

Michigan Department of Community Health, Behavioral Health and Developmental Disabilities Administration
BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES

TREATMENT POLICY # 06

SUBJECT: Individualized Treatment and Recovery Planning

ISSUED: September 22, 2006, revised February 29, 2012

EFFECTIVE: April 2, 2012

PURPOSE

The purpose of this policy is to establish the requirements for individualized treatment and recovery planning. Treatment and recovery plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is required to ensure appropriate level of care determination, identify true and realistic needs, and increase the client's motivation to participate in treatment. By participating in the development of their recovery plan, clients can identify resources they may already be familiar with in their community and begin to learn about additional available services. Treatment and recovery planning requires an understanding that each client is unique and each plan must be developed based on the individual needs, goals, desires and strengths of each client.

The planning process can be limited by the information that is gathered in the assessment or by actual planning forms. All planning forms should be reviewed on at least an annual basis to ensure that the information being gathered, or the manner in which it is recorded, continues to support the individualized treatment and recovery planning process.

SCOPE

This policy impacts the coordinating agency (CA) and its provider network of substance use disorder services.

BACKGROUND

Expectations for individualized treatment planning had been advisory requirements in the contract with the CAs from 2004 through 2006. This policy formalizes those expectations and introduces the need for recovery planning as an essential part of this process.

REQUIREMENTS

The Administrative Rules for Substance Abuse Programs in Michigan promulgated under PA 368 of 1978, as amended, state, "A recipient shall participate in the development of his or her treatment plan." [Recipient Rights Rules, Section 305(1)].

All CA providers must also be accredited by one of the approved national accreditation bodies. Accreditation standards also require evidence of client participation in the treatment planning process. Evidence of client participation includes goals and objectives in the client's own words, goals and objectives based on needs the client identified in the assessment, and evidence the client was in attendance when the plan was developed.

PROCEDURE

Treatment and recovery planning begins at the time the client enters treatment – either directly or based on a referral from an access system – and ends when the client completes or leaves formal treatment services. 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 client's needs change, the plan must be revised to meet the new needs of the client.

Recovery planning is undertaken as a component of the treatment plan and should progress as the client moves through the treatment process. It is important that the recovery plan be a viable and workable plan for the client and, upon the end of formal treatment services, he/she is able to continue along his/her recovery path with guidance from his/her plan. It is not acceptable that the recovery plan be developed the day before a client's planned completion of treatment services.

The treatment and recovery plans are not limited to just the client and the counselor. The client may request any family members, friends or significant others be involved in the process. Once each plan is developed, the client, counselor, and other involved individuals, such as significant others, family and mental health providers, must sign the form indicating understanding of the plan and the expectations.

Establishing Goals and Objectives

The initial step in developing an individualized treatment and recovery plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the client. From this assessment, the needs and strengths of the client are identified and it is this information that assists the counselor and client in establishing the goals and objectives that will be focused on in treatment. The identified strengths can be used to help meet treatment goals based on the client's individual needs. Examples of strengths might be a healthy support network, stable employment, stable housing, a willingness to participate in counseling, etc. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the client can provide motivation to participate in treatment, assist in identifying the most appropriate modality of treatment (individual, group, etc.), and may take the focus off any negative situations that surround the client getting involved in treatment, i.e., legal problems, work problems, relationship problems, etc.

Writing the Plan

Once the goals and objectives are jointly decided on, they are recorded in the planning document utilized by the provider. Goals must be stated in the client's words or based on the client'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, then the objectives – the activities the client needs to perform to achieve the goal – are recorded. The objectives must be developed with the client but do not have to be recorded in the client's exact words. 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 completion dates must be realistic to the client or the chances of compliance with treatment are greatly reduced.

Establishing Treatment Interventions

The next component of the plan is to determine the intervention(s) that will be used to assist the client in being able to accomplish the objectives. In other words – what action will the client take to achieve a goal, and what action will the counselor take to assist the client in achieving the goal. This should be specific, not just generalized statements of individual or group therapy. Again, these actions must be mutually agreed upon to provide the best chance of success for the client.

Framework for Treatment

The individualized treatment and recovery plan provides the framework by which services should be provided. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the plan. When progress notes are written, they reflect what goal(s)/objective(s) were addressed during a treatment session. The progress notes recorded by the clinician, should document progress or lack of progress and any adjustments/changes to the treatment and recovery plan. Once a change is decided on, it should then be added to the plan in the format described above and initialed by the client or with documentation of client approval.

Treatment and Recovery Plan Progress Reviews

Plans must be reviewed and documentation of such must be placed in the client record. The frequency of the reviews can be based on the time frame in treatment (60, 90, 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (8, 10, 12 episodes). The reviews must include input from all clinicians/treatment/recovery providers involved in the care of the client, as well as any other individuals the client has involved in his/her plan. This review should reflect on the progress the client 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 due to new needs of the client. As with the initial plan, the client, clinician, and other relevant

individuals should sign this review. If individual signatures are unable to be obtained, documentation explaining why must be provided.

The plan and plan reviews not only serve as tools to provide care to the client, they help in the administrative function of service authorization. Decisions concerning, but not limited to, length of stay, transfer, discharge, continuing care, and authorizations by CAs must be based on individualized determinations of need and on progress toward treatment and recovery goals and objectives. Such decisions must not be based on arbitrary criteria, such as pre-determined time or payment limits.

Policy Monitoring and Review

The CA will monitor compliance with individualized treatment and recovery planning and these reviews will be made available to the Bureau of Substance Abuse and Addiction Services (BSAAS) during site visits. BSAAS will also review for individualized treatment and recovery planning during provider site visits. Reviews of plans will occur in the following manner:

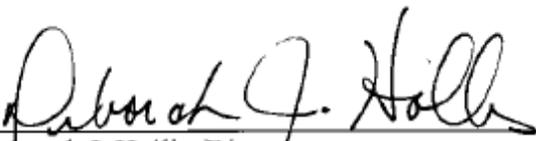
- A review of the biopsychosocial assessment to determine where and how the needs and strengths were identified.
- A review of the plan to check for:
 1. Matching goals to needs – Needs from the assessment are reflected in the goals on the plan.
 2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients.
 3. Measurable objectives – The ability to determine if and when an objective will be completed.
 4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan.
 5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
 6. Signatures – client, counselor, and involved individuals, or documentation as to why no signature.
 7. Recovery planning activities are taking place during the treatment episode.
- A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.

- An audit of the treatment and recovery plan progress review to check for:
 1. Progress note information matching what is in review.
 2. Rationale for continuation/discontinuation of goals/objectives.
 3. New goals and objectives developed with client input.
 4. Client participation/feedback present in the review.
 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

REFERENCES

- Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., and Griffith, J.H. (Eds.) (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R)*. Chevy Chase, MD: American Society of Addiction Medicine, Inc.
- Miller, S.D., and Duncan, B.L. (2000). *Paradigm Lost: From Model-Driven to Client-Directed, Outcome-Informed Clinical Work*. Institute for the Study of Therapeutic Change, Chicago, Illinois.
- Miller, S., Mee-Lee, D., Plum, B., and Hubble, M. (2005). *Making Treatment Count: Client-Directed, Outcome Informed Clinical Work with Problem Drinkers*. John Wiley & Sons, Inc. Hoboken, N. J.
- National Institute on Drug Abuse (2000). *Principles of Drug Addiction Treatment*. Washington, D.C.: NIDA.

APPROVED BY:



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