UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

The Center for Balanced Living

iTBT Temperament Based Treatment
Adult Behavioral Contract (template)

CLIENT:_____ Date:_____

This plan can be modified at various times by adding or changing different sections within this document.

This agreement to be used when

a. Client transitions from one level of care to another.

b. Client is within a level of care and wants or needs to hold him/herself accountable by identified supports

General Objectives

To restore patient to health, prevent further inpatient hospitalization and prevent weight loss. Help patient to be free from an eating disorder and enjoy a healthy, active life [can be modified as necessary].

	Patient	**Support Persons**
Long term goals: [Patient and carers decide together the patient's top 3 things that the patient	**a.** **b.**	

values or hopes to do in the long term.]	**c.**
Short term goals: [Patient and carers decide together the patient's short-term treatment goals.]	**a.** **b.** **c.**

SUPPORT PERSONS

In an effort to make the client's treatment more successful, the patient is willing to enter into the following agreement that integrates the patient's treatment plan with the **SUPPORT PERSONS** identified below:

a.

b.

c.

MEALS AND SNACKS

Breakfast, lunch, dinner, and identified snacks each day as prescribed is the foundation for physical strength.

	CLIENT	SUPPORT
GOALS/RESPONSIBILITIES (CIRCLE ALL THAT APPLY)	a. I will eat 100% of ___(#) meals and ___(#) snacks (based on treatment team's recommendations. b. All meals and snacks will be chosen, prepared and plated by _____. c. All condiments (butter, salad dressing) will be put on the food by _____. d. I will finish all meals within 30 minutes. e. I will not negotiate or change the meals that are presented by _____. f. Meals include caloric drinks such as	a. Provide 2-3 options for what to eat. b. Help client come up with/suggest a "safety" or "go-to" meal when he/she is struggling. c. Be present during meals and/or snacks. d. Be present for 30-60 minutes after meals. e. Plate food f. Narrow choices when struggling. g. Decide what client will eat when _____. h. Provide encouragement if client is struggling to eat. Specify: i. Suggest distractions/self-soothe activities.

	milk, Gatorade, juice, etc. g. I may have 16oz maximum of water per day. h. I will be supervised for 30 minutes following the meal. i. SUPPLEMENTING: If I eat more than 50% but less than 100%, I will drink 1 Boost/Ensure. If I eat less than 50%, I will drink 2	Specify: j. Validate client's thoughts and feelings. Specify: k. Refrain from making commnets about food, calories, weight, body. Specify:
POSITIVE OUTCOMES: List positive outcomes for client if meal/snack goals are achieved.	a. I will allow myself access to_____ (specify motivator). b. Increased independence (specify):	a. I will provide _____ b. I will stop monitoring _____ (specify what will change)once client achieves meal/snack goals for _____ (specify time period).
REPAIRS: List repairs if meal/snack goals are not	a. Increase supervision at meals/snacks by _____ for _____	a. I will be present for the following meals/snacks: Specify:

achieved.	meals/snacks. b. No exercise for _____ (time period) until meals/snacks are completed. c. Increase energy intake at _____ meal. d. I will not be able to go back to college if _____ meals/snacks are not completed. e. I will enter into a higher level of care (specify) if _____ meals are not completed.	b. Provide encouragement if patient is struggling. Specify:_____ _____ c. Suggest distraction/self-soothe activities/coping skills Specify:_____ _____ _____ _____ **d.** Validate patient's feelings/thoughts. Specify:_____ _____ _____

UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

The Center for Balanced Living

WEIGHT/PHYSICAL HEALTH

Breakfast, lunch, dinner, and identified snacks each day as prescribed is the foundation for physical strength.

	CLIENT	SUPPORT
GOALS/RESPONSIBILITIES (CIRCLE ALL THAT APPLY)	a. My weight and body mass will be measured by the medical team _____(state frequency). b. If my body mass or weight does not (increase / decrease) _____(# lbs) per _____(week/month) as medically recommended, I understand my food will be (Circle one: increased decreased) c. I will maintain my weight and health. d. I will maintain/achieve stable heart rate/blood pressure/other vitals. e. _____ _____ _____. f. _____ _____.	a. Increase patient's caloric intake. b. Provide encouragement if patient is struggling. Specify:_____ _____ c. Suggest distraction/self-soothe activities/coping skills Specify:_____ _____ _____ _____ **d.** Validate patient's feelings/thoughts. Specify:_____ _____ _____

POSITIVE OUTCOMES: List positive outcomes for client if meal/snack goals are achieved.	a. I will allow myself access to_____ (specify motivator). b. Increased independence (specify):	a. I will provide _____ (specify motivator b. I will stop monitoring _____ (specify what will change)once client achieves meal/snack goals for _____ (specify time period).
REPAIRS: List repairs if meal/snack goals are not achieved.	a. Increase supervision at meals/snacks by _____ for _____ meals/snacks. b. No exercise for _____ (time period) until meals/snacks are completed. c. Increase energy intake at _____ meal. d. I will not be able to go back to college if _____ meals/snacks are not completed. e. I will enter into a higher level of care (specify) if _____ meals are not completed. f. I will be hospitalized if weight goes below _____ (specify weight range) or I become medically unstable.	

UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

The Center for Balanced Living

EATING DISORDER/SELF-DESTRUCTIVE BEHAVIORS

Breakfast, lunch, dinner, and identified snacks each day as prescribed is the foundation for physical strength.

	CLIENT	SUPPORT
GOALS/RESPONSIBILITIES (CIRCLE ALL THAT APPLY)	I will work towards reducing the frequency and/or severity of the following behaviors: a. Over-exercising (or exercising beyond what is permitted by treatment team) b. Binging c. Purging d. Diuretic use e. Laxative use f. Hiding food g. Alcohol/Substance abuse h. Self-harm i. Isolating j. Body checking k. _____ _____ l. _____ _____	My support will offer the following support to help me in my goals (circle all that apply or add your own): c. Call/text/email to check in. d. Provide encouragement if I am struggling. Specify:_____ _____ _____ e. Suggest distraction/self-soothe activities/coping skills Specify:_____ _____ _____ f. Validate my feelings/thoughts. Specify:_____ _____.

		g. Refrain from actions that may make the problem worse. Specify:_____
POSITIVE OUTCOMES: List positive outcomes for client if meal/snack goals are achieved.	c. I will allow myself access to_____ (specify motivator). d. Increased independence (specify):	a. I will provide _____ (specify motivator). b. I will stop monitoring _____ (specify what will change)once client achieves _____ (list specific goal for stopping behavior).
REPAIRS: List repairs if meal/snack goals are not achieved.	g. Increase supervision at meals/snacks by _____ for _____ meals/snacks. h. No exercise for _____ (time period) until meals/snacks are completed. i. Increase energy intake at _____ meal. j. I will not be able to go back to college if _____ meals/snacks are not completed. k. I will enter into a higher level of care (specify) if _____ meals are not completed. l. I will be hospitalized if weight goes below _____ (specify weight range) or I become medically unstable.	

By signing this agreement, we are committing to the actions we have outlined and understand that the consequences are as important as the goals.

_____	_____
Client	Date
_____	_____
Support Person 1	Date
_____	_____
Support Person 2	Date
_____	_____
Treatment Provider	Date