Addendum To SAFE Report Prepared by ISAC

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List of Documents Submitted by ISAC as Evidence to Support our Complaints Against SAFE

I. Fax Transmittal Sheet

This is dated 12/93. This sheet indicates that clients began calling HRS and complaining about SAFE as early as 1993.

II. Letter from Scott Partin

This letter, dated June 2000, is from Scott Partin, a correctional probation officer. The letter indicates that SAFE hired a convicted felon, on probation at the time, for the position of peer counselor.

III. Criminal Record of Weaver Hastings

IV. Brian Seeber's interview with ISAC

According to his own statement to ISAC, Mr. Seeber has no previous experience with drug addiction or drug abuse counseling. He was an attorney for the previous 25 years, specializing in bankruptcy cases.

V. SAFE Organizational Chart

VI. Staff Signature – Credentials List

VII. Staff Credential Sheet

Most treatment centers have a MINIMUM requirement that employees are certified as a psychiatric technician and that the certification is from an accredited school. This psychiatric technician certificate also includes a certified nursing assistant certification. SAFE does not require any certification for even the higher positions of staff including Executive Director where no degree is indicated.

Note the following lack of credentials and experience of the people holding various positions at SAFE:

Program Supervisor – Nothing Beyond a High School Diploma. It is beyond our comprehension that the program supervisor of a drug treatment facility possesses no credentials other than a high school diploma.

Host Home Coordinator and Counselor Assistant – Nothing Beyond a High School Diploma. The host home coordinator is responsible for inspecting and placing children in host homes, also known as foster homes. However, this person holds no degree in social service, instead ONLY possesses a high school diploma.

Counselor Assistant For Aftercare – Nothing Beyond a High School Diploma

Senior Staff – Nothing Beyond a High School Diploma

Clinical Records – Nothing Beyond a High School Diploma
Most medical facilities and treatment programs require a medical records certificate or a unit clerk certificate from an accredited school in order to qualify for this position since this position requires familiarity with legal issues concerning patient records and more.

Medical Director –The Medical Director at SAFE is a licensed M.D., however; he is listed as an internist with no specific experience in substance abuse or the medications associated with such a diagnosis. His state information license sheet states that he has not had the responsibility of graduate medical education within the last ten years and does not hold any appointments at any medical/health related institutions of higher learning. It further indicates that he holds no committee appointments or memberships with any health related entity, has received no community service awards, has authored no publications and has no other community affiliations.

The tax returns for SAFE clearly state this medical doctor as being a PART TIME employee, despite the fact that over 80% of the clients at SAFE are taking daily prescription medications for the first time. The majority of the clients are between the ages of 13 and 17. It is important to note that some of these clients have existing medical conditions such as high blood pressure.

VIII. Jean Richardson –Resume

IX. Jean Richardson –Degree A

X. Jean Richardson –Degree B

The resume for Ms. Richardson indicates a bachelor's degree in General Studies and a Doctor of Psychology degree, however she has no previous experience with drug and alcohol addiction with the exception of her time at Straight, Inc.

XI. Timothy Field –Resume

XII. Timothy Field –Degree

The resume of Mr. Field shows his only degree to be a Master of the Arts of Biblical Studies. The resume shows no previous experience in the field of drug abuse treatment.

XIII. Michael Scaletta –Resume

Mr. Scaletta was the original Executive Director of SAFE. His resume indicates that his only experience with drug abuse treatment was gained during his employment at Straight, Inc.

XIV. Loretta Parrish – Resume

Ms. Parrish was the Marketing Director at Straight, Inc. She has no previous experience or degree concerning drug or alcohol addiction. Ms. Parrish served as Executive Director of SAFE, despite her lack of experience and education in the area of drug abuse treatment.

XV. Practitioner Profile of Frank Elaty

XVI. Newcomer Progress Report

This progress report is dated 5/99 and is signed by C. Beasley. According to the staff credentials sheet, Ms. Beasley holds no degrees whatsoever. C. Beasley also filled out the school section of the progress report.

This is consistent with many of the progress reports in our possession. Individuals with no previous experience or education in the field of substance abuse write most progress reports at SAFE. NONE of the newcomer progress reports were filed out by a qualified doctor, despite the fact that clients were on medication, many for the first time. We have no evidence of the staff monitoring the medication. We have no indication that any review of the effects of such medication ever took place.

XVII. Letter From Parents A:

A letter dated 5/99 is from parents and was intended for their child, then a client at SAFE. This letter was not given to the client. It was returned to the parents with a handwritten note stating that parental communication with the child is prohibited. The note was signed “C. Beasley.”

XVIII. Letter From Parents B:

This letter explains the concerns of a parent regarding their child, a client at SAFE at the time. It also indicates that the parents made arrangements to put him in another facility to ensure he was correctly monitored while weaned off the medication given to him while at

SAFE. It appears that the staff of SAFE hindered the parents efforts to withdraw their child, since the parents had to "plan out" a way to remove their child from SAFE.

XIX. Client's Chronology

This letter details a client's stay at SAFE. Items of importance are as follows:
Kids Helping Kids recommended SAFE and called it a "similar program." Kids Helping Kids is also under investigation by us and is considered a Straight-like program since it too is a direct descendant of Straight, Inc.

The parents state they were promised weekly progress reports on their child but had difficulty obtaining them from the staff of SAFE.

The parents state their son as being "addicted" to a variety of substances, however SAFE has no detoxification facility.

The client reports NEVER attending school while in SAFE, despite the counselor reporting he was doing well in school. The parent was denied access to their child during this visit.

The staff of SAFE never told the client that his/her parents had moved to a nearby location.

The parents report being denied access to their child for over two months. A staff member at SAFE told them to "rip" their child. The parents report that their son had socks on his hands to prevent him from carving on his arms. However, there was no progress report to this effect, or any evaluation by a certified counselor. SAFE's solution to self-injury was to force the client to wear socks on his hands.

What follows are the findings of Steven Levenkron, well known psychotherapist in New York City and the author of seven books. His work is widely acclaimed as original and groundbreaking in both the theoretical conception and clinical treatment of Anorexia Nervosa, Self-Mutilation, and Obsessive Compulsive Disorder. Levenkron believes child abuse is often the reason behind self-injury. In the case of this client, SAFE has assumed the role of "parent."

> Introduction
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> The greatest fear we all carry within us is the fear of self. We worry about losing our temper, about our violence emerging and hurting others – especially those we love the most. Regularly in television and newspaper accounts we learn of husbands beating or murdering their wives, of parents beating or killing their children. Such news sends a shudder through us all. We don't want to believe that members of our own species are capable of such terrible acts.
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> Just as we fear the human potential for violence against others, we may also fear the possible impulse to hurt ourselves. When we see the wounds or scars of a cutter, do we,

just for an instant, fear that we could harm our own skin by attacking it with a sharp instrument? The act of deliberately causing oneself to bleed frightens us in many complicated and varied ways. Clearly, people who harm themselves create in us a very uncomfortable mix of fear, guilt, anger, and frustration.

Chapter 1

In order to understand and treat self-mutilators, we have to understand enough about ourselves so that we can become effective in helping those who feel abandoned, without confusing our own fears with theirs. Each self-harming person has a different history, a different motive, and a different state of mind before, during and after harming themselves. As their helpers, we will have to overcome our own feelings of discomfort.

Self-mutilation is a truly gruesome behavior. It is the extreme nature of these external acts of self-harm that causes us to consider them worthy of psychological examination, and urges us to uncover the mental and emotional desperation they suggest. When the self-mutilator cuts himself, he is usually in a trance state, seeking out the pain and blood. He is far less concerned with the resulting change his skin will undergo. Self-mutilators do not plan their activity, but are overtaken by a compulsion to commit these acts, which are not about conscious intent. For the self-mutilator, it is the experience of physical pain – for its calming effect on his more painful physiological state – that is being sought.

In the most severely pathological firms, self-mutilation can be classified using the following diagnostic criteria:

- Recurrent butting or burning of one's skin
- A sense of tension present immediately before the act is committed.
- Relaxation, gratification, pleasant feelings, and numbness experienced accompanying the physical pain.
- A sense of shame and fear of social stigma, causing the individual to attempt to hide scars, blood, or other evidence of the acts of self-harm.

Of course, what is not mentioned here (and usually isn't in the psychiatric definitions) is "Why does such disordered behavior happen?" "What does it mean?" and "What does it tell us about other coexisting personality or mood disorders?"

As in the case of so many other disorders, and features of those disorders, the answer to these questions is that we don't know without understanding much more of the individual than just these acts of cutting or self-harming alone.

Our first task, then, is to interpret the act of self-mutilation. Is it a love of pain? Does the cutter enjoy pain? Is this like masochism, where the pain alone is the end in itself? No. Self-mutilation is different. We have to put ourselves inside the mind of a cutter to comprehend the personal value and meanings that pain holds for him.

Most self-mutilators give explanations about the "rewards" of such behavior. This suggests that somewhere in the past, pain was somehow connected to the idea of home and comfort. These kinds of associations – pain with comfort – are alien to most of us. But it is important to remember that people will generally seek the familiar, the repetitious, rather than what is new and constructive. If the familiar happens to be painful

or harmful, that rarely stops someone from seeking it out. Otherwise, we would never do what is not in our own best interest – especially during those times when we are aware that it's not with regard to our own health, welfare, financial well-being and healthy relationships. When the familiar is grotesque, a person seeks out the grotesque. We call such behavior a disorder.

Chapter 2:

The concept of cutting into our own skin, of feeling relief at both the pain and the sight of blood, seems totally alien to us. Relieving ourselves of pain is usually done with the help of something tranquilizing or anesthetic, not more painful. It seems paradoxical to utilize a great pain for relief from pain, paradoxical to use the sight of one's own blood for relief. Yet that is precisely the mechanism of relief for those whose world is one of choices between one kind of pain or another.

There are many explanations for how an individual develops such peculiar and limited choices. But all consist of scenarios that are radically different from most healthy childhood experiences, feelings and development.

As I've already stressed, we all seek the familiar. If we are lucky, the familiar experiences of our past are pleasant, supportive, kind, and caring. If we are unlucky, they are neglectful, insensitive, punishing, and abusive. As children, we are incapable of making judgments about the adults in our lives and how they treat us. We never decide that our parents or primary caretakers are wrong. If they are wrong, then we have no competent parents and are in effect abandoned. Fear of abandonment is the greatest fear a child has. It far supercedes the fear of death, which, to a child, is an abstraction at best.

If a child could designate a parent's act as "wrong," then the child would have to accept that he or she has an incompetent parent. This is the emotional equivalent to having no parent at all. And because parents are a child's only protection, having no parent means losing that protection and its sense of safety.

If a child's experience with his parents is uncomfortable, neglectful, or painful, the child accepts the pain and assumes that his parents behavior is justified because they must be "right." He has only himself to blame for the fault of failing to adjust to the pain, because the pain must be right. Think, for example, of the verbally abused child who is told that he's stupid and worthless. The painful verbal abuse becomes familiar, reliable, part of home. As the small child develops into an older child, an adolescent, and then a young adult, he needs his parents' protection for the world less and less. It is then his job to recreate the pain that guided him through his early life, the pain that means home, safety, and comfort.

This is an example of a pathological distortion of the superego, or conscience. The child has grown into a young person whose associations and meanings for everything in his world have been malformed by his earliest experiences. Although most of us can only comprehend his mode of thinking as backwards, or messed up, it is in fact, tragically, the most logical result of his childhood.

Like other disorders that result from failed trust relationships and attachments – eating disorders, obsessive-compulsive disorders, alcoholism, drug dependence – a behavior or a substance is used as a coping mechanism for the pain of the original wound. Self-

mutilation is just the most bizarre and paradoxical example, in which pain and self-damage are used to bring about relief, safety, and security.

The self-mutilator is very sensitive to his emotional pain, but even more than that, he is despairing of the trustworthiness of others. He prefers to be the one in charge of the pain he experiences and the feeling of numbness it leaves him with.

Chapter 3: Who is the self-mutilator?

How much resolution does it take to break the skin and draw blood? The nerves of the skin send pain signals to the brain to warn us of the danger from an impending injury. In the case of self-inflicted wounding, this pain acts as the body's own defense mechanism to stop one from proceeding in the effort at physical injury. If a person proceeds despite this pain, it means that he is motivated by something stronger than the pain, something that makes him capable of ignoring or enduring it.

What priority exists for the cutter which allows him to bypass his body's own defenses and ignore the pain? For the cutter, the act of creating pain (if pain is even experienced) or the drawing of blood, is in itself, the goal. The cutter must have experienced her own necessities, urgencies, and dangers on an emotional level. The self-mutilator is reacting to internal feelings – perhaps an event from the past or a collection of events, a buildup of angry or hurt feelings, or any combination of the above. The self-injurer may not even be aware of what she is doing to herself; and as for reasons, these most likely elude him as well. However, he does have his own goal – an urgent and immediate one.

So, what is this goal? His act solves no tactical problem for himself or for others; therefore we understand that he must be reacting to feelings within himself. By physically injuring himself, she is redressing existing grievances or pain symptomatically. This concept might strike us as ludicrous, treating one type of pain with another, but that is exactly what he is doing; that is his goal.

The option that he is not embracing – the one that is much with familiar to most of us – would be to take real verbal action and begin to bring his pain outside himself, where it could be diffused, shared, examined. Confronting an injustice usually relieves the tension that has built up inside. It is the way to achieve understanding. In the symptomatic or "substitute" method, the cutting never really puts the feelings of being hurt to rest, but rather provides only short-term relief. Thus, taking this route leads not only to a buildup of bad feelings, but also to an addiction to method itself for the short-term relief it provides.

The self-injurer turns increasingly inward, away from others, abandoning any real emotional connection, This "inward turning" is bound to reduce the sense of relation to others, or interpersonal reality, and eventually reduces the accurate sense of reality in general. This we call psychopathology or mental illness.

Why Self-Mutilation?

Self-mutilators have many different reasons for their actions and are tormented by a spectrum of different feelings. Yet, two characteristics are consistently encountered in all self-mutilators:

1. A feeling of mental disintegration, of inability to think.
2. A rage that can't be expressed, or even consciously perceived, toward a powerful figure in their life, usually a parent.

For the cutter, the experience of one or both of these feelings is unbearable and must therefore be "drowned out," as they report, by some immediate method. Physical pain and the sight of oneself bleeding become the solution because of their ability to overpower the strength of these feelings.

An Attempted Solution to Emotional Pain

Usually, the first incident begins with strong feelings of anger, anxiety, or panic. If the feeling is not too intense, throwing an object or knocking something over, may settle the person down. It's when the person becomes so overwhelmed that none of these remedies help that we may see them plunge a fist into a wall or through a window, bang their head against the wall, or finally take a weapon to use against themselves.

Someone who stumbles upon self-injury in this manner and discovers that it relieves one of the painful states listed above will be inclined to use this discovery again in the future. The individual who needs this kind of solution is a person who cannot redress the grievances he has with others, who is afraid to argue, to articulate what he is so angry about. The self-mutilator is ashamed of the mental pain that he experiences and has no language with which to describe it to others.

However they come to it, the self-mutilator is someone who has found that physical pain can be a cure for emotional pain. It is someone who, for one reason or another, has absolutely no outlet for his emotional pain, and therefore no relief from it. All he has is that short period of time when it is temporarily overpowered, "drowned out," by physical pain.

When a person attacks his own body with an instrument that will wound the skin, and often worse, it means that the person feels helpless to use any other means to manage the mental anguish and chaos that is borne out of unmanageable feelings. This goes far beyond frustration. Self-mutilating behavior means the mind has slipped away from its ordinary context or perspective, losing sight of the impracticality of pain and danger in order to commit an act that will bring immediate solution (however unrealistic or temporary in nature) to emotional pain.

Parental Behaviors that Influence Self-Mutilation

Parental aggression toward the "troubled" child will cause the child to be simultaneously protective of and afraid of displeasing her parents. This is a form of child abuse that can range from moderate to severe – one that leaves a child first with no one to blame, and then with no one to retaliate against, except himself. Usually, the self-blame builds up for years before the self-retaliation (in this case, cutting) begins. Healthy parenting does not produce a self-mutilating child."

Source: Cutting by Steven Levonkron, published 1999.

The client reports being kept in isolation on a daily basis.

The parent reports their 13-year-old child was prescribed medication while at SAFE. The dosage was twice that of the recommended dosage for an adult. The clinical staff at SAFE did not review this prescription and the client's blood pressure was not monitored after he began taking this medication. The staff at SAFE had already been informed of the child's pre-existing high blood pressure. This medication is also contradicted in patients who have a history of drug abuse.

The parent reports the child was put on additional medication without the parent's knowledge or consent. The staff at SAFE did not monitor the effects of this medication.

Client reports being placed in isolation and "black out," No one was allowed to speak to him and his sanitary items were withheld. Client reports he had no outside privileges and he was suffering from sleep deprivation. A skin condition developed due to the lack of sanitary items. Sanitary items and the chance to go outdoors are given to even the most hardened criminals in our justice system but not to these children who have been convicted of nothing.

The parents report that upon removing their son from SAFE and sending him to Fairwinds Treatment Center, the child was diagnosed with Post Traumatic Stress Disorder. This diagnosis is such that one must suffer a traumatic experience over a period of time severe enough to cause more than acute symptoms.

The parents state that even though their son had reported being been sexually assaulted at SAFE, the staff NEVER reported this to the parents or the authorities.

This statement from parents regarding over-medication, isolation, etc. at SAFE is typical of the statements we posses from clients and parents alike.

XX. Email from Parent

This email states attempts were made by parents to report SAFE to DCF but the parents were ignored. The parent mentions nightmares, which can be symptomatic of PTSD.

XXI. Excerpt from Parents Web Page

This details the physical and psychological abuse inflicted by SAFE and the subsequent consequences to the parent and child. 2001

XXII. Letter to a Judge, Written by a SAFE Parent

This letter is dated 12/1999 and is a very detailed account of the problems occurring in SAFE. This document includes an attachment by the parent titled "A Short List, Sample Of SAFE Rules."

XXIII. Letter Outlining the Condition of a Child

This letter addressed to Richard, states SAFE gave a 13-year-old child more drugs than he had used prior to entry into SAFE. The letter also explains that the child was immediately placed in the Fairwinds treatment facility upon leaving SAFE. At the Fairwinds treatment facility, the child was placed on a "danger watch" due to the high levels of Adderall in the child's body. This can be further verified through the medical records at Fairwinds.

XXIV. Email from one SAFE Parent to another Parent

This email details the frustration and concerns of one parent regarding the treatment at SAFE.

XXV. Parent-Staff Communication

This details the concerns of a parent after discovering their child was given medication by SAFE without their knowledge or consent.

XXVI. Family Weekend Rules

This details the rules imposed on parents during this weekend.

XXVII. EM Progress Note A

This progress report details the dosage of Adderall given to the client. This dosage is above what we have come to understand as acceptable. The progress reports obtained by ISAC were written on a monthly, and in some cases bi monthly, basis. It appears that this is the only time the client's blood pressure was checked. It further states that although SAFE was placing the child on Paxil, the case would not be reviewed for another six weeks. This client was approximately 13 years old and had a history of high blood pressure. This progress note also states that the patient was unable to speak to the doctor alone, instead a SAFE staff member accompanied the client. This is very suspicious, since it would hinder the client's ability to speak freely with the physician and prevent the client from reporting abuse.

XXVIII. EM Progress Note B

This progress notes states that the staff of SAFE discussed the risks and benefits of trying a psycho stimulant with a client. It further states that the client **agreed to take the medication.** The client referred to here was **13 years old**. This is beyond negligence. A 13 year old does not have the legal ability, knowledge, or the maturity to agree to an experimental medication. The report makes no mention that the use of this trial

medication was discussed with or approved by the parents of the client. The progress note clearly states that the PATIENT will update SAFE in a week with details pertaining to his tolerance to the medication and the progress of the medication trial. The note also states that SAFE staff member will reevaluate the patient in **four to eight weeks.**
According to records obtained, this client was prescribed 60 mg of Adderall daily upon his first visit with SAFE's doctor.

XXIX. Drug Information Data Sheet

Relevant information in this document is underlined for the reader/researcher.

XXX. Orlando Weekly Newspaper Article

XXXI. Corporate Papers for Information Systems Analysis and Design, Inc.

Note: The criminal record of Weaver Hastings, included and listed on Page 1 of this addendum, is supporting evidence for this statement as well.

This Florida Corporate record indicates that Brian Seeber, Attorney and Executive Director of SAFE, is the agent for this business. The President is none other than Weaver Hastings - convicted felon, former staff member of SAFE and recently arrested for heroin possession. This speaks to the poor judgment of Mr. Seeber. It also raises the question of why the Executive Director of a drug treatment facility is in business with a convicted felon whose past crimes include 2 counts of uttering a forged instrument and whose current charges include possession of heroin. Mr. Seeber is in charge of the lives of many children and we question his credibility and judgment. It is typical of SAFE to appoint people who hold no qualifications and/or experience and lack professional judgment as executive director.

XXXII. Authorization for Treatment of Minor – Also Referred to as Contract for Treatment and Intake Document

Sections 2 and 3 state all program rules and policies have been explained, however, the rules do not list isolation and denial of sanitary items as punishments used by SAFE. This document also fails to mention that some of the staff members may not have the expected qualifications to treat substance abuse.

Section 4 states one of the causes of termination from the program is the conviction of a felony, however SAFE does not tell the client or parents that convicted felons can and may be hired as staff members.

Section 5 addresses the issue of Voluntary Withdrawal from SAFE. During our interviews with many SAFE clients, we have never come across anyone who was able to "voluntarily withdraw" him or her self. Former clients have told ISAC the only response

they ever received after submitting a "Chain of Command" requesting withdrawal were instructions to resubmit the request because the original one had been "lost." We have presented evidence with this addendum showing that even parents had difficulty removing their own child from the program.

The Statement of Understanding states "clients are not to hit, grab, hold, tackle, etc. other clients. I understand that there are no circumstances in which it is acceptable for me to physically intervene with another client." However, we have presented evidence to the contrary in our report along with statements from parents and former clients who state physical intervention as being common practice at SAFE. This practice is also very evident on the video shown by Miami television station WAMI.

Section 16 States contradicts The Statement of Understanding. This section states "There may be times when employees, host parents, agents, etc. may have to restrain, hold or otherwise use acceptable means of physical restraint." Section 16 further states that any of its agents, SAFE or Associated Counseling shall not be held liable for the results of any such restraint. If restraint were used properly and with just cause, there would be no need for this kind of concern for liability. The indemnity clause however, does NOT release SAFE from liability if they act in a negligent manner. Aside from attempting to mislead parents and clients about legal liability, we see no purpose for this clause to be present in such a document.

Section 17 states "client may accidentally or intentionally self inflict injuries." This leads parents to believe this behavior to be "normal" behavior during the substance abuse recovery process. We are not aware of any qualified counselor who believes this behavior is "expected" during the course of treatment. This section is another attempt to convince clients and parents that no matter what happens to clients while in SAFE, clients and parents cannot sue SAFE, Associated Counseling, staff members, host homes, etc. ISAC believes SAFE could instead lower their risk of lawsuits or liability by hiring qualified personnel, understanding the treatment model they use, thoroughly investigating the information they give to clients, and following state and medically ethical guidelines.

XXXIII. Interview with Brian Seeber

Brian Seeber removed his previous answer to our question regarding strip searches. Mr. Seeber did state that he reads Miller Newton's book Gone Way Down to clients and has personally read it over 100 times. In the Orlando Weekly newspaper article, which we have included, Mr. Seeber clearly stated that the treatment methods at SAFE are based on this book.

This is very alarming to ISAC. SAFE insists they cannot be compared to Straight, Inc. yet the executive director uses teaching material that originated at Straight, Inc. This material is read to clients and the treatment method at SAFE is based upon it. The fact that Mr. Seeber chooses to use material written by Miller Newton indicates a positive view of Miller Newton's treatment methods. This is why information regarding Miller Newton is included in this addendum. Mr. Seeber stated he was not familiar with Miller Newton

when he read Newton's book. We take issue with that statement. It is the responsibility of the staff at SAFE to insure that the material presented to clients is credible and accepted in the substance abuse field.

We are enclosing our report on Miller Newton. We want to inform the researcher/investigator of the origin of the material being used at SAFE, its lack of credibility and the numerous controversies surrounding it and its creators – Straight, Inc. and Miller Newton.

Mr. Seeber also admits knowledge of the fact that Miller Newton's method of diagnosing drug abuse and Newton's approach to treatment (Four Stages of Drug Addiction) are not medically approved nor listed in the DSM IV. This means SAFE has used Miller Newton's creation, the "Four Stages of Drug Addiction," to diagnose clients and influence admissions to SAFE, despite the fact that Miller Newton has no credibility in the field of drug treatment.

Miller Newton, now Father Cassian Newton, will soon be named on a website which lists abusive priests and is in the process of losing the title of "Father."

It is vital that the researcher/investigator understand to what extent SAFE uses Miller Newton's approach. Recently an ISAC investigator phoned SAFE and talked with a staff member regarding a teenager who came home late one night without telling his parents where he had been. The junior staff member who took the phone call (and who possessed nothing beyond a high school diploma) immediately diagnosed the potential client with "Stage 2 drug addiction" and insisted that if we did not bring the child to SAFE soon, he would progress quickly to Stage 3, then die in Stage 4.

In the opinion of ISAC, SAFE is negligent in its use of a treatment model that originated at Straight, Inc.

XXXIV. Miller Newton Collection

XXXV. Investigative Contact List

XXXVI. Depositions of Civil Suit – Case Number 6:01-cv-1489-Orl-31JGG –Not Included in this Addendum but Available in Ninth Judicial Circuit Court Orange County, Florida

XXXVI. Three Statements from Parents and Survivors.