Michigan Department of Health and Human Services

State Hospital Administration

Applied Behavioral Treatment Manual V2

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Introduction

The Michigan Department of Health and Human Services (MDHHS) State Hospital Administration (SHA) directs and manages the State of Michigan psychiatric hospitals. Hospitals operated by SHA provides mental and behavioral health treatment to children, adolescents and adults. The Applied Behavioral Treatment (ABT) units are specialized units providing mental and behavioral health treatment to individuals with developmental disorders, including autism spectrum disorder, by a specialized multi-disciplinary clinical team including psychiatrists, psychologists, behavior analysts, occupational therapists, speech and language pathologists, social workers, nurses, and direct care providers. At hospitals with education centers, they also have educators on the treatment team.

The ABT units provide treatment to patients with developmental disorders, most commonly autism spectrum disorder, with intense and challenging behaviors that interfere with their ability to function. The individual plans of service are based in the science of Applied Behavior Analysis (ABA) and include behavior treatment plans (BTP) with identified target behaviors and these plans are approved by the MDHHS Behavior Treatment Plan Committee.

Hospital Applied Behavioral Treatment Criteria

This manual reflects the implementation of an ABT Unit utilizing the following criteria:

	Domain	Description
1.	**Program Leadership**	There is a clearly identified ABT Program Director who sets the clinical and operational philosophy and expectations of the program. This individual may be a board-certified behavior analyst, psychologist (PhD), or psychiatrist with expertise in treating patients with autism and intellectual developmental disabilities (IDD) and challenging behaviors.
2.	**Specialized Clinical Team**	The clinical team includes disciplines that are not always present in typical psychiatric units, including a board-certified behavior analyst, speech and language pathologist, and occupational therapist. The full clinical team consists of a psychiatrist, psychologist, nurse, board certified behavior analyst, speech-language pathologist, occupational therapist, social worker, and direct care providers. Education staff would also be on the clinical team if the hospital has a school on site or if the patient has an Individualized Education Program (IEP) with a school district. If the hospital has activity therapists, recreational therapists, or developmental disabilities programmers, they would also be members of the clinical team. All disciplines are represented by professionals who have experience with patients with

		developmental disorders and challenging behaviors. Each hospital has designated staff who are regularly scheduled on the unit.
3.	**Clinical Team Functioning**	The full clinical team meets at least twice weekly to review each patient's progress, medications, target behavior data, current interventions, and discuss treatment. The target behavior data is made available and visualized at each team meeting to all team members to drive evidence-based decision making for patients. If the patient is in school or has an IEP, a member of the education team is present at the meeting too.
4.	**Nursing and Direct Care Staffing**	The ABT Unit has identified core set of staff, including nurses and direct care workers (CCWs/RCAs) who are assigned to the unit. The utilization of non-core and untrained staffing is considered an "exception." There is at least one dedicated nurse per awake hour shifts to the ABT unit.
5.	**Direct Care Staff Training**	Direct care staff are defined as childcare workers, residential care aides, nurses, recreational therapy aides and activity therapy aides, teachers, and teacher assistants/ paraprofessionals. The direct care workers receive training in applied behavior analysis theory and skills (aligned with registered behavior technician coursework), developmental disorders, patient communication support, and applied behavioral treatment hospital operations, including unit programming, target behavior data collection and behavior plans. Direct care staff will have applied behavioral treatment training twice a year which may include principles, concepts and implementing applied behavior analysis protocols; data collection and reporting; skill development and activity programming. Direct care staff will also receive competency reviews annually aligned with the registered behavior technician requirements.
6.	**Clinical Team Training**	The multi-disciplinary team will receive behavioral science training, including applied behavior analysis, prior to joining the clinical team and treating patients. Multi-disciplinary team members attend ABT clinical trainings minimally twice a year. This training will include for treatment of patients and updated clinical research, recommendations, and evidence-based practices.
7.	**Referrals**	The patient referral submission from the Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) includes the current behavior plan, past treatment including medications and behavioral treatment, and the target behavior/reason for proposed hospitalization. There is a clear referral process where information on diagnosis, behavioral, functioning, and medical needs is reviewed by the staff. Referrals to the ABT unit are reviewed by the Program Director. The Program Director approves all patients being referred to the ABT unit to confirm the ABT is appropriate to successfully treat the medical need for inpatient treatment.
8.	**Clinical Assessment is Specific to Individuals with Autism and Intellectual Developmental Disabilities**	The psychiatric diagnostic evaluation, social work assessment and other assessments include questions about developmental history, communication impairment and ability, activities of daily living abilities, sensory needs, reinforcement preferences, and the specific behavioral history and current challenges presented by the individual. Referral submission of all recent assessments and plans of treatment/service within the last six months is utilized to determine the clinical assessments needed for patients.
9.	**Behavioral Assessment and Plan**	The program performs an initial systematic functional behavior assessment within 10 days of admission and then performs further assessments as needed based on response to intervention. There are written procedures for the unit's functional behavior

		assessment process. An initial BTP is issued for the patient within 24 hours of admission based on the available information at the time. An in-depth individualized BTP, with target behaviors identified, is developed within the first 10 days based on the functional behavior assessment. The behavior plan is submitted to the MDHHS Behavior Treatment Review Committee within 15 days of admission for each patient. The BTP is reviewed weekly and modified over the course of the hospitalization.
10.	**Behavioral Data Collection**	Behavior data is collected on all patients 24 hours a day on their individual target behaviors. The data is entered into a computer program and analyzed daily with documentation. The data is made readily available to the clinical team and visually displayed during team meetings to inform treatment decisions. The target behavior data is made available to parents, caregivers, guardians, and discharge service providers.
11.	**Behavioral Treatment**	More specialized behavioral assessment and treatment sessions may be run by board certified behavior analyst/psychology staff. Behavioral treatment in the form of application of the BTP is implemented by all staff, including school staff. Each patient receiving applied behavioral treatment has an individualized binder including data collection sheets, behavioral plan that includes target behavior definitions, antecedent strategies, and responses to target behavior occurrence, daily activity program schedule, laminated written and visual schedule, Velcro strips for visual (written/pictures) and zip bag to hold tokens, dry erase pens and other reinforcers.
12.	**Broad Assessment of Problem Behaviors**	The assessment of target problem behaviors includes screening for a medical etiology and pain, comorbid psychiatric disorders, family functioning, communication deficits and sensory and activities of daily living needs that may relate to the problem behavior. (*Remembering a problem behavior is never to be initially assumed to occur solely due to an operant function. Other etiologies must be considered and ruled out during the assessment process.)*
13.	**Generalization of Treatment**	The social worker or care coordinator is in weekly contact with the PIHP and the CMHSP during the hospitalization to communicate progress and improvements, home, and community services/residential serviced needed for discharge, anticipated discharge date, and estimated date of discharge ready. Training to implement the behavior plan and other patient needs after hospitalization will be offered and facilitated for the family, step down facility staff, school/education district, community residential or in-home supports as applicable. Prior to discharge the BTP is reviewed for feasibility with those who will continue treatment post-discharge, and the level of intervention or specificity of supports faded / adjusted to better match what is achievable in the post-discharge setting. The transition training is determined by the BTP, and medical necessity services needed after inpatient treatment. Training is conducted by the lead behavioral clinician, Program Director, Board-Certified Behavior Analyst, or Psychologist.
14.	**Educational Services for Children and Adolescents**	Education services are provided to youth and adolescents in the program 5.5 hours a day, 5 days a week at Hawthorn. The same BTP and behavior data collection is utilized during school hours as during the rest of the hospitalization. For children/adolescents who attend a local school district for services, staff will be trained on the behavior plan, invited to participate in programming at the hospital and daily written communication will be provided

		between hospital and school staff. Patients' who not at Hawthorn, will have educational services at the hospital or at the local school district based on their IPOS and Individualized Education Plan.
15.	**Developmentally Appropriate Programming**	There is a clear daily schedule of developmentally appropriate individual/group activities. Daily activity programing is occurring seven days a week. Individual in-bedroom time, downtime and free time is minimized to a total less than 2 hours each day during awake hours. Direct care staff are trained and facilitate basic group activities. The daily schedule is posted on the unit for patients and staff. The detailed weekly schedule with identified specific activities and staff running the programs are approved by the Program Director. Patients have the program schedule in their treatment binder.
16.	**Reinforcement**	The program has a variety of reinforcement options available for patients, including use of electronic tablets. The use of food as a reinforcer is rare and only utilized at direction of the clinical team for specific key purposes when needed (e.g., facilitating medication compliance).
17.	**Holds / Restraints / Seclusion Reduction**	It is a specific goal of the program to increase functional skills to eliminate the need for crisis level interventions. Incidents of holds/restraint/seclusion are reviewed daily and at clinical team meetings and adjustments are made to the behavior treatment plan that are intended to reduce their occurrence and allow freedom of movement.
18.	**Personal Protective Equipment (PPE)**	To increase staff safety and minimize the use of holds / restraint / seclusion, a base uniform of PPE is utilized by all direct care staff. Base uniform at a minimum includes lower arm padding and torso covering (e.g., jean jacket). *Additional PPE is available on the unit for use by staff working with specific patients for less common risks, as ordered by the physician.*
19.	**Medication**	Medication prescribed is informed by the evidence-base for individuals with autism and intellectual developmental disabilities. Medication is minimal and complimentary of the individualized behavior treatment plan. Use of "PRN" medication for behavioral control is minimized and limited to emergent situations.
20.	**Unit Environment**	The program environment (unit) is adapted to the needs of people with an IDD, including ASD. A space for sensory regulation is provided. Environmental noise is minimized. Program-wide communication supports are implemented for patients, such as visual schedules, visual supports for activities of daily living, task completion visual sequences for common routines, and reinforcers are readily available.
21.	**Operational Measurement**	Operational measurements are documented daily. The rate of holds/restraint/seclusion, emergent "PRN" medication use, staff injuries, length of stay, time from readiness for discharge to actual discharge and caregiver satisfaction surveys are reviewed minimally each quarter by the clinical team, and hospital leadership, and State Hospital Administration staff.
22.	**Outcome Measurement**	A validated outcome measure for behavioral functioning is administered to the individual at admission, monthly and at discharge to assess change over time, such as the ABC-I, rated by the same clinician / team member at each time point. The Vineland 3 is administered to the individual at admission and discharge by the same clinician/team member. Measures of other outcome domains can be utilized in addition to the behavioral functioning measure.
23.	**University Affiliation**	Each hospital will work towards establishing and maintaining affiliation agreements with a minimum of one university with a

		medical resident and fellow, and supervised placement of students in psychiatry, psychology, and applied behavior analysis minimally. Additional consideration for student rotations/placements from speech-pathology and occupational therapy university programs.

Treatment Team Members' Roles and Responsibilities

Program Leadership

The ABT unit operates within the hospital in alignment with hospital standard operating procedures. The hospital director is responsible for all operations. The ABT unit program director sets the clinical and operational philosophy and expectations of the unit and works collaboratively with hospital administration.

Specialized Clinical Team

Program Director – A psychologist or behavior analyst with experience treating individuals with developmental disorders and challenging behaviors.

- Responsible for overall management of the unit in coordination with hospital administration to include:
  - Coordination and communication with Nursing, Psychology, Activity Therapy and Social Work Managers
  - Work with Department Managers on staff assigned to the ABT unit
  - Conduct and coordinate evaluations and assessments
  - Review and submit behavioral treatment plans
  - Monitor the implementation of the behavioral treatment plans, data collection and activities on the unit
  - Coordinate trainings and quality improvement
  - Implement and monitor the ABT Action Plan
  - Attend and assist with treatment team meetings
  - Coordinate and facilitate the ABT Administration Meetings
  - Monitor programing and activity schedule
  - Support direct care workers and activity therapist assistants
  - Review and approve all admissions to the ABT unit
  - Supervision of unit behavior analysts
  - Active member of the SHA ABT Workgroup
  - Supervision of unit behavior analysts
  - Full time assignment to the ABT unit

Behavior Analyst(s)

- Responsible for the development and maintenance of a behavior treatment plan (BTP) for each assigned patient to include:
  - Functional assessment of behavior
  - Coordination with multidisciplinary treatment team
  - Development of data collection procedures and training of staff
  - Collection, analyses, and dissemination of behavioral data
  - Training treatment team and direct care staff on BTP (both inpatient and post discharge providers)
  - Coaching and guidance for direct care staff in behavior treatment in real time with patients
  - Updates to BTP after each treatment team review or as needed

    - Provide post discharge treatment recommendations, training on BTP and coordination of discharge services with providers and family/guardian
- Develop individualized patient binders
- Attend and assist with treatment team meetings, including sharing data and graphs from patients' BTPs
- Active member of the SHA ABT Workgroup
- Develop and run programming as requested

Social Worker

- Responsible for patient care coordination and communication on patient admission, plan of service, discharge, and progress to include:
    - Patient
    - Patient family and/or guardian
    - The appropriate PIHP and/or CMHSP
    - Treatment team
- Responsible for development and maintenance of individualized plan of service (IPOS) within the electronic medical record (EMR), inclusion of BTP in the EMR, and coordination of family visits, communication, and all discharge related activities.
- Active member of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly
    - Run programming, as requested

Occupational Therapist

- Responsible for development of environmental components in the unit, occupational therapy assessments, behavioral programming related to sensory related interventions and resources, and schedules and treatment for activities of daily living (ADLs)
- Active member of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly
    - Run programming, as requested

Psychiatrist

- Responsible for assessment and treatment of comorbid psychiatric disorders and overall management of patient care including psychotropic medication
- Assure medications are appropriate for patients with developmental disabilities, including autism spectrum disorder
- Active member of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly

Nurse Manager

- Responsible for supervision of direct care staff in coordination with Program Director and development of nursing care plan coordinated with the treatment team.
- Manage nursing staff and scheduling
    - At least one nurse will be dedicated to the ABT unit during awake shift hours
    - Direct care workers assigned to the ABT unit have been trained in applied behavior analysis concepts

    - Nurse Manager works closely with the ABT Program Director on staffing
- Assure nurses are active members of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly
    - Patients' treatment updates are shared with staff at shift change

Psychologist or Psychology Manager

- Responsible for psychological assessments and individual therapeutic interventions as needed
- Active member of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly

Internist/Family Medicine Physician

- Responsible for medical assessments and interventions as needed
- Communicate with ABT treatment team daily on patients' medical needs
- Provide patient updates at both treatment team meetings weekly

Behavior Technician/Resident Care Aid/Child Care Worker, all Direct Care Staff

- Active member of the ABT unit team with daily communication with team members
- Implements behavior treatment plan and interventions through day-to-day interactions
- Provide ADL and medical supports as defined in the IPOS and nursing plan
- Collects and records BTP target data
- Attend treatment team meetings weekly, as requested
- Run programming, as requested

Lead Behavior Technician/ Resident Care Aid/Child Care Worker, all Lead Direct Care Staff

- Active member of the ABT unit team with daily communication with team members
- Assists in treatment plan development
- Implements behavior treatment plan and interventions through day-to-day interactions
- Provide ADL and medical supports as defined in the IPOS and nursing plan
- Collects and records BTP target data
- Attend treatment team meetings weekly, as requested
- Organize, participate and/or lead group and one to one activity
- Assist with patients' treatment updates shared with staff at shift change
- Provide guidance and training to direct care staff on implementation of patients' BTPs
- Assists Program Director with trainings and assignments, as requested

Speech/Language Pathologist

- Responsible for speech/language assessments and functional communication interventions
- Develop and maintain unit and program-wide communication supports for patients
- Active member of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly

Recreational Therapist/Activity Therapist/Developmental Disabilities Programmer/Music Therapist

- Develop a written daily activity schedule for 14 days with developmentally appropriate programs, with goal of less than two hours per day of scheduled in-room or down time for patients

- Written descriptions of the activities are in a manual and available for ABT treatment staff
- Training is provided to ABT treatment staff and direct care staff on the activities
- Daily schedule is posted in several location on the unit for staff and patients
- Weekly schedule with the staff leading each activity is visual for staff and patients
- Therapists work with behavior analyst (s), occupational therapists and speech and language pathologists on modifications of programs, as needed for patients
- Collaborate with the behavior analyst (s) on the development of individualized patient binders to include the daily activity program schedule and support materials needed during activities
- Assistant Activity Therapists are trained on the BTP and target behaviors and patients' reinforcers by the treating board certified behavior analyst (BCBA)
- Responsible for coordination and implementation of educational services for patients with educational eligibility criteria per state education guidelines
- Active member of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly

Teacher

- Responsible for coordination and implementation of educational services for patients with educational eligibility criteria per state education guidelines
- Collaborate with the ABT unit staff on implementation of the BTP and collection of data
- Active member of the ABT unit team including:
    - Daily communication with the team members
    - Provide patient updates at both treatment team meetings weekly

Clinical Team Functioning

The ABT team meets twice weekly and includes the multi-disciplinary clinical team members to collaborate on the treatment and reduce the risk for patients at the hospital. These meetings are to review each patient's treatment by clinical discipline discussing 24-hour report, visualizing behavior data and graphs, discussing behavior functions, behavioral and medical modifications, programming/activities, supports, discharge readiness, relevant communication with family/guardian, and relevant communication with payor/ PIHP, CMHSP, and/or other relevant parties. The clinical team works together to provide the most efficient hospital treatment to accommodate the patients returning to the community, and school as appropriate. Required members of the treatment team include program director, behavior analysts, social worker, psychiatrist, occupational therapist, speech/language pathologist, nurse manager, unit nurse, psychologist, direct care worker, and teacher as appropriate.

The clinical staff report outs are brief, provide changes, recommendations, and clinical updates. There may be days when clinicians do not have updates on patients. The team should discuss each patient within 5-10 minutes.

The meeting includes all clinical team members and updates are provided in a routine order, such as, nursing, behavior analysis, occupational therapy, activity therapy, speech and language pathology, social work, psychiatry, direct care (childcare worker/direct care worker), dietician and education. If the hospital has recreational therapists and developmental disabilities programmers, they would also be members of the clinical team.

The behavior analyst assesses patients' progress on target behavior and BTP interventions for progress/lack of progress minimally every two weeks and reports on the behavior intervention status.

The behavior analyst assesses patients' progress on behavior plan for progress/lack of progress minimally every month and reports on the behavior intervention modifications.

Once the recommendations have been made from the treatment team at the weekly meetings, it is the responsibility of the behavior analyst to implement the changes to the behavior treatment plan efficiently (within 24 hours). This may also include visual supports and binder materials. Direct care staff will also be trained on the changes in the plan and binder. Once a behavior plan has been updated the procedures outlined above must be followed.

Direct Care Staff Training

For the purposes of this manual, direct care staff are defined as resident care aides (RCA), childcare workers (CCW), nurses, recreational therapists (RT), activity therapists (AT), activity therapist assistants (ATA), teachers, teacher aides, and paraprofessionals. Direct care staff receive the following training:

- Applied behavior analysis theory and implementation skills that is aligned with the registered behavior technician (RBT) coursework as defined by the Behavior Analyst Certification Board (BACB)
- Developmental disorders, include autism spectrum disorder (ASD)
- Patient communication support
- ABT unit and hospital operations including unit programming, target behavior data collection, behavior treatment plans, and patient binders

Direct care staff will receive behaviorally focused training twice per year which may include:

- Principles, concepts, and implementation of applied behavior analysis treatment protocols
- Data collection and reporting
- Skill development
- Activity programming

Direct care staff will receive competency reviews annually aligned with the RBT requirements as determined by the BACB.

All training will be documented in the staffs' human resource training records.

Clinical Team Training

Clinical staff includes behavior analyst, psychiatrist, social worker, occupational therapist, physician, speech/language pathologist, and psychologist. Clinical staff will receive training in behavioral science prior to joining the clinical team and treating patients. Clinical training is required in behavioral science, treatment of patients utilizing applied behavior analysis, updated clinical research, recommendations, and evidence-based practices minimally twice per year.

All training will be documented in the staffs' human resource training records.

Admission

Criteria

Patients referred to the ABT unit must have a diagnosis of ASD or Intellectual Developmental Disorder/Disability (ID and be expected to benefit from applied behavior treatment.

Psychiatric Populations
ASD and/or IDD are conditions chronic in nature and are defined by criteria listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Major characteristics of ASD and IDD are:

- **Autism Spectrum Disorder (ASD):** A disorder characterized by persistent deficits in social communication and social interaction across multiple contexts, including restrictive, repetitive patterns of behavior, interests, or activities causing significant impairments in functioning.
- **Intellectual Disability or Intellectual Developmental Disorder (ID):** A disorder characterized by both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.

Given the early onset and life-long nature of these conditions, as well as the complexity of symptoms and high prevalence of comorbid conditions, these individuals and their families require a multi-faceted approach to care that integrates therapy, medication management, and community engagement.

Referrals
Referrals to the ABT unit are submitted to the Program Director for review to determine appropriateness for the program and ability to successfully treat the presenting problems.

Referrals should include the current behavior plan, past treatment including medications and behavior treatment, support for the diagnosis of autism or intellectual disability, the target behavior/reason for proposed hospitalization and the anticipated plan for post-hospital discharge care.

After review of materials including referral application, the Program Director will communicate to hospital administration and coordinate appropriate admission if approved.

Clinical Assessment Specific to Individuals with ID

Initial Assessment
The goals of the initial evaluation and assessment are to document the patient's functional abilities in cognitive, language, and social domains; contributions of genetic/metabolic etiologies, self-care, psychiatric comorbidities, and presence of comorbid medical/neurologic disorders.

The evaluation and comprehensive assessment includes:
- Detailed developmental and symptom history to assess full range of psychiatric symptoms and disorders (i.e., irritability, inattention, impulsivity, aggressive behaviors, repetitive, restricted behaviors, anxiety, depression, psychotic symptoms, and sleep disturbances) as well as impairments from these symptoms and disorders. The use of rating scales is recommended.
- A full medical history and physical examination, including vision, hearing, and dental screening.
- Assessment of diet/nutritional deficiencies, seizures, sleep disturbances, gastrointestinal problems (i.e., constipation, gastric reflux), and other medical problems.
- Special consideration of developmental speech, language, communication, neuropsychological, and educational assessments.
- Medication history, including over the counter, complementary, and alternative medicine.
- Treatment history, including behavioral therapies, occupational therapy, speech therapy, physical therapy.
- Assessment of family structure and functioning, including safety assessment of the environment to identify:
    - ✓ Risk of harm to self or others
    - ✓ Nighttime wandering

- ✓ Low safety awareness/impulsivity
- ✓ Signs of abuse or neglect

- Behavior inventory using validated rating scales and checklists to document the occurrence of specific behaviors and the specific risks they present.

Based on results of history and physical examination, consider as clinically indicated:

- Metabolic evaluation
- Comprehensive psychological evaluation
- Neurological consultation
- Genetic consultation

Behavior Assessment and Plan

A process for identifying problem behaviors and developing interventions to improve or eliminate those behaviors.

A functional behavior assessment (FBA) consists of information-gathering procedures that result in a hypothesis about the function(s) of the identified challenging behavior is serving for the individual. The process also results in the identification of environmental antecedents (what happens before the behavior occurs) and consequences (what happens after the behavior occurs) that are likely maintaining the behavior. The information gathered is used to develop an effective and efficient BTP.

Data Based Decision Making

Information must be gathered indirectly through interviews of people who have observed the behavior of the individual in a variety of settings and conditions. The purpose of these interviews is the review of variables affecting the behavior and then to narrow the focus of the variables that are important to the individual. This information is not gathered through record review or anecdotal reporting from third parties.

Information should also be collected through direct observation across settings and times with consideration of other environmental factors (other persons present, task demands, changing conditions, etc.). Information gathered during the interview portion of the FBA identifies the type of data to collect during direct observations. A graphic representation of the data collected, written descriptions collected through structured anecdotal reports during direct observations, and the interview information result in the following:

1. Development of a specific, clear, description of the behavior(s) of concern
2. Identification of environmental factors such as antecedents and consequences corresponding with the behavior(s).
3. Development of summary statements identifying the perceived function(s) of the behavior(s) of concern.

This information serves as the basis for the development of a BTP that changes environmental conditions (antecedents and consequences) while providing instruction in the acquisition of new, more appropriate behaviors. Throughout the baseline and intervention phases, data are collected and evaluated, and decisions are made based upon analysis of the data. Ongoing revisions to the BTP should continue to be driven by data analysis.

The functional assessment and behavior treatment plan are included in the patient's EMR with a clinical signature and date.

Broad Assessment of Problem Behaviors

The assessment of target behaviors includes screening for a medical etiology and pain, comorbid psychiatric disorders, family functioning, communication deficits, sensory irregularities, and activity of daily living needs that may relate to the behavior.

The assessment should include:

- A specific description of the behavior(s) of concern (what it looks like, sounds like, etc.)
- Evaluation of physical and medical factors
  - Could the behavior be the result of a medical or psychiatric condition?
  - Could the behavior be caused by physical pain or discomfort?
  - Could the behavior be the side effect of a medication?
  - Could the behavior be the result of a physical deprivation such as hunger, thirst, lack of rest, etc.?
- Antecedent events
  - Are there circumstances where the behavior always occurs?
  - Are there circumstances where the behavior never occurs?
  - Does the behavior occur only (or more often) during particular activities?
  - Does the behavior occur only with (or more likely with) certain people?
  - Does the behavior occur in response to certain stimuli (demands, termination of preferred activities, tone of voice, noise level, ignoring, change in routine, transitions, number of people in the room, etc.)?
  - Does the behavior occur only (or more likely) at certain times of the day (morning, afternoon, end of day, night)?
- Skill deficits related to the behavior of concern
  - Cognitive skills (requirements presented are not at the individual's level of ability)
  - Participation skills (difficulty in small or large groups)
  - Social skills (difficulty acquiring or maintaining friendships/relationships)
  - Communication skills
  - Organizational skills
  - Self-regulation skills
  - Motor skills
  - Functional skills (daily living activities)
  - Leisure skills
- Consequence factors
  Does the behavior allow the individual to gain something?
  - Preferred activities or items?
  - Attention?
  - Escape from tasks or demands?
  - Stimulation (sensory, pleasure, activity)?

These assessments are included in the patient's EMR with a clinical signature and date.

Behavioral Treatment and Programming

Individualized Patient Binders

Each patient receiving ABT has an individualized binder including data collection sheets, BTP that includes target behavior definitions, antecedent strategies, and responses to target behavior occurrence,

daily activity program schedule, laminated written and visual schedule, Velcro strips for visual (written/pictures) and zip bag to hold tokens, dry erase pens and other reinforcers.

The behavior analyst will develop and maintain the individualized patient binders. Additional team members will assist with items within their responsibilities, such as, activity schedule.

Data Collection and Reporting

Data collection is the process of recording information regarding the behaviors that are targeted for decrease (aggression, tantrums, self-injury, etc.) or increase (requests, activities for daily living [ADL], leisure engagement, etc.). Typically, between two and five target behaviors are identified and data collected on at a time for an inpatient stay.

Data is used to understand behavior patterns and to measure progress. Accurate data enables clinicians to see what is working in the treatment and assess which types of intervention methods best work for the individual and what factors may be influencing behavior.

Some of the various data collection procedures include:

- Frequency/event & rate recording: This type of data collection tracks the number of times a behavior response occurs. When recording rate, the number of times is recorded per a specific time frame.
- Duration recording: This refers to the length of time the behavior occurred.
- Latency recording: This refers to the length of time from the instruction/request to the start of the behavior (i.e., how long did it take for the individual to respond to a request).
- Time sampling recording: This refers to taking data in periodic moments or periods of time rather than consistently.
- Permanent product: This refers to taking data based on the product or outcome of the behavior rather than the behavior as it is occurring (i.e., did the result/request occur?).
- Antecedent, behaviors, and consequence (ABC) data: This refers to taking data or information on the antecedents, behaviors, and consequences of behavior.

Data collection forms should be developed based on what type of data is collected and include the following elements:

- Date
- Patient name
- Staff person collecting data
- Context in which behavior occurs
- Detailed description of behavior to be observed
- Legends defined
- Parameters of anecdotal information if recorded
- Instructions for data collection

Daily collection sheets should be entered into a graphing program at the end of each day. Weekly graphs are aggregated for treatment team analysis.

Types of graphs for data reporting:

- Line graphs – representing a relationship between two variables that can demonstrate variability, level, and trend. (Indicate phase change lines when intervention is adjusted)
- Bar graphs/histograms – comparison and summary of data

- Cumulative records – record of responses over time
- Scatterplots – patterns between points that can indicate certain relationships

Behavioral Treatment

Behavior Treatment Plan

A BTP is a detailed plan tailored to the individual patient and is an important tool for engaging the patient in their treatment. Treatment plans usually follow a simple format and include high priority goals, measurable objectives, timeline for treatment progress, and data collection for tracking progress.

Steps to Writing a BTP

This is an active process that is not limited to writing. It will include substantial data collection, planning, and modifying for individual patient needs.

1. Acquire informed consent from the patient and/or guardian
2. Collect baseline data (only current problem/challenging behaviors)
3. Collect FBA data
4. Analyze the data to identify a hypothesized function of the target behavior(s)
5. Research appropriate interventions
6. Assemble the components of the plan
7. Review the plan with the Behavior Treatment Plan Review Committee for approval
8. Review the plan with the patient and/or guardian and obtain signature
9. Train staff to implement the plan

While some elements may be optional based on the setting or other supporting documentation, all plans should include the following components:

Identifying information

- Patient name and any nicknames/preferred
- Date of birth
- Diagnosis
- Date of the plan (include revision dates)
- Author

Goal(s)

Clearly identify the goal for the plan. Anyone reading the plan should understand the purpose behind the plan. Why is the behavior intervention plan necessary? What benefits will a behavior plan do for the patient? Writing a goal that is observable and measurable ensures that everyone involved is on the same page.

Good goal: To achieve independence required for discharge.
Better goal: To increase patient's ability to participate in self-care with a decrease in target behavior and increase in adaptive alternative behavior.
Best goal: To increase patient's ability to engage in appropriate social communication 95% of waking hours and actively participate in self-care with a decrease in noncompliance to less than 10 minutes per day.

Target behavior definition

Target behaviors should be defined operationally, meaning that anyone reading the definition can identify whether the behavior is occurring. For each target behavior define what is an example of the behavior and what is a non-example of the behavior

Examples include:

- *Shouting "no" and swatting the air with an open hand when asked to sit.*
- *Sitting on the floor when told to line up for medication.*
- *Running out of the room when asked to participate in group activity.*

Non-examples include:

- *Quietly saying "no" while sitting when asked to sit.*
- *Saying "I don't want to" while walking in line when told to line up for medication.*
- *Standing still for 15 seconds before walking to the group area when asked to participate in an activity.*

Hypothesized function

Based on the Functional Behavior Assessment (FBA), write a statement describing the hypothesized function of the target behavior for each. This statement helps keep everyone involved clear on the factors that likely maintain the challenging behavior.

Example: *Hypothesized Function: Based on the FBA data, including interviews with staff, ABC data, scatterplot data, and direct observation, patient's noncompliance is likely maintained by access to staff attention in the form of reprimands, coaxing, or chasing.*

Antecedent interventions

Antecedent interventions minimize challenging behavior by addressing common triggers, setting events, or other precipitating factors. Clearly understanding the conditions in which the behavior typically occurs improves the accuracy and effectiveness of interventions.

Examples: *Visual schedules*
Providing tasks/activities to occur during transitions
Increasing access to staff attention routinely

Alternative or replacement behaviors

Whenever an attempt is made to reduce a behavior, the plan must include a plan for teaching an appropriate alternative or replacement behavior. Without this, a replacement behavior may occur that is just as problematic as the original behavior. The replacement behavior should serve the same function as the maladaptive behavior targeted to be reduced.

Examples: *Functional Communication Training*
Social Stories

Consequent interventions

Specify what the schedule of reinforcement should be and include what behaviors staff should reinforce.

Examples: *Differential reinforcement of alternative behavior (DRA)*
Non-contingent reinforcement

Response to target behavior

Include specifics regarding how staff should respond when the target behavior(s) occur. This should include criteria for crisis response as well as when and how staff should call for help.

Examples: *Withhold attention to the extent possible (no eye contact, do not verbally respond, etc.)*
Monitor for safety

Use body positioning to minimize opportunities to elope from the area/room
Present demands with visuals if possible
Wait for compliance with initial demand
Resume reinforcement schedule once compliance has been re-established

Additional information for the behavior plan
At times, additional information may be relevant. This might include common setting events such as specific staff, the presence of loud noise, or being hungry. Include any other information that might help staff understand and respond to the behavior appropriately.

Keep this information relevant to the target behavior(s) without including extraneous information.

Daily data records are maintained in unit records by the Program Director. Weekly data summary reports are included in the patient's EMR with clinical signature and date.

Generalization of Treatment

Discharge planning will form part of the assessment and care planning process with a patient on admission to the ABT unit. Treatment teams, in collaboration with the patient and their caregivers will formulate a discharge care plan and risk and relapse plan relating to the specific needs of the individual. Planning for discharge should begin as soon as possible following admission in order that a comprehensive treatment and discharge plan can be formulated. The patient and caregivers should be fully involved in all aspects of the discharge plan.

It is important that a provisional discharge date is identified far enough in advance to permit necessary arrangements to be made and required meetings to take place. Documentation of discharge planning will include completed discharge instructions with patient name and signature, documentation that the patient and/or guardian understands and agrees with the discharge plan, including medications and follow-up care. Discharge progress is reported at each progress meeting to the patient's guardian, their CMHSP, and PIHP.

Contact will be made by the board-certified behavior analyst during the hospital stay with caregivers and community agencies who will continue treatment post-discharge.

Training in the implementation of the behavior plan and other patient needs during the hospitalization will be offered and facilitated for the family, step down facility staff, community residential or in-home supports.

Prior to discharge, the BTP is reviewed for feasibility with those who will continue treatment post-discharge, and the level of intervention or specificity of supports faded/adjusted to better match what is achievable in the post-discharge setting.

The treatment team social worker should be in weekly contact with PIHP and the CMHSP during the hospitalization on progress and improvements, home and community services/residential serviced needed for discharge, anticipated discharge date, and discharge readiness.

Discharge communication and progress updates are included in the patient's EMR with clinical signature and date.

Educational Services

Special education services are provided to youth and adolescents in the program, provided as a full 5.5 hour school day 5 days a week. Patients between the ages of 18 to 26 will have access to educational services as determined by their treatment team and parent/guardian. The same BTP is utilized during school hours as during the rest of the hospitalization. For children/adolescents who attend local school district for services, staff will be trained on the behavior plan, invited to participate in programming at the hospital and daily written communication will be provided between hospital and school staff.

Educational status and progress are included in the patient's EMR with clinical signature and date.

Developmentally Appropriate Programming

The program environment (unit) is adapted to the needs of people with a developmental delay to include at a minimum:

- A space for sensory regulation that is accessible at all times.
- Environmental noise is minimized.
- Lighting is appropriate for patients with sensory sensitivities.
- Program wide communication supports are implemented such as visual schedules, activities of daily living, task completion and visual sequences for common routines.
- Reinforcers are readily available and include electronic tablets.
- Individual behavior treatment plans are accessible for direct care staff and updated daily.
- There is a clear daily schedule of developmentally appropriate individual and group activities.
- In bedroom/down time is limited to less than two hours per day.

Reinforcement

Reinforcement options for patients are individualized and based on data driven preference assessments completed by the behavior analyst. A variety of reinforcement options are available including the use of electronic tablets, access to recreational programs, opportunities to engage in sensory activities, and social interaction. The use of food as a reinforcer is rare and only utilized at the direction of the clinical team for specific key purposes as identified in the BTP.

Food is not utilized as a reinforcer in the BTP unless it is approved by the Program Director for a specific target behavior (e.g., medication compliance) and there is a written plan of fading the food item. (This is in accordance with Professional and Ethical Compliance Code for Behavior Analysts; Code 4.0 Behavior Analysts and the Behavior-Change Program. More specifically *Code 4.10 Avoiding Harmful Reinforcers: Behavior analysts minimize the use of items as potential reinforcers that may be harmful to the health and development of the client, or that may require excessive motivating operations to be effective*.)

Holds/Restraints/Seclusion Reduction/Mechanical Restraint Reduction Procedure

It is a specific goal of the program to minimize the use of holds / restraint / seclusion. Incidents of holds/restraint/seclusion are reviewed daily and at clinical team meetings and adjustments are made to the behavior treatment plan that are intended to reduce their occurrence and allow freedom of movement.

The BTPs include interventions on how to avoid holds/restraints/seclusion. Staff are trained on the BTPs and responses to target behaviors. The use of restraint and seclusion must be consistent with Administrative Policy Facilities/Hospitals 171.

Environmental Management

Personal Protective Equipment (PPE)

To increase staff safety and minimize the use of holds/restraints/seclusion and reduce unintentional bias towards any particular patient, a base uniform of PPE is utilized by all direct care staff. The use of a base uniform also provides identification for patients to easily discern staff from visitors or other patients and supports a consistent environment.

Base uniform at a minimum includes lower arm padding and torso covering, such as a jean jacket.

Additional PPE is available on the unit for use by staff working with specific patients for less common risks, as ordered by the physician or recommended by the treatment team.

Medication

Medication prescribed by the psychiatrist and internist/family physician is informed by evidence-based practice for individuals with intellectual developmental disabilities and autism spectrum disorder. The use of medication is minimal and complimentary of the BTP.

Use of a "PRN" medication for behavioral control is mimimized and limited to emergent situations.

Operational Measurement

The following measurements are documented daily for the unit:

- Total minutes of holds/restraint/seclusion
- Emergent use of "PRN" medication
- Staff injuries
- Number of psychotropic medications for each patient
- Length of stay in days
- Time from readiness for discharge to actual discharge

Caregiver satisfaction surveys are utilized and results documented monthly and reviewed by the treatment team.

Caregiver satisfaction survey reports are completed and shared with the treatment team, hospital administration, and State hospital administration quarterly.

Outcome Measurement

The Aberent Behavior Checklist-second edition (ABC-2) is administered for each patient at admission, monthly and at discharge to assess change over time. This assessment should be completed by the same clinician at each interval.

The ABC-2 is an empirically developed scale designed to measure psychiatric symptoms and behavioral disturbances exhibited by individuals with ASD and ID across five domains:

- Irritability, Agitation & Crying;
- Lethargy/Social Withdrawal;
- Stereotypic Behavior;
- Hyperactivity/Noncompliance;
- Inappropriate Speech (Aman & Singh, 1986)

The ABC-2 was originally developed to assess the effectiveness of psychotropic medication, and has been used extensively in pediatric, as well as adult behavioral and psychiatric research due to its high reliability and validity. The measure is designed to use with individuals living in institutions and residential settings and was revised to include an option for community settings (Schmidt, et al 2013).

University Affiliation

Each hospital will work towards establishing and maintaining affiliation agreements with a minimum of one university with a medical resident and fellow, and supervised placement of students in psychiatry, psychology, and applied behavior analysis minimally. Additional consideration for student rotations/placements from speech-pathology and occupational therapy university programs.

References

Aman MG, Singh NN, *Abberrant Behavior Checklist Manual.* East Aurora, NY: Slosson Publications; 1986.

Jonathan D. Schmidt, John M. Huete, Jill C. Fodstad, Michelle D. Chin, Patricia F. Kurtz, An evaluation of the Aberrant Behavior Checklist for children under age 5, Research in Developmental Disabilities, Volume 34, Issue 4, 2013, Pages 1190-1197, ISSN 0891-4222, https://doi.org/10.1016/j.ridd.2013.01.002.

Appendix

Applied Behavioral Treatment Unit Checklist

The following list covers major areas for planning and opening an Applied Behavior Treatment Specialty Unit.

1. Clinical team hiring
    - Program Director (Psychologist or Behavior Analyst)
    - Occupational Therapist/Recreational/Activity Therapist
    - Speech Language Pathologist
    - Psychiatrist
    - Social Worker
    - Nurse Manager
2. Clinical administrative
    - Admission and discharge criteria
    - Referral process
    - Admission assessment process
    - Master treatment plan design
    - Direct care staffing plan

Staff supervision plan
Unit supplies - reinforcers
Personal protective equipment for staff
Clinical team meeting's schedule/structure

3. Behavioral treatment system
   Behavioral data recording, entry, and analysis
   Family/caregiver training model
   Management of agitation and de-escalation
   Minimizing use of restraint/seclusion
4. Programming
   Creating developmentally appropriate milieu programming and schedules
   Program-wide patient communication supports (patient binders/visuals)
5. Physical Plant
   Unit modifications – nursing station, rounding off corners, sensory room.
   Identify conference room with computer and large screen for treatment team meetings
6. Staff training
   Staff training and supervision plan
7. Educational program plan (if child unit)

Applied Behavioral Treatment Unit Quality Criteria

	Domain	Description
1.	**Program Leadership**	There is a clearly identified ABT Program Director who sets the clinical and operational philosophy and expectations of the program. This individual may be a board-certified behavior analyst, psychologist (PhD), or psychiatrist with expertise in treating patients with autism and intellectual developmental disabilities and challenging behaviors.
____ The hospital has a Program Director for the ABT unit defined in the person's position description and clearly identified on the organization chart. ____ The Program Director is a board-certified behavior analyst, psychologist (PhD) or psychiatrist. ____ The Program Director has expertise in treating patients with autism and intellectual developmental disabilities and challenging behaviors.		
2.	**Specialized Clinical Team**	The clinical team includes disciplines that are not always present in typical psychiatric units, including a board-certified behavior analyst, speech-language pathologist, and occupational therapist. The full clinical team consists of a psychiatrist, psychologist, nurse, board certified behavior analyst, speech-language pathologist, occupational therapist, social worker, and direct care providers. Education staff would also be on the clinical team if the hospital has a school on site. If the hospital has activity therapists, recreational therapists, or developmental disabilities programmers, they would also be members of the clinical team. All disciplines are represented by professionals who

		have experience with patients with developmental disorders and challenging behaviors. Each hospital has designated staff who are regularly scheduled on the unit.

Clinical Team includes:

____ Psychiatrist
____ Psychologist (Ph. D)
____ Board-Certified behavior analyst/s
____ Nurse
____ Occupational Therapist
____ Speech-Language Pathologist
____ Social Worker
____ Direct Care Workers
____ Education Staff, if relevant
____ Activity or Recreational Therapist, as available
____ Developmental Disabilities Programmer, as available

3.	**Clinical Team Functioning**	The full clinical team meets at least twice weekly to review each patient's progress, medications, target behavior data, current interventions, and discuss treatment. The target behavior data is made available and visualized at each team meeting to all team members to drive evidence-based decision making for patients. If the patient is in school, a member of the education team is present at the meeting too.

____ Full clinical team meets twice weekly.
____ All patient's progress, medications, target behavior data, current interventions, and treatment are reviewed twice a week with the full clinical team.
____ Patients' target behavior data is available at every meeting.
____ Patients' target behavior data is visual on a screen (in person) and/or online during the meeting.
____ Patients' target behaviors plans are assessed for modification minimally every two weeks based on the patients' progress or lack of progress.
____ Patients' behavioral plan is assessed for modification minimally every month based on the patients' progress or lack of progress.
____ School team member attends the clinical meetings when there is a patient (s) in the unit. *

*Adult units will invite school staff to meetings.

4.	**Nursing and Direct Care Staffing**	The ABT Unit has identified core set of direct care staff, including nurses and direct care workers (CCWs/RCAs) who are assigned to the unit. The utilization of non-core and untrained staffing is considered an "exception." There is at least one dedicated nurse per awake hour shifts to the ABT unit.

_____There are core direct care staff (CCWs/RCAs) dedicated and scheduled on the ABT Unit 24 hours a day.
_____There are core nurses dedicated and scheduled on the ABT Unit.
_____There is at least one ABT core nurse dedicated during awake hour shifts.

5.	**Direct Care Staff Training**	Direct care staff are defined as childcare workers, residential care aides, nurses, recreational therapy aides and activity therapy aides, teachers, and teacher assistants/ paraprofessionals. The direct care workers receive training in applied behavior analysis theory and skills (aligned with registered behavior technician coursework), developmental disorders, patient communication support, and applied behavior treatment hospital operations, including unit programming, target behavior data collection and behavior plans. Direct care staff will have applied behavioral treatment training twice a year which may include principles, concepts and implementing applied behavior analysis protocols; data collection and reporting; skill development and activity programming. Direct care staff will also receive competency reviews annually aligned with the registered behavior technician requirements.

_____ All direct care staff implementing applied behavioral treatment plans received applied behavior analysis training aligned with registered behavior technician course work.
_____*All direct care staff received behavioral health science treatment booster trainings twice a year.

_____Training initial and booster trainings are documented for each staff person. **These trainings can be built into standing trainings, conferences and/or clinical competency or be online modules.*		
6.	**Clinical Team Training**	The multi-disciplinary team will receive behavioral science training, including applied behavior analysis, prior to joining the clinical team and treating patients. Multi-disciplinary team members attend ABT clinical trainings minimally twice a year. This training will include for treatment of patients and updated clinical research, recommendations, and evidence-based practices.
____ The multi-disciplinary team receives behavioral science training, including applied behavior analysis, prior to joining the clinical team and treating patients. ____ *The multi-disciplinary team has clinical trainings supporting the behavioral science treatment minimally twice a year. _____Training initial and booster trainings are recorded in human resource records for all team members. **These trainings can be built into standing trainings, conferences and/or clinical competency or be online modules.*		
7.	**Referrals**	The patient referral submission from the Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) includes the current behavior plan, past treatment including medications and behavioral treatment, and the target behavior/reason for proposed hospitalization. There is a clear referral process where information on diagnosis, behavioral, functioning, and medical needs is reviewed by the staff. Referrals to the Applied Behavioral Treatment Unit are reviewed by the Program Director. The Program Director approves all patients being referred to the Applied Behavioral Treatment Unit to confirm the applied behavioral treatment is appropriate to successfully treat the medical need for inpatient treatment.
____ The referral submission is from the PIHP or the CMHSP with the PIHP included in the communication. ____ The referral submission includes the psychiatric diagnosis, evaluations and assessments within the past six months, current behavior plan, treatment, medications, and target behavior/primary reason when requesting hospitalization. ____ The Program Director reviews the referral submission for appropriateness to be on the ABT unit and approves all patients' placement on the unit.		
8.	**Clinical Assessment is Specific to Individuals with Autism and Intellectual Developmental Disabilities**	The psychiatric diagnostic evaluation, social work assessment and other assessments include questions about developmental history, communication impairment and ability, activities of daily living abilities, sensory needs, reinforcement preferences, and the specific behavioral history and current challenges presented by the individual. Referral submission of all recent assessments and plans of treatment/service within the last six months is utilized to determine the clinical assessments needed for patients.
____Individuals considered for receiving /applied behavior treatment have autism or an intellectual developmental disability. ____Evaluations and assessments align with the comprehensive evaluations and assessments to confirm the unit is still appropriate. ____Evaluations and assignments from referral submission are utilized in the assessment process.		
9.	**Behavioral Assessment and Plan**	The program performs an initial systematic functional behavior assessment within 10 days of admission and then performs further assessments as needed based on response to intervention. There are written procedures for the unit's functional behavior assessment process. An initial behavior plan is issued for the patient within 24 hours of admission based on the available information at the time. An in-depth individualized behavioral plan, with target behaviors identified, is developed within the first 10 days based on the functional behavior assessment. The behavior plan is submitted to the MDHHS Behavior Treatment Review Committee within 15 days of admission for each patient. The behavioral plan is reviewed weekly and modified over the course of the hospitalization.

____All patients receive a functional behavior assessment within 10 days of admission to the unit. ____Unit has a written functional behavior assessment process. ____Patients have an initial behavior plan within 24 hours of admission. ____Patients have an in-depth individualized behavior plan with target behavior identified utilizing the functional behavior assessment and other clinical assessments within 10 days of admission to the unit. ___ The behavior plan is submitted to the MDHHS Behavior Treatment Review Committee within 15 days of admission for each patient. ___Patients' target behavior plans are reviewed weekly to align with progress, lack of progress. ___Patients' target behavior plans are considered for modification minimally every two weeks based on progress. Patients' behavioral plan is assessed for modification minimally every month.		
10.	**Behavioral Data Collection**	Behavior data is collected on all patients 24 hours a day on their individual target behaviors. The data is entered into a computer program daily and analyzed daily with documentation. The data is made readily available to the clinical team and visually displayed during team meetings to inform treatment decisions. The target behavior data is made available to parents/caregivers/guardians and discharge service providers.
___ Behavior data, including target behaviors, is documented every 15 minutes daily, 24 hours a day. ___ Behavior data, including target behaviors, is entered into the computer program daily. ___ Behavior data, including target behaviors, is analyzed daily with documentation. ___ Behavior data, including target behaviors, is visually displayed at the twice a week at clinical meetings. ___ Behavior data, including target behaviors, is shared with parents/caregivers/guardians and discharge service providers.		
11.	**Behavioral Treatment**	More specialized behavioral assessment and treatment sessions may be run by board certified behavior analyst/psychology staff. Behavioral treatment in the form of application of the behavior plan is implemented by all staff, including school staff. Each patient receiving applied behavioral treatment has an individualized binder including data collection sheets, behavioral plan that includes target behavior definitions, antecedent strategies, and responses to target behavior occurrence, daily activity program schedule, laminated written and visual schedule, Velcro strips for visual (written/pictures) and zip bag to hold tokens, dry erase pens and other reinforcers.
___Specialized/complex behavior treatment sessions are run by board certified behavior analysts/psychology staff during trial period. ___Hospital and education staff are utilizing the same behavior plan (when a patient is of school age). ___Hospital staff are implementing the behavior plan 24/7 with evidence from documentation. ___School staff are implementing the behavior plan 24/7 with evidence from documentation. ___Patients' have an individualized binder that includes data collection sheets, a behavior plan with target behavior definitions, antecedent strategies, and responses to target behavior occurrence, daily activity program schedule, laminated written and visual schedule, Velcro strips for visual (written/pictures) and zip bag to hold tokens, dry erase pens and other reinforcers.		
12.	**Broad Assessment of Problem Behaviors**	The assessment of target problem behaviors includes screening for a medical etiology and pain, comorbid psychiatric disorders, family functioning, communication deficits and sensory and activities of daily living needs that may relate to the problem behavior. (*Remembering a problem behavior is never to be initially assumed to occur solely due to an operant function. Other etiologies must be considered and ruled out during the assessment process.)*
____ Assessment of target behaviors includes thorough screening for other medical conditions for all patients. ____There is documentation of this assessment in the records.		
13.	**Generalization of Treatment**	The social worker or care coordinator is in weekly contact with the Prepaid Inpatient Health Plan and the Community Mental Health Service Program during the hospitalization to communicate progress and improvements, home, and community services/residential serviced needed for discharge, anticipated discharge date, and estimated date of

		discharge ready. Training to implement the behavior plan and other patient needs after hospitalization will be offered and facilitated for the family, step down facility staff, school/education district, community residential or in-home supports as applicable. Prior to discharge the behavior plan is reviewed for feasibility with those who will continue treatment post-discharge, and the level of intervention or specificity of supports faded / adjusted to better match what is achievable in the post-discharge setting. The transition training is determined by the behavior plan and medical necessity services needed after inpatient treatment. Training is conducted by the lead behavioral clinician, Program Director, Board-Certified Behavior Analyst, or Psychologist.
____Each patient's PIHP and CMHSP are notified weekly of the medical progress and status of the patient's treatment, target discharge date, and treatment needed after discharge. ____Each patient's family/caregiver/guardian is notified weekly of the patient's treatment, progress target discharge date, and treatment needed after discharge. ____Generalization training is provided to family/caregiver/guardian weekly starting at (transition stage) four weeks or more prior to discharge. ____Transition training on the behavior plan and medically necessity services are provided by the lead behavior clinician to the home/community-based providers by the lead behavior clinician, Program Director, Board-Certified Behavior Analyst, or Psychologist. ____Written updates are provided to all education, home/community-based agencies (even when they do not attend weekly training) during the transition stage.		
14.	**Educational Services for Children and Adolescents**	Education services are provided to youth and adolescents in the program 5.5 hours a day 5 days a week. The same behavior treatment plan and behavior data collection is utilized during school hours as during the rest of the hospitalization. For children/adolescents who attend a local school district for services, staff will be trained on the behavior plan, invited to participate in programming at the hospital and daily written communication will be provided between hospital and school staff.
____ Patients at Hawthorn Center receive 5.5 hours of school 5 days a week. ____ Patients within the ages of 18-26 will receive educational opportunities in collaboration with the state hospital based on recommendations of the clinical team and wishes of the patient and/or guardian. ____ The same behavior Treatment Plan and behavior data collection is utilized for hospital programing and education services. ____ Direct care workers and educational support staff have the same training and receive treatment plan change updates daily.		
15.	**Developmentally Appropriate Programming**	There is a clear daily schedule of developmentally appropriate individual/group activities. Daily activity programing is occurring seven days a week. Individual in-bedroom time, downtime and free time is minimized to a total less than 2 hours each day during awake hours. Direct care staff are trained and facilitate basic group activities. The daily schedule is posted on the unit for patients and staff. The detailed weekly schedule with identified specific activities and staff running the programs are approved by the Program Director. Patients have the program schedule in their treatment binder.
____ The unit has a daily schedule for patients with individual/group activities. ____ Daily activity programming is occurring seven days a week. ____ Individual/in bedroom, down/free time is limited to less than 2 hours each day during awake hours. ____ Direct care staff are trained and facilitate daily programming. ____ Daily activity programming is posted on the unit. ____ Program schedule is in patients' individual treatment binder.		
16.	**Reinforcement**	The program has a variety of reinforcement options available for patients, including use of electronic tablets. The use of food as a reinforcer is rare and only utilized at direction of the clinical team for specific key purposes when needed (e.g., facilitating medication compliance).
____ Each patient has a variety of reinforcers available to them as prescribed by the behavior treatment plan.		

____ The reinforcers are reviewed during team meetings to assure they are still appropriate reinforcements and patients are motivated to work for them. ____ Tablets are available for patients as a reinforcer option. ____ Food is not utilized as a reinforcer in the behavior plan unless it is approved by the Program Director for a specific target behavior (e.g., medication compliance) and there is a written plan of fading the food item. * *This is in accordance with Professional and Ethical Compliance Code for Behavior Analysts; Code 4.0 Behavior Analysts and the Behavior-Change Program. More specifically *Code 4.10 Avoiding Harmful Reinforcers: Behavior analysts minimize the use of items as potential reinforcers that may be harmful to the health and development of the client, or that may require excessive motivating operations to be effective*.		
17.	**Holds / Restraints / Seclusion Reduction**	It is a specific goal of the program to increase functional skills to eliminate the need for crisis level interventions. Incidents of holds/restraint/seclusion are reviewed daily and at clinical team meetings and adjustments are made to the behavior treatment plan that are intended to reduce their occurrence and allow freedom of movement.
____ The behavior treatment plan includes treatment responses to the patient's challenging behavior which does not include holds/restraint/seclusion. ____ When holds, restraint or seclusion is utilized, it is reported to the Program Director for review. ____ All occurrences of holds, restraint or seclusion are reviewed at daily meetings and the bi-weekly clinical meetings.		
18.	**Personal Protective Equipment (PPE)**	To increase staff safety and minimize the use of holds / restraint / seclusion, a base uniform of PPE is utilized by all direct care staff. Base uniform at a minimum includes lower arm padding and torso covering (e.g., jean jacket). *Additional PPE is available on the unit for use by staff working with specific patients for less common risks, as ordered by the physician.*
____ Direct care staff have their own PPE base uniform of both a lower arm padding and torso covering. ____ Direct care staff wear their PPE base uniform daily per the behavior treatment plan. ____ Additional PPE is available on the unit for use by staff working with specific patients for less common risks, as ordered by the physician.		
19.	**Medication**	Medication prescribed is informed by the evidence-base for individuals with autism and intellectual developmental disabilities. Medication is minimal and complimentary of the individualized behavior treatment plan. Use of PRN medication for behavioral control is minimized and limited to emergent situations.
____ Medication prescribed for patients is based on evidence-base for individuals with autism and intellectual developmental disabilities. ____ Medication is minimal as possible and complimentary of the behavioral science behavioral treatment plan for each patient. ____ PRN medication is minimized and limited to emergent situations. ____Medications are reviewed at the clinical meetings twice a week.		
20.	**Unit Environment**	The program environment (unit) is adapted to the needs of people with an autism and an intellectual developmental disability. A space for sensory regulation is provided. Environmental noise is minimized. Program-wide communication supports are implemented for patients, such as visual schedules, visual supports for activities of daily living, task completion visual sequences for common routines, and reinforcers are readily available.
____ Unit (or within proximity) includes a sensory regulation space. ____ Unit includes minimal environmental noise. ____ Visual schedules, program activities, and self-care prompts are posted on the unit. ____ Each patient has his/her own visual schedule and visual prompts.		
21.	**Operational Measurement**	Operational measurements are documented daily. The rate of holds/restraint/seclusion, emergent PRN medication use, staff injuries, length of stay, time from readiness for discharge to actual discharge and caregiver satisfaction surveys are reviewed minimally each quarter by

		the clinical team, and hospital leadership, and State Hospital Administration staff.
Operational measurements are documented daily: ____ Total minutes of Holds, restraints, and seclusion are documented daily. ____ Number of PRN medications used for behavioral control is documented daily. ____ Number of psychotropic medications for each patient at admission and discharge. ____ Staff injuries are documented daily. ____ Number of staff injuries are accumulated each month and documented. ____ Length of stay in days is documented. ____ Time of discharge readiness to actual discharge is documented as number of days. ____ Caregiver satisfaction surveys are utilized, and results documented. ____ Caregiver satisfaction survey reports are shared with unit staff quarterly.		
22.	**Outcome Measurement**	A validated outcome measure for behavioral functioning is administered to the individual at admission, monthly and at discharge to assess change over time, such as the ABC-I, rated by the same clinician / team member at each time point. The Vineland 3 is administered to the individual at admission and discharge by the same clinician/team member. Measures of other outcome domains can be utilized in addition to the behavioral functioning measure.
____ A validated outcome measure for behavioral functioning is administered at admission, monthly and at discharge. ____ The results of the admission measure are reviewed as part of the functional behavior assessment to inform the behavior treatment plan. ____ The validated outcome measure is performed by the same person/group of people for the patient at each time point. ____ The ABC-I is performed at admission and discharge.		
23.	**University Affiliation**	Each hospital will work towards establishing and maintaining affiliation agreements with a minimum of one university with a medical resident and fellow, and supervised placement of students in psychiatry, psychology, and applied behavior analysis minimally. Additional consideration for student rotations/placements from speech-pathology and occupational therapy university programs.
____ The hospital and ABT unit have a minimum of one university affiliation. ____ The hospital and ABT unit have a supervised placement in psychiatry. ____ The hospital and ABT unit have a supervised placement in psychology. ____ The hospital and ABT unit have a supervised placement in applied behavior analysis. ____ *The hospital and ABT unit have a supervised placement or student training in speech-pathology. ____ *The hospital and ABT unit have a supervised placement or student training in occupational therapy. *Optional.		

Applied Behavioral Treatment Unit Referral Form

Date: _____

Demographics

Referral Source Name/Agency: _____

Referral Source Phone Number: _____ Email Address: _____

Paperwork completed by: _____

Patient Name: _____ DOB: _____ Age: _____

SSN: _____-____-_____ Sex: M / F Height: _____ Weight: _____

Home Address: _____

Home Phone #: _____ Alternative phone #: _____

Living with (names): _____

Guardian (relationship): _____

Guardian Phone # (if different from above): _____

Emergency contact and phone #: _____

School Name: _____ Grade: _____

School address: _____

School contact and phone #: _____

Sending School district (if different from attending): _____

Interpreter / Accommodations needed? Yes No if yes, please explain: _____
_____

Insurance Information

Primary: _____ Policy #: _____

Ins. Address: _____

Phone #: _____ Group #: _____

Ins. Subscriber: _____ SSN: _____-_____-_____

Subscriber DOB: _____ Relation to patient: _____

Subscriber Address (if different from above): _____

Subscriber Employer and Address: _____

Secondary: _____ Policy #: _____

Ins. Address: _____

Phone #: _____ Group #: _____

Ins. subscriber: _____ SSN: _____-_____-_____

Subscriber DOB: _____ Relation to patient: _____

Subscriber Address (if different from above): _____

Subscriber Employer & Address: _____

Preferred names that the patient goes by: _____

Does the patient have a current IEP and receive Special Education Services? Yes No

Clinical Information

Reason(s) for hospitalization: _____

What do you think is causing the problem? _____

What do you think would help the patient's behavior? _____

What are your goals for hospitalization? _____

Have there been any recent changes/losses in the patient's life at home/school? Yes No

If yes, please describe: _____

What concerns you most about hospitalizing the patient? _____

Prior psychiatric hospitalization? Yes No If yes, where, and when? _____

Current Providers:

Psychiatrist: _____ Phone: _____

Pediatrician/Family Physician: _____ Phone: _____

Developmental Behavioral Pediatrician: _____ Phone: _____

Psychologist: _____ Phone: _____

Neurologist: _____ Phone: _____

Therapist: _____ Phone: _____

Community Case Manager: _____ Phone: _____

In-Home Supports Agency(s): _____ Phone: _____

List of *current medications*, dosage, and time:

1._____ 4. _____ 7. _____

2._____ 5. _____ 8. _____

3._____ 6. _____ 9. _____

List of past medications and reason for discontinuing:

1. _____

2. _____

3. _____

Any current over the counter or herbal remedies? Please list: _____

Allergies to medication? Yes No If yes, please list: _____

Other allergies? Yes No If yes, please list: _____

Diagnoses:

AXIS 1: _____

AXIS 2: _____

AXIS 3: _____

Does the patient have a history of DRO (drug related organisms) such as MRSA or VRE? Yes No

Seizure Disorder? Yes No If yes, type: _____; Date of last seizure: _____

Other medical issues? 1. _____

2. _____

3. _____

Has the patient received any psychological testing? Yes No With whom? _____

If known, **please specify IQ**: _____; Date of testing: _____

Communication: The patient's communication could be best described as: (please circle one)

Verbal Limited Verbal Non-verbal

On a scale of 0-5, *0 being no concerns, 5 being strong concerns*, how concerned are you about the patient's ability to effectively communicate? Please circle: 0 1 2 3 4 5

no concerns strong concerns

Occupational Therapy:

Can the patient walk without assistance? Yes No If no, what type of assistance does he/she need? Wheelchair Gait belt Walker other_____

Does the patient have feeding or eating issues? Yes No Describe: _____

Does the patient have a history of choking or aspirating? Yes No Describe: _____

Self-Care Skills: How much assistance does the patient need?

Eating: Independent Minimal Assist Moderate Assist Total Assist

Dressing: Independent Minimal Assist Moderate Assist Total Assist

Toileting: Independent Minimal Assist Moderate Assist Total Assist

Behavioral Concerns:

Does the patient have **aggression**? Yes No if so, please describe: _____

How often? _____ Directed toward whom? _____

Most recent? _____ Does the patient punch with closed fists? Yes No

Has the patient ever required a physical restraint? Yes No If yes, please describe: _____

Any history of **self-harming** behaviors? Yes No If yes, please describe: _____

Any history of **sexualized behaviors** – including inappropriate touching, sexualized play, grooming or violence? Yes No

If yes, please describe: _____

Any history of **bolting or elopement**? Yes No

Does the patient utilize any protective equipment? Yes No If yes, please describe: _____

Does the patient demonstrate any of the following? If yes, please describe:

Animal Cruelty Yes No _____

Fire Setting Yes No _____

Sexual perpetration Yes No _____

Homicidal ideation: Yes No If yes, please describe: _____

Current or past suicidal ideation: Yes No If yes, please describe: _____

History of experiencing physical/sexual trauma or exposure to domestic violence: Yes No

If yes, please describe: _____

Family psychiatric history: Yes No If yes, please describe: _____

Discharge Planning

Is the plan that the patient will return home? Yes No

If yes, what services will be needed to assist in the transition? _____

If no, what alternative placement (e.g., residential) has been initiated? _____

Please send the following information:

_____IEP/BIP (from school)

_____Psychological/neuropsychological evaluation

_____Psychiatric evaluation/notes/meds

_____Occupational therapy evaluation

_____Speech/language therapy evaluation

_____Vision and/or hearing evaluations

_____Behavior plan (past or current)

Questions can be directed to Program Director or Social Worker (Enter names/contact information).

Please fax or email all information to Program Director Name at ##### or email address.

Applied Behavioral Treatment Unit Clinical Team Meeting Agenda and Description [Sample]

I. Welcome (Program Director, BCBA or Nurse facilitates the meeting.)

II. Patient Progress Review and Clinical Team Updates
- Clinical team order: nursing, behavioral analysis, psychology, psychiatry, developmental disabilities programmer, occupational therapy, activity/recreational therapy, speech and language pathology, social work, primary care/internist, direct care, dietician, and education.
- Patient Initials, Admission Date, Discharge Ready Date
- Patient Initials, Admission Date, Discharge Ready Date
- Patient Initials, Admission Date, Discharge Ready Date
- Patient Initials, Admission Date, Discharge Ready Date
- Patient Initials, Admission Date, Discharge Ready Date
- Patient Initials, Admission Date, Discharge Ready Date

III. New and Pending Admissions

IV. Materials/Supplies (PPE, Activities, Reinforcers), as needed

V. Future training topics, as needed

VI. Action Items, Target Date and Staff

VII. Meetings: Mondays at 1 pm, Thursdays at 1 pm

VIII. Historical Unit Patients
- Patient Initials, Admission Date, Discharge Ready Date, Discharged Date

Applied Behavioral Treatment Clinical Team Meeting Structure

Facilitator of the meeting welcomes the team members, confirms the note taker (BCBA), and calls on each discipline for their report. The BCBA makes modification to the behavior plans as needed within 24 hours.

The clinical staff report outs are brief, provide changes, recommendations, and clinical updates. There may be days when clinicians do not have updates on patients. Behavioral data for each patient is displayed on the screen when

patient is discussed. If no screen available, copies of behavioral data are handed out to all team members. Much better to have up on screen and viewable to all team members. The team will discuss each patient within 5-10 minutes in the same routine order each meeting.

1. Nurse reads the most recent 24-hour nursing notes and notes any significant medical issues and seclusion/restraints.
2. Behavior analyst summarizes current behavior plan, points out trends in target behaviors, identifies any issues and need for changes to behavioral treatment.
3. Psychologist summarizes assessment results, treatment recommendations and need for changes to behavioral treatment.
4. Psychiatrist summarizes any changes in diagnostic formulation, current medication regimen, changes since last meeting and future plans.
5. Developmental disabilities programmer summarizes observed behavior and suggests modifications for treatment and programming.
6. Occupational therapist, Recreational therapist and/or Activity therapist summarizes current intervention approach, any changes since last meeting, and any new recommendations.
7. Speech and language pathologist summarizes current intervention approach, any changes since last meeting, and any new recommendations.
8. Social Worker articulates discharge plan, coordinates discharge training of providers and family members/caregivers, supports and barriers to discharge and current family/external caregiver interactions.
9. Primary care/internist summarizes any changes in physical care, current medication regimen, changes since last meeting and future plans.
10. Direct care worker summarizes success and barriers of treatment plan strategies on target behaviors, reinforcer qualities and engagement in activities.
11. Dietician summarizes any changes to the nutritional plan.
12. Education/teacher summarizes changes to education plan or pertinent observations of behavior.

Applied Behavioral Treatment Unit Sample Behavioral Treatment Plan

Patient Name: Last, XXX
MR#: SH A#:BH
DOB: ADM:

Hospital Name
Positive Behavior Support Plan
Initially Written:

Introduction and Background
XXX presents with a history of aggressive and self-injurious behaviors in addition to darting (including running out of buildings and into traffic), undressing in inappropriate locations, emotional dysregulation, property destruction, and non-compliance. These behaviors are reported to have dramatically increased in severity during the summer of 2019.

Communication Overview *Clinician's Name, CCC-SLP*

Regulation Overview *Clinician's Name, OTR/L*

Activities of Daily Living (ADLs) *Clinician's Name, OTR/L*

Target Behaviors and Data Collection
To be recorded, aggression and self-injurious behavior must be non-accidental, and include forceful physical contact with self or others that has the potential to cause injury or causes actual injury. Attempts (behaviors that are blocked, missed, physically prevented from occurring) are included in data recording.

- Data for Aggression, Self-Injurious Behavior, darting, and inappropriate sexualized behavior are collected by recording the frequency of occurrences.
- Data for Emotional Dysregulation with or without Property Destruction are collected by recording the duration of episodes. If the duration is less than 1 minute, duration should be documented as 1 minute. Track as continuous episode if behavior occurs again within 2 minutes. If 2 minutes has passed, count as a new episode.
- Data for Non-Compliance are collected by recording the duration of episodes. Initiate data collection after the behavior has occurred for a minimum of 2 minutes. Track as continuous episode if the behavior occurs again within 2 minutes.
- Disrobing data are collected by using partial interval data collection such that: if the behavior occurs within a 15-minute time block, circle Y; if the behavior does not occur in a 15-minute time block, circle N.

- **Aggression:** hitting (open & closed), hitting with objects, throwing objects, spitting, pinching, digging, scratching, pulling/grabbing, and pulling to ground, biting, pushing, shoving, charging, kicking, head-butting, choking, hair pulling
- **Emotional Dysregulation with or without Property Destruction:** Verbal protest, tensed facial expression, clenched fist, pointing, head shaking, posturing, swearing, threatening, unkind remarks, inappropriate comments, inappropriate gestures (raised middle finger), name calling, crying, and yelling, throws self to floor, disrobing. In addition, throwing objects, ripping up papers, hitting or kicking walls, pounding tables & desks; clearing tables & counter tops, stepping on objects and repetitive, forceful door-slamming, breaking things

- **Self-Injurious Behavior:** Hitting self with part of own body or another object, picking scabs, cutting, digging, biting self, hair-pulling, head banging and pinching
- **Self-Injurious Behavior:** Non-accidental forceful physical contact with self that has the potential to cause harm/injury, or does cause harm/injury, including:
    - **Self-Injurious Behavior Level I:** Non-head directed hitting, picking, or digging, squeezing and/or bending own fingers backward, throwing body against the wall, and attempts that are blocked, missed, or are physically prevented from occurring
    - **Self-Injurious Behavior Level II:** Head directed hitting (side of face, ear), hair pulling, head banging, and attempts that are blocked, missed, or are physically prevented from occurring
- **Non-Compliance**: Includes active and passive refusal, including non-participation, and not transitioning between activities or locations
- **Non-Compliance – Refusal**: Includes active and passive refusal, including non-participation, and not transitioning between activities or locations, excluding flopping
    - Example - XXX remains in seat for 2 minutes after staff provide the prompt "standup"
    - Non-example – XXX drops to the ground and remains flopped for 2 minutes after staff provide the prompt "standup"
- **Non-Compliance – Flopping**: Includes lying or sitting on the ground for longer than 2 minutes and failing to comply with staff prompt.
    - Example – XXX drops to the ground and remains flopped for 2 minutes after staff provide the prompt "standup"
    - Non-example - XXX remains in seat for 2 minutes after staff provide the prompt "standup"
- **Darting:** Absenting oneself from the designated or assigned area of operation. Running or walking away from staff to a distance of at least 8-10 feet from staff or the designated area, and not responding within 2-3 seconds to an instruction to "Stop"
- **Leaving the Area**: Absenting oneself from the designated or assigned area of operation. Running or walking to a distance of at least 8-10 feet away from staff or the designated area, and not returning to the area within 3-5 seconds
- **Inappropriate Sexualized Behavior**: Including, and attempts that are blocked or redirected
- **Undressing:** removing or partially removing clothing (such that chest, buttocks, or genitals are exposed) in a location other than the bedroom or any bathroom

Working Hypothesis / Functional Behavior Assessment

Interviews and a record review indicate that the following setting events and antecedents may set the occasion for AGG, ED+/-PD, SIB, NC, Darting: restricted access to preferred activities (e.g., hearing "no"), non-preferred activities / demands, blocking of rituals, communication deficits, transitioning away from preferred item/activity, changes to schedule, seeing/hearing other peers dysregulated, low attention, and waiting

Precursor behaviors: tapping on head, vocalizations ("whining"), banging on surface, moving from seated to standing position without obvious reasons, deepening voice, scripting ("home", "Friday", "mom"), prolonged eye-contact, saying "move"

Antecedent Strategies

- **Visual Supports** – staff should utilize all available visual supports (i.e., visual schedule, 1st/then, ADL strips and choice boards). In particular, a visual schedule should be used for every transition
- **Darting / Safety Awareness** – per parent report, XXX has a history of leaving the area when upset. In addition, XXX is reported to have poor safety awareness near vehicles. Staff should be particularly vigilant around vehicles, parking lots, and roads
- **Pica –** per report, XXX ingests non-nutritive substances such as grass, dirt, dandelions, pinecones, paper, cardboard, paper towels, toilet paper, and sheet rock. Staff should be vigilant about XXX's environment to minimize access to materials he can place in his mouth
- **Mouthing objects** – staff should be aware that XXX is reported to mouth objects, including objects that could pose a choking risk (e.g., coins, marbles)
- **Self-Injurious Behavior** – staff should be aware that XXX has a history of engaging in SIB. This includes
- **Suicidal Statements** – per parent report, XXX sometimes makes statements indicating a desire to hurt himself. If he makes statements indicating a desire to hurt himself staff should: reassure they know how to keep him safe, not engage in prolonged conversation on the topic, and document the statements
- **Homicidal statements** – per parent report XXX sometimes makes statement indicating a desire to hurt others. If this occurs staff should not comment directly on the statements, document what was said, and continue implementing the behavior plan including responsive measures for emotional dysregulation

- **Responding to Internal Stimuli** – XXX is reported to respond to internal stimuli at times. If this occurs, staff will not engage in prolonged conversations on this topic, assure XXX they know how to keep him safe (if he appears in distress), document his behavior, and inform nursing
- **Abuse and Neglect History** – XXX is reported to make statements indicating past abuse and neglect and ask caregivers if he is going to be abused. If this occurs, staff should: ensure XXX that they know how to keep him safe, not engage in prolonged conversations on this topic, and document what he said
- **Targeting Peers** – per history, XXX has targeted peers on the unit. Staff should position themselves in such a manner that they can always intervene between XXX and a peer. If he starts to target or perseverate on a peer, staff should direct him out of the area. If the situation becomes dangerous, follow the safety management plan below
- **Rituals** – XXX engages in repetitive behaviors such as lining up objects up, counting objects, filling, and dumping objects, and touching and smelling objects. If these behaviors occur, staff should inform behavior team
- **Use of Tokens Visual** – due to throwing his tokens, XXX will earn checks on his token board visual instead of physical tokens
- **Hoarding / Collecting Items** – XXX is reported to collect large quantities of various items (e.g., roll of stickers, toothbrushes, air fresheners). He will place small items in his pocket throughout the day to contribute to his collection. See Reinforcer Restriction above for parameters of printed images and items/objects
- **Supporting Safety** – Staff may hold XXX's hand and/or provide contact guard assistance while transitioning between locations to increase balance and promote safety. Staff should continuously monitor XXX's balance and shadow his movements to prevent injury while walking, running, or transitioning from sit to stand and stand to sit
- **Climbing** – a safety risk exists when XXX climbs up onto elevated locations (e.g., chairs, desktops, etc.) staff should continually use body positioning to minimize XXX's climbing. If climbing up onto sturdy elevated locations occurs, the following steps should be followed:
    - Adjust the environment so that it is made to be as safe as possible, such as by moving furniture and placing a mat beneath XXX
    - Utilize first/then card and verbal prompts to prompt XXX off the unsafe location and to the current scheduled activity
    - If XXX continues to refuse to come off the unsafe location after 3 prompts, an additional staff should be utilized to physically remove XXX in a safe manner. Nursing/teacher input should be sought to determine appropriate staffing
        - If at any point during the assistance to a safe location XXX resists, documentation for a restraint must occur
        - Once in a safe location, XXX should immediately be directed to his schedule and programming should be arranged so that reinforcement can be earned as soon as possible
        - **NOTE:** For safety reasons, if possible, at least 2 staff should be involved in the above procedure
    - **If climbing onto an unstable surface, staff should follow all the steps above, except for giving XXX one prompt before continuing with the remainder of the steps**

Functionally Equivalent Replacement Behavior
Coping Skills – at early signs of emotional dysregulation, using his coping board, prompt XXX to identify his current emotional state, the reason for his emotion (if apparent), and to an available coping skill. Effective coping skills are reported to include
Coping Skills – at early signs of emotional dysregulation, prompt XXX to an available coping skill

Functional Communication - Where communicative intent is clear (e.g., bringing an empty cup to staff) and access to a tangible item/activity is available, staff gesture toward PECS binder, and provide support in making a request. Prompting is done by using gestures and minimal physical prompting (turning to the correct page, pointing to the icon) and not through verbal prompts. Following a successful exchange, provide access to the desired item/activity.

Requesting Social Attention (Poor Boundaries) – When XXX behaves as though he wants social attention (e.g., makes eye contact, sticks tongue out), gesture to the "Talk to me" icon in his PECS binder. If XXX engages in poor boundaries (e.g., light hitting, kicking) in an apparent effort to gain/maintain attention, staff wait for the behavior to stop and an additional five seconds before gesturing to the "Talk to me" icon. Following a successful exchange, staff provide XXX with high-quality attention for 15 seconds.

Reinforcement Procedures
TASK
- XXX should be reinforced for the completion of tasks, partial completion of multi-step tasks and behaviors incompatible with target behaviors (aggression, self-injury, and emotional dysregulation).
- Offer XXX a choice between two or three icons representing available reinforcers.

- XXX will earn access to reinforcement for 5 minutes.
- If at any time during earn time, XXX engages in a target behavior, earning time is done and XXX is directed back to his task.

Tokens
XXX earns 3 tokens to access a reinforcer for 5 minutes
Expectations: no target behaviors for the last 5 minutes, and compliance with an expectation
Rate of Reinforcement: one token every 3-5 minutes. Rate may be more rapid during academic instruction

TOKEN DRO
Differential Reinforcement of Other Behavior
XXX will earn a token for every 30 seconds – 2 minutes of safe behavior (absence of AGG, SIB) during all activities while awake (e.g., eating, morning and evening routine) except for while he is accessing reinforcement. Token delivery should be timed such that access to reinforcement occurs at natural times of transition or in between activities (e.g., earn between tooth brushing and shower). Upon earning 10 tokens, he may access a reinforcer for 5 minutes. XXX should access reinforcement roughly every 5-10 minutes.
Target behavior while accessing reinforcement:
- If XXX engages in AGG, ED+/-PD, or SIB for 10 seconds or less, staff should not address the behavior(s). This will not affect XXX's access to reinforcement
- If XXX engages in AGG, ED+/-PD, or SIB for more than 10 seconds, discontinue access to reinforcement, prompt him back to the task / activity, and restart the reinforcement procedure

Points
XXX's plan involves a time-based point system, where he earns at scheduled intervals. He has the possibility of earning 6 points for safety (the absence of AGG, SIB, ED+/-PD, Darting), cooperation/participation (the absence of non-compliance), and respectful language (see below) each block.
Respectful Language Earning: includes speaking kindly to others. This point is not earned if XXX engages in demeaning language targeting others. If XXX has minor breaches of kind and respectful behavior (e.g., says a mean comment to another person, etc.) he should be given a warning that next time it occurs in the block, he will not earn the point. If XXX simply expresses dissatisfaction or uses mild inappropriate language once or twice (not at others) he still has a chance to earn this point.

Each point that he earns is exchanged for access to a reinforcer during predetermined earn times (following the Milieu 2 schedule). The schedule of reinforcement is calculated by staff based on the 6 points he can earn, the duration of the expectation block, and the duration of the earn block. For example:

On the unit:

Duration of Expectation Block:	Duration of Earn Block:	Point earned every:	Each point is worth:
2 hours	30 minutes	20 minutes	5 minutes
1 hour	15 minutes	10 minutes	2.5 minutes

At SHA (Spring Harbor Academy):

Duration of Expectation Block:	Duration of Earn Block:	Point earned every:	Each point is worth:
2 hours 45 minutes	15 minutes	27.5 minutes	2.5 minutes
2 hours	15 minutes	20 minutes	2.5 minutes

Preferences/Potential Reinforcers:

•	•	•

Reinforcer Restrictions: edibles are not to be used as a reinforcer.

Responsive Measures

Behavior	Responsive Measures
Precursor Behaviors	1. Assess the area for safety. Be aware of body positioning 2. Use body positioning to the extent possible to minimize the behavior

(section VI)	3. Prompt XXX to use regulation strategy or encourage XXX to make a request if appropriate
Aggression (AGG)	1. In a neutral voice, using his schedule, redirect to the current task 2. Remain neutral, do not verbally acknowledge the behavior. Prompt to an incompatible behavior 3. Utilize the Safety Management Plan if imminent risk of harm exists 4. When XXX has stopped all aggression, prompt to the activity
Self-Injurious Behavior (SIB)	1. In a neutral voice, using his schedule, redirect to the current task 2. Remain neutral, do not verbally acknowledge the behavior. Prompt to an incompatible behavior (e.g., safe hands) 3. Utilize the appropriate steps of the Safety Management Plan if imminent risk of harm exists 4. When XXX has stopped all self-injurious behavior, prompt to the activity
Emotional Dysregulation (ED+/-PD)	1. In a neutral voice, using his schedule, redirect XXX to the current task or activity. After he has seen his schedule, continue to redirect him to the activity 2. Remain neutral, and do not directly acknowledge the ED+/-PD behavior. Prompt to incompatible alternative behavior 3. Utilize the Safety Management Plan if imminent risk of harm exists 4. Once XXX has stopped all emotional dysregulation redirect him to the activity **If Property Destruction is also involved with XXX's ED, follow these additional steps:** 1. Utilize the Safety Management Plan if imminent risk of harm exists 2. When XXX has stopped <u>all</u> destructive behavior, and returned the environment to its original condition, remind him what he is earning. Prompt him to continue with the activity **NOTE:** If the amount of property destruction is large, have XXX clean up a representative sample
Non-Compliance (NC)	1. Prompt every 2 minutes (done by one staff member). Use visual supports and minimize verbalization 2. When XXX shows signs of compliance, encourage him to resume the activities, referring to his schedule. Remind XXX of what he is earning once he is engaged in the activity 3. Utilize the Safety Management Plan if imminent risk of harm exists
Darting (Dart)	1. Alert others who are in the direction of XXX's darting with a neutral audible warning 2. Staff located between XXX and target area should utilize body positioning to maintain safety of XXX and others 3. Using a neutral tone and expression, prompt to return to assigned area 4. Utilize the Safety Management Plan if imminent risk of harm exists
Leaving the Area	1. Using a neutral tone and expression, prompt XXX to return to assigned area 2. Prompting is to be repeated every <u>30 seconds</u> and should be done by one staff member. Minimize verbalizations and utilize visual supports 3. Utilize the appropriate steps of the Safety Management Plan if imminent risk of harm exists
Pica	1. Using a tissue held out toward XXX's mouth, tell him, utilizing a calm tone, "spit it out" 2. If the substance XXX places in his mouth warrants, have him brush his teeth 3. Remind XXX that he is earning and refer to his visual safety strip of safe hands/safe mouth/safe feet 4. Once XXX is compliant with the above steps, utilizing his visual schedule, prompt him back to task **NOTE:** If XXX is observed to ingest any material, nursing should be notified immediately
Disrobing	1. Using a neutral tone, prompt XXX to redress or wear clothing appropriately 2. If XXX does not comply with prompts to dress, efforts should be made to remove patients and visitors from the area to maintain XXX's privacy 3. Utilize a mat or sheet to block others' view of XXX

	4. If unable to remove others from the area, utilize supportive guide and prompt XXX to a private area (bedroom, bathroom) 5. Continue to prompt XXX to redress or wear clothing appropriately every 5 minutes
• Inappropriate Touch	1. If XXX is inappropriately touching others, redirect him and refer to his visual schedule to prompt him to task 2. In addition, the individual he is touching should move away or be moved away

Safety Management Plan Options

If XXX's target behaviors reach a point where there is imminent risk of injury to staff, another patient, or himself, his safety will be supported by staff following the listed hierarchy of interventions below. A nurse must be notified immediately anytime physical intervention occurs.

These strategies are listed in hierarchical order. Unless directed otherwise by a nurse, physician, psychologist, or BCBA, staff will start intervening with the first step and if necessary, continue moving through the steps until safety is achieved

a. Guide to take space in the quiet room, or appropriate safe space
b. Initiate a 1/2 Person Stability Hold/Seated Stability Hold
c. Initiate a Chair Stability Hold/Chair Stability Hold with Leg Wrap
d. Initiate a 2/3-Person Wall Hold
e. Guide to the floor, for a hold.
f. Transport to the quiet room, or appropriate safe space, utilizing a blanket wrap, a transport wrap, and a stretcher
g. Open door seclusion
h. Locked seclusion

This behavior support plan has been developed in collaboration with the Applied Behavioral Treatment Team.

Signed By: ☐ Clinician's *Name*, LP/LLP; ☐ *Clinician's Name,* LBA; ☐ *Clinician's Name,* LBA/? Program Director

Signature: _____ Date/Time: _____

Applied Behavioral Treatment Unit Data Recording Sheet

KEY:

Date: 1/20/2022

C-Café **BR**- Bathroom **TTV**-Trial Therapeutic Visit RRR- Room, Resting, Respirations noted
RM- Room G-Gym AR- Art Room AX -Activity Room NS- Nurses Station H-Hallway
SCH-School SH-Shower QR-Quiet Room **O**-Outside

LNAME, FIRST
A#: BH0000
ADM: 00/00/2021
MR#: SH1001
DOB: ##/##/####

AM	# OF AGG	Start	End	# of SIB	Activity & Location	**00:00**	
00:00							
15						**15**	
30						**30**	
45						**45**	
1:00						**1:00**	
15						**15**	
30						**30**	
45						**45**	
2:00						**2:00**	
15						**15**	
30						**30**	
45						**45**	
3:00						**3:00**	
15						**15**	
30						**30**	
45						**45**	
4:00						**4:00**	
15						**15**	
30						**30**	
45						**45**	
5:00						**5:00**	
15						**15**	
30						**30**	
45						**45**	
0600-0715						**6:00**	
0715-1000							
1000-1200							

AM Count				

Breakfast:	Morning Snack:	Lunch:	BM– Times
List food item for meals and snacks			Y / N 0000-0715 Y / N 0715-1200

Print Name and Signature	Initial	Print Name and Signature	Initial	Print Name and Signature	Initial

PM	# Of AGG	ED +/- PD Start	ED +/- PD End	# Of SIB	Activity & Location	Time	Initials
1200-1400							
1400-1600							
1600-1800							
1800-2000							
20:00						20:00	
15						15	
30						30	
45						45	
21:00						21:00	
15						15	
30						30	
45						45	
22:00						22:00	
15						15	
30						30	
45						45	
23:00						23:00	
15						15	
30						30	
45						45	

*Please note when patient falls asleep
*Transfer data from Parent TTV sheet

TTV Counts				
AM Counts				
PM Counts				
Total				

Afternoon Snack:	Dinner:	Evening Snack:	BM – Times
List food item for meals and snacks			Y / N 1200-1415 Y / N 1415-1700 Y / N 1700- Bed

Tools: These include Helping Boards, Power Cards, Key Chains, etc.
Behavior Column Key: "Y" = Yes; "N" = No; "R" = Refused