CMHSP Measurement of Effectiveness of Behavior Treatment Plans DATE

To improve our Behavior Treatment services, we ask you to complete the following survey to the best of your ability. We are interested in your views on the development and implementation of the behavior treatment plan for (consumer's name), DOB

- What relationship do you have with the individual? (*Please circle)*
  Parent /Guardian/ Staff
- How long have you known this individual? _______________
- Where do you spend time with this individual?: (*Please circle all that apply)*
  Family Home/ Group Home/ AFC/ Community/ Other
- I am aware that restrictive behavior plans must be reviewed and approved by CMHSP Behavior Treatment Committee (*Please circle)* *Yes* *No*

	Strongly Agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly Disagree (5)	NA
1. This individual's behavior plan contributes to participation in the community to the maximum extent possible						
2. This individual's behavior plan provides necessary strategies to prevent or reduce behaviors that compromise the individual's safety						
3. The interventions in the behavior plan are based on a careful assessment						
4. I had opportunities to offer input into the development of the plan						
5. There was sufficient training to implement the plan correctly						
6. Necessary changes in the behavior plan occur in a timely manner						

7. The elements in this plan are: *(Please circle)*

1= Too restrictive 2= A bit restrictive 3= Just right 4= A bit too lenient 5= Too lenient

Please return by: ___________________

Comments:____
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Name (optional) ____