek court authorization for the Level III procedures. The student is successfully treated with less intrusive treatment which is an outcome that all parties to the IEP are pleased with. This process meets all the requirements of the IDEA

71. Four "students were receiving Level III aversive interventions with no indication on the IEPs that JRC would seek or had obtained court approval." (p. 15, par. 5) These four students were receiving Level III interventions at the time of the April and May, 2006 visits and those interventions were in the students' current IEPs that were at

JRC at the time of the April and May visits. The IEPs that did not have Level III interventions in them were older IEPs that had been written prior to the time that the students were approved for the interventions. They were accurate at the time they had been sent to NYSED (approximately March 2006), but were now out of date by the time of the April and May visits, and had been replaced with the new, current IEPs that were in JRCs files during the April and May visits.

72. The June Report claims that "the use of electric skin shock conditioning devices at JRC raises Health and Safety concerns." (p. 15) If the Review Team and NYSED was truly concerned for health and well being of the students at JRC these concerns should have been reported to JRC immediately, during the April and May visits, and not two months later in a report dated June 12. If the NYSED visitors had done so, JRC could have addressed any legitimate safety issues promptly or cleared up any misunderstandings. JRC has used the GED and GED-4 skin shock devices on hundreds of students over the last 17 years without any health or safety issues. JRC's safe and effective use of the GED and GED-4 devices is the subject of judicial findings in hundreds of cases before the Massachusetts Probate Courts.

73. The following statement was included in the report:
"In addition to the GED, JRC uses an additional form of electrical circuitry that automatically administers a series of aversives (e.g., skin shocks) as soon as a behavior is initiated. This device is not activated by a staff person and continues until the behavior stops. Should the student fall, for example, after getting out of his/her seat, the student would continue to receive electric shocks." (page 15) This statement is false. No student has ever fallen after getting off of his/her seatboard. Also, a staff member is with the student at all times and holds a remote control switch that can immediately shut off the device. There is also a manual shut off switch on the device itself. At no time did the NYSED visitors request the safeguard information concerning the automatic negative reinforcement device. This automatic procedure has been critical in the effective treatment of extremely dangerous and life-threatening behaviors that occur frequently for certain students and could not be effectively treated with any other form of treatment. For example, this procedure successfully stopped a student from gouging out the inside of his mouth and throat with his fingernails, and stopped another student's behavior of suddenly and very violently attacking people.

74. "As stated previously, NYSED could not find evidence that this automated electric shock device has been approved or cleared for marketing by FDA." (p. 15) FDA registration and approval is required for devices that are sold to the public. JRC does not sell its devices and only uses them within its practice and therefore falls with in an FDA exemption as so found by an FDA investigator who reviewed JRC's program in 2000.

75. "… NYSED has concerns regarding the long term health and safety of the students, particularly those students who may receive multiple electric shocks as

part of their behavior plans…" (p. 16) JRC has safely and effectively used the GED and GED-4 devices with hundreds of students since 1990 and 1992, respectively. No health or safety problems have arisen in over 15 years. There are over 100 professional, peer-reviewed articles that support the safety and effectiveness of skin-shock treatment to treat severe behavior disorders. There are judicial findings in hundreds of cases before the Massachusetts Probate Court evidencing the safety and effectiveness of these devices. This is in contrast to the only other treatment available for severe forms of behavior disorders, which is anti-psychotic and other potent medications, which medications have caused severe and permanent injuries to patients when used on a long-term basis such as liver and kidney damage, tardive dyskinesia, substantial weight gain, lethargy and drowsiness, etc. The June Report does not state any specific concerns about the GED and GED-4 devices and does not give any examples.

76. The June Report states that "despite the safety warning of the GED device that the GED should not be allowed to become wet or submerged in water, it was reported by JRC staff that for some students, the GED device remains on them while they take a bath or shower." (p. 16) JRC's use of the GED device in order to maintain the students safety during bath/shower is consistent with the FDA safety precautions. Bathing/showering is a very dangerous time for a student with a severe behavior disorder because an act of violent aggression or self-abuse could result in a life-threatening head injury from coming into violent contact with the tile of bathroom fixtures. In order to maintain the student's safety, the GED device is not in the tub or shower when the student bathes or showers. One arm is kept outside the bathing area and has no contact with the water. The electrode is placed on the forearm of that arm and wrapped. There is no danger of injury using this method and it insures consistent treatment. There have been no injuries as a result of this procedure but there have been many injuries during this time when the student was in the bathroom and not wearing the device. If a student exhibits self-injury or aggression while in shower stall or bathtub it is very difficult to keep everyone safe. From a behavioral approach it does not make sense to discontinue treatment, especially in the initial phase of its use. When the targeted behaviors are reduced to a low level the GED is faded from the bath or shower.

77. "Student records verified this…" (p. 16) The records only use the phrase "GED shower" which is JRC's short-hand phrase for using the GED device as described above in paragraph 76. Had the visitors asked JRC, JRC staff would have explained the procedure.

78. "…and one student interviewed stated that she had been burned by the GED device while taking a shower. By this student's report, a new staff person was not adequately trained to administer the GED4 shock during the student's shower, resulting in a burn to her skin where the device was attached…" (p. 16). This statement is not true. No female students from NY are receiving treatment with the GED-4 device and no student has been burned by the GED or GED-4 devices. JRC has a full-time nursing staff examining students on a daily basis, and three consulting

physicians that examine the students on at least a monthly basis. The students are always being watched by staff in person and on JRC's 24-hour live digital monitoring system that has cameras in every JRC classroom at the school buildings and in every room in the JRC group homes. If any student was injured in any way by the GED or GED-4 devices it would have been observed by staff, if not expressly told to them by the student injured. The Review Team did not disclose to JRC at the time of the visit the identity of any student claiming to be harmed by the devices. If they had then JRC would have investigated it immediately. The student in question has never had evidence of a burn and has never been on the GED-4. We know this because her clinician interviewed this student as soon as we received the June Report and read of the alleged suicidal behavior. She has received a total of five applications in 9 months, is now totally faded from the device and no longer wears it during her self care.

79. The June Report claims that "the Contingent Food Program and Specialized Food Program may impose unnecessary risks affecting the normal growth and development and overall nutritional/health status of students subjected to this aversive behavior intervention." (p. 16). Both the contingent food program and the specialized food program are monitored daily by JRC's full-time nutritionist and medical staff. Students on the contingent food program are weighed a minimum of once a week and the students on the specialized food program are weighed daily. Caloric intake is also monitored and adjusted when necessary. JRC's nursing staff monitors the student's health on a daily basis. JRC employs a nutritionist who oversees the nutritional status of its students and JRC consults with nationally-known experts on nutrition in the overall design of its food services. No JRC student has ever suffered adverse effects from the food programs. The health of the JRC students improves, usually dramatically, while on the food programs. The students' problematic behaviors improve as well which leads to a fading and ultimate elimination of the contingent and specialized food programs.

80. "JRC's current food service program promotes a diet that is largely based on whole plant foods and actively restricts meat and dairy products." (p. 16, par. 3) JRC has modified its regular student menus for breakfast, lunch and dinner in order to provide all of the JRC students with healthier meals. This is consistent with the national trend to improve children's' health by giving them healthier food to eat and eliminating much of the unhealthy food that was typically part of a school meal program. Most of JRC's menu is based on plants and is carefully overseen by JRC's nutritionist and well prepared by JRC's cooking staff. The JRC students have the best tasting and most healthy food of any residential school and the students' health has greatly benefited. The menu, however, is not exclusively plant and fruit based. Cow's milk is available at every meal. On four meals each week the students may choose a meat entrée and on a fifth they can order out any food they wish, provided they have passed their contracts. The make-up meal provided as part of the contingent food program is composed of chicken, mashed potatoes and spinach.

81. "School aged children consuming plant-based diets need to have access to a variety of foods that provide adequate amounts of calories and nutrients such as protein, iron, zinc, Vitamin B-12, calcium, Vitamin D, riboflavin, Vitamin A, n-3 fatty acids and iodine to ensure proper growth and development." (p.16) JRC has developed its menus with the consultation of nationally known experts on nutrition, to make sure that all needed nutrients are included. In 2004, the Massachusetts Department of Education audited JRC's modified school menu for the Federal school breakfast and lunch program and concluded that JRC's menu meets all of the Federal nutrition requirements.

82. "The Contingent and Specialized Food Programs focus only on the total number of calories "earned" and fail to identify on a daily basis what nutrients are being "discarded" as a result of the student not fulfilling their contracts. Students who do not fulfill their behavior contracts are made to throw a pre determined caloric portion of their food into the garbage."

"A review of the weight records, biochemical (lab work) and daily intake sheets for four NYS students on the contingent food program and one student on the specialized food program noted that at the current time all individuals are maintaining their weights and body mass index (BMI) within acceptable limits. However, the students' weights and body mass indexes are not complete indicators of the students' nutritional health status. There is no evidence that JRC conducts routine dietary intakes (both qualitative and quantitative) for participation in the Contingent Specialized Food Programs. Monitoring and evaluating routine dietary intakes is fundamental in assessing and identifying specific nutrition concerns or potential nutritional risks."

"JRC's document 'Food Services at the Judge Rotenberg Educational Center' stated that in pertinent part each student is given a multivitamin each day. A review of four Nutritional Assessments of individuals on the contingent and specialized food programs did not indicate that any of these students were receiving multivitamin."

"The Contingent and Specialized Food Programs do not indicate the order that the food portions should be served. Hot food leaving the kitchen at the appropriate temperature may be served to the student at any time during the established time frame for the program. A review of four individuals on the Contingent Food program and one student on the Specialized Food Program indicated that the food programs for each meal can delay food consumption from two to four hours, compromising required hot and cold food temperatures."

These statements are false. The food program is monitored by a JRC nutritionist and JRC's full-time nursing staff and JRC utilizes many consulting nutritional experts. Three JRC consulting physicians also oversee the health of each student. The contingent and

specialized food programs are monitored very carefully by the clinician, medical staff and nutritionist as outlined in the treatment plan. This statement is pure speculation that is belied by the medical records of these students which demonstrate unequivocally that the students are well fed, receiving all nutritional requirements, and in very good health. The JRC students receive more medical attention than the students of any other school.

JRC does not require its residents to follow an exclusively plant-based diet. The students at JRC have an option of choosing an entrée which contains meat four times per week. Students also have an opportunity once per week to order out from a variety of different restaurants, provided they are making their behavioral contracts, and they can order whatever they wish to at that time. Cow's milk (2% milk) is available to students at each breakfast and at each lunch. Chicken is used as part the make-up food used in certain procedures that are authorized as part of JRC's court-approved treatment. Students who come to JRC underweight, and who are not eating as much as JRC would like them to, are allowed to eat a variety of preferred foods, which can include animal-based foods.

Re the statement, "Vitamins and minerals of particular concerns are protein, iron, zinc, Vitamin B-12, calcium, Vitamin D, riboflavin, Vitamin A, n-3 fatty acids and iodine," all of these nutrients, with the exception of B12 are plentiful in any varied plant-based diet. Regarding vitamin B12, JRC students receive a multi-vitamin each day that takes care of that requirement.

Although the NYSED June Report addresses their unfounded concerns about deficiencies in vitamins, minerals and calories, it shows no concern about two of the biggest deficiencies in the American diet: fiber and antioxidants, both of which can only be obtained from plant foods, cannot be obtained from refined foods (without supplementation) and both of which are plentiful in the JRC menu plan.

The major health problems facing school age children today are all problems resulting from the excess consumption of calories and the inadequate intake of fiber, antioxidants, vitamins and minerals. The NYSED June Report fails to mention that the diet JRC promotes addresses all of these concerns and provides the students with an invaluable education on healthy eating that will pay them great dividends for the rest of their lives.

83. "A review of four Nutritional Assessments of individuals on the contingent and specialized food programs did not indicate that any of these students were receiving multivitamin." All students receive a multi-vitamin as prescribed by JRC's physician, so it is not mentioned by JRC's nutritionist in the Nutritionist Assessments. Had the Review Team asked JRC then they would have been given this information and this information is also in each student's medical records at JRC.

Food warmers and chillers are provided for students on contingent food. Again since this concern was never mentioned to JRC during the review, this information was not passed on to the Reviewer Team.

84. The June Report states that "JRC is receiving federal funds to administer the National School Lunch and School Breakfast Program that are not properly payable. JRC did not have adequate documentation to support that all meals served at the school met the minimum standards established by the United States Department of Agriculture (USDA). We have notified John Magnarelli, Director of Special Nutrition Programs for USDA Northeast Regional Office of this finding; he informed NYS that he has instructed the MDOE to formally notify JRC and request that they comply with the federal meal pattern requirements immediately." (page 17) JRC's current food menu was reviewed over the course of two days by a representative from Massachusetts Department of Education for the Federal Food Program in 2004. Full observation of the food program was observed and we were found to be in full compliance. NYSED has acted in an unprofessional and reckless manner by reporting JRC to Federal authorities without at least asking JRC about this concern.

85. The June Report claims that "The education program is organized around the elimination of problem behaviors largely through punishment, including the use of delayed punishment practice." (p. 17). This is not accurate. The opposite is true. The elimination of problem behaviors is largely done through Positive Programming. Positive programming is used as the first approach to treatment and works with about 50% of JRC's students. Aversives are added as a supplement to positive programming if and when positive programming alone proves to be insufficiently effective. Delayed punishment practices are only used with the approval of the clinician when there is a clear therapeutic value. JRC's treatment program maintains a high ratio of rewards to any other kinds of consequences.

JRC's educational software is configured to reward the students automatically at the end of each lesson, or when they have met their aim. Students can either earn a token or a reward of their choice, using the reward menu that the software presents as a reward. All of JRC's software programs are designed to give positive feedback for correct responses, through audio feedback or visual feedback. All programs are configured to the students' individual needs, including teaching methods that are most rewarding and effective for them. The higher functioning students can earn games or points for mastering a lesson. The software, through the means of the reward menu, enables JRC staff to find out exactly what is rewarding to each student and lets the student earn it through academic progress.

86. "JRC's Director of Clinical Services stated that less than 10 percent of the enrolled students are receiving a "reinforcement" only program. (p. 17, 3rd bullet) NYSED clearly misunderstood JRC's Clinical Director. What he actually told them was that approximately 10% of the student population has progressed to point where they no longer need to have staff monitor their behaviors using a recording sheet. These top 10% of JRC's students have progressed so far with their education and treatment that their

education and reward program resembles that of non-special education student and therefore no longer requires daily recording of education progress and earned rewards.

87. "JRC's "positive only intervention" includes a token system in which students are awarded tokens for the absence of exhibiting target behaviors and negatively reinforced by the removal of tokens or privileges for behaviors. It was observed that tokens are not awarded for exhibiting positive, appropriate alternative behaviors. (p.17, 4th bullet) This is not true. JRC students receive constant rewards for displaying positive behavior, including rewards for sitting quietly, focusing on task, appropriate eye contact, appropriate tone of voice, using his/her voice, following directions, working consistently, and interacting appropriately with others. These are only a few of the many behaviors rewarded with tokens.

88. "Students with reported histories of aggression or injury are "often excluded from participating in the classroom and placed in "conference rooms" as a means to control targeted behaviors. Some of these students were observed to be fully restrained in restraint chairs and wearing movement limiting helmets." (p. 17, 5th bullet) Only a very small percentage of JRC's students engage in behaviors that are so dangerous that they have to be removed from their classroom for safety reasons and given their lessons in a conference room. Typically these are students that have not progressed significantly with JRC's positive only behavior modification treatment plan and are awaiting court-approval of supplemental aversives. The need for a student's placement in a restrictive setting is reviewed daily by members of the student's treatment team. The treatment team for any student with a high frequency of dangerous behaviors is constantly working to make modifications to that students' program to reduce the unsafe behaviors and return the student to a less restrictive setting. Teachers are assigned to each student and meet with the student daily to go over academics. The students are always presented with academics pursuant to their IEP goals even when in alternate settings.

89. "One student left the school building in full restraint (hands and feet restrained with Velcro straps in a restraint chair), clearly agitated and upset, and returned the following morning carried to the conference room fully restrained in what appeared to be the same chair. "(p. 17, 5th bullet) What the Review Team observed was a student with a demonstrated risk of engaging in violent aggressive or self-abusive behavior during transport. He had been placed in transport restraint for the bus trip from the JRC school building to his JRC group home and then they saw his return to the school building the next morning in the same transportation restraint. JRC has a waiver from MA DEEC to use transportation restraint to keep students safe during the high safety risk associated with bus and van travel to and from the JRC group homes. Transportation restraint is applied with the approval of the student's clinician and the need for transportation restraint is assessed daily by the student's clinician and treatment team. The statement "in the same chair" is misleading and is meant by the Review Team to make the reader believe that the child was restrained from the time the student left the

program in the evening until his/her return in the morning. This is not true, and if this was truly a concern, the NYSED visitors did not ask if this was the case.

90. The June Report states that a staff member working with a student in a conference room reported to NYSED that "students can spend the entire day in the small room, restrained if necessary; only to be slowly released as they feel the target behaviors are decreasing in intensity."(p. 17, par. 6) This is not an accurate quote from this staff person. Students are only placed in a conference room or in emergency restraint when they engage in behaviors that demonstrate an imminent risk of serious physical harm to themselves or others. Restraint is removed as soon as this risk dissipates. Students are returned to their regular classrooms as soon as their behavior indicates that they can return to class without disrupting the classroom.

91. "It was observed that some of the students placed in the conference rooms were not exhibiting any inappropriate behaviors and were playing video games and/or completing worksheets".(p 18, 1st bullet) One of the first steps for determining whether a student is ready to return to his/her regular classroom safely is to give the student some school work to do in the conference room and observe whether to student can follow instructions without engaging in disruptive behavior. As in all other settings at JRC, students who follow their education lesson receive rewards which is why this student was playing a video game. A student who can be calm and participate in academics without engaging in disruptive behavior is returned to his regular classroom. A member of the student's treatment team monitors the time each student may spend in a conference room. In addition, rewards in the conference rooms are offered more frequently and for longer durations than those typically offered in a less restrictive environment. This is because these students have not yet learned to control their behavior for substantial periods of time. It is important that such students, even though they are in a restrictive type of educational environment, have access to rewards and are able to earn them frequently.

92. The June Report states that NYSED reviewers observed "A student, reported to have extreme head banging behaviors not exhibiting any inappropriate behaviors while having her hair braided by an adult in the classroom. Her appropriate interactions were not rewarded and for acknowledged by the staff."(pg. 18, 2nd bullet) The Review Team completely misunderstood this student's situation because they refused to receive any information about the JRC treatment program. Had the Review Team asked JRC staff, they would have learned that this student was already engaging in one of her favorite rewards by having her hair braided by staff. Hair braiding is extremely rewarding, in and of itself, for many students and many have this reward specified in their behavioral contracts. It is not necessary that verbal rewards be given constantly, at all times, for every desirable behavior that a student shows. The frequency with which rewards, verbal or otherwise, need to be given is individually determined. If a behavior is weak, and just being learned, it may need to be heavily rewarded, including constant verbal praise. If one behavior is strong, then rewards need to be concentrated on other behavior that still needs strengthening. In addition, we want to eventually wean all

students off of artificially high frequencies of verbal rewards so that they can function in a more normal environment that they will encounter outside JRC, where the frequency of rewards will be substantially less than it is at JRC. To simply make a criticism of the absence of rewards, based on a casual observation like this, without discussing these issues with the JRC clinician responsible for the student, is irresponsible.

93. "The behavioral program for [the same] student, not on GED, consisted solely of alternating her between a low demand setting and a situation of higher demand (academic computer work) which resulted in her be placed into emergency restraint." (p. 18, 3rd bullet) This student finds breaks on the couch in the classroom reward area very rewarding and has the ability to earn them frequently since she is just learning to have demands placed on her. This student is doing extremely well at JRC and has made major improvements when compared to her condition and lack of educational opportunities before admission to JRC. The Review Team would have learned this had they have been willing to accept information about JRC.

94. "Otherwise, no other intervention strategies were being used with this student. She is currently awaiting court approval for the use of Level III aversives." The visitors apparently disapproved of the fact that JRC was not trying more interventions with this student, pending application to the court for approval of Level III interventions. Their only discussion was apparently some brief questions they posed to the classroom supervisor, who does not design the clinical interventions. Because they did not address their questions to the appropriate person (the clinician) the visitors' criticisms were made without their having an adequate understanding of the entire case.

E.C's individualized program currently includes a total of 8 contracts that target her most problematic behaviors including health dangerous, aggressive and destructive behaviors. For example, her Less than a Day contract is for 10 minutes through task completion earns a 10 minute break in Classroom Reward Store (CRS) to watch one of her favorite DVD's. While in CRS, she may also listen to her MP3 player, her silver boom box, enjoy rewards in her Pink Reward Grab bag, which includes a CD player, CD's, DVD's, crayons, markers, construction paper, Sesame Street videos and music. E.C. also earns her favorite snack, Cheezits, for exhibiting no dangerous behaviors each hour. Also, for exhibiting no dangerous behaviors from wake up to lunch time, she earns a preferred take out lunch from a local restaurant. E.C. has her Tech/Speak vocal assistant available to her at all times to assist her in communicating her wants and needs. Since the time that she was admitted to JRC in November 2005, we have tried various reward systems such as a token economy and currently she is placed on an immediate reward system. We have also made several changes to her behavioral contracts, implementing new contracts, and adjusting them frequently in an attempt to design the most rewarding and positively reinforcing system for her. She has moved residences during her time here, and necessitates frequent emergency restraint due to her very high frequency and severe health dangerous (self injurious) behaviors, namely head-banging; as well as her

aggressive behaviors. We have created many special contracts to reward E.C. for the absence of those dangerous behaviors which may lead to an emergency restraint.

95. "Clinicians do not conduct routine preference assessments." (p. 18, 4th bullet) This is a completely false statement that was once again intentionally manufactured by the Review Team through their method of not asking JRC for information and refusing JRC's many requests to provide them with information about the JRC program. JRC's Clinicians and the other members of the treatment team, and all other staff do routinely conduct preference assessments on weekly and at times on a daily basis. Effective rewards are the preferred method of behavioral treatment at JRC and JRC has the most extensive reward program in the nation. Clinicians at JRC also conduct behavior counseling sessions and case managers speak with their students constantly. During both types of interactions students are again asked about their interests in other rewards that the student would like to add to their behavioral treatment program. Clinicians also review the students' behavioral charts with interventions phase-lined directly on them to determine the effectiveness of rewards.

In addition, JRC tries to use the concept of the pictorial reward menu as frequently as possible with its lower functioning students, so that the staff never have to guess whether a given item is rewarding in function for a given student. The preference is assessed, each time the student uses the reward menu. The same principle is at work when a student is taken to the Contract Store (something the visitors may not have seen because they declined the tour) or the Big Reward Store. These Stores are bright and colorful rooms that are stocked with personal electronics, clothing, toys, games and other items desired by the students. When a student enters one of these areas, he/she "expresses his preference" by selecting the item or activity of his/her choice.

Actual selection from a choice of rewards seems to be a better procedure than using a preference assessment. When one does a preference assessment, one has to assume that the preference that the student has at the time of the assessment will still be the same at some later point, when the item or activity is delivered to the student as a possible reward. By contrast, when one allows the student to choose from a wide variety of possible reward items or reward activities, there is no need to worry about the fact that a student's preferences can change from hour to hour, day to day, and week to week.

96. " JRC has a policy on modifying contingencies due to the special 'pleading" of students" (p. 18 para. 5). We do not understand what this statement is referring to. Nowhere does JRC have such a policy. Contingencies are modified based on the data and the students' expressed preferences, not on the "pleadings" of the students.

97. "Part of the treatment program for students involves deliberately setting up unfair or mistaken directions or decelerative (application of a skin shock with a GED device) consequences for the students. The student is expected to handle these unfair situations successfully and not 'plead' or appeal to a psychologist or clinician

regarding his/her treatment. In instances where the student "pleads" to the psychologist or clinician, there are consequences imposed on the student." (p. 18 para. 5) The Review Team had demonstrated a complete lack of understanding of JRC's treatment systems known as *programmed opportunities* or *programmed ops.* In a programmed opportunity, a stimulus is presented to a student that might trigger some inappropriate behavior. JRC is teaching the student how to respond properly to this stimulus, and how to eliminate a previous learned response such as past acts of violence when presented with the same stimulus. No student has a programmed opportunity in which the student receives an undeserved GED application, nor is that stated anywhere in a program or policy. This is a blatant misrepresentation of what the visitors read.

At JRC the term "programmed opportunities" is used to refer to three different types of situations: (1) *academic* programmed opportunities; (2) *social* programmed opportunities; and (3) *treatment* programmed opportunities. What is common to each of these three types of "programmed ops" is that in each case some stimulus is deliberately presented (this is why we call them *programmed*); a response is then sought from the student; training and prompting is provided to the student to help him respond correctly; and the student is then consequated appropriately, depending on how he responds. Exhibit 1 contains a section of JRC training materials that explains what programmed opportunities are, how they are used, and how they fit into the total treatment package for a given student.

98. "**JRC reported that four NYS students are approved for the "multiple application GED" (p. 18 para. 6)** This is not what JRC told the Review Team. They asked who was *receiving* multiple applications and we reported that there were four NYS students who were receiving multiple applications. <u>All</u> students who are approved for the use of the GED are approved for multiple applications.

99. "The report states that the GED is sometimes applied after a delayed period of time following the occurrence of a target behavior." (p. 18 par. 7) The GED is sometimes applied after a short delay in order to carry out a brief verification procedure, which typically requires only seconds to complete. Before the GED is administered, the staff member who intends to administer it is required to check with another staff member, in the same room, to make sure that the correct procedure is administered to the correct student for the correct behavior. This verification procedure takes a matter of seconds and avoids potential mistakes. In certain situations where a student is covered by a 1-1 staff member a "pre-verification" procedure is permitted that enables the GED to be administered without any delay at all.

100. The June Report states that it was reported by JRC's Director of Clinical Services that the routine administration of a skin shock by staff occurs 15-30 seconds after a target behavior has occurred. In other cases, the delay in the administration of the GED is much longer (p. 18 para7). Each JRC behavioral treatment plan is designed based upon an individual assessment of each student's

problematic behaviors, functioning level and treatment goals. The JRC Behavioral Treatment Plans and Program Descriptions identify specific targeted behaviors and assign specific consequences for each targeted behavior which are consistently applied by the JRC staff. JRC staff are required to apply a behavioral consequence as soon as possible after a targeted behavior is observed or is discovered to have happened and without prolonged delay between the occurrence of the behavior, or the discovery that it has occurred, and application of the consequence. JRC staff are not allowed to apply a decelerative consequence to a student unless the targeted behavior is observed by staff present with the student, observed live by a Monitor on JRC's DVR camera system or otherwise determined to have occurred. If a student's problematic behavior is not detected upon occurrence and is later discovered on a DVR tape, by admission of the student, or through some other means, then the student may receive the assigned consequence for the behavior when such a delayed consequence is determined to have significant therapeutic value by the student's Clinician.

When deciding whether there would be significant therapeutic value in treating a later-discovered problematic behavior, the JRC Clinician considers the functioning level of the student, the dangerousness of the behavior, and any possible negative side effects of delayed treatment of the behavior. JRC does not apply delayed consequences when there is minimal or no therapeutic value such as when the behavior is not dangerous or potentially dangerous and was not treated immediately due to staff error. Our handling of delayed consequences takes advantage of the rule –governed behaviors that our higher functioning student possess and that play a very important role in their treatment.

101. "The use of camera monitoring allows for delayed punishment. In cases where the student did not receive the GED, the individual reviewing the video footage from earlier in the day reports to the psychologist, who then makes the determination that the GED should be applied long after the targeted behavior occurred (p. 19, par. 1)." See the response given for the immediately preceding item (#100), which covers this item as well.

102. "One NYS student reported of an instance when she had returned to her residence and fallen asleep. She was woken without explanation and told to stand. She was given a GED across her stomach, and then was informed that the reason for the punishment was a target behavior earlier that day for which she did not receive a GED. "(p.19, par. 1) This statement is simply not true.

103. The June Report states that some students at JRC are forced to exhibit target behaviors so aversive behavioral interventions can be used. (p. 19, 1st finding) The student is not "forced" to exhibit a behavior. This is a court authorized treatment procedure referred to as *Behavior Rehearsal Lessons* ("BRL") (Recreating the Scene). The staff member presents a stimulus for some life threatening targeted behavior that the student has exhibited in the past such as putting his/her head or fist through a glass window. One more occurrence of this behavior could cause permanent disability or

death. Pursuant to this procedure, the staff member prompts the student to engage in the initial phase(s) of the behavior, and arranges some planned aversive stimulus. This procedure is arranged to be carried out at pre-specified times of the day, and over a specified number of days or weeks. The procedure is used to treat problem behaviors, such as pulling out the hair of others, biting others or self, and opening a car door while driving. It is has been very effective in treating behaviors with a low frequency of occurrence, such as eye gouging or life-threatening aggressive behavior, where even one natural occurrence of the inappropriate behavior could have serious consequences for the student or others.

104. "Staff reported that this type of behavioral intervention is difficult to participate in and dramatic to watch." (page 19, par. 2) No staff members who were interviewed by NYSED during either the April or May visits of NYSED reported that they were asked about the use of BRLs. The staff dealing with NYSED only gave the numbers of NY students who were approved for the procedure. JRC staff stressed to the NYSED Review Team that the procedure was not being used currently on any of the NY students, is a rarely used procedure and is only used for extremely intense, but infrequent behaviors where one instance could cause severe damage or even death.

105. "It was reported by a JRC staff member that one of the BRL episodes involved holding a student's face still while staff person went for his mouth with a pen or pencil threatening to stab him in the mouth while repeatedly yelling "YOU WANT TO EAT THIS? The goal was to aversively treat the student's target behavior of putting sharp objects in the mouth." (page 19) This student almost killed himself several times before his placement at JRC by swallowing the following while admitted to psychiatric hospitals: pencils, toothbrushes, a chess piece, a pen and a half a bar of soap. He was admitted to JRC in April, 1992, and successfully avoided swallowing any harmful item for 11years until December, 2003, when he swallowed an exacto knife which had to be removed from his stomach through surgery. The wording for his BRL is "do you want to swallow the knife" (i.e. do you want exhibit the inappropriate behavior). This is done as a verbal reminder of what behavior the intervention is being arranged for. This procedure is only used for such low frequency, high intensity behaviors where just one incident could be life threatening. The treatment has been very successful with this student who has not swallowed a harmful substance since he swallowed the exacto knife in December 2003 and is now enjoying again his in-school independent job in JRC's maintenance department.

106. The June Report states that "there is limited evidence of comprehensive functional behavioral assessments in accordance with the Individuals with Disabilities Education Act (IDEA) being conducted at JRC and limited evidence of the collection of data relevant to FBAs."(p. 3, 6th bullet) The JRC Clinicians conduct a functional analysis for each student at the time of admission and continue to do a functional analysis of every targeted behavior whenever required. For students of a residential 24-hour behavioral program such as JRC, functional analysis can be done on a

daily basis because the students are constantly monitored and their problematic behaviors are constantly evaluated by the Clinician and the rest of the student's treatment team. Information relevant to functional analyses also continues to be collected in the weekly behavioral counseling sessions conducted by the Clinicians and in the constant observations that the Clinicians can conduct because 90% of JRC's Clinicians work full-time at JRC.

JRC uses the following multiple methods to do its functional assessments: (1) direct observations; (2) observations via the digital video monitoring system which enables each clinician to observe the student in his classroom or residence at all times; (3) interviews with the student; (4) interviews with parents; (5) interviews with staff who work with the student; (6) record review; and (7) (most important) direct, ongoing, *in vivo* functional analysis through the manipulation of stimuli and consequence interventions and review of charted data to determine the functions of those interventions.

Regarding number (7) above, at JRC we practice an *ongoing, in-vivo functional analysis*. Instead of collecting data on the functions (causes) of behaviors only at certain discrete points (e.g., by doing some analog tests or rating scales prior to selecting an intervention, and then selecting an intervention on the basis of those tests or rating scales), we collect behavior data daily and are constantly examining our behavior data to test various assumptions that our clinicians are constantly making about functions, and to directly and continually assess the functions of behaviors, stimuli, and various interventions. If we suspect that a certain event is rewarding the problem behavior we remove that from the treatment and see if the charted behavior shows a drop in the behavior's frequency as a result. If we think a certain event, if added to a treatment plan, can increase the effectiveness of the reward program, we add it and see how that affects the behavior we are trying to reward. And so on. The charted data, our direct observations, and the DVR monitoring system, among other sources, give us data to support or reject our hypotheses about the functions of behaviors, stimuli and of various interventions.

JRC also designs all of its treatment systems so that the typical findings of a functional assessment (regarding the typical possible functions of consequences) are already taken into account when the treatment program is applied. This means that all systems are designed in such a way that: (1) we avoid or minimize any attention that is given after a problem behavior (this is facilitated by the GED which can be delivered remotely); (2) we avoid or minimize any escape-from-demands that might occur after a problem behavior occurs (again facilitated by the GED which does not require that the student be removed from his/her ongoing activity); and (3) that we avoid or minimize allowing any desired tangible item or activity to be accessed by the student as a result of a problem behavior.

By doing this it does not matter what function (supposed rewarding events), or combination of functions, a problem behavior has at any given time. Regardless of what the function happens to be, the JRC systems are prepared, in advance for that function. In

other words, the JRC systems will, in all cases, minimize the rewarding events (that a functional analysis is designed to uncover) that may be produced by the problematic behavior.

Functional analysis is largely promoted by those who are in the anti-aversives camp. Those who espouse it tend to argue that if you do a functional analysis well enough, you will not have to use aversives. Unfortunately, published data disprove this optimistic statement. In a comprehensive review[4] of 10 years of published studies that used Positive Behavior Support procedures (over 100 individual behavior modification results were involved), the authors found that even when a functional analysis had been done, positive behavior support procedures were effective in only 60% of the cases.

For most of the students who come to JRC, and who have had FBA's in their past, it has been determined that their behaviors were being maintained by multiple functions. Therefore, controlling for as many as possible functions, as is done automatically by JRC's treatment systems, is clearly indicated.

JRC does meet the IDEA standard for functional behavior assessment. Our procedure includes: interviewing; observing; hypothesizing; addressing all probable functions via the systems of the treatment program; and in vivo continual monitoring of functions by observing the effect of intervention changes on behavior frequencies. JRC does not choose to use certain types of functional analysis such as the analog (Iwata-type) or rating scale (Durand/Crimmins type). In the hundreds of referral packets JRC has received it is rare to see the results of an Iwata-style Functional Analysis or how the results may have been used to design a treatment program.

The best way to describe our approach to the understanding of the functions of behaviors is an ongoing functional assessment that begins with a review of historical records before the admission and continues until the day the student leaves. The initial step in trying to prevent the inadvertent reinforcement of problem behavior is to design behavior programs that minimize the roles that escape, attention and obtaining tangible items or activities can play in motivating unwanted behaviors. Minimal attention is given to a problem behavior but a lot of attention is given following positive behaviors. Preferred tangible items are programmed into DRO contracts and generally not available at other times and the means for students to request those items are taught as necessary. Tasks or IEP goals are initially set at a very short duration with a large reward for completion, to reinforce staying on task and reducing the chance of the individual engaging in a problematic behavior to escape the demand.

The tools that are used in our ongoing Functional Assessment include: interview with the

[4] Carr, E.G., Horner, R.H., Turnbull, A.P., Marquis, J.G., Magito McLaughlin, D., McAtee, M.L., Smith, C.E., Anderson Ryan, K., Ruef, M.B., & Doolabh, A. (1999). Positive behavior support for people with developmental disabilities: A research synthesis. Washington, D.C.: American Association of Mental Retardation.

student on the day of admission; direct observation; digital video recordings in all areas of the school, residence and even during transportation; review of the therapy notes of unusual behaviors that specify antecedent events and what followed the behavior; review of the GED recording sheets that specify what the student was doing, where the GED targeted behavior occurred and at what time; interviews with current staff; and ongoing review of daily, weekly and monthly behavior frequencies and evaluating how interventions affect these frequencies. Programs are constantly adjusted based on all of this information and our behavior charts show clearly the effects of these changes. Given the success of the program this shows the effectiveness of this approach.

107. "JRC relies heavily on brief observations of student behavior in combination with a history of the student's problems to recommend the use of aversive behavioral interventions." (page 19-20) This is not at all a true statement. Constant observation of student behavior occurs at JRC with 24 hour per day data collection. Students are observed and data is collected for months, sometimes years prior to recommending the use of aversive intervention. Student's behaviors are observed live as well as through digital video monitoring.

108. " JRC's process for assessing problem/target behaviors lacks specific information on the function/cause of the actual behavior, and primarily seeks to eliminate behavior through the use of punishment, including aversive interventions. Review of students' program plans did not reveal the identification of or interventions to be used to address the functions the behaviors were serving for the students." (page 20) JRC court-approved treatment plans contain a section on functional assessment. During the months or even years before going to court, positive only procedures and the results of the functional assessment can be seen in the many changes JRC makes to an individual's program. For example: (1) when contracts are changed the changes take into account the function of a behavior, particularly if the behavior appears to be motivated by obtaining tangible items; (2) shorter or simpler tasks are designed to accommodate behaviors that appear to be escape-motivated; (3) where behaviors appear to be motivated by attention-getting, social opportunities may be programmed as contingent rewards for behavioral contracts; and (4) where behaviors appear to be automatically reinforced, the use of manipulative items may be made part of the curriculum or reward scheme.

109. "JRC's use of restraints for self-abusive behavior or the attention paid to students' negative behaviors were not even considered as possible reinforcers of negative behaviors, yet at least one student's record indicated increases in behaviors when these interventions were employed." (page 20) JRC is well aware that restraints for a self-abusive client are very reinforcing and that attention motivates many negative behaviors. We have used restraint sparingly because in general we would like to see students get out of restraint. For those individuals where it is hypothesized that attention from staff or peers is motivating targeted behaviors, the behavior may be recorded but not pinpointed, the behavior may be ignored after the first few targeted behaviors, or the

student may be moved to a different classroom or residence where peers cannot reinforce the behavior. These are strategies that are a small part of a comprehensive behavior modification plan that rewards positive behaviors which replace the negative behaviors.

110. "There was no systematic focus on recording antecedent behaviors in order to modify or eliminate triggers so that problem behaviors as well as the punishing consequences could be prevented."(page 20) All antecedent behaviors for behaviors that are treated with the GED are recorded on a 24 hours basis. Specific behaviors are often charted separately for reasons such as tracking antecedent behaviors. If the NYSED visitors had reviewed the GED recording sheet, as we suggested they do, they would have seen that there is a clear indication of the location where the staff records the behavior or events that lead up to the exhibition of a targeted problematic behavior.

111. "Baseline data is not collected on behaviors across settings." (page 20) This is simply not true. JRC collects data from the moment of admission as is clearly indicated on the daily behavior charts. NYSED visitors did not discuss with JRC how, if any, baseline data was collected.

112. "Important incremental progress a student may make on a target behavior can be missed because JRC only gathers data on broad, generic behavioral categories:" aggression, health dangerous behavior, destructive behavior, major disruptive behavior and noncompliant behavior." (page 20) If the NYSED team had carefully reviewed the students' programs, NYSED would have clearly seen several cases where individual behaviors were charted separately for a lengthy period of time to collect the appropriate data. JRC Clinicians frequently separate specific behaviors out to track by themselves. Direct care staff, when recording an inappropriate behavior, circle the specific behavior exhibited within the category. It is clear that if NYSED had taken the time to learn and understand the program, these types of things would have been pointed out to them.

113. Students are provided insufficient academic and special education instruction, including insufficient related services. (p.20) JRC's academic and special education instruction and related services meet all of the state and federal requirements. It appears that the NYSED visitors made this conclusion after speaking with only one lower level employee in JRC's Education Department. JRC's Education Department consists of a Director of Education, an Assistant Director of Education, a Special Assistant for Education, an Educational Quality Control Specialist, two Educational Assistants, an Educational Testing Coordinator, a Director of Curriculum Development, two Curriculum Developers and eighteen teachers. The total number of administrators and teachers is twenty-eight. The NYSED visitors simply did not have a clear understanding of JRC's academic and special education instruction or of JRC's approach to related services.

114. "Students placed in the more segregated and restrictive settings (i.e., the small conference room) were not observed to receive instruction, even computer-based instruction, and a teacher is not available to provide instruction in that setting. The room is monitored by MHAs with high school diplomas and other nonteaching staff." (page 20) Again, if the NYSED visitors had taken the time to hear and learn about the program, and if questions were asked of us, they would have learned that students assigned to a small conference room or any alternative learning center receive direct instruction from their regular classroom teacher for part of the day and the students are assigned work to do while assigned to the alternative learning environment. The room is monitored by staff who are trained to respond to the behaviors exhibited by the student in the room. We do not have computers in the 1:1 rooms but do have them in the alternative classrooms. For students receiving individualized services, the instruction is given through worksheets and not computers.

115. "Most students in other classrooms at JRC receive instruction in the form of a computer-based curriculum that provides learning through repetition. While JRC staff report that the curriculum is aligned with the NYS standards, this was not verified." (page 20) The NYSED team did nothing to try and verify that JRC's curriculum is aligned with the NYS standard. No effort was made by the NYSED team to ask any of JRC's administrators about JRC's curriculum.

Much of JRC's instruction is based on the behavioral principles of programmed instruction and precision teaching. It is inaccurate to characterize this as merely "learning by repetition."

The standards that have been developed by both Massachusetts (Curriculum Frameworks) and New York (Core Curriculum with the Resource Guides/Curriculum Frameworks) are used to develop the goals and objectives in the student's IEP. All students' work is based on their IEP objectives, which are based on the JRC curriculum guide, which is approved by NYSED. Lesson plans are checked by the Education Department to ensure they are based on the students' IEP's and that no busy work or random assignments are given. JRC is always updating the curriculum guide to ensure that everything is up to date with all NYS standards. This was something that was discussed with the NYSED visitors by the Director of Curriculum Development. They were also told that she was working on this so that the computer curriculum, the transitional curriculum and the lower functioning curriculum would all be included. They were also told that the curriculum department was working to ensure the textbooks are standardized for all levels. At the time the NYSED visitors expressed that they were pleased to hear that. If they had had a problem or questions about this, they should have asked at that time.

116. "Many students spend their instructional day at individual computer terminals, performing the same instructional task over and over. The repetitive nature of the task was evident when the team visited classrooms and saw students repeatedly

tapping unresponsive computer screens. (page 20) JRC's curriculum and teaching methodologies have been approved at every education review conducted by NYSED and they have proven to be very successful in education students who were resistant to prior attempts to educate them. According to JRC's policy on the Educational Curriculum at the Judge Rotenberg Educational Center, one of the benefits of programmed instruction and precision teaching is that with these technologies, learning is completely individualized. Each student studies and learns at his or her own natural rate of progress, and competes with his or her own previous performance. If a student is not performing well for some reason, appropriate adjustments are made immediately in the curriculum or motivational system to remedy the problem. The students are also taught via group instruction. The NYSED visitors asked about the group instruction requirement that JRC has, not realizing that it was their own requirement that had been made during a previous NYSED visit six years ago. Students have individualized instruction with the teachers and some have separate instruction with special subject tutors.

117. "Observations showed that a return to academic task was often used as a consequence for problem behaviors that occurred during breaks or during earned activities." **(page 21)** Return to academic work is not a consequence for problem behaviors. Loss of the rewarding environment or activity they were participating in is the consequence for exhibiting the inappropriate behavior.

118. "JRC's Program Descriptions consistently prescribe positive consequences for absence of problem behaviors, but do not prescribe specific reinforcement procedures for completion of work or accuracy of work completed. " (page 21) This is completely false. The students are consistently rewarded through points, tokens, edibles, breaks, etc. for completing academics and for accuracy.

119. "One school district documented that JRC placed a student in a room where there were no desks or computers and that she worked on worksheets and flashcards and often did not leave her residence to attend school due to behaviors exhibited in the residence." (page 21) JRC staff were never asked about this by the NYSED visitors. We asked several times if the Review Team had questions about anything and they chose not to ask any about this topic**.** In the case in question, all regulations were followed regarding any suspension and instruction was provided as required. Students have their educational program in the residence only if, and only as long as, it is not safe to transport them to school. Additionally all districts are notified when the student reaches 10 consecutive days of suspension and team meetings are requested as required by NYSED and IDEA. This was in 2005 and as of today, some districts still have not replied to the letter sent by JRC. This was brought up by JRC with NYSED at the September 2005 visit.

120. "There was no evidence of social skills instruction or use of a curriculum or instruction to teach alternatives to aggressive behaviors. When asked about their social skills curriculum, JRC staff described opportunities to socialize and

opportunities for recreational trips. None of the staff mentioned any of the published social skills curriculum that are in common use for the treatment of children with autism spectrum disorders or curricular for teaching prosocial and anger management strategies For students with autism and students with diagnoses that represent social difficulties (e.g., oppositional defiant disorder; conduct disorder), there was no evidence of teaching students positive social ways to communicate or of teaching or programming for social skills during the observation periods. The complete lack of organized, instructional social interaction periods and reinforcement for positive social interactions also prevented developing time with other children as a reinforcing activity. This is a particularity glaring omission in programming when contemplating transition to a less restrictive school or adult settings where positive social play and interaction with other children and adults is necessary for success." (page 21) This is false. JRC teaches its autistic students how to communicate their needs appropriately with the use of a pictorial menu on their computers and by learning how to use a photocard exchange system. A significant part of JRC's instruction in social skills and anger management is carried out through JRC's Programmed Opportunities systems which are described in detail in Exhibit 1. Social skills are also taught through the teaching of cooperative behavior toward teachers, through behavioral counseling conducted on an individual basis with each student by JRC's Clinicians, and through skills that all students learn through JRC's behavior modification system. JRC has an extensive set of rules for the social conduct of its students and teaches its students how to follow these rules. In the course of doing so, the students acquire many valuable social skills. JRC's program has been very successful and has resulted in many of it students learning how to function in a classroom and work settings without engaging in violent and other problematic behaviors.

121. "During the May 16-18 site visit, it was confirmed that the majority of staff serving as classroom teachers at JRC are not certified teachers. It also stated that one crisis classroom teacher the team spoke to has a high school diploma and had acquired college credits through distance learning Internet courses." (page 21) This is false. JRC provided teacher license information and waivers during the April visit. NYSED visitors spoke with the ALC supervisor, but he is not considered to be the classroom teacher of that room. Had the visitors agreed to go on the tour of the program and receive a detailed orientation to JRC, they would have understood this. A licensed teacher oversees the room and the instruction of students in the room. At the time of the April visit the teachers statistics were 2 Massachusetts licensed SPED teachers, 1 Rhode Island licensed special education teacher, 3 Massachusetts licensed subject area teachers (1 Social Studies, 1 Science, and 1 Mathematics), 1 Massachusetts Emergency licensed (waivered) teacher in the area of Spanish, 1 Massachusetts licensed Physical Education/Special Education teacher, 10 Massachusetts Emergency licensed (waivered) SPED teachers, 3 Massachusetts Emergency licensed (waivered) SPED teacher's assistants, 4 MA licensed administrative staff in various areas. The use of waivered SPED teachers is entirely appropriate and lawful. It is common among nonpublic schools.

122. "Classroom visitations by the review team revealed that limited interactions occur between students or between staff and students. The main interactions witnessed involved staff rotating GED electrodes, as required for GED safety, on students' bodies when an alert, set at hourly Intervals, instructed staff to rotate the electrodes." (p.21) This is false. Staff are always interacting appropriately with the students. What was not witnessed was staff socializing with the students or students socializing with other students in the classroom setting. The classroom setting is designed to enable each student to work on his/her academics as related to his/her IEP. There are plenty of opportunities for the students to socialize with one another at the residence, during outdoor activities, during field trips into the community, during playground time, in the Big Reward Store, etc. None of these areas were observed for any significant time period by the review team. One student that NYSED interviewed was present for only part of the time NYSED was at JRC because he was on a field trip. JRC informed NYSED that a large group of students was attending a group outing on the third day of the May visit and offered to have them go along for part of the time. This would have been an opportune time for them to witness this social time between students, but the NYSED visitors chose not to go.

123. "Other observed interactions involved staff making rote statements regarding the student's behavior program, such as 'turnaround and keep working' or limited social praise "good eating.' " Making rote statements is not at all is what is heard during observation of JRC classrooms. The students are consistently rewarded with verbal praise for exhibiting positive behaviors.

124. "The June Report noted that students attend the school seven days per week from 9 AM to 4 PM, that the teachers are not present on the weekend days, and that the teachers interviewed by the team could not describe what the students did on the weekends at the school." Teachers in public and/or private schools do not typically work on the weekends. It is not their responsibility to know or plan what goes on during that time period. If anyone else that the team interviewed or those that assisted them during the visit had been asked, the weekend activities would have been thoroughly explained. No one else was asked. The weekends are a time for activities and field trips. A review of field trip logs would have shown this. Some students have part time jobs throughout the school and are training for jobs within the community.

125. "JRC often does not support the implementation of IEP-recommended related services and/or promote the transition of students to less restrictive environments. This is false. All required IEP related services are provided at JRC and are very closely coordinated with the JRC ongoing behavioral program. In a behavioral treatment program like JRC that strives to be as consistent as possible, it is important that: (1) every teacher and adult that interacts with the student carries out JRC's treatment procedures with the student; (2) that whatever the individual does with the student is done in a behavioral manner and from a behavioral perspective; and (3) that whatever is done is consistent with the other parts of the student's ongoing behavioral program.

Some services that are provided on an outside, supplementary basis in more traditional programs, are offered as a normal and integral part of JRC's basic set of services. For example, JRC's team of 16 behavioral clinicians, 13 of whom are doctoral level clinicians, provides behavioral counseling to its students. As a result, there normally is no need for individual or group counseling as an outside service. Similarly, JRC provides a behavioral approach to teaching nonvocal students how to engage in "manding" behavior (asking for things). As a result the need for the outside service of speech therapy may not be needed for some students.

Any related service that is dropped from the IEP, is done as a decision by the entire IEP team, including the parent and the school district. The need for related services usually diminishes after the student comes to JRC and benefits from JRC's effective behavioral treatment. History has not supported the effectiveness of these related services in helping to change the students' behaviors (e.g., individual/group counseling). Speech/OT/PT are added when necessary when data support the need. Behavioral counseling is used at the discretion of the clinician and when requested by the student. Historically, traditional counseling methods have failed to produce effective changes in the students' inappropriate behaviors prior to JRC.

126. Twenty students "current IEPs include recommendations for speech and language therapy. JRC records indicate that 12 students are receiving speech language therapy with most at a duration and frequency of 1x30 min/week (below the minimum NYS regulatory requirement)." (page 22) On March 14, 2006, JRC sent to NYSED all of the current IEP's for the NY school age students. Of the IEP's sent, only thirteen of the IEP's called for speech and language therapy as a direct service, not the twenty that was stated in the report. Another nine IEPs, of those sent to NYSED in March, called for a speech and language consult. The frequency of the direct service provided in some of the IEP's is listed as 1x30 min/week which is the duration of the service approved by the CSE. JRC provides greater than the required regulation of 2x30 min/week programmed throughout the entire day. If this had been discussed with the JRC Education staff as a concern, the NYSED staff would have been able to easily understand.

127. "At JRC behavioral counseling is provided in a nontraditional format…(The nature of counseling is unclear)." (page 22) JRC has explained its use of behavioral counseling in great detail on its web site.
The counseling that JRC makes available to its students has been carefully designed to enhance, support and be coordinated with JRC's behavior modification procedures. It is called *behavioral* counseling and differs from traditional forms of psychotherapy in a number of ways, including the following:

- behavioral counseling is based entirely on the use of Skinnerian behaviorism as an analytic and prescriptive tool;

- the contents of the counseling session are not kept totally private but may be shared with other members of the treatment team if that will enhance the effectiveness of the treatment/education program for that student;

The purposes of behavioral counseling are: to give the students a chance to express any concerns or problems; to reinforce the importance of the students following their behavioral program; to encourage and teach the students to view their own behavior, and the behavior of others, with the conceptual tools of behavioral psychology; to teach the students how to use behavioral principles to improve their own behaviors through self-management; to teach the students to "generalize" their behavioral progress to their home and community settings; to review the students' treatment program to insure that that the students' academic, treatment and vocational programs are appropriate for their goals; and to consider ways to make the programs more effective.

128. "Based on classroom observations, there was no evidence that language instruction, as required by NYS regulations for students with autism, was being provided." (page 23) This is false. JRC has all required students participate in a manding curriculum and all autistic students receive instruction in communication through JRC's teacher-and-software systems for teaching communication skills.

129. "Out of 148 NYS students at JRC, 128 students receive no related services. The provision of related services was not observed during either visitation." (page 23) This statement is false and irresponsible when one considers the fact that these NYSED visitors were present at JRC for only parts of five days. Every student with related services required by their IEP is receiving those services at JRC. The NYSED visitors should have asked a JRC administrator about this if they were truly concerned about this.

130. "Observers did not see a structured, systematic program for teaching of generalization of skills, self-care, social/recreational or community skills in the school or the residences to assist students in post-secondary transitions or to promote transitions to less restrictive settings." (page 23) This is false. JRC teaches daily living skills and promotes transitions to less restrictive settings. Self care and ADL instruction occurs at JRC's residences. The NYSED visitors spent only 20 minutes at one JRC group home residence and 5 minutes at another. Both visits took place when the students were first arriving at their residence or preparing to leave. As a result, the NYSED visitors did not have any opportunity to witness these activities. JRC has a very active and successful system for transitioning students out of JRC to jobs in the community, to independent living and to graduating from JRC. It is not clear what facts the team is using when they assert that they did not see a systematic plan for transitioning students.

131. "A student interviewed stated that she had entered JRC at the age of 19, with the expectation that she would receive vocational training while she resolved her emotional and behavioral problems. She had not received any and still remained in

the most restrictive settings offered by JRC. This student wept as she asked the team to bring her back to New York." NYSED suggests that this student was in some significant distress yet, the NYSED visitors never told JRC about this student's alleged statements until releasing the June Report to the public and NYSED has yet to give JRC the name of this student. This conduct by NYSED and the NYSED visitors is very unprofessional and unethical. This item cannot be addressed until we know what student is being discussed. However, if this student is the student we think it is, her behaviors have decelerated to a median of 0, she has lived in a less restrictive residence (Holbrook, which is one of our duplexes) since 10/25/05, and has been part of the cooking classes that started in January. She has been elevated to the transition program and is in the process of beginning an in-school job. She also talks to her clinician frequently. This student still occasionally engages in attention seeking behaviors but her affect is much improved since her admission to JRC and her parents are very pleased with her progress at JRC.

132. "Records and staff indicate that, once placed, very few students' transition out of JRC to a less restrictive environment prior to aging-out." (page 23) This statement incorrectly asserts that most JRC students stay until they age out and few transition to a less restrictive environment (p23). JRC does not systematically keep statistics on this information so it is unclear what facts NY is basing this statement on. As a student progresses at JRC, the high structure and high staffing that is employed at the start of their treatment diminishes as the students show their ability to function well under increasingly normal arrangements. When students first arrive at JRC, they live in one of our larger and highly staffed residences that specialize in handling new admissions. Each of these "Intake Residences" serves 8-12 students. As the students' behaviors improve, however, they advance to smaller homes and apartments that have fewer staff members and students (some have as few as four students) which allow for more privileges. There are five categories of residences: (1) Intake Residences; (2) Intermediate Residences; (3) High Privileges Residences; (4) High Privileges Apartments; and (5) Transitional Apartments/Residences.

After moving through these steps students transition out of JRC entirely if their behaviors permit this. Many students have been able to transition out of JRC prior to aging out. For example, this has been the case with one student who is now a sophomore at Brooklyn College. Another transitioned to a day student while a student at JRC and is now living on her own and attending a local community college. Several other students have transitioned back to their local public high school.

133. The June Reports claims JRC's Behavior Intervention Plans are "developed to support the use of aversive behavioral interventions with limited evidence of students "being faded" from the electrical skin shock skin shock conditioning devices or other aversive interventions." (p.3, 7th bullet). This is false. JRC's Behavior Intervention Plans are designed as to rely primarily on rewards and educational procedures. Aversives are introduced into a plan only if rewards and positive procedures

alone have not proved sufficiently effective. Once an aversive has been introduced, as a supplement, into a student's treatment plan, there is a natural fading process that then takes place: as the behavior, responding to the effectiveness of the aversive occurs less and less frequently, the aversive is used corresponding less and less. When the problem behavior stops occurring entirely, the aversive is, of course, no longer being delivered as a consequence.

In addition, every single student with whom we use aversives is faded from those aversives just as soon as his or her behavior permits. If the NYSED Review Team had asked the JRC staff, the staff could have pointed to numerous examples of students who were starting the fading process, who were in the middle of the fading process and who had completed the fading process. We are unclear as to what the reviewers are referring to when they state that JRC does not fade students from "other aversive interventions," because the use of the GED is the primary aversive used at JRC.

NYSED reviewers did not ask for specific fading information on any students other than those they reviewed. It should also be noted that NYSED reviewed this information for less than 10% of JRC's entire population and did not look at all pertinent information that was available for those students.

134. The BIPs contain broad, generic behavioral categories with the primary behavioral intervention being the use of the GED across various target behaviors (ranging from aggression to noncompliance). (p. 23) Approximately 45% of JRC's students have no aversives as part of their program. Those that do have the GED in their programs were tried on a non-aversive program for on average eleven months before aversives were introduced as a supplement to the positive programming. Therefore, how could it possibly be correct to say that the "primary behavioral intervention" is the GED? The primary behavioral intervention is JRC's positive programming procedures—its rewards and educational procedures, which is the case for all the students, including the 55% who have supplemental aversives added to their positive reward program. The GED is brought into play only as a supplement to those positive procedures when they prove to be insufficiently effective.

135. "Few students who present aggressive behaviors secondary to a thought and/or developmental disorder are provided with the necessary therapeutic interventions, but instead are treated only with an aversive intervention for the aggression." This is false. It is true that the JRC students, prior to their admission to JRC, were not receiving effective therapeutic interventions and were languishing in psychiatric hospitals and other ineffective placements and receiving no education and no benefits from psychotherapy or from drugs. For every student at JRC, the behavioral treatment they received at JRC has been the first effective treatment for them. JRC is not being paid by the school districts to provide the same treatments that failed the student in prior placements and the students' parents also do not want more of the same failed treatments. JRC's behavioral approach is to analyze each person's treatment problem as one of increasing certain

behaviors and decreasing other behaviors. We also decide what behavior changes will be of most help to the individual and treat those first. If aggression is a priority target, we treat this first.

Any student whose behaviors could be the result of a "thought disorder" is seen by one of JRC's 3 consulting psychiatrists. We currently have four students who are being maintained on anti-psychotic medications to help treat their thought disorders. Most students who are referred to JRC with some type of psychotic disorder diagnosis do not present with any thought disorder once their behaviors have improved and they are focusing on their educational and social development. For those students it becomes clear that the medication had been prescribed for the sedative effects and not for any true treatment purpose. All JRC students are evaluated by one of our psychiatrists.

136. The BIPs do not identify specific skills training for developing appropriate replacement or alternative skills to replace targeted behaviors. This is completely false. This is precisely what JRC does and it is why so many parents seek to have their child placed at JRC when other treatments and placements fail to effectively treat their child's severe behavior disorder. JRC uses intensive behavioral treatment to dramatically reduce or eliminate dangerous and disruptive behaviors and then JRC introduces that student to the joys and benefits education and social interaction and then those positive behaviors replace the problematic behaviors. JRC has accomplished this in hundreds of cases that are documented at JRC and at the Massachusetts Probate Courts.

It is a mistake to think of the behavioral repertoire of a person as being similar to a brick wall and that if one takes a brick (or negative behavior) out of the wall one must "replace" it with another brick (positive behavior). The complexities of this issue of "replacement behaviors" were dealt with intelligently by Jim Johnston in a recent paper in the *Behavior Analyst*. As he points out, it is not always necessary to teach a specific "replacement behavior" for a behavior that one has decreased and much depends on the specifics of each individual's case. The main objective of any good treatment program is to eliminate or decrease all of a person's problematic behaviors and to increase desired behaviors in whatever areas the individual is weak in. JRC does both of these things quite well.

137. "The June Report states that during a review of a student's file indicated that the student was receiving Level III aversive interventions for "aggression", but according to the teacher's notes, the only aggressions exhibited by the student were in anticipation of the GED the student was not otherwise aggressive." (page 23) This is false. No information is given on who the NYSED visitors claim made this statement and what student was discussed. JRC students do not wear a GED device unless they have exhibited extreme forms of aggressive and/or self-abusive behaviors both before admitted to JRC and after admission. It is clearly not the GED device itself that caused the student to engage in problematic behaviors. The students' prior treatment records

also demonstrate clearly that all other forms of treatment were not effective. The fact that this student is no longer engaging in aggression is a positive development.

138. "Fading procedures are not individualized and not well specified for all the aversive interventions used by JRC. JRC's policy states: "GED fading will not occur until the student has gone a minimum of one year with no major behaviors" and the Director of Clinical Services confirmed that the expectation for all students is that target behaviors, across all categories, are reduced to a zero frequency rate for one year. By JRC policy, students follow a set sequence by times of the day, days of the week or specific activities to fade the GED. This set sequence does not take into account data on the times and places behaviors are most and least likely to occur. The criterion of one year without a "major disruptive behavior is extremely long and is not determined based on the circumstances for each Individual student. Many NYS students remain on the GED for the entire time they attend the center. At least two students have been on the GED device since 1999; others began in 2000 and 2001.
One student was initially placed on the GED in 1999. The GED was faded at one time and then resumed and the student is currently on the device. Six NYS students have had the GED faded (they are no longer wearing the-GED device) However, it was reported that a faded student could be placed back on the GED if he/she demonstrated previously Inappropriate target behaviors." (page 23-4) This is false. JRC's policy for fading the GED requires that all fading be individualized and based on students' frequency and intensity of behaviors. JRC has a fading policy which specifically states guidelines for fading the GED based on students' behavior and current functioning level. It clearly states that the treatment team decides the specific course for each individual student. This was discussed with the NYSED visitors and was continually misinterpreted by them throughout the visits.

The NYSED team made the incorrect assumption that it should be possible to fade the use of the GED in all students. Unfortunately this is not the case. Some students have life-long disabilities, particularly some of the lower functioning students, and will need treatment support for the rest of their lives, including the availability of the GED device to maintain life, avoid self-mutilation or maintain a decent quality of life. In this respect the GED may need to be viewed in those cases as a prosthetic device, much like drugs, eyeglasses and artificial limbs.

The team's criticism that one year is a long time as a benchmark for starting the fading process is without foundation. It shows a lack of understanding of the level of disability that the JRC students suffer. They fail to understand that the GED treatment can fade itself during the first year of treatment if the student's targeted problematic behaviors are reduced to zero. None of the NYSED visitors have worked with aversives nor, in all probability, students who have behaviors so severe and case-hardened as those that JRC deals with. They have no experience with this fading process and are in no position to authoritatively make conclusions as to how it should or can be done.

139. The June Report states that "JRC promotes a setting that discourages social interaction between staff and students and among students." (p.3, 8th bullet) This is false. JRC promotes and teaches students how to engage in appropriate social interactions. JRC does, however, have rules to maintain the students' safety.

Staff-student interactions. JRC does deliberately discourage social interactions between staff and students that are not required as part of the student's educational and treatment program. We try to prevent any social interactions from occurring between staff and students other than those that are required by the staff member's role in carrying out the educational, treatment, and supervision responsibilities. We want the staff member to maintain a professional distance between him/herself and the student. If such a distance is not maintained, serious problems will arise such as inappropriate relationships between students and staff. It may also be difficult for the staff member to administer the various positive and negative consequences that must be administered objectively, without favor, and accurately day by day. Discouraging social interactions between staff and students also diminishes the likelihood that higher functioning students will succeed in fooling staff members with respect to various aspects of their programs.

Student-student interactions. Appropriate social interaction with other students is encouraged at JRC and increasing opportunities for social interaction with other students is used as a powerful reward for many of our students. We use opportunities to engage in it as part of our reward system. As in the case of any other reward, an event will not function as a reward if the student can enjoy it at any time, regardless of whether he/she has earned it or not. Therefore, there is a good reason to control student-student interaction in a program that uses all positive features, including social interaction, as part of a comprehensive reward system.

Students are allowed to socialize with peers when it is appropriate to do so such as at times when they have earned a chance to go to Reward Store, when they are enjoying recreational opportunities on our playground, when they are on field trips, when they have earned some leisure time at their residences, etc. Students are not allowed to socialize with peers during that part of their academic time when they should be doing their academic work and not when they are behaving inappropriately**.** JRC makes many efforts to provide social opportunities for students such as time spent in Big Reward Store, Field Day, field trips throughout the week, outside activities, dances, group classroom activities, etc.

If the NYSED visitors had been willing to go on a tour, watch the JRC video, talk to administrative staff in charge of setting up these specific social interactions with students, etc., they might have understood what our policies are in this area.

140. "Policy and procedures at JRC support limited social interactions between staff and students. Positive/appropriate skills' training was not observed in the

classroom. There was very limited social interaction between the classroom staff and students except for 1:1 prompting (jargon) to computer tasks and/or the awarding or removal of tokens." These statements are false. It was completely irresponsible for the NYSED visitors to make these conclusions after spending only parts of five days at JRC and without asking the JRC administrators to give them information about social interactions and skills training at JRC. JRC provides its students with ample opportunity for social interaction and provides it students with highly effective skills training. However, as in any other school setting, socialization between staff and students during classroom hours is not allowed. The focus of the academic day should be on their school work. Most JRC students came to JRC many grade levels behind their same age peers and should not be wasting their time with additional socializing instead of learning. This was also explained to the NYSED visitors repeatedly. The NYSED team appeared to either not understand or not agree with the response. JRC students have countless opportunities to socialize with one another including BRS, outdoor activities, field trips, leisure time, etc.

141. "JRC does not promote the development of social skills for any of their students and in fact requires that the students not attempt social interactions with staff or classmates as part of their behavior programs. Questions to staff about programs for social skills development were always answered by descriptions of social opportunities that included recess as well as scheduled recreational outings. The recreational outings were with groups of students and provided no opportunities for interaction with members of the general community." (page 24)

This is not true. JRC promotes social skills at school social events as well as at the group homes and in the community. Furthermore, the higher functioning students at JRC do not generally have a problem "socializing" with their peers but most do have a problem "socializing appropriately" with their peers as evidenced by their exhibiting inappropriate behaviors at those times. As the students learn to behave appropriately their interactions with their peers naturally become more appropriate. As they become more appropriate they also earn more frequent opportunities to socialize with peers, with certain staff, and out in the community. Positive social skills are taught and promoted with appropriate staff at appropriate times. In a regular classroom, students don't spend the day talking to other students or to the teacher. They are there to learn. Students socialize with peers at appropriate times when the students are behaving appropriately. It is not appropriate for staff to be sharing personal information or becoming friends with the students, as this would compromise their ability to appropriately follow the students' treatment program.

Opportunities to socialize with peers is one of the most powerful rewards that JRC has available to use with many of our higher functioning students. Therefore it is important to save access to these opportunities to situations where they have been earned as a result of the students' showing desired behaviors. To make them always available on a noncontingent basis—that is, without the student's having earned them—would mean that social opportunities would be less effective as rewards. The NYSED visitors may

have had a problem with the use of socialization as a reward, but such a choice is entirely within the parameters of what a behavioral program should be allowed to do in order to make its rewards effective.

142. "The June Report states that several observations were made of the outdoor recess periods and lunch breaks. The recreation area was set up with swings and a wooden structure for climbing and walking across bridges and several plastic slides. The area was very well maintained and appropriate for children under seven or eight years old. However, these students during all observations appeared to be adolescents. Staff was attentive and providing appropriate supervision to students and the interactions between staff and students were positive, supportive and respectful. However, they tended to be helping interactions rather than conversations or play. During five observations involving a total of 59 students, there were no instances of students socializing with other students and only five instances observed of students socializing with staff." This is a false depiction of JRC's out-door activities program for the JRC students. JRC's out-door activities consist of not just the swing-set and jungle gym area but also the basket ball courts, picnic area, the trail through the woods behind the school, the pools located at some of the residences and all of the many field trips. Students will also play double-dutch jump rope, tether ball, catch with a football/baseball/Frisbee, ride bikes/roller blades and various other outdoor activities, none of which were observed or asked about. Most observations made by the NYSED visitors were made in the classrooms, and they spent less than five full days at JRC in total. NYSED has no basis for making these incorrect conclusions about JRC. Until they were pushed to do so, many of the NYSED staff would not even take a look at Big Reward Store. JRC staff made many offers to the NYSED team members to show them other rewarding areas where they could find students socializing inside and outside while they enjoyed the rewards. The NYSED team members chose to decline our offers.

143. "Social interactions between students reportedly occur in the Big Reward Store where students go to select a reward for keeping to contracts. When questioned about friendships and social interactions among students, the students interviewed stated that they were unable to socialize in a natural way. (page 25) As noted above, social interaction is used as a frequent reward opportunity at JRC, just as access to video games and TV are. In this respect it is true that students cannot socialize whenever they choose just as they are unable to watch TV or play computer games whenever they choose. Any fair evaluation of JRC must be done with a clear understanding of the severe danger presented by the students do to the documented instances of life-threatening aggression and self-abuse that they exhibited prior to coming to JRC. JRC must be viewed as an emergency behavior hospital room. Just as many of the procedures in an emergency room are unusual and specifically designed to make the emergency room as efficient as possible, the same is true of JRC.

Students are able to socialize during activities that they have earned as rewards. Examples are on field trips, during field day, in rewarding environments and at the residence when they are behaving appropriately. We have students that have become friends while at JRC and have stayed in touch once discharged S. O. (former student) is friends with D. C. (current student) and they visit when D.C. goes home, S.O. has just been added to D.C.'s phone list. C.A. (graduating in June) keeps in touch with T.C. (former student). We can give many examples of true friendships.

144. "Opportunities to socialize with peers must be earned through compliance with behavioral contracts." (Page 25) JRC does require students to behave appropriately in order to socialize with peers. A similar practice is used in all schools (students are sent to the principal's office if misbehaving in class thus removing them from their peers). The June Report presents this effective use of reinforcement as though it were bad. This is another example of the pervasive anti-aversive bias and distortion which make this report a polemic, and not an example of professional, ethically-conducted review.

145. "Students in classrooms were docile and compliant and did not attempt to socially engage, either verbally or with eye contact, anyone in the rooms. This was also apparent in the residences visited by the team. Staff indicated, on at least three occasions, that it was unsafe to allow students to socialize because in the past students had plotted against staff." (page 25) This is false. The NYSED Review Team made only two visits to a JRC group home lasting 20 and 5 minutes during a transitional time. (JRC has over 43 group homes.) This was insufficient time to enable the NYSED team to make an informed statement about the character and extent of the socialization of students at JRC. As in any other school, students at JRC are not allowed to socialize during academic time so they may focus on their academic goals. While at the residence, it appears that the NYSED Review Team was observing lower functioning autistic students who, as a reward, were allowed to play with manipulative toys. Some students with autism may find "socializing" with other students aversive so JRC structures opportunities for the autistic students to socialize with one another as part of social skills training.

146. The June Report inaccurately claims that "The privacy and dignity of students is compromised in the Course of JRC's program implementation. " (p.3, 11th bullet) JRC protects the privacy and dignity of its students as much as possible. The JRC students enjoy much greater levels of privacy and dignity at JRC then at prior placements such as psychiatric hospitals. JRC makes every attempt to ensure the privacy and dignity of all of its students while at the same time carrying out its treatment program and ensuring the safety of staff and students. JRC's Digital Video Recording (DVR) system plays a strong role in this area. The parents agree that one of the most important aspects of JRC is the DVR monitoring system which provides a sense of security for the families of the students. We answer the specific observations that relate to this criticism below.

147. "Video surveillance system monitoring includes most bathrooms and all bedrooms but no formal staff monitoring system is in place to ensure the privacy and dignity of students & consumers during intimate grooming/hygiene or personal sexual behavior (e.g., masturbation). For example, no procedures were in place to ensure staff was not observing opposite sex residents during showering." JRC always takes into account student's dignity and privacy, along with safety priorities when establishing self-care protocols. (p25) The safety and human rights of our students are of the utmost priority to JRC and its personnel. All staff members who are employed in the Digital Video Recording (DVR) office work diligently to respect the privacy of each and every student during all aspects of supervision and care.

The bathrooms at JRC, in both the school and residences are not directly on camera, except in limited cases where there are serious safety concerns. Some of the JRC students have a history of engaging in life-threatening behavior whenever left unsupervised. In the school building, the cameras in the large bathrooms do not show the interior of the bathroom stalls or shower stalls. Instead, the cameras monitor the main common area of the bathroom. In the residences, the cameras are generally outside of the bathroom door and students keep the door ajar (approximately 6 inches) during use of the bathroom, unless they have achieved bathroom independence status. This status allows them to keep the door completely closed. In the overnight hours, the rooms that are viewed are dark with only silhouettes visible to those staff monitoring the DVR monitors. Any time that it appears that there is not a safety concern, and a privacy issue (e.g. masturbation) may be possible, the DVR staff member turns off the current view and moves to a camera in another room.

Most of the viewing that is done by our DVR monitors has as its targets the common areas of the classrooms and residences, the primary objectives of the DVR surveillance is ensuring proper staff performance and taking care of safety concerns. All of the staff in JRC's DVR Office are experienced veteran staff with a keen understanding of the importance of each student's rights and dignity regarding privacy issues.

JRC has DVR policies and procedures (Exhibit 2) that are designed to maximize the privacy of the individual with respect to the DVR monitoring process. For example, we insure that at all times male DVR monitoring staff watch male bedrooms and bathrooms and female DVR monitoring staff watch female bedrooms and bathrooms. When certain students want some completely private time, and can safely be given such time, this is pre-arranged with the DVR monitoring staff. These policies and procedures are part of JRC's pre-service and in-service training program.

148. "One NYS student's behavior program states, "C will wear two GED devices. C will wear 3 spread, GED electrodes at all times and take a GED shower for her full self care." This student as are all students at JRC, is monitored through JRC's video surveillance system and a staff person would monitor her in the shower." This statement incorrectly states that all JRC students are

monitored in the shower via DVR (p25). Only certain students with the highest frequency of dangerous behaviors take their self-cares at the school, where the shower area is monitored discretely. This is due to the high probability that these students may become aggressive or exhibit health-dangerous behaviors during their self- cares, which could easily lead to a devastating head injury or a mortal wound from a broken mirror or porcelain fixture.

149. "Students were observed as they arrived and departed from school. Almost all were restrained in some manner, some with metal 'police' handcuffs and leg restraints, as they boarded and exited the vehicles. Several students are transported in wheeled chairs that keep them in four-point restraint." This statement incorrectly infers that JRC transports all if not most of our students in restraint (p25) JRC has a school wide variance from EEC (MA Department of Early Education and Care) to use restraint during transport when clinically indicated for the students' safety. Transport restraint is permitted under the Massachusetts Department of Mental Retardation regulations. During the first NYSED visit in April, the average number of students transported in restraints was 49 out of 248 (19.75%) total students in restraint for those two days. During the next visit in May only 45 out 243 (18.51%) required restraint during transport. These numbers certainly do not constitute most of JRC's students.

150. The June Report states that "The collateral effects (e.g., increased fear, anxiety or aggression) on students from JRC's punishment model are not adequately assessed, monitored, or addressed," JRC's model is not a "punishment model." It is a massively rewards/positive programming/educational program that, with approximately 55% of students is supplemented with aversives. In view of the fact that the average student receiving aversives receives only one 2 second application per week, together with the massive positive procedures, it is inaccurate to characterize JRC as a "punishment model."

The collateral effects that are mentioned ("increased fear, anxiety or aggression) simply do not occur. If anything, students are much happier and relaxed when they are being treated with supplementary aversives. What happens at JRC with the typical student is this:

- Students are removed from psychotropic medication. This alone makes them feel better. They are relieved to be able to stop using this medication. These medications by report make them feel lethargic and without hope of ever achieving anything with their life.
- Overweight students tend to lose weight that they gained largely because of the psychotropic medication. With the loss of weight, the student's self-concept improves.
- Because the aversives are effective, the students' problem behaviors diminish markedly;

- Because the problem behaviors have diminished markedly, the students now earn more rewards, field trips, better residence, more advanced classroom, an education, a future and more and happier visits to their own family and home, etc.
- As a result of making more contracts and earning more rewards, the students become happier, more optimistic, and proud of their achievements. The student tends to smile more and interact more appropriately with peers/family. There is absolutely no increased fear, anxiety or aggression.

All of this works together to create a positive frame of mind for the student. The student's entire life is now turned around. Students who came to JRC with a diagnosis of depression are no longer depressed.

This finding is confirmed in the research literature. Students treated with supplementary aversives, within a program that is otherwise massively positive, tend to be happier and more relaxed. Some students actually welcome the use of the GED skin shock device, perhaps because it helps them to control self-mutilating behaviors. Many of our higher functioning students ask to go on the GED, because they see how much it has helped other students.

151. "There does not appear to be any measurement of, or treatment for, the possible collateral effects of punishment such as depression, anxiety, and/or social withdrawal. Student interviews revealed reports of pervasive fears and anxieties related to the interventions used at JRC. Students verbally reported a lack of trust, fear, feeling upset/anxious and loneliness."(page 25-6) The JRC students are not reporting this to their parents or the JRC staff so JRC seriously questions the veracity of this statement and whether the NYSED visitors coaxed the students to make these kinds of statements. These statements do not reflect the attitudes of the students while at JRC. (p25, 26) Again, students who are on the GED only experience positive side effects such as smiling, increase in appropriate social interactions, community outings, increased appropriate relationships with families to include home visits, increase in education (reading for pleasure!), and decrease in need for restraint. If a student is truly experiencing any negative feelings these can and would be addressed during meetings with their clinician. Many students exhibit attention seeking inappropriate behaviors and when encouraged to discuss these things may take advantage of the situation. Only five of 151 New York school-aged students were interviewed over the course of the two visits by the NYSED visitors. Such a general statement certainly cannot be made as a result of interviews of 3% of the New York school-aged students.

152. "The June Report states that one student's behavior plan indicated that the student is to be rewarded when he does not react to a staff member preparing to or administering the GED to another student, implying that this student may be having collateral effects when peers receive skin shock consequences." This statement is false and pure speculation at best. JRC trains its students to stay on task and remain focused on school work. That is the basis of this reward. Had the NYSED visitors asked anyone

at JRC for information about this procedure then their question would have been answered. The NYSED refused information and did not ask questions because they preferred to speculate in a manner critical of JRC.

153. "One student stated she felt depressed and fearful, stating very coherently her desire to leave the center. She is not permitted to initiate conversation with any member of the staff. She also expressed that she had no one to talk to about her feelings of depression and her desire to kill herself and told the interviewing team that she thought about killing herself everyday. Her greatest fear was that she would remain at JRC beyond her 21 birthday." (page 26) This is a completely false clinical picture of this student. The NYSED visitors probably knew it was false because they made no effort to inform JRC about a student contemplating suicide. NYSED representatives did not ask to see our policy on reporting or responding to suicidal threats/ideations. This observation was obviously made on either April 25th or April 26 when the first two students were interviewed. This June Report is the first time this alleged incident has been reported to JRC. Suicidal thoughts, which are asserted to have been reported to the NY agency representatives, were not even reported to her parents. If a student was having such severe suicidal ideation as described above, why would the psychologists that put this June Report together not bring it to the attention of the treatment team or the parents until June 12, 2006?

This student was admitted to JRC on January 18, 2005 after having been admitted and readmitted to Benedictine Hospital. She entered JRC on Effexor, Abilify and Topomax. All medications were totally DC'd by 6/19/05. She came into JRC extremely aggressive in constant physical and mechanical restraint. She was so difficult; we sought and received a restraint waiver form the Department of Mental Retardation. She exhibited a weekly median of 1051 major behaviors per week. She went on GED on September 28, 2005. She immediately went to a weekly median of zero major behaviors per week with zero restraint. She has received a total of five applications since she went on; her last application was on February 2, 2006. She is currently faded to from her devices and does not wear it the entire day. She is a part of our transition program and working part time in the school building. She advanced over two grade levels in reading within the year, and over four years in math.

Exhibit 1

PROGRAMMED OPPORTUNITIES

Types of Programmed Ops

Academic Programmed Opportunities are situations designed to teach the correct response to certain questions. For example, in an Academic Programmed Op, the student might be asked what his home telephone number is. Training and prompting is provided to help the student respond correctly. If he/she recites it correctly, he/she is rewarded for doing so. If he/she recites it incorrectly, he/she may receive some punishment, depending on the student's program.

Social Programmed Opportunities are situations designed to impart certain social skills that may currently be deficient in a particular student. To impart the skill, the usual rewards and educational procedures are tried first. If they are insufficiently effective, we may design programmed social opportunities that are designed to strengthen the social skill in question. For example, suppose a student does not display a smile when greeting a new person or does not makes eye contact or offer to shake hands when introduced to such a person. This is typically used when our normal educational and reward procedures have proven insufficiently effective to impart these skills. In such a case the psychologist might design some social programmed opportunities to remedy the situation. A social programmed op has two components. First, the student is given special training and practice to learn what the skill is, why it is important and how to exercise it. The training can include videotaped material that shows examples of the skill being performed correctly and incorrectly and teaches the student to discriminate good and bad performances. The training may also include practicing the skill in hypothetical situations. Second, after it is clear that the student can execute the behavior, we arrange situations in which we deliberately bring a new person into the student's classroom and introduce him/her to the student. Rewards would be administered for the desired responses. Punishment may be administered for incorrect responding, depending on the student's program.

Treatment Programmed Opportunities are designed to deal with certain important problematic behaviors. Consider, for example, the case of a student who, whenever he or she is disappointed or frustrated, tends to show aggression against the person who has caused the frustration, or display some other inappropriate behavior. The treatment programmed op for this type of problem might involve: (1) training the student in how to handle frustration and disappointment without aggressing; (2) deliberately introducing trials on which the student is exposed to disappointment and/or frustration; (3) supplying appropriate levels of prompting on each trial to make correct responding likely; (4) progressive "fading" of the prompts on later trials; and (5) rewarding or punishing the student, depending on what response he shows to the stimulus situation on each trial.

We attempt to determine, what consequences the aggression has produced for the student in the past. Presumably aggression has produced some favorable consequences and these consequences have strengthened the behavior in his/her repertoire. For example, aggression may in the past have caused the person who caused the frustration to back down and eliminate the frustrating situation. It also may have resulted in the receipt of approval from some of the student's peers.

The goal of the treatment programmed opportunity procedure is to weaken the stimulus control that certain antecedent events possess with respect to the student's inappropriate behaviors and to strengthen the stimulus control that those events possess with respect to appropriate behaviors. Treatment programmed opportunities would fit into a total behavioral treatment package for treating a behavior such as pulling false fire alarms. A few other examples of behaviors that might be treated with treatment programmed opportunities are: stealing; playing with matches; and showing aggression in response to teasing by ones' peers.

A few important aspects of treatment programmed ops are these:

1. The student is given training to make it likely that the will respond correctly to the triggering stimulus. JRC does not design a programmed opportunity unless the student has demonstrated an ability to perform the desired response.

2. Prompts may be given during the programmed op trials to facilitate correct responding. For example, the stimulus situations that are presented at first may be deliberately altered (e.g., attenuated, as part of a plan to help the student emit the appropriate response) from their normal parameters so that the undesired response will be less likely and so that the desired response will be more likely. Typically, on later programmed ops, the stimulus situations may be gradually returned to their full natural form that has previously resulted in generating the problematic behavior.

3. The frequency of the presentation of the stimulus is usually substantially increased from what would be the normal frequency of the stimulus in question. For example, if the stimulus situation is one that does not occur frequently under natural conditions, it may deliberately be presented more frequently as a programmed op. This has important advantages in that it allows much more practice and reinforcement for a skill than otherwise would occur.

It is characteristic of the typical programmed op that the student will receive special rewards for showing desired behaviors in response to stimulus situations that have been deliberately arranged. In some cases, however, even if the stimulus situation happens to occur naturally, and without deliberate arrangement, if the student encounters it and shows the appropriate behavior, the student will be given the same special rewards that are programmed to be given with the programmed ops. These situations are called "*non-programmed ops*."

Suppose we want to teach the student to handle frustration and/or disappointment without becoming aggressive. In order to treat this problem we need to teach the student to respond to frustration with different behaviors. As in the case of treating the false-alarm-pulling, there are a number of techniques that we can use for this purpose. These include the same types of procedures that might be use in a case of false-alarm-pulling. They are: verbal instruction, modeling, strengthening alternative behaviors that compete with and/or that generate the same rewards, extinction, rewarding appropriate behaviors when they occur, behavioral contracts and punishment.

If these are not sufficiently effective, we may add the use of treatment programmed opportunities to the total treatment package. In this case treatment programmed opportunities would involve: (1) exposing the student deliberately to trials in which the student is exposed to the triggering stimulus for aggression (in this case, frustration or disappointment); (2) training the student to handle the frustration or disappointment without displaying aggression; (3) using prompting, if necessary to help insure that the student responds appropriately when the triggering stimulus is presented; (4) gradually removing that prompting as the training trials progress; (5) rewarding the student on each trial on which he displays appropriate behavior; and (6) punishing the student on each trial on which he displays the inappropriate behavior.

JRC wants the student to be able to handle a wide variety of frustrating situations and not just the particular frustrating situation that is used in one or two programmed ops. Consequently it is necessary to present a wide variety of programmed ops that involve frustrations. When a response (e.g. accepting the disappointment comfortably, without losing one's temper and becoming aggressive) is shown in a wide variety of situations, we call that the acquisition of *stimulus generalization*.

Treatment programmed ops represent a special behavioral teaching procedure. Here are a few of their special characteristics.

1. *They are often very useful to treat low rate behaviors*. Treatment programmed ops often involve highly specific inappropriate behaviors that may occur at very low rates. If the behaviors occur at too low rates under normal circumstances, it is very difficult to treat the behaviors by arranging consequences whenever the behaviors occur—i.e., under those conditions there are just not enough opportunities to effectively condition some new responses. Programmed ops are, therefore, an extremely important and essential tool for the treatment of low-rate behaviors.

   Examples might include jumping out of a car while it is moving, note passing during class or in other situations where communication is not authorized, pulling false fire alarms, stealing objects, sniffing markers or setting fires. In these instances, programmed opportunities represent a means of contriving

supervised contact between the student and discriminative stimuli for specific inappropriate behavior. This allows consequation of behavior that might otherwise seldom be observed but has a history of occurring with potentially serious consequences. For many transitional students, only a few trials may be sufficient to establish (or re-establish) appropriate behavior (examples – stealing, assault).

2. *Treatment Programmed Opportunities may in some case require highly artificial and abnormal stimulus situations that do not necessarily occur in normal situations outside of JRC.* For example to teach a student not to play with matches, we might set up several opportunities every day in which the student is given easy access to matches—something that is unlikely to occur under normal circumstances outside of JRC. In designing programmed opportunities we obviously cannot limit ourselves to situations that might occur in normal circumstances outside of JRC. Our goal is to strengthen certain skills. Just as a track runner might practice 25 starts in a row to strengthen his skill of getting off the blocks quickly—a frequency of starts that does not normally occur in a race—so also do we at JRC create programmed opportunities that occur with a higher frequency than normally occurs in the natural outside-JRC situation.

3. *Our goal in presenting programmed opportunities is to strengthen certain behaviors even beyond the level that most people normally have*. For example, we try to teach certain students, who have problems handling frustration and anger, to cope successfully with an unfair or even inaccurately arranged pinpoint by a JRC staff member without losing his/her temper and getting enraged. If we can, indeed, bring one of our students to such a point, then he/she is more likely to be able to handle the normal frustrations of everyday life outside of JRC.

4. *Treatment programmed ops often involve creating a situation that some might consider "unfair"* if it were done outside the context of a behavioral treatment regimen. For example, most people would consider it unfair for a teacher to deliberately discipline a student for a behavior the student did not engage in; however, that might be an excellent programmed opportunity to teach a student to exercise self-control in frustrating circumstances, and to voice his objections in some polite and acceptable manner, instead of becoming violent or aggressive.

How the "Treatment Programmed Opportunities" Procedure At JRC Is Used as One Component of a Total Treatment Program To Weaken Undesired Stimulus Control And To Strengthen Alternative Stimulus Control

A. Verbal Instruction: For students who have adequate verbal behavior, we can give them verbal instruction in which we explain the detrimental consequences that may follow from the behavior identified for treatment. We also can explain what special added punishments we plan to administer in the future in case he or she engages in the behavior in the future.

B. Modeling: We place the student in groups where the other students in the group do not tend to engage in the problematic behavior.

C. Strengthening competing appropriate behaviors so that they can successfully compete with the inappropriate behavior.

(1) *Strengthening alternative behaviors that compete with the target inappropriate behaviors*. We might determine what particular times of day the student tends to engage in the behavior and make sure he/she is engaged in some alternative activity that is incompatible with the behavior.

(2) *Strengthening alternative, appropriate behaviors that generate the same accelerating consequences that the inappropriate behavior generates.* For example, we might try to teach the student other ways to generate the same function of the behavior.

D. Altering the consequences that the inappropriate behavior produces. In addition to the use of verbal instruction and modeling which, when applied to case-hardened behaviors are all-too-often insufficiently effective by themselves, we can also program the following changes in the consequences that immediately affect the problematic behavior.

(1) *Extinction (making sure that if the behavior occurs, it does not generate its accustomed accelerating consequences).* We can try to remove the accelerating consequences that are maintaining the problematic behavior at its current unacceptable level. We do this by arranging conditions so that if the problem behavior occurs, the rewarding consequences will be minimized or withheld entirely; that is, we arrange to minimize or eliminate any of the commotion or aggravation that normally ensues when the alarm is pulled, and any approval from peers.

(2) *Rewarding appropriate behaviors*. We can try to catch the student not engaging in the behavior under circumstances where in the past he/she did engage in the behavior it and reward this. At JRC we also call this procedure "rewarding non-programmed opportunities."

(3) *Behavioral contracts.* We can set contracts with the student in which, if the student goes for a certain period of time without displaying the problematic

behavior, he/she earns some special reward.

(4) *Punishment (adding a decelerating consequence to the consequences that the behavior produces).* We can arrange an effective point fine, loss-of-privileges, or (with court approval) physical aversive consequence each time that the student engages in the behavior.

E. Altering the Stimulus Control. If procedures A-D above are not sufficiently effective, by themselves, to treat the behavior effectively, we can also undertake some deliberate stimulus training to weaken the undesired stimulus control that the stimulus has acquired and by building and strengthening the stimulus control that the stimulus should have over more appropriate behaviors. The procedure that we employ to do this is called *Treatment Programmed Opportunities*.

The basic procedure is this:

We give the student training, based on the student's functioning level, on the dangers of the behavior and information on the problems that he/she will continue to face in life if the behavior continues. We explain programmed opportunities to the student and inform the student about the rewards/punishments that will be received for passing/failing the op.

a. We deliberately expose the student to the stimulus that has acquired the undesired control over the problem behavior.
b. We train the student to be exposed to the stimulus without showing the problem behavior. At first we might need to arrange some prompting to make it easier for the student to display the desired behavior. If, under those conditions, he does not exhibit the behavior, we reward him heavily;
c. Then we arrange additional trials on each of which the amount of prompting is gradually reduced from the amount used on the preceding successful trial. Eventually, the prompting is reduced to zero. On each successful trial on which he walks past the alarm without pulling it he is rewarded heavily.
d. If at any point in this training, the student engages in the behavior, he is punished.

The following valuable changes occur in the course of this training:

(1) On each trial on which the stimulus is presented and the student does not display the problem behavior, the stimulus *loses* a little bit of its stimulus control over the problem behavior (through a process known as *extinction).*
(2) On each trial on which the stimulus is presented and the student displays an alternative desired behavior the stimulus *acquires* a little bit more control over that desired behavior.
(3) Eventually, with a sufficient number of trials, the stimulus no longer triggers the problem behavior and triggers the desired behavior, instead.

It should be clear from the above explanation that one cannot determine whether an antecedent event has acquired some stimulus control over a problem behavior unless we can present that event to the student and see whether it has the effect in question. Similarly, it should also be evident that we cannot arrange the stimulus control training described above without being able to deliberately arrange occasions when the stimulus for the problem behavior is presented.

How to determine when we would use programmed opportunities with a student.

JRC conducts an individual assessment of the student and based on that assessment, and empirical data, determines whether programmed opportunities would have therapeutic value for the student. We encourage our psychologists to use programmed opportunities with all of our students, whenever there are academic, social, or other problematic behaviors can benefit from the programmed op procedure. The procedures are particularly helpful and even necessary in the treatment of behaviors that do not occur frequently enough under natural circumstances to enable the student to receive a sufficient number of conditioning trials. Good examples of this type of behavior are those of fire-setting and pulling false fire alarms.

Decisions to develop and use programmed opportunities are made in response to therapy notes, case manager/teacher/programmer observations concerning patterns of inappropriate behavior, or occasionally student self-report or direct observation of interactions.

The purpose of a programmed opportunity and how it is carried out.

The purpose of programmed opportunities is to provide numerous trials of reinforced practice for particular skills so as to change the current stimulus control over the both the inappropriate, and corresponding appropriate, behaviors. The frequency with which a programmed opportunity is offered can vary from very infrequently (e.g. once per day, per week, per month or even per year) to very frequently (for example, once every ten minutes).

Exhibit 2

JRC Policy on Audio and Video Monitoring

Activities in all classrooms and many other areas throughout the school and administrative buildings are monitored throughout the day by our monitoring department using a digital video recording (DVR) and audio recording system. One function of this system is to enable supervisors and visiting parents to observe what goes on in most areas of the school without having to make obvious the fact that they are observing. A second function is to enable our monitoring staff to view staff and student performance. The recording system allows supervisors to immediately provide feedback and support to staff and/or students. A third function is to enable staff to review any special incidents in the school, at the residences, or on transport vehicles.

Most areas of the school are equipped with cameras and microphones to enable the recordings to be made. Activities in the classrooms and associated areas are monitored, live, by monitoring personnel assigned for that purpose. Both audio and video recordings taken at the school are saved on a computer for thirteen days.

All activities at the residences are monitored twenty four hours per day by a staff of monitoring/quality control supervisors that are stationed at a central room at our administrative offices. The audio and video recordings of activities at the residences are saved for thirty days.

If there are specific instances whose recording someone has requested be saved, those instances may be saved for an indefinite period. Residential supervisors and staff are responsible for immediately notifying the Director or Assistant Director of Residences or the Weekend School Coordinator, and the Director of Information Technology whenever a problem is detected with the DVR system. Such notification should be made outside of the presence of students so as not to inform students that the DVR system is not working properly. Every effort will be made to fix the problem as soon as possible.

The JRC School Buses and many of the JRC vans are also equipped with DVR systems. The assigned bus monitor is responsible for ensuring that the equipment is working.

JRC makes every effort to respect the privacy of its students when using the DVR system. Cameras or voice recorders are not normally used in the bathrooms at the residences or in the stall areas within the school building. In an effort to respect the privacy and dignity of the students and continue to maintain the safety of all student and staff, JRC will assign only quality control staff of the same sex as the student to monitor self cares and bathrooms via DVR. In addition Quality Control staff members only monitor the bathrooms and self cares of students when it is absolutely necessary to ensure

the safety of the student. The DVR Supervisor and QC Supervisor will be responsible to ensure this policy is followed.

Students will be given an opportunity to request a reasonable amount of private time in their bedroom without DVR observing during this time frame if it is reasonably safe to do so. Once a request is made the staff working with the student will call DVR notifying them of the request and the timeframe. The DVR staff will not view the room during this time. During the course of their regular evaluation of staff performance Quality Control staff will also ensure staff members working directly with the students are respecting the students' privacy. Finally all quality assurance staff are required to attend training on how to respect the students' privacy and continue to maintain the level of safety needed to treat the population of students at JRC.

There is at least one bathroom at the school building, which is monitored and recorded. This type of bathroom is normally used only for a certain group of students. If, however, it has been determined that a student, who is not a member of that group of students, who is an extreme risk to him/herself or others and who requires intense supervision, the treatment team may request that the student's self care be completed in this type of area that is monitored and recorded. This is evaluated on a daily basis.

The bathrooms at certain residences are equipped with cameras placed just outside of the bathroom door.

JRC does not use cameras or voice recorders in certain Nursing offices or the Clinicians' offices and maintains certain conference rooms without recording devices for students to visit with their families or to make confidential phone calls as appropriate and needed.

The only staff members who are allowed to view tapes or DVR videos are those who are required to do so in order to fulfill their job requirements.

If a psychologist, member of the programming department or other administrator or staff member wishes to investigate an incident he/she must make a request to the tape monitoring department. Clinical and high level administrative staff members also have access to the DVR system from their own desktop computer if they wish to review an incident themselves. Administrative staff members do not have access to view bathrooms from their desktop. A log of all items viewed on DVR by administrators will be kept and reviewed periodically to ensure the system is not being abused. All other staff members must submit a request to the Monitoring Department if they wish to review a certain incident. The request must be submitted via email or in writing. The monitoring department will save the pertinent video in the DVR folder and also copy it onto a CD.