#3209

RE: Regulation No. 14- 546

Hello Tara Pride and the OMHSAS team,

My name is Joseph Cautilli. I have a master's degree in counseling psychology, a second master's in applied behavior analysis through and interdepartmental special education program, and a PhD. in school psychology from Temple University. After that I obtained a post-doctoral master's in clinical psychopharmacology. I am licensed in PA as a Psychologist, counselor and a behavior specialist. In addition, I am certified at the doctoral level in behavior analysis (BCBA-D) and certified as a Brain Injury Specialist (BCIS). Thus I have always considered myself to be cross trained and have kept at least on foot in academia. On the latter I have taught at Temple University in the regular education, special education, and applied behavior analysis programs. I founded and taught for many years in the Applied Behavior Analysis Program in Criminal Justice at Saint Joseph's University. I developed and taught in the Applied Behavior Analysis program online at Arcadia University. These positions have allowed me to conduct research on children with a host of problems including oppositional behavior (Cautilli & Dziewolska, 2004) and autism Calise, Cautilli, & Galino, 2009), as well as critiques, reviews, and conceptual model articles for treatment of problems such as schizophrenia (Cautilli, 2007), autism (Cautilli, Hancock, Thomas, & Tillman, 2002), socially maladjusted children (Cautilli & Tillman, 2004), communication disorders treatment (Cautilli, 2006) and depression (Kanter, Cautilli, Busch, & Baruch, 2005).

I have over thirty years of working in the Mental Health field in Pennsylvania to the point where approximately 12 years ago, I founded my own BHRS company- Behavior Analysis and Therapy Partners and even found time to publish some outcome research in the area of working with children with various emotional and behavioral disorders (Thoder, Hesky, & Cautilli, 2010). I began working in BHRS as a behavior specialist back around 1989-1990. Over the years, I have watched the programs grow. Thus, I felt a sense of pride in reading the new bulletin and thinking back over the years of service of so many working in BHRS. Thus, when I saw that 60,000 children presently receive the service I greeted the number with mixed feelings. Indeed, given the size of PA I was expecting a number closer to a little over 86,000 children. This is just based on the population size 12.8 million people in PA with 20.8% below the age of 18 (see https://www.census.gov/quickfacts/fact/table/pa/PST045217) and NAMBI stating that 13% of children have serious mental illness. (see https://www.nami.org/learn-more/mental-health-by-the-numbers) with about 25% of those children with serious mental illness needing BHRS. Thus, PA is servicing about 69% of children and adolescents would need and qualify for the service.

I think part of the reason for the low (but very respectable service rate) is the fact that while previously the bulletin made it clear that children with intellectual disability no real follow up has come on encouraging the integration. Nor, do I believe, have adequate attempts been made to reach specialty populations such as integrated BHRS programs with Brain Steps Programs in the school for children with acquired brain injury or integrated BHRS programs with addiction centers to meet the growing adolescent population of addictions. This has been true despite a growing body of evidence supporting behavior analytic approaches to such populations (for brain injury see meta-analysis by Hannike & Carr, 2014 and for a meta-analysis for Community Reinforcement Approach for addictions- see. Roozen et al. 2004 with update lit review in Meyers, Roozen, and Smith 2011). Thus, I was encouraged by the new standards being developed by this bulletin for evidenced based practice models. I hope that it allows programs to migrated out into areas not tried formally before, but which have strong research literature

supporting. Beyond the areas of addiction, developmental disabilities, and head injury, I can see a future where evidenced based programs for depression like behavioral activation (see review by Tindell and colleagues, 2017) are combined in problem solving training in a coaching format for treating children and adolescents with depression.

In addition, from my background and cross training it should come as no surprise that I find the bulletin's steps toward moving past scope of practice for behavior specialist (i.e, the license of their field suggest they can do a service) to scope of competence (i.e., there is some proof through training they can perform the service). I believe that certification in an area is a good first step for this process. Indeed, several certifications exist for doctoral level psychologists. The ABPP diplomate is probably the highest standard in behavior analysis and was the certification that Lovaas achieved. For master level professionals- a BCBA as the bulletin points out offers excellent proof of training in the behavioral areas. Still on this issue, I think that the bulletin does not go far enough for practitioners who are not behaviorally certified. When I applied for the name of my company- Behavior Analysis and Therapy Partners- Gary Ames (my business partner) and myself had to send the Pa Psychologists licensing board proof that we had training and expertise in this area. They reviewed our training and determined we were able to use the name. I think that for people who are practicing without a certification, agencies should be required to get a review letter from the licensing board that not only is this function in the persons scope of practice but that it is in their individual scope of competence. Scope of practice is built on the concept of what anyone in a profession can do but does nothing to answer if a specific person can perform the task. This will go a long way to preventing some of the mis-use of services and fraud that was so clear in Florida that led to the recent shutting down of agencies applying for ABA services. Of course, I do not believe this should be limited to ABA services- I feel a similar review should be done by respective licensing boards for mobile therapy, as well as for psychologists evaluating children. In my time in BHRS, I have sadly experienced many people who were licensed and the task they were performing was never in their scope of competence.

As you are all aware, licensing boards exist to protect the public. I did some reviews in this area for behavior analyst licensing (see Hassert, Kelly, Pritchard, & Cautilli, 2008). Scope of competence is an area they are well qualified to review. Indeed, moving the bulletin to this model will allow one of its oversights (the exclusion of licensed behavior specialists from the clinical director position for BHRS) to be corrected. While many licensed behavior specialists have no course work in therapy skills, I can attest that many who graduated from psychology programs or behavior analysis programs do have clinical skills. When I designed the program at Saint Joseph's University in criminal justice, all our students had course work in behavioral counseling, behavioral consultation, traditional behavior therapy [ie., exposure therapy, systematic desensitization, exposure therapy plus response prevention, behavioral skills training (i.e., social skills training, communication skills training, problem solving skills, self-control/self-management), operant based biofeedback, stimulus control for insomnia, contingency management, behavioral parent training (sometimes referred to as parent management training), behavioral models of normal development and developmental psychopathology, clinical behavior analysis (Acceptance and Commitment Therapy, Functional Analytic Psychotherapy, Behavioral Activation, and a touch of training on Dialectical Behavior Therapy) and even a little coursework on cognitive behavior therapy. Thus, a blanket exclusion for licensed behavior specialists would be unwarranted, especially given the successful impact of behavioral therapists in treating most childhood disorders (see meta-analytic review by Weisz et al. 2017 at http://psycnet.apa.org/record/2017-07146-

001). I would suggest the regulation be rewritten to allow for this type of professional under the condition: (1) they have coursework in therapeutic strategies and behavior therapy; (2) they have completed an intensive clinical internship in the areas identified above; and (3) a letter from their licensing board attesting to their scope of competence in this area.

On the opposite end, I believe that allowing unlicensed professionals to practice as behavior specialist places families at risk as even the BCBA board has investigated so few of its certificates. The license gives families a place to go and settle disputes that may involve issues of impaired professionals, abuse by the professional, etc. In addition to offering the family protection, it offers the taxpayer/community protections as well by having an enforcement mechanism that is clearly defined to prevent to needless levels of waste, fraud, and abuse like what is occurring in Florida. For training purposes, the state should consider opening a category of "Behavior Specialist in training" this category would function to allow people to get their hours toward licensure and still provide services under four conditions: (1) weekly ongoing supervision from a licensed psychologist or other MH license, (2) a statement made to the families of their training status, which is signed by the family,(3) the prescriber identifies in the prescription that a "training behavior specialist" may be appropriate for the case, and (4) the licensed professional signing off on all their notes and treatment plans, attesting to their functional utility in treating the condition they are assigned too.

To balance my comments, I would like to say I do find the bulletin to be a huge step in the right direction. Overall, this bulletin does a wonderful job in many areas including allowing for quick return to services after discharge, greater focus on allowing innovation to move to a better serving system for evidenced based practices and increased transportability of TSS (BHT now) by allowing their training workshops to not have to be retaken after they switch companies. Overall, I believe the bulletin makes some great steps forward in moving the system toward an integrated model that allows for the development of evidenced based practices in the community. I hope it lives up to this promise by drawing providers who will establish those practices. Still, nothing is ever perfect, and this proposed bulletin has several drawbacks (maybe even just oversights) that should be corrected. I would like to take a moment to address some of my concerns.

In the area of behavior specialists, my first concern are changes to the billable services for Behavior Specialist. The biggest problem I have in this area is that the list of payable services for a behavior specialist consultant. Two items missing form that list are (1) Behavioral Parent Training – sometimes referred to as Parent Management Training and (2) Behavioral Consultation to Teachers. Both of these areas have considerable evidence supporting their use.

On the area of behavioral parent training, meta-analytic research has found it to be effective for treating a host of childhood and adolescent problems. For autism, Postorino and colleague's (2017) meta-analysis found it to have a strong effect size. For antisocial behavior, Serketich and Dumas (1996) meta-analytically reviewed 117 studies behavioral parent training. They found it effective in modifying child antisocial behavior at home and school, and to improve parental personal adjustment. A follow up meta-analysis found behavioral parent training to be effective by Furlong and colleagues (2013) found behavioral parent training to be effective from 3-12 years old. Another meta-analysis (Zwi et al. 2011) found these programs to be highly effective for children with ADHD from 5 to 18-year olds. Thus for the bulletin to remove behavioral parent training as a billable service appears to be either an oversight or a step backwards.

On the area of behavioral consultation-Reviews, meta-analyses, and case studies (e.g., Bramlett & Murphy, 1998; Kratochwill, Elliott, & Busse, 1995; McLeod, Jones, Sommers, & Havey, 2001; Medway & Updyke, 1985; Sheridan, Welch, & Orme, 1996; Wilkinson, 1997, 2003) have consistently documented the effectiveness of behavioral consultation as a vehicle for delivering interventions to students with a wide variety of learning and behavioral problems. The model is considered a powerful tool in remediating children's learning and behavioral problems and for delivering preventive interventions in general education settings. Given its overall power and effect with even lower SES children, it has been argued that behavioral consultation represents a social justice issue to help students with low SES and behavioral disorders to get an appropriate education. (Garbacz, Watkins, Diaz, Barnabas, Schwartz, & Eiraldi, 2017). Behavioral consultation has not just been used with externalizing problems but even rare anxiety problems like selective mutism (see case study by Auster, Feeney-Kettler, & Kratochwil, 2006).

While the model provides for training, training is not enough to ensure that skills are executed, and on-going consultation is needed (for a study with anxiety disorders and cognitive behavior therapy see Beidas et al. 2012). Similarly, a growing body of literature suggests that the use of one-time workshops as a training tool is ineffective in influencing therapist behavior, although they do influence therapist knowledge and attitudinal change towards EBPs (Beidas & Kendall, 2010; Grimshaw et al., 2001; Rakovshik & McManus, 2010), as well as behavioral consultants (McDougall, Reschly, & Corkery, 1988). A number of review papers have highlighted that ongoing consultation is critical to promote uptake and adherence to EBPs (Beidas & Kendall, 2010; Herschell et al., 2010).

OMHSAS could take a huge step forward in clinical integrity with this bulletin by demanding a behavior specialist consultant write reports on the child they service. A sample of a formalized outline for a behavioral consultation report should developed and produced by the behavior specialist twice a year. There are samples of what behavioral consultation reports look like see Brinkman, and colleagues (2007). This produces a standard record from the behavior specialist of the child's progress and can be used for overall program evaluation by the department to ensure that tax payer funds are being used in an efficient manner.

I believe that if OMHSAS does not believe that Behavior Specialists have been effective with teacher consultation, they should employ an evidence- based training system for behavioral consultants such the highly effective training system outlined by Kratchowill and colleagues (1989) in their clinical replication program and the supervision system used by Kratchowill and colleagues (1981). The primary author on both those studies is still practicing and I am sure would be very willing to come out and offer his expertise to OMHSAS. Behavioral consultation impacts not just the child but strengthens teacher's skills and abilities work with other children with similar problems in the future.

Thus, I believe that for children and teachers, removal of behavioral consultation as a billable service under the bulletin is either a mistake, oversight, or a step backwards. Unfortunately, this oversight could be problematic for the workers in the area as well, as it will force the behavior specialist to have less knowledge and direct contact with parents and teachers. In addition to the above, removal of these items may create manning issues for behavior specialists. Think of the manning as such:

Average number of hours/week/case	Number of cases needed to be an FTE
4	10
3	13

2	20
1	40

From the above chart, one can see the possibility of extreme stress burden being placed on the behavior specialist leading reduced effectiveness, to less people wanting to perform the function, possibly higher burn out, and possibly higher rates of dissatisfaction, which could lead to fraud. This is not unique to behavior specialist, case managers have also experienced such factors, as have workers in DHS services.

On the evaluation end, I believe the bulletin does not go far enough in highlighting the evaluation process. The evaluation has been sorely missing from BHRS service integrity for a long time. Often the psychologists do not use standardized measures nor do the incorporate information from the direct observation/functional behavioral assessment from the behavior specialist. I believe the heart of this problem is reimbursement for psychologists. Unfortunately, given their expertise as individual child assessment and diagnosis. I think it was a mistake to make these evaluations once/year or even every six months. I think this bulletin would be wise to return to quarterly evaluations. But the evaluation process needs to change. This process should conform to best practice guidelines not just for immediate diagnostic purposes, but the evaluation is the point in which program evaluation should be conducted to determine if the treatment is making clinically significant gains. After reading hundreds of evaluations over the course of my career, I find many of them ignore the use of standardized instruments. Sadly, cognitive area such as problems with memory and linguistic delays are often not diagnosed in the current mental status exam given. I believe a team of psychologists, school psychologists, psychiatrists, and positive behavior support specialists should meet to discuss. Overall, this process is critical to determining if real change is being made and additive to graphs produced by behavior specialists. For example, with a child with social skills deficit a program of direct training and graph of observation may show the skill acquired but the question becomes was it additive. For example, a child with an Adaptive Behavior Score in Socialization of 55 would still learn skills at the rate of a person with the standard score of 55. The graph might show the child acquired the skill but maybe in focusing on this kill the hours have blocked other skills needed to be learned at this level and thus the overall program is not effective.

With respect to the BHTs, I found the bulletin's approach to be one that shows great insight. I had a few minor issues though. The first is that when the system began experiencing agencies billing for services that were inappropriate back in 1998, Zimmerman and colleagues at DPW then issued a letter clarifying services that were unbillable. I have attached this letter with this e-mail, as I believe it is critical for program integrity to continue all these activities as non-billable for TSS (now BHTs). As this bulletin codifies IBHS, these activities should all be included as non-payable for BHTs.

Another dismay I had is that contingency management (use of tokens, point system, contingent praise, level systems and contingency contracting) was not listed as a basic TSS intervention, nor was it listed as a training requirement. This is a huge mistake. From the earliest study by O'Leary et al (1969) this intervention has demonstrated very powerful behavioral effects on improving children's behavior. Even the earliest reviews were positive and showed bachelor level personal could implement such systems when properly trained (O'Leary & Drabman, 1971). Many studies on the use of reinforcement procedures have for disruptive behavior (Kazdin, 1985; O'Leary & Drabman; Patterson, Reid, & Dishion, 1992) and social withdrawn behavior (e.g., Walker & Hops, 1973) and such programs are enhanced with

the use of time out (Wahler, 1969; Wasik, Senn, Welch, & Cooper, 1969) and response cost (Kazdin, 1972, 1985, 1987; Rapport, Murphy & Bailey, 1982; Walker, 1989; Walker, Hops, & Greenwood, 1984, 1993; Walker, Colvin & Ramsey, 1995). Overall the meta-analysis completed by Stage and Quiroz, (1997) demonstrated the largest effect size for this combined intervention for disruptive behaviors. In particular, such programs have been found very beneficial for ADHD (Hinshaw, Klein, & Abikoff, 1998; Pfiffner & Barkley, 1998; Pelham, Wheeler, & Chronis, 1998; Murray, 2008). Indeed, only the behavioral contingency management systems were shown to be effective after the systems were faded in the MTA studies (Arnold, et al 2004) Also if children had anxiety or oppositionality in their ADHD profile, these secondary issues responded better to the behavior therapy condition and combined condition than medication (see Conners, Epstein, March et al. 2001). In addition, when the ADHD children presented with both depression and anxiety, the combined intervention was superior to the medication intervention especially to parental perception (see DosReis S, Zito JM, Safer DJ, et al. (2004).

Finally, contingency management interventions have also been found to be effective for children with autism in the classroom and as part of parent management training programs (Soorya, Carpenter, & Warren, 2013)

I would highly advise that TSS (BHTs) have contingency management added to their scope of services and that they receive 3-6 hours of training in developing and successfully employing such procedures. It training is done correctly, this one action could help reduce departmental costs and increasing service availability because it will allow clinical supervisors to have a case functioning under them without the need for either a mobile therapist or a BSC. This number could be even greater if TSS workers were specifically trained in best practices in social skills training on top of it (ala Gresham, 2005).

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JAN 06 1998

Dear Provider:

The Office of Medical Assistance Programs (OMAP), the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Mental Retardation (OMR) are aware of improprieties in the delivery and billing of children's behavioral health services, in particular, Therapeutic Staff Support (TSS). All providers of TSS services are responsible for ensuring appropriate and effective service delivery and supervision of TSS workers. The purpose of this letter is to inform enrolled providers of some of the inappropriate TSS activities. Please send a copy of this letter to any providers with whom you subcontract for this service. Also enclosed for your information is a copy of the CASSP document entitled "Guide to Professional Behavior for Therapeutic Staff Support Worker."

Examples of inappropriate delivery and billing of TSS include, but are not limited to, the following:

- Providing services not included or specified in the child's treatment plan.
- Performing the duties of school personnel such as teacher or teacher's aide
- Academic tutoring.
- Substituting for parent, community program staff or other adult responsible for providing care.
- General child care or housekeeping activities in the presence or absence of the parent/caretaker.
- Therapy or counseling rather than supportive and clarifying interactions with child and family, consistent with the child's treatment plan.
- Developing relationships with the purpose of providing a role model (i.e., Big Brother/Big Sister, time spent with the child providing no mental health interventions).
- Continued observation of a child's behavior without any planned follow-up intervention. The behavior patterns observed should be discussed with the mental health professional in order to plan an intervention for that behavior.
- Adding time with the TSS worker as a reward for good behavior or as a reward for the child controlling his or her outbursts.
- Providing services to children without the knowledge and/or permission of the parent(s) or primary care giver(s).
- Providing TSS services without appropriate supervision.
- Providing socialization activities, which are not described specifically in the treatment plan. (Note that the word "socialization" in the treatment plan is inadequate to justify a wraparound service.)

- Respite care.
- Transportation for the child and/or his or her family.
- Billing for time spent in travel, paperwork, and meetings even if the child is present and it is case specific time.
- Time spent interacting with family and friends of TSS worker.

Inappropriate TSS services and activities may affect your participation in the Medical Assistance Program and/or result in restitution.

Any questions regarding appropriate billing should be addressed in writing to the Office of Medical Assistance Programs (OMAP), Bureau of Program, Policy and Development, P.O. Box 8045, Harrisburg, PA 17105-8045.

Sincerely,

Robert S. Zimmerman, Jr.
Deputy Secretary for Medical
Medical Assistance Programs

Charles G. Curie
Deputy Secretary for Mental Health
and Substance Abuse Services

Nancy R. Thaler
Deputy Secretary for
Mental Retardation