Newport Mental Health - Person Centered Recovery Plan Quality Review Tool

Item #	Documentation Indicator & Review Tips	Fully Meets Criteria (Exemplar example – No recommendations for improvement)	Meets Most Criteria (Good demonstration of quality criteria but would benefit from some enhancements)	Limited Criteria Met (Limited demonstration of quality criteria; requires some significant improvement)	Does Not Meet Criteria/ Plan Element Absent (Does not reflect understanding of quality criteria; requires major revision)	Comments/ Observations* *Please add a qualitative comment for "exemplar" examples if something was particularly well-done AND for all "Most/Limited/Does Not Meet" ratings please describe what was lacking.
1	The **narrative/interpretive summary** includes brief references to the following required elements: 1. Strengths, interests, and current and/or desired life roles and priorities. 2. A brief reference to primary presenting problem/barriers. *This is critical to include in supporting your golden thread of medical necessity and explains the person's need for services. Note this can be a brief reference as you have the opportunity to elaborate later in the Recovery Plan in the Barriers fields. 3. Individual's stage of change/stage of recovery (Stage of readiness for any relevant behavior change that could help them move towards their goal) 4. Natural supports or community resources 5. Cultural factors and any impact on treatment 6. A core theme/understanding re: what drives the individual's experience of illness and recovery -the "why" question. Are there any unmet needs (e.g., trauma history) that have perpetuated the person's difficulties? May not always be known but is important to consider.					
2.	The plan/plan update is developed collaboratively and there is **evidence of direct input from the person**, e.g., the includes quotes from the individual and/or statements such as "Jose stated…" and there is evidence they were offered a copy of the plan (Note: This may be found in a progress note following the planning meeting or directly on the plan itself.)					

3.	The **goal statements** on the plan/plan update are about having a meaningful life in the community, not only symptom reduction or compliance. Ideally, the goal reflects something "higher" – a valued community/life role that they want to obtain and are in the individual's own words. Ideally goals are reflected by "I" statements in quotes. "I'd like to join a choir." "I want a better relationship with my dad." Consider both the content of the goal (i.e., it is quality of life oriented or more narrowly focused on clinical problems) and how it is written (i.e., ideally in quotes).					
4.	The person's **unique strengths and resources** (as noted in the assessment) are incorporated somewhere within the body of the recovery plan. Note that strengths should be individualized and specific, e.g., unique interests, hobbies, accomplishments, personal traits, community connections, abilities and accomplishments, natural support relationships, etc. Strengths should NOT be limited only to compliance with medication or active participation in treatment. Strengths can be used anywhere within the body of the plan (e.g., a person with a love of animals might have a goal to volunteer at the Humane Society) but often can be readily incorporated at the end of the plan in the *Personal Wellness Strategies field.*					
5.	The plan includes **barriers** that include descriptive and individualized detail regarding **mental health/substance use/ and/or physical health functional impairments** that cause the person distress and interfere with the attainment of valued goals. *This is critical to include in supporting your golden thread of medical necessity and explains the person's need for services. The plan makes clear how assessed barriers are relevant in interfering with identified goals, e.g., not simply "depressed," but depression and excessive sleep have led to chronic absenteeism at work or not simply "poor budgeting" but cognitive/concentration issues associated with psychosis interfere with budgeting tasks. The presence of these mental health/substance use/ and/or physical health functional impairments is what justifies service need and individualized detail helps to inform specific interventions.					

6.	**The plan notes systemic/and resource issues** (e.g., no transportation to clinic, services not available in primary language, wait lists for preferred program, etc.) which interfere with goal attainment but are not directly related to the individual's mental health or addictions issues. These systemic/resource issues also help to justify service need, often case management supports and/or referrals to additional community providers/programs.					
7.	**Objectives** meet the SMART criteria. They are written simply (understandable to the person), are measurable (they happened or not, "as evidenced by…"), are achievable, relevant and time limited. Well-written short-term objectives are concrete steps that when achieved are proof that the person making progress toward their goal. * Reminder: Plan objectives are logically linked to reducing/removing a barrier, i.e., it should be clear which documented MH or SA barrier you are working on overcoming to achieve the short-term objective. Think of it as "picking" a problem from the assessment that is getting in their way of the goal. Then document that in the left hand column and then add in the next column, the concrete change the person hopes to achieve, i.e., how will you know (the behavioral measure) that barrier is improving?					
8.	Do the **objectives go beyond service participation**? i.e., Are they only about "will attend X,Y,Z services" or do they capture a positive/meaningful change in behavior/change in functioning/change in status? e.g., instead of framing the objective as "Client will regularly attend Dialectical Behavior Therapy" focus on the desired behavior change associated with that treatment intervention, e.g., "Jane will use Mindfulness skills to improve regulation of emotions as evidenced by having no more than 2 incidents of self-injurious cutting per week for the next 30 days."					
9.	The plan/plan update describes attempts to help the person to **connect with chosen activities in the broader community** rather than relying on social supports coming solely from behavioral health agencies. (This item aims to reduce the amount of time people spend in segregated setting designed solely for people with mental illnesses)					
10.	**Professional interventions** include the necessary W's: **who** (responsible professional), **what** (billable service), **when** (frequency, intensity & duration of service), and **why** (purpose and intent). The interventions should also specify which Objectives they are intended to address.					

11.	The plan/plan update notes at least one quality **Personal Wellness Strategy.** Note: These are typically identified within the assessment process and build upon the person's strengths. What is the person's role in the plan? What action can theye take in the service of their recovery? This is often a place to capture strengths-based, self-directed wellness strategies that the person can perform independent of the treatment system. Wellness strategies ideally focus on personal, strengths-based activities the person will do in support of their recovery, and NOT only on the act of attending professional services. The person's Wellness Strategies should not merely be a "flipping" of the intervention statement as this does not add anything substantive to the plan. Instead, try to focus on the specific "value-added" task the person can pursue on their own. For example, NOT Client will consistently attend Creative Writing Rehab Group but instead Ingrid will journal for 15 minutes per day as this is an important wellness activity identified in her WRAP plan.					
12.	**Community and/or other natural supports** may be incorporated within the interventions/services sections of Recovery Plans but may also be evident in separate fields dedicated specifically to this purpose. This would include other people (external to your organization) who have important contributions to make to the individual's recovery plan – both professionals (e.g., a medical doctor, a probation officer, an employment specialist, school counselor, etc.) as well as natural supports (e.g. family member, friend, employer). Note that this item would be rated as N/A if it is the individual's stated preference NOT to include any natural supporters and this preference is stated in the Recovery Plan.					
13	The plan/plan update uses **"person-first" language and the person's name** (i.e., a person living with schizophrenia NOT a schizophrenic) and/or the individual's name throughout the document.					