

ACCR Quality Committee

Service Planning Principles

- 1) **The Service User drives the recovery planning process.** Their ability to do this may be limited during periods of incapacitation, but at very least the service user should assume an increasing role in directing the planning process as recovery progresses and as the intensity of services decreases. The service user's investment in the plan will be dependent upon the degree to which their needs and preferences are identified, recognized and incorporated into the plan.
- 2) **The service system must be structured in a way that encourages independence, affiliation and choice.** Recovery flourishes in an environment that provides hope and purpose, encourages productivity, personal growth and socialization, and which respects cultural values and self-determination.
- 3) **Individual differences should be recognized, respected and used in constructing a unique plan.** Even as these differences are defined, it will be important to understand them in the context of a shared humanity and the common bonds that bring people together and foster collaboration.
- 4) **Effective planning invites and incorporates a variety of potential methods for creating change.** The plan should address all aspects of a person's functioning including physical, mental, spiritual, cultural, interpersonal and economic variables.
- 5) **Effective collaboration is based on trust, which can only be achieved through honest, hopeful and respectful interactions.** Recognition and emphasis on one's potential is essential to a progressive planning process.
- 6) **Strengths and assets must be identified before solutions to change issues can be formulated adequately.** As in any planning process, resources must be identified early on in order to create realistic strategies to accomplish identified goals. Service users will often have the best knowledge of their own strengths.
- 7) **The plan should be free of jargon or other barriers to comprehension or collaboration.** The plan should be documented in a format that is easily understood and concise. The service user's own way of expressing their goals and desired outcomes should be used whenever possible.
- 8) **Family, significant others and elements of community support should be consulted whenever it may be advantageous.** Service users will define those who they would like to be involved in the planning process with them, and should not ever be forced to include those who they feel cannot be of assistance to them.
- 9) **The plan should provide a framework for the services to be received and an objective way to measure progress toward stated goals.** There must be a process in place that allows the treatment plan to be revisited on a periodic basis that allows the service user to see concrete changes that have been accomplished.
- 10) **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.** The plan should be designed in collaboration with the community of service providers that could potentially provide services to the service user. Significant similarities in process and format will assure that some continuity can be maintained.

- 11) **The service plan should emphasize health and wellness and individual contributions to establishing stable recovery.** Employing individual strengths in conjunction with treatment and community supports will help create a roadmap for change and overcoming the barriers to health identified in the planning process.