SENATE COMMITTEE ON BUSINESS PROFESSIONS AND ECONOMIC DEVELOPMENT

REGULATORY REQUEST QUESTIONNAIRE

Instructions for completing this questionnaire

- Responses to this questionnaire should be typed and dated. Each question should be answered within a single main document, which is limited to 50 pages. Supporting evidence for your responses may be included as an *Appendix*, but all essential information should be included within the main document.

- Each question from the questionnaire should be stated in upper case (capital) letters. The response should follow in lower case letters.

- Each part of every question must be addressed. If there is no information available to answer the question, state this as your response and describe what you did to attempt to find information that would answer the question. If you think the question is not applicable, state this and explain your response.

- When supporting documentation is appropriate, include it as an *Appendix*. Appendices would be labeled as follows: Each document appended should be lettered in alphabetical order. Pages within each appendix should be numbered sequentially. For example, the third page of the first appendix will be labeled A3, and the fifth page of the second appendix will be labeled B5. References within the main document to information contained in Appendices should use these page labels.

- Please read the entire questionnaire before answering any questions so that you will understand what information is being requested and how questions relate to each other.

Section A: Applicant Group Identification

This section of the questionnaire is designed to help identify the group seeking regulation and to determine if the applicant group adequately represents the occupation.

1. WHAT OCCUPATIONAL GROUP IS SEEKING REGULATION? IDENTIFY BY NAME, ADDRESS AND ASSOCIATIONAL AFFILIATION THE INDIVIDUALS WHO SHOULD BE CONTACTED WHEN COMMUNICATING WITH THIS GROUP REGARDING THIS APPLICATION.

   The California Association for Behavior Analysis (CalABA) is applying on behalf of nationally certified California practitioners of applied behavior analysis (ABA).

   Contact Information:

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2. LIST ALL TITLES CURRENTLY USED BY CALIFORNIA PRACTITIONERS OF THIS OCCUPATION. ESTIMATE THE TOTAL NUMBER OF PRACTITIONERS NOW IN CALIFORNIA AND THE NUMBER USING EACH TITLE.

   As of March 18, 2014 there were 2,198 practitioners in California certified by the Behavior Analyst Certification Board, Inc. (BACB®) at the following levels:

   - Board Certified Behavior Analyst® (BCBA®): 1779
   - Board Certified Behavior Analyst-Doctoral (BCBA-D™): 269
   - Board Certified Assistant Behavior Analyst®: (BCaBA®): 150

3. IDENTIFY EACH OCCUPATIONAL ASSOCIATION OR SIMILAR ORGANIZATION REPRESENTING CURRENT PRACTITIONERS IN CALIFORNIA, AND ESTIMATE ITS MEMBERSHIP. FOR EACH, LIST THE NAME OF ANY ASSOCIATED NATIONAL GROUP.

   Many BACB certificants practicing in California are also members of the following organizations:

   State
   - California Association for Behavior Analysis (CalABA) - ~1600 members
   - Southern California Consortium for Behavior Analysis (SCCBA) – 32 members (organizational memberships only)

   National/international
   - Association for Behavior Analysis International (ABAI) – ~520 CA resident members
   - Association of Professional Behavior Analysts (APBA) - ~400 CA resident members

   CalABA is a state affiliated chapter of the Association for Behavior Analysis International (ABAI) and an Affiliate of the Association of Professional Behavior Analysts (APBA).

4. ESTIMATE THE PERCENTAGE OF PRACTITIONERS WHO SUPPORT THIS REQUEST FOR REGULATION. DOCUMENT THE SOURCE OF THIS ESTIMATE.

According to a survey conducted by CalABA in March/April 2014, about 90% of respondents were either "extremely supportive" or "somewhat supportive" of state regulation in the form of licensure (see figure 1 below).

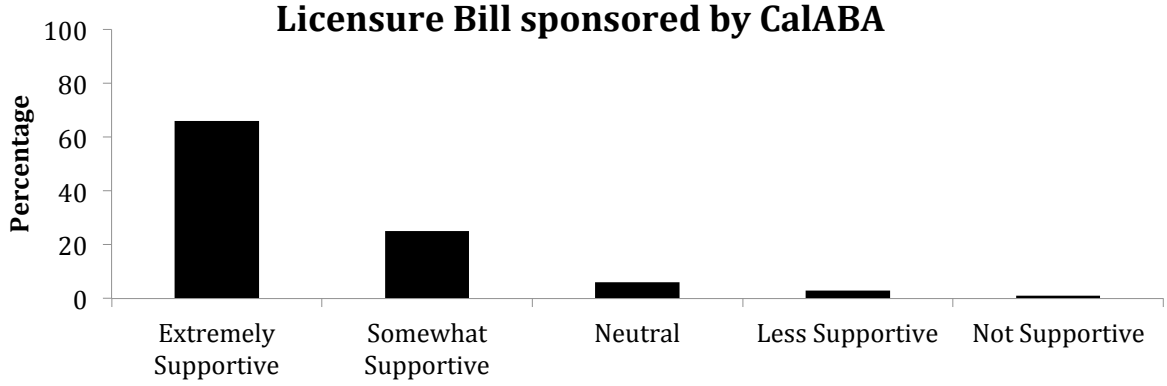

Figure 1

5. NAME THE APPLICANT GROUP REPRESENTING THE PRACTITIONERS IN THIS EFFORT TO SEEK REGULATION. HOW WAS THIS GROUP SELECTED TO REPRESENT PRACTITIONERS?

   CalABA is the applicant group representing practitioners in the effort to seek occupational regulation. CalABA was selected due to the association's status as the oldest and largest professional organization for behavior analysts in California. It is a nonprofit membership organization whose bylaws ensure that its governing board is elected by and represents its members. Furthermore, its membership is represented across all other similar organizations listed in question 3.

6. ARE ALL PRACTITIONER GROUPS LISTED IN RESPONSE TO QUESTION 2 REPRESENTED IN THE ORGANIZATION SEEKING REGULATION? IF NOT, WHY NOT?

   Yes.

Section B: Consumer Group Identification

This section of the questionnaire is designed to identify consumers who typically seek practitioner services and to identify nonapplicant groups with an interest in the proposed regulation.

7. DO PRACTITIONERS TYPICALLY DEAL WITH A SPECIFIC COMSUMER POPULATION? ARE CLIENTS GENERALLY INDIVIDUALS OR ORGANIZATIONS? DOCUMENT.

   Behavior analysts work with many different consumer populations to change socially important behaviors by altering aspects of the environment. Representative clients include individuals with autism and other developmental and intellectual disabilities, learning and communication difficulties, behavior disorders, brain injuries, physical disabilities, difficulties associated with aging, and typically developing individuals.

   Some behavior analysts who specialize in Organizational Behavior Management (OBM) work with organizations on the behavior of people in the workplace.

   Specific data on consumer populations collected through the March/April 2014 CalABA member survey are shown below.

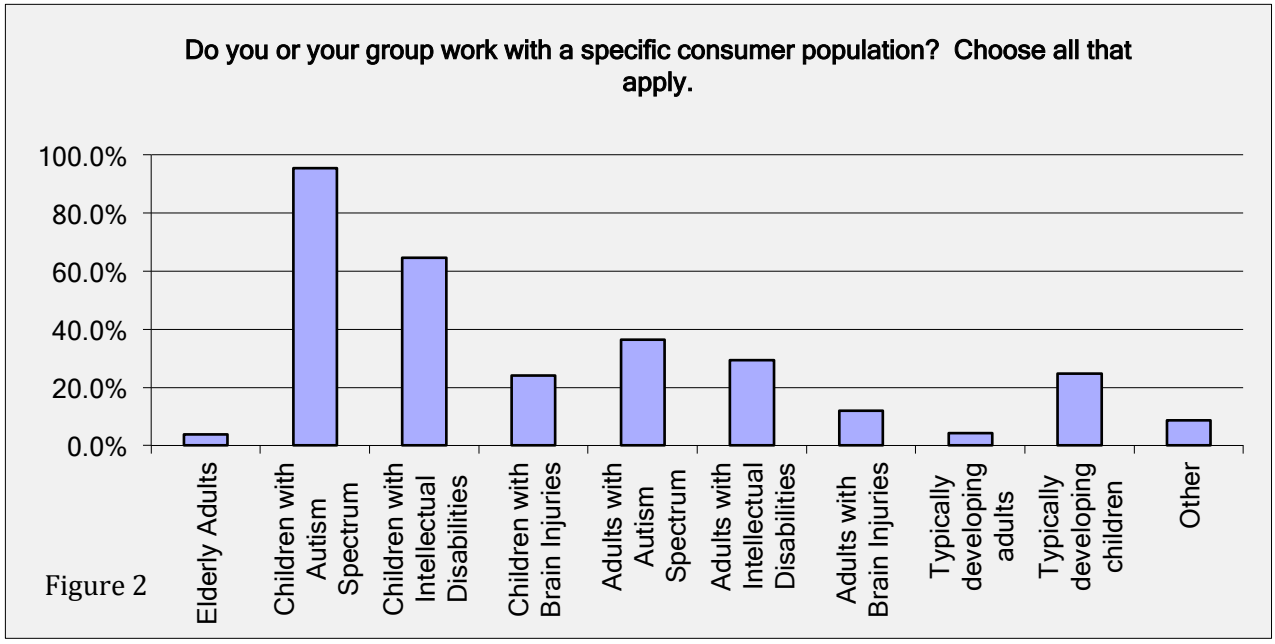

Figure 2

8. IDENTIFY ANY ADVOCACY GROUPS REPRESENTING CALIFORNIA CONSUMER OF THIS SERVICE. LIST ALSO THE NAME OF APPLICABLE NATIONAL ADVOCACY GROUPS.

   California Advocacy Groups

   - Disability Rights California
   - Autism Health Insurance Project
   - Talk About Curing Autism

- Autism Deserves Equal Coverage
- Families for Effective Autism Treatment
- Consumer Watchdog

National Advocacy Groups

- Autism Speaks
- Autism Society of America

9. IDENTIFY ANY CONSUMER POPULATIONS NOT NOW USING PRACTITIONER SERVICES LIKELY TO DO SO IF REGULATION IS APPROVED.

   If regulation is approved the consumer populations listed below would likely access services from professional practitioners of applied behavior analysis more than they do currently:

   - Individuals experiencing behavioral difficulties associated with aging
   - Individuals with traumatic brain injuries
   - Individuals with a wide range of intellectual, physical and developmental disabilities
   - Individuals with mental health disorders
   - Typically developing individuals

10. DOES THE APPLICANT GROUP INCLUDE CONSUMER REPRESENTATION? IF SO, DOCUMENT. IF NOT, WHY NOT?

    Leaders of advocacy groups including, but not limited to, Autism Speaks and the Autism Health Insurance Project are active in projects facilitated by CalABA. CalABA has also worked extensively with Consumer Watchdog on a lawsuit (Consumer Watchdog et. al. v. Department of Managed Health Care et. al.; 2d Civ. No. B232338) that was one of the catalysts for SB 946, a law requiring certain private health plans to cover ABA services for California consumers with autism.

    Additionally, CalABA hosts a parent conference in conjunction with its own professional conference annually. Consumer advocates are included in both the content development and participant recruitment for this event.

11. NAME ANY NON-APPLICANT GROUPS OPPOSED TO OR WITH AN INTEREST IN THE PROPOSED REGULATION. IF NONE, INDICATE EFFORTS TO IDENTIFY THEM.

Non-applicant groups that may have an interest in the proposed regulation include:

- Advocacy groups identified in Question 8
- Association of Professional Behavior Analysts
- Association for Behavior Analysis International

- Association of State and Provincial Psychology Boards
- Behavior Analyst Certification Board, Inc.
- California Association for Licensed Professional Clinical Counselors
- California Association of Marriage and Family Therapists
- California Department of Developmental Services and Regional Centers
- California Department of Education
- California Department of Insurance
- California Department of Managed Health Care
- California Psychological Association
- Health plans serving individuals in California
- Higher education institutions listed in Question 46
- National Association of Social Workers – California Chapter
- Southern California Consortium of Behavior Analysts

Section C: Sunrise Criteria

This part of the questionnaire is intended to provide a uniform method for obtaining information regarding the merits of a request for governmental regulation of an occupation. The information you provide will be used to rate arguments in favor of imposing new regulations (such as educational standards, experience requirements, or examinations) to assure occupational competence.

Part C1 – Sunrise Criteria and Questions

The following questions have been designed to allow presentation of data in support of application for regulation. Provide concise and accurate information in the form indicated in the *Instructions* portion of this questionnaire.

I. UNREGULATED PRACTICE OF THIS OCCUPATION WILL HARM OR ENDANGER THE PUBLIC HEALTH SAFETY AND WELFARE

12. IS THERE OR HAS THERE BEEN SIGNIFICANT PUBLIC DEMAND FOR A REGULATORY STANDARD? DOCUMENT. IF NOT, WHAT IS THE BASIS FOR THIS APPLICATION?

On July 1, 2012, SB 946 went into effect in California. That law mandates coverage of applied behavior analysis (ABA) services to individuals with autism spectrum disorders (ASD) by certain private health plans. Adoption of SB 946 substantially increased the already high demand for ABA services and the need for the state to adopt uniform, objective, verifiable standards and procedures for protecting consumers from risk of harms caused by individuals who make unsubstantiated claims that they are qualified 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 competences to practice ABA and standards for certifying practitioners based on extensive job analysis studies involving thousands of professional behavior analysts. The standards include degrees, coursework, supervised experiential training, and passage of a professionally designed and managed examination in behavior analysis (see www.BACB.com). 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. The BACB's standards and requirements as well as the procedures from which those are derived parallel many, if not most, legitimate professional licensing standards and procedures.

The BACB has also developed *Guidelines for Responsible Conduct for Behavior Analysts* and *Professional Disciplinary and Ethical Standards* (See Appendix A and also available at www.BACB.com), which are designed to protect consumers as well as BACB-certified practitioners. 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,* but it does enforce the *Professional Disciplinary and Ethical Standards* (See Appendix B) and imposes sanctions on violators (see "Ethics and Discipline" at www.bacb.com for the standards, complaint and review procedures, and public information about disciplinary actions to date). 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.

The BACB certifications have long been recognized as qualifications for practicing ABA in the California Department of Developmental Services regulations (California Code of Regulations Title 17, Division 2, Chapter 3, SubChapter 2, Article 3, §54342 (a) (8) and (11)) and in the state special education law (California Education Code, Part 30, Chapter 5.5, §56525). Board Certified Behavior Analysts (BCBAs) are also designated as qualified providers of ABA services in the aforementioned autism insurance law (SB 946/SB 126). At present, however, there are no laws clearly requiring that individuals document and demonstrate training and competence in ABA in order to practice in this state, and no entity within California that has legal authority to directly regulate the practice of ABA. The need for state regulation was also noted by an Autism Advisory Task Force convened by the Department of Managed Health Care, which stated in a February 2013 report to the Governor and Legislature "The Task Force concluded that all top level providers should be licensed by the state…"

The applicant therefore proposes establishment of state licensure of professional practitioners of ABA with BACB certification the principal requirement for obtaining and maintaining licenses. Benefits would include:

- Assuring the State and consumers that license holders meet standards for practicing ABA that are set by the profession. That includes passing a valid national 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 would provide California consumers of ABA services a double layer of protection, as the practice of licensees would 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 national professional examination in behavior analysis.

13. WHAT IS THE NATURE AND SEVERITY OF THE HARM? DOCUMENT THE PHYSICAL, SOCIAL, INTELLECTUAL, FINANCIAL OR OTHER CONSEQUNCES TO THE CONSUMER RESULTING FROM INCOMPETENT PRACTICE.

Many people with autism and related disorders, intellectual disabilities, and traumatic brain injuries 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 (Campbell, 2003; Hagopian, Rooker, & Rolider, 2011; Hassiotis, Canagasabe, Robotham, Martston, & Romeo, 2010) Heyvaert, Maes, Van den Noortgate, Kuppens, & Onghena, 2012;.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; Rogers & Vismara, 2008). 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.

14. HOW LIKELY IS IT THAT HARM WILL OCCUR? CITE CASES OR INSTANCES OF CONSUMER INJURY. IF NONE, HOW IS HARM CURRENTLY AVOIDED?

The availability of additional funding for ABA services through SB 946, together with increasing numbers of people receiving diagnoses of ASD and other conditions for which ABA services have proved effective, will further increase consumer demand for those services going forward. Without a statute and regulations formalizing minimum standards for practicing ABA competently and establishing a body within the state to oversee that practice, consumers will be at increasing risk of harm from individuals making false claims to be qualified to provide ABA services. The studies cited above show that such harm is likely and costly. Additional evidence is provided by a case in which an individual who fabricated training in ABA and BACB certification was found to have harmed children with autism whose behavioral services she was hired to oversee by school districts in Connecticut (see Appendix C and also available at http://ctwatchdog.com/health/schools-need-to-require-certification-of-behavior-analysts).

15. WHAT PROVIDIONS OF THE PROPOSED REGULATION WOULD PRECLUDE CONSUMER INJURY?

As described previously, establishment of licensure for ABA practitioners with BACB certification as the principal requirement would assure consumers that licensees have completed the formal and experiential training that the profession has determined is necessary to practice ABA, and have demonstrated competence by passing a valid national professional examination in the subject matter. Additionally, it would provide a licensing board within the state comprising professional behavior analysts to whom consumers could file complaints about individuals who are practicing behavior analysis but have not met the national and state standards, and about alleged unethical or incompetent practice by licensees. The licensing board's statutory authority to investigate such complaints and sanction violators, on top of the BACB's oversight, would provide strong protections against consumer injury as well as recourse for consumers who suffer harms.

II. EXISTING PROTECTIONS AVAILABLE TO THE CONSUMER ARE INSUFFICIENT

16. TO WHAT EXTENT DO CONSUMERS CURRENTLY CONTROL THEIR EXPOSURE TO RISK? HOW DO CLIENTS LOCATE AND SELECT PRACTITIONERS?

Many direct recipients of ABA services have limited communication, personal safety, and other self-care skills in addition to challenging behaviors, which makes them vulnerable to a variety of risks. It is typically their family members or other caregivers who seek services for them. Those consumers are also subject to risks, due in part to the difficulties inherent in

caring for family members with extensive needs. At present there are no legal restrictions on who can practice behavior analysis in this state. Consequently, many people who are not BACB certified and therefore have not met the standards for practicing ABA that have been established by the profession purport to provide "ABA" services to vulnerable consumers. Many of those consumers lack the knowledge required to discriminate such individuals from practitioners who have documented, bona fide qualifications in the practice of ABA. At present the state provides consumers with no safeguards from unqualified practitioners and no recourse if those practitioners harm them.

Consumers locate practitioners through (a) marketing tools such as websites, email promotions, and community events, (b) word-of-mouth referrals from friends, acquaintances, and parent advocacy groups, (c) referrals from medical doctors and other healthcare providers, (d) third-party funding sources such as the state's developmental services (Regional Center) system, health plans' lists of in-network providers, or local school districts, and/or (e) special education attorneys and advocates.

Consumers select practitioners based on factors such as (a) the practitioner's responsiveness and availability, (b) the speed with which the practitioner can commence provision of services, (c) marketing materials, (d) geographic convenience, (e) recommendations of the referral source, (f) the practitioner's fees and the availability of funding to cover them, and/or (f) the practitioner's education and qualifications. If the consumer is familiar with the BACB certifications and website, s/he may read the requirements for certification, the ethical and disciplinary guidelines and standards (including descriptions of disciplinary actions taken by the BACB), and other information about the practice of ABA at www.BACB.com. S/he may also search the registry of certificants on the BACB website certified practitioners in his/her area. BACB Certificants may be emailed directly via that registry.

17. ARE CLIENTS FREQUENTLY REFERRED TO PRACTITIONERS FOR SERVICE? GIVE EXAMPLES OF REFERRAL PATTERNS.

Clients are referred to ABA practitioners on an ongoing basis. Information about monthly referral patterns for California ABA provider organizations was collected as part of a survey conducted by CalABA in July 2013. Results are shown below in Figure 3.

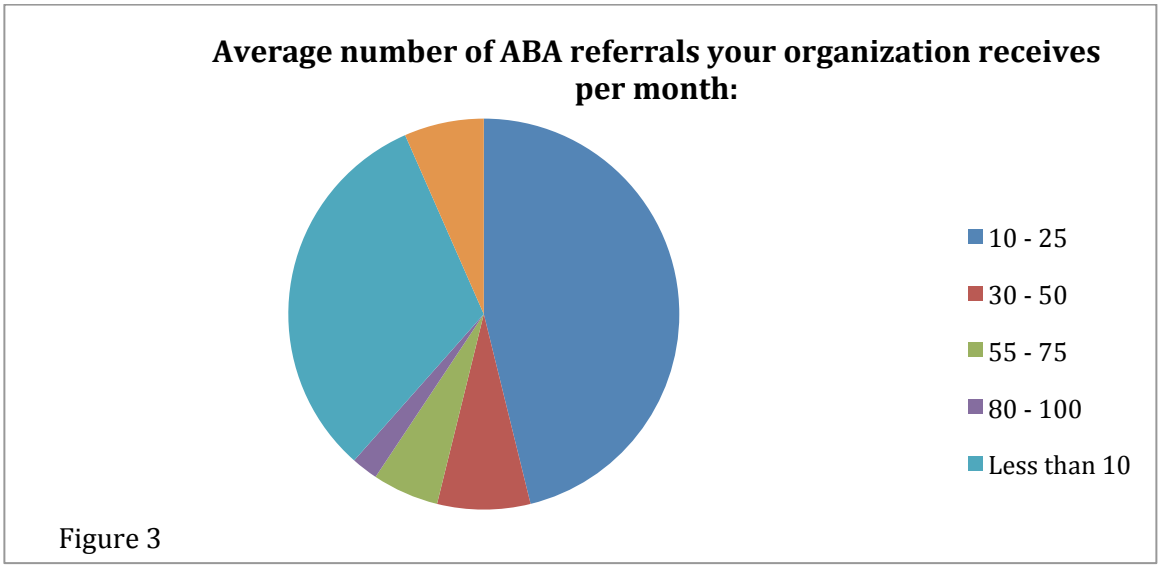

Figure 3

A large percentage of clients referred to ABA practitioners are children or adults with autism or other developmental disabilities. They are typically referred due to deficits in communication, social, self-help, vocational, and other skills) and/or the presence of problem behaviors (e.g., self-injury, aggression, tantrums, elopement, non-compliance, food refusal).

18. ARE CLIENTS FREQUENTLY REFERRED ELSEWHERE BY PRACTITIONERS? GIVE EXAMPLES OF REFFERAL PATTERNS.

California practitioners of ABA who are credentialed by the BACB are obligated to comply with the BACB *Guidelines for Responsible Conduct*, which include requirements to refer clients to other appropriately qualified providers if the client needs services (ABA services as well as non-behavior analytic services) that are outside of the boundaries of the practitioner's training and competence. In some cases the practitioner may continue to provide services to a client (e.g., one who is receiving medical services in addition to ABA treatment), but in others s/he may not (e.g., when a client no longer needs ABA services, or their parent/guardian opts to pursue non-ABA treatment exclusively). BACB certificants are also obligated to make referrals when other conditions exist that might compromise the certificant's ability to serve the client ethically and effectively. Examples of such conditions include but are not limited to:

- Limited client availability (e.g., only after school hours)
- Practitioner is not contracted with client's funding source
- Client is found clinically ineligible for ABA services
- Resources required to deliver effective ABA services are not available
- Practitioner is unable to serve the client appropriately due to personal circumstances

At present, however, there are many individuals in California who purport to provide "ABA" services but are not regulated by either the BACB or the state, so they are bound by no code of ethics or conduct regarding referrals or any other aspect of their practice.

19. WHAT SOURCES EXIST TO INFORM CONSUMERS OF THE RISK INHERENT IN INCOMPTENT PRACTICE AND WHAT PRACTITIONER BEHAVIORS CONSTITUTE COMPETENT PERFORMANCE?

As noted earlier, the BACB has conducted several job analysis studies to identify the competencies required to practice ABA. Consumers who are familiar with the BACB may find those competencies in the 4th Edition Task List (See Appendix D and also available at http://www.bacb.com/Downloadfiles/TaskList/BACB_Fourth_Edition_Task_List.pdf). The BACB *Guidelines for Responsible Conduct*, also available on the BACB website, describe the ethical practice of ABA. Additionally, in 2012 the BACB published *Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder* (see Appendix E), which includes information about practitioner qualifications and responsibilities. However, none of those sources explicitly describe the risks inherent in incompetent practice of ABA.

The Autism Special Interest Group of the Association for Behavior Analysis International (ABAI) has developed guidelines for consumers that describe some behaviors that constitute competent performance of ABA in the treatment of autism and incorporate the BACB's standards, including the Task List and conduct guidelines, by reference. However, they do not inform consumers of the risks inherent in incompetent practice. Additionally, consumers cannot readily access those guidelines, as they are being updated and are not currently accessible through the ABAI website.

Autism Speaks, a well-known non-profit organization dedicated to science and advocacy for individuals with autism, provides some information regarding practitioner qualifications, but does not describe specific practitioner behaviors that constitute competent practice, nor the risks of incompetent practice. Further, Autism Speaks warns clients and caregivers to "check the credentials of those who claim to be qualified in behavior analysis," since there is currently no restriction on who can identify him/herself as an applied behavior analyst or practice ABA in many states.

The following websites contain information about ABA that may be useful to consumers:

- Association for Behavior Analysis International — www.abainternational.org
- Association of Professional Behavior Analysts – www.apbahome.net
- Association for Science in Autism Treatment — www.asatonline.org
- ABAI Autism Special Interest Group — www.autismsig.org
- ABAI Parent Professional Partnership Special Interest Group — www.pppsig.org
- Behavior Analyst Certification Board, Inc. — www.bacb.com
- Cambridge Center for Behavioral Studies — www.behavior.org

20. WHAT ADMINISTRATIVE OR LEGAL REMEDIES ARE CURRENTLY AVAILABLE TO REDRESS CONSUMER INJURY OR ABUSE IN THIS FIELD?

A consumer who believes that a practitioner certified by the BACB has violated one or more of the BACB's nine *Professional Ethical and Disciplinary Standards* and has the required documentation can file a complaint with the BACB. After initial review of the complaint, the BACB establishes a Review Committee (if warranted) to determine if the alleged violations occurred and if so, what sanctions (if any) will be imposed on the certificant. The standards can be found as Appendix B, and the complaint form and description of documentation that must accompany it are included as Appendix F.

The BACB *Guidelines for Responsible Conduct* include the following provisions:

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
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.

Thus BACB certificants may exert informal social pressure on colleagues who behave in ways that harm clients or otherwise violate the conduct guidelines, but those guidelines are not enforced by the BACB, do not carry the authority of law, and generally do not apply to practitioners who are not certified by the BACB.

In a July 2013 CalABA survey, respondents who employ providers of ABA services were asked what percentage of their high-level clinicians were BACB certified. Results showed that many practitioners who are given responsibility for designing and overseeing ABA treatment in California are, in fact, not BACB certified (see Figure 4), so the BACB cannot review or act on disciplinary complaints about them unless they misrepresent that they are BACB certified or eligible for involve an applicant or misuse of a BACB certification, use the BACB exams, certificates, or logo without authorization, engage in any irregularity vis a vis a BACB examination, or make false, misleading, or fraudulent statements in an effort to obtain BACB certification for themselves or someone else.

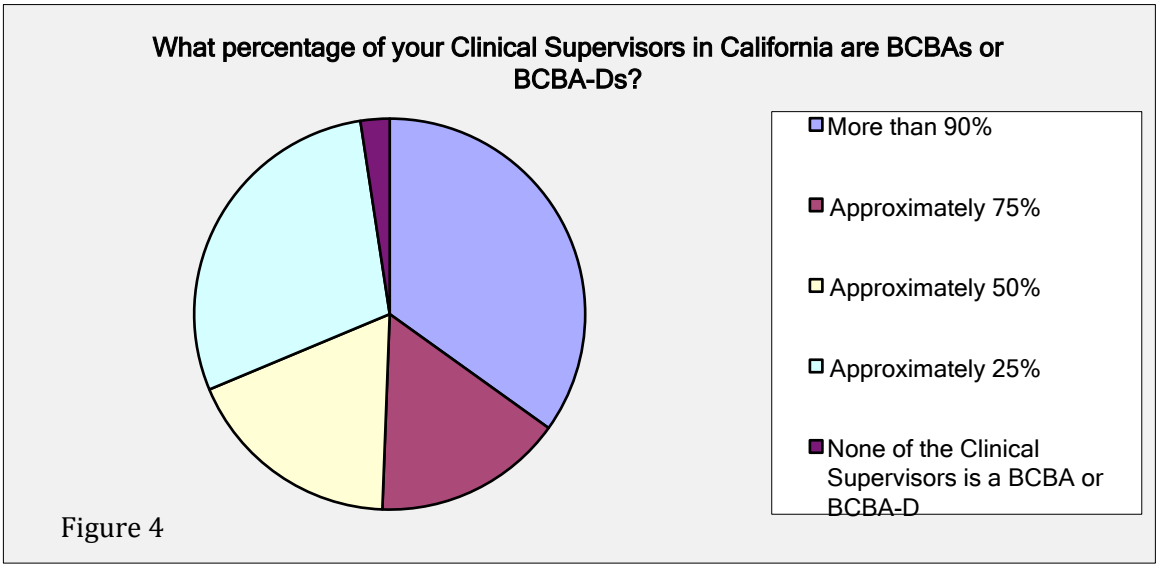

Figure 4

If a practitioner is not certified by the BACB, consumers can submit complaints to the practitioner's employer or to an entity that funds the practitioner's services, such as a health plan, Regional Center, or school district. All professionals who provide services funded by the California Department of Developmental Services or Department of Education are considered "mandated reporters" pursuant to Welfare & Institutions Code Section 15630 or Penal Code Sections 11164 through 11179.3, and must take action to ensure the health and safety of a consumer who may be the victim of abuse. Practitioners who are vendorized by Department of Developmental Services must post a link to the "Appeals, Comments, and Complaints" section of the DDS website on the public section of their website. Consumers may also report practitioners to local law enforcement agencies or to the district attorney's office. There is, however, no central body within the state at present that can redress injuries to consumers of ABA services caused by either BACB-certified practitioners or those who are not certified by the BACB.

21. ARE THE CURRENTLY AVAILABLE REMEDIES EFFICIENT OR INEFFICIENT? IF SO, EXPLAIN WHY.

The remedies currently available are insufficient to protect consumers. As noted previously, there is no central body within California that is authorized by law to protect consumers by regulating the practice of ABA. Consumers who believe that a BACB-certified practitioner has violated one or more of the BACB's *Professional Ethical and Disciplinary Standards* can file a complaint with the BACB. The ability of the BACB to protect the public is inherently limited, however, because it is an international credentialing body rather than a governmental entity, and the state where has not delegated legal authority to regulate the practice of ABA to the BACB.

There are stringent requirements for complaints to the BACB. At a minimum, the complainant must provide the BACB with a description of the complaint, written correspondence with the certificant in question in which the complainant specifies the nature of the complaint and a suggested remedy, and written correspondence regarding the complaint with the agency that employs or provides funding for the practitioner. Typically the BACB will only review complaints within very specific parameters and only after the complaint has already been "acted upon by an employer or governing state or health care agency." (Behavior Analyst Certification Board, 2008.).

The BACB generally requires complaints of incompetence or malpractice include "official determinations (such as, court orders, jury findings, or treatment professional findings of incompetence or malpractice)."

If a practitioner is found to have violated one of the BACB's *Professional Disciplinary and Ethical Standards,* there is no legal penalty. The strongest sanction available to the BACB is revocation of BACB certification. In contrast, governmental entities like licensing boards typically have authority to enforce laws and regulations and impose strong sanctions. For example, a Marriage and Family Therapist who is regulated by the California Board of Behavioral Sciences found to have violated any provisions of that profession's licensing laws and regulations, is guilty of a misdemeanor punishable by imprisonment in the county jail not exceeding six months, by a fine not exceeding $2500, or both (Board of Behavioral Sciences, 2014).

Generally speaking, the BACB can enforce its *Professional Ethical and Disciplinary Standards* only with practitioners who hold BACB certifications. California consumers currently have no recourse if a practitioner who is not certified by the BACB engages in unethical or incompetent behavior, except perhaps through the practitioner's employer or funding source.

III. NO ALTERNATIVES TO REGULATION WILL ADEQUATELY PROTECT THE PUBLIC

22. EXPLAIN WHY MARKETPLACE FACTORS WILL NOT BE AS EFFECTIVE AS GOVERNMENTAL REGULATION IN ENSURING PUBLIC WELFARE. DOCUMENT SPECIFIC INSTANCES IN WHICH MARKET CONTROLS HAVE BROKEN DOWN OR PROVEN INEFFECTIVE IN ASSURING CONSUMER PROTECTION.

Implementation of SB 946 has exacerbated the demand for ABA services for people with autism, which was already high. One result is that individuals who are not certified by the BACB and therefore have not met the standards established by the profession are asserting that they are qualified to be reimbursed by health plans for providing "ABA" services. Behavior analysis is younger than many other professions, and coverage of ABA services is very new to many health plans and other funding sources. For those and other reasons, relatively few funders and

consumers are familiar with the specialized training required to practice ABA competently and ethically, or with indicators of genuine, high-quality ABA services. That is, large segments of the marketplace lack the knowledge required to protect consumers of ABA services. Additionally, economic and other pressures may influence funders to adopt lower standards for identifying providers than those that are typically set by professions (i.e., specific degrees, coursework, supervised experiential training, and passage of a professional examination in the subject matter). That will result in consumers being subjected to subpar services against which they will have little protection unless the state adopts laws and regulations requiring ABA practitioners to meet the national standards of the profession and to be accountable to a state regulatory board comprising qualified professional behavior analysts.

As one example of the failure of the marketplace to protect consumers of ABA services, a large California agency that purported to provide ABA services was forced to abruptly shut its doors in March 2012 following an audit by the Department of Developmental Services that found that the agency employed individuals who were not certified by the BACB and did not have adequate training and competence in ABA. The findings of the audit can be found in Appendix G and here: http://www.dds.ca.gov/Transparency/docs/Vendors/wellspringHealthcareServicesInc.pdf That closure -- a direct result of the marketplace's inability to ensure public welfare -- left thousands of children and adults with developmental disabilities without services.
The 2010 Connecticut case highlighted in the response to question 14 provides further evidence that the marketplace is ineffective in protecting consumers of ABA services from individuals who are not appropriately credentialed to practice ABA professionally.

23. ARE THERE OTHER STATES IN WHICH THIS OCCUPATION IS REGULATED? IF SO, IDENTIFY THE STATES AND INDICATE THE MANNER IN WHICH CONSUMER PROTECTION IS ENSURED IN THOSE STATES. PROVIDE, AS AN APPENDIX, COPIES OF THE REGULATORY PROVISIONS FROM THESE STATES.

At this writing, 17 states have adopted laws requiring practitioners of ABA to be licensed, certified, or registered by the state. All of the laws and the regulations for implementing them that have been developed to date are based predominantly on the BACB's model act for regulating the practice of ABA, with BACB certification the foundational requirement for obtaining the state-issued credential(s). Although some of the state entities that regulate the practice of ABA also regulate other professions, it is important to note that in all 17 states behavior analysts are licensed, certified, or registered *in their own right*, not as members of other professions. The table that follows summarizes those laws.

State Regulation of Behavior Analysts as of May 6, 2014

State	Behavior Analyst (advanced degrees)	Asst Behavior Analyst (BA/BS)	Technician	BACB certificants qualify	Others may qualify	Regulatory board	Law adopted
AL*	L	L	NA	Y	N	BehAn	2014
AZ	L	NA	NA	Y[1]	Y	Psych	2010
KS*	L	L	NA	Y	?	BSRB	2014
KY	L	L	NA	Y	N	BehAn	2010
LA	L	C	R	Y	Y	BehAn	2013
MA*	L	L	NA	Y	Y	AMHHSP	2013
MD*	L	NA	NA	Y	?	BPCT	2014
MO	L	L	NA	Y	N	Psych	2010
ND	L	R	NA	Y	Y	Psych	2011
NV	L	L	C[2]	Y	N	Psych	2009
NY*	L	C	NA	Y	?	BehAn	2014
OH	C	NA	NA	Y	?	Psych	2013
OK	L	C	NA	Y	N	BehAn	2009
OR*	L	L	R	Y	Y	BehAn	2013
RI	L	L	NA	Y	Y	BehAn	2012
VA	L	L	NA	Y	N	Medicine	2012
WI	L	NA	NA	Y	N	None[3]	2010

*Regulations to be developed or finalized; no state credentials issued yet

BACB = Behavior Analyst Certification Board, Inc.

L = license; C = state certification; R = registration; NA = Not applicable

BehAn = Behavior Analysis; Psych = Psychology; BSRB = Behavioral Sciences Regulatory Board; AMHHSP = Allied Mental Health & Human Service Professionals; BPCT = Board of Professional Counselors & Therapists

[1] = Board Certified Behavior Analyst with 1500 hrs supervised experience
[2] = "Certified Autism Behavior Interventionist"
[3] = Direct license issued by Dept. of Safety & Professional Services

Figure 5. Laws regulating the practice of ABA (source: Association of Professional Behavior Analysts)

To date, 37 states have passed legislation similar to SB 946 requiring private health plans to cover treatments for autism spectrum disorders, including ABA (see Figure 6 below). As mentioned above 17 of those states regulate Behavior Analysts through state licensure, certification or registration. In all of the other states BCBAs (and in some, BCaBAs supervised by BCBAs) are recognized as qualified providers and reimbursed by health plans. The BACB

credentials are also recognized in other types of laws in many states (e.g., Medicaid rules, developmental disabilities services and special education codes).

Figure 6 – Adapted from Autism Speaks

24. WHAT MEANS OTHER THAN GOVERNMANTAL REGULATION HAVE BEEN EMPLYED IN CALIFORNIA TO ENSURE CONSUMER HEALTH AND SAFETY? SHOW WHY THE FOLLOWING WOULD BE INADEQUATE:

    As described previously, the BACB's limited regulation has been available to California residents, but only with respect to practitioners certified by that body. Consumers have also had the option to complain to employers and funding sources.

    a. code of ethics – The BACB's *Guidelines for Responsible Conduct* are inadequate to protect consumers because they apply only to practitioners certified by the BACB, compliance with them is voluntary, they carry no force of law, and there is no body within the state that is authorized to enforce them.

    b. codes of practice enforced by professional associations – see previous description of enforcement of the *Professional Ethical and Disciplinary Standards* by the BACB, which

is a credentialing body rather than a professional association. At present, no professional association enforces codes of practice with behavior analysts in California.

c. dispute-resolution mechanisms such as mediation or arbitration – We believe that direct regulation of ABA practitioners would provide more cost-effective protections for consumers than these mechanisms.

d. recourse to current applicable law – At present there are no state laws specifically regulating the practice of ABA.

e. regulation of those who employ or supervise practitioners – For employers who are licensed by the state, consumers could file complaints with the applicable licensing board, but not all employers are licensed, and the existing licensure boards do not regulate behavior analysts. We believe that direct regulation of ABA practitioners would afford better protections for consumers than the indirect route of complaining to boards that license employers of ABA practitioners.

f. treatment guidelines – As the name implies, guidelines do not have the authority of law, so compliance with them is entirely voluntary on the part of practitioners, and they provide little real protection to consumers.

25. IF A "GRANDFATHER CLAUSE" (IN WHICH CURRENT PRACTITIONERS ARE EXEMPTED FROM COMPLIANCE WITH PROPOSED ENTRY STANDARDS) HAS BEEN INCLUDED IN THE REGULATION PROPOSED BY THE APPLICANT GROUP, HOW IS THAT CLAUSE JUSTIFIED? WHAT SAFEGUARDS WILL BE PROVIDED CONSUMERS REGARDING THIS GROUP?

The proposed regulation does not include a grandfather clause that would allow current practitioners to be fully licensed without meeting eligibility standards. Rather, we propose to grant limited provisional licenses to certain practitioners who will be given two years to meet the licensure eligibility requirements and apply for regular licenses. To protect consumers, applicants for provisional licensure will have to register with the behavior analyst licensing board, be supervised by a licensed behavior analyst and complete criminal background checks. They will also be subject to the same disciplinary standards as all other licensees.

IV. REGULATION WILL MITIGATE EXISTING PROBLEMS

26. WHAT SPECIFIC BENEFITS WILL THE PUBLIC REALIZE IF THIS OCCUPATION IS REGULATED? INDICTAE CLEARLY HOW THE PROPOSED REGULATION WILL CORRECT OR PRECLUDE CONSUMER INJURY. DO THESE BENEFITS GO BEYOND FREEDOM FROM HARM? IF SO, IN WHAT WAY?

Adoption of state licensure of professional practitioners of ABA with BACB certification as the principal requirement will ensure that consumers receive ABA services from professionals who have met education, experiential training, and examination requirements derived from job analysis studies involving thousands of professional behavior analysts, in accordance with rigorous standards and best practices in professional credentialing. Practitioners who have verified training and competence in ABA principles and procedures are more likely to use ABA techniques safely and effectively and less likely to harm consumers than are those who lack adequate training.

The proposed licensing law will establish a board of professional behavior analysts within the state that is authorized to investigate complaints from consumers and others and to enforce the law and accompanying regulations, including standards of professional conduct, in coordination with the BACB. That will provide consumers with protection from a well-established international credentialing entity as well as a state regulatory board. The presence of a licensing law and state regulatory board that can enforce it will provide strong incentives for practitioners to comply with ethical and disciplinary standards and best practices, which will enhance the services they provide to consumers.

27. WHICH CONSUMERS OF PRACTITIONER SERVICES ARE MOST IN NEED OF PROTECTION? WHICH REQUIRE LEAST PROTECTION? WHICH CONSUMERS WILL BENEFIT MOST AND LEAST FROM REGULATION?

Vulnerable populations served by behavior analysts (children and adults with a wide range of intellectual, physical, and developmental disabilities, traumatic brain injuries, and mental health disorders) and their families are most in need of protection and most likely to benefit from additional regulation. Because of their skill deficits, such individuals are often at particular risk of abuse and neglect and unable to advocate for themselves. Many also exhibit behaviors that pose a danger to themselves or others. ABA techniques have proven effective for reducing those behaviors, and for building skills and reducing interfering behaviors in typically developing children and adults in schools, homes, community settings, and workplaces. The latter populations of consumers are arguably the least in need of protection; however, they will also benefit from a state law requiring practitioners to have their training in ABA verified independently and objectively, and to demonstrate competence in ABA by passing a national professional examination in behavior analysis.

28. PROVIDE EVIDENCE OF "NET" BENEFIT WHEN THE FOLLOWING POSSIBLE EFFECTS OF REGULATION ARE CONSIDERED:

a. restriction of opportunity to practice
We do not foresee any undue restriction of opportunity to practice as a result of the proposed regulation. Laws and regulations governing the California Department of Developmental Services and certain health plans operating in California already recognize BACB certifications as qualifications for practitioners of behavior analysis,

and many knowledgeable employers either require or prefer BACB certification for certain positions.

b. restricted supply of practitioners
Licensure will likely increase the supply of qualified professional behavior analysts in California over time as the demand for ABA services continues to grow and there is a clear path for obtaining state-issued credentials to practice and pursue careers in California. We also foresee the development of additional university programs that prepare students for licensure and careers in the practice of behavior analysis.

c. increased costs of service to consumer
We do not predict increased costs to consumers as a result of the proposed regulation. Reimbursement rates for BACB certificants through the Department of Education, Department of Developmental Services, and private health insurance carriers are already well-established and are not likely to change simply because those practitioners become licensed.

d. increased governmental intervention in the marketplace.
Increased governmental intervention as a result of the proposed regulation will provide a net benefit by assuring protections for consumers and funders who are in the market for qualified ABA service providers.

V. PRACTITIONERS OPERATE INDEPENDENTLY, MAKING DECISIONS OF CONSEQUENCE

29. TO WHAT EXTENT DO INDIVIDUAL PRACTITIONERS MAKE PROFESSIONAL JUDGEMENTS OF CONSEQUENCE? WHAT ARE THESE JUDGEMENTS? HOW FREQUENTLY DO THEY OCCUR? WHAT ARE THE CONSEQUNCES? DOCUMENT.

The range of professional judgments of consequence that individual practitioners make on a regular basis is relatively broad. Judgments can range from day-to-day treatment and staffing decisions such as: making an initial determination and recommendation of "dosage" or intensity of treatment; decisions around discontinuation of services; decision regarding when and how to adjust a treatment plan to ensure sufficient progress etc. Decisions made on a daily basis by behavior analysts can substantially affect the short- and long-term health, safety, and functioning of clients and people around them. Many decisions made by behavior analysts can directly impact a client's ability to function effectively at home, at school, at work, and in the community.

30. TO WHAT EXTENT DO PRACTITIONERS WORK INDEPENDENTLY (AS OPPOSED TO WORKING UNDER THE AUSPICES OF, AN EMPLOYER OR SUPERVISOR)?

The BACB describes the work circumstances of its certificants 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. BCBAs 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.

Data collected in the 2014 CalABA survey indicated that about 9% of respondents work as independent contractors, with the remainder working in various capacities under the auspices of an organization, agency, university, or school (see Figure 7 below).

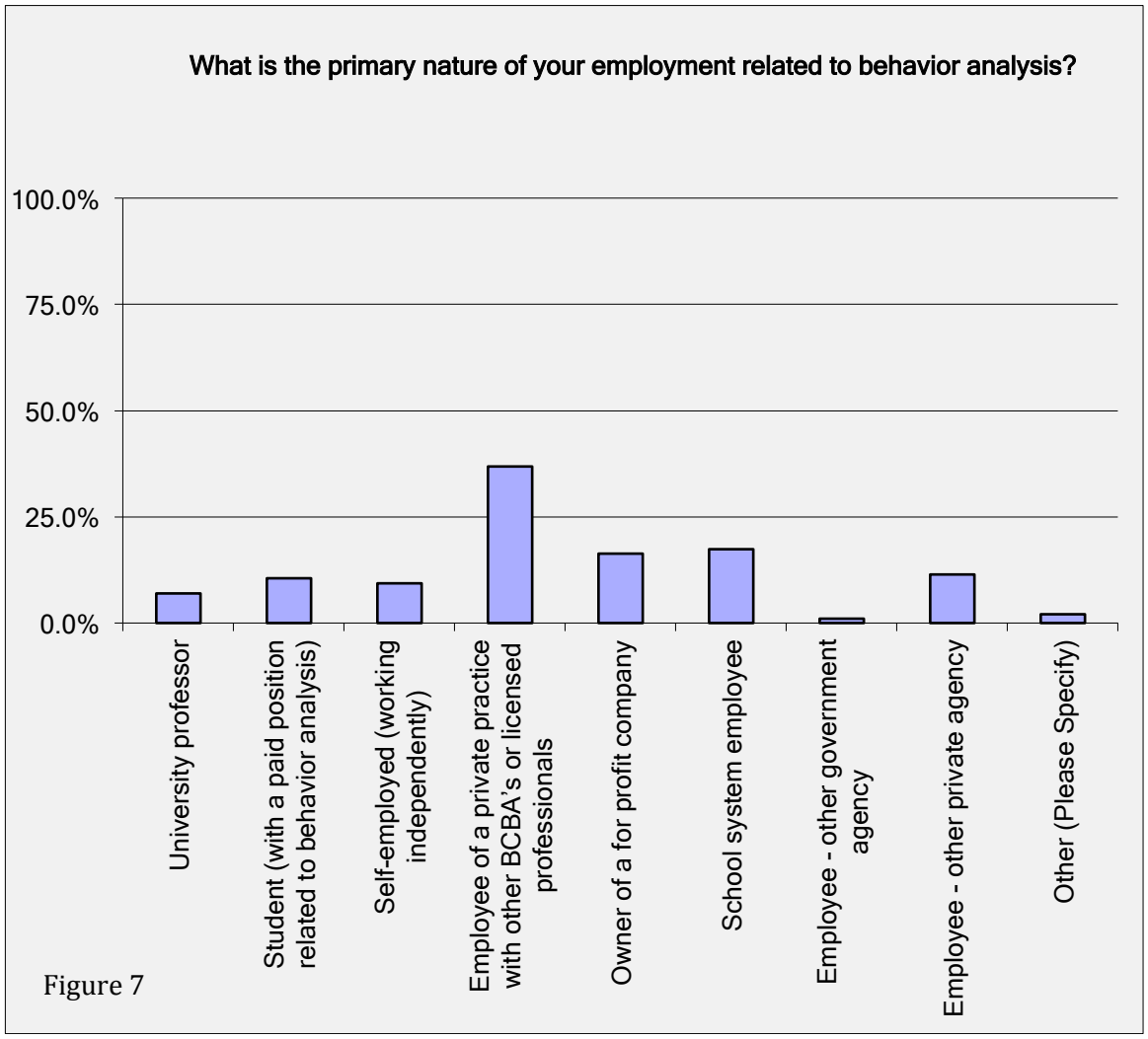

Figure 7

31. TO WHAT EXTENT DO DECISIONS MADE BY THE PRACTITIONER REQUIRE A HIGH DEGREE OF SKILL OR KNOWLEDGE TO AVOID HARM?

The contemporary practice of ABA is complex and intricate. Professional behavior analysts choose from a large, well-established array of scientifically validated assessment and intervention procedures to develop and implement highly individualized plans for producing meaningful change in client behavior. Behavior change can include the development of new skills, the reduction of maladaptive behaviors, and/or the increase of adaptive behaviors. Behavior analysts use a well-researched "toolbox" of interventions in their work, beginning with functional assessments of behavior-environment interactions. They measure client progress on a continuous basis and use those data to fine-tune interventions at every step of implementation. As noted above, decisions made by ABA practitioners determine whether socially significant client behaviors change in ways that improve the client's functioning in the short as well as the long run. The large repertoire of skills that is required to make appropriate decisions are described in the BACB Task List (see response to question 33).

VI. FUNCTIONS AND TASKS OF THE OCCUPATION ARE CLEARLY DEFINED

32. DOES THE PROPOSED REGULATORY SCHEME DEFINE A SCOPE OF ACTIVITY, WHICH REQUIRES LICENSURE, OR MERELY PREVENT THE USE OF A DESIGNATED JOB TITLE OR OCCUPATIONAL DESCRIPTION WITHOUT A LICENSE?

The proposed regulatory scheme includes a defined scope of practice and activity for licensees. It encompasses the knowledge, skills, and abilities in the BACB Task List (see below and also included as Appendix D).

Behavior Analyst Certification Board

◆ Fourth Edition Task List ◆

The BACB Fourth Edition Task List is organized in three major sections. 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. The second section, *Client-Centered Responsibilities*, includes tasks related to working with all clients and they should apply in most applied situations. 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.**

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.
	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.

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.

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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33. DESCRIBE THE IMPORTANT FUNCTIONS, TASKS AND DUTIES PERFORMED BY PRACTITIONERS. IDENTIFY THE SERVICES AND/OR PRODUCTS PROVIDED.

    The functions, tasks, and duties performed by practitioners are identified in the current (4th edition) BACB Task List, shown above and as Appendix D.

34. IS THERE A CONSENSUS ON WHAT ACTIVITIES CONSTITUTE COMPETENT PRACTICE OF THE OCCUPATION? IF SO, STATE AND DOCUMENT. IF NOT, WHAT IS THE BASIS FOR ASSESSING COMPETENCE?

    The foregoing BACB Task List was derived from extensive job analysis studies conducted over the past 15 years, and constitutes the empirical consensus of thousands of behavior analysts as to the competencies required to practice ABA professionally. The

Task List provides the content for the BACB certification exams, which have been developed and validated by professional psychometricians for assessing competence in the practice of ABA.

To be eligible to take a BACB certification exam, an applicant must provide documentation to the BACB that s/he has completed a degree conferred in behavior analysis or a field related to behavior analysis and approved by the BACB, specified numbers of classroom hours of instruction in behavior analysis, and a specified number of hours of supervised experiential training in behavior analysis. Once certified, individuals must document completion of continuing education in ABA (of which at least 3 CEUs must be in ethics) in order to maintain certification. Certificants must also attest that they comply with the BACB *Guidelines for Responsible Conduct* and *Professional Ethical and Disciplinary Standards.*

35. ARE INDICATORS OF COMPETENT PRACTICE LISTED IN RESPOSE TO QUESTION 34 MEASURABLE BY OBJECTIVE STANDARDS SUCH AS PEER REVIEW? GIVE EXAMPLES.

The competencies in the BACB Task List are measured via objective professional examinations. Completion of the eligibility requirements to take the exams (degrees, coursework, supervised experiential training) are objectively verified by BACB staff.

36. SPECIFY ACTIVITIES OR PRACTICES THAT WOULD SUGGEST THAT A PRACTITIONER IS INCOMPETENT. TO WHAT EXTENT IS PUBLIC HARM CAUSED BY PERSONAL FACTORS SUCH AS DISHONESTY? DOCUMENT.

Some specific activities that would suggest a practitioner is incompetent, is unethical or lacking competence may include: practitioner's using ABA assessment and/or intervention procedures incorrectly; failing regulation; failing to collect and analyze data during treatment to determine client progress or lack thereof; using non-behavior analytic procedures while practicing as a behavior analyst; failing to maintain proper clinical boundaries; breaching confidentiality; or using corporal punishment.

Public harm can be caused by personal factors such as dishonesty, as documented in the description of the 2010 Connecticut case in Question 14. In that case an individual falsely represented herself as a Board Certified Behavior Analyst and caused harm to the children receiving her services.

VII. THE OCCUPATION IS CLEARLY DISTINGUISHABLE FROM OTHER OCCUPATIONS THAT ARE ALREADY REGULATED

37. WHAT SIMILAR OCCUPATIONS HAVE BEEN REGULATED IN CALIFORNIA?

- Licensed Psychologists

- Licensed Professional Clinical Counselors
- Licensed Marriage and Family Therapists
- Licensed Clinical Social Workers
- Licensed Educational Psychologists

38. DESCRIBE FUNCTIONS PERFORMED BY PRACTITIONERS THAT DIFFER FROM THOSE PERFORMED BY OCCUPATIONS LISTED IN QUESTION 37.

The practice of behavior analysis is distinct from the practice of other professions in both content and methodology, and expressly excludes psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities. The BACB Task List presented previously differs very substantially from the task lists yielded by job analysis studies conducted by and for other professions (e.g., the job analysis study of the practice of licensed psychologists that was conducted by the Association of State and Provincial Psychology Boards in 2010).

39. INDICATE THE RELATIONSHIP AMONG THE GROUPS LISTED IN RESPONSE TO QUESTION 37 AND PRACTITIONERS. CAN PRACTITIONERS BE CONSIDERED A BRANCH OF CURRENTLY REGULATED OCCUPATIONS?

Although it could be said that behavior analysis – like several of the occupations listed in question 37 -- has some historic ties to psychology, the practice of behavior analysis actually originated in the experimental analysis of behavior rather than clinical psychology (the area in which most licensed psychologists are trained). Behavior analysis has long been a distinct scientific discipline with distinct concepts, research and clinical methods, professional journals, training programs, textbooks, ethical and practice standards, and scholarly and professional organizations. As the BACB Task List (question 33) shows, practitioners of behavior analysis do not do what members of the other professions listed above do. Further, the training and exam requirements for obtaining and maintaining professional certification in the practice of behavior analysis are very different from requirements for obtaining credentials in other professions.

The State of California has recognized that behavior analysis is a distinct profession for more than a decade. For instance, a written opinion issued by legal counsel for the California Department of Consumer Affairs in February 2000 stated clearly that the practice of behavior analysis is distinct from the practice of psychology (see Appendix H). Since that time, the California Code of Regulations governing the Department of Developmental Services has included unique vendor categories for behavior analysts (defined as Board Certified Behavior Analysts) and associate behavior analysts (defined as Board Certified Associate – now Assistant Behavior Analysts). The descriptions of those vendor categories state explicitly that behavior analysts do not practice psychology, and reflect the definition of the practice of behavior analysis presented earlier in this application, which also appears in the 17 state laws to license or otherwise regulate practitioners of ABA (see question 23) and most of the 37

state laws requiring private health plans to cover ABA services for people with autism, including the current California autism insurance law (SB 126).

40. WHAT IMPACT WILL THE REQUESTED REGULATION HAVE UPON THE AUTHORITY AND SCOPED OF PRACTICE OF CURRENTLY REGULATED GROUPS?

    None.

41. ARE THERE UNREGULATED OCCUPATIONS PERFORMING SERVICES SIMILAR TO THOSE OF THE GROUP TO BE REGULATED? IF SO, IDENTIFY.

    No. However, there are many individuals who call themselves "behavior analysts," "behaviorists," or "behavior specialists" and represent that they are qualified to provide ABA services to vulnerable client populations who have not met the standards for practicing ABA that have long been established by the profession, i.e., the BACB certification standards.

42. DESCRIBE THE SIMILARITIES AND DIFFERENCES BETWEEN PRACTITIONERS AND THE GROUPS IDENTIFIED IN QUESTION 41.

    N/A

VIII. THE OCCUPATION REQUIRES POSSESSION OF KNOWLEDGES, SKILLS AND ABILITIES THAT ARE BOTH TEACHABLE AND TESTABLE

43. IS THERE A GENERALLY ACCEPTED CORE SET OF KNOWLEDGES, SKILLS AND ABILITIES WITHOUT WHICH A PRACTITIONER MAY CAUSE PUBLIC HARM? DESCRIBE AND DOCUMENT.

    Yes. See the BACB Task List in question 33.

44. WHAT METHODS ARE CURRENTLY USED TO DEFINE THE REQUISITE KNOWLEDGES, SKILLS AND ABILITIES? WHO IS RESPONSIBLE FOR DEFINING THESE KNOWLEDGE, SKILLS AND ABILITIES?

    The BACB is responsible for defining the knowledge, skills and abilities required to practice ABA competently. It relies on subject matter experts who are currently certified as BCBA-Ds, BCBAs, and BCaBAs working under the guidance of the BACB's psychometrician. The BACB uses a job analysis process that begins with convening one or more panels of subject matter experts who, with guidance from the psychometrician, develop a comprehensive list of all of the tasks performed by practicing behavior analysts with accompanying foundational knowledge. The rationale for this approach is that jobs can best be described in terms of the tasks that are performed by successful practitioners.

The draft task list is used to create a validation survey that is distributed to all current BACB certificants. The survey asks practitioners to rate each task based on its importance and frequency and to rate the importance of the foundational knowledge for each task. Results from the survey and test development standards are then used to determine which tasks are of sufficient importance to be covered on the certification examinations. Tasks that are rated as being of low importance or are only performed by a minority of practitioners are excluded from the final examination content outlines.

Once the examination content outlines have been finalized, several additional panels of subject matter experts are convened. The first panel is tasked with identifying the knowledge, skills, and abilities required to perform each of the validated tasks. The second panel reviews the bank of examination questions (currently all multiple choice) to determine whether each question accurately reflects current practices and whether it matches the new task list. Any questions that are obsolete or cannot be matched to the new task list are discarded. Subsequent panels are charged with developing examination questions to address any new content that was added to the task list.

45. ARE THESE KNOWLEDGES, SKILLS AND ABILITIES TESTABLE? IS THE WORK OF THE GROUP SUFFICIENTLY DEFINED THAT COMPETENCE COULD BE EVALUATED BY SOME STANDARD (SUCH AS RATINGS OF EDUCATION, EXPEREICNE OR EXAM PERFORMANCE)?

Yes, and all applicants must pass a professional examination to obtain BACB certification. The BACB certification programs are accredited by the National Commission for Certifying Agencies, which conducts (NCCA) a third-party review of the BACB's examination development practices to ensure compliance with NCCA's standards for accreditation.

The psychometric properties of the BACB examinations are evaluated using classical test theory methods, which include conducting item and test analysis after each examination administration. The results of these analyses are reviewed by the BACB's psychometrician and any poorly performing items are reviewed by subject matter experts. Examination forms are statistically equated to ensure equivalence and fairness.

As described earlier, the job analysis serves as the primary source of evidence for the validity of the examinations, as it links the exam content directly to activities and knowledge that practitioners have indicated are important to the practice of behavior analysis. Reliability refers to the consistency with which the exam measures knowledge. After each item analysis, the Kuder-Richardson Formula 20 (KR-20) statistic is calculated to measure internal consistency. Exams are usually considered to have acceptable reliabilities when the KR-20 is over 0.85. BACB examinations typically have KR-20 indices that exceed 0.90.

The job analysis is updated every 5-10 years to ensure that examinations continue to reflect current research and practices in behavior analysis. The most recent job analysis study was

conducted in 2009-2010. It resulted in the 4th Edition Task List, which will govern the content of the examinations starting in February 2015 (the current examinations are based on the 3rd Edition Task List, which resulted from the 2001 job analysis).

The BACB examinations are currently developed and maintained by the BACB's in-house psychometrician. Along with BACB personnel and a team of subject matter experts, the psychometrician oversees conducting the job analysis survey; developing the Task List (the content foundation for the exam); developing knowledge, skill, and ability statements; identifying examination specifications; overseeing the item-writing process; examination construction; performing post-examination psychometric performance assessments; and analyzing examination results.

The examinations are currently administered by Pearson VUE, Inc. of Minneapolis, Minnesota. Pearson VUE offers secure, controlled computer-based testing environments at over 200 sites within the United States and at over 150 sites internationally.

46. LIST INSTITUTIONS AND PROGRAM TITLES OFFERING ACCREDITED AND NON-ACCREDITED PREPATORY PROGRAMS IN CALIFORNIA. ESTIMATE THE ANNUAL NUMBER OF GRADUATES FROM EACH. IF NO SUCH PREPATORY PROGRAMS EXIST WITHIN CALIFORNIA, LIST PROGRAMS FOUND ELSEWHERE.

The BACB does not accredit university-training programs, but it does approve on-campus and online course sequences that meet coursework requirements for eligibility to take BACB certification exams. BACB-approved course sequences (on campus only) at accredited California universities are listed below with an estimate of the number of students who complete the course sequence each year. Data not available is listed as N/A

BCaBA
California State University, Fresno – 22
California State University at Monterey Bay – N/A
California State University, Northridge – 2
California State University, Sacramento - 8
California State University, San Diego – 2
Palo Alto University – N/A

BCBA
Alliant International University – N/A
Azusa Pacific University – N/A
California Polytechnic University – N/A
California State University, Fresno – 7
California State University, Northridge – 30
California State University, Sacramento - 6
California State University, Los Angeles – N/A
California State University, San Diego – 25

California State University, San Marcos – N/A
California State University, Stanislaus – 8
Claremont Graduate University – 2
Fresno Pacific University – N/A
National University – N/A
Palo Alto University – N/A
The Chicago School of Professional Psychology, Los Angeles - 25
University of California, Santa Barbara – N/A
University of the Pacific – 3

47. APART FROM THE PROGRAMS LISTED IN QUESTION 46, INDICATE VARIOUS METHODS OF ACQUIRING REQUISITE KNOWLEDGE, SKILL AND ABILITY. EXAMPLES MAY INCLUDE APPRENTISHIPS, INTERNSHIPS, ON-THE-JOB TRAINING, INDIVIDUAL STUDY ETC.

Applicants for BACB certification must complete supervised experiential training as well as degree and coursework requirements in order to sit for a BACB examination. There are three options for fulfilling the supervised experiential training requirement:

1. **SUPERVISED INDEPENDENT FIELDWORK (1500 hours BCBA, 1000 hours BCaBA)**
   To qualify under this standard at the BCBA level, supervisees must complete 1500 hours of supervised independent fieldwork in behavior analysis. To qualify under this standard at the BCaBA level, supervisees must complete 1000 hours of supervised independent fieldwork in behavior analysis. A supervisory period is two weeks. In order to count experience hours within any given supervisory period, supervisees must be supervised by a BCBA at least once during that period for no less than 5% of the total hours spent in supervised independent fieldwork. For example, 20 hours of experience would include at least 1 supervised hour.
2. **PRACTICUM (1000 hours BCBA, 670 hours BCaBA)**
   To qualify under this standard at the BCBA level, supervisees must complete, with a passing grade, 1000 hours of practicum in behavior analysis within a university practicum program approved by the BACB and taken for graduate academic credit. To qualify under this standard at the BCaBA level, supervisees must complete, with a passing grade, 670 hours of practicum in behavior analysis within a university practicum program approved by the BACB and taken for academic credit. A supervisory period is one week. In order to count experience hours within any given supervisory period, supervisees must be supervised at least once during that period for no less than 7.5% of the total hours spent in Practicum. For example, 20 hours of experience would include at least 1.5 supervised hours.
3. **INTENSIVE PRACTICUM (750 hours BCBA, 500 hours BCaBA)**
   To qualify under this standard at the BCBA level, supervisees must complete, with a passing grade, 750 hours of intensive practicum in behavior analysis within a university practicum program approved by the BACB and taken for graduate academic credit. To

qualify under this standard at the BCaBA level, supervisees must complete, with a passing grade, 500 hours of intensive practicum in behavior analysis within a university practicum program approved by the BACB and taken for academic credit. A supervisory period is one week. In order to count experience hours within any given supervisory period, supervisees must be supervised at least twice during that period for no less than 10% of the total hours spent in intensive practicum. For example, 20 hours of experience would include at least 2 supervised hours.

For all three of the above options, no fewer than 10 hours but no more than 30 hours may be accrued per week. Supervisees may accrue experience in only one category at a time (i.e., supervised independent fieldwork, practicum, or intensive practicum).

All supervision must comply with the BACB's supervision standards (see Appendix I).

48. ESTIMATE THE PERCENTAGE OF CURRENT PRACTITIONERS TRIANED BY EACH OF THE ROUTES DECRIBED IN QUESTIONS 46-47.

Specific data is not available regarding the percentage of practitioners trained by each of the routes described above. However, it is important to note that any individual pursuing certification as a Board Certified Behavior Analyst must complete graduate level training through an accredited educational institution **in addition** to the clinical supervision outlined in question 47.

49. DOES ANY EXAMINATION OR OTHER MEASURE CURRENTLY EXIST TO TEST FOR FUNCTIONAL COMPETENCE? IF SO, INDICATE HOW AND BY WHOM EACH WAS CONSTRUCTED AND BY WHOM IT IS CURRENTLY ADMINISTERED. IF NOT, INDICATE SEARCH EFFORTS TO LOCATE SUCH MEASURES.

At present the only standardized, validated examinations of competence in the practice of behavior analysis as those that have been developed by the BACB, described above.

50. DESCRIBE THE FORMAT AND CONTENT OF EACH EXAMINATION LISTED IN QUESTION 49. DESCRIBE THE SECTIONS OF EACH EXAMINATION. WHAT COMPETNCIES IS EACH DESIGNED TO MEASURE? HOW DO THESE RELATE TO THE KNOWLEDGE, SKILLS AND ABILITIES LISTED IN QUESTION 4*3*?

The BACB examinations consist of 4-option multiple-choice questions, delivered using a computer-based testing platform. The content of each examination is based on the 4th Edition Task List, which specifies the number of questions that will be asked about each of the content areas and tasks identified during the job analysis survey. The BCBA examination consists of 150 scored questions while the BCaBA examination consists of 140 scored questions. Both examinations include an additional 10 non-scored "pilot" questions that are being evaluated for use on future examinations.

The examinations cover the content areas listed in the table below.

BACB Examination 4th Edition Content Outlines		Number of Questions	
Basic Behavior Analytic Skills		BCBA	BCaBA
A	Measurement	15	14
B	Experimental Design	11	11
C	Behavior Change Considerations	3	3
D	Fundamental Elements of Behavior Change	26	24
E	Specific Behavior Change Procedures	15	13
F	Behavior Change Systems	8	8
Client-Centered Responsibilities *(will include at least 2 questions addressing ethics per section)*			
G	Identification of the Problem	14	9
H	Measurement	9	6
I	Assessment	12	12
J	Intervention	23	18
K	Implementation, Management and Supervision	14	12
Total Number of Questions		150	130

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The competencies that the examinations are designed to measure are identified by the tasks listed within each of the content areas noted in the table above and described in the BACB's 4th Edition Task List.

Every question on the BACB examinations (BCBA and BCaBA) is directly linked to one of the tasks in the 4th Edition Task List. Each task is further described in terms of the knowledge, skills and abilities required to perform that task (i.e., the foundational knowledge.) It is important to note that although the examination content outlines are strictly based on the task list, each of the examination forms also covers a representative sample of the knowledge, skills and abilities identified in the foundational knowledge section of the 4th Edition Task List.

51. IF MORE THAN ONE EXAMINATION IS LISTED ABOVE, WHICH STANDARD DO YOU INTEND TO SUPPORT? WHY? IF NONE OF THE ABOVE, WHY NOT, AND WHAT DO YOU PROPOSE AS AN ALTERNATIVE?

    We support the only validated professional examinations in the practice of behavior analysis, the BACB examinations described above.

IX. ECONOMIC IMPACT OF REGULATION IS JUSTIFIED

52. HOW MANY PEOPLE ARE EXPOSED ANNUALLY TO THIS OCCUPATION? WILL REGULATION OF THIS OCCUPATION AFFECT THIS FIGURE? IF SO, IN WHAT WAY?

    In a report published by the California Health Benefits Review Program (See Appendix J) it is estimated that 12,700 enrollees in DMHC-regulated plans or CDI-regulated policies currently access intensive ABA therapies. Due to the wide scope of practice of behavior analysis previously discussed, in addition to the individuals already being served, we feel there are tens of thousands of individuals who could benefit from the services of a behavior analyst.

53. WHAT IS THE CURRENT COST OF THE SERVICE PROVIDED? ESTIMATE THE AMOUNT OF MONEY SPENT ANNUALLY IN CALIFORNIA FOR THE SERVICES OF THIS GROUP. HOW WILL REGULATION AFFECT THESE COSTS? PROVIDE DOCUMENTATION FOR YOUR ANSWERS.

    A typical ABA therapy session lasts between 1.5-3 hours and the cost is based on a number of variables including funding source, place of service etc. Therapy rates in California can range from ~$20-$75/hour for direct service. In addition to the direct service hours, ABA programs include both direct and indirect supervision by a Board Certified Behavior Analyst (BCBA). The cost for these supervision services range from $75-150/hour.

    As mentioned above in question 52, in a report published by the California Health Benefits Review Program (See Appendix J-10) it is estimated that 12,700 enrollees in DMHC-regulated plans or CDI-regulated policies currently access intensive ABA therapies. Current annual expenditures for intensive behavioral intervention therapies among these enrollees are estimated to be $686 million. Coverage for ABA services is currently required under both the existing behavioral health treatment mandate (SB 946/126), through the Department of Developmental Services Regional Center system and the current California mental health parity law. As a result, we do not expect additional governmental regulation to have a measurable cost impact.

54. OUTLINE THE MAJOR GOVERNMENTAL ACTIVITIES YOU BELIEVE WILL BE NECESSARY TO APPROPRIATELY REGULATE PRACTITIONERS. EXAMPLES

MAY INCLUDE SUCH PROGRAM ELEMENTS AS: QUALIFICATIONS EVALUATIONS, EXAMINATION DEVELOPMENT OR ADMINISTRATION, ENFORCEMENT, SCHOOL ACCREDIDATION, ETC.

A licensing board comprising professional behavior analysts will be required to (a) coordinate with the BACB to verify that applicants for licensure have met the degree, coursework, supervised experiential training, and examination requirements established by the profession; (b) verify that applicants have met any other state requirements, such as successful completion of a criminal background check; (c) review and investigate alleged violations of the licensure law or standards of conduct in coordination with other state entities and the BACB; and (d) impose sanctions when violations are found to have occurred. No development or administration of examinations or accreditation of training programs will be required.

55. PROVIDE A COST ANALYSIS SUPPORTING REGULATORY SERVICES TO THIS OCCUPATION. INCLUDE COSTS TO PROVIDE ADEQUATE REGULATORY FUNCTIONS DURING THE FIRST THREE YEARS FOLLOWING IMPLEMENTATION OF THIS REGULATION. ASSURE THAT AT LEAST THE FOLLOWING HAVE BEEN INCLUDED:
    a. costs of program administration, including staffing – see below
    b. costs of developing and/or administering examinations – None. This task is already in place through the Behavior Analyst Certification Board.
    c. costs of effective enforcement programs – see below

Draft Cost Analysis - California Behavior Analyst Licensure Board

Operating Expenses and Equipment

Program Components	Personnel	OE&E
Enforcement (15%)	$21,300	$25,000
Licensing (25%)	$35,500	$35,000
Administration (60%)	$85,200	$85,000
Pro Rata for Dept. which is housing Board (15% of OE&E)		$43,050
Total	**$142,000**	**$188,050**

	Year 1	**Year 2**	**Year 3**
Personnel	($71,000)	($142,000)	($142,000)
OE&E	($94,025)	($188,050)	($188,050)
GF Loan repayment	0	($50,000)	($50,000)

License Revenue				
Initial licensee fees	$630,000	$126,000	$126,000	
Biennial renewal fees			$420,000	
Total	$464,975	($254,050)	$165,950	$376,875

Assumptions:

- Data above is based on assumptions of 1400 initial applicants and 280 new applications for years two and three.
- Revenue assumptions based on the following fees: $250 application fee; $200 initial licensing fee; $300 Biennial Active License Renewal Fee
- $300,000 General Fund Loan for startup to be repaid over a five-year period

56. HOW MANY PRACTITIONERS ARE LIKELY TO APPLY EACH YEAR FOR CERTIFICATION IF THIS REGULATION IS ADOPTED? IF SMALL NUMBERS WILL APPLY, HOW ARE COSTS JUSTIFIED?

Year 1 – 1400 applicants
Year 2 – 280 applicants
Year 3 – 280 applicants

57. DOES ADOPTION OF THE REQUESTED REGULATION REPRESENT THE MOST COST EFFECTIVE FORM OF REGULATION? INDICATE ALTERNATIVES CONSIDERED AND COSTS ASSOCIATED WITH EACH.

Making BACB certification the principal requirement for obtaining and maintaining a California license to practice behavior analysis will be a very cost-effective way for the state to regulate this practice. The state licensing board or staff will not have to check each applicant's degrees, coursework transcripts, or evidence of supervised experiential training to see that s/he meets national standards for practicing behavior analysis; the board will merely need to confirm that the BACB has verified that the applicant has met those requirements. Nor will the state board have to develop or administer examinations, because applicants will have already passed the national professional examination in order to obtain BACB certification.

Passage of a professionally designed and administered, psychometrically valid and reliable examination in the subject matter is required to obtain a valid credential to practice most legitimate professions. At present the only professional examinations in the practice of behavior analysis that comport with accepted psychometric and legal standards are the BACB's. The BACB only gives its examinations to individuals that the BACB has vetted for compliance with its eligibility requirements. It does not contract with state regulatory boards to give its examinations to applicants that those boards deem eligible. We are not aware of

any other appropriately accredited entity that is developing a professional examination in the practice of behavior analysis that will meet accepted standards, or is likely to do so in the near future. Therefore, the only alternative we considered was to have the California behavior analyst licensing board develop an examination. We estimate that would take many thousands of hours of work on the part of that board, many other behavior analysts, expert psychometricians, and attorneys and would cost hundreds of thousands of dollars. We do not consider that alternative viable, and it is unnecessary because the BACB has already done the work and borne the costs of developing high-quality examinations that it is fully prepared to continue administering and updating.

Part C2 – Rating on Sunrise Criteria

Assign each Criterion a numeric rating of 0–5 in the space provided. The rating should be supported by the answers provided to the questions in *Part C1*. Scale descriptions are intended to give examples of characteristics indicative of ratings.

0_____1_____2_____3_____4_____5
(*Little Need for Regulation*) LOW HIGH (*Great Need for Regulation*)

I. UNREGULATED PRACTICE OF THIS OCCUPATION WILL HARM OR ENDANGER THE PUBLIC HEALTH SAFETY AND WELFARE 5

low: Regulation sought only by practitioners. Evidence of harm lacking or remote. Most effects secondary or tertiary. Little evidence that regulation would correct inequities.

high: Significant public demand. Patterns of repeated and severe harm, caused directly by incompetent practice. Suggested regulatory pattern deals effectively with inequity. Elements of protection from fraudulent activity and deceptive practice are included.

II. EXISTING PROTECTIONS AVAILABLE TO THE CONSUMER ARE INSUFFICIENT 4

low: Other regulated groups control access to practitioners. Existing remedies are in place and effective. Clients are generally groups or organizations with adequate resources to seek protection.

high: Individual clients access practitioners directly. Current remedies are ineffective or nonexistent.

III. NO ALTERNATIVES TO REGULATION WILL ADEQUATELY PROTECT THE PUBLIC 4

low: No alternatives considered. Practice unregulated in most other states. Current system for handling abuses adequate.

high: Exhaustive search of alternatives finds them lacking. Practice regulated elsewhere. Current system ineffective or nonexistent.

IV. REGULATION WILL MITIGATE EXISTING PROBLEMS 5

low: Little or no evidence of public benefit from regulation. Case not demonstrated that regulation precludes harm. Net benefit does not indicate need for regulation.

high: Little or no doubt that regulation will ensure consumer protection. Greatest protection provided to those who are least able to protect themselves. Regulation likely to eliminate currently existing problems.

V. PRACTITIONERS OPERATE INDEPENDENTLY, MAKING DECISIONS OF CONSEQUENCE 5

low: Practitioners operate under the supervision of another regulated profession or under the auspices of an organization which may be held responsible for services provided. Decisions made by practitioners are of little consequence.

high: Practitioners have little or no supervision. Decisions made by practitioners are of consequence, directly affecting important consumer concerns.

VI. FUNCTIONS AND TASKS OF THE OCCUPATION ARE CLEARLY DEFINED 5

low: Definition of competent practice unclear or very subjective. Consensus does not exist regarding appropriate functions and measures of competence.

high: Important occupational functions are clearly defined, with quantifiable measures of successful practice. High degree of agreement regarding appropriate functions and measures of competence.

VII. THE OCCUPATION IS CLEARLY DISTINGUISHABLE FROM OTHER OCCUPATIONS THAT ARE ALREADY REGULATED 5

low: High degree of overlap with currently regulated occupations. Little information given regarding the relationships among similar occupations.

high: Important occupational functions clearly different from those of currently regulated occupations. Similar non-regulated groups do not perform critical functions included in this occupation's practice.

VIII. THE OCCUPATION REQUIRES POSSESSION OF KNOWLEDGES, SKILLS AND ABILITIES THAT ARE BOTH TEACHABLE AND TESTABLE 5

low: Required knowledge undefined. Preparatory programs limited in scope and availability. Low degree of required knowledge or training. Current standard sufficient to measure competence without regulation. Required skill subjectively determined; not teachable and/or not testable.

high: Required knowledges clearly defined. Measures of competence both objective and testable. Incompetent practice defined by lack of knowledge, skill or ability. No current standard effectively used to protect public interest.

IX. ECONOMIC IMPACT OF REGULATION IS JUSTIFIED 4

low: Economic impact not fully considered. Dollar and staffing cost estimates inaccurate or poorly done.

high: Full analysis of all costs indicate net benefit of regulation is in the public interest.

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BEHAVIOR ANALYST CERTIFICATION BOARD®

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.

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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.

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(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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BEHAVIOR ANALYST CERTIFICATION BOARD®

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*

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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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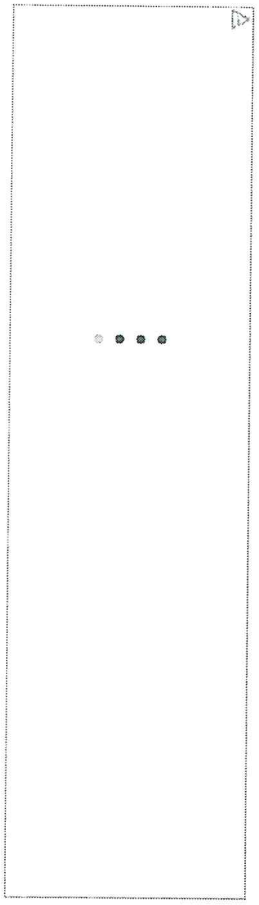

Schools Need To Require Certification Of Behavior Analysts

April 14, 2010
By Press Release

Attorney General Richard Blumenthal today urged the General Assembly to adopt legislation requiring that local school boards verify professional certification before hiring applied behavior analysts for special education of children with autism.

Blumenthal urged the legislation as a New York woman was arraigned in Connecticut state court today for allegedly using false credentials to charge taxpayers and parents tens of thousands of dollars for autism treatment services.

The operator of Spectrum Kids LLC was arrested last month following a joint investigative effort by Norwalk Police, the U.S. Department of Education and Blumenthalâ€™s office.

Blumenthalâ€™s office is continuing to work with Norwalk Police to seek restitution and possibly other remedies on behalf of taxpayers and consumers who were misled into spending thousands of dollars for services based on false credentials.

Meanwhile, Blumenthal said legislative action is necessary to ensure that local school boards — and particularly children — are protected from future harm. Blumenthal said local school boards should not be required to use applied behavior analysts — but those that do should ensure that such analysts are certified by the Behavior Analyst Certification Board (BACB).

â€œParents deserve a promise of professionalism when their child is at stake — particularly when their child requires specialized care,â€

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Blumenthal said. â€œThis legislation ensures that school boards, taxpayers, parents and â€“ most of all â€“ children are fully protected from deceptive and fraudulent services.

â€œIt became clear during our joint investigation that there is no state certification or license to ensure that individuals or agencies hired for behavior analysis services meet minimum educational and professional criteria. I proposed this legislation in consultation with concerned parents, state and local school officials and behavioral experts.â€

Other states that rely on BACB certification include Arkansas, California, Colorado, Florida, Illinois, Indiana, Kentucky, Maryland, Minnesota and Montana.

Similar Posts:

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2 Responses to *Schools Need To Require Certification Of Behavior Analysts*

1. Rocket on April 14, 2010 at 6:44 pm

   Actually, the Individuals with Disabilities Education Act (IDEA) does require school districts to perform Functional Behavior Analysis in certain circumstances. While Mr. Blumenthal is correct in advocating a certain amount of professional expertise be required to conduct these assessments , he is wrong in saying school boards should not be required to use these trained professionals. A principal or other teacher that managed to eek out a minor in psychology does not qualify or have the competence to perform the assessments correctly and without that, money will be flushed down the toilet, disabled children will be short changed and frustrated parents will resort to litigation to ensure that their child's educational needs are met. Have the job done right to begin with and save a lot of money and grief.

   Reply

2. Carly on April 17, 2010 at 10:46 pm

   My blog is an investigation of this very topic. So many ABA companies are exploiting autistic children at the expense of thousands of taxpayer dollars. It is out of control. Even the so-called reputable companies are using "ABA Therapists" who have had nothing but a week of training and are unprofessional and unqualified. Check out your local state-funded ABA providers and find out if they provide autistic children quality therapy. The sad truth is that many do not. Autism has become a means for companies to get rich off taxpayer funds.

   Reply

Leave a Reply

Your email address will not be published. Required fields are marked *

Name *

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BEHAVIOR ANALYST CERTIFICATION BOARD

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."

D

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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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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.

E4

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.

E6

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.

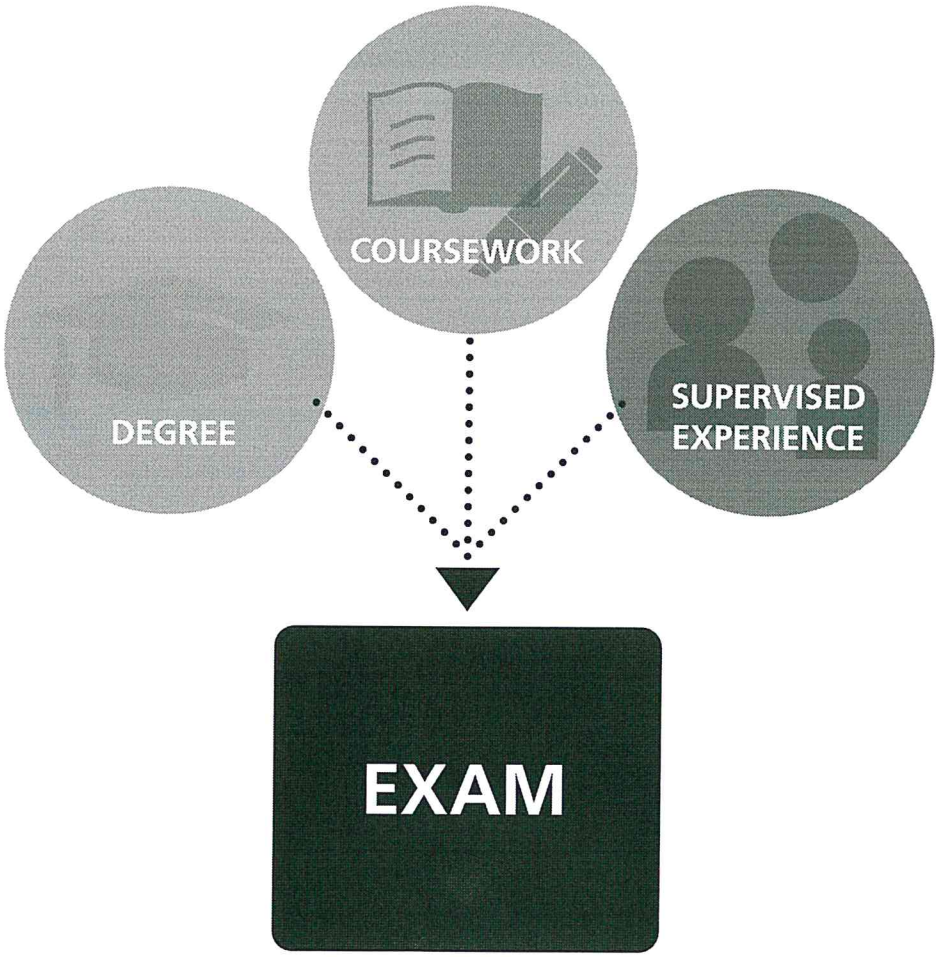
The BCBA and BCaBA certification programs are currently accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence. NCCA reviews and oversees all aspects related to ensuring the development and application of appropriate credentialing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

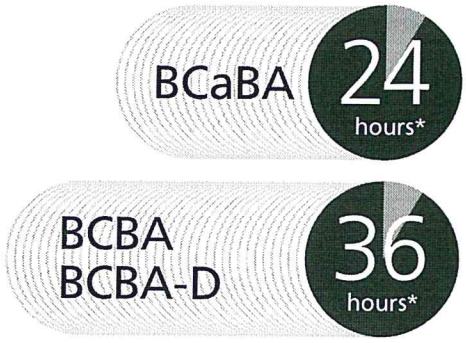
Applicants who meet the degree, coursework, and supervised experience eligibility requirements described in the next section are permitted to sit for either the BCBA or BCaBA examination (see figure below). Each examination is professionally developed to meet accepted examination standards and is based 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 BCBAs or BCBA-Ds 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.

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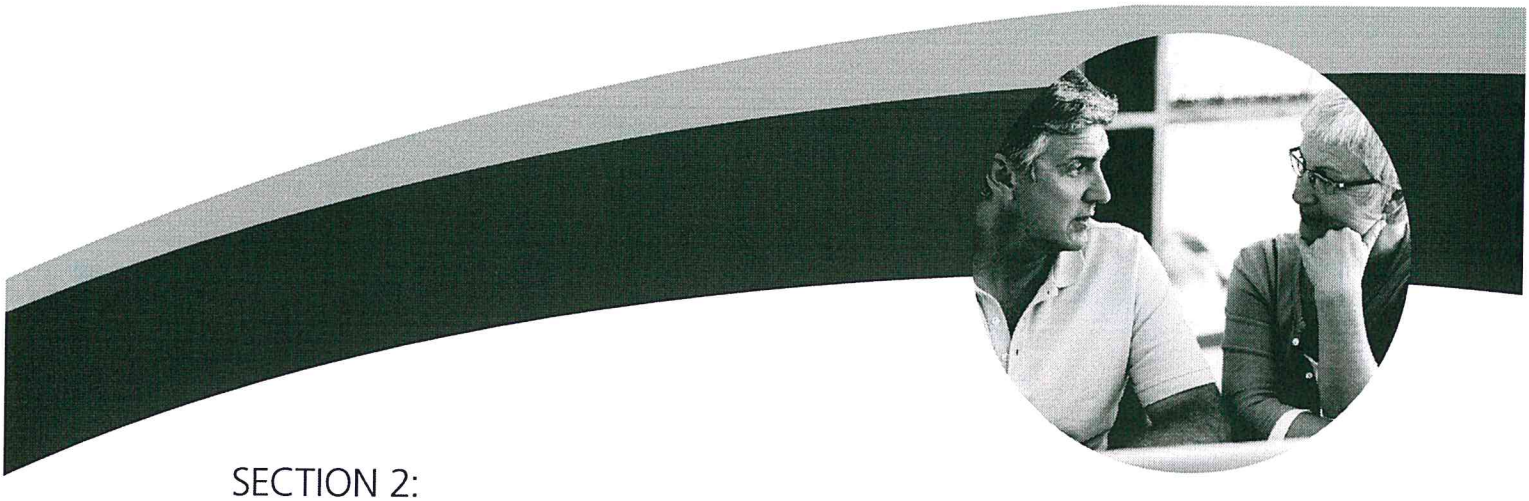

SECTION 2:
APPLIED BEHAVIOR ANALYSIS IN THE TREATMENT OF ASD

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.

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

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).

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.

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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.

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.

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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

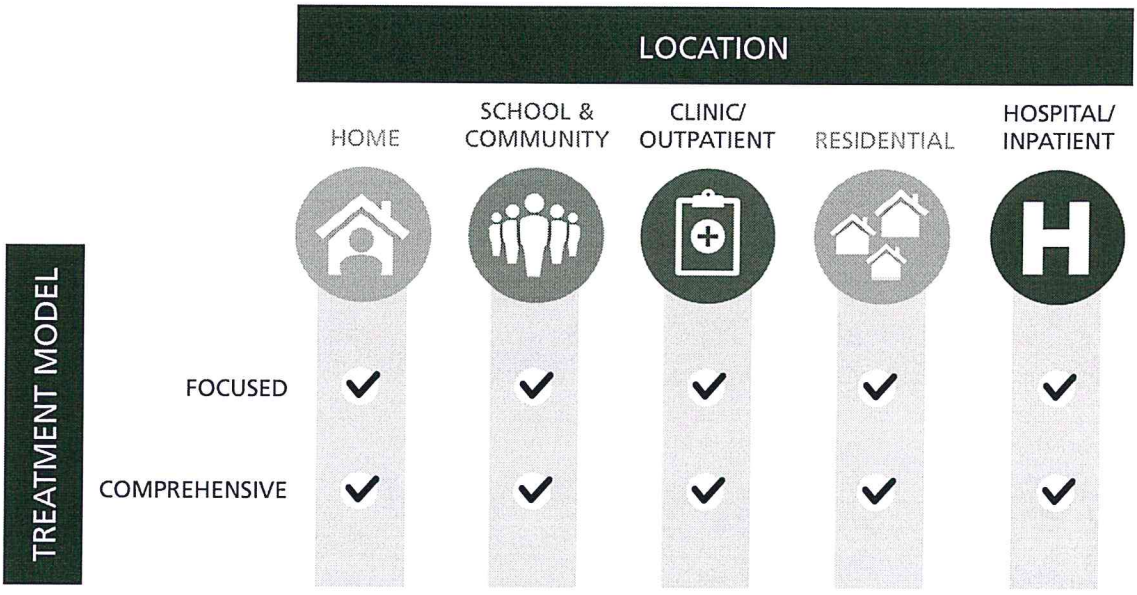
A large number of ABA procedures are routinely employed within the models previously described. They differ from one another in their complexity, specificity, and the extent to which they were designed primarily for use with individuals diagnosed with ASD. All are based on the principles of ABA and are 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.



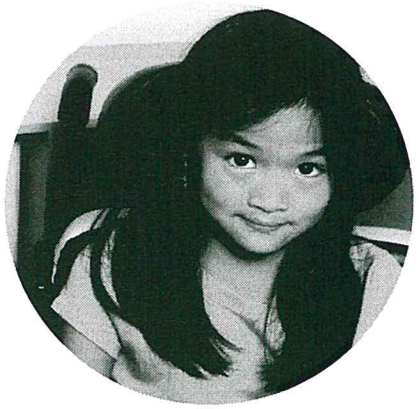
7 Client Age

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.



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.

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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.

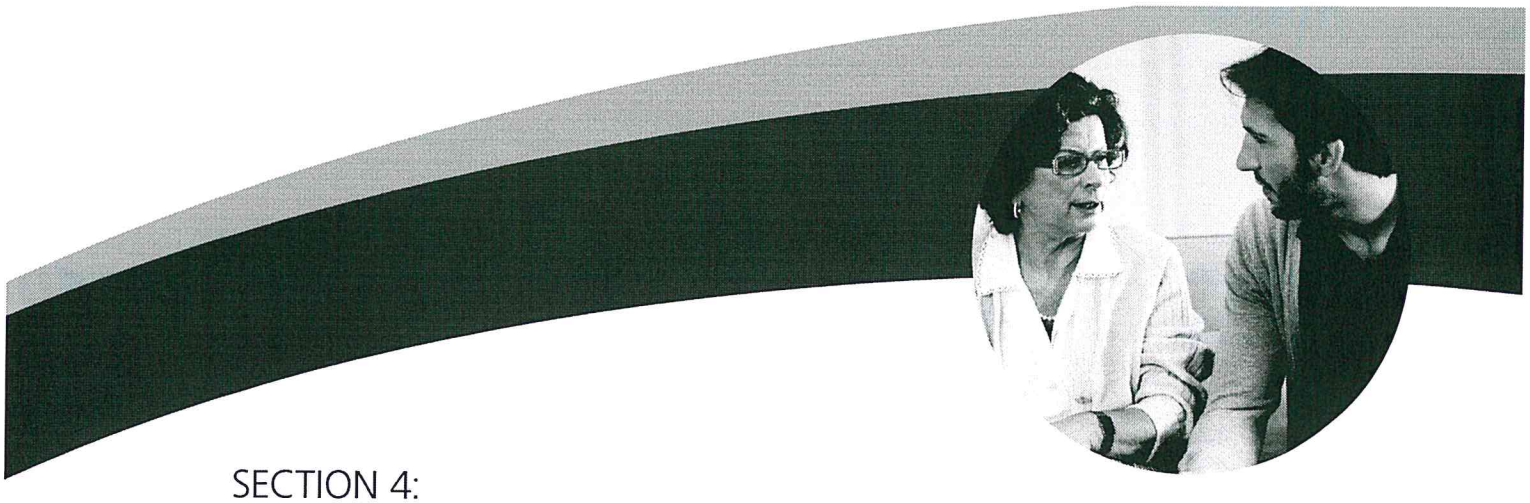
- Assessment batteries must be individualized so that they are appropriate for each client. For example, nonverbal assessments may provide a more accurate profile for a client with limited verbal abilities.
- Formal standardized assessments may also be appropriate in some cases for use on an annual basis 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.

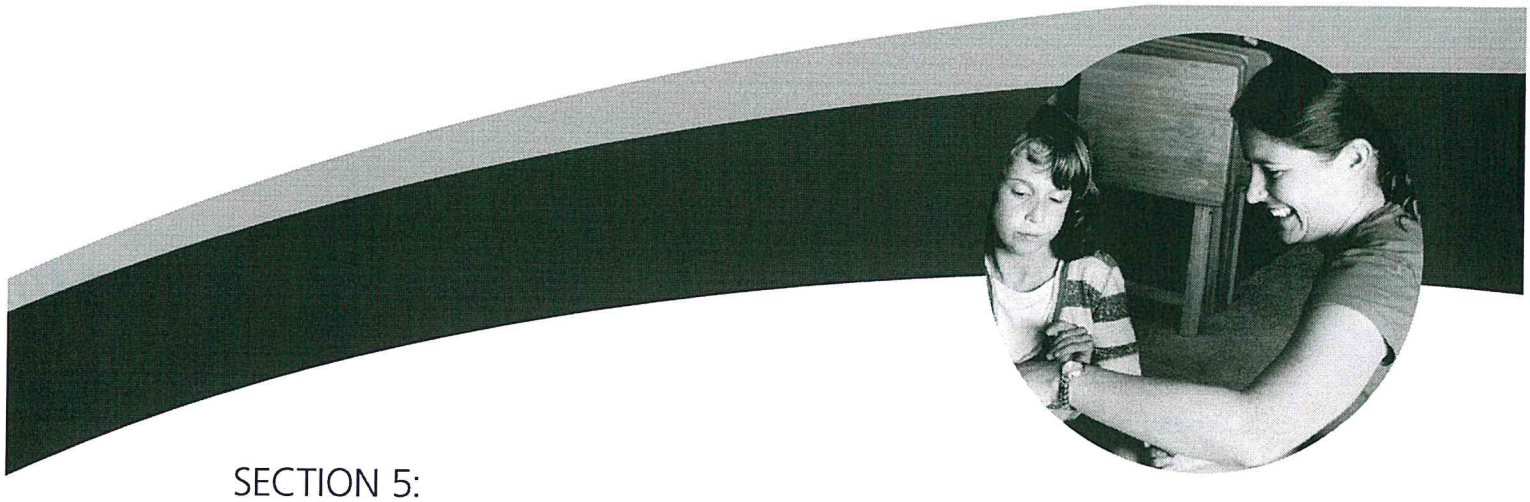
When the goal is to address a limited number of areas such as decreasing dangerous behavior or improving social skills (i.e., Focused ABA)**...**

- 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

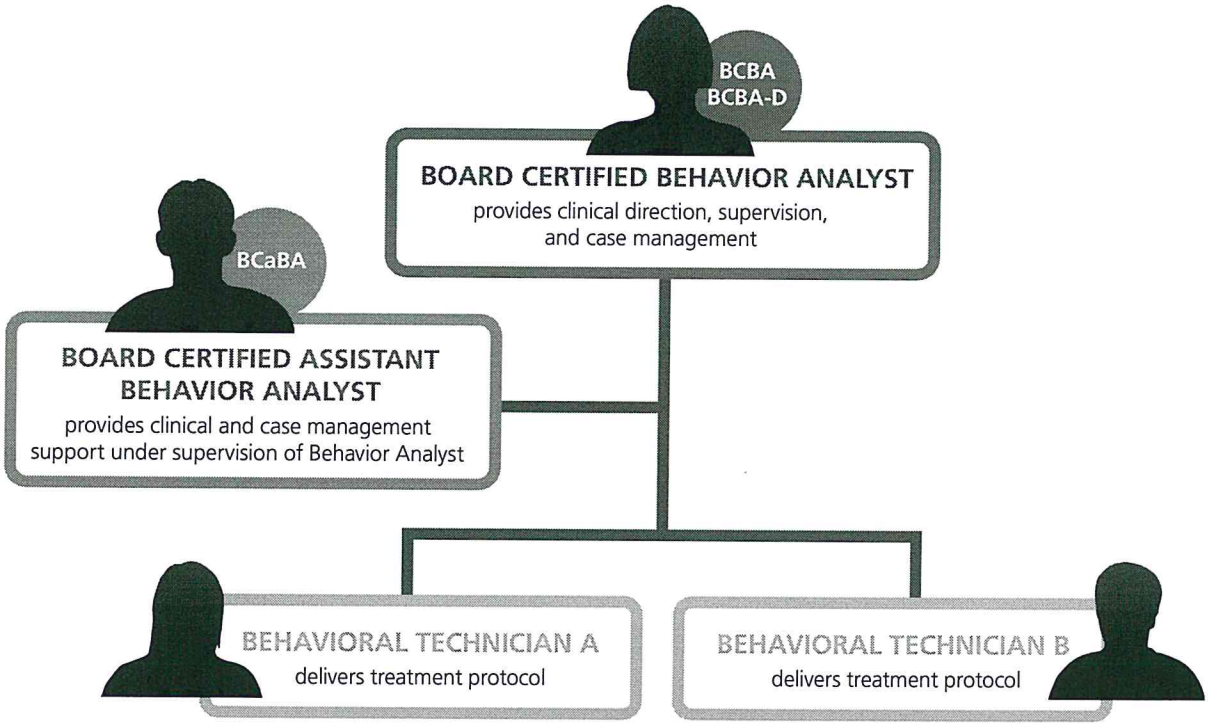
Most ABA treatment programs involve a tiered service delivery model where the Behavior Analyst designs and supervises a treatment program delivered by Behavioral Technicians.

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.

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.

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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 Requirements[7]

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

SAMPLE

Initial Training[8]

- ❑ 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

SECTION 6:
CLINICAL MANAGEMENT AND CASE SUPERVISION

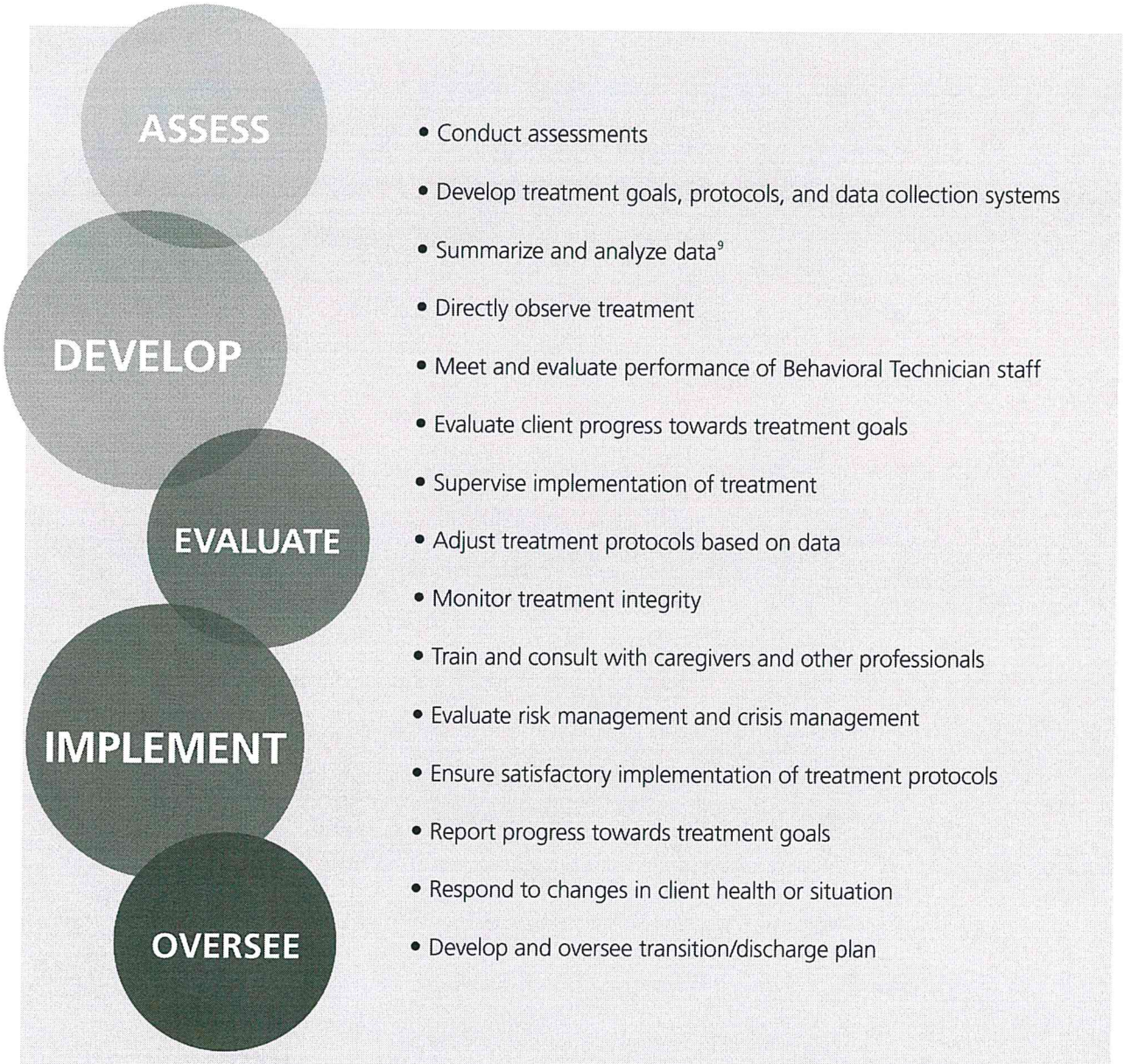
ABA treatments are often described in terms of the number of direct service hours per week. Sometimes absent from such discussions is reference to the required levels of clinical management and case supervision by the Behavior Analyst. Supervision begins with assessment and continues through discharge. 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.

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



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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 ASD[11]

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 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. E35

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.

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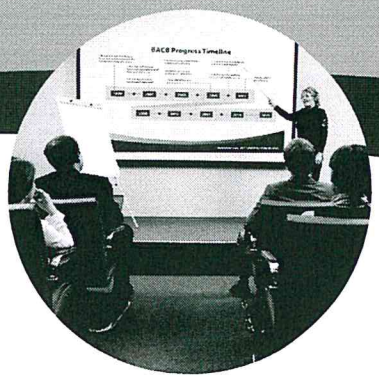


5 Coordination with Other Professionals

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

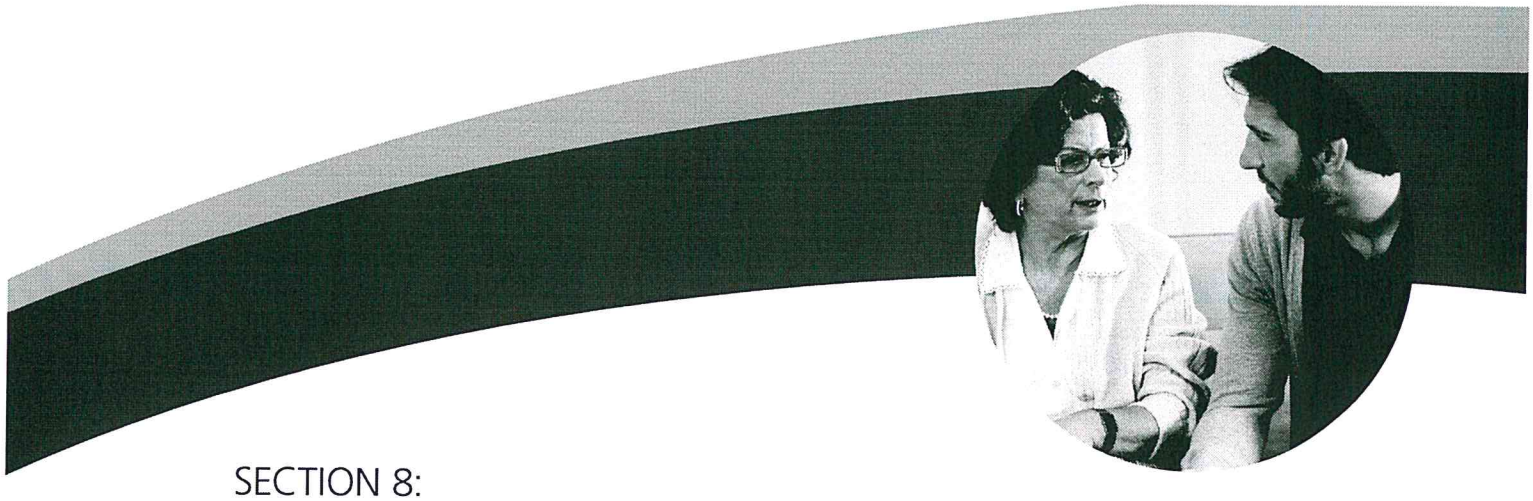
Treatment goals are most likely to be achieved when there is a shared understanding and coordination among all healthcare providers and professionals. Examples include collaboration between the prescribing physician and the Behavior Analyst to determine the effects of medication on treatment targets. 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.

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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

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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www.BACB.com

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COMPLAINT FORM

CONSENT AND RELEASE

This form must be completed whenever the BACB investigates a complaint that involves the provision of services to an adult, legal minor and/or incapacitated individual (collectively referred to in this form as Client). In accordance with HIPAA Privacy Notice requirements, the BACB may be limited in its conduct of investigations involving the provision of services to a Client. By signing below, you agree to the BACB's investigation of the Certificant named in the complaint. If a parent or legal guardian, you agree to assist the BACB by providing your consent to treatment facilities and professionals to release to the BACB any and all information relating to the provision of services by the Certificant named in the complaint. If this form is not being filed by a parent or legal guardian, please provide a copy to the parent or legal guardian for their completion and submission to the BACB. At anytime during or following an investigation by the BACB, the BACB may, in its sole discretion, comply with any state or federal agency request for release of the facts of the investigation and determination(s) by the BACB. By your signature below you consent to and waive any claims for liability against the BACB for the conduct of this investigation, the final determination, and the release (disclosure in any manner) of information involving the provision of services to Client. You expressly understand that the BACB may disclose your identity, the identity of Client and Certificant, and the outcome of the matter, if such information is required or requested by any state or government official or agency.

Name and address of the BACB certificant that provided services to the client ("Certificant"):

_____
_____
_____
_____

Level of certification of the Certificant – circle one: Board Certified Behavior Analyst ("BCBA") or Board Certified Assistant Behavior Analyst ("BCaBA") or Unknown.

Date(s) services provided:

_____
_____
_____
_____

Date(s) that is/are the subject of the complaint:

_____
_____
_____
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Name and address of employer of the Certificant (include contact names and numbers, if known):

_____
_____
_____
_____

Has a complaint been filed with a state agency, government official, professional organization, and/or the Certificant's employer? If yes, indicate below the parties complained to and the outcome (attach any official documentation, including a copy of the complaint, findings of fact and final determination): Yes _____ No _____. If "Yes," describe who filed and received the complaint and the outcome thereof:

_____
_____

Name of Client (if you are an adult):

_____

If Client is a minor or incapacitated individual, provide Client's initials with the name of the parent or legal guardian next to initials of Client:

_____

Address and contact information for Client:

_____
_____
_____

BACB Disciplinary and Ethical Standard alleged to have been violated by Certificant (check all that apply below):

☐ 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 any of these Disciplinary Standards; *(minor edit to reflect charges involving all standards)*

☐ 3. Unauthorized possession of, use of, distribution of, or access to

a. BACB exams,

b. Certificates,

c. Logo of BACB,

d.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*

e. Any other BACB documents and materials.

f. 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, including, but not limited to: exploitation or abuses of a consumer, assault and/or battery of a consumer, or violent or negligent behavior creating risk of harm to consumer;

☐ 9. Failure to adequately supervise or be supervised in accordance with the BACB Standards for Supervision.

FACTS (Each Disciplinary and Ethical Standard Checked above should be factually supported. Provide additional pages if necessary, using 81/2 by 11 paper)

Names and contact information for individuals who are able to verify the facts stated above, if any:

List of additional documents attached to and incorporated into this complaint:

DECLARATION AND AUTHORIZATION: I hereby declare that: (1) I am of legal age to sign this complaint; (2) I am the Client or the parent or legal guardian of Client or I have direct knowledge of the matter; (3) I agree to the terms and conditions stipulated in this form; (4) I waive all claims or liability against the BACB for the conduct of this investigation and/or the release of information relating to this investigation; and (5) the information provided in this complaint is true and accurate to the best of my knowledge. By signing, I agree to indemnify the BACB for any liability or damages arising out of the BACB's investigation of this complaint, if false, inaccurate or misleading information is provided in this complaint.

Agreed by Client or Parent or Legal Guardian of Client OR Eyewitness of Services:

Signed: _____ **Date:** _____

Printed Name: _____

DEPARTMENT

OF

DEVELOPMENTAL SERVICES

AUDIT

OF

WELLSPRING HEALTHCARE SERVICES, INC.

Programs:
Behavior Management Assistance – PL0815 and PL0921

Behavior Analyst – PL0814

Individual or Family Training – PL0894

(Audit Period: July 1, 2009 through June 30, 2010)

Audit Branch

Auditors: Michael Masui, Chief of Vendor Audits
Alton Kitay, Audit Supervisor
Treisa Muhammad, Lead Auditor
Mubashshir Ahmad, Auditor
Soi Ly, Auditor
Wilfredo Golez, Auditor
Agnieszka Mozdzen, Auditor

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WELLSPRING HEALTHCARE SERVICES, INC.

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EXECUTIVE SUMMARY

The Department of Developmental Services (DDS) has audited Wellspring Healthcare Services, Inc. (WHS). The audit was performed upon WHS' Behavior Management Assistance, Behavior Analyst and Individual or Family Training Services for the period of July 1, 2009, through June 30, 2010.

The last day of fieldwork was March 9, 2012.

The results of the audit disclosed the following issues of non-compliance:

Finding 1: **Behavior Management Assistance and Behavior Analyst - Unsupported Billings and Failure to Bill**

The review of WHS' Behavior Management Assistance and Behavior Analyst programs, Vendor Numbers PL0815, PL0921 and PL0814, revealed that WHS had both unsupported billings as well as appropriate support for services that it failed to bill to North Los Angeles County Regional Center (NLACRC). It was found that WHS had a total of $879,210.99 in unsupported billings and a total of $1,445.97 for which it failed to bill to NLACRC.

Finding 2: **Overpayment due to Unlicensed Staff Performing Behavior Analyst Duties**

The WHS staff that performed the duties and responsibilities of a Behavior Analyst for Vendor Number PL0814, lacked the Board Certified Behavior Analyst (BCBA) certifications as required per California Code of Regulations, Title 17 (CCR, title 17). The services billed under service code 612 should have been billed under service code 620. The $3,865.15 amount identified in this finding is the result of the rate differential between service code 612 and service code 620.

The total unsupported and unlicensed billing discrepancies identified in this audit amounts to $881,630.17, which is due back to DDS. A detailed discussion of these findings is contained in the Findings and Recommendations section of this report.

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BACKGROUND

The DDS is responsible, under the Lanterman Developmental Disabilities Services Act, for ensuring that persons with developmental disabilities receive the services and supports they need to lead more independent, productive, and normal lives. DDS contracts with 21 private, nonprofit regional centers that provide fixed points of contact in the community for serving eligible individuals with developmental disabilities and their families in California. In order for regional centers to fulfill their objectives, they secure services and support from qualified service providers and/or contractors. Pursuant to the Welfare and Institutions (W&I) Code, Section 4648.1, DDS has the authority to audit those service providers and/or contractors that provide services and support to persons with developmental disabilities.

OBJECTIVE, SCOPE, AND METHODOLOGY

The audit was conducted to determine whether WHS' Behavior Management Assistance, Behavior Analyst, and Individual or Family Training were compliant with the W&I Code, CCR, title 17, and NLACRC contracts with WHS for the period of July 1, 2009, through June 30, 2010.

WHS was vendorized by NLACRC and provides services to Frank D. Lanterman (FDLRC), Tri-Counties (TCRC), Orange County (RCOC), Eastern Los Angeles (ELARC), Westside (WRC), and San Gabriel/ Pomona (SGPRC) Regional Centers. Our audit reviewed the services provided to NLACRC consumers.

The initial review of WHS' programs consisted of a two-month sample period selected from the audit period of July 1, 2009, through June 30, 2010. Within the two months that were selected (March and April 2010), the audit sample revealed a large percentage of unsupported billings. As a result, the audit period was expanded to include November and December 2009.

The audit was conducted in accordance with the Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States. The auditors did not review the financial statements of WHS, nor was this audit intended to express an opinion on the financial statements. The auditors limited the review of WHS' internal controls to gain an understanding of the transaction flow and invoice preparation process as necessary to develop appropriate auditing procedures. The audit scope was limited to planning and performing audit procedures necessary to obtain reasonable assurance that WHS complied with CCR, title 17. Complaints that DDS' Audit Branch was aware of were addressed during the course of the audit.

Programs:

During the audit period, WHS operated five programs. The audit included the review of three programs. The programs audited are listed below:

- Behavior Management Assistance, Vendor Number PL0815 and PL0921, Service Code 615
- Behavior Analyst, Vendor Number PL0814, Service Code 612
- Individual or Family Training Service, Vendor Number PL0894, Service Code 102

The procedures performed at NLACRC, the vendoring regional center, and WHS included, but were not limited to, the following:

- Review of NLACRC's vendor files for contracts, rate letters, program designs, purchase of service authorizations, and correspondence pertinent to the review.
- Interview of NLACRC's staff for vendor background information and to obtain prior vendor audit reports.
- Interview of WHS' staff and management to gain an understanding of its accounting procedures and processes for billings.
- Review of WHS' service/attendance records to determine if WHS had sufficient and appropriate evidence to support the direct care services billed to the regional centers.
- Performed an analysis of WHS' payroll and attendance/service records to determine if WHS provided the level of staffing required.

CONCLUSION

Based upon items identified in the Findings and Recommendations section, WHS did not comply with the requirements of CCR, title 17.

VIEWS OF RESPONSIBLE OFFICIALS

The DDS issued a draft report on October 11, 2012. No response was received, due to the sudden closure of WHS. The draft report was forwarded to WHS' attorney of record, only to be returned with the explanation that that attorney no longer represented WHS.

RESTRICTED USE

This report is solely for the information and use of the DDS, Department of Health Care Services, NLACRC, FDLRC, TCRC, RCOC, ELARC, WRC, and SGPRC. This restriction is not intended to limit distribution of this report, which is a matter of public record.

FINDINGS AND RECOMMENDATIONS

Finding 1: <u>Behavior Management Assistance and Behavior Analyst - Unsupported Billings and Failure to Bill</u>

The review of WHS' Behavior Management Assistance and Behavior Analyst programs, Vendor Numbers PL0815, PL0921, and PL0814 for March to April 2010 and November to December 2009 revealed that WHS had both unsupported billings, as well as appropriate support for services that it failed to bill to NLACRC.

Unsupported billings occurred due to a lack of appropriate documentation to support the units of service billed to NLACRC. The failure to bill occurred when WHS had appropriate supporting documentation, but did not bill NLACRC for services provided.

<u>Vendor Number PL0815 (615)</u>

WHS was not able to provide appropriate supporting documentation for 12,319.99 units of services billed under Vendor Number PL0815. The lack of documentation resulted in unsupported billings to NLACRC in the amount of $515,924.51.

In addition, WHS provided appropriate supporting documentation for 14.50 units of service under Vendor Number PL0815 which was not billed to NLACRC. This resulted in an unbilled amount of $530.29.

<u>Vendor Number PL0921 (615)</u>

WHS was not able to provide appropriate supporting documentation for 2,614.37 units of services billed under Vendor Number PL0921. The lack of documentation resulted in unsupported billings to NLACRC in the amount of $40,925.80.

In addition, WHS provided appropriate supporting documentation for 29.50 units of service under Vendor Number PL0921 which was not billed to NLACRC. This resulted in an unbilled amount of $915.68.

<u>Vendor Number PL0814 (612)</u>

WHS was not able to provide appropriate supporting documentation for 4,431.07 units of services billed under Vendor Number PL0814. The lack of documentation resulted in unsupported billings to NLACRC in the amount of $322,360.68.

The net total of the billing discrepancies resulted in $877,765.02 of unsupported billings due back to DDS. (See Attachment A.)

CCR, title 17, section 54326(a) (3) and (10) states:

"All vendors shall:

(3) Maintain records of service provided to consumers in sufficient detail to verify delivery of the units of service billed…

(10) Bill only for services which are actually provided to consumers and which have been authorized by the referring regional center…"

Also, CCR, title 17, sections 50604(d) and (e) states:

"(d) All service providers shall maintain complete service records to support all billing/invoicing for each regional center consumer in the program.

(e) All service providers' records shall be supported by source documentation."

Recommendation:

WHS must reimburse DDS $877,765.02 for unsupported billings. In addition, WHS should develop and implement policies and procedures to ensure that proper documentation is maintained to support the amounts billed to NLACRC.

Finding 2: <u>Overpayment due to Unlicensed Staff Performing Behavior Analyst Duties</u>

The WHS staff that performed the duties and responsibilities of a Behavior Analyst for Vendor Number PL0814, lacked the Board Certified Behavior Analyst (BCBA) certifications as required per CCR, title 17. Pursuant to DDS Program Advisory for Group Practice, "All persons providing services as defined in Title 17, CCR, Section 54342, must hold the appropriate licensure or certification to be vendored to provide those specific services. Aides, trained staff, assistants, and others within a group practice who are allowed to provide services under a licensed or certified individual within a group practice must be authorized under a separate service code to be determined between the regional center and the vendor."

The audit revealed that 6 out of 34 staff providing the Behavioral Analyst Services were licensed BCBAs. Therefore, the services billed under service code 612 for the 28 unlicensed staff should have been billed under service code 620. The $3,865.15 identified in this finding is the result of the rate differential between service code 612 and service code 620.

CCR, title 17, Section 54342 (a)(11) states:

" (11) Behavior Analyst - Service Code 612. Behavior Analyst means an individual who assesses the function of a behavior of a consumer and designs, implements, and evaluates instructional and environmental modifications to produce socially significant improvements in the consumer's behavior through skill acquisition and the reduction of behavior. Behavior Analysts engage in functional assessments or functional analyses to identify environmental factors of which behavior is a function. A Behavior Analyst shall not practice psychology, as defined in Business and Professions Code

section 2903. A regional center shall classify a vendor as a Behavior Analyst if an individual is recognized by the national Behavior Analyst Certification Board as a Board Certified Behavior Analyst."

Recommendation:

WHS must reimburse DDS for the rate differential of $3,865.15 for services that were performed by 28 unlicensed staff but were billed under service code 612 for licensed BCBAs. In addition, WHS should ensure that staff performing the duties and responsibilities of a Behavior Analyst under service code 612 have the appropriate license or certification.

Wellspring Healthcare Services, Inc.
Summary of Unsupported Billings & Failure to Bill
Fiscal Year 2009-10

					A	B	C=A*B	D	E=A*D	
						Unsupported Billings		Failure to Bill		Amount Due to DDS
Finding #	*Vendor*	*Svc Code*	*Description*	*Sample Months*	*Rate*	*Units*	*Amount*	*Units*	*Amount*	
1	**Behavior Management Assistant**									
	PL0815	615	Behavior Mgmt Assist 1:1	Mar-10	Various	3,176.58	$ 134,959.07	-	$ -	$ 134,959.07
				Apr-10	Various	3,125.91	$ 126,389.64	(10.50)	$ (326.97)	$ 126,062.67
						6,302.49	$ 261,348.71	(10.50)	$ (326.97)	$ 261,021.74
				Nov-09	Various	2,215.02	$ 92,886.24	(4.00)	$ (203.32)	$ 92,682.92
				Dec-09	Various	3,802.48	$ 161,689.56	-	$ -	$ 161,689.56
						6,017.50	$ 254,575.80	(4.00)	$ (203.32)	$ 254,372.48
			Subtotal			***12,319.99***	***$ 515,924.51***	*(14.50)*	*$ (530.29)*	***$ 515,394.22***
	PL0921	615	Behavior Mgmt Assist 1:1	Mar-10	Various	786.04	$ 16,394.44	(29.50)	$ (915.68)	$ 15,478.76
				Apr-10	Various	1,737.83	$ 21,163.52	-	$ -	$ 21,163.52
						2,523.87	$ 37,557.96	(29.50)	$ (915.68)	$ 36,642.28
				Nov-09	Various	69.25	$ 2,708.24	-	$ -	$ 2,708.24
				Dec-09	Various	21.25	$ 659.60	-	$ -	$ 659.60
						90.50	$ 3,367.84	-	$ -	$ 3,367.84
			Subtotal			***2,614.37***	***$ 40,925.80***	*(29.50)*	*$ (915.68)*	***$ 40,010.12***
1	**Behavior Analyst**									
	PL0814	612	Behavior Analyst 1:1	Mar-10	$ 72.75	1,126.25	$ 81,934.78	-	$ -	$ 81,934.78
				Apr-10	$ 72.75	1,235.65	$ 89,893.65	-	$ -	$ 89,893.65
						2,361.90	$ 171,828.43	-	$ -	$ 171,828.43
				Nov-09	$ 72.75	939.41	$ 68,342.15	-	$ -	$ 68,342.15
				Dec-09	$ 72.75	1,129.76	$ 82,190.10	-	$ -	$ 82,190.10
						2,069.17	$ 150,532.25	-	$ -	$ 150,532.25
			Subtotal			***4,431.07***	***$ 322,360.68***	*-*	*$ -*	***$ 322,360.68***
TOTAL UNSUPPORTED BILLINGS:						***$ 17,003.54***	***$ 879,210.99***	*$ (44.00)*	*$ (1,445.97)*	***$ 877,765.02***

Wellspring Healthcare Services, Inc.
Summary of Unsupported Billings & Failure to Bill
Fiscal Year 2009-10

					A	B	C=A*B	D	E=A*D	
						Unsupported Billings		Failure to Bill		Amount Due to DDS
Finding #	*Vendor*	*Svc Code*	*Description*	*Sample Months*	*Rate*	*Units*	*Amount*	*Units*	*Amount*	
2	**Behavior Analyst**									
	PL0814	612	*BCBA License Review*	Nov-09	$ 21.92 [1]	68.50	$ 1,501.52	-	$ -	$ 1,501.52
				Dec-09	$ 21.92 [1]	107.83	$ 2,363.63	-	$ -	$ 2,363.63
TOTAL UNLICENSED BILLINGS:						***176.33***	***$ 3,865.15***	-	$ -	***$ 3,865.15***
TOTAL UNSUPPORTED & UNLICENSED BILLINGS:						***17,179.87***	***$ 883,076.14***	*(44.00)*	*$ (1,445.97)*	***$ 881,630.17***

[1] The rate of $21.92 was computed as the difference between the rate paid for services provided by BCBA Licensed staff ($72.75 per hour) and the rate that is paid for services provided by unlicensed staff ($50.83 per hour).

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor

Consumer Affairs

LEGAL AFFAIRS
400 R STREET, SUITE 3091
SACRAMENTO, CA 95814-6200

(916) 445-4216

February 11, 2000

CATHY BARANKIN
Sacramento Advocacy
2220 Capitol Advocacy
Sacramento, CA 95816

Re: **Behavioral Analysts**

Dear Ms. Barankin: Cathy

This is in response to your request that I memorialize in writing, a presentation and legal opinion relating to behavioral analysts that I offered at a meeting at the Department of Education in January of 1997. In that presentation I concluded that behavioral analysts, practicing as described, are not required to be licensed as psychologists or marriage, family and child counselors (now marriage and family therapists). LaVonne Powell, who serves as legal counsel to the Board of Behavioral Sciences, and who also attended that meeting, concurred in the opinion. I apologize that the press of business in our office precluded my getting this to you earlier.

The following memorializes the presentation, which included a history of the Department of Consumer Affairs (DCA) involvement in the matter.

DCA's involvement began in the latter part of 1996 when the department was asked to respond to a series of questions relating to implementation of SB 989 (1996) by the Department Education. At that time, Greg Hudson was a Special Project Consultant with the Department of Education and was responsible for formulating the implementing regulations. Mr. Hudson was working with a group of interested parties, called the "SB 989 Work Group," on the regulations.

In early November of 1996, Mr. Hudson met with representatives of DCA and provided information on the context and background of SB 989. Subsequent to that meeting, he provided information to the DCA Legal Office regarding what behavioral analysts actually do, in the form of a training manual from one of the firms which contracted with school districts to provide these services. There were several telephone conversations to clarify certain issues. The initial, preliminary review by the Legal Office indicated that some of the activities of behavioral analysts constituted the practice of psychology, and some activities bordered on the practice of medicine. The training manual described a major component of their activities as behavioral diagnosis, which, in part, included determining that a child's aberrant behavior may be the result of illness or a reaction to medication. We provided Mr. Hudson with a copy of pertinent provisions of the Psychology License law, a summary of an Attorney General's opinion, and a summary of a case entitled Magit v. Board of Medical Examiners.

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In early December 1996, a second meeting was then held with Mr. Hudson to discuss the issues.

Based on our discussions at that December meeting, Mr. Hudson sent a letter to the SB 989 Work Group, indicating that the preliminary opinion of the Legal Office, based solely on the information reviewed, was that some of the activities in which behavioral analysts engaged constituted the practice of psychology. The letter also requested any input the behavioral analysts wished to submit, and requested that it be submitted some two weeks prior to Legal Office attorneys Dan Buntjer and LaVonne Powell attending a meeting of the SB 989 Work Group, scheduled for January 30, 1997.

Significant and valuable input was provided by a number of interested parties and the Legal Office attorneys reviewed the information. The thrust of the information and argument was that behavioral analysts were not practicing psychology and, therefore, were not required to be licensed.

In mid-January, on behalf of the behavioral analysts, you requested a meeting with the Legal Office attorneys. On January 27, the undersigned and LaVonne Powell met with you, Greg Wagner, a licensed psychologist and behavioral analyst who works for the Department of Developmental Services, and Mark Levine, a behavioral analyst and co-owner of the Behavioral Counseling and Research Center. Dr. Wagner made it clear he was at the meeting solely in his private capacity and not as a representative of DDS. There was further extensive discussion of the actual practices of behavioral analysts. At this meeting, you indicated that legislation would be introduced to statutorily recognize behavioral analysts.

On January 30, 1997, the undersigned and LaVonne Powell attended a meeting of the SB 989 Work Group. We presented the above-noted chronological history of DCA's involvement in the regulatory process and our legal approach to analyzing the licensing issue that had arisen.

We advised the SB 989 Work Group that after review of all the information submitted, and the clarification of various matters through discussion and input, it was our legal opinion that behavioral analysts, performing as represented to us, were not engaged in the practice of psychology or marriage, family and child counseling (now marriage and family therapy).

The following information and analysis changed our preliminary conclusion.

1. Behavioral analysts do not engage in diagnosing mental disorders or treating mental disorders, but focus on external environmental factors that influence behavior.

2. When Individual Education Plans (IEPs) are developed for children needing special education services, it is common for a licensed mental health professional to be on the evaluation team, providing those services requiring licensure.

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3. While behavioral analysts are engaged in behavior modification, it is in a context and methodology different than that of psychologist and marriage, family and child counselors.

4. The term "diagnosis" is not being used in its commonly understood medical or clinical sense. A more accurate term in this context is functional analysis.

5. Most importantly, when the issue is viewed from a strict legal perspective, it would appear extremely difficult to prosecute a behavioral analyst for engaging in the unlicensed practice of psychology or marriage, family and child counseling. Unlicensed practice is a crime. This means that licensing boards would be required to prove beyond a reasonable doubt that the person engaged in unlicensed practice. Given that the Department of Education has, at least implicitly, recognized and authorized the practice of behavioral analysts, and it has been practiced for some 30+ years, successful prosecution for unlicensed practice seems doubtful.

I trust the foregoing is responsive to your request. If you have any questions, or need to further discuss the foregoing, please feel free to contact me at your convenience.

Sincerely,

DON CHANG
Supervising Counsel

Daniel Buntjer

By DANIEL BUNTJER
Senior Staff Counsel

cc: Tom O'Connor, EO, Board of Psychology
Sherry Mehl, EO, Board of Behavioral Sciences
LaVonne Powell, Staff Counsel

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BEHAVIOR ANALYST CERTIFICATION BOARD
- Experience Standards -

INSTRUCTIONS

This document contains all of the standards and forms for experience used to qualify for BACB certification.

All experience used toward the requirements for BACB certification must meet these standards. **The BACB requires the supervisor and supervisee review this entire document together and discuss any concerns before the experience begins.**

In addition to the experience-standards definitions, this document contains two forms for documenting experience used toward BACB certification. They are:

1. The Experience Supervision Form: This form, or equivalent, must be completed at least once during each supervision period, throughout the duration of your experience. This form must be duplicated with a copy retained by both the supervisor and supervisee.

   and

2. The Experience Verification Form: This form should be completed at the conclusion of your experience. If you have multiple experiences, you will need to complete multiple forms; one for each experience/supervisor. The original, unaltered form must be submitted. Forms with white-out or other alterations will not be accepted. Forms must bear the supervisor's original signature. Photocopies will not be accepted.
   All applicants for certification must submit documentation of their experience using the current version of the Experience Verification Form. Previous versions of the form will no longer be accepted.

Initial exam applications should include Experience Verification Forms only. **Do not submit the Experience Supervision Forms completed during each supervisory period unless specifically requested by the BACB.**

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EXPERIENCE CATEGORIES

SUPERVISED INDEPENDENT FIELDWORK (1500 hours BCBA, 1000 hours BCaBA): To qualify under this standard at the BCBA level, supervisees must complete 1500 hours of Supervised Independent Fieldwork in behavior analysis. To qualify under this standard at the BCaBA level, supervisees must complete 1000 hours of Supervised Independent Fieldwork in behavior analysis. A supervisory period is **two weeks**. In order to count experience hours within any given supervisory period, supervisees must be supervised **at least once** during that period for no less than **5%** of the total hours spent in Supervised Independent Fieldwork. For example, 20 hours of experience would include at least 1 supervised hour.

PRACTICUM (1000 hours BCBA, 670 hours BCaBA): To qualify under this standard at the BCBA level, supervisees must complete, with a passing grade, 1000 hours of Practicum in behavior analysis within a university practicum program **approved by the BACB** and taken for graduate academic credit. To qualify under this standard at the BCaBA level, supervisees must complete, with a passing grade, 670 hours of Practicum in behavior analysis within a university practicum program **approved by the BACB** and taken for academic credit. A supervisory period is **one week**. In order to count experience hours within any given supervisory period, supervisees must be supervised **at least once** during that period for no less than **7.5%** of the total hours spent in Practicum. For example, 20 hours of experience would include at least 1.5 supervised hours.

INTENSIVE PRACTICUM (750 hours BCBA, 500 hours BCaBA): To qualify under this standard at the BCBA level, supervisees must complete, with a passing grade, 750 hours of Intensive Practicum in behavior analysis within a university practicum program **approved by the BACB** and taken for graduate academic credit. To qualify under this standard at the BCaBA level, supervisees must complete, with a passing grade, 500 hours of Intensive Practicum in behavior analysis within a university practicum program **approved by the BACB** and taken for academic credit. A supervisory period is **one week**. In order to count experience hours within any given supervisory period, supervisees must be supervised **at least twice** during that period for no less than **10%** of the total hours spent in Intensive Practicum. For example, 20 hours of experience would include at least 2 supervised hours.

For all three of the above options, no fewer than 10 hours but no more than 30 hours, including supervision, may be accrued per week. Supervisees may accrue experience in only **one category per supervisory period** (i.e., Supervised Independent Fieldwork, Practicum, or Intensive Practicum).

COMBINATION OF EXPERIENCE CATEGORIES: Supervisees may elect to accrue hours in a single category or may combine any 2 or 3 of the categories above (Supervised Independent Fieldwork, Practicum, Intensive Practicum) to meet the experience requirement, with Practicum having 1½ times the temporal value of Supervised Independent Fieldwork, and Intensive Practicum having 2 times the temporal value of Supervised Independent Fieldwork.

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STANDARDS

ONSET OF EXPERIENCE: Supervisees may not start accumulating Supervised Independent Fieldwork, Practicum, or Intensive Practicum hours until they have started attending courses required to meet the BACB coursework requirements.

APPROPRIATE ACTIVITIES: The supervisee's primary focus should be acquiring **new behavior-analytic skills** related to the BACB Third Edition Task List or the BACB Fourth Edition Task List as appropriate. Activities must be consistent with the dimensions of applied behavior analysis identified by Baer, Wolf, and Risley (1968) in the article "Some Current Dimensions of Applied Behavior Analysis" published in the *Journal of Applied Behavior Analysis*. **The supervisor will determine if experience activities qualify based on these sources.**

Supervisees are strongly encouraged to have multiple experiences (e.g., sites, populations) with multiple supervisors and from each of the activity areas below.

- Conducting assessments related to the need for behavioral intervention (e.g., stimulus preference assessment, functional assessment, staff performance assessment);
- Designing, implementing, and systematically monitoring skill-acquisition and behavior-reduction programs;
- Overseeing the implementation of behavior-analytic programs by others;
- Training, designing behavioral systems, and performance management;
- Other activities normally performed by a behavior analyst that are directly related to behavior analysis such as attending planning meetings regarding the behavior analytic program, researching the literature related to the program, and talking to individuals about the program.

Examples of activities that will not count as experience include: attending meetings with little or no behavior-analytic content; providing interventions that are not based in behavior analysis; performing nonbehavioral administrative activities; and completing nonbehavioral assessments (e.g., diagnostic assessments, intellectual assessments), paperwork, documentation, billing, or any other activities that are not directly related to behavior analysis.

No more than 50% of the total accrued experience hours can be in the direct implementation of behavioral programs.

APPROPRIATE CLIENTS: Clients may be any persons for whom behavior-analytic services are appropriate. However, the supervisee may not be related to the client or the client's primary caretaker or be the client's primary caretaker. Supervisees must work with multiple clients during the experience period. (Also, see the following relevant sections of the *BACB Guidelines for Responsible Conduct for Behavior Analysts*: 1.06, 1.07, 2.0, 3.01, 3.03, 3.04, 3.05, 4.0, and 9.07.)

SUPERVISOR QUALIFICATIONS: During the experience period, the supervisor must be a Board Certified Behavior Analyst or Board Certified Behavior Analyst-Doctoral in good standing. The supervisor may not be related to, subordinate to, or employed by the supervisee during the experience period. Employment does not include compensation received by the supervisor from the

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supervisee for supervision services. (Also, see the following relevant sections of the *BACB Guidelines for Responsible Conduct for Behavior Analysts*: 1.05, 1.06, 1.07, and 5.0.)

NATURE OF SUPERVISION: The purpose of supervision is to improve and maintain the behavior-analytic, professional, and ethical repertoires of the supervisee and facilitate the delivery of high-quality services to his/her clients. Effective behavior-analytic supervision includes:

- Development of performance expectations
- Observation, behavioral skills training, and delivery of performance feedback
- Modeling technical, professional, and ethical behavior
- Guiding behavioral case conceptualization, problem-solving, and decision-making repertoires
- Review of written materials (e.g., behavior programs, data sheets, reports)
- Oversight and evaluation of the effects of behavioral service delivery
- Ongoing evaluation of the effects of supervision

The supervisor must observe and provide feedback to the supervisee on his/her behavior-analytic activities with a client in the natural environment during each required supervisory period. In-person, on-site observation is preferred. However, this may be conducted via web-cameras, videotape, videoconferencing, or similar means in lieu of the supervisor being physically present; synchronous (real-time) observation is strongly encouraged.

Supervision may be conducted in small groups for no more than half of the total supervised hours in each supervisory period. Small groups are interactive meetings in which 2-10 supervisees who share similar experiences participate in the supervision activities described above. If non-supervisees are present during the meeting, their participation should be limited so as to increase the interaction opportunities of supervisees. The remainder of the total supervision hours in each supervisory period must consist of individual supervision.

SUPERVISION CONTRACT: The supervisee and supervisor must execute a written contract prior to the onset of the experience. The purpose of the contract is to protect all involved parties and align experience activities with the purpose of supervision described under Nature of Supervision (below). The contract should:

- State the responsibilities of the supervisor and supervisee; and
- Include a description of the appropriate activities and instructional objectives; and
- Include the objective and measurable circumstances under which the supervisor will sign the supervisee's Experience Verification Form when the experience has ended; and
- Delineate the consequences should the parties not adhere to their responsibilities (including proper termination of the relationship); and
- Include a statement requiring the supervisee to obtain written permission from the supervisee's on-site employer or manager when applicable; and
- Include an attestation that both parties will adhere to the *BACB Guidelines for Responsible Conduct for Behavior Analysts* and the *BACB Disciplinary and Ethical Standards*

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The supervisee and supervisor are responsible for retaining and providing to the BACB, if requested, a copy of the contractual agreement.

DOCUMENTATION OF ONGOING SUPERVISION: The supervisee and supervisor are responsible for collecting documentation for each supervision period on the Experience Supervision Form during each supervisory period. One form should be completed at the end of each supervisory period. The BACB reserves the right to request this documentation at any time following an individual's application to take the certification exam. This documentation should **NOT** be submitted with an exam application unless specifically requested by the BACB.

Supervisors may develop their own version of the Experience Supervision Form. These alternative forms must include all of the following elements:

- Date of each supervisory meeting
- Duration of each supervisory meeting
- Format of each supervisory meeting (i.e., individual or small group)
- An evaluation of supervisee performance
- The total experience hours obtained during the supervisory period
- The total individual and small-group supervision hours obtained during the supervisory period
- Date lines for supervisor and supervisee indicating when the form was completed & signed
- Signature lines for supervisor and supervisee

The supervisee and supervisor are responsible for retaining and providing to the BACB, if requested, copies of supervision documentation. Supervision documentation should be retained for at least 7 years.

The BACB Experience Standards and Forms were updated in September 2012. Please be sure to use the current version, available in the Downloads section of www.bacb.com. All applicants for certification must submit documentation of their experience using the current version of the Experience Verification Form. Previous versions of the form will no longer be accepted.

CONTESTED EXPERIENCE: If a supervisee is unable to obtain the signature of a supervisor on the Experience Verification Form or disagrees with the total number of hours recorded on the form, the supervisee may supplement his or her application with proof of the following:

a. A copy of the supervisory contract
b. Copies of the signed Experience Supervision Forms completed during the experience
c. Letters or other documentation from third parties who observed the supervisory relationship

Supervisees also must provide the supervisor with copies of the documentation they are submitting to the BACB and must include proof of provision of this information to the supervisor (e.g., certified mail receipt along with a letter from the supervisee to the supervisor). The BACB may attempt to contact the supervisor to confirm receipt of this information and to provide him or her with an opportunity to address this matter in writing. Supervisors will be asked to provide documentation of dissatisfaction/concerns regarding the experience previously provided to supervisees claiming a contested supervision. If the application is denied based on the lack of proof of supervision, supervisees will have a right to appeal this denial.

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BACB Experience Supervision Form

This form (or equivalent) must be completed at least once during each supervisory period.

Supervisee:_____ Supervisor:_____

Supervisory Meeting Date(s) & Duration(s):_____

Supervisory Meeting Format (check all that apply): _____ individual _____ group

This document covers the supervisory period from ____/____/____ to ____/____/____

Experience Hours Accumulated During This Supervisory Period (complete all four lines)

A) Number of independent experience hours accumulated (excluding time spent with supervisor): _____
Of the hours listed above, state the number spent in direct implementation of behavioral programs: _____

B) Number of individual supervision hours accumulated: _____

C) Number of small-group supervision hours accumulated: _____

D) Total experience hours accumulated (add lines A through C): _____

Characteristics of Supervision Conducted During This Supervisory Period (check all that apply)

_____ BACB Task List skills covered (list Task numbers): _____
_____ Specific client(s) discussed
_____ Client privacy protected
_____ Observation of supervisee (video)
_____ Observation of supervisee (in-person)
_____ Supervisory discussion & feedback (in-person)
_____ Supervisory discussion & feedback (remote)
_____ Readings: _____

Evaluation of Supervisee Performance:

S – satisfactory **NI** - needs improvement **U** - unsatisfactory **N/A** – not applicable

	S	NI	U	N/A
Arrives on time for supervision				
Maintains professional and courteous interactions with:				
Clients/consumers				
Other service providers				
Coworkers				
Maintains appropriate attire & demeanor				
Initiates professional self-improvement				
Accepts supervisory feedback appropriately				
Seeks supervision appropriately				
Timely submission of written reports				
Communicates effectively				
Written				
Oral				
Demonstrates appropriate sensitivity to nonbehavioral providers				
Supervisee self-detects personal limitations				
Supervisee self-detects professional limitations				
Acquisition of target behavior-analytic skills				

Overall evaluation of supervisee performance during this period (circle one): S NI U

Supervisee signature: _____ Date: _____

Supervisor signature: _____ Date: _____

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DO NOT SUBMIT THIS FORM TO THE BACB WITH THE EXAM APPLICATION

SUPERVISOR AND SUPERVISEE MUST EACH RETAIN A COPY OF THIS FORM FOR AT LEAST 7 YEARS

BACB Experience Verification Form

SECTION A

Use one form per experience. Applicants may accrue only one type of experience at a time.

Applicant's Name: _____

Experience Hours Accumulated (complete all three lines):

A) Number of independent experience hours accumulated: _____
Of the hours listed above, state the number spent in direct implementation of behavioral programs: _____
B) Number of supervision hours accumulated: _____
C) Total experience hours accumulated (add lines A and B): _____

Experience Type Obtained (check only one):

☐ Supervised Independent Fieldwork

☐ BACB Approved University Practicum (transcript must show passing grade in approved courses)

☐ BACB Approved University Intensive Practicum (transcript must show passing grade in approved courses)

Experience Time-Frame:

Starting date (MM/DD/YYYY) ___ / ___ / _____ - Ending date (MM/DD/YYYY) ___ / ___ / _____
(Must NOT be prior to April 1, 2005) (Indicate specific date; do not write "present")

Supervisor's Name: _____

Supervisor's Title: _____ **Telephone:** _____

Experience Setting: _____ **City:** _____ **State/Country:** _____

SECTION B

Must be completed by supervisor

***By signing below, I hereby attest that*:**

- The applicant completed the experience as specified in this policy document under my supervision and in compliance with all of the stated requirements.
- I am the responsible supervisor designated in the supervision contract with this supervisee.
- During the applicant's experience I was a Board Certified Behavior Analyst # _____

Supervisor: By signing below, you attest that ALL of the information contained on this Experience Verification Form is true and correct to the best of your knowledge.

Printed Name of Supervisor: _____

Signature: _____ **Date:** _____

This document must bear the original signature of the supervisor. Photocopies, faxed, or emailed copies of this document will not be accepted. Original documents that have been altered (white-out, strike-through, etc.) will not be accepted. Incomplete documents will not be accepted.

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California Health Benefits Review Program

Executive Summary

Analysis of Senate Bill 126: Health Care Coverage: Pervasive Developmental Disorder or Autism

A Report to the 2013-2014 California Legislature March 24, 2013

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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A Report to the 2013–2014 California State Legislature

Analysis of Senate Bill 126
Health Care Coverage: Pervasive Developmental Disorder or Autism

March 24, 2013

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EXECUTIVE SUMMARY

California Health Benefits Review Program Analysis of Senate Bill 126

The California Senate Committee on Health requested on January 23, 2013, that the California Health Benefits Review Program (CHBRP) conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 126. In response to this request, CHBRP undertook this analysis pursuant to the provisions of the program's authorizing statute.[1]

In 2014, CHBRP estimates that approximately 25.9 million Californians (67%) will have health insurance that may be subject to a health benefit mandate law passed at the state level.[2] Of the rest of the state's population, a portion will be uninsured (and so has no health insurance subject to any benefit mandate), and another portion will have health insurance subject to other state laws or only to federal laws.

Uniquely, California has a bifurcated system of regulation for health insurance subject to state benefit mandates. The California Department of Managed Health Care (DMHC)[3] regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers,[4] which offer benefit coverage to their enrollees through health insurance policies.

DMHC-regulated plans and CDI-regulated policies would be subject to SB 126. However, SB 126 exempts Medi-Cal Managed Care Plans and the California Public Employees' Retirement System (CalPERS). Therefore, the mandate would affect the health insurance of approximately 18.5 million enrollees (48% of all Californians).

Developing Estimates for 2014 and the Effects of the Affordable Care Act

The Affordable Care Act (ACA)[5] is expected to dramatically affect health insurance and its regulatory environment in California, with many changes becoming effective in 2014. It is important to note that CHBRP's analysis of proposed benefit mandate bills typically address the marginal effects of the proposed bills—specifically, how the proposed mandate would affect benefit coverage, utilization, costs, and public health, holding all other factors constant. CHBRP's estimates of these marginal effects are presented in this report. Because expanded enrollment will not occur until January 2014, CHBRP relies on projections from the California

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[1] Available at: www.chbrp.org/docs/authorizing_statute.pdf.
[2] CHBRP's estimates are available at: www.chbrp.org/other_publications/index.php.
[3] The California Department of Managed Health Care (DMHC) was established in 2000 to enforce the Knox-Keene Health Care Service Plan of 1975; see Health and Safety Code (H&SC) Section 1340.
[4] The California Department of Insurance (CDI) licenses "disability insurers." Disability insurers may offer forms of insurance that are not health insurance. This report considers only the impact of the benefit mandate on health insurance policies, as defined in Insurance Code (IC) Section 106(b) or subdivision (a) of Section 10198.6.
[5] The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

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Simulation of Insurance Markets (CalSIM) model[6] to help set baseline enrollment for 2014. From this projected baseline, CHBRP estimates the marginal impact of benefit mandates proposed that could be in effect after January 2014.

Bill-Specific Analysis of SB 126

SB 126 would extend the sunset date of an existing state benefit mandate that requires coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A).[7] The existing state benefit mandate, **hereafter referred to as the behavioral health treatment mandate**, sunsets on July 1, 2014. SB 126 would extend the sunset date until July 1, 2019,[8] but otherwise contains the same language as the existing mandate (enacted in 2011) that requires coverage for behavioral health treatment for PDD/A.

The existing behavioral health treatment mandate defines behavioral health treatment as including but not limited to applied behavior analysis (ABA).[9] Specifically, it defines behavioral health treatment as "professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism." In this report, interventions based on ABA and other theories of behavior are referred to as intensive behavioral intervention therapies. This report focuses on intensive behavioral intervention therapies based on ABA because the behavorial health treatment mandate specifically mentions ABA.

The existing behavioral health treatment mandate requires that treatment be prescribed by a licensed physician and surgeon or developed by a licensed psychologist. The mandate requires that the treatment be "provided under a treatment plan prescribed by a qualified autism service provider," and administered by a "qualified autism service provider" (QAS provider), a "qualified autism service professional" (QAS professional), or a "qualified autism service paraprofessional" (QAS paraprofessional) who can be an "unlicensed and uncertified" person.

Of those persons who can administer intensive behavioral intervention therapies to enrollees with PDD/A under the behavioral health treatment mandate, QAS professionals and paraprofessionals must be employed and supervised by a QAS provider. The mandate requires that DMHC-regulated plans and CDI-regulated policies maintain an adequate network of QAS providers to supervise and employ QAS professionals and paraprofessionals.

The existing behavioral health treatment mandate additionally requires that the mandated benefits be provided in the "same manner and shall be subject to the same requirements as

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[6] CalSIM was developed jointly and is operated by the University of California, Los Angeles Center for Health Policy Research and the University of California, Berkeley Center for Labor Research and Education. The model estimates the impact of provisions in the ACA on employer decisions to offer, and individual decisions to obtain, health insurance.

[7] H&SC Section 1374.73 and IC Sections 10144.51 and 10144.52, as enacted by SB 946 (2011).

[8] H&SC Section 1374.73 and IC Sections 10144.51 and 10144.52 (as enacted by SB 946, 2011) become inoperative on July 1, 2014, and repealed on January 1, 2015. SB 126 would be inoperative on July 1, 2019, and repealed on January 1, 2020. Once the mandate is inoperative, coverage is no longer required, and therefore this analysis focuses on the date the mandate would become inoperative.

[9] H&SC Section 1374.73 and IC Sections 10144.51 and 10144.52, as enacted by SB 946 (2011).

provided in" current mental health parity law in California, which mandates parity with other benefits in terms of lifetime maximums, copayments, and deductibles.

Interaction With Other California Requirements

As stated, SB 126 extends the sunset date of the existing behavioral health treatment mandate that requires coverage for behavioral health treatment for PDD/A.[10] In addition, current California mental health parity law[11] requires coverage for the diagnosis and medically necessary treatment of severe mental illnesses, including for PDD/A, for persons of any age. The current California mental health parity law applies to most DMHC-regulated plans and CDI-regulated policies; it exempts Medi-Cal Managed Care Plans.[12] **Coverage for intensive behavioral intervention therapies for those with PDD/A is required under the current California mental health parity law.**[13]

Analytic Approach and Key Assumptions

The existing behavioral health treatment mandate requires coverage for intensive behavioral intervention therapies for persons with PDD/A, as does the current California mental health parity law.[14] **Therefore, as coverage for intensive behavioral intervention therapies for PDD/A is currently required under both the existing behavioral health treatment mandate and the current California mental health parity law, SB 126 would not require new coverage, and CHBRP does not expect SB 126 to have a measurable cost or public health impact.**

Pervasive developmental disorder or autism

Current law does not define PDD/A, but regulations governing DMHC-regulated plans[15] define PDD/A as inclusive of Asperger's Disorder, Autistic Disorder, Childhood Disintegrative Disorder, Pervasive Developmental Disorder Not Otherwise Specified (including atypical autism) (PDD-NOS), and Rett's Disorder, in accordance with the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition* (DSM-IV)–Text Revision (June 2000). CDI also includes these five disorders within PDD/A.[16] This report uses the term "PDD/A" in an effort to make clear that treatment is required for all five disorders.

Payers Other Than Health Plans and Insurers

Payment for intensive behavioral intervention therapies for PDD/A for persons enrolled in DMHC-regulated plans or CDI-regulated policies may come from other sources—a situation that may be more common than is the case for persons with other disorders. Patients (or their families) may pay directly for care, and charities may also become involved. Moreover, for

[10] H&SC Section 1374.73 and IC Sections 10144.51 and 10144.52, as enacted by SB 946 (2011).
[11] H&SC Section 1374.72 and IC Section 10144.5.
[12] The current California mental health parity law discussed here exempts Medi-Cal Managed Care (H&SC Section 1374.72 and IC Section 10144.5), as does the existing behavioral health treatment mandate, and thus SB 126.
[13] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, February 2013.
[14] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, February 2013.
[15] California Code of Regulations, (Vol. 38), Title 28, Managed Health Care, Section 1300.74.72(e).
[16] Personal communication, J. Figueroa, CDI, March 2013.

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PDD/A-related behavioral health treatment, regional centers contracting with the California Department of Developmental Services (DDS) may pay,[17] and public schools in California are mandated by state and federal law to provide related services to students that are found eligible by an individualized education program team to receive special education.[18]

DDS does not collect information about the sources of health insurance that would allow clients to be identified as having health insurance subject to the existing behavioral health treatment mandate,[19] and regional centers may serve persons without health insurance. Similarly, California Department of Education (CDE)-affiliated schools may serve persons without health insurance, but does not collect information on the health insurance status of public school students.[20] In addition, some enrollees with health insurance subject to the behavioral health treatment mandate may not seek assistance from a regional center or school, may pay directly for care, or may not meet severity threshold criteria to qualify for services per program eligibility rules. Therefore, the overlap between those with PDD/A who are served by DDS and/or CDE and those who are enrollees with health insurance subject to the behavioral health treatment mandate, and thus SB 126, is not clear.

Requirements in Other States

At least 32 states and the District of Columbia have passed health insurance benefit mandates related to autism. Some states identify treatments for which coverage is specifically required. Over half of the states with health insurance benefit mandates related to autism specifically require coverage for ABA.

Background on Pervasive Developmental Disorder or Autism

PDD/A includes neurodevelopmental disorders that typically become symptomatic in children aged 2 to 3 years, but may not be diagnosed until age 5 or older. PDD/A is a chronic condition characterized by impairments in social interactions, communication, sensory processing, stereotypic (repetitive) behaviors or interest, and sometimes cognitive function. Symptoms of PDD/A range from mild to severe. The cause of PDD/A is unknown, and there is no cure. PDD/A is associated with other comorbidities such as epilepsy and cognitive impairment.

Medical Effectiveness

Many children with PDD/A are treated with intensive (e.g., 25 or more hours per week) interventions based on ABA, hereafter referred to as intensive behavioral intervention therapies, that are aimed at improving behavior and reducing deficits in cognitive function, language, and social skills. The medical effectiveness review focuses on intensive behavioral intervention therapies based on ABA because SB 126 specifically mentions ABA.

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[17] Personal communication, E. Gelber and P. Choate, California Department of Developmental Services (DDS), February 2013.
[18] Services provided by public schools are related to Part B of the federal Individuals with Disabilities Education Act (2004).
[19] Personal communication, E. Gelber and P. Choate, DDS, February 2013.
[20] Personal communication, A. Smith, California Department of Education, March 2013.

CHBRP Terminology for Grading Evidence of Medical Effectiveness

CHBRP uses the following terms to characterize the strength of the evidence it identifies regarding the medical effectiveness of a treatment for which a bill would mandate coverage:

- Clear and convincing evidence;
- Preponderance of evidence;
- Ambiguous/conflicting evidence; and
- Insufficient evidence.

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies included in the medical effectiveness review are consistent in their findings that treatment is either effective or not effective. This can be further subdivided into preponderance of evidence from high-quality studies[21] and preponderance of evidence from low-quality studies.

A grade of *ambiguous/conflicting evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

A grade of *insufficient* evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

Methodological Considerations

The literature on intensive behavioral intervention therapies based on ABA has several important limitations.

- Most studies do not randomize participants to intervention and comparison groups. In nonrandomized studies, it is possible that differences between groups are due to differences in the characteristics of persons in the two groups rather than differences in the interventions studied. In addition, some studies assign children to intervention and comparison groups based on parent preferences, which may introduce bias.

[21] High-quality studies are studies that: (1) have sample sizes that are sufficiently large to detect statistically significant differences between the intervention and comparison groups (100 or more subjects); (2) have low attrition rates (less than 20%); (3) have intervention and comparison groups that are statistically equivalent prior to the intervention, with respect to baseline measures of the outcome and important factors associated with the outcome; (4) use controlled before and after designs (i.e., collect data on both the intervention and comparison groups prior to the intervention and after the intervention); and (5) either randomly assign participants to intervention and comparison groups or use instrumental variables, propensity scores, or other sophisticated statistical methods to address selection bias and control for confounders.

- Many studies have small sample sizes, which limit their ability to detect statistically significant differences between intervention and comparison groups.
- Most studies of intensive behavioral intervention therapies only assess outcomes immediately after treatment is complete. Because only a limited number of studies collect data on outcomes posttreatment, there is insufficient evidence to determine whether use of intensive behavioral intervention therapies has benefits that persist throughout childhood and into adulthood.

Findings from studies of intensive behavioral intervention therapies based on ABA are difficult to synthesize because:

- The duration and intensity of treatments studied vary widely as do the settings in which treatment is provided.
- The characteristics of comparison groups also vary. Some studies compare more intensive to less intensive ABA-based interventions. Others compare intensive ABA-based interventions to treatment as usual, which typically consists of an eclectic mix of interventions.
- The outcomes assessed also vary. Only four outcomes are measured by a plurality of studies: adaptive behavior, intelligence quotient (IQ), language, and academic placement.

Study Findings

Characteristics of populations studied

- Nine recent meta-analyses and systematic reviews and eight individual studies published after the literature searches that informed the meta-analyses and systematic reviews were completed assessed the effectiveness of intensive behavioral intervention therapies based on ABA.
- Only two randomized controlled trials (RCTs) on intensive behavioral intervention therapies based on ABA have been published. Each of these RCTs enrolled fewer than 30 participants. In addition, their findings are inconsistent in part due to differences between the comparison groups in the two studies. In light of the small size of these RCTs and their inconsistent findings, CHBRP assessed a broader body of literature consisting of all studies of intensive behavioral intervention therapies based on ABA that had a comparison group.
- The intensive behavioral intervention therapies studied were provided by a wide range of personnel including certified applied behavioral therapists, child care workers, nurses, occupational therapists, psychologists, speech and language therapists, students, teachers, teachers' aides, and parents. Persons who did not have graduate degrees in behavior analysis or a related field were typically supervised by personnel with graduate degrees.
- Most children enrolled in these studies were treated for 1 to 2 years.

- Studies of intensive behavioral intervention therapies enrolled children who ranged in age from 18 months to 9 years. Most of the children enrolled had Autistic Disorder or PDD-NOS and had IQs within the ranges for Mild or Moderate Mental Retardation.
- CHBRP identified no studies regarding effectiveness of intensive behavioral intervention therapies in children younger than 18 months and persons older than 9 years, nor is there direct evidence about the effectiveness of these treatments for persons diagnosed with Asperger's Disorder, Rett's Disorder, or Childhood Disintegrative Disorder. *The absence of evidence is not evidence of no effect.* Intensive behavioral intervention therapies may be appropriate for some persons with PDD/A who fall outside the populations that have been studied.
- Outcomes for individual children enrolled in studies of intensive behavioral intervention therapies vary widely. Findings from studies that have attempted to identify the characteristics of children who are most likely to benefit from these interventions suggest that children who are younger and who have higher IQs and greater adaptive behavior skills (e.g., communication, daily living, motor, and social skills) at initiation of treatment derive greater benefit from treatment.

Study outcomes

Adaptive behavior:

- The preponderance of evidence, which comes from low-quality studies, suggests that intensive behavioral intervention therapies based on ABA are more effective than usual treatment and that more-intensive ABA-based therapies are more effective than less intensive ABA-based therapies in improving adaptive behavior (e.g., communication, daily living, motor, and social skills).
- One meta-analysis of studies, which are primarily of low quality, found that the intensive behavioral intervention therapies of longer duration have greater impact on adaptive behavior.

Intelligence quotient:

- The preponderance of evidence, which comes from low-quality studies, suggests that intensive behavioral intervention therapies based on ABA are more effective in increasing IQ than usual treatment and that more intensive ABA-based therapies are more effective than less intensive ABA-based therapies.
- ***Most studies found that the changes in intelligence is not sufficiently large to enable the majority of children with PDD/A to achieve levels of intellectual and educational functioning similar to peers without PDD/A.***

Language:

- Findings are ambiguous as to the effects that intensive behavioral intervention therapies based on ABA have on both expressive language (i.e., ability to verbally express one's needs and wishes) and receptive language (i.e., ability to respond to requests from others)

relative to usual treatment. Evidence regarding the relative effectiveness of more intensive versus less intensive ABA-based therapies is also ambigious.

Academic placement:

- Findings are ambiguous as to the effect that intensive behavioral intervention therapies based on ABA have on academic placement relative to usual treatment. Evidence regarding the relative effectiveness of more intensive versus less intensive ABA-based therapies is also ambigious.

Benefit Coverage, Utilization, and Cost Impacts

SB 126 extends the sunset date of California's existing behavioral health treatment mandate that requires coverage for intensive behavioral intervention therapies for PDD/A. Current California mental health parity law[22] also requires coverage of intensive behavioral intervention therapies for persons with PDD/A[23] for most DMHC-regulated plans and CDI-regulated policies.[24] **Therefore, as coverage for intensive behavioral intervention therapies for PDD/A is currently required under both the existing behavioral health treatment mandate and the current California mental health parity law, SB 126 would not require new coverage, and CHBRP does not expect SB 126 to have a measurable cost impact.**

CHBRP estimates that 100% of DHMC-regulated plans and CDI-regulated policies subject to these two state benefit mandates that require coverage for intensive behavioral intervention therapies as a treatment for PDD/A provide this coverage. CHBRP estimates that 100% of DHMC-regulated plans and CDI-regulated policies subject to the existing behavioral health treatment mandate maintain an adequate network that includes QAS providers who supervise and employ QAS professionals or paraprofessionals who provide and administer behavioral health treatment.

CHBRP estimates that 127,000 enrollees are diagnosed with PDD/A in DMHC-regulated plans or CDI-regulated policies subject to SB 126, of which 12,700 are estimated to currently use intensive behavioral intervention therapies. Current annual expenditures for intensive behavioral intervention therapies among these enrollees is estimated to be $686 million.

Coverage Impacts

- No measurable change in coverage for these services is expected as CHBRP estimates that 100% of DHMC-regulated plans and CDI-regulated policies subject to SB 126 currently provide coverage for intensive behavioral intervention therapies as required by two existing California state benefit mandates.

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[22] H&SC Section 1374.72; IC Section 10144.5.
[23] Personal communication, S. Lowenstein, DMHC, and J. Figueroa, CDI, February 2013.
[24] The current California mental health parity law (H&SC Section 1374.72 and IC Section 10144.5) exempts Medi-Cal Managed Care, as does the existing behavioral health treatment mandate (H&SC Section 1374.73 and IC Sections 10144.51 and 10144.52, as enacted by SB 946 [2011]).

Utilization Impacts

- As no measurable change in benefit coverage is expected, no measurable change in utilization is projected.

Cost Impacts

- As no measurable change in benefit coverage is expected, no measurable changes in total premiums and total health care expenditures are expected.

Public Health Impacts

CHBRP expects the coverage and utilization of intensive behavioral intervention therapies to remain unchanged as coverage for this therapy for PDD/A is currently required under both the existing behavioral health treatment mandate and the current California mental health parity law. Therefore, CHBRP does not expect SB 126 to produce a public health impact on persons with PDD/A. Additionally, CHBRP estimates SB 126 would have no impact on possible gender and racial/ethnic disparities in health outcomes or economic loss, and no measurable impact on long-term health outcomes.

Interaction With the Federal Affordable Care Act

Below is an analysis of how this proposed benefit mandate may interact with the ACA's requirement for certain health insurance to cover "essential health benefits" (EHBs). [25]

SB 126 and Essential Health Benefits

SB 126 states that the benefit mandate would "not require any benefits to be provided that exceed the essential health benefits." SB 126 extends the sunset date of the existing behavioral health treatment mandate requiring coverage of intensive behavioral intervention therapies for enrollees with PDD/A.[26] The existing state benefit mandate was enacted before December 31, 2011, and is therefore included in California's EHBs for 2014 and 2015.[27] The state would not be required to defray any costs as a result of SB 126 in 2014 and 2015.[28]

[25] Resources on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.
[26] H&SC Section 1374.73 and IC Sections 10144.51 and 10144.52, as enacted by SB 946 (2011).
[27] Personal communication, S. Lowenstein, DMHC, February 2013.
[28] Personal communication, S. Lowenstein, DMHC, February 2013.

ACKNOWLEGMENTS

This report provides an analysis of the medical, financial, and public health impacts of Senate Bill 126. In response to a request from the California Senate Committee on Health on January 23, 2013, the California Health Benefits Review Program (CHBRP) undertook this analysis pursuant to the program's authorizing statute.

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CHBRP gratefully acknowledges all of these contributions but assumes full responsibility for all of the report and its contents. Please direct any questions concerning this report to:

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A group of faculty and staff undertakes most of the analysis that informs reports by the California Health Benefits Review Program (CHBRP). The CHBRP **Faculty Task Force** comprises rotating representatives from six University of California (UC) campuses. In addition to these representatives, there are other ongoing contributors to CHBRP from UC. This larger group provides advice to the CHBRP staff on the overall administration of the program and conducts much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and coordinates all external communications, including those with the California Legislature. The level of involvement of members of the CHBRP Faculty Task Force and staff varies on each report, with individual participants more closely involved in the preparation of some reports and less involved in others. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman Inc., to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. Milliman also helped with the initial development of CHBRP methods for assessing that impact.

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