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DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
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Testimony in SUPPORT of SB 739, SD 1
Relating to BEHAVIOR ANALYSIS SERVICES

REPRESENTATIVE DELLA AU BELLATI, CHAIR
HOUSE COMMITTEE ON HEALTH
Hearing Date: Thursday, March 16, 2017, 11 AM Room Number: 329

Fiscal Implications: None.

Department Testimony: The purpose of this measure is to expand the treatment capacity of behavior analysis services by changing certain licensing exemptions in Hawaii Revised Statutes (HRS) § 465D-7(a) for those who design or implement applied behavior analysis (ABA) services and to clarify the definition of "practice of behavior analysis".

The Department supports the work of licensed professionals and paraprofessionals, who provide services to those with challenging behavior under the Medicaid §1915(c) Home and Community-Based Services Waiver for People With Intellectual and Developmental Disabilities (Medicaid waiver).

The Department is willing to work with interested stakeholders to ensure that: (1) services to Medicaid waiver participants are delivered by qualified providers; (2) waiver participants have access to services, particularly on the Neighbor Islands; and (3) there is reasonable time to build workforce capacity.

Justification: Act 199, Session Laws of Hawaii (SLH) 2015, codified as HRS chapter 465D, requires the licensing of behavior analysts.

The licensed behavior analyst (LBA) is responsible for the design and development of the behavior plan, which is usually implemented by paraprofessional staff.

HRS § 465D-7(a) currently provides for certain exemptions from the licensing requirement.

The SD1 proposes exemptions for:

(1) Individuals working within the scope of practice of another licensed profession that overlaps with the practice of behavior analysis, including individuals supervised by the licensed professional, such as paraprofessionals, unlicensed professionals, students, and parents;

(2) Individuals who design or implement ABA services, where they have board certification from a national certifying agency, practice in accordance with supervisory and ethical requirements adopted by a national certifying agency, and practice under the direction of an LBA;

(3) Individuals who directly implement ABA services and are supervised by a licensed professional whose scope of practice overlaps with the practice of behavior analysis and:

(A) Have board certification from the Behavior Analyst Certification Board (BACB) and are under the direction of a licensed professional;

(B) Provide ABA services under the direction of a licensed or credentialed practitioner, where the practitioner maintains responsibility for and attests to the individual's training and qualifications; or

(C) Is a direct support worker who provides Medicaid waiver services on or before January 1, 2019;

(4) Caregivers who implement an ABA plan and who act under the direction of an LBA or licensed professional authorized to practice behavior analysis

Thank you for the opportunity to testify on this measure.

STATE OF HAWAII
STATE COUNCIL
ON DEVELOPMENTAL DISABILITIES
919 ALA MOANA BOULEVARD, ROOM 113
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March 16, 2017

The Honorable Della Au Belatti, Chair
House Committee on Health
Twenty-Ninth Legislature
State Capitol
State of Hawaii
Honolulu, Hawaii 96813

Dear Representative Au Belatti and Members of the Committee:

SUBJECT: SB 739 SD1 - Relating to Behavior Analysis Services

The State Council on Developmental Disabilities (DD) **supports SB 739 SD1**. This measure expands treatment capacity of behavior analysis services by allowing individuals with certain certification and under supervision conditions to implement behavior analysis services.

The Council supports the licensing of behavior analysts for the practice of behavior analysis. We appreciate the Legislature's commitment of this in the passage of Act 199, Session Laws of Hawaii (SLH) 2015, which requires the licensing of behavior analysts beginning on January 1, 2016. Furthermore, we supported legislation that provided certain exemptions from the licensing requirement for direct support workers. That measure was enacted as Act 123, SLH 2016.

HRS § 465D-7(a)(4) exempts a family member or legal guardian from the licensing requirement in order to implement an applied behavior analysis plan under the direction of a behavior analyst licensed in Hawaii. We appreciate the legislature adding the exemption of "or caregiver" on page 7 line 10. Caregivers who currently implement simple behavior interventions can continue to do so and the individual may continue to reside in the same home, receiving continuity of care. Without the risk of having to move to another home and suffer the possible effects of transfer trauma**.** We feel this addition will prevent the possible displacement of individuals with DD.

Thank you for the opportunity to submit testimony supporting SB 739 SD1 and for accepting our proposed amendment of exempting caregivers from the licensure requirements for behavior analysts.

Sincerely,

Waynette K.Y. Cabral, MSW
Executive Administrator

Josephine C. Woll
Chair

From: mailinglist@capitol.hawaii.gov
To: HLTtestimony
Cc: louis@hawaiidisabilityrights.org
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM
Date: Tuesday, March 14, 2017 2:38:18 PM

SB739
Submitted on: 3/14/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Louis Erteschik	Hawaii Disability Rights Center	Oppose	Yes

Comments: In the past few years, Hawaii has made great strides towards protecting and providing services for children with autism spectrum disorder. As a result of litigation brought by the Hawaii Disability Rights Center, Medicaid now covers applied behavior analysis services under its EPSDT program. A few years ago the Hawaii Legislature joined the overwhelming majority of states when it mandated that private insurance cover applied behavior analysis. At the same time, it passed legislation to license behavior analysts and to provide for proper credentialing of registered behavior technicians, so that there would be properly qualified professionals to administer the therapy. This measure represents a step backwards when we ought to be progressing forward. In the past few years a great many individuals have become appropriately and legally qualified to perform applied behavior analysis. Many, many children are currently receiving these services from these individuals and have already made demonstrable improvement. Some entities on the other hand, like the Department of Education, have resisted the law and instead of properly training their staff, have spent their energy trying to delay the implementation or simply resisting the legal requirements. It does not seem that this bill serves any useful purpose- it merely allows people who are not qualified to undertake the practice of applied behavior analysis to perform other forms of “therapy” under its guise. This is detrimental to the children that the law was designed to protect. Instead of rewarding those who have spent the past few years flouting the law, we should effectively ensure that they finally come into compliance.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 15, 2017 7:01 AM
To: HLTtestimony
Cc: apatterson@autismbehaviorservices.com
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM

SB739
Submitted on: 3/15/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Andrew Patterson	Autism Behavior Services Inc	Comments Only	No

Comments: The Autism Business Association has submitted an amendment for the para professional. Currently the bill lists one private company as the only group that can provide the para professional certification. The certification that they have is nationally accredited. The bill should allow other companies with a nationally accredited certification to be allowed. The bill in its current form gives a legislative monopoly to one private company's national certification. We ask that the market barrier is equal for all companies and that the bill does not create a monopoly.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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MOKIHANA
SBBH/MH Services
Island of Kauai

Together for the children: one child at a time

March 10, 2017

Hawaii State Legislature

Dear Madams and Sirs,

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health.

As a licensed psychologist, the Director of Training for the School-Based Behavioral Health program on Kauai, and the Kauai site director for the APA-accredited Hawaii Psychology Internship Consortium, my scope of practice *certainly* includes the practice of "Behavior Analysis" and includes supervising interns and other assistants in this practice.

Behavioral analysis was ***invented by psychologists*** (e.g. J.B. Watson, B.F. Skinner, etc.) and has been ***developed and refined by psychologists almost exclusively*** in the ensuing decades.

The theory and practice of behavior analysis and all other aspects of behaviorism including Functional Behavior Analysis and developing Behavior Plans ***is part and parcel*** of the education and training of all psychologists from license-eligible programs. The notion that psychologists would be somehow cut out of providing or supervising these services in any setting for any reason is entirely nonsensical.

Whereas I do not believe that doing this was the intent behind the original statute, I am very concerned that the Act 199 (providing for the licensure of Board Certified Behavior Analysts [BCBAs]) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision.

The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary and counter-productive narrowing of the qualified behavioral health workforce. Thank you very much for your support of this important bill.

Sincerely,

Alex Bivens, Ph.D.
Clinical Psychologist Lic.# 743
Mokihana School-Based Behavioral Health

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 15, 2017 11:01 AM
To: HLTtestimony
Cc: mkohr23250@aol.com
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM

SB739
Submitted on: 3/15/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Melinda Kohr, Ph.D.	Behavioral Health Center, Inc.	Comments Only	No

Comments: Testimony SUPPORTING SB739-SD1 RELATING TO BEHAVIOR ANALYSIS SERVICES Including amendments COMMITTEE ON HEALTH Rep. Della Au Belatti, Chair Rep. Bertrand Kobayashi, Vice Chair Thursday, March 16, 2017 11:00 AM Conference Room 329 State Capitol 415 South Beretania Street I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of “Behavior Analysis” and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists’ scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors. Thank you for the opportunity to provide testimony on this important topic. Sincerely, Melinda Kohr, PH.D.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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March 15, 2017

The Honorable Au Belatti
and Members of the Health Committee
Hawaii State Capitol, Room 402
Honolulu, HI 96813

Re: Letter in support of SB739 SD1, if amended

Dear Honorable Au Belatti and Members of the Health Committee:

I am the executive director of the Behavioral Intervention Certification Council (BICC). BICC is a nonprofit organization that has developed the Board Certified Autism Technician (BCAT) credential, the only autism-specific credential for behavior technicians accredited by the National Commission of Certifying Agencies (NCCA).

TRICARE, Magellan Behavioral Health, New Mexico Medicaid, Optum-United Behavioral Health, and Care 1st Health Plan recently approved the BCAT as a certification for behavior technicians. I wanted to make you aware that the BCAT is the only NCCA-accredited, autism-specific credential and give you some background on BICC.

BICC was established in 2013 to promote the highest standards of treatment for individuals with autism spectrum disorder (ASD) through the development, implementation, coordination, and evaluation of all aspects of the certification and certification renewal processes. BICC is an independent and autonomous governing body for the BCAT certification program.

Currently, over 2,000 individuals across the United States and internationally are certified to use the BCAT designation. That number is expected to grow rapidly as a result of the new accreditation by NCCA and the fact that Tricare is now accepting the BCAT credential.

BICC submits this letter is support of an amendment that would expand those eligible to implement autism treatment plans to include those credentialed by BICC, the Board Certified Autism Technician (BCAT). The BCAT is autism-specific and accredited by the National Commission for Certifying Agencies, the same organization that accredits the BCBA and BCaBA programs. BCATs must meet training and education requirements, sign and adhere to a Code of Ethics, pass an exam that demonstrates mastery of autism-specific applied behavior analysis, and pass a comprehensive background check which is ongoing (i.e., not reliant on self-reporting). Additionally, BCATs must accrue 12 units of continuing education based on the BCAT Task List in order to renew their certification, with 25% of the CEUs dedicated to ethics. BICC also recognizes that other licensed professionals may be qualified to supervise BCATs, allowing licensed professionals acting within the scope of their license to supervise BCATs in the implementation of an autism treatment plan.

In section 3, we would like the following changes made:

(2) An individual who implements or designs applied behavior analysis services and possesses board certification [~~as an assistant behavior analyst by the Behavior Analyst Certification Board~~] from a national certifying agency and who practices in accordance with the most recent supervisory and ethical requirements adopted by [~~the Behavior Analyst Certification Board~~] a national certifying agency under the direction of a behavior analyst licensed in this State;

(3) An individual who directly implements applied behavior analysis services under the supervision of a licensed professional whose scope of practice overlaps with the practice of behavior analysis and:

(A) [~~Is credentialed as a registered behavior technician by~~] Possesses national certification from a program accredited by the National Commission for Certifying Agencies (NCCA) or the American National Standards Institute (ANSI)

and is under the direction of a [~~behavior analyst~~] professional licensed in this State[~~,~~

~~(B) Is a direct support worker who provides autism treatment services pursuant to an individualized education plan on or before January 1, 2019; [or]~~] and acting within the scope of that licensure;

(B) Is an individual who provides applied behavior analysis services under the supervision of a licensed or credentialed practitioner working within that practitioner's recognized scope of practice; provided that the licensed or credentialed practitioner maintains responsibility for and attests to the training and qualifications of the individual who is providing the supervised applied behavior analysis services; or

BICC is committed to working with providers to ensure access to the BCAT exam, which is available on-demand at active test locations. BICC has three testing sites in Hawaii, located in Honokaa, Kahului, and Honolulu. Providers in rural areas where testing sites may be scarce have the option of applying to host a BCAT exam, which is then proctored by highly trained external proctors. This option increases both access and cost-effectiveness, two elements which contribute to a provider's ability to increase capacity to meet the community's needs.

BICC respectfully urges the members of this committee to support an amendment to SB 739 SD1, which would expand those eligible to implement autism treatment plans to include those credentialed by BICC, the Board Certified Autism Technician (BCAT). Should you have any questions, please do not hesitate to contact me at (917) 715-3880 or via email at L.Whitlock@behavioralcertification.org. I look forward to working with you.

Respectfully submitted,

Lauren Rivera Whitlock

Lauren Rivera Whitlock, M.S., BCAT
Executive Director
Behavioral Intervention Certification Council

2005 Palmer Avenue, Suite 206
Larchmont, NY 10538

Anuenue Behavior Analysts

03/16/17

Committee on Health
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

I am writing to you from a place of compassion and concern. The current standards for applied behavior analysis (ABA) services in Hawai'i were crafted with consumer protections in mind. This bill, as proposed will confuse consumers, by blurring the lines between behavior analysts and other "licensed, certified, or credentialed" professionals across a wide range of "overlapping" professions. The language in the current draft translates to the broadening of who can supervise ABA too widely; resulting in a dilution of expectations and training for direct support workers (DSW), implementing ABA in Hawai'i.

Question 1: What is the intention behind the amended language of the bill?

Answer: I believe the intention behind the amended language of this bill is to allow psychologists to practice behavior analysis, or at the very least, to avoid behavior analysts from limiting psychologists right to practice behavior analysis and therapy as outlined in Chapter 465, Hawai'i Psychology Licensure Law.

Question 2: Does the amended language address psychologists concerns about their right to practice behavior analysis in Hawai'i?

Answer: The amended language attempts to carve out psychologists, allowing them to practice behavior analysis and therapy in accordance with Chapter 465, Hawai'i Licensure Law. However, the language offered by Senator Baker and her committee, appears to carve out individuals beyond psychologists, to include unlicensed and non-credentialed individuals. The language in SB 739 SD1 broadens the language of "appropriately licensed or credentialed" individuals, to a degree, which will compromise the integrity of applied behavior analysis (ABA) services and lead to consumer confusion, rather than ensuring consumer protection of some of our most vulnerable populations. While I appreciate the intent of the Senator Baker and her committee members, I stand in support of the amended language, offered to this committee on behalf of the Hawai'i Association for Behavior Analysis (HABA).

Question 3: Should licensed psychologists have the right to practice behavior analysis, including the supervision and oversight of individuals providing behavior analysis and therapy?

Answer: Psychologists are trained very broadly across a number of areas including psychological testing, diagnosis of a mental or physical disorder, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities. While the majority of psychologists do not specialize in behavior analysis, there exists the likelihood that psychologists, particularly those in practice for quite some time, may have adequate training, experience, and demonstrated competency in the area of ABA.

While only a handful of psychologists in Hawai'i claim to practice behavior analysis, if properly trained and qualified, nothing in the existing Behavior Analyst Licensure law is intended to restrict those licensed individuals from practicing behavior analysis and therapy. If psychologists wish to practice behavior analysis and therapy, they must provide services in accordance with *their* licensure law. I would like to point out that existing licensure law for Psychologists in Hawai'i describes appropriate *implementers* of psychological services as being "person who performs any, or any combination of the professional services defined as the practice of psychology, under the direction of a licensed psychologist in *accordance with rules adopted by the board*; provided that the person may use the term "*psychological assistant*", but shall not identify the person's self as a psychologist or imply that the person is licensed to practice psychology" (Hawai'i Psychology Licensure Law 465-1). The language proposed (for our Behavior Analyst Licensure law) by the Hawai'i Psychological Association (HPA) states, "An individual working within the scope of practice or duties of another licensed profession that overlaps with the practice of behavior analysis, such as ***paraprofessionals, unlicensed professionals****, students, and parents.* In line with community testimony last year, paraprofessionals, who do not have a minimum level of training in applied behavior analysis (ABA), may not be implementers of behavior analysis and therapy. The legislature determined last year that direct support workers should possess minimum training, and demonstrate competency in applying behavioral technologies with the population they will serve, agreeing to a 3-year sunset (effective 1/1/2019, Act 107).

Registered behavior technicians (RBTs) must complete 40 hours of training in applied behavior analysis that follows a specific task-list issued by the Behavior Analyst Certification Board (BACB). RBTs must also demonstrate competency implementing specific behavioral strategies and are required to complete an examination at Pearson. Once credentialed, RBTs must have a Licensed Behavior Analyst assigned as their Responsible Certificant; an individual whose license is specifically connected to the practice and oversight of the RBT. Additionally, registered behavior technicians (RBT) *must* be supervised for a minimum of 5% of the services they provide and must adhere to a specific ethical code, issued by the BACB. Licensed behavior analysts (LBAs), who oversee direct support workers, specifically Registered Behavior Technicians, are required to complete an initial 8-hour supervision course approved by the Behavior Analyst Certification Board

(BACB), with an ongoing requirement of 3 supervision CEs per 2-year cycle. The American Psychological Association (APA) does not currently have established standards for ensuring supervisory competency of psychologists, particularly in the subspecialty area of applied behavior analysis.

This discrepancy may be significant enough for insurers to deny expanding coverage to psychologists or those practicing behavior analysis under their supervision. As noted by HMSA, "[we are] concerned that the Bill as currently written may not ensure the professional oversight or supervision that is required to meet the current professional standards that we believe are required to ensure quality care to our members" and added, "To that end we have met, and are continuing to meet, with the stakeholders and expressed our interest in finding a common standard of training/certification that meets or exceeds the BACB supervision/certification guidelines" (2/24/17, CPH Testimony).

Question 4: Who should be able to *implement* applied behavior analysis (ABA) services in Hawai'i?

Answer: Anyone who is able to *design* (licensed behavior analyst or licensed psychologist*)* should also be deemed appropriate to *implement* behavior analysis services.

In addition, the following individuals should be considered as viable implementers of applied behavior analysis, *under the direction of a behavior analyst or psychologist*, licensed in this State, practicing in their recognized scope of practice:

1. Any licensed professional, other than a licensed behavior analyst or licensed psychologist, including teachers
2. Direct support workers, trained as Registered Behavior Technicians (RBTs)
3. Psychological assistants, Board Certified assistant Behavior Analysts
4. Students of behavior analysis or psychology, during practicum or supervised field experience
5. Parents, legal guardians, foster families, domiciliary homes

Question 5: What are ABA services like currently?

Answer: In less than two decades, the Behavior Analyst Certification Board (BACB) has credentialed more than 50,000 behavior analysts and behavior technicians in more than 70 countries, and there are no indications of a slowdown in growth trends (Carr and Nosik, 2017). We are developing capacity for both licensed behavior analysts (LBA) and Registered Behavior Technicians™ (RBT) in Hawai'i at an impressive rate as well. When our licensure law went into effect on 1/1/2016, there were 60 Licensed Behavior Analysts in the state. As of 3/15/2017, there were 175 listed on the DCCA Behavior Analyst registry.

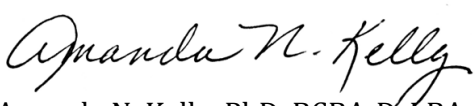
Since our ABA licensure law went into effect, the number of Registered Behavior Technicians (RBTs) has doubled from 250 to now over 500 credentialed; ranking Hawai'i in the Top 10 states for total number of RBTs.

If we want to know what services look like without RBTs and LBAs in place, we need only to look to our schools now. What is happening in our classrooms currently? We have a large number of emergency hires. We have large amounts of unlicensed and poorly supported classroom teachers, who are overwhelmed with an ever-growing amount of responsibilities. As providers, we experience resistance from school administration who attempt to sabotage or prohibit collaboration. As consumers, we witness children become aggressive and despondent, and when progress is not made, we are told the child is the reason.

Conversations with insurers have indicated they will push back and will not reimburse for non-credentialed direct support workers. If so, the consumers who will likely experience the largest degradation of services would be those receiving services by our state departments (e.g., Department of Education, Early Intervention, etc.).

The current Hawai'i behavior analyst licensure law was crafted with consumer protections in mind. This bill, SB 739 SD1, as proposed would decrease consumer protections. Mahalo for your efforts in continued support of protecting consumers and providers of applied behavior analysis (ABA) in our state. Our keiki and kupuna deserve properly licensed and trained professionals. It's our kuleana.

Respectfully Submitted,



Amanda N. Kelly, PhD, BCBA-D, LBA
Ph: (808) 298-2658 / akelly@anuenueaba.com
Director, Anuenue Behavior Analysts
Board Member, Hawai'i Disability Rights Center (HDRC)
Director, University of West Florida (UWF), Office of ABA, Hawai'i Cohort
Legislative Committee Member, Hawai'i Association for Behavior Analysis (HABA)

Hawai‘i Psychological Association

For a Healthy Hawai‘i

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TESTIMONY IN STRONG SUPPORT OF SB 739 SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Thursday, March 16, 2017, 11:00 am, Conference Room 329

Honorable Chair Belatti, Vice Chair Kobayashi and Members of the Committee on Health,

The Hawai'i Psychological Association (HPA) strongly supports passage of SB739 SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. This bill amends problematic provisions of Act 199, the original BCBA licensing law, related to the issue of supervising direct service workers.

Act 199 has explicit language in several places stating that the law is not intended to restrict the practice of other licensed or credentialed healthcare practitioners practicing within their own recognized scopes of practice. The statutes that provide for the licensing of Psychologists in Hawai'i also include the term "Behavior Analysis" in the description of Psychologists' scope of practice. Section 465-3 further allows an exemption for:

> (2) Any person who performs any, or any combination of the professional services defined as the practice of psychology under the direction of a licensed psychologist in accordance with rules adopted by the board; provided that the person may use the term "psychological assistant", but shall not identify the person's self as a psychologist or imply that the person is licensed to practice psychology;

Despite the fact that our own licensing law permits Psychologists to direct psychological assistants in providing behavior analysis services, some psychologists have been denied payment for the work of our paraprofessionals; some state agencies have also declined to contract with licensed psychologists as supervisors of direct service workers as a result of their interpretation of the original Act 199.

HPA contends that Psychologists' licensure permits us to direct psychological assistants whom we believe competent to provide psychological services, including behavioral analysis, without requiring them to shoulder the unnecessary expense of obtaining and maintaining a separate certification from an outside organization. Psychologists have

been training assistants to deliver these services and supervising their work in Hawaiʻi for years without incident.

The Senate Committee on Commerce, Consumer Protection, and Health's version of SB739 does an excellent job of clarifying these issues and addressing the concerns of psychologists and other mental health professionals who work in this field. We also appreciate the helpful changes in the definition of "Applied Behavioral Analysis" incorporated in this bill. This change would allow people to utilize simple behavioral interventions (such as making a chore chart for a child) without the supervision of a BCBA or other licensed professional.

The Hawai'i Psychological Association is sensitive to the concerns for consumer protection that have been raised in conversations with us by leaders of the Hawaiʻi Association for Behavioral Analysis (HABA) in defense of the original bill. However, HPA maintains that the Board of Psychology, in overseeing the practice of Psychologists, provides this protection in the case of our direct supervisees. It is our legal and ethical responsibility to ensure that these direct service workers are adequately trained and supported and that each consumer receives competent services.

Thank you for the opportunity to provide input on this bill.

Respectfully submitted,

Julie Y. Takishima-Lacasa, Ph. D.
Legislative Chair
Hawaii Psychological Association

From:	Dennis Dixon
To:	Rep. Della Belatti; Rep. Bertrand Kobayashi; HLTtestimony
Subject:	SB 739, SD1 - SUPPORT IF AMENDED
Date:	Wednesday, March 15, 2017 12:30:21 PM
Attachments:	Dixon Linstead Granpeesheh Novack French Stevens Stevens Powell (2016) S....pdf Linstead et al (2016) treatment hours.pdf

Dear Chair Au Belatti and Honorable Members of the Committee on Health:

I am the lead author on the research article cited by HABA in its effort to limit the practice of behavior analysis. HABA is mischaracterizing my study. While we did find that supervisors with a BCBA did produce improved outcomes, we specifically state that we were unable to compare BCBAs to psychologists in this study. In regards to a supervisor's credential, the analysis was simply "BCBA contrasted to No Credential" not "BCBA contrasted to Other Credential/License." Additionally, it is important to note that the single greatest variable impacting outcomes in autism treatment is the number of hours of direct 1:1 ABA received by the patient and delivered by a paraprofessional technician. (Both articles are attached.)

I urge the House to pass this bill with the proposed amendment to ensure that highly qualified professionals will be able to supervise and deliver evidence-based autism treatment.

Respectfully,

Dennis Dixon, Ph.D.
Center for Autism and Related Disorders, llc.
21600 Oxnard Street, Suite 1800
Woodland Hills, CA 91367
ph: 818.345.2345 x1188

Behav Analysis Practice
DOI 10.1007/s40617-016-0132-1

RESEARCH ARTICLE

An Evaluation of the Impact of Supervision Intensity, Supervisor Qualifications, and Caseload on Outcomes in the Treatment of Autism Spectrum Disorder

Dennis R. Dixon[1] · **Erik Linstead**[2] · **Doreen Granpeesheh**[1] · **Marlena N. Novack**[1] · **Ryan French**[2] · **Elizabeth Stevens**[2] · **Laura Stevens**[2] · **Alva Powell**[1]

Abstract Ample research has shown the benefits of intensive applied behavior analysis (ABA) treatment for autism spectrum disorder (ASD); research that investigates the role of treatment supervision, however, is limited. The present study examined the relationship between mastery of learning objectives and supervision hours, supervisor credentials, years of experience, and caseload in a large sample of children with ASD ($N = 638$). These data were retrieved from a large archival database of children with ASD receiving community-based ABA services. When analyzed together via a multiple linear regression, supervision hours and treatment hours accounted for only slightly more of the observed variance ($r^2 = 0.34$) than treatment hours alone ($r^2 = 0.32$), indicating that increased supervision hours do not dramatically increase the number of mastered learning objectives. In additional regression analyses, supervisor credentials were found to have a significant impact on the number of mastered learning objectives, wherein those receiving supervision from a Board Certified Behavior Analyst (BCBA) mastered significantly more learning objectives. Likewise, the years of experience as a clinical supervisor showed a small but significant impact on the mastery of learning objectives. A supervisor's caseload, however, was not a significant predictor of the number of learning objectives mastered. These findings provide guidance for best practice recommendations.

✉ Dennis R. Dixon
d.dixon@centerforautism.com

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Published online: 09 June 2016

Keywords Autism spectrum disorder · Supervision · Applied behavior analysis · Treatment outcomes

Applied behavior analysis (ABA) is a well-established framework for the treatment of autism spectrum disorder (ASD; Eldevik et al., 2009; Reichow, 2012; Reichow et al., 2012). ABA-based treatment is conducted at a high intensity, typically between 30 and 40 h/week, for multiple years, often beginning in early childhood (Eldevik et al., 2009; Reichow et al., 2012). While a strong consensus exists that ABA is an effective treatment for ASD, evidence also indicates a good deal of variance in individual response to treatment (Eldevik et al., 2010; Howlin et al., 2009).

Several factors have been suggested to have an effect on ABA treatment outcomes. Some factors are specific to the individual at the start of treatment; for instance, younger age (Ben-Itzchak & Zachor, 2011; Eldevik et al., 2012; Flanagan et al., 2012; Granpeesheh et al., 2009; Harris & Handleman, 2000; Makrygianni & Reed, 2010; Perry et al., 2011; Virués-Ortega et al., 2013), higher IQ (Ben-Itzchak & Zachor, 2007; Eikeseth et al., 2002, 2007; Eldevik et al., 2006; Eldevik et al., 2010; Eldevik et al., 2012; Harris & Handleman, 2000; Hayward et al., 2009; Magiati et al., 2007; Magiati et al., 2011; Perry et al., 2011; Remington et al., 2007; Smith et al., 2010), lower severity of ASD symptoms (Ben-Itzchak & Zachor, 2011; Eldevik et al., 2012; Perry et al., 2011; Remington et al., 2007; Smith et al., 2000), greater adaptive skills (Eldevik et al., 2010; Flanagan et al., 2012; Magiati et al., 2011; Makrygianni & Reed, 2010; Perry et al., 2011; Remington et al., 2007; Sallows & Graupner, 2005), stronger language skills (Ben-Itzchak & Zachor, 2011; Eldevik et al., 2006; Magiati et al., 2007; Magiati et al., 2011; Sallows & Graupner, 2005), and greater social skills (Ben-Itzchak & Zachor, 2007; Sallows & Graupner, 2005) have been

associated with superior outcomes. Other factors are treatment specific; for example, greater treatment intensity (Eldevik et al., 2010; Granpeesheh et al., 2009; Makrygianni & Reed, 2010; Remington et al., 2007), longer treatment duration (Luiselli et al., 2000; Makrygianni & Reed, 2010), and greater overall intervention time (Virués-Ortega, 2010; Virués-Ortega et al., 2013) have been shown to have a positive impact.

Although research is limited, there is evidence to suggest that variables related to the supervision of ABA-based treatment also significantly contribute to treatment outcome. For example, a meta-analysis conducted by Reichow and Wolery (2009) examined the relationship between supervisor training models and treatment outcomes. Their findings suggested that studies that implemented supervisor-training protocols based on the University of California, Los Angeles (UCLA) model produced greater gains in IQ than studies that employed other training procedures.

For the most part, evaluation of the impact of supervision on treatment outcomes has been limited to treatment programs that are parent managed, meaning parents are responsible for managing the implementation of their child's treatment program while receiving some degree of clinical oversight from a professional. Several studies have been conducted to evaluate parent-managed treatment, combined with varying levels of professional supervision, as a cost-effective alternative to clinic-based treatment programs. For example, Bibby et al. (2002) found parent-managed ABA programs (described in detail by Mudford et al., 2001) to produce relatively poor treatment outcomes as compared to the clinic-based treatment outcomes reported by Lovaas (1987). A number of factors were suggested by the authors to have contributed to the discrepant outcomes, including older age and lower IQ at start of treatment, fewer treatment hours, infrequent supervision conducted about once every 3 months, and less competent supervisors (approximately 80 % of whom were not trained to Lovaas treatment model standards). Therefore, though the outcomes were clearly poorer than those documented by Lovaas (1987), the role of supervision in the work by Bibby et al. (2002) is difficult to evaluate, as it is just one of numerous factors that may have impacted treatment outcomes.

Other studies evaluating the effectiveness of parent-managed ABA treatment programs when combined with more frequent supervision than reported by Bibby et al. (2002) have revealed better outcomes. Both Sallows and Graupner (2005) and Hayward et al. (2009) compared parent-managed treatment to clinic-based treatment and found participants in both groups to make meaningful gains with no significant differences detected between groups. Sallows and Graupner (2005) observed similar treatment outcomes between groups despite the fact that less frequent supervision was given to the parent-managed treatment group. However, in a further examination of the parent-managed treatment group described by Hayward et al. (2009), Eikeseth et al. (2009) identified a strong relationship between greater supervision intensity and improved treatment outcomes. Supervision intensity, which ranged from 2.9 to 7.8 h/month, was significantly correlated with improvements in IQ at follow-up. On average, IQ increased 0.21 points for each hour of supervision with no detectible point of diminishing returns. Given these studies, the relationship between supervision intensity and treatment outcomes is unclear. While there is some evidence to suggest that supervision intensity correlates with treatment outcomes in parent-managed treatment programs (e.g., Eikeseth et al., 2009), such research has not yet been conducted in clinic-based treatment settings.

In spite of limited research on the role of supervision in ABA programs, efforts have been made to promote uniformity in treatment provision. The Behavior Analyst Certification Board (BACB), established in 1998, is among the leading organizations helping to set standards in the field. The BACB summarized best practices for supervision of ABA-based autism treatment in its practice guidelines for funding agencies (BACB, 2014). While the individual demands of each case must be taken into account, the BACB specifies supervision conducted at a ratio of 2 h a week per every 10 h of treatment as the recommended standard, with a minimum of 2 h of supervision provided a week. This reflects an increase in the recommended supervision hours relative to the previously published BACB guidelines, which gave a range of 1–2 supervision hours for every 10 h of treatment (BACB, 2012). The BACB also describes average caseload sizes for supervisors overseeing comprehensive ABA treatment programs to range between 6 and 16 cases, depending on the treatment intensity and demands of each case, competency and accessibility of the supervisor, and the supervisor's level of support. Average caseloads for supervisors overseeing focused treatment programs are specified by the BACB as ranging between 10 and 24 cases. These recommendations have been suggested as best practices in the field; nonetheless, existing research does not establish whether these recommendations produce superior treatment outcomes.

The BACB has recommended standards for supervisor qualifications, as well. The BACB offers a Board Certified Behavior Analyst (BCBA) certification for clinicians in the field. To become a BCBA, applicants must, as of January 1, 2016, hold a master's degree in behavior analysis, education, or psychology (previously accepted master's degrees, which may better represent the current BCBA population, include behavior analysis or related field or other natural science, education, human services, engineering, or medicine); satisfy specific coursework requirements in behavior analysis; have a specific number of work experience hours directly supervised by a BCBA; and pass an exam. The BACB also offers a doctoral BCBA certification (BCBA-D) for those who hold a qualifying doctoral degree and satisfy all other BCBA

certification requirements. Additionally, a bachelor's level certification, Board Certified Assistant Behavior Analyst (BCaBA), is offered; however, the BACB stipulates that any supervision provided by a BCaBA must be overseen by a BCBA or BCBA-D. Despite the rigorous requirements to obtain a BCBA, it should be noted that ABA is a broad field not limited only to the treatment of ASD, and obtaining a BCBA does not necessarily indicate competency in the treatment of ASD (Eikeseth, 2010; Love et al., 2009). Therefore, training and supervised work experiences in ABA treatment specifically for ASD are typically recommended in addition to certification (Eikeseth, 2010) and fall within the BACB's requirement that certificants practice within the scope of their experience.

To identify the percentage of those with graduate degrees who also hold a BACB certification, Love et al. (2009) surveyed a large group of ASD treatment providers. From the survey of 211 supervisors, 72 % of respondents reported having a graduate degree, and 42 % reported having a BCBA or BCBA-D. These findings may reflect an effort to supplement the insufficient number of supervisors who possess BACB certifications to meet the high demand for ABA services. Additionally, it should be noted that ABA treatment services for ASD have been provided for over 30 years, predating certification efforts. As such, many well-trained and experienced clinicians are not certified, including individuals who pioneered the application of ABA to the treatment of ASD. Additionally, BCBA certification is only one of many credentials recognized by current and emerging state insurance mandates that often specify the education, training, certification, and/or licensure required to supervise ABA programs. While requirements vary from state to state, other recognized professionals include licensed psychologists, marriage and family therapists, speech and language pathologists, occupational therapists, and audiologists practicing within the scope of their licensure and competency. Although numerous state laws define who may supervise ABA programs for individuals with ASD, research evaluating whether such qualifications actually lead to superior treatment outcomes has not yet been conducted.

Given the lack of empirical evidence to guide the development of best practice guidelines for supervision of ABA-based ASD treatment, the purpose of the present study was to examine the relationship between factors related to supervision and ABA treatment outcomes. Specifically, the present study tested the hypothesis that supervision hours, supervisor credentials, years of experience, and caseload would be significant predictors of the number of mastered learning objectives within a large dataset collected from a community-based clinical setting.

Methods

Participants

Clinical records were gathered from a pool of 836 children between the ages of 18 months and 12 years who were receiving ABA-based services from a community-based autism treatment provider during a 12-month period (January 1, 2014 through December 31, 2014). Records were subject to the following inclusion criteria: a diagnosis of ASD (American Psychiatric Association, 2013), autistic disorder (American Psychiatric Association, 2000), pervasive developmental disorder-not otherwise specified (PDD-NOS; American Psychiatric Association, 2000), or Asperger's disorder (American Psychiatric Association, 2000) by an independent licensed clinician (e.g., psychologist and pediatrician); at least 20 h of ABA-based treatment per month; and at least one full month of continuous services. These criteria produced a sample size of 638 clinical records. The age, diagnosis, and gender profiles of the individuals whose clinical records were used in the study were as follows: 528 males (age range 2.08–11.92 years, mean age 7.42 years, 317 autistic disorder, 166 ASD, 41 PDD-NOS, 4 Asperger's disorder) and 110 females (age range 3.17–11.83 years, mean age 7.53 years, 73 autistic disorder, 30 ASD, 6 PDD-NOS, 1 Asperger's disorder). The mean age of the individuals whose records made up this sample was 7.44 years (SD = 2.30). The average number of treatment hours received per month was 71.01 (SD = 35.26), ranging from 20.02 to 197.30 h/month. An average of 10.98 (SD = 6.50) supervision hours were received per month, ranging from 1.40 to 67.40. Furthermore, an average ratio of 1.77 (SD = 1.14) supervision hours were provided for every 10 h of treatment, ranging from 0.25 to 9.73. The average number of mastered learning objectives per month was 31.42 (SD = 34.47), ranging from 1 to 245.75 per month. Individuals whose records were included in this sample resided and received services in the states of Arizona, California, Colorado, Illinois, Louisiana, New York, Texas, and Virginia.

Data Collection

Treatment data were collected retrospectively from a large archival database. Throughout treatment delivery, the Skills™ system was used to identify developmental deficits, design individualized treatment programs, and track ongoing progress. The Skills™ Assessment is an instrument that comprehensively evaluates skills across all areas of child development (Dixon et al., 2011). A study by Persicke et al. (2014) evaluated the validity of the Skills™ Assessment by contrasting parent response to the Skills™ items with direct observation. Pearson product-moment correlation coefficients ranged from moderate ($r = 0.65$) to high ($r = 0.95$). Treatment data were combined with the behavioral health agency's

operational data, including treatment hours, supervision hours, supervisor credentials, years of experience, and caseload.

Treatment

Treatment programs were individualized according to each participant's specific strengths and deficits. Treatment programs addressed all developmental areas in which the participant displayed deficits, including language, academics, social skills, play skills, motor skills, adaptive skills, executive functions, and cognition. Services were provided in the home, school, community, clinic, or a combination of settings, depending on funding agency requirements and other variables. All treatment programs in this study followed the CARD model of treatment delivery (Granpeesheh et al., 2014) and therefore shared the following commonalities: (a) trained behavioral therapists delivered one-to-one treatment; (b) both discrete trial training and natural environment training strategies were implemented; (c) a verbal behavior approach was used for language intervention; (d) both errorless and least-to-most prompting strategies were implemented; (e) empirically validated behavioral principles and procedures were used as needed, including reinforcement, extinction, stimulus control, generalization training, chaining, and shaping; (f) a function-based approach was implemented for the assessment and treatment of challenging behaviors; (g) parents received training regularly and were included in all treatment decisions; and (h) direct supervision was provided on a regular basis (e.g., bi-weekly). The number of treatment hours per participant was collected from billing records and included all direct treatment services provided to the participant. Activities that were not client-specific, such as attending training, or were not direct treatment services, such as traveling to participant's home, were excluded.

Mastery of learning objectives was used as the dependent variable for all analyses within this study. The definition of mastery of a learning objective was set on an individual basis by the treatment supervisor but was required to be within the bounds of the following criteria: >70 % accuracy of responding to the learning objective for a minimum of two treatment sessions across two different days. Typically, a more stringent mastery criterion of 80 % accuracy is required, but supervisors have the discretion to deviate if they feel it is clinically appropriate to do so.

Supervision

All supervisors in the present study received a minimum of 6 months of training in ABA-based treatment for ASD and earned a certification in supervision from the Institute for Behavioral Training. A multifaceted training approach was used, which included a combination of eLearning (www.ibehavioraltraining.com), classroom-style training, web classes, and mentorship. Supervisors received mentorship on a weekly basis, which involved direct observation, feedback, and follow-up training to improve clinical skills. Exams were administered at various stages of the training program, and trainees were required to demonstrate fluency in training material before advancing to the next stage. At the end of the training program, supervisors were required to demonstrate clinical competency by passing a written practicum and oral exam.

Supervisors in the present study were responsible for overseeing participants' treatment programs. The number of supervision hours per participant was collected from billing records. Supervision hours were required to be client-specific and were composed of both direct and indirect services, including: (a) making clinical recommendations on treatment intensity and duration, (b) conducting assessments, (c) developing individualized treatment plans, (d) holding regularly scheduled clinic meetings with families and therapists, (e) observing treatment sessions, (f) reviewing data and adjusting treatment plans accordingly, (g) reporting on treatment progress, (h) consulting with teachers and other service providers, (i) conducting therapist and parent training to implement client-specific protocols, and (j) preserving treatment integrity. Activities excluded from the analysis were as follows: (a) conducting client intakes, (b) conducting therapist performance evaluations, (c) providing staff trainings that were not client-specific, (d) developing discharge plans, and (e) travel to client homes. In general, supervision was provided at a minimum ratio of 1 h of supervision per every 10 h of treatment in accordance with the best practices set forth at the time these services were delivered (BACB, 2012). For a more detailed description of the supervisor training and responsibilities involved in the present study, see Granpeesheh et al. (2014).

Supervisor caseload was determined by counting the number of clients assigned to each supervisor during a 1-month interval (October of 2014) within the larger period of time that records were reviewed (January 1, 2014 through December 31, 2014). Given that each supervisor does not work the same number of hours each week but can range from part time to full time and that their work hours directly impact the number of treatment programs that each can supervise, caseloads were divided by the number of hours that the supervisor worked per week during the same 1-month interval. For example, a part-time supervisor with a caseload of 15, who works 25 h/week, would have a weighted caseload of 0.6. Similarly, a full-time supervisor with a caseload of 25, who works 43 h/week, would have a weighted caseload of 0.63. This adjustment made the caseloads comparable despite the number of hours the supervisor worked per week.

As a part of maintaining their personnel record, supervisors had previously reported the date that they first began to supervise ABA-based treatment for ASD (including times spent as

a supervisor at other treatment agencies). A supervisor's years of experience was calculated as the difference between their supervision start date and October 1, 2014. Supervisor credentials were also obtained through a review of personnel files.

There were 130 supervisors represented in the data set. A total of 37 supervisors were excluded because they held an alternative credential (e.g., licensed psychologists and licensed clinical social worker) or provided incomplete information, leaving 93 supervisors to analyze. Of the 93 supervisors, 67 had a BCBA credential and 26 did not. Of the 26 supervisors without a BCBA credential, 4 reported a bachelor's degree as their highest level of education and 22 reported a master's degree as their highest level of education. The 93 supervisors had an average of 8.87 (SD = 4.71) years of experience in the field, ranging from 0.76 to 25.35 and a mean caseload of 11.18 (SD = 4.06), ranging from 2 to 23, as shown in Figs. 1 and 2. The supervisor variables are summarized in Table 1.

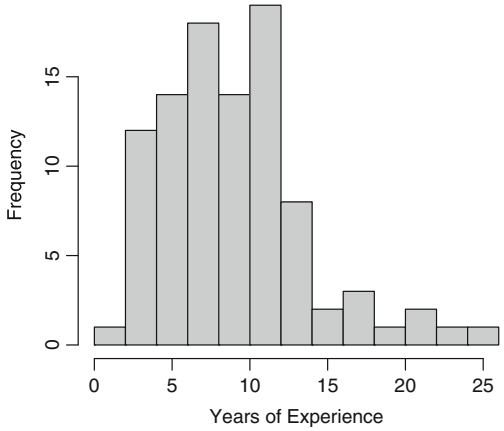

Fig. 1 Distribution of supervisor years of experience

Data Analysis

To explore the role of supervision in the mastery of learning objectives, several linear regression analyses were carried out. Linear regression is a statistical technique for modeling the mathematical relationship between independent variables and dependent variables. In the simple case, this relationship consists on only one independent variable, x, and one dependent variable, y. Linear regression is also named because the underlying assumption of the model is that given a value for x, the predicted value of the dependent variable, $\hat{y}$ can be explained with a simple line:

$$\hat{y} = mx + b$$

In the equation above, the slope of the line, m, and the intercept of the line, b, represent the regression parameters to be learned given the sample data. While more sophisticated approaches exist, the most basic technique for determining the value of the regression parameters is the method of least squares. This corresponds to minimizing the sum of squared differences between the observed value of y and its predicted value, $\hat{y}$. Mathematically this corresponds to minimizing error, E, where E is defined as:

$$E = \sum \left(\hat{y}_i - y_i\right)^2 \text{ for all observations (data points), } i$$

Table 1 Summary of supervisor variables

Variable	Mean (SD)	Range
Years of experience	8.87 (4.71)	0.76 to 25.35
Caseload	11.18 (4.06)	2 to 23
Credential	BCBA = 67	No credential = 26

The simple case of a single independent variable can be generalized to several independent variables, in which case the resulting model is referred to as a multiple linear regression model. For a more thorough mathematical treatment of regression, readers may refer to Ross (2010).

Because the number of treatment hours and mastered learning objectives naturally span orders of magnitude, a logarithmic transform was applied before fitting the linear regression model. During the process of data analysis, it is often the case that the values of both the independent and dependent variables span over several orders of magnitude. For example, one participant may have only mastered five objectives in a given period of time, while another participant may have mastered 100. When it can be verified that this large variance is a legitimate facet of the data, and not driven by outliers, standard mathematical transforms can be applied to the data to reduce the skew caused by this variance, as well as improve the visual and mathematical interpretability of models applied to the data. A common data transform for this purpose is the logarithmic transform, which simply applies the logarithm function to variable values. The logarithm function is order preserving. This is important to note because order-preserving

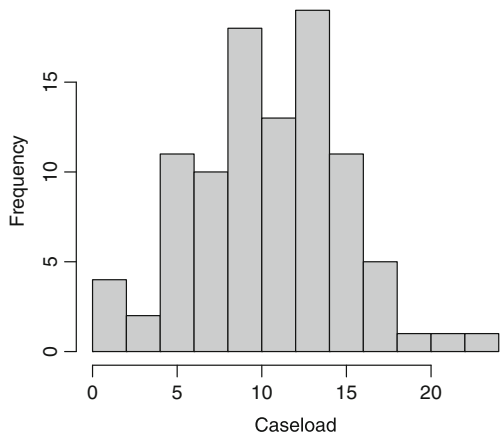

Fig. 2 Distribution of supervisor caseloads

transforms guarantee that the numerical relationship of variables is maintained, which makes it an appropriate choice for this task.

Results

A linear regression analysis on treatment hours was found to be significant and demonstrated a strong linear relationship (see Fig. 3). The resulting *R*-squared value of 0.32, based on the regression model, suggests that over 32 % of the variance in mastery of learning objectives is accounted for by the number of treatment hours. That is to say that 32 % of the variance in the number of mastered learning objectives can be accounted for by treatment hours alone.

To augment this analysis to include supervision hours, the same linear regression was repeated on log-transformed data, this time, capturing the relationship between solely supervision hours and mastered learning objectives. Figure 4 provides the scatter plot of the data, along with the best-fit line. In this case, the *R*-squared value of the model drops to 0.26, accounting for substantially less variance in learning objectives than treatment hours. This simple exploration of supervision hours, however, fails to account for the fact that best practice recommendations suggest a direct ratio of supervision hours to treatment hours (e.g., 1–2 supervision hours for every 10 h of treatment), and thus supervision and treatment intensities are highly correlated.

To identify the full extent of the impact of supervision on mastered learning objectives, a multiple linear regression was performed (again on log-transformed data), using both treatment and supervision hours as the independent variables, with

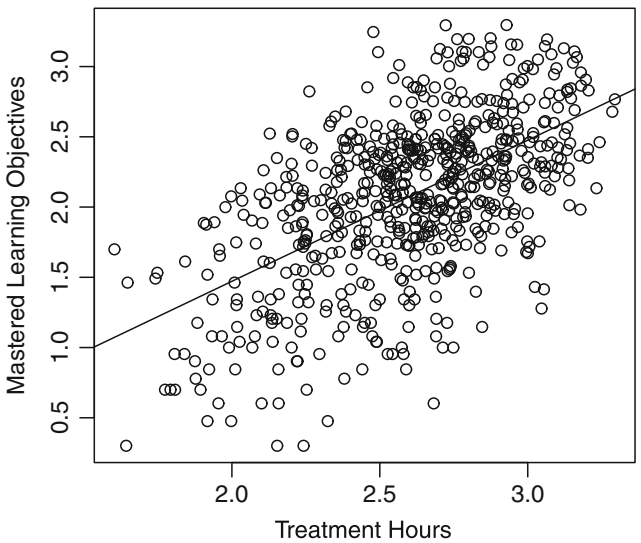

Fig. 3 Treatment hours vs. mastered learning objectives (log transformed)

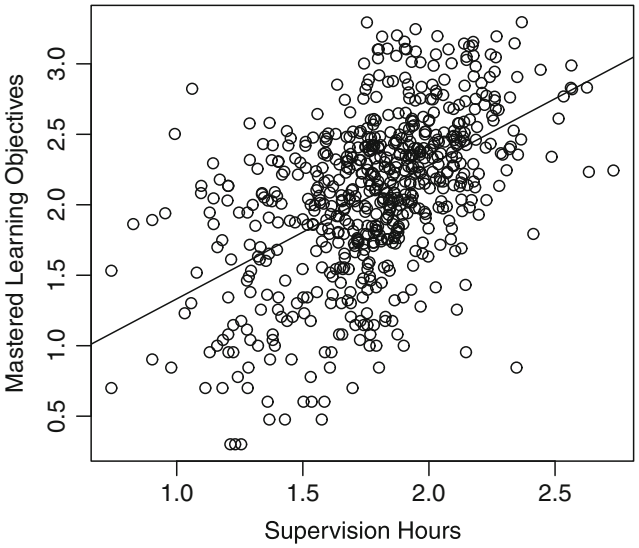

Fig. 4 Supervision hours vs. mastered learning objectives (log transformed)

mastered learning objectives as the dependent variable. Table 2 shows the regression parameters for this model, in addition to the parameters for the single variable model. The *R*-squared for the multiple regression considering both supervision and treatment increased to 0.34, accounting for less than 2 % more variance than treatment hours alone. This is perhaps best demonstrated visually in Fig. 5, which provides a three-dimensional scatterplot of the corresponding regression model. Here, the slope of the treatment-mastered learning objective line is substantially higher than the slope of the supervision-mastered learning objective line.

To further understand the role of supervision in the efficacy of ABA-based treatment, the following three attributes of the ABA supervisors represented by the data set were studied: whether they held a BCBA certification, their number of years of experience, and their caseload. The analysis was conducted using standard regression models. The number of years of experience was found to be statistically significant with a p value of 0.05. Additionally, whether the supervisor held a BCBA certification proved to be statistically significant, resulting in an F value of 9.77 for $\alpha = 0.05$. Table 3 provides regression coefficients for the three supervision attributes

Table 2 Linear regression coefficients for supervision and treatment hours

	Supervision	Treatment	Supervision + treatment
Intercept	0.39	−0.54	−0.52
Supervision	0.95	–	0.38
Treatment	–	1.00	0.74
R^2	0.26	0.32	0.34
F test	$p < 0.000$	$p < 0.000$	$p < 0.000$

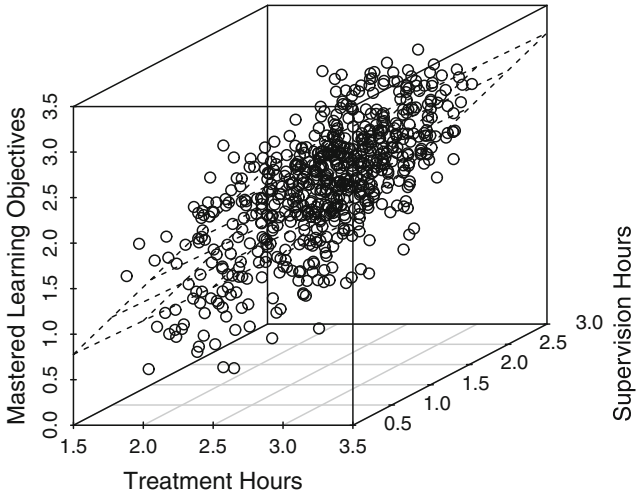

Fig. 5 Joint effect of treatment and supervision hours on mastered learning objectives (log transformed)

using mastered learning objectives as the dependent variable, with the *p* value for credential and experience providing the only statistical significance.

Discussion

The present study evaluated the relationship between mastery of learning objectives and elements of ABA supervision. When evaluated alone, a significant relationship was identified between the number of mastered learning objectives and the number of supervision hours. However, supervision hours were generally provided in a direct ratio to treatment hours (e.g., 1–2 h of supervision for every 10 h of treatment). Thus, participants who received greater supervision hours in the present study typically received higher treatment hours as well, which has previously been demonstrated to have a strong impact on treatment outcomes. To mitigate the impact of this confound, a multiple regression analysis was performed. When treatment hours and supervision hours were analyzed together, the addition of supervision hours improved the model's ability to account for the observed variance by less than 2 %. To be clear, this does not imply that supervision hours have a low impact on mastery of learning objectives. Instead, the implication is that the variance within the bounds of typical supervision intensity (e.g., 2 h of supervision for every 10 h of treatment; BACB, 2014) results in a relatively small improvement in mastered learning objectives.

Table 3 Regression coefficients for supervisor attributes

	Credential	Experience	Cases
Intercept	0.315	0.353	0.512
BCBA	0.232	–	–
Experience	–	0.015	–
Weighted cases	–	–	−0.053
Adj. R^2	0.087	0.031	−0.010
F test	$p < 0.002$	$p < 0.050$	$p < 0.764$

The relationship between mastery of learning objectives and supervisor credentials was examined in the present study. A significant correlation was found, revealing that supervisors with BCBA certifications produce 73.7 % greater mastery of learning objectives per hour as compared to supervisors without a BCBA. While the number of supervisors with BCBA certifications has grown since Love et al. (2009) reported that less than half of the surveyed supervisors to have BCBA certifications, a scarcity of BCBAs remains. Although requirements vary state to state, in many states, other professionals acting within the scope of their licensure are included among those who may supervise ABA programs. In the present study, samples of supervisors in these groups were either absent or not large enough to evaluate as standalone groups. Given the limited—albeit growing—number of BCBAs and the recognition by some states and funding sources of other licensed professionals, future research should examine the effectiveness of supervisors with BCBA certifications as compared to other licensed professionals practicing in the field.

A supervisor's years of experience overseeing ASD cases were shown to have a significant effect on the mastery of learning objectives. Specifically, the analysis indicated that for every year of experience that a supervisor had, the number of mastered learning objectives increased by 4 %. This may be trivial when considering the impact of a single year but would indicate that cases that are supervised by practitioners with 10 years of supervisory experience are mastering 40 % more per hour. These data indicate that experienced practitioners should consider ways to share their knowledge and skillset with less-experienced clinicians through mentorship and consultation. The relatively weak statistical significance of the result indicates though that there are still numerous other factors that impact the number of mastered learning objectives. Simply having worked as a supervisor for a long period of time does not guarantee that performance will be better. It may be the case that clinicians improve over time due to experiencing a variety of different cases as well as continuing to train and hone their skills. Unfortunately, determining why there was a correlation between years of experience and increased number of mastered learning objectives was beyond the scope of the current data.

Supervisor caseloads were not found to have a significant relationship to the number of mastered learning objectives. This finding was unexpected, but it is consistent with the relatively weak impact that an increase in supervision hours has on mastered learning objectives. It is likely the case that, once a sufficient level of supervision has been provided,

increasing supervision of a case does not improve the number of mastered learning objectives. Similarly, a supervisor with a smaller caseload would likely be able to provide more supervision to each case; as reflected in the analysis of supervision hours, however, the increased supervision hours did not result in a meaningful improvement.

In the current study, treatment and supervision hours were not randomly assigned. Hours were based on clinical recommendations and subject to authorization by diverse funding agencies. Thus, the treatment and supervision hours that an individual received may have been less than what was considered medically necessary by the treating clinician. Furthermore, the participants were not randomly assigned to supervisors. Case assignment was based on a variety of factors, including availability, clinical knowledge, and funding agency credential requirements. It stands to reason that more challenging cases may have been assigned to supervisors with greater experience. Furthermore, supervisors working on challenging cases may have had lighter caseloads than supervisors with less demanding cases. Future research should take into account these case-specific factors. ASD is a multifaceted disorder with each individual displaying unique symptom presentation and treatment response. The present study did not account for individual differences that are known to affect treatment response, including age, symptom severity, and skill level. In addition, a noteworthy limitation is that while interobserver agreement (IOA) is collected as a part of day-to-day clinical practice, these data were not stored in such a way as to be accessible for these analysis. Future researchers would do well to build IOA into their data tracking systems.

The present study examined supervision hours overall. Future research on supervision intensity should investigate the facets of supervision that have the greatest impact on mastered learning objectives to help guide clinical standards. For example, supervision involves a large variety of tasks, including treatment planning, parent training, direct observation, and therapist mentoring, among others. It is possible that particular tasks may improve outcomes more than others. For instance, preliminary evidence shows that support from supervisors positively impacts therapist self-ratings of performance and efficacy (Gibson et al., 2009). Moreover, it is possible that greater supervision intensity may benefit some treatment domains more than others. Similar findings have been revealed with respect to treatment intensity (Virués-Ortega, 2010).

The present study measured treatment outcome in terms of mastered skills. While standardized scales are more commonly used to measure outcome within ASD treatment literature, the measurement of acquired targeted skills may better show individualized progress that is comparable across groups (Matson & Goldin, 2014). However, this measure of outcomes is not without limitations; that is, degree of difficulty varies for each targeted skill, and targeted skills do not necessarily address core deficits of ASD (Fava & Strauss, 2014). As such, future research employing target mastery as a primary outcome measure could consider including only those targets directly associated with diagnostic criteria of ASD, including social communication, social interaction, and restricted, repetitive behaviors.

The findings reported in the present study have large implications. Best practice recommendations for supervision have been made by the BACB to provide needed guidance to funding agencies and to facilitate treatment integrity and effectiveness. Until now, little research has been conducted to substantiate those recommendations. While the results of the current study should be replicated in other samples and explored further, they indicate that the 1–2 h per every 10 h of treatment described in the 2012 version of the BACB guidelines may be more appropriate than the revised recommendations in 2014. Further, given the relationship between treatment response and the supervisor credential, it seems evident that BACB standards for behavior analysis have produced a meaningful certification. These standards, along with the aforementioned additional training in ASD treatment, may be the factors that enabled supervisors in the present study to take on greater caseloads and why, with hours of supervision per case that reflected the reduced 2012 BACB guidelines, supervisors were able to maintain strong clinical outcomes. Given that the current study found no relationship between mastered learning objectives and supervisor caseload, the optimal caseload should be reconsidered. Potentially, supervisor caseloads may be carefully and incrementally increased over time to expand treatment capacity while ensuring treatment quality and integrity.

Another implication of the current study is in regard to how funding resources are allocated. In real-world settings, treatment resources are always limited. Typically, consumers and providers alike often make hard decisions to trade one treatment component in favor of another in an effort to yield the greatest improvement for each individual with ASD. Given the relationship between treatment hours and mastered learning objectives in contrast to the relationship between supervision hours and mastered learning objectives, it seems likely that reallocating funding resources from supervision hours to treatment hours would yield better outcomes overall (see Fig. 5). That is to say, a 10 % increase in supervision hours would yield only a 3.6 % increase in mastered learning objectives. Rather, if those same hours were allocated to treatment, mastered learning objectives would improve by 7.3 %. This effect is further multiplied by the observation

that reimbursement rates are often significantly higher for supervision than for treatment, meaning that funding for 1 h of supervision could potentially fund 2–3 h of treatment, which are hours that research consistently demonstrates to produce better outcomes for each child. While supervision is required to ensure progress and treatment integrity, exactly how much supervision is required is an empirical question.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval For this type of retrospective analysis, formal consent was not required.

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Intensity and Learning Outcomes in the Treatment of Children With Autism Spectrum Disorder

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Abstract

Ample research has shown that intensive applied behavior analysis (ABA) treatment produces robust outcomes for individuals with autism spectrum disorder (ASD); however, little is known about the relationship between treatment intensity and treatment outcomes. The current study was designed to evaluate this relationship. Participants included 726 children, ages 1.5 to 12 years old, receiving community-based behavioral intervention services. Results indicated a strong relationship between treatment intensity and mastery of learning objectives, where higher treatment intensity predicted greater progress. Specifically, 35% of the variance in mastery of learning objectives was accounted for by treatment hours using standard linear regression, and 60% of variance was accounted for using artificial neural networks. These results add to the existing support for higher intensity treatment for children with ASD.

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Keywords
autism spectrum disorder, treatment intensity, applied behavior analysis, treatment outcomes

Applied behavior analysis (ABA) is a well-established treatment for the symptoms and behaviors commonly associated with autism spectrum disorder (ASD; Eldevik, Eikeseth, Jahr, & Smith, 2006; Matson & Goldin, 2014; Myers & Johnson, 2007; Reichow, 2012; Reichow, Barton, Boyd, & Hume, 2012). This intervention is typically initiated in early development and provided for multiple years, generally at 20 to 40 hr per week (Eldevik et al., 2009; Granpeesheh, Dixon, Tarbox, Kaplan, & Wilke, 2009; Reichow et al., 2012). Despite the overall consensus that ABA is the preeminent treatment for ASD, there is still debate surrounding the most effective "dosage," meaning the ideal quantity of treatment provided in a specific interval of time (e.g., hours per week). Some researchers speculate that there may be a point where treatment is too intense and the child "burns-out" (i.e., Matson & Smith, 2008) or that there may be a point of diminishing returns at which significant improvements are no longer made (reviewed by Fava & Strauss, 2014). However, others argue that as treatment hours increase, improvements likewise increase (e.g., Granpeesheh et al., 2009; Virués-Ortega, 2010).

Apart from the seminal study by Lovaas (1987) and a much later study by Reed, Osborne, and Corness (2007), few or no other studies have directly compared outcomes for groups receiving high- versus low-intensity ABA. Lovaas (1987) contrasted high intensity (40 hr) to low intensity (10 hr) and found that the high-intensity group achieved robust treatment effects, whereas the low-intensity group improved little. Likewise, Reed and colleagues (2007) contrasted high intensity (30 hr) to low intensity (12 hr) and found the high-intensity group performed much better than the low-intensity group. More information regarding the impact of treatment intensity may be gleaned from examining the study by Eldevik, Eikeseth, Jahr, and Smith (2006), who compared groups of participants with ASD and intellectual disability in two low-intensity groups. Participants received either 12.5 hr per week of treatment based almost exclusively on ABA principles or 12 hr per week of eclectic treatment (including alternative communication, ABA, sensory-motor therapies, programs based on principles from Division TEACCH®, etc.). While the ABA group outperformed the eclectic group, the gains made by the ABA group were significantly lower than those reported in studies in which ABA was implemented at an intensive level.

Several reviews and meta-analyses have been published that provide additional support for early intensive behavioral intervention (EIBI) while

highlighting the role of treatment intensity. Some reviews have indicated overall improvement among groups but discrepant results among individual participants, reportedly affected by various child-specific factors, such as pretreatment IQ, adaptive, and language skills (Fava & Strauss, 2014). These variables are critical to identify to maximize the outcome of individualized treatment. In their 2009 meta-analysis of EIBI based on the Lovaas model, Reichow and Wolery found only two studies that compared different levels of treatment intensity (Lovaas, 1987; Smith, Eikeseth, Klevstrand, & Lovaas, 1997). They concluded that the greatest changes in IQ occurred among those children treated at a high level of treatment hours (30-40) for a long duration of time. Virués-Ortega (2010) found a variety of treatment dose–response relationships, wherein IQ did not show a clear improvement from increased intensity, but language and adaptive skills did. Virués-Ortega, Rodríguez, and Yu (2013) later conducted a study investigating intervention time in terms of both intensity (i.e., hours per week) and duration (i.e., total number of weeks). Their results indicated that increased intervention time, lower age at the beginning of treatment, and higher preintervention functioning are important variables in determining outcomes for children in programs that are up to 4 years long.

One particular challenge in drawing conclusions regarding the role of treatment intensity is due to a lack of studies with consistent experimental methodology or similar study samples that can be appropriately contrasted and compiled as evidence. For instance, Howlin, Magiati, and Charman (2009) reviewed 11 studies and noted that the researchers found that EIBI was effective at the group level, primarily in terms of increasing IQ. However, hours of intervention were difficult to estimate because few studies reported these parameters in sufficient detail. If hours were reported, they were provided by parents or therapists, rather than systematically monitored by the research teams. For most studies, only approximate average hours per week were provided. Additionally, at the individual participant level, varying degrees of improvement were found. Eldevik and colleagues (2010) also argued for a need to evaluate outcomes, not just at the group level but by looking for meaningful changes in individual children. To perform an individual participant data meta-analysis, they obtained individual participant records from 16 published studies on intensive behavioral intervention. They found that pretreatment IQ and adaptive behavior skills were predictive of gains in adaptive behavior. They also noted the importance of treatment intensity as a variable affecting treatment outcomes. These results further support the need for individualization in terms of treatment components, including intensity.

From their meta-analysis, Strauss, Mancini, SPC Group, and Fava (2013) concluded that most of the studies they reviewed from 2009 to 2011 provided

insufficient reports of treatment hours. These inadequate reporting practices included only providing an approximate weekly range of intervention hours, not reporting control group hours, or not reporting details about treatment hours at all. The authors also found that caregiver involvement improved treatment results, with more intensive programs with parental inclusion (i.e., parents applying teaching strategies at home) resulting in better treatment outcomes.

As noted in numerous reviews and meta-analyses, the methodology (including outcome measures) chosen to evaluate these treatments has varied so significantly as to make contrasts difficult. In their recent article, Matson and Goldin (2014) reviewed targeted behaviors and outcome measures of EIBI. They concluded that there is not a current standard for outcome measures of studies of EIBI, which is problematic in that this prevents comparisons of studies and conclusions about appropriate dosage of intervention. In particular, they reported that standardized scales are the most frequently used method of measuring outcomes, with the most common being the Vineland Adaptive Behavior Scales, standardized tests of IQ, and the Bayley Scales of Infant Development. This is problematic in that many standardized measures have not been normed on children with ASD (Reichow & Wolery, 2009). Furthermore, use of IQ as an outcome measure of program efficacy is questionable, given that intelligence is not a diagnostic marker of ASD (Reichow & Wolery, 2009). Although some of the studies they included used measures of socialization, communication, repetitive behavior, and restricted interests to monitor outcomes, use of these measures was much less common. As such, the more common methods may be helpful in determining if more global improvements have taken place, but they do not allow monitoring of effects on core symptoms of ASD. As previously discussed by Granpeesheh and colleagues (2009), one alternative is to monitor the number of behavioral objectives a participant masters in a certain time period (e.g., mastered objectives per month). These data are readily available from ongoing ABA service delivery, as ABA service providers rely on such data on a daily basis to track treatment progress and make decisions regarding treatment planning.

Despite the difficulty in contrasting treatment intensity among studies to identify the ideal dosage of treatment, the emerging consensus among researchers is that treatment outcomes are significantly better when the dosage is high (over 30 hr per week). Nonetheless, this has not readily translated into clinical practice. Indeed, there is a high degree of variability among what clinicians provide. In a survey of 211 program supervisors, Love, Carr, Almason, and Petursdottir (2009) found an alarming degree of variability among the average hours of treatment reported, with roughly 25% of their sample falling into each of their four response options: 1 to 10, 11 to 20, 21

to 30, or 31 to 40 hr per week. Clearly, there is a disparity between what is reported in treatment literature as the optimal dosage of ABA and what is practiced in clinical settings. It would be easy to suggest that this disparity is simply due to mistranslation of research to practice. However, many factors impact the number of hours of treatment that each child receives in addition to the clinician's treatment recommendations, including determinations by funding agencies to authorize fewer hours than those recommended by the clinician, arbitrary financial caps placed on treatment, and caregiver availability, among many others. Bridging the gap between research and practice will need to take into consideration all of these factors to be successful.

One organization that has helped to set standards for the field of ABA is the Behavior Analyst Certification Board (BACB), which began offering a national certification in behavior analysis in 1998. Recently, the BACB released updated treatment guidelines for health plans addressing the treatment of ASD (BACB, 2014). In its document, the BACB defines comprehensive ABA as consisting of 30 hr to 40 hr of treatment per week. While these clinical guidelines are a welcome addition, it is too soon to tell if they will improve standards of care. There is a need for further studies that focus on treatment outcomes within clinical settings.

The purpose of the present study was to further examine the relationship between ABA treatment hours and mastery of learning objectives within a large archival data set collected from a community-based provider of ABA services, which implements the CARD Model of ASD service delivery (Granpeesheh, Tarbox, Najdowski, & Kornack, 2014).

Methods

Data Collection

Treatment data were collected retrospectively from a large archival database. Clinical records were selected from a pool of 1,258 children receiving behavioral intervention services from a large community-based behavioral health agency. The Skills™ Assessment is an instrument that evaluates skills across eight areas of child development (Dixon, Tarbox, Najdowski, Wilke, & Granpeesheh, 2011). A study by Persicke and colleagues (2014) evaluated the validity of the Skills™ Assessment by contrasting parent response to the Skills™ items with direct observation. Pearson product-moment correlation coefficients ranged from moderate (r = .65) to high (r = .95). Through the course of normal service delivery, clinicians used the Skills™ system to identify treatment targets, plan interventions, and track treatment response. These data were integrated with operational information (such as treatment hours)

collected by the participating treatment centers. These sources of information constituted the child's clinical record and were queried for the information included in the present study.

Clinical records were selected if they met the following criteria: a diagnosis of ASD (American Psychiatric Association, 2013), autistic disorder (American Psychiatric Association, 2000), pervasive developmental disorder–not otherwise specified (PDD-NOS; American Psychiatric Association, 2000), or Asperger's disorder (American Psychiatric Association, 2000); age between 18 months and 12 years old; and receiving a minimum of 20 hr of ABA treatment per month. Further, any individuals who were in their first month of treatment were excluded from the data set. These criteria resulted in a sample size of 726 individual records. The age (at end of study period), diagnosis, and gender profiles of the individuals whose clinical records were used in the study were as follows: 598 males (age range = 2.08-11.92 years, mean age = 7.46 years, 347 autistic disorder, 201 ASD, 46 PDD-NOS, four Asperger's disorder) and 128 females (age range = 3.17-11.83 years, mean age = 7.59 years, 82 autistic disorder, 39 ASD, six PDD-NOS, one Asperger's disorder). The average number of hours received per month was 72.81 (SD = 36.31) with a range from 20.02 to 197.25 (treatment hours per month did not significantly differ between gender groups). The vast majority of participants (N = 716) began treatment services prior to the study period (January 1, 2014-December 31, 2014). These participants on average had received 1.48 years of treatment (SD = 1.35, range = 0-4.67 months) prior to the start of the study period. For all participants, the average age at the start of treatment services was 5.15 years (SD = 2.04) with a range of 0.9 to 11.0 years. Participants in this study resided and received services in the states of Arizona, California, Colorado, Illinois, Louisiana, New York, Texas, and Virginia.

Treatment

Each child's treatment program was customized to build upon his/her individual strengths and to address his/her individual deficits in proportion to individual need. In addition, local and regional variables, such as funding agency requirements, influenced whether treatment was provided in home, school, clinic, or a combination of settings. Despite the individualization of each child's program, the following elements were common to all: (a) treatment was delivered on a one-to-one basis by trained behavioral therapists; (b) treatment included both more-structured (discrete trial training) and less-structured (natural environment training) behavioral teaching strategies; (c) language intervention took a verbal behavior approach; (d) both errorless and least-to-most prompting strategies were used; (e) all major empirically validated

behavioral principles and procedures were used (i.e., reinforcement, extinction, stimulus control, generalization training, chaining, and shaping), as appropriate; (f) assessment and treatment of challenging behaviors followed a function-based approach; (g) parents were included in all treatment decisions and received training on a regular basis; (h) direct supervision was provided frequently (e.g., biweekly) by an expert in behavioral intervention for children with ASD; and (i) treatment content was based upon the CARD curriculum (Granpeesheh et al., 2014). Training for behavioral practitioners was multifaceted and included a combination of an eLearning program (www.ibehavioraltraining.com), classroom-style training, field-experience training, and evaluation. Practitioners received supervision by a Board Certified Behavior Analyst (BCBA) and attended monthly staff meetings that review treatment procedures.

Billing records were reviewed to determine the number of treatment hours received. All direct treatment service hours provided to the participant were included. Activities that were not direct treatment services, such as traveling to a participant's home, were excluded. Further, any activities that were not client-specific would not have been a billed activity and thus were not included in the analyses.

Mastery of learning objectives was used as the dependent variable for all analyses within this study. The definition of mastery of a learning objective was set on an individual basis by the treatment supervisor, but was required to be within the bounds of the following criteria: greater than 70% accuracy of responding to the learning objective for a minimum of two treatment sessions across two different days. Typically, a more stringent mastery criterion of 80% accuracy is required, but supervisors have the discretion to deviate if they feel it is clinically appropriate to do so.

Data Analysis

To gain insight into the relationship between mastery of learning objectives and treatment intensity, an exploratory data analysis was conducted on the number of therapy hours and treatment duration received by the 726 participants included in the data set, as well as the number of learning objectives mastered during the course of a 12 months period (January 1, 2014 through December 31, 2014). The number of treatment hours an individual received during the 12-month period was matched with the total number of learning objectives mastered during that same time period. Not all participants received the same duration of treatment during this time period, with data on some spanning as little as 2 months of treatment and others having data through the entire 12-month period (range = 2-12, mean = 6.87, *SD* = 2.72). Further, the

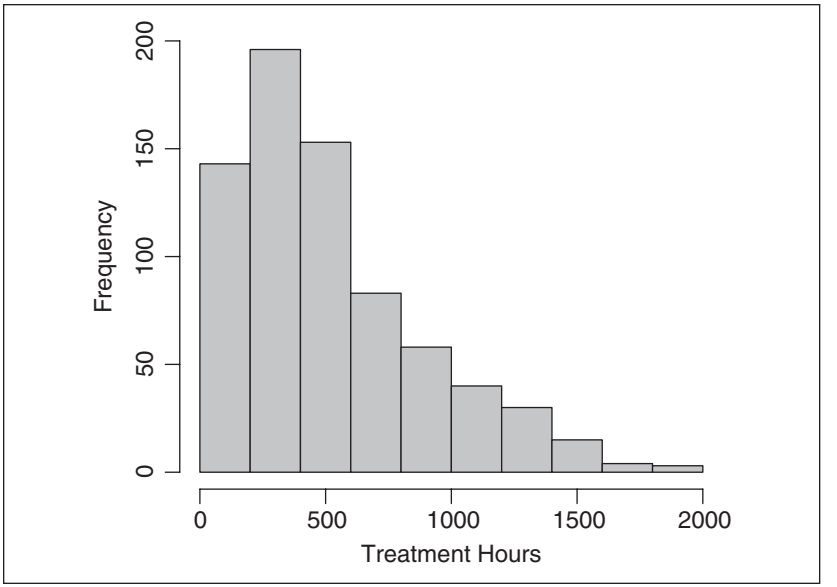

Figure 1. Histogram of total patient treatment hours.

initial months of treatment data do not imply that these were the individuals' first months of treatment. For some participants, the 12-month period may have captured the start of treatment whereas for others, they may have received treatment for a number of months prior to the 12-month period from which data were queried. Figure 1 and Figure 2 provide a visualization of the distributions for therapy hours and mastered learning objectives. From the histograms, it becomes apparent that the distributions for both treatment hours and mastered learning objectives are positively skewed. Furthermore, the value distribution for both variables spans several orders of magnitude, with the range of total therapy hours being 40 to 1,973 and the range of mastered learning objectives being 2 to 1,973. To ensure data integrity, a manual inspection of the database was undertaken, with the audit showing that data points representing extreme values were recorded correctly based on historical records.

Based on exploratory analysis of the raw data, a log transform was applied to the data to account for values spanning several orders of magnitude, which is a standard practice in the statistics community when working with non-negative data. This transform was chosen because it is both order-preserving and easy to interpret when it forms the basis for a regression model. Figures 3 and 4 show the log-transformed distributions for these variables, which result

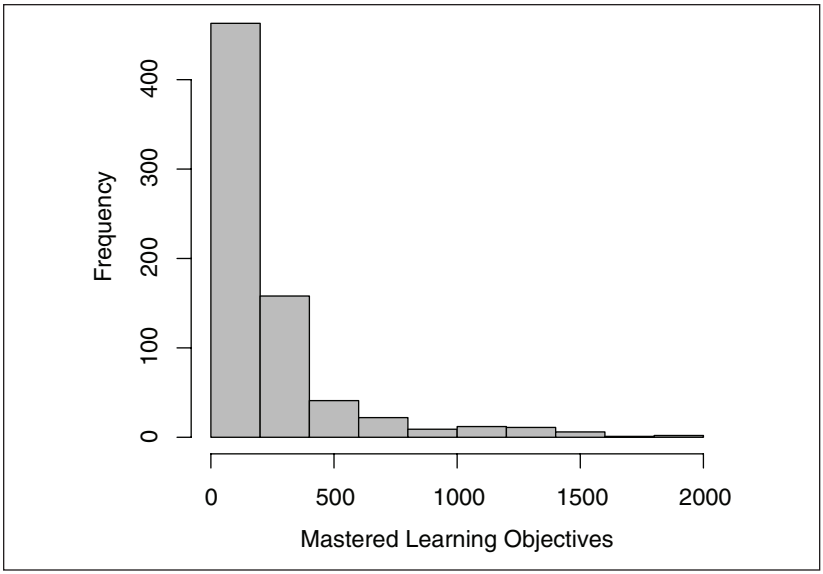

Figure 2. Histogram of total number of mastered learning objectives.

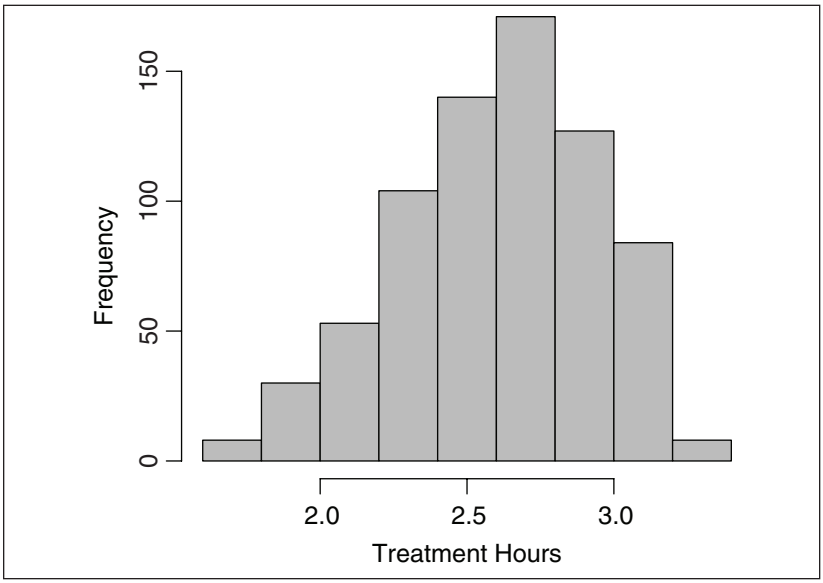

Figure 3. Histogram of log-transformed therapy hours.

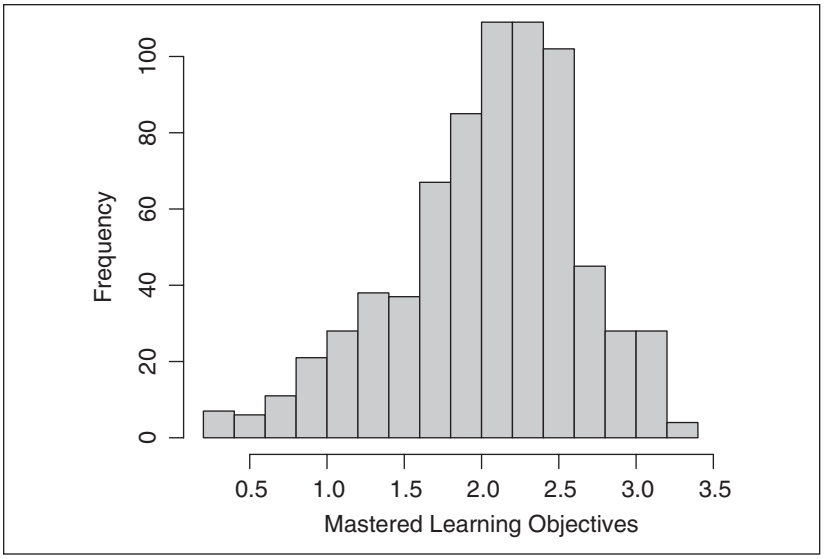

Figure 4. Histogram of log-transformed mastered learning objectives.

in normal distributions and form the basis of the regression analysis detailed in the next section.

Results

After transforming the data, a regression analysis was undertaken, with total treatment hours being used as the sole predictor variable for the number of total learning objectives mastered. A log transform was used for each variable. The scatter plot in Figure 5 depicts the relationship between these variables, as well as the line fit by a simple least-squares linear regression model. The linear relationship between treatment hours and mastery of learning objectives is apparent, with the R^2 statistic indicating that 35% of the variance in number of learning objectives mastered is explained by this relationship (see Table 1). For completeness, a linear regression model was fit to the untransformed data, yielding an R^2 of .18. This model is depicted in Figure 6.

Table 1 provides a listing of the pertinent parameters for the regression model. This is a substantial improvement over the results reported by Granpeesheh and colleagues (2009), who reported an R^2 of .147 for a sample size of 245 children. The previous study also leveraged age as a predictor variable in addition to treatment hours.

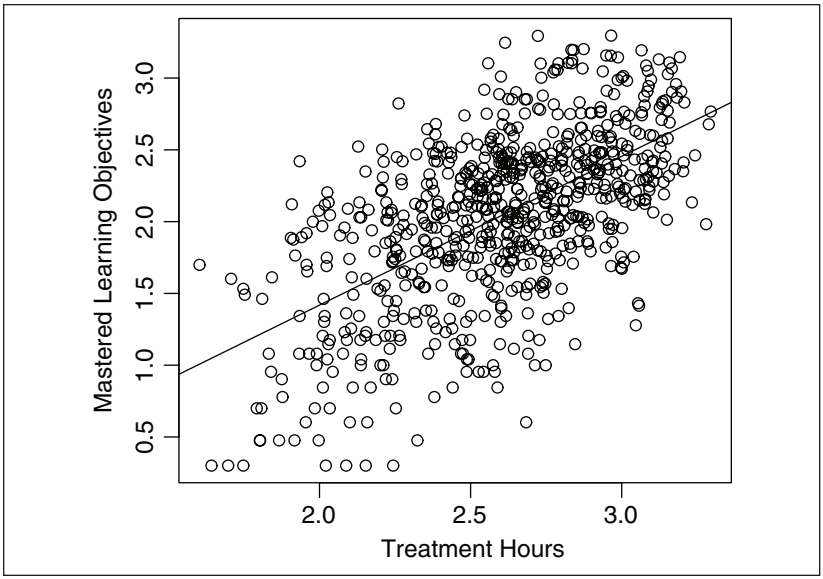

Figure 5. Relationship of treatment hours and mastered learning objectives based on linear regression.

Table 1. Linear Regression Parameters for Total Treatment Hours.

Regression parameters		
	Estimate	*p* value
Intercept	−0.65	.000
Hours	1.03	.000
R^2	.35	
F-test	394.2	.000

The use of total treatment hours as the independent variable in the regression analysis brought up a question of whether the source of the correlation was from the intensity of the treatment or the duration of the treatment. A secondary regression analysis was run using average monthly treatment hours and months of treatment as the predictor variables for the number of total learning objectives mastered. The results showed that both average monthly treatment hours and months of treatment significantly contributed to the number of total mastered learning objectives. This model resulted in an

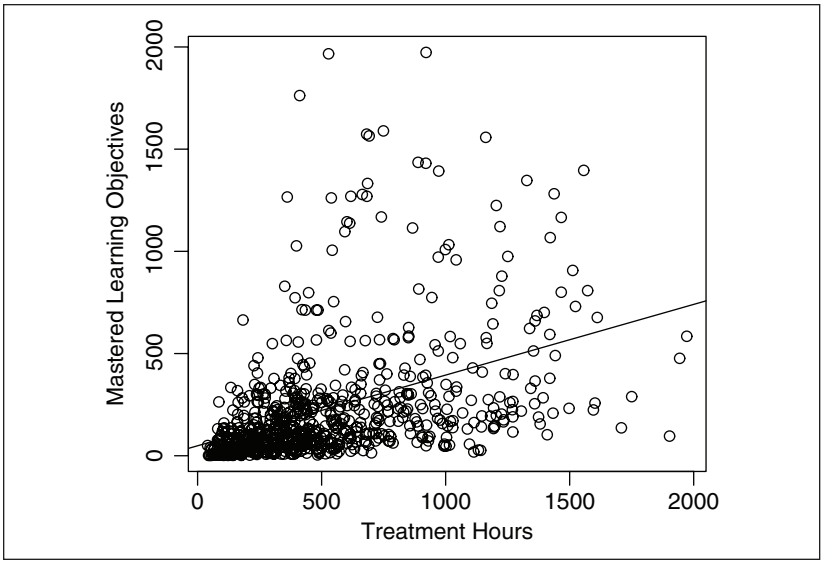

Figure 6. Relationship of the untransformed variables for treatment hours and mastered learning objectives based on linear regression.

Table 2. Linear Regression Parameters for Average Intensity and Duration.

Regression parameters		
	Estimate	*p* value
Intercept	0.03	.839
Intensity	0.34	.000
Duration	1.76	.000
R^2	.45	
F-test	300.0	.000

improved fit with an R^2 of .453. The relevant regression parameters can be seen in Table 2.

To compare more closely with Granpeesheh and colleagues (2009), the previous regression analyses were repeated with the addition of age as a predictor variable. In both cases, the age of the child was negatively correlated with the number of total mastered learning objectives. Although the effect of age was highly variable, the effect size was large enough to have a significant influence on the number of mastered learning objectives. The results of these

Table 3. Linear Regression Parameters for Total Treatment Hours With Age.

Regression parameters		
	Estimate	*p* value
Intercept	−0.25	.171
Hours	1.01	.000
Age	−0.38	.002
R^2	.36	
F-test	204.5	.000

Table 4. Linear Regression Parameters for Average Intensity and Duration With Age.

Regression parameters		
	Estimate	*p* value
Intercept	0.62	.001
Intensity	0.27	.001
Duration	1.75	.000
Age	−0.53	.000
R^2	.47	
F-test	213.9	.000

regressions can be seen in Table 3 and Table 4. As age and average monthly treatment hours were used as predictor variables in the same regression model, it is important to check their collinearity. A regression model using age as the predictor variable for average monthly treatment hours shows that the average number of monthly treatment hours was reduced by 3.13 for each year. Again, this relationship was highly variable resulting in an R^2 of .04 which shows that the correlations of these two variables is not a cause for concern in the previous model. These results are shown in Table 5.

With a baseline established using linear regression, it becomes possible to explore more sophisticated machine learning techniques to predict mastery of learning objectives. A hurdle in standard regression techniques is that the form of the function to be fit to the data must be picked a priori, despite the fact that in many cases the relationship between predictor and response variables is not well understood beforehand. To this end, a simple feed-forward neural network was applied, consisting of only 1 hidden layer, to the task of modeling the relationship of therapy hours to mastery of learning objectives.

Table 5. Age Influence on Average Intensity.

Regression parameters		
	Estimate	*p* value
Intercept	96.26	.000
Age	−3.13	.000
R^2	.04	
F-test	30.26	.000

Artificial neural networks (ANNs) are a widely studied and applied subset of data mining algorithms (Mitchell, 1997), and even small networks with simple topologies have the power to learn any continuous function (Hornik, 1991). In particular, the learning of the function is unsupervised, and a human need not specify the shape of the curve to be learned. This substantial benefit is the primary motivation for considering an ANN-based approach as a separate, but related, analysis to understand the relationship between treatment and learning outcomes.

Figure 7 shows a generic diagram of a feed-forward ANN with a single hidden layer. The independent variables (therapy hours in this case) are fed to the network as an input, and the weights of the network connections (initialized randomly at first) are used to produce a predicted output (mastered learning objectives). The data are then used to adjust the weights of the network until the predicted output is as close as possible to the desired output specified by the data, at which point the training of the network is complete. Mathematically, training the weights of the network corresponds to minimizing the error of the network predictions at the output layer. Because this error function is chosen to be continuous and differentiable, the internal weights can be adjusted incrementally by solving a system of partial derivatives. In computer science this algorithm is known as backpropagation (Rumelhart, Hinton, & Williams, 1986), one of the fundamental algorithms in ANN research. To ensure that the model learned by the network is generalizable, the network is trained on a random subset of the available data. Remaining data are used as an unseen test data set, which is used to measure the accuracy of predictions after training.

To apply neural networks to the data presented here, the data were randomly partitioned into training (65%), testing (30%), and validation (5%) subsets. The validation data were used in the training process to increase the efficiency of the algorithm and were not used to test the final fit of the learned model. The network was trained via backpropagation for 1000 iterations. Bayesian regularization (Foresee & Hagan, 1997) was applied as part of the

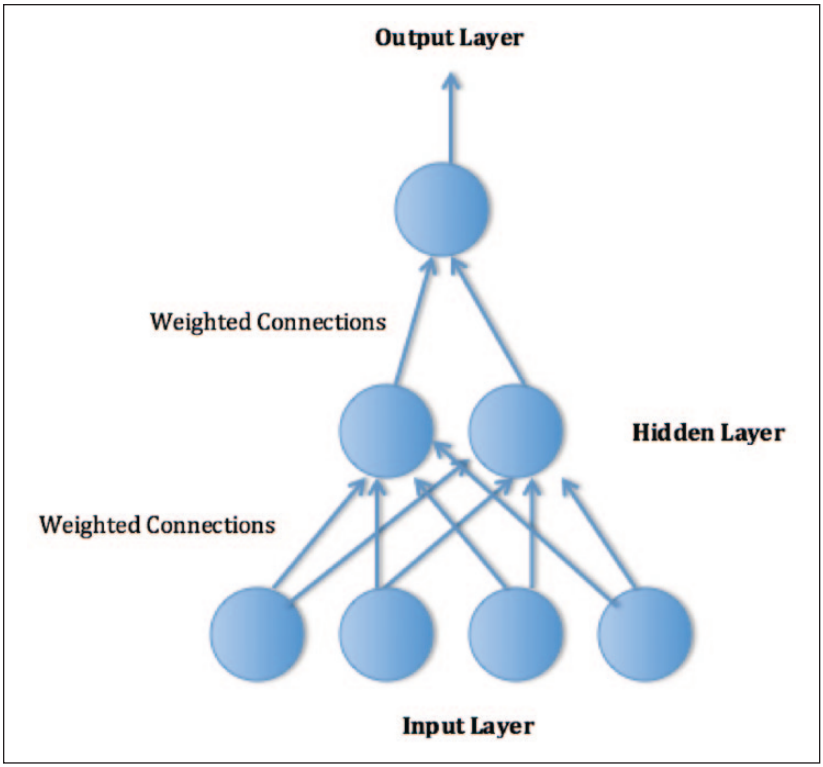

Figure 7. Topology of a feed-forward artificial neural network with one hidden layer.

training process to improve the robustness of the learned target function to noise, as well as improve generalization. While a treatment of Bayesian regularization is beyond the scope of this article, it effectively works by adding an additional term to the error function being optimized, which has an overall smoothing effect.

For the research question considered here, an ANN was trained consisting only of therapy hours as the input and mastered learning objectives as the target. To begin, we trained an ANN on untransformed data, which yielded an R^2 of .469, an immediate improvement over linear regression due to the model's ability to adapt to non-linearity in the data. We followed this with a model trained on log-transformed data, to parallel the analysis carried out using linear regression. Figure 8 shows the resulting fit, which demonstrates a non-linear trend to the line fit by the model. Using therapy hours alone, the neural

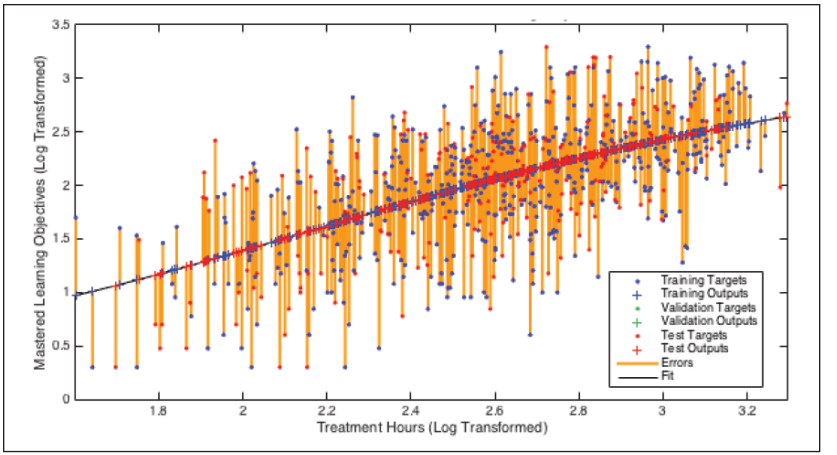

Figure 8. Relationship of treatment hours and mastered learning objectives learned by artificial neural network.

network achieves an R^2 of .60 on the entire data set, explaining a substantially higher amount of variance than the more simple linear regression model. Finally, for completeness, we trained a final model which incorporated patient age as an input in addition to therapy hours. This resulted in a trivial increase of the R^2 to .61.

While the artificial neural network outperforms linear regression, it is important to note that the nature of neural networks make them black boxes, meaning that the internal parameters used by the neural network to construct the fit function are not easily interpretable by humans. This parameters learned by the network have no direct probabilistic or geometric interpretation. Thus, researchers must make a tradeoff when determining whether to select neural networks to model the relationship between independent and dependent variables. The ANN offers the advantages of increased goodness of fit without having to constrain the form of the fit function a priori. Traditional models, linear regression in this case, may sacrifice some of this flexibility in exchange for interpretability of model parameters. Nevertheless, the properties of the backpropagation algorithm are well understood and mathematically sound, and so an artificial neural network approach to this regression problem still provides an attractive alternative to traditional techniques. In particular, the trained neural network model can be used to estimate the expected mastery of learning objectives for a given number of therapy hours, allowing for the same interpolation and extrapolation as provided by standard least-squares linear regression.

Discussion

These results show a clear relationship between treatment intensity and mastery of learning objectives in the context of behavioral intervention for children with ASD in a community-based clinical setting, regardless of the age of the child receiving the service. This study builds upon the findings of Granpeesheh and colleagues (2009) in several important directions. One of the limitations noted by Granpeesheh and colleagues (2009) was the non-standardized nature of using mastered learning objectives. A standardized assessment and treatment-tracking tool (Skills™), which has been shown to have strong reliability (Dixon et al., 2011) and validity (Persicke et al., 2014), was used to ensure that all participants were measured according to the same criteria in a valid and reliable manner. While there is still inherent variability in difficulty to master one objective from another, the impact of this is likely mitigated by the large sample size.

It is also worth noting that the current study found a clear relationship between treatment hours and mastery of learning objectives across a sample that included a substantial portion of older children (mean age of 7.1 years). As discussed in the introduction, previous research on treatment intensity has focused on young children with ASD. This study is among the first to evaluate the effects of treatment intensity on mastery of learning objectives in older children with ASD. Although further research on treatment intensity in older children with ASD is still needed, the current results suggest that the common assumption that intensive treatment is only appropriate for young children may not be true.

Multiple factors are involved in a child's response to treatment, and one consistent finding across EIBI outcome studies is a high degree of variability among participants in treatment response (Fava & Strauss, 2014). Therefore, while a complicated relationship among factors influencing treatment response is assumed, it is worthwhile to note that, across a large number of children receiving behavioral intervention services in a community-based clinical setting, a strong relationship was found that accounted for 35% of the variance in a child's mastery of learning objectives using a standard linear regression and 60% of the variance using ANN. That is to say, without taking into consideration any child-specific variables, such as age (Granpeesheh et al., 2009) or parent involvement (Strauss et al., 2013), this single treatment-specific variable of intensity accounts for a large portion of how much a child will progress during treatment. Further, these data were not limited to children receiving only intensive treatment (e.g., 25-40 hr). This relationship was found across all levels of treatment intensity, most notably those who were also receiving relatively low treatment hours.

Given the nature of the present study, that is, a retrospective analysis of archival data, we are able to describe what occurred but are left to only speculate as to why. However, based upon the improvement in the model by moving from a simple linear relationship to a non-linear relationship developed by the ANN, one may conclude that while increased treatment hours was strongly related to more learning occurring within a given period of time, there are also bands within the intensity spectrum wherein an individual receiving ABA-based treatment for ASD will learn more per hour. The relationship between treatment hours and learning objectives found in Figure 8 shows that the shape is slightly sigmoidal. That is, at the lowest and highest levels of intensity, learning per hour was not as great as in the middle of the distribution. It may be the case that as treatment intensity moves from low to high, there is a base level of exposure needed, that once received increases the rate of learning in subsequent presentation of other stimuli. Further, at the highest levels of treatment intensity, the learning objectives mastered per hour were slightly less. This is contrary to the results found by Granpeesheh and colleagues (2009) who found that as treatment hours increased, significantly more learning objectives were mastered for every hour of treatment. Future research is needed to further explore the relationship between treatment hours and mastery of learning objectives within both the high and low levels of intensity. It should be noted that the simple relationship observed between treatment hours and mastered learning objectives far outweighs the differential rate of learning at higher or lower levels of treatment intensity.

Response to treatment is multifaceted, and dose–response relationships are likely stronger for some domains than for others. For example, Virués-Ortega (2010) found that language skills benefited from increased treatment duration, whereas adaptive skills benefited from treatment intensity, and intellectual functioning appeared to not show a relationship to intensity nor duration, as discussed previously by Matson and Smith (2008). Further research looking at treatment response within particular curricula domains would allow for a more fine-grained analysis and could provide insight into which specific treatment manipulations would result in the best outcomes.

Per their 2014 review, Matson and Goldin noted that, although it is the most common practice, use of standardized scales as outcome measures might not be the best option. These authors argued that, although such measures evaluate a broad range of behaviors, they are not tailored to the individual and are not as sensitive as progress monitoring of target behaviors. Furthermore, most standardized measures utilized thus far for outcomes in studies on dosage are not necessarily representative of improvement in symptoms of ASD (i.e., socialization, communication, and repetitive behaviors and restricted interests; Reichow & Wolery, 2009). As such, using mastery of objectives to

monitor progress provides a manner by which to measure individualized gains in target behaviors and also allows comparison at the group level.

Nevertheless, as was noted by Granpeesheh and colleagues (2009) and recently discussed by Fava and Strauss (2014), mastery of learning objectives may or may not directly translate to making a change in the core deficits of ASD. This remains a limitation of the present methods of using mastery of discrete learning objectives as a primary outcome. Future research could consider including only mastery of particular behavioral domains that correspond directly to diagnostic criteria, such as language, social skills, and play, and decreasing repetitive behavior. Regardless, using mastery of behavioral objectives as a measure of treatment response is arguably more representative of what is commonly practiced in EIBI programs. In our experience, some service providers may administer standardized assessments when required by funding sources; however, this is the exception and not the norm.

Another limitation of the current study is that treatment hours were not randomly assigned. There may be a number of reasons that one individual received more treatment hours than another. The authors can only speculate as to the reasoning that each clinician used in making treatment recommendations, as well as each funding source's decision process either to fund or deny treatment at a particular intensity or duration. Nevertheless, the current study included a relatively large sample dispersed over a relatively large and heterogeneous geographical area, so it seems unlikely that any of these variables were systematically associated with individuals who would have been higher or lower treatment responders for other reasons.

The strong relationship between treatment intensity and mastery of learning objectives is an important finding and has implications for setting clinical standards and guiding public policy decisions. As reported by Love and colleagues (2009), there is a high degree of variability in the number of treatment hours that clients receive in clinical settings. This is likely due to multiple causes, one of which is the current role that funding sources play in determining treatment intensity and duration. Unfortunately, clinical practice until now has been shaped as much by financial constraints, such as the cost borne by families and arbitrary caps on treatment hours imposed by funding agencies, as it has by the establishment of best practice standards. Multi-pronged efforts, however, have begun to increase access to ABA at the proper dosage and intensity, shifting treatment decisions from the funding source to the clinician where best practices have greater influence. The momentum of autism insurance reform laws (commonly known as "autism mandates") has made ABA-based autism treatment a covered benefit of insurance policies in 43 states (as of the date of writing). Additionally, litigation arising from treatment denial by state agencies has clarified that ABA-based autism treatment is medically

necessary and must be included in Early Periodic Screening, Diagnosis, and Treatment (EPSDT), the child health component of Medicaid that is required in every state. Underpinning both of these efforts and representing a primary factor in this shift toward best practices is the large body of research documenting the effectiveness of ABA in treating the behaviors and deficits associated with ASD, which has disarmed funding agencies that relied on a characterization of ABA as "experimental" to deny authorizations for treatment. Collectively, these efforts have given weight to treatment guidelines that can safeguard critical decisions about treatment intensity by taking them out of inexpert hands and leaving them to the discretion of highly trained clinicians. The authors are hopeful that clinical practices will continue to evolve to ensure that treatment intensity reflects best practices, such as those described in the ASD treatment guidelines issued by the BACB (2014).

The current results suggest several potentially fruitful areas for future research. First, little previous research has evaluated the effects of the intensity of supervision included in behavioral intervention programs (Eikeseth, Hayward, Gale, Gitlesen, & Eldevik, 2009). The treatment intensity data included in the current study only comprised the number of direct therapy hours delivered by therapists, not the number of hours that such therapy was supervised by master's or doctorate-level clinicians and/or Board Certified Behavior Analysts. Future research should evaluate whether the amount of supervision impacts learning rate. Second, there is currently little consensus regarding the amount of training or experience required for line therapists or supervisors and whether or how much such training and experience impact learning rate in children with ASD. Future research could include a measure of clinician experience as a covariate in analyses of treatment intensity and learning rate. Finally, much more research is needed on the impact of parent training and parent involvement on learning rate. Future research should include some measure of parent training and/or parent involvement in ongoing intervention when analyzing the effects of treatment intensity on learning rate.

Perhaps, the most exciting potential direction for future research based on the current study is the possibility of using big data analytics to predict probable future learning rates based on child and other variables to ascertain reasonable expectations for dose–response at the outset of treatment. While it is unlikely that any other single variable would account for as high an effect as treatment intensity (e.g., 60%), numerous other variables must be targeted to account for the remaining unexplained variance in treatment outcome. These factors may include the child's medical conditions and other interventions (such as speech, diet, and medications). Based on such predictions, clinicians might someday be able to identify individuals who are likely to be lower

responders and target them for treatment enhancements, so they may be helped to respond to treatment at a higher rate. Possible treatment enhancements might include additional parent training, greater focus on visual supports, greater focus on establishing social interaction as a source of conditioned positive reinforcement, and/or early intervention for comorbid behavioral challenges, such as feeding or sleep disorders.

Declaration of Conflicting Interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Erik Linstead is an assistant professor of computer science and software engineering at Chapman University, where he leads the Machine Learning and Assistive Technology Laboratory (MLAT). He holds a BS from Chapman University, an MS from Stanford University, and a PhD from UC Irvine, all in computer science.

Dennis R. Dixon is the chief strategy officer at the Center for Autism and Related Disorders. He holds his PhD in psychology from Louisiana State University and completed a postdoctoral fellowship at Johns Hopkins University, School of Medicine.

Ryan French is a doctoral student of computational science at Chapman University, Schmid College of Science and Technology; a software engineer at the Economic Science Institute; and an adjunct professor of math and computer science. His research specializes in machine learning and computational economics.

Doreen Granpeesheh is the founder and executive director of the Center for Autism and Related Disorders. She received her PhD in psychology from the University of California, Los Angeles. She is a board certified behavior analyst and licensed psychologist with decades of experience treating individuals with autism spectrum disorder.

Hilary Adams is a predoctoral intern in clinical psychology at Indiana University School of Medicine, where she is fulfilling the final requirement to earn her PhD from Louisiana State University. She is a former therapist and current research assistant at CARD.

Rene German is an instructor of computer science and software engineering at Chapman University and a member of the MLAT. He holds an undergraduate degree in computer science, as well as an MS degree in computational and data science, both from Chapman University.

Alva Powell currently serves as chief technology officer at the Center for Autism and Related Disorders. Previously, he pioneered work with GPS mapping software, International Space Station software simulations, and developed large-scale websites. He received his BS degree in computer science from Michigan Technology University.

Elizabeth Stevens is a doctoral student in the Computational and Data Science program at Chapman University, where she previously earned her undergraduate degree in mathematics. Her research focuses on machine learning and data mining applied to autism spectrum disorder.

Jonathan Tarbox is director of research and regional clinic director at FirstSteps for Kids. He has published two books and over 60 peer-reviewed articles and chapters, is an associate editor of *Behavior Analysis in Practice*, and is on the editorial boards of *The Analysis of Verbal Behavior* and *Behavior Modification*.

Julie Kornack is the Director of Public Policy at the Center for Autism and Related Disorders. Her work includes identifying, developing, and supporting state and federal initiatives that increase access to autism treatment. She works directly with stakeholders to increase access to evidence-based treatment and serves on several advisory committees.

LATE

March 15, 2017

House District 24
Hawaii State Capitol
Room 402
Phone: (808) 586-9425
Fax: (808) 651-4936

Re: **SB 739 (Green)**

Dear Representative Della Au Belatti:

I am writing to express concern with **SB 739**, this bill was co-sponsored by the Autism Business Association and introduced by Senator Green. The goal of the bill was to allow military families to continue to receive applied behavior analysis intervention from the certifications approved by Tricare. These certifications had been allowed to serve Tricare clients diagnosed with autism prior to the licensure bill. Tricare has approved three certification agencies which are the Behavioral Intervention Certification Council (BICC), Qualified Applied Behavior Analysis Credentialing Board (QABA), and the Behavior Analyst Certification Board (BACB). The licensure for behavior analysts that was passed last year only cited the Registered Behavior Technician which is a BACB certification. Our association was contacted by multiple providers in Hawaii stating that their staff could no longer practice and that they were unable to serve children with autism. The legislation introduced by Senator Green identified the three certification agencies so that families could continue to receive services from their medical provider.

The bill was amended in the Senate CPH committee to state that the individual must possess a board certification from the Behavior Analyst Certification Board.

3 (A) Possesses board certification from the Behavior Analyst Certification Board

We have significant concern that the bill is citing only one private company that offers certification, while others exist. The bill in its current form creates a legislative monopoly for one company. We request that an equal standard be applied for other companies that have certifications. We have submitted amended language to the bill to ensure that there is an equal standard applied to all of the companies that offer certification in the field of applied behavior analysis.

Sincerely,

Andrew Patterson, President of the Autism Business Association
Phone (714) 717 - 5158

hmsa

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LATE

March 16, 2017

The Honorable Della Au Belatti, Chair
The Honorable Bertrand Kobayashi, Vice Chair
House Committee on Health

Re: SB 739, SD1 – Relating to Behavior Analysis Services

Dear Chair Au Belatti, Vice Chair Kobayashi, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to offer testimony on SB 739, SD1, which expands treatment capacity of behavior analysis services by allowing individuals with certain certification and under supervision conditions to implement behavior analysis services. HMSA has concerns with this Bill, and we offer comments.

HMSA appreciates the important role that behavior analysts play in treatment of autism and the distinct challenge that Hawaii faces in recruiting and licensing qualified applied behavioral analysis (ABA) service providers – especially in rural areas and on neighbor islands. SB 739, SD1, seeks, in part, to address this challenge by expanding who is recognized as a qualified paraprofessional to provide behavior therapy. However, we are concerned that the Bill as currently written may not ensure the professional oversight or supervision that is required to meet the current professional standards that we believe are required to ensure quality care to our members. That poses substantial quality of care risk for our members. The determination of paraprofessional competency will apparently be left up to individual licensed providers. Without an objective and uniform basis for measuring the competency of autism treatment paraprofessionals, there are going to be problems.

Our primary interest in to ensure that the supervising ABA service provider has appropriate training to supervise the other providers. To that end we have met, and are continuing to meet, with the stakeholders and expressed our interest in finding a common standard of training/certification that meets or exceeds the BACB supervision/certification guidelines.

Thank you for the opportunity to provide comments on SB 739, SD1.

Sincerely,

Mark K. Oto
Director, Government Relations

LATE

March 16, 2017

Representative Della Au Belatti
House District 24
Hawaii State Capitol
Room 402

Dear Representative Della Au Belatti

This letter is provided to you to formally express concern about SB 739(Green) and its obvious intent to permit a monopoly to exist in the credentialing of behavior therapists who provide critically important services to children and families impacted by autism in Hawaii.

One important goal of this bill was to include the credentials approved by the U.S. Department of Defense for behavioral services provided to military dependent children impacted by autism. Currently the Department of Defense approves credentials awarded by the Behavior Analyst Certification Board; the Behavioral Intervention Certification Council; and the Qualified Applied Behavior Analysis Credentialing Board.

We support the adaption of these same credentialing organizations so that and believe the adoption of these credentials will insure the availability of qualified behavior technicians who provide essential services to children diagnosed with autism.

We recognize that there is a shortage of qualified behavior technicians required to meet the needs of children diagnosed with autism. For many years direct behavioral services have been provided by individuals and organizations without any nationally recognized qualifications.

In 2011, a time when the autism epidemic was raising concerns around the world, there were no credentialing programs for the 87%[1] of behavior technicians who were providing services to children with autism across the US. That year, the Qualified Applied Behavior Analysis (QABA) Credentialing Board initiated a process to identify the Core Competencies required for the delivery of essential autism services.

This process included input from:

1. DSW National Resources Center

[1] Approximately 87% of direct services were provided by individuals with high school or bachelor degree levels of education

2. National Autism Center. (2009). National standards report.
3. National Autism Center and the National Professional Development Center on Autism Spectrum Disorders. (2010). Evidence-based practices for children and youth with autism spectrum disorders.
4. U.S. Office of Special Education Programs.

The results of this process identified fourteen essential core competencies that should be demonstrated by behavior technicians providing hands on services to children on the autism spectrum.

Standard 1: Autism Core Knowledge
Standard 2: Educational Training/Self Development
Standard 3: Principles of ABA
Standard 4: Instructional Interventions
Standard 5: Principles of Working with Autism Effectively
Standard 6: Treating Individuals with Challenging Behaviors
Standard 7: Data Collection and Evaluation
Standard 8: Positive Behavior Supports
Standard 9: Discrete Trial Teaching
Standard 10: Pivotal Response Treatment
Standard 11: Person Centered Planning
Standard 12: Functional Analysis
Standard 13: Philosophy and Values, and Advocacy
Standard 14: Legal and Ethical Considerations

In October 2014, this information was presented to the U.S. Department of Defense in an effort to identify the qualification for behavior technicians to be included in the DOD's TriCare Autism Demonstration Project. This project provides behavioral services to children of U.S. military dependents who have a diagnosis of autism.

On July 28, 2015, TRICARE recommended approval of the credentials by the Qualified Applied Behavior Analysis Credentialing Board in addition to credentials of the Behavior Analyst Certification Board. These credentials were included in the TRICARE Policy Manual, published in October 1015, which officially verified that individuals with these credentials are qualified to provide much needed autism behavioral services to TRICARE clients. In December 2016, TriCare expanded their approvals to include credentials of the Behavioral Intervention Certification Council.

The Department of Defense is committed to insuring that only qualified behavior technicians are authorized to provide essential behavior services under the supervision of a licensed professional within the scope and competency of that license.

In an effort to insure that Hawaii citizens impacted by autism have available to them an adequate number of qualified behavior technicians, the state of Hawaii should strongly consider the actions taken by the U.S. Department of Defense to identify the qualifications

of behavior technicians who are essential in our attempts to provide quality services to children on the autism spectrum.

Sincerely

Thomas P. McCool, Ed.D.
Chairman, QABA Credentialing Board

LATE

HAWAII STATE TEACHERS ASSOCIATION
Teaching Today for Hawaii's Tomorrow

1200 Ala Kapuna Street ♦ Honolulu, Hawaii 96819
Tel: (808) 833-2711 ♦ Fax: (808) 839-7106 ♦ Web: www.hsta.org

TESTIMONY BEFORE THE HOUSE COMMITTEE ON HEALTH

RE: SB 739, SD1 - RELATING TO BEHAVIOR ANALYSIS SERVICES

THURSDAY, MARCH 16, 2017

COREY ROSENLEE, PRESIDENT
HAWAII STATE TEACHERS ASSOCIATION

Chair Belatti and Committee members,

The Hawaii State Teachers Association **supports SB 739, SD1**, relating to behavior analysis services.

Last year, lawmakers approved Act 107, amending Luke's Law, Act 199 of 2015, to allow teachers to provide behavior analytic services to public school students. HSTA continues to have reservations about the unintended consequences of this action, which has led to cases of principals mandating that teachers create behavioral analysis plans for vulnerable children. While some teachers are certified to perform behavioral analysis the majority of teachers, not only lack the appropriate qualifications to create and implement such plans, but also are not certified nor licensed to do so.

Teachers, by license, are not psychologists, psychiatrists, or behavioral analysts. We rely on other experts–including school psychologists, behavioral analysts, social workers, occupational therapists, and skills trainers–to address and augment our instruction and assessments to support our specific students' learning needs, especially if they are students with special needs. Access to these specialists is vital for our students with special needs, our most vulnerable students, particularly with regard to autism-related behavioral analysis.

HAWAII STATE TEACHERS ASSOCIATION
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Tel: (808) 833-2711 ♦ Fax: (808) 839-7106 ♦ Web: www.hsta.org

Our state must not allow untrained individuals to provide behavior analytic services to vulnerable children. Therefore, the Hawaii State Teachers Association **supports** this bill.

David Lipsitt, Psy.D.
Clinical Psychologist

Testimony SUPPORTING SB739-SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Including amendments

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 16, 2017
11:00 AM
Conference Room 329
State Capitol
415 South Beretania Street

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors.

Thank you for the opportunity to provide testimony on this important topic.

Sincerely,

_____
David Lipsitt, Psy.D.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 14, 2017 9:26 PM
To: HLTtestimony
Cc: marieterry@mail.com
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM

SB739
Submitted on: 3/14/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Marie Terry	Individual	Support	No

Comments: Testimony SUPPORTING SB739-SD1 RELATING TO BEHAVIOR ANALYSIS SERVICES Including amendments COMMITTEE ON HEALTH Rep. Della Au Belatti, Chair Rep. Bertrand Kobayashi, Vice Chair Thursday, March 16, 2017 11:00 AM Conference Room 329 State Capitol 415 South Beretania Street I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors. Thank you for the opportunity to provide testimony on this important topic. Sincerely, Marie Terry

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Testimony SUPPORTING SB739-SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Including amendments

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 16, 2017
11:00 AM
Conference Room 329
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415 South Beretania Street

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision.

I have nearly 20 years of experience working with the autism population and their families. I conduct autism evaluations, develop behavior programs, and assist with IEP development. I make recommendations for treatment in the home, community, and the school. I also provide direct services to individuals with autism. These include children, adolescents, and young adults. In spite of my wealth of knowledge and qualification, I am unable to supervise interns and skills trainers who provide behavioral interventions. I have numerous families who have been on a waiting list to receive services from agencies providing ABA services due to shortages of trained providers. I have turned away these families because I am not able to bill insurance companies for these related services in my private practice.

The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors.

Thank you for the opportunity to provide testimony on this important topic.

Sincerely,

Nino L. Murray, Ph.D.
(Licensed Clinical Psychologist)
101 Aupuni St. Suite 313
Hilo, HI 96720
808 895-9760

Testimony SUPPORTING SB739-SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Including amendments

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 16, 2017
11:00 AM
Conference Room 329
State Capitol
415 South Beretania Street

Honorable Chair Belatti, Vice Chair Kobayashi, and members of the State House committee on Health. I served on the task force that supported the honorable chair in her tireless pursuit of Luke's Law. I spoke on behalf of the Hawaii Psychological Association supporting our colleagues with BCBA certificates providing services and pushed from my initial testimony to require licensure.

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors.

Thank you for the opportunity to provide testimony on this important topic.

Sincerely,

Jeffrey D. Stern, Ph.D.
Past President, Hawaii Psychological Association

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 14, 2017 8:37 PM
To: HLTtestimony
Cc: lauramengmeng@aol.com
Subject: *Submitted testimony for SB739 on Mar 16, 2017 11:00AM*

SB739
Submitted on: 3/14/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Laura Hufano-Kravetz	Individual	Support	No

Comments:

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Testimony SUPPORTING SB739-SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Including amendments

I am writing to you as a Hawaii licensed psychologist and President-Elect of the Hawaii Psychological Association. I have over twenty years of experience doing ABA/early intervention with children with autism. The ABA models that are currently recognized as best practice for children with autism are based on the pioneering work of Dr. Lovaas and his colleagues. Before moving back to Hawaii, I was the Associate Clinical Director for the Lovaas Institute (and worked directly with Dr. Lovaas); taught ABA classes at UCLA; and was a staff supervisor on the Lovaas Multisite Replication Project. Prior to working at the Lovaas institute, I was a clinic supervisor for Dr. Tristram Smith's ABA clinic. Dr. Smith is also recognized for his extensive research and clinical contributions in the autism/ABA field. I moved back home to Kauai with the intention of offering ABA services to Kauai's children and have been an autism consultant for Kauai's Department of Education since 2007. I also have my own private practice. However, despite having over 20 years of experience and being a supervisor and researcher in some of the top ABA clinics in the world, the way the current law is written is restricting my ability to provide comprehensive services to children with autism.

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors.

Hawaii is one of 45 states to approve insurance coverage for children with autism, as it is recognized across the world, that intensive early ABA intervention before the age of six is critical for the future of children with autism. However, Hawaii is one of only three states that gave a monopoly to the BACB board (and to the Hawaii Association of Behavioral Analysts) by only recognizing their proprietary training and certification for direct support workers (i.e., RBTs®). This unnecessary restriction is limiting psychologists' scope of practice and is significantly reducing the pool of qualified providers in Hawaii.

The current law restricts paraprofessional treatment services to Registered Behavior Technicians® (RBTs). This eliminates other appropriately trained paraprofessionals from providing services, and limits the workforce. It provides an additional barrier for psychologists as RBTs® are credentialed by the behavior analyst board and to maintain their RBT credential, they can only be supervised by BCBA's, thus unintentionally restricting the ability of psychologists to supervise a treatment team.

The Lovaas/UCLA method of supervision continues to be recognized as the gold standard for the supervision of direct support workers. Reichow and Wolery (2009), "examined the relationship between supervisor training models and treatment outcomes. Their findings suggested that studies that implemented supervisor-training protocols based on the University of California, Los Angeles (UCLA) model produced greater gains in IQ than studies that employed other training procedures." However, despite my background as a Clinical Director at The Lovaas Institute, working in the field of ABA and treating hundreds of children for over 20 years using the Lovaas method of treatment, the current law makes it difficult for me to supervise direct support workers as the current law specifies that direct support workers are credentialed as RBTs® and supervised by BCBAs. Despite the fact that the BCBA and RBT certification do not demonstrate that the candidate has specific training in autism and/or early intervention (as it is a broad certification specific to the practice of behavior analysis rather than autism). Additionally, the RBT® credentialing criteria does not follow the UCLA model of supervision and there is no empirical evidence showing that even well trained RBTs® are competent to provide ABA early intervention (as this is a proprietary certification that was not based on research findings).

A recent joint statement by Leaf and colleagues (2017), who are recognized as the leading autism researchers and clinicians (many of whom pioneered the current ABA strategies that we use with children with autism), expressed concern that there is no data that RBTs® are better trained than other appropriately trained paraprofessionals. I have highlighted their most important points below:

1. "The training hours requirement for the RBT® does not appear to be extensive nor does it appear to be consistent with the current body of research."
2. "It has not been demonstrated that better outcomes are obtained when using [RBT®] certified personnel."
3. "If funding sources begin limiting coverage to RBTs®, BCaBAs® and BCBAs®, it may be difficult for some individuals to get services from professionals who are highly trained but do not have these certifications/credentials. This can be especially difficult in more rural areas where there is a shortage of professionals to provide the needed services or internationally where there are limited behavior analytic services."
4. "There has been no empirical investigation of the specific components of the RBT® credential. There has been no empirical evidence that procedures are being implemented with a higher degree of fidelity or that consumers are better protected because of the certification process. There has been no empirical evidence showing that outcomes for individuals diagnosed with ASD will improve with the creation of the RBT® credential. Thus, at the present time, it remains unclear if the RBT® will result in improving the lives of individuals diagnosed with ASD. Furthermore, the possibility of unintended consequences may even cause harm to those whom the creation of RBT® was intended to help must not be overlooked. . . . . .it may be the case that many of these individuals have a vested interest (e.g., financial interest in an established credential for direct line staff . . . [and] it would appear that the RBT has potentially greater risks than benefits."

HABA and the BACB board directly benefit by limiting support workers to their proprietary certification, as it gives them a monopoly in the marketplace, but there is no data showing RBTs® are superior to other

appropriately trained paraprofessionals. This specification in the law is unnecessarily restrictive and is hurting our ability to provide quality treatment to children who need it. It is also at direct odds with the intention of the law which "provides exemptions for licensed/credentialed practitioners (including licensed psychologists and other mental health professionals), allowing them to practice within their recognized scope of practice, which regularly includes ABA/behaviorally based assessment, interventions, and supervision of paraprofessionals." Because only BCBAs® can supervise RBTs®, this language is making it difficult for other professionals to offer comprehensive treatment and supervision and is giving an inappropriate monopoly to one certifying agency. These unintentional restrictions are a violation of psychologists' ability to practice in the state of Hawaii and have the effect of severely reducing the number of qualified professionals who are able to provide such services.

I am further concerned by misleading testimony provided by HABA that states: "Dixon and colleagues (2016) found that supervisors with a BACB® certification produce approximately 74% greater mastery rates of learning objectives in comparison to supervisors without BACB® certification." Dixon et al.'s research specifically excluded psychologists and other certified professionals from the supervision comparison group. So this data does not show that BACBs are more qualified than psychologists or other licensed professionals, as they were not included in the research.

Additionally, it is widely recognized that people with autism spectrum disorders (ASDs) have more mental health disorders than the typical population. These mental health disorders include depression (which is considered to affect as many as 67% of persons with ASD), anxiety (57% comorbidity), ADHD (60% comorbidity), and other serious mental health disorders along with a significantly increased risk of suicide. Expertise in the co-occurring conditions in a person with autism is crucial to the development and implementation of an appropriate and comprehensive intervention plan and leads to better treatment outcomes. Behavior analysts (who are not necessarily mental health professionals) are not trained in these additional treatment strategies or disorders and often lack the expertise to diagnose and treat the comorbid conditions. Many mental health professionals, such as psychologists, have the necessary training and expertise to address the comorbid mental health needs as well as the behavioral and other treatment needs of individuals with autism and therefore, should not be restricted in their practice by the behavior analyst licensing law.

On Kauai, we have a shortage of providers and we have many children in need of services who are in the early intervention age range. These children are currently unable to access ABA services because the unnecessarily restrictive language in the current law is limiting our workforce and making it difficult to staff agencies with paraprofessionals. Despite decades of research showing the importance of early intervention, these children may "age out" of the critical age range for early intervention because of an unnecessary technicality in the language of the law. Other states recognize that there are a number of ways to assure quality provision of services and did not specify RBTs® as they recognized that was inappropriate and unnecessarily restrictive.

Amending SB739 increases the availability of quality ABA services for persons with autism and their families. All aspects of behavioral therapy associated with ABA services, including supervision of DSWs, is

a very long-standing professional privilege of psychologists and a cornerstone of the practice of psychologists. Psychologists researched and developed most of the current ABA protocols and should not be restricted in their scope of practice as many of us have been working with children with autism before the BCBA certification existed. Therefore, **I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health.**

Respectfully submitted,

Tanya Gamby, Ph.D.
Licensed Psychologist
President-Elect of the Hawaii Psychological Association

References

Dixon, D. R., Linstead, E., Granpeesheh, D., Novack, M. N., French, R., Stevens, E., & Powell, A. (2016). An evaluation of the impact of supervision intensity, supervisor qualifications, and caseload on outcomes in the treatment of autism spectrum disorder. *Behavior Analysis in Practice, 9,* 339-348.

Leaf, J. B., Leaf, R., McEachin, J., Taubman, M., Smith, T., Harris, S. L., et al. (2017). Concerns about the Registered Behavior Technician® in relation to effective autism intervention. *Behavior Analysis in Practice*. doi:10.1007/s40617-016-0145-9.

Reichow, B., & Wolery, M. (2009). Comprehensive synthesis of early intensive behavioral interventions for young children with autism based on the UCLA young autism project model. *Journal of Autism & Developmental Disorders, 39*(1), 23-41.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 14, 2017 7:06 PM
To: HLTtestimony
Cc: dshoup@iolalahui.org
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM

SB739
Submitted on: 3/14/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
David Shoup	Individual	Comments Only	No

Comments: COMMITTEE ON HEALTH Rep. Della Au Belatti, Chair Rep. Bertrand Kobayashi, Vice Chair Thursday, March 16, 2017 11:00 AM Conference Room 329 State Capitol 415 South Beretania Street I support Senate Bill 739- SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a 5th year Ph.D. student studying psycholog, I am aware that my scope of my future practice, as defined in Hawaii state statute, includes the practice of “Behavior Analysis” and including the use of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my future students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists’ scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors. Thank you for the opportunity to provide testimony on this important topic. Sincerely, David Shoup M.A.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 14, 2017 7:20 PM
To: HLTtestimony
Cc: takemotochock@hawaii.rr.com
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM

SB739
Submitted on: 3/14/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Naomi Takemoto-Chock	Individual	Support	No

Comments: Naomi Takemoto-Chock 1978 Komohana St Hilo, HI. 96720

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March 14, 2017

To: Representative Della Au Bellati, Chair, Bertrand Kobayashi, Vice Chair, Representative and Members of the Committee on Health

Hearing: Thursday, March 16, 2017, 11:00 a.m., Conference Room 329

From: Linda Hufano, Ph.D., Hawaii Licensed Psychologist, PSY #364

Re: Testimony in Support of SB739, SD1, Relating to Behavior Analysis Services

My name is Linda Hufano. I am a behaviorally-trained psychologist and have worked as a psychologist in the public and private sectors for over 30 years. Thank you for the opportunity to provide testimony.

Support for SB739, SD1

I am in **strong support** of SB739, SD1. It clarifies that licensed psychologists and other professionals whose scope of practice overlaps with behavior analysis will be allowed to continue to provide behavior analysis and supervise others to do so, which we had always understood the intent of ACT 199 to be.

Additionally, SB739, SD1, recognizes caregivers as exempt, as they should be.

Lastly, SB739, SD1, clarifies the definition of behavior analysis so that parents, counselors, teachers and direct support workers can continue to design and utilize behavioral interventions for the purpose of teaching new skills, reducing inappropriate behaviors, and the like – interventions that might include things like star charts, token economies, time-out, etc.

History of ABA in Hawaii

The Departments of Psychology and Special Education at the University of Hawaii were among the first behaviorally-oriented programs in the nation. Professors in both programs have outstanding credentials in behavioral psychology – including formulating learning principles underlying applied behavior analysis with various populations, developing behavioral/instructional techniques, and training many of Hawaii's practicing psychologists and special education teachers. Thus, to say that behaviorism or applied behavior analysis (ABA) is new to Hawaii would be a misstatement.

Twenty years ago, the state contracted services for students with ASD out to the private sector. Hoahana Institute and its successor organizations, Alaka'i Na Keiki, Inc. and CARE Hawaii, were among the first to propose and implement ABA services using a three-tiered model based on the pioneering work of Ivar Lovaas (who traveled to Hawaii to help kick-off the program since it had been proposed by one of his former students). In this model, Hawaii psychologists trained postdoctoral residents from Hawaii and the Mainland to 1) assess and design behavioral interventions for students with autism, 2) to consult with teachers, and 3) to supervise paraprofessionals and families implement ABA in the school, home and community.

In later years, agencies in Hawaii trained master's level to assess and design behavioral interventions, consult with teachers and supervise paraprofessionals – some of whom are now licensed clinical social workers, licensed special education teachers, licensed marriage family therapists, licensed mental health

counselors, and most recently, licensed behavior analysts. Thus, to say that psychologists do not supervise others in implementing ABA is untrue.

"The Gold Standard for Training and Supervision"

The Lovaas model has long been recognized as the gold standard for training and supervision based on research looking at "outcomes". There is no research evidence to support the notion that BCBAs achieve better outcomes than licensed psychologists or other licensed professionals. HABA cited a research study by Dennis Dixon et al. wherein BCBAs achieved better results than non-BCBAs. Per written testimony from Dr. Dixon to the Senate Committee on SB739, this was a mischaracterization of his findings since licensed psychologists and other licensed professionals were specifically excluded from the study.

Similarly, there is no evidence to support that RBT training is superior, i.e., more effective or leads to better outcomes, than the ABA paraprofessional training provided by other nationally certified groups (which require training in autism for paraprofessionals who implement ABA for individuals with ASD), or the ABA paraprofessional training, as specified by the funding agency[1], and provided by a contracted agency; or the ABA paraprofessional training provided by a licensed psychologist who is responsible, under his/her license, for ensuring competent service delivery to service recipients who require an individualized treatment plan.

Board Certification from the ABPP vs. Certification from the BACB

Opponents of SB739, SD1, seem to equate board certification from the Behavior Analysis Certification Board (BACB) with board certification from the American Board of Professional Psychology (ABPP). Thus, it is important to recognize the following:

- Board certification from the American Board of Professional Psychology (ABPP) is purely voluntary. Neither the Hawaii law pertaining to the licensure of psychologists or the American Psychological Association (APA) requires or recommends that psychologists obtain board certification from the American Board of Professional Psychology (ABPP)[2] to provide Applied Behavior Analysis (ABA) or to supervise others in implementing ABA services. (See the attached "Motion recently passed by the APA Council Pertaining to ABA Policy")[3].

- It is relevant to note that only 3-4% of all licensed psychologists in the U.S. - approximately 4,000 out of an estimated 107,000 - possess ABPP certification in one or more of 15 different areas. Of these 4,000 psychologists, only 141 possess certification in Behavioral and Cognitive Psychology. Per the ABPP[4], certification in this area could mean the psychologist was examined

[1] The Hawaii DOE, DOH, EIS, CAMHD, and DDD currently specify education, training and supervision requirement which meet or exceed RBT training in many areas, are less costly, and less likely to result in service delays. It is worth noting that paraprofessional turnover estimates in Hawaii are between 30-40 percent annually and 50% on the Mainland.

[2] The ABPP is a separate entity from the APA. The APA is the national professional organization for psychology which HABA confuses with the ABPP in various written communications.

[3] See APA Council Meeting Minutes dated 2/24 and 25, 2017, email shared by HPA Representative, June Ching.

[4] Personal communication to Dr. Linda Hufano from Kathy Holland, ABPP, on 2/28/17.

in ABA, but it could also mean he or she was examined in behavior therapy, cognitive-behavior therapy, or cognitive therapy.[5]

- HABA's position that psychologists should obtain ABPP certification is totally without merit, and would certainly have the effect of, restricting the pool of qualified professionals who are trained in ABA and have been providing services to individuals with autism under contracts with the Hawaii DOE, EIS and DD Division for several years.

- The BCBA credential is not consistent with generally accepted concept of board certification in other human services professions where board certification is understood to mean a level of proficiency "over and above" what is required by the practitioner's professional organization or by individual state licensing boards. Consumers and other professionals familiar with the more traditional use of the term "board certification" may mistake the credentialing of behavior analysts as implying advanced proficiency when in fact it reflects a pre-license, certification for professionals with a master's degree in an area that may or may not have been in a human service field[6], fewer course credits and supervised field hours than those required by than are required by licensed psychologists or other licensed professionals whose scope of practice overlaps with behavior analysis, and does not require post-master's or post-doctoral supervision prior to licensure.

- To our knowledge, no funding source requires the ABPP certification. It is unreasonable and creates an unnecessary barrier to treatment by imposing a requirement on psychologists who have already surpassed educational and experience requirements than those completed by the average BCBA.

- Just as a psychologist would be expected to have sufficient training in ABA, we trust the BCBA to have specific training in ABA with the target population he or she works with or risk losing his or her license. The fact that the psychologist is licensed is what prevents the psychologist from acting outside of the scope of that license. There is no need for suggesting an additional requirement.

Why Should Individuals and Families Have Options

Compared with LBAs who are not trained in mental health, ABA-trained psychologists have the advantage of experience in treating the anxiety, depression, or PTSD, that are frequently co-morbid with autism. As mental health providers, they can incorporate for individuals presenting co-occurring disorders during the assessment, planning, and monitoring phases of ABA service delivery.

There is also a huge workforce issue. Every ABA-trained professional and paraprofessional is needed, and we need to be able to train and supervise graduate student and provide post-master's and

[5] Only two licensed psychologists possess ABPP certification in Behavioral and Cognitive Psychology. The HPA knows both of these individuals, neither of whom specialize in ABA or ASD.

[6] The BACB website currently indicates a master's degree in behavior analysis, education or psychology is acceptable and that applicants who are unsure or whether the field of study of their degree is acceptable may request a preliminary review. In the past, however, the BACB has approved master's degrees in many other fields, including art, English, history, business, and economics.

postdoctoral professionals with supervised training for licensure. It is clear in speaking with representatives of state agencies that there will be a significant lack of trained professionals and paraprofessionals to deliver ABA services if ACT 199 continues to be misinterpreted as restricted to LBA's and the persons they supervise. It is our understanding from parents of individuals with autism and case managers, that waitlists for ABA services covered by insurance vary between providers from anywhere from 6 months to two years. Individuals with autism deserve access to all qualified professionals and their assistants.

Testimony SUPPORTING SB739-SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Including amendments

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 16, 2017
11:00 AM
Conference Room 329
State Capitol
415 South Beretania Street

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors.

Thank you for the opportunity to provide testimony on this important topic.

Sincerely,

Nicole Nakamura, Psy.D.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 14, 2017 5:37 PM
To: HLTtestimony
Cc: clareloprinzi@gmail.com
Subject: Submitted testimony for SB1312 on Mar 16, 2017 08:30AM

SB1312
Submitted on: 3/14/2017
Testimony for HLT on Mar 16, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
clare loprinzi	Individual	Comments Only	No

Comments: This bill needs to die for many reasons. Sen Baker was not honest in what she said would be admended and that was crucial to passing this bill, There are many problems with this bill The financial cost of having a board for a dozen CPMs is not feasible to maintain especially since the money is coming from Medicaid which is going to be compromized during the Trump administration. There are many midwives that would not be able to work and should be grandmothered in with out becoming CPMs, so the bill will not be available for all midwives as those grandmother midwives will now have to go back to school of three years and also take the exam, costly and the school is not here in the islands. So what Senator Baker said and wrote is not workable, giving them two years to join the CPM/MANA. This would take away midwives from our community that are crucial to the safety of homebirth. The solution is easily seen...first create a task force that would find solutions...i have been involved in this process before and studied it for years. This task force needs to be comprised of all midwives. 1. There are lots of changes going on with MANA (Midwives Alliance of North AMerica and NARM (National Administration of Registered Midwives). This is not a stable time for them as they are making many changes that will affect the midwives that would be allowed under this bill SB1312 as CPM and many of them will not be able to maintain their CPM status. That being said again financially how would a board for CPM be able to financially survive. 1. CPM and CNM are very similiar and the differences between them will be minute in a few years, and my suggestion is that this is where the CPM can join because they will be forced to go back to school to obtain standards that CNM. Please do not pass this bill and go back to what Sen Green suggested, creating a task force to study this issue and than put the correct bill through. This would be disasterous. Let us find a better solution, our mothers and babies need to stay safe and this bill is a problem to the safety of women and babies, As Dr, Misha Kassel said in his testimony we need safety with choices for homebirth, having women birth alone because it would be illegal for midwives to be with them would be irresponsible of our legislators. With respect Clare Loprinzi, Traditional Midwife

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: Rebecca Geftakys <mauigirlxo@gmail.com>
Sent: Tuesday, March 14, 2017 5:52 PM
To: HLTtestimony
Subject: I support SB1312_SD with amendments

Dear House Committee on Health,
I support SB1312_SD with amendments and ask to completely replace SB1312_SD with the exact language recommend in Midwives Alliance of Hawaii testimony.
Sincerely
Rebecca Russell

Sent from my iPhone

Testimony SUPPORTING SB739-SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Including amendments

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 16, 2017
11:00 AM
Conference Room 329
State Capitol
415 South Beretania Street

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. I have provided ABA based interventions among others as part of comprehensive autism treatment. I have also supervised para professional or master's level staff providing this services. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors.

Thank you for the opportunity to provide testimony on this important topic.

Sincerely,

Gabrielle Toloza, Psy.D.
Licensed Clinical Psychologist
Kailua, Hawaii

Testimony SUPPORTING SB739-SD1
RELATING TO BEHAVIOR ANALYSIS SERVICES
Including amendments

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 16, 2017
11:00 AM
Conference Room 329
State Capitol
415 South Beretania Street

I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors.

Thank you for the opportunity to provide testimony on this important topic.

Sincerely,

Kyla Stueber
Doctoral Student, Clinical Psychology Program
HSPP at Argosy University
State Advocacy Coordinator, Advocacy Coordinating Team (ACT)
American Psychological Association of Graduate Students (APAGS)

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 15, 2017 6:23 AM
To: HLTtestimony
Cc: cebisui@yahoo.com
Subject: *Submitted testimony for SB739 on Mar 16, 2017 11:00AM*

SB739
Submitted on: 3/15/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Cheryl Ebisui	Individual	Oppose	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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03/16/17

Committee on Health
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

SB739 SD1: Oppose as written

Honorable Chair Belatti, Vice Chair Kobayashi, and members of the committee,

Thank you for your support and considering my testimony. I oppose SB739 SD1 because I am concerned with most of the revised language in the proposed bill. I agree with some of the intentions of the bill.

1. Professionals in the fields of education and psychology may or may not have training and experience in designing and implementing ABA programs/services. Some credentialing bodies in these fields do not identify training requirements, competencies, ethical standards, and/or supervision requirements that are specific to ABA. However, the behavior analysis licensure law should not be interpreted as exclusionary. My concern with the proposed language in this bill is that it appears to identify a variety of professionals (licensed or otherwise) as exempt from duties/practices that are not clearly specified within the scope of their own respective regulations or licensure laws.

    a. For instance, it does not appear that the psychology licensure law specifies exemption for entry-level, front-line paraprofessional staff that implement interventions under the supervision of a licensed psychologist. The psychology licensure law does, however, identify psychological assistants and psychology students under exemption categories. To my understanding, paraprofessionals should not be misinterpreted as psychological assistants; but if licensed psychologists are to define these as the same, perhaps the requirements for psychological assistants in Hawaii could be made transparent to resolve this semantics concern. I believe the exemption category for licensed psychologists in the bill should have consistent language with the psychology licensure law.

    b. I also have concerns related to exemptions for licensed teachers in the proposed bill. I believe licensed teachers need to be identified in an exemption category, provided that the services performed are commensurate with the licensed teacher's education, training, and experience or those services are performed with the supervision of a licensed behavior analyst or licensed psychologist with

certification in Behavioral and Cognitive Psychology by the American Board of Professional Psychology (ABPP). Behavior analysis is rooted in the field of education. Some teachers, particularly special educators of individuals with severe disabilities, will have training and experience in designing and implementing intensive behavioral interventions. However, I am concerned with the fact that teachers could be required to design and carry out intensive behavioral supports without appropriate resources, training, or consultation. This risk could potentially be mitigated through clarified language in the bill.

2. I do not believe the definition of ABA proposed in this bill is clearer than the current law. This language is flawed and could be misinterpreted. If the definition of ABA should be clarified for the purposes of this licensure law, it could perhaps be defined more in line with the framework or model of multi-tiered systems of support (MTSS), in which intensive behavioral/educational interventions are distinguished (e.g., early intensive behavioral intervention, functional behavior assessment, wraparound services) from program/school-wide supports and low-intensity interventions that are behavioral in nature (e.g., behavior-specific praise, high-probability instructional sequences, token economies).

3. I support the exemption proposed related to caregivers, provided that "caregiver" be appropriately defined.

Respectfully submitted,

Jennifer Ninci, PhD, BCBA-D, LBA

03/16/17
Committee on Health
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Honorable Chair Belatti, Vice Chair Kobayashi, and members of the committee,

Thank you for the opportunity to testify in opposition of SB739 SD1. I am grateful to Senator Baker for removing the QABA and BICC credentials from the original bill, as these credentials would lower the bar for our consumers. The Registered Behavior Technician (RBT) is the only credential that values demonstrated competency and requires ongoing supervision at a minimum of 5% of the RBT's hours by a Licensed Behavior Analyst. I am concerned with the bill's current language allowing for any licensed or unlicensed professional, parent or student to implement applied behavior analysis (ABA). This is far too broad and opens our consumers up to abuse and neglect. Having the RBT credential as a standard of care allows us to ensure that the individuals working 1:1 with our most vulnerable are qualified to do so. Please uphold Act 199.

Licensed professionals, such as teachers, may be qualified to *implement* ABA strategies in their classrooms if it is within the scope of their practice. Teachers do not, however, have the training or qualifications to *develop* and *oversee* an ABA program. Nor do they want this responsibility added to their already overloaded jobs (as testified by the HSTA). Just as teachers may be qualified to implement movement breaks in their classrooms, they are not trained or qualified to develop and oversee occupational therapy programs for their students. ABA programs should be developed and overseen by a Licensed Behavior Analyst or a Licensed Psychologist working within the scope of their practice.

I am also concerned with the lack of professional specificity and supervision requirements in the bill's current language. This does not protect our consumers. Under the bill's current language, any licensed professional can oversee a paraprofessional for an undetermined amount of time (i.e. no minimum supervision requirement). As stated earlier, only a Licensed Behavior Analysts or a Licensed Psychologist working within the scope of their practice should be overseeing a paraprofessional. The skills needed to develop an ABA program and supervise a paraprofessional take years of education and

experience. Unfortunately, it appears that the DOE is seeking a way out of upholding Act 199. There have been no job postings for behavior analysts working in the DOE and no noticeable movement from the DOE to increase workforce and supports for its most vulnerable students. Even with Medicaid funding available, the DOE has not tapped this resource in providing ABA to its students in need. Please hold the DOE accountable and Malama Our Keiki.

Sincerely,
Kathleen Penland, M.Ed., BCBA, LBA
Kailua, HI

03/16/17

Committee on Health
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair
Conference Room 329
State Capitol
415 South Beretania St.

SB739 SD1: Oppose as written

Honorable Chair Belatti, Vice Chair Kobayashi, and members of the committee,

Thank you for the opportunity to present testimony on this important issue. And thank you for your support of Applied Behavior Analysis in the past years. First, I would like to thank the Commerce, Consumer Protection and Health committee for hearing the concerns raised in the previous hearing and limiting the credentials needed for providing Applied Behavior Analysis. Requiring Licensed Behavior Analysts, Licensed Psychologist and Registered Behavior Technicians require a demonstration of competence that is lacking in all of the other credentials initially proposed by this bill. There is much value in the demonstration of competency that goes far beyond what can be accounted for in pencil and paper testing. Additionally, the Behavior Analyst Certification Board and the Psychology Board focus on a wide range of diagnoses, something that the other credentials lack with their focus solely on autism. Additionally, the BCBA and RBT credentials are governed by compliance codes which require adherence to strict ethical standards, which are in place to protect consumers of ABA.

While the CPH committee has great intent with the bill, I believe that there is a need to revise language for clarity to ensure that consumers are protected. The proposed language is far too broad and allows for nearly anyone to provide Applied Behavior Analysis (ABA) services. I do not believe that this is what is intended. The following are points I believe should be clarified in the bill:

1. Only credentialed providers should be providing ABA services as direct service providers. At this point, even Licensed Behavior Analysts (LBA) cannot oversee noncredentialled staff. This is for the protection of our consumers. It would make sense that this would also be extended to Psychologists, with the exception of their Psychological Assistants as defined in their law.
2. Supervision standards are not listed in the bill. For LBAs, this is currently a minimum of 5% of the hours that the Registered Behavior Technician is working with each client. While we cannot dictate supervision minimums for Psychologists overseeing Psychological Assistants, it should be stated somewhere that it should meet minimum requirements as required by their state law.
3. Teachers continue to testify that they need help. I strongly believe that teachers need to be carved out in the bill to be allowed to implement ABA under the direction of an LBA or Psychologist, but that they need to be restricted from designing ABA interventions. This is not within a teacher's training and can potentially be harmful to students. I know that teacher's state they are not comfortable with designing these plans, but are being asked to do so anyway. Students are losing out on valuable service time. Problem behaviors are potentially being reinforced and the unintentional damage done could take years to undo.

4. The Department of Education has made no noticeable movement to increase their workforce and supports as required by the legislature last year. To my knowledge, there have been no postings for LBAs to date. Additionally, the Department has left considerable federal money unbilled by not using the necessary providers. They have access to Medicaid school-based claiming if they are using the appropriately licensed and credentialed providers- LBAs and RBTs.
5. Regarding changing the definition of Applied Behavior Analysis in our law. I would recommend returning the definition in our existing law. While I appreciate the intent of the Department of Health-DDD, I feel that this change is unnecessary. The concerns brought forth may be addressed through another method without potentially opening up the definition to allowing consumer harm. The proposed definition is broad enough to allow for the potential for misuse.

I would like to thank the committee for hearing these concerns and urge you to continue to protect consumers and #malmaourkeiki.

Thank you for your time,

Lara Bollinger

Haleiwa, HI

March 14, 2017

To: Representative Della Au Belatti, Chair, Representative Bertrand Kobayashi Vice Chair, and Members of the Committee on Health

Hearing: Thursday, March 16, 2017, 11:00 a.m., Conference Room 329

From: Linda Hufano, Ph.D., Hawaii Licensed Psychologist, PSY #364
122 Hoahana Place, Honolulu, HI 96825

Re: Testimony in Support of SB739, SD1, Relating to Behavior Analysis Services

My name is Linda Hufano. I am a behaviorally-trained psychologist and have worked as a psychologist in the public and private sectors for over 30 years. Thank you for the opportunity to provide testimony.

Support for SB739, SD1

I am in **strong support** of SB739, SD1. It clarifies that licensed psychologists and other professionals whose scope of practice overlaps with behavior analysis will be allowed to continue to provide behavior analysis and supervise others to do so, which we had always understood the intent of ACT 199 to be.

Additionally, SB739, SD1, recognizes caregivers as exempt, as they should be.

Lastly, SB739, SD1, clarifies the definition of behavior analysis so that parents, counselors, teachers and direct support workers can continue to design and utilize behavioral interventions for the purpose of teaching new skills, reducing inappropriate behaviors, and the like – interventions that might include things like star charts, token economies, time-out, etc.

History of ABA in Hawaii

The Departments of Psychology and Special Education at the University of Hawaii were among the first behaviorally-oriented programs in the nation. Professors in both programs have outstanding credentials in behavioral psychology – including formulating learning principles underlying applied behavior analysis with various populations, developing behavioral/instructional techniques, and training many of Hawaii's practicing psychologists and special education teachers. Thus, to say that behaviorism or applied behavior analysis (ABA) is new to Hawaii would be a misstatement.

Twenty years ago, the state contracted services for students with ASD out to the private sector. Hoahana Institute and its successor organizations, Alaka'i Na Keiki, Inc. and CARF Hawaii, were among the first to propose and implement ABA services using a three-tiered model based on the pioneering work of Ivar Lovaas (who traveled to Hawaii to help kick-off the program since it had been proposed by one of his former students). In this model, Hawaii psychologists trained post-doctoral residents from Hawaii and the Mainland to 1) assess and design behavioral interventions for students with autism, 2) to consult with teachers, and 3) to supervise paraprofessionals and families implement ABA in the school, home and community.

In later years, agencies in Hawaii trained master's level to assess and design behavioral interventions, consult with teachers and supervise paraprofessionals – some of whom are now licensed clinical social

workers, licensed special education teachers, licensed marriage family therapists, licensed mental health counselors, and most recently, licensed behavior analysts. Thus, to say that psychologists are [illegible] supervise others in implementing ABA is untrue.

"The Gold Standard for Training and Supervision"

The Lovaas model has long been recognized as the gold standard for training and supervision based on research looking at "outcomes". There is no research evidence to support the notion that BCBAs achieve better outcomes than licensed psychologists or other licensed professionals. HABA cites a research study by Dennis Dixon et al. wherein BCBAs achieved better results than non-BCBAs. Per written testimony from Dr. Dixon to the Senate Committee on Sb739, this was a mischaracterization of his findings since licensed psychologists and other licensed professionals were specifically excluded from the study.

Similarly, there is no evidence to support that RBT training is superior, i.e., more effective or lead to better outcomes, than the ABA paraprofessional training provided by other nationally certified groups (which require training in autism for paraprofessionals who implement ABA for individuals with ASD); or the ABA paraprofessional training, as specified by the funding agency[1], and provided by a contracted agency; or the ABA paraprofessional training provided by a licensed psychologist who is responsible under his/her license, for ensuring competent service delivery to service recipients who receive an individualized treatment plan.

Board Certification from the ABPP vs. Certification from the BACB

Opponents of SB739, SD1, seem to equate board certification from the Behavior Analysis Certification Board (BACB) with board certification from the American Board of Professional Psychology (ABPP). Thus, it is important to recognize the following:

- Board certification from the American Board of Professional Psychology (ABPP) is purely voluntary. Neither the Hawaii law pertaining to the licensure of psychologists or the American Psychological Association (APA) requires or recommends that psychologists obtain board certification from the American Board of Professional Psychology (ABPP)[2] to provide Applied Behavior Analysis (ABA) or to supervise others in implementing ABA services. (See the attached "Motion recently passed by the APA Council Pertaining to ABA Policy")[3]

- It is relevant to note that only 3-4% of all licensed psychologists in the U.S. - approximately 4,000 out of an estimated 107,000 - possess ABPP certification in one or more of 15 different areas. Of these 4,000 psychologists, only 141 possess certification in Behavioral and Cognitive Psychology. Per the ABPP[4], certification in this area could mean the psychologist was examined

[1] The Hawaii DOE, DOH, EIS, CAMHD, and DDD currently specify education, training and supervision requirements which meet or exceed RBT training in many areas, are less costly, and less likely to result in service delays. It is worth noting that paraprofessional turnover estimates in Hawaii are between 30-40 percent annually and 26% on the Mainland.

[2] The ABPP is a separate entity from the APA. The APA is the national professional organization for psychology which HABA confuses with the ABPP in various written communications.

[3] See APA Council Meeting Minutes dated 2/24 and 25, 2017, email shared by HPA Representative, Jane Gates

[4] Personal communication to Dr. Linda Hufano from Kathy Holland, ABPP, on 2/28/17.

in ABA, but it could also mean he or she was examined in behavior therapy, cognitive-behavior therapy, or cognitive therapy.[5]

- HABA's position that psychologists should obtain ABPP certification is faulty without merit and would certainly have the effect of, restricting the pool of qualified professionals who are trained in ABA and have been providing services to individuals with autism under contract with the Hawaii DOE, EIS and DD Division for several years.

- The BCBA credential is not consistent with generally accepted concept of board certification in other human services professions where board certification is understood to mean a level of proficiency "over and above" what is required by the practitioner's professional organization or by individual state licensing boards. Consumers and other professionals familiar with the more traditional use of the term "board certification" may mistake the credentialing of behavior analysts as implying advanced proficiency when in fact it reflects a pre-license, certification for professionals with a master's degree in an area that may or may not have been in a human service field[6], fewer course credits and supervised field hours than are required for licensure as a psychologist, or other master's level professional whose scope of practice overlaps with behavior analysis. BCBAs are also not required to obtain post-doctoral supervised hours prior to licensure as is required for psychologists, or post-master's supervised hours as is required for licensure by other master's level professionals.

- To our knowledge, no funding source requires the ABPP certification. It is unreasonable and creates an unnecessary barrier to treatment by imposing a requirement on psychologists who have already surpassed educational and experience requirements than those completed by the average BCBA.

- Just as a psychologist would be expected to have sufficient training in ABA, we trust the BCBA to have specific training in ABA with the target population he or she works with or risk losing his or her license. The fact that the psychologist is licensed is what prevents the psychologist from acting outside of the scope of that license. There is no need for suggesting an additional requirement.

Why Individuals and Families Should Have Options

Compared with LBAs who are not trained in mental health, ABA-trained psychologists have the advantage of experience in treating the anxiety, depression, or PTSD, that are frequently co-occurring (figures average 60%) with autism. As mental health providers, they can incorporate for individuals presenting co-occurring disorders during the assessment, planning, and monitoring phases of ABA service delivery.

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[5] Only two licensed psychologists possess ABPP certification in Behavioral and Cognitive Psychology. Dr. [illegible] knows both of these individuals, neither of whom specialize in ABA or ASD.

[6] The BACB website currently indicates a master's degree in behavior analysis, education or psychology is acceptable and that applicants who are unsure or whether the field of study of their degree is acceptable may request a preliminary review. In the past, however, the BACB has approved master's degrees in many other fields, including art, English, history, business, and economics.

Workforce Issues

There is also a huge workforce issue. Every ABA-trained professional and para-professional is [illegible], and we need to be able to train and supervise graduate student and provide post-master and postdoctoral professionals with supervised training for licensure. It is clear in speaking with representatives of state agencies that there will be a significant lack of trained professionals and paraprofessionals to deliver ABA services if ACT 199 continues to be misinterpreted as restricting LBA's and the persons they supervise. It is our understanding from parents of individuals with autism and case managers, that waitlists for ABA services covered by insurance vary between providers from anywhere from 6 months to two years. According to the most recent DCCA report, dated January 1st, 2017, there are one hundred sixty-six (166) licensed behavior analysts in Hawaii. Of those 166, forty-two (42), or roughly 25%, do not live in Hawaii. One hundred three (103) live on Oahu; one (1) lives on the Big Island; fifteen (15) live on Maui; five (5) live on Kauai; and none (0) live on Molokai or Lanai.

Individuals with autism deserve access to all qualified professionals and the individuals they supervise, including licensed psychologists and other licensed professionals whose scope of practice overlaps with behavior analysis.

More

Fwd: Motion passed by APA Council Pertaining to ABA Policy

Linda Hufano to you show details 2 days ago

From: June Ching <junewching@gmail.com>
Date: March 4, 2017 at 9:54:08 AM HST
To: Linda Hufano <lhufano@aol.com>
Subject: Re: Motion passed by APA Council Pertaining to ABA Policy

Hi Linda,
These are in the February 24 & 25, 2017 minutes for Council which covers all the agenda items. No official letterhead for that separate item.

X. PROFESSIONAL AFFAIRS

A.(14) Council voted to adopt as APA policy the following statement regarding applied behavior analysis:

The principles of applied behavior analysis (also known as behavior modification and learning theory), developed and researched by psychology and competently applied in the treatment of various disorders based on that research, is clearly within the scope of the discipline of psychology and is an integral part of the discipline of psychology. Across the United States, applied behavior analysis is taught as a core skill in applied and health psychology programs as part of psychology degree programs and in other training programs outside of psychology. As such, the American Psychological Association (APA) affirms that the practice and supervision of applied behavior analysis are well-grounded in psychological science and evidence-based practice. APA also affirms that applied behavior analysis represents the applied form of behavior analysis which is included in the definition of the "Practice of Psychology" section of the APA Model Act for State Licensure of Psychologists. Therefore, APA asserts that the practice and supervision of applied behavior analysis is appropriately established within the scope of the discipline of psychology.

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Honorable Chair Belatti, Vice Chair Kobayashi, and members of the committee,

Traditionally I would greet you with my moʻokūʻauhau (genealogy), where I am from, and the ancestors that came before me. Today's style of greeting has changed but still maintain the same information, giving insight into the past. Although who I am is important, I am reaching out to you about the future, the future of my children and thousands of children in Hawaiʻi. My name is Naomi Tachera I live in Waimea on Hawaiʻi Island; I am a Native Hawaiian mother and student. I have two sons' ages 6 and 4 that were diagnosed with autism spectrum disorder. I researched evidenced based therapy to treat the symptoms of autism and found a lot of research on Applied Behavior Analysis (ABA). My oldest son was the first in the State of Hawaiʻi to receive ABA through Medicaid, and after seeing amazing progress; I knew I wanted to become a Board Certified Behavior Analyst (BCBA). I graduated from UH Hilo with a Bachelor's in Psychology, and I am currently pursuing a Master's degree in Exceptional Student Education and Applied Behavior Analysis.

What is considered an appropriate treatment for children with autism? According to my children's Pediatrician, Behavioral Pediatric Specialist, Pediatric Neurologist, Psychologist, and BCBAs, both my children are recommended to have intensive ABA, supervised by a BCBA. This legislation seeks to expand direct support credentials to options which do not require demonstrations of competency. This puts consumers at risk, my two children Kaiao and Kaleohano. If you allow other professionals other than Registered Behavior Technicians (RBT) and BCBA's to practice and supervise ABA programs it will be disaster for our children, our future. A misconception has been circulating that Psychologists are not able to supervise RBTs, when in fact Psychologist who have passed an examination in behavior analysis, are able to oversee Registered Behavior Technicians. The law isn't limiting; it's protecting my children. If there's any veteran autism parents in support of SB739, it's because they will not feel the effects to the same degree, our children are still young and have a fighting chance!

If I can pursue board certification by going to graduate school, being a mother of two young children with autism, working full time, and living a rural community, then all the other professionals that want to "expand" their services to provide ABA, must do the same! From my perspective, SB739 has been initiated either because they want to save money or they want to make money, not about providing quality ABA services. The behavior analysts in Hawai'i have been tirelessly advocating for our communities. We stand in support of consumer protection and in opposition of SB 739.

Naomi Tachera

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Honorable Chair Belatti, Vice Chair Kobayashi, and members of the committee,

I urge you to oppose SB739. As a parent of a child with Autism who has received ABA for self-injurious behaviors as well as a host of other problem behaviors, it is imperative that our laws stay the way they are to insure that we are receiving highly qualified BCBA's and RBT's. If the law changes and therapist working with children in homes, schools and the public are not certified, our Keiki will NOT receive the essential quality of services. It will be devastating not only for families, but for schools and the community as well! Please do not let SB739 pass!

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis. ABA that is delivered by a person who is not certified a BCBA or RBT, is NOT ABA.

Brandi Picardal, Parent
Waipahu, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

The difference between the RBT and the other proposed credentials is the other credentials broaden the scope of supervisor to non-qualified professionals and remove the expectation for demonstration of competency by the direct support worker. It would be a disservice to all our keiki to make it that people that are not credentialed are able to supervise their cases without a greater knowledge of Applied Behavior Analysis.

Mele Stoner
Honolulu, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

To Whom It May Concern:

I would like to submit my testimony to OPPOSE Senate Bill 739. To remove the requirement for non-credentialed providers (removing the RBT requirement) would mean that there is no minimum supervision for those providing applied behavior analysis (ABA) to our most at risk population. The RBT credential requires that at minimum, a paraprofessional, teacher, anyone providing this excellent service be supervised by a Board Certified Behavior Analyst (BCBA) or Psychologist certified by the American Board of Professional Psychology (ABPP) in Behavioral and Cognitive Psychology 5% of the time they are providing ABA services and have to be seen at least twice a month. This supervisor is held accountable for the work that the RBT is performing.

By removing the requirement for RBT credential we are removing the specific requirement for supervision of this staff. Close supervision is one of the quality indicators of a ABA program. I think that instead of continually trying to create loopholes that we should be working on increasing quality services in Hawaii.

I personally have agreed to a contract to work with the Department of Education on Kauai, I offered a free RBT training for the school district, and am happy to continue working with the island to improve services here. Thank you for considering this testimony and PLEASE contact me (LShepherdBCBA@gmail.com) with any questions you may have.

Lindsey Shepherd, BCBA, LBA
Koloa, Kauai

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

To obtain the RBT credential, we go through 40 hours of training, a competency assessment, and an examination administered through Pearson. These certifications and proof of competency serve to provide the best services possible to clients. My clients are all children, who are some of the most malleable and the plans implemented have the possibility to greatly aid or be a detriment to the consumer, both the client and the family. With the competency that we are expected to have and exhibit in daily practice through supervision and re-certification, our clients receive the highest quality of services because of the experience and knowledge of Licensed Behavior Analysts (LBA). Without these proofs of competency, the practice is skewed and does not best serve the client.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Brittany Linville
Ewa Beach, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
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State Capitol
415 South Beretania St.

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I'm a parent of an ASD child whose ABA therapy was once supervised by a non-trained MSW. It was an epic fail as this so called Behavior Intervention Specialist was fired for having ABSOLUTELY no idea how to deliver therapy to my son. Please stop this from happening AGAIN.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Brandi Baretto
Honolulu, Oahu

03/16/17

Committee on Health

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State Capitol
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This seems like a no-brainer to me, especially when we are talking about consumer protection. Only individuals with rigorous training and demonstrated competency in behavior analysis should design and oversee ABA services. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Molly Stemmler
Haleiwa, Oahu

03/16/17

Committee on Health

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415 South Beretania St.

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As a parent and an educator, I oppose SB739. SB739 would allow our most vulnerable and marginalized keikis to be served by less committed and knowledgeable individuals. They and their families deserve better. Please oppose SB739 --we need to move forward, not backwards. A concerned parent, citizen and educator, I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Sungalina Lee
Honolulu, Oahu

03/16/17

Committee on Health

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415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Honorable Chair Belatti, Vice Chair Kobayashi, and members of the committee,

My name is Goldean Lowe, I am a Board Certified and Licensed Behavior Analyst, currently supervising two BCBA candidates during their master's coursework and practicums. I've been working with children and families for 23 years, the last 7 years as a manager and clinical supervisor of three accredited programs, serving 80+ families per year.

As someone who has developed service lines and programming, served families directly and clinically supervised others, I would like to point to the ethical problems and infringement of patients' rights in your suggestion of recommending unregulated individuals to deliver ABA services.

I can only begin to point at a few of the legal problems you will be facing in allowing other credentialed fields to practice outside of their training expertise. Parents are becoming more and more aware of the research base from which the science of ABA has expanded. The state will inevitably be faced with lawsuits from families who have received services that are not based in the rigorous scientific-based ABA field.

An analogy could be made that instead of licensing medical doctors to practice medicine, the State offers license to health technicians. If the public only had health technician service, they may lose faith that anyone could actually treat their health condition, because they are used to a low standard of training and care. This is a situation that is not uncommon in our field where someone who has taken a workshop or a class in ABA may think of themselves as trained in ABA. However, these claims only dissipate the public's belief that this applied science can actually work.

There is no question that while well-intentioned practitioners may be eager to share what they know, the field of ABA is based on 60+ years of research, that is ever expanding, it requires regulation, supervision, continuing education, following data, constant updating of current applications and following of an ethical code.

I hope you come to the understanding of protecting patients' rights to access ethical treatment from trained professionals.

Goldean Lowe MA BCBA LBA 146

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I am extremely concerned about the bill seeking to add other credentialing boards for ABA (QABA, BICC, etc.). With the current proposal, there is a lack of consideration as to the negative impact on clients/families who receive specific ABA services from credentialed BCBAs, BCaBAs, and RBT, as well as impacting future clients and the very treatment they seek.

As one who has earned a Doctorate in Clinical Psychology, I can speak to the FACT that psychologists do NOT receive specific training in the area of Applied Behavior Analysis (ABA), and graduate UNFIT to provide and/or supervise these services. One course in Behavior Theory is hardly adequate to prepare psychologists to apply the degree of evidence-based systematic programming that is both effective and efficient enough to produce behavior change. Although BCBAs certainly welcome collaboration with other disciplines toward common goals, our practices are dissimilar. The BACB offers specific guidelines to ensure that the systematic practices of BCBAs, BCaBAs, and RBTs are within the scope of ABA. Our credentials serve to indicate to consumers that we have passed coursework, been through rigorous supervision by a credentialed provider, and demonstrated mastery of the content. This vetting serves to confirm to the community we serve that we are educated and highly trained professionals working in an area of specialized expertise.

Just as psychologists must receive other endorsements and certifications to practice with specific populations (e.g. LGBT training, etc.), ABA is no different and should not be an area 'opened up' to those who do not possess the necessary education and proven mastery to practice in the field. Other credentials do NOT require evidence-based supervision by supervisors with DEMONSTRATED COMPETENCY in ABA. This would therefore serve to dilute practices AND direct services to those of our population who are most vulnerable, and is a grave disservice to our state and communities. Perhaps it is legislators who do not realize the specificity of ABA practices and therefore the full impact of this proposal. PLEASE research and understand the harm this bill will cause if passed.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Dr. Lori Babbitt
Kula, Maui

03/16/17

Committee on Health

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It would be a travesty for Senate bill SB739 to go through and strip children with autism the proper and professional services they need to function. I know this is being done so that children who are currently receiving proper ABA therapy from outside entities get stripped and thrown back into the DOE where they will receive sub par treatment and care because of money. my son was in special education class in the DOE system where they claimed they were doing ABA therapy, but it obvious the people doing the therapy was unqualified and in over their heads. we were fortunate enough for my son to get out of the DOE and into ABA therapy in a place that has structure, competent oversight and qualified people who genuinely care about helping children with autism get the help they desperately need to live and lead a good life. it's a shame that you are willing to strip children with autism the quality of care because the DOE is having to pay to send children to ABA therapy at outside sources. it's sad and pathetic because all I see on TV is how you all claim to care about the future of our children and making sure to do whatever you can to give them the best chance to succeed in life, blatantly lie to save money. money over the quality of care for children who need it the most. I truly hope this bill doesn't pass, because I know first hand the type of "care" kids will receive from the DOE.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Adonis Buttel
Hauula, Hawai'i

03/16/17

Committee on Health

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415 South Beretania St.

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Horizons Academy strongly supports only licensing and the practice of behavior analysis by individuals who meet the current State standard in collaboration with the Behavior Analysis Certification Board. Please continue to uphold the quality and standard of behavior analysis. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis. Please continue to uphold the quality and standard for behavior analysis in the State of Hawai'i.

Beau Laughlin, Horizons Academy of Maui, Inc.
Kihei, Maui

03/16/17

Committee on Health

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As someone who has been working with children in the field of ABA for 5 years, I know how important it is to have the proper training! Our keiki deserve the best education possible and to remove the RBT credential would mean a lower standard of ABA. I've seen so many children thrive because of the intensive work RBTs and BCBAs do with them, and to think someone without the training that is required now, could work with these children, is heartbreaking.

I strongly oppose SB739! I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Caitlin Prieto
Mililani, Oahu

03/16/17

Committee on Health

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State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

I strongly support licensing standards that will ensure consumers receive services by trained and qualified professionals. The proposed changes of SB739 would compromise consumer protection and lead to irreparable harm. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Amy Grant
Haleiwa, Oahu

03/16/17

Committee on Health

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Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

I strongly support the behavior analyst licensure as is. The proposed changes of SB739 would compromise consumer protection and lead to irreparable harm. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Lawson Cosseboom
Haleiwa, Oahu

03/16/17

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I am an RBT at Autism Behavior Consulting (ABC) Group, and due to the use of ABA principles, I constantly see incredible growth with all of the kids that I work with. My job is very demanding and constantly requires the use of ABA theories in everyday interactions with the kids. We technicians are always implementing antecedent interventions, reward systems, extinction, and other methods to teach appropriate behavior. Behavior interventions plans are not all-encompassing, and if technicians were not required to hold the RBT credential, they may be less capable of making appropriate decisions when children exhibit new or surprising behaviors. Technicians also work directly with the children much more often than BCBAs do, and as a result, are often the best people to suggest plan modifications and additions to the behavior analysts. We would not be as capable of this if we were not RBT trained. There are already enough under qualified people working with special needs children, and I feel that requiring the RBT credential is one of the best ways to ensure that these children receive the best possible services

Noelle Dennard, ABC Group, Inc.
Waipahu, Oahu

03/16/17

Committee on Health

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As a mother of a child with Autism, having an unqualified person to practice ABA fears me. Therefore I want all the personnel whoever works with students with autism or related disorders to be licensed. I oppose SB739. Having BCBA supervised or learning what ABA is or about what Autism is might reduce the chance of getting students with special needs abused which is our biggest fear as parents. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Juri Ishida, Parent
Mililani, Oahu

03/16/17

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As a licensed clinical social worker in the state of Hawaii and a director of a Behavioral Health company, I know first hand that it is medically necessary for services for children diagnosed with ASD to be provided by and overseen by licensed behavior analysts (LBA). Other licensed professionals do not have the education and experience required to complete behavior identification assessments, reassessments, treatment plans, and support and supervision of the direct support workers and families. Please look at the data and the facts, please take out keiki and their families in consideration, please allow yourself to see that the current licensure and credentialing standards for the practice of behavior analysis is working and is benefiting our keiki.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Eliza Lipp, BAYADA Home Care
Kahului, Maui

03/16/17

Committee on Health

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Our Legislative System has worked hard thus far to safeguard the safety and care for children and adults with autism. There have been countless hours on the part of your colleagues to ensure the right treatment, by the right professional, is available to those that need service. Please continue to make decisions that uphold the efforts that everyone has worked so hard for. Thank you!

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Anastasia Keller-Collins, Therapeutic Consulting Services
Ewa Beach, Oahu

03/16/17

Committee on Health

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I have worked in this field a number of years and can see the difference in those who are qualified as Registered Behavior Technicians (RBTs) working with our kids and those who are not qualified. There is a huge difference. Our kids deserve quality services that will help them reach their potential! I oppose bill SB739!!

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Cherlyn Tamura, BAYADA
Kailua, Oahu

03/16/17

Committee on Health

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I oppose SB739. I have worked in the field for almost 15 years and can truly say that we need highly trained and qualified individuals to practice ABA. I just read an article that mentioned that the state was sued over an aide that napped while his student with autism sexually assaulted another student. How much more needs to happen until this is taken seriously?! Our students deserve much more! With proper training and oversight, this would not have happened!

Carolyn De Jesus, Malama Pono Autism Center
Mililani, Oahu

03/16/17

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I have been teaching students with learning disabilities for the last 15 years. In that time, I have seen a dramatic increase in behaviors that impact the learning of our students and other students in the class. Our school had a Board Certified Behavior Analyst (BCBA) as a counselor. The work this counselor did with me and the students in my class helped me as a teacher work more effectively with the students with problem behaviors. There has been a decrease in problem behaviors and increased time on task. I also began a course of study in Behavior Analysis because of the insights I gained in through working with the counselor. What I have learned thus far has made my job much easier. I have gained insight into my students, what makes them different, and how to help them. The training of a professional with a BCBA gives that person specific tools that help them understand the function of the problem behavior, design a behavior support plan, and track that plan to be sure it is working. This work includes fading the supports so that the student or client is able to function independently. Applied Behavior Analysis (ABA) is based on close to 75 years of research and work directly with students with Autism Spectrum Disorders (ASD) and Intellectual and Developmental Disabilities (IDD). This work is what gives Behavior Analysts the unique training necessary to effectively help people with Autism, Developmental Disabilities, and Learning Disabilities. Since it is a specialty, it is best to have Licensed Behavior Analyst performing ABA services. They, like doctors, need specially trained support staff, to carry out the protocols for behavior change. Registered Behavior Technicians (RBTs) are the “nurses” to the BCBA “doctors”. As a teacher who cares deeply about her students and their growth into functioning happy members of our society, I ask you to oppose SB739.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Joanna Mackin
Kaneohe, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
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State Capitol
415 South Beretania St.

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Take care of all of our keiki, mind, body, and soul. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Nicole Ogata
Honolulu, Oahu

03/16/17

Committee on Health

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I oppose SB739. By removing the Registered Behavior Technician (RBT) credential, it puts our families who receive Applied Behavior Analysis (ABA) services at risk. The RBT goes through ABA-specific training, and demonstrates competency through skills demonstration and a written exam. Furthermore, they are closely supervised by a Licensed Behavior Analyst (LBA) to ensure they are delivering evidenced-based interventions for individuals receiving ABA services. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Grace Bunghanoy-Diama
Mililani, Oahu

03/16/17

Committee on Health

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ABA is imperative to be implemented by licensed individuals so we know ABA is done correctly, there is procedural integrity, and the individuals receiving ABA treatment deserve this right.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Lorelei Bandola, ABC Group, Inc.
Aiea, Oahu

03/16/17

Committee on Health

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Should we go back to letting Barbers practice medicine? Please let the educated and qualified people do what they are trained to do: analyzing behavioral differences and determining the best treatments. I was married to a therapist for 27 years and I know that I could not do what he did; I've been a teacher for 35 years and have worked with special needs children, I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Sharon Kuntz
Haleiwa, Oahu

03/16/17

Committee on Health

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My child has had to suffer through numerous people in the school system who do not qualify. Changing the wording will greatly impact children who receive services by introducing them to professionals who are not qualified and properly trained. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Alison Villiarimo
Hawai'i

03/16/17

Committee on Health

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Testimony in STRONG OPPOSITION to SB739 SD1

I am a direct support worker (DSW) for a contracted provider for DOE. I have seen on multiple occasions the harm that uncredentialed staff cause when attempting to devise or implement behavior analytic programs. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Deborah Hoohuli-Rosa
Kihei, Maui

03/16/17

Committee on Health

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I believe that if this bill gets signed it will cause issues and concerns on the safety of the children with unlicensed mentors. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Reid Oshiro
Honolulu, Oahu

03/16/17

Committee on Health

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My son is currently receiving ABA services through an agency, which uses unverified/unlicensed therapists, although it is against state law. The treatment he receives is well below the expected standard. We have tried discussing this with the agency but have been ignored. Lack of certified quality therapists from this agency has had a negative impact not only on his emotional and mental well-being but to the rest of the family as well. Within a year period, my son has been through several different therapists. Due to the lack of services from appropriately credentialed providers, we have made very little to no progress in his treatment. This bill will only continue to allow inexperienced people to serve in this area and will no doubt have a negative impact on those children and their families.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Roger Larson
Wahiawa, Oahu

03/16/17

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I am writing this testimony in opposition of the Senate Bill 739. As a Special Education Teacher, mother of three and former individual working in the field of Applied Behavior Analysis (ABA), I strongly believe that only trained persons should be allowed to provide ABA services. I truly feel that in order for ABA services to maintain its validity and be truly effective, staff needs to be appropriately qualified to implement its techniques and principles. When individuals are competently trained in ABA and required to get credentialed to provide ABA support it really is advantageous for everyone. I have an Autism Spectrum Disorders (ASD) Educational Assistant (EA) who is receiving her training towards her RBT this year and she is coming back from these trainings with a lot of new insight and a better understanding of behavior. The district I work for is incredibly supportive and seems to see the genuine value for training its support staff in Applied Behavior Analysis (ABA). Trainings and credentialing programs for support staff is so important in any field as it honestly can assist in reducing resistance to change, minimizing avoidable errors and allowing for the initial implementation of services to be focused on the client as it should be.

Requiring support staff to be credentialed in providing direct ABA support is a good thing and will help not only the individual receiving direct ABA services, but those that will feel the impact of the services being provided, like the community and the schools they attend. I have always valued knowledge as an open-minded individual and as an educator. Constantly looking to grow and become better at what I do is a part of my profession and what makes me love teaching so much. I feel that many teachers will agree with me that we need more competent service providers giving our students quality services to help them gain independent skills, manage behaviors and become valued members of society. Applied Behavior Analysis (ABA) can be a vital tool in providing that for our most challenged students BUT it has to be implemented competently, or we are doing a disservice to our students, parents, teachers and community.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Cheryl Goo
Mililani, Oahu

03/16/17

Committee on Health

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Please don't dilute the behavior profession with non-professionals. Be pono and do good for your people who have worked hard to get a good education.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Brian Powers
Mililani, Oahu

03/16/17

Committee on Health

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It is in the best interest of our children and families to rely on nationally respected professional standards, not leave it up to local organizations to decide whether a practitioner of Applied Behavior Analysis (ABA) is adequate in their practice, particularly because there will be significant economic incentives to "go cheap" and hire unqualified individuals, if the Registered Behavior Technician credential is not upheld. Our keiki and families deserve better. Children develop rapidly and poorly qualified professionals waste precious time for them.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Peggy Brandt
Honolulu, Oahu

03/16/17

Committee on Health

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It will be detrimental to our children with special needs if this goes through and there is no guidance on who can provide the services to children. There is a reason for credentialing and getting training for Registered Behavior Technician (RBT), who are required to be supervised by a Licensed Behavior Analyst (LBA).

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Yuri Lee
Honolulu, Oahu

03/16/17

Committee on Health

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The difference between the RBT and the other proposed credentials is the other credentials broaden the scope of supervisor to non-qualified professionals and remove the expectation for demonstration of competency by the direct support worker.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Laura Bonilla
Kapolei, Oahu

03/16/17

Committee on Health

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As a parent of a child with autism, I do not support removing this language from the legislation. My son should be entitled to care by competent providers who have completed their training and are filling versed in the behaviors and abilities of autistic children.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Jeaustine Larson
Wahiawa, Oahu

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

As a board certified and licensed behavior analyst, I know first hand how rigorous the processes is to reaching this level of certification. It requires years of education, supervision, and testing. We need to keep standards high to protect our children's rights and to ensure that ethical guidelines are followed. Behavior Analysis can be extremely effective- but also dangerous if not implemented correctly.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Sara Mayne-McClay
Honolulu, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

It has been my experience in participating in ABA (approximately 5 yrs) with my grandson with an autism diagnosis, that those we have worked who have credentials in behavioral analysis have made a life changing difference in our family. Without their expertise, we would be lost. To allow those less qualified would compromise the program. When you work so closely with these professionals you realize how knowledgeable they are. Please reconsider relaxing the standards, allowing those less qualified to conduct ABA. Behavioral analysis is complex, as are kids who need ABA. Money may be saved in the short run, but the relaxed standards will affect those in the need over the long haul and then to remedy that will probably never happen. Thank you for your time and consideration.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Brenda Broadus
Kapolei, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

First off, we should not allow just anyone to practice ABA therapy with the child. This could do more harm to the child in special education. If you think about it, would you allow just anybody to clean or work on your child's teeth? Or would you feel more safe if you knew these people went to school and got certified in the field? Would you want just anybody to give you anesthesia or would you want a trained anesthesiologist to give you medicine? We must always think about what is best for our children, and cannot always think about the easy way or the cheapest way. In order to have our child advance in society we need trained individuals to help. It is just like how we ourselves would want trained professionals to help us, we would also feel better knowing that they went to school and got certification in their profession.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Lisa Sakuda, Anuenue Behavior Analysts
Honolulu, Oahu

03/16/17

Committee on Health

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Testimony in STRONG OPPOSITION to SB739 SD1

Simply put, I oppose this bill. Reasoning: It puts the care of Hawaii's autistic and behavioral challenged children in the hands of cheaper, but less capable and less observant staff. One would not let a handyman try to analyze, much less correct a building's structural faults, why would we think unqualified personnel be able to properly care for a behaviorally challenged child. While it is cheaper, it is only cheaper in the short term. There long term, the child would receive lesser quality care, reducing the prognosis of a desirable outcome for that child. Qualified professional care is needed every step of the way. This bill will start the child with a State induced deficit that will markedly slow the child's progress and increase costs in the long term.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Michael Tober
Kaneohe, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
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Conference Room 329
State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

ACT 199 was a move in the right direction for Hawaii in providing QUALITY services by trained professionals to our children needing specialized services to prosper and grow. It is our DUTY as professionals and community to uphold high standards in what we do for our children requiring services. Our children DESERVE to receive services from competent professionals who are certified Registered Behavior Technicians (RBT) and licensed Board Certified Behavior Analyst (BCBA). What is the justification to say they do not? I stand with HABA in opposition to the change of licensure and credentialing standards for the practice of Applied Behavior Analysis (ABA).

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Haunani Tamashiro
Waikoloa, Hawai'i

03/16/17

Committee on Health

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415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

How dare you take away a program that is helping our children.I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Jacy Medina
Kamuela, Hawai'i

03/16/17

Committee on Health

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State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Uphold the existing licensure law for behavioral analysts. Qualified, credentialed individuals provide our keiki with effective care and treatment!

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Cindy Vanover
Kailua, Oahu

03/16/17

Committee on Health

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State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

To Whom it May Concern:

We are writing in reference to the 2 new bills that were recently submitted to the legislation regarding licensing of professionals providing Applied Behavior Analysis to individuals. Under the current law in Hawaii, Act 199, you must be licensed to practice Behavior Analysis. The proposed bills, SB 751 and SB 739 would seek to change this requirement.

During the 2015/2016 school year, we witnessed firsthand the devastation that inappropriately and unskilled behavior analysis (ABA) protocols can have on a child. Our now 9 year daughter, who has Down syndrome and Autism was provided behavior supports by the Department of Education , the intention being to provide her the skills necessary to have appropriate access to her learning as well as to make meaningful progress. Sadly, neither of these took place in the school setting.

During the 2015/2016 school year we watched our happy, joyful daughter become anxious, sad, angry, and fearful, losing the joy for learning that she had possessed prior to beginning at her current school. She developed many aversive behaviors to include self-injurious behaviors such as slapping herself on the head, hard hits on her chin, pinching herself on the cheeks, pulling her own hair, and biting herself.

By November, 2015 she would sometimes cry when we arrived at school. She refused to exit the car and we would have to physically assist her in doing so. By November, 2016 she developed a behavior where she would not walk more than 4-5 feet without stopping, and would plop down and refuse to resume walking. She began to have explosive bowel movements, sometimes at school, and almost daily at home immediately following school. Immediately following school she would require 30-60 minutes of intensive decompression before she could function in a meaningful way. We were baffled and concerned as to what was taking place during the school day to cause these behaviors. She was provided in her IEP, behavioral services which consisted of a contracted BISS (Behavioral Intensive Support Services). We quickly realized that the BISS was unable to answer any of our questions pertaining to the behavior supports specific to Applied Behavior Analysis that were recommended for our daughter by her private neuropsychologist and developmental pediatrician. We also learned that she had no background or training in Applied Behavior Analysis. She was not licensed. She was according to her Student Service Plan reports providing ABA protocols and methodologies. She without our knowledge developed a Behavior Support Plan with the Special Education teacher that included a CPI hold for our non-aggressive daughter. In February we were assured by the administrator that it would not be used...we were informed in April/May 2016 by the new BISS that it was still in place. We had educated ourselves thoroughly on Applied Behavior Analysis which we learned was communication based. Without functional communication our daughter could not have meaningful access to her learning. Our daughter's communication continued to regress.

In February 2016 we communicated our concerns to the school administrator. We were met with statements that the behavior services were not direct instruction or support for our child but rather support for the teachers and 1:1 para-pro. This was concerning as ABA when provided with integrity and by

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experienced professionals, usually a certified and licensed BCBA, will include direct instruction and support, and daily data collection.
Shortly following the meeting, the BISS was no longer available to provide behavioral services to our child. Our daughter was provided a new BISS. She as well, despite the newly enacted licensing law specific to licensing of ABA providers was not a licensed psychologist or BCBA, and attempted to provide Applied Behavior Analysis methodologies. We again on numerous occasions communicated our concerns to the school, requesting numerous times to please provide our child with either a licensed psychologist who practiced ABA in the scope of their practice or a licensed BCBA. We were denied again and again with assurances that our child was receiving appropriate behavioral supports.

Our daughter's behaviors became more concerning and self-injurious. In the Spring of 2016,We had several IEE assessments performed by experts in their field of practice to include:

- A licensed BCBA to perform a Functional Behavior Assessment to include an all-day observation in the school.
- A licensed occupational therapist to provide a comprehensive OT assessment, who has her masters in Applied Behavior Analysis that included an all-day observation.
- A speech language and feeding specialist to perform comprehensive sp/lg and feeding assessments that include school observations.
- A thorough review of the programming provided our daughter by the school behavioral supports, by a licensed and certified neuropsychologist who reported the BISS ABA programming to be ineffective.

As the IEE reports began to filter in they all had one thing in common. Our daughter was not being provided appropriate ABA /behavioral supports. Her behaviors were self-injurious, negative, non-compliant and completely lacking in consistency. Our child's behaviors had been created due to unlicensed and untrained persons provided attempts at Applied Behavior Analysis.

We know this because Since August 2016 our child has attended a clinically based program that is based on Applied Behavior Analysis. Every staff member is a licensed BCBA, BCaBA or RBT. (Registered Behavior Technician). Before the staff could even begin to implement the programming that they knew would help our daughter, they had to undergo months of intensive and supportive de-programming of the aversive behaviors that had been created in the unsupported DOE environment and by unskilled and unlicensed ABA providers.

Finally after 6 months of intensive and positive Applied Behavior Supports, she is once again demonstrating functional and meaningful communication to access her learning. She is completely toilet trained. She is demonstrating only approximately 15% of the aversive behaviors throughout her learning day and beyond that she had learned and developed with the provision of inappropriate behavioral programming by the untrained and unlicensed behavior staff in her previous school. She is once again joyful and learning.

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Passing SB 751 nd SB 739 will have devastating effects on children like our daughter who need licensed and skilled experts in the provision of Applied Behavior Analysis. We have seen it firsthand.

Thank you for the opportunity to share our testimony with you.
John and Maureen McComas

Would you let someone without a medical license operate on your child? I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Johnny Chan
Honolulu, Oahu

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

My son, diagnosed with autism, was unethically restrained, without consent, by untrained DOE employees. Abuse! A licensed behavior analyst (LBA) would never use a punishment procedure with mechanical restraints for behavior management.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Enough abuse.

Therese Ricks
Honolulu, Oahu

03/16/17

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Our children, their parents, and healthcare providers should be entitled to receive services and reports from professionally certified behavior analysts who are working for their best interests. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Marie Lynn
Honolulu, Oahu

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

PLEASE!!! uphold our existing licensure law and OPPOSE Senate Bill 739.

Haʻaloʻu Soares
Hilo, Hawai'i

03/16/17

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Would you want someone who doesn't have a license perform heart surgery or operate a vehicle? I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Ruth Buttel
Hauula, Oahu

03/16/17

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I am fortunate to have grandchildren that don't have Autism, but I have friends that do and cousins that have grandchildren that do. They need To be tested and these parents need help. Please take care of these children's needs. This is a crucial test for keiki's that could possible have. Autism. I oppose this bill SB739. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Sandra Ahlo
Hilo, Hawai'i

03/16/17

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I have personally seen the growth, development and benefits of HABA to two autistic children very dear to me. Without the level of expertise and appropriate knowledge they may not receive the care and therapy they need and deserve. I oppose SB 739! I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Jimi-Jean Kalaniopio
Kamuela, Hawai'i

03/16/17

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Do not pass this bill to maintain quality care. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Susan Barton
Ookals, Hawai'i

03/16/17

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I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Micah Olival
Honokaa, Hawai'i

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Testimony in STRONG OPPOSITION to SB739 SD1

I oppose SB739. It goes against common sense to allow unlicensed individuals to analyze a person's behavior. This will lead to improperly diagnosed cases.

Stewart Thomas
Honolulu, Oahu

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

Please uphold licensure law. My two nephews need continued care and quality services. They need qualified, experienced and competent individuals that practice behavioral analysis to provide the services they need!

Kaiolohia Tolentino
Kamuela, Hawai'i

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
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Testimony in STRONG OPPOSITION to SB739 SD1

Why would you want to take ANY help away from a CHILD with disabilities ‼ I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Bobbe Doran
Honokaa, Hawai'i

03/16/17

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ABA is a complex practice that can change the life of someone with autism and other special needs. ABA teaches fundamental life skills needed to help these children become functioning members of society. However, if we except people with little to no knowledge of ABA to implement such complex programs little or no change may occur. It is critical that all persons working in the field of ABA have the basic knowledge of the science in order to give the program and our children a chance to thrive.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Sierra Rainwater
Kihei, Maui

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

Aloha. I am writing to you in opposition of SB739. As a BCBA, a Licensed Behavior Analyst, and Behavioral Services Manager of BAYADA Behavioral Health, I have worked in this field for many years, and am familiar with it's challenges and achievements. In conducting ABA services, what we do as providers, by very definition, changes the lives of our clients in very meaningful ways. ABA is a scientifically administered therapy that can be extremely dangerous to clients if it is administered in an uneducated, unregulated, or unethical form. As BCBAs, we undergo extensive education, real-life training and supervision in order to practice with a means that is both safe and effective. The implementation of any of our strategies in an even slightly-compromised fashion can damage a client's progress, capabilities, and can even cause harm.

I personally have chosen to work in the ABA service line of our company, rather than in the DOE, because I value the training and credentialing that all of my colleagues in ABA are responsible to upkeep. Part of my duties as BSM is to train and check incoming RBTs for competency so that they may enter the field. I take their fitness to fulfill their duties very seriously, as I know how important their role is. I would never feel comfortable allowing a person that is incapable of obtaining an RBT credential to perform any sort of services with the clients I service. I entered this field because I care about those clients and caregivers impacted by Autism Spectrum Disorder. I wanted to do good and provide help. I worked hard to educate myself to a level and certification that allows me to feel confident in my work. I would hate to see this field that means so much to me be tarnished by companies who seek only to make money quickly, and without proper education and training, at the potential risk of Hawaii's ASD community. Thank you for your time.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Jessica Stark, BAYADA Behavioral Health
Kailua, Oahu

03/16/17

Committee on Health

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415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Protect our children. Make sure they receive the best! I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Jacqueline Sills
Kamuela, Hawai'i

03/16/17

Committee on Health

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Testimony in STRONG OPPOSITION to SB739 SD1

Do not take programs that are important to our keiki. Are you going to take another opportunity from our children, placing them further behind instead of being in the forefront of development. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Toni Ambrosio
Kamuela, Hawai'i

03/16/17

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All of Hawaii's keiki deserve the highest standard of excellence when it come to education. Professionals who work with our children should be of the highest quality and certification. By lowering the standard of qualification, we would be doing our children a dishonor by depriving them of what they deserve. There, I oppose SB739. Mālama e na keiki.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Ramona Herlihy
Paauilo, Hawai'i

03/16/17

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The effect of ABA provided by an RBT under the supervision of a licensed professional is demonstrated in the data. I believe the numbers for each client can truly speak volumes to the importance of ensuring competency in behavior analysis for professionals providing behavior analytic services. I, as a Licensed Behavior Analyst in Hawaii, oppose SB739.

I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Amanda Lipinski
Kailua-Kona, Hawai'i

03/16/17

Committee on Health

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Testimony in STRONG OPPOSITION to SB739 SD1

For the sake of our most vulnerable keiki, we must uphold the highest standards for those who provide services to children with special needs. Poor families struggling to support their children will suffer disproportionate harm from this bill. Without strict license and credential requirements, needy families will be forced to accept substandard care for their children and will continue paying the price as these children become adults without adequate institutional support.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Marielle Hampton
Honokaa, Hawai'i

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

In my years in the field of ABA in other states, I have seen the results of so called "ABA" intervention implementation completed by non-qualified technicians. From school- based interventions in Texas to home sessions throughout various regions of California, I have encountered a myriad of conditions in "behavioral programming" completed by non-certified staff that have led to increased self harm, aggression, and other challenging behaviors. When I was looking for places to relocate, one of the most attractive things about Hawaii, for me, was its commitment to providing certified, qualified professionals in all capacities within Applied Behavior Analysis services. Without this continued commitment, I fear that Hawaii's level of care for children receiving ABA services will plummet and our children will not receive the quality of health care and education that they deserve.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Joshua O'Kain
Ewa Beach, Oahu

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

Please protect those who need behavior analysis services by requiring only qualified, appropriately educated persons to be participants in their care. To do anything less is like swapping out Registered Nurses with Nurse Aides.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Deborah Aldrich
Haleiwa, Oahu

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

As a speech-language pathologist (SLP) of 41 years (35 in Hawaii), I have had the opportunity to work along some awesome behavior analysts and behavior technicians. While ABA is only type of therapy for students on the spectrum, every child is individually wired, therefore families should be given the choice and particularly a chance, to have this therapy available to them and to have it provided by competently licensed and credentialed professionals. I strongly oppose, as a professional in the communication arena, Senate Bill 739.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Genie Ruddle
Waikoloa, Hawai'i

03/16/17

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415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Aloha Legislators,

Please oppose SB 739 which seeks to remove the RBT credential requirements. This change will be detrimental to our keiki who desperately need quality behavior analysis services. This is a critical health service that requires the appropriate training & certification. Please do not short sell our keiki's health, wellbeing & futures.

Mahalo,
Jen Maydan
Haiku, Maui

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
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Testimony in STRONG OPPOSITION to SB739 SD1

Dear Legislators,

I highly oppose SB739, since I have first hand experience with ABA therapy with my autistic grandson in Honolulu. He is high functioning, but had multiple behavior problems, including meltdown, not having friend, not knowing how to be empathetic, being aggressive toward my daughter and the dog. He has learned appropriate behaviour through in home ABA therapy in Honolulu. Please vote against this measure and keep ABA therapy, provided by licensed and credentialed providers, as the current for children with autism and other special needs. Thank you for your time.

Vicli Davis
Hilo, Hawai'i

03/16/17

Committee on Health

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I oppose SB739. The language proposed leaves individuals receiving applied behavior analysis (ABA) vulnerable as un-credentialed individuals will be able to implement ABA therapy without any clear guideline on their qualifications to do so. If there is a population of people who are restricted in implementing ABA, there should be open discussions with affected parties and Hawai'i Association for Behavior Analysis (HABA) to discuss what can be done. It is important to remember that there may be credentialed individuals who are experts in autism, but not applied behavior analysis. ABA is an empirically evidenced science to speaks to not only individuals affected by autism but to all populations of people in all environments where observable behaviors can occur. We need to protect the quality of services provided to a vulnerable population and keep the integrity of the current law in tact. Populations of professionals who are impacted should reach out to HABA so there can be a community effort to keep service integrity intact.

Sara Dinkelo
Honolulu, Oahu

03/16/17

Committee on Health

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

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State Capitol
415 South Beretania St.

Testimony in STRONG OPPOSITION to SB739 SD1

Give our babies what they need to function in a normal environment. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Piilani Kaalekahi, Surfer's Healing
Pearl City, Oahu

03/16/17

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Testimony in STRONG OPPOSITION to SB739 SD1

To Whom It May Concern,

I am writing this piece of individual testimony in opposition of SB739 because of the greater impact it could have on the provision of applied behavior analysis (ABA) services. As a certified and licensed practitioner within the state of Hawaii, I believe that it is of the utmost importance to hold all practitioners to a high standard of certification. SB739 removes the current credentialing requirement for direct providers, which would be a disservice to consumers of applied behavior analysis (ABA). Without proper regulation, such as that maintained by the Behavior Analyst Certification Board (BACB), improperly trained individuals would have the opportunity to affect the lives of ABA consumers. The current standards requiring RBT certification ensure a standard of training and supervision for those staff who would shape the lives of children and adults. I urge you to reconsider the detrimental impact of this piece of legislature.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Respectfully,

Nancy Trujillo Sisemore, MS, BCBA, LBA
Honolulu, Oahu

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Testimony in STRONG OPPOSITION to SB739 SD1

My name is Amy Smith Wiech, I am a Doctoral Level Board Certified Behavior Analyst and Licensed Behavior Analyst. I am the Founder of Autism Behavior Consulting Group (ABC Group), a Kama'aina company for over 10 years. I have almost 25 years experience in Behavior Analysis. Thank you so much for the opportunity to testify in **STRONG OPPOSITION** of SB 739.

This proposed bill would allow for certain individuals unlicensed in behavior analysis to engage in the practice of behavior analysis (ABA) when done in a public educational setting.

THIS WILL BE AKIN TO ALLOWING SOCIAL WORKERS OR SPEECH PATHOLOGISTS WHO HAVE ATTENDED A ONE-DAY WORKSHOP ON SURGERY TO PERFORM LIFE THREATENING SURGERY ON THE CHILDREN OF HAWAII, INSTEAD OF BUILDING CAPACITY AND TRAINING AND ADEQUATE POOL OF BOARD CERTIFIED SURGEONS IN HAWAII. I would not even think of following protocols related to speech pathology or social work because I know that I do not have the requisite credentials, training or experience. The same goes for Behavior Analysis. It is a science that requires years of coursework, training, supervision and examination to meet the minimum standards.

The State of Hawaii needs to build a capacity of Licensed Behavior Analysts (LBA) and Registered Behavior Technicians (RBT) in Special Education and in the field of Health Care. The Behavior Analyst Certification Board (BACB) has established training and experience standards which establish **MINIMUM STANDARDS OF COMPETENCE for Board Certified Behavior Analysts (BCBAs) and Registered Behavior Technicians (RBT) who practice behavior analysis**. The State of Hawaii just recently passed licensure starting on 1/1/16 for Behavior Analysts. We have over 150 Licensed Behavior Analysts in Hawaii, and over 500 RBTs. This number will keep climbing, and these credentials will provide protection for consumers. Hawaii can build capacity. Let us help! Standards are good. They assist with promoting consumer protection and safety for our residents.

This bill presents an issue of **consumer protection and safety**. We need to protect the children of Hawaii from unlicensed and untrained people who do not possess the requisite credentials or experience within their license from providing ABA treatment to children in Hawaii. Last year, the news reported a boy with autism being reportedly strapped to a chair daily, and withheld food and liquid from him at Koko Head Elementary- these were people are not licensed in Behavior Analysis, nor are Educational assistants and Paraprofessionals. At Kipapa Elementary, there were several parents who raised similar

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concerns a few years ago about their children being fed vomit, and tied to chairs. Lawsuits were the outcome of these abuses in schools. These again are people who are not licensed in Behavior Analysis, like EAs and Paraprofessionals. We need to protect our children, and putting unlicensed persons in the schools to "do behavior analysis" is egregious. There are untrained EAs, Paraprofessionals, and other staff in schools already doing damage to kids with autism. **Let's raise the bar for our children and for our state.**

DO NOT PASS SB739!

Related Readings:

Behavior Analyst Certification Board (May 2011). *Online Newsletter*. http://bacb.com/wp-content/uploads/2015/07/BACB_Newsletter_05_2011.pdf

Behavior Analyst Certification Board (December 2013). *BACB Newsletter – Special Issue on the RBT Credential*. http://bacb.com/wp-content/uploads/2015/07/BACB_Newsletter_12-13.pdf

Green, G. (August 2011). How to evaluate alternative credentials in behavior analysis. *APBA Reporter, 31*.

Green, G. (October/November 2015). How to evaluate alternative credentials in behavior analysis, Part II. APBA Reporter, 55.

Johnston, J. M., Mellichamp, F. H., Shook, G. L., & Carr, J. E. (2014). Determining BACB examination content and standards. *Behavior Analysis in Practice, 7(1), 3-9.*

Shook, G.L., Hartsfield, F., & Hemingway, M. (1995). Essential content for training behavior analysis practitioners. *The Behavior Analyst, 18, 83-91*.

Shook, G. L., Johnston, J. M., & Mellichamp, F. (2004). Determining essential content for applied behavior analyst practitioners. *The Behavior Analyst, 27, 67-94.*

We look forward to maintaining consumer protection for children that will be afforded with the death of this bill. Thank you so much for addressing this important issue for our constituents.

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Sincerely,

Amy Wiech, PhD, BCBA-D, LBA
Board Certified Behavior Analyst- Doctoral
Founder /Executive Director

To Whom It May Concern:

I am submitting my testimony to OPPOSE Senate Bill 739. I am the mother of a child receiving Applied Behavior Analysis (ABA) services from a Board Certified Behavior Analyst (BCBA). Over the past 4 years, he has received effective ABA services from a variety of BCBAs and Registered Behavior Technicians (RBTs). He has also been *victimized* by a variety of purported "ABA services" provided through two school systems by Psychologists, Behavior Intervention Support Specialists (BISS), Autism Consulting Teacher (ACT), and Educational Assistants (EA) under their "supervision." Under the untrained and ineffective services provided by these "professionals", my son regressed socially and behaviorally, markedly increased aggressive and stimulatory behaviors in school, and made little academic progress. Thankfully, his home-based Licensed Behavior Analyst (LBA) was able to help him relearn appropriate behaviors and intervene with his social skills and executive functioning, as well as build fluency that helped him make academic gains as well. The RBT credential is the only direct support worker credential that is required to have a minimum of 5% supervision from a BCBA or Psychologist certified by the American Board of Professional Psychology (ABPP) in Behavioral and Cognitive Psychology. The credential also requires the direct support worker to meet with their supervisor at least twice per month. As the mother of a child who needs these vital services, I would only accept this *minimum level of competency* and oversight for such a vulnerable population.

If you allow other credentialed personnel to implement ABA you weaken its effectiveness at best; and at worst, you irreparably harm a person. Please uphold the current law so our most vulnerable population of people have access to appropriate and effective services, and please VOTE NO on SENATE BILL 739.

Respectfully Submitted,

Kate Disney
Wahiawa, Oahu

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I fight to keep the Registered Behavior Technician position and qualifications in ABA therapy. Standards are set according to the BCBA Code of Ethics, and it is a position necessary for young individuals like myself to continue to gain early years of experience that I am so appreciative of and hold high value in the clients, the work, and respect to authority at an objectified perspective. It is a challenging position that ensures competent individuals who have studied, practiced, and passed the coursework and examination. I've personally experienced and continue to be involved with improvements made on the oversight of Behavior Analysts due to the RBT credential.

Divine Dennis, ABC Group, Inc.
Honolulu, Oahu

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We need trained professionals with knowledge and experience in handling special needs children opposing this bill will hurt everyone especially the child by having them regress from things taught by professionals.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Taylor-Maigne Hayme
Honolulu, Oahu

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Education is of the utmost importance for these kids. If their heart is in it, they will take RBT course. I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Laura Rogers
Kihei, Maui

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As a current RBT as well as a BCBA candidate, I feel that it is imperative for individuals receiving ABA therapy be overseen by someone that the National Board for Behavior Analysis has deemed fit to practice ABA. The board sets rigorous standards for a reason- because not anyone is qualified to be able to practice this science. In addition, RBT's also go through a thorough training specifically overseen by a BCBA who can further explain the content being learned. Our almost vulnerable student population- those with disabilities such as autism not only deserve to be but need to be treated by professionals who are well trained and credentialed the BACB.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Kahalenoe Kamalani
Mililani, Oahu

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With a ratio of 1 every 68 kids diagnosed with autism would it be better if we place them in qualified hands rather than less competent people? What will be the future of these kids if we put them in less capable hands? I've been trying to get ABA services for my son who was just diagnosed with autism. He is currently attending public school with no ABA therapy. I finally got a Licensed Behavior Analyst (LBA), but getting the school to cooperate with my sons ABA provider for an observation at school has taken over a month! This is so frustrating since all I want to do is give him the best treatment, and that is Applied Behavior Analysis (ABA) as proven by studies! And getting insurance to approve it takes weeks. How can my son get better when just getting services takes months? Why is it hard for public schools to incorporate ABA when it is clearly needed?

I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis. I oppose SB739.

Mary Juinio
Aiea, Oahu

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We need RBT people to work with these individuals with special needs. When hiring a under qualified person,your basically stating that you don't care who works with them or what they do. They are just as much as human as you and I and deserve to be treated the same way. They deserve educated,qualified people that have an understanding of these special people . Also and understanding of how the program works and what will work for certain individuals. This can only be learned during RBT training. You can't put an unqualified individual with no knowledge to work with special needs person, it's practically just babysitting. So please keep RBT, it will help those that need that extra push have a chance in life and learning new things.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Danielle Talon
Kihei, Oahu

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SB739, if passed would affect the quality of care that people with autism spectrum disorders received. Without the specific behavior analytic education, supervision and ethical guidelines that BACB certification ensures, consumers of ABA treatment -a very vulnerable population- could be subjected to substandard treatment. **To think that any mental health professional can deliver behavior analytic treatment is like believing that any doctor could do brain surgery**. ABA is a very specific discipline. It requires years of training and supervision to acquire proficiency. We have a law that utilizes a well established board credential which has spent years setting forth ethical and clinical guidelines with input from the most well respected and experienced professionals in the field...Why would we want to move away from high standards? Laws should protect consumers. SB739 removes quality assurance from our current law. Please vote against SB739.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Faye Neves
Honolulu, Oahu

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I oppose SB739 due to the fact it removes the RBT (Registered Behavioral Tech.) requirement. This is detrimental to the individual needing that support and hinders the progress and development they could otherwise achieve.

Chuck Page
Kihei, Maui

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Hourly staff, without oversight by licensed behavior analysts (LBA) are simply not prepared to ensure the safety of our kids while actually working towards skills acquisition and behavior reduction. The functional perspective that has been research proven time and time again belongs solely to ABA and its practitioners.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Matthew Sartin
Kihei, Maui

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The difference between the RBT and the other proposed credentials is the other credentials broaden the scope of supervisor to non-qualified professionals and remove the expectation for demonstration of competency by the direct support worker.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Demi Mendoza, ABC Group, Inc.
Honolulu, Oahu

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In order to effectively support our kids and their families, we need credentialed individuals who can show competency in practicing applied behavior analytic practices. This small step can help us continue to impact their quality of life in the most positive way possible.

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Roxanne Bristol
Waipahu, Oahu

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These guys over here (the ones who are pushing for the bill), they are shady and up to no good. Us? We're busting our tails trying make things awesome. The DOE is doing the opposite and some psychologists want to cash in on the opportunity. That's no bueno, as a matter of fact, it's complete and utter bullshit!

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis. Uphold the Registered Behavior Technician credential for direct support workers!

Forest Penland
Kailua, Oahu

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I have worked as an RBT since November and love every minute of it. I am privileged to see growth in the clients I work with and am constantly learning more about the ABA practices that I am implementing. My training to become an RBT is invaluable to me and what I do on a daily basis. Without the proper training in Applied Behavior Analysis, I wouldn't be effective in working with my clients. Our clients need people trained and trained well and these credentials allow that to happen!

Jessica Funk, ABC Group, Inc.
Kailua, Oahu

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This new legislation opens the field up to professionals who may not be well trained themselves but claim to be. I'm only saying that due to my own experiences. As a special education teacher I do not feel comfortable with the implementation of a plan that has come from someone that isn't BCBA certified. The DOE has many licensed professionals but they lack the knowledge and experience to write behavior support plans for the autism population or any other child for that matter. Maybe I have just had a bad experience, but I have been misguided by too many in the DOE. "Behavioral specialists " are not trained to work with this population. I have had my share of email wars. Autism resource teachers are just teachers, not specialists. Autism EA's get the same training the teacher do. As a DOE teacher who is currently doing my coursework in ABA, I can just say that I wish ABA was part of my teacher training. Students who have moved on, I am sorry and wish I knew then, what I know now.

Jeanette Perez
Keaau, Hawai'i

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Please help us ensure that families and their children receive services from qualified professionals. By upholding the RBT credential in the current state law, you can help families continue to feel confident that they are receiving the most effective treatment for their child(ren). The RBT credential denotes a higher standard of service ensuring better trained, more qualified and more reputable therapists delivering services.

Tracy Bein
Kihei, Maui

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Thank you for this opportunity to submit testimony. I am writing to ask you to oppose SB739. This bill would be a detriment to the practice of Applied Behavior Analysis (ABA) for the state of Hawai'i. The requirements for Board Certified Behavior Analysts (BCBA) and Registered Behavior Technicians (RBT) require a demonstration of competence, something that is lacking in all of the other credentials proposed by this bill. Additionally, the BCBA and RBT credentials are governed by compliance codes which require adherence to strict ethical standards. Both of these are in place to protect consumers of ABA. Psychologists have stated that Act 199 restricts their ability to practice Behavior Analysis. This simply is not true. Psychologists have their own credentialing board (The American Board of Professional Psychology) and within that board, there is a specialization in Behavioral and Cognitive Psychology. With that specialization, Psychologist are able to design and implement ABA programs, and with an additional 8 hours of training in supervision (required by the Behavior Analysis Certification Board of all supervisors), they are able to supervise RBTs as well. Our most vulnerable keiki are in need of highly trained individuals. Please don't soften the law and take away that requirement. Give our kids a fighting chance!

I oppose SB739. I stand with HABA in opposing the change of licensure and credentialing standards for the practice of behavior analysis.

Lara Bollinger
Haleiwa, Oahu

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Imagine high school graduates with no special training providing medical services to people with physiological illnesses! Deciding that CNAs aren't valuable and instead hiring anyone who's looking for a job to take their places. Parity laws mandate equality of treatment for all types of medical illness, whether physical, neurological, or mental, so how can we deny effective treatment to people in need?Registered Behavior Technicians have been trained to implement behavior plans in specific, effective ways. They have the understanding of behavior analysis that is necessary in order to properly serve people in need of treatment. We wouldn't dream of lowering standards of care for people with other medical diagnoses; how could we be considering lowering them for people who often don't have a voice to advocate for themselves? An ugly history of atrocities committed against people with disabilities is still in sight in the rear view mirror, which is why it is of the utmost importance to provide specific training and education to the people who will be providing services to these populations. When we require training and education of the people who look to work in this field, we seek commitment, thereby weeding out people who are just looking for a paycheck and are much less likely to provide quality care. If we remove the RBT credential and hire anyone who wants to take a stab at this line of work, we heighten the risk of continuing to provide substandard care to people who have more to lose than we can imagine. Developmental disabilities such as autism are complex ailments, and people living with these conditions deserve the best we can offer, not just a warm body to watch over them. This is medically necessary, life-changing treatment. It is incredibly comprehensive, complex, and EFFECTIVE. How can we even consider discontinuing effective treatment for people who need it? Neglect would be an understatement. We have failed our sick and disabled long enough. It is time to do more, not less. One last consideration, regarding the bottom line: 20 years of work in this field has made it crystal clear that providing quality treatment to children with autism is far more cost effective than paying for lifelong care that is not concerned with growth and progress toward goals. The proof is in the pudding. Behavior analytic services work, plain and simple, and if we want to optimize the progress of the rapidly growing number of children and families living with autism, we MUST provide the most effective treatment! Otherwise we will hinder their progress, maintain greater levels of dependence and diminished functioning, and ultimately pay much more for people to have poorer outcomes. When legislation approves a reduction in care, a virtual guarantee of doing harm to people in need, civil rights are being violated. This day in age, knowing what we do about the suffering of

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people with disabilities, to add unnecessary suffering is unconscionable. Thank you for your time and consideration.

Mahalo,

Lauren Kelly

This testimony is in opposition of SB739. The removal of Registered Behavior Technician (RBT) opens up for unqualified, potentially incompetent individuals working with our keiki therefore, removing consumer protection. As a result, this could yield poor implementation of behavior support plans which could potentially be even more costly because the child will require treatment for a longer duration. As a mother, I am frightened by SB739. If my child is sick, she goes to her pediatrician. If my child has a heart condition, she goes to a pediatric cardiologist. If my child has cancer, she goes to a pediatric oncologist. If my child has behavioral needs, she needs a Licensed Behavior Analyst (LBA) with direct work provided by an RBT. We do not let an oncologist provide heart surgery. We do not let the pediatrician conduct a Functional Behavior Assessment (FBA). I strongly oppose for my future of my child and all children. As a community, we can do better than this. Let's do the right thing!

Kim Wolff
Haleiwa, Oahu

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My son Chris was diagnosed with Autism Spectrum Disorder in 2011. Since then, our family has benefitted greatly from Applied Behavior Analysis (ABA) with licensed and certified providers (LBA/RBT). Removing the certification requirement as SB 739 is currently written would be a mistake not only for optimal developmental therapy, but for health and safety.

Before Chris learned to communicate verbally, he demonstrated some self-injurious and violent behaviors. Certified providers with training in intervening with these types of behaviors are vital to the **safety** of children, peers, and themselves.

Because of his differences from neurotypical peers, Chris has endured egregious bullying. Certified providers have used therapeutic tools such as social stories to train him to initiate and elicit **positive social interactions**, and to respond appropriately to bullying.

Chris currently attends Alvah Scott Elementary in Aiea, which is a model for optimal Special Education services. At a previous school, he was a victim of “the soft bigotry of low expectations” (GWBush) in lower elementary classrooms. All he did in first grade was color. All he did in second grade was endure relational aggression of peers and adults. Certified providers have painstakingly and incrementally elicited substantial **academic** supplementation to close the resulting skill gaps. He is currently enjoying math block in General Education along with his neurotypical peers, and we are confident his reading will continue to improve as he is being appropriately challenged.

Thank you for your time and attention. I hope you choose to oppose SB 739 in the interest of Hawaii’s children and families.

Jen Eberlein, M.Ed., Chris’ Mom

kobayashi2 - Jessi

From: Amanda Kelly <akelly@anuenueaba.com>
Sent: Wednesday, March 15, 2017 11:03 AM
To: HLTtestimony
Subject: SB 739 Opposition (on behalf of Joy Moana Oliveria)

Chair Belatti, Vice Chair Kobayashi and members of the committee,

I am a special education teacher from the Big Island of Hawai'i. I would like to express my strong opposition to Senate Bill 739 by submitting my testimony demonstrating the devastating impact that this bill may have on the keiki and teachers of Hawai'i. Like many of my colleagues in Special Education I came to the field after experiencing challenges with a family member who is autistic. Not only were some interventions implemented on him completely inappropriate, but some were emotionally and physically damaging. After watching the devastating effects of unqualified personnel interacting with my family member, I pursued and earned multiple degrees and certifications in Psychology and Special Education. I continued working in the field as a teacher and soon realized there was still a staggering shortage of qualified people able to appropriately conduct functional behavioral assessments, develop behavioral support plans, and implement evidenced based and research-proven strategies to address behavioral concerns.

Over more than a two year period I was employed at a local charter school and was instructed to complete Functional Behavioral Assessments. I explained that I was untrained, and that my six plus years of coursework in Psychology and Education had not covered this task in depth. I was instructed by my department head that as a Special Education teacher, by virtue of our certification, we were qualified to complete a Functional Behavioral Assessments (FBA) and develop Behavioral Support Plans (BSP). She suggested I review existing plans for other students to educate myself how to complete the FBA/BSP. Initially, I muddled through the process and requested the support of the School Based Behavioral Health personnel. To attempt to gain more knowledge, during the summer break, I flew to another island with a colleague and undertook a 40-hour course designed as a part of a certification requirement towards becoming Registered Behavior Technicians (RBTs).

Upon my return to school, I discussed what I had learned with the district School Based Behavioral Health (SBBH), the special education team, and repeatedly requested our Special Education department head to review the laws and clarify for us how the law impacted teachers, and me specifically in regards to an RBT candidate completing any behavioral analytical procedures related to FBA/BSP. I reminded her there were legal ramifications for noncompliance with the legislation and that I wanted to protect my licensure by complying fully. I asked to defer FBA/BSP's to more qualified personnel in accordance the law, was told to continue to complete them as required or be immediately terminated. I was also told that if I continued to pursue the Registered Behavioral Technician credential and was unable to perform the FBA's/BSP's that I would be immediately terminated.

My colleague and I were forced to write a letter stating that we would would comply with the Principal's directive to conduct a FBA's and develop BSP's for our students or face immediate termination for insubordination. I asked my principal if I continued to pursue the RBT credential what would happen and he reasserted that if I elected to not complete FBA/BSP's as required I would be terminated. I needed to remain employed, therefore I was unable to pursue the RBT credential. Furthermore, my colleague and I were told that if we failed to comply that any prospective employer contacting the school for a reference would be told that we had been fired for insubordinate behavior and refusal to complete our jobs as directed. We were also told that if we "made our stand" on this issue, despite the time and effort spent to achieve our Special Education licenses would be unable gain employment in the state of Hawaii. We were also threatened if we went through our union and grieved this through the HSTA it would be a year long exercise in futility as the administrator "knew special education laws" and we did not. My

administrator claimed that he had spoken to his resources in regards to our request and knew the law and directed us to comply or face immediate termination.

As a result of this request for clarification, I was put on a principal directed development plan to monitor my compliance with this directive. The work environment became hostile. I was told by a fellow colleague that if I was going to leave the school to "leave gracefully." I then began to seek alternative employment and asked my HSTA uni-serve representative for help. Less than three weeks later, I tendered my resignation. I was told that I needed to stop servicing my students in the classroom and work on completing upcoming Individual Education Plans for my two grade levels and another teacher before I left my position. I was told my office was to be moved from the other side of the building where my classrooms were located so that I could be closer to the vice principal and other special education teachers for my last two weeks. Four days prior to my last day, my school email account was disabled. On my last day I was refused access to my personnel records and I was presented with and asked to sign a Notice of Trespass. This is unacceptable. We can not subject our teachers to this kind of treatment for attempting to seek training, ask for clarification, and attempt to understand and comply with legislation to better serve our students. Despite our extensive training, our teachers are not specifically trained nor are they qualified to serve as behavior analysts.

My greatest concern lies with the undeniable negative impact of inadequately trained personnel on our special education students. Teachers should not have to perform behavior analytic tasks that create and drive behavioral support plans and interventions without adequate training and supervision from qualified personnel. Our keiki deserve better.

As a result of my observations and experience, I am currently pursuing my coursework for future certification as a Board Certified Behavior Analyst (BCBA).

Joy Moana Oliveira
Hawai'i Island

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 15, 2017 11:00 AM
To: HLTtestimony
Cc: btklontz@aol.com
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM

SB739
Submitted on: 3/15/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Dr. Brad Klontz	Individual	Comments Only	No

Comments: Attn: Rep. Della Au Belatti, Chair Rep. Bertrand Kobayashi, Vice Chair DEAR COMMITTEE ON HEALTH, I strongly support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of “Behavior Analysis." In fact, the entire field of Behavioral Analysis was created by psychologists and is a standard part of our doctoral training. Thank you for your consideration on this very important matter.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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February 19, 2017

Hawaii Legislature
415 S Beretania Street
Honolulu, HI 96813

Subject: Opposition to SB739

Dear Members of the House and Senate:

My wife and I have been advocating for applied behavior analysis (ABA) services, since we learned it was the most effective treatment recommended for children with autism. Our eldest daughter, Abigail, was diagnosed with autism at age 7, she is 17 today. She did not begin receiving services until 2014; when she was 14 years old. When we began services, Abi had difficulty with her behavior, with changes in routines, with hygiene, socializing with others, and in establishing motivation in developing independence with daily skills. Over the past 3 years of receiving ABA services, Abi has blossomed! She has made tremendous progress with ABA services, provided by a licensed behavior analyst (LBA).

Unfortunately, we are not able to have Abi's services covered by our health insurance. They told us psychologists do not provide ABA services, plus we already had access to psychological services. We petitioned our insurer to cover our daughter's ABA services, particularly because we had already tried every other insurer-available approach, without significant results. Our appeal was denied. Despite this, as a family, we decided to continue with ABA services. With the support of our consultant, who is highly qualified and licensed as a behavior analyst (LBA), our family has made many successful gains; Abi spends more time with the family, we are learning how to effectively interact, and contribute as a household. We have great hopes for Abi and we are relieved to learn that our insurance will begin covering ABA services for her, effective July 1, 2017.

This bill, as proposed stands to open up the providers who can oversee ABA services to individuals who do not have proper training or demonstrated competency in behavior analysis. This bill would also allow individuals trained in autism, not behavior analysis, to be seen as qualified to provide ABA services to our keiki. We have waited too long, fought too hard, and spent too much money, time, and energy to see unqualified providers erode the quality of ABA services, currently being provided in Hawai'i. As parents, we stand in STRONG OPPOSITION of SB 739 and we respectfully ask you to reconsider your support of this very detrimental and backwards legislation.

Mahalo nui,

Calvert and Emily Chun
1054-A Alewa Drive
Honolulu, HI 96817

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 15, 2017 11:21 AM
To: HLTtestimony
Cc: jcwhite54@gmail.com
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM

SB739
Submitted on: 3/15/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Judith White	Individual	Support	No

Comments: Testimony SUPPORTING SB739-SD1 RELATING TO BEHAVIOR ANALYSIS SERVICES Including amendments COMMITTEE ON HEALTH Rep. Della Au Belatti, Chair Rep. Bertrand Kobayashi, Vice Chair Thursday, March 16, 2017 11:00 AM Conference Room 329 State Capitol 415 South Beretania Street I support Senate Bill 739-SD1 with the amendments made by the Senate Committee on Commerce, Consumer Protection, and Health. As a licensed psychologist, I am aware that my scope of practice, as defined in Hawaii state statute, includes the practice of "Behavior Analysis" and includes the direction of psychological assistants in this practice. I am very concerned that the original statute, Act 199, providing for the licensure of Board Certified Behavior Analysts (BCBAs) has been over-interpreted as making it illegal for my students and psychological assistants to provide behavioral interventions under my supervision. The proposed amendments would clarify psychologists' scope of practice as including the supervision of behavioral interventions and would prevent an unnecessary narrowing of the behavioral health workforce by allowing more variety in the acceptable training and certification requirements for paraprofessional workers and their supervisors. Thank you for the opportunity to provide testimony on this important topic. Sincerely, Judith C. White, Psy.D. Kapaa

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Lesley A. Slavin, Ph.D.
317C Olomana Street
Kailua, HI 96734

Testimony Strongly SUPPORTING SB739-SD1 RELATING TO BEHAVIOR ANALYSIS SERVICES
And supporting the amendments proposed by the Hawaii Psychological Association (HPA)

I agree with the Hawaii Psychological Association (HPA) position strongly supporting SB739-SD1 I am a licensed psychologist and the past-president of HPA. My training in clinical psychology at the University of Vermont included an emphasis on behavioral approaches to behavior change. My practice has been primarily in the area of child and family therapy with a specialization in youth with severe emotional disturbances. Unlike some of my colleagues who will be testifying on this bill, I am not an expert in the area of autism. Nonetheless, as a child specialist, my scope of practice and areas of competence overlap significantly with the description of applied behavior analysis (ABA) included in Act 199. For this reason, it is important to me to have the language of that statute changed and clarified.

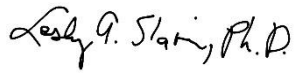
In my role as a supervising psychologist for the Hawaii State Child and Adolescent Mental Health Division, I work with a range of mental health services including in-home interventions and residential treatment programs. These often utilize behavioral approaches (which are defined in Act 199 as ABA) and they frequently include direct services by paraprofessional workers. For example, paraprofessional workers in a residential program may use a point system for all residents, or follow a unique behavior plan to address one resident's problematic behavior. These paraprofessionals are all supervised by mental health professionals who are **not** BCBAs. A literal reading of Act 199 as it stands would lead to the conclusion that this is "illegal." If so, CAMHD will need to shut down many of its services to children and youth with serious emotional disturbances and close its residential programs.

I know that this was not the intention of the legislature in passing Act 199, and the BCBA group is not eager or equipped to take on all of these mental health services for high-end youth, but I raise this to emphasize the how vital it is for other, non-BCBA mental health professionals to supervise the work of direct service providers of behavioral interventions in our state. The revision in the definition of ABA and the other amendments included in this version of SB739 address these concerns well. [Please note that I am not testifying on behalf of CAMHD or the Department of Health]

This law amending Act 199 would make it clear to everyone that it is perfectly legal for licensed mental health professionals to supervise direct service providers within their scopes of practice, including supervising them on the use of behavioral techniques and interventions.

Thank you for the opportunity to provide input on this important bill.

Respectfully submitted,



Lesley A. Slavin, Ph.D.

I stand in opposition of SB739 SD1.

Mahalo Senator Baker and the CPH Committee for limiting the credentials to the BACB. The alternative credentialing boards BICC and QABA are concerning to me as an autism parent because the direct support worker and supervisor do not need demonstrated competency in ABA, in addition to having 0 credentialed individuals in Hawai`i. Only the BACB has a comprehensive ethical compliance code which include cultural competency. It is absolutely vital to have an understanding of the unique culture of the people of Hawai'i not only to build repore but trust with their loved ones. The language in SD1 need revisions for clarity, in efforts to maintain consumer protection.

Health Insurance (Medicaid and commercial) plans are limiting the access to medically necessary treatment based on the premise that "DOE provides ABA". So both my children can only receive ABA either before or after school hours, really limiting providers and families. There have been no observable efforts from the DOE to increase the workforce or financially support the efforts of staff who are currently pursing board certification. What's even more concerning is that the DOE is leaving federal money untouched specifically to address the needs of our students in special education.

School Based Claiming

> "State of Hawaii's objective to maximize federal revenue for off-setting the cost of providing health and education services to children with special needs, the Hawaii Legislature of 2005 passed Act 141. The purpose of the Act is to authorize the Department of Education (DOE) to establish and implement a federal maximization program for all Medicaid-eligible health services provided to Hawaii's school-aged children. Pursuant to the Act, the DOE became a Medicaid provider. This designation allows the DOE to claim reimbursement for health-related services provided to special education students who are also enrolled the state Medicaid program known as Med-QUEST." (Department of Education State of Hawaii, 2010)

Part of the language that needs clarity in SB739 SD1 was intended to carve out Licensed Psychologist, however what the Hawai'i Psychological Association's adopted language did was open the direct support worker and supervisor to any unlicensed and licensed professional respectfully. In addition to the intent of DOH-DDD to include foster families or "caregivers" however the potential harm to use strategies without assessments are not considered best practice in the field of ABA.

Mahalo,
Naomi Tachera

References

Department of Education State of Hawaii. (2010, 5 5). *Schhol Based Claiming*. Retrieved from Department of Education State of Hawaii:

https://lilinote.k12.hi.us/STATE/CCCO/SBCWeb.nsf/By+Category/A2CC00FE94D7D1570A2575A8000E236B?OpenDocument

Sean W. Scanlan, Ph.D.
Licensed Clinical Psychologist
1019 University Ave. #6A
Honolulu, HI 96826

3/14/17

To: Representative Della Au Bellati, Chair, Senator Bertrand Kobayashi, Vice Chair, and Members of the Committee on Health

Hearing: Thursday, March 16, 2017, Conference Room 329

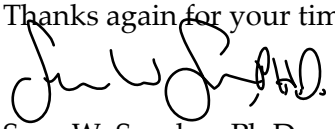
Re: Testimony in **STRONG SUPPORT** of SB 739, SD1, Relating to ABA Services

Thank you so much for taking the time. I'll try to briefly introduce myself. I have been working with children with ASD since 1997, and supervising aides since 2000. I have my Ph.D. in Clinical Psychology and was licensed by the State in 2005. To be licensed, we are required to have 4,000+ hours in supervised training. When I was applying for licensure, they actually said that I had too many hours of work with only the ASD population, and I had to prove that I was trained in other areas. Thankfully, I was. In my ASD experience, I worked in the role of an Autism Consultant with the DOE and DOH, ran 2 ABA-based biopsychosocial programs with 75+ children with ASD, and was the director of CARE Hawaii's autism services (ensuring the appropriate provision of services related to D.O.E.'s intensive instructional services contract, including management of services of 100+ providers). Over the years, I've attended dozens of workshops by prominent ASD experts (e.g., Lovaas, Leaf), read numerous books and articles by prominent authors (e.g., the Koegels, Schopler, Seigal, Granpeesheh, Lovaas, Leaf, Harris & Handleman, Smith), and was intensively supervised by several psychologists and BCBAs. Currently, I have a private practice, but I continue to oversee ABA programs (and the paraprofessionals on the cases) for children with ASD.

Along with many of my colleagues who are licensed psychologists trained in ABA, I am requesting that the legislature amend the new law to make it clear that licensed psychologists and other qualified practitioners are able to **continue** supervising paraprofessionals in the implementation of ABA/behavioral interventions in addition to continuing to train their respective students, interns, and post-doctoral trainees.

Unfortunately, current phrasing has left room for misinterpretation, and it seems unfair that this ambiguity might restrict me from helping the kids that I've helped for almost 20 years. And considering how much help this population needs, I don't think it was the intent of the law to be adding restrictions at this time.

Thanks again for your time.



Sean W. Scanlan, Ph.D.
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From: mailinglist@capitol.hawaii.gov
To: HLTtestimony
Cc: jfed411@gmail.com
Subject: Submitted testimony for SB739 on Mar 16, 2017 11:00AM
Date: Wednesday, March 15, 2017 2:18:53 PM

SB739
Submitted on: 3/15/2017
Testimony for HLT on Mar 16, 2017 11:00AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
jessica federowicz LBA BCBA LMHC	Individual	Comments Only	No

Comments: Aloha) it seems like there should be a clause in the bill that allows for licensed master or doctoral level providers who are knowledgeable of the principles of bx and have experience in the field of bx analysis to supervise RBTs and work on ABA cases. This would ensure that licensed clinical and general psychologists are not excluded from the pool of supervisors granted they have knowledge and experience in bx analysis (which is not all of them). I think The concern is that psychologists who do not have this knowledge base would be eligible to provide the service even if it out of their scope of practice. Most importantly, kids with ASD are unable to receive treatment at this time and are often put on long wait lists because there is such a lack of BCBA providers on island. It is likely that we can expand the provider pool significantly (maybe even double) if we include other licensed professionals who have just as much knowledge and experience in the field of behavior analysis. Anyways, just my thoughts.. see you at 12:45 :) Jessica Federowicz LBA BCBA LMHC

LATE

3-16-17

Good Morning Representatives,

My apologies for my late testimony. I am fighting daily for Luke. Today I am meeting with DVR and cannot be here to testify.

I am in opposition to people delivering services to our keiki who are NOT certified Applied Behavior Analysts.

Luke's one service he receives is being seen by a psychologist at Kapiolani and Luke still doesn't get applied behavior analysis. The psychologist says I'll work with you parents who in turn can work with Luke. When I ask about his behaviors of anger and throwing things I am told to treat him like a two year old. And unlike helping a tantruming two year old, helping a tantruming 17yr. old is VERY different.

Luke has attended Hawaii Department of Education Schools since age three. He left elementary school with a 2.2 reading level. He just had his IEP. He has one more year till he's a graduating senior and age 18. Remember how Representative Sylvia Luke and others saw the potential in him? Well at the IEP it was reported out that his reading level is now……. 2.2. What?!!

Luke has never been offered ABA in all his years in the Department of Education. I had to fight at his last IEP for an FBA. Then after waiting a long time I was told it was going to be completed by someone who is not a licensed Behavior Analyst. I said no. I **fought** again. I waited and waited and wrote letters of plea and waited and waited.

Ok, I know how to wait but Luke CAN NOT wait! He CAN NOT afford it.

Luke complains daily about his school environment. He has tried to problem solve on his own to try to get out of that environment but he is relying on **YOU** to help him. You see if you ALLOW people who are not certified in Applied Behavior Analysis to practice ABA it will hurt Luke and kids like him.

Let's not go backward Hawaii. Move forward and continue to have a solid plan with **solid credentialed skilled people**.

With great hopes,

Gerilyn Pinnow M.Ed.