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OF THE

STATE OF NEW JERSEY

## 2017

# REORGANIZATION PLAN

(2517)

# REORGANIZATION PLAN NO.001-2017

## A PLAN FOR THE TRANSFER OF MENTAL HEALTH AND ADDICTION FUNCTIONS FROM THE DEPARTMENT OF HUMAN SERVICES TO THE DEPARTMENT OF HEALTH

PLEASE TAKE NOTICE that on June 29, 2017, Governor Chris Christie hereby issues the following Reorganization Plan, No.001-2017 ("the Plan"), to provide for the increased efficiency, coordination and integration of the State's mental health and addiction prevention and treatment functions by the transfer of those functions, powers, and duties of the Department of Human Services ("DHS"), including the Division of Mental Health and Addiction Services ("DMHAS" or "Division"), from DHS to the Department of Health ("DOH"). Transferring the provision of mental health and addiction services to DOH is necessary to improve health care, remove bureaucratic obstacles to the integration of physical and behavioral health care, and effectively address substance use disorder as the public health crisis that it is.

## GENERAL STATEMENT OF PURPOSE

DHS is responsible for coordinating and implementing the State's mental health and addiction-related services and programs, which are largely distinct and separate from the public health programs and providers that treat physical health conditions. The Division is the unit in DHS functionally charged with such responsibility. Additionally, DMHAS is the State mental health authority and the Single State Authority on Substance Abuse. Along with DHS, the Division's mission is to plan, monitor, evaluate, and regulate New Jersey's mental health and substance abuse prevention, early intervention, treatment, and recovery providers and programs.

The Division oversees New Jersey's system of community-based behavioral health services for adults. Through contracts with and payments to private non-profit agencies and governmental entities, this system provides a full array of services, including substance abuse prevention and early intervention, emergency screening, outpatient and intensive outpatient mental health and addiction services, partial care and partial hospitalization, case management, medication assisted treatment for substance use disorder, and long- and short-term mental health and substance use disorder residential services. It also utilizes other evidence-based practices such as the Program for Assertive Community Treatment, supported employment and education, and supportive housing. In addition, DHS licenses mental health and substance use disorder treatment providers.

The Division also:

Coordinates and manages substance use disorder treatment delivery for criminal justice programs through collaboration with other State entities, including the Administrative Office of the Courts (Drug Court), Department of Corrections and State Parole Board.

Operates three regional adult psychiatric hospitals (Ancora Psychiatric Hospital, Greystone Park Psychiatric Hospital and Trenton Psychiatric Hospital) and one specialized facility providing maximum security (Ann Klein Forensic Center).

Is responsible for the treatment of civilly committed sexually violent predators at the Special Treatment Unit, in coordination with the Department of Corrections, which is responsible for the security of the facility.

Contains a specialized Disaster and Terrorism Branch responsible for activating the State's mental health disaster response plan in coordination with the New Jersey Office of Emergency Management.

DOH, the State's public health agency, recently achieved accreditation from the Public Health Accreditation Board. DOH's focus is on improving population health, which involves helping healthy New Jerseyans stay well, preventing those individuals at risk from getting sick, and keeping those individuals with chronic health conditions from becoming sicker. It accomplishes these goals through the coordinated work of its four branches – Public Health Services, Health Systems, the Office of Population Health, and the Office of Policy & Strategic Planning - as well as through the Population Health Action Team, which brings together eight departments of State government and is chaired by the Commissioner of Health.

Given DOH's overarching responsibility for the health of all New Jerseyans, its powers and resources as currently constituted are inadequate to that task, as they are limited to the facilities providing physical health care, including acute care hospitals, ambulatory care facilities such as Federally Qualified Health Centers, Nursing Homes, Home Health Agencies, and medical day care facilities, and do not include the provision of either mental health or addiction services.

## THE RATIONALE FOR RELOCATING MENTAL HEALTH AND ADDICTION SERVICES IN THE DEPARTMENT OF HEALTH

A substantial body of research demonstrates that integrating physical and behavioral health care is the most effective way to treat the "whole person"; yet for historical reasons, health care is too often fragmented into separate components: physical; mental; and substance use disorder. As has been noted elsewhere, "[a] solid clinical consensus has existed for decades that behavioral and physical health care should not be separated. The health regulatory and finance system nationally, however, has lagged behind this clinical judgment." John V. Jacobi, J.D., Tara Adams Ragone, J.D. and Kate Greenwood, J.D., *Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey,* Seton Hall Law Center for Health & Pharmaceutical Law & Policy (Mar. 31, 2016), available at https://thenicholsonfoundation.org/sites/default/files/Integration_Healthcare_Seton_Hall_report.pdf.

An April 2016 report by the federal Substance Abuse and Mental Health Services Administration found that "adults in poor physical health with behavioral health conditions had higher physical health care expenditures compared to adults in poor physical health with no behavioral health conditions. Carter Roeber, Ph.D., Chan-

dler McClellan, Ph.D. and Albert Woodward, Ph.D., M.B.A., Adults in Poor Physical Health Reporting Behavioral Health Conditions Have Higher Health Costs, Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality, The CBHSQ Report (April 26, 2016), available at https:// www.samhsa.gov/data/sites/default/files/report_2107/ShortReport-2107.pdf. In the absence of integrated health care, persons with serious mental illness often suffer from physical health conditions that go unaddressed. Mental illness and addictions often correlate with health risk behaviors such as tobacco use and physical inactivity and are risk factors for chronic illnesses such as hypertension, cardiovascular disease, and diabetes; yet behavioral health treatment providers are often unable to provide basic primary care services on-site due to licensing restrictions. The effects of mental illness and addictions, especially opioid addiction, are evident across the life span and among all ethnic, racial, and cultural groups at every socioeconomic level.

Conversely, persons suffering mild behavioral health conditions such as depression often go undiagnosed by the health care provider whom they are most likely to visit: a primary care physician or nurse. Jacobi, Ragone and Greenwood, supra. Without diagnosis and treatment, depression can progress to attempted or actual suicide. Persons with any degree of behavioral health problems would therefore benefit from greater integration of physical and behavioral health care. Incorporating the provision of mental health and addiction programs and services into DOH would help to eliminate the currently fragmented delivery system (for example, conflicting and duplicative licensing statutes) and facilitate the integration of primary, acute, mental health, and addiction care.

A substantial and growing body of literature also finds that integrating behavioral and physical health care can be cost-effective, producing net savings over the course of several years. One study found that enrolling depressed geriatric patients into a collaborative care model cost an additional $522 per patient during the first year but saved $3,363 per patient by the fourth year - a return on investment of $6.44 for every $1 invested. Jurgen Unutzer, M.D., M.P.H., Henry Harbin, M.D., Michael Schoenbaum, Ph.D., Benjamin Druss, M.D., M.P.H., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, prepared for the Centers for Medicare & Medicaid Services by the Center for Health Care Strategies and Mathematica Policy Research (May 2013), cited by Jacobi, Ragone and Greenwood, supra, and available at http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf.

Finally, behavioral health problems in general, and opioid addiction in particular, need to be treated as illnesses no different than infectious diseases such as Zika virus or chronic conditions such as hypertension - all are best addressed by preventive measures. Only through such a public health approach can we overcome the stigma that for too long has characterized efforts to treat addiction as something that must be cordoned off from the rest of health care. In January of this year, Executive Order No. 219 declared the abuse of and addiction to opioid drugs "a public health crisis in New Jersey." DOH, as the State's public health agency, can and should

play the leading role in addressing that crisis. The opioid epidemic is one example of patients being harmed by the disconnect between behavioral health and physical health; physicians continue to overprescribe opioids to patients with chronic pain without first screening for substance use disorders and without a thorough understanding of how the ongoing use of opioids can lead to an addiction.

*SOME PERTINENT DATA:*

The Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers analyzed 2013 New Jersey Medicaid data and found that among patients in the top 1% in terms of expenditures, 86.2% had a mental health and/or substance use diagnosis. *Analysis and Recommendations for Medicaid High Utilizers in New Jersey* (Jan. 2016), available at http://www.cshp.rutgers.edu/Downloads/10890.pdf. The Working Group called this "one of the most striking findings" of its analysis and recommended, among other things, locating behavioral health services in primary care settings.

Among the uninsured, an estimated 50% of adults who reported behavioral health care treatment also reported being in poor physical health, more than double the rate (22%) for those not in behavioral health treatment. Roeber, McClellan and Woodward, supra.

A meta-analysis of 40 studies of suicide victims found that during the month before their suicide, on average, 45% had had contact with a primary care provider while only one in five had received mental health services. Jason B. Luoma, M.A., Catherine E. Martin, M.A., Jane L. Pearson, Ph.D, *Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence*, Am. J. Psychiatry 159:909 916 (June 2002), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5072576/. The authors concluded that if those trends continue, "suicide prevention efforts involving primary care may be most effective in preventing suicide among older adults and possibly women."

A random survey of primary care providers in New Jersey conducted in 2015 by the Rutgers Center for State Health Policy asked whether they agreed or disagreed with the proposition that it is easy to secure mental health services for their patients. Of the respondents, 47.2% disagreed strongly and another 28.1% disagreed somewhat.

People with severe mental illness die, on average, 25 years earlier than the general population. In general, these early deaths are due not to suicide or mental illness but rather to treatable chronic conditions such as heart and lung disease for which they often receive little or no treatment. Joseph P. McEvoy et al., *Prevalence of the Metabolic Syndrome of Patients with Schizophrenia,* Schizophrenia Research at 19-32, (Dec. 2005), cited by Jacobi, Ragone and Greenwood, supra.

As the State's public health agency, DOH is best positioned to identify risk factors for addiction and mental health problems (which include physical health diagnoses), increase awareness about prevention and treatment, remove the stigma associated with receiving behavioral health treatment, address health disparities, and

improve access to mental health and addiction services for all persons. DOH is also able to incorporate these areas into its ongoing efforts to promote physical health and wellness and to prevent chronic disease, in part by leveraging its partnerships with local health authorities, employers, faith-based organizations, and the many others involved in promoting community health.

Both DOH and DMHAS conduct epidemiological surveys within their respective areas of responsibility, which sometimes overlap. For example, DOH's Behavioral Risk Factor Surveillance System Questionnaire inquires mainly about factors affecting physical health (diet, exercise, cigarette use) but also contains questions on emotional health and alcohol consumption. DMHAS conducts its own surveys on substance use, including alcohol consumption. Combining the expertise of the two entities will lead to a stronger body of epidemiological data and inform the analysis of how behavioral health conditions affect physical health and vice-versa. In turn, this will facilitate the development of policies and interventions that improve the health of individual patients and the population at large. This is not only a smarter use of State resources, but it may also lead to reduced health care spending in the State.

As the clinical expertise regarding behavioral health will be moving from DHS to DOH, it is necessary for all aspects of behavioral health to transition to DOH. This includes the commitment of individuals to inpatient programs, the inpatient programs themselves (including at State-run psychiatric hospitals and secure facilities), and the community-based care (including supportive housing programs) that together maintain the continuum of care for a very vulnerable and at-risk population. As noted above, these patients are also more likely to have substantial physical health needs. This transition will ensure an effective and efficient administration of a full range of health treatment and will ultimately help the citizens of New Jersey receive more integrated, comprehensive health care.

Finally, moving both the responsibility for mental health and addiction services and the employees who carry out that responsibility from DHS to DOH will better balance the size and duties of both departments. With more than 11,000 State- and non-State-funded positions and myriad responsibilities, DHS is the largest department of State government. With fewer than 1,100 State- and non-State-funded positions, DOH is one of the smaller departments and one-tenth the size of DHS. Transferring responsibility for mental health and addiction-related functions to DOH will allow DHS to better focus on its remaining core functions while giving DOH both the powers and resources to focus on the vitally important tasks of integrating physical and behavioral health care, improving access to both types of care, and confronting opioid addiction as the public health crisis that it is.

NOW, THEREFORE, in accordance with the provisions of the Executive Reorganization Act of 1969, P.L. 1969, c.203, (C. 52:14C-1 et seq.), I find, with respect to the transfer and reorganization provided for in this Plan, that they are necessary to accomplish the purposes set forth in Section 2 of that Act and will do the following:

1. Promote the better execution of the laws, the more effective management of the Executive Branch and of its agencies and functions, and the expeditious administration of the public business;

2. Reduce expenditures and promote economy consistent with the efficiency operation of the Executive Branch;

3. Increase the efficiency of the operations of the Executive Branch;

4. Group, coordinate, and consolidate functions of the Executive Branch according to major purposes; and

5. Eliminate overlapping and duplication of effort.

## PROVISIONS OF THE REORGANIZATION PLAN

THEREFORE, I hereby order the following reorganization:

1. The Division of Mental Health and Addiction Services in the Department of Human Services is continued and transferred from the Department of Human Services to the Department of Health.

2. All of the functions, powers, and duties of the Commissioner of Human Services, the Department of Human Services, and the Division of Mental Health and Addiction Services, including, but not limited to, the functions, powers and duties under:

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| (a) | L.1952, c.157, s.3 | as amended | (C.12:7-46) |
| (b) | L.1986, c.39, s.9 | as amended | (C.12:7-57) |
| (c) | L.1975, c.305, | as amended | (C.26:2B-7 et seq.) |
| (d) | L.1984, c.243 | | (C.26:2B-9.1) |
| (e) | L.2001, c.48 | | (C.26:2B-9.2) |
| (f) | L.1983, c.531 | | (C.26:2B-32 et seq.) |
| (g) | L.1995, c. 318 | | (C.26:2B-36 et seq.) |
| (h) | L.1989, c.51 | | (C.26:2BB-1 et seq.) |
| (i) | L.1969, c.152 | | (C.26:2G-1 et seq.) |
| (j) | L.1970, c.334 | | (C.26:2G-21) |
| (k) | L.2015, c.293 | | (C.26:2G-25.1 et seq.) |
| (l) | L.1971, c.128 | | (C.26:2G-31 et seq.) |
| (m) | L.2015, c.9 | | (C.26:2G-38) |
| (n) | L.1996, c.29, s.4 | | (C.26:2H-18.58a) |
| (o) | R.S.39:4-50, | as amended | (C.39:4-50) |
| (p) | L.1998, c.111 | | (C.30:1-2.4) |
| (q) | L.1948, c.60; L.1952, c.64 | as amended | (C.30:1-7; C.30:4-160) |
| (r) | L.1997, c.68 | | (C.30:1-12a et seq.) |
| (s) | L.1997, c.69 | | (C.30:4-3.12 et seq.) |
| (t) | L.1997, c.70 | | (C.30:4-3.15 et seq.) |
| (u) | L.2009, c161 | | (C.30:4-3.23 et seq.) |
| (v) | L.1997, c.361 | | (C.30:4-7.7 et seq.) |
| (w) | L.1987, c.116; L. 1991, c.233 | as amended | (C.30:4-27.1 et seq.) |

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| (x) L.1998, c.71 | | (C.30:4-27.24 et seq.) |
| (y) L.1996, c.150 | | (C.30:1-7.4) |
| (z) L.1965, c.59 | as amended | (C.30:1-12; C.30:4-24 et seq) |
| (aa) L.2011, c.145 | | (C.30:4-7.10) |
| (bb) L.1978, c.95 | as amended | (C.2C:4-1 et seq.) |
| (cc) L.1973, c.101 | | (C.30:1-12.1) |
| (dd) L.1971, c.384 | | (C.30:1-13 et seq) |
| (ee) L.1947, c.83 | | (C.30:1-19) |
| (ff) L.2007, c.76 | | (C.30:1A-13) |
| (dd) L.1988, c.45 | as amended | (C.30:4-3.4 et seq.) |
| (gg) L.2009, c.220 | | (C.30:4-3.27) |
| (hh) L.1973, c.93 | | (C.30:4-16.1) |
| (ii) L.1953, c.29 | as amended | (C.30:4-60 et seq.) |
| (jj) L.1962, c.207 | as amended | (C.30:4-75.1) |
| (kk) L.1938, c.239 | as amended | (C.30:4-80.6, -80.6a) |
| (ll) L.1919, c.139 | | (C.30:4-129 et seq.) |

are continued, transferred to, and vested in the Commissioner of Health and the Department of Health. These functions, powers, and duties shall be organized and implemented within the Department of Health as determined by the Commissioner of Health. To the extent the functions, powers, and duties under these statutes are necessary or convenient for the Commissioner of Human Services to carry out the functions, powers, and duties remaining with the Commissioner of Human Services or the Department of Human Services, such functions, powers and duties are continued in the Commissioner of Human Services and the Department of Human Services. A proportionate share of personnel, support services, or funds to purchase such services utilized for support of the Division of Mental Health and Addiction Services in the Department of Human Services shall be transferred to the Department of Health. Such transfers shall be made as determined by agreement between the Commissioner of Human Services and the Commissioner of Health after considering the number and type of positions presently utilized for the support of mental health and addiction services and the appropriateness of transferring personnel, positions, funding or equipment.

3. The functions, powers, and duties of the Department of Human Services exercised through the Office of Program Integrity and Accountability that pertains to the licensure and inspection of mental health programs and providers, and addiction services programs and providers are continued and are transferred to the Department of Health. These functions, powers, and duties shall be organized and implemented within the Department of Health as determined by the Commissioner of Health. These transfers shall be made as determined by agreement between the Commissioner of Health and the Commissioner of Human Services after considering the number and type of positions presently utilized for support of mental health and addiction services and the appropriateness of transferring personnel, positions, funding, or equipment.

4. The functions, powers, duties, and personnel of Trenton Psychiatric Hospital, Ancora Psychiatric Hospital, Greystone Park Psychiatric Hospital, Ann Klein Forensic Center, and the Special Treatment Unit are continued and transferred from the Department of Human Services to the Department of Health.

5. All functions, powers, and duties of the Commissioner of Human Services and the Department of Human Services not transferred to the Commissioner of Health and the Department of Health, including, but not limited to, those functions, powers, and duties of the Division of Developmental Disabilities, including oversight of the State's developmental centers and the moderate security unit, shall remain with the Commissioner of Human Services and the Department of Human Services.

6. This Plan is not intended in any way to amend or alter the functions, powers, and duties of the Commissioner of Corrections or the Department of Corrections as they relate to the Commissioner of Corrections' or the Department of Corrections' authority and obligations under the Sexually Violent Predator Act, P.L. 1998, c. 71 (as amended) or to the Special Treatment Unit.

7. All files, books, papers, records, equipment, and other property including real property held by the Commissioner of Human Services or the Department of Human Services, including the Division of Mental Health and Addiction Services, in connection with the mental health and addiction services functions identified herein including, without limitation, funds and other resources and any such property or funds received after the effective date of this Plan, and personnel are transferred to the Department of Health, pursuant to the "State Agency Transfer Act," P.L. 1971, c.375 (C. 52:14D-1 et seq.). Funds shall be deposited in such accounts as may be required by law.

8. The Commissioners of the Department of Human Services and the Department of Health may enter into interagency agreements, as necessary and appropriate, to effectuate the provisions of this Plan.

9. Whenever, in any law, rule, regulation, order, contract, tariff, document, judicial or administrative proceeding, or agreement otherwise relating to the functions or authority of the Commissioner of Human Services or the Department of Human Services regarding mental health or addiction services as described herein, or the Division of Mental Health and Addiction Services, the same shall mean the Commissioner of Health or the Department of Health, as appropriate.

## GENERAL PROVISIONS

1. I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Executive Branch and its agencies, and it will promote economy to the fullest extent consistent with the efficient operation of the Executive Branch according to major purposes. It will group, coordinate, and consolidate functions in a more consistent and practical manner and eliminate overlapping and duplication of functions.

2. Any section or part of this Plan that conflicts with federal law or regulation shall be considered null and void unless and until addressed and corrected through an interagency agreement, federal waiver, or other means.

3. All acts and parts of acts and reorganization plans or parts of reorganization plans inconsistent with any of the provisions of this Plan are superseded to the extent of such inconsistencies.

4. If any provision of this Plan or the application thereof to any person or circumstance or the exercise of any power or authority hereunder is held invalid or contrary to law, such holding shall not affect other provisions or applications of the Plan, or affect other exercises of power or authority under such provisions not contrary to law. To this end, the provisions of the Plan are declared to be severable.

5. This Plan is intended to protect and promote the public health, safety, and welfare and shall be liberally construed to attain the objectives and effect the purposes thereof.

6. All transfers directed by this Plan shall be effected pursuant to the "State Agency Transfer Act," P.L. 1971, c.375 (C. 52:14D-1 et seq.).

7. A copy of this Reorganization Plan was filed on June 29, 2017 with the Secretary of State and the Office of Administrative Law for publication in the New Jersey Register. This Plan shall become effective at the end of a period of 60 calendar days after the date of filing, unless disapproved by each House of the Legislature by the passage of a concurrent resolution stating in substance that the Legislature does not favor this Reorganization Plan, or at a date later than the end of such 60-calendar day period after the date of filing, should the Governor establish such a later date for the effective date of the Plan, or any part thereof, by Executive Order.

PLEASE TAKE NOTICE that this Plan, if not disapproved, has the force and effect of law and will be printed and published in the annual edition of the Public Laws and in the New Jersey Register under the heading of "Reorganization Plans."

Filed June 29, 2017.
Effective August 28, 2017.