

14-546-23

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From: Nadeige Theophile <nadeigetheophile@gmail.com>
Sent: Tuesday, August 14, 2018 8:12 PM
To: Pride, Tara; Rosenberger, Michelle
Subject: Regulation No. 14-546
Attachments: Nadeige's-mail letter.docx

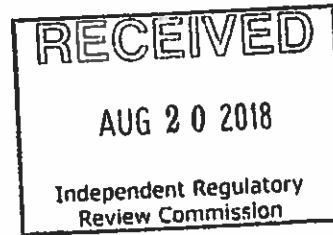
Good evening Ms. Tara Pride, Michelle Rosenberger,

Hope this email finds you well. I am emailing in regards to the proposed regulations for BHRs. Please take the time to read my concerns and the articles that provide evidence that will assist in the point I am attempting to communicate.

Thank you in advance for your time.

Have a great evening!

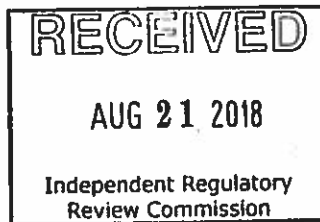
Nadeige Theophile



3204

To: Michelle Rosenberger & Tara Pride

RE: Regulation No. 14- 546



Hello Michelle Rosenberger & Tara Pride,

It was with great appreciation that I read the upcoming BHRS regulation changes that transition to IBHS. Generally, I found the changes to be beneficial; however, the regulation is excessively restrictive of behavior specialist trade and is unwarranted. On page 88 (of the PDF and page 33 of the document), licensed behavior specialist is not listed as a person eligible to be clinical director. This change directly effects my livelihood and others I know who are similarly trained as I was trained. I am a graduate of Rider University's program in Applied Psychology with a concentration in Applied Behavior Analysis. I have had courses in Introduction to Applied Behavior Analysis, Interventions for Autism, Intervention for Individuals with Disabilities, Subject Research Design and Analysis, Observational Methods, Language Assessment and Interventions, Social Skills Assessment and Interventions, and Principle of Learning. In addition, I had three clinical internships in Applied Behavior Analysis. I am currently under internship to become a Board Certified Behavior Analyst. Yet, under the regulation changes I would not qualify on page 88 to be a clinical director/supervisor outside of autism. My current position at Behavior Analysis and Therapy Partners as clinical supervisor/director allows me to managing treatment and positive behavioral supports for children with all aspects of childhood psychopathology. This is above all catastrophic not just for myself but also for the entire system. I have completed coursework in applied behavior analysis; it is approved by the BACB.

With over 11 years in the field of Applied Behavior Analysis, I have worked with a wide range of children with autism, oppositional defiant disorder, down syndrome, etc., in the home, school and clinic setting. Not only do I work with the children, I also worked with the parents and/or guardian. This was done to ensure consistency in all setting and generalization of skills. With the guidance of a BCBA, it was effective in seeing progress in the population served. In the area of therapeutic services for children, there are five decades of research reviewed meta-analytically support behavioral interventions for children (see Weisz et al. 2017 at <http://psycnet.apa.org/record/2017-07146-001>) Not only for externalizing disorders but also internalizing disorders. This is not the only meta-analysis to reach this conclusion. 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.

Behavioral interventions are not just limited to parent training in contingency management. For example, with an area of behavioral interventions for ADHD including contingency management, parent training and behavioral skills training including social skills are highly effective (see Fabiano et al. 2009).

Research reviews in this area are not just limited to externalizing problems but internalizing problems as well. Barlow and colleagues (2016) reviewed emotional adjust for young children from parent training programs and found a strong effect. Just one aspect of behavior therapy social skills training has become a cornerstone adjunctive piece in treating emotional disorders (Spence, 2003).

More specifically with depression, behavior therapy treatments like skills training such as problem-solving and self-control training have research as successful treatment back to 1987 (see Stark and colleagues, 1987). Studies like this led David-Ferdon & Kaslow (2008) to conclude behavior therapy (not just cognitive behavior therapy) to be probably efficacious for children and adolescence. Most recently, one particular behavior analytically based therapy behavioral activation has been found in a meta-analysis by Martin and Oliver (2018) to be probably efficacious for children and adolescence of lower socio-economic status. The general pitch of the Martin and Oliver review is comparable in conclusions to the meta-analytic review by Tindall and colleagues (2017) on the subject.

With respect to anxiety disorders, behavioral analytic approaches are spelled out at (<https://www.appliedbehavioranalysis.edu/anxiety-disorders/>). Behavior analysis in the treatment of anxiety disorders lists standard behavior therapy techniques such as systematic desensitization, exposure therapy, and behavioral activation. Research in this area reviewed by Thomas and colleagues to state behavioral intervention is a well established intervention for phobias including social phobia and school phobia. Standard behavioral interventions such as systematic desensitization, assertiveness training, and applied relaxation training are all well-established treatments.

On the issue of post-traumatic stress disorder, respondent conditioning based standardized behavior therapy intervention such as imaginal exposure and in vivo exposure showed the largest effects in a recent meta-analysis with no difference compared to cognitive behavior therapy (see Diehle, et al. 2014)

Finally, even in serious mental illnesses such as schizophrenia behavioral interventions such as social skills training, behavioral family therapy, and contingency management are all well-established treatments (O'Donohue & Ferguson, 2006). In the area of adolescent drinking and addiction, Community Reinforcement is a well-established model (O'Donohue, & Ferguson, 2006).

Over time in mental health, I have personally been greeted with some hostility, as people have referred to me as not "really a clinician." These sad misconceptions often lead to bridges and siloes between treatment professionals that do not serve our children. Thus, to counter this view, I believe it is imperative to state here that behavior analysts are not driven to be technicians to implement treatment manuals. As Slocum and colleagues (2014) noted "Evidence-based practice of applied behavior analysis is a decision-making process that integrates (a) the best available evidence with (b) clinical expertise and (c) client values and context." I hope you see the obvious that we are clinicians trained to conduct functional behavioral assessments of our client's skills and motivation and to design contextually based treatments using established treatments and treatment packages tailored to meet client's needs. Behavior analysts have well developed and researched comprehensive models of psychopathology like depression (Kanter, Cautilli, Busch, & Baruch, 2005) and developmental psychopathology like conduct disorder (Dishion, Patterson, & Kavanagh, 1992; Patterson, 2002; Snyder et al., 2004; Snyder et al. 2006).

So, I conclude as I started. This bulletin denotes an unwarranted restriction of trade that damagingly impacts children from receiving evidence-based psychological services. It destructively impacts me in my current position and negatively impacts others like myself, who would seek such positions in the near future. The solution would be to insert (on page 33 of the document and page 88 of the pdf) licensed behavior specialists who have coursework in behavior therapy and clinical behavior analysis to the list of those eligible to become supervisors in MH BHRS.

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