

Torture Not Treatment:

Electric Shock and Long-Term Restraint in the United States on Children and Adults with Disabilities at the Judge Rotenberg Center



**Urgent Appeal to
the United Nations
Special Rapporteur
on Torture**

mdri

Mental Disability Rights International



-Child restrained at waist, arms, chest, groin and feet in isolation room



-Leg cuffs used to restrain children in chairs

-Cover Photo: Child face-down on a four-point restraint board attached to electric shock device.

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Mental Disability Rights International

Mental Disability Rights International (MDRI) is an international human rights organization dedicated to the human rights and full participation in society of people with disabilities worldwide. MDRI documents human rights abuses, supports the development of disability rights advocacy, and promotes international awareness and oversight of the rights of people with disabilities. MDRI advises governments and non-governmental organizations to plan strategies to bring about effective rights enforcement and service-system reform. Drawing on the skills of attorneys, mental health professionals, people with disabilities and their families, MDRI challenges the discrimination and abuse faced by people with disabilities worldwide.

MDRI is based in Washington, DC, with offices in Kosovo and Serbia. MDRI has investigated human rights conditions and assisted mental disability rights advocates in Argentina, Armenia, Azerbaijan, Bulgaria, the Czech Republic, Estonia, Hungary, Japan, Kosovo, Lithuania, Macedonia, Mexico, Paraguay, Poland, Peru, Romania, Russia, Serbia, Slovakia, Slovenia, South Korea, Turkey, Ukraine, Uruguay, and Viet Nam. MDRI has published the following reports: *Torment Not Treatment: Serbia's Segregation and Abuse of Children and Adults with Disabilities* (2007); *Ruined Lives: Segregation from Society in Argentina's Psychiatric Asylums* (2007); *Hidden Suffering: Romania's Segregation and Abuse of Infants and Children with Disabilities* (2006); *Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey* (2005); *Human Rights & Mental Health: Peru* (2004); *Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo* (2002); *Human Rights & Mental Health: Mexico* (2000); *Children in Russia's Institutions: Human Rights and Opportunities for Reform* (2000); *Human Rights & Mental Health: Hungary* (1997); *Human Rights & Mental Health: Uruguay* (1995).

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MDRI is the recipient of the American Psychiatric Association’s 2009 Human Rights Award, the 2009 Senator Paul and Mrs. Sheila Wellstone Mental Health Visionary Award, and the 2007 Thomas J. Dodd Prize in International Justice and Human Rights.

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For the purposes of this Convention, the term torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted...*for any reason based on discrimination of any kind*, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, article 1 (1)

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment...States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment.

UN Convention on the Rights of Persons with Disabilities, art. 15

All human beings are born free and equal in dignity and rights...

Universal Declaration of Human Rights, article 1

Report of the United Nations Special Rapporteur on Torture to the United Nations General Assembly:

...The Special Rapporteur draws attention of the General Assembly to the situation of persons with disabilities, who are frequently subjected to neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence. He is concerned that such practices, perpetrated in public institutions, as well as in the private sphere, remain invisible and are not recognized as torture or other cruel, inhuman or degrading treatment or punishment. The recent entry into force of the Convention on the Rights of Persons with Disabilities and its Optional Protocol provides a timely opportunity to review the anti-torture framework in relation to persons with disabilities. ***By reframing violence and abuse perpetrated against persons with disabilities as torture or a form of ill-treatment, victims and advocates can be afforded stronger legal protection and redress for violations of human rights...***¹

**- Manfred Nowak, UN Special Rapporteur on Torture,
July 28, 2008**

Table of Contents

Executive Summary	1
Methodology and Sources	5
Introduction	6
The Judge Rotenberg Center Program	6
Critique of aversive treatment from research and policy	10
Findings: The Use of Aversives at JRC	12
Electric shock	12
Restraints	15
Provocation of bad behavior	18
Food deprivation	19
Creating social isolation	20
Aversives for harmless behavior	20
Lack of Legal Protection against Torture and Ill-Treatment	21
Protections under International Law	22
Pain is severe	23
Pain is inflicted intentionally	25
Pain is inflicted for a prohibited purpose	25
Acquiescence of a public official or other person acting in an official capacity	28
Lack of protection under Federal Law	28
Lack of protection under State Law	29
Massachusetts law permits torture or inhumane treatment	31
Laws on physical restraint violates Convention against Torture	32
Domestic Remedies Have Failed	33
Futility of current oversight regime	34
Deaths and subsequent legal challenges	35
New York’s attempts to limit use of aversives	37
Recent incidents of abuse	38
Massachusetts recertification in 2009	39
Conclusions and Recommendations	41
Appendix 1 – Media Coverage of the JRC	43
Appendix 2—JRC Employee Confidentiality Agreement	45

Executive Summary

Torture not Treatment: Electric Shock and Long-Term Restraint in the United States on Children and Adults with Disabilities at the Judge Rotenberg Center is the product of an investigation by Mental Disability Rights International (MDRI) into the human rights abuses of children and young adults with mental disabilities residing at the Judge Rotenberg Center (JRC) (formerly known as the Behavior Research Institute) in Canton, Massachusetts, United States of America (US). This report is an **urgent appeal** to the United Nations Special Rapporteur on Torture or other Cruel, Inhuman or Degrading Treatment or Punishment, by Mental Disability Rights International (MDRI). **We request that the Special Rapporteur initiate an inquiry into the abusive practices perpetrated against the residents of JRC and licensed by the State of Massachusetts. MDRI contends that the severe pain and suffering perpetrated against children and adults with disabilities at JRC violates the UN Convention against Torture.** US law fails to provide needed protections to children and adults with disabilities.

This urgent appeal documents human rights abuses at what is called a “special needs school.” The fact that the intentional infliction of pain to punish students for certain behaviors is called “treatment” - for children and adults with disabilities - does not render these practices acceptable, necessary or legal. At JRC, pain is the treatment. JRC practices a form of “aversive therapy” that is unique in the United States. JRC’s practices are based on a theory of behaviorism that mental disabilities can be extinguished by an elaborate system of rewards and punishments for acceptable or unacceptable behavior. To implement this program, authorities at JRC intentionally inflict severe pain on children with disabilities entrusted to their care. The maltreatment of children and adolescents with disabilities at JRC constitutes both physical and psychological abuse, couched in the name of “treatment.” The “treatment” at JRC is punishment. Children are subject to electric shocks on the legs, arms, soles of their feet, finger tips and torsos – in many cases for years, and for some, a decade or more. Electric shocks are administered by a remote-controlled pack attached to a child’s back called a Graduated Electronic Decelerator (GED). The shocks, which last 2 seconds each, are so strong as to cause red spots or blisters to the skin. Some students have received dozens – even hundreds – per day.

...The level of shock is unbelievable, very painful No other class of citizen in the United States could be subjected to this. You could not do this to a convicted felon. – MDRI interview with psychologist who visited JRC on behalf of the New York State Department of Education

The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ratified by the US in 1994, prohibits torture without exception – even

if it takes place in a school or a medical establishment and is justified by authorities as a form of treatment.

By reframing violence and abuse perpetrated against persons with disabilities as torture or a form of ill-treatment, victims and advocates can be afforded stronger legal protection and redress for violations of human rights – Manfred Nowak, United Nations Special Rapporteur on Torture

Additionally, children are shackled, restrained and secluded for months at a time. Social isolation and food deprivation as punishment is common. Mock and threatened stabbings – to forcibly elicit unacceptable behaviors which then result in electric shock punishments (known as Behavioral Research Lessons or BRLs) - have been reported to MDRI and state regulatory bodies as well.

The worst thing ever was the BRLs. They try and make you do a bad behavior and then they punish you. The first time I had a BRL, two guys came in the room and grabbed me – I had no idea what was going on. They held a knife to my throat and I started to scream and I got shocked. I had BRL's three times a week for stuff I didn't even do. It went on for about six months or more. I was in a constant state of paranoia and fear. I never knew if a door opened if I would get one. It was more stress than I could ever imagine. Horror. – MDRI interview with former JRC student

Behaviors deemed “aggressive” – getting out of a chair without permission – and behaviors referred to as “minor” and “non-compliant” behaviors – raising your hand without permission – are all punishable by electric shocks, restraints and other punishments.

MDRI's findings are consistent with decades of reports by numerous state agencies, legal and disability advocates, media reports, first-hand accounts and interviews of former students, parents of students, staff, and in many cases, JRC's own informational website.

It is imperative that JRC devise a protocol for reassessing the effectiveness of the aversive interventions [shock] once they have been tried for 5 years with only limited effectiveness... – April 2009 report Massachusetts Department of Mental Retardation (DMR)

Despite the overwhelming evidence of abuse at JRC, domestic remedies to end these abuses have failed. **And in some cases, states have adopted regulations permitting the use of painful aversives, and the courts have upheld such regulations which undermine the protection of children and adolescents at JRC from cruel and inhuman treatment or torture.**

The prohibition against torture under international law is reserved for the most egregious acts. To rise to the level of torture, an act must meet each of four criteria identified in article 1 of the UN Convention against Torture. Some practices documented at JRC meet each of these elements of

torture because (1) the pain and suffering inflicted is severe; (2) this pain is inflicted intentionally; (3) the infliction of pain is for a purpose that is coercive or discriminatory; and (4) these practices are conducted with the consent or acquiescence of public officials.

The use of electric shock or long-term restraint would never be tolerated on individuals without disabilities. The discriminatory nature of JRC's practices becomes clear when they are compared to strikingly similar practices widely understood to constitute torture or ill-treatment.

One girl who was blind, deaf and non-verbal was moaning and rocking. Her moaning was like a cry. The staff shocked her for moaning. Turned out she had broken a tooth. Another child had an accident in the bathroom and was shocked. – MDRI interview with former JRC teacher

To the best of our knowledge, JRC is the only facility of any kind in the United States – and perhaps indeed in the world – which uses electricity, combined with long-term restraint and other punishments, to intentionally cause pain to its children with behavioral challenges and calls it “treatment.”

I was kept in a small room, isolated...one staff and me for a year and a half. – JRC video testimonial in support of GED, JRC website

I was in restraints constantly...I was in an isolated room. Then I went on the GED - JRC video testimonial in support of GED, JRC website

Long-term effects from electric shock can reportedly include muscle stiffness, impotence, damage to teeth, scarring of skin, hair loss, post-traumatic stress disorder, severe depression, chronic anxiety, memory loss and sleep disturbance.

Physical restraints combined with electric shocks are also used as a form of aversive treatment. While receiving electric shocks, children can be tied down in four-point restraints – sometimes in a prone, face-down position. In testimony posted on JRC's website, children and parents have reported that restraints may be used over-and-over for months at a time. One mother reported to MDRI that her child was held in restraints for two years.

If students are non-compliant or aggressive, 4 or 5 staff will wrestle kids to the floor and strap them to a board face down and then shock them. I have seen it more than once. They yell “help” and “send someone.” They could be there like that for 12 hours or more until they “complied.” – MDRI interview with former JRC teacher

Because these abuses have continued unabated for almost four decades and because the use of domestic remedies has been unsuccessful in stopping these human rights abuses, MDRI submits this document to the office of the United Nations High Commissioner for Human

Rights and the Special Rapporteur on Torture and to the Committee Against Torture (CAT), as an *urgent appeal*.

The dehumanization and depersonalization of children at JRC by way of state-sanctioned punishment with electric shocks, 4-point restraint boards, mock assaults, food deprivation, shock chairs and shock holsters fosters an environment ripe for abuse and one that would not be tolerated – especially against children - in any other setting.

MDRI also calls on the Obama Administration and the U.S. Department of Justice to take immediate action to end the abuses against children with disabilities living at JRC. MDRI calls for a total and immediate ban on the use of electricity and long-term restraints to punish children. Under international human rights law, the United States is obligated to investigate and prosecute acts of torture or inhuman and degrading treatment and to provide reparations for individuals subject to these practices.

Methodology and Sources

This report primarily draws on facts that are in the public record – the findings of numerous state agencies and licensing boards, judicial decisions, and testimony before the Massachusetts legislature during the consideration of legislation to regulate aversive treatment. More than any other source, the report relies on the information that the Judge Rotenberg Center (JRC) provides about its own programs on its website. The website includes first-hand testimonies of students and parents. MDRI has supplemented these sources by conducting interviews with one former student, three mothers of former students, one former staff, and numerous mental health professionals and attorneys who have been involved in regulating JRC or representing clients at JRC.

There has been extensive reporting in the press on practices at JRC. We provide references to press sources to supplement public sources or the JRC website, but we do not rely on press sources for our major findings.

MDRI makes a number of references to two in-depth public reports based on site visits by professionals to JRC. Both reports provide helpful background information and analysis. The first is the recertification report of the Commonwealth of Massachusetts, Department of Mental Retardation, published on April 27, 2009. This report was written by a multi-disciplinary Certification Team with expertise in development and implementation of behavioral modification plans. The team included two doctoral level psychologists and a board-certified psychiatrist. The team reviewed extensive documentation at JRC, including the written application for certification, individual records, outcome data and independent clinicians' reports. The team also interviewed and observed numerous students.

MDRI also refers to the analysis and findings of the New York State Education Department (NYSED) published in June 9, 2006. This report was based on an announced visit to JRC April 25-26, 2006 and an unannounced visit May 16-18, 2006. The team included three behavioral psychologists and four members of the NYSED staff.

MDRI has no way of determining whether all the practices observed by the Massachusetts Certification Team or NYSED team are still taking place. As described in this report, however, many of the findings of NYSED in 2006 were later documented by the Massachusetts team in 2009. As presented on JRC's website, however, the essential nature of JRC's core treatment program remains the same. **MDRI's core findings and analysis would remain the same if we relied solely on the current information about practices at JRC now available on their own website and if we assumed that JRC were complying substantially with Massachusetts regulations on aversives.**

Introduction

The Judge Rotenberg Center (JRC) was founded by psychologist Matthew Israel almost 40 years ago in California when it was known then as the Behavior Research Institute (BRI) . According to Israel, the school's philosophy is based on the work of renowned behaviorist B.F. Skinner.² In the 1950s, Israel was a student of Skinner's at Harvard University, and today he is a self-proclaimed devotee of radical behaviorism.

In 1981, a 14 year old boy died face down, tied to his bed. JRC (then known as BRI) was not held responsible for the boy's death, but the death resulted in an investigation by California's Department of Social Services. California issued a critical report the following year, citing widespread abuse of children at the facility and the state of California greatly limited the use of punishment as treatment.³ The facility was then moved to Rhode Island and then again to Canton, Massachusetts, where it is located today.

Today, JRC boasts a main campus with a school and offsite residential apartments with 24 hour staffing. The facility serves as a residential school for children with disabilities, as well as a residential facility for adults. There are approximately 200 children and adults at JRC at any given time,⁴ with costs paid for by state and local school districts and state agencies serving adults with disabilities at approximately \$220,000 per year, per person. People with disabilities living at the JRC residential center mostly come from New York and Massachusetts, and seven other states.

The Judge Rotenberg Center Program

The program of "behavior modification" and "aversive treatment" and the rationale for its use is spelled out on JRC's website. The theory of behavior modification is that every human being responds to positive rewards or negative punishments and that all behavior can be manipulated through a combination of rewards and punishments. Using this approach, "rewards" and "punishments" constitute treatment.⁵ Treatment entails the infliction of pain. JRC is clear that this approach "differs markedly" from "traditional approaches" to mental health care.⁶ The website boasts that "JRC is probably the most consistently behavioral treatment program in existence."

JRC maintains that the same form of reward and punishment works for anyone, justifying a "near-zero rejection policy" for admission.⁷ As a result:

...we really pay relatively little attention to psychiatric diagnosis which are essentially labels for groups of behaviors....Of the first two students we worked with, one was labeled autistic and one was labeled schizophrenic.⁸

The implication of this approach is a highly unorthodox program for treatment and education. All residents, regardless of diagnosis or history, are subjected to the same behavior modification techniques of reward and punishment. The use of traditional psychological therapies and/or medication is virtually non-existent at JRC.⁹ Psychotropic medications are rarely used.¹⁰ According to JRC, seventy percent of educational instruction in the school consists of solitary work on a computer referred to by JRC as “self-paced, programmed instruction.”¹¹

The “rewards” used at JRC include “a contract store” where students can “pick rewards to purchase” based on points they earn in the program. Rewards also include such basics as the right to social interaction with other patients or staff,¹² as well as other fundamentals of daily living. For example:

By making our school building as rewarding as possible, both in its look and in its various reward functions and areas, we have been able to use the opportunity to attend the school building as an earned reward. Similarly, students who behavior extremely poorly are required to stay in their residence and receive academic instruction there, instead of at our school building.¹³

One of the implications of the behaviorist model of care is that JRC takes anyone so long as “needed treatment procedures are made available to us.”¹⁴ As the JRC website states, “Our policy of near-zero reject and expulsions, coupled with the success we demonstrated in treating our students, resulted in agencies referring their most difficult behavior problems to us. Most of our referrals had been unsuccessfully served in numerous other private and public mental health and educational facilities before they were referred to JRC.”¹⁵

The “near-zero rejection” policy has allowed the facility to become what JRC calls a “hospital of the last resort”¹⁶ for children or adults with disabilities who simply have nowhere else to go. The fact that JRC is the last stop for parents looking for a placement for their child may explain the fervent support for the program that some parents have expressed over the years. In other cases, however, JRC actively markets its programs by visiting families and giving them brochures and gifts to recruit new students.¹⁷

When I visited the place, I was expecting much more difficult, non-communicative behavior in these children. It was a total surprise to me to find out that half to two thirds of the kids from NY had learning disabilities or emotional problems – street kids, kids of color – carrying these shock backpacks. It is prison-like and they are prisoners of the apparatus.— Psychologist who visited JRC on behalf of the New York State Department of Education¹⁸

In the early days of the facility, most students were diagnosed with autism or mental retardation and accompanying self-injurious behaviors. As of 2006, however, according to a New York State Department of Education (NYSED) report, most students from New York State “have the

disability classification ‘emotional disturbance’ with IQ scores that fall in the low average to average range of intelligence.¹⁹ There are also a number of students with the classification of autism with cognitive abilities falling in the range of mild to profound mental retardation.²⁰ Many of the students from New York have a diagnoses of post traumatic stress disorder (PTSD), schizophrenia, attention deficit disorder (ADD), obsessive compulsive disorder (OCD) and bipolar disorder.²¹ A number of students have a history of abuse and abandonment.”²² More recently, some adolescents have also been coming to JRC through the juvenile justice system and transfers from Rikers Island prison in New York.²³

Early on, punishments – known as aversives – were used to control the behavior of people who were called severely “mentally retarded” and children with autism. Punishments included pinching, spatula spankings, water sprays, muscle squeezes, forced inhalation of ammonia and helmets which battered the brain with inescapable white noise.²⁴

In the late 1980s, JRC began using SIBIS (Self-Injurious Behavior Inhibiting System) machines on students, as an alternative to spanking, squeezing and pinching. The machine, developed in 1985, produced a 0.2 second shock of 2.02 milliamps on the arms or legs of the recipient, with the intention of stopping self-injurious behaviors in children with autism and other developmental disabilities. Controversial from the outset and shunned by advocates, the use of SIBIS was largely abandoned in the 1990’s in favor of “positive-based” practices.²⁵

Over the years, JRC has found that an individual who responds to low levels of electricity may become “adapted” to pain and “needs a stronger stimulation.”²⁶ The 12 year old nephew of Massachusetts State Representative Jeffrey Sanchez was diagnosed with autism and was a student at JRC in 1989 when JRC began using the SIBIS machine. As described in testimony before the Massachusetts legislature,²⁷ one day he received more than 5,000 shocks to stop his behaviors – to no avail. When the manufacturer of SIBIS refused JRC’s request to provide them with a stronger and more painful shock machine, JRC developed its own mechanism for administering shock, the Graduated Electronic Decelerator (GED). The GED is a remotely controlled device that can be strapped to an individual’s back or another part of the body with electrodes attached to the torso, arms, legs, hands and feet. The GED administers 15.5 milliamps of electricity. A stronger version, the GED-4, subjects an individual to a shock of 45.5 milliamps. Both may be used up to 2.0 seconds. The director of JRC, Matthew Israel, describes the shock as “very painful.”²⁸ Sanchez’s nephew is now 31 years old and remains at JRC. According to testimony before the Massachusetts Legislature in November 2009, he is still tethered to the GED shock machine.²⁹

JRC also uses physical restraints as a form of aversive treatment, sometimes simultaneously with electric shock.³⁰ The GED and restraints are sometimes combined because it is necessary to stop a person from ripping the GED pack off his or her body. Other times, physical restraints may be

added to the use of the GED when the aversive power of electricity alone is not sufficient. As described on the JRC website, “[T]he safest way to do this is to use mechanical restraint to contain the student, in a prone position, on a flexible plastic restraint platform that has been specially designed for the purpose.”³¹ It is worth noting that, outside JRC, the use of any “prone” (face down) restraints are widely considered to be inherently dangerous, and many states have banned any form of prone restraints in the mental health context.³²

JRC’s rationale for the use of powerful shocks and other aversives – both in the past and currently – is that his facility serves some children or adults with the most severe cases of self-injurious behaviors, not controlled with any other treatment.³³ According to JRC, parents come to JRC after all other services have failed.

JRC is technically a school, licensed by the Massachusetts Department of Elementary & Secondary Education, and children are theoretically placed there voluntarily. It additionally receives its Level III aversive certification by the Massachusetts Department of Developmental Services (formerly Department of Mental Retardation) as well as licensing for its over residential program for adults over 22 years old. Children and adolescences’ residences at JRC are licensed by the Massachusetts Department of Early Education and Care.

The voluntary consent to treatment, however, is a legal fiction for children and adults with disabilities who have been declared mentally incompetent. In practice, parents or guardians consent to placement at JRC.³⁴ Once there, JRC must seek a court hearing to request permission to use electric shock or other Level III aversives on residents. Referred to as a “substituted judgment” hearing, the court determines whether the child or adult would have chosen to receive such treatment if he or she were competent to do so.³⁵ Parents or other legal guardians must also approve the use of the GED. The court rarely denies approval.

JRC is not an open facility but a closed institution where children are transported from their JRC owned and operated residences to the JRC school in shackles. As the NYSED report stated in 2006:

Students were observed as they arrived and departed from school. Almost all were restrained in some manner, with metal ‘police’ handcuffs and leg restraints, as they boarded and exited vehicles. Several students are transported in wheeled chairs that keep them in four-point restraint.

In practice, for many residents, JRC is a closed institution where children and adults with disabilities are segregated from the non-disabled world.

Critique of aversive treatment from research and policy

What's wrong with punishments is that they work immediately, but give no long-term results. The responses to punishment are either the urge to escape, to counterattack or a stubborn apathy. – B.F. Skinner interview, The New York Times, 1987³⁶

This urgent appeal challenges the use of aversives at JRC on the ground that it violates international human rights law. Whether or not such treatment is narrowly defined as “effective,” international human rights law places limits on the amount of pain that can be inflicted on a person. To put this in context, however, it is important to recognize that the use of electric shock and restraints as treatment, as practiced at JRC, lacks evidenced-based proof of long-term efficacy or safety.³⁷ Indeed, there is reason to be concerned that these practices create risk of “psychological trauma, marginalization, or alienation.”³⁸ There are non-dangerous approaches to the management of dangerous or disruptive behaviors that do not entail the infliction of pain.³⁹

The New York Psychological Association Task Force on Aversives Controls with Children reviewed the field in 2006 and found that “prohibitions on the use of techniques that essentially punish disabled students for symptoms of their disability have been promulgated by a variety of federal agencies and professional organizations.”⁴⁰ The NY Psychological Association Task Force concluded that “aversive behavior interventions be prohibited, without exception, as part of a behavioral intervention plan.”⁴¹ Professional disability organizations like TASH, which includes many of the leading psychologists and behavior experts in the United States, have come out against *any* use of aversives.⁴²

The NYSED evaluation team that visited JRC in 2006 expressed concern about the lack of “adequately controlled and replicated research supporting the use of many of the identified aversive behavioral interventions,” particularly in this “school setting.”⁴³ Given the “lack of peer reviewed research on the effectiveness and safety of the GED used at JRC, the NYSED has concerns regarding the long-term health and safety of the students, particularly those students who may receive multiple electric shocks as part of their behavior plans.”⁴⁴

The NY Psychological Association Task Force, which reviewed NYSED’s report, raised particular concerns about the use of aversives at JRC without careful attention to the patients’ diagnosis. They point out that for certain children – in particular abuse or trauma survivors – aversives can be particularly dangerous.⁴⁵ Other researchers have warned that “restraints and seclusion should never be used with children who present with certain psychological or medical characteristics....Contraindications for the use of seclusion and restraints with children include a history of sexual abuse, physical abuse, or neglect and abandonment.”⁴⁶

Following the release of the NYSED report on JRC in 2006, the New York Psychological Association Task Force found that

“some of the techniques described as ‘aversive behavioral interventions’ not only constitute corporal punishment, but are included in literature on torture techniques...”⁴⁷

While the infliction of pain may stop a person from engaging in a specific behavior while being subject to a course of aversive treatment, aversive treatment cannot treat an underlying emotional disorder or intellectual disability. A review of the research found that “the implementation of punishment-based procedures, including those that incorporate noxious stimulation, do not guarantee long-term reductive effects in the treatment of severe disorders.”⁴⁸ The alleviation of symptoms only takes place while aversives are in place, leaving a person subject to this painful treatment over a long period of time. This is why JRC has had to create increasingly strong systems for administering pain and shock. JRC’s website candidly acknowledges that aversives only bring about the temporary alleviation of symptoms:

***Expecting an aversive consequence to keep having its effect long after we have stopped using it is to criticize aversives for something that we have no right to expect them to do.*⁴⁹**

One study examined a sample of five adults with developmental disabilities who had been subjected to an aversive program of electric shock, mechanical restraints, and food deprivation. This study found that the same individuals could be served in the community over two years, with the same alleviation of symptoms, using only positive behavioral supports.

***The results are encouraging in demonstrating that punishment-based approaches can be terminated, alternative strategies can be substituted, and through a clinically responsive system of monitoring and decision-making, behavioral adjustment can be supported without having to resort to invasive forms of treatments.*⁵⁰**

MDRI has interviewed providers who serve individuals once detained at JRC, and their experience is consistent with the findings of this research. Contrary to the notion that only JRC can serve the most disabled individuals, other programs are able to serve the same people without aversives:

***I was touring JRC and saw a little boy, maybe 6 or 8 years old, laying on the floor and shackled and handcuffed behind his back. We do not use mechanical restraints here ever! When people are given what they need, they don’t act out. – MDRI interview with director of group homes for people with developmental disabilities serving former JRC residents*⁵¹**

People come here from JRC and are doing quite well. There are no mechanical devices, and we don't punish people. They are frightened at first and ask "can I sit in that chair?" It is always shocking to me when I am told that 5 staff restrained a person in a shower. Here, they just take a shower. – Psychologist who works with former JRC students⁵²

The use of physical restraint as a form of treatment goes against federal policy and the findings of mental health research. The President's New Freedom Commission on Mental Health has stated that "restraint will be used only as safety interventions of last resort, not as treatment interventions."⁵³ The US Department of Health and Human Services Substance Abuse and Mental Health Administration has found that such practices as seclusion and restraints are "detrimental to the recovery of persons with mental illnesses."⁵⁴

The concept of Positive Behavioral Intervention Support (PBIS) was developed in the 1990's and has gained wide acceptance as the preferred approach to helping individuals with behavior problems.

PBIS states that the interventions need to be those that would be considered acceptable if used in community and school environments. Interventions that result in humiliation, isolation, injury and /or pain would not be considered appropriate. – U.S. Department of Education Office of Special Education Programs⁵⁵

The National Disability Rights Network and TASH have outlined a wide variety of best practices used throughout the United States, demonstrating that realistic options exist for the treatment of the most severe disabilities.⁵⁶ Serious deficiencies may exist in the United States regarding the availability of these services, and parents may rightfully be desperate to find appropriate treatment for children. The lack of services, however, is a product of a lack of funding and planning – not because such alternatives are impossible to provide.

Findings: The Use of Aversives at JRC

Electric shock

As described above, JRC's stated reason for the use of electric shocks is behavior modification and punishment.⁵⁷ Children and adults at JRC are routinely subject to electric shock, receiving multiple skin shocks on their legs, arms, hands, feet, fingers and torsos for behaviors such as getting out of their seats, making noises, swearing or not following staff directions.⁵⁸ The homemade shock devices, invented by the school's founder, Matthew Israel, and manufactured at the school, are carried by students in backpacks with electrodes attached to their skin.⁵⁹ The shock is administered remotely by minimally trained staff – some with only two weeks of

training.⁶⁰ Students never know when they will receive a jolt or where on their body they will be shocked. Some children are subjected to dozens of shocks over the course of a day. The April 2009 report by the Massachusetts Department of Mental Retardation (DMR), found that of the 109 children subjected to electric skin shocks, 48 had been receiving the shocks for 5 years or more.⁶¹

For 16 years, nearly half her life, Janine has been hooked up to Israel's device. A couple of years ago, when the shocks began to lose their effect, the staff switched the devices inside her backpack to the much more painful GED-4. – Jennifer Gonnerman, author of School of Shock, Mother Jones Magazine⁶²

It is imperative that JRC devise a protocol for reassessing the effectiveness of the aversive interventions [shock, restraint] once they have been tried for 5 years with only limited effectiveness... – April 2009 report Massachusetts DMR⁶³

I got the shocks for swearing, saying no, leaving a supervised area without asking and even for popping a pimple- any non-compliant behavior. I had one [electrode] on each arm, one on each leg and one around my waist. It is the worst pain, like a third degree burn. They tell people it feels like a bee sting but they lie. – MDRI interview with former student⁶⁴

When you start working there, they show you this video which says the shock is “like a bee sting” and that it does not really hurt the kids. One kid, you could smell the flesh burning, he had so many shocks. These kids are under constant fear, 24/7. They sleep with them on, eat with them on. It made me sick and I could not sleep. I prayed to God someone would help these kids. – MDRI interview with former JRC teacher⁶⁵

One time I was visiting my son and I saw the other students with the backpacks on. It really pained my heart. One child got a shock and then the others started to scream and cry. They were scared, and they were cringing. They were waiting for their turn. – MDRI interview with mother of former student⁶⁶

The device used to shock children, referred to by JRC as the Graduated Electronic Decelerator (GED) has been designed and manufactured at JRC. The Food and Drug Administration (FDA) has “cleared” the device for marketing but it has not specifically approved the device. According to the NYSED report, JRC informational material is misleading about this. “While JRC has information posted on their website and in written articles which represents the GED device as ‘approved,’ it has not been approved by the Food and Drug Administration.”⁶⁷

The shock administered is both painful and dangerous. The first generation of the GED administers 15.5 milliamps RMS of electricity for approximately 2 seconds – with a peak intensity of 30 milliamps.⁶⁸ The GED-4 is approximately 3 times stronger than the original shock

machine developed by Israel for children whose behavior cannot be controlled by the GED or who have become inured to the pain.⁶⁹ It delivers 45.0 milliamps RMS for 2 seconds, with a peak intensity of 91 milliamps.⁷⁰ According to the JRC website, they are now developing a third, more painful iteration of the GED.⁷¹

To put the use of shock into context, the use of electronic devices on animals must comply with the legal requirements according to state law. Most states prohibit the abuse of animals, and many animal protection societies protest the use of shock collars on dogs. Torture of an animal in Massachusetts is a felony and carries up to a 5 year prison sentence.

Whoever [...] mutilates or kills an animal, or causes or procures an animal to be overdriven, overloaded, overworked, tortured, or tormented, deprived of necessary sustenance, cruelly beaten, mutilated or killed; and whoever [...] knowingly and willfully authorizes or permits it to be subjected to unnecessary torture, suffering or cruelty of any kind shall be punished by imprisonment in the state prison for not more than 5 years or imprisonment in the house of correction for not more than 2 ½ years or by a fine or not more than \$2,5000, or by both such fine and imprisonment. – Massachusetts Statute Prohibiting Cruelty to Animals⁷²

Other comparisons may be helpful in understanding the power of the electrical force to which JRC residents are subjected:

A stun gun [used by police] is a legal electrical self-defense device that puts out a high voltage and low amperage shock. To put things in perspective, one amp will kill a person. Our stun gun will deliver 3-4 milliamps. However, most stun guns on the market are only 1-2 milliamps. – Definition of a Stun Gun⁷³

The level of shock is unbelievable, very painful....No other class of citizen in the United States could be subjected to this. You could not do this to a convicted felon. – MDRI interview with psychologist who visited JRC on behalf of the New York State Department of Education

According to the Boston Globe, two former employees from JRC described the pain level of electric shock as follows:

The employees, Gail Lavoie and Colleen Seevo, said that they also worked with a female student who received as many as 350 shocks in one day, another figure confirmed by the school. The women, who left the school at the end of 1992, said the shock is more painful than described by school officials. “I got hit accidentally on my thumb and I had a tingling up to my elbow on the inner part of my arm I would say for four hours,” said Seevo, referring to a shock. “I was saying I can’t believe these kids can do this. My

hand was shaking. I wanted to go home, that's how bad it was." Lavoie said the device also had side effects and she had observed students whose skin was burned and blistered by the shocks.⁷⁴

Since the early 1990's when these employees were working, JRC has introduced the GED-4 which uses almost 3 times this level of electricity.

Restraints

Some problem behaviors can be controlled and prevented by putting the student into continual manual or mechanical restraint. To manually restrain a vigorous young man can take the efforts of many staff members and is inevitably a dangerous exercise. Putting a student in continuing restraints is much more cruel than changing his/her behavior quickly with a powerful positive reward program that is supplemented with occasional two-second skin shocks. – JRC website, Frequently Asked Questions

JRC refers to physical restraints as "limitation of movement" (LOM), and this is a core part of its aversive treatment program. According to the JRC website, some students receive shocks while strapped prone to a platform board in 4-point mechanical restraints.⁷⁵ Restraints are used in combination with the GED to stop a person from ripping off the GED pack while receiving painful electrical impulses.⁷⁶ Restraints may also be used to increase the level of pain and discomfort when electric shock alone is not adequate to produce the behavior changes sought by JRC.⁷⁷

A nurse at the facility is responsible for monitoring abrasions due to restraints, according to the NYSED. Depending on the recommendations of the nurse, "a student may be restrained in a prone, seated, or upright position."⁷⁸ As described by the NYSED investigators:

With mechanical movement limitation the student is strapped into/onto some form of physical apparatus. For example, a four-point platform board designed specifically for this purpose; or a helmet with thick padding and facial grid that reduces sensory stimuli to the ears and eyes. Another form of mechanical restraint occurs when the student is in a five-point restraint in a chair. **Students may be restrained for extensive periods of time (e.g. hours or intermittently for days)** [emphasis added] when restraint is used as a punishing consequence. Many students are required to carry their own 'restraint bag' in which the restraint straps are contained.⁷⁹

MDRI's investigation suggests that restraints may last even longer than reported by the NYSED team. A former patient, a mother, a former teacher at JRC, and an attorney who represented clients at JRC all informed MDRI that children are restrained for weeks and months at a time.

According to MDRI interviews with the mother of an adolescent and with the attorney representing the mother, one boy spent two years almost continually strapped to a chair. From 2007 to 2009, when the mother refused the use of the GED on her child, he was almost continually strapped to a chair, until she was finally able to find another placement for him in a supervised group home.⁸⁰

They had him in a “chest protector” – a strap on his shoulders, a strap over his middle, over his crotch and leg straps too, if he acts up. – MDRI interview with the mother of a former JRC student⁸¹

He has been strapped to a chair for 2 years – MDRI interview with attorney representing mother to get him out of JRC⁸²

According to this mother, the boy’s only reprieve was when he was sleeping or being transported from his residence to the main school. Even during transport, however, he was shackled and handcuffed.

If students are non-compliant or aggressive, 4 or 5 staff will wrestle kids to the floor and strap them to a board face down and then shock them. I have seen it more than once. They yell “help” and “send someone.” They could be there like that for 12 hours or more until they “complied.” – MDRI interview with former JRC teacher⁸³

They use the restraint board. Staff would take hold of them and get them on the ground and bring the board into the room. Mechanical restraints on both arms and legs face down and just left there. One student was in a classroom next to mine on GED. They put her on the board and would shock her and shock her. I was put in a GED seat board, strapped onto a chair. They turned a key to turn it on and it would automatically trigger a shock if I stood up without asking. I was in the chair for several months. I was also put in a room by myself and put in a 4-point chair – feet and chest tied to chair. I was strapped to the chair, except when I was sleeping, for four months. – MDRI interview with former JRC student⁸⁴

According to the JRC website and video, the school uses an automatic holster-like device, attached to a chair, in which children are made to keep their hands. Removal of the hands from the holster triggers an automatic shock.⁸⁵

It looked like a gun holster and they had to put their hands in there or automatically get a shock. Some children are in the devices for days and weeks at a time... – MDRI interview with former JRC teacher⁸⁶

One student, who suffered from seizure disorder and was labeled with a mild developmental disability, was sent to JRC from a public school system, after they could no longer handle his behaviors. He then spent seven years receiving a combination of shock and long-term restraint.⁸⁷

The first few months they put him in restraints. Then they said his [bad] behaviors escalated and he needed the GED. When he was in restraints, they put him in diapers – he was a teenager – he was never in diapers before and he always used a toilet. But they didn’t want to untie him and let him use the bathroom. – MDRI interview with mother of former JRC student⁸⁸

According to this mother, her son was eventually put on a GED and restraint program. This program included up to 20 shocks per day for 6 months and the use of handcuffs and leg straps to transport him to and from his residence and the school. He was also put on the 4-point board “for hours at a time.” “They wanted to give him GED for all of his behaviors – loud noises, hands in the air – anything. But I wouldn’t let them. JRC was very angry with me and said it was my fault it [GED] was not working, because I would not let them shock him for all the behaviors.”⁸⁹

MDRI interviews indicate that students are likely to be restrained after they are admitted and before they go before a court to determine whether they can be subject to Level III aversive treatment. These findings are supported by the findings of the New York State and Massachusetts evaluation teams.⁹⁰ These findings raise concerns that restraints may be used to pressure or coerce individuals into consenting to the GED.

When I started off in the Judge Rotenberg Center, I was in restraint at least fifteen times a day. – Video statement by student posted on JRC’s website

According to the NYSED evaluation team:

It is during this initial restrictive placement at JRC that the frequency of behaviors is documented for purposes of obtaining a substituted judgment for the use of Level III aversive procedures.... In this setting, interactions with students involved little to no instruction; staff primarily attended to students’ negative behaviors and employed the use of physical and mechanical restraints at a high frequency and for extended periods of time.⁹¹

The Massachusetts Certification Team found that restraints were used without being included in treatment plans.⁹² According to one observer from the Massachusetts team, “the more JRC used these interventions, the more aggressive the students became.”⁹³

The use of restraints as a form of coercion is suggested in the statement of a patient currently posted on JRC’s website.⁹⁴ This statement is likely posted because the patient eventually determines that the GED helped him. He states that, after admission, “I would be frequently restrained and placed in a small room....Punishments that JRC would employ involve me spending the day in a small room with a staff person whom I was forbidden from socializing with, going to bed at 7pm, having to do schoolwork and chores on the weekend, without being

able to socialize with my housemates. Other punishments included being deprived of foods that were rewards.” After this, he states that:

I reluctantly agreed to the GED and decided not to fight JRC’s attempt to place me on the device. I figured that, although unpleasant, the GED would deter me from displaying behaviors that would result in me being restrained and losing out on the rewards that come with the program.

The JRC website includes a video clip of a father who testified at the Massachusetts legislative hearing on November 19, 2009, in Boston in an effort to block proposed legislation that would stop the use of the GED. His daughter has epilepsy and autism, and he said he was eventually won over by the use of the GED which stopped her from punching herself. His testimony makes clear, however, that his daughter was subjected to restraints before the court hearing allowing GED:

I refused to allow the GED....They used other methods – restraints, arm splints....I agreed after a long time. The hardest day of my life was going before Judge...asking for them to allow her to use the GED.

Provocation of bad behavior

One component of treatment at JRC is referred to as the behavioral rehearsal lesson (BRL).⁹⁵ Students are restrained and GED administered as the student is forcibly challenged to do the behavior the punishment seeks to eliminate. JRC students are sometimes induced to exhibit a behavior for which they will receive a shock punishment. Students endure surprise mock attacks and threatened stabbings by staff, which compel them to react with aggression, fear or screaming – deemed unacceptable or inappropriate behavior – for which they are subject to more shock for their reactions.

Former students report BRLs as particularly terrifying and some staff describe BRLs as “difficult to participate in and dramatic to watch.”⁹⁶

It was reported by a JRC staff member that one of the BRL episodes involved holding a student’s face still while a staff person went for his mouth with a pen or pencil threatening to stab him in the mouth while repeatedly yelling “You want to eat this?” – June 2006 report on JRC by New York State Education Department⁹⁷

The worst thing ever was the BRLs. They try and make you do a bad behavior and then they punish you. The first time I had a BRL, two guys came in the room and grabbed me – I had no idea what was going on. They held a knife to my throat and I started to scream and I got shocked. I had BRL’s three times a week for stuff I didn’t even do. It went on for about six months or more. I was in a constant state of paranoia and fear. I

never knew if a door opened if I would get one. It was more stress than I could ever imagine. Horror. - MDRI interview with former JRC student⁹⁸

Food deprivation

In addition to the use of electric shock, restraints, mock stabbings and assaults as a means of punishment, JRC uses dangerous food deprivation techniques to further abuse children, adding to the environment of fear, pain, punishment and control. Collectively known as “Loss of Privileges” or “LOPs,” the abuses are masked in clinical sounding terminology. The “Contingent Food Program” (CFP) and the “Specialized Food Program” (SFP) include the systematic withholding of food as a form of punishment.⁹⁹ The CFP “is widely applied and designed to motivate students to be compliant.”¹⁰⁰ If children or adolescents exhibit any behaviors not tolerated by JRC staff, a portion of food is withheld during the day. **Food not earned during the day is then given to the child in the evening, “which consists of mashed food sprinkled with liver powder.”**¹⁰¹ The SFP is “more restrictive” for those whose behavior does not improve – there is no make-up food given at the end of the day.¹⁰²

The Contingent Food Program and Specialized Food Program may impose unnecessary risks affecting the normal growth and development and overall nutritional/health status of students subjected to this aversive behavior intervention – New York State Education Department report¹⁰³

They made us all vegans by default. The food is disgusting. I could not eat without becoming sick. Their behavior would dictate when/how much they would eat. Called Loss of Privileges (LOP). LOP food is more gross than the regular food. – Former JRC student¹⁰⁴

Other LOPs include limitations and restrictions with regard to visits to the school’s store, television viewing, bedtime, and permission to talk with other students. And some LOPs result in even harsher consequences. One former student reported that she was forced to eat her dinner tied to a chair, alone in her room, for almost a month – LOPs she earned for talking in class without raising her hand.¹⁰⁵

When we first visited JRC, she had a beautiful room with a TV and stereo. Within one month, she only had a mattress on the floor. – MDRI interview with mother of a former JRC student¹⁰⁶

Stopping work for more than 5 seconds and you would lose points and get LOPs. I sat in front of the computer all day, other than lunch. And we couldn’t have a social conversation with any staff member. – MDRI interview with former JRC student¹⁰⁷

Creating social isolation

To further maintain strict control, socialization among students, between students and staff, and among staff, is also extremely limited.¹⁰⁸ For students, socialization with other peers must be earned. Children spend their school days in classrooms facing the walls and staring at a computer screen. Using self-teaching software, conversations and discussions are virtually non-existent and getting up from a chair or attempting to leave the classroom without permission could result in a shock or other form of punishment.

JRC promotes a setting that discourages social interaction between staff and students and among students. – Member of New York State Education Department review team¹⁰⁹

One student stated she felt depressed and fearful...She is not permitted to initiate conversation with any member of the staff. Her greatest fear was that she would remain at JRC beyond her 21st birthday. – Report, New York State Education Department review team¹¹⁰

Additionally, staff is not allowed to carry on any personal conversations with the students and all are under 24 hour video surveillance. Employees must also sign a confidentiality agreement at the beginning of their tenure with JRC, effectively barring them from ever talking about what they observe or participate in at the school – including the use of GEDs – or face legal action against them by the school.¹¹¹

You are sworn to secrecy. It is like a secret society. We had to sign a paper that if we said anything that would harm their reputation, they would prosecute you. If you talked bad about the school, everything is taped. If we needed to talk, we had to go outside. – MDRI interview with former JRC employee¹¹²

Aversives for harmless behavior

One of the critiques of the GED identified by the NYSED evaluation team is that it is used on behaviors that “the district did not consider problematic for a student that they had placed at JRC (i.e. getting out of seat, nagging).”¹¹³ Indeed, the NYSED evaluators found that:

Many of the students observed at JRC were not exhibiting self-abusive/mutilating behaviors, and their IEP’s had no indication that these behaviors existed. However, they were still subject to Level III aversive interventions, including the use of the GED device. The review of the NYS students’ records revealed that Level III interventions are used for behaviors including ‘refuse to follow staff directions’, ‘failure to maintain a neat appearance’, ‘stopping work for more than 10 seconds’, ‘interrupting others’,

*‘nagging’, ‘whispering and/or moving conversation away from staff’, ‘slouch in chair’....*¹¹⁴

The observations of the NYSED evaluators were mirrored by a former teacher at JRC.¹¹⁵ According to this teacher, children are routinely given shock for behaviors as normal or innocuous as reacting in fear when witnessing other students getting shocked; attempting to remove electrodes from their skin; tearing a paper cup; blowing bubbles with saliva; standing up out of a seat without permission; going to the bathroom in one’s pants; or asking to go to the bathroom more than five times, which is considered an inappropriate verbal behavior.¹¹⁶

MDRI interviewed a teacher and a former JRC student who told similar stories:

One girl who was blind, deaf and non-verbal was moaning and rocking. Her moaning was like a cry. The staff shocked her for moaning. Turned out she had broken a tooth. Another child had an accident in the bathroom and was shocked. – MDRI interview with former JRC teacher¹¹⁷

I felt terrible for the kids with autism getting shocked. This one 13 year old girl with autism kept getting the GED. They get it for verbal inappropriate behaviors. They made noises, that’s how they communicate. They are non-verbal but they would get more shocks. The poor girl would hurt herself a lot. – MDRI interview with former JRC student who was also getting shocked¹¹⁸

Lack of Legal Protection against Torture and Ill-Treatment

The conditions documented in this urgent appeal – including the use of electricity or shock or long-term restraint to control and punish the behavior of children and adolescents with disabilities– violate the UN Convention against Torture.¹¹⁹ In addition to the UN Convention against Torture, the United States has ratified the International Covenant on Civil and Political Rights (ICCPR).¹²⁰ Article 7 of the ICCPR prohibits torture as well as cruel, inhuman or degrading treatment or punishment (also known as ill-treatment).¹²¹ It is the obligation of governments under the UN Convention against Torture to “take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.”¹²² Under the ICCPR, the States Parties (i.e. governments that have ratified the convention) have an obligation to ensure enforcement of international human rights law even if a practice is governed by state law in our federal system.¹²³ The obligation to enforce international human rights law includes the obligation to ensure that private actors (such as private schools or hospitals regulated/funded by the government) do not perpetrate torture under government authority.¹²⁴ In recognition of the seriousness of torture and the need to ensure that such practices are prevented, the UN Convention against Torture requires each government party to the convention “to ensure that all acts of torture are offences under its criminal law.”¹²⁵

MDRI contends that that the severe infliction of pain perpetrated against children or adults with disabilities at JRC rises to the level of torture or ill-treatment prohibited by the UN Convention against Torture. No population is more powerless and vulnerable than children with disabilities whose parents have consented on their behalf to treatment and who are subject to restraints and electric shock within an institution. This is not a matter that has ever been considered by an international court or oversight body. Indeed, the rights of persons with disabilities have been widely overlooked by international human rights authorities until recently,¹²⁶ when the United Nations adopted the UN Convention on the Rights of Persons with Disabilities.¹²⁷ Due to the importance of these protections – and the fact that this is a new area of concern for international law – MDRI provides a detailed examination of the issue of aversive treatment as torture or ill-treatment below. Using these standards, MDRI then examines protections established under US federal and state law. We conclude that US laws fail to provide adequate protections against torture or ill-treatment as required by the UN Convention against Torture.

Protections under International Law

Torture is defined in article 1(1) of the UN Convention against Torture as:

*... any act by which severe pain and suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.*¹²⁸

The prohibition against torture under international law is reserved for acts worthy of the highest level of international reprimand. To rise to the level of torture, an act must meet each of four criteria identified in article 1 of the UN Convention against Torture. The practices documented at JRC meet each of these elements of torture because (1) the pain and suffering inflicted is severe; (2) this pain is inflicted intentionally; (3) the infliction of pain is for a purpose that is discriminatory; and (4) these practices are conducted with the consent or acquiescence of public officials.

The powerlessness of the victim is the essential criterion which the drafters of the Convention had in mind when they introduced the legal distinction between torture and other forms of ill-treatment. – UN Special Rapporteur on Torture, Manfred Nowak¹²⁹

The main legal difference relates to whether pain is inflicted for a purpose listed in article 1(1).¹³⁰ This prong of the definition is described in section 4 below. For many years, international authorities have failed to examine whether practices by medical authorities were perpetrating torture simply because the stated purpose of the act was for the purpose of “treatment.” With the adoption of the new UN Convention on the Rights of Persons with Disabilities (UN CRPD) and the Report of UN Special Rapporteur on Disability and Torture, it is now possible to examine medical practices more closely to determine whether they meet the standard of ill-treatment or torture.

The following four elements are required by the UN Convention against Torture to determine that an act is torture. Only the first and last elements are needed to show that a practice constitutes ill-treatment.

Pain is severe

The prohibition against torture under international human rights law applies only to pain and suffering that is “severe.” Such pain can be physical or mental. In analyzing whether a practice of inflicting pain rises to the level of severity that would constitute torture, human rights bodies will consider all “the circumstances of the case, including the existence of a disability.”¹³¹ The subjective experience of the victim is critical to understanding what pain might cause the emotional terror and physical suffering that rise to the level of torture. The powerlessness and vulnerability of children or adolescents with mental disabilities, held in detention, and subject to treatment against their will are all factors that contribute to suffering. As UN Special Rapporteur on Torture, Manfred Nowak, has explained:

*All purposes listed in Article 1 CAT (Convention against Torture)...refer to a situation where the victim of torture is a detainee or a person “at least under the factual power or control of the person inflicting the pain or suffering,” and where the perpetrator uses this unequal and powerful situation to achieve a certain effect, such as extraction of information, intimidation, or punishment.*¹³²

In the law enforcement context, the UN Committee Against Torture (CAT) has taken a strong stand against “the use of electric shock devices to restrain persons in custody” and “recommended that they be eliminated as inevitably leading to breaches” of the Convention.¹³³ The UN Special Rapporteur has taken a similarly strong stand against “the prolonged use of restraints, which may amount to torture or ill-treatment.”¹³⁴ The isolation of the individual and prohibition of human contact are also factors that have been found to cause “persistent and unjustified suffering which amounts to torture.”¹³⁵

The UN Special Rapporteur has recommended that any use of electric shock be prohibited “to restrain persons in custody” as such practices may “inevitably” devolve into ill-treatment along with other practices, even if a low level electric shock does not violate the UN Convention

against Torture by itself.¹³⁶ If the use of electric shock and long-term restraints can constitute violations of the UN Convention against Torture in the law enforcement context, then such practice can certainly inflict pain that rises to the level prohibited by the Convention for children or adults with disabilities who are detained at a school or psychiatric facility. As described above, children and adults with disabilities are subject to a combination of many types of painful practices at once. These individuals, who lack any control over their lives, may be isolated from friends and family. Social and human contact is limited and must be earned. A person with a disability may not even comprehend the context of this treatment because of their disability. Taken together, the subjective experience of pain and suffering for a child or adult with a disability could be as severe as that of any political prisoner subject to punishing physical abuse during the course of an interrogation.

The infliction of severe pain has been found to have dramatic health consequences on those subjected to it. According to a report by Physicians for Human Rights (PHR) documenting the treatment of detainees at Guantanamo and Abu Ghraib prisons, the infliction of pain and suffering can result in memory impairment, depression, feelings of shame, worthlessness and humiliation, disorientation, anger, paranoia, nightmares, thoughts of suicide and post traumatic stress.¹³⁷ These consequences were a result of physical and psychological torture techniques similar to those being used at JRC. Detainees reported short-shackling, verbal abuse, isolation, taking away comfort items, hooding and threats to induce fear of injury or death. JRC uses electric shocks, shock chairs, 4-point restraint boards with shock, shock holsters, shackles, food deprivation, mock attacks, social isolation and helmets.

*An official who worked at Camp Delta, the main prison facility at Guantanamo, admitted that sessions involving making uncooperative detainees strip to their underwear and sit in a chair while shackled hand and foot to a bolt in the floor while enduring strobe lights and loud rock and rap music...*¹³⁸

*A source with knowledge of interrogation at Guantanamo told PHR that isolation, repeated interrogation, deprivation of social contacts, an extremely harsh and overly stringent regime of internment and constant sources of harassment, culture or otherwise, were major causes of deterioration of mental health of detainees at Guantanamo in 2002.*¹³⁹

Children's negative reactions to being in restraints and put into seclusion are widely reported in the literature and mirror many of the same consequences as those suffered by detainees. Fear, loss of control, vulnerability, anger, anxiety, depression, humiliation, loss of dignity, powerlessness, abandonment and despair have all been reported, as well as anger, anxiety, boredom, confusion, embarrassment, depression, humiliation, abandonment, loneliness, sadness, loss of dignity, powerlessness, helplessness, despair, and being delusional.¹⁴⁰ Additionally, it was found that "the improper use of seclusion and restraints may lead to feelings that one is

‘bad’ or ‘sick’ and needs to be locked up. The experience may be particularly problematic for children who have been victims of violence or abuse.”¹⁴¹

The state of Massachusetts, in its own regulations governing the use of Level III aversives at JRC, which include electric shock and restraint, describe the punishments as any that “pose a significant risk of physical or psychological harm to the individual.”¹⁴²

Pain is inflicted intentionally

The definition of torture under the UN Convention against Torture requires that pain or suffering be inflicted intentionally. When the United States ratified the UN Convention against Torture, it adopted an explicit understanding that “in order to constitute torture, an act must be specifically intended to inflict severe physical or mental suffering.”¹⁴³ Negligent conduct alone cannot rise to the level of torture, though it may constitute inhuman and degrading treatment also prohibited by the UN Convention against Torture.¹⁴⁴

A practice might not constitute torture in the narrowest sense of the term if it is an “unintended side-effect” of the treatment.¹⁴⁵ The practices of electric shock and long-term restraints at JRC, however, fit within the definition because they are inflicted systematically and specifically to induce pain and inflict punishment. Pain is not the incidental side-effect of the practices perpetrated against children or adults at JRC – it is exactly what is intended.

The UN Special Rapporteur on Torture, Manfred Nowak, has made clear that the stated intent of a health care professional to cure a person of his or her illness or disability is no defense of a practice that meets the other elements of torture. “This is particularly relevant in the context of medical treatment of persons with disabilities,” says Nowak, “where serious violations and discrimination against persons with disabilities may be masked as ‘good intentions’ on the part of health professionals.”¹⁴⁶

Pain is inflicted for a prohibited purpose

For a practice to constitute torture, it must have a purpose prohibited by article 1(1) of the Convention against Torture. Nowak has described the purpose requirement as “the most decisive criterion which distinguishes torture from cruel or inhuman treatment.” The requirement of a prohibited purpose is probably the main reason why abuses in a medical context are not usually thought of as torture – since the stated purpose is to ameliorate a condition or illness. At JRC, clearly the intentional infliction of severe pain is for the purpose of coercing individuals to end behaviors deemed by JRC medical authorities to be improper.

It is important to note that under international law, a prohibited purpose need not be an improper purpose. Torture is prohibited for law enforcement authorities seeking to investigate violations of criminal law or security officials investigating terrorism – whether or not the torture is

effective in aiding this legitimate purpose. Similarly, a practice may constitute torture even if it is an effective way of modifying behavior for individuals with disabilities.

Article 1(1) of the Convention against Torture lists examples of prohibited purposes. The “common denominator,” of this list, according to Nowak, includes:

- extracting a confession
- obtaining from the victim or third person information
- punishment
- intimidation and coercion
- discrimination¹⁴⁷

What links these prohibited purposes is “where the perpetrator uses the unequal and powerful situation to achieve a certain effect.”¹⁴⁸ Despite the supposedly therapeutic purpose of placement at JRC, the authorities admit that their treatment is *explicitly meant as punishment* to achieve the purpose of extinguishing an unwanted behavior or disability. The mechanism of treatment is intimidation and coercion. For these reasons alone, the intentional infliction of severe pain at JRC meets the definition established in article 1(1) of the UN Convention against Torture.

International human rights law does recognize that severe pain and suffering may be induced, at times, for “a fully justified medical treatment.” This exception does not apply, however, for “medical treatments of an intrusive or irreversible nature, when they lack a therapeutic purpose, or aim at correcting or alleviating a disability. [Such practices] may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned.”¹⁴⁹ The shock and long-term restraints are indeed intrusive, and they may create irreversible psychological trauma. The electric shock and long-term restraints used at JRC do not “cure” an ailment; they merely aim at curtailing a behavior. A large percentage of patients subjected to this treatment are left in the institutions for years, and some continue to receive aversive treatment for years. The legal fiction of “consent” to this treatment is determined by the “substituted judgment” of a court. In practice, the most severe forms of pain are inflicted upon children and adults at JRC without their consent, rather; consent to the infliction of severe pain and suffering is given by parents, guardians and the court.

The treatment at JRC is explicitly used to coerce children and adults with disabilities to end their negative behaviors. Coercion, mainly through shock but also through the physical force of restraints, is the mechanism by which aversive treatment operates. One of the reasons that torture is considered more serious than inhuman and degrading treatment is that, when there is a purpose, authorities have a motivation to continue to increase the level of pain they induce. When low level pain is not sufficient to bring about an intended result, JRC uses higher and higher levels of pain. The threat of pain is also used to intimidate. Among students who are

emotionally disabled and have the cognitive ability to understand what lies ahead, JRC's website is explicit that the threat of electric shock is enough to bring about the end of negative behaviors.¹⁵⁰

The most widely overlooked prong of the definition of torture is discrimination. Even if the purpose of a practice were otherwise considered legitimate, the infliction of pain based on disability cannot be justified. As Nowak has stated, "the requirement of intent in article 1 of the Convention against Torture can be effectively implied where a person has been discriminated against on the basis of disability."¹⁵¹

The use of electric shock or long-term restraint is never tolerated on individuals without disabilities. The New York Psychological Association Task Force points out, for example, that New York's proposed regulation "for disabled students would constitute corporal punishment if employed as interventions for non-disabled students....The implications of regulations that selectively permit the use of corporal punishment with disabled youth but not nondisabled youth are both obvious and disturbing, regardless of whether one calls it 'corporal punishment' or 'aversive behavioral intervention.'"¹⁵²

The New York Psychological Association Task Force also says that "[d]isturbingly, some of the 'techniques' listed...sound eerily similar to recent reports about methods for interrogation of suspected terrorists that have been labeled as 'torture' and widely condemned by human rights organizations."¹⁵³ This point is strongly reinforced upon closer examination to similar practices widely understood to constitute torture or ill-treatment. What is being justified as beneficial "treatment" for people with disabilities is widely understood to be psychologically damaging when perpetrated against non-disabled individuals.

The infliction of electric shock is widely understood to constitute torture in any other context and they are understood to be extremely damaging to the individual. In 1997, Amnesty International did an exhaustive report on electro-shock torture used around the world against people in custody by law enforcement officials, governments and military forces. It described the use of stun guns, tasers, cattle prods, stun batons and remote controlled stun belts, documenting electric-shock torture and ill treatment in 50 countries as torture. As these practices are described:

...Electro-shock weapons have been deliberately, and often repeatedly, applied to sensitive parts of prisoners' bodies, including their armpits, necks, faces, chests, abdomens, the inside parts of their legs, the soles of their feet...Depending on the application and the individual, immediate effects include severe pain, loss of muscle control, nauseous feelings, convulsions, fainting and involuntary defecation and urination. **Long term effects from electric shock torture can reportedly include muscle stiffness, impotence, damage to teeth, scarring of skin, hair loss, post**

traumatic stress disorder, severe depression, chronic anxiety, memory loss and sleep disturbance.¹⁵⁴

Acquiescence of a public official or other person acting in an official capacity

International human rights law requires some form of state action to identify a practice such as torture.¹⁵⁵ It has been established that governments can be held responsible for actions taken at private hospitals, psychiatric facilities or other institutions that detain individuals for treatment under government authority.¹⁵⁶ The UN Special Rapporteur on Torture has stated that “the prohibition against torture related not only to public officials, such as law enforcement agents in the strictest sense, but may apply to doctors, health professionals, and social workers, including those working in private hospitals.”¹⁵⁷ It is, therefore, the obligation of the government “to prevent, investigate, prosecute and punish such non-State or private actors.”¹⁵⁸

JRC is licensed and certified by agencies of state government and receives state and federal funding, and it provides services that are sanctioned by the government. It is the obligation of the US federal government to protect children and adults with disabilities from torture or ill treatment by outlawing the use of electric shock and long-term restraints as a form of treatment.

Lack of protection under Federal Law

There are a number of gaps in federal law that make it possible for state law to permit and regulate aversive treatment. The Eighth Amendment to the US Constitution prohibits cruel and unusual punishment. However, the US Supreme Court has ruled that protections under the Eighth Amendment apply only in the context of criminal law and do not provide students any protections in school.¹⁵⁹ In the absence of constitutional protections, Human Rights Watch has observed that federal and state laws have failed to provide protections required by international law against corporal punishment.¹⁶⁰ The National Disability Rights Network has released a recent report showing the restraints and seclusion are used widely in US schools in almost every state, resulting in serious dangers to children.¹⁶¹ At the request of Congress, the Government Accountability Office conducted an inquiry into the practice of restraints in schools, as well. The GAO report found that no federal law exists limiting the use of restraints in schools.¹⁶²

The Individuals with Disabilities Education Act (IDEA), the main federal legislation regulating education of children with disabilities, strongly supports the commonly accepted preference for Positive Behavioral Intervention and Supports (PBIS). “[I]n the case of a child whose behavior impedes his or her learning or that of others,” IDEA states that “when appropriate, strategies, including *positive behavioral interventions, strategies and supports*” [italics added] should be considered.¹⁶³ Yet IDEA does not prohibit aversives. Despite the recommendations of IDEA

to use positive supports, the US Department of Education has certified JRC as a school that can receive federal funds.¹⁶⁴

The Americans with Disabilities Act (ADA) does provide protections against discrimination on the basis of disability. And in 1975, Congress passed the “Developmental Disabilities Assistance and Bill of Rights Act” (DD Act) which states in part:

...The Federal Government and the States both have an obligation to ensure that public funds are provided only to institutional programs, residential programs, and other community programs, including educational programs in which individuals with developmental disabilities participate, that... meet minimum standards relating to— provision of care that is free of abuse, neglect, sexual and financial exploitation, and violations of legal and human rights and that subjects individuals with developmental disabilities to ***no greater risk of harm than others in the general population***... and prohibition of the use of such restraint and seclusion as a punishment or as a substitute for a habilitation program...¹⁶⁵

However, in a class action suit filed in federal district court - the *Pennhurst State School and Hospital v. Halderman* - on behalf of all Pennhurst School residents alleging inhuman and dangerous conditions at the school, the US Supreme Court ruled that the DD Act did not create any new legal rights or protections and the language of the DD Act was “hortatory not mandatory.”¹⁶⁶

...the Act does no more than express a congressional preference for certain kinds of treatment. – US Supreme Court

In theory, treatment that subject children with disabilities to harm could be struck down by the courts as a violation of the DD Act and ADA. In practice, they have not done so.

Lack of protection under State Law

In the absence of federal law that would limit aversive treatment, states have the ability to use and regulate aversives as they see fit. Massachusetts and New York have adopted laws and regulations on aversive treatment, as have some of the other states that send children to JRC. As described above, JRC moved from California to Rhode Island when California adopted regulations that made it almost impossible to use aversives. Ultimately, federal law is needed to ensure that the protections under international human rights law are implemented throughout the country. Since JRC is based in Massachusetts, this analysis will focus on Massachusetts law.

The Massachusetts regulations from the Department of Developmental Services (DDS) create protections that appear relevant, but they include exceptions that permit aversives essentially without limitation as to intensity or duration. The general policy against aversives that pose a “significant risk” are stated in the introduction to the regulation:

...As a general matter, it is the Department's strong policy that behavior modification procedures which pose a significant risk of physical or psychological harm to the clients or which are highly intrusive or restrictive should be used only as a last resort, subject to the most extensive safeguards and monitoring. Such interventions, under normal circumstances, would be considered to be corporal punishment and ordinarily would not be permitted in facilities operated, licensed or funded by the State.¹⁶⁷

The regulation goes on to recognize “that there are extraordinary cases in which there is a need to treat the most difficult or dangerous behavioral problems.” This is the exception that permits treatment at JRC. “In such cases it may be necessary to use extraordinary behavior modification procedures which would otherwise involve too much risk or potential harm to the dignity, health or safety of the client to be permitted.”¹⁶⁸ It then creates extensive procedural protections to determine when such treatment is authorized, including “rigorous review and approval by clinicians, human rights committees, and the Department.”¹⁶⁹ Ultimately, any procedure must meet the standard that “**the likely benefit of the procedure to the individual out-weighs its apparent risk, intrusiveness, or restrictiveness.**”

The regulations then divides up interventions into three tiers, depending on their level of intensity. Level I interventions entail only positive reinforcement and aversive stimuli that ‘involve no more than a minimal degree of risk, intrusion, restriction on movement, or possibility of physical or psychological harm.’¹⁷⁰ Level II interventions include those approved as Level I but “must be physically enforced to overcome the individual’s active resistance.”¹⁷¹ The description of Level III punishments are described as follows:

1. Any Intervention which involves the contingent application of physical contact aversive stimuli such as spanking, slapping or hitting.
2. Time Out wherein an individual is placed in a room alone for a period of time exceeding 15 minutes.
3. Any 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.
4. Any Intervention which alone, in combination with other Interventions, or as a result of multiple applications of the same Intervention *poses a significant risk of physical or psychological harm to the individual* [emphasis added].¹⁷²

Under a 1987 consent agreement between JRC and the state of Massachusetts, JRC has agreed to submit any case of Level III interventions to a court for review.¹⁷³ The court must find that the parents or guardian consent to Level III aversives. Additionally, the court must find that the person is mentally incompetent and would consent to treatment if he or she is capable of doing so. Finally, the court must determine whether the treatment meets the final standards, identified above that the likely benefit to the individual outweighs its risk.

Massachusetts law permits torture or inhumane treatment

Despite extensive procedural protections, Massachusetts law fails to provide the protections required by the UN Convention against Torture. The law creates extensive requirements of professional and judicial review. If the person goes through all procedural requirements, the final decision comes down to a balance between the symptoms of the disorder against the risks of treatment. In practice, JRC can claim these symptoms are extremely dangerous or life-threatening, providing justification for the infliction of correspondingly painful and dangerous treatment. In such circumstances, **there is no upper limit on the amount of pain that can be imposed short of killing a person.** Where a disability is severe and can be characterized by treating authorities as dangerous, Massachusetts law permits severely painful treatments to be imposed on an individual. The very definition of Level III aversives is that they create “a significant risk of physical or psychological harm” to the individual. The UN Convention against Torture requires that governments protect their citizens against the infliction of severe pain. The Massachusetts regulations of aversive treatment fail that test.

MDRI contends the pain induced at JRC by electric shock, restraints, and social isolation can rise to the level prohibited by the UN Convention against Torture as ill-treatment or torture. The fact that individuals have disabilities, they are placed in institutions by parents who have consented to treatment on their behalf, and they are in a position of complete powerlessness at the hands of state authorities, renders this form of mistreatment a form of torture.

Some of the practices at JRC may go beyond what is permissible under Massachusetts law. Once aversives are approved, for example, JRC admits that they are used to stop behaviors that are not necessarily dangerous or life-threatening. The logic of the “behavioral rehearsal lesson” justified students with non-dangerous behaviors to be subjected to the most painful aversives because they could lead to more dangerous behaviors. Using this logic, once a court approves aversives for the most dangerous behaviors, JRC then acts as if it has license to use aversive treatment on any and all non-dangerous behaviors that it can argue might lead to dangerous behavior.

JRC practices in this regard appear to violate Massachusetts law. The use of Level III aversives are supposed to be restricted to behaviors that are “difficult or dangerous behavioral problems,” such as “serious self-mutilation or other self-destructive acts.”¹⁷⁴ JRC commonly imposes aversive treatments that are well out of proportion to the risk of the underlying behavior. The fact that JRC has the capacity to abuse judicially approved aversives demonstrates the danger of permitting any aversives.

Laws on physical restraint violates Convention against Torture

Despite promising “freedom from discomfort, distress, and deprivation which arise from an unresponsive and inhumane environment,”¹⁷⁵ the Massachusetts regulations designed to protect children with disabilities in any program funded by the Department of Developmental Services create gaping holes that leave children and adults at JRC without adequate protections. The use of physical restraints are inherently dangerous and create risk of severe emotional trauma – particularly for children.¹⁷⁶ Thus, it is widely understood that physical restraints should only be used as an emergency measure to protect against imminent harm.¹⁷⁷

In contrast with the regulation of restraints for purposes of “behavior modification,” Massachusetts regulations create detailed procedural protections to limit the use of restraints in emergency situation where there is an imminent threat of self-injurious behavior, physical assault or other danger.¹⁷⁸ In addition, Massachusetts prohibits the use of “continuous” physical or mechanical restraint beyond a 6 hour period¹⁷⁹ and “non-continuous” restraint beyond 8 hours.¹⁸⁰ The regulation has additional procedural safeguards in place when restraints are used on children (“any minor placed in mechanical restraint or physical restraint shall be examined within fifteen minutes....”¹⁸¹ And restraints “exceeding one hour in any 24 hour period” must be reviewed and reported to the Department of Developmental Services¹⁸²).

Once at JRC, many students are restrained and kept isolated in a small room with one staff person, and “inappropriate major behaviors” are documented until the school has amassed enough evidence to ask for court approval for the use of the electric shock.

I was always in restraint when I came to JRC... Being in restraints wasn't helping me so I wanted GED...I had 20,813 problem behaviors in 5 months before the GED. – JRC video testimonial of student in support of GED, JRC website

I was kept in a small room, isolated. One staff and me for a year and a half. – JRC video testimonial in support of GED, JRC website

I was in restraints constantly...I was in an isolated room. Then I went on the GED – JRC video testimonial in support of GED, JRC website

In theory, even with all these protections, the regulation on emergency restraints would be subject to tremendous abuse. In practice, the regulation permitting emergency restraints does not speak to the use of restraints for eight hours day after day. The pain and suffering that can be caused by a lifetime of eight hour days in restraints is almost limitless.

Yet Massachusetts does not include these limited protections for children or adults subject to a “behavior plan.” Any use of restraints as part of an approved behavior modification plan, is

technically called “Limitation of Movement” and is not included in the above system of protections.¹⁸³ The regulation is confusing, poorly drafted, and includes numerous sloppy errors. The regulation states that restraints used in accordance with behavior modification plans are to be regulated by a section of the law that does not exist.¹⁸⁴ Another section of the regulation, however, appears to regulate the relevant use of restraints as part of a “behavior plan.”¹⁸⁵ This section of the regulation lacks the procedural protections used in emergency cases. It creates no upper limits on the amount of restraint that may be used. If restraints are used “more than once within a week or more than two times a month, an intervention strategy must be promptly developed to respond to the behavior and reduce the likelihood of its recurrence.”¹⁸⁶ The behavior plan must be reported to the provider’s human rights committee and must meet all other requirement of behavior modification plans.

The use of Level III restraints is painful and inherently dangerous,¹⁸⁷ yet there are no limits on the pain that may be inflicted on children with disabilities for purposes of behavior modification. There is no more regulation of restraints in Massachusetts law than there is on any other form of behavior modification. In its 2009 recertification of JRC, the Department of Mental Retardation (now the Department of Developmental Services”) called on JRC to include restraint as Level III aversives, making clear that JRC did not use even this level of protection as of early 2009.¹⁸⁸ Even if JRC did implement the due process protections required for other Level III aversives, the Massachusetts regulation does not protect against torture. As described above, protections for Level III aversive treatment do not create an upper limit on the infliction of pain.

The fact that Massachusetts regulates restraints as behavior modification violates federal policy against the use of restraints as treatment. As noted above, the Substance Abuse and Mental Health Services Administration under the US Department of Health and Human Services has stated that restraints should never be used for treatment. The Massachusetts regulation also contradicts itself, since they explicitly ban the use of restraints as a form of punishment.¹⁸⁹ At JRC, “aversive treatment” is punishment.

The Massachusetts certification report suggests that JRC is violating these regulations. According to the 2009 Massachusetts Level III Recertification Report, “some of the plans contained no reference at all to LOM [Limitation of Movement], but there was evidence it was being used.”¹⁹⁰ In other cases, LOM was included in a plan as a “health-related” measure, which was described by the recertification team as an “inaccurate and inappropriate” use of the term.¹⁹¹

Domestic Remedies Have Failed

The findings of MDRI’s investigation corroborate with documentation that has long been a matter of public record. The state of Massachusetts and other states and individual school

districts have knowingly sent children and adults to this facility, and they continue to fund the abusive practices that take place at JRC. While the infliction of severe pain on children and adults at JRC has been challenged in the courts time and time again, the legal system of the United States has failed to provide basic human rights protections for this population.

There have been many attempts over the decades to legally ban the use of the pain and punishment perpetrated against children and adolescents residing at JRC. JRC's vast financial and legal resources have been instrumental in defending practices used at JRC and beating back numerous legal challenges in the courts. As described below, cases upholding JRC practices have resulted in leading professionals and mental health officials losing jobs in state leadership positions.

JRC has taken to requiring staff to sign confidentiality agreements so that they cannot speak publicly about treatments provided at the facility.¹⁹² Coupled with threats of lawsuits against any and all detractors – including state officials – JRC has fended off efforts to ban its practices. The Massachusetts legislature has, instead, adopted laws that permit the use of shock and long-term restraints.

A climate of fear appears to have kept officials from enforcing existing laws and challenging dubious laws and treatment practices that have been widely criticized by mainstream mental health professionals. Despite the existence of federally-funded human rights oversight mechanisms, oversight agencies charged with the protection of rights have not been successful in protecting vulnerable children and adults with disabilities from continuing to abuse and mistreatment. Current laws create extensive legal oversight, but these protections have not stopped the practice of aversive treatment.

MDRI turns to the United Nations to seek enforcement of international human rights law after decades of political and legal advocacy have failed to stop abuses at JRC

Futility of current oversight regime

As part of JRC's settlement with the state of Massachusetts, the Bristol County probate court ruled that JRC must get judicial approval for every child it seeks to use the most severe punishment against – electric shock, restraint, food deprivation - as treatment. JRC is required to document the inappropriate behaviors of its new admissions and make a case before the court as to why the punishment is needed. In each case, the court must find that the treatment poses less of a danger than the behavior caused by the underlying disability.

The courts are a rubber stamp for JRC. The doctors tell the court that treatment is necessary, and the courts defer to medical authority. You have to understand, their dockets are overloaded and they don't have time to look into this. And they hear the

same arguments over and over again. The only time I ever prevailed against JRC was when my client was transferred to Mass General Hospital and I brought the case to a court that had never before heard from JRC. – MDRI interview with an attorney formerly involved with JRC litigation¹⁹³

Despite each person being awarded a public counsel to protect their best interest and civil rights, the court rarely denies JRC permission to use punishment as treatment. The procedural protections seem impressive on paper, but they have proved ineffective and futile.

When the JRC settlement agreement was first executed, a small cadre of defense attorneys handled all the JRC cases. However, after a few years of frustration and disappointment, all the original attorneys opted out. – MDRI interview with an attorney, formerly involved with the JRC substituted judgment cases¹⁹⁴

In theory, shock cannot be authorized by the court until all other avenues of treatment have failed. In practice, as described above, JRC appears to be able to create the behavior patterns that can justify the court to order shock. One mother of a new student reported to MDRI that her son was permanently restrained in a chair for several months, alone in a room, upon his admission to JRC. During that time, according to her, her son was understandably upset and angry – inducing him to exhibit bad behaviors. These behaviors were documented by JRC staff, and they give them the ammunition they needed to get judicial authorization to use the electric shocks on her son.¹⁹⁵

Deaths and subsequent legal challenges

From the outset, Israel's treatment for children with disabilities was controversial and the focus of much media attention. This was especially true when the magnitude and severity of punishments being perpetrated against children came to light or when an unexplained death occurred at the facility, of which there have been six. As previously described, it was a death at the facility in 1980 that resulted in the virtual ban on the use of aversives in California.

In 1990, the Massachusetts DMR conducted an exhaustive investigation on the horrific death of a 19 year old, a young woman diagnosed with severe mental retardation, who also died at the facility. The report states that the staff and administration committed acts against her that were “egregious” and “inhumane beyond all reason” and violated “universal standards of human decency.”¹⁹⁶ The young woman, who was unable to speak, became ill and refused to eat, attempted to vomit and made sounds and noises that were not usual for her. For this she was punished repeatedly as the staff translated her actions as misbehaviors. In the hours leading up to her death from a perforated stomach and ulcers, the investigation found that she endured “8 spankings, 27 finger pinches, 14 muscle squeezes” and was forced to smell ammonia and eat “either vinegar mix, or jalapeno peppers or hot sauce.”¹⁹⁷

Prior to her death, she had been subjected to the school's punishment of withholding food for being unable to do school work on the computer or getting wrong answers, despite having the mental capacity of a pre-schooler. At times she was limited to 300 calories per day.

In the end, DMR concluded that there was not enough evidence to link the punishments to her death.

The Massachusetts Office for Children (OFC) ordered the closure of JRC. The school and its parents sued the OFC and appealed the closure. A state administrative law judge ruled that the school could remain open but limited the use of aversives during the litigation.¹⁹⁸

In 1986, in the midst of the OFC litigation, JRC (then called the Behavior Research Institute) brought one of its most self-abusive students before the Bristol County Probate Court (MA) and Chief Judge Ernest Rotenberg (for whom the school is now named) for a substituted judgment hearing to allow JRC to use aversive treatments on the student. Judge Rotenberg found in JRC's favor and JRC began to bring each student they felt needed aversives before Judge Rotenberg for approval.

Despite the objections of the OFC, Judge Rotenberg was eventually given judicial authority over all pending legal actions between the OFC, JRC and parents of students and a settlement was reached. In the December 1986 agreement, aversives were permitted with a court-ordered treatment plan, and a monitor must report to the court on the clients' treatment.¹⁹⁹

Additionally, licensing for the facility was taken out of the hands of the OFC and given to another state agency – the Massachusetts Department of Mental Health (DMH), later to be transferred to the Department of Mental Retardation (DMR).²⁰⁰ The OFC agreed to apologize to the JRC parents and pay over \$580,605 in legal fees. The defendant in the case, Mary Kay Leonard – the Director of the Massachusetts Office for Children – was deemed personally liable if the state failed to make restitution.²⁰¹

From 1987 to 2009, advocates have introduced bills and proposed legislation to the Massachusetts State Legislature to ban or limit the use of pain and punishment against children with disabilities. Every year, Rep. Jeffrey Sanchez – whose nephew has been at JRC for nearly 2 decades and is the same young man who once received 5,000 shocks in one day – brings him in front of legislative hearings touting the benefit of the shocks. Senator Brian Joyce – whose district includes Canton, Massachusetts and JRC - has led the way to stop their use, stating publically that, "If this treatment were used on terrorist prisoners in Guantanamo Bay, there would be worldwide outrage."²⁰² However, every attempt has failed.

In the early 1990's, the Department of Mental Retardation (DMR) attempted to close down JRC and stop the use of electric shock on children. In 1995, the Bristol County Probate Court again ruled in JRC's favor, charging the state with violating the previous settlement agreement and

stripping DMR of licensing responsibilities for the school. As a result, the DMR commissioner was forced to resign – after being held in contempt of the original settlement agreement for leading a campaign of harassment against the school. The state was mandated to pay more than one million dollars in legal fees to JRC.²⁰³

Although the DMR appealed the finding of contempt the Supreme Court of Massachusetts, the Supreme Court upheld it, affirming that the original settlement agreement constituted a “clear and unequivocal command”²⁰⁴ and that the judge’s finding that department had acted in “clear and undoubted disobedience” was not “clearly erroneous.”²⁰⁵

Over these many years, JRC has spent millions of dollars in legal costs to keep JRC open and to continue to defend its use of pain and punishment – shock, long-term restraint, food deprivation and mock attacks - as its main course of treatment for all students. In 2007, the non-profit, tax-exempt school spent \$2.8 million in legal fees, according to its 990 form, filed with the United States Department of Treasury, Internal Revenue Service. During the course of this investigation, former JRC students and teachers, state officials, legal advocates and others, expressed fear about criticizing JRC publically. Several state officials would not return calls or e-mails, and all who agreed to be interviewed would only be interviewed anonymously.

In addition to failed lawsuits and legislative action by civil rights, disability rights and human rights activists, the media has written extensively on JRC including editorials, feature stories and breaking news pieces and yet little or nothing has resulted in terms of ending the use of punishment at JRC.

New York’s attempts to limit use of aversives

New York State sends more of its children to JRC than any other state. As a result of questions and concerns by NY lawmakers regarding the use of punishment at JRC, specifically electric shock and restraint, the NYSED sent a review team to JRC in April and May 2006. The team included NYSED staff and three behavioral psychologists. One visit was announced; the other was unannounced. The NYSED review team reported a litany of abuses involving the most painful of punishments used by JRC. Following the publication of the NYSED report, New York held public hearings. As a result, NYSED adopted restrictive new regulations that would phase out new cases where aversive treatment would be approved.²⁰⁶ Before New York could implement these new regulations, parents representing children at the school challenged the regulations in federal court, claiming they have a right to subject their children to Level III aversives. They claim that such treatment is necessary for their children to receive an appropriate education as required by IDEA. The federal court has ordered a stay on the implementation of New York’s regulations until the substantive issues under IDEA are heard.²⁰⁷

A summary of the NYSED review team findings include:

- Level III punishments are given to children with all kinds of disabilities, many without self-injurious behaviors;
- Level III punishments are given for swearing, nagging and failure to maintain a neat appearance;
- The use of electric shock skin devices raises health and safety concerns;
- The withholding of food as punishment could pose risks affecting growth and development;
- Delayed punishment practices are used so that subjects may not be able to comprehend any relationship between a punishment and a behavior;
- The JRC setting discourages social interactions;
- There is insufficient academic and special education instruction;
- JRC compromises the privacy and dignity of students.²⁰⁸

Ultimately, the NYSED's review team concluded that the effects of the punishment on children at JRC are increased fear, anxiety or aggression.²⁰⁹

One of the findings of the NYSED review team was that "behavioral programming at JRC is not sufficiently monitored by appropriate professionals at the school and in many cases the level of background and preparation of staff is not sufficient to oversee the intensive treatment of children with challenging emotional and behavioral disorders."²¹⁰

The reality is that JRC staff may have had even less training than was represented to the NYSED review team. In May 2006, the Massachusetts Division of Professional Licensure found that JRC had improperly claimed that fourteen JRC clinicians were trained as licensed psychologists. In a consent agreement with the Board of Registration of Psychologists, JRC paid \$43,000 in fines.²¹¹ Dr. Matthew Israel, the Director of JRC, was personally fined \$29,600 and was reprimanded by the Board.²¹²

Recent incidents of abuse

In August 2007, an investigation of JRC was conducted by the Massachusetts Department of Early Education and Care (EEC) – the licensing agency for JRC residences - following the unauthorized administering of shock to two boys at their JRC residence. According to the report, one boy received 29 electric shocks, and the other received 77 shocks within a three hour time period.²¹³ The incident occurred when a former JRC student phoned the residence in the middle of the night, pretending to be a staff person, and ordered the residence staff to use shocks on the sleeping adolescents. EEC investigators interviewed the boys and staff and reviewed video footage and found that both boys had been awoken from their sleep when they received the shock; both boys had additional shocks when they were strapped to a 4-point restraint board;

both were in transport restraints (legs and waist) while they were in their beds; and one of the boys did not have the required Level III court approval for restraints in his record. Neither boy was evaluated by any medical staff until the following day after the incident, despite asking for a nurse and complaining of pain.

Staff reported that it is not atypical for a resident to say that they have injuries following a GED application. It was reported that typically staff would not call a nurse when a resident voices that he is in pain from a GED application and described it as a pinch.

The EEC report stated that staff observed that the “skin was off” and there were “fresh marks” on the calf of one of the boys, who complained of leg pain. It was later diagnosed as a stage two ulcer. These wounds were located at the same site that the resident had received the shock.

The EEC investigation further concluded that:

- staff was physically abusive toward the residents;
- the staff was unable to provide for the safety and well being of a child;
- staff lacked necessary training and experience;
- staff used poor judgment;
- staff failed to provide a safe environment;
- staff failed to follow policies regarding medical treatment;
- staff were neglectful in the care of residents.

The incidents of unlawful restraint of the boys at the JRC residence would never have been discovered had EEC not been investigating the unauthorized shock “prank.”

Massachusetts recertification in 2009

In addition to court approval for Level III punishments, the Massachusetts DMR requires that JRC undergo Level III certification by the state’s Level III Certification Team which includes two psychologists, a psychiatrist and the Massachusetts Department of Mental Retardation’s Director for Human Rights and assistant general counsel.

In its report dated April 27, 2009, JRC was given recertification, despite the team’s findings, which included numerous violations, abuses and concerns. It is difficult to imagine under what circumstances the state would not recertify JRC to use Level III punishments given the amount of violations they reported. Previous successful legal action by JRC against the state may also be a factor in the state’s decision.

Findings by the team included:

- 48 students receiving electric shock for over 5 years; the use of shock for ‘destroying, major disruptive, and non-compliance’;²¹⁴
- only 23 of 105 treatment plans received the required annual review by JRC’s Human Rights Committee (HRC);²¹⁵
- JRC’s Human Rights Committee failed to meet its regulatory requirement of conducting quarterly meetings;²¹⁶
- the failure to meet resulted in an inadequate opportunity to properly oversee rights issues in Level III behavioral plans;²¹⁷
- HRC failed to review any emergency restraints used for 2 years; ‘Irregularities’ in mechanical restraint practices (referred to in the report as ‘Limitation on Movement’ or LOM) such as authorizing restraint devices for medical reasons; no waivers or approvals from DMR existed for these devices as required; undocumented restrictions for visitations, possessions and locked buildings [residences];²¹⁸
- the use of Level III punishments for ‘relatively minor behaviors’ remains problematic; concern that the impact of physical disability or acute illness might have on ‘problem behavior’ or ‘targeted negative behavior’ which would result in punishment; seemingly minor behaviors punished with electric shock;²¹⁹
- student described as having anxiety but not treated with behavioral interventions commonly used to treat anxiety;²²⁰
- absence of explanation of which authorized Level III punishment used; labeling non-compliance as a behavior was not acceptable;²²¹
- Level III punishment for minor behaviors and the argument that these minor behaviors are antecedent to more dangerous behaviors must be augmented with more data demonstrating this relationship;²²²
- Limitation of Movement [restraint] interventions must be treated as Level III aversives and documented accordingly;²²³
- plans routinely refer to the use of helmets as ‘health related protection,’ authorized by a physician. When LOM is included in a treatment plan, there must be specific individualized data to support its inclusion.²²⁴

JRC was granted a six month certification to use Level III aversives. The DMR report cited partial compliance to state regulations, previous recommendations and conditions. The state promised to work with JRC to address the deficiencies and assist JRC in developing a “monitoring plan” for compliance. Additionally, certification was subject to full compliance in the areas of: improved behavioral plans subject to the specific needs of the individual students; explanation for increase/decrease in effectiveness of Level III aversives and a plan to fade (discontinue) the use of aversives; rationale for using Level III aversives on minor behaviors; an outside expert engineering and medical report on the safety of the GED devices; mandate that the Peer Review Committee meet with the frequency required by state regulation; mandate that the

Human Rights Committee be in compliance with their responsibilities as stated in the state regulations; ensure that restraint devices used be “clearly articulated” – including conditions for their use. As of this writing, JRC continues to be certified to use Level III punishments on its residents.

Conclusions and Recommendations

The intentional infliction of severe pain perpetrated against children and adults with disabilities by JRC violates the UN Convention against Torture. Aversive treatment is used to inflict pain as punishment to coercive and intimidate people with disabilities to change their behavior. The legal framework which allows such treatment is discriminatory – as it permits such practices to be perpetrated only against individuals with disabilities. The dehumanization and depersonalization of children at JRC by way of state-sanctioned punishment with electric shocks, 4-point restraint boards, mock assaults, food deprivation, shock chairs and shock holsters fosters an environment ripe for abuse and one that would not be tolerated – especially against children - in any other setting. These practices induce extreme and severe pain and suffering on an extremely vulnerable population of children and adults with disabilities and constitute ill-treatment or torture against the UN Convention against Torture.

No population is more vulnerable to abuse than children with disabilities detained in an institution. This population needs the strongest level of international protection to protect them against abuse. For this population, the use of electric shock, long-term restraint, and other aversives used by JRC constitute human rights violations that are even more serious than corporal punishment in a school, where children eventually go home to friends and family in the community. The UN Special Rapporteur on Torture has stated that corporal punishment constitutes inhuman and degrading treatment. For a population detained in an institution, such as JRC, the vulnerability is much greater -- and the experience of pain and suffering is likely more extreme. Thus, severe pain perpetrated against this population should be viewed as fully tantamount to torture. According to Nowak, “[t]he powerlessness of the victim is the essential criterion which the drafters of the Convention had in mind when they introduced the legal distinction between torture and other forms of ill-treatment.”²²⁵

The UN Convention against Torture prohibits practices that amount to the intentional infliction of severe pain. It could be argued that any one aversive practice, used in a mild form, does not entail severe pain. MDRI does not and cannot attempt to define exactly when the repeated use of restraint adds up to a violation of international human rights law or exactly what level of electricity might constitute ill-treatment or torture. The practice of ill-treatment or torture is considered so serious that the UN Committee Against Torture (CAT) has recommended governments adopt clear and absolute standards to protect against abuse.

A flat ban on the use of electricity or long-term use of restraints to treat or modify behavior would be the best way to prevent future abuse. Such a ban would be consistent with federal policy and best practice in the field of behavior modification that strongly supports positive behavioral supports instead of painful aversives. Such a ban would be consistent with what CAT has called for to protect people in custody in a law enforcement context. In 2000, as described above, CAT recommended that the United States “abolish electro-shock stun belts and restraint chairs as methods of restraining those in custody since ‘their use almost invariably leads to breaches of article 16 of the Convention [defining inhuman and degrading treatment].’”²²⁶

This year, CAT will be conducting its fifth periodic review and report of the United States of America and its compliance with the UN Convention against Torture. In its last review of the US in 2006, CAT’s report made a number of recommendations to the US government with regard to torture, including a concern they voiced over the use of electro-shock devices: “*restricting it to substitution for lethal weapons and eliminate the use of these devices to restrain persons in custody...*”²²⁷ In this year’s review by CAT, in their list of issues of concern, they again bring up the use of electro-shock devices and ask the government if they have restricted its use as a substitution for lethal weapons only, as recommended in CAT’s previous observations. And they ask point blank, “Are such devices still used to restrain persons in custody?”²²⁸ CAT has also asked for updated information on steps taken to “address the concern about the conditions of detention of children” with a particular emphasis on the use of excessive force.²²⁹ And finally CAT asks:

Please describe steps taken to end the practice of corporal punishment in schools, in particular of mentally and/or physically disabled students.²³⁰

This year, the United States human rights record is being scrutinized by the United Nations as part of a process known as “universal periodic review” under all the human rights conventions the United States has ratified. The United States report to the United Nations should include detailed information on the use of force against children with disabilities at JRC.

Since the United States legal system has failed to protect children and adults with disabilities, **MDRI brings this urgent appeal to the UN Special Rapporteur on Torture and recommends:**

- The UN Special Rapporteur on Torture should demand a full international accounting by the United States government of the abusive practices being perpetrated at the facility;
- The use of electric shock and long-term restraints should be brought to an immediate halt as a form of behavior modification or treatment;
- New federal law should be adopted to completely ban the infliction of severe pain for so-called therapeutic purposes in any context;
- Torture as treatment should be banned and prosecuted under criminal law.

Appendix 1 – Media Coverage of the JRC

Ed Cafasso, *Tragedy sparks 2nd ‘therapy’ probe*, The Boston Herald, June 24, 1987.

Gregory Witcher, *Therapy not blamed in BRI student collapse*, The Boston Globe, June 25, 1987.

Daniel Coleman, *A Panel Backs Punishment Therapy*, The New York Times, Sept. 14, 1989.

AP, *Autism school under fire after student dies*, Daily Hampshire Gazette, June 26, 1987.

Gregory Witcher, *Autistic student dies after cardiac arrest*, The Boston Globe, June 26, 1987.

Don Aucoin, *Former institute workers charge clients are often beaten, shocked*, The Boston Globe, Nov. 8, 1993.

David Armstrong, *State says school’s use of restraints violated youth’s human rights*, The Boston Globe, Feb. 10, 1994.

Tim Greene, *Gain worth the pain? Autistic institute’s methods come under attack*, Middlesex News, March 6, 1994.

Time Greene, *Behind the walls of BRI, Institute claims success with behavior therapy*, Middlesex News, March 7, 1994.

Tim Greene, *BRI founder, under fire, defends record*, Middlesex News, March 8, 1994.

Tim Greene, *BRI parents: strong praise, strong disdain*, Middlesex News, March 9, 1994.

Michael Lasalandra, *Group home OK’d despite death*, The Boston Herald, Feb. 16, 1995.

Michael Lasalandra, *Mom to lawmakers: End aversive therapy*, The Boston Herald, Feb. 23, 1995.

Connie Paige, *BRI shock treatment probed by lawmakers*, The Boston Herald, Feb. 24, 1995

Connie Paige, *Life inside an aversion therapy facility*, The Boston Herald, March 26, 1995.

Fred Hanson, *Bill to ban ‘aversive therapy’ backed*, The Patriot Ledger, April 9, 1996.

David Armstrong, *Improved facility faces doubts about monitoring*, The Boston Globe, July 28, 1998.

Scott Allen, *State checking burn claims at school, 10 complaints about shocks in past six months*, The Boston Globe, June 26, 2006.

Michele Morgan Bolton, *Therapy ban’s repeal sought, Controversial treatment is the best hope for some severely disturbed children lawsuit says*, Times Union, Aug. 22, 2006.

Rory Schuler, *Mistrust of center grows with title slips*, Tauton Gazette, Oct. 26, 2006, available at http://www.judgerc.org/NewsArticles/mistrust_of.html.

John Hilderbrand & Jennifer Sinco Kelleher, *Revamped punishment plan, State officials are expected to prohibit student discipline deemed emotionally or physically damaging*, Newsday, Nov. 29, 2006.

Bill Myers, *D.C. students sent to schools facing numerous abuse, neglect allegations*, The Examiner, Sept. 20, 2007.

TORTURE NOT TREATMENT

Bill Myers, *Therapists petition for no electroshock*, The Examiner, Dec. 17, 2007.

Bill Myers, *Aide: Kids will leave shock-therapy clinic*, The Examiner, Dec. 17, 2007.

Bill Myers, *Fenty aide says kids will be out of shock-therapy clinic*, The Examiner, Dec. 17, 2007.

Patricia Wen, *Prank led school to treat two with shock –Special ed center duped, report says*, The Boston Globe, Dec. 18, 2007.

Patricia Wen, *Rotenberg group home under scrutiny*, The Boston Globe, Dec. 20, 2007.

Patricia Wen, *Showdown over shock therapy, Testimony moves some critics; new bill would limit, not ban, treatment*, The Boston Globe, January 17, 2008.

Patricia Wen, *Parent details toll taken by shocks at group home*, The Boston Globe, Jan. 19, 2008.

Bill Myers, *Cops raid Massachusetts clinic where Virginia teen was shocked*, The Examiner, May 19, 2008.

Paul Kix, *The Shocking Truth*, Boston Magazine, Aug. 2008, available at http://www.bostonmagazine.com/articles/the_shocking_truth/.

Abbie Ruzicka, *Rotenberg Center director fined over clinicians' titles*, The Boston Globe, Oct. 7, 2009.

Sara Brown, *Rotenberg Center's controversial shock therapy on hot seat at State House Hearing*, The Patriot Ledger, Oct. 28, 2009.

Jay Turner, *House blocks latest attempt to restrict electric shocks at JRC in Canton*, Canton Citizen, Nov. 6, 2009, available at <http://cantoncitizenonline.com/072408/joyce.htm>.

Appendix 2—JRC Employee Confidentiality Agreement

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THE JUDGE ROTENBERG EDUCATIONAL CENTER, INC.

CONFIDENTIALITY AGREEMENT FOR EMPLOYEES

I am an Employee of the Judge Rotenberg Educational Center, Inc. ("JRC"). As an Employee, I understand that from time to time I will have access to confidential, proprietary, non-public information of JRC. This information may be received by me in verbal, written, or machine readable form and may include, without limitation, student records and other student related information, educational software, curriculum, business and financial information, technical information concerning JRC's graduated electronic decelerator device, business plans, trade secrets and other non-public data and information (collectively, "Confidential Information"). For purposes of this Agreement, the term Confidential Information shall be construed in the broadest possible manner.

As an Employee, I agree that (i) all Confidential Information shall remain the sole property of JRC; (ii) I will treat all such information as confidential and proprietary; (iii) I will make use of Confidential Information only for purposes directly related to the services I render as a Employee of JRC; and (iv) I will not disclose or disseminate any Confidential Information to any third parties without the express consent of the Dr. Matthew L. Israel. I further understand and agree that I will not remove any materials containing or incorporating Confidential Information from JRC's premises without the express permission of Dr. Matthew L. Israel.

Upon termination of my relationship as a Employee of JRC for any reason, I agree to immediately return all keys, pass cards, or any other property belonging to or leased or licensed by JRC, and all copies of all material containing any Confidential information which I have within my possession or control to JRC. I explicitly agree that the provisions of this Agreement will survive the termination of my consulting relationship/employment at JRC. Finally, I acknowledge that a breach of this agreement by me could result in irreparable harm to JRC. In addition to any other available remedies, in the event of a breach of this Agreement by me, I agree that JRC shall be entitled to injunctive and other equitable relief, and that JRC shall be entitled to recover the costs of enforcing its rights under this agreement, including reasonable attorneys fees.

Endnotes

¹ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General*, U.N. GAOR, 63rd Sess., Provisional Agenda Item 67(a), ¶ 69, U.N. Doc. A/63/175 (July 28, 2008).

² Matthew L. Israel, History of JRC, 1971 – 1985: Beginnings, Philosophy and Early Growth, *available at* <http://www.judgerc.org/history.html>. (last visited April 8, 2010).

³ Jennifer Gonnerman, *School of Shock*, 32 *Mother Jones*, 36, 41 (Sept.-Oct. 2007).

⁴ The number of students is an average taken from a legislative hearing.

⁵ Matthew L. Israel, Frequently Asked Questions, “Supplementary aversives at JRC—13. How is an aversive defined and which aversives are considered acceptable?” Judge Rotenberg Center, *available at* <http://www.judgerc.org/> (last visited April 8, 2010).

⁶ Matthew L. Israel, *supra* note 2, at 1971 – 1985: Beginnings, Philosophy and Early Growth.

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*, at 1971 – 1985: Beginnings, Philosophy and early Growth—No or minimal use of psychotropic medication.

¹¹ Matthew L. Israel, Distinguishing Features of the Judge Rotenberg Center, Judge Rotenberg Center, *available at* <http://www.judgerc.org/> (last visited April 20, 2010).

¹² Matthew L. Israel, *supra* note 5.

¹³ *Id.*

¹⁴ Matthew L. Israel, *supra* note 2, at 1971-1985: Beginnings, Philosophy and Early Growth, Near-zero rejection and expulsion policy.

¹⁵ *Id.*

¹⁶ *Id.* at 1971-1985: Beginnings, Philosophy and Early Growth, A complete treatment facility—i.e., not tossing the treatment problem to others when the problem becomes difficult.

¹⁷ NYSED Review Team, *Observations and Findings of Out-of-State Program Visitation Judge Rotenberg Educational Center*, New York State Education Department, Board of Regents, 5 (June 9, 2006) (*available at* http://boston.com/news/daily/15/school_report.pdf). [hereinafter “NYSED Review Team”]

¹⁸ MDRI Interview (2009).

¹⁹ NYSED Review Team (2006), *supra* note 17, at 5.

²⁰ *Id.*, at 4.

²¹ *Id.*

²² *Id.*

²³ Jennifer Gonnerman, *Nagging? Zap. Swearing? Zap.*, 32 Mother Jones, 36, 41 (Sept.-Oct. 2007).

²⁴ Matthew L. Israel, *supra* note 2.

²⁵ Sharon Lohrmann-O'Rourke and Perry A. Zirkel, *The Case Law on Aversive Interventions for Students with Disabilities*, 65 Exceptional Children 101 (Fall 1998).

²⁶ Matthew L. Israel, *supra* note 5, at "Is it true that one of the consequences JRC uses is to administer several GED applications, over a half-hour period during which a student may be restrained on a restraint board?"

²⁷ Patricia Wen, *Showdown over shock therapy testimony moves some critics; new bill would limit, not ban, treatment*, The Boston Globe 1 (Jan. 17, 2008), available at http://www.boston.com/news/local/articles/2008/01/17/showdown_over_shock_therapy/.

²⁸ Paul Kix, *The Shocking Truth*, Boston Magazine Online 3 (2008), available at http://www.bostonmagazine.com/articles/the_shocking_truth/.

²⁹ Patricia Wen (2008), *supra* note 27, at 1.

³⁰ Matthew L. Israel, *supra* note 5, at "The use of restraint as an aversive consequence."

³¹ Matthew L. Israel, *supra* note 5, at "Multiple Applications of GED Combined with Restraint as an Aversive."

³² Gregory D. Kutz, *Seclusions and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers*, US Government Accountability Office, GAO-09-719T 4 (2009).

³³ Matthew L. Israel, *supra* note 5.

³⁴ *Id.*, at "What aversives does JRC use, and what policies does JRC follow in using them?"

³⁵ *Behavior Research Institute v. Mary Kay Leonard* (Settlement Agreement), No. 86E-0018-GI (Mass. Super. Ct. Dept. of Trial Ct. and the Prob. Ct. and Fam. Ct. Dept. of the Trial Ct. Oct. 10, 1995)

³⁶ Daniel Goleman, *Embattled Giant of Psychology Speaks His Mind*, N.Y. Times, Aug. 25, 1987, at C1 and C3.

³⁷ New York Psychological Association Task Force, "Report of the New York Psychological Association Task Force on Aversive Controls with Children," 6 (August 22, 2006) [hereinafter NY Psychological Association Task Force].

³⁸ *Id.* Also, the National Disability Rights Network has documented the widespread use of restraints and seclusion in schools throughout the United States which has resulted in physical injuries, emotional trauma and even deaths.

National Disability Rights Network, *School is Not Supposed to Hurt: Investigative Report on Abusive Restraint and Seclusion in Schools* (January 2009).

³⁹ G.W. LaVigna and A.M. Connellan, *Alternatives To Punishment: Solving Behavior Problems With Non-Aversive Strategies* (1986). See TASH Statement on Positive Behavioral Approaches, http://www.tash.org/iRR/positive_behavior_supports.html; The Association for Positive Behavior Support <http://www.apbs.org/index.html>.

⁴⁰ NY Psychological Association Task Force (2006), *supra* note 37, at 1.

⁴¹ The New York Psychological Association leaves open the possibility that particular techniques of aversive intervention may be need if they are “medically necessary to protect the child from serious self-injurious or other-injurious behavior.” *Id.*, at 6.

⁴² The Alliance to Prevent Restraint, Aversive Interventions, and Seclusion (APRAIS) is a coalition of groups whose mission is “To seek the elimination of the use of seclusion, aversive interventions, and restraint to respond to or control the behavior of children and youth.” TASH is a member of the Alliance, available at <http://aprais.tash.org/index.htm> (last visited April 21, 2010).

⁴³ NY Psychological Association Task Force (2006), *supra* note 37, at 6.

⁴⁴ NYSED Review Team (2006), *supra* note 17, at 16.

⁴⁵ NY Psychological Association Task Force (2006), *supra* note 37, at 13.

⁴⁶ *Id.* at 11, *quoting* D. Day, “A review of the literature on restraints and seclusion with children and youth: toward the development of a perspective in practice” (2000), *available at* <http://rccp.cornell.edu/pdfs/Day.pdf> (retrieved July 26, 2006).

⁴⁷ *Id.*

⁴⁸ Frank L. Bird & James K. Luiselli, “Positive behavioral support of adults with developmental disabilities: assessment of long-term adjustment and habilitation following restrictive treatment histories,” 31 *Journal of Behavior Therapy and Experimental Psychiatry* 5, 7 (2000).

⁴⁹ Matthew L. Israel, *supra* note 5, at “there is extensive research and disagreement as to the efficacy of the use of aversives.”

⁵⁰ Bird & Luiselli (2000), *supra* note 48, at 18.

⁵¹ MDRI Interview (2009).

⁵² MDRI Interview (2009).

⁵³ NY Psychological Association Task Force (2006), *supra* note 37, at 3.

⁵⁴ *Id.*

⁵⁵ MDRI Interview (2009).

⁵⁶ TASH, TASH Resolution on Positive Behavioral Supports 1 (adopted Oct. 1981, revised March 2000), *available at* <http://www.tash.org/IRR/resolutions/res02behavior.htm> (last visited April 23, 2010).

⁵⁷ Matthew L. Israel., Use of Skin Shock as a Supplementary Aversive, Judge Rotenberg Center, para. 1 (2002), *available at* <http://www.judgerc.org/> (last visited April 21, 2010).

⁵⁸ Matthew L. Israel (2002), *supra* note 57, at 1990-date: Development of the GED and GED-4 Devices.

⁵⁹ *Id.*

⁶⁰ Certification Team, *Report of the Certification Team on the Application of the Judge Rotenberg Education Center for Level II Behavior Modification Certification*, Commonwealth of Massachusetts, Executive Office of Health & Human Services, Department of Mental Retardation 10 (April 27, 2009) (on file with author).

⁶¹ *Id.*

⁶² Jennifer Gonnerman (Sept.-Oct. 2007), *supra* note 3, at 41.

⁶³ Certification Team (2009), *supra* note 60, at 28.

⁶⁴ MDRI Interview (2009).

⁶⁵ MDRI Interview (2009).

⁶⁶ MDRI Interview (2009).

⁶⁷ NYSED Review Team (2006), *supra* note 17, at 7.

⁶⁸ Matthew L. Israel (2002), *supra* note 57, at Exhibit 203.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.* at “Development of the GED-4.”

⁷² M.G.L. c. 272, § 77.

⁷³ 1,000 milliamps equals 1 amp. The Physicals Factbook, Electric Current of a Stun Gun, *available at* <http://hypertextbook.com/facts/2004/LukeWorkoff.shtml> (last visited April 8, 2010). 1,000 milliamps equals 1 amp.

⁷⁴ Letter from Disability Advocates, Addendum to A Call to Action to Eliminate the Use of Aversive Procedures and Other Inhumane Practices 3 (Sept. 2009), *citing* The Boston Globe, April 28, 1995.

⁷⁵ Matthew L. Israel, *supra* note 5, at "Is it true that one of the consequences JRC uses is to administer several GED applications, over a half-hour period during which a student may be restrained on a restraint board?" See also, Jennifer Gonnerman (2007), *supra* note 3, at 38.

⁷⁶ Matthew L. Israel, *supra* note 5, at "Multiple applications of the GED skin shock."

⁷⁷ Matthew L. Israel, *supra* note 5.

⁷⁸ NYSED Review Team (2006), *supra* note 17, at 8.

⁷⁹ *Id.*

⁸⁰ MDRI Interview (2009).

⁸¹ MDRI Interview (2009).

⁸² MDRI Interview (2009).

⁸³ MDRI Interview (2009).

⁸⁴ MDRI Interview (2009).

⁸⁵ Matthew L. Israel, Optional Court-Authorized Intensive Treatment (Aversives), Films, Judge Rotenberg Center, available at <http://www.judgerc.org/> (last visited April 8, 2010).

⁸⁶ MDRI Interview (2009).

⁸⁷ MDRI Interview (2009).

⁸⁸ MDRI Interview (2009).

⁸⁹ MDRI Interview (2009).

⁹⁰ Certification Team (2009), *supra* note 60, at 32. See also, NYSED Review Team (2006), *supra* note 17, at 5.

⁹¹ NYSED Review Team (2006), *supra* note 17, at 6.

⁹² Certification Team (2009), *supra* note 60, at 32.

⁹³ *Id.*

⁹⁴ Matthew L. Israel, *supra* note 85.

⁹⁵ Matthew L. Israel, *supra* note 5, at "1. Is it true that at JRC a staff member will sometimes prompt a student to begin to engage in a problem behavior and then arrange an aversive for that? 2. Is there any professional support in the literature for that procedure?"

⁹⁶ NYSED Review Team (2006), *supra* note 17, at 19.

⁹⁷ *Id.*

⁹⁸ MDRI Interview (2009).

⁹⁹ NYSED Review Team (2006), *supra* note 17, at 10.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ MDRI Interview (2009).

¹⁰⁵ MDRI Interview (2009).

¹⁰⁶ MDRI Interview (2009).

¹⁰⁷ MDRI Interview (2009).

¹⁰⁸ NYSED Review Team (2006), *supra* note 17, at 24.

¹⁰⁹ MDRI Interview (2009).

¹¹⁰ MDRI Interview (2009).

¹¹¹ Jennifer Gonnerman (2007), *supra* note 62, at 46-47.

¹¹² MDRI Interview (2009).

¹¹³ NYSED Review Team (2006), *supra* note 17, at 14.

¹¹⁴ *Id.*

¹¹⁵ Greg Miller, *Response to Dr. Matthew Israel's letter entitled "Outrage Over Jennifer Gonnerman's Article, 'School of Shock,'"* (Sept. 4, 2007) (posted on Mother Jones comment blog for "School of Shock" article) *available at* <http://motherjones.com/politics/2007/08/school-shock?page=4>.

¹¹⁶ *Id.*

¹¹⁷ MDRI Interview (2009).

¹¹⁸ MDRI Interview (2009).

¹¹⁹ UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Oct. 21, 1994, art. 4(1), GA res. 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984), ratified by the United States 21 Oct 1994 (hereinafter Convention against Torture).

¹²⁰ International Covenant on Civil and Political Rights, art 7, GA res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc. A/6316 (1966), ratified by the United States 8 June 1992 (hereinafter Covenant on Civil and Political Rights).

¹²¹ Covenant on Civil and Political Rights, *supra* note 120, at art. 7.

¹²² Convention against Torture, *supra* note 119, at art. 2(1).

¹²³ Covenant on Civil and Political Rights, *supra* note 120, at art. 50 (“The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions.”).

¹²⁴ Manfred Nowak & Elizabeth McArthur, *The United Nations Convention against Torture: A Commentary* 54 (2008).

¹²⁵ Convention against Torture, *supra* note 119, Art. 4(1).

¹²⁶ Eric Rosenthal & Clarence J. Sundram, “International Human Rights in Mental Health Legislation,” 21 New York School Journal of International and Comparative Law 469 (2002) (providing an overview of international human rights law and the neglect of disability issues in advance of the UN Convention on the Rights of Persons with Disabilities).

¹²⁷ UN Convention on the Rights of Persons with Disabilities (CRPD), Dec. 13, 2006, G.A. Res. 61/106, U.N. Doc. A/RES/106, *entered into force* May 3, 2008, signed by the United States 30 July 2009.

¹²⁸ Convention against Torture, *supra* note 119, at art. 1(1).

¹²⁹ Nowak & McArthur (2008), *supra* note 124, at 77.

¹³⁰ *Id.* The distinction between torture and inhuman or degrading treatment was described by the European Commission of Human Rights in *The Greek Case*, Report to the Commission of 5 November 1969 (1969) XII Yearbook 186 (“The word ‘torture’ is often used to describe inhuman and degrading treatment, which has a purpose, such as obtaining of information or confessions, or the infliction of punishment, and it is generally an aggravated form of inhuman treatment.”).

¹³¹ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General* (2008), *supra* note 1, at para. 47.

¹³² Manfred Nowak, What Practices Constitute Torture?: US and UN Standards, 28 Hum. Rts. Q. 809, 832 (2006).

¹³³ Nowak & McArthur (2008), *supra* note 124, at 549.

¹³⁴ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General* (2008), *supra* note 1, at para. 77.

¹³⁵ Nowak & McArthur (2008), *supra* note 124, at 71, *citing* UN Doc. A/56/44 Sections 42-43.

¹³⁶ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General* (2008), *supra* note 1, at para. 61.

¹³⁷ Physicians for Human Rights, *Break Them Down: Systematic Use of Psychological Torture by US Forces* 1, 45 (2005).

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ NY Psychological Association Task Force (2006), *supra* note 37, at 10, *citing* D.M. Day, *Examining the therapeutic utility of restraint and seclusion with children and youth: The role of theory and research in practice*, 72 American Journal of Orthopsychiatry 234-233 (2002).

¹⁴¹ *Id.*

¹⁴² 514 C.M.R. § 5.14(3)(d)(4) (1987).

¹⁴³ Nowak & MacArthur (2008), *supra* note 124, at 73-74, *citing* the U.S. reservations, declarations, and understandings, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Cong. Rec. S17486-01 (daily ed., Oct. 27, 1990).

¹⁴⁴ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General* (2008), *supra* note 1, at para. 49.

¹⁴⁵ Nowak & McArthur (2008), *supra* note 124, at 74, *citing* Herman Burgers & Hans Danelius, The United Nations Convention against Torture: Handbook on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment 119 (2008).

¹⁴⁶ *Id.*

¹⁴⁷ Nowak & McArthur (2008), *supra* note 124, at 75.

¹⁴⁸ *Id.* at 75-76.

¹⁴⁹ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General* (2008), *supra* note 1, at para. 47.

¹⁵⁰ Matthew L. Israel, *supra* note 57, at “Mere Announcement of Court Approval to Use GED as an Effective Intervention.”

¹⁵¹ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General* (2008), *supra* note 1, at para. 49.

¹⁵² NY Psychological Association Task Force (2006), *supra* note 37, at 6.

¹⁵³ *Id.* at 5.

¹⁵⁴ Amnesty International, *Arming the Torturers*, ACT 40/004/1997 2 (March 4, 1997).

¹⁵⁵ Nowak & McArthur (2008), *supra* note 124, at 229; *see also* Dinah L. Shelton, Regional Protection of Human Rights 311 (2008).

¹⁵⁶ UN Committee Against Torture (CAT), *General Comment No. 2: Implementation of Article 2 by States Parties*, 24 January 2008, CAT/C/GC/2, para. 15, *available at*: <http://www.unhcr.org/refworld/docid/47ac78ce2.html> [accessed 16 April 2010].

¹⁵⁷ *Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General* (2008), *supra* note 1, para. 51. In the case of *Ximenes Lopes*, the Inter-American Court of Human Rights found a private psychiatric hospital liable under international law. 2006 Inter-Am. Ct. H.R. (ser. C) No. 149 (July 4, 2006).

¹⁵⁸ *Id.*

¹⁵⁹ *Ingraham v. Wright*, 430 U.S. 651 (1977).

¹⁶⁰ Human Rights Watch & ACLU, *Impairing Education: Corporal Punishment of Students with Disabilities in US Public Schools* 65 (2009).

¹⁶¹ National Disability Rights Network (2009), *supra* note 56.

¹⁶² Government Accountability Office (GAO), “Seclusion and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers,” 1 (May 19, 2009).

¹⁶³ Individualized Education Plans, 34 C.F.R. Section 300.346(a)(2)(i).

¹⁶⁴ Matthew L. Israel, *supra* note 5.

¹⁶⁵ 42 U.S.C. § 15009(a)(3)(B)(i-iii) (2000).

¹⁶⁶ *Pennhurst State School and Hospital v. Holderman*, 451 U.S. 1, 23 (1981).

¹⁶⁷ 115 C.M.R. § 5.14(1)(c) (1987).

¹⁶⁸ 115 C.M.R. § 5.14(1)(c) (1987).

¹⁶⁹ *Id.*

¹⁷⁰ 115 C.M.R. § 5.14(1)(b) (1987).

¹⁷¹ 115 C.M.R. § 5.14(1)(c) (1987).

¹⁷² 115 C.M.R. § 5.14(3)(d) (1987).

¹⁷³ *Behavior Research Institute et al v. Mary Kay Leonard*, No. 86E-0018-GI, 12 (Mass. Super. Ct. Dept. of Trial Ct. and the Prob. Ct. and Fam. Ct. Dept. of the Trial Ct. Dec. 12, 1986).

¹⁷⁴ 115 C.M.R. § 1 (1987).

¹⁷⁵ 115 C.M.R. § 5.03(2)(f)(9) (1987).

¹⁷⁶ GAO (2009), *supra* note 162, at 1.

¹⁷⁷ *Id.*

¹⁷⁸ 115 C.M.R. § 5.11(1) (1987).

¹⁷⁹ 115 C.M.R. § 5.11(6)(e)(3) (1987).

¹⁸⁰ 115 C.M.R. § 5.1..(6)(e)(4) (1987).

¹⁸¹ 115 C.M.R. § 5.1..(5) (1987).

¹⁸² *Id.*

¹⁸³ 115 C.M.R. § 2.01 Limitation of Movement (1987).

¹⁸⁴ *Id.* The definition of Limitation of Movement refers to two sections of law that do not exist. These two sections include section(d) Health-related protections; (See 115 CMR 22.22(1)(b), (2)((c)) and section (e) “Holds implemented in accordance behavior modification plans; (See 115 CMR 2.30; 5.10). Although section 2.30 does not appear to exist, section 115 C.M.R. § 5.11(7) “Behavior Plan” appears to cover this matter instead. ;

¹⁸⁵ 115 C.M.R. § 5.11(7) (1987).

¹⁸⁶ *Id.*

¹⁸⁷ 115 C.M.R. § 5.14(3)(d)(4) (1987).

¹⁸⁸ Certification Team, *supra* note 60, at 32.

¹⁸⁹ 115 C.M.R. § 5.05(g) (1987).

¹⁹⁰ Certification Team (2009), *supra* note 60, at 32.

¹⁹¹ *Id.* at 33.

¹⁹² See Appendix 2—JRC Employee Confidentiality Agreement

¹⁹³ MDRI Interview (2009).

¹⁹⁴ MDRI Interview (2009).

¹⁹⁵ MDRI Interview (2009).

¹⁹⁶ Letter from Disability Advocates, Addendum to A Call to Action to Eliminate the Use of Aversive Procedures and Other Inhumane Practices, 6 (Sept. 2009), *citing* Coalition for the Legal Rights of People with Disabilities, 6 The Communicator 1 (1995).

¹⁹⁷ *Id.*

¹⁹⁸ Matthew L. Israel, *supra* note 2, at “1985-1987 Failed Attempt by Office for Children to Close JRC.”

¹⁹⁹ *Behavior Research Institute v. Mary Kay Leonard*, Sup. Ct. Dept. of the Trial Ct., and Prob. and Fam. Ct. of the Dept. of the Trial Ct., Docket No. 86E-0018-GI, Settlement Agreement, (December 12, 1986). Under the settlement agreement, aversive procedures are only permitted with a court-ordered “substituted judgment” treatment plan. In presenting requesting a court-ordered “substituted judgment” treatment plan, the petitioner must show (1) the client’s inability to provide informed consent and (2) “target behaviors” to be treated; what procedures will be used to treat the target behaviors; foreseeable adverse side-effects; professional discipline of staff members; prognosis should the procedures be implements; opinions of the client’s family; client’s previous treatment at BRI or elsewhere; description of appropriate behaviors; client’s IEP. The settlement agreement requires a monitor to report to the court on the client’s treatment. The court will also appoint a doctor to oversee BRI’s compliance.

²⁰⁰ *Id.*

²⁰¹ *Behavior Research Institute et al v. Mary Kay Leonard*, No. 86E-0018-GI, 12 (Mass. Super. Ct. Dept. of Trial Ct. and the Prob. Ct. and Fam. Ct. Dept. of the Trial Ct. Dec. 12, 1986).

²⁰² Jennifer Gonnerman, *Why Can’t Massachusetts Shut Matthew Israel Down?* 32 *Mother Jones* 36, 44 (Sept.-Oct. 2007).

²⁰³ *Behavior Research Institute, Inc. v. Philip Campbell*, No. 86E0018-GI, 5 (Mass. Super. Ct. Dept. of Trial Ct. and the Prob. Ct. and Fam. Ct. Dept. of the Trial Ct. Oct. 10, 1995).

²⁰⁴ *Judge Rotenberg Educ. Ctr. v. Commissioner of the Dep’t of Mental Retardation (No. 1)*, 424 Mass. 430, 450-451 (1997).

²⁰⁵ *Id.* at 459.

²⁰⁶ Rick Karlin, *Regents set to reject use of electric shock*, Albany Times Union, January 9, 2007.

²⁰⁷ *Jeanette Alleyne v. N.Y. State Educ. Dep’t*, No. 1:06-cv-00994-GLS (N.D.N.Y 2010) (memorandum-decision and order to the parties).

²⁰⁸ NYSED Review Team (2006), *supra* note 17, at 2-3.

²⁰⁹ *Id.*

²¹⁰ NYSED Review Team (2006), *supra* note 17, at 11.

²¹¹ Massachusetts Office of Consumer Affairs and Business Regulation, “Judge Rotenberg Center clinicians fined \$43,000, Consent agreement with Board of Psychologists Reached,” Oct. 9, 2006, *available at* <http://www.arcmass.org/AversivesPress/tabid/592/Default.aspx#JRCfine>

²¹² Abbie Ruzicka, *Rotenberg Center director fined over clinicians’ titles*, The Boston Globe, October 7, 2009.

²¹³ Investigation Report, Massachusetts Department of Early Education and Care 4, November 1, 2007.

²¹⁴ Certification Team (2009), *supra* note 60, at 10.

²¹⁵ *Id.* at 11.

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.* at 12.

²¹⁹ *Id.* at 19-20.

²²⁰ *Id.* at 21.

²²¹ *Id.* at 23.

²²² *Id.* at 31.

²²³ *Id.* at 32.

²²⁴ *Id.* at 33.

²²⁵ Nowak & MacArthur (2008), *supra* note 124, at 76-77.

²²⁶ Committee Against Torture, Conclusions and Recommendations of the Committee against Torture: United States of America, 15 May 2000, A/55/44, para. 180(c).

²²⁷ Committee Against Torture, Conclusions and Recommendations of the Committee Against Torture: United States of America, 18 May 2006, CAT/C/USA/CO/2, para. 35.

²²⁸ Committee Against Torture, List of issues prior to the submission of the fifth periodic report of UNITED STATES OF AMERICA 9, 20 Jan. 2010, CAT/C/USA/Q/5.

²²⁹ *Id.*

²³⁰ *Id.*