COMMONWEALTH OF MASSACHUSETTS

BRISTOL, ss

PROBATE AND FAMILY COURT
DEPARTMENT
NO. 86E-0018-GI

JUDGE ROTENBERG EDUCATIONAL CENTER, INC., et al.,
Plaintiffs,
v.

COMMISSIONERS of the DEPARTMENT OF DEVELOPMENTAL SERVICES and the DEPARTMENT OF EARLY EDUCATION AND CARE,
Defendants.

AFFIDAVIT OF GARY W. LAVIGNA, Ph.D., BCBA-D

Professional Background

I, Gary W. LaVigna, do hereby depose and state as follows:

1. I am the Clinical Director at (and co-owner of) the Institute for Applied Behavior Analysis (IABA) in Los Angeles, California. I have held that position since 1981. In that position, my duties and responsibilities include providing clinical direction and oversight for almost 600 staff in their provision of a range of services to children and adults with intellectual disability and other disorders. These services include Supported Living, Supported Employment, Intensive Support, Early Intervention, In-home Behavioral Respite, Forensic, Crisis Prevention and Resolution, Training and Consultation Services all in support of children, adolescents and adults with challenging behavior. ("Challenging behavior" or "problem behavior" is defined as "culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities" (Emerson,

1995).) I have a Ph.D. in the fields of clinical psychology and applied behavior analysis from the University of Chicago. I am licensed as a clinical psychologist in California and I am certified as a behavior analyst by the Behavior Analysis Certification Board. (See attached curriculum vitae.)

2. My work has included supporting people with the most severe and challenging behavior (including extreme self injury and physical aggression) using positive behavior support, including those whose problems, in fact, could not and were not solved using a punitive approach attempted by others. (e.g., LaVigna, Willis & Donnellan, 1989; LaVigna & Willis, 1992; and LaVigna & Willis, 2012).

Synthesis

3. In the course of my career, which includes 7 years as a staff psychologist at a state hospital (where the Autism unit I worked on was initially placed on the psychiatric side of the hospital and then was reassigned to the Developmental Disability side) and 4 years as clinical director of another community-based agency before forming IABA 31 years ago, there has been a fundamental shift in the field of applied behavior analysis (ABA) in support of people with challenging behavior. Based on the ethical requirement that the least restrictive procedure be used consistent with effective treatment, in the early days, *i.e.*, more than 25 years ago, some practitioners would sometimes use two forms of punishment to reduce the occurrence of challenging behavior. The first of these two forms included consequences that applied aversive stimuli or events such as those used at the Judge Rotenburg Center (JRC), including, but not limited to, painful spanks, pinches, muscle squeezes, and more recently, contingent

electric shock. The second of these two forms included loss of privileges and restrained time out, *i.e.*, physical restraint to prevent access to anything desired, also used by JRC.

4. However, given the significant amount of research that has been carried out over the last quarter of century, starting in 1985, the field of positive behavior supports (PBS), *i.e.*, applied behavior analysis without punishment, has been firmly established. Professionals who have extensively used evidenced-based PBS over the past 25 years have reached a consensus opinion that punitive procedures are not necessary and, therefore, are not ethical.

5. The clinical and empirical support for this consensus opinion is considerable and has significantly changed professional standards of care when applying behavior analysis in support of people with challenging behavior. The first study of the efficacy of PBS was published in 1985 (Donnellan, LaVigna, Zambito & Thvedt). In January 1987, the field and study of PBS was promising but still in its infancy. Over the past twenty-five years, numerous studies have established the effectiveness of PBS.

6. In fact, some studies have shown that PBS can be effective in cases where punishment has failed (e.g., LaVigna, Willis & Donnellan, 1989; LaVigna & Willis, 1992; LaVigna & Willis, 2012).

7. PBS that meets defined standards can solve the most serious problems, even when they occur at a high rate, is accessible to those who need it and is cost effective for funding agencies. (See Appendix A for an example of defined standards for evaluating a behavioral assessment and associated behavior support plan. These standards have been evaluated as clinically valid and have been used in various research

studies (e.g., Ballmaier, 1992; LaVigna, Christian & Willis, 2005; and Crates & Spicer, 2012).)

8. There has not been a single peer reviewed research study to show that punitive strategies have been necessary when PBS has been tried and meets objectively defined (current) standards (of care).

9. Accordingly, unlike the professional opinion that may have prevailed in the mid 1980's, the use of punishment is now considered professionally unnecessary and inappropriate. Behavior analysts are ethically bound to use the least restrictive methods consistent with effective treatment.

Introduction

10. While there is a long history of debate in the field of ABA about whether or not there is a proper role for punishment in the support of people with challenging behavior, there is universal agreement that the behavior analyst has the ethical responsibility to recommend and use the least restrictive methods consistent with effective treatment (http://bacb.com/; http://www.abainternational.org; Van Houten, et al., 1988).

11. A fundamental principle in behavior analysis is that the behavior analyst recommends reinforcement rather than punishment whenever possible. In other words, the behavior analyst recommends the least restrictive form of treatment that will be effective. Given this ethical principle, there are still those who maintain that punishment is sometimes necessary. In asserting this position, articles (*e.g.*, Lerman & Vorndran, 2002) have cited literature from the 1990's (*e.g.*, Grace et al., 1994; Hagopian, 1998;

Wacker et al., 1990). Such reliance makes this position dated since it does not take into account the research trends and findings in the area of positive behavior support over the last nearly two decades. See LaVigna and Willis (2012) for a recent literature review of developments in PBS.

12. PBS, as it has developed over the last quarter-century, includes the trends and strategies outlined below. Punitive procedures, also known as "punishment" or "aversives" or "aversive interventions," can take a variety of forms. In the 1986 "Settlement Agreement," entered into by the Behavioral Research Institute ("BRI"), which now operates as JRC, and the Massachusetts Office for Children, certain types of "physical aversive procedures" are listed. At the time of the Settlement Agreement, the types of procedures JRC used included: "spanks, pinches and muscle squeezes, and the restrained time-out." See Settlement Agreement at ¶ A3, pp. 2-3. At the time of the Settlement Agreement, these listed "physical aversive procedures" were "considered the *most intrusive, most restrictive* forms of treatment." Id. (emphasis added). Also, as BRI explained in its Second Amended Complaint in this action "BRI has also employed certain aversive techniques since its inception. The aversive techniques employed by BRI to decrease its students' aggressiveness and self-destructiveness consist of the application of stimulation that BRI students will seek to avoid, such as water sprays, taste aversives and muscle squeezes. When necessary, these aversive techniques are used in conjunction with mechanical restraints. BRI employs these punitive, aversive techniques not as a punishment, but as part of a systematic behavior modification program. BRI employs these techniques *in lieu of* anti-psychotic medication and *other more restrictive*

procedures such as seclusion and electroshock." Second Amended Complaint at ¶ 16 (emphasis added).

13. Instead of the procedures listed in the 1986 Settlement Agreement or the Second Amended Complaint, it is my understanding that JRC now uses contingent skin shock as one of, if not its primary, aversive technique. I understand, based in part on a "GED Electronics Report" generated in November 2009 by Bay Computer Associates for JRC, that JRC now uses two contingent skin shock devices – the GED and the GED-4. According to this November 2009 report, the GED delivers a shock with a "nominal voltage of 12.0 Volts" and that the GED-4 delivers a shock with a "nominal voltage of 22.2 Volts." Contingent skin shock, in general, is more intrusive and more restrictive than the procedures JRC used at the time of the Settlement Agreement. Based on the voltage of shock administered, the GED-4 is more intrusive and restrictive than the GED.

14. Contingent skin shock is a much more intrusive and restrictive intervention than any of the interventions listed in the Second Amended Complaint or by the parties in the Settlement Agreement .

15. There is near-universal agreement that contingent skin shock is professionally unnecessary and inappropriate because there are other, far less restrictive methods available to treat challenging behaviors, as detailed below.

Historical Trends

16. There have been a number of themes embedded in the research trends that have established positive behavior supports as ABA in support of people with challenging behavior. These trends are rooted in the broad range of outcomes established

in the field for a behavior support plan. These outcomes, which are metrics for measuring progress, include not only the rapid reduction of the occurrence and episodic severity of the challenging behavior itself (meaning that the challenging behavior occurs less frequently and is less serve when it does occur), but also the generalization and durability of these gains in settings beyond the treatment setting (meaning that progress toward positive outcomes can be replicated outside of the treatment setting), minimizing negative side effects, assuring acceptability to the service recipient regarding the plan's objectives and methods, and improvement in the focus person's overall quality of life as measured by socially valued outcomes (Favell, et al., 1982). The literature demonstrates that, when using these generally accepted outcome measures for any behavioral support plan, PBS is effective in the treatment of even the most challenging behaviors.

Trend #1: Move from Experimental Research with Animals to Applied Research with People

17. One trend in the research associated with this broad range of outcomes has been a move away from basic research using animals as subjects to applied research with people, since acceptability and improved quality of life are not applicable outcome measures with animals.

18. One example of how the literature on punishment fails to account for this trend is Lerman and Vorndran (2002), in which the authors reviewed more than three dozen *experimental and/or animal* studies in support of using punishment in supporting people with challenging behavior. One of these references (Van Houten, 1983) explicitly ties the use of punishment to the "animal laboratory," as indicated in the title *"Punishment: from the animal laboratory to the applied setting."*

19. In contrast, the research of the past 25 years contributing to the development of positive behavior plans in support of people with challenging behavior cites virtually exclusively applied research with people; the PBS literature of the last quarter century does not rely on the animal studies. The distinction is critical because animal studies are largely inapplicable when considering the broader context of all the required outcomes for people (*e.g.*, Carr, et al., 2002; LaVigna & Willis, 2005a; 2012).

Trend #2: Move from Behavior Support Plans with Isolated Strategies to Behavior Support Plans with a Fully Defined Structure

20. Over the past twenty-five years, there has been growing awareness that behavior support plans must be comprised of multiple procedures. Multiple procedures are used to address and designed to achieve a variety of desired outcomes. By contrast, one procedure alone does not produce broad range of desired outcomes.

21. This trend was anticipated in *Alternatives to Punishment* (LaVigna & Donnellan, 1986), in which hundreds of research studies of isolated (positive) strategies were reviewed. In a concluding chapter, we acknowledged that the desired effects, including the direct effects on the challenging behavior, may require "*additive,*" *i.e.*, multiple strategies.

22. This recognition has evolved into a defined set of standards, defined below, for the strategies that a behavior support plan needs to include when less inclusive plans have not been effective (e.g., Carr, et al., 2002; LaVigna & Willis, 2005a, 2012; LaVigna, Christian & Willis, 2005). A minimum of one procedure, if not more than one, would be included under each strategic heading in a full multi-element plan:

Strategy #1: Ecological Strategies

23. Challenging behaviors are often, at least partly, a function of a mismatch between the person's needs and characteristics and the physical, interpersonal, and/or service environments. Fully developed positive behavior support plans include strategies for "smoothing the fit" by eliminating these mismatches. Some examples of environmental changes include:

- the physical environment may need to be altered by reducing the amount of noise and/or crowding;
- the interpersonal environment may require staff to interact using a "prescriptive" style (i.e., as described in an "interaction style" procedural protocol) rather than their natural style of interaction. An example of this would be a protocol which prescribed, among other things, a specific script to follow when needing to deny access to something the person may want or be asking for, in order to minimize the likelihood of triggering a episode of the challenging behavior;
- the interpersonal environment may need to have staff assigned who are fluent in the communication system (for example, sign language) or language (for example, Spanish) used by the focus person;
- the service environment may need to have a richer staffing ratio;
- the service environment may require the benefit of different teaching methods, for example, "discrete trial teaching" (a very structured method which removes all irrelevant stimuli that may distract the student) or "direct

instruction" (which uses lectures and/or demonstrations) as opposed to least to most "correction prompting" (which can lead to a dependence on prompts from the teacher) (Donnellan, LaVigna, Negri-Shoultz, & Fassbender, 1988).

24. Such environmental changes are often aimed at directly improving the person's quality of life, but may also represent "establishing operations" (Michael, 1993) that reduce the likelihood of the challenging behavior. ("Establishing operations" are setting events that can occur minutes, hours, days or even longer before a behavior that may increase or decrease a person's reactivity to an antecedent to a behavior or increase a person's motivation to achieve or avoid a consequence for a behavior.) Further, for both of these reasons, (both contributing to a high quality of life and maintaining a setting event that is likely to be associated with the lower likelihood of challenging behavior), certain changes will have to be maintained even after the behavior challenge is brought under control in order to maintain the desired treatment outcomes. For example, if our ecological strategies included making sure that the person spent his days with people who understand sign language given that he is deaf and that sign language is his main means of communication, even after his challenging behavior is solved, he will still need to be with people who understand and who can use sign language.

Strategy #2: Positive Programming Strategies

25. It is fundamental to ABA that a behavior support plan includes the teaching of new skills to expand the focus person's behavioral repertoire (Goldiamond, 1974; 1975). In multi-element planning, these are referred to as "positive programs" and each recommendation for a positive program includes a specific instructional objective and a specific instructional method. There are four specific skill categories that should be

included in a fully developed, positive, multi-element support plan: general skills, functionally equivalent skills, functionally related skills, and coping and tolerance skills.

26. ***General skills*** include self-care, domestic, community, recreational, and academic skills. It is likely that the larger the behavioral repertoire under the person's command, the lower the likelihood that challenging behavior will occur (Goldiamond, 1974; 1975). Further, to the extent that (at least some of) these skills will give the person direct access to reinforcing activities, items or events (for example, the ability to cook a homemade pizza, or to access their favorite TV show without staff or parent assistance or participation) these reinforcers will compete with the reinforcers that are motivating the challenging behavior.

27. ***Functionally equivalent skills*** rest on the premise that what is referred to as challenging behavior always serve a legitimate function; put another way, that the challenging behavior meets a particular need for the individual (*e.g.*, a need or desire for something to eat or drink or the need to escape an aversive environment or activity). The rationale for including functionally equivalent skills in a multi-element support plan is to teach the focus person a more socially acceptable way of getting that need met. One major strategy for doing this to teach the person how to communicate the message they are communicating through their challenging behavior in a more socially acceptable way. This is referred to in the literature as functional communication training (Carr & Durand, 1985). An example would be teaching the person how to communicate "no" or "I don't understand" or "I don't know how" or "I want ____." While functional communication training represents one way to teach a functionally equivalent skill, it is not the only way to do so. For example, someone may engage in PICA behavior (i.e., dangerously eating

inedible objects) when they are hungry in order to access something to ingest. A functionally equivalent skill could be for the person to be able to communicate their hunger to another person. Alternatively, the person could be taught, whenever they are hungry, to independently (without staff or parent presence or participation) go to the kitchen, open the refrigerator door, and access the yogurt, veggie sticks, or fresh fruit that has been placed there for just that purpose.

28. ***Functionally related skills*** do not serve the same function as the challenging behavior or the functionally equivalent skill but are related to that function. For example, we may be teaching the person to independently access a snack or to prepare one to meet hunger/need to ingest motivated behavior, but a skill related to this is to be able to discriminate between edible and inedible items. If this skill is missing from the person's repertoire, it will be necessary to teach it. Further examples might include teaching the person to follow an explicit rule, teaching the person when, where and under what circumstances it is acceptable to engage in the behavior, how to make choices (increasing the choices available would go under the heading of ecological strategies), and how to use a visual schedule to predict what is going to happen (introducing a visual schedule would also go under the heading of ecological strategies).

29. ***Coping and tolerance skills*** are, technically, functionally related skills since they are aimed at giving the focus person the ability to cope with and tolerate the typical antecedents associated with the higher likelihood of the challenging behavior but to be able to do that without exhibiting the behavior. These skills are so important for durable outcomes that, although they are functionally related, they justify a category of their own. To say it another way, these skills allow the person to cope with and tolerate

the naturally occurring adverse events that are part of life but that, for the focus person, increase the likelihood of the challenging behavior. Examples of antecedents that may increase the likelihood of challenging behavior but which are part of life include being told you have to wait for something you want, being told you can't have something you want, having to do something you don't want to do, being too hot, being too cold, etc. Unfortunately, the list of naturally occurring adverse events is a long, perhaps unending, list. Ironically, the more successful we are in helping the people we support live a typical life, the more we assure that they will come into contact with these realities. To the extent that the realities are associated with a higher likelihood of challenging behavior, our plans need to include positive programs teaching them how to cope with and tolerate these events in more socially acceptable ways.

Strategy #3: Focused Support Strategies

30. It will take a while to "smooth the fit" in the ecological mismatches that are identified. It will take a while to teach the skills that are identified for the positive programs that make up the multi-element plan. Accordingly, ***focused support strategies*** are also included in order to prevent occurrences of the challenging behavior to the greatest extent possible. That is, in the multi-element model, the definition and role of a focused support strategy is to reduce and, if possible, eliminate the need for a reactive strategy by reducing the occurrence of the challenging behavior. Perhaps one of the most effective focused support strategies is antecedent control (LaVigna & Donnellan, 1986; Luiselli & Cameron, 1998). While ecological and positive programming strategies are aimed at long-term and permanent outcomes, focused support, *i.e.*, preventative

strategies, are aimed toward the more immediate goal of reducing if not eliminating the occurrence of the challenging behavior.

31. Antecedent control is inherently superior to punishment as a rapid control strategy as it is a before-the-fact procedure that may preclude the occurrence of the challenging behavior, while punishment is an after-the-fact procedure that requires the occurrence of the challenging behavior.

32. There are two major variations to antecedent control. The first involves removing the antecedents associated with the higher likelihood of the challenging behavior. For example, this may mean not asking or requiring the person to do those things they do not want to do. The second involves introducing antecedents associated with the lower likelihood of the behavior. For example, this may require the provision of an exceptionally frequent schedule for the delivery of the person's preferred events based on the clock and calendar rather than being based on behavior. In both cases, such antecedent control strategies would be paired with positive programs aimed at teaching skills for coping with and tolerating the naturally occurring antecedents, e.g., the need to perform an important but non-preferred activity or the need to tolerate a more typical schedule of preferred events.

33. Another whole category of possible focused support strategies involves certain schedules of reinforcement. For example, one particularly useful schedule is the differential reinforcement of other behavior (DRO). In this schedule the criterion for reinforcement is the non-occurrence of the target behavior for a specified period of time, regardless of what else the person does or doesn't do. In fact, one of the more powerful variations of this schedule is the differential reinforcement of other behavior with a

progressively increased amount of reinforcement available for each consecutive interval during which the target behavior does not occur (DROP), up to a specified maximum (LaVigna & Donnellan, 1986). In fact, with a clear and concrete enough explanation of the reinforcement contingency, and with the use of a significant magnitude of reinforcement, such schedules can also preclude the occurrence of target behavior as behavior can be rule-governed as well as contingency-governed (Hayes, 1989). That is, telling someone how they can earn a reinforcer can lead to a direct and immediate change in behavior before the person even experiences earning the reinforcer.

34. For example, I had the opportunity to work with a 17-year old girl with Aspergers Syndrome upon her discharge from a locked psychiatric hospital. She was going home since no residential school would accept her given the seriousness of her challenging behavior. Specifically, she would run away from her home (and had even run away from the psychiatric hospital). It would sometimes take up to a week for her to be found and brought back home. While gone, she would engage in promiscuous sex with homeless men and any other men who would accept her invitation. This behavior was justifiably considered to be life threatening, since she could have ended up with a violent male or she could have contracted a fatal sexually transmitted disease. (It may be worth mentioning here that from its roots [Donnellan, et al., 1985] and throughout its history to the present [LaVigna & Willis, 2012], PBS has proven effective regardless of the person's diagnosis or functioning level, including severe and profound mental retardation.)

35. To simplify it, the comprehensive functional assessment for this girl concluded that this behavior was motivated by her desperate desire to interact socially

with others and reflected her marked inability and frustration in her struggle to meet these critical needs. Based on this conclusion, a full multi-element PBS plan was developed and implemented, but the critical piece was the focused support strategy that was included to prevent her from running away.

36. This involved a progressive DRO (DROP) schedule of reinforcement in which she could earn anywhere from 1 – 10 exchangeable tokens, depending on how many consecutive days she had gone without running away. That is, she could earn one token for the first day she did not run away, two for the second day in a row, three for the third, up to ten tokens for the tenth consecutive day and then 10 tokens for every consecutive day thereafter. Whenever she had accumulated 300 tokens (which she would ultimately be able to do once a month), she was able to turn those in for a grab in the grab bag. There were always five wrapped gifts in the grab bag, for example, articles of clothing, gift certificates to the movies, etc. However, in every grab bag, one of the wrapped gifts was a $100 bill. This was what she really was hoping for since she had a very strong desire to shop in various thrift stores and charity shops to buy articles of clothing. Her allowance simply did not give her the money she very much wanted. This schedule was affordable to her family as she, at most, would get one "grab" a month, and on average, pick the $100 bill one out of five times (for an average monthly cost of $20). Cognitively, she was able to understand this schedule of reinforcement and with its implementation she stopped running away immediately. This kept her safe, allowing the rest of the PBS plan to be implemented leading to the entire range of outcomes desired, including teaching her safe ways of getting her socialization and relationship needs met.

37. Similar methods have proven effective for people with less cognitive ability. For example, in LaVigna & Willis, 1992, we effectively used PBS to support a person with severe self injurious behavior. This person was diagnosed with Autism and was also deaf due to maternal rubella and was considered to have a very low level of functional skills. He had been treated by another agency using extremely punitive procedures (e.g., bare bottomed smacks) without success. After a comprehensive functional assessment, a full PBS plan was developed and implemented successfully.

38. In addition to DRO and its variations, Other schedules of reinforcement, for example, the differential reinforcement of alternative responses or the differential reinforcement of low rates of responding can also be used as focused support strategies as well as other procedures such as stimulus satiation which involves giving the person greater than even wanted, free access to the reinforcer maintaining the challenging behavior (LaVigna & Donnellan, 1986), for example, free access to a fruit bowl to satisfy one's desire for food.

Strategy #4: Reactive Strategies

39. Fully developed multi-element, positive behavior support plans also include reactive strategies. In such plans, the role of a reactive strategy is not to teach a lesson or to reduce the future occurrence of the behavior, as would be the role of punishment. In the full multi-element approach, the responsibility for future effects is assigned to the proactive ecological, positive programming and focused support strategies.

40. The role of the reactive strategy is narrow but important, *i.e.*, to get the quickest, safest control over the behavior (LaVigna & Willis, 2005b). Rapid and safe

situational management may be accomplished through such strategies as: (a) ignoring the challenging behavior, that is, continuing with what you were doing as if the behavior has not occurred, knowing you will naturally redirect the person back to the scheduled activity; (b) explicitly redirecting the person to the activity at hand; (c) providing informational feedback to the person, for example, reminding them what they are working toward; (d) prompting a preferable response (for example, prompting the use of the functionally equivalent skill being taught through positive programming); (e) active listening; and (f) stimulus change.

41. In cases of particularly severe behaviors and/or in cases where the reactive strategies listed above have not worked, it may also be necessary to use what are referred to as "counter-intuitive strategies" (LaVigna & Willis, 2002). They are called counter-intuitive because, at first glance, they would appear to be strategies that would reinforce the target behavior. Counter-intuitive reactive strategies include getting rapid and safe control over the target behavior by redirecting the person to a preferred event or activity or, even, capitulating as a way of getting the dangerous behavior to stop, that is, giving the person what he wants or allowing the person to escape the current demand, if that is what he wants.

42. There is certainly an intuitive element to such strategies, *i.e.*, it is very likely that access to a strongly preferred event or activity or being allowed to escape an unwanted event or activity will interrupt a behavioral episode. The counter-intuitive element is that such strategies would appear to set the target behavior up for reinforcement, making it more likely to occur under similar circumstances in the future. However, behaviors that are followed by preferred events are not always reinforced by

those events. Preventing reinforcement from occurring under these circumstances can be understood within the full context of non-linear ABA (Goldiamond & Thompson, 1967, reprinted in 2004). For example, non-contingent access to the preferred event being used (as part of the proactive plan) and a DROP schedule aimed at the target behavior are among the non-linear establishing operations, i.e., setting events as described above, that can prevent reinforcement from occurring. (The phrase non-linear is used to make explicit that the understanding of behavior using ABA goes beyond simply understanding the A-B-C's (antecedents, behavior, consequences). History, setting events, rules, and other factors also need to be fully considered.)

Trend #3: Move to Additional Measures, Principles and Procedures

43. While the severity of challenging behavior has always been a focus in ABA (Favell, et al., 1982), changes in severity have not typically been measured in either basic or applied research. In 2005, episodic severity was introduced to the field of ABA as an outcome measure (LaVigna & Willis 2005b).

44. Episodic severity is defined as the quantified measure of the intensity or gravity of each behavioral incident, summarized by calculating both the average level of severity and range of severity over a specified period of time, based on the quantified measure of severity selected. The objective is to have a reduction in episodic severity measured as one of the outcomes in a behavior support plan.

45. In a multi-element positive behavior support plan, the responsibility for reducing the episodic severity of the target behavior is assigned to the reactive strategies.

46. For example, the episodic severity of tantrum behavior might be measured by the duration (in minutes) of each tantrum that occurs, with the behavior support plan

being responsible for reducing the average duration and the top of the range over the specified period of time. The episodic severity of each incident of physical aggression or self injury might be measured by a five point scale, with level five being the measure of episodic severity when the incident results in the need for someone to receive medical treatment, level four being the measure if first aid is required (but not medical treatment), level three if there is resulting redness and/or bruising (but not the need for medical treatment or first aid), and so on. For example, in such a case, if during the initial week of plan implementation, the average level of episodic severity was 3.5, with a range of from 1 to 5, but after 4 weeks of implementation, the average level was 1.8, with a range of from 1 to 3, we would consider this to represent considerable improvement.

47. The introduction of episodic severity as a new dependent variable (*i.e.*, outcome measure) for ABA in support of people with challenging behavior also required the introduction of new principles and procedures because reactive strategies in the multi-element model are measured by their *situational* effects whereas the traditional principles and procedures of ABA are defined by their *future* effects.

48. ***Resolution*** and ***Escalation*** are two of these new principles (LaVigna & Willis, 2005b).

49. *Resolution* is defined as the reactive presentation or withdrawal of a stimulus or event that results in the immediate reduction of the likelihood of response continuation or escalation.

50. In contrast, *escalation* is defined as the reactive presentation or withdrawal of a stimulus or event that results in an increase in the immediate probability of response continuation or escalation.

51. When developing a multi-element behavior support plan, with the availability and use of the new outcome measure of episodic severity and with the new principles and procedures of resolution and escalation at hand, we can explicitly take responsibility for recommending reactive strategies, or for that matter, consequences, that result in resolution (reductions in episodic severity), rather than escalation (increases in episodic severity).

Trend #4: Move from Functional Analysis Alone to an Emphasis on Functional Assessment

52. It is generally agreed upon that understanding the variables that control challenging behavior can be essential in developing an effective behavior support plan. A formal, if limited, method for performing a "functional analysis" has been amply described in the ABA literature (*e.g.*, Iwata, et al., 1982; Hanley, Iwata & McCord, 2003). In order to identify the complex variables that may be contributing to the behavior, however, the full multi-element approach, and, for that matter, positive behavior support in general, relies more typically on the "functional assessment" of the behavior as described by Kanfer and Saslow (1969) and Schwartz, Goldiamond and Howe (1975).

53. With this functional assessment approach, the possible contributing factors of certain historical setting events, organismic variables (*e.g.*, certain neurological impairments such as poor impulse control), behavioral skills repertoire and other factors that are not identified through a functional analysis alone can be identified to further empower a full multi-element support plan.

54. For example, we had a client once whose extreme challenging behavior was primarily triggered when she was required to go somewhere in a car. She did not

want to get into the car. Based on a functional analysis, this would be understood in operant terms as "task avoidance" behavior. However, as a result of a functional assessment, we learned that she had been sexually abused as a child by her father in the family car. Accordingly, her behavioral support plan included providing counseling and therapy to help her deal with this traumatic childhood experience and her behavior challenges were solved with a strictly positive plan. (The lack of such therapy and counseling could be understood as an ecological mismatch with reference to the service environment.) Within months she was confidently and without resistance willing and able to go to various places in a car.

55. Using punishment because this individual refused to get into the car would not have been ethical. Nor would it be ethical to use punishment if a person's physical aggression were due to a psychomotor seizure, that is, due to a neurological event.

Review of Specific Research That Meets Defined Criteria

56. The above sections describe a multi-element model for providing positive behavioral support for people who exhibit seriously challenging behavior without needing to resort to the use of punishment techniques. Positive behavior support is ABA in support of people with challenging behavior. It is aimed at producing the broad range of outcomes prescribed by ABA in support of people with such challenges.

57. There have been challenges raised as to the efficacy and usefulness of PBS in a number of ways (Foxx, 2005; Johnston et al., 2006). These have included the assertion that PBS is not effective with really serious challenging behavior, it is not effective with high rate behavior, it is not effective in institutional settings, it is

prohibitively expensive, and it is not accessible to most who would need it because to meet the rigorously defined criteria requires highly trained specialists that would not be available to most people.

58. In fact, the standards of care defined above are measurable. (For example, see the evaluation instrument attached to this affidavit.) Recently, the Journal of Intellectual and Developmental Disability (JIDD) published a series of articles reporting research on the efficacy of positive behavior support. One of these articles provided a literature review (LaVigna & Willis, 2012) of the published research addressing the questions that have been raised regarding PBS. Three other articles published as a part of this series added to this literature (Crates & Spicer, 2012; McClean & Grey, 2012a; 2012b). To be included in the literature review or as a study in this series, the standards of care described above needed to have been met. Excluded were any studies that addressed behavior challenges that would not be considered particularly severe, for example, non-compliance, and studies that may have been self-described as positive but which, in fact, included punitive strategies. The studies included control group comparison studies, multiple baseline across subjects studies, and Type 3 case studies that met Kazdin's (1981) criteria allowing the drawing of valid inferences (for example, case studies that included continuous data collection through baseline, intervention and follow-up and that involved subjects with different diagnoses exhibiting different behaviors that are typically resistant to change.)

59. All told, there were 15 studies (12 summarized in the literature review and 3 additional studies published as part of the special JIDD series). In fact, some of the cases included those for whom a punitive approach had previously been tried and failed.

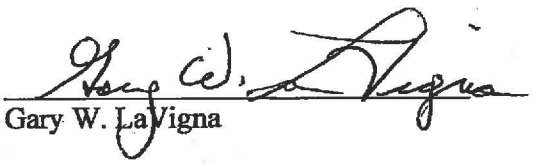
These 15 studies reported the results for over 500 cases. The findings support the conclusions that: (1) PBS is effective with the most severe (as well as the less severe) behavior challenges; (2) PBS is effective with high rate (as well as low rate) behavior challenges; (3) PBS can be used effectively in institutional as well as community settings; (4) PBS is cost effective; and (5) PBS is easily disseminable and accessible to those who need it.

60. Given the ethical principle of using the least restrictive methods, these findings have important implications for practitioners in the field. If a practitioner were to argue that the positive approach was tried and failed, thereby justifying the use of punitive procedures, the burden of proof should include a clear demonstration that those attempts to solve the problem using positive strategies met the standards of care described above, including the performance of a comprehensive functional assessment and the implementation of a fully developed multi-element plan. This standard is not always met in the field (e.g., Salvy, et al., 2004).

Conclusion

61. In conclusion, when positive behavior supports meet certain standards of care, punishment is not necessary. Given the fundamental, guiding principle that effective treatment must be accomplished by the least restrictive means necessary, punishment cannot be justified. Punishment is inherently more intrusive than PBS. The evidence of the past twenty-five years has demonstrated the efficacy of PBS in treating individuals with intellectual and developmental disabilities who exhibit challenging behaviors. PBS has reached the point where it is the generally accepted standard of care in the relevant treatment community. Accordingly, regulating bodies, human rights committees, and funding agencies have not just the right but the obligation to restrict and regulate against the use of punishment. Punishment is unnecessary, and is not the accepted standard of care in the relevant treatment community.

Signed under the pains and penalties of perjury this 6th day of February, 2013.



Gary W. LaVigna

COMMONWEALTH OF MASSACHUSETTS

BRISTOL, ss

PROBATE AND FAMILY COURT
DEPARTMENT
NO. 86E-0018-GI

JUDGE ROTENBERG EDUCATIONAL CENTER, INC., et al.,
Plaintiffs,
v.

COMMISSIONERS of the DEPARTMENT OF DEVELOPMENTAL SERVICES and the DEPARTMENT OF EARLY EDUCATION AND CARE,
Defendants.

AFFIDAVIT OF ELIN M. HOWE

I, Elin M. Howe, do hereby depose and state as follows:

1. I am the Commissioner of the Department of Developmental Services ("the Department" or "DDS"). I was appointed to that position in July 2007. (A true and accurate statement of my experience and education in the form of a resume is attached hereto as Exhibit 1.) The information contained in this Affidavit is based upon my personal knowledge, reports given to me by DDS staff and records of the Department, unless otherwise indicated.

2. As Commissioner, I am responsible for policy development, planning, financing, regulating, managing and providing services to approximately 34,000 individuals with intellectual and developmental disabilities (including adults with intellectual disability, children with intellectual disability or developmental delays, and children with autism). These services are provided by more than 6,000 state employees and over 300 provider agencies. The Department's annual funding is approximately $1.4 billion. The Department currently estimates that the Commonwealth will receive $525.7 million in federal reimbursement in fiscal year 2013.

3. The Department provides 24/7 residential services (in state-operated community-based homes, state-operated intermediate care facilities for the persons with intellectual disability ("ICFs"), and provider-operated community-based homes), day and employment services, transportation, respite and family supports, and behavioral supports to children with autism.

Professional Background and Experience

4. Immediately prior to being appointed the Commissioner of DDS, from 2003-2007, I was employed as Vice President of Consulting Services for the Columbus Organization, a national provider of on-site professional staffing and

consultative services focusing exclusively on agencies that serve individuals with special needs. In this role, I provided leadership for all of Columbus' consulting projects, including projects in the states of California, New Mexico, New Jersey, Kentucky, Tennessee, Washington, Missouri, Texas, Iowa and the District of Columbia. See Exhibit 1.

5. While at Columbus, I served as a jointly selected Independent Monitor in cases involving the United States Department of Justice ("DOJ") and claims under the Civil Rights of Institutionalized Persons Act ("CRIPA") against the state of New Jersey and the New Lisbon Developmental Center (Docket No.: 3:04-cv-03708-GEB-JJH) and the Woodbridge Developmental Center (Docket No.: 3-05-cv-05420-GEB).[1] In this capacity I was qualified as an expert in the standard of care for services for individuals with intellectual disability.

6. I also served as the Internal Compliance Monitor for the State of New Mexico in a class action lawsuit, *Jackson et al. v. Fort Stanton, et al.* (Docket No.: Civ. No. 87-839 JP) and was responsible for monitoring compliance with the terms of the Joint Stipulation on Disengagement. The *Jackson* suit was a class action contesting the institutionalization of developmentally disabled individuals at state-supported institutions for the disabled in the State of New Mexico.

7. In my role at Columbus, I consulted with various states on achieving compliance with applicable federal regulations governing programs and services for individuals with intellectual disability. In this role, I observed and monitored state-operated or funded programs, and advised states on what was needed to achieve compliance with applicable standards.

8. Prior to my role as a federal court monitor, from 1989 to 1993, I was the Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities with responsibility for policy development, planning, financing, regulating, and providing services to over 75,000 individuals with intellectual or developmental disabilities. See Exhibit 1.

9. In total, I have over 35 years' experience in the field of intellectual and developmental disability as a senior level executive and federal court monitor, and am familiar with the standard of care in both ICF programs and community-based programs for persons with intellectual or developmental disabilities.

10. I am also a member of the National State Directors of Developmental Disabilities Services (NASDDS), an association of state directors from around the country that serves as a policy and planning resource for states on issues affecting persons with intellectual disability and developmental services.

States' Practices and the Standard of Care for Behavioral Services

11. Over the years in my role first as a state director for New York's Office of Mental Retardation and Developmental Disabilities (formerly Department of

[1] As a condition of my employment in Massachusetts, I requested and received approval to complete my assignments as an independent monitor. A review and approval from the Massachusetts Ethics Commission was received in 2007, 2008 and 2009. This work was completed in 2009.

Mental Hygiene, currently the Office for People with Developmental Disabilities), then as a court monitor and more recently as Commissioner of the Department, I have consistently been charged with developing and reviewing the standard of care for persons with intellectual and developmental disability, in particular with respect to challenging behaviors.

12. Over the years, the practice of behavior modification involving persons with intellectual and developmental disability has evolved. In particular, the rise in Positive Behavioral Supports ("PBS") to treat individuals with intellectual disability and autism who have extremely difficult or dangerous behaviors, along with enhanced training of staff and attention to the individual's environment, is now the overwhelmingly prevalent standard for such services.

13. Whereas the use of so-called aversive interventions or "punishments" including noxious spray, pinches, slaps, and, later, contingent skin shock, was previously accepted behavioral treatment of individuals with intellectual disability, that is no longer the case. Aversive interventions have been specifically disallowed or banned in many states, and even where not specifically banned by statute, are not permitted as a matter of policy.

Federal Standards Regarding Aversives

14. In my work as a consultant on behalf of various states, I have read and am also familiar with numerous finding letters, settlement agreements and remedies obtained by DOJ regarding systems of care for persons with intellectual and developmental disabilities, including ones in Texas, Kentucky (Oakwood), New Mexico, and Indiana. As a consultant, I was also familiar with DOJ's expectations for behavioral supports in their investigations in Missouri and California.

15. I am familiar with generally accepted standards for behavioral interventions in state-operated and federally-certified facilities.

16. Based upon my experience, federal authorities charged with compliance of civil rights law for individuals with intellectual and developmental disabilities emphasize PBS and seek the prohibition of aversive interventions

17. I am also familiar with a class action that was settled in June of 2011, *Jensen, et al . v. Minnesota Department of Human Services* in the Federal District Court, District of Minnesota, Docket No. 09-CV-1775 DWF/FLN, in which plaintiffs brought suit against the state of Minnesota for subjecting their children to aversive interventions. The plaintiff class was defined as all individuals subject to the use of aversives or deprivation procedures including restraints or seclusion. The settlement agreement which was entered as an order of the Court in that class action litigation eliminated the use of any aversives, including restraints, for persons within the state's care and established a state-wide acceptance of positive behavioral supports.

DDS' Regulation of the Judge Rotenberg Center

18. Just prior to my becoming Commissioner in July of 2007, the Department had recently emerged from a 10-year receivership with regard to its relationship to the Judge Rotenberg Center ("JRC") imposed by the October 6, 1995 Order of the Bristol County Probate Court ("the Receivership Order"). I have been told that during the receivership the Commissioner and senior departmental staff met quarterly with the Receiver and JRC representatives to discuss any disputes concerning JRC's programs.

19. Upon assuming the position of Commissioner, I was advised as to the terms and effect of the 1986 Settlement Agreement which was entered as an Order of the Bristol County Probate Court on January 1, 1987 ("the Settlement Agreement"). I was made aware that the Settlement Agreement imposed a duty to act in "good faith" in all regulatory matters involving JRC.

20. Although I had throughout my career found that the best practices in behavior management involved positive behavior supports, in addition to the use of medication, if required, I have at all times exercised good faith in my interactions with JRC and eschewed bias against the program.

21. The Department had, prior to the receivership, and has since the termination of the receivership, a significant role in the regulation of JRC. This has included the investigation and disposition of complaints of abuse involving individuals at JRC; the appointment of independent clinicians to review court-approved treatment plans; the participation by the Department in the development of individual support plans; the review of proposals and awards of contracts between the Department and JRC; the approval to occupy and licensing of residences occupied by adults with intellectual disability; the licensing of day programs; the review of restraint forms; and the program certification to administer level III (aversive) interventions.

Investigations into Abuse

22. Pursuant to G.L. ch. 19C, the Disabled Persons Protection Commission ("DPPC") investigates allegations of abuse against persons with disabilities between the ages of 18 and 59, including allegations of abuse at JRC. Under a delegated authority, the Department also investigates such complaints on behalf of and under the supervision of DPPC. The Department also investigates complaints of "mistreatment" under G.L. ch. 19B, 115 C.M.R. 9.00.

23. Prior to the receivership, and in the contempt action brought against the Department, it was alleged that the Department had used the investigations process unfairly against JRC and that the Department had notified funding agencies of serious allegations of abuse and deaths at the Judge Rotenberg Center prior to the "substantiation" of any such complaints.

24. In its Revised Verified Third Amended Complaint for Contempt Pursuant to Rule 65.3 of the Massachusetts Rules of Civil Procedure ("Third Contempt Complaint"), JRC alleged that "[f]rom 1993 to the present time, the Department has been conducting frivolous abuse investigations at JRC. The Department has used its so-called abuse investigations to harass JRC and its staff and to create

the appearance that JRC is an abusive agency." (A copy of this Third Contempt Complaint is attached hereto as exhibit 2). Third Contempt Complaint at ¶ 78.[2]

25. JRC went on to allege that DMR's pursuit of such "frivolous" complaints against JRC had imposed inordinate demands on BRI staff, and that "[d]ue to the bias evident in all the Department's dealings with JRC, these abuse investigations have resulted in the substantiation of the allegations of abuse by investigators unqualified to make such findings, as well as defective Action Plans to remedy the supposed and purported abuse." Third Contempt Complaint, ¶¶ 81-83.

26. In the contempt action, JRC alleged that DMR's communications with JRC's funding agencies were intended to harm JRC's relationships with those funding agencies. See, *e.g.*, Third Contempt Complaint at ¶ 85.

27. Upon the termination of the receivership on September 4, 2006, the Department resumed the function of investigating complaints of abuse at JRC, under the DPPC-delegated authority of G.L. ch. 19C, and complaints of mistreatment, pursuant to 115 CMR 9.00 et seq. Since approximately January 1, 2006, a total of 164 cases of alleged abuse involving JRC were reported to the DPPC. Of those, approximately 37 cases were "dismissed"; 13 were referred to agencies other than DDS (the Department of Early Education and Care ("DEEC"), Department of Children and Families ("DCF"), Department of Mental Health ("DMH")); 43 were referred to law enforcement (and investigation by DDS was deferred pending such investigation); 89 were investigated by the DPPC; and 21 cases were assigned to be investigated by DDS.

28. Of the 21 cases assigned to DDS to investigate, 4 resulted in a finding of "substantiated"; 7 were "unsubstantiated." The remaining cases were either deferred to law enforcement or resolved administratively.

29. JRC has several pending appeals of substantiated abuse which are under review.

30. During this period, there has been no assertion that the Department has been in contempt of the Settlement Agreement insofar as the investigations process is concerned.

Appointment of Independent Clinicians

31. Pursuant to the Settlement Agreement, DMH, as the Department's predecessor, was required, when notified of a referral and acceptance of an admission to JRC, to arrange for clinicians to review the proposed clinical treatment plans of individuals admitted to JRC; these clinicians were to advise the Probate Court of their findings and recommendations. Settlement Agreement, Part A, ¶ 7.

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[2] The Department referred to in this paragraph is the Department of Mental Retardation or "DMR" is the Department of Developmental Services' predecessor agency; the agency name change became effective in June 2009. Prior to 1994, the Judge Rotenberg Center operated under the name Behavior Research Institute or "BRI."

32. On or around December 29, 1988, upon DMH's motion, the Bristol County Probate Court amended the Settlement Agreement to make this clinical review requirement discretionary, rather than mandatory, due primarily to the challenges presented to DMH in retaining clinicians to perform such reviews.

33. When the Department later assumed this obligation and after the imposition of the receivership, it retained independent clinicians, *i.e.* clinicians not employed by the Department, to perform this function.

34. During the receivership, with the approval of the Receiver and JRC, and as a condition that the Receiver imposed for Level III certification, DDS asked the independent clinicians to begin reviewing behavior treatment plans for individuals who had been at JRC for over three years, rather than at the time of admission. This decision was based both upon the relative dearth of clinicians able to review treatment plans, and the desire to put such expertise to use for those individuals who were not being "faded" from the Level III aversive intervention JRC administered using a Graduated Electronic Decelerator ("GED") or updated GED-4 manufactured by JRC. The GED/GED-4 are devices used to deliver contingent skin shocks to individuals. The most commonly used aversive procedure at JRC is the contingent skin shock.

35. Independent clinicians, hired under contract with McLean Hospital, conducted reviews of individuals who received Level III interventions for a period of three years and began to attend case conferences, with the individual service planning[3] team, clinicians and family or guardian, to discuss the treatment plan. These were referred to as "three-year case conferences" for those individuals.

36. In the last several years, two independent clinicians not employed by the Department have attended case conferences and issued reports to the court, ward counsel, DDS, the individual's parent or guardian, the individual's ISP team coordinator regarding the individual treatment plans .

37. The Commonwealth has expended approximately $22,715 per year in fees to these independent clinicians.

Participation by the Department in Individual Support Planning

38. Individuals receiving residential services funded by the Department are entitled to an individual support plan ("ISP"). The 42 Massachusetts residents who are receiving adult services at JRC funded by the Department each have an annual ISP.

39. DDS service coordinators (case managers) attend annual ISP meetings along with the individual's other ISP team members, including the individuals' guardian(s) or family members, and staff from JRC that support the individual.

40. When individuals at JRC "age-out" of special education service and become eligible for the Department's services at the age of 22, DDS service

[3] An ISP is an individualized written plan for services or supports for an individual receiving services or supports provided, purchased or arranged by the Department. See 115 CMR 2.01.

coordinators and other Department staff work with the individual and his or her guardian or guardians to consider what is the most appropriate placement for the individual.

41. Several individuals have successfully transitioned from JRC to other, less restrictive providers. See discussion below at ¶¶ 105-106.

Contracts for Services between the Department and JRC

42. Pursuant to the Settlement Agreement, Part F, ¶ 2, "[t]he Department of Mental Health, the Office for Children ("OFC"), and all state placement and funding agencies shall give [JRC] equal consideration with all other private providers for new clients referred for private placement by state agencies."

43. Throughout the period of the receivership and continuing to the present, the Department has contracted with JRC to fund the placement of many of the original members of the class who filed suit to retain their services at JRC.

44. The Department has also funded individuals placed at JRC during the receivership through Local Education Authorities ("LEAs").

45. The Department has also contracted with JRC to provide residential and "respite" (short-term) services that do not involve the use of aversive interventions.

Licensing

46. The Settlement Agreement provided that "[u]pon the execution of this agreement, the outstanding OFC licenses for the operation of [JRC's] residential facilities shall be restored. These licenses shall not be revoked without the approval of the Court or until such time as DMH licenses [JRC]." Settlement Agreement, Part C, ¶ 1.

47. With respect to licensing, the Department's Office of Quality Management ("OQM") is responsible for licensing all services and supports offered to persons with intellectual disability, G.L. ch. 19B §15; 115 CMR 7.00 et seq., 8.00 et seq.

48. OQM is responsible for licensing JRC's residential programs (homes) and its day program for adults with intellectual disability, including these programs at JRC. (DEEC licenses the residential sites for children.) 103 CMR 3.030 et seq. The Department of Elementary Education ("DESE") is responsible for certifying the JRC's special educational (Chapter 688) programs. G.L. ch. 71B.

49. JRC currently has 16 adult residential program sites.

50. I understand that JRC also has approximately 20 residential sites for children, defined as any home with any individual under the age of 18 residing in the home, which are licensed by the DEEC.

51. During and after the termination of the receivership, and in light of the history of disputes between JRC and what was then the Department of Quality

Assurance, the OQM licensing survey focused on the conditions for licensure applicable to all providers serving individuals with intellectual disability. Compliance with the regulations pertaining to behavior management has been addressed by the Level III Certification Team[4], and not by OQM.

52. Since the end of the receivership, OQM staff has worked closely with JRC to address issues in the licensure process, and, despite concerns expressed about the restrictiveness of the environment and JRC's practices (as set forth below in ¶¶ 63-80) the Department has consistently licensed JRC's residential and day programs.

53. On July 5, 2006, two months before the termination of the receivership, the Department issued a two-year license to JRC. By statute and regulation, a two year license is the longest period for which a license is awarded. At the time of that review, JRC provided services to 250 adults and children in its programs. Although JRC earned a two-year license, there were areas needing correction which were addressed by the Department in a Follow-up Report to JRC on November 6, 2006. Of five areas addressed by the Follow-Up Report as needing correction, one was found to be "Not Corrected", and three were found to be "Partially Corrected." On March 20, 2007, the Department conducted an Area Office Review of those areas the Follow-Up Report had found were not fully corrected. The review found some improvement among the areas of concern, but not enough to fully correct the outstanding deficiencies. The findings of the Area Office Review did not affect the issuance of a two-year license to JRC.

54. On January 9, 2009[5], JRC received a conditional one-year license from the Department. At the time, the total number of adults and school-aged children at JRC ("the JRC census") had declined to approximately 180. Concerns about some practices, including JRC's practice of requiring individuals to remain at the JRC central location, as opposed to returning home in the afternoon and early evening, were identified as issues in this licensing survey, as were other restrictive practices such as mandatory bedtime and bed checks, restrictions on talking, and not allowing deviation from the food menu.[6] Areas needing

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[4] The role of the Level III Certification Team is to conduct reviews of Level III interventions (aversives) by certified providers for compliance with Department regulations and consistency with professional standards. See also paragraphs 57-80. JRC is the only provider in the Commonwealth certified to provide Level III interventions.

[5] Department regulations provide that if a provider timely submits an application with OQM prior to the expiration of their existing license they are deemed to be operating with a valid license during the renewal process. JRC submitted a timely application prior to the expiration of the license issued in July 2006. See 115 CMR 8.03(6).

[6] On or about February 3, 2009, JRC filed a request for reconsideration of the one-year licensure award. In response, on March 20, 2009, OQM issued a revised provider report; the revisions contained in the March report did not impact the overall summary or outcome of the licensing survey. On April 27, 2009, JRC filed a second request for reconsideration on procedural grounds. OQM conducted a

correction were addressed in OQM's Follow-Up Report to JRC dated May 13, 2009. Of twenty-two areas addressed by the Follow-Up Report as needing correction, three were found to be "Corrected", seventeen were found to be "Partially Corrected", one was found to be "Not Corrected", and one was deferred to the Level III Certification Team.

55. On January 4, 2010, JRC received a two-year license from the Department. At this time, JRC's census had increased to 205. OQM's Follow-Up Report addressing areas needing correction was sent to JRC on or about March 18, 2010. Of ten areas addressed by the Follow-Up Report as needing correction, two were found to be "Corrected", six were found to be "Partially Corrected", and two were found to be "Not Corrected". The Follow-Up Report did not recommend any further review or follow up, but did inform JRC that the areas which remained uncorrected or partially corrected would be the subject of evaluation during the next licensing survey.

56. Most recently, on January 18, 2012, JRC was awarded another two-year license. At the time of the licensing report that culminated in this two-year license, JRC's census was 234 adults and children.

Level III Program Certification Review

57. With regard to Behavior Modification, and as set forth in the Department's regulations, it is the purpose of the Department to "assure the dignity, health and safety of its clients . . . It is the Department's expectation that strategies used to modify the behavior of clients will not pose a significant risk of harm to clients and will not be unduly restrictive or intrusive. Indeed, the Department believes that it is both sound law and policy that in individual cases the only procedures which may be used are those which have been determined to be the least restrictive or least intrusive alternatives." 115 CMR 5.14(1)(c).

58. Level III interventions are: "[a]ny Intervention which involves the contingent application of physical contact aversive stimuli such as spanking, slapping or hitting"; "Time Out wherein an individual is placed in a room alone for a period of time exceeding 15 minutes"; "[a]ny Intervention not listed in 115 CMR 5.14 as a Level I or level II Intervention which is highly intrusive and/or highly restrictive of freedom of movement"; or "[a]ny Intervention which alone, in combination with other Interventions, or as a result of multiple applications of the same Interventions poses a significant risk of physical or psychological harm to the individual." 115 CMR 5.14(3)(d)1-4.

59. The Department's regulations, 115 CMR 5.14, permit the use of aversive (Level III) interventions for individuals who, as of September 1, 2011, had a court-approved substituted judgment behavior treatment plan involving the use of such aversives. 115 C.M.R. 5.14. These interventions are considered the most intrusive of all behavior management techniques, and are therefore subject to

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review of the licensing process and responded to JRC on June 2, 2009 with a determination that the licensing process was free from substantive error.

the requirements of 115 CMR 5.14, including that the interventions used be the "least restrictive" required and that they are used only after other treatment measures have been exhausted.

60. Regulations further provide that

> Level III Aversive Interventions that are allowed under 115 CMR 5.14(4)(b)4 may be used 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.

115 C.M.R. 5.14(4)(b)(8).

61. A Level III program must be "certified" by the Department and must meet all the requirements set forth in its regulations. 115 CMR 5.14(f). Prior to the receivership, all during the receivership, and after the termination of the receivership, the Department (and at relevant times, the Receiver) appointed a Level III certification team consisting of both legal experts and experts in the field of intellectual disability and behavior management to review JRC's Level III (aversive) programs. This review was in addition to court approval of any such treatment plan through substituted judgment. The primary purpose of the review was and is to ensure compliance with the Department's regulations, with particular attention to the regulatory requirements found at 115 C.M.R 5.14.

62. Upon information and belief, during the period of the receivership, the court-appointed Receiver, retired Judge Lawrence T. Pereira, formed two Level III Certification Teams to review JRC's program – one in 1997 and a second in 2002-2003.

63. In 1997, the Team consisted of: a physician, Curtis Prout, M.D; two psychologists, Philip Levendusky, Ph.D and John Daignault, Psy.D. (Dr. Daignault was also the Court Monitor); and the Receiver's counsel, Andrea H. Maislen, Esq. This Certification Team reviewed a sample of twelve (12) individuals and their behavior treatment programs at JRC, reviewed documents at JRC, interviewed staff and clinicians and observed individuals on site. On November 13, 1998, the Commissioner adopted the Report and Recommendations of the Level III Certification Team to certify JRC for a period of two years, subject to six (6) Conditions imposed upon JRC. See Report of the Certification Team on the Application of the Judge Rotenberg Educational Center for Level III Behavior Modification Certification, October 14, 1998 (1998 Report). (A copy of this Report is attached hereto as Exhibit 3.)

- 1. Consult with a medical records expert to assist in synthesizing recorded data in a meaningful and accessible form. See ex. 3 at p. 86.
- 2. Institute quarterly internal reviews for all students receiving Level III interventions and integrate such reviews with court ordered reviews. Id. at p. 86.

- 3. For students who have received Level III interventions for three years, independent clinicians will present their findings in a case conference and will submit a final report including the rationale for continuing or discontinuing Level III interventions. Id. at p. 87.

- 4. Institute a scheduling system to insure adequate time off for doctoral level psychologists and institute mandatory yearly continuing education requirements. Id. at p. 87.

- 5. JRC will add a sufficient number of clinicians to the Peer Review Committee (PRC) to permit the required number of non-treating clinicians to pass on every proposed plan. Id. at p. 87.

- 6. JRC will add a physician or nurse and a psychologist to its Human Rights Committee. Id. at p. 87.

64. In 2002-2003, this Certification Team consisted of: Curtis Prout, M.D.; two psychologists, Dennis Upper, Ph.D. and Mark Fridovich, Ph.D. (Dr. Fridovich was also Deputy Commissioner of the Department); Elliot A. Berusch of the Department's OQM; Tom Anzer, the Department's Director of Human Rights; and the Receiver's new Counsel, Maureen Curran, Esq. The 2002-2003 Certification Team also reviewed a sample of twelve individuals and their behavior treatment programs at JRC, reviewed documents at JRC, interviewed staff and clinicians and observed individuals on site.

65. On or about December 29, 2003, the Receiver adopted the Team's Report and Recommendations and issued a two-year certification effective January 1, 2004 subject to eleven conditions and two recommendations. See Report of the Certification Team on the Application of the Judge Rotenberg Educational Center for Level III Behavior Modification Certification, December 29, 2003. (2003 Report). (A copy of this Report is attached hereto as Exhibit 4.) Five of the conditions were similar to or the same as those identified in the Report adopted on November13, 1998.

- 1. Integrate all relevant documents into a single complete behavioral plan. See ex. 4 at p. 108. Compare with ¶ 63(1).

- 2. Individualize integrated behavioral plans by including (a) comprehensive functional analysis, (b) conditions for termination of intervention, (c) assess and determine applicability of alternative treatment options, (d) individualize criteria for plan revision and termination, and eliminate generic interventions from behavior plans. Id. at p. 109.

- 3. Continue quarterly internal individualized reviews for individuals receiving Level III interventions. Id. at p. 109. Compare with ¶ 63(2).

- 4. Utilize computerized charting of negative behaviors to measure educational goals as a proxy for quality of life assessment. Id. at p. 109.

- 5. Structure discharge plans involving fading for students leaving JRC and develop fading programs for students remaining at JRC which facilitate community integration of the student. Id. at pp. 109-110.
- 6. Peer Review Committee shall document and discuss each recommendation of independent clinicians and psychologist; maintain minutes of recommendations and rationale. Id. at p. 110.
- 7. For students who have received Level III interventions for three years, independent clinicians will present their findings in a case conference and will submit a final report including the rationale for continuing or discontinuing Level III interventions. Id. at p. 110. Compare with ¶ 63(3).
- 8. Institute a scheduling system to insure adequate time off for doctoral level psychologists and institute mandatory yearly continuing education requirements. Id. at pp. 110-111. Compare with ¶ 63(4).
- 9. Add psychologist to Human Rights Committee (HRC); JRC will document dialog between JRC and HRC in its minutes. Id. at p. 111.
- 10. JRC behavior plans must be consistent with Department regulations to insure that Level III interventions only are used "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," in accordance with department regulations [115 CMR 5.14(4)(b)(5)]. JRC must make a clear showing of necessity and document the basis for using Level III intervention for behaviors that do not meet the regulatory standard. Id. at p. 111.
- 11. Document the rationale for imposing limitations on personal possessions, funds, and visitation; document teaching and planning to eliminate the need for such restrictions. Id. at p.111.
- Recommendations: (1) JRC should continue to strive to reduce the interval between the observation of dangerous behavior and the implementation of the level III aversive. (2) DDS should continue to monitor whether it is necessary to appoint an independent clinician to the PRC. Id. at p. 112.

66. Upon information and belief, the next Level III Certification Team was appointed by my predecessor-Commissioner on or about November 2006. This Team consisted of: Dr. Philip Levendusky, a licensed psychologist and Director of outpatient services at McLean Hospital in Belmont, Massachusetts; a psychiatrist with experience in the field of intellectual disability, Dr. Edwin Mikkelson, M.D.; Lauren Charlot, Ph.D., Assistant Professor Department of Psychiatry, University of Massachusetts Medical School; Thomas Anzer, the DDS Director for Human Rights; Bruce LaFlamme, LICSW, a surveyor from the Department's Office of Quality Enhancement; and an Assistant General

Counsel, Andrea Maislen.[7] This Level III Certification Team included two prior members of the Level III Certification engaged by the Receiver's Office: Dr. Levendusky and Attorney Maislen. Staff from DEEC who had newly become responsible for licensing any JRC homes with children under 18, requested to be included in the Certification Team's site visits and interviews at JRC to better understand the Level III aversive issue. They did not participate in evaluating the program.

67. The 2006-2007 Certification Team reviewed a sample of fifteen individuals and their behavior treatment programs at JRC, reviewed documents at JRC, interviewed staff and clinicians and observed individuals on site. On or about December 17, 2007, I adopted the Team's Report and Recommendations. JRC was awarded a one-year certification with conditions at that time. See Report of the Certification Team on the Application of the Judge Rotenberg Educational Center for Level III Behavior Modification Certification, December 17, 2007. (2007 Report). (A copy of this Report is attached hereto as Exhibit 5.)

68. This 2006-2007 Certification Report imposed eight conditions:

- 1. Develop a single, integrated behavior treatment plan for each student subject to Level III intervention and submit a sample report to the Department. See ex. 5 at p. 146. Compare with ¶¶ 63(1) and 65(1).
- 2. Limit the number of problem behaviors included in any single category in the behavior treatment plan and develop a protocol to limit the frequency with which behaviors are recategorized for purposes of changing the treatment response. Ex. 5 at p. 146.
- 3. Individualize integrated behavioral plans by including (a) comprehensive functional analysis, (b) conditions for termination of an intervention, (c) assessment of feasible treatment alternatives and the conclusions for treatment choice, (d) evaluation of a broader range of non-aversive alternative treatments, (e) individualized criteria for plan revision and termination, and eliminate generic interventions from behavior plans. Id. at pp. 146-147. Compare with ¶ 65(2).
- 4. Continue quarterly internal individualized reviews for individuals receiving Level III interventions and in all future plans: include the rationale for increases/decreases in effectiveness of use of Level III intervention and articulate the rationale for continuing use of Level III interventions. Ex. 5 at p. 147. Compare with ¶¶ 63(2) and 65(3).
- 5. Utilize computerized charting of negative behaviors to measure educational goals as a proxy for quality of life assessment and design a similar system for tracking replacement behaviors. Ex. 5 at p. 147. Compare with ¶ 64(4).

[7] Attorney Maislen had previously served on the Team when employed as an attorney for the Receiver. After disclosure of her prior representation, JRC agreed to allow her to serve on the Team.

- 6. Structure discharge plans involving fading for students leaving JRC and develop fading programs for students remaining at JRC which facilitate community integration of the student. JRC will submit on a quarterly basis behavior plans of students scheduled to leave JRC and behavior plans for all students that JRC has been fading the use of Level III aversives. Ex. 5 at p. 147. Compare with ¶ 65(5).

- 7. JRC behavior plans must be consistent with Department regulations to insure that Level III interventions only are used "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 they have seriously harmed or are likely to seriously harm the individual or others," in accordance with department regulations [115 CMR 5.14(4)(b)(5)]. JRC must make a clear showing of necessity and provide a rationale related to the analysis of the function of the behavior and document data that shows a direct link between the behavior and the direct harmful outcomes or utilize less restrictive interventions to address the behavior. Ex. 5 at pp. 147-148. Compare with ¶ 65(10).

- 8. The DDS Commissioner must appoint one or more members to the JRC Peer Review and Human Rights Committees. Ex. 5 at p. 148.

69. This Certification Team required JRC to submit fifteen behavior treatment plans each quarter to monitor JRC's compliance with the Conditions.

70. JRC submitted a new application for certification of its Level III program on or about October 2008. I again appointed a Level III Certification Team, consisting of: Dr. Levendusky; Dr. Mikkelson; Dr. Charlot; Thomas Anzer; Bruce LaFlamme,; and Andrea Maislen. At the request of JRC, an attempt was made to add an expert in applied behavior analysis to the Certification Team. Dr. Michael Cameron was engaged, however, he ultimately was unable to participate as a member of the team.

71. The 2008-2009 Certification Team reviewed a sample of nineteen individuals and their behavior treatment programs at JRC, reviewed documents at JRC, interviewed staff and clinicians, and observed individuals on site. This Team concluded that the conditions imposed by the 2006-2007 Team had not been complied with; therefore in May, 2009, I issued JRC a six-month certification with conditions. After another monitoring review, again based upon the Team's Report, I issued a second six-month certification on October 2, 2009. At that time, the Team commended JRC for its "progress" in certain areas, but recommended a period of close oversight to ensure that JRC continued to make progress in compliance.

72. Although it was my experience as both a commissioner and court monitor that failure to substantially comply with imposed conditions of certification would ordinarily result in a decertification, given the extensive history of litigation and receivership, and in the exercise of "good faith," I extended JRC's Level III

certification several times to allow them additional time to comply with the conditions.

73. JRC submitted another Level III Certification application on October 30, 2009. The same Level III Team was asked to review this application and on July 12, 2010, after reviewing the Team's Certification Report, I issued the Report and sent it to JRC, certifying JRC for 60 days. See Report of the Certification Team on the Application of the Judge Rotenberg Educational Center for Level III Behavior Modification Certification, July 12, 2010. (2010 Report). (A copy of this Report is attached hereto as Exhibit 6.)

74. After reviewing sample plans submitted by JRC, the Team again identified eight Conditions with which JRC had to comply to remain certified to administer Level III interventions. Once again, primary issues of concern were: the grouping together of non-like behaviors in categories to be targeted with Level III interventions; use of Level III Interventions to treat minor behaviors; content of the functional behavioral analyses, including failure to address contextual factors in behavior; and the failure to teach "replacement behaviors."

75. JRC was required to submit a progress report concerning its compliance with these Conditions within 45 days, and every 45 days thereafter until fully compliant. JRC's certification was extended 60 days to allow them to do so. On August 9, 2010, JRC submitted its response, titled "JRC's Corrective Action Plan and Response to the DDS Level III Certification Report of July 12, 2010. A copy of this response is attached hereto as Exhibit 14.

76. On November 4, 2010, DDS approved JRC's Corrective Action Plan conditioned upon JRC submitting a sample behavior treatment plan for approval. I again extended Certification for 60 days, to January 3, 2011. At this time, and with JRC's knowledge and approval, I also appointed an additional member to the team, Dr. Christopher Fox, a licensed doctoral level psychologist who is certified in Applied Behavioral Analysis and had over 30 years' experience in providing behavioral treatment to individuals with intellectual and other disabilities. Dr. Fox works for the Department.

77. On December 19, 2010, JRC submitted its first 45-day progress report. On January 5, 2011, the Team responded to JRC's 45-day Progress Report, stating that while progress had been made, JRC was still noncompliant. I again extended certification 45 days to allow JRC to come into compliance. JRC responded with a 45-day progress report dated February 3, 2011, and a demand for arbitration under the Decree. (A copy of that February 3, 2011 letter is attached hereto as exhibit 16.) A similar letter and demand was submitted on March 18, 2011. (A copy of that March 18, 2011 letter, without the referenced enclosures, is attached hereto as exhibit 17.) On March 28, 2011, DDS granted JRC another 45-day certification to give it time to come into full compliance. JRC again demanded arbitration, and on or about May 3, 2011, the Department notified JRC that it would engage in mediation with Judge Lawrence T. Pereira.

78. The mediation process lasted for over one year after which the parties agreed that they would terminate the mediation through JRC's filing of a new application for Level III certification on September 4, 2012. JRC also agreed to eliminate several aspects of its aversive programming: the Contingent or Specialized Food Program, Behavioral Rehearsal Lessons (BRLS) and Automatic Negative Reinforcement (ANR). (A copy of JRC's Application dated September 4, 2012, without the enclosures referenced therein, is attached hereto as Exhibit 15.)

79. JRC submitted a new application for certification of its Level III program on or about September 4, 2012. In its application, as in prior applications and responses to the Level III certification reports issued by the Department, JRC asserted full compliance with the Department's regulations as well as the Settlement Agreement, and reserved its rights under the Settlement Agreement. I again appointed a Level III Certification Team, consisting of: Dr. Levendusky; Dr. Mikkelson; Dr. Charlot, Dr. Christopher Fox, and Thomas Anzer. The 2012-2013 Certification Team is in the process of reviewing a sample of thirteen individuals and their behavior treatment programs at JRC, reviewing documents at JRC, interviewing staff and clinicians, and observing individuals on site.

80. Although the Level III Certification Team has consistently identified serious issues in JRC's utilization of Level III aversives, both the Department and the Certification Team have throughout this six-year post-receivership period worked with JRC and its clinicians to attempt to bring JRC into compliance with the Department's regulations governing behavior management. It should be noted that in each response that JRC has made to the Level III Team's reports, it has asserted that the Department's efforts to enforce compliance with its regulations violated the Decree, and has most recently, demanded arbitration on its own compliance.

Monitoring Restraint Use

81. The Department's regulatory monitoring of restraints at JRC includes oversight of emergency restraint practices, issuance of mechanical restraint waivers, and the review of individual restraint forms.

82. The Department's Office for Human Rights is delegated the authority for oversight of the use of mechanical restraints in the community per DDS regulations, 115 CMR 5.11(6)(b)(2). For approximately 10 years, the DDS Office for Human Rights has worked cooperatively with JRC in this regulatory oversight and monitoring function to ensure restraint practices at JRC are appropriate and consistent with DDS regulations.

83. Through the oversight and collaboration of the DDS Office for Human Rights with JRC, the utilization of waivers for the use of mechanical restraints at JRC has dropped dramatically from earlier years and by 2008 there were only three short-term restraint waivers issued to JRC. Renewals of these short-term restraint waivers have been granted to JRC by DDS as-needed. The utilization

of less restrictive behavioral strategies than restraint at JRC has been largely successful, although JRC has continued to include limitation of movement or restraint as part of Level III behavior plans for those already authorized to receive Level III aversives. In 2011, there was only one waiver issued for one individual with renewals between January and April granted as needed.

84. With respect to the monitoring of emergency restraints at JRC, the Department's Office for Human Rights has developed, with JRC's assistance, a routine submission process for the review of emergency restraint data. Monitoring emergency restraints at JRC initially involved a massive submission of paper each month. A representative sampling of the paper submission would be reviewed by the Office for Human Rights to assess certain trends and factors. Through the oversight of the DDS Office for Human Rights, the utilization of emergency restraints has decreased since the end of the receivership and there continue to be ongoing discussions about the use of less coercive approaches to de-escalation and the prevention of unnecessary restraint at JRC facilities.

Promulgation of Regulations Prohibiting the Use of Aversives

85. On June 8, 2011, DDS issued a notice of its intent to amend its existing behavior modification regulations to prohibit the use of Level III aversives. In response, on July 6, 2011, JRC notified DDS that of its position that "[t]he Proposed Amendments violate the 1986 Settlement Agreement between DDS and ... JRC" and "demand[ed] that DDS immediately withdraw the Proposed Amendments and cancel any public hearings about same as they constitute acts of contempt subjecting DDS, the Commonwealth, and responsible parties to contempt sanctions and penalties." (A copy of this July 6, 2011 letter is attached hereto as exhibit 7.) If DDS refused to withdraw the Proposed Amendment, JRC demanded arbitration. Id. at p. 185. On or about July 12, 2011, the Department responded to JRC's claims of contempt, request for mediation and insistence on the withdrawal of the proposed regulatory amendments. (A copy of the Department's July 12, 2011 letter is attached hereto as exhibit 18.) The Department encouraged JRC to submit comment on the proposed amendments. Id.

86. The Department conducted two days of public hearings in venues across the state. It heard testimony and received written comments from national, state and local disability advocacy organizations, human rights organizations, clinicians and professionals serving individuals with disabilities and severe behavioral challenges, provider organizations, a union whose members serve individuals with disabilities, family members of persons with intellectual disabilities, autism and other disabilities with challenging behaviors, attorneys representing such individuals and others.

87. The overwhelming number of written comments received by the Department were in support of the proposed regulations. Of a total of 286 written comments received, 271 were in support of the proposed regulations and 15 were opposed to the proposed regulations. Of a total of 97 oral comments, 24 people submitted their comments in writing as well. Of the 73 unduplicated oral comments, 15

were in support and 56 were opposed to the proposed regulations. All of the comments opposed to the regulations came from individuals affiliated with JRC including approximately 59 JRC employees, 2 attorneys, 9 family members and one former student. (Copies of all written comments received by the Department are attached hereto as exhibit 8; copies of the transcripts from the two days of public hearing are attached hereto as exhibits 9 and 10.)

88. The written comments received from national and state associations were overwhelmingly in support of the proposed regulations. Of particular note were comments from the President's National Council on Disabilities, the American Association on Intellectual and Developmental Disabilities (Massachusetts Chapter), the ARC of Massachusetts, the National Association of State Directors of Developmental Disability Services, the Association of Developmental Disability Providers, the Massachusetts Developmental Disabilities Council, MA Advocates Standing Strong, the Providers Council, TASH and many others. None of the oral or written comments received from national or state organizations opposed the proposed regulations. To the limited extent that the written comments, other than those received from people affiliated with JRC, disagreed with the proposed regulation, they did so only because the regulation imposed only a *prospective* ban on aversives, rather than an outright ban. See, *e.g.*, exhibit 8, at pp. 367-375, 447-451, 586-608, 673-675, 681-683, 705-719, 722-723.

89. In its response to public comments, the Department noted that as of the October 14, 2011 publication of its comments, a review of the other forty-nine states and the District of Columbia indicated that 21 states specifically "ban" or prohibit aversive interventions through statutes, regulation or policy: Alabama, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Illinois, Indiana, Maryland, Michigan, Missouri, Montana, Nevada, New Mexico, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Vermont, and Washington. Our review further indicated that other states have informally adopted practices of using only positive supports and, in practice, have banned the use of aversive interventions. We located no state whose practice includes the use of aversives such as contingent skin shock.

90. A complete and accurate summary of the oral and written comments was publically posted at http://www.mass.gov/eohhs/gov/departments/dds/.

Behavioral Treatment of Persons with Intellectual Disabilities in Massachusetts

91. The Department provides residential services to over 900 individuals, many with severe behavioral challenges, in its state-operated community system. None of these programs utilize Level III interventions.

92. The Department currently operates five (5) ICFs with a total census of 552 individuals: the Hogan Regional Center, the Glavin Regional Center, the Templeton Developmental Center, the Wrentham Developmental Center and the Fernald Developmental Center.

93. At the Hogan Regional Center in Hathorne, Massachusetts, the Department operates a Stabilization Unit for individuals with serious behavioral problems, including self-injurious behavior (SIB) and aggressive behavior that poses a threat of physical harm to the individual or others.

94. The Stabilization Unit is staffed with psychologists, medical and nursing staff, and direct care staff specially trained in the treatment of individuals with serious behavior problems which pose a serious threat to the individual and others. Level III interventions are not used at Hogan.

95. The Glavin Regional Center in Shrewsbury also provides intensive behavioral supports to individuals with intellectual disabilities and some of the most challenging behaviors, including severe aggression, severe SIB, PICA behavior (the persistent ingestion of non-nutritional substances), and forensic behaviors. The Glavin Regional Center does not utilize Level III interventions. Likewise, Level III interventions are not used at the Templeton Developmental Center or the Fernald Developmental Center.

96. The Department also provides residential and day supports to thousands of individuals with serious behavioral challenges through its provider system. Among the Department's 300 providers are several that specialize in providing supports to persons with severe behavioral problems. Providers such as Amego, Inc. and Community Resources for Justice, specialize in providing residential and other supports to individuals with severe behavioral problems without the use of Level III interventions.

97. These providers use primarily behavior planning, positive behavioral supports, staff training, environmental controls and, where appropriate, medication, to teach individuals how to successfully control or regulate their own behavior.

98. Under the Department's current regulations, a provider must be authorized before it may use Level II or Level III aversive interventions.

99. Level II aversive interventions may include "contingent application of unpleasant sensory stimuli such as loud noises, bad tastes, bad odors or other stimuli which elicit a startle response[,]" short delay of meal, or time out up to 15 minutes. 115 C.M.R 5.14 (3)(c).

100. Although permitted by regulation, no DDS-funded provider other than JRC uses "contingent application of unpleasant sensory stimuli such as loud noises, bad tastes, bad odors or other stimuli which elicit a startle response[,]" or "short delay of meal." Some providers are authorized to use a "time out up to 15 minutes." 115 C.M.R 5.14 (3)(c).

101. As explained above, Level III aversive interventions are permitted to be used by providers who are certified by the Department only for individuals who had a substituted judgment treatment plan that included Level III aversive interventions as of September 1, 2011.

102. Currently, and throughout my tenure as Commissioner, the Department has received applications for and certified only two providers to utilize Level III

interventions: JRC and the Wrentham Developmental Center. The Wrentham Developmental Center formerly used a Level III intervention of time-out greater than 15 minutes for one person; currently, it does not use any Level III intervention.

103. As of January 17, 2013 JRC had a total student population of 232; of those, 86 students had current court-approved treatment plans that authorized the use of Level III interventions.

104. In its community system and in its state facilities, the Department provides care and treatment to individuals with as severe disabilities and as difficult (aggressive SIB) behaviors as individuals at JRC.

105. From January 1, 2007 to the present, the Department has transferred seven (7) individuals from JRC to community or its ICFs successfully. In all cases but one, those individuals were successfully transitioned from treatment with aversives to treatment without aversives.

106. A primary obstacle to transitioning individuals who are receiving GED treatment from JRC to less restrictive settings is that the individuals have a learned dependence upon the GED to control their behaviors; they have no internalized methods to control their behaviors. One individual who was transitioned from JRC would beg staff at his new placement to give him the GED in order to stop his behavioral outbursts. Although the dependence was eventually overcome, and the individual learned other methods of controlling his own aggressive or self-destructive impulses, the transition period was characterized by a period of explosive behavior and he required months of close monitoring.

107. Another obstacle to transitioning individuals from JRC to less restrictive settings can be the guardian's refusal to consider any medication as an adjunct to other behavioral treatment. Some guardians have had prior experiences with medication that have made them unwilling to consider any new medication or combination of medications that may prove effective. One individual who had resided at JRC for many years with the GED, and whose guardian refused any psychotropic medication even after a move from JRC to the Hogan Regional Center, had an unsuccessful transition, and his guardians insisted that he return to JRC.

108. There are other individuals who reside at JRC whose parents or guardians refuse to consider non-aversive treatment options, but for whom the Department believes it could provide or arrange less restrictive placements without Level III interventions.

The August 2007 Incident & Criminal Investigation

109. On August 26, 2007, a serious incident of abuse occurred at JRC involving the erroneous application of over 77 applications of contingent skin shock to one student at JRC, and 29 applications to another.

110. The events that occurred were all captured by JRC on the video system that JRC uses to monitor students' behavior.

111. JRC issued a "corrective action plan" following the incident, in which certain changes were made to JRC's policies.

112. After the reporting of the August 26, 2007 incident, three agencies of the Commonwealth conducted investigations: DPPC pursuant to M.G.L. chapter 19C (for disabled adults age 18-59); DCF (for children under 18 years of age) pursuant to G.L. c. 51A; in conjunction with DEEC (responsible for licensing JRC's children's residences).

113. In 2008, EOHHS also convened a group of psychologists familiar with the treatment of individuals with intellectual disability and extremely problematic behaviors and medical doctors to consider, as a policy matter, the efficacy of aversive treatment and its prevalence as a treatment for persons with disabilities. The group met twice, and ultimately made recommendations to the Secretary of EOHHS that aversive treatment for persons with disabilities was not the standard of care.

114. Upon information and belief, at or around the same time the Attorney General convened a grand jury to investigate the August 26, 2007 incident for criminal wrongdoing. In May of 2011, the grand jury issued an indictment, charging JRC's then-Executive Director, Dr. Mathew Israel, with interfering with an investigation by allegedly destroying the tape recording of the incident. Dr. Israel entered into a Deferred Prosecution Agreement and resigned on June 1, 2011.

115. During the period of criminal investigation and prosecution of the incident, the Department deferred taking any action with respect to the incident.

Department of Justice Investigation

116. Moreover, numerous settlement agreement and remedies obtained by DOJ in major civil rights cases regarding systems of care for persons with intellectual and developmental disabilities reflect an emphasis on PBS and prohibitions on aversive interventions. *See, supra.* ¶¶ 14-16.

117. Consistent with the remedies in those cases, DOJ sent the Commonwealth a letter in May 2011 informing the Commonwealth of an investigation regarding whether its use of JRC as a service setting violated the federal Americans with Disabilities Act. (A copy of that letter is attached hereto as exhibit 11.)

Centers for Medicare and Medicaid Services

118. Likewise, in July 2012, the federal Centers for Medicare and Medicaid Services ("CMS") sent a letter raising "serious concerns" about whether the Commonwealth was complying with the requirement that it "protect the health and welfare of" certain Medicaid participants with mental retardation. (A copy of this July 2011 letter is attached hereto as exhibit 12.) The letter observed that "[p]ublished descriptions of aversive interventions and deprivation procedures

[at JRC] provide a picture of residential settings which cannot be characterized as 'home-like.' Aversive and intrusive interventions reportedly include repeated and painful electric shock, potentially unnecessary restraint and seclusion, and meal deprivation." Id. at pp. 1111-1112.

119. On or about December 14, 2012, CMS notified the Department that due to the fact that individuals funded by the Department and for whom the Department receives federal reimbursement (Federal Financial Participation, or "FFP"), were either receiving Level III aversive interventions, or receiving services in a setting in which Level III interventions were authorized, the Department failed to satisfy the required federal assurances of health and safety for all home and community-based services waiver participants. (A copy of this December 14, 2012 letter is attached hereto as exhibit 13.) As a result, the Department cannot claim federal reimbursement for any of the services delivered to individuals at JRC, contrary to the directive of the Massachusetts Legislature to "maximize federal reimbursement" for services funded through its appropriation.

Signed under the pains and penalties of perjury, this 7th day of February, 2013.

Elin M. Howe

Elin M. Howe, Commissioner
Department of Developmental Services