**TESTIMONY OF JOYCE BERNHEIM, JD**
**ON SB 135 -2 AMENDMENTS**
March 12, 2019

## 1. Introduction

My name is Joyce Bernheim. I am submitting this testimony as the parent of a 24-year old son with autism spectrum disorder (***"ASD"***) who practiced health care business law in Portland for 20 years. My resume, which outlines my personal and public career in greater detail, is attached. However, let me highlight a few points here. As a lawyer, I represented a great many health care organizations and professionals from all over the state. I was involved in health professional disciplinary issues through hospital medical staff processes, employment agreements, and licensing agency actions. Through that work I became familiar both with the general structure of health care licensure and the types of disputes that arise when trying to discipline health care professional practice.

As a parent and someone trained to obtain and analyze evidence, for much of the past 20 years I have also been engaged in studying the current scientific research on human social behavior, including but not limited to how that research relates to ASD and other mental health disorders. During that time I have also been extensively involved in public policy issues concerning ASD.

Thus, in my capacities as a parent, a lawyer, and a person engaged in public policy arenas, I have engaged continuously with health professionals and educators from various disciplines from all over the state for 35 years.

## 2. Summary of Testimony

**2.1.** I support SB 135 and the -1 amendments.

**2.2. Scope of Practice Issues.** Insofar as the -2 amendments change the licensure regime for the practice of ABA into an enforcement regime, it raises significant scope of practice questions that can only partly be resolved with minor tweaks to the current bill. Specifically, the current statutory definition of ABA is extremely broad and fails to provide a clear standard to distinguish ABA from psychology, education, and activities that should not be considered the practice of a health profession.

Since ABA is a subdiscipline of psychology, administrative and enforcement support for the Behavior Analysis Regulatory Board (the ***"BARB"***) should be transferred from the Health Licensing Office to the Mental Health Regulatory Agency, which provides these services for other mental and behavioral health licensing agencies. The Mental Health Regulatory Agency would be better placed to resolve boundary disputes between ABA and other mental and behavioral health professional practices.

Even if that step is taken, the -2 amendments and the statutory definition of ABA do not provide a sufficient basis to distinguish ABA from teaching both inside and outside of schools. A number of stakeholders have only recently become aware of the -2 amendments and their potential impact on them. A deliberative process to gather further input from a broader range of stakeholders should be considered in order to develop a clearer standard for what constitutes the practice of ABA as a health care profession regulated by the BARB. The -2 amendments could have significant unintended consequences in schools and deprive families of services currently being provided by knowledgeable individuals who are helping their children.

**2.3.** Stronger consumer protection can and should be considered before SB 135 is voted out of the Senate Committee on Health Care. Specifically, language should be added to regulate the use in patient care of individuals who are fulfilling experience requirements for various levels of ABA practice. At a minimum, no individual should be allowed to engage in patient care without verification of the individual's education and performance of a criminal background check.

## 3. Scientific and Regulatory Context of SB 135 and the -2 Amendments.

SB 135 comes at the end of a long history of struggle to understand ASD spectrum disorder ("***ASD***") as a distinct disorder and to develop and obtain services for those who have it. In order to understand the bill and the nature of my reservations about it, it is necessary to review some of this history.

### 3.1 ASD and ABA In the 1980s.

Although some clinicians recognized ASD as a syndrome starting as early as the first years of the 20th century, it was not until 1980 that it was first officially recognized as a separate disorder by the bible of mental health diagnostic classification, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS ( 3rd ed. 1980) (Various editions of this manual are abbreviated as the ***"DSM,"*** with the edition number hyphenated at the end. The current edition is the DSM-5, published in 2013.) The DSM forms the backbone for the diagnosis, treatment and reimbursement of mental disorders in the United States. The current version was the result of 14 years of work by multidisciplinary panels of researchers and clinicians in various clinical areas using systematic reviews of the research literature, taking broad public input, and performing field trials to ensure the reliability of the resulting diagnostic categories and the diagnostic criteria for each. Darryl A Regier et al, "*Introduction," in* THE CONCEPTUAL EVOLUION OF DSM-5 (Darrel A. Regier, et al., eds., 2011).

One of the dominant theories of human behavior in United States departments of academic psychology from the early 20th century until well into the second half of

the century was behaviorism, a theory championed by its best-known proponent, B. F. Skinner. Behaviorism rests on a view "from the outside," in which various environmental "stimuli" are held to be responsible for human behavior by means of either rewarding or adverse consequences, which results in the individual altering behavior in order to increase rewards and reduce adverse consequences. Within the field of behaviorism, this process has sometimes been called learning, and behaviorism is thus sometimes referred to as learning theory (although not all behaviorists employ this term in the context of ABA and a great deal of subsequent scientific research has shown that learning involves quite a bit more than stimulus-response interactions based on rewards and adverse consequences). **See** MORTON HUNT, THE STORY OF PSYCHOLOGY (2007), chap 9.

For a number of decades prior to 1980, the dominant theory of the cause of ASD was cold and distant parenting by the mothers of children with ASD, as popularized by the work of Bruno Bettelheim in such works as THE EMPTY FORTRESS (1967). Given that ASD was thought to result from the behavior of parents and behaviorism focused on changing behavior, the match between ASD and behaviorism seemed perfect. Ivar Lovaas was the first to use behavioral techniques as an ASD intervention in the mid 1960s, which culminated in the publication in 1981 of his influential book, TEACHING DEVELOPMENTALLY DISABLED CHILDREN. Although early claims that ABA could cure ASD proved to be vastly overblown, ABA attracted an ardent following among the parents of some children with ASD. Yet the belief that ABA is the best intervention for all children with ASD is far from universal for reasons that are discussed below. **See** JOHN DONVAN, CAREN ZUCKER, IN A DIFFERENT KEY (2016), chaps 18, 19.

ABA as an intervention approach rests on the theoretical underpinnings described above. That this theoretical infrastructure remains the core of ABA practice can be seen from three sources. The first is the definition of ABA that has been adopted into the Oregon statutes establishing the Behavior Analysis Regulatory Board, ORS 676.802(1), which reads as follows:

> (1)(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.
>
> (b) "Applied behavior analysis" does not mean psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy or long-term counseling as treatment modalities."

Second, this theoretical infrastructure can be seen in the required coursework for applied behavioral analysis masters and doctoral degrees. For example, at Florida State University, one of the leading ABA training programs in the country, applicants are not required to have an undergraduate degree in psychology before they enter

the program. The graduate program does not require students to take coursework in any other psychological theories or intervention approaches, neuroscience, or psychopathology generally. Requirements for obtaining a masters degree include a full semester's course on Skinner's theory of behaviorism, and are almost exclusively focused on applied behavioral analysis. https://pc.fsu.edu/academics/graduate-programs/ABA/ABA-program.

Third, this theoretical framework is evident from the description of behavior analysis offered by the Behavior Analysis Certification Board (the national certifying body for behavior analysts), which states, among other things,

> "[The] underlying philosophy [of applied behavioral analysis] is behaviorism, which is based upon the premise that attempting to improve the human condition through behavior change (e.g., education, behavioral health treatment) will be most effective if behavior itself is the primary focus, rather than less tangible concepts such as the mind and willpower. To date, basic behavior-analytic scientists have conducted thousands of studies to identify the laws of behavior; that is, the predictable ways in which behavior is learned and how it changes over time. The underlying theme of much of this work has been that behavior is a product of its circumstances, particularly the events that immediately following the behavior." https://www.bacb.com/about-behavior-analysis/

I believe that behavioral approaches are an important tool in the toolbox of those caring for children with ASD and I do not seek to deny either such services or insurance coverage for ABA. I do, however, believe that the sciences of human behavior and the scientific understanding of ASD have evolved greatly in recent decades, and that sound public policy should take into account this broader scientific context.

### 3.2 The Behavioral Sciences Since the 1980's.

In 1987, B.F. Skinner himself acknowledged that behaviorism as a theory has some critical gaps:

> "A behavioral account has two unavoidable gaps – between stimulus and response, and between reinforcement and a resulting change in behavior. Those gaps can be filled only with the instruments and techniques of [neuroscience]. A complete account is no doubt highly desirable but the [neuroscience] is not what behavior really is; the two sciences deal with separate subject matters. A third discipline may very well wish to deal with how the two can be brought together, but that is not my field." Quoted in JAAK PANKSEPP, AFFECTIVE NEUROSCIENCE (1998) at 12.

Since the late 1980s, neuroscience, genetics, developmental psychology, social psychology, evolutionary biology, and a host of other disciplines have worked to fill

in the gaps Skinner alluded to. With the advent of imaging technology in the 1990s there has been explosive growth in understanding how the brain uses both internal and external sensory data to orchestrate behavior. With the advent of gene sequencing we are rapidly gaining insight into how brains are built through the unspooling of genetic processes. Meanwhile, the field of cognitive behavioral therapy has enjoyed tremendous success in treating a host of mental disorders and creating behavioral change precisely by working with concepts like the mind. In 2019 few scientists, physicians, or psychologists outside the discipline of ABA would agree that stimulus response learning is the primary source of behavior or that "behavior is a product of its circumstances, particularly the events that immediately follow the behavior." Rather, a good deal of work in the behavioral sciences has established that behavior is the product of events, structures, and processes within the organism and the species that ***precede*** the behavior and are not created solely by learning. **See, e.g.,** ROBERT SAPOLSKY, BEHAVE (2018) (review of the contemporary science of behavior as studied by multiple disciplines; organized by analyzing events from seconds to millions of years before a behavior and emphasizing that the exact same behavior can be either bad or good, depending on the context), MICHAEL TOMASELLO, BECOMING HUMAN (2019) (human language, culture, and social interaction rest on an evolved psychological infrastructure driven by unlearned pro-social motivations to interact with, cooperate with, help, respect, and imitate others, as well as by cognitive abilities to co-ordinate different perspectives; the development of children's social behavior follows a predictable sequence reflecting biological, emotional, and cognitive developments, all of which are necessary to produce typical social behavior). The current scientific consensus, therefore, is that you can't understand behavior without understanding the biology, the psychology, ***and*** the environment. To put it in very simple terms, if ABA provided a complete understanding of behavior, you could train a cat to be a dog and every child with ASD who had ABA therapy would be cured. As we all know, neither is true.

### 3.3 ASD Research Since the 1980s.

Turning to ASD itself, many researchers now believe that ASD is not a single biological disorder. Rather, the best scientific evidence supports the view that ASD results from a myriad of brain differences at birth that affect the ability of the infant to engage in typical social emotional interactions, first with caregivers and then with others. These brain differences are thought to be the result of both inherited genes and new mutations, as well as other factors within the uterus during fetal development. More than a hundred gene mutations have been associated with ASD, most of which appear to be involved in brain development, but none of which accounts for more than a few percent of the ASD population. **See, e.g.,** Yamimi J. Howe, et al., *Genetics of ASD Spectrum Disorder*, *in* AUTISM SPECTRUM DISORDER (Christopher J. McDougle, ed., 2016).

This is consistent with the tremendously variable nature of the ASD population. Different types of functioning are affected in different ways and to different extents in different individuals with ASD. For example, some children with ASD are

hypersensitive to sound, while others are hypersensitive to touch, and still others are under sensitive in one or more internal or external sensory systems. Some children have problems in the motor systems sensing or controlling their facial muscles or gait. Some are nonverbal, some are minimally verbal, and some have verbal skills approaching the typically developing. **See generally**, AUTISM SPECTRUM DISORDER, **supra**, HANDBOOK OF ASD AND PERVASIVE DEVELOPMENTAL DISORDERS (Fred R. Volkmar et al, eds., 2014). Meanwhile, almost all of the symptoms of ASD, including the ones most closely identified with it in popular culture, are seen in other mental disorders. DSM-5.

Adding to this complexity is the very high rate of co-occurring mental and physical conditions. Recent studies have shown that over 95 percent of children with ASD have at least one co-occurring condition, and more than 50 percent have 4 or more co-occurring conditions. GN Soke, et al, *Prevalence of Co-occurring Medical and Behavioral Conditions/Symptoms Among 4- and 8-Year-Old Children with ASD Spectrum Disorder in Selected Areas of the United States in 2010*, *in* J ASD DEV DISORD, https://doi.org/10.1007/s10803-018-3521-1 (2018).

What ties this diverse population together in large part results from how the biological differences of newborns with ASD interfere with their engaging in social interaction very early in life. This affects both foundational steps in psychological development and the considerable part of brain development that occurs during the early childhood period. TOMASELLO, **supra,** DANIEL SIEGEL, THE DEVELOPING MIND (1999) at 13-15.

Under the DSM-5, a diagnosis of ASD requires significant impairments in "social emotional reciprocity." DSM-5 at 50. This is a concept that arose within the field of infant developmental psychology (not behaviorism). **See, e.g.,** ED TRONICK, THE NEUROBEHAVIORAL AND SOCIAL-EMOTIONAL DEVELOPMENT OF INFANTS AND CHILDREN (2007) at 178 et seq (brief history of the term and related concepts with respect to infants). Social emotional reciprocity pertains not just to behavioral responses to environmental stimuli, but also to an individual's innate capacities to feel and her desire to engage emotionally with others. Similarly, the second and third criteria for identifying ASD, are not intelligible outside of a framework that includes psychological states – precisely the types of entities that behaviorism eschews.

Within the landscape of human behavioral science and the science of ASD, therefore, ABA occupies a limited territory. As we broaden the licensing regime for ABA and move into authorizing civil penalties, the legislature should be sure that a broader swath of professionals in the behavioral sciences have given some thought to where the practice of ABA as a health profession starts and ends.

### 3.4 History of ABA Regulation In Oregon.

The regulation of ABA practice in Oregon arose in conjunction with demands for insurance coverage of ABA by parents of children with ASD. For many years parents paid for ABA therapies out of pocket because insurance companies denied coverage for ABA. In response to persistent litigation and parental lobbying, in 2007 the Oregon legislature passed a law prohibiting the denial of insurance coverage for children with developmental disabilities. ORS 743A.190. Some insurance companies still denied coverage, leading to further litigation in federal district court under mental health parity laws. While that litigation was still underway, Paul Terdal, the proponent of SB 135 and the -1 and -2 amendments, succeeded in shepherding through the legislature a temporary insurance mandate specifically for ABA, Chapter 771, Oregon Laws 2013, with the strong support of the ASD Society of Oregon, among others. Section 2 of the law provides for insurance coverage of ABA. Section 3 of the law established the Behavioral Analysis Regulatory Board to govern the licensure and regulation of the individuals authorized under state law to provide the services covered under Section 2.

The provisions of Section 2 were further revised by Chapter 674, Oregon Laws 2015 (codifed at ORS 676.802 et seq). That legislation was prompted by attempts of the BARB to govern the practice of other licensed health professionals insofar as their activities might be described as providing ABA. The 2015 revisions were not widely discussed within the ASD community as a whole, and few people outside the ABA community understood them as part of a long term plan to establish full and independent licensure for ABA practitioners.

The 2015 revisions can be considered an intermediary step in the evolution of the ABA licensure category. Section 5 of the 2015 act (current ORS 676.820) did several things. First, it reconstituted the BARB, reducing the presence of behavior analysts to four out of nine seats on the Board. Notably, the right to practice ABA was no longer tied to ASD, although the three health professional seats on the BARB must be held by individuals "with experience or training in treating autism spectrum disorder." ORS 676.806 (1)(b) – (d). Second, it gave individuals licensed by or registered with the BARB the right to practice applied behavior analysis. Third, it gave such individuals the exclusive right to use the titles, "licensed behavior analyst," "licensed assistant behavior analyst," and "registered behavior analysis interventionist." And finally, it exempted other licensed health professionals from ABA licensure. Given the shaky performance of the BARB under the 2013 legislation, it specifically did not give the BARB the authority to regulate any professionals other than those submitting themselves to its jurisdiction via licensure or regulation. It is this omission that brings us to the -2 amendments to SB 135.

## 4. Scope of Practice Issues Raised By the -2 Amendments

As mentioned above, many in the ASD community did not fully appreciate the thrust of the 2015 amendments to the ABA licensure scheme and have only recently

become aware of SB 135. The -2 amendments clearly raise several scope of practice issues in the context of granting authority to impose fines and other sanctions.

**a. Which Interventions Qualify As ABA and Which Do Not?**

Historically, the intervention approach most closely associated with ABA was discrete trial training, a form of therapy in which short behavioral challenges are introduced in an artificial, one-on-one setting, and a child's behavioral response is met with either a reward or an adverse consequence (sometimes referred to as a "punishment," which in the 1980's involved actual physical punishment, such as pinching or the use of electrical shocks). The technique of fading prompts over time has been used in order to generalize behavior to other contexts without prompts. As the practice of ABA evolved, the punishment side of the equation subsided and increasing attention was paid to behavioral challenges in less structured settings.

Once you leave behind discrete trial training, the picture begins to get somewhat less clear. Pivotal response training, or PRT, draws on behavioral learning principles but also focuses on and uses the child's individual motivations and choices. Here we are necessarily taking a step toward those psychological states that are not an explicit part of "behavior." Nonetheless, PRT is without doubt considered an ABA intervention.

Apart from discrete trial training and PRT, there are a number of intervention types that are primarily based in other disciplines and theoretical frameworks or that are blended models drawing on both ABA and other disciplines and theoretical frameworks. Such interventions draw on standard features of all sound teaching and professional practice, but might fall under the very broad legal definition of ABA incorporated into the Oregon statutes. Some of these interventions are offered by ABA programs to supplement their more strictly behavioral approaches while others are not.

One example is DIR Floortime, an intervention pioneered by the child psychiatrist Stanley Greenspan. It is rooted in developmental psychology proper, and, to that extent requires some grounding in that discipline, as well as training in the model and intervention techniques. It has been offered by ABA programs in Oregon. Does DIR Floortime fall within the scope of practice of ABA even though its theoretical framework arises from another branch of psychology that behavior analysts are not expected to be trained in?

Another example is the Early Start Denver Model (***"ESDM"***), developed by Sally Rogers and Geraldine Dawson, among others. While it incorporates behavioral principles, ESDM also draws "directly from developmental and child clinical psychology, early childhood education, speech pathology, [and occupational therapy]." SALLY ROGERS AND GERALDINE DAWSON, EARLY START DENVER MODEL FOR YOUNG CHILDREN WITH ASD (2010) at 36. In the words of those who developed this approach, "Any individual who is using the ESDM needs background in the

knowledge base, concepts, and practices from these disciplines. This is most easily gained within a team of early interventionists who can cross train each other in the concepts and practices underlying ESDM." Id.

The challenge of distinguishing ABA from other interventions grows directly from the broad definition currently contained in ORS 676.802(1). Careful examination of the definition shows that it could encompass virtually any intervention that falls short of physical procedures on an individual's body, drugs, or biologicals. Many of us (whether we are health care providers, lawyers, or parents) spend much of our days planning, implementing, and using behavioral stimuli and consequences to change other people's behavior. Much of that effort is directed at producing an improvement in other people's social behavior. In the course of those efforts, we observe what other people are doing and we often analyze what is causing the behavior we hope to change. In many contexts we assess the outcomes of our efforts, and analyze what we should do next to further improve the results. When does that process leave the realm of everyday life and turn into ABA?

The current statute specifically states that those who are licensed by other health professional licensing bodies do not have to be licensed by the BARB, and it specifically lists therapies that are not ABA. However, within the universe of interventions for ASD and other conditions there remain a large number that rely on "behavioral stimuli and consequences," but that many people would not characterize as ABA.

In this context, it is worth remembering that, in essence, ABA is a subdiscipline of applied psychology. To a significant extent these scope issues constitute boundary disputes between the practice of psychology and the practice of ABA. In 2017 the legislature established the Mental Health Regulatory Agency to provide administrative and enforcement services to the Oregon Board of Psychology and other mental and behavioral health licensing boards. Apparently, no one thought to include the Behavior Analysis Licensing Board in the list of boards receiving administrative and enforcement services from the Mental Health Regulatory Agency, but I believe that the Mental Health Regulatory Agency is the more appropriate body to provide these services to the BARB. 675.160(2) gives the Mental Health Regulatory Agency the authority to: "Resolve disputes between regulated boards regarding the scope of practice of persons with authorizations in regulated professions." A body with greater expertise in mental health is better charged with resolving scope of practice disputes regarding mental health professions than one more focused on the physical health care professions.

Transferring administrative and enforcement services to the Mental Health Regulatory Agency would go a long way toward alleviating concerns about the very broad definition of applied behavior analysis. I believe, however, that further consideration should be given to clarifying precisely which techniques constitute the practice of ABA as a health care profession and which do not. Enforcement agencies must apply the standards set forth in the licensing statutes. We believe

that current definition of ABA is too broad to provide meaningful guidance to an enforcement agency.

**b. When Is ABA Treatment and When Is It Education?**

One reason for the years of litigation and legislative efforts relating to ABA is that those within education considered interventions for the core symptoms of ASD to be health care and those within health care (or at least health insurance companies) believed they were education. As noted above, Ivar Lovaas' seminal work on using ABA in children with ASD was titled TEACHING DEVELOPMENTALLY DISABLED CHILDREN. And indeed, many of the activities that help individuals with developmental disabilities like ASD are both health care ***and*** education. It is not unusual for studies of interventions for ASD to report increases in IQ as a primary outcome, even though IQ has nothing to do with the criteria for diagnosing ASD.

The proponents of the -2 amendments may claim that educators are exempted from regulation by the BARB because Section 3 proposes to prohibit the practice of ABA without BARB licensure only for treatment purposes and not for educational purposes. The -2 amendments would insert a new subsection (2) into ORS 676.820 as follows:

> "(2) An individual may not practice applied behavior analysis for the purpose of treating a mental, emotional or behavioral disorder unless the individual is licensed under ORS 676.810 or registered under ORS 676.815. This subsection does not apply to:
>
> (a) A licensed health care professional; or
>
> (b) A family member of a patient if the family member is acting at the direction of an individual licensed under ORS 676.810 or a licensed health care professional."

Family members are not ordinarily considered to be practicing a health care profession when they are following orders from a licensed health care provider, so an exemption for family members is somewhat anomalous to begin with. Moreover, under standard rules of statutory construction, by expressly excluding family members but not educators, the -2 amendments establish the presumption that educators are covered by the prohibition in this provision.

Possibly because of the difficulties of drawing clear lines between education and treatment, the Behavior Analysis Certification Board's Model Act includes a provision exempting from ABA licensure:

> "K. Individuals employed by a school [board, district] performing the duties of their positions. Such individuals shall not represent themselves as Licensed Behavior Analysts or Licensed Assistant Behavior Analysts unless

> licensed under this Act, and shall not offer applied behavior analysis services to any persons or entities other than their school employer or accept remuneration for providing applied behavior analysis services other than the remuneration they receive from their school employer." Model Act at 12.

A Pennsylvania bill before that state's legislature in 2018 contained exemption substantially in this form. https://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2017&sessInd=0&billbody=H&billtyp=B&billnbr=2725&pn=4258 at 7-8.

Education organizations might wish to amend this language, but something like it would at least clearly exempt educators in schools. (Note that the Model Act languge omits behavior analysis interventionists for reasons that are not explained.)

However, there are also a number of educators with masters degrees and higher who have significant experience as special educators of children with ASD and who are currently teaching social skills to children with ASD in Oregon outside of school settings. If they were teaching math or English they would be considered tutors. Some parents have found such services extremely helpful. They may be the only privately available services of this nature in their area, or the only ones the parents can afford, or the ones with whom their children have the greatest rapport. They do not seek health insurance coverage for their services, but their services arguably fall within the very broad definition of applied behavior analysis set forth in ORS 676.802(1).

So again we must ask, what turns general principles of teaching and supporting behavioral change into the health profession of applied behavior analysis? Is it the fact that you are teaching a child with a mental health or physical health diagnosis? The fact that you hold yourself out as offering ABA? Or that you represent yourself as providing "treatment?" Or that you think about your actions in terms of the specific vocabulary of behaviorism? Or that you seek health care reimbursement? Or that you keep and analyze data on the success of your efforts (and if so, how often do you have to take data and analyze the effects of your actions)? Obviously, no law can cover every eventuality through a verbal formula, but the current definition of ABA so obviously bleeds into other disciplines and no disciplines at all that it fails to establish a clear standard for a regulatory agency to apply in an enforcement action.

## 5. Consumer Protection Issues Raised By the -2 Amendments

The apparent impetus for the -2 amendments was the case of an unregistered ABA interventionist who was employed by a Portland area ABA program in the home of a child with ASD and who was recently convicted of raping her client. https://www.oregonlive.com/crime/2019/03/behavioral-therapist-28-found-guilty-of-raping-sexually-abusing-13-year-old-autistic-boy-in-her-care.html

The interventionist apparently did not comply with the existing ABA licensure law, but unless the interventionist had already been convicted of a criminal offense, neither the existing laws nor the -2 amendments as proposed would have prevented the tragic situation in this case. Licensure laws simply do not prevent sexual assault, as the case of Larry Nasser has so abundantly shown. Nonetheless, this case has revealed some weaknesses in the current licensure regime.

We understand that a number of ABA programs have been hiring unregistered interventionists and failing to follow up to ensure registration after they have been placed in service. This type of situation apparently arises in part because of provisions in 676.815 that require practicum experience before full registration is granted.

We believe that there are additional steps that can be taken to address the regulatory weaknesses revealed by this case. The Behavior Analysis Certification Board (the national accreditation organization for behavior analysts) has developed a Model Act for Licensing/Regulating Behavior Analysts, (the ***"Model Act"***), https://cdn.ymaws.com/www.apbahome.net/resource/resmgr/pdf/APBA_ModelLicensureAct_Aug20.pdf. That Act contains exemptions for those gaining practicum experience, Model Act at 11, but a better solution would be to require another registration designation for trainees, which would include a requirement that verification of education and a criminal background check be completed before the individual is allowed to see clients, and a prohibition on the use of such individuals after a designated period of time unless full licensure or registration is obtained. Additionally, the licensure process could be strengthened by including provisions along the lines of the following:

> "(1) No licensed behavior analyst may supervise the practice of applied behavior analysis by another person without first having verified that the Behavior Analysis Licensing Board has issued the licensure or registration required for that individual's role.
>
> "(2) No person or entity offering applied behavior analysis to the public may use the services of a behavior analyst, assistant behavior analyst, or behavior analysis interventionist without first confirming the licensure or registration of the prospective employee, independent contractor, or subcontractor."