

Information Summary and Recommendations

Behavior Analyst

Sunrise Review

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THE SUNRISE REVIEW PROCESS

A sunrise review is an evaluation of a proposal to change the laws regulating health professions in Washington. The Washington State Legislature's intent, as stated in chapter 18.120 RCW, is to permit all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. Changes to the scope of practice should benefit the public.

The Sunrise Act (RCW 18.120.010) says a health care profession should be regulated or scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions, and criminal prohibitions are not sufficient to eradicate existing harm.
2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business, when a service being performed for people involves a hazard to the public health, safety or welfare.
3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act (chapter 18.130 RCW).
4. *Certification.* A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.¹ A certified person is subject to the Uniform Disciplinary Act.
5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act.

¹ Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement such as nursing assistants-certified, home care aides, and pharmacy technicians.

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EXECUTIVE SUMMARY

Background and Proposal

Central Washington University describes applied behavior analysis (ABA)² as “a systematic approach to the assessment and evaluation of behavior, and the application of interventions that alter behavior.”³ Although ABA is not a therapy or treatment for any disease or condition, it has been proven to be effective in promoting the health and well-being of children with autism spectrum disorders (ASD)⁴ and other conditions. The goal of ABA is to decrease unwanted or harmful behaviors and increase positive behaviors. ABA is practiced in a variety of settings including hospitals, clinics, private homes, schools, nursing homes, group homes, and businesses. ABA providers often work as part of a team of health care providers, consulting with others, such as physicians, mental health providers or speech-language pathologists.

A patchwork of ABA provider requirements currently exists solely for insurance reimbursement for ASD and other conditions. Because no specific ABA credential exists in Washington, some providers have obtained counseling or other health care credentials to meet requirements of insurers who cover ABA services.⁵ Medicaid reimbursement requires a state license for medically necessary treatment of ASD and other developmental disorders. The Health Care Authority (HCA) and Department of Social and Health Services (DSHS) regulations for ABA services include credentialing and referral requirements.⁶

This system provides some level of public protection for individuals using ABA services covered by insurance because the providers must meet minimum credentialing qualifications and are subject to background checks and regulatory oversight. Private pay clients of ABA providers, however, do not have the same protections. In addition, there are waiting lists to access ABA services and the current system limits some qualified providers from practice. These are individuals with master’s degrees in education and specialized ABA education and training, many with national certification to provide ABA, who do not qualify for a mental health counselor or other counseling credential.⁷

In May of 2014, the Chair of the House Health Care and Wellness Committee asked the Department of Health (department) to conduct a sunrise review of a proposal to license behavior analysts as a new and distinct profession. The legislative request included draft bill H-4577.1, which would require licensure for some behavior analysis providers.⁸ The Washington Association for Behavior Analysis (applicant) contends that ABA is not a form of counseling and that ABA providers should not be regulated as mental health professionals.⁹

² The applicant uses “behavior analysis” and “applied behavior analysis” interchangeably.

³ Central Washington University, School of Psychology, <http://www.cwu.edu/psychology/about-applied-behavior-analysis>.

⁴ Mental Health: A Report of the Surgeon General (1999), page 164, www.surgeongeneral.gov.

⁵ The department’s position has been that a counseling credential is required if the services provided meet the broad definition of counseling in RCW 18.19.020. Medicaid and others require a state license for reimbursement of ABA services.

⁶ The department met with HCA and DSHS prior to releasing this report to ensure they did not have concerns that our recommendations would negatively impact their current structure.

⁷ Many ABA’s master’s or higher level degrees are in the field of education and their coursework does not align with what is required for a counseling degree.

⁸ The bill refers to “behavior analysis” rather than the more commonly used term “applied behavior analysis.”

⁹ Applicant report, page 43.

H-4577.1 would require certain professionals engaging in the practice of behavior analysis, or using certain titles, to be licensed as a behavior analyst or assistant behavior analyst. It would not require any form of credential for behavior technicians, the individuals who implement treatment plans created by a behavior analyst or assistant behavior analyst by providing the hands-on services to the client. Licensed ABA providers would have to meet education and supervised clinical experience requirements and pass an examination. The bill would form a new board to regulate ABA practice. The bill would exempt other licensed providers acting within their scopes of practice, ABA services provided in schools, and ABA services provided to organizations when not provided for an individual. The bill would also allow family members to implement behavior plans without licensure.

The applicant states that regulation is necessary to protect the public from ABA providers who lack adequate knowledge and skill in the practice of behavior analysis. This may include untrained and unlicensed individuals offering services, as well as otherwise credentialed providers offering ABA services without specific ABA education and training. The applicant report cites several studies demonstrating the harm that can come to children or adults with ASD or other serious disorders from untrained providers. These include making dangerous behaviors worse or losing valuable time on ineffective therapies, which the applicant states are critical factors for children with ASD.¹⁰

Recommendations

The department recommends licensure for behavior analysts and assistant behavior analysts because the applicant's proposal meets the sunrise review criteria for a new profession.

However the legislature should not enact the bill in its current form for the following reasons:

- The proposed definition of the “practice of behavior analysis” is confusing and encompasses myriad acts of daily human interaction;
- Without clarification of the proposed definition, there will be undue confusion for ABA providers, licensees in other professions, and the disciplinary authorities charged with enforcing scopes of practice and unlicensed practice;
- The bill potentially limits services by other licensed health care professionals who have ABA within their existing scopes of practice;
- The bill does not require regulation of the ABA technicians who provide hands-on services to the client, thus putting them outside of the reach of the Uniform Disciplinary Act (UDA), chapter 18.130 RCW, including mandatory background checks; and
- The bill creates a new board to regulate a very small profession when regulation under the secretary of health would be more efficient and no compelling need for a board was presented.

To alleviate the confusion regarding the definition of “the practice of behavior analysis” in the proposed bill, the department recommends:

¹⁰ Applicant report, pages 40-41.

- Clarification that the use of behavior techniques alone, such as positive reinforcement and antecedent stimuli, does not constitute the practice of ABA; and
- Use of the term “applied behavior analysis (ABA)” rather than “behavior analysis” because it is more commonly understood by other health care providers and the public, and is used in existing Medicaid rules regulating ABA services.

In the absence of an amended definition of the scope of practice (see proposed definition on page 17), the department alternatively recommends title protection only for this profession. This would mean that while anyone could conduct these broad activities, a person could not use the title of “licensed behavior analyst,” “licensed assistant behavior analyst,” or “certified behavior technician” unless he or she first received a credential from the department. This would allow the public to evaluate a provider’s level of education and training without unduly burdening other credentialed health care professionals and unlicensed persons.

SUMMARY OF INFORMATION

Proposal and Bill Draft

In May of 2014, Representative Eileen Cody, Chair of the House Health Care and Wellness Committee, asked the department to conduct a sunrise review of a proposal to license behavior analysts as a new and distinct profession. The request included draft bill H-4577.1, which would require licensure for behavior analysts and assistant behavior analysts. The applicant contends that ABA is not a form of therapy but a scientific discipline separate from mental health counseling, and ABA providers should not be regulated as mental health providers.¹¹

The draft bill would require certain persons engaging in the practice of ABA,¹² or using certain titles, to be licensed as a behavior analyst or assistant behavior analyst. ABA providers would be required to meet minimum education standards, complete supervised clinical experience, and pass an examination in order to be licensed. The bill would create a new board to regulate the practice of behavior analysis. Behavior technicians are defined in the draft bill as paraprofessionals who implement treatment plans under supervision of behavior analysts or assistant behavior analysts, but would not be credentialed or regulated. The bill would exempt other licensed providers providing ABA services within their own scope of practice, services provided within a school setting, and ABA services provided to organizations for the good of the organization but not an individual. It would also allow family members to implement behavior plans without licensure.

The applicant states regulation is necessary to protect the public from ABA providers who lack adequate knowledge and skill in the practice of behavior analysis. This may include untrained and unlicensed individuals offering services, as well as otherwise credentialed providers offering ABA services without specific ABA education and training. The applicant report cites studies demonstrating the harm that can come to children or adults with ASD or other serious disorders from untrained practitioners. These include making dangerous behaviors worse, increasing occurrence of such behaviors, or losing valuable time on ineffective therapies, which the applicant states are critical factors for children with ASD.¹³

Background

Central Washington University describes ABA as “a systematic approach to the assessment and evaluation of behavior, and the application of interventions that alter behavior.”¹⁴ It is a defined discipline that uses a systematic approach to changing behavior. Although ABA is not a therapy or treatment for any disease or condition, the U.S. Surgeon General has said ABA has been proven effective in promoting the health and well-being of children with ASD¹⁵ and other conditions by decreasing unwanted or harmful behaviors and increasing positive behaviors.

¹¹ Applicant report, page 43.

¹² The applicant uses behavior analysis and applied behavior analysis interchangeably in their report. This report will also use those terms interchangeably.

¹³ Applicant report, page 3.

¹⁴ Central Washington University, School of Psychology, <http://www.cwu.edu/psychology/about-applied-behavior-analysis>.

¹⁵ Mental Health: A Report of the Surgeon General (1999), page 164, www.surgeongeneral.gov.

In general, behavior analysts work with people, animals and organizations in fields such as:¹⁶

- Education
- Autism spectrum disorders
- Developmental disabilities
- Organizational performance management
- Training and instructional design
- Gambling
- Behavioral pharmacology
- Traumatic brain injury rehabilitation
- Gerontology
- Animal training

ABA is practiced in a variety of settings including hospitals, clinics, private homes, schools, nursing homes, group homes, and businesses. Although ABA can have far-reaching applications, it is most closely regarded as a behavioral intervention for children with autism spectrum disorders and behavioral disorders.¹⁷

Public Participation and Hearing

The department received the request from the legislature to conduct this sunrise review on May 8, 2014, and received the applicant report on June 2, 2014. The department posted the proposal and all applicant materials to the sunrise webpage and notified interested parties of the public hearing schedule for August 12, 2014. Written comments were accepted until the close of the public hearing, with an additional comment period for follow up after the hearing

At the public hearing, Christopher Jones, a doctoral-level nationally certified behavior analyst, presented the sunrise proposal and responded to questions from the hearing panel. He provided additional information on the practice of ABA, stating:

- ABA is not a therapy for kids with autism, but rather an approach or a philosophy about how we understand human behavior.
- Licensure is needed to protect the public because registration or certification doesn't ensure the quality of services the way licensure does.
- The national Behavior Analyst Certification Board (BACB – discussed later in this report) is really the only sufficient documentation currently available of a behavior analyst's training, and the only infrastructure in place to ensure quality of these services.
- What a typical behavior plan might look like, relaying the story of a family he worked with to help a child in the family reduce injurious behaviors.
- Some examples of the types of harm that can come from practice by unqualified providers include the child regressing or not progressing similarly enough to typically developing peers.
- Part of a behavior analyst's core training for national certification (BACB - discussed later in this report) is that progress must be continuously made (and observable) or something must change in the behavior plan.
- The reason 1,500 hours of supervision is enough for licensure of behavior analysts is because the supervision is specifically in the field of behavior analysis and not mental health therapy.

¹⁶ Central Washington University, School of Psychology, <http://www.cwu.edu/psychology/about-applied-behavior-analysis>.

¹⁷ Beyond Autism Treatment: The Application of Applied Behavior Analysis in the Treatment of Emotional and Psychological Disorders, International Journal of Behavioral Consultation and Therapy, Volume 3, No. 4, 2007.

In addition, 19 members of the public testified at the hearing (See Appendix C for public hearing summary). Eighteen testified in support of the proposal, including ABA providers, advocacy organizations, and parents of children with ASD. Some included concerns or specific recommendations about the proposal that are summarized below. One group, the Washington Occupational Therapy Association (WOTA), testified in opposition to the proposal with specific concerns and recommendations. We also received 11 letters in support of the proposal, five in support with concerns or recommended changes, two opposed or with serious concerns, and one letter that did not state a position but asked questions on billing and insurance coverage for ABA. (See Appendix D for written comments.) These comments are summarized below.

Washington Occupational Therapy Association opposed the proposal and stated that creation of a stand-alone licensure is inappropriate because ABA is only a single technique for intervention. The WOTA representative said that behaviorism is one of the theoretical frameworks taught in occupational therapy (OT) programs and behavior modification and evaluation are included in OT practice. The WOTA believes the proposal is being requested for the good of the ABA profession rather than public protection. If the department supports licensure, the WOTA recommended amendments to limit the practice to treatment of children with ASD and medically stable children with complex behavior problems; require ABA providers to practice in cooperation with and under a diagnosis and prescription from a qualified licensed professional; and clarify that behavior analysis does not include OT and that OT should be exempted from the proposed bill. In follow-up after the hearing, WOTA indicated support for a title protection option that was brought up at the hearing.

There was wide support for creating a state credential for behavior analysis, mainly regarding treatment of ASD. Individuals with ASD are vulnerable, and some may engage in dangerous or self-injurious behaviors. ABA by a qualified provider can greatly reduce these negative behaviors. Anecdotal stories were shared from parents of children with ASD, telling of bad outcomes from unqualified providers. Examples included inconsistencies in therapy, lack of follow-up, making bad behaviors worse, and isolating children with ASD by using inappropriate methods or even restraints.

We heard from insurance providers and agencies that provide ABA services. They contend that there are challenges in the way providers are currently providing these services. Insurance carriers identified problems with developing their networks of providers because some ABA providers are not licensed as independent providers (some are credentialed as agency-affiliated counselors who may only work under the auspices of a state, local government or tribal agency). There are insufficient numbers of qualified ABA providers, creating wait lists, particularly in rural areas. Lack of licensure is a barrier to having adequate numbers of providers. In addition, we heard that the agency-affiliated counselor credential often used for ABA providers is not appropriate because it has a very broad scope of practice and behavior analysis is a narrow and highly specific practice.

We received comments stating that many people do not understand ABA, which some commenters attempted to clarify. Descriptions included that it is the empirically validated non-pharmaceutical intervention for behavior disorders for children with ASD. Applied behavior analysis focuses on making measurable, meaningful changes in overt, observable behaviors; compared to the mental health field which focuses on internal, covert mental processes. Applied behavior analysis is a therapeutic approach, which demands operational implementation and

clinical consistency to be effective, and the methods can be learned naturally but cannot be mastered without intensive board-certified training.

We received many comments supporting licensure of behavior analysts, but with concerns and recommendations regarding the proposed bill. Many commenters stated that the definition of the practice of behavior analysis is much too vague and broad, and must be clarified and narrowed in order to allow effective regulation of the profession. Some commenters suggest linking the definition to treatment of ASD since that is the focus of most of the ABA programs.

There were concerns that behavior technicians are included in the proposal as unlicensed providers without any requirements for education, experience, or oversight. These technicians provide as many as 40 hours per week of hands-on care of children with ASD, often in the home, and may be entirely unsupervised. Commenters said behavior technicians should be licensed with requirements for background checks, education and supervised experience, and with supervision defined.

We heard concerns about creating an ABA board as included in the draft bill. Some commenters felt that board membership should be expanded to include other providers like psychologists trained in ABA and other mental health providers. Some groups suggest the board should be under the umbrella of another established health profession board.

The Washington State Society for Clinical Social Workers had concerns with the proposal because patients with ASD often have other diagnoses that must be addressed and require a differential diagnosis by a mental health provider. It stated that ABA providers should work in tandem with licensed mental health providers. It recommends certification of ABA providers with supervision by licensed mental health providers on a regular basis, at least once a quarter and before beginning ABA treatment.

Washington Speech-Language-Hearing Association stated there is a need to clearly delineate the scope of practice of behavior analysts and to ensure they are not providing treatment of communication disorders, for which they are not trained. The proposed scope of practice is very broad and should be amended to capture what the practice of behavior analysis is not. The practice of speech-language pathology should be excluded in the bill, including communication disorders, alternative communication evaluation, and language evaluation and treatment.

The Arc of Washington stated the supervised field work should be increased to help new providers deal with significant behavioral issues. It has heard from many families that new providers are often not prepared for this. It is also concerned that the proposal does not take into account that there are some members of other professions, such as mental health counselors and psychologists, who are trained and should be able to bill for ABA services. It stated the proposal should include continuing education to ensure behavior analysts understand the importance of teaming with other providers. It also believes the proposed board, if enacted, should include other mental health providers, as well as more public members.

The Washington State Psychological Association stated ABA is a well-established component of the practice of psychology, so the board, if enacted, should be housed within the Examining Board of Psychology and comprised of both ABA providers and appropriately trained psychologists. This will help ensure the scope of practice is defined so providers know when treatment moves beyond

ABA into mental health treatment. The association also recommends the proposed bill include more precise supervision requirements for behavior analysts working in home or school settings, as well as requiring a state law (jurisprudence) examination.

The State Developmental Disabilities Council and Washington Alliance and Advocacy recommended additional requirements. These include additional coursework in the areas of child development, abnormal psychology, and family systems; additional supervised experience to be on par with other mental health providers (1,500 hours are inadequate); and a requirement that a percentage of the provider's practice include low income individuals.

The department shared a draft report in September with interested parties, including everyone who had commented at the hearing or in writing, and invited rebuttal comments. We did not receive rebuttals or concerns on the draft recommendations from any of the above parties. The rebuttals and concerns we received are summarized beginning on page 21 and are included in their entirety in Appendix F.

Applied Behavior Analysis and Autism Spectrum Disorders

“Autism spectrum disorders are pervasive developmental disorders characterized by impairments or delays in social interaction, communication and language, as well as by repetitive routines and behaviors. . . .Some children with ASD display violent or self-harmful behaviors.”¹⁸ ABA is recognized as effective in improving behavioral outcomes associated with ASD by the U.S. Surgeon General,¹⁹ American Academy of Pediatrics, Autism Society of America, American Society of Speech-Language Hearing Association, American Academy of Occupational Therapy Association, and many others.²⁰

The department conducted a mandated insurance benefit sunrise review for ASD in 2009. It found that, “ABA is an effective treatment for ASD when provided by appropriately-educated and experienced providers.”²¹ The department also found that “current standards for national ABA certification ensure adequate training.”²²

Behavior Analyst Education and Training

Colleges and universities across the country offer undergraduate and graduate ABA coursework. These courses are offered in a variety of academic departments, including departments of education or psychology, and cover a range of topics in behavior analysis and its applications.

In addition, many colleges and universities offer course sequences that meet the coursework eligibility requirement for the national examinations administered by the Behavior Analysis Certification Board (BACB). Individuals who successfully complete that coursework as well as the degrees and supervised experiential training specified by the BACB are allowed to sit for the

¹⁸ Treatment of Autism Spectrum Disorders Mandated Benefit Sunrise Review, Washington State Department of Health, January 2009, Executive summary.

¹⁹ Mental Health: A Report of the Surgeon General (1999), page 164, www.surgeongeneral.gov.

²⁰ <http://www.appliedbehaviorcenter.com/ABAEndorsements.htm>.

²¹ Treatment of Autism Spectrum Disorders, Mandated Benefit Sunrise Review, Washington State Department of Health, January 2009, <http://www.doh.wa.gov/portals/1/Documents/Pubs/631002Autism.pdf>.

²² Ibid.

exam for Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA) certification. In Washington, the University of Washington and Gonzaga University offer coursework approved by the BACB that are housed within their schools of education. Central Washington University's courses are located in its psychology department. Central Washington University's courses are awaiting BACB approval.²³

National Voluntary Certification

The BACB has developed standards for approving coursework and experiential training to meet its certification examination eligibility requirements; professional examinations for ABA; continuing education requirements for maintaining certification; standards for approving continuing education providers; ethical guidelines; disciplinary standards; and an online registry of holders of BACB certification. The BACB's certification procedures, including its exam, are psychometrically reviewed and validated regularly.²⁴ In addition to the master's level, the certification body offers a separate designation for those analysts who hold doctoral credentials, the BCBA-D. As of August, 2014, there were 285 nationally certified behavior analysts or assistant analysts in Washington.²⁵ Thirty-two of the analysts hold doctoral level credentials.

- **Analysts:** BACB requirements for Board Certified Behavior Analysts (BCBA) include a master's degree in behavior analysis or a related field²⁶ and 750 or 1,000 hours (depending on type) of university practical experience or 1,500 hours of independent fieldwork, and passage of the BACB exam.

BCBAs are independent practitioners who may work as an employee or contractor. BCBAs do not diagnose or treat medical conditions. Analysts conduct assessments that include functional analysis, interpret the results, and design the treatment plan.²⁷ "The BCBA supervises the work of Board Certified Assistant Behavior Analysts (BCaBA) and others who implement behavior analytic interventions."²⁸

- **Assistant Analysts:** Board Certified Assistant Behavior Analysts (BCaBA) are not independent practitioners. They must work under the supervision of the BCBA to conduct assessments, interpret results, and design behavior interventions.

BACB requirements for BCaBAs include at least an undergraduate degree in behavior analysis or a related field²⁹ and 500 or 670 hours (depending on type) of practical experience or 1,000 hours of independent fieldwork, and passage of the BACB exam.

- **Registered Behavior Technicians:** To be included in the BACB Registered Behavior Technician (RBT) registry, the technician is required to take 40 hours of training based on the BACB task list and pass an assessment given by a BCBA or a BCaBA. The technician is also required to pass a background check.

²³ Central Washington University psychology department website, <http://www.cwu.edu/psychology/bcba-certification>.

²⁴ Behavior Analyst Certification Board. www.bacb.com.

²⁵ BACB registry. www.bacb.com.

²⁶ Related fields include the following approved academic areas: education; clinical, counseling, or school psychology; clinical social work; occupational therapy; speech/language therapy; engineering; and medicine, <http://www.bacb.com/index.php?page=100378>, accessed September 1, 2014.

²⁷ About BCBA credentials. www.bacb.com

²⁸ Ibid.

²⁹ Related fields are the same as those listed for BCBAs.

The BACB states that behavior technicians implement the behavior plans designed by analysts under close, ongoing supervision.³⁰ The RBT is primarily responsible for the direct implementation of skill-acquisition and behavior-reduction plans developed by the supervisor. A behavior analyst creates a plan that can require 30-40 hours per week of one-on-one treatment that is performed by a person other than the behavior analyst, such as an RBT. BACB requires RBTs to be supervised for a minimum of five percent of the hours spent providing ABA services per month. Supervision must include at least two face-to-face contacts per month during which the supervisor observes the technician providing services (may be conducted via the Internet). At least one of the two supervisory contacts must be one-on-one, but the other may occur in a small-group meeting.

Current Provision of Services in Washington

Because no specific ABA license exists in Washington, some ABA providers have obtained counseling or other health care credentials to meet licensing and reimbursement requirements. The department's position has been that a counseling credential is required if the ABA provided to a client involves counseling as broadly defined in RCW 18.19.020.³¹ Reimbursement from Medicaid and other insurers requires a state license for medically necessary treatment of ASD and other developmental disorders. The Health Care Authority requires ABA providers to be credentialed by the department as physicians, psychologists, or some level of mental health provider. In addition:

- HCA requires referral from a health care professional, school staff, or parent to a Medicaid recognized Center of Excellence for Autism, such as Mary Bridge Children's Hospital Autism Center, where a qualified licensed physician or psychologist must conduct an evaluation, confirm diagnosis and recommend ABA services.
- In DSHS licensed agencies, patient referral by a physician or psychologist is required for ABA services. Master's level counselors with ABA experience must create the treatment plan and provide supervision for hands-on treatment.

There are issues related to licensing behavior analysts as counselors. The applicant and many other ABA providers state that ABA is not counseling because it deals with behavior related to environment, rather than the mind or emotional state of the person. The requirement for ABA providers to be supervised by mental health providers such as counselors or psychologists is problematic in their eyes because many mental health providers have not received specific training in ABA. In addition, many nationally certified BCBA's and BCaBA's cannot meet the requirements for a counselor credential because their degrees are in education or other fields and their coursework and supervised experience do not meet licensing requirements.

³⁰ The department could not locate a definition of close, ongoing supervision.

³¹ RCW 18.19.020(6) "Counseling" means employing any therapeutic techniques, including but not limited to social work, mental health counseling, marriage and family therapy, and hypnotherapy, for a fee that offer, assist or attempt to assist an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential.

Other States

Insurance benefit mandates, lawsuits under mental health parity laws, and inclusion of behavioral health services as one of the 10 essential health benefits under the Affordable Care Act have prompted 38 states to adopt legislation to address ABA services.³² Although there has been a general movement toward credentialing providers, states have responded in different ways.

Almost all states involve the national BACB certification process for ABA practitioners in some way, including:

- Direct disciplinary authority over the state practitioners;
- Recognition of BACB certificate recipients as qualified providers of ABA services under autism insurance laws;
- Licensing providers with BACB certification required either initially or on an ongoing basis.

Oregon has a state regulatory board and incorporates a requirement for national voluntary certification. Oregon's legislation, Senate Bill 365 (2013 regular session), requires the licensing of behavior analysts and assistant behavior analysts, and registration of behavior analyst interventionists (equivalent to technicians in the proposal under review). It sets up a seven member disciplinary board to oversee the profession within its department of licensing. The board's make-up is relatively unique among the states, as its board members are required to represent a balance of health care interests outside of practicing BACB credential holders. The board must include three members certified by the BACB, a licensed psychiatrist or developmental pediatrician who has experience or training in ABA, a licensed psychologist who has experience in the diagnosis or treatment of ASD; a licensed speech-language pathologist who has experience or training in ABA; and a member of the public. Licensed behavior analysts and assistant behavior analysts are required to be certified by the BACB. Interventionists must complete coursework and training prescribed by the board and pass a criminal background check.³³

Analysis of Applicant Report and Proposal

The applicant contends licensure is necessary to protect the health and safety of the public from unqualified providers offering and providing ABA services. Because the subject of ABA is behavior, not mental health, the applicant states that unqualified providers could include counselors or other licensed health providers who may be inadequately trained in the practice of ABA. However, because elements of ABA interventions are widely used in many daily human interactions, there will be some overlap with other health care providers practicing within their scopes of practice, as well as special education teachers and paraprofessionals working with students who have behavior issues in the classroom or an Independent Educational Program (IEP).

The definition of the practice of behavior analysis in the proposed bill has been described as too vague and broad, with no clear practice parameters. Lack of clarity is a problem for regulation of ABA providers because it will make it difficult to determine what constitutes unprofessional or

³² Appendix E

³³ Oregon Enrolled Senate Bill 365, 77th Oregon Legislative Assembly, 2013 Regular Session.

unlicensed practice. The draft bill creates licensure exemptions for teachers working within a school setting, providers who practice general behavior analysis in organizations, and parents who work to implement behavior plans with their own children. It clearly states ABA does not include mental or physical diagnosis or mental health treatment. It overlaps with other licensed health professions, such as psychology, mental health counseling, occupational therapy, and speech-language pathology. However, the department believes that if amended and clarified, the scope of practice in the proposal could be implemented and regulated.

The department accepts that behavior analysis is a “distinct profession and that it is not the same as developmental psychology, school psychology, counseling, social work, special education, and other mental health and education professions.” We agree that licensure could provide the public with a clear designation, scope of practice, and regulatory oversight of ABA providers, and will help protect consumers by requiring that those individuals who are licensed to provide behavior analysis services have received the necessary and sufficient training.³⁴

Some patient advocacy organizations and professional associations have expressed concerns about the proposal. They have suggested adding requirements for supervision or oversight of ABA by mental health providers because of the potential for complex mental health conditions that would require a differential mental health diagnosis. They are concerned that the length of supervised experience required for BCBA or BCaBA certification is inadequate to meet the demands of a child with complex psychological and medical needs; and have suggested the requirement be on par with that of mental health providers. However, ABA providers cannot diagnose mental health (or physical) conditions and the discipline of ABA is much narrower than mental health treatment. ABA providers often work in consultation with mental health providers and other types of health care providers and should always do so if a team-based approach is in the client’s best interest or medically necessary. They are required to do so by Medicaid when providing ABA for ASD and other developmental disorders.

The department finds that ABA practitioner requirements for reimbursement under various insurers, including Medicaid, provide some level of public protection, since these insurers typically require that the practitioner be nationally certified or hold a mental health credential. This assures the provider meets certain standards, although not to the degree that could be achieved by regulating the profession. Private pay patients have no assurance of ABA provider qualifications and may be left vulnerable without state regulation. The high incidence of autism and behavioral disorders among children³⁵ and the demand for ABA services creates a crucial need for easily identifiable and credible providers. According to DSHS, Division of Behavioral Health and Recovery, there are waiting lists for ABA services, which are increasing due to the availability of insurance reimbursements by Medicaid and other insurance providers. There are not enough licensed providers to fill the need for ABA services.

³⁴ Applicant report and follow up response to sunrise review supplemental questions (Appendix B).

³⁵ The National Autism Society cites autism affects 1 in 68 children.

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act, in RCW 18.120.010, states that a health care profession should be regulated or the scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

First Criterion: Unregulated practice can clearly harm or endanger health or safety.

This criterion has been met.

The department finds a strong potential for harm with the practice of ABA by unregulated, inadequately trained, or unscreened providers because they often work with vulnerable children and adults with developmental and behavioral disorders.³⁶ ABA providers also may work unsupervised in the homes of clients. Credentialing would provide for state background checks and regulation under the UDA. A finding of unprofessional conduct would provide notice to the public and other states that the person may not be able to practice with reasonable skill or safety.

The system that has developed to meet reimbursement requirements of insurers like Medicaid provides some level of public protection, although not to the degree possible by actively regulating the ABA profession. By comparison, private pay patients do not have the same protections. In addition, behavior technicians would be completely unregulated under the proposal. Public protection requires adequate regulation of these providers, who may have as many as 20-40 hours of unsupervised contact each week with a vulnerable client.

Second Criterion: The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

The proposal meets this criterion as long as it is amended to ensure professional ability of all ABA providers, including behavior technicians.

The applicant has proven the need to ensure that all providers of ABA are held accountable to initial and continuing standards for education and competency through regulation of the profession. The proposal does not include regulation of behavior technicians, which must be included to ensure the professional ability of this group.

New credentials for ABA providers must not limit other credentialed professions from providing care already within their statutory scopes of practice. There are laws and rules in place to ensure initial and continuing professional ability of professions like psychologists, licensed mental health counselors, and occupational therapists who may be able to provide behavior analysis

³⁶ The evidence of potential harm from unqualified providers focuses on services provided for children diagnosed with ASD.

under their existing scopes of practice. As a matter of course, no health care provider should practice any treatment modality, even those within their scope of practice, unless they are adequately trained to do so.

Third Criterion: The public cannot be effectively protected by other, more cost-beneficial means.

The proposal meets this criterion as long as it is amended to ensure all ABA providers are regulated, including behavior technicians.

The current system of providing ABA for children with ASD protects the public from unregulated and unqualified providers within Medicaid and other insurance programs under the HCA. However, there are waiting lists to access ABA services, and the current system limits some qualified providers from practice. These are individuals with master's degrees and specialized ABA education and training, often with national ABA certification, who do not qualify for a counselor credential that is required under the current system.³⁷

The proposal does not regulate behavior technicians who may have 20-40 hours of contact per week with vulnerable individuals. It also proposes creation of a board, which is not necessary to achieve the goals of regulation. The secretary of health could appropriately oversee the profession, perhaps with the assistance of an advisory committee comprised of ABA providers to give additional expertise related to educational and licensing standards.

³⁷ Their master's or higher level degrees are in the field of education and their coursework does not align with what is required for a counseling degree.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The department supports the concept of licensure of ABA providers. The applicant has supported the need for uniform regulation of all ABA providers to protect the public because they often work with vulnerable individuals, including children with ASD and developmental and behavioral disorders. Applied behavior analysis providers often work in the client's home and without direct supervision.

There is also a need to address the group of master's level providers with specialized ABA training who cannot qualify for a counselor credential that is required under the current system, and are excluded from practicing in this field where there is great need.

The department recommends the following changes to the proposal:

1. Make the following changes to Sections 1(6), 2(1), and 3(1) in the proposed bill:

Sec. 1 (6) (a) "Practice of applied behavior analysis" means:

(i) the design, implementation, and evaluation of instructional and environmental modifications based on scientific research and the direct observation and measurement of behavior and the environment to produce socially significant improvements in human behavior;

(ii) Empirical identification of functional relations between behavioral and environmental factors, known as functional assessment and analysis; and

(iii) Utilization of contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to assist individuals in developing new behaviors, increasing or decreasing existing behaviors, and emitting behaviors under specific environmental conditions.

(b) "Practice of applied behavior analysis" does not include psychological testing, diagnosis of a mental or physical disorder, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or ~~long-term~~ counseling as treatment modalities. It also does not include use of behavioral techniques in section 1(6)(a)(ii) alone as treatment modalities.

Sec. 2(1) Except as provided in section 3 of this act, no person may engage in the practice of applied behavior analysis unless he or she holds a license or a temporary license under this chapter. Use of behavioral techniques in section 1(6)(a)(ii) alone does not constitute the practice of applied behavior analysis.

Sec. 3 Nothing in this chapter may be construed to prohibit or restrict:

(1) An individual who holds a credential issued by this state, other than as a licensed behavior analyst or a licensed assistant behavior analyst, to engage in the practice of that occupation or profession without obtaining an additional credential from the state, so long as the practice is within that profession's or occupation's scope of practice ~~and the individual's scope of training and competence.~~

Rationale: The definition in the proposal is so broad it encompasses myriad daily human interactions, and does not clearly distinguish ABA from behavioral tools that fall under other professions' scopes of practice or practices that do not require any license at all. In addition, the department recommends using the term "applied behavior analysis (ABA)" because it is

more commonly understood by other health care providers and the public, and is used in existing rules under the Health Care Authority.

Alternative to Recommendation 1 — Although the primary recommendation is to include a carefully defined protected scope of practice, title protection is an alternative to consider. Title protection means that while anyone could conduct these broad activities, a person could not use the title of “licensed behavior analyst,” “licensed assistant behavior analyst,” or “certified behavior technician” unless he or she first received a credential from the department. This would allow the public to evaluate a provider’s level of education and training without unduly burdening other credentialed health care professionals and unlicensed persons.

Rationale: Restricting those who can use certain titles to individuals who meet required qualifications helps the public identify qualified providers.

2. Require a state credential for technicians with minimum hours of training and a background check. The level of credential should be certification, although the certification should be mandatory rather than voluntary.

The elements of regulation, including what a technician can and cannot do, as well as training requirements, should be further defined by the secretary in rule. The exemption from regulation for family members implementing an ABA treatment plan should be retained in Sec. 3(6). Family member should include legal guardians and should be defined in rule.

Rationale: Behavior technicians often provide many hours of ABA services to vulnerable individuals in their homes. Credentialing will allow the department to set minimum qualifications and place behavior technicians under the UDA to allow investigation and discipline when needed.

3. Levels of supervision for assistant behavior analysts and behavior technicians should be defined.

Behavior technicians require “close, ongoing supervision” in the proposed bill but this term is not defined. Licensed assistant behavior analysts require “supervision” of a licensed behavior analyst but this term is not defined. The department recommends definitions of these terms. Other regulated professions use direct or indirect levels of supervision based on whether the supervisor is physically present or immediately available. This level of detail is necessary to inform providers of their responsibilities under the law.

Rationale: Minimum levels of supervision should be defined in order to ensure provider compliance and public protection. The bill should specify that the secretary shall establish definitions for different levels of supervision in rule.

4. Create an advisory committee under the authority of the secretary of health.

Rationale: An ABA advisory committee will achieve the goals of the proposal, such as using the expertise of the regulated providers. Disciplinary activities can be quite challenging for small professions due to the small pool of board candidates, which makes it more likely board members will know respondents or witnesses and have to be recused from decisions.

5. Define basic requirements for licensure in statute.

The department recommends amending section 5 of the proposed bill to identify the basic requirements the applicant must meet for licensure, with the specifics to be determined in rule by the secretary, in consultation with the advisory committee. The statute should include requirements to provide evidence to the secretary of the following education and experience requirements:

- Behavior Analyst:
 - Graduation from a master's or doctorate degree program in behavior analysis or other natural science, education, human services, engineering, medicine, or a field related to behavior analysis approved by the secretary.
 - Completion of a minimum of 225 classroom hours at graduate level instruction in specific behavior analysis topics to be set in rule.
 - Successful completion of a supervised experience requirement, consisting of a minimum of 1,500 hours or alternative to be determined in rule.
 - Successful completion of an approved examination.
- Assistant Behavior Analyst:
 - Graduation from a bachelor's degree program approved by the secretary.
 - Completion of 135 classroom hours of instruction in specific behavior analysis topics to be set in rule.
 - Successful completion of a supervised experience requirement, consisting of a minimum of 1,000 hours or alternative to be determined in rule.
- Behavior technician:
 - Minimum of a 40-hour training program approved by the secretary.
- The statute could also provide an acceptable alternative of national certification approved by the secretary in lieu of some of the requirements.

Rationale: These are the requirements set by the national BACB, which has been approved by the National Commission on Certifying Agencies. The department's 2009 mandated insurance benefit sunrise of ASD found that current standards for national certification ensure adequate training.

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REBUTTALS TO DRAFT REPORT

The department shared a draft report and recommendations with sunrise participants and interested parties and invited rebuttal comments or suggested corrections. We received five letters of rebuttal, correction, or support. One of the letters indicated support for the draft report. The remaining four letters are summarized below along with the department's response. The full rebuttals are included in Appendix F.

Applicant

We received a letter of rebuttal/requested corrections from the applicant addressing the following topics.

Definition of the practice of ABA in the draft bill

The applicant states that the definition of ABA in section 1(6) should remain as written in the proposed bill because:

- The definition and scope of practice were developed by professional behavior analysts with input from the Behavior Analyst Certification Board (BACB) and the Association of Professional Behavior Analysts (APBA).
- The definitions incorporate the BACB's task list, which was derived from several job analysis studies involving thousands of professional behavior analysts and panels of subject matter experts over 15 years.
- Such procedures are used by most legitimate professions to determine competencies and scope of practice.
- This definition is similar to that in several other states that license behavior analysts.

Department response: The department accepts this argument for retaining the definition originally submitted in the proposal, with one exception. We proposed amending Sec.2(1) to add "Utilization of behavioral techniques in section 1(6)(a)(ii) alone does not constitute the practice of applied behavior analysis." The department believes this is an appropriate clarification to address issues related to identifying unprofessional or unlicensed practice and concerns voiced from other health professions. It is a necessary distinction to make. The definition has been changed accordingly in the report.

Deletion of "and the individual's scope of training and competence" from section 3 of the proposed bill

The applicant states that if that phrase were deleted, the bill would permit anyone in the category covered by this exemption to engage in ABA, regardless of their training, knowledge, and competence and put vulnerable consumers at risk of receiving poor services from unqualified individuals. This is inconsistent with the department's acknowledgment and with data from job analysis studies that the practice of ABA is a distinct profession requiring specialized training.

Department response: Acknowledgment that the practice of ABA is a distinct profession requiring specialized training does not mean we should limit other professions from providing therapies already authorized under their much broader scopes of practice, or require education and training above and beyond what is required by these professions' regulatory authorities.

The department addressed the issue with the exemption for other licensed health care providers when we assessed the second criterion in stating, “A new credential for ABA providers must not limit other credentialed professions from providing care already within their statutory scopes of practice. There are laws and rules in place to ensure initial and continuing professional ability of professions like psychologists, licensed mental health counselors and occupational therapists who may be able to provide behavior analysis under their existing scopes of practice. As a matter of course, no health care provider should practice any treatment modality, even those within their scope of practice, unless they are adequately trained to do so.”

A remedy already exists for credentialed health care providers who practice below the standard of care or outside the scope of practice. They are subject to the UDA and potential disciplinary action by their regulatory authority if these providers engage in unprofessional conduct. Restricting a health care provider’s scope of practice in the statutes of another profession is unnecessary, inappropriate, and may fail to place the provider on adequate notice of the restriction.

Alternate recommendation for title protection instead of protected scope of practice

The applicant stated title protection would fail to adequately protect consumers because it would not provide a means of regulating how licensees practice or those who purport to practice ABA without meeting the standards of the profession.

Department response: The department supports a clearly delineated, protected scope of practice, but offers an alternative approach that would be simpler to implement, while retaining a higher level of public protection than currently exists.

Credential for behavior technicians

The applicant is not opposed to this requirement, but states that initial implementation would be technically challenging due to the large number of technicians providing services in Washington. It offers an alternative approach of requiring the national Registered Behavior Technician (RBT) credential that is voluntary through the BACB. The applicant also suggests a one-year grace period for technicians to comply.

Department response: The department cannot delegate authority for setting licensure standards. We recommend the statute mirror the current BACB standards as the minimum requirements, which can be made more stringent in rule if needed. Also, there is generally a 12 month implementation period after the passage of any licensure bill to allow the department to engage in collaborative rulemaking with interested stakeholders. It is unlikely RBTs would be required to meet certification requirements immediately after passage of the bill. No changes were made to the report in response to this comment.

Department’s recommendation to create an advisory committee under the secretary of health rather than a full authority board

The applicant disagrees with this recommendation and asserts:

- Rules to implement the licensure law, including defining levels of supervision and specific requirements for licensure should be made by a regulatory board consisting

mostly of licensed behavior analysts and assistant behavior analysts rather than the secretary.

- If complaint investigations were under the secretary's authority, it would result in administrative personnel investigating complaints of professional misconduct without sufficient knowledge of ABA and ethical standards of the profession.
- Authority for rules should not be placed in the hands of other professions, which would be inconsistent with other regulated professions and with the department's recognition of ABA as a distinct profession.
- The applicant disagrees with the rationale for an advisory committee based on the small pool of licensees, stating precedence exists for other professions with small numbers, such as denturists, podiatric physicians, etc.
- BACB certification should be the principal requirement for licensure, which would make a regulatory board of professional behavior analysts cost-effective to operate since the requirements will have been vetted by the BACB.

Department response: There is no recommendation in the report to include other professions beside behavior analysts on the advisory committee.

The secretary of health is the regulatory authority for more than half of the 83 health care professions credentialed by the department. The applicant has not provided compelling evidence that ABA providers require a board. Scope of practice decisions are made by the legislature for all professions. Rulemaking would be performed in consultation with an advisory committee, if created, and in collaboration with interested stakeholders. Licensing decisions generally hinge on whether or not the applicant has met requirements in rule and rarely require professional expertise. Investigation and discipline decisions often relate to conduct issues such as moral turpitude, substance abuse, or criminal convictions that do not require professional expertise.³⁸ When such expertise is needed, expert witnesses are retained to assist with case evaluations.

The department's assertion that disciplinary activities can be challenging for professions with smaller pools of board candidates is based on actual experience with other smaller professions. In addition to the problem of board member familiarity with the licensees requiring recusal, there are significant challenges finding licensees willing to devote the time and endure the practice interruption that comes with board membership. No changes were made to the report in response to these comments.

Current BACB certification requirements listed in draft recommendations

The applicant stated that rather than listing current BACB requirements in statute, BACB certification should be a requirement for licensure and renewal of licensure to ensure Washington credential holders always meet the national standards and law changes are not required each time the national standards change.

³⁸ According to the 2011-13 Uniform Disciplinary Act Biennial Report, moral turpitude was the most frequently cited violation in the 2,353 disciplinary actions for that period, appearing in 40 percent of the cases. Conviction of a felony or gross misdemeanor was cited in 21 percent of the cases, and substance abuse was cited in 14 percent. See: <http://www.doh.wa.gov/Portals/1/Documents/2000/UDAReport2011-2013.pdf> at page 32.

Department response: The recommended statutory requirements are minimum standards. If national standards increase, the department could consider those changes in rulemaking. No changes were made to the report in response to this comment.

Association of Professional Behavior Analysts (APBA)

We received a letter of rebuttal/requested corrections from the APBA, a national nonprofit membership organization who promotes and advances the practice of ABA. The APBA submitted comments and rebuttals on the follow topics.

Revised definition of practice of ABA

The APBA sent similar concerns as the applicant regarding the revised definition recommended in the draft report. Reasons supporting this position were also similar to those of the applicant. The APBA added:

- In response to comments about the bill being broad and overlapping other scopes of practice; that those same comments would apply to other regulated professions such as psychologists and counselors and should not be seen as flaws in the proposed bill.
- The scopes of practice in most licensure laws tend to be succinct and nonspecific, without detailed operational definitions of specific procedures or techniques. This is true for psychologists and counselors.
- Determinations about practicing outside of a scope of practice are typically aided by licensing requirements, professional codes of ethics, practice standards, etc.

Department response: See response to applicant’s rebuttals.

Deletion of “and the individual’s scope of training and competence” from section 3 of the proposed bill

APBA sent similar comments to the applicant’s on this topic, adding that it is essential to make it clear that professionals who hold other credentials should practice ABA only if they have had formal and experiential training required to produce the competencies for that practice (delineated in the BACB Task List). It included suggested language, “Such individuals may use ABA techniques on which they are competent under the auspices of their professional credentials.”

Department response: See response to applicant’s rebuttals.

Alternate recommendation for title protection instead of protected scope of practice

APBA stated similar concerns to the applicants. In addition, it stated that this alternative would result in little or no functional change from the status quo in Washington, which the department has acknowledged is unacceptable.

Department response: See response to applicant’s rebuttal.

Credential for behavior technicians

APBA’s comments were similar to those of the applicant.

Department response: See response to applicant’s rebuttal.

Supervision standards

APBA suggested the recommendations include language stating that licensed assistant behavior analysts and registered behavior technicians shall be supervised, “in accordance with the supervision standards of the Behavior Analyst Certification Board” to ensure Washington credential holders always meet the national standards and laws are not required to change each time the national standards change.

Department response: The recommended statutory requirements are minimum standards. If national standards increase, the department could consider those changes in rulemaking. No changes were made to the report in response to this comment.

Department’s recommendation to create an advisory committee under the secretary of health rather than a full authority board

APBA’s comments were very similar to the applicant’s.

Department response: See response to applicant’s rebuttal.

Current BACB certification requirements listed in draft recommendations

APBA stated that rather than listing current BACB requirements in statute, BACB certification should be a requirement for licensure and renewal of licensure to ensure Washington credential holders always meet the national standards and laws are not required to change each time the national standards change.

Department response: See response to applicant’s rebuttals.

Descriptions of behavior analysis

APBA suggested alternate descriptions of behavior analysis to those described in background of the report.

Department response: These were broad descriptions of behavior analysis intended for a wide audience, not definitions. The only changes made in response to these comments were clarification that these descriptions were taken from Central Washington University.

Clarifications

APBA requested the following clarifications in the body of the report:

- Behavior analyst education and training. Not all university ABA programs are in departments of psychology or education.
- Clarification and corrections to the information under Behavior Analyst Education and Training that describes university programs’ eligibility for the BACB national examination.
- Corrections under National Voluntary Certification regarding BACB standards.
- Clarifications under Other States, regarding recognition of BACB certification.

Department response: The department agrees with these requests and the report has been revised as requested.

Gene McConnachie, Ph.D.

Dr. McConnachie supports the draft recommendations, stating he has been a psychologist in Washington for 20 years and has been trained in and has used ABA therapies for a wide-range of human behavioral disorders for 40 years after being taught by the founders of the ABA field and their students. He has also taught ABA at the university level and published clinical research on effective ABA-based treatment of autism. He has felt no need to become board-certified in ABA to continue his clinical practice.

The only concern he shared was of the potential for restraint of trade for psychologists with expertise in ABA if they are not allowed to say they do behavior analysis. He stated he thinks the recommendations in the draft report cover his concerns, so he either supports the draft report or is advocating for ensuring final rules do not prohibit psychologists from stating/advertising expertise in behavior analysis, which is a broad field that is not just for children with autism.

Department response: No changes are needed to the draft report in response to this comment.

Curtis Thompson

Mr. Thompson's comments were brief and not covered under the other rebuttals so they are included here in their entirety.

I strongly agree with the department's recommendation to treat behavioral analysis as a new profession if that new profession is regulated to the same standard as that of "Psychologist".

Observing, analyzing, understanding, and attempting to change behavior is not a new profession. It is exactly what the already regulated professions commonly known as psychology, counseling, psychotherapy, psychiatry, and the like purport to do. Focusing on a narrow definition and application of what these acknowledged and regulated professions already do does not avoid the need to regulate what may be referred to as a new profession. Any claim that a third/paid party is only analyzing behavior avoids recognizing the need for training and the ability to hold these people accountable on behalf of the public as we do with those other professions. It would be unconscionable for the department to fail to regulate people attempting to change human behavior that is only presumed to be maladaptive by special interest groups such as homosexuality.

Assuming that some or most of the people who might be viewed as needing behavioral analysis and behavioral change are likely to be children, their interests will not be well protected by a sub-group of lesser prepared and unregulated specialists.

Department response: No changes were made to the report in response to this comment.

Appendix A

Request from Legislature and Draft Bill

State of
Washington
House of
Representatives



May 8, 2014

John Wiesman, Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Wiesman,

I am requesting that the Department of Health consider a sunrise review application for a proposal that would create a new licensed profession for behavior analysts. Under the attached proposal, the practice of behavior analysis is defined to include the design, implementation, and evaluation of instructional and environmental modifications to improve human behavior. The proposal establishes standards for licensing behavior analysts and assistant behavior analysts.

A copy of the proposal is attached. I appreciate your consideration of this application, and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Eileen Cody".

EILEEN CODY, Chair
House Health Care and Wellness Committee

Cc: Representative Ruth Kagi
Martin Mueller, Washington State Department of Health
Christopher Jones, Washington Association for Behavior Analysis
Alexa Silver, Office of Program Research
Jim Morishima, Office of Program Research

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-4577.1/14

ATTY/TYPIST: AL:eab

BRIEF DESCRIPTION: Requiring licensure for behavior analysis professionals.

1 AN ACT Relating to behavior analysts; reenacting and amending RCW
2 18.120.020 and 18.130.040; adding a new chapter to Title 18 RCW;
3 creating a new section; and providing an effective date.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** The definitions in this section apply
6 throughout this chapter unless the context clearly requires otherwise.

7 (1) "Behavior technician" means a paraprofessional who implements
8 a behavior analysis treatment plan under the close, ongoing supervision
9 of a licensed behavior analyst or a licensed assistant behavior
10 analyst, but who does not design or supervise the implementation of a
11 behavior analysis treatment plan.

12 (2) "Board" means the Washington state board of behavior analysis.

13 (3) "Department" means the department of health.

14 (4) "Licensed assistant behavior analyst" means an individual who
15 is licensed under this chapter to engage in the practice of behavior
16 analysis under the supervision of a licensed behavior analyst.

17 (5) "Licensed behavior analyst" means an individual who is licensed
18 under this chapter to engage in the independent practice of behavior
19 analysis.b

1 (6) (a) "Practice of behavior analysis" means:

2 (i) The design, implementation, and evaluation of instructional and
3 environmental modifications based on scientific research and the direct
4 observation and measurement of behavior and the environment to produce
5 socially significant improvements in human behavior;

6 (ii) Empirical identification of functional relations between
7 behavior and environmental factors, known as functional assessment and
8 analysis; and

9 (iii) Utilization of contextual factors, motivating operations,
10 antecedent stimuli, positive reinforcement, and other consequences to
11 assist individuals in developing new behaviors, increasing or
12 decreasing existing behaviors, and emitting behaviors under specific
13 environmental conditions.

14 (b) "Practice of behavior analysis" does not include psychological
15 testing, diagnosis of a mental or physical disorder, neuropsychology,
16 psychotherapy, cognitive therapy, sex therapy, psychoanalysis,
17 hypnotherapy, or long-term counseling as treatment modalities.

18 (7) "Secretary" means the secretary of health.

19 NEW SECTION. **Sec. 2.** (1) Except as provided in section 3 of this
20 act, no person may engage in the practice of behavior analysis unless
21 he or she holds a license or a temporary license under this chapter.

22 (2) A person not licensed under this chapter may not represent
23 himself or herself as a "licensed behavior analyst" or a "licensed
24 assistant behavior analyst."

25 NEW SECTION. **Sec. 3.** Nothing in this chapter may be construed to
26 prohibit or restrict:

27 (1) An individual who holds a credential issued by this state,
28 other than as a licensed behavior analyst or a licensed assistant
29 behavior analyst, to engage in the practice of that occupation or
30 profession without obtaining an additional credential from the state,
31 so long as the practice is within that profession's or occupation's
32 scope of practice and the individual's scope of training and
33 competence;

34 (2) A person employed as a behavior analyst or assistant behavior
35 analyst by the government of the United States if the person provides

1 behavior analysis services solely under the direction or control of the
2 agency by which the person is employed;

3 (3) An employee of a school district, charter school, or private
4 school approved under chapter 28A.195 RCW in the performance of his or
5 her regular duties of employment, so long as the employee does not
6 offer behavior analytic services to any person or entity other than the
7 school employer and does not accept remuneration for providing behavior
8 analytic services other than the remuneration he or she receives from
9 the school employer;

10 (4) The practice of behavior analysis by a matriculated college or
11 university student if he or she: (a) Participates in a defined course,
12 internship, practicum, or program of study; (b) is supervised by
13 college or university faculty or a licensed behavior analyst; and (c)
14 uses a title that clearly indicates trainee status, such as "behavior
15 analysis student," "behavior analysis intern," or "behavior analysis
16 trainee";

17 (5) The practice of behavior analysis by an individual pursuing
18 supervised experiential training to meet eligibility requirements for
19 licensure under this chapter or national certification in behavior
20 analysis, so long as the training is supervised by a licensed behavior
21 analyst who meets any additional requirements established by the board
22 or by a professional who meets supervisor requirements determined by a
23 national certifying entity;

24 (6) Implementation of a behavior analysis treatment plan by a
25 behavior technician or a family member of a recipient of behavior
26 analysis services so long as the behavior technician or family member
27 is under the supervision of a licensed behavior analyst or a licensed
28 assistant behavior analyst;

29 (7) The activities of a behavior analyst who practices with
30 nonhumans including, but not limited to, animal trainers and applied
31 animal behaviorists; or

32 (8) The activities of a behavior analyst who provides general
33 behavior analysis services to organizations so long as those services
34 are for the benefit of the organization and do not involve direct
35 services to individuals.

36 NEW SECTION. **Sec. 4.** (1) The Washington state board of behavior
37 analysis is created, with members appointed by the governor.

1 (2) The board consists of the following five members:

2 (a) Three members who are licensed behavior analysts or, for the
3 initial members of the board, certified by the national behavior
4 analyst certification board as either a board certified behavior
5 analyst or a board certified behavior analyst - doctoral;

6 (b) One member who is a licensed assistant behavior analyst or, for
7 the initial members of the board, certified by the national behavior
8 analyst certification board as a board certified assistant behavior
9 analyst; and

10 (c) One member of the public who is not a member of any other
11 health care licensing board or commission and does not have a material
12 or financial interest in the rendering of services regulated under this
13 chapter. The public member may be the parent or guardian of a
14 recipient of behavior analysis services.

15 (3) The members of the board shall serve for four-year terms.
16 Members hold office until their successors are appointed. The governor
17 shall appoint the initial members of the board to staggered terms from
18 one to four years. Thereafter, all members must be appointed to full
19 four-year terms.

20 (4) No appointee may serve more than two consecutive terms.

21 (5) The board shall elect officers each year. The board shall meet
22 at least twice each year and may hold additional meetings as called by
23 the chair. Meetings of the board are open to the public, except that
24 the board may hold executive sessions to the extent permitted by
25 chapter 42.30 RCW. The department shall provide secretarial, clerical,
26 and other assistance as required by the board.

27 (6) Each member of the board must be compensated in accordance with
28 RCW 43.03.240. Members must be reimbursed for travel expenses incurred
29 in the actual performance of their duties, as provided in RCW 43.03.050
30 and 43.03.060.

31 (7) A majority of the board members appointed and serving
32 constitutes a quorum for the transaction of board business. The
33 affirmative vote of a majority of a quorum of the board is required to
34 carry a motion or resolution, adopt a rule, or pass a measure.

35 (8) The governor may remove a member of the board for neglect of
36 duty, misconduct, or malfeasance or misfeasance in office. If a
37 vacancy occurs on the board, the governor shall appoint a replacement
38 to fill the remainder of the unexpired term.

1 NEW SECTION. **Sec. 5.** In addition to any other authority provided
2 by law, the board has the authority to:

3 (1) Determine the qualifications of persons applying for licensure
4 under this chapter in conformance with section 6 of this act;

5 (2) Adopt a professional examination in the practice of behavior
6 analysis that is developed and administered by a nationally accredited
7 professional credentialing entity; and

8 (3) Adopt rules under chapter 34.05 RCW as necessary to implement
9 this chapter, including rules establishing continuing competency as a
10 condition of license renewal and rules establishing standards for
11 delegation and supervision of assistive personnel.

12 NEW SECTION. **Sec. 6.** (1) The secretary shall issue a license to
13 an applicant who submits a completed application, pays the appropriate
14 fees, and meets the following requirements:

15 (a) Successfully completes any educational or practical experience
16 requirements established by the board;

17 (b) Successfully completes the examination approved by the board
18 pursuant to section 5 of this act;

19 (c) Demonstrates good moral character;

20 (d) Has not engaged in unprofessional conduct as defined in RCW
21 18.130.180;

22 (e) Is not currently subject to any disciplinary proceedings; and

23 (f) Is not unable to practice with reasonable skill and safety as
24 defined in RCW 18.130.170.

25 (2) In addition, an applicant for an assistant behavior analyst
26 license must provide proof of ongoing supervision by a licensed
27 behavior analyst.

28 (3) A license issued under this section is valid for a period of
29 two years.

30 NEW SECTION. **Sec. 7.** Applications for licensing must be submitted
31 on forms provided by the secretary. The secretary may require any
32 information and documentation that reasonably relates to the need to
33 determine whether the applicant meets the criteria for licensing
34 provided for in this chapter and chapter 18.130 RCW. Each applicant
35 shall pay a fee determined by the secretary under RCW 43.70.250. The
36 fee must accompany the application.

1 NEW SECTION. **Sec. 8.** (1) The board shall establish by rule the
2 requirements for renewal of a license, but may not increase the
3 licensure requirements provided in this chapter. The secretary shall
4 establish administrative procedures, administrative requirements, and
5 fees for license periods and renewals as provided in RCW 43.70.250 and
6 43.70.280.

7 (2) Failure to renew the license invalidates the license and all
8 privileges granted by the license. If a license has lapsed for a
9 period longer than three years, the person shall demonstrate competence
10 to the satisfaction of the board by completing continuing competency
11 requirements or meeting other standards determined by the board.

12 NEW SECTION. **Sec. 9.** The secretary may grant a temporary license
13 to a person who does not reside in this state if he or she: (1) Is
14 licensed to practice behavior analysis independently in another state
15 or province of Canada; or (2) meets other qualifications established by
16 the board. A temporary license holder may only practice behavior
17 analysis for a limited period of time, as defined by the board.

18 NEW SECTION. **Sec. 10.** An applicant holding a license in another
19 state or a province of Canada may be licensed to practice in this state
20 if the board determines that the licensing standards of the other state
21 or province are substantially equivalent to the licensing standards in
22 this chapter.

23 NEW SECTION. **Sec. 11.** The uniform disciplinary act, chapter
24 18.130 RCW, governs unlicensed practice, the issuance and denial of a
25 license, and the discipline of persons licensed under this chapter.

26 **Sec. 12.** RCW 18.120.020 and 2012 c 153 s 15, 2012 c 137 s 18, and
27 2012 c 23 s 8 are each reenacted and amended to read as follows:

28 The definitions in this section apply throughout this chapter
29 unless the context clearly requires otherwise.

30 (1) "Applicant group" includes any health professional group or
31 organization, any individual, or any other interested party which
32 proposes that any health professional group not presently regulated be
33 regulated or which proposes to substantially increase the scope of
34 practice of the profession.

1 (2) "Certificate" and "certification" mean a voluntary process by
2 which a statutory regulatory entity grants recognition to an individual
3 who (a) has met certain prerequisite qualifications specified by that
4 regulatory entity, and (b) may assume or use "certified" in the title
5 or designation to perform prescribed health professional tasks.

6 (3) "Grandfather clause" means a provision in a regulatory statute
7 applicable to practitioners actively engaged in the regulated health
8 profession prior to the effective date of the regulatory statute which
9 exempts the practitioners from meeting the prerequisite qualifications
10 set forth in the regulatory statute to perform prescribed occupational
11 tasks.

12 (4) "Health professions" means and includes the following health
13 and health-related licensed or regulated professions and occupations:
14 Podiatric medicine and surgery under chapter 18.22 RCW; chiropractic
15 under chapter 18.25 RCW; dental hygiene under chapter 18.29 RCW;
16 dentistry under chapter 18.32 RCW; denturism under chapter 18.30 RCW;
17 dental anesthesia assistants under chapter 18.350 RCW; dispensing
18 opticians under chapter 18.34 RCW; hearing instruments under chapter
19 18.35 RCW; naturopaths under chapter 18.36A RCW; embalming and funeral
20 directing under chapter 18.39 RCW; midwifery under chapter 18.50 RCW;
21 nursing home administration under chapter 18.52 RCW; optometry under
22 chapters 18.53 and 18.54 RCW; ocularists under chapter 18.55 RCW;
23 osteopathic medicine and surgery under chapters 18.57 and 18.57A RCW;
24 pharmacy under chapters 18.64 and 18.64A RCW; medicine under chapters
25 18.71 and 18.71A RCW; emergency medicine under chapter 18.73 RCW;
26 physical therapy under chapter 18.74 RCW; practical nurses under
27 chapter 18.79 RCW; psychologists under chapter 18.83 RCW; registered
28 nurses under chapter 18.79 RCW; occupational therapists licensed under
29 chapter 18.59 RCW; respiratory care practitioners licensed under
30 chapter 18.89 RCW; veterinarians and veterinary technicians under
31 chapter 18.92 RCW; massage practitioners under chapter 18.108 RCW; East
32 Asian medicine practitioners licensed under chapter 18.06 RCW; persons
33 registered under chapter 18.19 RCW; persons licensed as mental health
34 counselors, marriage and family therapists, and social workers under
35 chapter 18.225 RCW; dietitians and nutritionists certified by chapter
36 18.138 RCW; radiologic technicians under chapter 18.84 RCW; nursing
37 assistants registered or certified under chapter 18.88A RCW; ((and))
38 reflexologists certified under chapter 18.108 RCW; ((and)) medical

1 assistants-certified, medical assistants-hemodialysis technician,
2 medical assistants-phlebotomist, and medical assistants-registered
3 certified and registered under chapter 18.360 RCW; and licensed
4 behavior analysts and licensed assistant behavior analysts under
5 chapter 18.--- RCW (the new chapter created in section 14 of this act).

6 (5) "Inspection" means the periodic examination of practitioners by
7 a state agency in order to ascertain whether the practitioners'
8 occupation is being carried out in a fashion consistent with the public
9 health, safety, and welfare.

10 (6) "Legislative committees of reference" means the standing
11 legislative committees designated by the respective rules committees of
12 the senate and house of representatives to consider proposed
13 legislation to regulate health professions not previously regulated.

14 (7) "License," "licensing," and "licensure" mean permission to
15 engage in a health profession which would otherwise be unlawful in the
16 state in the absence of the permission. A license is granted to those
17 individuals who meet prerequisite qualifications to perform prescribed
18 health professional tasks and for the use of a particular title.

19 (8) "Professional license" means an individual, nontransferable
20 authorization to carry on a health activity based on qualifications
21 which include: (a) Graduation from an accredited or approved program,
22 and (b) acceptable performance on a qualifying examination or series of
23 examinations.

24 (9) "Practitioner" means an individual who (a) has achieved
25 knowledge and skill by practice, and (b) is actively engaged in a
26 specified health profession.

27 (10) "Public member" means an individual who is not, and never was,
28 a member of the health profession being regulated or the spouse of a
29 member, or an individual who does not have and never has had a material
30 financial interest in either the rendering of the health professional
31 service being regulated or an activity directly related to the
32 profession being regulated.

33 (11) "Registration" means the formal notification which, prior to
34 rendering services, a practitioner shall submit to a state agency
35 setting forth the name and address of the practitioner; the location,
36 nature and operation of the health activity to be practiced; and, if
37 required by the regulatory entity, a description of the service to be
38 provided.

1 (12) "Regulatory entity" means any board, commission, agency,
2 division, or other unit or subunit of state government which regulates
3 one or more professions, occupations, industries, businesses, or other
4 endeavors in this state.

5 (13) "State agency" includes every state office, department, board,
6 commission, regulatory entity, and agency of the state, and, where
7 provided by law, programs and activities involving less than the full
8 responsibility of a state agency.

9 **Sec. 13.** RCW 18.130.040 and 2013 c 171 s 8 and 2013 c 19 s 45 are
10 each reenacted and amended to read as follows:

11 (1) This chapter applies only to the secretary and the boards and
12 commissions having jurisdiction in relation to the professions licensed
13 under the chapters specified in this section. This chapter does not
14 apply to any business or profession not licensed under the chapters
15 specified in this section.

16 (2) (a) The secretary has authority under this chapter in relation
17 to the following professions:

18 (i) Dispensing opticians licensed and designated apprentices under
19 chapter 18.34 RCW;

20 (ii) Midwives licensed under chapter 18.50 RCW;

21 (iii) Ocularists licensed under chapter 18.55 RCW;

22 (iv) Massage practitioners and businesses licensed under chapter
23 18.108 RCW;

24 (v) Dental hygienists licensed under chapter 18.29 RCW;

25 (vi) East Asian medicine practitioners licensed under chapter 18.06
26 RCW;

27 (vii) Radiologic technologists certified and X-ray technicians
28 registered under chapter 18.84 RCW;

29 (viii) Respiratory care practitioners licensed under chapter 18.89
30 RCW;

31 (ix) Hypnotherapists and agency affiliated counselors registered
32 and advisors and counselors certified under chapter 18.19 RCW;

33 (x) Persons licensed as mental health counselors, mental health
34 counselor associates, marriage and family therapists, marriage and
35 family therapist associates, social workers, social work associates--
36 advanced, and social work associates--independent clinical under
37 chapter 18.225 RCW;

1 (xi) Persons registered as nursing pool operators under chapter
2 18.52C RCW;

3 (xii) Nursing assistants registered or certified or medication
4 assistants endorsed under chapter 18.88A RCW;

5 (xiii) Dietitians and nutritionists certified under chapter 18.138
6 RCW;

7 (xiv) Chemical dependency professionals and chemical dependency
8 professional trainees certified under chapter 18.205 RCW;

9 (xv) Sex offender treatment providers and certified affiliate sex
10 offender treatment providers certified under chapter 18.155 RCW;

11 (xvi) Persons licensed and certified under chapter 18.73 RCW or RCW
12 18.71.205;

13 (xvii) Orthotists and prosthetists licensed under chapter 18.200
14 RCW;

15 (xviii) Surgical technologists registered under chapter 18.215 RCW;

16 (xix) Recreational therapists under chapter 18.230 RCW;

17 (xx) Animal massage practitioners certified under chapter 18.240
18 RCW;

19 (xxi) Athletic trainers licensed under chapter 18.250 RCW;

20 (xxii) Home care aides certified under chapter 18.88B RCW;

21 (xxiii) Genetic counselors licensed under chapter 18.290 RCW;

22 (xxiv) Reflexologists certified under chapter 18.108 RCW; and

23 (xxv) Medical assistants-certified, medical assistants-hemodialysis
24 technician, medical assistants-phlebotomist, and medical assistants-
25 registered certified and registered under chapter 18.360 RCW.

26 (b) The boards and commissions having authority under this chapter
27 are as follows:

28 (i) The podiatric medical board as established in chapter 18.22
29 RCW;

30 (ii) The chiropractic quality assurance commission as established
31 in chapter 18.25 RCW;

32 (iii) The dental quality assurance commission as established in
33 chapter 18.32 RCW governing licenses issued under chapter 18.32 RCW,
34 licenses and registrations issued under chapter 18.260 RCW, and
35 certifications issued under chapter 18.350 RCW;

36 (iv) The board of hearing and speech as established in chapter
37 18.35 RCW;

1 (v) The board of examiners for nursing home administrators as
2 established in chapter 18.52 RCW;

3 (vi) The optometry board as established in chapter 18.54 RCW
4 governing licenses issued under chapter 18.53 RCW;

5 (vii) The board of osteopathic medicine and surgery as established
6 in chapter 18.57 RCW governing licenses issued under chapters 18.57 and
7 18.57A RCW;

8 (viii) The pharmacy quality assurance commission as established in
9 chapter 18.64 RCW governing licenses issued under chapters 18.64 and
10 18.64A RCW;

11 (ix) The medical quality assurance commission as established in
12 chapter 18.71 RCW governing licenses and registrations issued under
13 chapters 18.71 and 18.71A RCW;

14 (x) The board of physical therapy as established in chapter 18.74
15 RCW;

16 (xi) The board of occupational therapy practice as established in
17 chapter 18.59 RCW;

18 (xii) The nursing care quality assurance commission as established
19 in chapter 18.79 RCW governing licenses and registrations issued under
20 that chapter;

21 (xiii) The examining board of psychology and its disciplinary
22 committee as established in chapter 18.83 RCW;

23 (xiv) The veterinary board of governors as established in chapter
24 18.92 RCW;

25 (xv) The board of naturopathy established in chapter 18.36A RCW;
26 ((and))

27 (xvi) The board of denturists established in chapter 18.30 RCW; and

28 (xvii) The board of behavior analysis established in chapter 18.---
29 RCW (the new chapter created in section 14 of this act).

30 (3) In addition to the authority to discipline license holders, the
31 disciplining authority has the authority to grant or deny licenses.
32 The disciplining authority may also grant a license subject to
33 conditions.

34 (4) All disciplining authorities shall adopt procedures to ensure
35 substantially consistent application of this chapter, the uniform
36 disciplinary act, among the disciplining authorities listed in
37 subsection (2) of this section.

1 NEW SECTION. **Sec. 14.** Sections 1 through 11 of this act
2 constitute a new chapter in Title 18 RCW.

3 NEW SECTION. **Sec. 15.** Except for sections 4, 5, and 16 of this
4 act, this act takes effect July 1, 2016.

5 NEW SECTION. **Sec. 16.** The secretary of health and the board of
6 behavior analysis may adopt such rules as authorized by this act to
7 ensure that the sections in this act are implemented on their effective
8 dates.

--- END ---

Appendix B

Applicant Report and Follow Up

Applicant Report Cover Sheet and Outline
Washington State Department of Health Sunrise Review

COVER SHEET

- Legislative proposal being reviewed under the sunrise process (include bill number if available):

Bill H-4577.1/14 Regarding licensure for behavior analysts

- Name and title of profession the applicant seeks to credential/institute change in scope of practice:

Name and Title of Profession: Behavior Analyst

- Applicant's organization: Washington Association for Behavior Analysis

Contact person: Christopher Jones, PhD, BCBA-D

Address: 3211 NE 87th St., Seattle, WA

Telephone number: 206-853-9531

Email address: chrjones@washingtonaba.org

- Number of members in the organization: 95

Approximate number of individuals practicing in Washington: Unknown. Possibly 150-500.

Name(s) and address(es) of national organization(s) with which the state organization is affiliated:

Association for Behavior Analysis International: 550 W. Centre Ave., Portage, MI. 49024.

Association of Professional Behavior Analysts: 6977 Navajo Rd. #176, San Diego, CA. 92119.

- Name(s) of other state organizations representing the profession:

Washington Association for Behavior Analysis

Applicant Report
Washington State Department of Health Sunrise Review
Outline of Factors to be Addressed

Please refer to RCW 18.120.030 (attached) for more detail. Concise, narrative answers are encouraged. Please explain the following:

(1) Define the problem and why regulation is necessary:

- a. *The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety*

Behavior analysis is a scientific discipline whose subject matter is individual behavior interacting with environmental events. Like other scientific disciplines, behavior analysis has theoretical, experimental, and applied branches, journals, scholarly and professional organizations, university training programs, and professional credentials. The applied branch of the discipline (applied behavior analysis; ABA) involves using scientific principles and procedures discovered through basic and applied research to improve socially significant behavior to a meaningful degree. Thousands of studies published in peer-reviewed scientific journals have demonstrated the efficacy of many ABA procedures – singly and in various combinations -- for building skills and reducing problem behaviors in many clinical and non-clinical populations in a wide range of settings. Almost as soon as that evidence began to accrue in the 1960s, there was great interest in using it within a variety of human service settings, and the practice of applied behavior analysis was born. It has grown exponentially in recent years with increased demand for ABA services from consumers, employers, and funding sources.

The practice of behavior analysis involves the design, implementation, and evaluation of instructional and environmental modifications by a behavior analyst to produce socially significant improvements in human behavior. It includes the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis. Applied behavior analysis interventions are based on scientific research and the direct observation and measurement of behavior and environment. They utilize contextual factors, establishing operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions. Typical clients of ABA practitioners include individuals with autism and other developmental disabilities, intellectual disabilities, learning and communication difficulties, brain injuries, physical disabilities, and difficulties associated with aging, as well as typically developing individuals. Practitioners of ABA work in a variety of settings, including private and public clinics, private homes, hospitals, schools, nursing homes, group homes, universities, and business settings.

Many people with autism and related disorders, intellectual disabilities, traumatic brain injuries, and other conditions exhibit behaviors that directly jeopardize their health and safety, such as self-injury, elopement, pica (ingesting inedible items), feeding problems, and aggression. Such behaviors often result in costly and largely ineffective use of psychotropic medications, emergency room services, hospitalizations, and residential services as well as tremendous emotional and financial burdens for families (e.g., Mandell, 2007; Montes & Halterman, 2008; Tsakanikos, Costello, Holt, Sturmey, & Bouras, 2006). Substantial research shows that

competently designed and delivered ABA interventions are effective for reducing problem behaviors (e.g., Campbell, 2003; Hagopian, Rooker, & Rolider, 2011; Hassiotis, Canagasabe, Robotham, Martston, & Romeo, 2010; Heyvaert, Maes, Van den Noortgate, Kuppens, & Onghena, 2012; and Lang et al., 2009). Conversely, research has shown that interventionists who lack sufficient training in ABA can actually *increase* the occurrence of such behaviors in people with autism and other disorders (e.g., Lovaas, Freitag, Gold, & Kassorla, 1965; Lovaas & Simmons, 1969; Mason & Iwata, 1990; also see Hanley, Iwata, & McCord, 2003).

Abundant research also shows that early, intensive ABA treatment can produce moderate to large improvements in the overall functioning of many young children with autism when that treatment is designed and supervised by qualified professional behavior analysts (e.g., see Eldevik et al., 2009, 2010; Green, 2011). The resulting decreased need for specialized services yields large cost savings for the systems that are responsible for education, healthcare, and other services for people with autism (Chasson, Harris, & Neely, 2007; Jacobson, Mulick, & Green, 1998; Motiwala, Gupta, & Lilly, 2006). In contrast, studies have shown that early “behavioral” intervention overseen by individuals who made unsupported claims to be qualified as ABA “consultants” produced no improvements in young children with autism (Bibby, et al., 2002; Mudford, et al., 2001). Thus the fees paid to those consultants as well as the very precious time of the children they served were lost.

The knowledge just summarized, coupled with the demand for ABA services for people with autism that began to accelerate in the early 1990s, underscores the need for uniform, objective, verifiable standards and procedures for consumers, governments, and funding sources to use to identify individuals with the training and competencies required to practice ABA. The Behavior Analyst Certification Board (BACB) was established in 1998 to develop such standards and procedures. The BACB is an independent, nonprofit organization that is accredited by the National Commission for Certifying Agencies (NCCA) of the Institute for Credentialing Excellence to certify professional practitioners of ABA. The NCCA’s rigorous standards are grounded in case law and best practices regarding professional credentialing. Over the past 15 years, the BACB has developed competencies to practice ABA and standards for certifying practitioners based on extensive job analysis studies involving thousands of professional behavior analysts (see Task List at http://www.bacb.com/Downloadfiles/TaskList/BACB_Fourth_Edition_Task_List.pdf). This document is also included within the appendix at the end of this report. The standards include degrees, coursework, supervised experiential training, and passage of a professionally designed and managed examination in behavior analysis. The BACB is required to repeat the job analysis periodically and to use the results to upgrade the certification requirements so that they reflect new developments in research and in the professional practice of behavior analysis. *In short, the BACB certification requirements represent empirically derived international standards for practicing ABA that have been developed by the profession.* Those standards parallel requirements for practicing most legitimate professions. At present the BACB is the only entity that is accredited to certify practitioners of ABA, and it administers the only psychometrically and legally validated professional examination in the practice of ABA. For those and other reasons, BACB certifications have been incorporated in many licensure and other laws specifying qualifications to practice ABA around the U.S.

The BACB credentials practitioners at three levels. The current requirements for BACB certification are as follows:

Board Certified Behavior Analyst (BCBA):

- At least a master's degree in applied behavior analysis or a related field from an accredited institution.
- Completion of required coursework in applied behavior analysis (currently 225 classroom hours of graduate-level instruction in specified topics in behavior analysis. This increases to 270 hours of coursework in 2015).
- Completion of specified hours of supervised experience in applied behavior analysis, obtained either through BACB-approved university practica (currently 750 or 1000 hours, depending on the intensity of supervision) or independent fieldwork (currently 1500 hours), conducted and documented in accordance with standards set by the BACB.
- Passage of the BACB examination for BCBA certification.
- Alternative pathways exist for individuals who teach behavior analysis in full-time university faculty positions and individuals with doctorates and at least 10 years' experience in behavior analysis to qualify to take the BCBA examination.

BCBAs with doctoral degrees can also apply for the designation Board Certified Behavior Analyst – Doctoral (BCBA-D).

Board Certified Assistant Behavior Analyst (BCaBA):

- At least an undergraduate degree behavior in analysis or a related field from an accredited institution.
- Completion of required coursework in behavior analysis (currently 135 classroom hours of instruction in specified behavior analysis topics. This increases to 180 hours of coursework in 2015).
- Completion of specified hours of supervised experience in applied behavior analysis, obtained either through BACB-approved university practica (currently 500 or 670 hours, depending on the intensity of supervision) or independent fieldwork (currently 1000 hours), conducted and documented in accordance with standards set by the BACB.
- Passage of the BACB examination for BCaBA certification.

The BACB has also developed *Guidelines for Responsible Conduct for Behavior Analysts* and *Professional Disciplinary and Ethical Standards* (available at www.BACB.com, “Ethics and Discipline”), which are designed to protect consumers as well as BACB-certified practitioners. These documents are also included as appendices at the end of this report. All BACB certificants must comply with BACB standards as well as continuing education requirements in order to maintain their certifications. The BACB does not enforce its *Guidelines for Responsible Conduct* at present, but it does enforce the *Professional Disciplinary and Ethical Standards* and imposes sanctions on violators. It is important to note, however, that the BACB does not have the same authority to oversee practice as a governmental entity, such as a state regulatory board. For instance, the BACB can do little about the practice of individuals who claim to be qualified to practice ABA but are not certified by the BACB unless they are representing themselves as holding the BCBA or BCaBA certification.

At present, there is no entity in Washington State that is authorized by law to regulate all practitioners of ABA, and thus no mechanism to protect state agencies, employers, and consumers from individuals who make false claims to the necessary competence. Requirements to provide ABA services differ dramatically from one funding source to another (e.g., Medicaid,

private insurance, state waivers, etc.). For example, the HCA lists a variety of educational and supervision requirements that are complex and burdensome, and are not consistent with the standards established by the profession. On the opposite end of the spectrum, many health insurance plans have specified few or no requirements for supervising and delivering ABA services. That makes it impossible to evaluate, much less assure, the quality of services that are characterized as “ABA.” It also means that consumers of those services have few protections. They have no assurance that only professionals who have met the international standards for practicing ABA are permitted to oversee and deliver ABA services.

To secure reimbursement for their services, some behavior analysts in Washington have been required to attain a state-issued credential as a counselor whose practice is regulated by Chapter 18.19 RCW. The practice of counseling differs substantially from the practice of behavior analysis (defined above), so the training and competencies required to practice counseling differ substantially from the training and competencies required to practice ABA. Therefore, credentialing behavior analysts in Washington as counselors misleads and confuses the public. Additionally, the current regulation requires behavior analysts to consult with licensed mental health counselors (LMHCs) who may not have any bona fide training and experience in ABA and may have an approach to intervention that differs very substantially from that of behavior analysts. That not only creates unnecessary administrative red tape and costs, it also puts consumers at risk of being caught in the middle of disagreements between professionals.

Relatedly, Washington agencies that are licensed by the Division of Behavioral Health and Recovery to provide services that may include ABA interventions (e.g. “wraparound services”) require those services to be supervised by a Mental Health Professional (MHP). An MHP is not required to have any training or to pass a professional examination in ABA, so all of the concerns discussed in the preceding paragraph apply here as well.

The need for state regulation of ABA practitioners has been further exacerbated by decisions in several recent legal cases designating ABA services as medically necessary for children with autism and a benefit that must be covered by private and public health plans, including Medicaid. With a 2012 settlement and agreement by Washington’s Healthcare Authority (HCA) to provide coverage of ABA services for children on the autism spectrum, the need has increased for a body of professional behavior analysts in Washington to apply objective standards and procedures for determining who is qualified to practice ABA professionally and to oversee that practice. Without such regulation, our most vulnerable citizens are at significant risk of harm from individuals who lack the training that the profession deems necessary to practice ABA, and have not demonstrated competence by passing a professional examination in ABA. Establishing state licensure of behavior analysts with BACB certification as the primary qualification will fill that void and protect the public.

- b. The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health professions*

The legislation proposed here would make passage of the only professional examinations in the practice of ABA that are administered by a nationally accredited credentialing body – the BACB certification exams – the principal requirement for obtaining and maintaining licenses to practice ABA in Washington. Everyone who passes a BACB exam is certified by the BACB; therefore, successful applicants for licensure in Washington will be certified by the BACB. That will remediate

the problems described above and afford the following benefits to consumers, employers, and the state:

- Assuring that license holders meet international standards for practicing ABA that are set by the profession. That includes passing a valid professional examination in the subject matter – a common requirement for obtaining most legitimate professional licenses.
- Establishing a state licensing board comprising professional behavior analysts to regulate the practice of licensees, and to coordinate with the BACB on disciplinary matters. That will provide Washington consumers of ABA services a dual layer of protection, as the practice of licensees will be overseen by both the state licensing board and the BACB.
- A cost-effective means of providing the protections just described, because those who apply to the state licensing board will have had their degree(s), coursework, and supervised experiential training in behavior analysis verified by the BACB and will have passed a psychometrically and legally validated international professional examination in behavior analysis.

c. *The extent of autonomy a practitioner has, as indicated by:*

- i. *The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment*

The independent practice of ABA requires a high level of specialized formal and experiential training, as reflected in the BACB certification standards. Behavior analysts often work with individuals who engage in severe problem behavior such as aggression, property destruction, and self-injury. Those highly vulnerable populations have very different needs than clients that are typically served by several other mental health professionals. To treat such behaviors effectively, a behavior analyst must conduct specialized assessments to identify the environmental events that trigger and reinforce the behaviors, and design highly individualized, evidence-based interventions to build appropriate alternative behaviors. Intervention plans must include procedures for measuring client performance on each treatment target continuously. The independent behavior analytic practitioner is responsible for training direct care personnel, clients' family members, and others who work with the client to implement the intervention and measurement procedures correctly and ethically, and for monitoring data on client progress frequently so that intervention procedures can be modified if necessary. Additional descriptions of the roles of ABA practitioners can be found in Section 9 of this report.

- ii. *The extent to which practitioners are supervised*

As noted in section 9, the BACB requires BCaBAs to be supervised by BCBAs. Currently, however, there is no law in Washington requiring such supervision, and no regulation whatsoever of practitioners who are not certified by the BACB.

(2) The efforts made to address the problem:

a. *Voluntary efforts, if any, by members of the health profession to:*

- i. *Establish a code of ethics*

As discussed earlier, the BACB has developed *Guidelines for Responsible Conduct for Behavior Analysts* and *Professional Disciplinary and Ethical Standards* (available at www.BACB.com and as an appendix to this report). Although the BACB does not enforce the conduct guidelines at present, all certificants must attest to complying with them in order to maintain their certifications. The BACB does enforce the *Professional Disciplinary and Ethical Standards*; however, individuals who are not certified by the BACB are not bound by the BACB's standards unless they misrepresent that they are certified by the BACB. Additionally, the BACB has limited investigatory abilities (i.e., no subpoena power) when addressing violations of the *Professional Disciplinary and Ethical Standards*. Without a state law establishing requirements to practice ABA professionally and a regulatory body to enforce that law, there is no mechanism for holding non-BACB certificants in Washington ethically accountable for the services they provide unless they have a state-issued credential to practice another profession that clearly has behavior analysis in its scope of practice.

ii. *Help resolve disputes between health practitioners and consumers*

Because there are no uniform requirements for practicing ABA and no central body to enforce such requirements in Washington, there is no clear, reliable mechanism for resolving disputes between ABA practitioners and consumers. Currently the burden for resolving grievances rests predominantly on consumers. Procedures for resolving disputes vary substantially from one agency or funding source to another, depending on their proprietary grievance policies. There does not appear to be a formal means of appeal if a consumer feels that their grievance has not been resolved.

b. *Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem*

Existing WACs (388-877, 388-877a) regulate some practices that some behavior analysts perform in Washington State. However, the WACs provide limited and uncoordinated oversight, to the detriment of consumers. For example, the WACs do not apply to ABA practitioners who are not required to be Licensed Mental Health Counselors (LMHC) or Agency Affiliated Counselors (AAC). As noted earlier, the requirements for those credentials are not consistent with international standards for practicing behavior analysis professionally. Furthermore, there are inconsistencies and contradictions in the regulations of state agencies governed by the WACs.

In sum, current regulations regarding the practice of ABA in Washington State are vague, inconsistent, and often conflicting because there are different agencies trying to regulate the practice (DOH and DBHR). Consumers of ABA services will be much better protected by a single regulatory body of professional behavior analysts who are empowered to implement a cohesive set of requirements for practicing ABA in this state.

(3) The alternatives considered:

a. *Regulation of business employers or practitioners rather than employee practitioners*

WACs 388-877 and 388-877A apply only to businesses that operate under a specific agency license. As a result, it is a currently acceptable practice in Washington State for individuals to

purport to provide “ABA” services with no standards and no oversight. There are no other relevant regulations of business employees or practitioners, to our knowledge.

b. Regulation of the program or service rather than the individual practitioners

Regulation of programs and services are not sufficient to prevent individuals who have not met the standards of the profession (i.e., are not BACB certified) from asserting that they are qualified to practice ABA. It is akin to regulating entities that provide medical services without also regulating the practitioners who provide those services. Even if such regulation were adequate, many individuals in the state who are not employed by the regulated agencies claim, but have not demonstrated, competence to practice ABA professionally. At present consumers have no means of verifying the qualifications of those individuals and no central body with which to file complaints about unethical or incompetent practice by those providers. That is, simply regulating programs or services does not protect the vulnerable recipients of ABA services and their family members from harm.

c. Registration of all practitioners

Although registering ABA practitioners in Washington State might begin to address some of the issues described above, it will not remedy most of them, and will not provide adequate protection for consumers. Compiling and making public a list of practitioners without establishing a regulatory board in the state will not ensure that practitioners who do not comply with ethical standards will be held accountable. Additionally, because the BACB already has a registry of all practitioners who pass the exam, adopting BACB certification as the primary standard for licensure will automatically create a registry of those eligible.

d. Certification of all practitioners

State certification of ABA practitioners might afford some protections to consumers *if* BACB certification were the principal requirement for state certification, and *if* a statute and the accompanying regulations established a body of professional behavior analysts within the state and gave that body full authority to regulate the practice of state certificants. We contend, however, that state licensure is necessary to clearly distinguish this profession from others for the sake of consumers and funders, give behavior analysis parity with other professions, afford full protections to consumers of ABA services, and enhance the likelihood that genuine ABA services will be available to the many Washington consumers who seek them. It is worth noting that of the 18 states that have adopted laws to regulate the practice of ABA as of this writing, 17 have elected to license independent practitioners of ABA; only one (Ohio) issues a state certification to practitioners at that level (though three states certify and one registers assistant behavior analysts).

e. Other alternatives

N/A

f. Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest

To date, Washington State has created unacceptably low and conflicting criteria for those who purport to deliver ABA services, and inadequate oversight of the practice. That has produced

considerable confusion among consumers and funders of ABA services. The alternatives specified above will not adequately distinguish behavior analysts from other health professionals nor provide sufficiently strong mechanisms for identifying and overseeing qualified practitioners of ABA that are comparable to those of other professions .

g. *Why licensing would serve to protect the public interest*

By enacting the legislation proposed here, the legislature will ensure that Washington consumers receive ABA services from practitioners who have met standards comparable to those that apply to most other legitimate professions. It will also ensure that, like most other professions, the practice of behavior analysis is regulated by a board of professional behavior analysts with full authority to enforce the licensure law and regulations. That includes authority to investigate alleged violations of ethical standards, and to impose sanctions on those who are found guilty, up to and including revocation of licenses.

(4) The benefit to the public if regulation is granted:

a. *The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation*

At present Washington consumers have little protection from individuals who represent themselves as behavior analysts but have not documented the necessary training nor demonstrated competence through examination by obtaining BACB certification. As a result, unqualified individuals are permitted to provide services to vulnerable citizens and those citizens and their families have no reliable recourse should they suffer harm. Many of those problems will be reduced or eliminated by the proposed licensure law.

b. *Whether the public can identify qualified practitioners*

Members of the public can verify if an individual is certified by the BACB by checking the BACB's online certificant registry. However, there is no state law requiring all practitioners of ABA to hold BACB certification, and no objective, independently verifiable means for the public to evaluate the training and skills of persons who are not certified by the BACB. The proposed licensure law will establish a clear means for consumers to identify qualified practitioners of ABA.

c. *The extent to which the public can be confident that qualified practitioners are competent*

The BACB has conducted several job analysis studies over the past 15 years. Those studies involved extensive surveys of thousands of professional behavior analysts, as well as several panels of subject matter experts. They resulted in a detailed description of the competencies for practicing ABA (the BACB Task List referenced previously). Results of those studies also served as the basis for developing the degree, coursework, and supervised experience requirements necessary to sit for BACB certification exams. The contents of the exams have also been derived from the job analysis studies. The exams have been developed and validated under the guidance of an expert psychometrician to ensure that they comport with best practices for developing and administering high-stakes professional exams. In order to maintain their certification, all BACB certificants must obtain a specified amount of continuing education in behavior analysis and comply with the aforementioned BACB ethical guidelines and disciplinary standards. Thus the

public can be confident that BACB certificants – and therefore Washington licensed behavior analysts and assistant behavior analysts – have met requirements that are comparable to those of many, if not most, other healthcare professions. The fact that the BACB programs are accredited by the well-respected National Commission on Certifying Agencies (NCCA) means that the public can also be assured that requirements for obtaining and maintaining BACB certification/Washington licensure cannot be changed in response to transitory economic or political pressures. All procedures for changing the requirements must comport with the NCCA’s rigorous standards.

- i. *Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners; and how fees would be levied and collected to cover the expenses of administering and operating the regulatory system*

The proposed regulatory entity would comprise five members appointed by the governor. Four members of the board must be persons licensed under the proposed law, except for the initial appointees, who must be certified by the BACB. An additional member must be a public member who is not a member of any other health care licensing board, has no financial obligation to a facility rendering services regulated under the chapter, and does not have material or financial interest in the services that are provided under this licensure.

The responsibilities of the licensure board will be to determine the qualifications for licensure, adopt a professional examination in the practice of behavior analysis that is developed and administered by a nationally accredited credentialing entity, and adopt rules for implementing the licensure law. The board will also receive, investigate, and respond to complaints and grievances from the public and discipline licensees, if necessary. The board will partner with the administration in the Department of Health to levy and collect fees from applicants and to cover the expenses of administering and operating the licensure program.

- ii. *If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date*

Due to the substantial risk of harm to the consumer, the proposed regulation does not have a grandfather clause; therefore, all practitioners will be required to fulfill all licensure requirements prior to seeking licensure.

- iii. *The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions*

The proposed standards for licensure of behavior analysts and assistant behavior analysts are comparable to the standards in other states that have adopted laws regulating practitioners of behavior analysis. As of this writing, 18 states have adopted such laws (see table below). In all 18, BACB certification serves as a qualification for licensure.

State	Assistant Behavior Analyst (bachelor's degree)	Licensed Behavior Analyst (advanced degree)
Alabama	Licensed	Licensed
Arizona	NA	Licensed
Kansas	Licensed	Licensed
Kentucky	Licensed	Licensed
Louisiana	Certified	Licensed
Maryland	NA	Licensed
Massachusetts	Licensed	Licensed
Missouri	Licensed	Licensed
Nevada	Licensed	Licensed
New York	Certified	Licensed
North Dakota	Registered	Licensed
Ohio	NA	Certified
Oklahoma	Certified	Licensed
Oregon	Licensed	Licensed
Rhode Island	Licensed	Licensed

Tennessee	Licensed	Licensed
Virginia	Licensed	Licensed
Wisconsin	NA	Licensed

- iv. *Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions*

The proposed legislation will allow an applicant holding a license to practice behavior analysis in another state or province of Canada to be licensed to practice in Washington if the board determines that the licensing standards of the other state or province are substantially equivalent to the licensing standards in Washington.

- v. *The nature and duration of any training including, but not limited to, whether the training includes a substantial amount of supervised field experience; whether training programs exist in this state; if there will be an experience requirement; whether the experience must be acquired under a registered, certificated, or licensed practitioner; whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; whether all applicants will be required to pass an examination; and if an examination is required, by whom it will be developed and how the costs of development will be met.*

The regulatory board will require applicants to have BACB certification, as that will ensure that they have passed the only professional examination in behavior analysis that is administered by a nationally accredited credentialing body per the proposed licensure statute. The current formal and supervised experiential training requirements for BACB certification are listed in the response to item 1a. They can also be found, along with descriptions of paths for fulfilling the exam eligibility requirements, at <http://www.bacb.com/index.php?page=53>

The BACB pre-approves sequences of university courses that meet the coursework requirements for taking the certification exams, and university practica that meet the supervised experience requirements. Currently there are 3 institutions of higher education in Washington State that have BACB-approved course sequences (Central Washington University, Gonzaga University, and the University of Washington). The University of Washington provides courses via both distance education and on-campus. In addition to the three in-state options, there are also numerous online course sequences offered by other accredited universities. All university course sequences and practica that have been approved by the BACB are listed at <http://www.bacb.com/index.php?page=100358>

As of June 2014, There were 246 BCBA's in the state of Washington who could potentially supervise individuals who pursue the supervised field experience option for fulfilling the BACB's experiential training requirement to sit for a certification exam.

- vi. *What additional training programs are anticipated to be necessary to assure training accessible statewide; the anticipated time required to establish the additional training programs; the types of institutions capable of providing the training; a description of how training programs will meet the needs of the expected work force, including reentry workers, minorities, placebound students, and others*

No additional training programs are anticipated to be necessary to assure that training is accessible statewide.

d. *Assurance of the public that practitioners have maintained their competence*

- i. *Whether the registration, certification, or licensure will carry an expiration date*

The proposed licenses will require renewal every 2 years. If the licensee does not renew, the license will expire at the end of 2 years.

- ii. *Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement*

Renewal of state licensure will require documented ongoing certification and verification by the BACB. That will ensure that applicants for renewal have fulfilled the continuing education requirements set by the profession. This provision is consistent with standards in other state laws regulating practitioners of ABA.

(5) The extent to which regulation might harm the public:

a. *The extent to which regulation will restrict entry into the health profession:*

It is likely that the proposed regulation will restrict the number of individuals who will qualify for licensure slightly. This may occur because some who purport to be “practicing” ABA at present may not be BACB-certified and therefore have not passed the national examination in behavior analysis and met the requirements to take the exam, or have not maintained their BACB certification. The BACB standards have been in place for 15 years, albeit with periodic increases following each job analysis study conducted by the BACB. During that time the number of BACB certificants has increased substantially, suggesting that the standards have not restricted entry into the profession unduly. We anticipate that adoption of the proposed licensure law will ultimately increase the quantity of individuals in Washington who meet the standards set by the profession as well as the quality of ABA services provided to consumers.

- i. *Whether the proposed standards are more restrictive than necessary to insure safe and effective performance.*

The proposed standards are not more restrictive than necessary to insure the safe and effective performance of ABA practices. Rather, the BACB standards are the minimum requirements that the profession deems necessary to practice ABA. The standards are similar to those established by other professions in this state, and by other states that license or otherwise regulate practitioners of behavior analysis.

- ii. *Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same*

manner as state applicants for registration, certification, and licensure when the other jurisdiction has substantially equivalent requirements for registration, certification, or licensure as those in this state.

When a licensed behavior analyst migrates from another jurisdiction to Washington State, s/he may be granted a temporary license to practice in Washington on a time-limited basis. Additionally, applicants who are licensed to practice behavior analysis in other jurisdictions may obtain licensure in the State of Washington if the board determines that the licensing standards of the other jurisdiction are substantially equivalent to the licensing standards in this state.

- b. *Whether there are similar professions to that of the application group which should be included in or portions of the applicant group which should be excluded from, the proposed legislation*

The proposed licensure statute allows members of other professions to practice behavior analysis without being licensed as a behavior analyst, provided that the practice of behavior analysis is in that profession's scope of practice and the individual's scope of training and competence. It also exempts from licensure (a) certain employees of the federal government and school districts who are working within the boundaries of their defined employment; (b) college and university students who engage in ABA activities under appropriate supervision as part of a defined course or program of study; (c) properly supervised individuals who are completing the supervised experiential training requirement for BACB certification/state licensure; (d) behavior technicians and family members who deliver some ABA services under the supervision of licensed behavior analysts or licensed assistant behavior analysts; (e) behavior analysts who practice with nonhumans and provide behavior analysis services to organizations (as opposed to individual clients).

(6) The maintenance of standards:

- a. *Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics:*

The BACB standards and procedures for enforcing them were described previously. The Washington Board of Behavior Analysis will work closely with the BACB to develop and enforce standards that are similar or equivalent to requirements for obtaining and maintaining the BACB credentials.

- b. *How the proposed legislation will assure quality:*

The proposed legislation will assure quality by requiring practitioners who develop and oversee delivery of ABA services in this state to obtain a license demonstrating that they have met the standards established by the profession, including passage of a professional examination in ABA that is developed and administered by a nationally accredited credentialing body (i.e., the BACB).

- i. *The extent to which a code of ethics, if any, will be adopted*

The Washington Board of Behavior Analysis will incorporate the BACB *Guidelines for Responsible Conduct* into the licensure regulations. .

- ii. *The grounds for suspension or revocation of registration, certification, or licensure.*

The Washington Board of Behavior Analysis will develop rules for revoking or suspending licenses that incorporate the BACB Guidelines for Responsible Conduct and Professional Ethical and Disciplinary Standards, along with other standards that may be required by the state.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice:

The tasks typically performed by behavior analysts, the client populations they serve, and the settings in which they work are described in section 9 of this report. At this writing, there are 246 BCBAs and 22 BCaBAs in Washington State. The Washington Association for Behavior Analysis (WABA) is the professional organization for behavior analysts in this state. Its mission is to promote the effective and ethical practice of applied behavior analysis and represent the interests of scientists, providers, and consumers of ABA services. WABA is an Affiliated Chapter of the Association for Behavior Analysis International (ABAI) and an Affiliate of the Association of Professional Behavior Analysts, the two international organizations in the field. Many behavior analysts in Washington are members of one or both of those organizations.

(8) The expected costs of regulation:

- a. *The impact registration, certification, or licensure will have on the costs of the services to the public*

Because the cost of administering the proposed licensure is low, it is not anticipated that adoption of the licensure law will have a measurable impact on the costs of ABA services to the public.

- b. *The cost to the state and to the general public of implementing the proposed legislation*

The Washington Board of Behavior Analysis will not be as costly to operate as the typical licensing board because BACB certification will be the primary qualification for state licensure. The BACB will have vetted applicants for licensure to see that they meet the degree, coursework, and supervised experience requirements set by the profession, and will verify that the applicant has passed the international examination in behavior analysis. The Washington board will not have to incur any of those costs. Additionally, the BACB has mechanisms established for coordinating with state regulatory entities in vetting applicants and on disciplinary matters. Therefore, the Washington Board of Behavior Analysis will be able to function in a cost-effective manner, even when the number of licensees is small to begin with, without charging prohibitive licensure fees. The sample budget that follows is based on actual first year costs of operating the Kentucky behavior analyst licensing board (where BACB certification is the principal requirement for licensure).

Given that some of the 268 BCBAs and BCaBAs in Washington are also licensed in other professions, it can be assumed that not all of them will seek behavior analyst licensure. Therefore, the costs here are based on an estimated 150 initial licensees paying a licensing fee of \$150. Because costs are not substantially tied to number of licensees, it is assumed that if there are more than 150 licensees, the total revenue/cost ratio will improve.

Annual revenue generated: 150 licensees x \$150 = \$22,500

Annual costs:

- Administrative fees: These include DOH staff salaries, office supplies, computer services, telephone services, lease, janitorial services, etc. These are anticipated to be approximately \$10,000 annually.
- Board fees: It is suggested that all board members serve on a voluntary basis for the first year. If revenue supports it, a stipend may be added after the first year. Fees for an attorney to attend board meetings (quarterly for 2 hours each) are estimated at \$1500 annually.
- Travel expenses: It is estimated that at least 2 board members will travel to meetings from the east side of the state by air while the remaining 3 will be within driving distance. Airfare is estimated at \$500 per meeting or \$2000 for the year. Travel costs for the remaining board members are estimated at \$0.55 per mile x 150 miles round trip = \$250 per meeting or \$1000 for the year. A meal per diem is proposed for each board member at \$30 per person = \$150 for each meeting or \$600 for the year. The total annual budget for travel expenses (airfare, miles, meals) would be \$3600.

Total costs:

Admin fees: \$10,000

Board fees: 1,500

Travel: 3,600

TOTAL \$15,100

\$22,500 (revenue) - \$15,100 (expenses) = \$7400 net

- c. *The cost to the state and the members of the group proposed for regulation for the required education, including projected tuition and expenses and expected increases in training programs, staffing, and enrollments at state training institutions.*

We do not anticipate any additional costs for education, tuition, or expenses at this time as the infrastructure for training new behavior analysts currently exists in three state universities.

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:

The BACB describes the roles of ABA practitioners as follows:

The **Board Certified Behavior Analyst® (BCBA®)** is an independent practitioner who also may work as an employee or independent contractor for an organization. The BCBA conducts descriptive and systematic (e.g., analogue) behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases. The BCBA seeks the consultation of more experienced practitioners when necessary. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in

behavior analysis. BCBA's supervise the work of Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions. Certain BCBA certificants with qualifying doctorate degrees may be recognized as "BCBA-D" level certificants.

The **Board Certified Assistant Behavior Analyst® (BCaBA®)** conducts descriptive behavioral assessments and is able to interpret the results and design ethical and effective behavior analytic interventions for clients. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during their training) that are consistent with the dimensions of applied behavior analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to carry out interventions once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA. Governmental entities and other third-party funders, such as Medicaid and TRICARE (the U.S. military's health plan), private health plans, and others utilizing BCaBAs must require this supervision.

The following is a list of the major functions that the proposed Behavior Analyst licensees are expected to perform on a routine basis as part of their normal work responsibilities. Additional descriptions can be found in the Guidelines for Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorders developed by the Behavior Analyst Certification Board (www.bacb.com) and are included as an appendix to this report.

- I. Program Management (50%): Program management includes all the activities that result in the development and effective implementation of a client's intervention plan. The Licensed Behavior Analyst (LBA) has primary responsibility for program management, though s/he may delegate some tasks to a Licensed Assistant Behavior Analyst (LABA) and/or behavior technicians working under the supervision of the LBA. These activities require that a behavior analyst:
 - a. Conduct/update assessments: This involves conducting criterion-referenced and/or curriculum-based assessments and direct observation and measurement of behavior in order to determine current skill level of a client and to determine a plan of treatment. Assessments are also updated on a regular basis in order to determine treatment effectiveness. Sample duties include:
 - i. Conducting descriptive assessments of problematic behavior (open-ended and structured antecedent-behavior-consequence (ABC) assessments)
 - ii. Conducting pattern analysis (e.g., scatterplot analysis)
 - iii. Conducting functional analyses (brief, reversal, alternating treatments) to determine causation of problematic behavior
 - iv. Conducting preference assessments to determine motivators
 - v. Graphing and interpreting results of the assessment for clinical decision making
 - b. Write treatment plans: Behavior analysts utilize the results of the assessments described above, care coordination, and guardian/client input to develop treatment plans. Effective treatment plans include targeted behaviors for change, preventative strategies, skill-building strategies, and responsive strategies. Plans include projected goals and objectives for a set amount of time (3-12 months). Treatment targets are measured at baseline rates and continuously throughout implementation of the treatment plan.
 - c. Write intervention programs: Writing intervention programs involves mapping out detailed instructions for how to develop targeted skills and/or reduce problem behaviors using empirically supported behavior analytic strategies. These programs prescribe delivery of intervention to the client. The process of program writing includes but is not limited to

- i. Selecting treatment targets
- ii. Defining treatment targets clearly and objectively using measurable terms
- iii. Designing and implementing data sheets and graphs to appropriately display data for effective analysis
- iv. Setting mastery criteria
- v. Describing behavior change procedures clearly and completely. For problem behaviors those procedures may include procedures for preventing the behaviors and/or responding to occurrences in ways that protect the safety of the client and those around him/her
- vi. Creating a plan to promote maintenance and generalization of behavior change across time, people, and settings
- d. Program/graph review: The behavior analyst reviews and analyzes data to determine:
 - i. Mastery of targets
 - ii. Why a client may not be progressing
 - iii. How to solve stagnation in progress
 - iv. Future goals and objectives
- e. Write progress reports: Behavior analysts are held accountable for client progress. Therefore, an important part of any intervention is reporting client progress, or lack thereof. Minimum components of a report include:
 - i. Current intervention programs, including a brief description of each
 - ii. Progress made to date on each treatment target
 - iii. Reasons for lack of progress
 - iv. Recommendations for revising intervention procedures, terminating the program, or introducing new targets/intervention programs
- f. Conduct parent/family training: Parent/caregiver training is critical to the success of any ABA intervention program. Trainings should include didactic instruction, modeling correct implementation of procedures, and having the parent/caregiver practice implementing the procedures with coaching and feedback until s/he implements them correctly.

II. Staff Training/Management (45%)

- a. Training staff (LABAs, behavior technicians): Since LABAs and behavior technicians often deliver many interventions directly to clients, it is of utmost importance they be trained by the LBA (or an LABA under supervision) to implement assessment and treatment procedures correctly. Training activities include but are not limited to:
 - i. Didactic instruction on the principles and applications of behavior analysis
 - ii. Conducting treatment team meetings
 - iii. Conducting performance reviews of LABAs and behavior technicians
 - iv. Modeling correct implementation of assessment and intervention procedures
 - v. Assessing the accuracy with which another staff member implements procedures
- b. Ongoing supervision: Due to the nature of behavior analytic work and the variability of behavior, ongoing supervision of treatment delivery by an LBA or LABA under supervision is required. This includes but is not limited to:
 - i. Observing staff implementing procedures and providing feedback
 - ii. Modeling appropriate interventions
 - iii. Monitoring the delivery of all aspects of intervention
- c. Staff development: This involves an LBA or LABA under supervision providing staff members with training about:
 - i. Selecting treatment targets and goals
 - ii. Intervention techniques
 - iii. Behavior analytic research

iv. Ethical considerations

- III. Care Coordination and Collaboration with Related Service Providers (5%): This can include meetings, clinical observations, phone conversations, etc. by the LBA with related service providers to ensure continuity of care.

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Appendices

1. BACB Fourth Edition Task List
2. BACB Guidelines for Responsible Conduct for Behavior Analysts
3. BACB Professional Disciplinary and Ethical Standards
4. BACB Guidelines for Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorders



Fourth Edition Task List

Introduction

The BACB Fourth Edition Task List is organized in three major sections:

I

The first section, **Basic Behavior-Analytic Skills**, covers tasks that a practicing behavior analyst will perform with some, but probably not all, clients. These tasks represent basic, commonly used skills and procedures.

II

The second section, **Client-Centered Responsibilities**, includes tasks related to working with all clients and they should apply in most applied situations.

III

The third section, **Foundational Knowledge**, covers concepts that should have been mastered prior to entering practice as a behavior analyst. The topics listed in this section are not tasks that a practitioner would perform; instead, they are basic concepts that must be understood in order to perform the tasks included in the first two sections.

This list is provided mainly as a resource for instructors and a study tool for candidates. Candidates for the BCBA and BCaBA credentials should have a thorough understanding of these topics.

All of the questions on the BCBA and BCaBA examinations are linked to the tasks listed under Basic Behavior-Analytic Skills and Client-Centered Responsibilities. Each examination form will contain one or two questions evaluating candidate knowledge of every task from these two sections. The topics listed in the Foundational Knowledge section will not be directly assessed with a specific number of questions; however, they may be indirectly assessed through questions about related tasks. For example, a test question about the Client-Centered Responsibility task J-11 “Program for stimulus and response generalization” might cover Foundational Knowledge item 36 “Define and provide examples of response generalization” or item 37 “Define and provide examples of stimulus generalization.”



Ethics and Professional Conduct are subsumed within each section of the task list. The BACB Professional Disciplinary and Ethical Standards and Guidelines for Responsible Conduct for Behavior Analysts are essential companion documents to the task list. BACB certificants must practice in compliance with the professional disciplinary and ethical standards and should structure their practices in accordance with the conduct guidelines. Candidates are expected to have a complete understanding of these documents, including, but not limited to, the importance of ethical conduct as it relates to professional practice of the tasks identified in the Fourth Edition Task List. **As a result, questions addressing ethical issues related to specific tasks will appear on the examination.**

Section I: Basic Behavior-Analytic Skills



A. Measurement

A-01	Measure frequency (i.e., count).
A-02	Measure rate (i.e., count per unit time).
A-03	Measure duration.
A-04	Measure latency.
A-05	Measure interresponse time (IRT).
A-06	Measure percent of occurrence.
A-07	Measure trials to criterion.
A-08	Assess and interpret interobserver agreement.
A-09	Evaluate the accuracy and reliability of measurement procedures.
A-10	Design, plot, and interpret data using equal-interval graphs.
A-11	Design, plot, and interpret data using a cumulative record to display data.
A-12	Design and implement continuous measurement procedures (e.g., event recording).
A-13	Design and implement discontinuous measurement procedures (e.g., partial & whole interval, momentary time sampling).
A-14	Design and implement choice measures.

B. Experimental Design

B-01	Use the dimensions of applied behavior analysis (Baer, Wolf, & Risley, 1968) to evaluate whether interventions are behavior analytic in nature.
B-02	Review and interpret articles from the behavior-analytic literature.
B-03	Systematically arrange independent variables to demonstrate their effects on dependent variables.
B-04	Use withdrawal/reversal designs.
B-05	Use alternating treatments (i.e., multielement) designs.
B-06	Use changing criterion designs.
B-07	Use multiple baseline designs.
B-08	Use multiple probe designs.
B-09	Use combinations of design elements.



B-10	Conduct a component analysis to determine the effective components of an intervention package.
B-11	Conduct a parametric analysis to determine the effective values of an independent variable.

C. Behavior-Change Considerations

C-01	State and plan for the possible unwanted effects of reinforcement.
C-02	State and plan for the possible unwanted effects of punishment.
C-03	State and plan for the possible unwanted effects of extinction.

D. Fundamental Elements of Behavior Change

D-01	Use positive and negative reinforcement.
D-02	Use appropriate parameters and schedules of reinforcement.
D-03	Use prompts and prompt fading.
D-04	Use modeling and imitation training.
D-05	Use shaping.
D-06	Use chaining.
D-07	Conduct task analyses.
D-08	Use discrete-trial and free-operant arrangements.
D-09	Use the verbal operants as a basis for language assessment.
D-10	Use echoic training.
D-11	Use mand training.
D-12	Use tact training.
D-13	Use intraverbal training.
D-14	Use listener training.
D-15	Identify punishers.
D-16	Use positive and negative punishment.
D-17	Use appropriate parameters and schedules of punishment.
D-18	Use extinction.
D-19	Use combinations of reinforcement with punishment and extinction.



D-20	Use response-independent (time-based) schedules of reinforcement (i.e., noncontingent reinforcement).
D-21	Use differential reinforcement (e.g., DRO, DRA, DRI, DRL, DRH).

E. Specific Behavior-Change Procedures

E-01	Use interventions based on manipulation of antecedents, such as motivating operations and discriminative stimuli.
E-02	Use discrimination training procedures.
E-03	Use instructions and rules.
E-04	Use contingency contracting (i.e., behavioral contracts).
E-05	Use independent, interdependent, and dependent group contingencies.
E-06	Use stimulus equivalence procedures.
E-07	Plan for behavioral contrast effects.
E-08	Use the matching law and recognize factors influencing choice.
E-09	Arrange high-probability request sequences.
E-10	Use the Premack principle.
E-11	Use pairing procedures to establish new conditioned reinforcers and punishers.
E-12	Use errorless learning procedures.
E-13	Use matching-to-sample procedures.

F. Behavior-Change Systems

F-01	Use self-management strategies.
F-02	Use token economies and other conditioned reinforcement systems.
F-03	Use Direct Instruction.
F-04	Use precision teaching.
F-05	Use personalized systems of instruction (PSI).
F-06	Use incidental teaching.
F-07	Use functional communication training.
F-08	Use augmentative communication systems.

Section II: Client-Centered Responsibilities



G. Identification of the Problem

G-01	Review records and available data at the outset of the case.
G-02	Consider biological/medical variables that may be affecting the client.
G-03	Conduct a preliminary assessment of the client in order to identify the referral problem.
G-04	Explain behavioral concepts using nontechnical language.
G-05	Describe and explain behavior, including private events, in behavior-analytic (non-mentalistic) terms.
G-06	Provide behavior-analytic services in collaboration with others who support and/or provide services to one's clients.
G-07	Practice within one's limits of professional competence in applied behavior analysis, and obtain consultation, supervision, and training, or make referrals as necessary.
G-08	Identify and make environmental changes that reduce the need for behavior analysis services.

H. Measurement

H-01	Select a measurement system to obtain representative data given the dimensions of the behavior and the logistics of observing and recording.
H-02	Select a schedule of observation and recording periods.
H-03	Select a data display that effectively communicates relevant quantitative relations.
H-04	Evaluate changes in level, trend, and variability.
H-05	Evaluate temporal relations between observed variables (within & between sessions, time series).

I. Assessment

I-01	Define behavior in observable and measurable terms.
I-02	Define environmental variables in observable and measurable terms.
I-03	Design and implement individualized behavioral assessment procedures.
I-04	Design and implement the full range of functional assessment procedures.
I-05	Organize, analyze, and interpret observed data.



I-06	Make recommendations regarding behaviors that must be established, maintained, increased, or decreased.
I-07	Design and conduct preference assessments to identify putative reinforcers.

J. Intervention

J-01	State intervention goals in observable and measurable terms.
J-02	Identify potential interventions based on assessment results and the best available scientific evidence.
J-03	Select intervention strategies based on task analysis.
J-04	Select intervention strategies based on client preferences.
J-05	Select intervention strategies based on the client's current repertoires.
J-06	Select intervention strategies based on supporting environments.
J-07	Select intervention strategies based on environmental and resource constraints.
J-08	Select intervention strategies based on the social validity of the intervention.
J-09	Identify and address practical and ethical considerations when using experimental designs to demonstrate treatment effectiveness.
J-10	When a behavior is to be decreased, select an acceptable alternative behavior to be established or increased.
J-11	Program for stimulus and response generalization.
J-12	Program for maintenance.
J-13	Select behavioral cusps as goals for intervention when appropriate.
J-14	Arrange instructional procedures to promote generative learning (i.e., derived relations).
J-15	Base decision-making on data displayed in various formats.

K. Implementation, Management, and Supervision

K-01	Provide for ongoing documentation of behavioral services.
K-02	Identify the contingencies governing the behavior of those responsible for carrying out behavior-change procedures and design interventions accordingly.
K-03	Design and use competency-based training for persons who are responsible for carrying out behavioral assessment and behavior-change procedures.



K-04	Design and use effective performance monitoring and reinforcement systems.
K-05	Design and use systems for monitoring procedural integrity.
K-06	Provide supervision for behavior-change agents.
K-07	Evaluate the effectiveness of the behavioral program.
K-08	Establish support for behavior-analytic services from direct and indirect consumers.
K-09	Secure the support of others to maintain the client's behavioral repertoires in their natural environments.
K-10	Arrange for the orderly termination of services when they are no longer required.

Section III: Foundational Knowledge Accompanying the BACB Fourth Edition Task List



Explain and Behave in Accordance with the Philosophical Assumptions of Behavior Analysis

FK-01	Lawfulness of behavior
FK-02	Selectionism (phylogenic, ontogenic, cultural)
FK-03	Determinism
FK-04	Empiricism
FK-05	Parsimony
FK-06	Pragmatism
FK-07	Environmental (as opposed to mentalistic) explanations of behavior
FK-08	Distinguish between radical and methodological behaviorism.
FK-09	Distinguish between the conceptual analysis of behavior, experimental analysis of behavior, applied behavior analysis, and behavioral service delivery.

Define and Provide Examples of:

FK-10	behavior, response, response class
FK-11	environment, stimulus, stimulus class
FK-12	stimulus equivalence
FK-13	reflexive relations (US-UR)
FK-14	respondent conditioning (CS-CR)
FK-15	operant conditioning
FK-16	respondent-operant interactions
FK-17	unconditioned reinforcement
FK-18	conditioned reinforcement
FK-19	unconditioned punishment
FK-20	conditioned punishment
FK-21	schedules of reinforcement and punishment



FK-22	extinction
FK-23	automatic reinforcement and punishment
FK-24	stimulus control
FK-25	multiple functions of a single stimulus
FK-26	unconditioned motivating operations
FK-27	conditioned motivating operations
FK-28	transitive, reflexive, surrogate motivating operations
FK-29	distinguish between the discriminative stimulus and the motivating operation
FK-30	distinguish between motivating operation and reinforcement effects
FK-31	behavioral contingencies
FK-32	contiguity
FK-33	functional relations
FK-34	conditional discriminations
FK-35	stimulus discrimination
FK-36	response generalization
FK-37	stimulus generalization
FK-38	behavioral contrast
FK-39	behavioral momentum
FK-40	matching law
FK-41	contingency-shaped behavior
FK-42	rule-governed behavior

Distinguish between the Verbal Operants

FK-43	Echoics
FK-44	Mands
FK-45	Tacts
FK-46	Intraverbals



Measurement Concepts

FK-47	Identify the measurable dimensions of behavior (e.g., rate, duration, latency, interresponse time).
FK-48	State the advantages and disadvantages of using continuous measurement procedures and discontinuous measurement procedures (e.g., partial- and whole-interval recording, momentary time sampling).

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Disciplinary and Ethical Standards & Disciplinary Procedures

I. BACB Professional Disciplinary and Ethical Standards

The BACB may issue sanctions, including, but not limited to, denials of initial certification, renewal or recertification, revocation, suspension or any other limitation of certification or combination of sanctions. Grounds for issuing sanctions include:

1. Ineligibility for certification, regardless of when the ineligibility is discovered;
2. Any violation of a BACB rule or procedure, as may be revised from time to time, and any failure to provide information requested by BACB, or to update (within thirty days) information previously provided to BACB, including, but not limited to, any failure to timely report to BACB an action, complaint, or charge that relates to rules 6-8 of these grounds for disciplinary action;
3. Unauthorized possession of, use of, distribution of, or access to
 - i. BACB exams,
 - ii. Certificates,
 - iii. Logo of BACB,
 - iv. Trademarks and abbreviations relating thereto, including, but not limited to, misrepresentation of self, professional practice or BACB certification status, prior to or following the grant of certification by BACB, if any. *Individuals not certified by the BACB are expressly prohibited from misrepresenting that they are BACB certified as either a BCBA or BCaBA, or misrepresenting eligibility for BCBA or BCaBA certification, including misrepresentations of similar designations designed to imply BACB certification or eligibility status. **This rule will be enforced against individuals who have graduated from a certificate awarding educational program, who are not entitled to represent BACB certification until such time as they are certified by the BACB.** Applicants for certification who have previously misrepresented BACB*



certification or eligibility status may be subject to additional fines and penalties (\$500 for each occurrence) for the misrepresentations prior to consideration of their certification application; and

- v. Any other BACB documents and materials.
 - vi. Mischaracterization of inactive status, and/or any other inaccurate representation of BACB certification status.
4. Any examination irregularity, including, but not limited to, copying answers, permitting another to copy answers, disrupting the conduct of an examination, falsifying information or identification, education or credentials, providing and/or receiving unauthorized advice about exam content before, during, or following the examination. In addition to other authorized sanctions, the BACB may delay, cancel or refuse to release examination results if an exam irregularity has been demonstrated;
5. Obtaining or attempting to obtain certification or recertification for oneself or another by a false or misleading statement or failure to make a required statement, or fraud or deceit in any communication to BACB;
6. Gross or repeated negligence, incompetence, misconduct, or malpractice in professional work, including, but not limited to, a. any physical or mental condition that currently impairs competent professional performance or poses a substantial risk to the client/consumer of behavior analysis services; b. Professional conduct that constitutes an extreme and unjustified deviation from the customary standard of practice accepted in the applied behavior analytic community and that creates a serious risk of harm to or deception of consumers; c. Abandonment of a consumer resulting in the termination of imminently needed care of a consumer without adequate notice or provision for transition; d. Professional record keeping and/or data collection that constitutes an extreme and unjustified deviation from the customary standard of practice for the field, and/or deceptively altering consumer records or data; e. Engaging in blatant fraud, deception, misrepresentation, false promise or pretense or intimidation in the practice of applied behavior analysis or in solicitation of consumers; and f. The unauthorized material disclosure of confidential consumer information. Gross or repeated negligence complaints must include evidence of a disciplinary review and formal finding by an employer, professional peer review organization/group, governing official, federal or state agency, or other licensing or certification board. If the certificant was not overseen by an employing agency, governing official agency, or other Board, then the BACB President and Executive Director shall determine, by consensus, whether the complaint should be submitted to a Review Committee. Incompetence or malpractice must be evidenced by official determinations (such as, court orders, jury findings, or treatment professional findings of incompetence or malpractice);



7. Limitation, sanction, revocation or suspension by a health care organization, professional organization, or other private or governmental body, relating to behavior analysis practice, public health or safety or behavior analysis certification;
8. Any conviction of a felony or misdemeanor directly relating to behavior analysis practice and/or public health and safety.
9. Failure to adequately supervise or be supervised in accordance with the BACB Standards for Supervision.

II. Reporting Requirements

Applicants and certificants must report the following to the BACB within thirty (30) days of the occurrence of:

1. A change in name, address or other vital information;
2. The filing of any criminal or civil charges against the applicant or certificant;
3. The initiation of any disciplinary charges, investigations or findings/sanctions by a health care organization, federal or state agency, or other professional association against the applicant or certificant; and
4. Any other change in information provided by the applicant or certificant to the BACB.

All notices to the BACB must be sent via verifiable methods of delivery, such as, certified mail return-receipt requested. E-mail notices will not be deemed valid unless the sender receives a (non-automatic) confirmation e-mail letter from the BACB.

III. Limitations on Applying

An individual convicted of a felony directly related to behavior analysis practice and/or public health and safety shall be ineligible to apply for BACB certification or recertification for a period of three (3) years from the exhaustion of appeals, completion of parole or probation, or final release from confinement (if any), whichever is later.



IV. Procedures: The Review Committee

The BACB Chair shall appoint to the Review Committee at least two BACB certificants and one current or former Director who shall serve as Chair of the Review Committee. The BACB Chair may also appoint additional members to the Review Committee in the discretion of the BACB Chair. For example, the BACB Chair may appoint an in-state certificant, or a person with special expertise to serve on the Review Committee. In designating an additional person to serve on the Review Committee, the BACB Chair shall also identify whether that person's service will be voting or non-voting (advisory only).

The Review Committee is authorized to review and decide the following:

1. Written appeals from denials of applications, examination conditions, renewal or recertification decisions. The appeal must be filed in within thirty (30) days of the date of the decision being appealed or the examination administration being contested; and
2. Alleged violations of the BACB Professional (Disciplinary) Standards.

Examination content may not be appealed to the Review or Appeal Committees.

The Review Committee shall only conduct its review through written documentation. However, if deemed necessary by the Review Committee, the Review Committee may telephonically or otherwise contact applicants, certificants, witnesses, and/or BACB staff to receive additional information.

All decisions of the Review Committee are final unless appealed to the Board of Directors within thirty (30) days of the date of receipt of the Review Committee decision.

Appeals of alleged violations of the BACB Professional Disciplinary Standards shall be heard by an Appeals Committee consisting of a minimum of three BACB current or former Directors. The BACB Chair shall appoint the BACB current or former Directors to the Appeals Committee and may (in the sole discretion of the BACB Chair) submit the appeal to be heard by the entire Board of Directors. In person appeals will be held at the next regularly scheduled in-person Board meeting if such hearing is requested by the appellant. Candidates and Certificants are responsible for their own costs associated with attending the appeal hearing. Candidates and Certificants entitled to an appeal hearing may waive the in-person hearing, and request, instead, that the hearing be held telephonically or in writing.



All other appeals must be in writing and shall not be entitled to an in-person hearing. Candidates and Certificants appealing decisions regarding applications, renewals and recertifications that do not involve alleged violations of the Professional Disciplinary and Ethical Standards are not entitled to an in-person hearing.

In the case of any appeal/hearing, the decision of the Appeals Committee is final and may not be further appealed. The BACB may publish the name, standard(s) found to have been violated and sanction issued against any current or former certificant that is sanctioned in a final Review or Appeal Committee action with a sanction that results in a limitation on practice, such as a suspension or revocation of certification.

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Guidelines for Responsible Conduct for Behavior Analysts

Revised July 2010 in accordance with the 4th Edition Task List for behavior analysts

Introduction

Portions of the BACB certification examinations relating to ethical and professional practices are based on the following Guidelines. The Guidelines address ethical and professional concerns particular to BACB certificants, as well as concerns that are salient to the interactions between behavior analysts, the people they serve, and society, in general. The Guidelines are provided for general reference to practitioners, employers and consumers of applied behavior analysis services. For concerns about specific practices by a BACB certificant, please refer to the BACB Professional Disciplinary and Ethical Standards. The Guidelines may be referenced in complaints alleging violation of Section 6 of the BACB's Disciplinary and Ethical Standards; these Guidelines, however, are not separately enforced by the BACB.

[RBT = The guideline is relevant to Registered Behavior Technicians™]

1.0 Responsible Conduct of a Behavior Analyst.

The behavior analyst maintains the high standards of professional behavior of the professional organization.

1.01 Reliance on Scientific Knowledge. ^{RBT}

Behavior analysts rely on scientifically and professionally derived knowledge when making scientific or professional judgments in human service provision, or when engaging in scholarly or professional endeavors.

1.02 Competence. ^{RBT}

- (a) Behavior analysts provide services, teach, and conduct research only within the boundaries of their competence, based on their education, training, supervised experience, or appropriate professional experience.
- (b) Behavior analysts provide services, teach, or conduct research in new areas or involving new techniques only after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas or techniques.



1.03 Professional Development. ^{RBT}

Behavior analysts who engage in assessment, therapy, teaching, research, organizational consulting, or other professional activities maintain a reasonable level of awareness of current scientific and professional information in their fields of activity, and undertake ongoing efforts to maintain competence in the skills they use by reading the appropriate literature, attending conferences and conventions, participating in workshops, and/or obtaining Behavior Analyst Certification Board certification.

1.04 Integrity. ^{RBT}

- (a) Behavior analysts are truthful and honest. The behavior analyst follows through on obligations and professional commitments with high quality work and refrains from making professional commitments that he/she cannot keep.
- (b) The behavior analyst's behavior conforms to the legal and moral codes of the social and professional community of which the behavior analyst is a member.
- (c) The activity of a behavior analyst falls under these Guidelines only if the activity is part of his or her work-related functions or the activity is behavior analytic in nature.
- (d) If behavior analysts' ethical responsibilities conflict with law, behavior analysts make known their commitment to these Guidelines and take steps to resolve the conflict in a responsible manner in accordance with law.

1.05 Professional and Scientific Relationships. ^{RBT}

- (a) Behavior analysts provide behavioral diagnostic, therapeutic, teaching, research, supervisory, consultative, or other behavior analytic services only in the context of a defined, remunerated professional or scientific relationship or role.
- (b) When behavior analysts provide assessment, evaluation, treatment, counseling, supervision, teaching, consultation, research, or other behavior analytic services to an individual, a group, or an organization, they use language that is fully understandable to the recipient of those services. They provide appropriate information prior to service delivery about the nature of such services and appropriate information later about results and conclusions.
- (c) Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status significantly affect behavior analysts' work concerning particular individuals or groups, behavior analysts obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals.
- (d) In their work-related activities, behavior analysts do not engage in discrimination against individuals or groups based on age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.



- (e) Behavior analysts do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status, in accordance with law.
- (f) Behavior analysts recognize that their personal problems and conflicts may interfere with their effectiveness. Behavior analysts refrain from providing services when their personal circumstances may compromise delivering services to the best of their abilities.

1.06 Dual Relationships and Conflicts of Interest. ^{RBT}

- (a) In many communities and situations, it may not be feasible or reasonable for behavior analysts to avoid social or other nonprofessional contacts with persons such as clients, students, supervisees, or research participants. Behavior analysts must always be sensitive to the potential harmful effects of other contacts on their work and on those persons with whom they deal.
- (b) A behavior analyst refrains from entering into or promising a personal, scientific, professional, financial, or other relationship with any such person if it appears likely that such a relationship reasonably might impair the behavior analyst's objectivity or otherwise interfere with the behavior analyst's ability to effectively perform his or her functions as a behavior analyst, or might harm or exploit the other party.
- (c) If a behavior analyst finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen (i.e., one in which the reasonable possibility of conflict of interest or undue influence is present), the behavior analyst attempts to resolve it with due regard for the best interests of the affected person and maximal compliance with these Guidelines.

1.07 Exploitative Relationships. ^{RBT}

- (a) Behavior analysts do not exploit persons over whom they have supervisory, evaluative, or other authority such as students, supervisees, employees, research participants, and clients.
- (b) Behavior analysts do not engage in sexual relationships with clients, students, or supervisees in training over whom the behavior analyst has evaluative or direct authority, because such relationships easily impair judgment or become exploitative.
- (c) Behavior analysts are cautioned against bartering with clients because it is often (1) clinically contraindicated, and (2) prone to formation of an exploitative relationship.



2.0 The Behavior Analyst's Responsibility to Clients.

The behavior analyst has a responsibility to operate in the best interest of clients.

2.01 Definition of Client. ^{RBT}

The term client as used here is broadly applicable to whomever the behavior analyst provides services whether an individual person (service recipient), parent or guardian of a service recipient, an institutional representative, a public or private agency, a firm or corporation.

2.02 Accepting Clients.

The behavior analyst accepts as clients only those individuals or entities (agencies, firms, etc.) whose behavior problems or requested service are commensurate with the behavior analyst's education, training, and experience. In lieu of these conditions, the behavior analyst must function under the supervision of or in consultation with a behavior analyst whose credentials permit working with such behavior problems or services.

2.03 Responsibility. ^{RBT}

The behavior analyst's responsibility is to all parties affected by behavioral services.

2.04 Consultation.

- (a) Behavior analysts arrange for appropriate consultations and referrals based principally on the best interests of their clients, with appropriate consent, and subject to other relevant considerations, including applicable law and contractual obligations.
- (b) When indicated and professionally appropriate, behavior analysts cooperate with other professionals in order to serve their clients effectively and appropriately. Behavior analysts recognize that other professions have ethical codes that may differ in their specific requirements from these Guidelines.

2.05 Third-Party Requests for Services.

- (a) When a behavior analyst agrees to provide services to a person or entity at the request of a third party, the behavior analyst clarifies to the extent feasible, at the outset of the service, the nature of the relationship with each party. This clarification includes the role of the behavior analyst (such as therapist, organizational consultant, or expert witness), the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality.
- (b) If there is a foreseeable risk of the behavior analyst being called upon to perform conflicting roles because of the involvement of a third party, the behavior analyst clarifies the nature and direction



of his or her responsibilities, keeps all parties appropriately informed as matters develop, and resolves the situation in accordance with these Guidelines.

2.06 Rights and Prerogatives of Clients. ^{RBT}

- (a) The behavior analyst supports individual rights under the law.
- (b) The client must be provided on request an accurate, current set of the behavior analyst's credentials.
- (c) Permission for electronic recording of interviews and service delivery sessions is secured from clients and relevant staff of all other settings. Consent for different uses must be obtained specifically and separately.
- (d) Clients must be informed of their rights, and about procedures to complain about professional practices of the behavior analyst.
- (e) The behavior analyst complies with all requirements for criminal background checks.

2.07 Maintaining Confidentiality. ^{RBT}

- (a) Behavior analysts have a primary obligation and take reasonable precautions to respect the confidentiality of those with whom they work or consult, recognizing that confidentiality may be established by law, institutional rules, or professional or scientific relationships.
- (b) Clients have a right to confidentiality. Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.
- (c) In order to minimize intrusions on privacy, behavior analysts include only information germane to the purpose for which the communication is made in written and oral reports, consultations, and the like.
- (d) Behavior analysts discuss confidential information obtained in clinical or consulting relationships, or evaluative data concerning patients, individual or organizational clients, students, research participants, supervisees, and employees, only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

2.08 Maintaining Records. ^{RBT}

Behavior analysts maintain appropriate confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. Behavior analysts maintain and dispose of records in accordance with applicable law or regulation, and corporate policy, and in a manner that permits compliance with the requirements of these Guidelines.



2.09 Disclosures. ^{RBT}

- (a) Behavior analysts disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.
- (b) Behavior analysts also may disclose confidential information with the appropriate consent of the individual or organizational client (or of another legally authorized person on behalf of the client), unless prohibited by law.

2.10 Treatment Efficacy.

- (a) The behavior analyst always has the responsibility to recommend scientifically supported most effective treatment procedures. Effective treatment procedures have been validated as having both long-term and short-term benefits to clients and society.
- (b) Clients have a right to effective treatment (i.e., based on the research literature and adapted to the individual client).
- (c) Behavior analysts are responsible for review and appraisal of likely effects of all alternative treatments, including those provided by other disciplines and no intervention.
- (d) In those instances where more than one scientifically supported treatment has been established, additional factors may be considered in selecting interventions, including, but not limited to, efficiency and cost-effectiveness, risks and side-effects of the interventions, client preference, and practitioner experience and training.

2.11 Documenting Professional and Scientific Work. ^{RBT}

- (a) Behavior analysts appropriately document their professional and scientific work in order to facilitate provision of services later by them or by other professionals, to ensure accountability, and to meet other requirements of institutions or the law.
- (b) When behavior analysts have reason to believe that records of their professional services will be used in legal proceedings involving recipients of or participants in their work, they have a responsibility to create and maintain documentation in the kind of detail and quality that would be consistent with reasonable scrutiny in an adjudicative forum.
- (c) Behavior analysts obtain and document: (1) Institutional Review Board (IRB), and/or local Human Research Committee approval; and/or (2) confirmation of compliance with institutional requirements when data gathered during their professional services will be submitted to professional conferences and peer reviewed journals.



2.12 Records and Data. ^{RBT}

Behavior analysts create, maintain, disseminate, store, retain, and dispose of records and data relating to their research, practice, and other work in accordance with applicable laws or regulations and corporate policy and in a manner that permits compliance with the requirements of these Guidelines.

2.13 Fees, Financial Arrangements and Terms of Consultation.

- (a) As early as is feasible in a professional or scientific relationship, the behavior analyst and the client or other appropriate recipient of behavior analytic services reach an agreement specifying compensation and billing arrangements.
- (b) Behavior analysts' fee practices are consistent with law and behavior analysts do not misrepresent their fees. If limitations to services can be anticipated because of limitations in financing, this is discussed with the patient, client, or other appropriate recipient of services as early as is feasible.
- (c) Prior to the implementation of services the behavior analyst will provide in writing the terms of consultation with regard to specific requirements for providing services and the responsibilities of all parties (a contract or Declaration of Professional Services).

2.14 Accuracy in Reports to Those Who Pay for Services.

In their reports to those who pay for services or sources of research, project, or program funding, behavior analysts accurately state the nature of the research or service provided, the fees or charges, and where applicable, the identity of the provider, the findings, and other required descriptive data.

2.15 Referrals and Fees.

When a behavior analyst pays, receives payment from, or divides fees with another professional other than in an employer-employee relationship, the referral shall be disclosed to the client.

2.16 Interrupting or Terminating Services.

- (a) Behavior analysts make reasonable efforts to plan for facilitating care in the event that behavior analytic services are interrupted by factors such as the behavior analyst's illness, impending death, unavailability, or relocation or by the client's relocation or financial limitations.
- (b) When entering into employment or contractual relationships, behavior analysts provide for orderly and appropriate resolution of responsibility for client care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client.
- (c) Behavior analysts do not abandon clients. Behavior analysts terminate a professional relationship when it becomes reasonably clear that the client no longer needs the service, is not benefiting, or is being harmed by continued service.



- (d) Prior to termination for whatever reason, except where precluded by the client's conduct, the behavior analyst discusses the client's views and needs, provides appropriate pre-termination services, suggests alternative service providers as appropriate, and takes other reasonable steps to facilitate transfer of responsibility to another provider if the client needs one immediately.

3.0 Assessing Behavior.

Behavior analysts who use behavioral assessment techniques do so for purposes that are appropriate in light of research. Behavior analysts recommend seeking a medical consultation if there is any reasonable possibility that a referred behavior is a result of a medication side effect or some biological cause.

- (a) Behavior analysts' assessments, recommendations, reports, and evaluative statements are based on information and techniques sufficient to provide appropriate substantiation for their findings.
- (b) Behavior analysts refrain from misuse of assessment techniques, interventions, results, and interpretations and take reasonable steps to prevent others from misusing the information these techniques provide.
- (c) Behavior analysts recognize limits to the certainty with which judgments or predictions can be made about individuals.
- (d) Behavior analysts do not promote the use of behavioral assessment techniques by unqualified persons, i.e., those who are unsupervised by experienced professionals and have not demonstrated valid and reliable assessment skills.

3.01 Behavioral Assessment Approval.

The behavior analyst must obtain the client's or client-surrogate's approval in writing of the behavior assessment procedures before implementing them. As used here, client-surrogate refers to someone legally empowered to make decisions for the person(s) whose behavior the program is intended to change; examples of client-surrogates include parents of minors, guardians, and legally designated representatives

3.02 Functional Assessment.

- (a) The behavior analyst conducts a functional assessment, as defined below, to provide the necessary data to develop an effective behavior change program.
- (b) Functional assessment includes a variety of systematic information-gathering activities regarding factors influencing the occurrence of a behavior (e.g., antecedents, consequences, setting events, or motivating operations) including interview, direct observation, and experimental analysis.



3.03 Explaining Assessment Results.

Unless the nature of the relationship is clearly explained to the person being assessed in advance and precludes provision of an explanation of results (such as in some organizational consultation, some screenings, and forensic evaluations), behavior analysts ensure that an explanation of the results is provided using language that is reasonably understandable to the person assessed or to another legally authorized person on behalf of the client. Regardless of whether the interpretation is done by the behavior analyst, by assistants, or others, behavior analysts take reasonable steps to ensure that appropriate explanations of results are given.

3.04 Consent-Client Records.

The behavior analyst obtains the written consent of the client or client-surrogate before obtaining or disclosing client records from or to other sources, including clinical supervisor.

3.05 Describing Program Objectives.

The behavior analyst describes, in writing, the objectives of the behavior change program to the client or client-surrogate (see below) before attempting to implement the program. And to the extent possible, a risk-benefit analysis should be conducted on the procedures to be implemented to reach the objective.

4.0 The Behavior Analyst and The Individual Behavior Change Program.

The behavior analyst (a) designs programs that are based on behavior analytic principles, including assessments of effects of other intervention methods, (b) involves the client or the client-surrogate in the planning of such programs, (c) obtains the consent of the client, and (d) respects the right of the client to terminate services at any time.

4.01 Describing Conditions for Program Success.

The behavior analyst describes to the client or client-surrogate the environmental conditions that are necessary for the program to be effective.

4.02 Environmental Conditions that Preclude Implementation.

If environmental conditions preclude implementation of a behavior analytic program, the behavior analyst recommends that other professional assistance (i.e., assessment, consultation or therapeutic intervention by other professionals) be sought.



4.03 Environmental Conditions that Hamper Implementation.

If environmental conditions hamper implementation of the behavior analytic program, the behavior analyst seeks to eliminate the environmental constraints, or identifies in writing the obstacles to doing so.

4.04 Approving Interventions.

The behavior analyst must obtain the client's or client-surrogate's approval in writing of the behavior intervention procedures before implementing them.

4.05 Reinforcement/Punishment.

The behavior analyst recommends reinforcement rather than punishment whenever possible. If punishment procedures are necessary, the behavior analyst always includes reinforcement procedures for alternative behavior in the program.

4.06 Avoiding Harmful Reinforcers. ^{RBT}

The behavior analyst minimizes the use of items as potential reinforcers that maybe harmful to the long-term health of the client or participant (e.g., cigarettes, sugar or fat-laden food), or that may require undesirably marked deprivation procedures as motivating operations.

4.07 On-Going Data Collection. ^{RBT}

The behavior analyst collects data, or asks the client, client-surrogate, or designated others to collect data needed to assess progress within the program.

4.08 Program Modifications.

The behavior analyst modifies the program on the basis of data.

4.09 Program Modifications Consent.

The behavior analyst explains program modifications and the reasons for the modifications to the client or client-surrogate and obtains consent to implement the modifications.

4.10 Least Restrictive Procedures.

The behavior analyst reviews and appraises the restrictiveness of alternative interventions and always recommends the least restrictive procedures likely to be effective in dealing with a behavior problem.

4.11 Termination Criteria.



The behavior analyst establishes understandable and objective (i.e., measurable) criteria for the termination of the program and describes them to the client or client-surrogate.

4.12 Terminating Clients.

The behavior analyst terminates the relationship with the client when the established criteria for termination are attained, as in when a series of planned or revised intervention goals has been completed.

5.0 The Behavior Analyst As Teacher And/Or Supervisor.

Behavior analysts delegate to their employees, supervisees, and research assistants only those responsibilities that such persons can reasonably be expected to perform competently.

5.01 Designing Competent Training Programs and Supervised Work Experiences.

Behavior analysts who are responsible for education and training programs and supervisory activities seek to ensure that the programs and supervisory activities:

- are competently designed
- provide the proper experiences
- and meet the requirements for licensure, certification, or other goals for which claims are made by the program or supervisor.

5.02 Limitations on Training.

Behavior analysts do not teach the use of techniques or procedures that require specialized training, licensure, or expertise in other disciplines to individuals who lack the prerequisite training, legal scope of practice, or expertise, except as these techniques may be used in behavioral evaluation of the effects of various treatments, interventions, therapies, or educational methods.

5.03 Providing Course or Supervision Objectives.

The behavior analyst provides a clear description of the objectives of a course or supervision, preferably in writing, at the beginning of the course or supervisory relationship.

5.04 Describing Course Requirements.

The behavior analyst provides a clear description of the demands of the supervisory relationship or course (e.g., papers, exams, projects, reports, intervention plans, graphic displays and face to face



meetings) preferably in writing) at the beginning of the supervisory relationship or course.

5.05 Describing Evaluation Requirements.

The behavior analyst provides a clear description of the requirements for the evaluation of student/supervisee performance at the beginning of the supervisory relationship or course.

5.06 Providing Feedback to Students/Supervisees.

The behavior analyst provides feedback regarding the performance of a student or supervisee at least once per two weeks or consistent with BACB requirements.

5.07 Feedback to Student/Supervisees.

The behavior analyst provides feedback to the student/supervisee in a way that increases the probability that the student/supervisee will benefit from the feedback.

5.08 Reinforcing Student/Supervisee Behavior.

The behavior analyst uses positive reinforcement as frequently as the behavior of the student/supervisee and the environmental conditions allow.

5.09 Utilizing Behavior Analysis Principles in Teaching.

The behavior analyst utilizes as many principles of behavior analysis in teaching a course as the material, conditions, and academic policies allow.

5.10 Requirements of Supervisees.

The behavior analyst's behavioral requirements of a supervisee must be in the behavioral repertoire of the supervisee. If the behavior required is not in the supervisee's repertoire, the behavior analyst attempts to provide the conditions for the acquisition of the required behavior, and refers the supervisee for remedial skill development services, or provides them with such services, permitting them to meet at least minimal behavioral performance requirements.

5.11 Training, Supervision, and Safety.

Behavior analysts provide proper training, supervision, and safety precautions to their employees or supervisees and take reasonable steps to see that such persons perform services responsibly, competently, and ethically. If institutional policies, procedures, or practices prevent fulfillment of this obligation, behavior analysts attempt to modify their role or to correct the situation to the extent feasible.



6.0 The Behavior Analyst and the Workplace.

The behavior analyst adheres to job commitments, assesses employee interactions before intervention, works within his/her scope of training, develops interventions that benefit employees, and resolves conflicts within these Guidelines.

6.01 Job Commitments. ^{RBT}

The behavior analyst adheres to job commitments made to the employing organization.

6.02 Assessing Employee Interactions.

The behavior analyst assesses the behavior-environment interactions of the employees before designing behavior analytic programs.

6.03 Preparing for Consultation.

The behavior analyst implements or consults on behavior management programs for which the behavior analyst has been adequately prepared.

6.04 Employees' Interventions.

The behavior analyst develops interventions that benefit the employees as well as management.

6.05 Employee Health and Well Being.

The behavior analyst develops interventions that enhance the health and well being of the employees.

6.06 Conflicts with Organizations. ^{RBT}

If the demands of an organization with which behavior analysts are affiliated conflict with these Guidelines, behavior analysts clarify the nature of the conflict, make known their commitment to these Guidelines, and to the extent feasible, seek to resolve the conflict in a way that permits the fullest adherence to these Guidelines.



7.0 The Behavior Analyst's Ethical Responsibility to the Field of Behavior Analysis.

The behavior analyst has a responsibility to support the values of the field, to disseminate knowledge to the public, to be familiar with these guidelines, and to discourage misrepresentation by non-certified individuals.

7.01 Affirming Principles. ^{RBT}

The behavior analyst upholds and advances the values, ethics, principles, and mission of the field of behavior analysis. Participation in both state and national or international behavior analysis organizations is strongly encouraged.

7.02 Disseminating Behavior Analysis. ^{RBT}

The behavior analyst assists the profession in making behavior analysis methodology available to the general public.

7.03 Being Familiar with These Guidelines. ^{RBT}

Behavior analysts have an obligation to be familiar with these Guidelines, other applicable ethics codes, and their application to behavior analysts' work. Lack of awareness or misunderstanding of a conduct standard is not itself a defense to a charge of unethical conduct.

7.04 Discouraging Misrepresentation by Non-Certified Individuals. ^{RBT}

Behavior analysts discourage non-certified practitioners from misrepresenting that they are certified.

8.0 The Behavior Analyst's Responsibility to Colleagues.

Behavior analysts have an obligation to bring attention to and resolve ethical violations by colleagues.

8.01 Ethical Violations by Behavioral and Non-behavioral Colleagues. ^{RBT}

When behavior analysts believe that there may have been an ethical violation by another behavior analyst, or non behavioral colleague, they attempt to resolve the issue by bringing it to the attention of that individual if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. If resolution is not obtained, and the behavior analyst believes a client's rights are being violated, the behavior analyst may take additional steps as necessary for the protection of the client.



9.0 The Behavior Analyst's Ethical Responsibility to Society.

The behavior analyst promotes the general welfare of society through the application of the principles of behavior.

9.01 Promotion in Society. ^{RBT}

The behavior analyst should promote the application of behavior principles in society by presenting a behavioral alternative to other procedures or methods.

9.02 Scientific Inquiry.

The behavior analyst should promote the analysis of behavior as a legitimate field of scientific inquiry.

9.03 Public Statements.

- (a) Behavior analysts comply with these Guidelines in public statements relating to their professional services, products, or publications or to the field of behavior analysis.
- (b) Public statements include but are not limited to paid or unpaid advertising, brochures, printed matter, directory listings, personal resumes or curriculum vitae, interviews or comments for use in media, statements in legal proceedings, lectures and public oral presentations, and published materials.

9.04 Statements by Others. ^{RBT}

- (a) Behavior analysts who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.
- (b) Behavior analysts make reasonable efforts to prevent others whom they do not control (such as employers, publishers, sponsors, organizational clients, and representatives of the print or broadcast media) from making deceptive statements concerning behavior analysts' practices or professional or scientific activities.
- (c) If behavior analysts learn of deceptive statements about their work made by others, behavior analysts make reasonable efforts to correct such statements.
- (d) A paid advertisement relating to the behavior analyst's activities must be identified as such, unless it is already apparent from the context.

9.05 Avoiding False or Deceptive Statements. ^{RBT}

Behavior analysts do not make public statements that are false, deceptive, misleading, or fraudulent, either because of what they state, convey, or suggest or because of what they omit, concerning their



research, practice, or other work activities or those of persons or organizations with which they are affiliated. Behavior analysts claim as credentials for their behavioral work, only degrees that were primarily or exclusively behavior analytic in content.

9.06 Media Presentations and Emerging Media-Based Services.

- (a) When behavior analysts provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, printed articles, mailed material, or other media, they take reasonable precautions to ensure that (1) the statements are based on appropriate behavior analytic literature and practice, (2) the statements are otherwise consistent with these Guidelines, and (3) the recipients of the information are not encouraged to infer that a relationship has been established with them personally.
- (b) When behavior analysts deliver services, teach or conduct research using existing or emerging media (e.g. Internet, e-learning, interactive multi-media), they consider any ethical challenges presented by media-based delivery (e.g. privacy, confidentiality, evidence-based interventions, ongoing data collection and program modifications) and make every effort possible to adhere to the ethical standards described herein.

9.07 Testimonials. ^{RBT}

Behavior analysts do not solicit testimonials from current clients or patients or other persons who because of their particular circumstances are vulnerable to undue influence.

9.08 In-Person Solicitation. ^{RBT}

Behavior analysts do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential users of services who, because of their particular circumstances, are vulnerable to undue influence, except that organizational behavior management or performance management services may be marketed to corporate entities regardless of their projected financial position.

10.0 The Behavior Analyst and Research.

Behavior analysts design, conduct, and report research in accordance with recognized standards of scientific competence and ethical research. Behavior analysts conduct research with human and non-human research participants according to the proposal approved by a local Human Research Committee, and/or Institutional Review Board.

- (a) Behavior analysts plan their research so as to minimize the possibility that results will be misleading.



- (b) Behavior analysts conduct research competently and with due concern for the dignity and welfare of the participants. Researchers and assistants are permitted to perform only those tasks for which they are appropriately trained and prepared.
- (c) Behavior analysts are responsible for the ethical conduct of research conducted by them or by others under their supervision or control.
- (d) Behavior analysts conducting applied research conjointly with provision of clinical or human services obtain required external reviews of proposed clinical research and observe requirements for both intervention and research involvement by client-participants.
- (e) In planning research, behavior analysts consider its ethical acceptability under these Guidelines. If an ethical issue is unclear, behavior analysts seek to resolve the issue through consultation with institutional review boards, animal care and use committees, peer consultations, or other proper mechanisms.

10.01 Scholarship and Research.

- (a) The behavior analyst engaged in study and research is guided by the conventions of the science of behavior including the emphasis on the analysis of individual behavior and strives to model appropriate applications in professional life.
- (b) Behavior analysts take reasonable steps to avoid harming their clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable. Harm is defined here as negative effects or side effects of behavior analysis that outweigh positive effects in the particular instance, and that are behavioral or physical and directly observable.
- (c) Because behavior analysts' scientific and professional judgments and actions affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence.
- (d) Behavior analysts do not participate in activities in which it appears likely that their skills or data will be misused by others, unless corrective mechanisms, e.g., peer or external professional or independent review, are available.
- (e) Behavior analysts do not exaggerate claims for effectiveness of particular procedures or of behavior analysis in general.
- (f) If behavior analysts learn of misuse or misrepresentation of their individual work products, they take reasonable and feasible steps to correct or minimize the misuse or misrepresentation.

10.02 Using Confidential Information for Didactic or Instructive Purposes.

- (a) Behavior analysts do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their individual or organizational clients, students, research participants, or other recipients of their services that they obtained during the course



of their work, unless the person or organization has consented in writing or unless there is other ethical or legal authorization for doing so.

- (b) Ordinarily, in such scientific and professional presentations, behavior analysts disguise confidential information concerning such persons or organizations so that they are not individually identifiable to others and so that discussions do not cause harm to identifiable participants.

10.03 Conforming with Laws and Regulations.

Behavior analysts plan and conduct research in a manner consistent with all applicable laws and regulations, as well as professional standards governing the conduct of research, and particularly those standards governing research with human participants and animal subjects. Behavior analysts also comply with other applicable laws and regulations relating to mandated reporting requirements.

10.04 Informed Consent.

- (a) Using language that is reasonably understandable to participants, behavior analysts inform participants of the nature of the research; they inform participants that they are free to participate or to decline to participate or to withdraw from the research; they explain the foreseeable consequences of declining or withdrawing; they inform participants of significant factors that may be expected to influence their willingness to participate (such as risks, discomfort, adverse effects, or limitations on confidentiality, except as provided in Standard 10.05 below); and they explain other aspects about which the prospective participants inquire.
- (b) For persons who are legally incapable of giving informed consent, behavior analysts nevertheless
 - (1) provide an appropriate explanation, (2) discontinue research if the person gives clear signs of unwillingness to continue participation, and (3) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted by law.

10.05 Deception in Research.

- (a) Behavior analysts do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's prospective scientific, educational, or applied value and that equally effective alternative procedures that do not use deception are not feasible.
- (b) Behavior analysts never deceive research participants about significant aspects that would affect their willingness to participate, such as physical risks, discomfort, or unpleasant emotional experiences.
- (c) Any other deception that is an integral feature of the design and conduct of an experiment must be explained to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the research.



10.06 Informing of Future Use.

Behavior analysts inform research participants of their anticipated sharing or further use of personally identifiable research data and of the possibility of unanticipated future uses.

10.07 Minimizing Interference.

In conducting research, behavior analysts interfere with the participants or environment from which data are collected only in a manner that is warranted by an appropriate research design and that is consistent with behavior analysts' roles as scientific investigators.

10.08 Commitments to Research Participants.

Behavior analysts take reasonable measures to honor all commitments they have made to research participants.

10.09 Ensuring Participant Anonymity.

In presenting research, the behavior analyst ensures participant anonymity unless specifically waived by the participant or surrogate.

10.10 Informing of Withdrawal.

The behavior analyst informs the participant that withdrawal from the research may occur at any time without penalty except as stipulated in advance, as in fees contingent upon completing a project.

10.11 Debriefing.

The behavior analyst informs the participant that debriefing will occur at the conclusion of the participant's involvement in the research.

10.12 Answering Research Questions.

The behavior analyst answers all questions of the participant about the research that are consistent with being able to conduct the research.

10.13 Written Consent.

The behavior analyst must obtain the written consent of the participant or surrogate before beginning the research.



10.14 Extra Credit.

If the behavior analyst recruits participants from classes and the participants are provided additional credit for participating in the research, nonparticipating students must be provided alternative activities that generate comparable credit.

10.15 Paying Participants.

The behavior analyst who pays participants for research involvement or uses money as a reinforcer must obtain Institutional Review Board or Human Rights Committee approval of this practice and conform to any special requirements that may be established in the process of approval.

10.16 Withholding Payment.

The behavior analyst who withholds part of the money earned by the participant until the participant has completed their research involvement must inform the participant of this condition prior to beginning the experiment.

10.17 Grant Reviews.

The behavior analyst who serves on grant review panels avoids conducting any research described in grant proposals that the behavior analyst reviewed, except as replications fully crediting the prior researchers.

10.18 Animal Research.

Behavior analysts who conduct research involving animals treat them humanely and are in compliance with applicable animal welfare laws in their country.

10.19 Accuracy of Data.

Behavior analysts do not fabricate data or falsify results in their publications. If behavior analysts discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

10.20 Authorship and Findings.

Behavior analysts do not present portions or elements of another's work or data as their own, even if the other work or data source is cited occasionally, nor do they omit findings that might alter others' interpretations of their work or behavior analysis in general.



10.21 Acknowledging Contributions.

In presenting research, the behavior analyst acknowledges the contributions of others to the conduct of the research by including them as co-authors or footnoting their contributions.

10.22 Principal Authorship and Other Publication Credits.

Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as Department Chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are appropriately acknowledged, such as in footnotes or in an introductory statement. Further, these Guidelines recognize and support the ethical requirements for authorship and publication practices contained in the ethical code of the American Psychological Association.

10.23 Publishing Data.

Behavior analysts do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

10.24 Withholding Data.

After research results are published, behavior analysts do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release.

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GUIDELINES

Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder



These standards are provided for informational purposes only, and do not represent professional or legal advice. There are many variables that influence and direct the professional delivery of ABA services. The BACB and authors of these standards assume no liability or responsibility for application of these standards in the delivery of ABA services. The standards presented in this document reflect the consensus of a number of subject matter experts, but do not represent the only acceptable practice. These standards also do not reflect or create any affiliation among those who participated in their development. The BACB does not warrant or guarantee that these standards will apply or should be applied in all settings. Instead, these standards are offered as an informational resource that should be considered in consultation with parents, behavior analysts, regulators, and third-party payers.

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PART I: Overview

SECTION 1: EXECUTIVE SUMMARY

The purpose of this document is to inform decision-making regarding the use of Applied Behavior Analysis (ABA) to treat medically necessary conditions so as to develop, maintain, or restore, to the maximum extent practicable, the functioning of individuals with Autism Spectrum Disorder (ASD) in ways that are both efficacious and cost effective.¹

The document is based on the best available scientific evidence and expert clinical opinion regarding the use of ABA as a behavioral health treatment for individuals diagnosed with ASD. The guidelines are intended to be a brief and user-friendly introduction to the application of behavior analysis for ASD when funded by health care plans. Although the guidelines are written primarily for insurers and health plans, they will also be useful for consumers and providers.

This document provides clinical guidelines and other information about ABA as a treatment for ASD. ABA has a number of clinical and delivery components that make it unique among evidence-based behavioral health treatments. Thus, it is important that those charged with building a provider network understand the components and delivery of ABA, including:

- training and credentialing of Behavior Analysts
- ABA as a treatment for ASD
 - treatment components
 - assessment, formulation of treatment goals, and measurement of client progress
 - clinical procedures
 - treatment dosage and duration
 - supervision model
 - tiered service delivery
 - involvement of caregivers and other professionals
 - discharge, transition planning, and continuity of care
- service authorization and benefit management

This is the first edition of this resource manual and it will be updated periodically to reflect changes in clinical practice and research findings. Additional references and information can be found in the appendices.



SECTION 2: **AUTISM SPECTRUM DISORDER AND APPLIED BEHAVIOR ANALYSIS**

1 What is ASD?

ASD is characterized by varying degrees of difficulty in social interaction and verbal and nonverbal communication, and the presence of repetitive behavior and restricted interests.² This means that no two individuals with an ASD diagnosis are the same with respect to how the disorder manifests. However, the severity of the disorder is a reality for all individuals with this diagnosis and their families. Because of the nature of the disability, people with ASD will often not achieve the ability to function independently without appropriate medically necessary treatment.

2 What is ABA?

ABA is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior. These relevant environmental events are usually identified through a variety of specialized assessment methods. ABA is based on the fact that an individual's behavior is determined by past and current environmental events in conjunction with organic variables such as their genetic endowment and ongoing physiological variables. ABA focuses on treating behavioral difficulties by changing the individual's environment rather than focusing on variables that are, at least presently, beyond our direct access.

The successful remediation of core deficits of ASD, and the development or restoration of abilities, documented in hundreds of peer-reviewed studies published over the past 50 years has made ABA the standard of care for the treatment of ASD.



SECTION 3: CONSIDERATIONS

- This document contains guidelines and recommendations that reflect established research findings and best clinical practices. However, individualized treatment is a defining feature and integral component of ABA, which is one reason why it has been so successful in treating this heterogeneous disorder.
- Some individuals diagnosed with ASD have co-occurring conditions including, but not limited to intellectual disabilities, seizure disorders, psychiatric disorders, chromosomal abnormalities, feeding disorders, and a variety of other conditions that require additional medical treatment. **These guidelines apply to individuals diagnosed with ASD with these co-occurring conditions, as research has established ABA as effective for these client populations as well.**
- The guidelines provided in this document are pertinent to developing, maintaining, or restoring, to the maximum extent practicable, the functioning of an individual with ASD and thus, may not necessarily represent the optimal guidelines for producing an “appropriate education” in school settings.
- These guidelines should not be used to diminish the availability, quality, or frequency of currently available ABA treatment services.
- Coverage of ABA treatment for ASD by a health plan does not supplant responsibilities of educational or governmental entities.
- Specification of ABA in an Individualized Educational Plan or government program does not supplant ABA coverage by a health plan.
- ABA treatment must **not** be restricted *a priori* to specific settings but instead should be delivered in those settings that maximize treatment outcomes for the individual client.
- This document provides guidance regarding ABA treatment only; other behavioral health treatments are not addressed.
- In addition to ASD, ABA as a behavioral health treatment has a profound impact on the treatment of individuals with a range of clinical needs such as smoking cessation, severe problem behavior (e.g., self injury), weight loss, attention deficit disorder, pediatric feeding/eating disorders, and rehabilitation of acute medical conditions. Elements of this report may be applicable to the treatment of these other conditions as well, but this document is specifically directed towards the use of ABA in the treatment of ASD.



PART II:

Unique Features of Applied Behavior Analysis

SECTION 1: TRAINING AND CREDENTIALING OF BEHAVIOR ANALYSTS

ABA is a specialized behavioral health treatment and most graduate or postgraduate training programs in psychology, counseling, social work, or other areas of clinical practice do not provide in-depth training in this discipline. Thus, an understanding of the credentialing process of Behavior Analysts by the Behavior Analyst Certification Board® (BACB®) can assist health plans and their subscribers in identifying those providers who meet the basic competencies to practice ABA.

The formal training of professionals certified by the BACB is similar to that of other medical and behavioral health professionals. That is, they are initially trained within academia and then begin working in a supervised clinical setting with clients. As they gradually demonstrate the competencies necessary to manage complex clinical problems across a variety of clients and medical environments, they become independent practitioners. In summary, Behavior Analysts undergo a rigorous course of training and education and have an “internship” period in which they begin by working under the direct supervision of an experienced Behavior Analyst.

It should be noted that other licensed professionals may have ABA within their particular scope of training and competence. In addition, a small subset of clinicians may be licensed by another profession and also hold a credential from the BACB, thereby providing evidence of the nature and depth of their training in ABA.

While health plan coverage of behavioral health treatments supervised by Behavior Analysts is relatively recent, Behavior Analysts, like other medical and behavioral health providers, rely upon strategies and procedures documented in peer-reviewed literature, established treatment protocols, and decision trees. They continually evaluate the current state of the client and customize treatment options based on the results of direct observation and data from a range of other assessments. They also solicit and integrate information from the client and family members and coordinate care with other professionals.

The Behavior Analyst Certification Board

The BACB is a nonprofit 501(c)(3) corporation established to meet professional credentialing needs identified by Behavior Analysts, governments, and consumers of behavior analysis services. The mission of the BACB is to develop, promote, and implement an international certification program for Behavior Analyst practitioners. The BACB has established uniform content, standards, and criteria for the credentialing process that are designed to meet:

- The legal standards established through state, federal, and case law;
- The accepted standards for national certification programs; and
- The “best practice” and ethical standards of the behavior analysis profession.

The BCBA and BCaBA certification programs are currently accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence. NCCA reviews and oversees all aspects related to ensuring the development and application of appropriate credentialing processes.

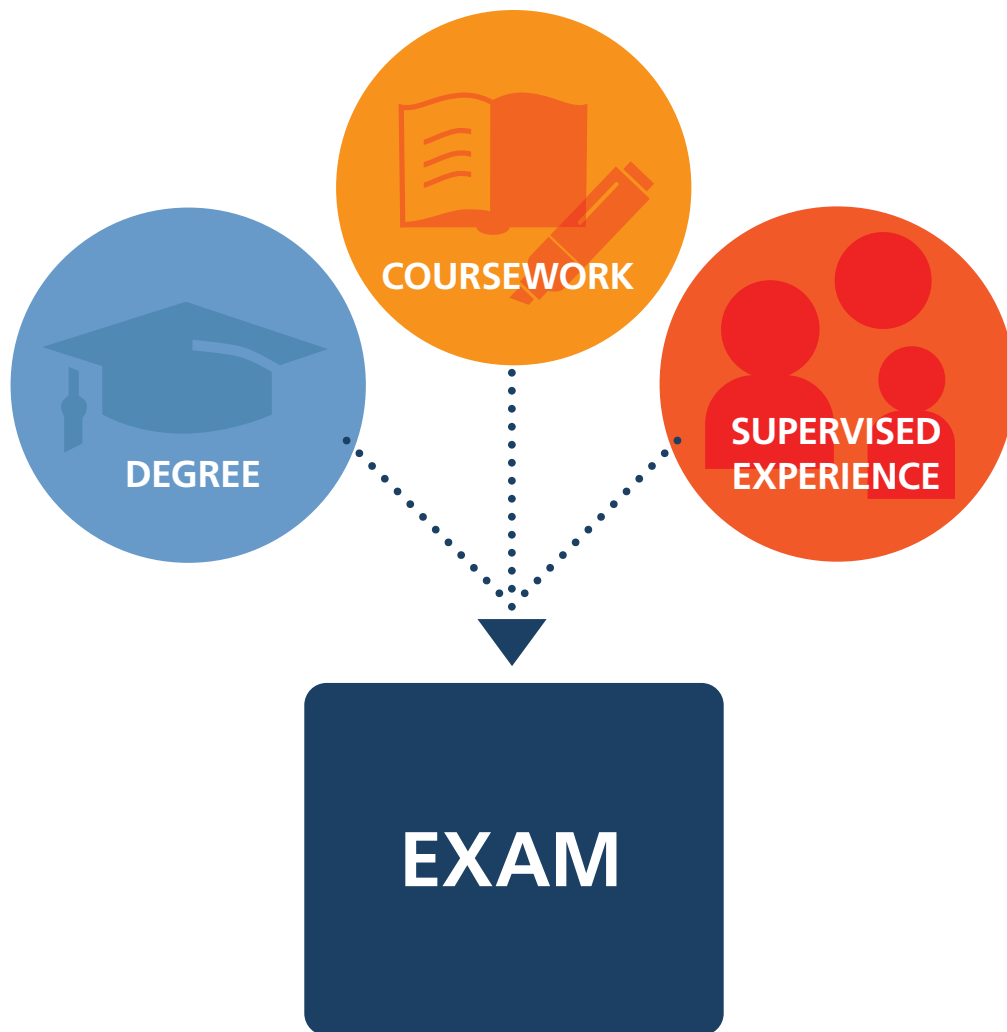
The BACB credentials and recognizes practitioners at three levels:



Professionals credentialed at the BCBA-D and BCBA levels are defined as Behavior Analysts. The BACB requires that BCaBAs work under the supervision of a BCBA-D or BCBA.

Eligibility Requirements

Applicants who meet the degree, coursework, and supervised experience eligibility requirements described in the next section are permitted to sit for either the BCBA or BCaBA examination (see figure below). Each examination is professionally developed to meet accepted examination standards and is based on the results of a formal job analysis and survey. In addition, all BACB examinations are offered under secure testing conditions and are professionally administered and scored by independent professional entities that meet industry standards.



Primary requirements for certification by the BACB.

Continuing Education and Maintaining Certification

BACB certificants are required to attest to their compliance with the organization's ethical and disciplinary rules (see below) on an annual basis and obtain 24 (BCaBA) or 36 (BCBA, BCBA-D) hours of continuing education credits every three years, three hours of which must relate to ethics or professionalism. Agencies that employ Behavior Analysts need to support and provide this training as needed.



*continuing ed. credits every 3 years

Disciplinary Procedures

All certificants must annually attest that they will follow the Guidelines for Responsible Conduct for Behavior Analysts and they are subject to disciplinary action by the BACB if they violate one or more of the nine Professional Disciplinary and Ethical Standards (www.BACB.com).

The BACB uses an online complaint system by which the organization is alerted to potential disciplinary violations. Each complaint is evaluated by the BACB legal department and if there appears to be merit to the complaint it is forwarded to a disciplinary Review Committee. The committee members are senior BCBA's or BCBA-D's selected for their knowledge and independence (including a member from the certificant's state). Disciplinary actions for certificants include, but are not limited to, mandated continuing education, suspension of certification, or revocation of certification. Resulting disciplinary actions are publicly reported online.

Licensure of Behavior Analysts

BACB credentials are currently the basis for licensure in those states where Behavior Analysts are licensed. Basing licensure on BACB credentials is cost effective and ensures that critical competencies with regards to practice and research are periodically reviewed and updated by practitioners and researchers. Whether it is used as the basis for licensure or as a "free standing" credential, BACB credentials are recognized in those states where insurance reform laws have been enacted.



SECTION 2: **APPLIED BEHAVIOR ANALYSIS IN THE TREATMENT OF ASD**

The field of Behavior Analysis evolved from the scientific study of the principles of learning and behavior. Applied Behavior Analysis is a well-developed discipline among the helping professions, with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and educational requirements for practice, and identified sources of requisite education in universities. Professionals in ABA engage in the specific and comprehensive use of principles of learning, including operant and respondent learning, in order to address behavioral needs of widely varying individuals in diverse settings.

1 Identifying ABA Treatment

Health plans and insurers must be able to recognize bona fide ABA treatment and those qualified to provide it. ABA treatment has some important characteristics that should be apparent throughout treatment:

- 1.** An objective analysis of the client's condition by observing how the environment affects the client's behavior, as evidenced through appropriate data collection
- 2.** Importance given to understanding the context of the behavior and the behavior's value to the individual and the community
- 3.** Utilization of the principles and procedures of behavior analysis such that the client's health, independence, and quality of life are improved

2 Essential Practice Elements of ABA

These characteristics should be apparent throughout all phases of assessment and treatment:

1. **Description of specific levels of behavior at baseline** when establishing treatment goals
2. A practical focus on **establishing small units of behavior** which build towards larger, more significant changes in functioning related to improved health and levels of independence
3. Collection, quantification, and analysis, of **direct observational data** on behavioral targets during treatment and follow-up to maximize and maintain progress towards treatment goals
4. An emphasis on **understanding the current function** and future value (or importance) of behavior(s) targeted for treatment
5. Efforts to design, establish, and **manage the treatment environment(s)** in order to minimize problem behavior(s) and maximize rate of improvement
6. Use of a **carefully constructed, individualized and detailed behavior analytic treatment plan** which utilizes reinforcement and other behavior analytic principles as opposed to the use of methods or techniques which lack consensus about their effectiveness based on evidence in peer-reviewed publications
7. An emphasis on **ongoing and frequent direct assessment, analysis, and adjustments to the treatment plan** (by the Behavior Analyst) based on client progress as determined by observations and objective data analysis
8. Use of **treatment protocols that are implemented repeatedly, frequently, and consistently** across environments until the client can function independently in multiple situations
9. **Direct support and training of family members and other involved professionals** to promote optimal functioning and promote generalization and maintenance of behavioral improvements
10. **Supervision and management by a Behavior Analyst** with expertise and formal training in ABA for the treatment of ASD



3 Treatment Models

ABA treatment programs for ASD incorporate findings from hundreds of applied studies focused on understanding and treating ASD published in peer-reviewed journals over a 50-year span. Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number of behavioral targets, specific aspects of those behaviors, and the client's own response to treatment help determine which model is most appropriate. Although existing on a continuum, these differences can be generally categorized as one of two treatment models: Focused ABA or Comprehensive ABA.³

Focused ABA

Service Description

Focused ABA involves direct service delivery to the client. It is not restricted by age, cognitive level, or co-occurring conditions. Focused ABA refers to treatment provided directly to the client for a limited number of behavioral targets.

Although the presence of problem behaviors may more frequently trigger a referral for Focused ABA treatment, the absence of appropriate behaviors should be prioritized, as this is often the precursor to serious behavior problems. Therefore, individuals who need to acquire skills (e.g., communication, tolerating change in environments and activities, self-help, social skills) are also appropriate for Focused ABA. In addition, all treatment plans which target reduction of dangerous or undesired behavior must concurrently introduce and strengthen more appropriate and functional behavior.

Examples of behavior-change targets in a focused ABA treatment plan for children who lack key functional skills include establishing compliance with medical and dental procedures, sleep hygiene, self-care skills, safe and independent leisure skills (e.g., appropriate participation in family and community activities).

Focused ABA involves direct service delivery to the client. It is not restricted by age, cognitive level, or co-occurring conditions.



Examples of treatment targets where the primary goal is to reduce behavior problems might include, but are not limited to, physical or verbal aggression towards self or others, dysfunctional speech, stereotypic motor behavior, property destruction, noncompliance and disruptive behavior, or dysfunctional social behavior.

When prioritizing the order in which to address multiple treatment targets, the following should be considered:

- **behaviors that may threaten the health or safety of themselves or others** (e.g., aggression, self-injury or self-mutilation, property destruction);
- **behavior disorders that may be a barrier to their ability to remain in the least restrictive setting, and/or limit their ability to participate in family and community life** (e.g., aggression, self-injury, noncompliance);
- **absence of developmentally appropriate adaptive, social, or functional skills** (e.g., toileting, dressing, feeding, compliance with medical procedures) that are fundamental to maintain health, social inclusion, and increased independence.

When the focus of treatment involves the reduction of a problem behavior, the Behavior Analyst will determine which situations are most likely to precipitate problem behavior and begin to isolate its function or purpose. This may require conducting a functional analysis to empirically demonstrate the “purpose” (i.e., function) of the problem behavior. The results enable the Behavior Analyst to develop the most effective treatment protocol. When the function of the problem behavior is identified, the Behavior Analyst may design a treatment plan that alters the environment to reduce the motivation for problem behavior and/or establish a new and more appropriate behavior that serves the same function and therefore “replaces” the problem behavior.

Social skills deficits, a core deficit of individuals diagnosed with ASD, are often addressed in focused treatment programs. Treatment may be delivered in either an individual or small-group format. When conducted in a small group, typically developing peers, or others with similar diagnoses, participate in the session. Clients practice behavioral targets while simultaneously mediating delivery of the treatment to the other members of the group. As is the case for all treatments, programming for generalization of skills outside the session is critical.

Focused treatments generally range from 10-25 hours per week of direct therapy (plus direct and indirect supervision hours) and are sometimes part of a step down or discharge plan from a Comprehensive ABA Treatment program.

Comprehensive ABA Treatment

Service Description

Comprehensive ABA refers to treatment where there are multiple targets across all developmental domains that are affected by the individual's ASD. These programs tend to range from 26-40 hours of direct treatment plus supervision per week. Initially, this typically involves 1:1 staffing and may gradually include small group formats as is appropriate.

Although there are different examples of comprehensive treatment, one example is intensive early treatment where the overarching goal is to close the gap between the client's level of functioning and that of typically developing peers. Targets are drawn from multiple domains of functioning including cognitive, communicative, social, and emotional. Targets also include reducing the symptoms of co-occurring behavior disorders such as aggression, self-injury and stereotypy. However, comprehensive behavioral treatment may also be appropriate for older individuals diagnosed with ASD, particularly if they engage in severe or dangerous behaviors across environments. In some cases, residential placement or inpatient hospitalization may be required for a period of time.

Treatment hours are increased or decreased as a function of the client's response to treatment as well as the intensity needed to reach treatment goals. In some cases, direct treatment hours increase gradually, are maintained at maximum intensity for a period of time, and are then systematically decreased in preparation for discharge. In other cases, treatment may begin at maximum levels.

Treatment is intensive and initially provided in structured therapy sessions. More naturalistic treatment approaches are utilized as soon as the client demonstrates the ability to benefit from these treatments. As the client progresses and meets established criteria for participation in larger or different settings, treatment in those settings and in the larger community should be provided. Training and participation by caregivers are also seen as an important component.



Treatment Models > Comprehensive ABA Treatment, cont.

Program Components

Treatment components should generally be drawn from the following domains:

- cognitive functioning
- pre-academic skills
- safety skills
- social skills
- play and leisure skills
- community integration
- vocational skills
- coping and tolerance skills
- adaptive and self-help skills
- language and communication
- attending and social referencing
- reduction of interfering or inappropriate behaviors

Intensity of Comprehensive ABA Treatment

When the goal is to change developmental trajectories to match that of typically developing peers, research, including several meta-analyses, show that 30–40 hours per week (6–7 hours daily, 5–6 days/week) of intensive ABA treatment is needed. Hours generally decrease as the client progresses in independence and generalizes behavioral changes to other critical settings.

Children who are under 3 years of age with an ASD diagnosis have better outcomes when they receive 25-30 hours/week, and it is not uncommon for children in this age group to receive 30 hours of treatment or more as they approach 3 years of age. Children who present characteristics of ASD at age 36 months will continue to require ongoing treatment.

Recommended hours and session lengths are based on the individual’s characteristics, goals and availability for therapy (e.g., endurance, attention span, need for naps). Although the recommended number of hours of therapy may seem arduous to some parents of young children, it should be noted that time spent away from therapy may move children even farther away from desired normal developmental trajectories. Such delays will likely result in increased costs and greater dependence on more intensive services across their life span.

4 Variations Within These Models

Treatment programs within any of these models vary along several programmatic dimensions, including the degree to which they are primarily provider- or client-directed (sometimes described as “structured vs. naturalistic”). Other variations include the extent to which peers or parents serve as behavior change agents. Finally, some differ in terms of the degree to which they are “branded” and available commercially.

Decisions about how these various dimensions are implemented within individual treatment plans must reflect many variables, including the research base, the age of the client, specific aspects of the target behaviors, the client’s own rate of progress, demonstration of prerequisite skills, and resources required to support implementation of the treatment plan across settings.

Despite such differences, if a given treatment meets the Essential Practice Elements of ABA described in this section (p.11), a treatment program should be considered an ABA treatment.

5 ABA Procedures Employed In These Models






A large number of ABA procedures are routinely employed within the models previously described. They differ from one another in their complexity, specificity, and the extent to which they were designed primarily for use with individuals diagnosed with ASD. All are based on the principles of ABA and are employed with flexibility determined by the individual’s specific treatment plan and response to treatment. If one ABA procedure or combination of ABA procedures is not producing the desired response, a different one may be systematically implemented and evaluated for its effectiveness.

These procedures include different types of reinforcement and schedules of reinforcement, differential reinforcement of other behavior, differential reinforcement of alternative behavior, shaping, chaining, behavioral momentum, prompting and fading, behavioral skills training, functional communication training, discrete trial teaching, incidental teaching, self-management, preference assessments, activity schedules, generalization and maintenance procedures, among many others. The field of behavior analysis is constantly developing and evaluating applied behavior change procedures.

6 Locations Where Treatment is Delivered

The standard of care provides for treatment to be delivered in multiple settings in accordance with clinical judgment to promote generalization and maintenance of therapeutic benefits. No ABA model is specific to a particular location and all may be delivered in a variety of settings, including residential treatment facilities, clinics, homes, schools, and places in the community. Treatment provided in multiple settings, with multiple adults and/or siblings under the proper circumstances, will support generalization and maintenance of treatment gains. In some cases, the consistent application of ABA across all settings of the person's life may be the most cost-effective means of treatment.

Where possible, most children under 3 years of age should receive at least some treatment in their home. However, treatment should not be withheld, nor should family members be expected to forego employment, etc., in order to receive such treatment. Under certain circumstances, clinic-based services are most appropriate.

		LOCATION				
		HOME	SCHOOL & COMMUNITY	CLINIC/ OUTPATIENT	RESIDENTIAL	HOSPITAL/ INPATIENT
TREATMENT MODEL	FOCUSED					
	COMPREHENSIVE	✓	✓	✓	✓	✓

7 Client Age

Services should be provided as soon as possible after diagnosis, and in some cases services are warranted prior to diagnosis. Evidence suggests that the earlier treatment begins, the greater the likelihood of positive long-term outcomes. Comprehensive ABA treatment can result in reduced need for services as the child grows older. However, research also demonstrates that ABA is effective across the life span. Older individuals may also need intensive and comprehensive treatment, especially if they present with dangerous behaviors. Research has not established an age limit beyond which ABA is not effective.

Evidence suggests that the earlier treatment begins, the greater the likelihood of positive long-term outcomes.

8 Combining ABA With Other Forms Of Treatment

Findings from several studies show that an eclectic model, where ABA is combined with other forms of treatment, is less effective than ABA alone. Therefore, treatment plans which involve a mixture of methods, especially those which lack proven effectiveness, should be considered with caution and, if approved, should be monitored carefully. If there are treatment protocols that are not aligned with the ABA treatment approach, these differences must be resolved in order to deliver anticipated benefits to the client.



Behavior Analyst Sunrise



SECTION 3: **ASSESSMENT, FORMULATION OF TREATMENT GOALS, AND MEASUREMENT OF CLIENT PROGRESS**

1 The Assessment Process

A developmentally appropriate ABA assessment plan must identify strengths and weaknesses across domains. The data from such a plan should be the basis for developing the individualized treatment plan. An ABA assessment typically utilizes data obtained from multiple methods and multiple informants, such as:

Direct observation and measurement of behavior

Direct observation, measurement, and recording of behavior is a defining characteristic of ABA. These data serve as the primary basis for identifying pre-treatment levels, discharge goals, and evaluation of response to an ABA treatment program. They also assist the Behavior Analyst in developing and adapting treatment protocols on an ongoing basis. Direct observation of behavior should happen during naturally occurring opportunities, as well as, structured interactions.

File review and administration of a variety of behavior scales or other assessments as appropriate

The types of assessments should reflect the goal of treatment and should be responsive to ongoing data as they are collected and analyzed.

Interviews with the client, caregivers, and other professionals

Caregivers and other stakeholders are included when selecting treatment goals, protocols, and evaluating progress as appropriate. Caregiver interviews, rating scales, and social validity measures should be used to assess the caregiver's perceptions of their child's skill deficits and behavioral excesses, and the extent to which these deficits and excesses impede the life of the individual and the family. The client should also participate in these processes as appropriate.

2 Selection and Measurement of Goals

- Selection of a target-behavior definition, method and frequency of measurement approach, and data presentation must be individualized to each situation, behavior, and available resources.
- Behavioral targets should be prioritized based on their risk to client safety, independence, and implications for the client's health and well-being.
- Both baseline performance and treatment goals should be developed for each critical domain and specified in terms that are observable and measurable so that there is agreement regarding the presence, absence, or degree of behavior change relative to treatment goals and discharge criteria.
- Treatment plans should specify objective and measurable treatment protocols. It should include the service setting(s), and level of service for the client.
- Data collection and analysis should occur frequently enough so as to permit changes to the treatment plan at a rate which maximizes progress. Data should be represented in numerical or graphical form.

3 Data From Standardized Assessments

These data may help inform issues related to selection and prioritization of treatment goals and determining the response to treatment.

- Standardized tests that assess performance in cognitive, communicative, social, adaptive, behavioral domains may be appropriate to establish pre-treatment levels of performance and inform decision-making during treatment planning. Scores on such assessments, however, should not be used to exclude individuals from receiving ABA treatment. For example, cognitive functioning is not an accurate or appropriate determiner of an individual's response to ABA treatment.

Data From Standardized Assessments, cont.

- Assessment batteries must be individualized so that they are appropriate for each client. For example, nonverbal assessments may provide a more accurate profile for a client with limited verbal abilities.
- Formal standardized assessments may also be appropriate in some cases for use on an annual basis as part of assessing progress in a Comprehensive ABA treatment program where the goal is to close performance gaps with typically developing peers. However, scores on such assessments should not be used as the sole basis to terminate ABA treatment for individual clients.

4 Problem Behavior Assessment

Problem behavior assessment may also be required when co-occurring behavior disorders (e.g., aggression, self-injury, property destruction, stereotypy) are present, to identify the likely reason(s) problem behavior(s) occur and the skills and strategies necessary to ameliorate them. This necessitates a functional assessment, which may or may not involve a functional analysis (i.e., manipulation of environmental events and record of changes in strength of target behavior) to determine the function of the behavior problem.

5 Complexity of Assessment

In most cases, the ABA assessment can be completed in 15-20 hours (including report writing). However, up to 40 hours may be required if the Behavior Analyst needs to conduct a functional analysis to determine the function of the problem behavior.



SECTION 4: SERVICE AUTHORIZATION AND DOSAGE

1 Services Authorized

Authorization periods should not be for less than 6 months and may involve some or all of the following services. If there is a question as to the appropriateness or effectiveness of ABA for a particular client, a review of treatment data may be conducted more frequently (e.g., after 3 months of treatment).

1. Assessment
2. Treatment Plan Development
3. Direct Treatment
4. Supervision (direct and indirect)
5. Parent and Community Caregiver Training
6. Consultation to Ensure Continuity of Care
7. Discharge Planning

2 Treatment Dosage

Treatment dosage, which is often referenced in the treatment literature as “intensity,” will vary with each client and should reflect the goals of treatment, specific client needs, and response to treatment. Treatment dosage should be considered in two distinct categories: intensity and duration.

Intensity

Intensity is typically measured in terms of number of hours per week of direct treatment. Intensity often reflects whether the treatment is comprehensive (across multiple domains) or focused (limited number of behavioral targets).

If the goal of treatment is to bring the client's functioning to levels typical for that chronological age or maximize independence in multiple areas (e.g., cognitive, social, adaptive)...

- Comprehensive ABA requires intensive treatment, defined as 26-40 hours per week of direct treatment with adjustments based on individual client needs and response to treatment.
 - Treatment hours are most commonly in the range of 26-30 hours per week for children under 3 years of age and 30-40 hours per week for children over 3 years of age.
 - Treatment hours do not include time spent with other professionals or family members specifically trained to extend and amplify the benefits of treatment.

When the goal is to address a limited number of areas such as decreasing dangerous behavior or improving social skills (i.e., Focused ABA)...

- Direct treatment hours will be related to the client's individual needs and learning history, the need to train direct-care staff, assessment time, and data analysis.

In addition to intensity being measured in terms of treatment hours per week, intensity may be further defined in terms of the number of client behaviors or responses per hour as arranged by the treatment protocol. These are sometimes referred to as trials. Higher rates of trials, programmed with consistent implementation, are often important to obtaining adequate progress. Thus, intensity of treatment must reflect other aspects in addition to the number of treatment hours per day, week, or month.

Duration

Treatment duration is effectively managed by evaluating the client's response to treatment. This evaluation can be conducted prior to the conclusion of an authorization period. Some individuals will continue to demonstrate medical necessity and require treatment for a substantial duration (e.g., over a period of years). For example, the benefits of Comprehensive ABA require treatment to be delivered over multiple years.



SECTION 5: TIERED SERVICE DELIVERY MODELS AND BEHAVIORAL TECHNICIANS

Most ABA treatment programs involve a tiered service delivery model where the Behavior Analyst designs and supervises a treatment program delivered by Behavioral Technicians.

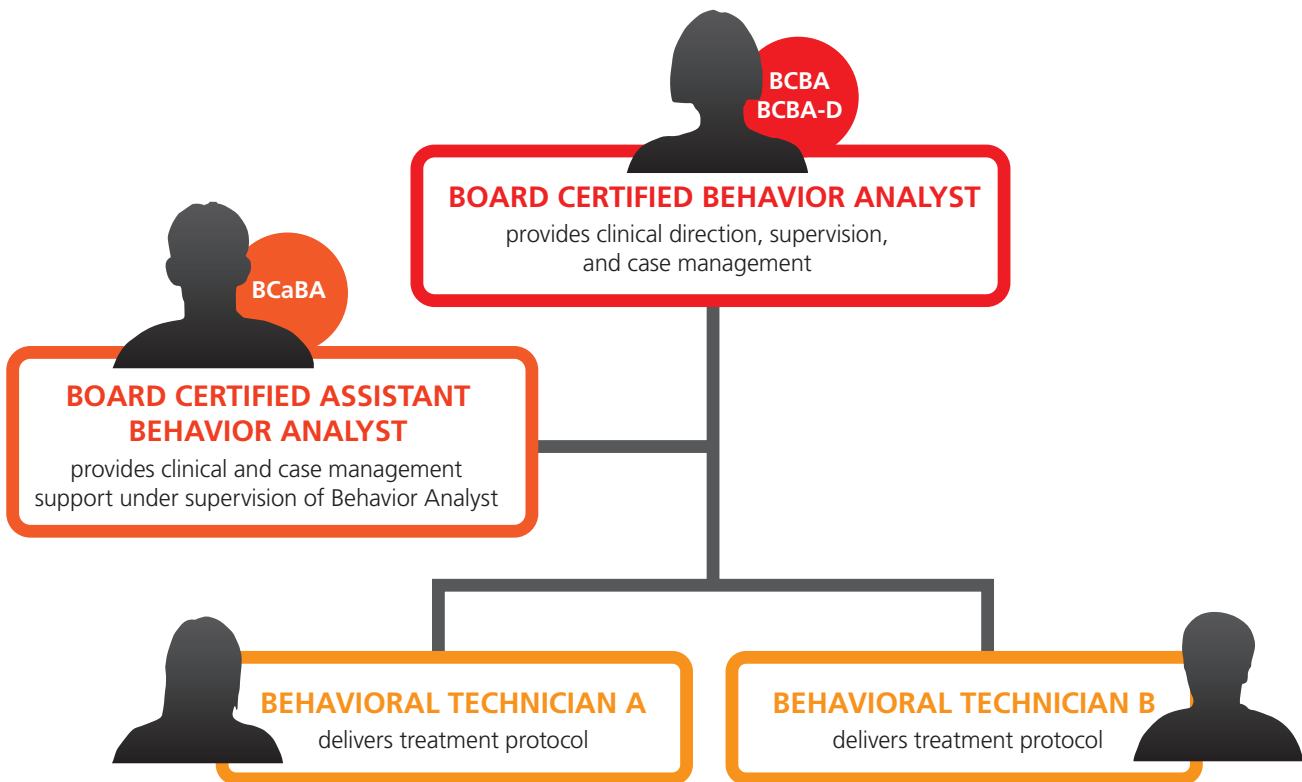
1 Rationales for a Tiered Service Delivery Model

- Tiered service delivery models which rely upon the use of Behavioral Technicians have been the primary mechanism for achieving many of the significant improvements in cognitive, language, social, behavioral, and adaptive domains that have been documented in the peer-reviewed literature.⁴
- The use of carefully trained and well-supervised Behavioral Technicians is a common practice in ABA treatment.^{5,6}
- The use of Behavioral Technicians enables health plans and insurers ensure that they maintain adequate provider networks and deliver medically necessary treatment in a way that manages costs.
- The use of Behavioral Technicians produces more cost-effective levels of service for the duration of treatment because it allows the Behavior Analyst to manage more cases/hours of direct treatment.
- The use of the tiered service delivery model permits sufficient expertise to be delivered to each case at the level needed to reach treatment goals. This is critical as the level of supervision required may need to shift rapidly in response to rapid client progress or demonstrated need.
- Tiered service delivery models can help ensure that treatment is delivered to families in hard to access rural and urban areas as well as families who have complex needs.

Rationales for a Tiered Service Delivery Model, cont.

The BCBA and BCBA-D's clinical, supervisory, and case management activities are often supported by other staff such as BCaBAs working within the scope of their training, practice, and competence.

Below is one example of this specific tiered service delivery model, an approach considered cost-effective at delivering desired treatment outcomes.



Such models assume the following:

1. The BCBA or BCBA-D is responsible for all aspects of clinical direction, supervision, and case management, including activities of the support staff (e.g., a BCaBA) and Behavioral Technicians.
2. The BCBA or BCBA-D must have knowledge of each person's ability to effectively carry out activities before assigning them.
3. The BCBA and BCBA-D provides case supervision, which must include direct, face-to-face supervision on a consistent basis, regardless of whether or not there is clinical support provided by a BCaBA.

2 Selection, Training, and Supervision of Behavioral Technicians

- Behavioral Technicians should meet specific criteria before providing treatment (refer to Sample Background Requirements on p. 27).
- Case assignment should match the needs of the client with the skill-level and experience of the Behavioral Technician. Before working with a client, the Behavioral Technician must be sufficiently prepared to deliver the treatment protocols. This includes a review by the Behavior Analyst of the client's history, current treatment programs, behavior reduction protocols, data collection procedures, etc.
- Caseloads for the Behavioral Technician are determined by the:
 - complexity of the cases
 - experience and skills of the Behavioral Technician
 - number of hours per week employed
 - intensity of hours of therapy the client is receiving
- Quality of implementation (treatment integrity checks) should be monitored on an ongoing basis. This should be more frequent for new staff, when a new client is assigned, or when a client has challenging behaviors or complex treatment protocols are involved.
- Behavioral Technicians should receive direction on the introduction and revision of treatment protocols on a weekly to monthly basis. This activity may be in client briefings with other members of the treatment team each month, including the supervising Behavior Analyst or individually, and with or without the client present. The frequency and format should be dictated by an analysis of the treatment needs of the client to make optimal progress.
- While hiring qualifications and initial training are important, there must be ongoing observation, training, and supervision to maintain and improve the Behavioral Technician's skills while implementing ABA-based treatment.

Sample Training and Job Requirements for Behavioral Technicians:

Background Requirements⁷

- High school graduate (minimum)
- AA degree (preferred)
- Pass criminal background check
- Pass TB test

Initial Training⁸

- CPR
- HIPAA
- mandated reporting, problem solving and conflict management related to employment
- confidentiality and ethics
- ASD
- developmental milestones
- data collection
- basic ABA procedures such as reinforcement, shaping, prompting, etc.

Initial Competency Demonstration

- correctly respond to written and oral scenarios
- demonstrate ability to correctly respond to treatment protocols as evidenced by direct observation and written evaluation

Sample Duties

- implement treatment protocols
- collect and summarize data
- implement feedback delivered during live supervision and from written evaluations
- satisfactorily pass treatment integrity checks and ongoing evaluations
- attend client staffings and trainings

Supervision

- frequent direct observation and feedback during initial employment period, when being assigned a new client, and when working with severe problem behavior
- ongoing supervision and training

SAMPLE



SECTION 6: **CLINICAL MANAGEMENT AND CASE SUPERVISION**

ABA treatments are often described in terms of the number of direct service hours per week. Sometimes absent from such discussions is reference to the required levels of clinical management and case supervision by the Behavior Analyst. Supervision begins with assessment and continues through discharge. ABA treatment requires comparatively high levels of supervision because of the individualized nature of treatment, its reliance on frequent collection and analyses of client data, and need for frequent adjustments to the treatment plan.

This section will describe the Clinical Management and Case Supervision activities that are individualized for the client and medically necessary to achieve treatment goals. Routine agency activities that would not be directly billable are not included here.

1 Clinical Supervision and Case Management Activities

Clinical management and case supervision activities can be described as those that involve contact with the client or caregivers (direct) and those that do not (indirect). Some activities are primarily clinical in nature, while others are more related to case management. On average, direct supervision activities comprise 50% or more of supervision; both direct and indirect supervision activities are critical to producing good treatment outcomes.

Clinical Supervision and Case Management Activities, cont.

The list below, while not exhaustive, identifies some of the most common supervision activities:

ASSESS

- Conduct assessments
- Develop treatment goals, protocols, and data collection systems
- Summarize and analyze data⁹
- Directly observe treatment

DEVELOP

- Meet and evaluate performance of Behavioral Technician staff
- Evaluate client progress towards treatment goals
- Supervise implementation of treatment

EVALUATE

- Adjust treatment protocols based on data
- Monitor treatment integrity
- Train and consult with caregivers and other professionals

IMPLEMENT

- Evaluate risk management and crisis management
- Ensure satisfactory implementation of treatment protocols
- Report progress towards treatment goals

OVERSEE

- Respond to changes in client health or situation
- Develop and oversee transition/discharge plan

1 Modality

Some clinical management and case supervision activities occur face to face; others can occur remotely (e.g., through telemedicine). However, whenever possible, telemedicine should be combined with some “face to face” supervision. In addition, depending on the situation, some training of caregivers and treatment updates may occur in small groups rather than in an individual format. Finally, some indirect case management activities are more effectively carried out in venues other than those used during the actual treatment session.

2 Dosage

Although the amount of supervision for each case must be responsive to individual client needs, 1-2 hours for every 10 hours of direct treatment is the general standard of care. When direct treatment is 10 hours per week or less, a minimum of 2 hours per week of clinical management and case supervision is generally required. Clinical management and case supervision may need to be temporarily increased to meet the needs of individual clients at specific time periods in treatment (e.g., intake, assessment, significant change in response to treatment).⁹

This ratio of clinical management and case supervision hours to direct treatment hours reflects the complexity of ASD and the responsive, individualized, data-based decision-making which characterizes ABA treatment. A number of factors increase or decrease clinical management and case supervision needs on a shorter- or longer-term basis. These include:

- treatment dosage/intensity
- client behavior problems (especially if dangerous or destructive)
- the sophistication or complexity of treatment protocols
- the ecology of the family or community environment
- lack of progress or increased rate of progress
- changes in treatment protocols
- transitions with implications for continuity of care



3 Caseload Size

Caseload size for the Behavior Analyst is typically determined by these same factors and reflects:

- complexity of the case and needs of the client
- training, experience level, and skills of the Behavior Analyst
- number of hours of treatment each client is receiving
- location and modality of supervision
- expertise and availability of support for the Behavior Analyst (e.g., a BCaBA)

The average caseload for one (1) Behavior Analyst supervising comprehensive treatment *without support by a BCaBA* is 6 - 12.

The average caseload for one (1) Behavior Analyst supervising comprehensive treatment *with support by one (1) BCaBA* is 12 - 16. Additional BCaBAs permit modest increases in caseloads.

The average caseload for one (1) Behavior Analyst supervising focused treatment *without support of a BCaBA* is 10 - 15.

The average caseload for one (1) Behavior Analyst supervising focused treatment *with support of one (1) BCaBA* is 16 - 24.

As stated earlier, even if there is a BCaBA assigned to a case, the Behavior Analyst is ultimately responsible for all aspects of case management and clinical direction. In addition, it is expected that the Behavior Analyst will provide direct supervision 2-4 times per month.

Supervisory Staff Qualifications:

BEHAVIOR ANALYST

Qualifications

- BCBA-D/BCBA or License in related field
- Competence in supervising and developing ABA treatment programs for clients with ASD¹¹

Responsibilities

- Summarize and analyze data
- Evaluate client progress towards treatment goals
- Supervise implementation of treatment
- Adjust treatment protocols based on data
- Monitor treatment integrity
- Train and consult with caregivers and other professionals
- Evaluate risk management and crisis management
- Ensure satisfactory implementation of treatment protocols
- Report progress towards treatment goals
- Develop and oversee transition/discharge plan

ASSISTANT BEHAVIOR ANALYST

Qualifications

- BCaBA (preferred)

Responsibilities

- Assists Behavior Analyst in various roles and responsibilities as determined appropriate by Behavior Analyst and delegated to BCaBA



SECTION 7: WORKING WITH CAREGIVERS AND OTHER PROFESSIONALS

1 Family Members/Others as Important Contributors to Outcomes

Family members, including non-caregiver siblings, and other community caregivers should be included in various capacities and at different points during both Focused and Comprehensive ABA treatment programs. In addition to providing important historical and contextual information, caregivers must receive training and consultation throughout treatment, discharge, and follow-up.

Treatment targets, protocols, and determination of outcomes should reflect the individual client as well specific aspects of family life. The significant deficit and excess behaviors that usually accompany a diagnosis of ASD impact the family's functioning and the health of all of its members. In addition, the client's progress may be altered by the extent to which caregivers support treatment goals outside treatment hours. Their ability to do this will be partially determined by how well matched the treatment protocols are to the family's own values, needs, priorities, and resources.

The need for family involvement, training and support reflects the following:

- Caregivers frequently have specialized information about the client's functioning, preferences, and behavioral history.
- Caregivers may be responsible for provision of care, supervision, and dealing with challenging behaviors during all waking hours outside of school or a day treatment program. Some percentage of individuals with ASD present with atypical sleeping patterns. Therefore, some caregivers may be responsible for ensuring the safety of their children and/or implementing procedures at night and may, themselves, be at risk for problems associated with sleep deprivation.
- Caring for an individual with ASD presents many challenges to caregivers and families. Studies have documented the fact that parents of children and adults with ASD experience higher levels of stress than those of parents with typically developing children or even parents of children with other kinds of special needs.

- The behavioral excesses commonly encountered with persons diagnosed with ASD (e.g., repetitive, nonfunctional behavior such as vocal or motor stereotypy) and behavioral challenges (e.g., tantrums or aggression) secondary to the social and language deficits associated with ASD, often present particular challenges for caregivers as they attempt to manage their behavior problems. Typical parenting strategies are often insufficient to enable caregivers to improve or manage their child’s behavior, which can impede the child’s progress towards improved levels of functioning and independence.
- Note that while family training is supportive of the overall treatment plan, it is not a replacement for professionally directed and implemented treatment.

2 Parent and Community Caregiver Training

Training is part of both Focused and Comprehensive ABA treatment models. Although parent and caregiver training is sometimes delivered as a “standalone” treatment, there are relatively few clients for whom this would be recommended as the sole or primary form of treatment. This is due to the severity and complexity of behavioral excesses and deficits that can accompany a diagnosis within the autism spectrum.

Training of parents and other caregivers usually involves a standard, but individualized, curriculum regarding the basics of ABA. Training emphasizes skills development and support so that caregivers become competent in implementing treatment protocols across critical environments. Training usually involves an individualized behavioral assessment, a case formulation, and then customized didactic presentations, modeling and demonstrations of the skill, and practice with in vivo support for each specific skill. Ongoing activities involve supervision and coaching during implementation, problem-solving as issues arise, and support for implementation of strategies in new environments to ensure optimal gains and promote generalization and maintenance of therapeutic changes. Please note that such training is not accomplished by simply having the caregiver or guardian present during treatment.

Training of parents and other caregivers usually involves a standard, but individualized, curriculum regarding the basics of ABA.

3 Sample Behavioral Targets

The following are common behavioral targets for which caregivers often seek assistance. Note that caregiver training for these targets is typically in conjunction with a Focused or Comprehensive ABA treatment program for these same behavioral targets.

- Generalization of skills acquired in treatment settings into home and community settings
- Treatment of co-occurring behavior disorders that risk the health and safety of the child or others in the home or community settings, including reduction of self-injurious or aggressive behaviors against siblings, caregivers, or others; establishment of replacement behaviors which are more effective, adaptive, and appropriate
- Adaptive skills training such as functional communication, participation in routines which help maintain good health (e.g., participation in dental and medical exams, feeding, sleep) including target settings where it is critical that they occur
- Contingency management to reduce stereotypic, ritualistic, or perseverative behaviors and functional replacement behaviors as previously described

4 Program Components

This should be a multifaceted approach that includes didactic instruction for caregivers and family members, including when necessary extended family members, modeling of procedures by Behavioral Technician staff and supervisors, and hands-on training with caregivers (including verbal explanation, modeling, role play, in-vivo practice, and feedback). Supervision should include in-vivo observation and/or review of videotaped sessions and feedback.



5 Coordination with Other Professionals

Consultation with other professionals helps ensure client progress through efforts to coordinate care and ensure consistency including during transition periods and discharge.

Treatment goals are most likely to be achieved when there is a shared understanding and coordination among all healthcare providers and professionals. Examples include collaboration between the prescribing physician and the Behavior Analyst to determine the effects of medication on treatment targets. Another example involves a consistent approach across professionals from different disciplines in how behaviors are managed across environments and settings. Professional collaboration that leads to consistency will produce the best outcomes for the client and their families.

Differences in theoretical orientations or professional styles may sometimes make this difficult. In addition, reviews of research on purported treatments for ASDs have demonstrated that there are a number of unproven, ineffective and sometimes dangerous treatments for ASDs. Occasionally such treatments are prescribed by some professionals in combination with ABA. Some research suggests such practices may result in less effective outcomes than might otherwise be achieved. Consultation to resolve significant differences that undermine the benefits of ABA treatment or any evidence-based treatment should be prioritized.

Treatment goals are most likely to be achieved when there is a shared understanding and coordination among all healthcare providers and professionals.

The *BACB Guidelines for Responsible Conduct for Behavior Analysts* (www.BACB.com) require the Behavior Analyst to recommend the **most** effective scientifically supported treatment for each client. The Behavior Analyst must also review and evaluate the likely effects of alternative treatments, including those provided by other disciplines as well as no treatment.

In addition, Behavior Analysts refer out to professionals from other disciplines when there are client conditions that are beyond the training and competence of the Behavior Analyst, or where coordination of care with such professionals is appropriate. Examples would include, but are not limited to, a suspected medical condition or psychological concerns related to an anxiety or mood disorder.



SECTION 8: **DISCHARGE, TRANSITION PLANNING, AND CONTINUITY OF CARE**

Transition and discharge planning from a treatment program should include a written plan that specifies details of monitoring and follow-up as is appropriate for the individual and the family. Parents, community caregivers, and other involved professionals should be consulted in the planning process 3-6 months prior to the first change in service.

A description of roles and responsibilities of all providers, effective dates for behavioral targets that must be achieved prior to the next phase, should be specified and coordinated with all providers, the client, and family members.

Discharge and transition planning from all treatment programs should generally involve a gradual step down in services. Discharge from a comprehensive ABA treatment program often requires 6 months or longer.

Discharge

Services should be reviewed and evaluated and discharge planning begun when:

- The client has achieved treatment goals
- The client no longer meets the diagnostic criteria for ASD (as measured by appropriate standardized protocols)
- The client does not demonstrate progress towards goals for successive authorization periods.

When there are questions about the appropriateness or efficacy of services, the procedures should be reviewed by an expert panel of Behavior Analysts and other professionals. When there are issues about the appropriateness or efficacy of services in an individual case, including pursuant to any internal or external appeal relating to insurance benefits, the reviewing body should include appropriately qualified Board Certified Behavior Analysts.



PART III: Appendices

APPENDIX A: ELIGIBILITY REQUIREMENTS FOR BACB CERTIFICATION

BCBA Eligibility Requirements

A. Degree Requirement

Possession of a minimum of a bachelor’s and a master’s degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine or a field related to behavior analysis and approved by the BACB from an accredited institution of higher education.

B. Training and Experience Requirements

Option 1: Coursework

1. Coursework: The applicant must complete 225 classroom hours of graduate level instruction (see Acceptable Coursework below) in the following content areas and for the number of hours specified:

- a. Ethical considerations - 15 hours
- b. Definition & characteristics and Principles, processes & concepts - 45 hours
- c. Behavioral assessment and Selecting intervention outcomes & strategies - 35 hours
- d. Experimental evaluation of interventions - 20 hours
- e. Measurement of behavior and Displaying & interpreting behavioral data - 20 hours
- f. Behavioral change procedures and Systems support - 45 hours
- g. Discretionary - 45 hours

2. Experience:

1500 hours Supervised Independent Fieldwork (non-university based); 1. biweekly supervision required	OR	1000 hours Practicum (university based); 1. weekly supervision required	OR	750 hours Intensive Practicum (university based); 1. twice-weekly supervision required
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Option 2: College Teaching

- 1. College Teaching:** The applicant must complete a one academic-year, full-time faculty appointment at a college or university (as described in Section A above) during which the applicant:
 - Teaches classes on basic principles of behavior, single-subject research methods, applications of basic principles of behavior in applied settings, and ethical issues; and
 - conducts and publishes research in behavior analysis.
- 2. Experience:** same as the Coursework option (1)

Option 3: Doctorate/BCBA Review

- 1. Doctorate Degree:** The applicant must have a doctoral degree, conferred at least ten (10) years prior to applying. The field of study must be behavior analysis, psychology, education or another related field (doctoral degrees in related fields are subject to BACB approval).
- 2. BCBA Review:** The applicant must have 10 years post-doctoral experience in behavior analysis. Experience must be verified independently by three Board Certified Behavior Analysts (BCBAs) and supported by information provided on the applicant’s curriculum vitae.

BCBA-D Eligibility Requirements

The BCBA-D is a designation that recognizes doctoral-level BCBAs who:

- 1.** Are individuals who are actively certified as a BCBA; AND
- 2.** Are individuals who have earned a doctorate degree in applied behavior analysis, other human services, education, science, medicine or other field approved by the BACB and strongly related to applied behavior analysis, that was conferred by an accredited university; AND
- 3.** Are individuals who:
 - a. Used graduate-level university coursework (taken for graduate academic credit) to qualify initially for the BCBA; or
 - b. Have taught courses in behavior analysis in a university program with a BACB approved course sequence full-time for at least two years; or
 - c. Could currently qualify under one of the existing BCBA eligibility options

BCaBA Eligibility Requirements

A. Degree Requirement

Possession of a minimum of a bachelor's degree that was conferred in behavior analysis or other natural science, education, human services, engineering, medicine or a field related to behavior analysis and approved by the BACB from an accredited institution of higher education.

B. Coursework and Experience Requirements

1. Coursework: The applicant must complete 135 classroom hours of instruction (see Definition of Terms below) in the following content areas and for the number of hours specified:

- a. Ethical considerations - 10 hours
- b. Definition & characteristics and Principles, processes & concepts - 40 hours
- c. Behavioral assessment and Selecting intervention outcomes & strategies - 25 hours
- d. Experimental evaluation of interventions, & Measurement of behavior and Displaying & interpreting behavioral data - 20 hours
- e. Behavioral change procedures and Systems support - 40 hours

2. Experience:

1000 hours Supervised Independent Fieldwork (non-university based); 1. biweekly supervision required	OR	670 hours Practicum (university based); 1. weekly supervision required	OR	500 hours Intensive Practicum (university based); 1. twice-weekly supervision required
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APPENDIX B: SELECTED BIBLIOGRAPHY

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APPENDIX C: FOOTNOTES

¹ Throughout this document the term Autism Spectrum Disorder (ASD) is used to refer to a group of complex neurological disorders that are sometimes referred to as Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Asperger's Syndrome, High Functioning Autism, among others.

² The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is undergoing revision, with the DSM-V scheduled for publication in 2013. According to the public materials made available by the American Psychiatric Association, the term "Autism Spectrum Disorder" will be used to describe the impairments listed here. The present guidelines are intended for individuals who meet DSM-V criteria for ASD or who have similar behavioral health needs.

³ Focused and Comprehensive ABA exist on a continuum which reflects the number of target behaviors and hours of direct treatment and supervision.

⁴ These staff are competent to administer treatment protocols and are often referred to by a variety of terms including ABA therapist, senior therapist, paraprofessional tutor, or direct line staff.

⁵ The training and responsibilities of Behavioral Technicians who implement treatment protocols are distinctly different from those of workers who perform caretaking functions.

⁶ When possible, several Behavioral Technicians are often assigned to each case in order to promote generalized and sustained treatment benefits for the client. This also helps prevent a lapse in treatment hours due to staff illness, scheduling availability, and turnover, etc. Intensive, comprehensive treatment programs may have 4-5 Behavioral Technicians assigned to a single case. Each Behavioral Technician may also work with several clients across the week.

⁷ Depending on the needs of the individual client, Behavioral Technicians may also require training in commercially available risk management programs for aggression and assaultive behavior (e.g., CPI®). Occasionally, Behavioral Technicians may need to be BCaBAs for the purpose of stabilizing behavior and refining treatment protocols.

⁸ Other trainings may relate to informing employees of policies and procedures at the agency, state, and federal levels.

⁹ Given the intensity of the program, frequent review of the data and the treatment plan are needed. The Behavior Analyst should generally review direct-observation data at least weekly.

¹⁰ Note that direct treatment and clinical supervision are frequently delivered on the same day of service and are both billable services for that day.

¹¹ See also recommended guidelines for Behavior Analysts from the Autism Special Interest Group of The Association for Behavior Analysis International. http://www.abainternational.org/special_interests/autism_guidelines.asp

Development of the Guidelines

The BACB Board of Directors authorized the development of practice guidelines for ABA treatment of ASD covered by health plans. A coordinator was appointed who then created a five-person oversight committee that designed the overall development process and content outline. The oversight committee then solicited additional content-area leaders and writers from a national pool of experts that included researchers and practitioners to produce a first draft of the guidelines. The coordinator, oversight committee, and BACB staff then generated a second draft that was reviewed by dozens of additional reviewers, which in addition to being comprised of experts in ABA, also included consumers and experts in public policy. This second draft was also sent to all BACB directors for additional input. The project coordinator and BACB staff then used this feedback to produce the final document, which was approved by the BACB Board of Directors. The professionals who served as coordinator, oversight committee members, content-area leaders, content writers, and reviewers were all subject matter experts in ABA as evidenced by publication records, substantial experience providing ABA services, and leadership positions within the discipline.



Behavior Analyst Certification Board

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Licensure of Behavior Analysts Sunrise Review June 26, 2014

1. What are the specific benefits you anticipate by creating a board as opposed to secretary regulation?

Response: Applied behavior analysis is a very specific practice that is derived from and founded in the science of behavior. Effective implementation of behavior analytic practices takes training and practice. It is vital that those responsible for appointing and renewing licensure, monitoring practice, and evaluating potential disciplinary action are well versed and skilled in behavior analysis. Additionally, because of the highly technical background of behavior analysis, the group that decides the rules and regulations by which behavior analysts will be held to must be comprised of behavior analysts themselves. The creation of a “stand alone” board of behavior analysts is the best way to ensure that those who monitor behavior analytic practice in the state have sufficient experience and background.

2. What is your definition of “supervision” as used in various sections of the bill?

Response: Supervision is defined as direct contact with the supervisee as well as oversight of a client’s clinical decision making and treatment. This can include 1:1 meetings to review specific cases, direct observation of the supervisee working with a client(s), writing and review of documentation and reports, caregiver training, and much more. The multitudes of supervisory responsibilities are detailed in the last section (Section 9) of the Sunrise Review application.

3. Why should non-family member behavior technicians, who spend large amounts of time alone with vulnerable children, be exempted from any regulation?

Response: There is no national process by which behavior technicians are assessed, evaluated and regulated. The only current quality assurance process is to have them registered with in the BACB (as “Registered Behavior Technicians”). However, that registration has not been implemented yet and will only begin in the next couple of months. Currently, in the state of Washington, to be providing services with a DBHR licensed facility, technicians are required to have a specific amount of training as well as approval from state/insurance boards in addition to fingerprinting and background checks. In addition, they are required to implement plans written, trained, and monitored by a behavior analyst. While regulation of these individuals is recommended, there is insufficient infrastructure in place currently to put these regulations in place.

4. The practice of behavior analysis is very broad and can include treatment of typically developing individuals in the school and work setting, not just the health care setting.

Response: The Department of Health regulates the delivery of health care. How would you ensure the bill only applies to the provision of applied behavior analysis as health care as opposed to education, life-coaching, professional mentoring or other modalities not regulated by the department? Several categories of professionals regulated by the WA Department of Health have broad scopes of practice and provide services to a wide range of clients in non-healthcare as well as healthcare settings. Examples include clinical social workers, marriage and

family therapists, mental health counselors (see Chapter 18.225 RCW), occupational therapists (Chapter 18.59 RCW), and speech-language pathologists (Chapter 18.35 RCW). The licensure statutes and regulations for those professions do not restrict practice to the provision of healthcare services directly to clients. As one example, the regulations for Chapter 18.35 RCW state that "Licensed speech-language pathologists are independent practitioners who provide a comprehensive array of services related to the identification, assessment, habilitation/rehabilitation, of communication disorders and dysphagia. Speech-language pathologists serve in a number of roles including but not limited to clinician, therapist, teacher, consultant, researcher, and administrator. Speech-language pathologists provide services in hospitals, clinics, schools, nursing facilities, care centers, private practice, and other settings in which speech-language pathology services are relevant. Speech-language pathologists provide services to individuals of all ages." (WAC 246-828-105). The proposed bill to license behavior analysts parallels the licensure laws of several professions that are currently regulated by the Department of Health.

5. Why does Sec. 1(6)(b) only include "long-term" counseling as outside the practice of behavior analysis?

Response: "Long term counseling" is a term that is too broad to be considered under the scope of the practice of behavior analysis and can include mental health practices that are clearly outside of the behavior analysis field. While there may be clinical contexts where aspects of counseling may include behavior analytic strategies, the field of counseling also includes many forms of therapy that do not meet ABA standards.

6. Do you feel ABA is within the scope of practice of the counseling professions such as mental health counselors? If so, do you feel it is within their scope of training and competence or would it be up to the individual's ABA-specific training?

Response: The practice of Behavior Analysis is not typically within the scope of practice of mental health counselors. The National Board of Certified Counselors' National Counselor Examination, which is one exam that is required for licensure in Washington, includes the following content areas: Human Growth and Development, Social and Cultural Diversity, Helping Relationships, Group Work, Career Development, Assessment and Diagnosis, Research and Program Evaluation, and Professional Orientation and Ethical Practice. The Work Behaviors included within these content areas include Fundamental Counseling Issues, Counseling Process, Diagnostic and Assessment Services, Professional Practice, and Professional Development. The content covered by the exam includes ethics, psychotherapy, career counseling, diagnosis of mental health disorders, psychometric assessment, and theory, history and systems of psychotherapy, family therapy, and counseling. Although the exam includes some items related to BF Skinner's work, these are very general and do not approach the depth and intensity of the scope of behavior analysis that a Board Certified Behavior Analyst is expected to know and understand. The exam does not include applied behavior analysis content such as how to design interventions based on positive reinforcement; how to analyze continuous behavioral data; or how to assess the function of challenging behavior for persons with developmental disabilities, to name only a few. There is no content specific to developmental disabilities; teaching habilitation skills for home and community living to persons with cognitive, behavioral, or developmental challenges; or how to design, oversee, and implement intensive ABA intervention for children with autism. All of these interventions are clearly within applied

behavior analysis and expectations on the knowledge skills and abilities of the national certification exam. Finally, the NCE includes questions regarding how to address the needs of clients who have children with ADHD, autism, and challenging behavior. According to the NCE study guide, a counselor should refer the client to a “behaviorist” or behavior analyst for in-home behavioral intervention, in addition to providing counseling for the family to help them deal with adjustment, emotional and relationship issues. The NBCC clearly views behavior analysis intervention as beneficial and appropriate in some circumstances, and also as different from counseling or psychotherapy.

Similarly, the National Clinical Mental Health Counseling Examination (NCMHCE), the other examination that is included in Washington’s licensing requirements for Licensed Counselors, includes Assessment and Diagnosis, Counseling and Psychotherapy, and Administration, Consultation and Supervision as content areas. Behavior analysis interventions, other than those few procedures that originated in behavior analysis and are now included in some evidence-based psychotherapy interventions, are not included in the content areas or in the study guides for either NBCC exam.

There are some licensed counselors and psychologists in the state who have additional training and national certification in behavior analysis; these individuals practice behavior analysis within the scope of their training, under the license of their profession. There are also some interventions in evidence-based psychotherapy, particularly for children and families, that behavior analysts originally developed and that are now within the scope of practice of licensed psychologists or counselors who specialize in child or family therapy, such as time out and star charts (token reinforcement systems). The proposed law explicitly states that members of other professions can use behavior analytic interventions within their training and scope of practice. Behavior analysts have no wish to remove commonly used and beneficial behavior analytic interventions from the scope of practice of other professions.

Another concern is that the current regulatory practice of designating ABA practitioners as certified or agency affiliated counselors is inaccurate and confusing to the public, given the very small area of overlap between counseling and ABA. Behavior analysts typically have no training in diagnosis of mental health disorders, psychometric assessment, or psychotherapy, as counselors do. Currently, members of the public have no easy way to distinguish a professional who is really a behavior analyst but is practicing as a certified or agency-affiliated counselor, as currently required by the state, from a counselor who practices counseling, i.e., psychotherapy. Behavior analysts have no wish to falsely present themselves as counselors, diagnosticians, or psychotherapists. The proposed law would remedy the current confusing situation, and provide the public with a clear designation, scope of practice, and regulatory oversight of ABA practitioners.

7. Sec. 3(6) exempts family members working under the supervision of a licensed behavior analyst. What if the child is in state care/foster care? Should “family members” be changed to include legal guardians?

Response: This is an excellent point. Thank you. The bill should include family members and all other legal guardians (e.g., foster parents). The term “family members” in Section 3(6) should be changed to “legal guardians.”

8. Why does the public member of the board in Sec. 7(2)(c) allow parents or guardians of a recipient of behavior analysis services? Wouldn't this be a material or financial interest?

Response: The principle of limiting dual relationships, including conflicts of interest, is important. However, the principle of representation in oversight and due process (e.g., having the consumers of a service represented in the oversight board) is also important. In medical oversight boards or agencies, every member is a potential recipient of medical treatment, as we all need medical help at some point in our lives. However, that is not a general conflict of interest, only a potential conflict. In other professional situations, the typical requirement is that an individual board member would recuse him or herself, and/or designate another consumer representative, if the specific agenda item or action directly affects the board member's financial or material interests. For example, if a parent board member is asked to consider a complaint made against the service provider from whom s/he is currently receiving services, the most ethical course of action would be for that board member to request recusal.

9. What types of delegated tasks does Sec. 5 envision? And are there other "assistive personnel" envisioned beyond the assistant behavior analyst or BA technician?

Response: Delegated tasks from a Behavior Analyst to an assistant behavior analyst or behavior analysis technician typically fall under the implementation of the treatment plan. However, they could also include assistance in program development, therapy material creation, and first drafts of therapy documents (treatment plans, instructional programs, data charts, etc.,).

There are no other personnel envisioned beyond the assistant behavior analyst or BA technician. All required tasks will be performed by these individuals.

10. In lay terms, what does a behavior analyst or assistant do? What kinds of instructional and environmental modifications do they design, implement to evaluate?

Response: A behavior analyst's job is varied and multifaceted. A trained behavior analyst looks at a problem in client behavior and derives a plan for solving that particular problem. This involves clearly defining the behavior, assessing the current environment to establish what is influencing the behavior, as well as changing the environment to promote a desired outcome (i.e. change in behavior). All plans designed by a behavior analyst are based upon scientifically supported methodology and only use research-supported strategies. The assistants and technicians are the individuals who carry out that plan.

A behavior analyst may be requested to solve problem behaviors such as: decreasing tantrums and aggression, decreasing property destruction, decreasing self-stimulatory behavior (e.g., flapping hands, lining up toys, turning wheels of cars again and again, etc.), pica (eating non-nutritive objects), or decreasing self-injurious behavior. This is a sample list (though not exhaustive) of many of the possible cases that behavior analysts are asked to consult with.

Simply stated, a behavior analyst's job can be described as follows:

- a) One of the tenets of behavior analysis is that all behavior serves a purpose, or function. When presented with a problem behavior, the behavior analyst figures out the function of the behavior. Why is the behavior being repeated? Is the function to gain attention? Is it to escape from a task? Or, is it maintained by sensory consequences (e.g., is scratching a comforting sensation)? Behavior analysts use scientific methodology called Functional Assessment and Functional Analysis to hypothesize the function of behavior.

- b) Once the function of the behavior is determined or theorized, the behavior analyst comes up with a plan about how to increase or decrease that behavior. The behavior analyst maps out exactly how to react when the client engages in that behavior, and the team carries out the plan. The plan is usually two-fold: first, come up with a way to increase/decrease the behavior right away. Second, she figures out the long-term skills that we need to teach the client so as to avoid this behavior occurring again in the future. Throughout the implementation of the plan, the team is taking data for the purpose of monitoring and evaluating progress.
- c) Perhaps most importantly, the behavior analyst is constantly monitoring the data to assess whether the plan is working. If the plan is working, then the team continues with the plan. If the plan is not working, then modifications or adjustments to the plan are made by the behavior analyst. Once again, all strategies are based upon research and evidence-based practices.

11. Who diagnoses the conditions that a behavior analyst treats? Is there a referral relationship between the diagnosing provider and the behavior analyst? How does the practice of behavior analyst interact with other providers? In what situations might a behavior analyst work with patients independently?

Response: Behavior analysts provide intervention related to behavior that the client or the client's parents or guardians would like to change, in order to improve the client's quality of life. Sometimes these behaviors are related to a mental health diagnosis; more frequently, the types of behavioral needs addressed by behavior analysts are related to a neurodevelopmental disorder such as developmental delay, autism, attention deficit disorder, or learning disabilities. These disorders are typically diagnosed by a private physician, pediatrician, licensed mental health counselor, psychologist, or psychiatrist. These professions frequently refer clients to behavior analysts for intervention, because the recognized evidence-based treatment for the behavior related to the disorder is behavior analysis. For example, a psychiatrist may diagnose a young child with autism spectrum disorder, but the medication or psychotherapy treatment options are very limited. The National Association of Child and Adolescent Psychiatry has recognized ABA as the evidence-based treatment of choice for autism since 2001.

Licensure of Behavior Analysts Sunrise Review June 26, 2014

1. What are the specific benefits you anticipate by creating a board as opposed to secretary regulation?

Response: Applied behavior analysis is a very specific practice that is derived from and founded in the science of behavior. Effective implementation of behavior analytic practices takes training and practice. It is vital that those responsible for appointing and renewing licensure, monitoring practice, and evaluating potential disciplinary action are well versed and skilled in behavior analysis. Additionally, because of the highly technical background of behavior analysis, the group that decides the rules and regulations by which behavior analysts will be held to must be comprised of behavior analysts themselves. The creation of a “stand alone” board of behavior analysts is the best way to ensure that those who monitor behavior analytic practice in the state have sufficient experience and background.

2. What is your definition of “supervision” as used in various sections of the bill?

Response: Supervision is defined as direct contact with the supervisee as well as oversight of a client’s clinical decision making and treatment. This can include 1:1 meetings to review specific cases, direct observation of the supervisee working with a client(s), writing and review of documentation and reports, caregiver training, and much more. The multitudes of supervisory responsibilities are detailed in the last section (Section 9) of the Sunrise Review application.

3. Why should non-family member behavior technicians, who spend large amounts of time alone with vulnerable children, be exempted from any regulation?

Response: There is no national process by which behavior technicians are assessed, evaluated and regulated. The only current quality assurance process is to have them registered with in the BACB (as “Registered Behavior Technicians”). However, that registration has not been implemented yet and will only begin in the next couple of months. Currently, in the state of Washington, to be providing services with a DBHR licensed facility, technicians are required to have a specific amount of training as well as approval from state/insurance boards in addition to fingerprinting and background checks. In addition, they are required to implement plans written, trained, and monitored by a behavior analyst. While regulation of these individuals is recommended, there is insufficient infrastructure in place currently to put these regulations in place.

4. The practice of behavior analysis is very broad and can include treatment of typically developing individuals in the school and work setting, not just the health care setting.

Response: The Department of Health regulates the delivery of health care. How would you ensure the bill only applies to the provision of applied behavior analysis as health care as opposed to education, life-coaching, professional mentoring or other modalities not regulated by the department? Several categories of professionals regulated by the WA Department of Health have broad scopes of practice and provide services to a wide range of clients in non-healthcare as well as healthcare settings. Examples include clinical social workers, marriage and

family therapists, mental health counselors (see Chapter 18.225 RCW), occupational therapists (Chapter 18.59 RCW), and speech-language pathologists (Chapter 18.35 RCW). The licensure statutes and regulations for those professions do not restrict practice to the provision of healthcare services directly to clients. As one example, the regulations for Chapter 18.35 RCW state that "Licensed speech-language pathologists are independent practitioners who provide a comprehensive array of services related to the identification, assessment, habilitation/rehabilitation, of communication disorders and dysphagia. Speech-language pathologists serve in a number of roles including but not limited to clinician, therapist, teacher, consultant, researcher, and administrator. Speech-language pathologists provide services in hospitals, clinics, schools, nursing facilities, care centers, private practice, and other settings in which speech-language pathology services are relevant. Speech-language pathologists provide services to individuals of all ages." (WAC 246-828-105). The proposed bill to license behavior analysts parallels the licensure laws of several professions that are currently regulated by the Department of Health.

5. Why does Sec. 1(6)(b) only include "long-term" counseling as outside the practice of behavior analysis?

Response: "Long term counseling" is a term that is too broad to be considered under the scope of the practice of behavior analysis and can include mental health practices that are clearly outside of the behavior analysis field. While there may be clinical contexts where aspects of counseling may include behavior analytic strategies, the field of counseling also includes many forms of therapy that do not meet ABA standards.

6. Do you feel ABA is within the scope of practice of the counseling professions such as mental health counselors? If so, do you feel it is within their scope of training and competence or would it be up to the individual's ABA-specific training?

Response: The practice of Behavior Analysis is not typically within the scope of practice of mental health counselors. The National Board of Certified Counselors' National Counselor Examination, which is one exam that is required for licensure in Washington, includes the following content areas: Human Growth and Development, Social and Cultural Diversity, Helping Relationships, Group Work, Career Development, Assessment and Diagnosis, Research and Program Evaluation, and Professional Orientation and Ethical Practice. The Work Behaviors included within these content areas include Fundamental Counseling Issues, Counseling Process, Diagnostic and Assessment Services, Professional Practice, and Professional Development. The content covered by the exam includes ethics, psychotherapy, career counseling, diagnosis of mental health disorders, psychometric assessment, and theory, history and systems of psychotherapy, family therapy, and counseling. Although the exam includes some items related to BF Skinner's work, these are very general and do not approach the depth and intensity of the scope of behavior analysis that a Board Certified Behavior Analyst is expected to know and understand. The exam does not include applied behavior analysis content such as how to design interventions based on positive reinforcement; how to analyze continuous behavioral data; or how to assess the function of challenging behavior for persons with developmental disabilities, to name only a few. There is no content specific to developmental disabilities; teaching habilitation skills for home and community living to persons with cognitive, behavioral, or developmental challenges; or how to design, oversee, and implement intensive ABA intervention for children with autism. All of these interventions are clearly within applied

behavior analysis and expectations on the knowledge skills and abilities of the national certification exam. Finally, the NCE includes questions regarding how to address the needs of clients who have children with ADHD, autism, and challenging behavior. According to the NCE study guide, a counselor should refer the client to a “behaviorist” or behavior analyst for in-home behavioral intervention, in addition to providing counseling for the family to help them deal with adjustment, emotional and relationship issues. The NBCC clearly views behavior analysis intervention as beneficial and appropriate in some circumstances, and also as different from counseling or psychotherapy.

Similarly, the National Clinical Mental Health Counseling Examination (NCMHCE), the other examination that is included in Washington’s licensing requirements for Licensed Counselors, includes Assessment and Diagnosis, Counseling and Psychotherapy, and Administration, Consultation and Supervision as content areas. Behavior analysis interventions, other than those few procedures that originated in behavior analysis and are now included in some evidence-based psychotherapy interventions, are not included in the content areas or in the study guides for either NBCC exam.

There are some licensed counselors and psychologists in the state who have additional training and national certification in behavior analysis; these individuals practice behavior analysis within the scope of their training, under the license of their profession. There are also some interventions in evidence-based psychotherapy, particularly for children and families, that behavior analysts originally developed and that are now within the scope of practice of licensed psychologists or counselors who specialize in child or family therapy, such as time out and star charts (token reinforcement systems). The proposed law explicitly states that members of other professions can use behavior analytic interventions within their training and scope of practice. Behavior analysts have no wish to remove commonly used and beneficial behavior analytic interventions from the scope of practice of other professions.

Another concern is that the current regulatory practice of designating ABA practitioners as certified or agency affiliated counselors is inaccurate and confusing to the public, given the very small area of overlap between counseling and ABA. Behavior analysts typically have no training in diagnosis of mental health disorders, psychometric assessment, or psychotherapy, as counselors do. Currently, members of the public have no easy way to distinguish a professional who is really a behavior analyst but is practicing as a certified or agency-affiliated counselor, as currently required by the state, from a counselor who practices counseling, i.e., psychotherapy. Behavior analysts have no wish to falsely present themselves as counselors, diagnosticians, or psychotherapists. The proposed law would remedy the current confusing situation, and provide the public with a clear designation, scope of practice, and regulatory oversight of ABA practitioners.

7. Sec. 3(6) exempts family members working under the supervision of a licensed behavior analyst. What if the child is in state care/foster care? Should “family members” be changed to include legal guardians?

Response: This is an excellent point. Thank you. The bill should include family members and all other legal guardians (e.g., foster parents). The term “family members” in Section 3(6) should be changed to “legal guardians.”

8. Why does the public member of the board in Sec. 7(2)(c) allow parents or guardians of a recipient of behavior analysis services? Wouldn't this be a material or financial interest?

Response: The principle of limiting dual relationships, including conflicts of interest, is important. However, the principle of representation in oversight and due process (e.g., having the consumers of a service represented in the oversight board) is also important. In medical oversight boards or agencies, every member is a potential recipient of medical treatment, as we all need medical help at some point in our lives. However, that is not a general conflict of interest, only a potential conflict. In other professional situations, the typical requirement is that an individual board member would recuse him or herself, and/or designate another consumer representative, if the specific agenda item or action directly affects the board member's financial or material interests. For example, if a parent board member is asked to consider a complaint made against the service provider from whom s/he is currently receiving services, the most ethical course of action would be for that board member to request recusal.

9. What types of delegated tasks does Sec. 5 envision? And are there other "assistive personnel" envisioned beyond the assistant behavior analyst or BA technician?

Response: Delegated tasks from a Behavior Analyst to an assistant behavior analyst or behavior analysis technician typically fall under the implementation of the treatment plan. However, they could also include assistance in program development, therapy material creation, and first drafts of therapy documents (treatment plans, instructional programs, data charts, etc.,).

There are no other personnel envisioned beyond the assistant behavior analyst or BA technician. All required tasks will be performed by these individuals.

10. In lay terms, what does a behavior analyst or assistant do? What kinds of instructional and environmental modifications do they design, implement to evaluate?

Response: A behavior analyst's job is varied and multifaceted. A trained behavior analyst looks at a problem in client behavior and derives a plan for solving that particular problem. This involves clearly defining the behavior, assessing the current environment to establish what is influencing the behavior, as well as changing the environment to promote a desired outcome (i.e. change in behavior). All plans designed by a behavior analyst are based upon scientifically supported methodology and only use research-supported strategies. The assistants and technicians are the individuals who carry out that plan.

A behavior analyst may be requested to solve problem behaviors such as: decreasing tantrums and aggression, decreasing property destruction, decreasing self-stimulatory behavior (e.g., flapping hands, lining up toys, turning wheels of cars again and again, etc.), pica (eating non-nutritive objects), or decreasing self-injurious behavior. This is a sample list (though not exhaustive) of many of the possible cases that behavior analysts are asked to consult with.

Simply stated, a behavior analyst's job can be described as follows:

- a) One of the tenets of behavior analysis is that all behavior serves a purpose, or function. When presented with a problem behavior, the behavior analyst figures out the function of the behavior. Why is the behavior being repeated? Is the function to gain attention? Is it to escape from a task? Or, is it maintained by sensory consequences (e.g., is scratching a comforting sensation)? Behavior analysts use scientific methodology called Functional Assessment and Functional Analysis to hypothesize the function of behavior.

- b) Once the function of the behavior is determined or theorized, the behavior analyst comes up with a plan about how to increase or decrease that behavior. The behavior analyst maps out exactly how to react when the client engages in that behavior, and the team carries out the plan. The plan is usually two-fold: first, come up with a way to increase/decrease the behavior right away. Second, she figures out the long-term skills that we need to teach the client so as to avoid this behavior occurring again in the future. Throughout the implementation of the plan, the team is taking data for the purpose of monitoring and evaluating progress.
- c) Perhaps most importantly, the behavior analyst is constantly monitoring the data to assess whether the plan is working. If the plan is working, then the team continues with the plan. If the plan is not working, then modifications or adjustments to the plan are made by the behavior analyst. Once again, all strategies are based upon research and evidence-based practices.

11. Who diagnoses the conditions that a behavior analyst treats? Is there a referral relationship between the diagnosing provider and the behavior analyst? How does the practice of behavior analyst interact with other providers? In what situations might a behavior analyst work with patients independently?

Response: Behavior analysts provide intervention related to behavior that the client or the client's parents or guardians would like to change, in order to improve the client's quality of life. Sometimes these behaviors are related to a mental health diagnosis; more frequently, the types of behavioral needs addressed by behavior analysts are related to a neurodevelopmental disorder such as developmental delay, autism, attention deficit disorder, or learning disabilities. These disorders are typically diagnosed by a private physician, pediatrician, licensed mental health counselor, psychologist, or psychiatrist. These professions frequently refer clients to behavior analysts for intervention, because the recognized evidence-based treatment for the behavior related to the disorder is behavior analysis. For example, a psychiatrist may diagnose a young child with autism spectrum disorder, but the medication or psychotherapy treatment options are very limited. The National Association of Child and Adolescent Psychiatry has recognized ABA as the evidence-based treatment of choice for autism since 2001.



Second Round of Comments for the Sunrise Proposal on the Licensure of Behavior Analysts in Washington State

From: **Washington Association for Behavior Analysis**

WABA would first like to extend its appreciation to the Department of Health for providing the opportunity to testify on our support for this licensure. The hearing was very informative and was effective in revealing the overwhelming support from professionals and consumers for this bill to go forward in the legislative process.

1. During testimony, one question by a Department of Health panel member revealed the possibility of rewriting this bill as a 'title protection' act rather than a 'scope protection' act. While title protection is a necessary component for inclusion in this bill, WABA does not believe it would be sufficient in providing the protections that are necessary for consumers of ABA services. Title protection is put in place to protect the use of certain professional titles from those who may lack the sufficient background to refer to themselves and their professional practices as such. However, what it does not do is provide protections against unlicensed professionals claiming to implement ABA while naming it by an "unprotected title". For example, if 'behavior analysis' and 'behavior analyst' were protected terms, this would not prevent an untrained and unlicensed provider calling their services by another name ("behavior intervention" for example), thereby putting unknowing vulnerable consumers at risk. This is where a 'scope protected' license would actually be protecting the public. It would give a disciplinary review board the recourse to discipline those professionals who are claiming to provide services within the scope of a behavior analyst.

It is true that the scope of behavior analysis is broad, as is the scope of psychologists, occupational therapists, social workers, and mental health counselors. Other professions have explicit title protection and, historically, the Department of Health has protected their scope of practice through regulatory action because they recognized the danger to the public of allowing untrained people to provide services, such as psychological assessment. To our knowledge some of these professions also have licenses that protect BOTH their scope of service and their titles. A fundamental purpose of this bill is to protect vulnerable consumers of ABA services by having a license that encompasses scope of service and title protection.

2. During the course of testimony, there were questions raised about the use of punishment as a viable therapeutic treatment. First, WABA believes that the issue of punishment as a treatment is not directly relevant to the issue of licensure for behavior analysts presented at the Sunrise Hearing. This distinction is important to the members of WABA as we don't want the question of licensure to be clouded with the connotations and emotions tied up in the term *punishment*.

That said, we believe that the discussion pertaining to punishment, as well as some of the testimony regarding its use, only solidifies the need for providers who are adequately trained in

behavior analysis as well as an infrastructure for consumers to differentiate between those who are trained and those who are not.

Punishment is a technical term used in the applied behavior analysis field to describe procedures that reduce behavior. On the surface there is nothing harmful or inappropriate about applying techniques to lessen behavior (e.g., self-injury, aggression, smoking, etc.). However, when procedures (all procedures, not just punishment) are implemented by untrained individuals or well-meaning individuals who do not recognize the inadequacy of their training, significant consequences can ensue. These include harm to the individual and/or the development of additional maladaptive behaviors including additional aggression and self-injury. If behavior analysts are licensed in the state of Washington, our most vulnerable populations will be much better protected from incorrect implementation of behavior analytic procedures. In addition, the title Licensed Behavior Analyst will signal to consumers that the provider has been adequately trained.

3. There were letters and some testimony recommending that, if behavior analyst licensure were to occur, the regulatory board should not be made up of all or a majority of licensed behavior analysts. While these claims were made by more than one party, none of the claims were satisfactorily followed with a rationale for why a regulatory board for behavior analysts should be comprised of professionals who are not primarily behavior analysts. The profession of applied behavior analysis is fundamentally distinct from other professions with a nationally accredited certification board, and national and state organizations representing it. The only logical make up of a regulatory board for this profession is one of other professionals in the field, not of professionals in fields that are tangentially related to our field. There is no other stand-alone regulatory board in Washington State where the make-up of the board has a majority of professionals OUTSIDE the profession. The regulation of behavior analysts requires representation BY behavior analysts. For the protection of consumers, it is logical to have 1-2 individuals on the board who are outside of the field (members of the public, consumers, or other professionals) to ensure that alternative perspectives on regulatory matters are considered. However, the recommendation that the majority of the board be comprised of professionals who are not explicitly behavior analysts simply does not make logical sense.
4. WABA believes that several of the claims made in some of the written commentaries are not accurate. Chief among these is the claim that other fields provide the same services as behavior analysts, or are qualified to provide the same services. The use of the term 'behavior modification' illustrates this point. Only individuals who have a basic understanding of the field of applied behavior analysis would use that term. Behavior analysis is not the same as behavior modification. The latter term has been out of date and nearly unused in our field since the 1980s. Although mental health, education, and rehabilitation professionals sometimes use specific procedures that originated in behavior modification, behavior therapy, and more recently in behavior analysis, that does not demonstrate that these other professions have enough expertise specifically in behavior analysis to provide comprehensive or effective behavior analytic services. With respect to our colleagues in other fields who think they are qualified to provide ABA services, we believe that the practice of behavior analysis requires a graduate degree and extensive training explicitly in behavior analysis. One class, or more

typically, one part of a class, in applied behavior analysis strategies (typically what is received in other fields that are making this claim) simply does not compare to the level of education that Board Certified Behavior Analysts receive. Additionally the extent of experience, supervision, and continuing education specific to the field of applied behavior analysis further differentiates behavior analysts from other professionals. While we are pleased that some professionals from other fields use effective behavioral strategies as 'tools' when in their scope of education and training permit it, we do not agree that these professionals can provide applied behavior analysis services as a primary function of their business without training and supervision experience consistent with what a BACB certificant receives. The fact that this 'equality' claim has been made in written comments supports our contention that we need licensure to ensure that consumers can have access to behavior analysis services that are delivered safely and effectively by qualified and properly trained professionals.

5. One concern that was brought up in testimony noted that the standards of practice provided by the international Behavior Analyst Certification Board were the only "game in town". WABA disagrees with this statement as there are other professional groups who provide their recommendations about standards for applied behavior analysis and we are happy to share those standards if requested. What distinguishes the BACB's standards is that they are the only group who has had their standards and certification process rigorously tested, vetted and approved by the National Commission on Certifying Agencies. Additionally, their standards are regularly reviewed and updated to remain current with the profession and empirically supported best practices. The BACB standards are not the only 'game in town'. They are simply the best game in town. The original claim again illustrates the lack of background and understanding that other professions have about the field of applied behavior analysis.

The rationale described in WABA's applicant report, the testimony and letters provided by supporters of licensure, as well as the comments above create a compelling argument for licensure of behavior analysts. Clearly licensees should be regulated by a board comprised primarily of fellow licensed behavior analysts. The Department of Health has an important opportunity to make a significant impact on the lives of some of the State's most vulnerable populations. We look forward to hearing your decision.

Christopher Jones, PhD, BCBA-D
President and Co-chair Legislative and Public Policy Committee
Washington Association for Behavior Analysis

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Co-Chair Legislative and Public Policy Committee
Washington Association for Behavior Analysis

Appendix C

Public Hearing Summary

Behavior Analyst Sunrise Review Summary of Public Hearing August 12, 2014

Kristi Weeks, director of legal services and legislative liaison at the Department of Health (department), called the hearing to order at 1:02 PM and gave instructions to participants. She introduced department staff assisting with the hearing, and introduced the hearing panel. The panel's role is to make sure we have all the information we need to make a sound recommendation, so they will ask a lot of questions. The panel members were:

- Tim Talkington is a staff attorney in our office of legal services.
- Sue Gragg is a program manager in our office of health professions and facilities.
- Jennifer Coiteux is a program manager in our office of customer service.

Ms. Weeks announced that after the hearing, there will be a 10-day written comment period before the department drafts the initial report. This is to allow interested parties to provide additional information on topics brought up at the hearing, and allow those who could not attend the hearing to submit information. Ms. Weeks reminded participants that the sunrise review process has statutorily mandated criteria that should be the focus of discussion at the hearing.

Next, Ms. Weeks welcomed the applicant panel to make their presentation on the proposal.

Applicant Presentation

Christopher Jones

Dr. Jones stated he has heard of some questions the department has had as it reviews the applicant materials. One of them was general lack of clarity about what applied behavior analysis (ABA) is, so he stated he wanted to clarify that behavior analysis is not a therapy for kids with autism. That's not what applied behavior analysis is. It is an approach; some people call it a philosophy, about how we understand human behavior and animal behavior. One of the things behavior analysts do choose for change behaviors that have social significance to the client or the child they're working with. What that means is behaviors that are going to have the most meaningful impact on that child's life.

Dr. Jones explained that a typical behavior plan for a child that a behavior analyst would work with will have anywhere from nine or ten goals, all the way up to twenty or thirty. Each of those are different behaviors that they're working on while at the same time trying to increase certain behaviors that the child has deficits in; trying decrease certain behaviors that are causing problems for the child or that are challenging for the child. Some of the strategies of ABA are positive reinforcement, reward charts, behavior contrast exposure therapy; these are all different types of approaches that behavior analysts use in their work.

As of this morning, there were 287 board certified behavior analysts in Washington, which has changed just a bit from the 285 listed in the applicant report. The large majority of them are masters level board certified behavior analysts, a small number of assistant behavior analysts, and about 39 doctoral level behavior analysts. The behavior analysts discussed in the applicant report are master's level and doctoral level. Assistant behavior analysts are at a bachelor's level. Those behavior analysts reside in about 63 cities throughout the state, and we are seeing more and more throughout the state as the field of behavior analysis has been. Only a few years ago, there were only two or three in Spokane and now there are 17, so it gives you an indication of how quickly it's growing as the number of training programs across the nation increase.

Dr. Jones used the Gentry family he previously worked with in Pierce County as his example to make some of his points. They were a mother and father who were separated and lived in a rural area of Pierce County and the child

was eight year when he started working with him. He had autism and ADHD. He was diagnosed at age four and had a typically developing twelve year old sister. The primary problem the family was experiencing was that this child had been hospitalized three times for severe self-injury and aggression towards others. Self-injury was ranging from biting his hand until it bled, all the way to hitting his head against walls so that he had to wear a helmet most of the time. The aggression on others resulted in the last hospitalization after putting his sister in the hospital because he broke her arm and pushed her off a deck. He had no functional communication system, no way of communicating his wants and needs, and aggression and self-injury when Dr. Jones began working with him. He was getting some speech services and was connected with the DDA (what is now the DDA). He was receiving some social services.

His first point he wanted to make was that unregulated practice is causing harm to consumers, with those with autism and other neurodevelopmental disabilities in Washington. He said there wasn't a behavioral analyst in the hearing room who didn't have a story from a family that was experiencing some form of harm before they started providing ABA. He discussed three different forms. Harm doesn't necessarily mean that the child is regressing in some way; it could also mean that the child is not progressing in a typical pattern or staying level. This is what happened with Jackson from the Gentry family. At four he was developing at approximately a three year old level. Before Dr. Jones began working with him until he was eight, he was still functioning at that three year old level, so he lacked progress. He didn't regress but lacked progress in his developmental milestones.

Another form is when a child is not progressing similar enough to their typically developing peers. A child might be functioning with other four year olds at a four year old level; but as his peers grow to five, six year, or seven year olds, they're progressing at a much slower rate. These are all different ways children can be harmed by not having effective services that are supervised by a well-qualified behavior analyst.

There are a number of families and behavior analysts that are going to testify with their stories. There is no database about these complaints and the harm that has been caused because there's no infrastructure in place. For those whose therapy is being supervised by a licensed mental health counselor or social worker, they can complain to Department of Health but for the most part, there's no standardized structure in place for these families to voice their grievances.

Back to the Gentry family, Jackson was eight years old and had failed to progress, so he was functioning at that three year old level. He became more aggressive and ended up hurting his sister on multiple occasions despite the fact that he was receiving services from a number of different entities. These ranged from psychologists to a developmental pediatrician to speech pathologists and his DDA case manager. He was getting services approximately once a week to once a month from these various entities; and one of the things about behavior analysis is that you need much more frequent services for these kids.

Another reason the public can't be more effectively protected in a more cost-beneficial manner is that options like registration or certification, or associations don't assure the quality of services being provided the way licensure would. Simple registration is just tracking who is providing services but does not provide any constraints upon what those registrants are doing, and the background and experience and supervision they've had. Licensure would assure that type of quality assurance.

Also, whether from the goodness of their heart or through due process, a number of insurance companies in Washington are now providing ABA for kids with autism and other developmental disabilities. The large majority of those insurance companies require that a BCBA be supervising that program. They've done their due diligence and their research to determine that a BCBA is what's required to run that type of program. If any entity is going to be worried about the cost, I think it's going to be private insurance companies. A lot of the work has already been done by some of these insurance companies to determine the most cost-beneficial basis for providing these services effectively; and they've all determined that a BCBA is what's necessary.

What he said he wanted everyone to take home from his testimony was that BACB certification, the Behavior Analyst Certification Board, is really the only sufficient documentation currently available. It's the only

infrastructure currently in place to ensure quality of those who provide behavior analysis services and are designing the programs and treatment plans for these kids.

Consumers should expect to benefit from the initial and continued licensing of behavior analysts. In their training to become board certified, a core aspect is that progress needs to be made. If progress is not made, they need to change something in the program. They have three days, so three consecutive data points without progress means they need to change something in the programming, and they know this by intensive and rigorous data collection. They collect data on every single behavior they're working on and every single instructional moment they're working on. Through those data they're able to tell whether progress is being made. If it's not, they change something, their approach, the reinforcement strategy, any number of different things. But the focus is that progress needs to be made, and consumers should be able to expect that.

Where that differs from other professions is that, while other professions might have that as a goal, it's not an essential part of their training. It's not something that is ingrained in their philosophies, but it's very core in what certified behavior analysts do. Back to the Gentry family, after the third hospital visit where he put his sister in the hospital, the DDA eventually helped the family access ABA support through the company Dr. Jones worked for. He first set up a communication system, giving him a way to use pictures to show people what he wants and needs, such as when his head hurts and he needs a break for work. Behavior analysts know that nine times out of ten, challenging behavior is a communicative attempt; the child is trying to communicate something and can't find any way other than hitting you or hitting themselves. That gets a response out of people. As soon as you create alternative behaviors and create alternative ways of communicating, a lot of challenging behaviors go away, which is what happened in Jackson's case. Jackson is now thirteen and last time he spoke with Jackson's parents, he was using an iPad for communication. He can press different buttons on his iPad to communicate for him. He still isn't speaking, and that's not atypical for many kids who are at the lower end of the spectrum. But his aggression and self-injury are almost completely gone. He's also integrated in three of his six classes, so he's with typically developing peers in those classes whereas he was completely segregated before. And probably most important for his family is the relationship he now has with his sister, which has gone from aggressive and contentious to his sister describing one of her favorite activities as playing Plants vs. Zombies online with her brother. This facilitates interaction, they're joking with each other, they're having a lot of positive interaction; and that's self-described from his sister. They've come a long way. But his parents still feel like they've lost eight years of his life because they didn't have someone qualified to provide behavior analysis services during that time.

Today, there is an opportunity to further this legislation and join 19 states that have some sort of licensure law in place for behavior analysts. There is also an opportunity to give very highly educated and experienced behavior analysts in this state the due respect they deserve. They've been practicing behavior analysis for decades, and only recently has it become more mainstream and understood so it's time to differentiate this from other fields. Also, there is an opportunity to develop more infrastructure to ensure the quality of behavior analytic services being provided in Washington. This will ensure that behavior analytic plans and services are overseen by somebody who has the background and experience in ABA that is necessary and will ensure the protection of the most vulnerable citizens of this state.

He stated that there would be various perspectives given at the hearing, such as that behavior analysts, or board certified behavior analysts have insufficient supervision. There are professions that have 4,000+ hours, and they will argue that's a better metric of who's going to be more qualified to provide these services and to supervise these services. However, board certified behavior analysts get 1500 hours of supervision specifically in the field of behavior analysis. No other field can say that; so the supervision they experience is more than any other field and is necessary to assure quality of services. He also stated there would be testimony that behavior analysts have insufficient training to supervise some of the programs and need additional classes because more than behavior analysis is needed for these kids. It's true that some of these kids have a host of other issues affecting them; from anxiety disorders to obsessive compulsive disorders and depression. However, these are not areas behavior analysts are trained in, nor should be trained in. They are instructed to seek out the appropriate consultation with other providers who are experienced with those fields. That's what an ethical behavior analyst would do; they would seek out that help if those kinds of issues arose.

He stated there will also be testimony about the difference between being a counselor in this state and a behavior analyst, and that non-BCBAs should qualify for licensure in this state. There are a number of exemptions in the bill that talk about who should be able to provide services if not licensed. As long as it's within the scope of your practice and within the scope of your training and experience; if you're licensed in another field you should be able to continue providing behavior analytic services. However, where it would differ is that you would no longer be calling it behavior analysis services when you are charging insurance companies. For example, an LMHC would call it counseling services or a psychologist would call it psychological services, not behavior analysis services.

Also there will be testimony from consumers and ABA providers on why licensure is needed, how lack of licensure has affected their ability to provide decent services or have prevented them from receiving decent services, and about the quality of the training of the people that have worked with their kids. And there will be testimony from BCBAs who are licensed in other fields like licensed mental health counselors and psychologists. They will provide perspectives from both sides of the spectrum. People have very strong opinions on the issue so there needs to be open discussion even after today.

Panel Questions

Q. The proposed legislation essentially establishes a scope of practice credential, and given that other licensed credential holders can engage in this scope of practice, why wouldn't title protection work for you?

Clarification. There was confusion on what title protection is, so it was explained as:

Only the people who are granted a license as an applied behavior analyst could call themselves an applied behavior analyst, but it would not constrain the scope of practice for other mental health providers who may be engaging in and trained to do it. Title protection protects the use of that title, to people who are licensed and receiving compensation.

A. Having that title protection wouldn't necessarily assure quality of the people who are providing the service. There are a number of people who are providing ABA now, some who are not BCBAs and some who. Some have had very little training in behavior analysis services. He stated he thinks the bill will standardize some of that and ensure defined criteria in terms of background, history, education, and their supervision experience. Does that answer your question?

Clarification. Part of the issue is the definition in the proposed bill of the practice of behavior analysis is extraordinarily vague. It's huge, and what lots of people do every day as part of their lives and their jobs, so to say this is an exclusive scope of practice for one profession doesn't provide good parameters for somebody to know what they can do. It also doesn't provide clearly what can't do, or for the Department of Health to know who it can prosecute for doing this without a license. Because this is a very, very broad definition.

A. The field of behavior analysis in many ways *is* broad, because it's human behavior. To define in a very isolated scope what specific behavioral criteria they're going to be able to do is going to limit the scope of practice or limit them out of a job. When talking about human behavior, you don't want to restrict it to autism. There are a host of different behaviors they work with and they're fluid. The programs they work on change rapidly from one six-month treatment plan to the next and they'll continue working on the goals they're working on within this period. But as soon as they master that they are working on whatever's going to be most socially significant to that child at the current time in his or her life, so it kind of *needs* to be vague in some respects.

Q. There are a lot of professions that are vague, but what the panel is getting at is instead of having scope of practice protection, they have title protection. So others can still do those things, but can't *call* themselves behavior analysts unless they're licensed to do so. Also, what happened to "applied"? It's always been "applied behavior analysis."

A. It's still applied behavior analysis.

Q. Would it be the technicians, generally, that are working with the patient and applying ABA?

A. Yes.

Q. What sort of training will they have if they aren't regulated through the department?

A. None at this point. There's not an infrastructure existing in place anywhere in the nation right now to ensure the quality of the technicians. The Behavior Analysis Certification Board does have some guideline, their best practice guideline. They say a certain level of training, 40 hours of classroom training in ABA studies. Those are pretty much what every behavior analyst in this room adheres to. It's required by most insurance companies they work with and it's required by the code of ethics to follow those guidelines. The BACB has a registered behavior technician that just came into place starting in June, so as that comes on board and more and more people become registered, there may be an infrastructure in place for bringing those folks on as a license. But it's not established yet.

Q. To follow up on that, regardless of whether there's a national structure for licensure for the technicians, these are the people that spend twenty or thirty hours hands on with a vulnerable person. Shouldn't there at least be a registration, if nothing else, so the department has authority over them under the Uniform Disciplinary Act?

A. That would make sense.

Q. Some of the language in the bill and the proposal discusses maintaining BCBA certification. Is that the expectation, that they continue to hold that credential?

A. Correct. They would have to show evidence of that when they reapply for licensure or renewal. He stated it is his understanding that would typically be described in the rules after licensure is in place.

Q. Understanding complex human behaviors and that differential diagnosis can involve multiple co-occurring disorders, if a behavior analyst does not have training in recognition of these co-occurring disorders, what happens when a behavior analyst engages sees a patient or client exhibiting behaviors that are outside ABA training? How would he or she recognize it, let alone deal with it?

A. An example would be one where a BCBA was working with a child that started showing signs of schizophrenia; where she was hallucinating and seeing things that weren't there. The behavior analyst did not have training to handle this, so she worked very closely with the child's psychologist and psychiatrist and they worked together as a team. The BCBA worked within her background and knowledge to address the behaviors, while at the same time, the psychologist and psychiatrist were working to address how to get her on better medications so she can have fewer hallucinations and treat the schizophrenia. It requires the whole wrap-around process, where you use multiple entities to have an impact on that child. Behavior analysis doesn't treat disorders. It focuses on behaviors.

Q. Does your explanation argue for an independent scope of practice or a supervised scope of practice within mental health?

A. An independent scope of practice.

Q. If a behavior analyst does not have the training to even recognize co-occurring disorders, what happens? If there's a client who's behaving in a way that the behavior analyst is not trained to recognize and they have an independent scope of practice...

A. They'll figure that out quickly, because if progress isn't being made on their goals and they're experiencing something that's outside of their understanding, a behavior analyst is ethically bound to change something or get the resources they need to figure it out. That's part of the ethical guidelines, to seek that support elsewhere.

Q. Is the data you collect on progress measurable?

A. It depends on the behavior that's being recorded. If he is working on object identification, someone with very little language, he might be presenting three objects in front of the child and ask him or her to point to the phone, and do that for a number of trials. Other things they might be looking at, such as for how long his tantrums are occurring or for how long his head-banging is occurring. It would depend on the situation how the data was collected, for instance taking frequency data, meaning how many times it's happening, instruction might be based on how many times he is answering the question correctly. Others we might be looking at duration, trying to decrease the duration of a challenging behavior, and a number of other ways the behavior is operationalized.

Q. You said around three separate measurements, how far apart may they be?

A. It could happen three times within the same session, where the adaptation might need to be a minor adaptation in the instructional approach. He may have not prompted him correctly, or the reinforcement he's given isn't frequent enough, or it might be a larger or more global behavior that is looked at across three times. So if he worked with the client three times during a week, it might be a week.

Q. So, there is not like a month in between each of these?

A. Never, because it wouldn't be an effective ABA program if they were only seeing him once or twice a month.

Public Testimony

Jay Minn

Mr. Minn said he would refer to his son as "T" to save time. Mr. Minn told the story of his son, "T" who was diagnosed with autism in 2005 when he was two. His wife is a professor at the university so they actually received early intervention, a strict 35-40 hours of ABA from the start. "T" has been receiving that quality of care from the team his family built, working with the people from UW Autism center and now is twelve and going to a private middle school, fully integrated in all classrooms. He's doing fantastic, in martial arts and all that, but it was very hard work. They have binders full of data at home, showing trials of everything from getting him to hold his pencil correctly to working on self-monitoring that "T" is doing now, understanding his emotional behavior that's happening in the classroom. He stated his son has a lot more self-awareness than anybody else in the room about how he feels, and that's all come from the strict, quality ABA care he's received since he was two and a half.

He stated he and his wife have poured 80-90% of their income into this effort, paying pretty much out of pocket. He doesn't have a job at Microsoft so it's been very difficult. They are now able to get some of the treatment paid for, so they started to look for an ABA coordinator so they could keep their team. They had grown this team from eight years of hard work, hiring and firing techs, getting BCBAs to work with them over the eight year period. It was very difficult to find an ABA coordinator who worked with an independent team, and they didn't want to go to a large agency because they didn't want to lose that team. They finally found someone who was willing to take them on it turned out terrible.

It was not a BCBA. It was a mental health counselor who did not have the same background. The team had some disagreements - they were two different practices trying to come together. The mental health counselor was put into a supervisory role over the BCBAD with a PhD and it turned out terrible. They worked for about three months and when they got their first explanation of benefits, it didn't look like what they were actually billed for. He asked the counselor for a statement to reconcile how many hours she billed their insurance, and she quit.

After several months they received a new explanation of benefit. The mental health counselor is no longer doing business as the ABA coordinator, and the revised paperwork from the insurance company said \$19,000 was billed for a three month period. It was ridiculous because they were actually getting one technician covered for about fifteen hours a week for \$9,000. Where did the other \$11,000 go? He said he didn't know and doesn't think he'll ever know. He wants to make sure there is efficiency and quality of care or the system will suffer. He said they have spent the last year looking for another coordinator. What they really need is if BCBAs to be licensed and able to bill directly to the insurance, and then a whole layer of fat will just go out of the system. It will give families choice. His family will be able to choose the highest quality BCBAs and the techs they want, and can keep their own independent practices. They don't have to join up with giant organizations if they don't want to, and the pool of highly qualified providers will increase. There will be competition, which again increases quality for everyone, which is what he cares about.

Diana Stadden

Ms. Stadden stated she works for the Arc of Washington as the policy and advocacy coordinator. She is also the parent of a 21-year-old with autism, and has a daughter who is a special education teacher. Her daughter is not currently a teacher because she quit so she could work privately with kids. She's working on her Master's in mental health counseling and has been doing ABA for years. She's working under a program manager who's not a BCBA licensee either but who has been working and doing BCBA for over 20 years.

Both have families who are tremendously happy with the services they get, the ABA services. She said she thinks that as with any profession, you're going to have good people and you're going to have bad people. She has talked to families who have been badly burned by people who were BCBAs; especially the ones who come straight out of school and try to treat children with significant behavior challenges they're not prepared for. They don't have the experience that it takes to do that.

She stated she strongly supports regulating the practice, and agrees with comments she saw from Group Health stating licensed mental health counselors should be included. The billing is difficult because if only BCBAs can bill under ABA, where you get up to 40 hours a week in services, then a licensed mental health counselor would have to bill under counseling, which can be only like twelve visits a year. That takes away from what they can do for the families they're serving and that's who Arc cares about. They care about the families looking for services, and it is hard to find someone who provides good services, whether BCBAs, mental health counselor, or psychologists who are all trained in ABA practices.

She stated part of what is needed is to not decrease the number of competent professionals. You need to get those people out who say they do ABA but have no training, but if you've got a master's degree have been doing ABA for years, you can't do it anymore. Apparently the timeline is closed through the BACB to be able to sit for the exam. I did some research and found out that in Pennsylvania and Arizona, where they have worked on licensing issues, they don't require people to maintain their certification with the BACB or pay any related renewal or recertification fees. There are different licensing standards out there and we need to do something to regulate this, but I it doesn't need to be as narrow as saying only the BACB gets to define who does this in Washington. Licensed mental health counselors do a lot of hours of supervised, and it's not all ABA. But that is the problem she has heard from families about the co-occurring disorders they're running into that cause problems. Anxiety and depression are huge problems for kids with autism. If you can't recognize these co-occurring disorders, then you're not working with those other professionals and you're going to cause more problem than you're fixing. She stated what needs to be addressed is making sure there are qualified people to do this, but not make it so strict that the number of people available to provide services is not sufficient. Also, the board should not be all BCBAs. The Arizona board includes three public members.

Kathleen Prosch-Jensen:

She stated she has a doctoral degree in psychology and is a licensed mental health counselor and board certified behavior analyst. She came to say thank you because the state of Washington licenses professionals that have helped her, personally, with a couple of different problems she's had. First, was her sprained her right ankle which

she went to see her MD for bit who had no treatment to offer. He referred her to a physical therapist, who helped and also referred her to a licensed massage therapist.

She stated there will be testimony that because behavior analysts don't provide mental health diagnoses or psychotherapy, they shouldn't be licensed to practice behavior analysis. However, her right ankle needed three different professionals with varying amounts of training from bachelor's level to post-doctoral, all practicing independently within their scopes of practice, all using different treatment methods, and all regulated by their own professional boards. She went to the medical doctor first for her medical problem. Similarly, any person with a behavioral challenge needs to see a licensed mental health professional for assessment and diagnosis before seeking other kinds of treatment, which isn't the same as supervision. That's just the appropriate scope of care. Behavior analysts do not provide diagnosis, but they also, according to their ethics, do not take clients who have not already been seen by a licensed mental health professional for diagnosis.

She stated there will also be testimony that the behavior analyst scope of practice overlaps with some professionals who provide behavior therapy or behavioral techniques. The state of Washington already licenses five different professions that provide mental health diagnosis and psychotherapy, so clearly overlap is not in itself a barrier to licensure as a distinct field. She's glad the state does that because she believes that saved the life of someone she loves. A close family member attempted suicide a few years ago and the psychiatrist said he didn't need inpatient treatment. Her relative refused to continue to see the psychiatrist for medication, but a social worker at the ER referred him to a licensed mental health counselor who he agreed to see. She provided psychotherapy and was able to help him to consider medication and he's doing fine now. He's alive and he is actually doing fine.

She stated on behalf of her family, she thanks the department for licensing all those mental health professionals who practice independently so they didn't have to wait for a hospital admission or an appointment with a medical doctor or psychologist or a suicide attempt that could have killed him to get him some help. She stated there are many families like hers who need access to mental health diagnosis and therapy and these families also need behavior analysis services to solve their very real and sometimes devastating problems. She hopes these families will be provided the same help she was provided and to please consider licensing behavior analysts to practice independently in the state of Washington.

Rick Shaw

Rick Shaw introduced himself as a BCBA, former OSPI president, and current treasurer and member. He has a teaching degree in special education and endorsement in psychology as well, with a double major in psychology and education. He's a business owner, an entrepreneur, an advocate for groups and families, military families, parents and individuals. His specialty is with kids with self-injurious behavior, challenging behaviors, and aggression. He stated that once they go through rigorous training, they have to go through a test that is 150 questions long and very intensive. Only about 60 pass the test because they want a BCBA to come out and know what they're doing, so it's not an easy process to become a BCBA.

He told a story about applying for a job for an autism specialist and being denied because he didn't have a master's in social work, psychology, or counseling. He said a social worker who has maybe one class if they're lucky in behavior analysis or applied behavior analysis, can get a job and he didn't qualify for it. Things are changing. He told another story of a school who was recently sued. Their autism specialist and behavior specialist was a social worker who admitted she didn't have any experience with it. He told of another time he got a call about a child who was engaging in behaviors and beating up his paraplegic roommate. They asked for his help, because the state was going to make them wait three to four months for help.

He stated he has worked in school districts for ten years and they hire unqualified autism specialists who they tell to go learn about autism. He looked at their functional behavior analysis state paperwork that comes to the school districts and it is horrible. They are testing, but are not in the field of working directly with the kids. As alluded to earlier, they work as a wrap-arounds and if he has questions and doesn't know what he's talking about, he works with his colleagues and finds resources to help, through psychologists or speech language pathologists, or parents,

anybody who's involved in that child's life, because he wants to have the best information to provide the best services.

He discussed the importance of data. The data behavior analysts gather supports that the plan is working, based on spikes in the behaviors, decreases in behaviors, or if they are stable. They can give that information to doctors or others. It's valuable.

Also being a business owner and working six counties from Port Angeles to Thurston County, King County, Jefferson County, Clallam County, parents have this need. Working as an expert with self-injurious behavior, he has seen five year old kids breaking faces and bloodied, defecating and smearing it. He is scarred up left and right, but he has a tolerance for the patients and the education, because he knows how to work with these students and has trained staff to work with them. The need is out there and he doesn't want parents to be wasting their time or getting advice that's not helping their kid or is maybe even hurting their kid. He told another story about receiving a call from a doctor who said he had a girl engaging in hitting her wrists. The doctor said to ignore the behavior, but you can't just ignore self-injurious behavior when it spikes up. This is why it's important to have the BCBA's as a big part of this process.

Kelly Ferris

Ms. Ferris introduced herself as a board certified behavior analyst who has been providing services to citizens of this state for over ten years. She represents Organization for Research and Learning, an office and agency serving approximately sixty families. They employ thirteen board certified behavior analysts, and more than forty ABA paraprofessionals. She wants to ensure the committee comes to understand that behavior analysis is a distinct discipline with theoretical, experimental, and applied branches. The evidence-based techniques have meaningfully improved the lives of thousands of Washingtonians, and have the potential to positively affect thousands more. Robust behavior change for clients is more probable when intervention is designed, overseen, and implemented by professionals with documented training and experience in the discipline of behavior analysis.

A goal of this legislation is to protect consumers by ensuring those individuals who are licensed to provide behavior analytic services have received the necessary and sufficient training. This bill in its current form will provide a framework for the regulation of practitioners of behavior analysis. Crucial to its success is the proposed independent practice board. As a Washingtonian, and behavior analyst, she supports this licensure bill on two conditions, the behavior analysis licensure board is an independent and stand-alone board that is not organized or subsumed under any other existing licensure board, and the bill specifies a pathway to licensure for paraprofessionals who work under the supervision of behavior analysts in our state. It is her position that placing this field, or science and practice under a different existing board will defeat the objective of protecting the citizens of Washington. She urged the department to carefully review the essential feature and understand its importance.

Q. Your paraprofessionals are who we assume actually do the hands-on work?

A. There are three different terms in this state: paraprofessionals, tutors, or therapy assistants.

Q. What is their training in your organization?

A. Similar to what CJ said in terms of following best practices laid out by the BCBA. She stated her organization is also a licensed behavioral health agency. DBHR has a minimum of forty hours of classroom-based training, and the concept of reinforcement, how to identify that you're not just providing rewards, but that it actually is changing and increasing future probability of behavior. For data collection systems, they go through a classroom-based model across their employment term, so those are usually every 6-8 weeks. In addition, anyone delivering services to clients is supervised for three hours a week at a minimum, in person, where they are supervised actually delivering the intervention, coached, and those intervention practices are modeled by the BCBA. Data is actually recorded on their behavior. They're not the clients so that is called "staff training data," which is basically their ability to implement that program of fidelity, the way it was designed, to ensure again that those quality measures are upheld. That way, when they look at those three data points to say, "is it robust, is it working, do we need to

change, do we need to make it harder, to we need to make it easier”, they can trust the truthfulness of those data because they also have data on the implementers’ behavior, if that makes sense.

Stacey Shook:

Ms. Shook introduced herself as a BCBA-D like Dr. Jones and she is director of Northwest Behavioral Associates, which opened their doors in 1999 as the first not-for-profit organization that provided direct intervention to learners on the autism spectrum. She stated “ditto” to Kathy and to Kelly who testified before her. As the director of Northwest Behavioral Associates and secretary of the Washington Association for Behavior Analysis, she wanted to be on record saying she supports licensure for behavior analysts. She shared an anecdotal example to piggy back on something Dr. Jones said earlier in response to a panel question. Regarding recognition of related disorders by behavior analysts and subsequent intervention, behavior analysts are not in the business of diagnosing children. They’re in the business of identifying observable and measurable behaviors and trying to impact those in a socially significant type of way.

It’s not unlike a speech therapist or an occupational therapist that also has specific training in identifying specific mental disorders, or other diagnoses in the DSM. They would also need to be in a wraparound service situation with other providers, yet they have their own licensure. She said all the behavior analysts in this room will agree with her frustration when dealing with insurance companies. They want to know what licensure they have. They call to inquire about services that fit as closely as possible to a mental health professional world, services and codes that provide a very outdated term, “outpatient behavior modification”. It’s very frustrating to hear that, as a behavior analyst who has over ten years higher education in the field in both experimental and applied, and for someone who’s been working in the field since the late 80s, that she doesn’t have the qualifications to provide behavioral services. But a clinical social worker or a marriage and family counselor does. She supports this legislation.

Dawn Sidell

Ms. Sidell introduced herself as a registered nurse and Executive Director for Northwest Autism Center, which is a non-profit organization in Spokane. She has four children; one of whom has very severe autism and is nineteen. She started the non-profit in 2003 because there were no services for individuals with autism in Spokane. There were pockets and a few people doing things here and there, but no organization dedicated to that in the community. She stated she is thankful to be at this point and it’s exciting to see this move forward. The new insurance coverage has been badly needed for a long time, and she’s very proud of Arzu for spearheading a lot of that. She said it’s like swimming through mud watching the political process take place to open the gate for this, and she actually believes it’s going to happen. Even if it doesn’t happen today, she said she thinks it’s going to happen because it *needs* to happen.

She said some of the questions asked today reminder her that ABA continues to be poorly understood and poorly appreciated. Nobody is saying that no one else can influence human behavior and no one is saying that no one else can work with children with autism. Fortunately, she had some incredibly good providers of behavioral intervention services for her son, even when BCBA’s were not available to her. Unfortunately, because there was no coverage, it was spotty at best. It would have been nice if they could’ve consistently worked with him over the year, but even what little she had was much appreciated.

A good analogy would be that family practice physicians frequently can deliver babies. They can do that and do a fairly decent job at it, but nobody calls them obstetrician/gynecologists. They are not saying that people can’t provide this service. They are trying to argue for a structure that provides some standardization of practice, so that families and even other providers understand what entry-level qualifications are for this particular discipline. There’s a difference between looking at providers who have an interest or focus in what they are now going to be calling behavioral interventions instead of ABA. They’ve got an interest or a focus in it, and so they have excelled in it, and have chosen to go in that direction. That is different than talking about creating a structure for standardization that allows us all to understand what the entry-level criteria are.

She stated she is a registered nurse, has a four-year degree, a bachelor’s degree, and people know what that means, immediately. They know that she went to school for four years and that she can be hired on a unit or clinic, and

that she has some fundamental background knowledge. But when you work in an unrelated discipline and there are no requirements or oversight for the amount of time or hours you're going to spend delivering ABA, the family does not know what they're getting. And sometimes, it's too late by the time they figure it out.

Her son's needs are so critical that a BCBA/ABA qualified person is needed to help with a dental appointment. He can't get access to dental care without an ABA approach to teaching him how to experience that, and he can't get access to a clinic or a hospital. Getting vital signs from him has always been a challenge until they had social stories, and had an ABA approach to teaching him how to be able to be successful with those things. She does presentations for registered nurses, physicians, dentists, and all other kinds of health professionals to help them understand how to successfully apply what they know to the child with autism. This is a missing link currently.

Nicolette Brigham

Ms. Brigham introduced herself as director of training and outreach at the UW Autism Center and a board certified behavior analyst. She said her team works collaboratively with a team of psychologists, MDs, and speech pathologists providing distinct categories of service in their treatment and support of children and families on the autism spectrum. She stated that in her role as director of training and outreach, they provide training across the state of Washington and across the different counties. Last year they reached over 900 individuals, individuals who are parents, professionals, educators that are working with or have a family member with autism spectrum disorders. She thinks it's really critically important that when we think about training and direct service, we think about the quality and oversight level of professionals that are providing these services to families. She thinks it's really important, in addition when talking about autism, that the components of applied behavior analysis are part of what are considered best practice when working with children on the autism spectrum. She wants to provide that level of assurance that the oversight is there and that the individuals that are providing the training, as well as the direct service, have the certification as well as the licensure at the state level to provide those kinds of support for families and children.

Paul Rogers

Paul Rogers introduced himself as a board certified behavior analyst and a Washington State agency affiliated counselor in his current designation. He is employed by West Coast Behavioral Consultants, a Seattle based behavioral health agency that serves three distinct clients: corporations, individuals and families. Not just children with autism. He currently serves as a behavioral consultant within the company's clinical division, Blueprints. They provide behavioral consultative services to families struggling with defiant, oppositional children and teens that are at risk of out of home placement, and adults suffering from severe personal difficulties in the Puget Sound area. He's a member of the Washington Association of Behavior Analysts and a member of the legislative committee and is speaking in support of licensure.

His colleagues on the committee have spoken pretty eloquently about how this proposal will benefit Washingtonians, and he just wanted to highlight two provisions. He's largely concurring with Kelly Ferris, that it's imperative that the stand-alone board be comprised of behavior analysts and that there be a route to licensure for therapy assistants, or some sort of regulation of those. On the first point, in his job as a behavioral consultant, he's responsible for designing and monitoring the implementation of effective behavior intervention programs that help individuals establish pro-social adaptive skills, reduce the occurrence of challenging behavior and allow them to access their communities. In that capacity he's working with children at risk of an out of home placement, so there are many other concerns. He does not make diagnoses, prescribe medications, or provide psychotherapy; but he counts on his colleagues in licensed health professions to do that. He can only proceed in helping these families if he has those other members of the team on board; because it doesn't matter if they have different certifications or theoretical backgrounds. If they're not aligned to help the family, then no progress happens. He doesn't want to do the things that they do, nor does he know how, but he provides a complementary and necessary service that enables these families dealing with such complex problems to make progress..

Mary Tinsley

Ms. Tinsley introduced herself as a BCBA, whose been practicing for over ten years, and has been a service provider for ABA services for over fifteen years. She supports licensure and wanted to share the stories that she's

experienced, as well as the stories of families she's worked with that have experience with non-behavior analytic providers that were claiming to be ABA providers. In two specific instances within the last five to seven years, she's had families that have come to her after seeing a provider that's not in the behavior analytic field. These providers ranged from speech therapists to mental health counselors. One of these providers used non-behavior analytic procedures, or procedures they deem to not be best practices. These included strapping kids in chairs for hours, using aversive stimulation, which can be things like water mist. Again, these are things that are not best practices and are known to be not best practices for ABA. Through these procedures, two of these children's behaviors increased to very dangerous levels. They went from crying behaviors to screaming and self-injury in the form of hitting and biting themselves. This caused anxiety to the families. Luckily, the families noticed that something wasn't quite right, and they contacted her, a BCBA provider. After she started working with the children, they got the behaviors down to almost zero levels. They talked in functional communication and saw a lot of appropriate behaviors increase, replacing that inappropriate behavior.

These non-behavior analysts, while many of them had been practicing in the field for years, were for some reason not familiar with best practices. They hadn't read the journal of applied behavior analysis and weren't familiar with where to get these resources. As behavior analysts, they are required through the national board to have continuing education credits. Many attend not just online trainings, but conferences every year where they learn the best of new and upcoming research that can help support the clients they work with. These individuals the families had experienced weren't even familiar with the journal or conferences. They had read a couple of books about ABA, parent-friendly books. There's absolutely nothing wrong with that, but this is what they were basing their scope and sequence of treatment upon. The therapy these non-behavior analysts provided to this child and to these families was really harmful to the child, in that they exhibited inappropriate and dangerous levels of behavior, and to the parents who had extreme anxiety and stress. It was also an extreme burden on their financial resources.

Monica Chen

Ms. Chen introduced herself as a BCBA who has been practicing for over fifteen years. She thanked the panel for the very substantive questions and stated she could see that they had done their homework. She said she thinks the BCBAs in the room know that they spend a lot of time explaining exactly what it is that they do. And she said she thinks they know more than her own mother what her job is. As behavior analysts, their jobs are to change behavior, and their job holds incredible significance because they change lives. With this responsibility comes moral and ethical responsibilities as well. This is why she supports standardization of care and licensure. She stated that she wants people to take away three points:

1. The current system is not working. There's no standardization of care and no board where parents and families can go to for grievances. She has seen a lot of families with questionable quality of service from their previous providers. For example, you would not teach algebra before you could properly add and subtract. All of this results in loss of time, money, and resources for families who are already financially strapped. She has seen poor ethical practices or judgment, and families who have had their providers hold their child's program hostage or hold their data hostage. She has seen providers not show up or quit very abruptly. You can't become complacent or keep doing the same thing and expecting different results. That is one of the basic tenets of behavior analysis.
2. To address the panel member's question regarding how behavior analysts can recognize a disorder or a diagnosis that is unfamiliar within the scope of practice, all of them are trained professionals have been through thousands of hours of practicum and recognize behaviors that are unfamiliar. They know to reach out and consult with other professionals who have a greater breadth of knowledge or practice specialties. It's very much like a teacher in a classroom where they may come into contact with students on the autism spectrum or other diagnoses they're not familiar with. They would reach out to the school nurse or psychologist and look for more resources. That's what behavior analysts are trained to do.
3. Why now? Why *not* now, for the family whose son is bashing his head on the wall and wants that help now, not next year or three years from now; or for the teacher whose student who is throwing desks at her? She wants help now, not next month, or three years from now. The time for change is now.

Charna Mintz

Dr. Mintz introduced herself as the clinical director for Imagine Behavior and Developmental Services, which provides services for the entire state of Washington, not just the Seattle area. There have been some points that have been made about co-occurring diagnoses, and there's still one comment that's been left unsaid. To give you background of how a client might come to a behavior analyst currently, they already have a diagnosis, which has been stated. They are not responsible for that, nor are they guessing at what the diagnosis is. A licensed professional has written a report that is normally 10 to 15 to 20 to 25 pages long. It includes an extensive history and background information, along with recommendations that are tied to the diagnoses that were uncovered during their assessment process.

Number two, they are bound both by funding sources and ethically to work in a team. No one she knows in the state of Washington functions solo, whether a mental health professional, social worker, speech pathologist, or occupational therapist. The children they support have comprehensive needs and she said they're not foolish enough to think they have the capacity to treat all of those needs. They are bound not only ethically, by their code of ethics from the BACB, and also by their funding sources. For example, the Medicaid reports they need to turn in for ABA benefits have a specific section where they have to outline how they intend to work in conjunction with other providers in the state. This isn't left to chance, it's something that's already been programmed and is required.

The third thing that hasn't been talked about yet is that their perspective on treating behavior is based on function. In order to pass a BACB exam, you have to be able to answer questions about functional behavior assessment. Part of their practical experience is to be able to conduct a proper functional behavior analysis. When that assessment tool is implemented appropriately, they're able to discern whether or not behaviors are being maintained by environmental variables, things happening in the environment like attention or to get a tangible item in the grocery store line, or whether or not these behaviors are being maintained by an internal state. When they find that behaviors are being maintained by an internal state, it automatically provides a clue, the green light that there's something else going on beyond the things they have immediate control of. There are checks and balances that are in place in multiple ways to address those co-occurring diagnoses. She said she understands the concern and she is concerned too because she doesn't want to work with children she's not providing effective treatment and support for.

She did not want to comment on whether or not technicians should be regulated, but clarifies what it is that BCBA's do versus what it is that technicians do. As BCBA's they are responsible for assessing the situation, writing up the treatment plan, and utilizing all of their training and background from BCBA certification. Then they train on the plan, evaluate data on the plan, and that is ongoing. Technicians are responsible for implementing the prescription. Technicians are not responsible for coming up with a treatment plan and deciding whether or not that treatment plan is effective or ineffective. That's the purpose of the BCBA, who is providing supervision to that technician. And back to the funding sources, the sources as well as the BACB have made recommendations and/or requirements as to what the minimum amount of supervision is that's required for technicians. There's a requirement of 5% supervision to protect the consumer. If a client is seen by a technician for ten hours a week, there's 5% supervision that's mandated as a minimum requirement. Most of them recognize that's the part they get paid for, but that's not the part that makes the science work effectively.

Lastly, she said she thinks it might be a mistake to some degree to look at behavior analysis as a series of tools or a technique. Applied behavior analysis comes from a science of behavior analysis. It's a set of philosophical approaches that then resulted in the generation of principles that have been tested scientifically over and over again. Those techniques derived from the principles only work when they're implemented appropriately, hence the need for regulation and licensure for behavior analysts.

Q. Assuming the technician has the most hands on face time with the client, if there are instances where the client or patient becomes frustrated or starts to act out, what sort of reporting mechanism is in place for the technician to report these behaviors? What sort of training does the technician have in order to do that consistently and professionally?

A. Presumably, there's a plan that's already in place for the technician. The plan would include specific strategies that are outlined in the case of aggression, what the response should be. That's just a small portion of the plan, but it's part of the training that the technician would receive. Then there would be data collected on the occurrence and it would go through the reporting process. Anything in the plan also has data to back it up, which is what makes it behavior analytic. The supervisor would see the data, either on their next visit or there would be direct communication via text messages, phone calls, emails. Then decisions would be made following that report. They are also required to report incidences, again tied to that funding source.

Q. Is the technician expected to intervene?

A. It depends on what the plan says; whether or not those behaviors have been observed previously, and the plan has a protocol in place. Then, she said she doesn't know if this is true for all agencies, but she thinks that it is actually a requirement to have staff trained in therapeutic options as a last resort safety measure to keep the client safe and the staff safe. If the behavior analytic plan is written well, then that staff should have a very good idea of how to respond to behaviors as they present themselves. Also, families are trained and are considered part of the therapeutic team. The therapists are not there all by themselves. There are other people there, qualified, caring, well-meaning family members that are present as well.

Joshua Fouts

Mr. Fouts introduced himself as BCBAD with fifteen years of experience in Washington, Hawaii, and British Columbia. He stated he wanted to talk more about the science. In particular, he wanted to talk about the use of punishment. In his fifteen years of experience, it is those individuals who may be practicing ABA, or say they're practicing ABA but aren't licensed as a BCBA that will sometimes use punishment procedures that aren't the best practice procedures. They know from research that people take the path of least resistance, and punishment is a lot easier to do than a reinforcement procedure. For example, a differential reinforcement or something like an escape extinction can have extreme long term side-effects for that individual. What they also know about punishment is that it's reinforcing to the punisher. It's easy to do, it feels good for the person doing it, but has horrible side effects for the individual, such as modeling that behavior down the road. The individual who has punishment procedures done to him or her may have internal or psychological issues. They're not best practice.

He fully supports this bill for licensure because it allows them to standardize their care, in particular, the science part of it and procedures that are misused by those who may be doing ABA but are not licensed to do it.

Kate White Tudor:

She introduced herself as a lobbyist for the Washington Occupational Therapy Association. They submitted written comments that are included in the packet, and she just wanted to highlight a few of those points.

They have concerns about the licensure of applied behavior analysis professionals. Many folks have already commented that the techniques of behavior modification are used in a wide variety of different professional practices, including the practice of occupational therapy. Since the occupational therapy profession was developed back in the 40's, they've been involved with mental health treatment and with the treatment of children with various types of developmental challenges in schools and clinics, from birth through the rest of the life span.

They're aware of ABA as a technique and are aware that it has been proven to be very effective for children and especially those with autism. They are concerned that this proposal is attempting to turn a particular strategy and technique into a licensed profession. In the more general comments, the association does not support independent licensure for ABA professionals. They share some of the concerns that have been articulated about making appropriate diagnoses, assuring appropriate referrals and supervision. They like many of others who testified believe that behavior modification therapies belong in the context of team-based approaches with comprehensive, coordinated care. Many of the patients who benefit from these therapies are in a complex situation where behavior analysis is one of many different types of interventions that would benefit their outcomes.

At the moment, many of the ABAs are practicing in the context of a mental health agency or as an add-on to a mental health license, and they prefer that approach to make sure there's another, more health-care oriented

credential that the ABA certified person would have as a foundation for their behavioral work. The proposal is very broad so she echoed Kristi Weeks' comments that it's also very vague. It makes other licensed professionals look at this proposal and wonder what it is covering. They know the value of ABA interventions for children with autism. The proposal says it works for everybody everywhere, and they think there's perhaps a more appropriate boundary to be drawn around that practice and the kinds of patients and conditions for which it's appropriate.

Finally, the occupational therapists are concerned about protecting their own scope of practice and making sure they can continue to practice the full range of approaches OTs can bring to enabling their patients to achieve the fullest benefit of their lives. Some of that includes behavioral analysis techniques so they want to make sure that whatever recommendation comes from the department to the legislature, that it includes the protection of the scope of practice as it exists for license holders and that there won't be problems for OTs using their traditional box of techniques to work with their patients.

Q. Have you considered the title protection issue, and does your organization support that?

A. She responded she hasn't looked at that angle yet, but it seems like a promising approach. She offered to take it back to the association for their consideration. She said they originally said they don't think they should be licensed or even certified. But title protection might be a more appropriate direction. They haven't really nailed that one down, and certification seems like another approach might work.

Lucy Homans:

Dr. Homans introduced herself as director of professional affairs for the Washington State Psychological Association and a licensed psychologist. WSPA provided written comments and at the end suggested three or four recommendations, which she briefly highlighted. Speaking on behalf of WSPA, it supports the notion of regulation of behavior analysts. They fully support that applied behavior analysis is appropriate, effective, and an evidence-based treatment for autism spectrum disorders and several other disorders. They have no particular statements to make beyond that level of support for the applicant program. She said she has a slightly different perspective than Dr. Jones in his comment that insurance companies operate out of the goodness of their heart. She said she believes that autism spectrum disorders are being treated now because insurance companies were violating the state mental health parity law. As an association, because they wrote the original legislation, they are very proud of that statute and are probably more proud of the families that brought the lawsuits and the attorneys that helped to litigate them successfully.

Their specific points toward the end of our letter included four recommendations. One is that regulation not be a stand-alone independent board, with members only including behavior analysts and the public, but that it should be housed within the Examining Board of Psychology. Not with only psychologists and members of the public as board members, but a combination of applied behavior analysts, members of the examining board of psychologists, and an appropriate number of members of the public. ABA is a set of behavioral techniques firmly rooted within the discipline of psychology. Two of their concerns have to do with how a behavior analyst knows when they have stopped engaging in a technique of applied behavior analysis and are engaging in the practice of treating a mental health disorder. If they don't have the experience and supervision in understanding both, then it would be difficult to know when you start to engage in an act of unprofessional conduct.

Additionally, as she discussed this issue with a number of our colleagues they have expressed concerns with appropriate experience and supervision; not only in school settings where supervision is likely to be more hands on, but in homes. She said she thinks more consideration needs to be given prior to regulation about these issues, including the differences between treatment in schools and treatment in homes.

Finally, she stated that all ABA providers should be required in statute to pass a state law exam similar to the state law exams that are required of other health care providers.

Q. One of the aspects of the proposed legislation cedes a lot of authority to the national organization for regulation and discipline. How does your board feel about that?

A. Dr. Homans clarified that she doesn't speak for the Examining Board of Psychology, but for the Washington State Psychological Association. They did not directly address this question in their written comments because the National Certification Board for applied behavior analysts, for lack of a more serious and appropriate way of putting it, seems to be the only game nationally. The other states that are regulating ABA have simply subsumed their criteria as their state's criteria. Is that appropriate and effective? She said she didn't know and they had a lot of disagreement among psychologists who are autism and ABA specialists. She recommended taking a good look as to whether it is appropriate to simply accept the BACB national certification as the template for Washington.

Eric Bolter

Dr. Bolter introduced himself as a licensed psychologist and a doctoral level BCBA. He wanted to take some time to talk about his training as a licensed psychologist and as a BCBA. Through his master's program in a clinical psychology program, most of his focus was on psychological testing, cognitive testing, psychopathology, diagnostics, developmental and cognitive therapies. This included cognitive behavioral therapy, which is a program he focused in. He had the opportunity to have his PhD in school psychology, and the opportunity to work with some really top notch behavior analysts that drew him into the field.

The training is different to some degree, especially with master's level mental health therapists. A lot of BCBA's at the hearing talked about applied behavior analysis as a science, and it is a science. What people need to remember is the "analyst" part in that. Some folks talked a little bit about "pulling tools out of their toolbox," and "using a variety of different procedures." He's the clinical supervisor for applied behavioral program at Seattle Children's Hospital autism Center and has taught at the University of Massachusetts in one of their BCBA courses. He has seen a lot of providers in the field use tools out of their toolbox that don't have the foundation in applied behavior analysis. It is the science of analyzing behavior; not pulling tools out of your toolbox that you hope will work clinically, and sometimes do work on an anecdotal level. Having the knowledge to use design, data collection, and to be accountable for behavior change is important. You need to have a root understanding of those procedures beyond just the basics to be able to make those decisions on a clinical basis.

This is behavior analysis. It isn't throwing out procedures and hoping they work, and sometimes they do and sometimes they don't. It's about analyzing it and making data-based decisions. He stated he does not think the proposed bill is stating that they want BCBA's to be able to diagnose a variety of different mental health issues. They want them to be a core member of a team, working in collaboration, but being very good at their role in that team. They also want to make sure the bill ensures others who don't have that particular training, but have other good skills that are also part of that team, aren't trying to implement procedures in a way that may be detrimental to the particular individual.

Ryan Hannig:

Mr. Hannig introduced himself as a BCBA and a member of WABA. He voiced his support for this bill. He is a clinical supervisor at Maxim Behavioral Health which services clients in Pierce and King County. He heard some concerns about behavior technicians and their requirements. At Maxim, they carefully screen all applicants, a clinical supervisor has to be in attendance for two interviews, and they give new technicians forty hours of intensive ABA training before they do in-house training and crisis prevention training and even then, they shadow technicians for a number of sessions. If it's an existing client, they'll shadow with that client in order to get a sense of the programming. Even then, if in 90 days, they feel they're not up to snuff, then they don't retain them.

He was previously a BCBA in California, and wishes he could say he got that kind of training. When he became a technician about ten years ago, he applied for a job at an agency that was worked with any child who had an IEP with behavior programming. It was still probably the oddest interview of his career. Because he had been a teacher at a performing arts school, he felt confident going into the interview. They asked him whether he had ever worked with children with autism, and he stated that he hadn't. They also asked whether he had worked in the special education classroom or had a degree in psychology, which he hadn't. They hired him threw him in there with a binder with very loosely written goals. He did not have a BCBA supervisor. Luckily, he had a knack for it or would have had trouble within a month with the kid they assigned him to.

He said he made mistakes because he didn't have the supervision he needed. There were very little tabs being kept on who was supervised. He thinks their requirement was just a master's degree in *anything* and the district was fine with it. To the district and his agency's credit they caught on and started hiring BCBAs, which made quite a difference. He said he wishes he could say his initial reaction when he started being given very systematic programming was being thankful they had arrived. But he had already been conditioned to how he was already doing it it was very loose reinforcement. They used punishment when necessary, and then they showed him that it wasn't effective, and wasn't conceptually systematic, which is one of the mantras of ABA. And they showed him that he hadn't exhausted all of the reinforcement procedures yet. They turned him around and he became a BCBA.

He realized you need that systematic structure in place. Another dimension of ABA is technological, which means whatever programming's agreed upon, it has to be written out in a way that anybody working with the client can understand the programming and apply it. That is crucial in any kind of wraparound service that anybody who's working with a person, whether it's a behavior technician or trained caregiver or the parent who understands ABA, it has to be written in a way that can be understood and applied consistently. That's what ABAs are all about. They have to be consistent in the program implementation, because if it's not consistent, they'll find a way to get around it. Behaviors are stubborn, and their clients *will* utilize their old behaviors if they're still effective, or if there's still wiggle room there. It's technological and that's what increases effectiveness as a generalization to all parties on a wraparound team. BCBAs are the ones who create such programming, such technological write-ups, and that helps keep tabs on the behavior technicians. It's about effective regulation and that's why he supports licensure for BCBAs.

Shaun Wood

Mr. Wood introduced himself as a BCBA working for the Washington Initiative for Supported Employment, trainer, consultant, IT provider in Washington State. He works to support employees and job coaches in the DDA system. He's a newly certified BCBA who started working as an ABA tutor a little over a decade ago. He primarily serves people who experience intellectual disability as well as autism spectrum disorder. He gets called in to help job coaches either restart employment services after something having to do with the client's behavior has happened; or when a job coach has a difficult time training somebody on the job or reducing their support for a support worker. In his practice he has worked to save thousands of dollars for the state by reducing the need for one-on-one direct services and helping people experiencing intellectual disabilities become taxpayers. He wanted to echo what had been said about punishment. When he meets people who say they do ABA who are not BCBAs, what he primarily sees are people who are implementing punishment-based procedures, without actually knowing it is punishment. He wanted to address a small point that comes up almost weekly in his practice. Licensure will increase access to qualified ABA services such as functional behavior assessments for adults who experience intellectual disabilities. The functional behavior assessment is an in-depth look at how the environment impacts a person's behavior, and it's a foundation for ABA service, whether you're working with children or adults. It emerges from the literature and science, primarily out of early research, that showed that children and adults who have destructive behavior can be taught alternative ways to communicate to meet those needs.

Washington State DDA policy is consistent with best practice around how to move forward serving an adult who experiences behavioral challenges. Policy 514 requires that professionals engage in professional, functional assessment of behavior and build a positive behavior support plan that examines why a person engages in the challenging behavior, what the needs are, and a more functional and more dignified way to express those needs. Without licensure, the state has a really difficult time verifying who can provide these types of assessments. They need to verify it because they're paying for this assessment through the waiver. The default for the state has been mental health professionals, and this is problematic because many plans are written with reference to emotions and behaviors; and the strategies given to direct service providers usually can't be implemented because they're ambiguous. They sound like a counseling plan more often than not, and he believes these professionals just don't have the training or philosophical background to be the sole provider who creates these actionable plans. Certainly, the job coaches he works with are not qualified to make counseling decisions.

He believes that the population he serves needs to have more access than they have today to mental health counselors, occupational therapists; but there's also a role that behavior professionals can play in having a big impact on how people with behavior challenges access and fully participate in their community. They're trained in creating actionable plans that people on the front line can implement easily and with fidelity. The professional code of ethics requires them to couple their services with rigorous data collection procedures that show the effects of their work. He urged the department to approve this.

Q. A lot of people have talked about punishment as being a very bad technique in this situation. Is there a time, and I'm not in favor of it, but is there ever a time when it is appropriate with ABA?

A. That's a really huge question, and the way he addressed it was his work in the DDA system. He's not supposed to use punishment.

Q. She said the reason she asked was that so many people now say that punishment is a very bad thing in ABA, but would use of punishment possibly be unprofessional conduct for a licensed ABA provider?

A. He stated he is going to default to other people to answer that question. He said it's an issue of dignity, and he thinks it's really important to have licensure to know that the people who are using whatever procedure, has the background, training, and supervision in applying those procedures. Nobody that doesn't have that background or training within their repertoire of experience should be applying any of the tools talked about. It's really an analysis of behavior, so you're looking at the result of your work through the data. That's what should be driving the professional decisions.

Q. It's something that so many people have mentioned, that if it's something that's so common and that punishment is a horrible thing, maybe it should be addressed in the bill.

A. That's already within the DDA guidelines.

Arzu Forough:

Ms. Forough introduced herself as the founder of Washington Autism Alliance and Advocacy. She already submitted comments from her organization and came to speak as a parent. Her children are diagnosed with autism spectrum, and they've been accessing applied behavior analysis for a number of years. They also access other types of service providers, and there are concerns here from those other service providers.

They access occupational therapy; however, the OT's are really not able to work with her son unless an ABA trained behavior technician is present throughout those sessions. With the facilitation of an ABA trained behavior technician, the occupational therapist has been able to engage in their practice and engage her son and provide the OT exercises, for lack of a better word. Her son also works with a speech and language pathologist, probably one of the few speech and language pathologists who's been able to successfully work with him because she's been trained in applied behavior analysis for a number of years. They've accessed another speech and language pathologist through the Seattle Children's Autism Center, who is also a BCBA. There are a number of speech and language pathologists who have recognized that, in order for them to work successfully with populations that experience very significant emotional and behavioral challenges, that they need to pursue training in applied behavior analysis. They've done so, and they are able to work with that population successfully.

She said she is speaking as a mother and a consumer and can answer any questions. She said that her son's psychologists, psychiatrists, speech and language pathologists, occupational therapists, and physical therapists have not been able to provide the types of services that ABA providers have because they did not have that training. Within their own field, they are able to manage medications for her children, to prescribe medications and provide speech and language goals for her children. They are able to work successfully in a session if an ABA provider facilitates their services..

Applicant Follow Up

Dr. Jones wanted to make a quick comment on the punishment piece. He thinks what people are referring to is a description of aversive practices. There are a number of aversive strategies that behavior analysts and other providers have that they can use when they're providing services; but they're typically used after they've exhausted all of the reinforcement strategies. All punishment really means is the implementation of, or the adding or removing of some stimulus that results in decreasing of behavior. There are a lot of behaviors that need to be decreased. They want to decrease chewing on your hand, head banging, or other kinds of aversive or challenging behaviors. When they implement strategies, if they try reinforcement strategies that don't work, then they will use punishment-based strategies. That is something that has been used, but should not be used until all other non-aversive strategies have been exhausted.

Wrap Up and Next Steps

Ms. Weeks thanked everyone for attending the hearing and gave the follow information:

- There is an additional 10-day written comment period starting today through August 22nd at 5:00 PM for anything that has not been addressed.
- An initial draft report will be shared with interested parties in September for rebuttal comments. Those participating will receive the draft as long as the department has contact information for them.
- Rebuttal comments will be incorporated into the report and then we will submit it to the Secretary of the department for approval in October.
- Once the secretary approves the report, it is submitted to the Office of Financial Management for approval to be released to the legislature. OFM provides policy and fiscal support to the governor, legislature, and state agencies.
- It will be released to the legislature prior to the next legislative session, January 2015, and will be posted to our Web site once the legislature receives it.

Hearing Attendees

Name	Representing	Position
Arzu Forough	Washington Autism Alliance & Advocacy	Support
Jay Minn	Family	Support
Sue Murdoch	Family	Support
Chris Jones	Provider – WABA	Support
Diana Stadden	The Arc of Washington State	Support w/concerns
Kathleen Prosch-Jensen	WABA/LMHC	Support
Rick Shaw	WABA	Support
Kelly ferris	O.R.L.	Support
Ann Sturtz	O.R.L.	Support
Jewelya Ianniciello	DBHR	None Indicated
Gina Dick	DBHR	None Indicated
Laura O'Rourke	Magnolia	None Indicated
Nicolette Brigham	UW Autism Center	Support
Paul Rogers	West Coast Behavioral	None Indicated
Mary Tinsley	Jigsaw Junction	None Indicated
Monica Chen	Jigsaw Junction	None Indicated
Charna Mintz	Imagine	Support
Joshua Fouts	Imagine	
Patty Solano-Fah	O.R.L.	Support
Holly Almon	West Coast Behavioral	None Indicated
Erin Buckalew	West Coast Behavioral	None Indicated
Gabe Gomez	West Coast Behavioral	Non Indicated

Appendix D

Written Comments

Behavior Analyst Sunrise
Written Comments Received
August 12, 2014

Although this proposal potentially obtains a health licensure for behavior analysts, there are still no standard billing codes for applied behavior analysis that can be used to bill for services rendered. Is the state going to be working with both fully funded and self-funded insurance to require CPT codes to be created for this profession?

How are the services going to be defined so that they are distinctly different from what a speech therapist, an occupational therapist or even a psychologist provide already?

BCBA's are only part of standardization of care for the autism population, ABA technicians are providing most of the care for the children and have a wider range of skills and ability, will both of these be recognized as health care providers and have standards for licensure?

There are several organizations that have used mental health as a loophole to get services for children with ASD including the use of psychotherapy codes by master's level clinicians in the community. Are BCBA's going to be recognized as mental health providers because they are treating primarily children with ASD and it is in the DSM manual for diagnosis?

What is the scope of practice that will be allowed with this professional licensure?

Thank you for the consideration of my questions.

Dan Stachelski

Thank you for the opportunity to comment on the Behavioral Analyst Sunrise Review conducted by the Department of Health (DOH). We appreciate DOH's engagement with stakeholders regarding the proposal to create a new licensed profession of behavioral analysts.

Group Health Cooperative covers applied behavior analysis (ABA) for the treatment of autism. In developing a contracted network for these services, we have run into a few challenges related to determining how to credential individuals providing ABA services given that many are not independently licensed to practice in Washington.

Foundationally, we support the overarching goal of this draft legislation as it provides an oversight mechanism for the practice of ABA services. However, we have a few comments, outlined below, to share with DOH as it conducts this Sunrise Review.

- I. **Scope of practice for new behavior analyst profession.** We are concerned there is no mention in the draft legislation of the scope of ABA services. It is our understanding that the majority of current evidence-based treatment programs for ABA services are specific to individuals with autism spectrum disorders. We recommend the draft

legislation clearly define the scope of practice for this new profession based off of current evidence .

- II. **Licensure for current mental health professionals.** If it is determined that ABA services are within the scope of practice for independently licensed mental health professionals, will these professionals be able to provide ABA services without having to be additionally licensed as an ABA provider? We recommend the draft legislation allow qualified mental health professionals to provide ABA services without additional licensure.
- III. **State Board Membership.** Regarding membership to the State Board of Applied Behavior Analysis, we are concerned that Board members are limited to those who have been certified by the national Board Certified Behavioral Analyst (BCBA) Board. We recommend the draft legislation include membership of other professionals-such as psychologists trained in ABA-as part of the State Board of Applied Behavior Analysis.

We look forward to continuing to work with DOH to inform the potential formation and scope of this new profession. Please do not hesitate to let us know if you have any questions.

Scott Plack, Director of State Government Relations, Group Health Cooperative

My name is Ryan Hannig - I reside in Tacoma and I am very much in support of House Bill H-4577.1/14. This bill provides for the licensure of Behavior Analysts in the State of Washington. I am a Board Certified Behavior Analyst and I practice Applied Behavior Analysis (ABA) therapy with clients in Washington. I primarily work with children and youth with a disability, such as Autism or Traumatic Brain Injury. Many of these children have aggressive behaviors which can impact their ability to access the least restrictive school environment, be safe at home and in the community. ABA is widely recognized as the most effective treatment for individuals with Autism Spectrum Disorder. ABA has made a world of difference for many individuals in the State of Washington. One of the primary reasons I support House Bill H-4577.1/14 is the Consumer Protections it provides. At this time and without this licensure bill being passed, there are no formal mechanisms to protect vulnerable Washingtonians.

You may have seen the recent article in the New York Times touting the incredible results of children rising above their autism spectrum diagnosis through the intensive usage of ABA therapy.http://www.nytimes.com/2014/08/03/magazine/the-kids-who-beat-autism.html?_r=0 ABA is a therapeutic approach which, in order to be effective, demands operational implementation and a clinical consistency. The methods used in ABA can be learned naturally, but cannot be mastered without an intensive period of board certified training. There is always a noticeable difference between ABA therapies performed by certified BCBAs and those who have not received such rigorous training.

I look forward to the opportunity to discuss these points at the Hearing on August 12.

1. Your support of licensure for Behavior Analysts

2. Creation of an independent licensing board so that Behavior Analysts can regulate their own practice under the auspices of the Health Related Boards.

3. Consumer Protections provided by the passage of House Bill H-4577.1/14.

Thank you for your time and interest in this very important bill.

Ryan Hannig, MA, BCBA

I am the Clinical Director of Sendan Autism Services and Sendan ABA Services, located in Bellingham, Washington. I support the Sunrise Review Proposal to license behavior analysts in Washington State.

As a licensed clinical psychologist and doctorate-level, certified behavior analyst, I have directly observed the benefits of behavior analysis with many of my clients/patients. Among these individuals, Applied Behavior Analysis (ABA) has not only decreased problematic behaviors, but has contributed to the acquisition of new skills necessary to function in the home, community, and/or school environments.

ABA therapy is the empirically validated non-pharmaceutical intervention for behavior disorders for children with autism spectrum disorder. As such, ABA is now covered by Medicaid, as well as other private insurance companies within the state. However, currently there is no appropriate mechanism for qualified individuals who provide ABA to obtain licensure, independent of affiliation with a licensed state agency.

First, the existing “agency-affiliated counselor” designation is not an appropriate license for behavior analysts or technicians. The clinical scope of work of a behavior analyst or behavior technician is extremely narrow and highly specific and merits its own unique license. Second, the mandate to become a licensed state agency places an overwhelming and undue burden on small organizations and practices that provide ABA. This burden has a deterring effect on ABA service provision at a time when we need to be growing the field to meet the needs of our state’s population.

There is already a significant shortage of qualified providers of behavior analytic services, resulting in extensive wait lists for services, particularly outside of major metropolitan areas. Lack of access to appropriate licensure further limits the service providers available and therefore limits access to services to many children.

The scientific literature is very clear that early intervention is critical. As such, it is imperative that we do all we can to remove barriers to service access so that children can be treated as quickly as possible.

Passing of this Sunrise Proposal will get us one step closer to ensuring that:

- 1) ABA service providers are appropriately licensed, i.e. the scope of practice is accurately defined, and high ethical and professional standards maintained,
- 2) Entities providing ABA therapy are not deterred from doing so by overwhelming administrative demands,
- 3) The needs of our population are met in a timely manner.

Thank you very much for your time and attention to this matter. Please let me know if you have any additional questions.

Sara White

The Washington State Society for Clinical Social Work, representing many of the over 4000 Licensed Independent Clinical Social Workers (LICSWs) in Washington, has a strong interest in the mental health assessment and treatment of children who are diagnosed as having autism spectrum disorders. These disorders are some of the most complex, thus difficult to diagnose and treat, among the mental health disorders which affect children and adolescents. LICSWs are qualified to diagnose and treat all disorders found in the Diagnostic and Statistical Manual, Fifth Edition, including those on the autism spectrum. The Society would like to offer comments on the Sunrise Request for licensure of the Board-Certified Behavioral Analysts (BCBAs) in the context of representing LICSWs, independent mental health clinicians.

The National Institute of Child Health and Human Development definition of autism is as follows:

“Autism is a complex developmental disability that causes problems with social interaction and communication. Symptoms usually start before age three and can cause delays or problems in many different skills that develop from infancy to adulthood. The main signs and symptoms of autism involve problems in the following areas: Communication - both verbal (spoken) and non-verbal (unspoken, such as pointing, eye contact, and smiling); Social - such as sharing emotions, understanding how others think and feel, and holding a conversation; and Routines or repetitive behaviors (also called stereotyped behaviors) - such as repeating words or actions, obsessively following routines or schedules, and playing in repetitive ways.”
(<http://www.nichd.nih.gov/health/topics/asd.cfm>)

Thus, patients who have disorders on the autistic spectrum have special difficulties in communicating with others, reading social cues, and expressing their own wishes and needs. While autistic spectrum children and adults may clearly have symptoms that are on the autism spectrum, there are often other diagnoses which need to be addressed along with the autism spectrum disorder, which require the ability to do a differential mental health diagnosis.

The distress that autistic disorder symptoms cause the parents of these children is understandably traumatic as young children fail to reach developmental milestones and become

less and less able to function in social relationships or school. Parents need to be evaluated by clinicians who are able to understand how the parents' own history and emotional functioning affects their view of their child's difficulties. Differential diagnoses of parents can be as important as the diagnoses of the child.

The current requirements for clinicians who provide services to children with these severe disorders in Washington need updating, having been put in place in 1983. The development of new techniques for working with these patients, as the BCBAs do, is welcome and an important contribution to helping these patients.

The techniques developed by applied behavioral analysis (ABA) are a sincere, and often successful, attempt to help children overcome the symptoms of autism which are so devastating and terrifying for parents of autistic spectrum children. An excellent summary written by Ruth Padawar on the use of ABA techniques with autistic children, with varying degrees of success, can be found in the New York Times Magazine, August 3, 2014, "The Kids Who Beat Autism" (http://www.nytimes.com/2014/08/03/magazine/the-kids-who-beat-autism.html?_r=0).

However, WSSCSW has some concerns about the way that the applicant for licensure of BCBAs, the Washington Association for Behavior Analysis, would like to create regulatory recognition of this group of practitioners. The autistic spectrum (DSM-5 299.00) is one of over 300 mental health disorders identified in DSM-5. While the diagnosis of autistic spectrum disorders may seem obvious to those who work with these patients, there are many other emotional disorders to consider. Unless a clinician has been trained to make a differential diagnosis, problems may not be considered that are not solely in the autistic spectrum, e.g., depression, anxiety, attachment disorders, etc.

The standard for licensure being proposed in this Sunrise Review does not require the ability to make a differential diagnosis. The educational standard of a Master's degree is a fine one for giving BCBAs the knowledge they need to provide ABA techniques that may be useful in resolving the behaviors that interfere with normal social development, but is not a degree that allows BCBAs to consider the other mental health disorders which may be involved in the problems faced by autistic spectrum children and adolescents. The independent practice of BCBAs would not be appropriate; mental health licensure is based on the ability to make independent mental health diagnoses. In short, the autism spectrum is one mental health condition, to be considered along with others. BCBAs perform a valuable service when children have developmental problems on the autism spectrum, but need to work in tandem with licensed mental health professionals who can make a differential diagnosis.

WSSCSW therefore proposes two alternatives to the licensure request in this Sunrise Review: Certified Behavioral Analysts – BCBAs who have received their Master's degree in applied behavioral analysis be granted this certification. All CBAs would be required to have supervision by licensed mental health practitioners on a regular basis, at least once a quarter and before beginning a specific course of ABA treatment.

Endorsement in ABA Practice for psychologists, ARNPs, LICSWs, LMFTs, and LMHCs – BCBAs who have an LICSW or LMHC (Licensed Mental Health Counselor) could be given an

endorsement as having been certified in ABA techniques, e.g., LICSW-ABA. This would acknowledge their special training in treating autism spectrum disorders in the ABA modality as well as insure that they have the broad understanding of mental health disorders needed to treat mental health disorders independently.

WSSCSW supports the use of applied behavioral analysis for some autistic spectrum children and adolescents and acknowledge the value of this treatment modality. The Society also respectfully recommends that independent practice is restricted to clinicians who have the broad understanding of mental health disorders needed to make a differential diagnosis.

We thank you for the opportunity to present these comments. Please contact Laura Groshong for further discussion on this issue.

Ann DeMaris Davids, LICSW, President
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Laura Groshong, LICSW, Legislative Chair
Washington State Society for Clinical Social Work
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The Washington State Developmental Disabilities Council (DDC) supports with recommendations the process to establish licensure of Behavior Analysts and Assistants in the State of Washington.

The DDC plans and promotes services and supports for people with developmental disabilities and their families. The DDC is comprised of 27 Governor appointed members representing all areas of the State who address public policies that impact individuals with intellectual and other developmental disabilities, such as Autism and their families.

Using Applied Behavior Analysis (ABA) has resulted in decreased problematic behaviors with individuals with autism and has promoted the acquisition of new skills necessary to function in the home, community, and school environments. Due to recent case law and negotiated settlements with medical insurance providers, children with Autism Spectrum Disorder are able to receive behavioral intervention that is planned and supervised by Behavior Analyst funded by either Medicaid or medical insurance companies.

We feel that Behavior Analyst is a group of practitioners worthy of formal recognition through licensure. The proposed sunrise legislation will provide consumer protections that are needed to enhance access to well-qualified practitioners. Licensure is critical to ensuring that Behavior Analyst will uphold high ethical and professional standards of practice to ensure the highest benefit to the recipient.

However, we recommend that licensure of this group should come with high standards such as:

- Appropriate coursework that includes child development, abnormal psychology and family systems;
- Supervision of practice that is equivalent to other licensed professionals;
- Requirement for a percentage of their practice to include low income individuals; and
- The adoption of a code of ethics that governs professional practice and responsibilities to recipients of the service.

Given the critical demand for Behavior Analysts and recent developments in the field, we ask that the Washington State Department of Health consider creative ways under the proposed legislation to establish a Behavioral Analyst Licensing Board to initiate the licensing process.

Thank you for your consideration. If we can provide more information, Please contact David Maltman at david.maltman@ddc.wa.gov or 360 586 3540.

Ed Holen, Executive Director

The Washington Autism Alliance & Advocacy (WAAA) appreciates this opportunity to provide input on your planned review of applied behavior analysis (ABA) as a new category of healthcare provider. We understand that this review is central to determining whether professional behavior analysts will be licensed in Washington as independent healthcare providers.

As you know, ASDs are neurological conditions that affect virtually all aspects of everyday functioning to some degree. Difficulties are typically seen in communication, social interaction, adaptive functioning, and self-care skills. Unfortunately, many people with ASD engage in behaviors that jeopardize their safety and health, such as self-injury, pica (ingesting inedible items), elopement (running away), flopping (throwing themselves on the ground), aggression, sleep disorders, and severely restricted eating. Several studies have found that such behaviors lead to disproportionate numbers of emergency room visits, hospitalizations, and prescriptions of psychotropic drugs for people with ASD, with associated high costs. Extensive research by behavior analysts has shown that such behaviors are often learned, and are triggered and reinforced by environmental events. Behavior analysis methods have proved effective for identifying those environmental events, reducing problem behaviors, and developing appropriate alternative behaviors, such as requesting help with a task instead of eloping or aggressing, eating a healthy diet, and sleeping through the night.

Although some drugs can reduce some of the problem behaviors mentioned above, relatively few psychotropic medications have been tested adequately with children with ASD. Further, as the American Academy of Pediatrics noted recently, no drugs ameliorate the core symptoms of ASD, and many drugs that are prescribed for problem behaviors have negative side effects. For example, the only drug that has been approved by the FDA to date for the treatment of ASD – Risperidone - has been shown to reduce irritable and agitated behavior. But Risperidone is not 100% effective, and its negative side effects include incontinence and weight gain, which

increases the risk of diabetes and other health problems. ABA methods, on the other hand, can effectively reduce problem behaviors without adverse physical side effects.

The behavioral excesses and deficits exhibited by people with ASD often hamper the delivery of health care services to this population. Communication difficulties and fearful responses to unfamiliar situations, for example, can make routine medical and dental checkups major ordeals for people with ASD and their families. Studies have shown that with ABA intervention, people with ASD can learn to communicate and cooperate with health care professionals, to comply with medical and dental care routines, and to undergo medical procedures like scans and EEGs.

Many people with ASD have difficulty recognizing and responding appropriately to situations that put them at risk of harm. Research has shown that ABA methods are effective for teaching people with ASD to be aware of and to avoid potentially hazardous situations, to seek help when necessary, and to communicate essential information to individuals who can assist them.

Numerous objective, independent reviews of scientific research have identified ABA as a proven, safe, and effective approach to ASD intervention. That conclusion is based on hundreds of published studies documenting the efficacy of a variety of ABA techniques for increasing a wide array of specific skills and decreasing a wide array of problem behaviors in people with ASD of all ages. In addition to those focused interventions, comprehensive, intensive early intervention programs using combinations of many ABA techniques have been shown to produce large improvements in multiple skill domains in many children with ASD, more modest but still clinically important improvements in many other children. Those effects have been obtained when ABA intervention was designed and overseen by qualified professional behavior analysts.

In sum, ABA intervention for ASD is similar to certain treatments that are commonly provided to children and adults with other neurological disorders to develop or restore independent functioning. With competently delivered ABA intervention, many people with ASD can enjoy safe and healthy lives. When an individual with ASD receives effective intervention, the more likely she or he is to achieve large improvements in multiple skill areas, and the less likely it is that health-threatening problem behaviors will develop. Adolescents and adults with ASD also benefit from ABA intervention.

Planning, directing, and monitoring effective ABA programs for individuals with ASDs requires specific skills and competencies. Individuals with autism, their families, and other consumers struggle to determine whether people who claim to be qualified to direct ABA programs actually have the necessary competencies, and are unable to hold prospective providers accountable for delivering quality services. Not every ABA service provider has the competencies required to optimally address the needs of every individual with autism.

Please note that professional certification in behavior analysis is evidence that a professional has met **minimum competency standards** related to the practice of behavior analysis; however, it does not guarantee that the individual has specific expertise in the treatment of autism nor that she/he has the training or skills needed to produce optimal treatment outcomes. Please refer to *Training Necessary to Direct ABA Programs for Individuals with ASD's (Adopted from Association of Professional Behavior Analysts and BACB Autism Special Interest Group (SIG))*

In Washington State, there is a large gap between the supply of qualified behavior analysts and the demand for ABA services. Agencies and third party payers are looking to professional behavior analysts to work with a wide range of patients, including those with very complex clinical and mental health needs. The same agencies and payers don't have an effective mechanism in place to evaluate those who *claim to have credentials and expertise in designing, overseeing or implementing behavior analysis*.

We strongly support licensure of professional behavior analysts to ensure the safety and well-being of a very vulnerable population and ask for the following considerations when developing minimum standards for licensure:

- Additional Coursework that includes child development, abnormal psychology and family systems.
- Additional supervision by a professional behavior analyst that is at least in par with other mental health professions (i.e. 3000 hours of supervised practice as a professional behavior analyst). The current standards of 1500 hours are more appropriate for a licensed associate, similar to a LMHCA.
- Commitment that a percentage of their practice will include low income children and individuals in order to be licensed as a health care professional.

WAAA stands ready to assist you in conducting your review and formulating policies regarding licensure of professional behavior analysts. Please do not hesitate to contact me if I can answer any questions or provide any additional information.

All my best,

Arzu Forough - Founding President, CEO

The purpose of this letter is to state my strong support for Bill H-4577.1/14 that is currently in Sunrise Review with the Washington State Department of Health. This bill would provide an infrastructure for licensing behavior analysts in Washington. I have lived in Washington State and worked as a Professor in the UW College of Education for over 20 years. My area of teaching and research expertise is interventions for children with autism and applied behavior analysis. During that time I have seen the prevalence of people with Autism Spectrum Disorders increase dramatically, and unfortunately, the medical and education agencies and elected officials in our state do very little in response. Approving this bill is a simple and inexpensive way that legislators can have a big impact on the lives of their constituents with autism and their families. Let me tell you more about why this bill is important.

Behavior Analysts are professionals who practice applied behavior analysis (ABA). ABA is the application of scientific principles of behavior (e.g., positive reinforcement) to improve socially significant behavior to a meaningful degree. It is also the most effective intervention strategy for working with people of all ages with autism and has been endorsed as the intervention of choice by professionals across disciplines (e.g., medicine, education, speech-language pathology, psychology).

The practice of behavior analysis is a distinct profession. It is different from education and psychology and should only be practiced by someone with appropriate classroom and field-based

training. Like any profession, the services provided by behavior analysts who have appropriate training and qualifications are most often better than those services provided by non-trained or undertrained providers. Licensure is the only way to insure that the citizens of Washington State will have access to well trained and regulated behavior analysts.

The primary consumers of ABA are people with autism and related disorders, ensuring that these citizens have access to well-trained professionals is vital. The research is clear that when provided with early, intensive behavioral interventions the majority of children with autism make dramatic improvements across developmental domains. Washington State citizens deserve to have licensed behavior analyst at the head of these intervention teams.

Please feel free to contact me at Ilene@uw.edu if you would like additional information.

Ilene Schwartz, Ph.D., BCBA-D

Thank you for the opportunity to provide comment on the current Sunrise Review process for proposed licensure for behavior analysts, HB 4577.1/14.

The Washington Occupational Therapy Association (WOTA) fully supports the work of behavior analysts in Washington State, particularly with children who have autism spectrum disorders. However, we have concerns about the Sunrise Review application for applied behavior analysts (ABA) to become licensed as health professionals in Washington State.

Behavioral theory is the basis of evaluation and intervention methods used by practitioners certified by the Behavior Analyst Certification Board, but the analysis of behavior and the application of interventions to change behavior are not exclusive to those who consider themselves applied behavioral analysts. Behaviorism is one of many theoretical frameworks taught in all occupational therapy programs, and activity and environmental analysis has been at the heart of occupational therapy practice since its foundation.

Occupational therapy practitioners use applied behavioral frames of reference in practice, and have incorporated behavior modification in their interventions since the 1940's. In addressing the needs of children and adults with special needs, occupational therapists evaluate what is interfering with successful performance, whether it pertains to the person, the task itself, or to the environment. Providing interventions, which include altering the environment or changing the kinds of motivations, that elicit a person's engagement in the everyday activities that he or she needs to do to be successful is well within the education and scope of practice of occupational therapy.

WOTA is concerned that the appropriation of a common theoretical base of knowledge and techniques based on behavioral theory, and the application of such by a particular group of practitioners, behavior analysts, would effectively limit the legitimate application of evaluation and intervention techniques included in occupational therapy's education and permitted by our scope of practice.

While ABA practitioners focus on a specific behavior technique, OTs evaluate and provide a wide variety of interventions for the “whole person,” including physical, mental, and psychosocial challenges. The Sunrise proposal acknowledges that other licensed practitioners use behavior strategies within their scope of practice and training. However, this appears to be in opposition to the need to establish separate licensure for practitioners utilizing ABA techniques as they are already regulated under established professions.

To maintain the focus of professional licensure on the protection of public health, safety and welfare ABA should not be considered a “stand alone” service for individuals with behavior and learning problems. These individuals need a more comprehensive approach that will benefit the public instead of a small group of practitioners seeking to distinguish their profession. In order to best protect the public and respect the scope of existing licensed professionals,

WOTA recommends the following:

Maintain focus on established Sunrise review criteria and recommend that ABA not be regulated as a licensed health profession.

Creating a separate stand-alone licensure for ABA practitioners is inappropriate--ABA is only a single technique for intervention, one that requires extensive training, but it is only one among many that children with autism and others may benefit from. We believe that this application for licensure is not focused on the protection of public health, safety and welfare— WACs 388-877 and 388-877A already regulate the services of ABA—but instead is being pushed in the self-interest of a small group of practitioners seeking to restrict entry into a profession or service area.

The Washington Association for Behavior Analysis (WABA) has stated in a published letter on their website (<http://www.washingtonaba.org/news.html>) that:

The purpose of this bill is to provide a framework for regulation of practitioners of behavior analysis. There currently is no mechanism in Washington State to protect consumers, employers, and state agencies **from individuals who make false claims about their training in behavior analysis. This legislation will also distinguish behavior analysis as a distinct profession,** making clear that it is not the same as developmental psychology, school psychology, counseling, social work, special education, and other mental health and education professions. (Emphasis added)

We are concerned that the proponents of this bill are promoting the proposal as a means to define a profession and to protect against false claims about qualifications to use a particular technique. The purpose stated in the WABA letter is not in alignment with the Sunrise criteria. We believe certification would be a more appropriate credential for behavior analysts, to avoid turning a technique into a stand-alone profession.

Focus scope of ABA practice on appropriate patient population and care setting pursuant to a diagnosis or prescription from a licensed professional

If the Department moves forward with a recommendation to license behavior analysts as a stand-alone profession, we urge the recommendation to include additional requirements to assure consumer protection and the appropriate scope of behavior analysis.

The Sunrise Review proposal for licensure asserts that “typical clients of ABA practitioners include individuals with autism and other developmental disabilities, intellectual disabilities, learning and communication difficulties, brain injuries, physical disabilities, and difficulties associated with aging, as well as typically developing individuals. Practitioners of ABA work in a variety of settings, including private and public clinics, private homes, hospitals, schools, nursing homes, group homes, universities, and business settings.”

We believe this characterization of ABA clients and practice settings is far too broad and does not reflect the reality that ABA services are typically provided to children on the autism spectrum. Washington state health coverage for ABA services in Medicaid and the Uniform Medical Plan limit eligibility to children on the autism spectrum.

The educational background of ABA practitioners does not include the knowledge and skills needed to practice with a broader variety of patients and health care settings included in the Sunrise proposal. The current professional requirements for ABA certification include course work from the fields of education, special education, and psychology. To our knowledge, ABA practitioners are not required to take courses in health care.

We suggest that the Sunrise recommendations limit the client population independent ABA professionals can serve to children on the autism spectrum and medically stable children with other complex behavior problems. Furthermore, ABA professionals should be required to practice only in cooperation with and under a diagnosis and prescription from a licensed health professional qualified to provide such a diagnosis and prescription.

Assure appropriate access to behavioral health treatments for individuals with ASD or other developmental disabilities

If the ABA professionals move forward with licensing legislation we believe there exists a significant possibility that the number of licensed practitioners will not be sufficient to meet the demand for behavioral health treatments in the state. As stated in the Sunrise application the number of individuals practicing in Washington is unknown, but may be less than 100 practitioners. This regulation will leave an underserved population seeking behavioral health treatment that the existing ABA practitioners will not be able to meet. We will propose amendments to the licensure bill to clarify that the “practice of behavior analysis” does not include occupational therapy and to provide appropriate exceptions for OTs to continue utilizing behavioral techniques. These exemptions may help to meet the demand for behavioral treatments should the department move forward with licensure.

WOTA welcomes a continuing dialogue with behavior analysts in Washington State through both our national and state associations to ensure all concerns are addressed and the needs of the public are best served. Thank you again for this opportunity to comment.

If you have further questions, please contact:

Kate White Tudor, WOTA Lobbyist

The purpose of this letter to express my deep and passionate support of Bill H-4577.1/14, which would provide an infrastructure for licensing Behavior Analysts in the state of Washington. If this bill is enacted, thousands of individuals in the state of Washington would benefit tremendously, especially the current and future consumers of Applied Behavior Analysis (ABA) services, who are primarily individuals suffering from an autism spectrum disorder or other developmental disability. Below, I will provide additional details on the benefits that this law would produce.

The field of Applied Behavior Analysis is very distinct, and has a very specific and unique set of principles and procedures that are utilized within the discipline. These principles and procedures differ significantly from the methods commonly used in other fields, including clinical psychology, developmental psychology, counseling, and social work. These fields tend to focus on internal, covert mental processes, whereas behavior analysis focuses on making measurable, meaningful changes in overt, observable behaviors. This is just one of many fundamental differences that sets our field apart from these other disciplines. Since behavior analysis is clearly a distinct, separate entity, it is important that the state of Washington implements legislation that will allow the field of behavior analysis to be recognized as such. Currently, behavior analysts are forced to apply for licenses that are not applicable to them, because many insurance companies and other funding sources in the state of Washington mandate that providers have a state license in order to become a credentialed provider. For example, many behavior analysts have reluctantly applied to become an “Agency Affiliated Counselor” through the DBHR due to the absence of a more appropriate, relevant license in our state. If behavior analysts do not obtain this particular license through the DBHR, they will be unable to accept many insurances in the state of Washington, which prevents the behavior analyst from building their caseload and prevents families who have insurance plans or funding through these companies/sources from accessing the ABA services they desperately need. Behavior analysts are not counselors, and do not utilize traditional counseling procedures in practice. Behavior analysts should have the right to a state license that adequately describes their discipline, duties, and scope of practice, rather than trying to make behavior analysts fit into existing licenses, such as the “Agency Affiliated Counselor” license, that are not applicable and not appropriate.

Applied Behavior Analysis is currently the most evidence-based and most effective treatment for autism spectrum disorders. (American Academy of Pediatrics, 2007). With the prevalence of autism now at an estimated 1 in 68, and the numbers continuing to increase at staggering rates, the profession of behavior analysis is rapidly growing as a result. While a behavior analyst may wish to provide ABA services to individuals in the state of Washington, without a proper state license being available to them, they will likely opt to practice in one of the 18 other states that have already enacted laws to safely, effectively, and appropriately license behavior analysts. This could lead to a shortage of behavior analysts in the state of Washington, and would cause our citizens who are affected by autism to suffer simply due to the state they live in. The members of our community deserve far better than this. Washington has a reputation for being a progressive state, and I believe it is time for Washington to step up to the plate and join the other 18 states who have decided to license behavior analysts in order to protect their consumers and ensure they have access to ABA services from competent, well-trained individuals.

The current laws in Washington make it extremely difficult for competent, qualified individuals like myself, who have graduate degrees specifically in Applied Behavior Analysis and are

certified by the Behavior Analyst Certification Board, to obtain a state license to practice ABA in Washington. Even worse, the current laws open the door for individuals who have little to no education, training, or experience in ABA to receive a state license that would allow them to practice ABA therapy in our state. Many of these providers will work with individuals diagnosed with autism and other disabilities. Individuals with autism and other disabilities are, by nature, extremely vulnerable, and they may have a difficult time deciphering who is a qualified provider of ABA services and who is not. This burden should not fall on the shoulders of these individuals or their families. By enacting Bill H-4577.1/14, it would ensure that all licensed behavior analysts in the state of Washington have met the rigorous requirements that have been carefully designed by the Behavior Analyst Certification Board, including strict mandates regarding specific college degrees, coursework, supervised experiential training, and passing a professional examination that is the only legally and psychometrically validated exam in the field of behavior analysis.

In conclusion, this is an absolutely critical bill that would assure consumers, employers, and the state of Washington that individuals who are providing ABA services in our state are competent in behavior analysis and have the proper experience, education, and training to perform their duties to the highest level of effectiveness. Providing ABA services without the proper training and experience could have disastrous and extremely dangerous consequences for the recipients of these services. Our friends and family in Washington, especially those with special needs, deserve the absolute best, and this bill would allow them to receive the finest, most effective ABA therapy possible. Having worked with hundreds of individuals with autism and other disabilities throughout my career, I can attest to the stress and struggles these individuals and families face on a daily basis. The passage of this bill can help alleviate one of their primary concerns, which is to readily receive access to high quality ABA services from providers who have clearly and objectively proven their expertise in the very unique and distinct field of behavior analysis.

Rachel D. Wagner, M.S., BCBA, Blue Water Behavioral Consulting Executive Director

We were told you were looking for testimonial experience about the devastating impact bad behavior analysts have had on our family.

We were very on top of our son's diagnosis of Autism, which happened nearly 11 years ago when our son, Nigel, turned 2. We immediately tried to find help and we knew that ABA was the only treatment with any scientific research to show effectiveness. We have since found that other treatment modalities are probably just as important, but like most families we were all-in with ABA and fought to find someone to work with our son. The available Behavior Analysts were very expensive and at the time very hard to access. DDD provided virtually no help in accessing either treatment or community support.

When we finally did get regular ABA treatment from Northwest Behavioral Associates, we found the programming to provide very little benefit. There seemed to be very inconsistent follow-up. We were put through a series of program managers with monthly team meetings with the executive director. These meetings produced very little benefit in refocusing or helping to keep the learning goals moving forward. The pattern was always that our son would stop making improvements in a program and then it would be dropped and something else tried. The

learning goals reinforced scripting and never lead to generalization of the skill because there wasn't the long-term follow through or knowledge of how to generalize. The skill would only be useful for one exact program that was being run at the table, and Nigel failed to progress for the most part.

Finally we left NBA and tried APPLE Consulting. Here the problem was a little different, while we felt the executive director really did understand and know how to treat our son, she was way overburdened with too many clients. Therefore, she never dedicated the time necessary to build out a progressive program of skills that could be generalized. As time went by, we felt as if Nigel was going from mildly autistic to more profoundly autistic and developing behaviors that made him stand out more and more. His social skills really stagnated and his verbal ability never progressed past a certain point.

The saddest thing is that we always felt Nigel was capable of much more. From the very beginning, everyone said to us, "Nigel has great potential." He could read and responded to social attention and facial expressions. However, his sensory dysfunction was quite profound and we feel that if he had been able to develop more functional language and vocabulary, he would have had an easier time coping with his sensory problems.

Also, during this time we continually pressed the issue with the different ABA providers, becoming very assertive and demanding that more effective supervision and experienced program management be provided. But it was never forthcoming. We changed again to Connections last year, partly because of their promise that they would work with the child as an individual and address his/her individual needs. Unfortunately, these were the worst yet. Nigel had become quite large and strong by his 12th birthday, and these folks had no idea how to work with him. They seemed to aggravate his anxiety and make all the wrong choices in working with him. The Program Manager, Beth Bacon, though well-meaning and intelligent, was just out of college and very inexperienced. Part of the problem is that many of these providers have had very limited experience working only with very young children. Paul Mullan, the executive director of Connections, had no guidance to impart to Beth even if he did have the time. Working in the UW kindergarten or running an Academic BCBA program does not prepare you for an adolescent with social, emotional, sensory and cognitive challenges. These providers don't seem to know how to work with the community and access resources from outside their very limited academic backgrounds.

This problem is also making its way into the schools as the schools cast about for professionals who can help address the needs of a growing population of autistic students. Last year, LWSD brought in a brand new first-year teacher at Inglewood Middle School. The autism specialist they brought in, Jeremy Erickson had been working on a PhD in autism at the UW, but his experience was limited to kindergarten at the Autism Center school. He is completely at a loss as to what to advise the school team to do with our son. Again, he is well-meaning and academically educated, but inexperienced and, in his case, very defensive and not very professional, which you can expect from someone who has spent most of their time in academia with practicum of a very limited nature. During the last part of this last school year, our son has been isolated and restrained every day at school with the knowledge and guidance of Jeremy and

also Kathy Zanolli. Meanwhile, they've brought in an outside agency, Basic Beginnings, with unqualified Para-educators to supervise him in his isolation.

After all these years, we have finally found an ABA provider, Penny Latham, BCBA, who is much better, more prepared and more experienced, and progress is finally being made in the home program. Her programs are much more well thought out and practical. She spends much more time with both the programming and the tutors. Up til now she has limited her client base and we hope she will continue to do that.

Unfortunately the pressures that exist for running a business in that field are great. The state needs to provide more support and better financial incentive to remain with a small client base in order to gain experience and consistency with a wider real-world population of young people and adults with autism. They need to be encouraged to draw more heavily on the community for resources in fields such as mental health, occupational therapy, speech and language, special social programming, community involvement and community skills training. There needs to be better oversight and verification of real-world experience before providers are allowed to go out trolling for as many clients as they can get with deep pockets or very good insurance. The insurance carriers cannot be expected to police these providers on their own. Some of the largest and best known providers in the area are the worst for children on the lower functioning or higher needs end of the spectrum. They really only know how to work with high-functioning individuals, and the clients like our son need much more skilled and structured follow through.

In addition, many of the tutors are only in it for the money. Or they are caring, but untrained individuals who may do well with very strong oversight. However, as stated, the most well-known Ph.D. directors of these provider agencies do not make the time to provide the needed oversight. There are many different problems with these directors, but they all get into the business side of things with little attention to the actual clients and their families. We have heard anecdotal that these problems are not nearly as prevalent in other states, and it makes us wonder if the economic or regulatory atmosphere is promoting these conditions. If so, the impact is devastating to our children and the lives of their Washington families.

Until recently, we would have said that it was a hopeless cause, but now that we have met and worked with Penny Latham, we see that it is possible to be caring, consistent and effective. This makes us all the more angry and upset at the terrible services that have been provided to us at very great cost.

We can honestly state that the stress over the poor services provided by behavior analysts has been far greater than the stress created by the autism itself. It is quite literally the single worst thing that has ever happened to us - not the autism, the treatment. The horrible treatment and programming provided by Lake Washington School District has also been traumatic, but we still put the experience with Behavior Analysts (some of whom have worked at the school district) at the top for sheer useless investment of time, stress and money.

Treating a child like our son is not easy. However, most of these people aren't even trying or holding themselves accountable for any results. In a case like ours where results are possible,

and extremely beneficial when they occur, this is very nearly a crime for which they should be prosecuted.

We'd be happy to talk directly about our experiences and provide documentation to enhance our claims and observations.

Adam Burns

I am writing in support of creation of a licensure category for Behavior Analysts. To introduce myself, I am a Developmental/Behavioral Pediatrician at Seattle Children's Hospital. As a member of the faculty at the University of Washington School of Medicine as well an attending physician in the Division of Developmental Medicine at Seattle Children's Hospital I have considerable expertise in issues of diagnosis and management of a large number of Developmental Disorders. Additionally approximately 20 years ago I became interested in the issue of childhood autism and developed the first clinic for this disorder at the hospital in 2001. That program grew to its current incarnation as the Seattle Children's Autism Center, for which I now serve as its Medical Director. My study of Autism Spectrum Disorders over that period of time has allowed me to observe many changes in the understanding of this increasingly significant public health problem. When I began my studies little was known about the underlying causes of this disorder or how it might be effectively treated.

Fortunately, much work across the United States and internationally has demonstrated increasingly that Applied Behavior Analysis, also referred to as ABA, is currently one of the most effective therapies for what is a serious, neurologically based developmental and behavioral disorder. This field of study is solidly based in scientific evidence and deserves licensure recognition and safeguards similar to many other disciplines that are currently licensed by Washington State Department of Health. Licensure assures that practitioners of this discipline are adequately trained and experienced such that the services they provide to the citizens of our state are safe and effective following the national standards of the Behavior Analyst Certification Board (BCBA). Behavior Analysis is a specific field of professional study and training different enough from other mental health approaches that it deserves its own recognition via licensure. This conforms to what is occurring in other parts of the United States. The lack of licensure currently serves as a barrier to having adequate numbers of these therapists available to individual affected by Autism Spectrum Disorders and other severe neurologic and developmental disorders that have significant behavioral issues.

In summary I strongly support this legislation which will have significant positive benefits for our citizens in Washington State.

Charles A. Cowan MD

The purpose of this letter to express my support of Bill H-4577.1/14, which would provide an infrastructure for licensing Behavior Analysts in the state of Washington. If this bill is enacted, thousands of individuals in the state of Washington would benefit tremendously, especially the

current and future consumers of Applied Behavior Analysis (ABA) services, who are primarily individuals suffering from an autism spectrum disorder or other developmental disability. Below, I will provide additional details on the benefits that this law would produce.

The field of Applied Behavior Analysis is very distinct, and has a very specific and unique set of principles and procedures that are utilized within the discipline. These principles and procedures differ significantly from the methods commonly used in other fields, including clinical psychology, developmental psychology, counseling, and social work. These fields tend to focus on internal, covert mental processes, whereas behavior analysis focuses on making measurable, meaningful changes in overt, observable behaviors. This is just one of many fundamental differences that sets our field apart from these other disciplines. Since behavior analysis is clearly a distinct, separate entity, it is important that the state of Washington implements legislation that will allow the field of behavior analysis to be recognized as such. Currently, behavior analysts are forced to apply for licenses that are not applicable to them, because many insurance companies and other funding sources in the state of Washington mandate that providers have a state license in order to become a credentialed provider. For example, many behavior analysts have reluctantly applied to become an “Agency Affiliated Counselor” through the DBHR due to the absence of a more appropriate, relevant license in our state. If behavior analysts do not obtain this particular license through the DBHR, they will be unable to accept many insurances in the state of Washington, which prevents the behavior analyst from building their caseload and prevents families who have insurance plans or funding through these companies/sources from accessing the ABA services they desperately need. Behavior analysts are not counselors, and do not utilize traditional counseling procedures in practice. Behavior analysts should have the right to a state license that adequately describes their discipline, duties, and scope of practice, rather than trying to make behavior analysts fit into existing licenses, such as the “Agency Affiliated Counselor” license, that are not applicable and not appropriate.

Applied Behavior Analysis is currently the most evidence-based and most effective treatment for autism spectrum disorders. (American Academy of Pediatrics, 2007). With the prevalence of autism now at an estimated 1 in 68, and the numbers continuing to increase at staggering rates, the profession of behavior analysis is rapidly growing as a result. While a behavior analyst may wish to provide ABA services to

individuals in the state of Washington, without a proper state license being available to them, they will likely opt to practice in one of the 18 other states that have already enacted laws to safely, effectively, and appropriately license behavior analysts. This could lead to a shortage of behavior analysts in the state of Washington, and would cause our citizens who are affected by autism to suffer simply due to the state they live in. The members of our community deserve far better than this. Washington has a reputation for being a progressive state, and I believe it is time for Washington to step up to the plate and join the other 18 states who have decided to license behavior analysts in order to protect their consumers and ensure they have access to ABA services from competent, well-trained individuals.

The current laws in Washington make it extremely difficult for competent, qualified individuals like our company hires, who have graduate degrees specifically in Applied Behavior Analysis and are certified by the Behavior Analyst Certification Board, to obtain a state license to practice

ABA in Washington. Even worse, the current laws open the door for individuals who have little to no education, training, or experience in ABA to receive a state license that would allow them to practice ABA therapy in our state. Many of these providers will work with individuals diagnosed with autism and other disabilities. Individuals with autism and other disabilities are, by nature, extremely vulnerable, and they may have a difficult time deciphering who is a qualified provider of ABA services and who is not. This burden should not fall on the shoulders of these individuals or their families. By enacting Bill H-4577.1/14, it would ensure that all licensed behavior analysts in the state of Washington have met the rigorous requirements that have been carefully designed by the Behavior Analyst Certification Board, including strict mandates regarding specific college degrees, coursework, supervised experiential training, and passing a professional examination that is the only legally and psychometrically validated exam in the field of behavior analysis.

In conclusion, this is a critical bill that would assure consumers, employers, and the state of Washington that individuals who are providing ABA services in our state are competent in behavior analysis and have the proper experience, education, and training to perform their duties to the highest level of effectiveness. Providing ABA services without the proper training and experience could have disastrous and extremely dangerous consequences for the recipients of these services. Our friends and family in Washington, especially those with special needs, deserve the absolute best, and this bill would allow them to receive the finest, most effective ABA therapy possible. The passage of this bill can help alleviate one of their primary concerns, which is to readily receive access to high quality ABA services from providers who have clearly and objectively proven their expertise in the very unique and distinct field of behavior analysis. If the problem is not addressed now, it will lead to a crisis in the future when these children become adults and their families have passed on leaving the responsibility for their care to state agencies. When passed, this bill will enable professional ABA providers to assist these individuals in obtaining the skills necessary to maintain a life outside of the state agencies and systems. Please help our special needs community to get the badly needed services by qualified providers and avoid a future crisis.

Jason A. Wagner, Blue Water Behavioral Consulting, Chief Financial Officer

On behalf of the Washington Speech-Language-Hearing Association (WSLHA), I am providing comments on the behavior analyst sunrise review proposal. WSLHA represents speech-language pathologists (SLP), speech-language pathology assistants (SLPA), and audiologists across Washington state.

Access to speech-language pathology services from SLPs and SLPAs is critical early on in a child's life. Equally critical is collaboration with other rehabilitative providers such as physical therapists and occupational therapists, along with behavior analysts, when appropriate. As such, there is a need to clearly delineate the scope of practice of each provider so individuals with autism spectrum disorder and their families are well-informed of treatment options. The proposed legislation creates a very broad scope of practice for behavior analysts. WSLHA is concerned about this broad scope and suggests that the language be amended to capture what the practice of behavior analysis does NOT include. Our overarching concern is that behavior

analysts are not educated and trained in communication disorders. However, under the definitions in the proposed legislation, a communication disorder could be considered a “human behavior” which impacts one’s quality of life and requires support for “socially significant” outcomes even though there is no education or training in communication disorders. Therefore, it is not appropriate that communication disorders be included in the definition of “practice of behavior analysis” in Section 1(6)(a).

Specifically, we are concerned that augmentative, alternative communication (AAC) evaluation and language evaluation and treatment are not appropriate practices for a behavior analyst. We ask that language be added to Section 1(6)(b) that excludes the practice of speech-language pathology, communication disorders, AAC evaluation, and language evaluation and treatment.

WSHLA appreciates the opportunity to provide comments on the behavior analysis sunrise review proposal.

Leslie Power, MS, CCC-SLP, President, Washington Speech-Language-Hearing Association (WSLHA)

On behalf of Premera Blue Cross, thank you for the opportunity to provide comments as part of the Department of Health (DOH) sunrise review process concerning licensure of behavior analysts.

I am writing to express Premera’s support for the proposal to establish a new licensed profession for behavior analysts. The approach to license and regulate behavior analysts is sound and would enhance patient safety and the quality of care for patients seeking these services. Patient safety is a key priority for Premera as we seek to improve quality of care and support the delivery of evidence-based medicine.

Thank you for the opportunity to offer our comments on this proposal.

Sheela Tallman, Senior Manager, Legislative Policy

The Arc of Washington State has been advocating for individuals with intellectual/developmental disabilities and their families since 1936. This includes people on the autism spectrum, many of whom receive or have received Applied Behavior Analysis (ABA) services. Currently the Sunrise Review Committee is looking at the licensure of professionals who provide these ABA services. Although The Arc supports licensure for these services, we have concerns about the proposal.

1. We are hearing from families about services they get from professional Board Certified Behavior Analysts (BCBA), especially newer ones, who are often unprepared to work with children with autism who have more significant issues. This seems to be particularly true with children receiving services through the Children's Intensive In-home Behavioral Supports waiver (CIIBS). These children receive state services through the Developmental Disabilities Administration as a way of trying to avoid out-of-home placement and a break-up of the family. We hear of families who start services with a BCBA, but then are dropped by that professional

when they realize they are not equipped to deal with significant behavioral issues that arise. The number of hours of supervised field work needs to be increased. An LMHC must do 3,000 hours of supervised work, BCBA's need an additional number of supervision hours as well and it should include a variety of settings. We believe that would help with the complex situations in which new BCBA's currently find themselves not prepared.

2. Families have indicated that some BCBA's represent themselves as being able to provide speech therapy services as part of ABA and bill the family's insurance for those services under speech therapy. This leaves the family with fewer of their benefits available for their professional speech therapists. We need to ensure that BCBA's do not practice and do not bill for services they are not qualified to provide that are out of their scope of practice.

3. Some insurance companies have already begun to require that ABA program managers hold a BCBA certification to bill for ABA services. This proposal does not take into consideration that there are other professionals who are competent in devising and administering ABA programs. Licensed Mental Health Counselors (LMHC), Psychologists (PhD), Doctor of Psychology (PsyD), and others who have experience and training to provide ABA should be able to bill for ABA under insurance plans. ABA therapy is part of the coursework for LMHCs. If an LMHC provides ABA as a counseling service, it's not covered under the ABA benefit (where kids can get up to 40 hrs/week), rather an LMHC would have to bill for ABA as cognitive behavior therapy where it is only covered under the mental health counseling benefit (usually 1-2 hrs/wk or a small number of sessions per year). ABA itself is a standard type of therapy that LMHCs, PhDs and PsyDs are trained on in their graduate programs. If not included in this licensure, insurance companies will stop allowing them to bill for ABA services, restricting the amount of service they can provide. The BACB model license act says in its exemption section: "Applied behavior analysis may be utilized by a number of licensed professionals. The Act should address the practice of applied behavior analysis by individuals licensed in other professions (such as speech/language pathologists, special educators, and other mental health practitioners licensed by the State)."

4. Treating a child with autism is not just about using ABA. An LMHC, PhD or a PsyD has training around ethics, pharmacology, family counseling and more that are factors in treating the whole person. Children with autism often have anxiety issues, take medications and their families need to be trained and involved. BCBA's don't have these additional training pieces that are needed with some children who have complex problems and are not trained to include anxiety and depression issues in their plans. The proposed rules need to include ongoing continuing education as part of licensure to ensure that BCBA's understand the importance of teaming with other professionals as needed and know where to access resources for families.

5. The proposed state licensing board should be comprised of behavior analysts, but also include other professionals with ABA experience such as an LMHCs, PhDs and PsyDs. There should also be some positions for members of the public. (The Arizona Board of Psychologist Examiners, which regulates their BCBA's, includes three members of the public who do not have a substantial business interest in the industry.)

Thank you for your consideration of this issue and for allowing us to provide input into the process.

Diana Stadden, Policy and Advocacy Coordinator, The Arc of Washington State

I am writing you concerning Bill H-4577.1/14 regarding licensure for behavior analysts. The sunrise review is scheduled for August 12, 2014. My understanding is that the recommendations resulting from the sunrise review will be considered by the legislators when making their decision on the law. I am autistic and have two autistic sons who participate in applied behavioral analysis (ABA), so my input is particularly relevant to this process.

While I agree wholeheartedly that board certified behavior analysts (BCBAs) should be regulated by the state, or other independent organization, I have several concerns about current requirements and practices that are not addressed in this bill.

My first concern is that insurance companies have already begun to require ABA program managers hold a BCBA certification. On the surface, that seems like a good idea because you certainly want ABA providers to be qualified. However, it fails to take into consideration the fact that there are other routes to becoming competent in devising and administering ABA programs than the BCBA program. ABA is essentially cognitive behavioral therapy (CBT), yet a licensed mental health counselor (LMHC) or PsyD with experience treating autistic people with CBT can no longer provide ABA under most insurance plans in the state of Washington unless they go back to school for a year or more to meet the specific coursework qualifications and internship just to sit for the BCBA certification exam.

I would argue that an LMHC or PsyD experienced in CBT is actually more qualified to provide ABA because he/she will have been trained to take the emotional needs of the client into account. Anxiety and depression are prevalent in the autistic community and often need to be considered when administering ABA programs. Not that BCBAs couldn't recognize anxiety or depression, but they are not trained to address them in the programs they write, which often means progress will halt or, worse, they may push too hard and exacerbate the emotional state of the client, which can have long-term deleterious effects.

For example, our eight-year-old has had great difficulty with toileting. When he was six, his BCBA designed a potty party for him. She knew he was generally anxious and had a tendency to focus that anxiety in specific areas. Toileting had not been part of his ABA program up to that point, but we asked for her help.

About ten minutes into the party, our son had a severe meltdown. Eventually he calmed down enough to go find a piece of paper and draw a pair of underwear with a circle around it and a line through the circle. Our BCBA recognized his anxiety and stopped the party. I think she suggested we take him to a therapist for the anxiety. There was no follow-up program for toileting and we were left on our own to cope once again.

Eight months after the potty party, a friend suggested an LMHC who might be able to address the problem. The LMHC noted his extreme anxiety around toileting and, at the mention of the potty party, our son melted down almost as much as he had done at the actual party. The LMHC determined he has PTSD and began treating him as such. Not long after, we changed management of both our sons' (we have two boys on the autism spectrum) ABA programs to her.

I am not suggesting that our BCBA did anything wrong here. She went with her training and, when she realized she couldn't address the situation, suggested we consult with an appropriate professional.

Nor am I suggesting that BCBA's cannot, or should not, provide ABA. I'm merely asserting that LMHCs and PsyDs with CBT and autism experience can as well, and have additional skills they bring to the table. That's good for families because it provides consistency among providers and continuity of services. LMHCs and PsyDs should be allowed to provide ABA under insurance without requiring a BCBA certification or be allowed to sit for the BCBA certification exam based on experience without additional coursework or internships. That is the best way to provide the most appropriate services for the widest variety of families.

There should also be a limit to the scope of services a BCBA can provide. Our original BCBA (when our boys were three and five) offered speech therapy services as part of the ABA program. One day, the "speech therapist" asked me some questions about speech therapy. She also told me she had been reading some books her son had given her to get up to speed with speech therapy. Not with current practices, with speech therapy in any context because this was her first experience providing it. She'd had no training in it at all.

I fired that BCBA after two months working with him. I am still appalled that a BCBA can charge insurance for speech therapy. An incompetent speech therapist would lose his or her license, but there seems to be no recourse against a BCBA claiming to provide speech therapy with no license at all.

We have now found a licensed speech therapist who does a wonderful job with our boys. We are also very happy with the LMHC who acts as program manager for our boys' ABA therapy. We're lucky that she is "grandfathered" in to our insurance program because she had been providing care for their clients for more than three years before the new policy of only allowing BCBA's to provide ABA program management services came into effect. If she hadn't, or if we were covered by insurance through another company that did not honor a grandfather clause, we wouldn't be able to work with her because we couldn't afford to pay her out of our own pocket.

Michelle May

I live in Seattle and I support the Sunrise Review Proposal to License Behavior Analysts in Washington State. I am a clinical psychologist treating citizens of this state. I specialize in diagnosis and treatment of autism spectrum disorders. Although I am not currently board certified in behavior analysis, I have the equivalent background and training and use an applied

behavior analysis framework in the care of my patients at Seattle Children's Autism Center. I have observed the benefits of behavior analysis directly with many of my patients. Applied Behavior Analysis (ABA) has resulted in decreased problematic behaviors within these individuals as well as acquisition of new skills necessary to function in the home, community, and school environments. In my previous position as assistant clinical professor of psychiatry at Stanford University, the majority of the children I served had intensive applied behavior analysis programs in place, as California has a long track record of funding these services. In my observation, those patients had more promising long-term outcomes as a result of receiving this therapy than those who did not have intensive behavior analytic programming. As such, I am a strong advocate for the use of ABA therapy in the treatment of children with autism spectrum disorders. In the state of Washington, very few children are currently receiving ABA therapy. This is partially because of a lack of insurance coverage; however, insurers are slowly beginning to cover this much-needed treatment. As more families begin to have coverage, it is now evident that we have a very serious shortage of board certified behavior analysts (BCBA's) in our state. Further, many of the BCBA's that are currently providing services are unable to obtain insurance contracts because their BCBA is not recognized as a license or credential in our state. Obtaining state recognition of the BCBA is crucial to decreasing this major barrier in providing services to the children and families who very much need them at this time. Licensing behavior analysts is also critical from a public safety perspective. These individuals are currently practicing in our state and new agencies are opening on a regular basis in response to the increased availability of funding through insurance. Lack of regulation of the profession of behavior analysis put the public at risk, as anyone can currently call themselves a behavior analyst and provide this service. Given that more than 9000 children with autism are currently served in our state by Medicaid alone, lack of regulation of this profession poses a major public health and safety risk that must be addressed. Licensure of behavior analysts would allow for much needed state regulation and oversight of this profession. Passing of this Sunrise Proposal will get this bill one step closer to ensuring that ABA services accessed by others will uphold high ethical and professional standards of practice so that the most benefit may be received. Thank you for your time and interest in this very important bill.

Mendy Minjarez, PhD Licensed Psychologist, Seattle Children's Autism Center

The Washington State Psychological Association (WSPA) appreciates the opportunity to provide comments about the Sunrise application by the Washington Association for Behavior Analysis (Applicant) for licensure of applied behavior analysts and assistant applied behavioral analysts and the creation of an independent disciplinary board.

Subsequent to passage of the Washington State mental health parity law in 2010 and successful lawsuits brought by families of children with autism spectrum disorders (ASD), insurers in Washington State are now providing coverage for treatment of ASD. This has resulted in a proliferation of agencies and individuals offering applied behavior analyses services, with no regulation of the activity. Behavior analysts may, if they choose, become certified by a national certification organization, the Behavior Analyst Certification Board (BACB). However, this organization has no disciplinary function. Additionally, consumers can easily misconstrue certification with state regulation. WSPA supports regulation of applied behavior analysts.

However, we have concerns about several components of the regulatory plan outlined by the Applicant.

WSPA would like to be clear that our comments here do not focus on the Applicant's arguments supporting the effectiveness of applied behavior analysis as a treatment protocol, or on the need for regulation of providers of these treatments. WSPA agrees that this evidence-based intervention for ASD is effective, and that regulation is in the best interest of the public. Our questions and concerns are:

1. Are the academic and supervised experience requirements outlined in the applicant report as required for licensure necessary and sufficient to protect the public?
2. Is an independent board of behavior analysis comprised exclusively of behavior analysts and a public member the appropriate regulatory body?

Applied behavior analysis (ABA) is an appropriate and effective treatment for ASD and is also used to treat individuals with other developmental and intellectual disabilities. ASD and other developmental and intellectual disorders are listed in the Diagnostic and Statistical Manual of Mental Disorders (Vol. 5). However, it should be clear that ABA is only one of several appropriate treatment protocols for ASD. ABA may be defined as a set of techniques by which psychologists, behavior analysts and others may successfully modify behavior, similar to the definition offered in Section (1a) of the Applicant Report.

ABA is also well established as a part of the practice of psychology. Psychologists, including Dr. Donald Baer at the University of Washington, during the 1950's and 1960's, developed behavior therapy techniques now known as applied behavior analysis. In fact, RCW 18.83.010(1), the Washington State psychology licensing statute states:

“The “practice of psychology” means the observation, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures for the purposes of preventing or eliminating symptomatic or maladaptive behavior and promoting mental and behavioral health.”

ABA involves application of the principles of learning science to a variety of areas of client functioning. BCBAs are trained in the practice of implementing behavior techniques. Typically, BCBAs who provide services to clients with ASD are working to transform clients' behaviors in their academic, social skills, language, emotional regulation, behavior, and/or daily living skills, in addition to educating and training parents and other family members in supportive techniques. Behavior analysts may work in many settings with the same client and family members, including home, school, and institutional settings. The same behavior analyst or assistant analyst may move from one setting to another with one or more clients.

Individuals diagnosed with ASD are typically diagnosed by 4 years of age and display difficulty with communication, both verbal and nonverbal, social interaction, and often engage in highly repetitive behaviors or thought patterns. In addition, many individuals also suffer from associated mental health disorders including Attention Deficit Disorder (with or without hyperactivity), Depression, Anxiety, emotional dysregulation, pica, sleep disturbances, and other physical disorders. Importantly, according to Autism Speaks, a national support and advocacy organization, approximately 40% of individuals diagnosed with ASD show average and above

average intellectual functioning. The standard of care for ASD diagnosis includes direct assessment of cognitive ability, social communication skills and a thorough developmental history by experts with specialized training in ASD, including psychologists and neuropsychologists or neurologists, developmental pediatricians, and pediatricians.

ABA providers are not, according to the curricula established by the BACB, trained in the diagnosis and treatment of mental disorders. Additionally, two of the three existing behavior analyst training programs in Washington State (and most nationwide) are housed in university schools of Education. The academic programs and faculty are excellent. However, as a psychologist colleague who has directed clinic programs staffed by behavior analysts, who supervises analysts and is an ASD program coordinator for a Washington State commercial insurer has observed, a significant number of ABAs receive their training in educational settings, not in homes, while most ABA treatments are based in client homes. This is a critically important matter because there is significantly less direct supervision and support for BCBA's in private homes than in school settings. This is especially concerning because the issues that are addressed in therapy become much more complex in home environments.

WSPA believes that the Applicant must address the question of whether ABAs are primarily trained as educators who are applying psychologically based techniques. If so, this may affect regulation and disciplinary activity. For example, how will a BCBA know if or when a client would better benefit from another approach to intervention, such as CBT? There are significant operational similarities between “behavioral interventions” used by ABA providers including teaching social and emotional regulation skills and psychological interventions such as systematic desensitization, exposure with response prevention, and PCIT (parent-child interaction therapy). BCBA's – indeed all providers - must be clear about when a referral to another type of provider and another type of therapy is in order.

WSPA has noticed in the Applicant report that, in addition to Board Certified Behavior Analysts and Assistant Analysts, behavior technicians and others who implement behavior analytic interventions (Section 9) are referred to as well. Technicians are defined in the draft legislation as “paraprofessionals who implement a behavior analysis treatment plan under close ongoing supervision,” by a BCBA or Assistant BCBA. There is no reference in the draft bill as to who the others might be. The draft legislation does not include any regulation of technicians. This is insufficient. It is essential that families know the specific qualifications of technicians and others. Do technicians work in homes with vulnerable clients without direct supervision? These are all important questions that must be addressed in the process of regulating behavior analysts.

The Applicant has listed 18 States that have established regulatory requirements for ABA providers. While the majority use the BACB certification requirements as state licensure or certification requirements, the regulatory agencies involved vary widely. Of the 18, only 3 or 4 (lack of clarity as to the definition of the agency) have created independent ABA boards. Currently, 4 are housed within their state's equivalent of the Washington State DSHS, 2 are housed within their state's Department of Health (DOH), 2 are housed within their state's medical disciplinary board, 1 is housed within its state Board of Education, and 6 or 7 are housed within their state's Board of Psychology.

As we mentioned at the beginning of this letter, WSPA agrees that applied behavior analysis techniques are appropriate ASD treatment approaches, and we support regulation of ABA providers. However, we also believe that the Applicant report does not adequately and effectively address the supervisory and regulatory concerns we have elaborated herein. As a result, WSPA's recommends the following changes to the application.

Recommendations:

1. WSPA recommends that the licensing and disciplinary activity for ABA providers be housed within the Examining Board of Psychology, in the DOH, but with a board comprised of both ABA providers and appropriately trained psychologists. We have presented cogent arguments that ABA is a set of behavioral techniques firmly rooted within the discipline of psychology. We are concerned that the Applicant has not clearly defined the scope of practice of BCBAs, even though Section 1(6)(b) of the draft legislation attempts to do so in part by defining what it is not. Section 1(6)(a) enumerates a number of specific techniques that would be utilized by BCBAs, but does not clearly define when the use of these techniques becomes an activity that is not ABA. WSPA believes that both ABA providers and psychologists together will best determine when conduct by ABA providers moves beyond ABA and becomes unprofessional.
2. WSPA urges the DOH to require more precise supervision requirements for BCBAs practicing in client homes in addition to supervision in school settings. As the Applicant describes, ABAs will be required to "work with individuals who engage in severe problem behavior such as aggression, property destruction and self-injury" (Section 1 c.i.). The State must be clear as to the qualifications of those providing supervision, the frequency of supervision, and specific safety procedures when intervention is occurring in homes.
3. While the term "behavior technician" is defined in the draft legislation this category of provider is not regulated in any way by the legislation. Appropriate education, supervised experience and supervision requirements must be established. If technicians do not have a bachelor's degree with adequate supervised experience, we urge the DOH to require that an attending Applied Behavior Analyst or senior level Assistant analyst supervise them in person in all home settings.
4. WSPA urges that all types of ABA providers be required in statute to pass a state law exam, similar to the state law exam now required of applicants for the psychology and other counselor licenses.

A representative for WSPA will attend the Sunrise Applicant hearing scheduled for August 12, 2014. We will be happy to respond to questions at that time, or in advance by contacting our Director of Professional Affairs, Dr. Lucy Homans at lucy.homans@gmail.com. Thank you very much.

Maile M. Bay, JD, PsyD, MCSP, President
Washington State Psychological Association

Behavior Analyst Sunrise
Written Comments Received After Hearing
August 22, 2014

The Washington Occupational Therapy Association appreciates the opportunity to reiterate and add to our comments on the pending sunrise review on the proposal to license Behavior Analysts. We have considered the DOH panel question about whether we would support a title protection approach to recognizing a behavior analyst credential. We like this approach, and think it is consistent with our concern that patients in need of ABA services should have care referred by a licensed healthcare professional with a whole-patient perspective.

We believe title protection would help assure consumers and insurance carriers that the behavior analyst had achieved a specific level of training, and help protect against misrepresentation, without creating a new (and possibly vague and unenforceable) scope of practice, licensing board, and regulatory structure. Title protection might be a sensible first step to allow ABA practitioners to gain more experience practicing in the new insurance environment and determine on the basis of this experience whether licensing eventually makes sense or not.

Kate White Tudor, JD, Advocacy – Strategy – Policy



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August 22, 2014

VIA CERTIFIED MAIL – RETURN
RECEIPT REQUESTED TO:

VIA EMAIL TO:

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Reviews - Health Systems Quality Assurance
P.O. Box 47850
Olympia, WA 98504-7850

sunrise@doh.wa.gov

RE: Licensure of Behavior Analysts

Dear Ms. Thomas,

As President and Chief Executive Officer of West Coast Behavioral Consultants, Inc., I am writing this letter to document our company's support for creating a license for professional behavior analysts as described in the bill request number H-4577.1/14.

West Coast Behavioral Consultants is a Seattle-based behavioral health agency that serves three distinct clients: corporations, individuals, and families. Our two divisions, Optimal and Blueprints, employ approximately 26 clinical staff members, including one doctoral level Board Certified Behavior Analyst (BCBA-D), 5 Masters' level Board Certified Behavior Analysts (BCBA), and 13 Behavior Technicians. The company's clinical division, Blueprints, provides behavioral consultative services to families struggling with defiant, oppositional children/adolescents that are at risk of out-of-home placement, as well as adults suffering from severe personal difficulties. Blueprints currently serves nearly 30 families with children throughout Washington.

Our Community Outreach Liaison, Paul Rogers M.A., BCBA currently represents West Coast Behavioral Consultants on the Washington Association for Behavior Analysis (WABA) Legislative Committee. Mr. Rogers attended the Sunrise Review hearing on August 12, 2014 to speak in support of licensure for behavior analysts. Although our company has expressed its position on this matter both through written testimony and here in written comment, we want to ensure the Sunrise Review Board understands that our support for creating a licensed profession for behavior analysts is completely dependent on the following specific conditions.

First, it is imperative that behavior analysts have their own specific licensure board, rather than be placed under the authority of another discipline's board. While some concepts exist within other disciplines,

behavior analysis differs in fundamental ways. Behavior analysis is a natural-science approach to understanding and remedying the behavior of individuals. Similar to other natural sciences, behavior analysis has experimental and applied research domains i.e., The Experimental Analysis of Behavior (EAB) and Applied Behavior Analysis (ABA). Although the setting and phenomena under study may differ between these two domains, the principal activity of EAB and ABA is to carry out research that “(a) discovers and disseminates new knowledge or (b) integrates and disseminates existing knowledge.”¹

Moreover, behavior analysis also has third domain – service delivery, where the principle activity is to design and implement interventions that “develops, advances, and maintains socially desirable behavior–environment interactions or that reduces socially undesirable or otherwise dysfunctional behavior environment interactions.”² Although the licensure under question in this sunrise review is only concerned with the qualifications and activity of providers in this third domain, that does not negate the existence of the other two domains, nor does it negate the fact that behavior analysis is a distinct discipline. Since every Department of Health (DOH) board focuses on actual practice of a health care profession, and the actual practice of behavior analysis differs fundamentally from the practice of other social sciences (such as psychology), DOH should have a board specifically for behavior analysis.

In our capacity as a behavioral health agency, we are responsible for designing, and implementing individualized behavioral intervention programs that help individuals establish greater pro-social, adaptive, self-control skills and reduce the occurrence of challenging behavior. In addition, we are responsible for educating parents/teachers/caregivers about behavior analytic principles, procedures, and tactics, and coaching them to implement antecedent & consequent strategies, shaping, and contingency management. Our credentialed professional behavior analytic practitioners are able to design effective programs and successfully train parents, caregivers, and therapy assistants (i.e., paraprofessionals) to implement said programs due to the expertise acquired through graduate training in behavior analysis and ongoing continued education approved by the Behavior Analyst Certification Board (BACB). And, since behavior analysis is a distinct discipline, it is crucial that only professionals with specific education, training, experience and expertise in behavior analysis oversee the practice of behavior analysis within the State of Washington -- not professionals from another health care profession. The proposal under consideration ensures that this requirement is met. That element must not be lost.

Second, any legislation that creates licensure for professional behavior analysts must include a credential for therapy assistants, also known as Registered Behavior Technicians (RBTs) (i.e., the “paraprofessional” practitioners that implement the behavioral programs designed by the professional behavior analysts). We refer to these individuals here as “technicians,” to avoid confusion and differentiate them from Board Certified Assistant Behavior Analysts (BCaBAs), who would be licensed under the proposed legislation. It is important that the legislation be revised to require technicians to be licensed in behavioral health, in part, because many individuals in Washington State rely on funding from the State and/or Federal governments to cover the costs of behavioral consultation and therapy, and these

^{1 2} Moore, J. & Cooper, J. O. (2003). Some proposed relations among the domains of behavior analysis. *The Behavior Analyst*, 1, 74-76.



funding sources require that all practitioners, including technicians, delivering behavior analysis services maintain a designated credential issued by the state. Additionally, health insurers are adding coverage for behavioral consultation and therapy; historically private payers have only covered the costs of services provided by licensed providers.

Currently, since no specific licensure exists for behavior analysts in Washington State, all our providers maintain one of the eight counseling credentials that were established in 2010. If a license is created for professional behavior analysts (i.e., those who hold a BCBA) and assistant behavior analysts (i.e., those who hold a BCaBA), a corresponding credential must also be created for technicians because the proposed assistant behavior analyst license will not capture everyone who needs an ABA-related license/credential. If a credential is not created specially for the technicians, a situation will arise where “paraprofessionals” implementing the behavioral services will be credentialed in one discipline (e.g., counseling), while the professionals supervising the behavioral services, and training the paraprofessionals will be credentialed in another discipline (e.g., behavior analysis). Therefore, requiring behavior analysis-specific licensure for technicians who provide behavior analysis services under the supervision of a BCBA is essential to ensure the provision of quality services, and must be included in any legislation.

Please contact me if you have any questions.

Thank you,



Shane Isley
CEO / President



Appendix E

Other States

Other States
Behavior Analysis Laws and Coverage

State	Regulates Providers	National BACB Cert. Required	Insurance Mandate	Regulatory Body	Notes
Alabama	Yes	Yes		Behavior Analyst Licensing Board Department of Mental Health, Division of Developmental Disabilities	New board. Applications due June, 2014. Developed within the Division of Developmental Disabilities. Authorizing legislation SB 13 (2014) . The scope of practice in SB 13 is very similar to the proposal in Washington.
Alaska	Yes	Yes		Department of Commerce, Community, and Economic Development	HB 361 (2013-2014 legislature)
Arizona	Yes	Yes	Yes	Arizona Board of Psychologist Examiners Arizona Board of Psychologist Examiners	Authorizing legislation SB 1087 (2010) . Behavior analyst must have a graduate degree, coursework and practice requirements. After August 2012, requirements waived with BACB certification.
Arkansas		Yes	Yes		Defines ABA, including providers, in insurance mandate. Same definition as in WA proposal. HB 1315 (2011)
California		Yes	Yes		SB 946 (2011)
Colorado		Recognized	Yes		SB 09-244 (2009)
Connecticut		Yes	Yes	Title Protection and insurance mandate Behavior Analyst Certification Board	Title protection SB 799 (2011) Scope of practice Public Act No. 09-115 Autism Insurance law covers aba definitions and behavioral therapy definitions and applications. Public Act No. 09-115. SSB 301 (2009) During 2014 session speech language pathologists pursued legislation to expand their scope to include ABA.
Delaware		Yes	Yes		SB 22 (2012) Defines applied behavior analysis and providers
Florida		Recognized	Yes		Recognizes BACB certification.

State	Regulates Providers	National BACB Cert. Required	Insurance Mandate	Regulatory Body	Notes
					Florida Statutes §627.6686
Illinois			Yes		Illinois Compiled Statutes Ch. 215, § 5
Indiana		Yes	Yes	Insurance mandate and title protection	Title protection House Enrolled act 1288 (2008) Insurance mandate IC 27-8-14.2
Kansas	Yes	Yes	Yes	Kansas Behavioral Sciences Regulatory Board	Licensure and insurance mandate HB 2744 (2013)
Kentucky	Yes	Yes	Yes	Applied Behavior Analyst Licensing Board	Applied behavior statutes KRS 319C Title protection. Requires BACB certification.
Louisiana	Yes	Yes		Louisiana Behavioral Analyst Board	Requires master's degree and certification from a national behavioral analysis certifying body. More detailed statute than most states. Only mentions BACB organization generally, requiring passage of text from national agency. .SB 134. Act No. 351 (Regular session, 2013)
Maine			Yes		Insurance mandate Title 24-A, sections 2847-Q and 4257
Maryland		Yes		Behavior Analyst Advisory Committee State Board of Professional Counselors and Therapists	CH 0328 (2014)
Massachusetts	Yes	Yes (according to BACB)		Allied Mental Health and Human Service Professionals – Consumer Affairs and Business Regulation	H4555 , licensing as an applied behavior analyst requires doctoral degree from recognized institution with 60 graduate credit hours in ABA or master's degree with 30 grad credit hours in ABA. Successful completion of practicum. Requires board approved exam. Recognizes BACB for licensure.
Michigan		Yes	Yes		Insurance mandate SB 414 (2012)
Missouri	Yes	Yes		Missouri Behavior Analyst Advisory Board Under the Committee of psychologists within the Division of Professional	Licensure with scope of practice under HB 1311 and 1341 (2010)

State	Regulates Providers	National BACB Cert. Required	Insurance Mandate	Regulatory Body	Notes
				Regulation	
Montana		Yes	Yes		Insurance mandate SB 0234 (2009)
Nevada		Yes	Yes		Insurance mandate Chapter 331, AB 162 (2009)
New Hampshire		Yes	Yes		Insurance mandate HB 569 (2010)
New Jersey			Yes		Insurance mandate P.L. 2009, Chapter 115
New Mexico			Yes		Insurance mandate SB 0039
New York	Yes			State Board for Behavior Analysis New York State Education Department, Office of the Professions	Licensure under A06963B (2013-2014 session) – only pertains to autism treatment
North Dakota	Yes	No		State board of psychologist examiners	At time of passage of bill, only two BACB certified analysts in state. Not enough for separate licensing process. ABA License is on same form as psychologist license.
Ohio	Yes	Yes		Ohio State Board of Psychology	Certification by board of psychology HB 59
Oklahoma	Yes	Yes		Department of Human Services	In addition to initial test and BACB certification, must remain in active BACB status. Statute
Oregon	Yes	Yes		Oregon Health Licensing Agency/Behavior Analysis Board	SB 365 Licenses Behavior analysts, assistant behavior analysts and requires registration of licensed health care professionals practicing applied behavioral analysis and behavior analysis interventionists (technicians in WA draft bill) Requires BACB certification.
Pennsylvania	Yes	No	Yes	Pennsylvania Department of State	Licensing is in insurance mandate. Law required licensing of analysts. Law is modeled after BACB requirements for analysts but not tied to BACB in any way. HB 1150 (2007)
Rhode Island	Yes	No		Licensing board of applied behavior analysts within RI dept. of health	S 2559 Substitute B 2012 Requires national test, certification, active status.
South Carolina			Yes		Insurance mandate S.20 (2007-2008 session)
Tennessee	Yes	Yes		Applied Behavior Analyst Licensing committee of the	Licensing required SB 1047

State	Regulates Providers	National BACB Cert. Required	Insurance Mandate	Regulatory Body	Notes
				Board of Examiners in Psychology	
Texas			Yes		Insurance mandate SB 1484 (2013)
Vermont		Yes	Yes		Insurance mandate Act 158
Virginia		Yes	Yes	Board of Medicine	Requires certification by BACB or any entity that is nationally accredited to certify practitioners of behavior analysts. (HB 1106 (2012))
West Virginia		Yes		BACB	BACB handles all aspects of oversight
Wisconsin	Yes	Yes	Yes	Department of Safety and professional regulation	Licensure requires certification from Behavior Analyst Certification Board (BACB). Authorizing legislation SB 667 (2009)

Appendix F

Rebuttals

Behavior Analyst Sunrise
Rebuttals and Comments on Draft Report
October 7, 2014

Thank you for sharing this information. I think you are on the right track.

Andrew D. Whitmont, PhD, WA State Lic. Clinical Psychologist

I strongly agree with the department's recommendation to treat behavioral analysis as a new profession if that new profession is regulated to the same standard as that of "Psychologist".

Observing, analyzing, understanding, and attempting to change behavior is not a new profession. It is exactly what the already regulated professions commonly known as psychology, counseling, psychotherapy, psychiatry, and the like purport to do. Focusing on a narrow definition and application of what these acknowledged and regulated professions already do does not avoid the need to regulate what may be referred to as a new profession. Any claim that a third/paid party is only analyzing behavior avoids recognizing the need for training and the ability to hold these people accountable on behalf of the public as we do with those other professions. It would be unconscionable for the department to fail to regulate people attempting to change human behavior that is only presumed to be maladaptive by special interest groups such as homosexuality.

Assuming that some or most of the people who might be viewed as needing behavioral analysis and behavioral change are likely to be children, their interests will not be well protected by a sub-group of lesser prepared and unregulated specialists.

Curtis Thompson

I've reviewed your recent report and applaud you on your reasoned review and proposed fixes to the flawed proposal submitted by the Washington Assoc. for Behavior Analysis. I have been a licensed psychologist for 20 years in Washington state, but I have been trained in and have been using ABA therapies for a wide-range of human behavioral disorders for 40 years. My training came from the founders of the ABA field, and their students. I have taught ABA at the University level, and frequently guest-lecture for the UW program training graduate level behavior analysts. I have published clinical research on effective ABA-based treatment of children with autism and have co-authored a best-selling treatment manual in this clinical area. Yet, as Licensed Psychologist, felt no need to become board-certified in ABA by the BACB in order to continue my clinical practice. To do so now would cost me several thousand dollars and require taking additional graduate training to meet the new BACB requirements, though not improve my current expertise.

I support your efforts to set up a state credential for those who practice ABA, but don't qualify for other credentials DOH grants, like the Psychology License or a Speech Language therapy license (many SLP's are trained in and use ABA in their practice with persons with disabilities as you note). But, I am concerned that a restraint of trade situation could develop wherein Psychologists with expertise in ABA are not allowed to say they do Behavior Analysis due to the proposed rules. I think that you have covered my concern in your proposed revisions, so I am either writing to support that revision to WABA's proposal, or to advocate for insuring the final rules do not prohibit myself or other psychologists from stating and/or advertising our expertise in Behavior Analysis. Behavior Analysis is a broad ranging field as you note in your Sunrise Review, not just for children with autism. Therefore please insure that the final rule allows for your proposed revision in Sec. 3, below, and that Psychologists whose scope of expertise includes ABA are not restricted from stating that expertise in our practice and public statements.

Sec. 3 Nothing in this chapter may be construed to prohibit or restrict:

(1) An individual who holds a credential issued by this state, other than as a licensed behavior analyst or a licensed assistant behavior analyst, to engage in the practice of that occupation or profession without obtaining an additional credential from the state, so long as the practice is within that profession's or occupation's scope of practice and the individual's scope of training and competence.

Gene McConnachie, Ph.D.

We appreciate this opportunity to respond to the draft review of the sunrise application submitted by our Affiliate organization, the Washington Association for Behavior Analysis (WABA). By way of background, the Association of Professional Behavior Analysts (APBA) is a nonprofit membership organization whose mission is to promote and advance the science and practice of applied behavior analysis (ABA). One way the organization fulfills its mission is by working on public policies that affect the practice of ABA. To that end, we have been involved in adoption and implementation of many state and federal laws and regulations governing health insurance coverage of ABA services, and many of the laws that require a state-issued license or other credential to practice ABA professionally.

General Comments

APBA applauds and concurs with the following aspects of the draft report:

- The finding that the application meets sunrise review criteria;
- The recognition that the practice of ABA is a distinct profession (p. 13);
- The reiteration of the Department's 2009 finding that the Behavior Analyst Certification Board's (BACB) standards ensure adequate training for professional practitioners of ABA (p. 10);
- The recommendation for licensure of behavior analysts and assistant behavior analysts. We agree that adding some form of regulation of behavior technicians could be considered and offer a suggestion below;
- The recommendation that national (i.e., BACB) certification be incorporated in the licensure statute, but as the principal requirement for licensure rather than "in lieu of some of the requirements" (p. 19).

We respectfully disagree with

- The authors' definition and characterizations of ABA;
- Some of the information about regulation of ABA practitioners in other states;
- Statements that the proposed behavior analyst licensure bill would limit the practice of other licensed professionals who have ABA in their profession's scope of practice and the scope of their individual training and competence;
- Suggested changes in the definition of the practice of ABA and the scope of practice in the proposed licensure bill;
- The recommendations that the legislature consider title protection only and/or regulation of licensees by the Secretary of the Department and an "advisory committee" rather than a behavior analyst licensing board.

Responses to the detailed recommendations in the draft report are provided next, followed by suggestions for other revisions.

Rebuttals to Detailed Recommendations to the Legislature (pp. 17- 19)

Recommendation 1. We understand that some parties expressed concerns about the definition of the practice of behavior analysis in Sections 1(6) and 2(1) of the proposed licensure bill. With all due respect, the suggested revisions to those sections on p. 17 would render the definition inaccurate and considerably less, rather than more, clear. For instance, it is not the case that "the practice of applied behavior analysis is a defined discipline..." nor that it is merely a "systematic approach to design[ing] and employ[ing] interventions for challenging behavior" (see suggested revision to Section 1(6)(a), p. 17). Rather, as indicated in the sunrise application, ABA is one branch of the scientific discipline of behavior analysis, and the contemporary practice of ABA involves much, much more than interventions for "challenging" behavior. It is the case, however, that the practice of ABA is a distinct, defined profession (as opposed to a "discipline"), as noted on p. 13 of the draft report.

The suggested additions to Sections 1(6)(b) and 2(1) of the proposed bill are confusing. The term "behavioral" is often used in reference to techniques and approaches that are not at all behavior analytic; however, to the extent that the term may be understood as encompassing behavior analytic techniques, the statement that the "utilization of behavioral techniques...does not constitute the practice of applied behavior analysis" is contradictory. We understand that the Department wants to make it clear that members of some other professions may use some behavior analytic techniques without being licensed as behavior analysts, but we respectfully suggest that is better done elsewhere in the licensure bill (see below).

We strongly recommend leaving the definition of the practice of behavior analysis as it is written in the proposed licensure bill, with the addition of "applied" before "behavior analysis" but no other revisions, for the following reasons:

- It is our understanding that the definitions of practices that appear in most licensure bills/laws come from the professions themselves. The definitions in the proposed bill to license behavior analysts in Washington were drawn from the BACB's model act for licensing behavior analysts, which was written and refined by behavior analysts with extensive knowledge and experience in the professional

practice of ABA. Those definitions describe that practice more accurately and clearly than does the recommended revised version that appears in the draft report.

- The authors of the draft report noted the need for Washington to build its capacity for providing professional ABA services to its citizens. To meet that need, it will be helpful if individuals who relocate to Washington from other states where they are licensed as behavior analysts and assistant behavior analysts can obtain licenses to practice in Washington with relative ease. That can be achieved by making the definition of the practice of ABA and the requirements in the Washington behavior analyst licensure law parallel those components of behavior analyst licensure laws adopted by other states. The definition of the practice of ABA in the proposed licensure bill is substantially similar to the definitions in many, if not most, of the other state licensure laws that reflect the input of knowledgeable professional behavior analysts.
- In response to comments that the scope of practice in the proposed licensure bill is broad and overlaps the scopes of practice of some other professions to some extent, we respectfully submit that those comments also apply to the scopes of practice of several other professions that are licensed by the State of Washington (e.g., psychologists - RCW 18.83.010; counselors -- WAC 246-810-010). Therefore they should not be seen as flaws in the proposed behavior analyst licensure bill.
- The comments that the scope of practice definition in the proposed licensure bill needs to be more specific are puzzling, because our observation is that the scope of practice sections of most licensure laws tend to be succinct and nonspecific. They do not typically include detailed operational definitions of every procedure or technique the licensed professionals may use, or specific parameters of practice. That is illustrated by the scope of practice section of the Washington licensure law for psychologists, which does not include specific definitions of such terms as “psychological measurement, assessment, and evaluation,” “counseling and guidance,” “psychotherapeutic techniques,” “remediation” and “consultation.” Examples of nonspecific, undefined terms in the counselors licensure law include “hypnotherapy” and “therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential.”

Licensees, licensing boards, and consumers are typically aided in distinguishing among professions and determining if an individual is practicing outside of his/her scope of practice by such tools as the requirements for obtaining the license, the profession’s code of ethics and practice standards, the conduct standards in the licensure law and/or regulations, and each individual’s documented education and training. In the case of behavior analyst licensure laws that make BACB certification the principal requirement for licensure, the scope of practice of licensed behavior analysts and licensed assistant behavior analysts is detailed in the BACB’s Task List (included in the sunrise application and Appendix A of the draft report). The Task List also comprises the knowledge, skills, and abilities required to practice ABA professionally and the content of the national professional examinations in ABA (i.e., the BACB’s certification exams). It clearly differentiates the practice of ABA from other professions. The Task List has been developed and updated via several job analysis studies involving thousands of professional behavior analysts that have been conducted over the past 15 years. Professionals who have met the BACB’s degree, coursework, and supervised training eligibility requirements and have demonstrated competence in ABA by passing a BACB examination thus should be well-equipped to evaluate allegations about individuals practicing ABA without a license and licensees practicing outside of their scope of practice – a strong argument for making BACB certification the principal requirement for licensure to practice ABA in Washington, and for establishing a state licensing board made up mostly of licensed behavior analysts and licensed assistant behavior analysts.

We strongly recommend leaving Section 3(1) – the exemption for other appropriately credentialed professionals – as written in the proposed bill, including the phrase “and the individual’s scope of training and competence.” There are widespread misconceptions that ABA consists of nothing more than some techniques for changing “negative” behaviors in children with autism and related disorders, and that all that is required to practice ABA is to take a few courses or workshops on the “theory of behaviorism” or “behavior modification” (an outmoded and misleading term, in our view). It is therefore essential for the licensure bill to make it clear that professionals who hold other credentials should practice ABA only if they have had formal and experiential training required to produce the competencies required for that practice (i.e., those delineated in the BACB Task List).

If it is deemed necessary to address concerns about professionals who are not credentialed in behavior analysts using some ABA techniques, we recommend adding to the end of Section 3(1) “Such individuals may use ABA techniques on which they are competent under the auspices of their professional credentials.”

It is important to note that this and other exemptions in the proposed bill parallel exemptions in several existing behavior analyst licensure laws and do not unduly restrict the activities of those who fall in the exempt categories any more than exemptions in the licensure laws of other professions in Washington.

Alternative to Recommendation 1. We very strongly recommend deleting mentions of the alternative of title protection only from the report. As the authors note on p. 18, that alternative would allow anyone to practice ABA in Washington. It would provide consumers with no protection whatsoever from individuals who have not had the training that the Department has recognized since 2009 as appropriate for practicing ABA (i.e., BACB certification), and no recourse if they or their family members were harmed by such individuals. In short, this alternative would result in little or no functional change from the status quo in Washington, which the Department acknowledges is unacceptable.

Recommendation 2. We understand the rationale for adding a state credential for behavior technicians to the licensure bill, but would point out that doing so will add substantially to the work of the state entity that issues credentials and regulates the practice of ABA, because there are likely to be large numbers of technicians. It is also likely to increase the cost of providing ABA services, which will be passed on to consumers.

Instead of a state-issued credential, we strongly recommend adding a requirement that all technicians who work under the supervision of licensed behavior analysts and licensed assistant behavior analysts hold the BACB’s Registered Behavior Technician™ (RBT™) credential, for the following reasons:

- The standards for obtaining and maintaining the credential have been established via the aforementioned job analysis process. They include minimum age and education requirements, successful completion of a criminal background check, completion of a training program conducted by a BACB certificant and based on the BACB’s RBT™ Task List, and passing a competency-based assessment administered by a BACB certificant annually (see <http://www.bacb.com/index.php?page=101118>).
- Practice parameters for RBTs™ have also been established. They include practicing under the close supervision of a BACB certificant. Both the supervisors and the RBTs™ must comply with BACB

supervision standards. Among other things, those standards make supervising behavior analysts responsible for the actions of the RBTs™ they supervise.

- The BACB regulates the practice of RBTs™ by requiring them to abide by the supervision standards just described as well as a subset of the BACB’s Guidelines for Responsible Conduct. That, coupled with state regulation of the supervising Licensed Behavior Analysts and Licensed Assistant Behavior Analysts, would assure adequate and cost-effective regulation of technicians in Washington.

If this requirement is added to the licensure bill, we recommend including a “sunset” date that allows sufficient time for technicians to obtain the RBT™ credential.

Recommendation 3. We strongly recommend adding the following provisions to the proposed licensure bill:

- “Licensed Assistant Behavior Analysts shall be supervised by Licensed Behavior Analysts in accordance with the supervision standards of the Behavior Analyst Certification Board.”
- “Registered Behavior Technicians™ shall be supervised by Licensed Behavior Analysts or Licensed Assistant Behavior Analysts in accordance with the supervision standards of the Behavior Analyst Certification Board.”

If the requirements for licensure are current BACB certifications, as we recommend, then all state licensees will be required to comply with the BACB’s supervision standards. Since those standards are likely to increase periodically, simply referencing them in the statute and/or regulations (as opposed to listing the current supervision standards) will ensure that holders of Washington credentials always meet the national supervision standards, and will save amending the Washington licensure law and/or regulations every time the BACB supervision standards change.

Recommendation 4. We very strongly urge the Department to replace this recommendation with a recommendation to establish a behavior analyst licensing board as per the proposed bill, for the following reasons:

- Given (a) the Department’s recognition that the practice of ABA is a distinct profession; (b) the results of multiple job analysis studies that have identified the distinct competencies and training required to practice ABA; and (c) the fact that the practice of other licensed professionals in Washington is regulated primarily by members of those professions rather than people who do not have training in those professions, it follows that the practice of ABA in Washington should be regulated primarily by professional behavior analysts.
- Regulation of ABA practitioners by a licensing board comprising Licensed Behavior Analysts, Licensed Assistant Behavior Analysts, and a public member will parallel regulation of other licensed professionals and will better achieve the goals of protecting consumers, payers, and the state than regulation by non-behavior analysts.
- If BACB certification is the main requirement for licensure in Washington,
 - The cost of operating the behavior analyst licensing board will be substantially lower than that of many licensing boards because all applicants for licensure will already have had their degrees, coursework, and experiential training verified by the BACB and will have passed the national examination in ABA. The BACB has developed efficient procedures for providing such verifications to state licensing boards.
 - Washington consumers will have an extra layer of protection in the form of BACB oversight of licensees, at no additional cost to them or to the state. The BACB also has procedures for coordinating with state licensing boards on disciplinary matters.

Recommendation 5. We very strongly urge the Department to delete the recommendation to list the current BACB certification requirements in the licensure requirements sections of the proposed bill and to recommend instead that those sections specify that current certification by the BACB is required to obtain

and renew licenses for Licensed Behavior Analysts and Licensed Assistant Behavior Analysts. As noted in the application, the BACB conducts job analysis studies and revises its eligibility requirements, examination content, and standards every few years. Since its inception the BACB has steadily increased its requirements. Making current BACB certification the requirement for licensure in Washington will ensure that licensees meet national standards (including complying with continuing education and ethical and disciplinary standards set by the profession) without necessitating amendments to the licensure bill every time BACB eligibility requirements or standards change.

Other Recommended Revisions to the Draft Report

- Please replace the definition of ABA that appears near the top of p. 3 and near the bottom of p. 6 with the following: “Behavior analysis is a natural science whose subject matter is behavior interacting with environmental events. Applied behavior analysis is the branch of that discipline that uses procedures derived from the principles of behavior analysis to produce meaningful improvements in socially significant behaviors.”
- Please change the second sentence in the first paragraph on p. 3 and the third sentence in the last paragraph on p. 6 to “ABA is much more than a therapy or treatment; however, ABA interventions have proved effective for improving the health and functioning of people with various disorders and conditions and people without diagnoses.”
- Better sources of information about ABA than the ones cited in footnotes include

Baer, D.M, Wolf, M.M, & Risley, T. (1968). Current dimensions of applied behavior analysis. *Journal of Applied Behavior Analysis*, 1, 91-97.

Cooper, J. O., Heron, T.E., & Heward, W.L. (2014). *Applied behavior analysis*. Columbus: Merrill Publishing.

Johnston, J.M., & Pennypacker, H.S. (2009). *Strategies and tactics of behavioral research* (3rd ed.). New York: Routledge.

- Section headed “Behavior Analyst Education and Training” (p. 10):
 - Please change the second sentence of the first paragraph to “These courses are offered in variety of academic departments and cover a range of topics in behavior analysis and its applications.” (It’s not the case that all university ABA courses or programs are in psychology or education departments, nor that the only content they cover is applications to “special education students or parents seeking mental health and other licensed providers for children with serious behavioral challenges.”)
 - Please change the second paragraph to “In addition, many colleges and universities offer course sequences that meet the coursework eligibility requirement for the national examinations administered by the Behavior Analyst Certification Board (BACB). Individuals who successfully complete that coursework as well as the degrees and supervised experiential training specified by the BACB may sit for the BACB exam for Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA) certification. In Washington State, the University of Washington and Gonzaga University offer coursework approved by the BACB within their schools of education Central Washington University’s courses, which await BACB approval, are offered by its psychology department.” (There are several eligibility requirements for the BACB’s exams besides coursework, and the BACB does not approve or accredit programs of study; it approves sequences of courses that fulfill its coursework eligibility requirements).

- Section headed “National Voluntary Certification” (p. 11):
 - Please change the first sentence to “The Behavior Analyst Certification Board, Inc. (BACB) has developed standards for approving coursework and experiential training to meet its certification examination eligibility requirements; professional examinations in ABA; continuing education requirements for maintaining its certifications; standards for approving continuing education providers; ethical guidelines; disciplinary standards; supervision standards; and an online registry of holders of its credentials.”

- Section headed “Other States” (pp. 12-13):
 - Please change the second bulleted item to “Recognition of BACB certificants as qualified providers of ABA services under autism insurance laws” (It’s not the case that those laws “limit eligible reimbursements for ASD treatments to nationally certified providers.” Several other appropriately credentialed professionals are also eligible for reimbursement under those laws.)
 - Please change the first full paragraph on p. 13 to “The North Dakota licensure law makes BACB certification one means of qualifying for licensure as an applied behavior analyst. Pennsylvania licenses “behavior specialists,” not behavior analysts. Neither training in ABA nor BACB certification is required for that license.”

If I can answer any questions or provide additional information, please don’t hesitate to contact me.

Gina Green, PhD, BCBA-D, Executive Director

WABA Sunrise Review Rebuttal

The Washington Association for Behavior Analysis (WABA) would, once again, like to thank the Department of Health for providing us the opportunity to contribute our input to the department's final report on the Sunrise Review of Licensure for Behavior Analysts in Washington State. The draft report made available to the public on 9/26/14 is very encouraging, and we are pleased that the Department of Health supports licensure of behavior analysts. The Department's draft report set forth five detailed recommendations to the legislature for changes, additions, and deletions to the proposed licensure bill. Our comments below represent WABA's position and suggested revisions to those recommendations.

The report indicated that the committee and some professions that provided commentary on the application and draft bill are concerned that the definition and scope of applied behavior analysis is so broad that "it encompasses myriad daily human interactions, and does not clearly distinguish ABA from behavioral tools that fall under other professions' scopes of practice or practices." As noted by multiple parties during the sunrise review hearing, ABA interventions in fact are proven to be effective for improving human behavior in many arenas, not just autism treatment or reducing "challenging behaviors." That is, the scope of practice of ABA is rather broad, but no more so than the scopes of practice of several other professions licensed by the Department. The defined scope of practice in the proposed bill is similar to the scope of practice sections of existing licensure laws for other professions in its level of detail.

The definition and scope of practice in the proposed behavior analyst bill were written with input from the Behavior Analyst Certification Board (BACB) and the Association of Professional Behavior Analysts (APBA). They were developed by professional behavior analysts, and summarize the BACB's Task List, which comprises the knowledge, skills, and abilities the profession has determined are necessary to practice ABA professionally and the contents of the national examinations in ABA. The Task List was derived from several job analysis studies involving thousands of professional behavior analysts and panels of subject matter experts over the past 15 years. Such procedures are used by most legitimate professions to determine the competencies required to practice the profession, and the scope of practice. Further, the definition of the practice of ABA in the proposed licensure bill is similar to the definition in several state laws to license behavior analysts. WABA's position is that the scope of practice should remain as written in the proposed licensure bill.

With regard to the proposed changes in the bill draft language:

1. WABA agrees that "applied behavior analysis" should be used throughout the licensure bill instead of "behavior analysis".
2. WABA does not agree with the suggested changes to Section 1 (6). The definition of the practice of ABA should remain as written in the proposed bill, for reasons discussed above.

3. WABA disagrees with the proposed addition to Section 1(6)b. The statement, “It also does not include utilization of behavioral techniques in section 1(6)(a)(ii) alone as treatment modalities” is untrue and will provoke confusion. The practice of ABA by definition includes the utilization of behavioral techniques. The same rationale applies to the recommended addition to Section 2(1). Both of those sections should remain as written in the proposed licensure bill.
4. WABA also disagrees with the deletion of “and the individual’s scope of training and competence” from Section 3. If that phrase were deleted, the bill would permit anyone in the category covered by this exemption to engage in ABA, regardless of their training, knowledge, and competence in ABA. That would put vulnerable consumers in Washington State at risk of receiving poor quality services from unqualified individuals, and is inconsistent with the Department’s acknowledgment - as well as data from the aforementioned job analysis studies - that the practice of ABA is a distinct profession requiring specialized training.
5. The alternative recommendation for the bill to be changed to a title act would fail to adequately protect consumers. A title act would only regulate the use of specified titles; it would provide no means of regulating how licensees practice or those who purport to practice ABA without having met the standards of the profession.
6. WABA is not opposed to requiring state regulation of behavior technicians. However, because of the large number of technicians currently providing ABA services in Washington State, the initial implementation would be technically challenging. As an alternative, WABA recommends adding to the proposed licensure bill the requirement that technicians hold the Registered Behavior Technician™ (RBT™) credential that is offered and regulated by the BACB. In addition, WABA recommends a 1-year grace period for technicians to comply with that requirement. This recommendation is consistent with the recommendations to make BACB credentials the principal requirements for Licensed Behavior Analysts and Licensed Assistant Behavior Analysts. In addition, this would decrease the workload and administrative costs of the regulatory board.
7. WABA agrees that elements of regulation should be defined in rule. However, WABA asserts that the rules for implementing the licensure law should be made by a regulatory board consisting of a majority of Licensed Behavior Analysts and Licensed Assistant Behavior Analysts rather than the Secretary, as is the case with other professions licensed by the Department.
8. It was recommended that definitions of the levels/amount of supervision of technicians and Licensed Assistant Behavior Analysts be detailed in statute. Although WABA agrees that this “level of detail is necessary to inform providers of their responsibility under the law,” a more appropriate place for such detail is in the rules and regulations to be created by the regulatory board. Additionally, if BACB certifications are made the principal requirement for licensure, as WABA recommends, then the rules/regulations should specify that supervision must be conducted in accordance with the BACB’s supervision standards and its professional ethical and disciplinary standards. As the

field and profession of applied behavior analysis evolves over time the standards of supervision that are set by the BACB may change to meet current trends and best practices. As such, linking supervision standards to BACB standards will permit for the evolution of the field and profession without having to change the statute.

9. WABA contends that the recommendation to create an advisory committee instead of a regulatory board consisting of behavior analysts contradicts a fundamental purpose of licensure: protection of Washington State consumers of ABA services. One function of a regulatory board is to investigate allegations of misconduct by licensed professionals and individuals practicing without a license per the Uniform Disciplinary Act. If that function were assigned to the Secretary, it would result in administrative personnel investigating allegations of professional misconduct without sufficient knowledge of the practice of ABA and the ethical standards of the profession. That would put consumers and professionals at unnecessary risk. Additionally, WABA does not agree that the authority for developing rules and regulations to implement the licensure law should be placed in the hands of members from other professions. That is not consistent with the way other professions licensed by the Department are regulated, nor the Department's recognition of ABA as a distinct profession. We also disagree with the contention that the practice of ABA should be regulated by an advisory committee and the Secretary because the number of Licensed Behavior Analysts and Licensed Assistant Behavior Analysts is likely to be relatively small. Precedent exists in Washington State for other professions with small numbers to have their own regulatory boards (e.g., denturists, podiatric physicians and surgeons, etc.). Further, if BACB certification is the principal requirement for licensure, a regulatory board consisting mainly of professional behavior analysts will be cost-effective to operate because applicants for licensure will have had their degrees, coursework, and supervised training vetted by the BACB and will have passed the national examination in ABA. That will save the state regulatory board a substantial amount of work and money.
10. Finally, the Sunrise Review Report recommended that the draft bill include the basic requirements for licensure with "specifics to be defined by the Secretary" in rule. Again, WABA disagrees that the Secretary should be responsible for defining requirements for licensure of behavior analysts. Instead those requirements should be set by the profession, as is the case for other licensed professions. In fact, as noted in the sunrise application and the draft report, the profession of behavior analysis has identified the requirements for practicing ABA: the BACB certification requirements. Those are regularly updated. For example, the current coursework requirements listed in the Sunrise Review Report will be out of date as early as 2016, because the BACB has announced that an increase in those requirements will go into effect at that time. WABA strongly recommends that instead of listing the current BACB requirements, the licensure bill should state that current BACB certification is required to obtain and maintain licensure as a Licensed Behavior Analyst or Licensed Assistant Behavior Analyst. That will preclude revising the licensure statute and/or rules every time BACB requirements change, and will make the licensure process logical and efficient.