**PBS**

**Targeted Supports**

**A Guide for Agencies Implementing**

**Positive Behavior Supports**

**Department of Developmental Services**

**October 2013**

**Revised August 2014**



**PBS TARGETED SUPPORTS**

**Targeted Supports Goal: Proactive Intervention Prevents Problems**

**I. PURPOSE**

Targeted Supports are implemented fairly rapidly on an “as needed” basis for an individual or group at risk for developing problem behavior and needing intervention beyond Universal Supports.

**II. INTRODUCTION**

A proactive approach to problem behavior is a goal of PBS. By providing intervention at the earliest signs of a problem, larger or more prolonged problems may be avoided as well as the disruption to an individual’s relationships and quality of life. Targeted Supports also are used to prevent the need for Intensive Supports for challenging behavior. Targeted Supports are put in place as part of a Team based collaborative process with expert assistance as needed.

Targeted Supports are procedures that can be put in place fairly quickly for an individual or a group. Targeted Supports are intended to be minimally intrusive and not restrictive. Targeted Supports may involve reuniting an individual with a trusted friend, increased monitoring of behaviors of concern, referral to social activity groups, to name just a few possibilities. Targeted Supports also may involve teaching skills to replace a problem behavior. There are a variety of other standardized interventions that can be used depending on the problem addressed and the individual’s needs and preferences.

**III. WHO SHOULD RECEIVE TARGETED SUPPORTS**

Targeted Supports are intended to support an individual(s) who is at risk of a reduced quality of life due to actions or the actions of another person. The reasons for initiating Targeted Supports may include life events (e.g. death in family, romantic break-up, or job loss, etc.) and/or behaviors that are not immediately high risk such as:

* A change in social responsiveness such as chronically avoiding work or social events;
* Increase in teasing or disruption of others;
* Clinically known risk factors for the individual such as a change in baseline habits (e.g. sleep, eating, toileting, etc. or
* Individual’s request for additional support.
* Stressful life events combined with the individual’s prior history of serious challenging behavior.

The initiation of Targeted Supports may be a prudent means to avoid serious problem behavior. Clinical examples of behaviors that would be appropriate for referral to the Targeted Supports Team are presented in **Appendix[[1]](#footnote-1)**.

Individuals are referred to the Targeted Supports Team via a variety of methods ranging from referral by the Universal Supports Team, review of incident, restraint, and risk management reports, requests by an individual. If an individual begins to show signs of needing additional support an assessment will be conducted to guide the Team in choosing the most helpful supports for the individual(s).

**IV. TARGETED SUPPORTS TEAM**

The Leadership Team is required to configure the Targeted Supports Team(s) for the agency and include this information in the agency PBS Action Plan. The number of Targeted Supports Teams needed will depend on the number of individuals needing Targeted Supports and the availability of clinical personnel in the agency.

**Targeted Supports Team Membership**

The agency Leadership Team determines the membership of Targeted Supports Team. The size and complexity of the agency in concert with the number of individuals supported and their characteristics partially determine composition of this Team. Membership is required to include clinical and administrative staff.

The Targeted Supports Team may be made up of the same individuals as the agency’s Intensive Supports Team (i.e. a joint Targeted/Intensive Team) or a combination of the Targeted and Universal Team or a combination of all three tiers depending on the agency’s population and needs. It is also possible that an agency with a number of individuals needing Targeted Supports may need more than one Targeted Supports Team. When teams are combined, it is recommended that separate meetings occur and separate meeting minutes are written to accomplish the tasks of each support level.

For each Targeted Supports Team, there should be an assigned team leader. At least one member of the Team must be a qualified clinician from within or outside the agency. An administrative representative(s) with decision-making authority also is required for the Targeted Supports Team. The administrative representative is responsible for ensuring there is a data system that informs the Team’s work and allocation of resources as needed.

**Responsibilities of the PBS Targeted Supports Team**

 The Targeted Supports Team is required to meet regularly (monthly, at minimum, is recommended.) Minutes should be taken and distributed in a timely manner. The agency PBS Leadership Team reviews minutes from the Targeted Supports Team meetings. When individuals are referred to in meeting minutes, names must be redacted for review as needed.

The key responsibilities of the Targeted Supports Team include:

1. On-going monitoring of individuals;
2. Brief assessment of problem behavior(s);
3. Selection of Targeted Supports based on behavioral assessments;
4. Providing training and technical assistance;
5. Review of the effectiveness of Targeted Supports via on-going progress monitoring information and related adjustment of Targeted Supports (e.g. progress may result in ending the Targeted Supports and;
6. Referral of individuals not responding to Targeted Supports for assessment by the agency’s Intensive Supports Team.
7. Regular monitoring of treatment integrity at the Targeted Supports level.

The need for Targeted Supports results from a team-based review of objective data and information about the individual. When an individual is showing signs of needing extra help or when based on the individual’s history is very likely to show signs of needing help, data are regularly reviewed by the Targeted Supports Team. Additionally, when an individual or group experiences a change in life circumstances that may be a significant stressor such as death of a significant person, change in residence or work site, etc. then the Targeted Supports Team likely would monitor those individuals affected and may consider instituting Targeted Supports.

**V. TARGETED SUPPORTS ASSESSMENT**

When Targeted Supports are needed a brief functional assessment is required. The goal of the assessment is a better understanding of the problem so that an appropriate support can be implemented. Such an assessment may consist of conducting a brief assessment of the behavior of concern (see **Appendix[[2]](#footnote-2)** for two examples). The purpose of such an assessment is to identify relevant “triggers”, the conditions under which the behavior is likely to occur and the maintaining consequences. Other Targeted assessments may consist of thoughtful discussions and brief consultation with the person such as when an individual suffers an unexpected loss and is encouraged to reunite with a former clinician and/or for a period is excused from typical household expectations.

The assessment may be completed by the qualified clinician. In some circumstances the assessment may be conducted by other team members but is always overseen by the qualified clinician. Once a brief assessment is completed and reviewed by the qualified clinician and team, the Targeted Supports Plan can be developed

**VI. TARGETED SUPPORTS PLAN**

Following a brief assessment of behavior, the Targeted Supports Team can begin to consider appropriate supports for the individual(s). Targeted Supports often include a greater emphasis on the Universal Supports already in place For example, a more frequent implementation of a Universal teaching or reinforcement plan may be sufficient to alleviate distress caused by the referring behavior.

Targeted Supports often address:

* Systems for increasing structure and predictability;
* Simple progress monitoring for at risk individuals;
* Systems for increasing contingent feedback aimed at preventing problem behavior;
* Systems for ensuring positive consequences for targeted behavioral performance;
* Systems for increasing Team communication regarding individual;
* Social skills training;
* Referral to specific mental health intervention (individual or group work to address trauma, anxiety, depression);

**Evidenced based Practices**

The Targeted Supports Team supports and guides the selection of evidence based practices. Evidenced-Based Practices are strategies based on procedures, assessments and interventions that are validated through peer-reviewed research.

Practices that are not evidenced-based may be used if there are studies with supporting data but do not demonstrate experimentally that a functional relationship exists. These are “promising practices” for which adoption and use should proceed with caution.

When no evidence is available for an intervention or practice, conservative use of the practice should be applied to avoid unforeseen negative side effects, extreme costs, and inefficient use of resources and time. At a minimum, new or innovative practices should be pilot-tested, measured frequently for the extent to which desired and undesired effects are experienced, and evaluated for their costs and benefits. Equally important, innovative practices must be based on

sound theory. Regardless of the evidence available for a practice, consideration for adoption should be based on a documented need.

Data for treatment integrity will be presented, reviewed, and used at each Targeted Supports Team meeting to make decisions regarding the quality of implementation and services provided. A visual (graphic) presentation is highly recommended.

In conjunction with the Leadership Team, the Targeted Supports Team will determine an acceptable standard for treatment integrity measures and actions needed when assessments reveal below standard performance.

**VII. TARGETED BEHAVIOR SUPPORT PLAN**

If it is determined, based on review of data and team discussion, that a behavior support plan is needed, the plan should be documented as a Targeted Behavioral Support Plan. The Targeted Behavior Support Plan should include the following components:

**Background**: a brief description of history of problem (e.g. *behavior*) and previous interventions, brief assessment conducted and conclusions, consent process if needed

**Target behavior:** define the target behavior for increase and decrease in objective, measureable terms include data collection requirements.

**Prevention:** identify opportunities to prevent problems by anticipating when they may occur and defining procedures to address potential problems.

**Teaching Component:** specify component of teaching functional adaptive or replacement behavior: who will teach, when, where, what is criteria for success, criteria for revision; specify reinforcement component of teaching plan: what are reinforcers, who will deliver reinforcers, on what schedule.

**Intervention:** describe procedures for preventing problem from occurring, e.g. eliminating antecedents, increasing preferences; and describe procedures for reducing problem behavior if needed

**Evaluation:** how plan will be evaluated, by whom, and how frequently; and criteria for revision.

For an example of a Targeted Behavior Support Plan see **Appendix[[3]](#footnote-3).**

**Standardized Supports**

When the supports needed for an individual occur in the home or work setting, a Targeted Supports Plan will detail each component of the intervention. Each agency Targeted Supports Team will have a menu of targeted supports available to them. The targeted supports available will be determined by that agency’s PBS Leadership Team and all such interventions previously would be approved by DDS. Examples of standardized supports can be found in **Appendix[[4]](#footnote-4)**

Additional interventions to address unique situations for an individual or an agency may be needed. In this case, the Targeted Supports Team can develop original plans to support the individual(s) under the supervision of the qualified behavioral clinician. The Targeted Behavior Support Plan must include all components listed in **Appendix[[5]](#footnote-5).** An example ofaTargeted Behavior Support Plan Template is presented in **Appendix[[6]](#footnote-6).** Targeted Supports developed uniquely by a Targeted Supports Team must comply with all DDS regulations.

**VII. TRAINING**

When a Targeted Supports Plan is implemented, it must be preceded by training staff to competency in the plan. The Targeted Supports Team member most closely identified with the support should assume responsibility for training. For example, if a medical intervention is included in the plan, then a medical staff person should provide staff training. For a Targeted Behavior Support Plan, the qualified clinician, writing the plan, is responsible for training staff. . It is recommended that some measure of staff competence in all aspects of the procedure be included as a standard part of this training. The staff providing training also must retrain staff at regular intervals and as needed.

**VII. TARGETED SUPPORTS ASSESSMENT PROCESS**

As with the other PBS interventions concerted effort is dedicated to ensuring that staff implement all Targeted Supports accurately and that data on implementation are generated and reviewed at each Targeted Supports Team meeting.

The Leadership Team is required to select a treatment integrity instrument appropriate to the setting and population. The Targeted Implementation Checklist (TIC) can be used for this purpose. See **Appendix [[7]](#footnote-7)**. Other treatment integrity tools are available at [www.pbis.org](http://www.pbis.org).

The qualified clinician responsible for writing the Targeted Behavior Support Plan, or designee, is required to conduct quality of implementation checks at frequent intervals. The frequency will be determined by the clinician and the Targeted Supports Team. In addition to the qualified clinician, the Targeted Supports Team may designate other staff responsible for conducting treatment integrity checks at the Targeted Supports Level.

**VIII. REFERRAL FOR ADDITIONAL SUPPORTS**

The Targeted Supports Team is required to assess individuals at regular and frequent intervals for their need for change in supports. The Targeted Supports Team and the agency Leadership Team will determine how frequently and by what method, individuals will be assessed for their need for a change in their support level. Following review of data collected on the target behavior for an individual receiving Targeted Supports as well as treatment integrity data for an implemented Targeted Supports Plan, an individual(s) may be determined to be in need of a change in support level. When increased supports are indicated, the Targeted Supports Team may refer to Intensive Supports Team. Successful resolution of the identified problem may indicate the need for an individual(s) supports to return to the Universal Supports level.

**Appendix TA-1**

**Examples of Targeted Supports**

1. Focus on Behavior at Work: John, an individual who is working at a local restaurant earning about $80 a week, has challenges with change. His job is changing so that he will work with the same staff but have several new tasks. He has been identified as needing Targeted Supports (job preparation) based on experience with changing his routine. In the past for him and for other people with whom he works, such help has largely been in the form of practice for the first week or so and much positive feedback. In the past (10 years ago) John used to shout and throw items when introduced to new work; some shouting will be tolerated at his job if it resolves fairly quickly. Due to injury concerns, throwing items will not be tolerated at all, he works with industrial screws. The brief assessment for John has consisted of a review of his record, a brief interview with his mother and an extensive interview with Jeanne, his current work supervisor and former 1:1 (he has not needed 1:1 support for more than five years). The Team decides to try a modified Targeted Supports Plan that provides him with more structure and reinforcement in the form of a familiar staff working near him to provide direct coaching on how to do the job and suggest a break if he appears to need one and to provide frequent verbal encouragement to him.

**2**. **Focus on Physical Health**: Alan, a forty year-old man has a seizure disorder (well controlled with medication), autism, and significant expressive communication challenges. Alan is very medication compliant and has no problem behavior to speak of beyond some minor disruption such as spinning in a circle before entering a new room; he is a picky eater but drinks fluids normally. Alan has been functioning well with support provided at the Universal Supports level including regular community trips of his choosing. His main interest is to go to a near-by park and feed pigeons. When available he loves going to homing pigeon “races” and he does so every couple of months (when they are available).

Last weekend Alan had his first seizure in two years while out during very hot weather. His seizure lasted 30 seconds. He was brought to the Emergency Room then sent home. There was no specific finding at the Emergency Room but a concern that he might have been dehydrated. The agency nurse called Alan’s neurologist’s office to report the seizure and an appointment was made that week for a review of Alan’s seizure disorder by the neurologist.

The Program Director and House Manager consulted with the agency nurse regarding possibility of dehydration playing a role in the seizure. They find that the staff has not been asked to monitor how much people in the house drink when in the community and they have no way to determine if he had adequate fluids on the day of the seizure. Staff are requested to complete **standardized** fluid intake protocol and provide information at the next Targeted Supports Team meeting showing that the standardized protocol now is in place for Alan and all other people when in the community

**3.** **Focus on Mental Health / Family**: There has been a recent death in Elizabeth’s family. She is an individual diagnosed with Down syndrome and depression. Elizabeth lived at home until age 32, then moved to her new home five years ago when her parents were starting to face age related challenges. Since her move, Elizabeth has spent all major holidays with her parents and visited her family home one weekend a month. Elizabeth’s depression has manifested in the past as her “shutting down” and just staying in bed. Her parents are her guardians and had been reticent to have her take medications until she was hospitalized once for three days after having spent 10 days in a row in bed. For the last six years she has taken Prozac 20 mg. daily and she only spends two to five days a year “in bed” when there is no physical illness evident. Elizabeth’s house and day program staff meet with a consulting clinician four times a year to discuss how to support Elizabeth to “***Stay positive, Stay involved***”. She was tried with three different counselors (including an art therapist), but there was no evidence the counseling or art therapy helped her and it was clear she did not want to go. Elizabeth’s mother has died unexpectedly and, of course, this is a very significant change in life for her. A referral was made to The Targeted Supports Team and they promptly institute a targeted intervention: the **standardized** grief intervention protocol. This consists of:

* Consulting clinician will meet with the Team ASAP for general consultation on Elizabeth with a focus on grief related issues that may arise.
* Regularly screening of depression symptoms will be conducted on a weekly basis
* The clinic where she meets with her prescribing psychiatric nurse has been called and her next appointment has been moved up to 5 days from now (her next medication review visit had been in two months).

**4. Focus on Behavior at Home**: Staff are concerned about Linda whose level of problem behavior suddenly changed. Linda does not have verbal language and a history of head-hitting. In the last week Linda’s rate of sucking her hand and tapping her face and making loud noises has doubled. The matter has been referred to the Targeted Supports Team. The major element of their brief assessment is an interview of the home manager, the focus of which is identifying likely setting events to Linda’s change in behavioral status. The brief assessment also includes review of Linda’s data sheets for the past two weeks and data summaries for the past two years and reading of the “House Log” notes. The results of the brief assessment seem to all point to Linda’s sleep being disrupted by a new housemate who is in the room next to Linda. The new housemate is still adjusting to her new home/room/bed and the report of the House Manager is that the new housemate is making “benign noises” including humming loudly and rocking such that she produces a “thumping noise” until she falls asleep at about 1:00 AM.

The Targeted **standardized** interventions selected by the Team to help Linda are as follows:

* Check to make sure current Universal interventions are all being implemented accurately (including data collection);
* Try a modified Behavior Education Plan that provides more structure and reinforcement for her during the day
* Encouraging Linda to take a nap when she comes home and her housemate is up and around;
* Providing Linda with soft music at night per her House Manager’s “best guess” that the music would sooth Linda and potentially drown out other ambient noises.
* Refer the housemate to the Targeted Supports Team team to try to improve her sleeping habits.

As can be seen from the four examples above, the Targeted Supports are based on the brief assessment done by the Targeted Supports Team. The assessments and interventions chosen are tailored to the situation and individual of concern but also are **standardized** within the agency and thus easy to implement quickly and could be used for any person if needed.

Targeted systems and practices are intended to promptly respond to changes in an individual’s status. Targeted Supports are intended to prevent problem behavior and by so doing help maintain or improve the individual’s and others’ quality of life. Supports are selected based on a brief assessment overseen or completed by a qualified clinician working with the PBS Targeted Supports Team. On-going evaluation of an individual’s response to Targeted Supports and organizational outcomes are tracked. When an individual needs Targeted Supports the Universal Supports are maintained as the Targeted Supports are added. Universal practices can help sustain behavior change produced by Targeted Supports.

**Appendix TA-2**

**Brief Functional Behavior Assessment (Example 1)**

|  |  |
| --- | --- |
|  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Information source: Record Review Data Observations Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Interview: Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Observations: dates, locations, times, completed by:

**CONTRIBUTING INFORMATION**

Individual’s strengths:

Medical conditions:

Medications:

Psycho-social issues:

Has the individual expressed concerns/difficulties that may relate to the problem behavior?

**PROBLEM BEHAVIOR(S):** Describe in measureable and observable terms

What does the behavior look/sound like?

Does it begin at a low intensity and escalate?

Estimated frequency:

When did behavior first begin?

**TRIGGERS/ANTECEDENT**

What typically occurs before or during behavior?

Where is the behavior most likely to occur?

With whom does the behavior occur or not occur?

Setting Events? Home difficulties, peer influence, etc.?

**CONSEQUENCE(S)**

What happens immediately after problem behavior? Think about the last few times it happened.

What does the individual obtain? Attention? Something else?

What does the individual; avoid? Demands? Negative interactions?

**PLAN/STRATEGIES**

Describe the current plan or strategies being used.

What plan or strategies have been used in past?

**Summary/Hypothesis Statement:**

Completed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brief Functional Assessment Interview (Example 2)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person(s) Interviewed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior of concern**

**Antecedent:**

**Behavior:**

**Consequence:**

**Setting Event (if possible):**

**Additional notes:**

**Summary Statement**

Setting Event/Antecedent Behavior Maintaining Consequence

**Appendix TA-3**

**Targeted Supports Plan**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Concern: (e.g. behavior of concern):**

**2. Describe sources of information used to conduct assessment.**

**When relevant attach copy of brief functional assessment.**

**3. Plan to support person includes:**

 **a.**

 **b.**

 **c.**

 **d.**

**4. Describe how and when plan will be reviewed and documentation:**

**Team Members:**

**1. 2.**

**3. 4.**

**5. 6.**

**Appendix TA-4**

**Examples of**

**PBS Targeted Supports**

**Check-In/ Check-Out (CICO)**

**Check-in/Check-out:** check-in/check-out is a procedure that helps an individual and staff remain focused on supporting positive behavior outcomes throughout the day. CICO can be used to support behavior in all domains: social, academic, vocational, self-care, emotional regulation, etc. A critical factor is to be positive and supportive and not suggest that the individual is to blame or otherwise failing in his/her efforts.

**Procedure:**

**Check-in:**

1. A staff designated and trained to conduct this intervention meets with the individual in a distraction free setting in the morning at a time that is convenient for the individual.

2. Staff begin the meeting on a positive note. Thank individual for meeting and talk briefly about the day.

3. Staff give the individual a sheet that has the goal(s) the person is working on (usually their Universal expectations.)

4. Staff and individual talk briefly about how the goal can be accomplished and what to do if there are problems. The idea is to encourage the person.

5. Throughout the day staff speak briefly with the individual to provide praise and encouragement.

**Check-out:**

1. At the end of the day, a designated, trained staff meets again with the individual in a distraction free setting at the convenience of the individual.

2. Staff briefly talks with the person, asking about feelings, successes, and areas to work on. Again, the idea is to encourage the person (not to make negative, blaming statements).

**Reinforcement:**

1. Following a check-out, sit with individual and talk about preferred topic for 5 minutes.

**To evaluate:**

1. The sheet may be part of the home/day program communication. Staff in all sites should know the person’s goals and the extra support an individual is receiving as well as to encourage the individual without negative or blaming comments.

2. Progress toward the goals is charted over time (e.g. percent goals met by week.) **PBS Targeted Supports**

**Individualized Reinforcement Plans**

**Individualized reinforcement plan:** Reinforcement is the strongest intervention we have to support behavior change. The effects of reinforcement when done correctly can be long-lasting and beneficial to skill acquisition and relationship building. It is important to know that reinforcement does not fail. Reinforcement “does not work” only when too much behavior is required to earn it, the frequency of accessing reinforcer is too long, the reinforcer is not that powerful for the individual, the individual has access to reinforcer without engaging in desired behavior. Remember too, that reinforcers are highly specific to the individual. What will reward one individual may not have an effect for another individual at all.

**Procedure:**

**To begin:**

1. Conduct a reinforcer preference survey, observe the individual making naturally-occurring choices, talk with individual about desirable items/activities to earn, observe what the individual does with free-time.

2. Ensure reinforcers selected are available and easily accessible when earned.

**To implement:**

1. Select behavior(s) for increase and define in observable, measureable terms.

2. Select a reinforcer: edible, activity, item, reinforcer menu, token (points, checks, and money).

3. Determine the schedule of reinforcer delivery: how frequently the behavior is to be observed for reinforcer to be delivered or how much time must pass before reinforcer is delivered.

4. Determine how much of the reinforcer is given when earned, who delivers it, and in what setting.

5. Introduce the contingency to the individual and practice to establish success.

6. Before giving the reinforcer, make eye contact, smile, say individual’s name, and state the specific behavior demonstrated that earned the reinforcer.

7. Remind the individual throughout the day of reinforce available to earn.

8. Plan staff response if reinforcer is not earned and individual asks for it.

**To evaluate:**

1. Progress toward goals is charted over time (e.g. percent or number of reinforcers earned by week.)

2. Determine revision plan and thinning schedule for reinforcer.

**PBS Targeted Supports**

**Behavioral Contracting**

**Behavioral contracting:** Behavioral contract are opportunities to positively engage an individual in discussion and action to reduce problem behavior or to increase acceptable behaviors.

**Procedure:**

**Writing contract:**

1. Staff designated and trained to write a behavioral contract who also has the authority to assure that contracted items will be provided, meets with the individual in a distraction free setting to discuss contracting.

2. Staff begin meeting on a positive note, thank individual for meeting and make small talk.

3. Staff and individual talk briefly regarding behavior of concern. It is important to be positive at this point. Staff should find aspects of individual’s behavior related to concern to praise.

4. Staff and individual talk briefly about the goal and discuss what event or item the individual would want to earn for meeting the behavioral goal.

5. Staff and individual come to an agreement regarding the behaviors to be demonstrated and item or activity to be earned. Staff write the contract in a format that is understandable to the individual and both parties’ sign and receive a copy. Contract is communicated with other relevant team members.

6. Staff praise and remind individual of contract throughout the interval contract is in place. Staff do NOT threaten individual with loss of contract.

**Reviewing contract:**

1. At end of contract interval, staff and individual meet to review contract. Staff always begin by making positive comments about individual’s effort or success.

2. Contract is reviewed and schedule for earned item/activity is agreed to. Discussion occurs regarding renewing contract for another interval.

3. If contract was not earned, then discussion occurs regarding problems encountered and what changes to make. Discussion occurs regarding rewriting contract for another interval.

**To evaluate:**

1. Progress toward the goals is charted over time (e.g. percent contracts met by week.)

**PBS Targeted Supports**

**Transition Planning**

**Transition planning:** It is not uncommon for an individual to have difficulty leaving one setting or task and entering another setting or task. It is important to recognize transition issues and to address them so that an individual can feel secure and focused in a setting. By providing consistent support and structure to a transition, problem behavior can be reduced and functional skill acquisition increased.

**Procedure:**

**To begin:**

1. Identify transitions throughout the day that are difficult for an individual such as being rushed, crowded, confused, leaving a preferred activity, entering a noisy or large physical setting, etc.. 2. Consider the usefulness of transition objects and/or activities to assist the individual in feeling comfortable:

 a. Provide a preferred object to hold or carry during transition.

 b. Provide staff or peer accompaniment during physical transition from one setting to another.

 c. Provide tangible reward for successful transition.

 d. During a known transition time, such as a 3PM change of shift, structure an activity for individual to participate in.

**To implement:**

1. Discuss with the individual what is to occur next and provide encouragement. Even if the individual does not understand the words said, a positive tone will convey safety and support.

2. Discuss with individual what would be helpful or if known, provide the item or activity.

**Reinforcement:**

1. Following each successful transition, immediately praise individual enthusiastically and provide item or activity of preference.

**To evaluate:**

1. Progress toward the goals is charted over time (e.g. percent successful transitions by week.)

**PBS Targeted Supports**

**De-stimulation Procedures**

**De-stimulation:** It is common for individuals, regardless of cognitive level, to become over-whelmed by a great deal of stimulation. Loud noise, multiple conversations, multiple request, or waiting are common sources of distress caused by overstimulation. It is important to understand an individual’s in preferences for stimulation and to accommodate preferences.

**Prevention:**

1. Identity sources of overstimulation for the individual.

2. Define the individual’s response to overstimulation in observable and measureable terms.

3. Identify accommodations that can be made so that individual does not encounter overwhelming amounts of stimulation. For example:

 a. avoid certain settings at times when stimulation is likely to be increased (such as going to bank on Tuesday morning rather than Friday afternoon)

 b. wear noise reducing headphones or an iPod when situation cannot be avoided

 c. provide an alternative activity when over-stimulating events occur

 d. get on van first or last depending on preference. .

**Teaching component:**

1. When the individual is calm, practice asking (verbally or non-verbally) for accommodations, alternative activities, and/or leaving the over-stimulating situation.

2. Staff demonstrate asking to and leaving situation and ask individual to repeat.

3. Staff and individual then demonstrate skill together until individual is fluent in words/ actions.

4. Following each teaching session, staff and individual sit together and spend time talking about preferred subjects while sharing a snack.

**Intervention:**

1. At the first sign(s) of overstimulation, provide already-practiced verbal or non-verbal cues to begin moving towards an area/activity that is less stimulating.

2. Identify activities that are comforting to the individual. Some examples of comforting activities include: sensory room, sensory items providing reassurance, relaxation exercise, walking, listening to music, art work, puzzles, reading, magazines, etc.

3. Redirect individual by beginning to move towards an area/activity that is less stimulating Ask individual if you should remain with him/her or if privacy is preferred. Honor preference,

 **Reinforcement:**

1. Staff praise individual when individual asks to or leaves situation or seeks alternate comforting activity.

2. Staff, with individual’s permission, review this success at House Meeting.

**To evaluate:**

1. Progress is charted such as stimulating settings encountered without distress each week.

**Appendix TA-5**

**Agency Name**

**Targeted Behavior Support Plan**

**Review dates(s):**

**Name:** **DOB:**

**Address:**  **Author:**

**Guardian:**  **Setting:**

**Background:**

1. Brief description of individual—include individual’s strengths
2. Brief description of history of problem (e.g. *behavior*) and previous interventions
3. Describe brief assessment conducted and conclusions
4. Describe consent process if needed

**Target behavior:**

1. Define the target behavior for increase and decrease in objective, measureable terms include data collection requirements.

**Prevention**

1. Identify opportunities to prevent problems by anticipating when they may occur and defining procedures to address potential problems.

**Teaching Component:**

1. Specify component of teaching functional adaptive or replacement behavior: who will teach, when, where, what is criteria for success, criteria for revision.
2. Specify reinforcement component of teaching plan: what are reinforcers, who will deliver reinforcers, on what schedule.

**Intervention:**

1. Describe procedures for preventing problem from occurring, e.g. eliminating antecedents, increasing preferences,
2. Describe procedures for reducing problem behavior if needed

**Evaluation:**

 a. How will plan be evaluated, by whom, and how frequently?

 b. Criteria for revision.

**Appendix TA-6**

**Example of Targeted Behavior Support Plan**

 **ABC Agency**

**PBS Targeted Behavior Support Plan**

**Name:** John Doe **DOB:** 05/13/71

**Address:** 123 Main St.,Statetown, MA **Author:** Sam Psychologist, Ph.D.

**Guardian:** M. and F.Doe  **Setting:** Home

**Review date(s):**

**Background**

John is a friendly, engaging man who has a diagnosis of autism. John enjoys puzzles, drinking tea, and walking. His family, mother and father (who are his guardians) and a sister, visit often. John communicates by using sign and gestures. John attends a day habilitation program and enjoys the van ride to and from his program as well as music and walking groups. John has a history of making loud vocalizations when he is confused or upset. He has not done this behavior for several years. However, recently John is vocalizing again and it is disruptive to peers in his home. John is sleeping and eating well and continues to enjoy previous activities. John does not take any medications and is in good health.

A brief functional assessment indicates that John is most likely to vocalize disruptively in the afternoon when he returns from his day habilitation program. John is usually not engaged in an activity when he makes vocalizations. Vocalizations also occur during times when there is increased stimulation in the home such as getting on the van in the morning and before dinner when everyone gathers at the table. John’s day program did not indicate any change in behavior. The brief assessment suggests John’s vocalizing functions to indicate boredom and/or stress.

**Prevention**

1. John’s advocate will check the leisure cabinet on a weekly basis to be sure that John’s puzzles are available, a walk is on his schedule every day, and tea is available in the kitchen.

2. John demonstrates overstimulation by vocalizing loudly when getting on the van in the morning, returning home from day habilitation program, and before dinner; thus:

(a) **Getting on the van:** John should be the last individual to get on the van in the morning or at other times when more than one individual is going out. John likes to wait in his room while listening to music or sitting in front of the fan.

(b) **Before dinner:** John should be the last individual called to the dinner table. Housemates should be sitting at the table when John enters the kitchen to take his place at the table.

(c) **Coming home from program or at afternoon change of shift:** When John and housemates come home in the afternoon, greet each individual by name, smile, and ask if he/she would like a snack.Offer each individual a choice between two items of fruit and two types of beverage to drink. Have a pleasant conversation about the day.

3.Offer John a choice of two activities when there is more than 15 minutes of unstructured time. Always ask John to sign or point to his preference and assist him in accessing his choice. Check in with him every 10 minutes and praise him for participation.

**Teaching Component**

**Signing:** using sign for “loud” when the situation is noisy or disruptive**. Record choice made on behavior log.**

1. Every day following the afternoon snack, when John is calm, assigned staff should practice calmly signing the word “loud.”

2. Staff demonstrate signing the word. Ask John to demonstrate.

3. Staff and John then demonstrate skill together until John is fluent in sign.

4. Following 5 successful demonstrations, John and staff take a walk together for 10 minutes.

**Intervention**

**Loud vocalizations:** making soundslouder than a conversation; when John stops making vocalizations for one minute, that episode is over. **Record the occurrence of the episode and the duration on the behavior log**

1. When John vocalizes disruptively, say, “John, can you sign “loud?””

2. If John then signs or gestures “loud”, say, “John, great telling me it is loud in here. Come with me to a quieter place.”

3. Go with John to a quieter area of the house. Staff give John a choice of music or a fan which are both soothing for John.

**Evaluation**

1. This plan will be evaluated monthly at the Targeted Team meeting.

2. Data on behavior for increase and decrease will be graphed for each Targeted Team meeting.

3. If behavior for decrease does not decrease by 50% of baseline within 3 months, the plan will be revised.

4. If behavior for increase does not increase by 50% of baseline within 3 months, the plan will be revised.

5. When criteria for increase and decrease are met, the next step of the teaching component, moving to an identified quieter place will be implemented.

**Appendix TA-7**

**Targeted Implementation Checklist (TIC)**

**Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Setting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time: Start \_\_\_\_\_\_\_\_\_Stop\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Interaction Skills | Score | Comments |
| 1. Staff names behavior(s) targeted for increase and decrease |  |  |
| 2. Staff identifies possible function of behavior as indicated on brief assessment |  |  |
| 3. Staff demonstrates or identifies prevention measures |  |  |
| 4. Staff demonstrates or describes reinforcement procedures |  |  |
| 5. Staff demonstrates or describes procedures for behaviors for increase |  |  |
| 6. Staff demonstrates or describes procedures for behaviors for decrease |  |  |
| 7. Data recorded as required |  |  |
| Total checks: |  |  |

**Scoring Key:** = Skill demonstrated all opportunities for entire observation

  **X =** Skill not demonstrated throughout the observation.

 **N/A** = No opportunity to demonstrate the skill.

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 **Reviewer Signature Observer Signature**

1. TA-1 [↑](#footnote-ref-1)
2. TA-2 [↑](#footnote-ref-2)
3. TA-3 [↑](#footnote-ref-3)
4. TA-4 [↑](#footnote-ref-4)
5. TA-5 [↑](#footnote-ref-5)
6. TA-6 [↑](#footnote-ref-6)
7. Universal Appendix UAi [↑](#footnote-ref-7)