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**
1. The person(s) in recovery drives the recovery planning process	• I decide on the goals of my service plan. • I decide about the services I want to receive. • I choose the people involved.	• 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	• Regulatory standards support client/family driven plans. • Monitoring includes direct feedback from service users • Mandates uniformity in planning process
2. Service planning and the service system must be constructed in a way that encourages independence, develops natural community supports and provides for choice of services.	• I choose the service system that I want to be involved. • I am encouraged to develop individual recovery strategies. • I am supported by friends and the community.	• 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.	• County System has wide range of service to meet the needs of its population. • Mechanisms to support rehabilitation services at all levels of care • Mechanisms to support peer to peer and other peer support activities
3. Individuality should be recognized, respected and used in constructing unique plans.	• I am respected. • I am treated as a unique individual. • My culture is recognized and respected.	• 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.	• Supports culturally informed practices • Funding available for culturally specific outcome analysis
4. A wide variety of methods should be explored for developing an effective plan for change and growth.	• I have explored a variety of ways to reach my goals. • My ideas and desires for change are part of my plan.	• 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	• 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.
5. Successful working relationships are based on trust which is gained by communicating honestly and respectfully.	• The people who work with me care about me. • I trust my service provider. • I am encouraged to be myself by those involved with my recovery services.	• Staff does not use negative, stereotyping, or stigmatizing language • Staff encourages clients to pursue personal goals in treatment planning	• Establishes guidelines for professional-client interactions • Monitoring activities include interviews with clients directly and inquiry re: interactions with caregivers

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6. A person's strengths must be identified before setting goals.	• The service planning process helps me identify my strengths and assets. • The strengths I have that will help me make the changes I want are recognized in my plan.	• 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.	• 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
7. Plans should be in easy to understand language that helps everyone involved work together.	• I understand my plan because I helped develop it. • My plan uses language that I choose and understand.	• The service plan incorporates client's own words • The service plan is in a simple format and is easy to understand	• 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
8. The individual's chosen support network should be involved whenever the individual decides it may be helpful	• I choose who helps me with my plan. • People who can be supportive to me are identified and included in my plan.	• Provide education on how to identify supports. • Significant others' input is included according to client's wishes	• Provides strong support for advocacy/peer support groups • Supports training for family members re: recovery oriented services and participation in planning
9. Ideas for progress toward goals must be tested within reasonable timeframes and reviewed at regularly defined times.	• I choose the goals I work on and the time frame for achieving them. • I choose how and when to measure my progress and achievements.	• Easily measured (observable) actions are identified with the client to demonstrate progress • Services to be used are clearly identified with the rationale for use	• Uniform planning format is developed and implemented • Monitoring activity includes methods to measure client's understanding of progress measurement
10. Service plans should belong to the person(s) in recovery and be in a form that can be built upon and carried from one service provider to another.	• 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.	• 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.	• Standards have been developed for continuous planning processes across service types and time. • Monitoring reviews processes for incorporating existing plans into updated service plan.
11. The service plans should promote wellness for the whole individual. Plans should reflect ways to make healthy and personally meaningful choices for body, minds, and spirit.	• I understand and use things I can do to keep myself mentally and physically healthy. • I have an individual recovery plan with which my service plan can be used. • My plan considers my whole life.	• 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.	• Guidelines for interaction of individual recovery plans and service plans have been developed. • Training re: health/wellness planning is supported and available.