

Delaware Association of Rehabilitation Facilities

Behavioral Health Commission

My name is James Larks. I am Chair of the Government Relations Commission (GRC) of the Delaware Association of Rehabilitation Facilities (DeARF). I am testifying today on behalf of DeARF and our member agencies who serve adults with mental health, substance use, and gambling conditions under contracts with the Division of Substance Abuse and Mental Health (DSAMH).

DeARF's number one strategic goal is to advocate for community alternatives to institutionalization for all people with disabilities, including those who are living with mental health, substance use, and gambling conditions. Delaware's community-based system of service providers, contracting with the Department of Health and Social Services (DHSS), supports thousands of people living in the community.

The Business Case for Adequate Funding - In any given year, more than 100,000 Delaware citizens suffer from a mental health, substance use, or gambling condition. Research shows that these conditions have a huge financial and human impact in lost productivity, disability, institutionalization, homelessness, health care costs, and premature deaths.

A strong continuum of community-based services is an essential component of a balanced service system. According to the Center for Mental Health Service (CMHS, 2007), Delaware varies significantly from the U.S. average on several key measures of mental health service effectiveness in terms of low rates of penetration of mental health services, longer lengths of state hospital stays, low rates of funding for community-based services, and low overall increases in expenditures for mental health services.

The evidence shows that it is always more humane and usually less costly to serve people in adequately funded community settings than it is to keep them unnecessarily in a hospital. In Delaware, the average cost of even the most expensive contractual community-based service is significantly lower than the reported cost per person per year at the Delaware Psychiatric Center (DPC). Not only does it cost less to serve people in the community on an actual per person per year basis, in many cases, it is possible to leverage almost dollar for dollar from other sources, doubling the resources available to expand the system.

Funding for community-based services does not all come from Delaware's General Fund budget. These services bring in as much revenue in Medicaid and other federal and local funds as they receive in general funds. By contrast, DPC, because of federal regulations, is almost entirely funded with general fund dollars.

We are *not* suggesting that more money be added to the budget, but that funding for DPC be reduced as units there are closed in favor of community placements. As patients have moved to the community, units have been closed over the years, beginning in the late 1980s when the Springer Building, which housed four

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hospital wards, was converted to an administrative building. A unit was closed in 2002, and now another will be closed in 2008. At the same time, the budget of the DPC and the complement of staff have remained unchanged.

Both the *Report of the Delaware Psychiatric Center Investigative Committee* and the *Final Report of the Governors' Task Force on DPC* recommend that as many as 50 new community placements be added each year for the next several years. Secretary Meconi has proposed a number of initiatives to annualize community programs that were started in FY2008. It is vital that the continuation of these programs be funded for FY2009. The Secretary has also proposed that \$370,000 of the \$500,000 (earmarked by the Governor to implement the recommendations of her task force) be used for community placements. We support that proposal.

Because of flat funding over the last seven years, community-based services have actually been reduced as providers struggle to pay for cost increases without increases in revenues. Between 2001 and 2007, contractual providers received increases totaling less than 4% for inflation. During the same period, the consumer price index increased by almost 30%. Rates for services, many of them set in 2001, have not increased.

It is vitally important that community-based services are not eroded further. While we have demonstrated that larger shifts of resources could greatly expand and enhance the system of community-based services, we are also concerned about survival.

We recognize there will be difficult years such as this one when revenue is tight. As the size of DPC continues to be reduced, moving relatively small amounts out of the hospital budget into the budget for community services could be the solution. Consider the example of moving just \$1 million out of DPC's \$40 million budget. What can \$1 million buy?

- ✓ 12 licensed group home beds; OR
- ✓ 38 beds in a staffed apartment program; OR
- ✓ 77 slots in the Community Continuum of Care Program; OR
- ✓ 250 slots in an outpatient clinic with mental health and substance use treatment capability; OR
- ✓ A cost of living increase of more than 3% for DSAMH's contractors who operate the current community-based care system.

For these reasons, we support moving \$1 million from the DPC budget to the community mental health budget to support continued stability and growth of community based alternatives to institutionalization.

I thank you for your time and consideration.