

ACCR QUALITY COMMITTEE SERVICE PLANNING PRINCIPLES

Elements of recovery-oriented service planning	Ways this indicator can be demonstrated		
Indicator	Individual Indicator/Outcome	By Program/Services	By County, Regional, or Statewide
The Service User drives the recovery planning process	<ul style="list-style-type: none"> • I decide on the goals of my service plan • I decide about the services I want to receive. • I choose who I work with 	<ul style="list-style-type: none"> • Evidence that service plans use the goals chosen by the service user. • Evidence that a person chooses the services received. • Evidence of collaboration in planning 	<ul style="list-style-type: none"> • Regulatory standards support client/family driven plans. • Monitoring includes direct feedback from service users • Mandates uniformity in planning process
The service system must be structured in a way that encourages independence, affiliation and choice	<ul style="list-style-type: none"> • I choose the service system that I want to be involved with. • I am encouraged to develop individual recovery strategies • I am supported by friends and the community 	<ul style="list-style-type: none"> • Service system encourages clients to choose services they want. • Service plan considers methods that enhance self-sufficiency and community connections • Assessment is completed recognizing the person right to choose. 	<ul style="list-style-type: none"> • County System has wide range of service to meet the needs of it's population. • Mechanisms to support rehabilitation services at all levels of care • Mechanisms to support peer to peer and other peer support activities
Individual differences should be recognized, respected and used in constructing a unique plan.	<ul style="list-style-type: none"> • I feel respected • I am treated like a unique individual <p>I feel my culture is recognized</p>	<ul style="list-style-type: none"> • Cultural competence is a goal of all programs in the system. • Assessment should recognize the uniqueness of the individual and all his/her cultural influences. 	<ul style="list-style-type: none"> • Supports culturally informed practices • Funding available for culturally specific outcome analysis
Effective planning invites and incorporates a variety of potential methods for creating change.	<ul style="list-style-type: none"> • I am informed of a variety of ways to reach my goals • My ideas and wishes for change are part of my plan 	<ul style="list-style-type: none"> • Planning presents all options that could be potential support to the person. • Adequate time is available to explore all options for planning • There is a flexible process for revising plans 	<ul style="list-style-type: none"> • Information from County, State and Federal Resources are available by phone, website, and pamphlets to providers and persons in need of services. • Regulations specify need for an array of individualized services. • Incentives created for programs to allocate time for planning processes.
Effective collaboration is based on trust, which can only be achieved through honest, hopeful and respectful interactions.	<ul style="list-style-type: none"> • I feel like the people who work with me care about me • I trust my service • I am encouraged by those involved with my treatment 	<ul style="list-style-type: none"> • Staff does not use negative, stereotyping, or stigmatizing language • Staff encourages clients to pursue personal goals in treatment planning 	<ul style="list-style-type: none"> • Establishes guidelines for professional-client interactions • Monitoring activities include interviews with clients directly and inquiry re: interactions with caregivers

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<p>Strengths and assets must be identified before solutions to change issues can be formulated adequately</p>	<ul style="list-style-type: none"> • The service planning process helps me identify my strengths and assets. • I feel that I have strengths that will help me make the changes I want 	<ul style="list-style-type: none"> • The provider uses a strength-based assessment. • The organization values and employs persons in recovery • Strengths and assets are used to identify methods for achieving desired outcomes. 	<ul style="list-style-type: none"> • Qualified individuals in recovery are employed by government agencies. • Standards for strengths based service planning have been developed • Training for providers and consumers re: using strengths in planning is available
<p>The plan should be free of jargon or other barriers to comprehension or collaboration</p>	<ul style="list-style-type: none"> • I understand my plan because I helped develop it • My plan uses language that I choose and understand. 	<ul style="list-style-type: none"> • The service plan incorporates client's own words • The service plan is in a simple format and is easy to understand 	<ul style="list-style-type: none"> • Monitoring activities include opportunities to speak with clients directly about their understanding of the plan. • Standard elements of a simple and uniform planning format have been developed
<p>Family, significant others and elements of community support should be consulted whenever it may be advantageous</p>	<ul style="list-style-type: none"> • I choose who helps me with my plan. • I feel that people who can be supportive to me are identified and included in my plan. 	<ul style="list-style-type: none"> • Provide education on how to identify supports. • Significant others' input is included according to client's wishes 	<ul style="list-style-type: none"> • Provides strong support for advocacy/peer support groups • Supports training for family members re: recovery oriented services and participation in planning
<p>The plan should provide an objective way to measure progress toward stated goals and a framework for the services to be received.</p>	<ul style="list-style-type: none"> • I choose the goals I work on and the time frame for achieving them. • I choose how to measure my progress and achievements 	<ul style="list-style-type: none"> • Easily measured (observable) actions are identified with the client to demonstrate progress • Services to be used are clearly identified with the rationale for use 	<ul style="list-style-type: none"> • Uniform planning format is developed and implemented • Monitoring activity includes methods to measure client's understanding of progress measurement
<p>The service plan ultimately belongs to the consumer, and so should be in a form that can be carried through to and built upon in subsequent treatment experiences</p>	<ul style="list-style-type: none"> • I have a copy of my service plan that I can share with future helpers • All those who provide help to me use my plan to help me update my needs and plans. 	<ul style="list-style-type: none"> • Clients are encouraged to hold a copy of their plan and to share it with persons of their choosing. • Clients' existing plan is used to help formulate updates or new plans. 	<ul style="list-style-type: none"> • Standards have been developed for continuous planning processes across service types and time. • Monitoring reviews processes for incorporating existing plans into updated service plan.
<p>The service plan should emphasize health and wellness and individual contributions to establishing stable recovery.</p>	<ul style="list-style-type: none"> • I understand and use things I can do to keep myself healthy. • I have an individual recovery plan with which my service plan can be used. 	<ul style="list-style-type: none"> • The planning process includes methods to maintain health and minimize setbacks • Fully developed overall recovery plans are encouraged and the service plan is identified as one element of it. 	<ul style="list-style-type: none"> • Guidelines for interaction of individual recovery plans and service plans have been developed. • Training re: health/wellness planning is supported and available.