St. Clair County Community Mental Health

Positive Behavior Supports Survey

Person Completing Form: ☐**Individual** ☐**Guardian** ☐**Family** ☐**Advocate**

Date: ____

Case Number: ____

HOW WELL IS YOUR SERVICE PLAN WORKING FOR YOU?
Please let us know what you think by checking Yes or No to the questions below. Check N/A if you feel that the question does not apply to you. (Guardian / Family / Advocate please read and respond to the questions as you see them applying to the individual.) Thank you for your help.

Since you started your Service Plan…	Yes	No	N/A
Has your Service Plan been based on Positive Behavior Supports? (Understanding what I really want and how we all can best work together)	**Yes** ☐	**No** ☐	**N/A** ☐
Are fewer Restrictive or Intrusive interventions being used? (Fewer things done that take hold of me or my personal space)	**Yes** ☐	**No** ☐	**N/A** ☐
Are fewer Emergency Management interventions being used? (Fewer things done that take hold of me or my personal space when I am having a crisis)	**Yes** ☐	**No** ☐	**N/A** ☐
Are fewer medications (type of medication, dosage) being given to you to help you control behavior?	**Yes** ☐	**No** ☐	**N/A** ☐
Are you doing more in the community and / or doing more things independently?	**Yes** ☐	**No** ☐	**N/A** ☐
Are you meeting identified goals/objectives	**Yes** ☐	**No** ☐	**N/A** ☐

Comments:

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