SENATE BILL NO. 120

INTRODUCED BY FRANKLIN
BY REQUEST OF THE DEPARTMENT OF CORRECTIONS
AND HUMAN SERVICES

IN THE SENATE

JANUARY 11, 1993	INTRODUCED AND REFERRED TO COMMITTEE ON PUBLIC HEALTH, WELFARE, & SAFETY.
	FIRST READING.
FEBRUARY 16, 1993	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 17, 1993	PRINTING REPORT.
FEBRUARY 18, 1993	SECOND READING, DO PASS.
FEBRUARY 19, 1993	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 50; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

FEBRUARY 23, 1993	INTRODUCED AND REFERRED TO COMMITTEE ON HUMAN SERVICES & AGING.
	FIRST READING.
MARCH 9, 1993	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
MARCH 11, 1993	ON MOTION, CONSIDERATION PASSED FOR THE DAY.
MARCH 12, 1993	ON MOTION, CONSIDERATION PASSED FOR THE DAY.
MARCH 13, 1993	SECOND READING, CONCURRED IN.
MARCH 16, 1993	THIRD READING, CONCURRED IN. AYES, 98; NOES, 2.
MARCH 17, 1993	RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

MARCH 19, 1993	RECEIVED FROM HOUSE.
	ON MOTION, CONSIDERATION PASSED TILL 64TH LEGISLATIVE DAY.
MARCH 22, 1993	SECOND READING, AMENDMENTS CONCURRED IN.
MARCH 23, 1993	THIRD READING, AMENDMENTS CONCURRED IN.
	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.

Senate BILL NO. 120

INTRODUCED BY Franklin

BY REQUEST OF THE DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO TREATMENT AND DISCHARGE OF PATIENTS ADMITTED TO A MENTAL HEALTH FACILITY; REVISING THE REQUIREMENTS GOVERNING THE ESTABLISHMENT AND PERIODIC REVIEW OF PATIENT TREATMENT PLANS, THE KEEPING OF PATIENT RECORDS, AND THE DEVELOPMENT OF INDIVIDUALIZED DISCHARGE PLANS; AMENDING SECTIONS 53-21-162 AND 53-21-165, MCA; AND REPEALING SECTION 53-21-163, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 53-21-162, MCA, is amended to read:

"**53-21-162. Establishment of patient treatment plan -- patient's rights.** (1) Each patient admitted as an inpatient to a mental health facility ~~shall~~ must have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the mental health facility.

(2) Each patient ~~shall~~ must have an individualized treatment plan. This plan ~~shall~~ must be developed by appropriate professional persons, including a psychiatrist, and ~~shall~~ must be implemented no later than 10 days after the patient's admission. Each individualized treatment plan ~~shall~~ must contain:

(a) a statement of the nature of the specific problems and specific needs of the patient;

(b) a statement of the least restrictive treatment conditions necessary to achieve the purposes of ~~commitment~~ hospitalization;

(c) a description of ~~intermediate---and---long-range~~ treatment goals, with a projected timetable for their attainment;

(d) a statement and rationale for the plan of treatment for achieving these ~~intermediate-and-long-range~~ goals;

(e) a specification of staff responsibility ~~and--a description--of--proposed-staff-involvement-with-the-patient in-order-to-attain-these-treatment-goals;~~ for attaining each treatment goal; and

~~(f)--criteria-for-release-to-less-restrictive--treatment conditions-and-criteria-for-discharge;-and~~

~~(g)~~(f) a notation of any therapeutic tasks and labor to be performed by the patient.

~~(3)--As--part--of-his-treatment-plan,-each-patient-shall have-an-individualized-aftercare-plan.-This--plan--shall--be developed--by--a--professional-person-as-soon-as-practicable after-the-patient's-admission-to-the-facility.~~

SB 120 INTRODUCED BILL

~~(4)--In-the-interests-of-continuity--of--care,--whenever possible--one--professional--person--(who-need-not-have-been involved-with-the-development-of-the-treatment--plan)--shall be--responsible--for--supervising--the-implementation-of-the treatment-plan,--integrating--the--various--aspects--of--the treatment--program,--and--recording--the-patient's-progress. This-professional--person--shall--also--be--responsible--for ensuring--that--the--patient-is-released,-where-appropriate, into-a-less-restrictive-form-of-treatment.~~

~~(5)--The-treatment-plan-shall-be--continuously--reviewed by--the--professional-person-responsible-for-supervising-the implementation--of--the--plan--and--shall--be--modified---if necessary.--Moreover,--at--least--every-90-days-each-patient shall-receive-a-mental-examination-from--and--his--treatment plan--shall--be-reviewed-by-a-professional-person-other-than the-professional--person--responsible--for--supervising--the implementation-of-the-plan.~~

(3) Overall development, implementation, and supervision of the treatment plan must be assigned to an appropriate professional person.

(4) The inpatient mental health facility shall periodically reevaluate the patient and revise the individualized treatment plan based on changes in the patient's condition. At a minimum, the treatment plan must be reviewed:

(a) at the time of any transfer within the facility;

(b) at the time of discharge;

(c) upon any major change in the patient's condition;

(d) at the conclusion of the initial estimated length of stay and subsequent estimated lengths of stay; and

(e) no less than every 90 days.

~~(6)~~(5) A patient has the right:

(a) to ongoing participation, in a manner appropriate to the patient's capabilities, in the planning of mental health services to be provided and in the revision of the plan;

(b) to a reasonable explanation of the following, in terms and language appropriate to the patient's condition and ability to understand:

(i) the patient's general mental condition and, if given a physical examination, the patient's physical condition;

(ii) the objectives of treatment;

(iii) the nature and significant possible adverse effects of recommended treatments;

(iv) the reasons why a particular treatment is considered appropriate;

(v) the reasons why access to certain visitors may not be appropriate; and

(vi) any appropriate and available alternative

treatments, services, or providers of mental health services; and

(c) not to receive treatment established pursuant to the treatment plan in the absence of the patient's informed, voluntary, and written consent to the treatment, except treatment:

(i) during an emergency situation if the treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or

(ii) permitted under the applicable law in the case of a person committed to a facility by a court.

~~(7)~~(6) In the case of a patient who lacks the capacity to exercise the right to consent to treatment described in subsection ~~(6)(c)~~ (5)(c), the right must be exercised on behalf of the patient by a guardian appointed pursuant to the provisions of Title 72, chapter 5.

~~(8)~~(7) The department shall develop procedures for initiating limited guardianship proceedings in the case of a patient who appears to lack the capacity to exercise the right to consent described in subsection ~~(6)(c)~~ (5)(c)."

Section 2. Section 53-21-165, MCA, is amended to read:

"**53-21-165. Records to be maintained.** Complete patient records ~~shall~~ must be kept by the mental health facility for the length of time required by rules established by the department of health and environmental sciences. All records

kept by the mental health facility ~~shall~~ must be available to any person authorized by the patient in writing to receive these records and upon approval of the authorization by the board. The records ~~shall~~ must also be made available to any attorney charged with representing the patient or any professional person charged with evaluating or treating the patient. These records ~~shall~~ must include:

(1) identification data, including the patient's legal status;

(2) a patient history, including but not limited to:

(a) family data, educational background, and employment record;

(b) prior medical history, both physical and mental, including prior hospitalization;

(3) the chief complaints of the patient and the chief complaints of others regarding the patient;

(4) an evaluation ~~which~~ that notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive rather than interpretative fashion;

(5) a summary of each physical examination ~~which~~ that describes the results of the examination;

(6) a copy of the individual treatment plan and any modifications ~~thereto~~ to the plan;

(7) a detailed summary of the findings made by the reviewing professional person after each periodic review of the treatment plan ~~which~~, required under 53-21-162(4), that analyzes the successes and failures of the treatment program and ~~directs whatever modifications are necessary~~ includes recommendations for appropriate modification of the treatment plan;

(8) a copy of the individualized ~~aftercare~~ discharge plan and any modifications ~~thereto~~ to the plan and a summary of the steps that have been taken to implement that plan;

(9) a medication history and status ~~which~~ that includes the signed orders of the prescribing physician. The staff person administering the medication shall indicate by signature that orders have been carried out.

~~(10) a detailed summary of each significant contact by a professional person with the patient;~~

~~(11) a detailed summary, on at least a weekly basis, by a professional person involved in the patient's treatment, of the patient's progress along the treatment plan;~~

~~(12) a weekly summary of the extent and nature of the patient's work activities and the effect of such activity upon the patient's progress along the treatment plan;~~

(10) documentation of the implementation of the treatment plan;

(11) documentation of all treatment provided to the

patient;

(12) chronological documentation of the patient's clinical course;

(13) descriptions of any changes in the patient's condition;

~~(13)~~(14) a signed order by a professional person for any restrictions on visitations and communications;

~~(14)~~(15) a signed order by a professional person for any physical restraints and isolation; and

~~(15)~~(16) a detailed summary of any extraordinary incident in the facility involving the patient, to be entered by a staff member noting that ~~he~~ the staff member has personal knowledge of the incident or specifying ~~his~~ any other source of information ~~and initialed~~. The summary of the incident must be initialed within 24 hours by a professional person~~, and~~

~~(16) a summary by the professional person in charge of the facility or his appointed agent of his findings after the 30 day review provided for in 53 21 163.~~"

NEW SECTION. **Section 3.** **Discharge plan.** Each patient admitted as an inpatient to a mental health facility must have an individualized discharge plan developed within 10 days after admission. The discharge plan must be updated as necessary. Each individualized discharge plan must contain:

(1) an anticipated discharge date;

(2) identification of the facility staff member responsible for discharge planning;

(3) identification of the community-based agency or individual that is assisting in arranging postdischarge services; and

(4) other information necessary to ensure an appropriate discharge and adequate postdischarge services.

NEW SECTION. **Section 4.** Repealer. Section 53-21-163, MCA, is repealed.

NEW SECTION. **Section 5.** Codification instruction. [Section 3] is intended to be codified as an integral part of Title 53, chapter 21, part 1, and the provisions of Title 53, chapter 21, part 1, apply to [section 3].

-End-

APPROVED BY COMMITTEE
ON PUBLIC HEALTH, WELFARE
& SAFETY

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BY REQUEST OF THE DEPARTMENT OF CORRECTIONS

AND HUMAN SERVICES

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(a) a statement of the nature of the specific problems and specific needs of the patient;

(b) a statement of the least restrictive treatment conditions necessary to achieve the purposes of ~~commitment~~ hospitalization;

(c) a description of ~~intermediate and long-range~~ treatment goals, with a projected timetable for their attainment;

(d) a statement and rationale for the plan of treatment for achieving these ~~intermediate-and-long-range~~ goals;

(e) a specification of staff responsibility ~~and a description of proposed staff involvement with the patient in order to attain these treatment goals;~~ for attaining each treatment goal; and

~~(f) criteria for release to less restrictive treatment conditions and criteria for discharge; and~~

~~(g)~~(f) CRITERIA FOR RELEASE TO LESS RESTRICTIVE TREATMENT CONDITIONS; AND

(G) a notation of any therapeutic tasks and labor to be performed by the patient.

~~(3) As part of his treatment plan, each patient shall have an individualized aftercare plan. This plan shall be~~

~~developed by a professional person as soon as practicable after the patient's admission to the facility.~~

~~(4) In the interests of continuity of care, whenever possible one professional person (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program, and recording the patient's progress. This professional person shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.~~

~~(5) The treatment plan shall be continuously reviewed by the professional person responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every 90 days each patient shall receive a mental examination from and his treatment plan shall be reviewed by a professional person other than the professional person responsible for supervising the implementation of the plan.~~

(3) Overall development, implementation, and supervision of the treatment plan must be assigned to an appropriate professional person.

(4) The inpatient mental health facility shall periodically reevaluate the patient and revise the individualized treatment plan based on changes in the

patient's condition. At a minimum, the treatment plan must be reviewed:

(a) at the time of any transfer within the facility;

(b) at the time of discharge;

(c) upon any major change in the patient's condition;

(d) at the conclusion of the initial estimated length of stay and subsequent estimated lengths of stay; and

(e) no less than every 90 days; AND

(F) BY A TREATMENT TEAM THAT INCLUDES AT LEAST ONE PROFESSIONAL PERSON WHO IS NOT PRIMARILY RESPONSIBLE FOR THE PATIENT'S TREATMENT PLAN.

~~(6)~~(5) A patient has the right:

(a) to ongoing participation, in a manner appropriate to the patient's capabilities, in the planning of mental health services to be provided and in the revision of the plan;

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(ii) the objectives of treatment;

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(iv) the reasons why a particular treatment is considered appropriate;

(v) the reasons why access to certain visitors may not be appropriate; and

(vi) any appropriate and available alternative treatments, services, or providers of mental health services; and

(c) not to receive treatment established pursuant to the treatment plan in the absence of the patient's informed, voluntary, and written consent to the treatment, except treatment:

(i) during an emergency situation if the treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or

(ii) permitted under the applicable law in the case of a person committed to a facility by a court.

~~(7)~~(6) In the case of a patient who lacks the capacity to exercise the right to consent to treatment described in subsection ~~(6)(c)~~ (5)(c), the right must be exercised on behalf of the patient by a guardian appointed pursuant to the provisions of Title 72, chapter 5.

~~(8)~~(7) The department shall develop procedures for initiating limited guardianship proceedings in the case of a patient who appears to lack the capacity to exercise the right to consent described in subsection ~~(6)(c)~~ (5)(c)."

Section 2. Section 53-21-165, MCA, is amended to read:

"**53-21-165. Records to be maintained.** Complete patient records ~~shall~~ must be kept by the mental health facility for the length of time required by rules established by the department of health and environmental sciences. All records kept by the mental health facility ~~shall~~ must be available to any person authorized by the patient in writing to receive these records and upon approval of the authorization by the board. The records ~~shall~~ must also be made available to any attorney charged with representing the patient or any professional person charged with evaluating or treating the patient. These records ~~shall~~ must include:

(1) identification data, including the patient's legal status;

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assets in descriptive rather than interpretative fashion;

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(6) a copy of the individual treatment plan and any modifications ~~thereto~~ to the plan;

(7) a detailed summary of the findings made by the reviewing professional person after each periodic review of the treatment plan ~~which~~, required under 53-21-162(4), that analyzes the successes and failures of the treatment program and ~~directs-whatever-modifications--are--necessary~~ includes recommendations for appropriate modification of the treatment plan;

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~~(10) a detailed summary of each significant contact by a professional person with the patient;~~

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(10) A SUMMARY OF EACH SIGNIFICANT CONTACT BY A PROFESSIONAL PERSON WITH THE PATIENT;

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(18) A SUMMARY BY THE PROFESSIONAL PERSON IN CHARGE OF THE FACILITY OR BY AN APPOINTED AGENT OF THE FINDINGS AFTER THE 30-DAY REVIEW PROVIDED FOR IN 53-21-163."

NEW SECTION. **Section 3.** **Discharge plan.** Each patient admitted as an inpatient to a mental health facility must have an individualized discharge plan developed within 10 days after admission. The discharge plan must be updated as necessary. Each individualized discharge plan must contain:

(1) an anticipated discharge date;

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~~(2)~~(3) identification of the facility staff member responsible for discharge planning;

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NEW SECTION. **Section 4.** **Codification instruction.** [Section 3] is intended to be codified as an integral part of Title 53, chapter 21, part 1, and the provisions of Title 53, chapter 21, part 1, apply to [section 3].

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~~(3)~~(4) identification of the community-based agency or individual that is assisting in arranging postdischarge services; and

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~~NEW SECTION. Section 4. Repealer. Section 53-21-163 MCA is repealed.~~

NEW SECTION. **Section 4.** Codification instruction. [Section 3] is intended to be codified as an integral part of Title 53, chapter 21, part 1, and the provisions of Title 53, chapter 21, part 1, apply to [section 3].

-End-

HOUSE STANDING COMMITTEE REPORT

March 12, 1993

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Bill 120 (third reading copy -- blue) be concurred in as amended .

Signed: Wm E Boharski
Bill Boharski, Chair

And, that such amendments read: Carried by: Rep. Smith

1. Page 4, line 9.
Following: "(F)"
Insert: "at each of the times specified in subsections (4)(a) through (4)(e),"

2. Page 9, line 3.
Strike: "FINDINGS"
Insert: "determination made"

-END-

HOUSE

SB 120 3/12/93 4:33

561610SC.Hpf

Committee Vote:
Yes ___, No ___.

SENATE BILL NO. 120

INTRODUCED BY FRANKLIN

BY REQUEST OF THE DEPARTMENT OF CORRECTIONS

AND HUMAN SERVICES

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO TREATMENT AND DISCHARGE OF PATIENTS ADMITTED TO A MENTAL HEALTH FACILITY; REVISING THE REQUIREMENTS GOVERNING THE ESTABLISHMENT AND PERIODIC REVIEW OF PATIENT TREATMENT PLANS, THE KEEPING OF PATIENT RECORDS, AND THE DEVELOPMENT OF INDIVIDUALIZED DISCHARGE PLANS; AND AMENDING SECTIONS 53-21-162 AND 53-21-165, MCA~~;--AND--REPEALING--SECTION 53-21-163, MCA~~."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 53-21-162, MCA, is amended to read:

"**53-21-162. Establishment of patient treatment plan -- patient's rights.** (1) Each patient admitted as an inpatient to a mental health facility ~~shall~~ must have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the mental health facility.

(2) Each patient ~~shall~~ must have an individualized treatment plan. This plan ~~shall~~ must be developed by appropriate professional persons, including a psychiatrist, and ~~shall~~ must be implemented no later than 10 days after the patient's admission. Each individualized treatment plan ~~shall~~ must contain:

(a) a statement of the nature of the specific problems and specific needs of the patient;

(b) a statement of the least restrictive treatment conditions necessary to achieve the purposes of ~~commitment~~ hospitalization;

(c) a description of ~~intermediate---and---long-range~~ treatment goals, with a projected timetable for their attainment;

(d) a statement and rationale for the plan of treatment for achieving these ~~intermediate-and-long-range~~ goals;

(e) a specification of staff responsibility ~~and--a description--of--proposed-staff-involvement-with-the-patient in-order-to-attain-these-treatment-goals;~~ for attaining each treatment goal; and

~~(f)--criteria-for-release-to-less-restrictive--treatment conditions-and-criteria-for-discharge;-and~~

~~(g)~~(f) CRITERIA FOR RELEASE TO LESS RESTRICTIVE TREATMENT CONDITIONS; AND

(G) a notation of any therapeutic tasks and labor to be performed by the patient.

~~(3)--As-part-of-his-treatment-plan,-each--patient--shall have--an--individualized--aftercare-plan.-This-plan-shall-be~~

~~developed by a professional person as soon as practicable after the patient's admission to the facility.~~

~~(4) In the interests of continuity of care, whenever possible one professional person (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program, and recording the patient's progress. This professional person shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.~~

~~(5) The treatment plan shall be continuously reviewed by the professional person responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every 90 days each patient shall receive a mental examination from and his treatment plan shall be reviewed by a professional person other than the professional person responsible for supervising the implementation of the plan.~~

(3) Overall development, implementation, and supervision of the treatment plan must be assigned to an appropriate professional person.

(4) The inpatient mental health facility shall periodically reevaluate the patient and revise the individualized treatment plan based on changes in the

patient's condition. At a minimum, the treatment plan must be reviewed:

(a) at the time of any transfer within the facility;

(b) at the time of discharge;

(c) upon any major change in the patient's condition;

(d) at the conclusion of the initial estimated length of stay and subsequent estimated lengths of stay; and

(e) no less than every 90 days; AND

(F) AT EACH OF THE TIMES SPECIFIED IN SUBSECTIONS (4)(A) THROUGH (4)(E), BY A TREATMENT TEAM THAT INCLUDES AT LEAST ONE PROFESSIONAL PERSON WHO IS NOT PRIMARILY RESPONSIBLE FOR THE PATIENT'S TREATMENT PLAN.

~~(6)~~(5) A patient has the right:

(a) to ongoing participation, in a manner appropriate to the patient's capabilities, in the planning of mental health services to be provided and in the revision of the plan;

(b) to a reasonable explanation of the following, in terms and language appropriate to the patient's condition and ability to understand:

(i) the patient's general mental condition and, if given a physical examination, the patient's physical condition;

(ii) the objectives of treatment;

(iii) the nature and significant possible adverse

effects of recommended treatments;

(iv) the reasons why a particular treatment is considered appropriate;

(v) the reasons why access to certain visitors may not be appropriate; and

(vi) any appropriate and available alternative treatments, services, or providers of mental health services; and

(c) not to receive treatment established pursuant to the treatment plan in the absence of the patient's informed, voluntary, and written consent to the treatment, except treatment:

(i) during an emergency situation if the treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or

(ii) permitted under the applicable law in the case of a person committed to a facility by a court.

~~(7)~~ (6) In the case of a patient who lacks the capacity to exercise the right to consent to treatment described in subsection ~~(6)(c)~~ (5)(c), the right must be exercised on behalf of the patient by a guardian appointed pursuant to the provisions of Title 72, chapter 5.

~~(8)~~ (7) The department shall develop procedures for initiating limited guardianship proceedings in the case of a patient who appears to lack the capacity to exercise the

right to consent described in subsection ~~(6)(c)~~ (5)(c)."

Section 2. Section 53-21-165, MCA, is amended to read:

"**53-21-165. Records to be maintained.** Complete patient records ~~shall~~ must be kept by the mental health facility for the length of time required by rules established by the department of health and environmental sciences. All records kept by the mental health facility ~~shall~~ must be available to any person authorized by the patient in writing to receive these records and upon approval of the authorization by the board. The records ~~shall~~ must also be made available to any attorney charged with representing the patient or any professional person charged with evaluating or treating the patient. These records ~~shall~~ must include:

(1) identification data, including the patient's legal status;

(2) a patient history, including but not limited to:

(a) family data, educational background, and employment record;

(b) prior medical history, both physical and mental, including prior hospitalization;

(3) the chief complaints of the patient and the chief complaints of others regarding the patient;

(4) an evaluation ~~which~~ that notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory

functioning, orientation, and an inventory of the patient's assets in descriptive rather than interpretative fashion;

(5) a summary of each physical examination ~~which~~ that describes the results of the examination;

(6) a copy of the individual treatment plan and any modifications ~~thereto~~ to the plan;

(7) a detailed summary of the findings made by the reviewing professional person after each periodic review of the treatment plan ~~which~~, required under 53-21-162(4), that analyzes the successes and failures of the treatment program and ~~directs whatever modifications are necessary~~ includes recommendations for appropriate modification of the treatment plan;

(8) a copy of the individualized ~~aftercare~~ discharge plan and any modifications ~~thereto~~ to the plan and a summary of the steps that have been taken to implement that plan;

(9) a medication history and status ~~which~~ that includes the signed orders of the prescribing physician. The staff person administering the medication shall indicate by signature that orders have been carried out.

~~(10) a detailed summary of each significant contact by a professional person with the patient;~~

~~(11) a detailed summary, on at least a weekly basis, by a professional person involved in the patient's treatment, of the patient's progress along the treatment plan;~~

~~(12) a weekly summary of the extent and nature of the patient's work activities and the effect of such activity upon the patient's progress along the treatment plan;~~

(10) A SUMMARY OF EACH SIGNIFICANT CONTACT BY A PROFESSIONAL PERSON WITH THE PATIENT;

~~(10)~~(11) documentation of the implementation of the treatment plan;

~~(11)~~(12) documentation of all treatment provided to the patient;

~~(12)~~(13) chronological documentation of the patient's clinical course;

~~(13)~~(14) descriptions of any changes in the patient's condition;

~~(13)~~~~(14)~~(15) a signed order by a professional person for any restrictions on visitations and communications;

~~(14)~~~~(15)~~(16) a signed order by a professional person for any physical restraints and isolation; and

~~(15)~~~~(16)~~(17) a detailed summary of any extraordinary incident in the facility involving the patient, to be entered by a staff member noting that ~~he~~ the staff member has personal knowledge of the incident or specifying ~~his~~ any other source of information ~~and initialed~~. The summary of the incident must be initialed within 24 hours by a professional person~~;~~ ~~and~~.

~~(16) a summary by the professional person in charge of~~

~~the facility or his appointed agent of his findings after the 30-day review provided for in 53-21-163~~

(18) A SUMMARY BY THE PROFESSIONAL PERSON IN CHARGE OF THE FACILITY OR BY AN APPOINTED AGENT OF THE ~~FINDINGS~~ DETERMINATION MADE AFTER THE 30-DAY REVIEW PROVIDED FOR IN 53-21-163."

NEW SECTION. **Section 3.** Discharge plan. Each patient admitted as an inpatient to a mental health facility must have an individualized discharge plan developed within 10 days after admission. The discharge plan must be updated as necessary. Each individualized discharge plan must contain:

(1) an anticipated discharge date;

(2) CRITERIA FOR DISCHARGE;

~~(2)~~(3) identification of the facility staff member responsible for discharge planning;

~~(3)~~(4) identification of the community-based agency or individual that is assisting in arranging postdischarge services; and

~~(4)~~(5) other information necessary to ensure an appropriate discharge and adequate postdischarge services.

~~NEW SECTION. Section 4. Repealer. Section 53-21-163, MCA, is repealed.~~

NEW SECTION. **Section 4.** Codification instruction. [Section 3] is intended to be codified as an integral part of Title 53, chapter 21, part 1, and the provisions of Title

53, chapter 21, part 1, apply to [section 3].

-End-