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SI: COMPASSION IN APPLIED BEHAVIOR ANALYSIS

An Introduction to a Child's Rights Approach to Applied Behavior Analysis

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Abstract

The effective application of behavior analysis requires compassionate care that protects the rights of child clients while adhering to the core principles of applied behavior analysis (ABA). Although ethical practices for behavior analysis have been established, including the protection of clients' rights, there remains limited guidance on implementing these expectations in professional practice. Moreover, criticism of the field by autistic advocates, other professionals, and even those within the field often lacks meaningful recommendations for future practice. However, readily available frameworks can help improve the field by developing tools and practices that protect clients through practical assessment and compassionate care. This article introduces a new framework, *The Behavior Intervention Checklist: A Child Rights Approach,* based on the United Nations Convention on the Rights of the Child, to assist practitioners in defining and protecting the rights of the children they work with. The article focuses on the creation and implementation of *The Behavior Intervention Checklist* as a self-assessment tool for behavior analysts to evaluate initial intake procedures and develop and review behavior plans through a children's rights lens.

Keywords Rights of the child · Compassionate care · Autism services · Equity

The provision of compassionate care has become an emergent area for research and practice. Compassionate care requires more than technical skill and focuses on practitioners' interpersonal skills to strengthen therapeutic relationships with children and families (Taylor et al., 2018). Compassionate care is a critical component in delivering effective and ethical applied behavior analysis (ABA) services (Taylor et al., 2018; Rohrer et al., 2021), but it must also be bolstered by a defined practice that supports the rights of children and families. To provide such care, it is essential for behavior analysts to have a clear understanding of their client's rights and ensure these rights are protected throughout treatment (Behavior Analyst Certification Board [BACB], 2020). However, the field of ABA faces challenges in addressing concerns raised by autistic advocacy communities and other interested parties (Leaf et al., 2021; Kirkham, 2017; Wilkenfeld & McCarthy, 2020), who highlight the need for a better-defined framework that respects the rights and autonomy of the clients it serves. Melton et al. (2023) also highlight the need for clearer, behavior based, definitions of compassion and empathy and specifically identify in their definition of compassionate behavior that behavior analysts must identify suffering contingencies and take actions to help individuals in distress. Canon and Gould (2022) explore potential ways to increase relationship-building skills and found instruction and feedback were effective in increasing these skills among behavior analysis practitioners. This discussion suggests utilizing the United Nations Convention on the Rights of the Child (UNCRC) as an all-encompassing framework to guide behavior analysts in identifying areas of potential suffering and safeguarding and advocating for children's rights (Melton et al., 2023; UNICEF, 2007). Furthermore, it led to the development of *The Behavior Intervention Checklist: A Child's Rights Approach*, an instrument influenced by the UNCRC, which can aid behavior analysts in evaluating and improving the social appropriateness of their intervention plans.

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Social Validity and Compassionate Care

The application of behavior analysis stands on the principles of social validity when designing interventions for behavior change (Carter & Wheeler, 2019). However, autistic advocacy communities, parents, and other interested parties have issued public criticism of applied behavior analysis (ABA) which points out the lack of necessary interpersonal skills to provide compassionate care (Taylor et al., 2018). Compassion is not only a broadly defined way of treating individual learners and caregivers, it must also be part of our policies, institutions, and ethics. Creating institutional support for compassionate care can be a significant challenge for behavior analysts, who are taught to analyze from a scientific perspective (Taylor et al., 2018). Skills around building positive therapeutic relationships with child clients should have both valid report measures, and be built on an institutional framework of socially valid definitions of children's rights that support compassionate care. As pointed out by Epstein (2017) and reiterated by Taylor et al. (2018), we need to address institutional values and atmosphere to provide compassionate care. This means our applied behavior analysis institutions must have well-defined values that align with and support compassionate care. One way of doing this is by examining the Behavior Analyst Certification Board's (BACB) foundational values, specifically that of social validity, and the ethical mandate of protecting our clients' rights (BACB, 2020).

Defining an instructional approach to obtaining skills related to compassionate care are critical to teaching the skills among practitioners (Rohrer & Weiss, 2022). Furthermore, the generalization of these skills among practitioners requires continued professional development (Canon & Gould, 2022). This article looks to better define what it means for a behavior analyst to protect children's rights through the lens of social validity. Moreover, this article focuses on ABA delivery for child clients, however, this framework could be modified to be applied across age groups with further research. Supporting this foundational ethic is a prerequisite to meaningful, compassionate care. Along with recent literature related to targeted skill development in this area and enhancing efficacy there is the potential for expanding the ways behavior analysis is practiced (Canon & Gould, 2022; Rohrer & Weiss, 2022).

Autistic advocates within the ABA field have provided suggestions on the ways that the field can improve. These include tools around trauma informed care frameworks (Kolu, 2019; Middleton, 2021) and other foundational values that would provide paths toward better practice (NeuroClastic, 2022). Advocates outside the field, such as NeuroClastic, have also provided helpful insight that although kindness and compassion are important traits, they are not enough to shift harmful practices because they do not address the actual implementation of behavior analysis, and kind or compassionate feelings can be demonstrated in conjunction with traumatizing practices (NeuroClastic, 2022). In addition to kindness and compassion, analysts must dedicate time to learning about other helpful tools, including the rights of clients, trauma-informed practices and the lived experiences of the populations we work with (Kolu, 2019; Middleton, 2021).

Social validity is defined in three components: (1) social significance of the goals of treatment; (2) social appropriateness of the treatment procedures; and (3) social importance of the effects of treatment (Wolf, 1978). All three components contribute to deciding if a behavior analytic intervention is needed and how to implement it. The goals and effects of treatment look at the conclusions of intervening, but component two, social appropriateness requires that we look at the *way* the intervention is provided. Social appropriateness can be a challenge to define for behavior analysts, as it relies on an understanding of changing social appropriateness, as well as consultation with those who are receiving or consenting to treatment (Carter & Wheeler, 2019). Further, in order to assess social appropriateness and social validity community members, and particularly underrepresented community members, should give input on the methods, techniques and on the outcomes of a practice to determine if a program is valid (Schwartz & Baer, 1991). Social validity assessments should be standard practice, a wide variety of consumers should be queried about programming, assessments should be rigorous and have clear definitions, and consumers and extended community members should be offered objective education about goals, specifically not propaganda aimed at changing their values or opinions (Schwartz & Baer, 1991).

Input from the autistic advocacy community, who are both direct consumers and extended community members, has indicated that the field contains harmful practices and does not honor the rights or autonomy of the people it is meant to serve (Leaf et al., 2021; Kirkham, 2017; Wilkenfeld & McCarthy, 2020). One of the challenges in addressing these concerns is the ambiguity around the rights of child clients contained in the code of ethics for credentialed behavior analysts as outlined by the BACB (2020). It simply states that we should protect the rights of clients, however a clear definition of those rights is not provided. If protecting the rights of our clients is one of our first ethical guidelines, we must find a framework for defining their specific rights. This article will focus on the introduction of *The Behavior Intervention Checklist: A Child's Rights Approach* (see Table 1) which the authors based on the established framework of the United Nations Convention on the Rights of

Table 1 Behavior intervention checklist: A child's rights approach

Part 1: Caregiver/Child Consultation
1) Does this client belong to any historically marginalized groups?
a. Does the treatment plan acknowledge the ways this could be a barrier to care?
b. Does this plan discriminate against the child based on any of the areas identified by UNICEF (2007)?
1) Does this plan follow all legal requirements in the area where the child resides?
2) Does this plan operate in the best interests of the child?
3) Does the child have access to everything needed to thrive (food, wellness care, shelter, education)?
4) Does this plan provide an avenue for the child to influence or make decisions for themselves once they have "sufficient understanding" of the situation?
5) Are parents educated about their child's changing capacity for self-determination on this issue?
6) Does this plan interfere with the child's right to freedom of expression, thought, conscience or religion?
7) Does this plan interfere with the child's right to developmentally appropriate privacy?
8) Does this plan interfere with the child's right to appropriate information?
9) Does this plan interfere with the child's right to education or health care services?
10) Does this plan interfere with the child's right recreation and play, cultural or artistic opportunities?
11) Is this plan periodically reviewed to ensure the child's right to review of treatment?
Part 2: Plan Creation & Evaluation
1) Safety
a. Is the client physically safe?
b. Is there a plan in place to ensure there are no negative effects of the plan, such as trauma?
c. Does the plan include an avenue for self-advocacy?
d. Does this plan include cultural or other individual factors that may be relevant to the child?
2) Modeling Positive Relationships
a. Does the plan include reciprocity, and client-based direction?
b. Does the plan include rapport building after the client has a meltdown?
c. Does the plan include instances of appropriate negotiation and flexibility?
3) Bodily Autonomy
a. Does the plan interfere with the client's freedom of movement?
b. Does the plan interfere with any stimming or coping behaviors?
If the plan does interfere with the freedom of movement, is it in circumstances where it is necessary for safety?
c. If physical prompting is part of the plan, is assent/consent sought or an explanation associated with it (i.e. I'm going to help you do____')?
4) Self-Determination
a. Does the plan include times when the client may ask for space or alone time?
b. Does the plan include options in the order, materials etc. for the completion of the tasks?
c. Does the plan include acknowledgement of the client's preferences?
d. Does the plan include teaching self-advocacy skills and adjusting to them?
5) Supports/Includes Special Interests & Preferences
a. Does the plan engage the client using their preferences or follow their lead?
b. Does the plan offer time for the client to engage with or talk about their interests?

Note. Adapted from The United Nations on the Convention on the Rights of the Child & Convention on the Rights of Persons with Disabilities by R. A. Cianci & M. A. Sevon

the Child (UNCRC) to define our child client's rights and to enhance the social appropriateness of treatment plans created by behavior analysts by using the checklist as an assessment tool.

Adopting the UNCRC in Applied Behavior Analysis

The UNCRC is the most universally ratified human rights treaty in the world (UNICEF, 2007). The cross-cultural acceptance of the treaty by governments across the world speaks to its near global social validity as a measure for the rights of all children. In addition, the UNCRC provides guidance for practitioners on discussing the rights of children (UN, 1989) and aims to ensure protection and freedom for all children (Cohen & Naimark, 1991). Although the implication of the UNCRC has been enforced across the European Union for over 3 decades (Lundy, 2012), it was not formally endorsed in the United States. However, UNCRC provides a comprehensive framework to assess how professional practice acknowledges the rights of child clients. The substantive components of the UNCRC include 41 articles ranging from civil-political rights to economical-social-cultural rights and was innovative in its approach to seeing a child independent from their parents. Moreover, the convention urges that the rights of the individual child are vital and shaped a contemporary view of childhood (Cohen & Naimark, 1991). A positive ideology of the child emerged and determined minimum standards for care and treatment (Hart & Hart, 2020). Such standards could be applied to the application of behavior analysis when serving children.

Over the last decades other clinical fields have used the UNCRC framework to evaluate assessment procedures, treatment planning and implementation of services for children (Kennan et al., 2021; Prunty, 2011). For example, the field of school psychology has made substantial steps toward embedding the framework provided and supported by governments in the UNCRC into professional best practice. School psychology provides a helpful model for how a child rights approach can be used in clinical treatment (Nastasi & Naser, 2014). Hart and Hart (2014) provide reasoning that using the UNCRC changes the social contract between school psychologists and those they serve, moving from a problem-oriented approach to proactive promotion of well-being. Applied behavior analysis has the same obligation to shift the field, to better serve the whole client, not just to address or minimize behaviors the clinician or caregiver desires to change. Making these changes is the only way for behavior analysts to create socially valid interventions for the children we serve.

Building on this idea, as the field of behavior analysis moves to compassionate service delivery (Taylor et al., 2018; Rohrer et al., 2021), it becomes crucial to differentiate compassion from saviorism (Wake, 2022; Cerda, 2023). Acknowledging the rights of child clients, aligns with compassion and involves working with children

collaboratively, empowering them to have a voice in their own care, and advocating for their rights. In contrast, saviorism involves a top-down approach, in which the caregiver or professional assumes they know what is best for the child without considering the child's perspective or experiences (Cerda, 2023). In the context of child rights, the compassionate approach is essential for ensuring that children's voices are heard and that their rights are respected. By valuing and understanding each child's perspective, behavior analysts can work collaboratively with children and their families to provide effective and respectful treatment.

To further support this compassionate approach, Nastasi and Naser (2014) have analyzed rights described in the UNCRC and associated it with a professional or ethical standard, as described by school psychology organizations. This association can be seen as a way to align ethical practices with the rights of children (Nastasi & Naser, 2014). *The Behavior Intervention Checklist: A Child's Rights Approach* introduced in this article provides a similar tool to behavioral analysts, but on an individual scale. Instead of looking at the broader profession for alignment, the checklist provides a framework that can be used by individual behavior analysts to determine if their plans are in alignment with children's rights as defined by the UNCRC.

The Behavior Intervention Checklist: A Child's Rights Approach was adapted from the UNCRC and is a self-assessment measure for behavior analysts. The checklist is composed of two portions, the first portion provides a broader framework which examines if the child is experiencing challenges to their rights that may be a barrier to effective treatment and the second which looks at the specific implementation of behavior plans. The first portion, Part 1: Caregiver/Child Consultation**,** helps a clinician to begin asking themselves questions about the child's environment which may affect the effectiveness of the behavior plans themselves. If the child is experiencing violations of their rights in those areas, referrals to additional services or resources may be required. The behavior analyst will know to look for additional expertise or support while working with the client. The second portion of the checklist, Part 2:Plan Creation & Evaluation, focuses on implementation of the behavior plans themselves, and each question is directly associated with an article from the UNCRC.

Checklist Introduction

The *Behavior Intervention Checklist: A Child's Rights Approach* is a self-assessment tool for behavior analysts. The theory of cultural humility (Tervalon & Murray-Garcia, 1998) recommend that before intervening in the lives of others, behavior analysts must exercise due diligence, starting with self-reflection (Wright, 2019). As part of this process, we suggest using the self-assessment tool on the rights of the child to enhance understanding of the child's perspective and ensure that interventions are respectful and appropriate. The *Behavior Intervention Checklist: A Child's Rights Approach* asks questions to focus the practitioner's attention on areas of children's rights as defined by the UNCRC. Although using the checklist if the practitioner does not know the answer to a question, this should prompt them to gather more information, either through conversation, observation or the formal intake paperwork. The practitioner should use the checklist to become aware of potential barriers or environmental concerns, as well as to examine the plans that they develop. The framing of the checklist is in yes or no questions, this framing is helpful because each "yes" should be a prompt for the behavior analyst to examine the situation further. They should consider what that yes means for the client, their plans, and advocate for their clients within their natural environment.

The formatting for the *Behavior Intervention Checklist: A Child's Rights Approach* is divided into two parts. The first focuses on broad questions to be asked by the practitioner after intake is complete. The second part focuses on questions the practitioner should ask themselves about each behavior plan. The checklist should be reviewed every 6 months, or as reauthorization with insurance or reassessment occurs. The checklist should also be used in the case of any major change in behavior plans or treatment. A "yes" answer may not always be simple to solve, but serves to focus the behavior analyst's attention on an area where a referral or additional support is needed, outside of behavioral interventions. This does not necessarily mean a full referral out, but in addition to or complementing behavior analytic services. Some of the problems it may not be possible for the behavior analyst to solve, but increased awareness of barriers, systemic injustices and other issues influencing each child's wellbeing provide insight for areas of advocacy on both an individual and community level.

The code of ethics for board certified behavior analysts states that we should protect the rights of clients and The UNCRC is the primary framework used within this article, because of the specific focus on the rights of child clients. Many clients also fall under the United Nations Convention on the Rights of Persons with Disabilities (United Nations Human Rights Office of the High Commissioner [UNHRC], 2006). Article 7 in particular deals with the rights of children with disabilities, and Article 25 addresses health rights of individuals with disabilities. Connecting and adding to the presented checklist as it supports the rights of persons with disabilities is an area for future research.

Understanding the rights of clients is essential from an ethical perspective and to provide effective behavioral interventions (BACB, 2020). If the client is not able to

consistently count on these basic rights being protected, they are experiencing significant barriers to reaching their fullest potential (Waterston & Goldhagen, 2007). The checklist identifies freedom from discrimination as a right for all children, and references an extensive list in the *Implementation Handbook for the Convention on the Rights of the Child* that includes factors that may lead to discrimination in different cultures (UNICEF, 2007). This right may seem outside of the scope of behavior analytic practice, but it can also be a significant barrier to the success of behavioral programming, supported by research in educational, health, and behavioral health outcomes (Mehta et al., 2013; Alegría et al., 2015). Therefore, culturally responsive practice is essential to mitigate the impact of systemic discrimination. By adopting culturally aware and responsive practices, behavior analysts can ensure that treatment is effective and respectful for all clients, regardless of their cultural or linguistic background. Culturally responsive practice is necessary to facilitate access to effective treatment (Slim & Celiberti, 2021). This is just the first example that helps illustrate why each of these rights must be considered, protected and supported by behavior analysts when working with any child client.

In addition, the BACB *Code of Ethics* (Behavior Analyst Certification Board, 2020) highlights the importance of promoting the welfare of clients and protecting their rights. This includes collaborating with other professionals as needed to ensure that the client's needs are being met and advocating for the appropriate use of behavior analytic techniques. Therefore, upholding the rights of our clients to areas for growth, advocacy, and collaboration with other professionals is not only a moral imperative but also a professional responsibility. By engaging in these behaviors, behavior analysts can help to ensure that their clients receive the highest quality services and that their rights are being protected.

Part 1: Caregiver/Child Consultation

The first portion of the checklist (Part 1) addresses outside issues that may affect the client's rights and barriers to successful support. The behavior analyst should be able to answer these questions after intake paperwork and initial meetings with a child and family. If they don't know the answer, they can ask parents or the child to better understand what barriers they may encounter. Using the child rights framework behavior analysts can gain insight into related rights that are outside of the behavior analytic scope. This will help the analyst identify barriers to therapeutic success and provide direction for referrals or opportunities to collaborate with other professionals, as recommended by the BACB *Code of Ethics* (BACB, 2020).

Part 2: Plan Creation and Evaluation

The next part of the checklist is broken down into areas that behavior analysts should clearly identify in their behavior plans. When this checklist is used as a tool for the creation of behavior plans it examines these core, behavior analytic and child-rights based factors; safety, modeling positive relationships, bodily autonomy, self-determination and supports/includes special interests and preferences. These core ideas are supported directly by the UNCRC, and the questions associated with each portion provide direction to evaluate how these rights may be protected in behavior analytic practice.

Safety

Children's right to safety is supported in Article 8 (Preservation of Identity), Article 12 (Respect for Views of the Child), Article 16 (Child's Right to Privacy), Article 19 (Child's Right to Protection from All Forms of Violence), Article 27 (Child's Right to Adequate Standard of Living), and Article 31 (Right to Leisure, Play and Culture; UNCRC, 1989). Safety is one of the most basic rights, and the questions asked in this section prompt the behavior analyst to examine the physical safety of the client in combination with their emotional and psychological safety from future negative effects. Culture, community, and family support are safety enhancing, and behavior plans should enhance, not detract from those cultural safety nets (Srivastav et al., 2020).

The questions also direct the behavior analyst to examine future safety and well-being. Does following the plan protect the client's future safety or if they continue to follow it into adulthood, what dangers might they encounter? For behavior analysts, safety includes ensuring that the client is physically safe during sessions and teaching future safety skills (Rossi et al., 2017). Plans should also enhance future safety, both by addressing safety skills for clients who elope etc., and by ensuring the plans provide emotional safety (Rossi et al., 2017). Because families and culture offer protective factors (Srivastav et al., 2020), all behavior plans should support these additional areas that act as prevention for adverse childhood experiences.

Modeling Positive Relationships

The ideas of safety stated above look at current protective factors, the next section, Modeling Positive Relationships, looks at future safety and children's rights in relationships, supported by Article 12 (Respect for Views of the Child) and

Article 31 (Right to Leisure, Play and Culture). If behavior plans protect clients rights, how are the views of the client protected and supported in the plan being examined? In the continued vein of enhancing both the present right to play, leisure and the child's views, behavior plans should also have avenues for those both within the session and in the future. Multiple positive adult relationships are also protective factors for prevention of adverse childhood experiences (Srivastav et al., 2020).

Behavior analysts have the unique position of spending significant amounts of time with clients, with children attending 20–40 hr per week in many early intensive behavioral interventions (EIBI; Makrygianni & Reed, 2010). This means that the relationships within the clinic setting are a model for what relationships may look like in the future.

Bodily Autonomy

The UNCRC Article 12 (Respect for Views of the Child), Article 16 (Child's Right to Privacy), Article 19 (Child's Right to Protection from All Forms of Violence), Article 31 (Right to Leisure, Play and Culture) support the necessity for age-appropriate bodily autonomy. According to the United Nations Population Fund (2021) "Not only is bodily autonomy a human right, it is the foundation upon which other human rights are built. It is included, implicitly or explicitly, in many international rights agreements, such as the Programme of Action of the International Conference on Population and Development, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of Persons with Disabilities." In addition, when specifically addressing Health Rights for Persons with Disabilities in Article 25, it is clear that autonomy, informed consent, and dignity are inherent parts of appropriate treatments. This section focuses on whether or not the plan includes developmentally appropriate bodily autonomy. For behavior analysts, bodily autonomy can be demonstrated by communicating what the analyst is doing, seeking consent and assent to program implementation and allowing the client's freedom of movement whenever safety is not a concern.

Self-Determination

This section of the checklist is supported by Article 16 (Child's Right to Privacy), Article 31 (Right to Leisure, Play and Culture), Article 12 (Respect for Views of the Child), and Article 19- Child's Right to Protection from All Forms of Violence). Self-Determination is an important area for children, especially when considering assent or informed consent to treatment as one of the areas where the child's evolving capacity must be taken into consideration (Varadan, 2019). Article 7 of the Convention on the Rights of Persons with Disabilities doubly supports this when specifically addressing children. "States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right" (Article 7, 3. UNHRC, 2006). This is particularly well-articulated because it makes clear that the purpose of disability services is to realize this right to express views, communicate and determine for themselves, meaning all disability services for children should support and encourage accessing these rights, not be compliance or assimilation based. For behavior analysts, this means taking client preferences into programming, even if the preferences are not vocally communicated. Client's should have input on programming, including target selection, the way the target is implemented, and alternatives.

Supports/Includes Special Interests and Preferences

One of the rights that is mentioned frequently is Article 31 (Right to Leisure, Play and Culture), and supporting children to engage in their special interests, preferences and play allows them to access these rights. According to behavioral definitions of reinforcement, reinforcement is defined by its effect on an individual, and extensive preference or reinforcement assessment is completed to establish these reinforcers (Cooper et al., 2019). Because leisure and play are the rights of children, all plans should acknowledge and help them access play that includes their preferences and interests.

Checklist Implementation: Example Case Study 1

The following case study provides an example of implementation of the *Behavior Intervention Checklist*, using the description of a fictional child. A parent was seeking ABA treatment for their son, named Liam for the purposes of this example. Liam was 7 years old, received a diagnosis of autism spectrum disorder at age 4, had Medicaid health insurance, and was from a historically marginalized group. He lived in an English speaking home with his parents, as well as his grandmother and two older siblings. He lived in a city and attended a public school, which supported the recommendation for ABA services.

Part 1 of the *Behavior Intervention Checklist* helped frame the questions asked by the BCBA during the intake and all areas were completed during the intake process. The first question asked if Liam belonged to a historically marginalized group, which he does and which indicated he may

have been exposed to discrimination or prejudices within larger systems and institutions. He also received an autism diagnosis which means he may have been discriminated against due to disability. His family also qualified for Medicaid, indicating that they may have an income that falls below the state or federal poverty line. These categories for potential discrimination are listed in the *Implementation Handbook for the Convention on the Rights of the Child* (2007). This question allowed the behavior analyst to do additional research on how discrimination based on these factors may interfere with effective behavior analytic treatment and the rights of the child. They also allow the behavior analyst to seek out effective consultation with others who may have lived-experience or other expertise in these areas.

The next questions in Part 1 of *The Behavior Intervention Checklist* further examines the broader areas that may affect the intervention, based on a children's rights perspective. It required the BCBA to look at the treatment plan as a whole, rather than a specific behavioral intervention. Liam's plans should be in line with legal requirements and operate in his best interest. The treatment plan for Liam followed legal guidelines, and the child, parents and caregivers were consulted to ensure it was in his best interests.

Barriers to the plan were also discussed with parents, such as making sure Liam had everything needed to thrive. As part of the intake process parents were asked about any specific challenges they were facing and referrals or resources that might be helpful to meet their family needs. In this case study Liam's family described some barriers, including the communication device the client used to communicate not being part of his individualized education program (IEP). This would be a significant barrier to any communication goals, and was an area where the BCBA needed to advocate for the client's access.

Parents also mentioned that Liam regularly got in trouble for "playing" on his communication device at school. This alerted the BCBA to a potential challenge in treatment, and an area for additional resources. Research into school discipline indicated that culturally minoritized students are more likely to receive punitive discipline, and this may be a factor to consider when providing services in school (Sevon, 2022).

During intake with the parents the child also has the opportunity to demonstrate or ask to work on specific things. Communication had already been identified as an area for support, particularly using the AAC device which Liam had shown a preference for throughout the meeting. The conversation with parents also included the child, and acknowledged that as Liam gets older he should have increasing influence on the plans and goals. Parents should be engaged in that process, and the BCBA also asked about their family's cultural expectations as children age. In this case, parents identified other areas of concern including; washing hands, skin picking, and following school routines. Parents also indicated a concern that Liam sometimes touched walls while walking and made guttural giggling sounds while watching videos.

After reviewing questions 6–11 in Part 1 of *The Behavior Intervention Checklist* it was determined that cleaning hands, following school routines (or communicating about them) and functional communication were appropriate behaviors for increase. Skin picking was determined as an appropriate target for decrease, as long as the plan focused on providing an appropriate alternative. Making sounds during leisure time was determined to be not a socially significant behavior, and the BCBA shared information regarding vocal stimming with the parents. The BCBA also let the parents know that touching the wall could be an example of another stim, and they would assess to see if there were safety concerns when Liam touched some surfaces or if it was a safe stim. At the conclusion of the initial meeting a time is set for the review of Liam's treatment plan, to ensure that review happened regularly and included the parents as well as the child.

For the purposes of this case study we selected a single targeted behavior, hand cleaning, to provide an example for the use of Part 2: Plan Creation and Evaluation of the *Behavior Intervention Checklist.* Section 1 of Plan Creation & Evaluation deals specifically with safety . Handwashing was the parent's original requested target, but after talking with them about their goals for their child they indicated that they are concerned about potential infection from picked skin on hands and dirt, bacteria or other items left on hands, the method of cleaning was flexible. This behavior target does have safety implications, and the plan acknowledged the risks of not learning to clean hands. Parents also indicated that they have washed hands with the child before, but he cried, and did not seem to learn the steps. The BCBA acknowledged that hand cleaning was an important goal, and looked at options that required the least amount of physical intervention because the client crying indicated that there may be negative future effects that they are not able to communicate.

The BCBA also asked Liam's family if there are any cultural norms around hand cleaning that made it an important behavior. The parents shared that everyone in the family washes their hands before dinner, as part of their dinner routine, before they hold hands to pray. Having clean hands would allow the client to participate in this family, cultural, and religious routine.

In order to develop the plan, the BCBA first conducted a preference assessment. They tried wet wipes, dry soap bars, wet liquid soap, wet foam soap and dry towels followed by hand sanitizer. The client was offered the items, the BCBA modeled how to use them, and the client exhibited a preference for wet wipes by engaging with the wipes without prompting or any distress as demonstrated by crying,

whining or removing hands. The client also engaged with the wipe for 30 s, indicating interest.

Section 2 of Plan Creation & Evaluation focuses on Modeling Positive Relationships. The BCBA used the assessment time to begin building a relationship with Liam. They followed Liam's lead, carried out simple instructions when Liam made requests using their AAC device or other communications, and provided comfort when Liam heard a vacuum that resulted in him crying. The BCBA also modeled "too loud" on the communication device and helped the client find their headphones. These actions helped model to Liam what a positive, helping relationship should look like. The BCBA also presented tasks, but if Liam indicated that he wanted more time, the BCBA made adjustments to the client's negotiation.

While working on the details of the plan the BCBA used the same principals above in the plan, including allowing for flexibility of when to start, selecting the item Liam liked the best to clean hands (wet wipes) and providing opportunities for communication. The plan also included an opportunity to include Plan Creation & Evaluation, Section 3 Bodily Autonomy. The plan included a prompt sequence that ended in physically helping Liam clean his hands, meaning that it did interfere with Liam's freedom of movement. Due to the nature of the task, hand under hand was not an option. In order to ensure that bodily autonomy was still maintained, the plan indicated that the BCBA or therapist should stand to the side and face Liam, not behind him, allowing Liam to move away. The plan also included letting go of Liam if he was done, and slowly increasing the surface area of the hand cleaned. The plan also included the therapist saying clearly, "I can help you clean your thumb" or other parts of the hand, to gain Liam's assent. The plan does not interfere with any stimming or coping behaviors.

The BCBA also included environmental antecedents in their plan, to ensure Plan Creation & Evaluation, Section 4: Self-Determination was included. Before starting the learning part of the plan Liam should have had time to play, with or without the therapist based on client preference. It also included that Liam could select the order, and other options for hand cleaning should still be available in case his preference changed. In addition, at any point during the plan, communication should be acknowledged and adjustments made that respect the child's self-advocacy.

The final part of the checklist is Plan Creation & Evaluation, Section 5:Supports/Includes Special Interests & Preferences. The selection of wet wipes followed Liam's preferences, and he influenced when the plan was implemented. The plan also offered time for the client to engage with other preferred activities, including during the environmental antecedent and reinforcement time, where he was able to take the lead and freely engage in activities of his choosing.

This case study provided a single example of using the *Behavior Intervention Checklist* as a framework to conduct a portion of the intake process and to create a behavior plan. The checklist can be used as a framework for building a behavior plan with child right's based elements and goals and it can also be used to review existing plans from a child right's lens.

Checklist Implementation: Example Case Study 2

Behavior analysts may find different portions of the checklist more or less relevant to a specific child, depending on their current environment. This example focuses on how age and independence changed the things a behavior analyst may notice. A parent was seeking ABA intervention for their daughter, Anna. Anna was currently enrolled in a public school and the school had indicated that there are significant behaviors of concern. She was 11 years old. The school reported she often engaged in outbursts when denied access, refused to transition and refused to engage in tasks.

Anna lived in a suburb and is one of a few people of her culture and skin color who attended her school. She lived in a home where both another language and English were spoken, everyone in the household spoke English. She had no siblings, and both of her parents lived in the home.

Part 1 of the *Behavior Intervention Checklist* helped frame the questions the BCBA needed to ask during the intake process. The first questions the BCBA asked themselves was about the identity data collected in the intake. The paperwork requested demographic data about race, community and identity, indicating Anna belonged to a historically marginalized group. Discussing it further with parents, the BCBA learned that there are not many others from their community in the area or in the school attended. This meant Anna may have experienced discrimination or prejudice, and her parents indicated that they miss the sense of community where they lived previously. Anna is also autistic, and had recently received a diagnosis for anxiety, which meant she may have been discriminated against due to disability or mental health issues. Both parents indicated that they feel confident meeting the financial needs for any of Anna's care, and did not struggle meeting any household financial needs. These questions helped the BCBA consider areas of support the family might enjoy outside of ABA-based parent training.

The BCBA also considered the other questions in Part 1. During the initial meeting with the BCBA the parents did not want Anna to be present. The BCBA discussed with the parents the changing independence of the child, and they agreed that in the future Anna should be invited to meetings,

and if needed they could set aside time to discuss parent concerns.

Next the BCBA considered other portions Part 1, specifically 7. Does this plan interfere with the child's right to developmentally appropriate privacy? 8. Does this plan interfere with the child's right to appropriate information? 9. Does this plan interfere with the child's right to education or health care services? The BCBA requested a one-on-one meeting with Anna as part of the intake process. The BCBA described what a BCBA does, who might work with Anna, and asked about things she experienced as difficult. The BCBA also explained to Anna the limits of confidentiality. The BCBA established with Anna and her parents that they would have monthly meetings where Anna could bring up concerns, but also that she could bring up concerns at any time.

During this meeting, Anna indicated that at times other students and even teachers said things to her that make her feel badly. She said she had told the principal, but no one cared. She said sometimes she felt really sad and wanted to be left alone, not asked questions. The BCBA made note of these concerns, and let parents know she intended to observe and consult with the school about them.

For the purposes of this case study we focused on the behavioral assessment for Anna in school. After consulting with the school on their concerns, an observation was scheduled. During the observation the BCBA took data on Anna's reaction to adverse peer responses (peers ignoring Anna's questions, a peer knocking a book off a desk and a group of peers indicating she could not play with them). Anna pointed out the concern to the teacher, who told her that she should ignore the other students. Anna became increasingly upset, eventually escalating into an outburst, and a refusal to transition to lunch. The outburst consisted of Anna yelling at the teacher that she was bad at her job and didn't even care. When considering Part 2 of the behavior checklist, it seemed clear that the school environment was having a negative effect on Anna. Bullying issues in groups were not part of the BCBA's clinical expertise.

The BCBA did notice that there were some other students who approached Anna to ask her questions about artwork she was completing. Anna ignored these students and told them she was busy. The BCBA made note of Anna treating all these interactions as adverse, she seemed to struggle to recognize the difference between positive peer interactions and negative ones.

After the observation was complete the BCBA met with the parents and Anna again. The BCBA described the things within the scope of their practice, including supporting social skills, identifying positive social approach and expressing the need for a break.

As there was a safety concern, brought to the BCBA's attention by Part 2: 1, The BCBA also reported on a meeting with the school social worker, where the bullying was discussed. The school social worker would be working on an evidence-based, anti-bullying education program for the students, and they would continue to collaborate. The BCBA also referred Anna to two options, a biweekly group for middle schoolers with anxiety and a counselor who worked with anxiety and neurodivergence. As a group, parents and Anna discussed which she would prefer, and the benefits of those referrals.

When developing the supporting behavior plans, the BCBA also referred to the areas for Part 2, Section 3, finding no areas where plans interfered with bodily autonomy. To ensure that Part 2, Sections 4 and Section 5 was addressed the BCBA asked for Anna's input on how they would work on those new skills. Anna indicated that she preferred to have someone with her at school during lunch and recess, but not during academic learning because she said she felt "watched" during the observation. She wanted her ABA program to involve talking with her support person, not just observation and prompting. The BCBA explained why observation was important for some things, but agreed that the targets they were working on together did not require it often. Anna also asked that they practice scenarios where kids couldn't watch, as she was sometimes embarrassed. The BCBA was able to accommodate those requests, but also indicated that they would need some peers to work with. They discussed safe peers, and Anna agreed that she might like to do some initial sessions with another client of BCBAs who did not attend the same school. She said she didn't want others at school to see her practicing some of the steps of the plans. The BCBA talked with parents, and they agreed to bring Anna to a social group that took place biweekly at the BCBA's office.

Recommendations for Future Practice and Conclusion

The ABA field has faced criticism regarding its historical and current practices, particularly concerning services provided to autistic children (Leaf et al., 2021; Kirkham, 2017; Wilkenfeld & McCarthy, 2020). ABA has traditionally sought operational definitions of behaviors, and in this context, we have aimed to define and examine the ethical mandate to protect clients' rights (BACB, 2020). The *Behavior Intervention Checklist* represents an initial effort to clarify and assess how behavioral interventions can support or violate children's rights. This checklist serves as a starting point for BCBAs to evaluate their own practices, identify areas for further education and support, and collaborate with others who can provide insights into the child's lived experience. It also guides BCBAs in seeking referrals to community resources that can offer legal advocacy, basic

needs, and other collaborative services to promote children's well-being.

At present, no study has examined the implementation of *The Behavior Intervention Checklist*, presenting an opportunity for future research. Investigations into ABA practitioners' understanding of child clients' rights and the impact on programming selection and client outcomes would be valuable. In addition, adapting the checklist for broader populations by incorporating *The Convention of the Rights of Persons with Disabilities* (UNHRC, 2006) could strengthen its applicability. Moreover, future ABA practice should focus on enhancing the scientific expertise of behavior analysts and fostering a deeper understanding of the foundational values that underpin compassionate care. The field has a responsibility to address the concerns of those receiving services, both in the moment and as they grow older. Without this foundational shift, we risk falling short of our ethical aspirations. *The Behavior Intervention Checklist* serves as a small step towards reflecting on behavior analytic practices and their implications for each individual.

In conclusion, this article emphasizes the critical role that protecting children's rights plays in delivering effective, ethical, and truly socially valid ABA services, providing a base of defined practices that lead to more compassionate care based practices. By introducing *The Behavior Intervention Checklist: A Child's Rights Approach*, we offer a practical tool, grounded in the UNCRC, for behavior analysts to assess their practices, foster self-evaluation, and enhance the social appropriateness of their treatment plans. Engaging in dialogue with clients, their families, and autistic advocacy communities, behavior analysts can continue to refine their practices and develop a more inclusive and effective approach. The field of behavior analysis, like any other profession, continues to evolve and work to incorporate diverse voices and perspectives in our commitment to ongoing improvement. This results in addressing concerns raised by the autistic community and ensuring a foundational shift towards compassionate and just care. The *Behavior Intervention Checklist* presented in this article represents a step towards achieving these goals, promoting meaningful improvements in ABA practice to better serve and empower the individuals we support.

Declarations

Conflicts of interest We have no conflict of interest to disclose.

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