




Section: Substance Use Treatment & Prevention	Policy Name: Treatment Planning SUD	Policy Number: 11.01
Owner: Substance Use, Prevention & Treatment Director	Reviewed By: Joel A. Smith	Total Pages: 6
Required By: <input type="checkbox"/> BBA <input checked="" type="checkbox"/> MDHHS <input type="checkbox"/> NCQA <input checked="" type="checkbox"/> Other (please specify): PA 368 of 1978; SUD Administrative Rules	Final Approval By:  Joel Smith, LMSW (Jan 21, 2026 11:33:29 EST)	Date Approved: 01/21/26
Application: <input checked="" type="checkbox"/> SWMBH Staff/Ops <input checked="" type="checkbox"/> Participant CMHSPs <input checked="" type="checkbox"/> SUD Providers <input type="checkbox"/> MH/IDD Providers <input type="checkbox"/> Other (please specify): <hr/>	Line of Business: <input checked="" type="checkbox"/> Medicaid <input type="checkbox"/> Other (please specify): <input checked="" type="checkbox"/> Healthy Michigan <input checked="" type="checkbox"/> SUD Block Grant <input checked="" type="checkbox"/> SUD Medicaid <input type="checkbox"/> MI Health Link	Effective Date: 1/1/2014

Policy: It is the policy of SWMBH that treatment planning must be a product of the active involvement and informed agreement of the customer. The direct involvement of the customer in establishing the goals and expectations for treatment is expected to ensure appropriate level of care determination, identifying true and realistic needs, and increasing the motivation to participate in treatment. Treatment planning requires an understanding that each individual is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each customer.

Purpose: To establish the standards that define, guide and detail how Southwest Michigan Behavioral Health (SWMBH) and its provider network system comply with the federal laws and Michigan Department of Health and Human Services (MDHHS) Contract requirements pertaining to the practice of individualized treatment planning for persons with a Substance Use Disorder (SUD).

Scope: This policy applies to all SWMBH contracted SUD treatment providers.

Responsibilities: SWMBH contracted SUD treatment providers are responsible for treatment planning creation and implementation. SWMBH is responsible for monitoring treatment plans and associated documentation.

Definitions: None



Standards and Guidelines:

A. Requirements:

1. The Administrative Rules for Substance Use Disorders Service Programs in Michigan, promulgated under PA 368 of 1978, as amended, state “a recipient shall be allowed to participate in the development of his or her treatment plan” [Recipient Rights Rules, Section 325.1393(1)].
2. All SUD providers of SWMBH must also be accredited by one of six approved national accreditation bodies. Accreditation standards also require evidence of customer participation in the treatment planning process.
3. Based upon the assessments made of a customer's needs, a written treatment plan shall be developed and recorded in the customer's record. A treatment plan shall be developed as promptly after the recipient's admission as feasible, but no later than either of the following, and before the recipient is engaged in therapeutic activities [Service Plan Rules, Section 325.1363(1)].:
 - i. The conclusion of the next session attended by the client for outpatient programs.
 - ii. Twenty-four hours for opioid treatment programs, residential, and withdrawal management programs.

B. All SUD Providers shall comply with the following procedures:

1. Treatment planning begins at the time the customer enters treatment, either directly or based on a referral from an access system and ends when the customer is discharged. Treatment planning is a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the needs of the customer change, the treatment plan must be revised to meet these new needs.
2. The treatment plan is not limited to just the customer and the clinician(s) providing services/treatment. The customer can request any family member, friend or significant other, be involved in the treatment process. Once the treatment plan is completed, the customer, clinician(s) and other involved individuals must sign the form indicating understanding of the plan and the expectations.
3. Establishing Goals and Objectives:
 - i. The initial step in developing an individualized treatment plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the customer. From this assessment, the needs and strengths of the customer are identified, and it is this information that assists the clinician and customer in establishing the goals and objectives that will be focused on in treatment. The identified strengths (i.e., healthy

support network, stable employment, stable housing, willingness to participate in counseling, etc.) can be used to help meet treatment goals and objectives of treatment. After strengths are identified, the clinician assists the customer in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the customer can provide motivation to participate in treatment and may take the focus off possible negative situations that surround the customer getting involved in treatment (i.e., legal problems, work problems, relationship problems, etc.).

4. Writing the Plan:

- i. Once the goals and objectives are jointly decided on, they are recorded in the treatment plan document utilized by the provider. Goals must be stated in the words of the customer or based on the customer's reported concerns. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, the objectives (i.e., the steps that need to be taken to achieve the goal and/or specific skills needed to be developed) are recorded. The objectives must be developed with the customer, but do not have to be recorded in the exact words of the customer. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a targeted completion date. The target completion dates must be realistic to the customer, or the chances of compliance with treatment are greatly reduced.

5. Establishing Treatment Interventions:

- i. The next component of the plan is to determine the intervention(s) that will be used to assist the customer in being able to accomplish the objectives (i.e., what action will the clinician take to assist the customer in achieving the goal).

6. Framework for Treatment:

- i. The individualized treatment plan provides the framework by which the treatment should be conducted. Any individual or group sessions that the customer participates in must address or be related to the goals and objectives in the treatment plan. When progress notes are written, the note should reflect what goal(s)/objective(s) were addressed during a treatment episode. The progress notes are also where to document any adjustments/changes to the treatment plan. Once a change is decided on, it should then be added to the treatment plan in the format described above through a treatment plan addendum.

7. Treatment Plan Progress Reviews:

- i. Per the administrative rules, treatment plans must be reviewed by a licensed or certified professional including the service plans under a limited certified counselor, as referenced in the SUD Administrative rules, at least every 120 days. The reviews must include input from the customer, all clinicians/treatment providers involved in

the care of the person being served, as well as any other individuals the person being served has involved in their treatment plan. This review should reflect on the progress the customer has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them and the need to add any additional goals/objectives and services due to new needs of the customer. As with the treatment plan, the customer, clinician, and other relevant individuals should sign this review.

1. The treatment plan and the treatment plan reviews not only serve as tools to provide treatment, but they also help in the administrative function of service authorization for the customer. All decisions concerning, but not limited to, authorizations, length of stay, transfer, discharge, continuing care and authorizations by SWMBH or delegated access management and utilization management providers must be based on individualized determinations of need and on progress toward treatment goals and objectives. Such decisions must not be based on arbitrary criteria such as pre-determined time or payment limits.

8. Policy Monitoring and Review

- i. As the PIHP, SWMBH will monitor compliance with individualized treatment planning. Reviews of treatment plans will include:
 1. A review of the biopsychosocial assessment to determine where and how the needs were identified.
 2. A review of the Treatment Plan to check for:
 - a. Matching goals to needs (needs from assessment to goals on the treatment plan).
 - b. Goals are in the words of and are unique to the customer (no standard or routine goals that are used by all persons being served) or based on the customer's reported concerns.
 - c. Measurable objectives. This includes objectives that are specific, measurable, achievable, relevant to identified needs and diagnoses.
 - d. Target dates for completion (the dates identified for completion of the goals and objectives are unique and realistic to the customer and not just routine dates put in for completion of the plan).
 - e. Intervention strategies (the specific types of strategies that will be used in treatment [i.e., group therapy, individual therapy, cognitive behavioral therapy, didactic groups, evidence-based practices, etc.]) or more specific strategies as known.
 - f. Signatures (customer, clinician and involved individuals).



3. A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.
4. A review of the treatment plan progress review to check for:
 - a. Documentation of progress note information matching what is in review.
 - b. Documentation of progress or lack of progress for goals/objectives.
 - c. Rationale for continuation/discontinuation of goals/objectives.
 - d. New goals and objectives developed with input from the customer.
 - e. Participation/feedback from the customer is present in the review.
 - f. Signatures of clinician and customer.

References:

- A. MDHHS/OROSC Policies and Technical Advisories #P-T-06
- B. Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems, Substance Use Disorders Service Program

Attachments: None



Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	6/20/22	Multiple locations	Merged to new policy template; Aligned policy to updated SUD admin rules	J. Smith
2	3/28/24	Multiple locations	Aligned policy to updated SUD admin rules approved 6/26/23.	J. Smith
3	1/2/26	A.3	Added admin rules reference for timeliness requirements	J. Smith







SOP Template

Final Audit Report

2026-01-21

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