BTEC Behavioral Therapy, Inc.

Dear Parents and Caregivers,

Welcome to BTEC Behavioral Therapy! We're confident we can supply the best possible care for both you & your child and look forward to the wonderful possibilities the future holds for your family!

If this is your first experience with ABA therapy, the amount of information you've encountered may seem overwhelming. We've compiled a list of questions that we're commonly asked in hopes that you will feel more comfortable with the important step you are taking for your child.

Please know that we are always available to discuss any questions or concerns you might have. We provide frequent parent training concurrently with your child's therapy sessions to discuss the procedures we are using and the progress your child is making. It's imperative that we all work as a team for your child to reach his or her fullest potential, and we believe open communication is key in this ongoing process.
Thank you for giving us the opportunity to improve your families' lives!

Sincerely,

The BTEC Team

8550 University Pkwy, Pensacola, FL 32514
12385 Sorrento Rd. Suite C-3, Pensacola, FL 32506
151 Mary Esther Blvd. Suite 311, Mary Esther, FL 32569
1186 Eglin Pkwy., Shalimar, FL 32579
www.btectherapy.com
Phone: 850-483-1508
FAX: 850-435-7704

- **What is ABA Therapy?**

ABA stands for Applied Behavior Analysis. It is based upon scientific principles of behavior to build socially useful repertoires and reduce problematic behaviors. It is based upon the premise that all behavior (whether verbal, socially appropriately or socially inappropriate) is influenced by one's history of reinforcement.

The goal of an effective ABA intervention is to identify what reinforcing properties are maintaining an undesired behavior (i.e., causing the behavior to continue to occur), and teaching a replacement behavior that will provide those same reinforcing properties. ABA therapy is an ongoing process that consists of assessment, teaching small incremental and measurable steps of skills (often in one-on-one settings), providing appropriate reinforcement for each step, data collection, assessment regarding progress, and adjustment of interventions dependent on behavior change.

- **How effective is ABA Therapy?**

ABA is considered by many researchers and clinicians to be the most effective evidence-based therapeutic approach demonstrated thus far for children with autism. The US Surgeon General and American Psychiatric Association have both recognized ABA as the best practice evidence-based treatment, as it has passed scientific tests of its usefulness, quality, and effectiveness.

Over 550 published research studies indicate that young children affected by autism who are treated with ABA procedures exhibit substantial improvement in many adaptive, useful skill areas and reductions in problematic behaviors.

- **What is a BCBA?**

B.C.B.A. stands for Board Certified Behavior Analyst. Effective use of ABA therapy requires special training by qualified practitioners. In order to become certified as a BCBA, a practitioner must hold at least a Masters' degree and have completed

additional post-graduate course work (including but not limited to 1500 hours of field experience).

A BCBA's oversight and supervision is essential for treatment of children with autism. Research has demonstrated that providing ABA therapy to children with autism by individuals without specific training can potentially cause more harm than good and may increase aberrant behaviors.

- **What will my child be doing during therapy sessions?**

ABA therapy is a broad approach, rather than a "cookie cutter" method of intervention. The activities and methods used with your child will be uniquely tailored to his or her needs, abilities, deficits, and strengths. No one child's therapy will be exactly the same as another's. Therapy at BTEC is conducted exclusively by our team of experienced BCBAs in a manner that promotes generalization of skills to other environments outside of therapy. We do this by allowing children to "lead" by identifying what they are interested in (often referred to as Natural Environment Training) and utilizing those interests in order to teach important developmental skills in manners that will be "naturally" reinforced in other settings.

One of the first things we do with your child at BTEC is begin the process of "pairing." This involves creating an environment that your child finds reinforcing, as well as establishing ourselves, as therapists, as reinforcers for your child. This is an ongoing process that continues throughout your child's therapy but is particularly important at the onset.

Once your child has had the opportunity to "pair" with his or her Behavior Analyst and BTEC's physical environment, it then becomes appropriate to begin assessment and intervention procedures. These procedures will include functional assessments of behaviors, reinforcement strategies for teaching new behaviors, teaching functionally equivalent replacement behaviors, generalization goals, and parent training. Our BCBAs continually collect data regarding your child's progress and response to interventions. This data is used to guide the future decisions we make concerning your child's treatment plan.

- **Where will my child's therapy sessions take place?**

We generally prefer to conduct therapy sessions at our office, as research indicates better long-term outcomes in a clinic-based program. Our therapeutic settings have been specifically designed to facilitate learning of functional, socially significant skills. Keeping this instructional control intact is of particular importance in the early stages of skill acquisition. However, as development progresses, it sometimes becomes appropriate to include other learning environments in order to facilitate generalization or to teach a skill that is specific to a particular setting.

- **What types of assessment tools and curriculums do you use?**

Once our Behavior Analysts have had the opportunity to meet with families, review background information, and interact with your child, they determine which tools are appropriate for each individual's needs. Some focus on verbal behavior, while others directly address functional living skills, social skills, etc.

Some frequently used assessments include VB-MAPP, ABLLS-R, PEAK, AFLS, Vineland, SSIS, PDDBI, FAST, MAS, BLAF, and a variety of parent and caregiver questionnaires. Based on the results, each child's program is then uniquely designed to meet his or her needs.

- **Why all the "treats"? Will my child become dependent on them?**

ABA therapy is rooted in the premise that all behavior is determined by our histories of reinforcement. Simply put, if a person behaves in a certain manner (whether appropriate or inappropriate) and that behavior is followed by something good happening, that person is more likely to repeat the behavior again. For example, imagine someone sitting at a slot machine; once in a while, the machine will light up and pay them, which keeps them on the hook for hours at a time.

Using tangible reinforcement or access to highly preferred activities is a common practice among ABA practitioners. In order to induce behaviors and skills that a child may have little or no interest in performing, it is important to set up a situation that will motivate him or her to do so. Therefore, identifying what a child finds reinforcing is incredibly important when teaching a new skill.

The fear of having their child become dependent on those reinforcers is often a concern of parents when their child begins ABA therapy. However, at BTEC we begin to decrease how often and how much reinforcement is provided for each particular skill as quickly as possible and transfer the source of reinforcement to something more socially appropriate. For example, it is far more appropriate to tell your child "Good job!" after completing a task than it is to hand them an M&M - so that becomes our goal!

- **What types of skills will my child be learning?**

ABA is the science of applying research-based principles of behavior in order to improve socially significant behaviors. It is important to note that what is considered socially significant for one child may not be so significant for another. At BTEC, each child's program is developed based upon his or her individual needs, strengths, interests, and family situations. The input from family members, caregivers, and our clients themselves is vital to determining what skills and target behaviors are priorities for each child's treatment plan.

- **Will my child interact with other children at BTEC?**

BTEC provides social skills training in a group setting (usually 2-3 children) when it is appropriate for a particular child's situation. Therapists closely monitor and guide children toward age-appropriate play and interaction through modeling and reinforcement, which is vital in their progress.

- **Who will be working with my child? Will it always be the same Behavior Analyst?**

As your child's therapy progresses, it becomes important that their treatment plan is carried out by a variety of people they encounter, including different therapists and the incorporation of family members and caregivers. This variety encourages generalization of the skills they acquire at BTEC to environments and people away from the therapeutic setting. The collaboration of multiple practitioners ultimately provides the best opportunity for success!

- **What does all this ABA terminology mean?**

Often ABA therapists sound like they are speaking another language, leaving parents & loved ones wondering just what they're talking about. As stated previously, our intention is to communicate as clearly as possible, so feel free to ask us if you need any kind of clarification! While the list of terminology could go on for days, here are some commonly used terms that are found in ABA programs.

Mand: Requesting something desired – this could be an object, activity, person, information, etc. The word "mand" has its roots in "command" or "demand".

Tact: Naming or identifying objects, actions, events, etc. in the immediate environment. A tact does not imply a desire for an object or activity, it simply names it.

Intraverbal: Verbal behavior that is under the control of other verbal behavior – in simple terms, it is "conversational language". Teaching intraverbal language begins with "fill-ins", such as saying, "Twinkle, twinkle little…" and a child responds, "star". More advanced intraverbals might be answering questions such as, "How are you today?" or, "What did you eat for breakfast this morning?"

Echoing: Repeating something that is heard.

Imitation: Copying the movements of others.

Reinforcement: Anything that follows a behavior that increases the future occurrence of that behavior.

Punisher: Anything that follows a behavior that decreases the future occurrence of that behavior.

Prompt: A verbal or physical cue that is designed to incite a particular behavior. The levels of prompt intrusiveness cover a wide range including physical assistance, modeling the desired behavior, positioning of items or people, gesturing, visual cues, or spoken words.

Prompt Fading: Decreasing the intrusiveness or frequency of prompting in order to avoid prompt dependency (e.g., when a child waits for a prompt before they will provide a response, which is undesirable).

Generalization: Generalization is evident when a skill learned in one setting can be demonstrated in other settings or with other people.

Extinction: After determining what is maintaining or reinforcing an undesirable behavior (e.g., what makes the behavior continue to happen), extinction is the act of withholding that reinforcement in order to decrease the behavior.

Ignoring: Ignoring means giving no attention whatsoever to a behavior, while simultaneously giving attention to some other person, event, activity, etc. that is appropriate.

BTEC
BEHAVIORAL
THERAPY

INNOVATIVE 1-ON-1 ABA THERAPY...

ONLY WITH BCBAS.

COMMITMENT TO EXCELLENCE

At BTEC, we are committed to providing your child the best possible care they can receive. To us, this means guaranteeing they will exclusively see highly qualified and passionate Board Certified Behavior Analysts (BCBAs) - never minimally trained Registered Behavior Technicians (RBTs).

IT'S WHO WE ARE

For over a decade, BTEC Behavioral Therapy has provided innovative, cutting-edge ABA Therapy to children affected by autism. Our practitioners work together to foster a welcoming environment focused on education and improvement for both parents & children.

COMMUNICATION IS KEY

At BTEC, we are in constant contact with our families to ensure they are informed and happy with their child's treatment.

INNOVATIVE ABA THERAPY

ABA Therapy is widely recognized as the most effective way to improve socially significant skills for children with autism.

MEASURABLE STEPS

ABA Therapy is provided in moderate, incremental and measurable steps to ensure your child's progress can be seen.

CALL US FOR MORE INFO

(850) 483-1508

lauriturner@btectherapy.com

www.btectherapy.com

Perdido Key ~ NAS *at 12385 Sorrento Rd., Suite C-3* ***North Pensacola*** *at 7100 Plantation Rd., Suite 9* ***Hurlburt ~ Navarre*** *at 151 Mary Esther Blvd. Suite 311* ***Eglin ~ Shalimar*** *at 1186 Eglin Pkwy.*

Because BTEC is dedicated to providing your children the best possible care they can receive, our team consists of only dedicated, passionate BCBAs. Here we compare the requirements to become a BCBA to those required to become an RBT, a position virtually all other ABA programs use for ABA Therapy with clients.

	RBT	BCBA
High school degree	✓	✓
1-on-1 treatment with clients	✓	✓
Bachelor's & Master's Degree	✗	✓
1,500+ hours of field experience	✗	✓
Passed BCBA Examination	✗	✓
Qualified to make decisions and recommendations regarding a child's treatment	✗	✓

BTEC

Behavioral Therapy

BTEC is now serving

MILITARY FAMILIES ONLY!

At BTEC, every client is guaranteed to be seen by a Masters level Board Certified Behavior Analyst (BCBA). Military children diagnosed with autism deserve the best possible treatment from the most qualified practitioners in the field. For more information about BTEC Behavioral Therapy and BCBAs, read the chart on the back of this flyer!

Perdido Key at 12385 Sorrento Rd., Suite

C-3 **North Pensacola** at 7100 Plantation

, Suite 9 **Navarre** at 151 Mary Esther Blvd., Suite 311

Shalimar at 1186 Eglin Pkwy.

(850) 483-1508

lauriturner@btectherapy.com

btectherapy.com

Date: ___/___/___

Preferred Location and Times: (circle all that apply):

Garden St Perdido University FWB JAX

Mornings Mid-day Afternoons

BTEC Behavioral Therapy

CLIENT INFORMATION

Personal Information

Client's Name:_____ DOB:_____

Height:_____ Weight:_____

Mother's Name:_____

Email:_____

Phone:_____ Cell:_____ Work:_____

Address:_____

City:_____ State:_____ Zip:_____

Father's Name:_____

Email:_____

Phone:_____ Cell:_____ Work:_____

Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact:_____ Relationship:_____

Phone:_____ Cell:_____ Work:_____

Please list any other people that have permission to drop off/pick up your child from therapy sessions.

Name	Relationship	Phone Number

Doctor(s),
Location/Phone:_____

Diagnosis (list ALL and AGE when diagnosed):_____

_____

Allergies/Special Diets:_____

Medications:_____

In school? Yes / No If Yes, where? In what setting?_____

_____

Comments:_____

_____

_____

TRICARE Information:

Sponsor Name and #:_____

Providing this information gives BTEC Behavioral Therapy permission to bill for services and collect payment on this patient's behalf and agrees that patient will be responsible for any charges not covered by insurance.

Have you received prior therapy of any kind? (e.g. ABA, Speech, Occupational, etc.) If so, with whom and when?

Type:_____Provider:_____Dates:_____

Type:_____Provider:_____Dates:_____

Type:_____Provider:_____Dates:_____

Type:_____Provider:_____Dates:_____

Type:_____Provider:_____Dates:_____

****Please provide BTEC with copies of any diagnostic assessments, reports from other therapy providers, and your child's IEP. Review of this documentation is required by insurance companies.****

Which behaviors (or lack thereof) are you most concerned about?

Behavior	What does it look like?	How often does it occur?	For how long?

Describe sleeping habits:

Describe eating habits:

Does your child prefer to keep a routine? How does he/she typically handle unexpected changes in routine?

What are his/her favorite things?

Foods:

Toys:

Movies/TV:

Activities at home:

Activities outside the home:

Places to go:

Other preferred items/activities:

What places or activities does he/she find aversive (doesn't like/avoids)?

1. _____

2. _____

3. _____

4. _____

5. _____

Behaviors of priority to address in ABA Therapy? Why?

_____

_____

_____

Any OTHER factors that may influence your child's behavior? *Please explain in detail. All communication with BTEC is confidential personal health information and cannot be disclosed except under certain conditions listed in BTEC's Confidentiality and HIPAA Disclosure policies.* (For example: major life events, multiple diagnoses/physical disabilities, family history/other family members with mental health or medical diagnoses, non-adherence to medication, history of abuse/neglect, financial or legal difficulties, language barrier, school difficulties, unsupportive family members, suicidal intent/attempts, etc.)

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BTEC Behavioral Therapy

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Phone: (850) 483-1508
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www.btectherapy.com
lauriturner@btectherapy.com

Presentation of DSM-V Criteria for ASD

Parent Respondent:_____ Date:_____

BCBA Observer:_____ Date:_____

Check any deficits/excesses based on the DSM-V criteria for ASD observed during the assessment period (by BCBA) and/or reported by parents and caregivers. Specific examples of how the deficits manifest are included (adapted from Carpenter, 2013).

A1. Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction.

- *Abnormal social approach*
  - Unusual social initiations (e.g. intrusive touching; licking of others)
- *Failure of normal back and forth conversation*
  - Poor pragmatic/social use of language (e.g. does not clarify if not understood; does not provide background information)
  - Failure to respond when name called or when spoken directly to
  - Does not initiate conversation
  - One-sided conversations/monologues/tangential speech
- *Reduced sharing of interests*
  - Doesn't share
  - Lack of showing, bringing, or pointing out objects of interest to other people
  - Impairments in joint attention (both initiating and responding)
- *Reduced sharing of emotions/affect*
  - Lack of responsive social smile
  - Failure to share enjoyment, excitement, or achievements with others
  - Failure to respond to praise
  - Does not show pleasure in social interactions
  - Failure to offer comfort to others
  - Indifference/aversion to physical contact and affection
- *Lack of initiation of social interaction*
  - Only initiates to get help; limited social initiations
- *Poor social imitation*
  - Failure to engage in simple social games

A2. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated- verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.

- Impairments in social use of eye contact
- Impairment in the use and understanding of body postures (e.g. facing away from a listener)
- Impairment in the use and understanding of gestures (e.g. pointing, waving, nodding/shaking head)
- Abnormal volume, pitch, intonation, rate, rhythm, stress, prosody or volume in speech
    - Abnormalities in use and understanding of affect Impairment in the use of facial expressions (may be limited or exaggerated)
    - Lack of warm, joyful expressions directed at others
    - Limited communication of own affect (inability to convey a range of emotions via words, expressions, tone of voice, gestures)
    - Inability to recognize or interpret other's nonverbal expressions
- Lack of coordinated verbal and nonverbal communication (e.g. inability to coordinate eye contact or body language with words)
- Lack of coordinated non-verbal communication (e.g. inability to coordinate eye contact with gestures)

A3. Deficits in developing and maintaining relationships, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people

- *Deficits in developing and maintaining relationships, appropriate to developmental level*
    - Lack of "theory of mind"; inability to take another person's perspective (CA $\geq$ 4 years)
- *Difficulties adjusting behavior to suit social contexts*
    - Does not notice another person's lack of interest in an activity
    - lack of response to contextual cues (e.g. social cues from others indicating a change in behavior is implicitly requested)
    - Inappropriate expressions of emotion (laughing or smiling out of context) (*note: other abnormalities in the use and understanding of emotion should be considered under A2*)
    - Unaware of social conventions/appropriate social behavior; asks socially inappropriate questions or makes socially inappropriate statements
    - Does not notice another's distress or disinterest
    - Does not recognize when not welcome in a play or conversational setting
    - Limited recognition of social emotions (does not notice when he or she is being teased; does not notice how his or her behavior impacts others emotionally)
- *Difficulties in sharing imaginative play (Note: solitary imaginative play/role playing is NOT captured here)*

        - Lack of imaginative play with peers, including social role playing (>4 years developmental age)
    - *Difficulties in making friends*
        - Does not try to establish friendships
        - Does not have preferred friends
        - Lack of cooperative play (over 24 months developmental age); parallel play only
        - Unaware of being teased or ridiculed by other children
        - Does not play in groups of children
        - Does not play with children his/her age or developmental level (only older/younger)
        - Has an interest in friendship but lacks understanding of the conventions of social interaction (e.g extremely directive or rigid; overly passive)
        - Does not respond to the social approaches of other children
    - *Absence of interest in others*
        - Lack of interest in peers
        - Withdrawn; aloof; in own world
        - Does not try to attract the attention of others
        - Limited interest in others;
        - Unaware or oblivious to children or adults
        - Limited interaction with others
        - Prefers solitary activities

B1. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases).

- *Stereotyped or repetitive speech*
    - Pedantic speech or unusually formal language (child speaks like an adult or "little professor")
    - Echolalia (immediate or delayed); may include repetition of words, phrases, or more extensive songs or dialog
    - "Jargon" or gibberish (mature jargoning after developmental age of 24 months)
    - Use of "rote" language
    - Idiosyncratic or metaphorical language (language that has meaning only to those familiar with the individual's communication style); neologisms
    - Pronoun reversal (for example, "You" for "I"; not just mixing up gender pronouns)
    - Refers to self by own name (does not use "I")
    - Perservative language (note: *for perseveration on a specific topic, consider B3*)
    - Repetitive vocalizations such as repetitive guttural sounds, intonational noise-making, unusual squealing, repetitive humming
- *Stereotyped or repetitive motor movements*
    - Repetitive hand movements (e.g., clapping, finger flicking, flapping, twisting)
    - Stereotyped or complex whole body movements (e.g., foot to foot rocking, dipping, & swaying; spinning)
    - Abnormalities of posture (e.g., toe walking; full body posturing)
    - Intense body tensing

        - Unusual facial grimacing
        - Excessive teeth grinding
        - Repetitively puts hands over ears (*note: if response to sounds, consider B4*)
        - Perseverative or repetitive action / play / behavior (note: *if 2 or more components, then it is a routine and should be considered under B2*)
        - Repetitive picking (unless clear tactile sensory component, then consider B4)
    - *Stereotyped or repetitive use of objects*
        - Nonfunctional play with objects (waving sticks; dropping items)
        - Lines up toys or objects
        - Repetitively opens and closes doors
        - Repetitively turns lights on and off

B2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).

- *Adherence to routine*
    - Routines: specific, unusual multiple-step sequences of behavior
    - Insistence on rigidly following specific routines (*note: exclude bedtime routines unless components or level of adherence is atypical*)
    - Unusual routines
- *Ritualized Patterns of Verbal and Nonverbal Behavior*
    - Repetitive questioning about a particular topic (distinguish from saying the same word or phrase over and over, which goes under B1)
    - Verbal rituals - has to say one or more things in a specific way or requires others to say things or answer questions in a specific way
    - Compulsions (e.g. insistence on turning in a circle three times before entering a room) (*note: repetitive use of objects,, including lining up toys, should be considered under B1*).
- *Excessive resistance to change*
    - Difficulty with transitions (should be out of the range of what is typical for children of that developmental level)
    - Overreaction to trivial changes (moving items at the dinner table or driving an alternate route)
- *Rigid thinking*
    - Inability to understand humor
    - Inability to understand nonliteral aspects of speech such as irony or implied meaning
    - Excessively rigid, inflexible, or rule-bound in behavior or thought

B3. Highly restricted, fixated interests that are abnormal in intensity or focus; (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

- Preoccupations; obsessions
- Interests that are abnormal in intensity
- Narrow range of interests
- Focused on the same few objects, topics or activities
- Preoccupation with numbers, letters, symbols
- Being overly perfectionistic
- Interests that are abnormal in focus
- Excessive focus on nonrelevant or nonfunctional parts of objects
- Preoccupations (e.g. color; time tables; historical events; etc)
- Attachment to unusual inanimate object (e.g., piece of string or rubber band)
- Having to carry around or hold specific or unusual objects (not common attachment objects such as blankets, stuffed animals, etc.)
- Unusual fears (e.g. afraid of people wearing earrings)

B4. Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).

- *High tolerance for pain*
- *Poking own eyes*
- *Preoccupation with texture or touch (includes attraction/aversion to texture)*
    - Tactile defensiveness; does not like to be touched by certain objects or textures
    - Significant aversion to having hair or toenails cut, or teeth brushed
- *Unusual visual exploration / activity*
    - Close visual inspection of objects or self for no clear purpose (for example, holding things at unusual angels) (no vision impairment)
    - Looks at objects, people out of corner of eye
    - Unusual squinting of eyes
    - Extreme interest or fascination with watching movement of other things (e.g., the spinning wheels of toys, the opening and closing of doors, electric fan or other rapidly revolving object)
- *In all domains of sensory stimuli (sound, smell, taste, vestibular, visual), consider:*
    - Odd responses to sensory input (e.g. becoming extremely distressed by the atypical sound)
    - Atypical and/or persistent focus on sensory input
- *Unusual sensory exploration with objects (sound, smell, taste, vestibular)*
    - Licking or sniffing

RELEASE OF INFORMATION AND ASSESSMENT CONSENT FORM

BTEC BEHAVIORAL THERAPY, INC.

CLIENT:_____DOB:_____

PARENT/GUARDIAN NAME:_____

I consent for the above-named client to participate in an assessment through BTEC Behavioral Therapy, Inc. I consent to have the assessment with the above-named individual conducted in the following locations (Circle relevant ones):

Office/Clinic Home School Other:_____

I understand and consent to have the individuals responsible for care in the above-named locations involved in the assessment of the above-named client. In order to coordinate the assessment with these individuals, I authorize the release of the following confidential records to BTEC Behavioral Therapy, Inc.: Evaluations/Assessments from: _ IEP/IFSP from: _ Medical Records from: Other: I authorize

BTEC Behavioral Therapy, Inc. to release the following records in order to coordinate

treatment with the following Agencies and/or Individuals:

Records:	Agency/Individual:
_____	_____
_____	_____
_____	_____
_____	_____

I understand that these records may contain psychiatric and/or drug and alcohol information. I understand that these records may also contain references to blood-borne pathogens (e.g. HIV/AIDS). I understand that I may revoke this consent at any time; however, I cannot revoke consent for action that has already been taken. A copy of this release shall be as valid as the original. This consent automatically expires 30 days after termination of services.

Client and/or
PARENT/GUARDIAN:_____

DATE:_____

CONFIDENTIALITY ACT and ABUSE REPORTING PROTOCOL

BTEC BEHAVIORAL THERAPY, INC.

CLIENT:_____DOB:_____

I understand that all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the client, either verbal or written, will be released to other agencies or individuals without the express written consent of the client's legal guardian. By law, the rules of confidentiality do not hold under the following conditions:

- If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the Department of Children and Families for investigation.
- If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn a potential victim.
- If our records, our subcontractor records, or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

PARENT/LEGAL GUARDIAN:_____

DATE:_____

BTEC BEHAVIORAL THERAPY, INC.
HIPAA Notice of Privacy Practices

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you (or your legal dependent), including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapy practice, and any other uses required by law.

A. **Treatment:** We may use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a 3rd party. For example, we may disclose your information as necessary to a home health agency that cares for you or to a physician to whom you have been referred to ensure the physician / therapist has the necessary information to diagnose and treat you.

B. **Payment:** Your protected health information will be used as needed, to obtain payment for your health care services.

C. **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of the therapy practice. These activities include, but are not limited to, quality assessment activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call your name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information in the following situations without your authorization: As required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmate information. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician/ therapist or physician / therapist's clinic has taken an action in reliance on the use of disclosure located in the authorization.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. However, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or in use in, a civil, criminal, or administrative action or proceeding, and protective health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your information. You have the right to request confidential communications from us even if you have agreed to accept this notice alternatively (i.e. electronically). You have the right to have your physician / therapist amend your protected health information. You have the right to receive an accounting of certain disclosures we have made, if any, of you protected health information.

COMPLAINTS:

You may complain to us or to the Secretary of health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask us to explain. Signature below confirms acknowledgement of our Privacy Practices:

Signature_____ **Print Name**_____ **Date**_____

In order to coordinate care, BTEC Behavioral Therapy staff may communicate via □ TEXT □ PHONE □ EMAIL □ Other_____

INFORMED CONSENT FORM BTEC

BEHAVIORAL THERAPY, INC.

CLIENT:_____DOB:_____

STATEMENT OF AUTHORITY TO CONSENT: I certify that I have the authority to legally consent to assessment, release of information, and all legal issues involving the above-named client. Upon request, I will provide BTEC Behavioral Therapy, Inc., with proper legal documentation to support this claim. I further hereby agree that if my status as legal guardian should change, I will immediately inform BTEC Behavioral Therapy, Inc., of this change in status and will further immediately inform BTEC Behavioral Therapy, Inc., of the name, address, and phone number of the person or persons who have assumed guardianship of the above-named client.

TREATMENT CONSENT: I consent for behavioral treatment to be provided for the above-named client by BTEC Behavioral Therapy, Inc., and its staff. I understand that the procedures used will consist of manipulating antecedents and consequences to produce improvements in behavior. At the beginning of treatment behavior may get worse in the environment where the treatment is provided (e.g., “extinction burst”) or in other settings (e.g., “behavioral contrast”). As part of the behavioral treatment, physically prompting or manually guidance may be used. Once initial assessment has been conducted, the actual treatment protocols that will be used will be explained to parents/guardians and their authorization will be documented on the client’s treatment plan.

I understand that I may revoke this consent at any time. However, I cannot revoke consent for action that has already been taken. A copy of this consent shall be valid as the original.

PARENT/GUARDIAN:_____DATE:_____

WITNESS:_____DATE:_____

PERMISSION TO VIDEO/AUDIO RECORD AND PHOTOGRAPH

BTEC BEHAVIORAL THERAPY, INC.

CLIENT:_____DOB:_____

I grant BTEC Behavioral Therapy, Inc. permission to record therapy sessions via video, audio, or photographic devices. These recordings will be used for therapeutic purposes only, and will be bound by the same confidentiality agreement as all other information regarding my child. No information, including recordings, related to clients will be released to other agencies or individuals without the express written consent of the child's legal guardian. However, by law, the rules of confidentiality do not hold under the following conditions:

- If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the Department of Children and Families for investigation.
- If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn a potential victim.
- If our records, our subcontractor records, or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

PARENT/LEGAL GUARDIAN:_____

DATE:_____

POLICY REGARDING PARENT PARTICIPATION AND APPOINTMENT ATTENDANCE

BTEC BEHAVIORAL THERAPY, INC.

CLIENT:_____DOB:_____

Behavioral therapy based on Applied Behavior Analysis (ABA) methodologies is an ongoing, continuous process that requires consistency in treatment. In order to effectively implement behavior change procedures, regular attendance at scheduled therapy sessions and participation by parents and caregivers is imperative.

All caregivers will be offered training to implement their child's program through a combination of explanation, modeling, coaching, and performance feedback. IT IS ESSENTIAL THAT THE PROCEDURES IN CLIENT'S BEHAVIOR INTERVENTION PLANS ARE CARRIED OUT WITH CONSISTENCY ACROSS ALL CAREGIVERS (PARENTS, TEACHERS, CHILDCARE PROVIDERS) IN ALL ENVIRONMENTS (HOME, SCHOOL, and COMMUNITY SETTINGS). Otherwise, it is unlikely that any meaningful behavior change will occur outside the clinical setting. If parents are unable or unwilling to implement these procedures, it is the parent/caregiver's responsibility to communicate with BTEC personnel so that alternative strategies may be considered. Inconsistency in behavior change strategies is not only confusing to a child, but will likely also contribute to an increase in problem behaviors. If needed, BTEC will offer to collect caregiver performance data regarding the implementation of behavior intervention programs.

As there may be other clients that could benefit from available therapy sessions, BTEC requires that a 24 hour notice be given for cancellation of appointments. In addition, please notify BTEC as early as possible if there will be an extended period of missed appointments (due to family vacation, medical treatment, etc.).

BTEC is frequently contacted by families in need of services, and scheduling to meet the needs of all families is important to us. Therefore, BTEC reserves the right to cancel enrollment in the program if a client habitually misses appointments or if it becomes apparent that parents/caregivers are not making adequate effort to participate in behavior change procedures outside the clinical setting.

It is the parent/caregiver's responsibility to transition clients in and out of BTEC clinics. Children are considered to be under the parent/caregiver's care if the parent/caregiver is present. Should a client arrive early for an appointment, it is the parent/caregiver's responsibility to ensure that the client remains in the lobby until the scheduled therapy session so that other clients' sessions are not interrupted. Client care is the parent/caregiver's responsibility until the scheduled appointment time so that 1:1 supervision can be provided.

I have read, understand, and agree to this policy:

PARENT/LEGAL GUARDIAN:_____

DATE:_____

POLICY ON RESTRAINT OR SECLUSION

BTEC BEHAVIORAL THERAPY, INC.

Client Name:_____ DOB:_____

BTEC's policy regarding the use of physical restraint and seclusion is outlined by the position statement of the Association for Behavior Analysis International (ABAI), which follows. Restraint and/or seclusion will only be used if a client is behaving in a manner that presents a threat to the client's safety or the safety of others. In the event that restraint/seclusion is necessary, a BTEC Incident Report for Elopement or Restraint will be immediately completed by the client's supervising behavior analyst and provided to the parent/guardian.

I have read, understand, and accept BTEC's policy on restraint and seclusion:

_____ _____

Parent/Guardian Date

The Association for Behavior Analysis International Position Statement on Restraint and Seclusion

Abstract

A task force authorized by the Executive Council of the Association for Behavior Analysis International (ABAI) generated the statement below concerning the techniques called *restraint* and *seclusion*. Members of the task force independently reviewed the scientific literature concerning restraint and seclusion and agreed unanimously to the content of the statement. The Executive Council accepted the statement, and it was subsequently approved by a two-thirds majority vote of the general membership. It now constitutes official ABAI policy. The position statement is posted on the ABAI Web site (www.abainternational.org/ABA/statements/RestraintSeclusion.asp). The purpose of the position statement is to provide guidance to behavior analysts and other professionals interested in the position of ABAI on these controversial topics. In extreme cases, abuses of procedures erroneously used in the name of behavior analysis are not defensible. On the other hand, behavior analysts acting ethically and in good faith are provided with guidelines for sound and acceptably safe practice. To the extent that behavior-analytic positions influence public policy and law, this statement can be presented to officials and lawmakers to guide informed decision making. At the conclusion of the document, a bibliography is provided of articles and presentations considered by one or more task force members in developing the position statement.

Keywords: seclusion, restraint, position statement, ethics

The Association for Behavior Analysis International (ABAI) and its members strongly oppose the inappropriate or unnecessary use of seclusion, restraint, or other intrusive interventions. Although many persons with severe behavior problems can be effectively treated without the use of any restrictive interventions, restraint may be necessary on some rare occasions with meticulous clinical oversight and controls. In addition, a carefully planned and monitored use of time-out from reinforcement can be acceptable under restricted circumstances. Seclusion is sometimes necessary or needed, but behavior analysts would support only the most highly monitored and ethical practices associated with such use, to be detailed below.

This Position Statement on Restraint and Seclusion summarizes critical guiding principles. With a strong adherence to professional judgment and best practice, it also describes the conditions under which seclusion and restraint may be necessary and outlines proper strategy to implement these procedures appropriately and safely. This statement is consistent with ABAI's 1989 Position Statement on the Right to Effective Behavioral Treatment, which asserts numerous rights, including access to the most effective treatments available, while emphasizing extensive procedural safeguards.

GUIDING PRINCIPLES

The Welfare of the Individual Served is the Highest Priority

Clinical decisions should be made based on the professional judgment of a duly formed treatment team that demonstrates knowledge of the broad research base and best practice. Included in this process are the individuals being served and their legal guardians. The team should be informed by the research literature, and should determine that any procedure used is in that person's best interests. These interests must take precedence over the broader agendas of institutions or organizations that would prohibit certain procedures regardless of the individual's needs. A core value of ABAI with regard to behavioral treatment is that welfare of the individual being served is the absolute highest priority.

Individuals (and Parents or Guardians) Have a Right to Choose

ABAI supports the U.S. Supreme Court ruling that individuals have a right to treatment in certain contexts, and that many state and federal regulations and laws create such rights. Organizations and institutions should not limit the professional judgment or rights of those who are legally responsible for an individual to choose interventions that are necessary, safe, and effective. A regulation that prohibits treatment that includes the necessary use of restraint violates individuals' rights to effective treatment. The irresponsible use of certain procedures by unqualified or incompetent people should not result in policies that limit the rights of those duly qualified and responsible for an individual through the process of making informed choices.

The Principle of Least Restrictiveness

ABAI supports the position that treatment selection should be guided by the principle of the least restrictiveness. The least restrictive treatment is defined as that treatment that affords the most favorable risk-to-benefit ratio, with specific consideration of probability of treatment success, anticipated duration of treatment, distress caused by procedures, and distress caused by the behavior itself. One may conclude from this premise that a nonintrusive intervention that permits dangerous behavior to continue while limiting participation in learning activities and community life,

or results in a more restrictive placement, may be considered more restrictive than a more intensive intervention that is effective and enhances quality of life.

APPLICATION

General Definitions

Restraint involves physically holding or securing the individual, either (a) for a brief period of time to interrupt and intervene with severe problem behavior or (b) for an extended period of time using mechanical devices to prevent otherwise uncontrollable problem behavior (e.g., self-injurious behavior) that has the potential to produce serious injury. When used in the context of a behavior intervention plan, restraint in some cases serves both a protective and a therapeutic function. These procedures can reduce risks of injury and can facilitate learning opportunities that support appropriate behavior.

Seclusion involves isolating an individual from others to interrupt and intervene with problem behavior that places the individual or others at risk of harm. When used in the context of a behavior intervention plan, seclusion in some cases serves both a protective and a therapeutic function. These procedures can reduce risks of injury and can facilitate learning opportunities that support appropriate behavior. ABAI is opposed to the use of seclusion when it is operationally defined as placing someone in a locked room, often combined with the use of mechanical restraint or sedation, and not part of a formal behavior intervention plan to which the individual served or his or her guardian has consented. We support the use of a planned time-out treatment or safety intervention that conforms to evidence-based research, is part of a comprehensive treatment or safety plan that meets the standards of informed consent by the individual served or his or her legal guardian, and is evaluated on an ongoing basis via the use of contemporaneously collected objective data.

Time-out from reinforcement is an evidence-based treatment intervention that involves reducing or limiting the amount of reinforcement that is available to an individual for a brief period of time. It can entail removing an individual from his or her environment, or it may entail changes to the existing environment itself. When time-out involves removing an individual from the environment, it should only be used as part of an approved behavior intervention plan. Time-out from reinforcement is not seclusion, but it may involve seclusion if it is not safe to have others in the room. In addition, some innocuous versions of time-out from reinforcement, such as having a child take a seat away from a play area, are not deemed to be intrusive. Such procedures are commonly used and are generally safe.

Use of Restraint as Part of a Behavior Intervention Plan

The use of restraint in a behavior intervention plan is done as part of an integrated effort to reduce the future probability of a specified target behavior or to reduce the episodic severity of that behavior. A behavior intervention plan that incorporates contingent restraint must (a) incorporate reinforcement-based procedures, (b) be based on a functional behavior assessment, (c) be evaluated by objective outcome data, and (d) be consistent with the scientific literature and current best practices. Procedures describing the use and monitoring of this type of procedure should be designed by a Board Certified Behavior Analyst, or a similarly trained and licensed professional who is trained and experienced in the treatment of problem behavior.

Use of Time-Out (or in Rare Cases, Seclusion) as Part of a Behavior Intervention Plan

Time-out may be used as part of an integrated behavior intervention plan designed to decrease the future probability of a prespecified target behavior or to reduce the episodic severity of that behavior. The behavior intervention plan that incorporates the use of time-out must (a) be derived from a behavioral assessment, (b) incorporate reinforcement strategies for appropriate behavior, (c) be of brief duration, (d) be evaluated by objective outcome data, and (e) be consistent with the scientific literature and current best practices.

The Necessity for the Use of Emergency Restraint and Seclusion

Emergency restraint involves physically holding or securing a person to protect that person or others from behavior that poses imminent risk of harm. These procedures should be considered only for dangerous or harmful behaviors that occur at unpredictable times, that make the behavior not amenable to less restrictive behavioral treatment interventions, and that place the individual or others at risk for injury, or that will result in significant loss of quality of life. The procedures should be considered only when less intrusive interventions have been attempted and failed or are otherwise determined to be insufficient given adequate empirical documentation to prove this point.

When applied for crisis management, restraint or seclusion should be implemented according to well-defined, predetermined criteria; include the use of deescalation techniques designed to reduce the target behavior without the need for physical intervention; be applied only at the minimum

level of physical restrictiveness necessary to safely contain the crisis behavior and prevent injury; and be withdrawn according to precise and mandatory release criteria.

Emergency restraint procedures should be limited to those included within a standardized program. Medical professionals should review restraint procedures to ensure their safety.

Consideration of emergency restraint should involve weighing the relative benefits and limitations of using these procedures against the risks associated with not using them. Associated risks of failure to use appropriate restraint when necessary include increased risk of injury; excessive use of medication; expulsion from school; placement in more restrictive, less normalized settings; and increased involvement of law enforcement.

Crisis management procedures are not a replacement for behavioral treatment and should not be used routinely in the absence of an individualized behavior intervention plan. The best way to eliminate restraint use is to eliminate behavior that invites its use via systematic behavioral treatment procedures. If crisis intervention procedures are used on a repeated basis, a formal written behavior plan should be developed, reviewed by both a peer review committee and human rights committee (when available), and consented to by the individuals served and their parents or legal guardians.

Informed Consent

As members of the treatment team, the individual and parents or guardians must be allowed the opportunity to participate in the development of any behavior plan.

Interventions that involve restraint or seclusion should be used only with the full consent of those who are responsible for decision making. Such consent should meet the standards of “information,” “capacity,” and “voluntary.” The individual and his or her guardian must be informed of the methods, risks, and effects of possible intervention procedures, which include the options to both use and not use restraint.

Oversights and Monitoring

Restraint or seclusion (not including brief time-out) for both treatment and emergency situations should be made available for professional review consistent with prevailing practices.

The behavior analyst is responsible for ensuring that any plan involving restraint or seclusion conforms to the highest standards of effective and humane treatment, and the behavior analyst is responsible for continued oversight and quality assurance.

These procedures should be implemented only by staff who are fully trained in their use, receive regular in-service training, demonstrate competency using objective measures of performance, and are closely supervised by a Board Certified Behavior Analyst or a similarly trained professional. The use of restraint or seclusion should be monitored on a continuous basis using reliable and valid data collection that permits objective evaluation of its effects.

Procedures that involve restraint or seclusion should be continued only if they are demonstrated to be safe and effective; their use should be reduced and eliminated when possible. *Efficacy* with respect to treatment programs refers to a reduction in the rate of the specified target behavior or reduction in the episodic severity of that behavior. With respect to emergency treatments, *efficacy* refers only to the time and risk associated with achieving calm.

COMMUNICATING PHYSIOLOGICAL AND ENVIRONMENTAL CHANGES

By signing this document all parties acknowledge and understand that withholding pertinent information can be detrimental to the efficacy of your child's treatment. These include but are not limited to: medication changes, co-morbid diagnosis, illness, sleep patterns, trauma, etc. Communicating these changes with your child's BCBA should be done in a timely manner.

_____ _____

Parent name/signature Date

_____ _____

BCBA name/signature Date

Behavior Analysts are bound to follow the BACB Code of Ethical Conduct (2014). At BTEC Behavioral Therapy, Inc. we believe communicating this with our families assists in effective collaborative efforts with all parties involved in your child's treatment. Below are specific areas of the Code of Conduct (BACB, 2014) referenced for physiological/environmental changes:

1.01 Reliance on Scientific Knowledge.

- □ Behavior analysts rely on professionally derived knowledge based on science and behavior analysis when making scientific or professional judgments in human service provision, or when engaging in scholarly or professional endeavors.

1.02 Boundaries of Competence.

- □ (a) All behavior analysts provide services, teach, and conduct research only within the boundaries of their competence, defined as being commensurate with their education, training, and supervised experience.

1.04 Integrity.

- □ (a) Behavior analysts are truthful and honest and arrange the environment to promote truthful and honest behavior in others.
- □ (c) Behavior analysts follow through on obligations, and contractual and professional commitments with high quality work and refrain from making professional commitments they cannot keep.
- □ (d) Behavior analysts' behavior conforms to the legal and ethical codes of the social and professional community of which they are members.

1.05 Professional and Scientific Relationships.

- □ (a) Behavior analysts provide behavior-analytic services only in the context of a defined, professional, or scientific relationship or role.
- □ (b) When behavior analysts provide behavior-analytic services, they use language that is fully understandable to the recipient of those services while remaining conceptually systematic with the profession of behavior analysis. They provide appropriate information prior to service delivery about the nature of such services and appropriate information later about results and conclusions.
- □ (c) Where differences of age, gender, race, culture, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status significantly affect behavior analysts' work concerning particular individuals or groups, behavior analysts obtain the training, experience, consultation, and/or supervision necessary to ensure the competence of their services, or they make appropriate referrals

2.03 Consultation.

- (a) Behavior analysts arrange for appropriate consultations and referrals based principally on the best interests of their clients, with appropriate consent, and subject to other relevant considerations including applicable law and contractual obligations.
- (b) When indicated and professionally appropriate, behavior analysts cooperate with other professionals, in a manner that is consistent with the philosophical assumptions and principles of behavior analysis, in order to effectively and appropriately serve their clients.

2.04 Third-Party Involvement in Services.

- (d) Behavior analysts put the client's care above all others and, should the third party make requirements for services that are contraindicated by the behavior analyst's recommendations, behavior analysts are obligated to resolve such conflicts in the best interest of the client. If said conflict cannot be resolved, that behavior analyst's services to the client may be discontinued following appropriate transition.

2.09 Treatment/Intervention Efficacy.

- (d) Behavior analysts review and appraise the effects of any treatments about which they are aware that might impact the goals of the behavior-change program, and their possible impact on the behavior change program, to the extent possible.

3.02 Medical Consultation.

- Behavior analysts recommend seeking a medical consultation if there is any reasonable possibility that a referred behavior is influenced by medical or biological variables.

4.06 Describing Conditions for Behavior-Change Program Success.

- Behavior analysts describe to the client the environmental conditions that are necessary for the behavior-change program to be effective.

4.07 Environmental Conditions that Interfere with Implementation.

- (a) If environmental conditions prevent implementation of a behavior-change program, behavior analysts recommend that other professional assistance (e.g., assessment, consultation or therapeutic intervention by other professionals) be sought.
- (b) If environmental conditions hinder implementation of the behavior-change program, behavior analysts seek to eliminate the environmental constraints, or identify in writing the obstacles to doing so.

4.09 Least Restrictive Procedures.

- Behavior analysts review and appraise the restrictiveness of procedures and always recommend the least restrictive procedures likely to be effective.

6.01 Affirming Principles.

- (a) Above all other professional training, behavior analysts uphold and advance the values, ethics, and principles of the profession of behavior analysis.

A note about scheduling…

ABA therapy requires consistent, frequent treatment sessions in order to be most effective. While we do our best to schedule therapy at convenient times for families, please keep in mind that the more flexibility families have in scheduling, the sooner your child will be able to get started at the intensity of service recommended by your Behavior Analyst. ABA THERAPY IS CONSIDERED A MEDICALLY NECESSARY FORM OF TREATMENT FOR AUTISM. BY LAW, YOUR CHILD WILL BE EXCUSED FROM SCHOOL IN ORDER TO ATTEND THERAPY SESSIONS.

IMPORTANT INFORMATION
FOR PARENTS OF SCHOOL AGED CHILDREN

FLORIDA STATUTE:

6A-1.09515 Excused Absences for Treatment of Autism Spectrum Disorder.

(1) Release time during the school day to participate in therapy services for the treatment of autism spectrum disorder. Each school district shall adopt policies authorizing a parent to request and be granted permission for absence of a student to receive therapy services for treatment of autism spectrum disorder to implement section 1003.21(2)(b)2., F.S. The school district's rules shall include, but are not limited to, the following:

(a) Provisions establishing the procedures and time frames for parents to request excused absences for scheduled appointments for treatment of autism spectrum disorder.

(b) Provisions for establishing the school district's requirements for verification of therapy provided by licensed health care practitioners or certified behavior analysts pursuant to section 393.17, F.S., for the treatment of autism spectrum disorder.

(2) For purposes of this rule, a school district may accept documentation of excused absences from certified behavior analysts pursuant to section 393.17, F.S.; speech-language pathologists licensed under section 468.1185, F.S.; occupational therapists licensed under Part III of chapter 468, F.S.; psychologists licensed under chapter 490, F.S.; clinical social workers licensed under chapter 491, F.S.; or other health care practitioners as defined in section 456.001(4), F.S.

Rulemaking Authority 1001.02(1), 1003.21(2)(b) FS. Law Implemented 1002.20, 1003.21(2)(b), 1003.24 FS. History–New 4-30-18.

Parent's Guide to ABA Therapy
Authorization, Assessment, and Treatment

This guide has been provided to you to help you understand the process involved with starting applied behavior analysis (ABA) therapy with a Board Certified Behavior Analyst (BCBA). Please use this check list to help you keep track of the different events that occur.

Your provider / BCBA will be responsible for different activities as indicated by the darkened boxes (■). Please make sure to track your responsibilities as indicated by the open boxes (□) to help ensure your needs are met. We look forward to serving your family!

Authorization – Before services start

■ Your child's physician sends the referral for ABA therapy to your provider (BTEC). This referral should include your child's diagnosis and areas of concern to be addressed.
■ Once received, your ABA provider will contact the insurance and verify benefits
■ Your provider will then contact you to set up an appointment for the assessment and request any additional documentation needed for authorization. Please make the following records available for review:

- □ Diagnostic report
- □ Any previous ABA treatment plans from other providers available
- □ IEP, ARD, or 504 plan

What you can do during this time:

- ✔ Wait to be contacted by the provider for an assessment to be scheduled.
- ✔ Continue following up with your provider, but understand that the timeline varies by insurance company and schedule availability.
- ✔ Be prepared for ideal times that you would like the assessment to occur. *Keep in mind that the more flexibility your family has for scheduling can significantly impact wait times.*
- ✔ Be prepared to set aside two hours for the initial meeting.
- ✔ Be prepared with questions to ask the BCBA.
- ✔ Be prepared to discuss what you are wanting out of ABA therapy. If you are unsure, your BCBA will provide you with guidance.
- ✔ Spend time familiarizing yourself with quality ABA therapy. Some great resources include:
  - □ Marybarbera.com
  - □ Behaviorbabe.com
  - □ Iloveaba.com
  - □ Autismspeaks.org
  - □ Asatonline.org

Assessment – Beginning the process to determine what treatment will look like

■ A BCBA will meet with you and your child

□ You will sign a form indicating that you consent to an assessment. The assessment will include the following components:

- □ Parent/caregiver interview
- □ Administration of indirect assessment tools (e.g. forms and questionnaires you fill out)

□ Observation of your child, generally over one to three sessions (varies depending on individual needs)

□ Interaction with your child, including "pairing" the practitioner and environment with reinforcement. Remember – this process should look and feel like "play". Practitioners make efforts to ensure children don't feel like they're being "tested" during the assessment process.

□ Documentation of your child's behavior via data collection and standardized assessment tools.

- The BCBA will schedule a time with you to review the assessment results and recommended treatment plan prior to submitting to insurance for approval / authorization.

What you can do during the assessment phase:

- ✔ Understand the timeline for this process varies by individual.
- ✔ Understand that the timeline varies by insurance company for approval and authorization of a treatment plan.
- ✔ Be prepared to review the assessment results and treatment plan with the BCBA.
- ✔ Know that the assessment writing will be reflected on your Explanation of Benefits (EOB) from your insurance company expressed as codes and on dates that you may not have seen the BCBA.
- ✔ Understand that your child may not get all hours requested authorized by the insurance company. If so, your BCBA will contact you and discuss how to proceed.

<u>Treatment – Services have begun</u>

- Your child's BCBAs will be providing therapy through direct interaction. Your child's progress will be recorded through data collection and documentation. You may also be asked to collect data regarding your child's behaviors at home and in the community.

□ Your signature will be required on the treatment note each session.

□ You will participate in parent training on strategies and interventions used in therapy, often at the beginning or end of sessions via consultation with your child's BCBA.

- The BCBA will report on both child and parent progress at the end of the authorization period, as required by insurance.

What you can do during the treatment phase:

- ✔ ASK your BCBA questions when you have them!
- ✔ Make sure to participate in parent training/consultation and open communication with your BCBA. Both are key to the success of your child's treatment.
- ✔ Ask your provider about any questions that you have about scheduling or billing.
- ✔ Know that your will be informed and consulted with regarding any changes made to your child's treatment.

Questions and Answers About ABA

August 11, 2021

Applied Behavior Analysis (ABA) is one of the most common interventions for people with autism, but much of the information available about it online is outdated or contradictory. This opens the door to confusion about its usefulness, in part because the therapy varies so widely and is typically geared towards children. The fact is there is no one ABA—it is a highly individualized therapy that looks different for every person and practitioner.

Here, Arianna Esposito, Board-Certified Behavior Analyst (BCBA), shares information about what to expect from ABA, its methods, and its impact on autistic people across the lifespan.

Q: What is ABA therapy?

ABA is a therapy based on the science of learning and behavior. It is typically used to help people with autism and other developmental disorders learn behaviors that help them live safer and more fulfilling lives.

ABA focuses on teaching necessary skills and stopping dangerous behaviors rather than preventing harmless self-stimulatory behavior (stims). Therapists work with autistic people to improve skills like:

- Communication and language abilities
- Social skills
- Self-care and hygiene routines
- Play and leisure skills
- Motor abilities

The goal is not for someone to appear neurotypical. The goal is for their life to be improved in a way that is meaningful to them.

There are many evidence-based treatments based on ABA principles. No one therapy or intervention will be effective for every person. Common behavioral interventions include:

- **Early Intensive Behavioral Intervention (EIBI)** - A school, center or home-based therapy for children under the age of 5 that is effective for developing functional skills and communication.
- **Early Start Denver Model (ESDM)** – An approach for children between the ages of 12 to 48 months that is effective for developing communication and cognitive skills.
- **Joint Attention, Symbolic Play, Engagement & Regulation (JASPER)** – A model for children between 12 months to 8 years old that is effective for improving play and communication skills.
- **Natural Environment Teaching (NET)** - Designed for children aged 2 to 9, this therapy is effective in reinforcing language, play and social skills in the natural environment.
- **Pivotal Response Treatment (PRT)** – A play-based and child-initiated therapy that is effective for communication, self-management and social behaviors.

These approaches all fall under the umbrella of ABA, and people usually receive a combination of interventions. For example, a therapist may work with a client in ABA therapy to develop language skills using the EIBI approach for a short period of time and then move to NET to practice the skills in a more natural environment. In all cases, ABA therapists should work with their patients and their families to set goals and choose interventions based on each patient's unique strengths, needs and desired outcomes.

While many ABA therapies are shown to be effective for young children, ABA interventions can also help autistic adolescents and adults learn greater independence or limit harming behaviors.

Q: What does ABA therapy look like?

ABA treatment approaches are not one-size-fits-all. Plans are designed by a qualified BCBA who evaluates the autistic person's unique needs, skills, preferences, interests, challenges and family situation.

The BCBA uses this information to create goals and an intervention plan. This plan is then delivered by a licensed professional, such as a registered behavior technician (RBT) or board-certified assistant behavior analyst (BCABA). Generally referred to as a behavior therapist, this is the person who usually runs the therapy sessions, with guidance from the BCBA.

In therapy, the BCBA works with the autistic person and their care team to identify a goal and break it down into small parts. For example, learning to wash hands may be broken down into these steps:

- Turning on the faucet
- Wetting hands
- Picking up the soap
- Lathering hands
- Rinsing hands
- Turning off the faucet
- Drying hands with a towel

Each step that is performed successfully is followed by a positive response, such as a reward or natural reinforcer in the environment. Unwanted behaviors are generally ignored and the person is redirected toward the practice skill. Rewards differ depending on the person and their interest, but can include things like praise, a toy or book, or TV time. Positive reinforcement and repetition are the main tools of ABA practitioners. Punishment should never be used as a tool to draw out a desired behavior.

Progress is measured by collecting data in each therapy session. The therapist regularly meets with family members to review information about progress. If the patient does not show progress, the ABA therapist can adjust teaching plans as needed.

Q: How can ABA help with behaviors that are harmful or destructive?

ABA is often used to help autistic children and adults cope with harmful or dangerous behaviors. The therapy usually begins by identifying the unsafe behavior, learning about the trigger(s), and then teaching a safer alternative response.

For example, if someone bangs their head frequently and is injuring themselves, the therapist begins by trying to understand the cause of the behavior. Some questions may include:

- Who was present?
- What happened before, during and after the behavior?
- When did it happen?
- Where did it happen?
- What might that person be trying to communicate with that behavior?

The answers to these questions can help therapists understand what is causing someone to engage in the behavior and how to help them communicate their needs more safely. The therapist might find that it is a response to pain, overstimulation, frustration due to communication issues, or a way to avoid an unpleasant situation. Importantly, the behavior may have more than one cause and may serve more than one function.

In this example, the therapist may find that the behavior happens in loud environments and that the head-banging serves two purposes:

- It is a way for the person to communicate that they are overwhelmed and need a quiet place to calm down.
- It causes their family to remove them from the situation.

The therapist can then work with the person to teach them safer ways to ask for or get quiet time. For example, the person may learn to use noise canceling headphones or go to a quiet room when they feel overstimulated. They can also learn to use or point to the word “loud” so they can better communicate their needs with the people around them.

In this way, ABA therapy can help keep someone from harming themselves by teaching healthy communication skills and strategies that they can use to get what they need.

It is important to note that ABA therapy should focus on the needs that the autistic person is trying to meet and teach ways to have those needs met safely.

Q: How can ABA be applied throughout the lifespan?

ABA is effective for people of all ages. While therapy looks different in young children versus adolescents and adults, the principles remain the same. ABA can help adults achieve goals that they want to work on. These might include:

- Strategies for coping with waiting
- Using public transportation
- Other skills to help them be more independent at home, in the community or at work

Because autistic people past age 14 often have difficulty getting funding for formal ABA therapy through their private insurance, adults usually utilize ABA principles more casually in their everyday lives. For instance, someone learning to greet others by saying "hello" may practice this skill in the grocery store and on a walk in the neighborhood rather than in a clinic. Similarly, a mother using positive reinforcement to teach her son how to get to work on a public bus is using ABA principles.

Without as much in-clinic support, parents, family members and caregivers often play a more active role in ABA-based learning for this age group. The key is for the person to get rewarded for their efforts with positive reinforcement, either from a therapist, family member or the environment.

How can families embrace ABA principles to help the autistic adults in their lives achieve their goals?

- Work together to understand the goals or skills they would like to work toward.
- Encourage independence by prompting them to complete tasks by themselves, using verbal, visual and physical prompts as needed.
- Break down tasks into small steps. Use picture prompts or other communication supports if needed to show each step.
- Spend time working with the person on their goals every day. Practice the same activity several times until it's mastered.
- Reward positive behaviors and ignore and redirect negative behaviors.
- If you observe harming behaviors developing, get in touch with the person's care team. Specialists can help look at these behaviors more closely to understand the root causes and set goals around those needs to keep them safe.

Parent's Guide to Applied Behavior Analysis for Autism



These materials are the product of on-going activities of the Autism Speaks Autism Treatment Network, a funded program of Autism Speaks. It is supported by cooperative agreement UA3 MC 11054 through the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Research Program to the Massachusetts General Hospital. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the MCHB, HRSA, HHS, or Autism Speaks."

This tool kit is an informational guide to Applied Behavioral Analysis (ABA). It is designed to provide you with a better **understanding of ABA**, **how your child can benefit**, and **where/how you can seek ABA services.**

WHAT IS ABA?

"ABA" stands for Applied Behavior Analysis. ABA is a set of principles that form the basis for many behavioral treatments. ABA is based on the science of learning and behavior. This science includes general "laws" about how behavior works and how learning takes place. ABA therapy applies these laws to behavior treatments in a way that helps to increase useful or desired behaviors. ABA also applies these laws to help reduce behaviors that may interfere with learning or behaviors that may harmful. ABA therapy is used to increase language and communication skills. It is also used to improve attention, focus, social skills, memory, and academics. ABA can be used to help decrease problem behaviors.

ABA is considered an evidence-based "best" practice treatment by the US Surgeon General and by the American Psychological Association. "Evidence based" means that ABA has passed scientific tests of its usefulness, quality, and effectiveness.

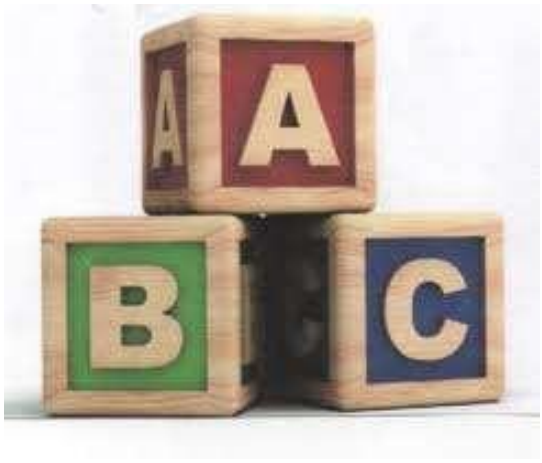
ABA therapy includes many different techniques. All of these techniques focus on antecedents (what happens before a behavior occurs) and on consequences (what happens after the behavior). One technique is "positive reinforcement." When a behavior is followed by something that is valued (a reward), that behavior is more likely to be repeated. ABA uses positive reinforcement in a way that can be measured in order to help bring about meaningful behavior change.

ABA In a Nutshell

Understanding (and modifying) behavior in the context of environment is the basis for ABA therapies.

- "***Behavior***" refers to all kinds of actions and skills (not just misbehavior).
- "***Environment***" includes all sorts of physical and social events that might change or be changed by one's behavior.

A few types of therapies based on ABA principles are ***discrete trial learning, incidental teaching (or natural environment training), verbal behavior, pivotal response training, and natural language paradigm (see next page for details).*** All of these ABA-based therapies:



- Are structured
- Collect data for target skills or behaviors
- Provide positive strategies for changing responses and behaviors

ABA focuses on positive reinforcement strategies. It can help children who are having difficulty learning or acquiring new skills. It can also address problem behaviors that interfere with functioning through a process called "functional behavioral assessment."

The principles and methods of behavior analysis have been applied effectively in many circumstances to develop a wide range of skills in learners with and without disabilities.

Discrete Trial Learning (Training) is based on the understanding that practice helps a child master a skill. It is a structured therapy that uses a one-to-one teaching method and involves intensive learning of specific behaviors. This intensive learning of a specific behavior is called a "drill." Drills help learning because they involve repetition. The child completes a task many times in the same manner (usually 5 or more). This repetition is especially important for children who may need a great deal of practice to master a skill. Repetition also helps to strengthen long-term memory. Specific behaviors (eye contact, focused attention and facial expression learning) are broken down into its simplest forms, and then systematically prompted or guided. Children receive positive reinforcement (for example: high-fives, verbal praise, and tokens that can be exchanged for toys) for producing these behaviors. For example, a therapist and a child are seated at a table and the therapist prompts the child to pay attention to her by saying "look at me." The child looks up at the therapist and the therapist rewards the child with a high-five.

Incidental Teaching (or Natural Environment Training) is based on the understanding that it is important to give real-life meaning to skills a child is learning. It includes a focus on teaching skills in settings where your child will naturally use them. Using a child's natural everyday environment in therapy can help increase the transfer of skills to everyday situations and helps generalization. In Incidental Teaching, the teacher or therapist utilizes naturally occurring opportunities in order to help the child learn language. The activity or situation is chosen by the child, and the caregiver or teacher follows the child's lead or interest. These teaching strategies were developed to facilitate generalization and maximize reinforcement. Once naturally occurring situations in which a child expresses interest are identified, the instructor then uses graduated prompts to encourage responses from the child. For example, a child is playing on the swings and needs the therapist to push him so that he can swing higher. The therapist waits on the child to ask for a push. Only after the child asks does the therapist push the swing. The therapist waits for the child to ask each time before he/she pushes the child again.

Verbal Behavior is similar to discrete trial training in that it is a structured, intensive one-to-one therapy. It differs from discrete trial training in that it is designed to motivate a child to learn language by developing a connection between a word and its meaning. For some children, teaching a word or label needs to include a deliberate focus on teaching them how to use their words functionally (E.g. What is this? A cup. What do you use a cup for? Drinking. What do you drink out of? A cup.)

Pivotal Response Training is a naturalistic, loosely structured, intervention that relies on naturally occurring teaching opportunities and consequences. The focus of PRT is to increase motivation by adding components such as turn-taking, reinforcing attempts, child-choice, and interspersing maintenance (pre-learned) tasks. It takes the focus off of areas of deficits and redirects attention to certain pivotal areas that are viewed as key for a wide range of functioning in children. Four pivotal areas have been identified: (a) motivation, (b) child self-initiations, (c) self management, and (d) responsiveness to multiple cues. It is believed that when these areas are promoted, they produce improvements in many of the non-targeted behaviors. The "Early Start Denver Model" is an early behavioral intervention model appropriate for children as young as 18 months of age. This model has a strong emphasis on Pivotal Response Training.

generalization. For example, a child who is allowed to leave after being prompted to say “goodbye” has a greater likelihood of using and generalizing this word when compared with a child who receives a tangible item for repeating this word. NLP transfers instruction from the therapy room to the child’s everyday environment with the interest of the child serving as the starting point for interventions.

✔ . So your child can learn what "to do," not just what "to stop doing."

✔ and . For example, reinforcement procedures increase on-task behavior or social interactions and reduce behaviors like self-injury or stereotypy.

✔ . For example: Teaching self-control and self- monitoring procedures to maintain and generalize job-related social skills

✔ . These responses could unintentionally be rewarding problem behavior.

✔

✔ Improve ability to on tasks, with tasks, and increase to perform.

✔ Aim to . Helps your child be .

✔ or response to another (For example, from completing assignments in the resource room to performing as well in the mainstream classroom).

Will ABA Benefit My Child?

Is your child…

✔ …having difficulty learning?

✔ …having problems acquiring new skills?

✔ …having difficulty communicating?

✔ …experiencing problem behaviors* that get in the way of functioning?

If your child has any of these or other concerning behaviors, an ABA-based approach to behavior intervention may be useful.

**Problem behaviors may include temper tantrums, aggression, or self-injury.*

What Does ABA Look Like?

ABA is such a broad approach that it is difficult to define what a typical program will look like. The amount of therapy and level of parent involvement varies, often according to the specific needs of the child. ABA skills training programs (such as discrete trial training, incidental teaching) can require several hours each day. While skills training programs are usually implemented by behavior therapists or teachers, parents are often taught critical skills to help their children transfer what they have learned in therapy to everyday life.

ABA skills training programs for young children are often based in the home and require special materials and a dedicated area for working. ABA behavior modification therapy may include 1-2 hours of parent training per week with the parents using strategies they learn in between visits. An ABA therapist may also consult with teachers to help support positive behaviors in the classroom.

A **first step in skills training** during an ABA session is usually includes an in-depth parent interview and an assessment measure such as the

Assessment of Basic Language and Learning Skills "ABLLS-R"

or

Verbal Behavior Assessment and Placement Program "VB-MAP"

Components of a Strong ABA Program

- ***Supervision*** – The program should be designed and monitored by a Board Certified Behavior Analyst (BCBA) or someone with similar credentials. Supervisors should have extensive experience working with children with autism.

- ***Training*** – All participants should be fully trained, with supervisors providing support, monitoring, and ongoing training for the duration of the program.

- ***Programming*** – The program should be created after a detailed assessment has been conducted and tailored to the child's specific deficits and skills. Family and learner preferences should be given consideration in determining treatment goals. Generalization tasks should be built into the program to ensure performance of skills in multiple environments.

- ***Functional programming*** – Goals selected should be beneficial and functional to the individual and increase or enhance his/her quality of life. A mix of behavior analytic therapies should be used so that the child has an opportunity to learn in different ways.

- ***Data collection*** – Data on skill acquisition and behavior reduction should be recorded and analyzed regularly. This data should be reviewed by the supervisor and used to measure the progress of the individual and provide information for program planning.

- ***Family training*** – Family members should be trained in order to teach and reinforce skills. They should be involved in both the planning and review process.

- ***Team Meetings*** that involve the therapists, supervisor and involved family members are necessary to maintain consistency, identify pertinent issues and discuss progress.

Who Provides ABA Services?

ABA providers may vary in training, experience, and certification:

- **Certifications in ABA**: Therapists may be certified through the Behavior Analyst Certification Board. If they are board certified and have at least a Master's degree, then they will have the letters BCBA after their name. BCBA-D means they have a doctoral degree. Other therapists may have BCABA credentials. This means education in ABA at a Bachelor's level.

- **Experience in ABA**: Some ABA therapists may have years of experience providing ABA but may not be formally "certified." Uncertified ABA therapists may have trained under and had their work supervised by a certified ABA therapist. While uncertified therapists may provide individual ABA skills instruction, they should be supervised by someone with credentials or similar experience.

When seeking ABA services, it is important that you request and receive information about the therapist's experience. Ask him or her to *provide references* from other parents or caregivers

Where is ABA Therapy Provided?

ABA can be provided at school, at home, or in the community depending on the needs of the child and the services that are available in a particular area. Some school programs use ABA strategies within the classroom. They may also be used as part of a child's individual education plan ("IEP"). In addition, community-based therapists may provide ABA in the home to children diagnosed with autism.

Most large to medium sized cities will have certified ABA therapists. Smaller towns and rural areas may not. This is why asking about experience of the provider is important.

How Do I Obtain ABA Services?

- Check with your local chapter of Autism Speaks or visit the Family Services tab on the Autism Speaks website: www.autismspeaks.org. Search for ABA services offered in your state.
- Check your local chapter of the Autism Society of the America. Go to their website www.autismsociety.org to find state-by-state resources.
- Find Board Certified Behavior Analysts at www.bacb.com.
- Talk with your child's education team about local providers.
- Talk with families living with autism at local support groups.

Insurance Coverage for ABA

Insurance companies vary in their willingness to pay for ABA therapies. Policies also differ from state to state. You will need to check your policy to determine if ABA services will be covered or reimbursed.

Resources

The Autism Speaks Family Services Department offers resources, tool kits, and support to help manage the day-to-day challenges of living with autism (www.autismspeaks.org/family-services). If you are interested in speaking with a member of the Autism Speaks Family Services Team contact the Autism Response Team (ART) at 888-AUTISM2 (288-4762), or by email at familyservices@autismspeaks.org.

ART En Español al 888-772-9050.

Websites

Read about evidence-based treatments for autism at:

- The National Autism Center Website at www.nationalautismcenter.org
- The Organization for Autism Research (OAR) website at www.researchautism.org

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CASP
The Council of Autism Service Providers

Facts About

ABA for Families

Q My physician is recommending a therapy called Applied Behavior Analysis (ABA). What does ABA look like for people with au◆sm?

A ABA is o◆en prescribed for people with au◆sm and can be provided in schools, homes, clinics, and community se◆ngs. ABA is based on the ◆ence of behavior. It is individualized based on the au◆s◆c person's strengths and the challenges they experience.

ABA providers are called Behavior Analysts. Like other medical and behavioral health providers, Behavior Analysts rely upon strategies and procedures from peer-reviewed research. They con◆nually evaluate and customize treatment op◆ons based on the needs of the au◆s◆c person. Behavior Analysts request and integrate informa◆on from the au◆s◆c person and their caregivers and coordinate care with other professionals who serve the au◆s◆c person.

Q Does ABA acknowledge the differences that make a person with au◆sm unique?

A The oldest and largest na◆onal cer◆fica◆on board in ABA is the Behavior Analyst Cer◆fica◆on Board® (BACB®). BACB cer◆fica◆on can help health plans, and subscribers iden◆fy qualified ABA providers.

Q Is the goal of ABA to make a person normal?

A Yes. ABA providers work with the person ◆h au◆sm and their circle of support to learn what is important to them over different points in ◆me.

For example,

- for a toddler, this may be learning to speak or point;
- for a tween, this could be learning how to safely walk in a parking lot or take turns playing video games with peers;
- for a teenager, this could be learning how to navigate social media or prac◆cing healthful hygiene.

ABA providers celebrate each au◆s◆c person's

unique iden﷽ty and personality and incorporate personal preferences throughout treatment.

No. Safety, dignity, and personal preferen are essen﷽al components of any ABA program. ABA providers work directly with people with au﷽sm to choose meaningful goals. For example, ABA therapists implement programs that can help create awareness of exis﷽ng societal expecta﷽ons so that they can make informed choices.

Q Do ABA providers allow clients to make choices?

A Yes. Choice is an essenﬁal part of an ABA program. Providers incorporate choice throughout the treatment process. This begins at int[illegible] when auﬁsﬁc people and caregivers work with providers to set goals that are important to them. The incorporaﬁon of choice is conﬁnually evaluated throughout treatment.

Q How does ABA align with neurodiversity?

A ABA providers teach evidence-based com[illegible]nicaﬁon skills to people with auﬁsm, so they can express their wants and needs, strengthening their ability to advocate and parﬁcipate in ongoing treatment decisions and person- centered planning. ABA therapy focuses on empowering people with auﬁsm to navigate their world and live connected and healthy lives.

Q Does the ABA profession accept the exploitaﬁon of people with auﬁsm?

A No. All recipients of ABA services have a [illegible]t to receive effecﬁve treatment that is free from exploitaﬁon. ABA providers who exploit or aﬁempt to use their power to take advantage of auﬁsﬁc people should be reported to the appropriate legal or regulatory authoriﬁes.

Q Has ABA changed over ﬁme?

A Yes. All science-based health care profes[illegible]s are constantly evolving. The last few decades have seen the pracﬁce of ABA advance with the establishment of more quality controls in the field. For example, conversion therapy would violate several of the current ethical codes in the profession of applied behavior analysis.

Q Do behavior analysts consider the reasons why a behavior might be happening?

A Yes. ABA providers very deliberately cons[illegible]r why clients behave the way they do. An enﬁre methodology known as funcﬁonal behavior assessment is designed around this basic idea. These reasons are expected to be incorporated into treatment to ensure needs, wants, and preferences are being met.

Although historically, person-first language has been preferred by the broader disability community, people diagnosed with auﬁsm spectrum disorder, their families, and providers have expressed dramaﬁcally different preferences. Because of this, we use both person- first and idenﬁty-first language in this Q&A.

For reference informaﬁon, please contact info@casproviders.org.

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