The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Mental Retardation
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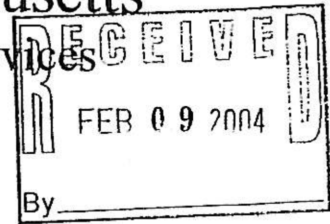
Boston, MA 02118



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February 3, 2004

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

Dear Dr. Israel:

Effective January 1, 2004, the application of the Judge Rotenberg Education Center ("JRC") for certification for use of Level III intervention pursuant to 115 C.M.R. 5:14 has been approved for two years subject to the following conditions:

1. JRC will integrate all the various documents, i.e. reports to the court, program description, quarterly reports, computer records, tally sheets, independent clinician's reports and Dr. Sassaman's report, including his most recent physical examination, into one complete behavioral plan that incorporates all these various documents. All subsequent reviewers, such as the Court, Peer Review Committee, Human Rights Committee, Independent Clinicians, Guardians, and applicable governmental agencies should have access to this integrated record so that better informed approvals and/or consents can be made.

2. JRC's integrated behavioral plans must be more individualized in the following respects: (a) comprehensive functional analysis for each intervention; (b) conditions under which an application for intervention will be terminated; (c) assessment of the feasible treatment alternatives and its ultimate conclusions for treatment; and (d) individualized criteria for plan revision and termination. Behavioral plans should not include generic interventions that are not specifically intended for use with a particular individual.

3. JRC will continue its quarterly internal review for all students receiving Level III interventions, which is a helpful tool to evaluate the effectiveness of the Level III interventions. JRC will maximize the effectiveness of this tool by ensuring that the quarterly reports accurately reflect an individualized review of a client's increase or decrease in the effectiveness of the Level III intervention, articulate a proposed individualized rationale for any recorded increase or decrease in the effectiveness of the interventions, and articulate an individualized rationale for continuing the use of the Level III interventions until the next quarterly review.

4. JRC will utilize its excellent computer generated method of charting negative behaviors to measure educational goals as a proxy for quality of life assessment.

5. JRC must structure a discharge plan for students who are required to leave JRC at a particular time (e.g. due to aging out of a funded program) that involves fading the use of the GED in favor of rewards and consequences that occur naturally in the outside world. In cases where students are not required to leave, the GED should be faded as soon as safely possible and a developmentally appropriate program should be created that will facilitate the integration of the student into the community to the greatest extent feasible.

6. The Peer Review Committee (PRC) shall document and discuss each recommendation made by the independent clinicians and/or the psychologist on the Human Rights Committee regarding an individual plan. The PRC shall keep minutes that will reflect its discussions of all such recommendations, whether the recommendations were accepted into the plan or rejected, and the reasons for such acceptance or rejection.

7. For students who have received Level III interventions for a period of three years, the McLean independent clinician reviewing the individual will present his or her findings in a case conference format. Attending these case conferences will be (1) the other McLean independent clinicians; (2) the JRC consulting psychiatrist; (3) the JRC treating psychologist; (4) the JRC classroom teacher; (5) the parent or guardian; (6) the JRC nurse; and (7) the JRC case manager. The final report submitted by the independent clinician in these instances should include the results of these conferences, including the rationale for continuing or discontinuing the Level III interventions. This report will be placed in the student's file, included in the next submission to the Court, forwarded to the student's parent or guardian, the coordinator of the student's ISP team, and the ward's counsel.

8. JRC will continue to institute a scheduling system for its doctoral level psychologists who develop and supervise the use of Level III interventions that ensures adequate time off and will also continue to institute a mandatory yearly continuing education requirement of 10 credit hours from programs approved by the American Psychological Association.

9. JRC will add a psychologist to its Human Rights Committee (HRC) without delay. JRC will better document the dialogue between it and the members of the HRC in the HRC minutes.

10. JRC's plans must reflect in greater detail that they are consistent with the regulatory requirement that Level III interventions may only be employed "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 115 C.M.R. 5.14 (4) (b) 5. Any time JRC desires to utilize a Level III intervention for what appears to be a behavior that is less than required by the above standard, it must make a clear showing of the necessity to do so. This means that it either must include a rationale related to the analysis of the function of the behavior and document the data that shows the direct link between the intended behavior to consequate and direct harmful outcomes (that leads them to this conclusion), or it must utilize less restrictive interventions to address the behavior.

11. JRC will document both the rationale for limitations of personal possessions and funds pursuant to 115 C.M.R. 5.10 and visitation rights pursuant to 115 C.M.R. 5.04(3)(c) as well as the teaching or other planning to be done to help relieve the need for the restriction over time.

In addition to the above conditions for JRC's certification, the Certification Team made the following recommendations:

1. JRC should continue to strive for the shortest interval possible between the observation of a dangerous behavior and the implementation of the Level III aversive without sacrificing JRC's verification procedures.

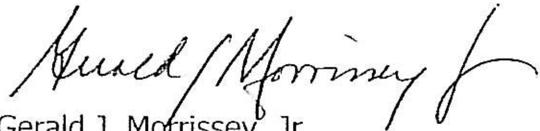
2. DMR should continue to monitor whether it is necessary to appoint an independent clinician to the Peer Review Committee to ensure performance by such committee of their review responsibilities consistent with the requirements established by 15 C.M.R. 5.14. <u>See</u> 115 C.M.R. 5.14(4)(f)(7).

I have enclosed a copy of the complete Certification Team report, from which the above recommendations are transcribed. The Receiver has reviewed the Certification Team report and approved it.

A member of my staff will contact you shortly regarding follow up with the above conditions.

On behalf of the Certification Team and the Department, I want to extend my appreciation to JRC and to Lynn Parrillo, in particular. All of your staff were extremely cooperative and helpful. Lynn, in particular, as the primary point of contact between the team and JRC, made exceptional efforts to address scheduling issues, provide team members with helpful information, including directions, and, in general, made their tasks easier. On their behalf, thank you very much.

Sincerely,



Gerald J. Morrissey, Jr.
Commissioner

Encl. Certification Team Report

Cc: The Honorable Lawrence Perera, Receiver
M. Meacham, General Counsel – DMR
M. Fridovich, Deputy Commissioner - DMR

TO: Lawrence T. Perera, Receiver, Department of Mental Retardation

FROM: Curtis Prout, M.D., Dennis Upper, Ph.D., Mark Fridovich, Ph.D., Elliot A. Berusch, Tom Anzer, Atty. Maureen E. Curran

RE: REPORT OF THE CERTIFICATION TEAM ON THE APPLICATION OF THE JUDGE ROTENBERG EDUCATIONAL CENTER FOR LEVEL III BEHAVIOR MODIFICATION CERTIFICATION

DATE: December 29, 2003

I. SUMMARY OF REVIEW

A. Certification Team

In accordance with 115 C.M.R. 5:14(4)(f), the Receiver appointed a Certification Team ("the Team") and charged its members to conduct a thorough and independent review of the Judge Rotenberg Center's ("JRC") use of Level III interventions. In accordance with the Administration of Level III Interventions Certification Protocol, the multi-disciplinary Team included licensed doctoral level psychologists or psychiatrists with expertise in the design and implementation of behavioral modification plans, Curtis Prout, M.D., Philip Levendusky, Ph.D., and Mark Fridovich, Ph.D.; a surveyor from the Department of Mental Retardation's Office of Quality Enhancement, Connie Lehr; a member with legal expertise, Attorney Maureen Curran; and a member with human rights expertise, Tom Anzer. Dr. Levendusky later determined that he was unable to devote the time necessary to participate fully in the Team's work. Also, Connie Lehr retired from the Department of Mental Retardation. As a result, Dennis Upper, Ph. D. and Elliot A. Berusch joined the Team.

B. Background

JRC has significant history and experience of providing sound behavioral interventions, as well as other supports and interventions, to adults, adolescents, and children, who have mental retardation, other developmental disabilities, mental illnesses, and a variety of concurrent behavioral disturbances. These behavioral disturbances are either extremely disruptive to relationships, dangerous to others, or dangerous to the individual (i.e. self destructive). In addition these behaviors have either not responded to standard interventions, or the individuals with these behaviors have not been able to be either safely maintained in other treatment settings, or other treatments have been unsuccessful. Finally, many of the individuals at JRC have concurrent physical health problems that require continuing monitoring, physical health interventions, or both.

In its treatment of these individuals, JRC often utilizes interventions that the Department of Mental Retardation ("DMR") regulations define as Level III. Pursuant to those regulations, a Special Certification Requirement is required for programs utilizing Level III interventions. Attorney Lawrence T. Perera, Receiver for the Department of Mental Retardation, pursuant to an order of the Bristol County Probate Court, appointed the Team to review JRC's use of Level III interventions and recommend whether JRC should be re-certified, with or without conditions, to administer such treatment.

After, its review and inspection, the Team in general concluded that JRC demonstrates substantial capacity to provide care to individuals receiving Level III interventions, and specifically, to safely implement behavioral modification plans that are substantially in accordance with 115 C.M.R. 5.14, as well as substantially consistent with relevant practice

standards. The Team recommends that the Receiver approve JRC's application and certify JRC's Level III program subject to the applicable conditions recommended below.

In support of the Team's recommendation, detailed below are (1) a description of the program elements reviewed; (2) the findings derived from that review; and (3) the recommendations derived from those findings.

II. DESCRIPTION OF PROGRAM ELEMENTS REVIEWED

A. Documents Reviewed

The Team reviewed the written materials submitted by JRC in its "Application for Continued Certification by the Department of Mental Retardation for Authority to Administer Level III Interventions" including:

1. A 40-page document entitled "The Judge Rotenberg Educational Center" which described JRC's basic policies, facilities, educational programs, reward systems, treatment program, and the history of JRC's use of aversives;

2. A detailed description of the JRC program;

3. JRC's Policy and Procedure for the Development and implementation of Plans Employing Level III Interventions;

4. A description of JRC's prior use of Level III interventions;

5. A description of current and anticipated numbers of individuals receiving Level III interventions and the descriptions of their use;

6. A chart summarizing all students currently receiving Level III intervention, including the student's age, diagnosis, and type of intervention employed;

7. A sample treatment plan employing Level III interventions;

8. A sample of the court findings in the case of one student to appoint a permanent guardian with authority to monitor behavior of modification treatment plan;

9. A sample decree of permanent guardianship;

10. A sample notice of decree of permanent guardianship;

11. A sample "Program Description", which is the document that contains key information to help the direct care staff implement certain authorized parts of the treatment plan;

12. A sample "Recording Sheet", which is a document that JRC uses to collect daily data and guide direct care staff;

13. Curriculum Vitae and Resumes for staff responsible for developing and implementing *behavioral* modification plans involving Level III interventions;

14. Documentation regarding the hiring policy and requirements for direct care positions;

15. Documentation regarding direct care staff's orientation and in service training;

16. A list of current staff;

17. Curriculum vitae and resumes for members of the Peer Review Committee;

18. Minutes of Peer Review Committee meetings for the past two years;

19. Documents identifying members of the Human Rights Committee with a brief biography of each member;

20. Documentation of Procedures followed by JRC's Human Rights Committee;

21. Minutes of Human Rights Committee for the last two years;

22. Curriculum vitae and resumes of physicians and qualified health professionals who review behavioral plans;

23. Documentation regarding notices to the Department of Mental Retardation pursuant to 115 C.M.R. 5.14;

24. Documentation regarding JRC's procedures to obtain consent for the implementation of Level II plans in accordance with 115 C.M.R. 5.14(e);

25. Documentation regarding JRC's Policies and Procedures regarding student referrals and admissions;

26. Documentation regarding JRC's authorized permission forms;

27. Documentation of specific continuing education credits earned by each doctoral level psychologist overseeing substituted judgment;

28. A chart detailing the current and anticipated numbers of individuals who have been authorized to receive Level III interventions, the length of time Level III Interventions have been authorized, age, diagnosis, and residence for each individual. The chart also includes students who have been approved for the use of Level III Interventions, but whom are not wearing the GED device 24 hours per day;

29. A document entitled "Follow-Up Study Results" regarding a sampling of former students who have received comprehensive behavioral treatment, including the use of aversives;

30. A chart of individuals who have been authorized to receive Level III interventions for three years or more. The chart also includes students who have been approved for the use of Level III Interventions, but whom are not wearing the GED device 24 hours per day; and

31. Case conference reports for residents who have received Level III interventions for three years or more.

In addition, subgroups of the Team reviewed individual records of a sample population (see description of sample below).

B. Interviews

The Team as a whole interviewed the following people: (1) Robert Von Heyn, Director of Psychology and Member of Peer Review Committee; (2) Robert Worsham, Psychologist and Member of the Peer Review Committee; (2) Joe Assalone, Director of Student Services; (4) Rosemary Silva, Business Manager; (5) Robert Duquette, Director of Human Resources; (6) Sue Parker, Assistant to the Director of Programming; (7) Lynn Parrillo, Assistant to the Director of Programming; (8) Ralph Antonelli, Director of Training; (9) Glenda Crookes, Assistant Director of Administration; and (10) Corine Watson, Parent and Member of the Human Rights Committee.

In addition, individual members of the team either met with or spoke with guardians, other members of the Human Rights Committee, and the independent clinicians from McLean's.

C. Site Visits

The Team as a whole had a daylong meeting at JRC where they took a tour and interviewed several staff members identified above. The Team then broke off into three teams of two each. Those sub-groups collectively spent several days at JRC reviewing records, observing students, participating in a chart share, and informally speaking to several staff members. In addition, the sub-groups visited several of the residences and observed both students and staff in that setting.

D. Sample

Based on the information provided at the time of its written application, the JRC population consisted of 60% adults and 40% children. The Team chose a sample of 12 JRC students who were receiving Level III interventions to specifically review. The sample was derived with attempt to cover a full range of individuals that JRC supports, the length of time interventions have been utilized with an individual, the types of Level III interventions currently utilized and representing a variety of residential homes. The sample was randomly selected initially to ensure the appropriate number of children and adults. The individuals selected almost completely represented all of the variables desired for the sample. There was only one substitution to fully represent the desired variables for the sample. The sample follows:

Name	Age	Diagnosis	Date of Intervention	Residence	Team Members
MH	16	Mental Retardation	Jan., 2000	Norton	Prout/Anzer
NB	15	Autism	Nov., 2001	Crystal V2	Prout/Anzer
RM	14	Mental Retardation/PDD	June, 2003	Rehoboth	Prout/Anzer
BS	25	Mental Retardation/Autism	Dec., 1990	Brae	Prout/Anzer
CR	16	Bipolar/schizophrenia	July, 2000	Old Maple	Berusch/Upper
OG	13	Mental Retardation/Autism	Oct., 2002	611 Arboretum	Berusch/Upper
KC	18	Schizophrenia/bipolar/MR	March, 2003	Old Maple	Fridovich/Curran
SH	32	Mental Retardation/bipolar/Autism	June, 2001	Highland	Berusch/Upper
MM	26	Mental Retardation/Autism	June, 1998	Frenier	Fridovich/Curran
EV	37	Mental Retardation	July, 1995	Frenier	Fridovich/Curran
PD	42	Mental Retardation	Nov., 1991	Aspen	Fridovich/Curran
JM	26	Personality Disorder/Brain Injury	May, 2002	Lorusso	Berusch/Upper

INTERVENTIONS FOR EACH INDIVIDUAL

- MH – GED, Movement Limitation, Contingent Food, Helmet
- CR – GED, Movement Limitation, Contingent Food, Helmet
- OG – GED, GED4, Behavior Rehearsal Lessons, Movement Limitation, Contingent Food, Specialized Food, Helmet
- NB – GED, Movement Limitation, Contingent Food, Helmet
- RM – GED, Movement Limitation, Contingent Food, Helmet
- KC – GED, Movement Limitation, Contingent Food, Helmet
- SH – GED, Movement Limitation, Contingent Food, Helmet
- MM – GED, Movement Limitation, Contingent Food, Helmet
- BS – GED, GED4, Movement Limitation, Contingent Food, Helmet

- EV – GED, Behavior Rehearsal Lessons, Movement Limitation, Contingent Food, Helmet, Restitution Over Correction, Positive Practice Over Correction, Negative Reinforcement
- PD – GED, Movement Limitation, Contingent Food, Helmet
- JM – GED, Movement Limitation, Contingent Food, Helmet

III. FINDINGS

A. Application

In accordance with 15 C.M.R. 5.14(4)(f)2, JRC submitted a written application and provided other, supplemental materials as required by the Administration of Level III Interventions Certification Protocol. The Team reviewed the written application upon its receipt and has found that the written application is complete and satisfies all applicable requirements. 115 C.M.R. 5.14(4)(f)(3-5).

B. Environmental Observations

The Team found that the environment in which Level III interventions are administered is clean, safe, and to the greatest extent possible, homelike and positive. 115 C.M.R. 7:07. In addition, with one noted concern, the Team found no environmental issues impacting the safety or dignified treatment of individuals. The Team's only concern in this regard involved an observation where an individual was awakened every two hours to check his hands for significant self-destructive picking. See 15 C.M.R. (4)(b)1. There was a significant delay between the apparent occurrence of the self-destructive behavior and the initial detection by night staff. Moreover, the individual returned to sleep and was reawakened 3-4 minutes later for staff verification after which he received an aversive. The Team recognizes, however, the necessary balance that must take place between insuring a proper verification procedure (which is a JRC strength) and the necessity of having a consequence implemented as close as possible

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in time to the occurrence of the dangerous behavior. The Team was encouraged by the fact that a JRC psychologist agreed that the 3 to 4 minute interval between the observation and the consequence was too long. The Team thus simply recommends that JRC continue to strive for the shortest interval possible between the observation of a dangerous behavior and the implementation of the Level III aversive without sacrificing JRC's verification procedures.

The Team observed the Time Out rooms and found them to be spacious and to have met or exceeded reasonable standards. 115 C.M.R. 5:14(4)(b)7.

C. Behavioral Planning Issues

1. Records[1]

After review of the behavioral plans, the Team found that there is no single written document that contains all the required components for a behavioral plan. Instead, the behavioral plan is broken up into several components, including a "program description", the court documents, the quarterly reports, the independent clinician's reports, medical records,

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[1] See 115 C.M.R. 5:14(4)(c) where all proposed uses of Level III Interventions for treatment purposes shall be set forth in a written plan which shall contain at least the following:

1. A clear specification of the behaviors which the treatment program seeks to decelerate or decrease, a specification of the methods by which the behaviors are to be measured (using measures such as frequency, severity, duration, etc.) and the available data concerning the current state of the behaviors with respect to these methods of measurement.
2. A clear specification of the behaviors which the treatment program seeks to have replace the behaviors targeted for deceleration, the methods by which these behaviors are to be measured, and available data concerning the current state of the behaviors with respect to these methods of measurement.
3. A description and classification by Level of each of the Interventions to be used; a rationale, based on a comprehensive functional analysis of the antecedents and consequences of the targeted behavior for why each Intervention has been selected; the conditions under which each Intervention will be employed; the duration of each Intervention, per application; the conditions or criteria under which an application of each Intervention will be terminated; in measurable terms, the behavioral outcome expected from the use of each proposed Intervention; the criteria for measuring success of each Intervention and the Behavior Modification plan as a whole and for revising and terminating the plan; the risks of harm to the individual with each Intervention and the plan as a whole; the individual's prognosis if the treatment is not provided; feasible treatment alternatives; and a statement indicating the nature of the less restrictive or less intrusive Interventions which have been employed and the clinical results thereof, or those which have been considered and the reasons they have not been tried.
4. The name of the treating clinician or clinicians who will oversee implementation of the plan.
5. A procedure for monitoring, evaluating and documenting the use of each Intervention including a provision that the treating clinician(s) who will oversee implementation of the plan shall review a daily record of the frequency of target behaviors, frequency of Interventions, safety checks, reinforcement data, and other such documentation as is required under the plan. Such treating clinician(s) shall review the plan for effectiveness at least weekly and shall record his/her assessment of the plan's effectiveness in achieving the stated goals.

the computer records, "tally cards", and "recording sheets". If one considers all of these various components as a whole, the behavioral plan then contains all the required components. (See discussion below). As a result, however, a typical observer cannot gain a complete picture of the behavioral plan. Thus, staff members, the peer review committee, the human rights committee, independent clinicians, guardians, attorneys, and the Court may not all have access to the complete behavioral plan.

The Team found the computer generated records an excellent tool to track an individual's negative behaviors. The Team felt that it was harder to track more positive behaviors, and thus, recommends that a similar tool be developed to measure educational goals as a proxy for a quality of life assessment.

The Team found the format of the quarterly psychological report to be an extremely helpful tool in evaluating the effectiveness of Level III interventions. Many of the reports, however, contained incorrect references from previous reports, mismatched names and inconsistent data. Also, large portions of the reports were boiler template replications of previous reports. The Team recommends that JRC maximize the effectiveness of this tool by ensuring that the quarterly reports accurately reflect an individualized review of a client's increase or decrease in the effectiveness of the Level III intervention, articulate a proposed individualized rationale for any recorded increase or decrease in the effectiveness of the interventions, and articulate an individualized rationale for continuing the use of the Level III interventions until the next quarterly review.

2. Components of the Plan

Based upon a review of each of the actual components of the behavioral plans, the Team made the following findings.

a. Medication and other health care needs are considered in the development and implantation of the behavioral plans. 115 C.M.R. 5:14(4)(d)4.[2]

b. The behavioral plans provide for dignified and respectful treatment, and the interventions, as observed, are consistent with the behavioral plans. There was some concern, however, that further documentation is necessary to support the choice of Level III interventions which do not appear from the description given to rise to a level that warrants the severity of the intervention as required by 115 C.M.R. 5.14(4)(b)(5). For example, some issues of non-compliance and yelling are not ordinarily considered "extraordinarily difficult or dangerous behavioral problems that significantly interfere with appropriate behavior and the learning of appropriate and useful skills and that have seriously harmed or are likely to seriously harm the individual or others." The Team, therefore, recommends that if JRC desires to utilize a Level III intervention for a non-Level III behavior, it must clearly support the necessity for doing so.

c. The behavioral plans include a comprehensive functional analysis for each intervention. A greater effort needs to be made, however, toward the development of functional analysis that is more individualized.

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[2] See concern noted at Section III2h below regarding certain medical contraindications.

d. Assuming, as the Team has, that the Program Description is incorporated into the behavioral plan, the plans specify each condition under which the intervention will be employed and indicates the duration and intensity of each intervention, per application.

e. The behavioral plans indicate generically the conditions under which an application of each intervention will be terminated.

f. The behavioral plans and quarterly reports include behavior success criteria for each intervention but success criteria for the plan as a whole were less well defined, if defined at all.

g. The behavioral plans are frequently revised, and behavioral criteria are adjusted, in part, in response to individual progress. However, the behavioral plans do not contain explicit criteria for plan termination. Also, the behavioral plans do not contain an explicit and graduated program for extending the learning an individual has experienced to new and less structured settings. The absence of explicit criteria for plan revision or termination and the lack of systematic generalization training is somewhat at odds with the observation that some of the individuals (e.g. PD and KC) sometimes go on extended home visits without the GED delivery device. The home visits are not always without incident, but these visits are remarkably free of major problems. This suggests that these individuals are fundamentally able to generalize outside of the JRC environment the behaviors they have acquired at JRC. The behavioral plans should contain individualized criteria for plan revision and termination.

h. For the most part, risks of harm to individuals are described for each intervention and for the behavioral plans as a whole. The Team did note, however, that certain risks were either not noted or in some instances understated. For example, it was noted that the risks of asphyxiation or aspiration during restraint of an obese individual were not noted. In addition, the risk for bruising of an individual using a helmet was not noted. Due to the disaggregation of the record, as noted above, these risks do not come before the Human Rights Committee, as they should.

i. The behavioral plans appropriately describe prognosis if the treatment is not provided.

j. The behavioral plans generically describe feasible treatment alternatives.

k. The behavioral plans describe less restrictive or less intrusive interventions that have been employed or the reasons why such interventions have not been tried. It was noted, however, that these descriptions are conclusory in nature with no individualized assessment that supports the conclusion. As an example, the following general statement is found in a number of individuals' records: "Psychotherapy will not be helpful because the individual does not have the capacity for insight or to develop empathy." As a general statement about psychotherapy, this may or may not be true. It probably depends on the type of therapy. For instance, behavioral counseling may well be appropriate and consistent with JRC's policies. The behavioral

plan nonetheless should contain the results of the individualized assessment that supports the plan's conclusion.

l. The data generally describes the current state of behaviors of interest, but the description only emerges after a review and integration of behavior recording sheets, court authorization data analyses, quarterly psychologists reports, computer generated reports, reports of independent clinicians, if any, and tally sheets. The computer-generated charts that were shown to the Team were quite helpful in assessing the progress of treatment.

m. The Team found that there is a clinical judgment being exercised, but the disaggregation of the documentation constituting the plans makes them difficult to understand. This impedes the ability of the Peer Review Committee and Human Rights Committee to fully evaluate the plans being presented to them for review.

n. There are appropriate authorizations for the Level III plan, but as noted in Section III2h above, some risks are underestimated. This information should be provided to the appropriate persons prior to obtaining necessary consents.

o. The Team found that on occasion interventions are utilized but not described in the written plans. As an example, there was an intervention described as a "no demand" program where JRC placed no expectations upon the individual. The individual spent much of the day observing classmates and sitting quietly alone. This intervention has the features of a time out. The individual did not appear to respond negatively to this intervention, but under

DMR regulations there needs to be a written plan for all interventions utilized including the "no demand" program.

3. Review of ISP (if applicable)

The Team reviewed ISP's for the sample population and found that the ISP's reviewed conformed to DMR regulatory standards. The Team also found that there was adequate documentation of coordination of the behavioral plan with other required components when the individual was a client of another agency or state.

There were two areas that need to be better detailed in the program description in order to meet DMR regulations. These include any limitations of possessions and funds (115 C.M.R. 5.10), and visitation rights (115 C.M.R. 5.04(3)(c)). The regulations require documentation of both the rationale for the restriction and the teaching or other planning to be done to help reduce the need for the restriction over time.

D. Peer Review

The Team found that all behavioral plans are presented to and approved by the Peer Review Committee ("PRC"). 115 C.M.R. 5.14(4)(d)5. It is not clear, however, that the peer review process generates sufficient debate to ensure that each plan conforms to the requirements for appropriate treatment established by 115 CMR 5:14. Specifically, the Team found that the PRC has never disapproved or even modified in any substantive way a behavioral plan based upon feedback offered through the peer review process.

The Team noted that the 1998 Certification Team recommended that JRC consider adding a clinician member to the PRC who is not affiliated in any way with JRC. JRC chose not to do so. In making that determination, JRC considered the facts that (1) an independent clinician serves on the Human Rights Committee; and (2) an independent clinician is required

through the court process. JRC also was concerned that it would be difficult to find someone with a behavioral background who understands and accepts the role of aversives in the JRC program and who would be available upon short notice to ensure that there would be no lapse in needed court ordered treatment and who would work on a voluntary unpaid basis. In considering JRC's response to the previous team's recommendation, the Team also noted that JRC has in place other meetings, such as chart share, that provide some measure of ongoing review of the behavioral plans.

In conclusion, the Team found that under the present circumstances and with the understanding that the McLean Hospital independent clinicians will continue their role, it is not necessary at this time for the Receiver to appoint an additional independent clinician to the Peer Review Committee. The Team is of the opinion, however, that the Department of Mental Retardation should continue to monitor the situation to determine whether such an appointment might be required to ensure that the performance by the Peer Review Committee of their review responsibilities is consistent with the requirements established by 115 C.M.R. 5.14.

E. Human Rights Committee

In accordance with 115 C.M.R. 5.14(4)(d)(3), all behavioral plans must be reviewed by the program's human rights committee. The Team as a whole interviewed one member of the Human Rights Committee ("HRC"). In addition, one member of the Team attended a meeting of the HRC on October 20, 2003. The Team also reviewed the HRC Minutes for the prior two years. Finally, one member of the Team interviewed the psychologist member of HRC who left the HRC last Fall. Based on these efforts as well as their overall survey observations, the Team found as follows:

1. With the current exception of a psychologist, the HRC's makeup meets the requirements of 115 C.M.R. 3.09. This, however, is a critical member to be missing, and JRC must upgrade its efforts to find a psychologist for the HRC.

2. The Team found that there is good dialogue between the HRC members and JRC, and that JRC responds well to the HRC's advocacy on behalf of the residents. The depth and extent of this dialogue is not evident in the minutes of the committee, however, and greater effort should be made to record such dialogue in the minutes.

3. As noted earlier in this report, the Team is concerned with the disaggregation of the records setting forth the behavioral plans. As a result, the HRC lacks critical information to undertake a thorough review of those plans. For example, quarterly reports are not given to the HRC. These would be useful to the HRC in assessing an individual's progress. In addition, one member requested a copy of the recording sheet for an individual and was told that the Program Description should suffice. The regulations require that the HRC be given unfettered access to the records. 115 C.M.R. 5:14(4)(d)3.b.

4. In one plan involving a restraint board, no data was available to the HRC on an individual's height and weight. A review of medical records showed that the individual in question was obese and that the use of the restraint board in a prone position would put the individual at a significant risk of asphyxiation. The HRC did not discuss this risk, however, because the entire plan, including the medical record, was not before the HRC. A physician must review each behavioral plan to determine whether, given the individual's medical

characteristics, the intervention is medically contraindicated. 115 C.M.R. 5:14(4)(d)4. It is the Team's understanding that Dr. Sassaman, a JRC consultant, performs this evaluation for all students. A copy of Dr. Sassaman's report should be made available to the HRC, including his most recent physical examination, so that the HRC can understand any risks associated with the Level III intervention. The HRC needs all relevant information before it to balance the appropriateness of the Level III intervention with its apparent risk, intrusiveness, or restrictiveness. See 115 C.M.R. 5:14 (1).

F. The Staff

The Team found that one of JRC's great strengths is its staff. JRC's staff is well trained and committed to meeting the needs of individuals. The staff receives very comprehensive orientation and training, is thoroughly familiar with an individual's goals through the record keeping system, and is well supervised. As a result, the staff is able to readily see the progress that an individual is making and feel value from their work. The staff is committed, gentle and shows evidence of caring support to individuals. The staff has clear instructions as to how to work with individuals. The staff is well trained in the Program Description. Interventions are consistently and safely implemented, including the application of the GED and periodic checks. There is an extensive process to review staff competency and a system is in place for clinicians to review the data that is recorded throughout each day. Procedures are in place in case of emergencies or unforeseen circumstances. While the Team had some concern that it is very difficult to discern if all staff are implementing plans consistently given the fact that the prescribed behavioral specifications are sometimes relatively subtle and target behavior topographies change quite often, it was found that there is an

extensive system of supervision, monitoring and verification which seems to be effectively addressing most issues regarding consistency.

G. Restraints

The Team found that restraints are utilized as part of the plan. The Staff is trained in the restraints utilized and administers them appropriately. There is a menu of treatment purposes articulated for such holding. Daily clinical reviews of behavior are an area of strength for JRC. The Clinician does interact with the staff in implementing the plan, and the plan is reviewed weekly for effectiveness and modified as indicated. The Behavioral Plans in a limitation of movement program should specify the specific purpose for which that individual's movement is being limited.

H. Guardians

The Team found that the guardians that were interviewed evidenced a good understanding of plans, provided what appeared to be appropriate informed consent, and by and large were adequately involved in the lives and care of their wards. In light of previous comments above (III C. 2. h.) consideration should be given to a greater documentation of the risks involved in plans to ensure guardians have adequate information to weigh the full risks and benefits of treatment.

IV. RECOMMENDATIONS

The Team recommends that JRC be granted a two-year certification to continue to employ Level III behavior modification interventions to certain of its populations subject to the following conditions:

1. JRC will integrate all the various documents, i.e. reports to the court, program description, quarterly reports, computer records, tally sheets, independent clinician's reports

and Dr. Sassaman's report, including his most recent physical examination, into one complete behavioral plan that incorporates all these various documents. All subsequent reviewers, such as the Court, Peer Review Committee, Human Rights Committee, Independent Clinicians, Guardians, and applicable governmental agencies should have access to this integrated record so that better informed approvals and/or consents can be made.

2. JRC's integrated behavioral plans must be more individualized in the following respects: (a) comprehensive functional analysis for each intervention; (b) conditions under which an application for intervention will be terminated; (c) assessment of the feasible treatment alternatives and its ultimate conclusions for treatment; and (d) individualized criteria for plan revision and termination. Behavioral plans should not include generic interventions that are not specifically intended for use with a particular individual.

3. JRC will continue its quarterly internal review for all students receiving Level III interventions, which is a helpful tool to evaluate the effectiveness of the Level III interventions. JRC will maximize the effectiveness of this tool by ensuring that the quarterly reports accurately reflect an individualized review of a client's increase or decrease in the effectiveness of the Level III intervention, articulate a proposed individualized rationale for any recorded increase or decrease in the effectiveness of the interventions, and articulate an individualized rationale for continuing the use of the Level III interventions until the next quarterly review.

4. JRC will utilize its excellent computer generated method of charting negative behaviors to measure educational goals as a proxy for quality of life assessment.

5. JRC must structure a discharge plan for students who are required to leave JRC at a particular time (e.g. due to aging out of a funded program) that involves fading the use of

the GED in favor of rewards and consequences that occur naturally in the outside world. In cases where students are not required to leave, the GED should be faded as soon as safely possible and a developmentally appropriate program should be created that will facilitate the integration of the student into the community to the greatest extent feasible.

6. The Peer Review Committee shall document and discuss each recommendation made by the independent clinicians and/or the psychologist on the Human Rights Committee regarding an individual plan. The PRC shall keep minutes that will reflect its discussions of all such recommendations, whether the recommendations were accepted into the plan or rejected, and the reasons for such acceptance or rejection.

7. For students who have received Level III interventions for a period of three years, the McLean independent clinician reviewing the individual will present his or her findings in a case conference format. Attending these case conferences will be (1) the other McLean independent clinicians; (2) the JRC consulting psychiatrist; (3) the JRC treating psychologist; (4) the JRC classroom teacher; (5) the parent or guardian; (6) the JRC nurse; and (7) the JRC case manager. The final report submitted by the independent clinician in these instances should include the results of these conferences, including the rationale for continuing or discontinuing the Level III interventions. This report will be placed in the student's file, included in the next submission to the Court, forwarded to the student's parent or guardian, the coordinator of the student's ISP team, and the ward's counsel.

8. JRC will continue to institute a scheduling system for its doctoral level psychologists who develop and supervise the use of Level III interventions that ensures adequate time off and will also continue to institute a mandatory yearly continuing education

requirement of 10 credit hours from programs approved by the American Psychological Association.

9. JRC will add a psychologist to its Human Rights Committee without delay. JRC will better document the dialogue between it and the members of the HRC in the HRC minutes.

10. JRC's plans must reflect in greater detail that they are consistent with the regulatory requirement that Level III interventions may only be employed "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 115 C.M.R. 5.14 (4) (b) 5. Any time JRC desires to utilize a Level III intervention for what appears to be a behavior that is less than required by the above standard, it must make a clear showing of the necessity to do so. This means that it either must include a rationale related to the analysis of the function of the behavior and document the data that shows the direct link between the intended behavior to consequate and direct harmful outcomes (that leads them to this conclusion), or it must utilize less restrictive interventions to address the behavior.

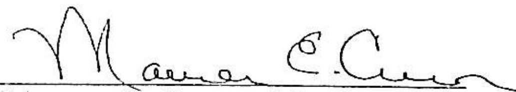
11. JRC will document both the rationale for limitations of personal possessions and funds pursuant to 115 C.M.R. 5.10 and visitation rights pursuant to 115 C.M.R. 5.04(3)(c) as well as the teaching or other planning to be done to help relieve the need for the restriction over time.

In addition to the above conditions for JRC's certification, the Team makes the following recommendations:

1. JRC should continue to strive for the shortest interval possible between the observation of a dangerous behavior and the implementation of the Level III aversive without sacrificing JRC's verification procedures.

2. DMR should continue to monitor whether it is necessary to appoint an independent clinician to the Peer Review Committee to ensure performance by such committee of their review responsibilities consistent with the requirements established by 15 C.M.R. 5.14. See 115 C.M.R. 5.14(4)(f)(7).

Respectfully Submitted,



Maureen E. Curran, Member and
Secretary for Certification Team on the
Application of the Judge Rotenberg
Educational Center for Level III Behavior
Modification Certification

Dated: December 29, 2003

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