

Central East Alcoholism and Drug Council

A NOT-FOR-PROFIT CORPORATION

SINCE 1972

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September 20, 2011

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Dear Honorable Members of the Human Services Commission,

On behalf of the Board of Directors, administration, employees, patients, and concerned citizens of the surrounding communities of Central East Alcoholism and Drug Council (CEAD Council), an Illinois not-for-profit corporation, we appreciate the opportunity to comment on the effects of the FY12 budget cuts to the substance abuse prevention and treatment field. We offer these comments in a spirit of cooperation with our fellow human services that have also been ravaged by the multi-year cuts; however, we limit our comments to those that pertain solely to the substance abuse field as that is our specialty and primary mission.

Central East Alcoholism and Drug Council has been providing state-of-the-art substance abuse treatment and prevention services since 1973. Our primary service area includes the rural counties of Coles, Douglas, Shelby, Cumberland, Moultrie, Edgar, and Clark. Our communities exist within the heart of the methamphetamine epidemic that has been so devastating during the past decade and we have higher than statewide-average unemployment rates and corresponding poverty issues within many of our communities. There is very little industry left in our area as many of the local factories have gone out of business or moved jobs out of the country. The only two major towns, Mattoon and Charleston, each have a census of less than 20,000 individuals.

All of our treatment services are licensed by the Division of Alcoholism and Substance Abuse. We have maintained voluntary multi-year accreditation from CARF, a national accrediting body, for well over the past decade though such accreditation has never been mandated for service providers within the substance abuse field. In addition to our almost 40 year history of developing quality substance abuse and dependency prevention and treatment across the full-array of the service continuum, we have participated in and completed various published research studies thereby contributing to the scientific literature and documenting our performance outcomes. We have a lengthy history of developing, implementing, and evaluating innovative services to meet the needs of the individuals, families and communities that we serve that include being one of the first substance abuse treatment facilities to develop specialized services for

women with children since 1985. We have been the recipient of a National Award from the Center for Substance Abuse Treatment, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration in conjunction with the Rural Institute, Menomonie, WI in 1998 for our services for women with children. Additionally, our history of developing scientifically based innovative substance abuse treatment has also included being the sole provider in Illinois to implement specialized adolescent residential treatment that enhances traditional treatment programming with equine-assisted therapies. Though rural living has inherent difficulties, we have incorporated the ethics, values, culture, and naturalistic strengths of our environment to be among the inventors of “best practices” long before the term gained its current popularity.

The above comments speak to the history and foundation of our organization and about the dedicated individuals at both the local and state levels who have contributed to comprehensive planning for service development and implementation, were concerned with the well-being of our citizens and communities, and worked collaboratively to assure access to needed services. Despite that history, we have now arrived at a repeating cycle of further devastating budget cuts on top of multiple years of budget cuts, delayed payments, re-bidding of contracts, re-writing of contracts, performance measures, and increasing unfunded mandates within an environment of chaos. We have been asked over and over to “do more with less.” We have increased our efficiency and our effectiveness. We have done more with less over and over again.

But now, let me add my very personal comments about what will be the effects of the current budget cuts to the substance abuse field. I am the Executive Director of Central East Alcoholism and Drug Council where I have worked for the past 34 years. I have worked in the capacity of student intern, addictions counselor, clinical director, and for the past 20 year as the Executive Director. I remember the faces of clients that were the very first clients of the organization. We have now exceeded 21,000 unique individuals that have received treatment from us. Our total annual budget is less than five million dollars and our services to indigent patients funded by State contract or Medicaid makes up 67%-73% of our annual budget. The FY12 budget has cut our funding over \$400,000 (an approximately 18% cut) on top of a 24% cut last year and a similar cut the year before. In 2008, we had 116 full-time equivalent staff; for the past two years, we’ve barely maintained employment for 92 staff. We’ve stopped admitting patients to two of our programs and have constant issues with retaining sufficient numbers of staff to operate existing services. If the FY12 budget is allowed to remain and funding is not restored, we will be forced to close programs and reduce additional staff. The closing of programs will mean 300-400 clients will not get services. The reduction in staff will mean 10-15 more people in our area will join the ranks of the unemployed with very little likelihood that they will find comparable employment elsewhere in the area. The FY12 budget as it currently stands requires me to dismantle what I have spent a lifetime building. It requires me to deny appropriate quality care to persons desperately in need of treatment. It requires me to put women and children out on the streets with no resources. It requires me to tell parents that we have no way to help their child who is at risk of destroying their life with combinations of alcohol, methamphetamine, cocaine, and illicit prescription drugs. It requires the Commission, the Governor, and the Legislature to turn your backs on the very lives you were elected and appointed to protect.

The existing FY12 budget cuts for substance abuse services will be devastating in human costs but it will also create a backlash fiscal spiral that will further weaken the Illinois economic picture. Research has repeatedly shown that funding substance abuse treatment saves from \$7.00 to \$14.00 for every dollar spent on treatment in reduction in other costs to society. No one questions that the State of Illinois has budgetary and fiscal problems that are both difficult and complex; however, to respond with budget cutting measures that ignore decades of research will

only produce greater human and fiscal costs. Let me offer just a glimpse of the top-notch research that is readily available for almost 30 years that would suggest that any cuts to the substance abuse field will produce far greater costs to the State both in human lives and fiscal realities.

The efficacy of providing substance abuse treatment in “freestanding” (i.e. non-hospital) facilities was originally tested in the early 1980’s which resulted in the allowance of billing Medicaid for substance abuse treatment in the same manner that exists today. Prior to these Demonstration Projects Medicare and Medicaid services were only able to be billed when provided by physicians and/or hospitals. According to Lo and Woodward (1993), “In 1980 the Health Care Financing Administration (HCFA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in conjunction with six states designed a 4-year Alcoholism Treatment Demonstration Project. The Demonstration began in 1982 and ended in 1985. The six states that participated in the Demonstration were Connecticut, **Illinois**, (emphasis added), Michigan, New Jersey, New York, and Oklahoma. There were 111 facilities selected on the basis of state and federal licensing and certification standards. (CEAD Council was a participant in the second phase of Illinois providers included in the study).

According to the authors, “This study is a comparison analysis in which Demonstration (freestanding) and hospital treatment settings are compared on the basis of total health care expenditures following the initiation of treatment. This evaluation of freestanding alcoholism treatment centers considers two questions: do they save money for Medicare; and do their patients have the same or lower health care use following the initiation of treatment than patients treated in hospital-based facilities? ...Health expenditures include in-and outpatient hospital, nursing home, home health, physician, drugs and equipment, and all other care for which Medicare pays.”

The results of this benchmark study were as follows: “The most significant finding of this study is that average health expenditures are lower for the patient group treated in freestanding facilities, when compared with those treated in hospital-based facilities... One desired outcome at the outset of alcoholism treatment is a decline in the recurring need for alcoholism treatment and an improvement in general health. As general health improves following the start of treatment, general health expenditures decline even allowing for the costs of alcoholism treatment itself....The findings of this study are consistent with other evaluations of the Demonstration. Thus, the conclusion of this study is that for some patients with alcohol problems, treatment in freestanding facilities is less costly and leads to less recurrent treatment than treatment in hospitals.... **From a program or policy perspective, it is clear that freestanding facilities do have the desired effect on the outcome most desired by Medicare: reductions in the total health expenditures and in recurrent alcoholism treatment**” (emphasis added).

As a result of these and other studies promulgated through the Demonstration Project, the current Illinois funding mechanisms of State contract funding and Medicaid payments for eligible individuals have been developed to support the work of non-profit “freestanding” community-based treatment centers across the State. Other seminal studies that fostered the development of the substance abuse treatment system that currently exists in Illinois created a significant breadth of understanding of the complexities of treating addiction and the cost-benefits of providing rapid access to the appropriate and diagnostically-matched level of care.

The first “national, comprehensive study of the costs of all substance abuse” was conducted by the Center of Addiction and Substance Abuse at Columbia University examining the impact of substance abuse and addiction on inpatient hospital costs of the Medicaid program (Merrill, Fox, and Chang, 1994). Some of the findings of the study are listed below:

- More than 70 conditions requiring hospitalization are attributable in whole or in part to substance abuse.
- On average, Medicaid patients with substance abuse as a secondary diagnosis are hospitalized twice as long as patients with the same primary diagnosis and no substance abuse problem.
- Substance abuse problems complicate treatment for specific illnesses. Patients treated for burns, pneumonia, and septicemia who have a secondary diagnosis of substance abuse stay more than twice as long as those without such diagnosis.
- The largest share of Medicaid substance abuse costs in hospitals – 81% of the total costs – was for medical treatment of substance abuse related illnesses and conditions and for the increased length of stay required for patients with coexisting substance abuse disorder.
- Reductions in substance abuse can have a real and immediate impact on costs. In the case of birth outcomes, trauma, AIDS, and strokes among younger people, reducing substance abuse can have a significant immediate effect on health spending.

Please note – the above data was gathered almost 20 years ago – and thoroughly documented the extreme explosion of costs that are related to untreated substance abuse. The cost figures in today’s dollars would be astronomical.

Similarly, in 1994, Gerstein and his colleagues completed a now-famous cost-benefit analysis of substance abuse state-funded treatment programs in California with the following results:

- The cost of treating approximately 150,000 participants represented by the CALDATA study sample in 1992 was \$209 million, **while the benefits received during treatment and in the first year afterwards were worth approximately \$1.5 billion in savings to taxpaying citizens** (emphasis added), due mostly to reductions in crime.
- Each day of treatment paid for itself (the benefits to taxpaying citizens equaled or exceeded the costs) on the day it was received, primarily through an avoidance in crime.
- Benefits after treatment persisted through the second year of follow-up for the limited number of participants followed for as long as two years.
- The level of criminal activity declined by two-thirds from before treatment to after treatment. The greater the length of time spent in treatment, the greater the percentage reduction in criminal activity.
- About one-third reductions in hospitalizations were reported from before treatment to after treatment. There were corresponding significant improvements in other health indicators. Emergency room admissions, for example were reduced by one-third following treatment.

And in yet another of the foundational studies that have substantiated the cost-benefits of providing ready access to substance abuse treatment, researchers Holder and Blose (1992) state the following:

“This study utilized two separate research designs to examine whether the initiation of alcoholism treatment is associated with a change in overall medical care cost in a population of alcoholics enrolled under a health plan sponsored by a large midwestern manufacturing corporation. In the longest longitudinal study of alcoholism treatment costs to date, a review of claims filed from 1974 to 1987 identified 3,729 alcoholics (3,068 of whom received treatment and 661 of whom did not). In one design, a time-series analysis found that following treatment initiation the total

health care costs of treated alcoholics – including the cost of alcoholism treatment – declined by 23% to 55% from their highest pretreatment levels. Costs for identified but untreated alcoholics rose following identification. In a second design, analysis of variance was used to control for group differences including pretreatment health status and age. This analysis indicated that the posttreatment costs of treated alcoholics were 24% lower than comparable costs for untreated alcoholics.... In conclusion, **this study provides considerable evidence that alcoholism treatment can have a significant impact on overall medical care costs in a heterogeneous alcoholic population where that are no restrictions of the choice of provider and no experimental control over the nature or duration of treatment.** (emphasis added) This population, including treated and untreated individuals, blue-and white-collar workers, employees and dependents, HMO members and enrollees in fee-for-service plans – all covered under the same basic benefit provisions – provides a picture of the cost impact of alcoholism treatment in a more diverse population than has previously been examined.”

Again, the above mentioned cost-savings have been well-known foundations for the development of treatment services across the entire country. For well over 20 years, extensive research has been completed that repeatedly has shown the cost benefits of providing readily accessible substance abuse treatment. For well over 30 years, the substance abuse treatment and prevention field has been responding to the needs of Illinois citizens with ever-increasing levels of quality and professionalism. For well over 50 years, chemical dependency has been defined as a “chronic, progressive, and fatal illness.”

As is evident in a 30 year history of research, State dollars will NOT be saved by these budget cuts because costs in general medical expenses, crime and other areas will increase exponentially as a result of untreated addiction. Various studies have postulated cost savings from the first day of treatment to range from \$7 to \$14 for every dollar spent on treatment. Thus if \$28,000,000 is removed from DASA funding lines within the State budget, it will likely increase expenses in other areas of State costs via Medicaid, public health, criminal justice, etc. by \$196,000,000 to \$392,000,000!

Social services in general are frequently referred to as “the safety net.” The substance abuse field, however, is far more than a safety net. The substance abuse field also serves as a predominant “Gatekeeper” to ward off far more costly expenses in hospital days of care and criminal justice system increased expenses. A huge body of research exists to substantiate the enclosed comments. I have only summarized but a brief sample of the wealth of information that is available to caution against dismantling the gatekeepers that have served the State of Illinois to save millions of dollars (and millions of lives) over the last four decades.

I would suggest that allowing the current budget to remain in effect will precipitate far greater problems for Illinois citizens and communities than have been seen in the last 30 years. I humbly request that the Commission do all that is possible to increase funding to the substance abuse prevention and treatment field such that we may continue to save lives while contributing to the fiscal viability of the State. Thank you for your thoughtful consideration of our concerns.

Sincerely,



Pamela P. Irwin, Ph.D.
Executive Director