



Senate

General Assembly

February Session, 2002

File No. 22

Senate Bill No. 86

Senate, March 8, 2002

The Committee on Public Health reported through SEN. HARP of the 10th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT AMENDING STATUTES GOVERNING THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (f) of section 17a-671 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective*
3 *October 1, 2002*):

4 (f) Each council may solicit and accept for use local, public and
5 private funds from municipalities, foundations and corporations. Such
6 funds shall be expended to close gaps in the service delivery system
7 identified in the annual plan developed by the council, provided such
8 plan is not in conflict with the department's plan adopted pursuant to
9 [section 19a-7] subsection (j) of section 17a-451.

10 Sec. 2. Subsection (o) of section 17a-451 of the general statutes is
11 repealed and the following is substituted in lieu thereof (*Effective*
12 *October 1, 2002*):

13 (o) The commissioner shall establish uniform policies and
14 procedures for collecting, standardizing, managing and evaluating
15 data related to substance use, abuse and addiction programs
16 administered by state agencies, state-funded community-based
17 programs and the judicial branch, including, but not limited to: (1) The
18 use of prevention, education, treatment and criminal justice services
19 related to substance use, abuse and addiction; (2) client demographic
20 and substance use, abuse and addiction information; and (3) the
21 quality and cost effectiveness of substance use, abuse and addiction
22 services. The commissioner shall, in consultation with the Secretary of
23 the Office of Policy and Management, ensure that the judicial branch,
24 all state agencies and state-funded community-based programs with
25 substance use, abuse and addiction programs or services comply with
26 such policies and procedures. Notwithstanding any other provision of
27 the general statutes concerning confidentiality, the commissioner,
28 within available appropriations, shall establish and maintain a central
29 repository for such substance use, abuse and addiction program and
30 service data from the judicial branch, state agencies and state-funded
31 community-based programs administering substance use, abuse and
32 addiction programs and services. The central repository shall not
33 disclose any data that reveals the personal identification of any
34 individual. The Connecticut Alcohol and Drug Policy Council
35 established pursuant to section 17a-667 shall have access to the central
36 repository for aggregate analysis. The commissioner shall submit [an
37 annual] a biennial report to the General Assembly, in accordance with
38 the provisions of section 11-4a, the Office of Policy and Management
39 and the Connecticut Alcohol and Drug Policy Council. The report shall
40 include, but need not be limited to, a summary of: (A) Client and
41 patient demographic information; (B) trends and risks factors
42 associated with alcohol and drug use, abuse and dependence; (C)
43 effectiveness of services based on outcome measures; and (D) a state-
44 wide cost analysis.

45 Sec. 3. Subsection (t) of section 17a-451 of the general statutes is
46 repealed and the following is substituted in lieu thereof (*Effective*
47 *October 1, 2002*):

48 (t) The commissioner may direct clinical staff at Department of
 49 Mental Health and Addiction Services facilities or in crisis intervention
 50 programs funded by the department who are providing treatment to a
 51 patient to request disclosure, to the extent allowed under state and
 52 federal law, of the patient's record of previous treatment in order to
 53 accomplish the objectives of diagnosis, [or] treatment or referral of the
 54 patient. If the clinical staff in possession of the requested record
 55 determines that disclosure would assist the accomplishment of the
 56 objectives of diagnosis, [or] treatment or referral, the record may be
 57 disclosed, to the extent allowed under state and federal law, to the
 58 requesting clinical staff without patient consent. Records disclosed
 59 shall be limited to records maintained at department facilities or crisis
 60 intervention programs funded by the department. The Commissioner
 61 of Mental Health and Addiction Services shall adopt regulations in
 62 accordance with chapter 54 to administer the provisions of this
 63 subsection and to ensure maximum safeguards of patient
 64 confidentiality.

This act shall take effect as follows:	
Section 1	<i>October 1, 2002</i>
Sec. 2	<i>October 1, 2002</i>
Sec. 3	<i>October 1, 2002</i>

PH *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Fund-Type	Agency Affected	Current FY \$	FY 03 \$	FY 04 \$
GF - Savings	Various	None	Minimal	Minimal

Municipal Impact: None

Explanation

This bill makes several changes to statutes concerning the Department of Mental Health and Addiction Services (DMHAS). Changes in the bill concerning patient record disclosure and plan conformity do not result in any fiscal impact. The bill also allows DMHAS to submit the alcohol and drug abuse report to the legislature biennially rather than annually. This change may result in savings to DMHAS, the judicial branch and other state agencies related to the compilation of data and the submission of the report. Any such savings will be minimal.

OLR Bill Analysis

SB 86

AN ACT AMENDING STATUTES GOVERNING THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES**SUMMARY:**

This bill (1) allows clinical staff in Department of Mental Health and Addiction Services (DMHAS) facilities and in other DMHAS-funded programs to release a patient's records without his consent to other such staff who ask for them in order to make a referral, (2) makes DMHAS report every two years rather than annually on drug and alcohol abuse, and (3) changes the state plan to which subregional mental health council annual plans must conform.

EFFECTIVE DATE: October 1, 2002

PATIENT RECORD DISCLOSURE

The bill allows clinical staff in DMHAS facilities and in DHMAS-funded crisis intervention programs to disclose the records of a patient they have treated to other such staff who ask for them in order to refer the patient for treatment. The law currently allows such disclosures for diagnosis and treatment purposes. Only records maintained at DMHAS facilities and DMHAS-funded crisis intervention programs can be disclosed and only to the extent allowed by federal and state law.

BIENNIAL REPORTING

The bill makes biennial rather than annual DMHAS' alcohol and drug abuse report to the legislature, the Office of Policy and Management, and the Drug and Alcohol Policy Council. The report covers: (1) client and patient demographics, (2) alcohol and drug use and abuse trends and risk factors, (3) service effectiveness, and (4) statewide costs.

PLAN CONFORMITY

The bill requires DMHAS' subregional action councils' annual plans to

conform to the State Substance Abuse Plan, not the State Health Plan as current law requires.

BACKGROUND

Federal Record Disclosure Law

Federal law governs the confidentiality of information obtained by federally assisted, specialized substance abuse treatment programs that would identify a client. Without a client's consent, information may be exchanged within the program providing services, but only to the extent necessary to provide services. In other words, information is to be exchanged even within the treatment program on a "need to know" basis. Disclosures may be made without consent to other service providers that have a "qualified service agreement" with the treating program. This is to permit the treating program to obtain collateral services, for example, blood work, that are not performed by the program itself. Disclosures to other providers not part of a qualified service agreement can only occur with consent. A client must consent to disclosure in writing. The consent must name the client, the program making the disclosure, and the intended recipient of the information; state the purpose of the disclosure and the information to be disclosed; and state the duration of the consent and conditions under which it expires (42 U.S.C. 290dd-2; 42 C.F.R. 2.1, et. seq).

COMMITTEE ACTION

Public Health Committee

Joint Favorable Report
Yea 21 Nay 0