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October 5, 2011

Senator Jeffrey M. Schoenberg, Co-Chair
Representative Patricia Bellock, Co-Chair
Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706

Re: Proposed Closure of H. Douglas Singer Mental Health Center

Dear Senator Schoenberg and Representative Bellock:

Thank you for this opportunity to comment on the proposed closure of the Singer Mental Health Center in Rockford, a 76-bed state-operated psychiatric hospital funded and operated by the Illinois Department of Human Services Division of Mental Health (DMH). The Illinois Hospital Association (IHA) presents the following comments on behalf of our 200 member hospitals and health systems and the patients and communities they serve.

DMH's proposed closure of Singer and two other of Illinois' nine state-operated hospitals and the transfer of forensic patients in these facilities to the remaining civil acute inpatient state-operated hospital beds will greatly weaken an already fragile mental health system in Illinois. It will reduce access to acute psychiatric care in northwest Illinois as well as in communities throughout Illinois. It will cause the loss of beds at Singer and will reduce the statewide existing state-operated hospital capacity from approximately 1,400 civil acute beds to approximately 200 civil acute beds. The closure of Singer will mean loss of access to a state psychiatric hospital for persons who are not committed there through the criminal justice system.

For individuals with serious mental illness who need the level of care provided in a hospital, the loss of close to 1,200 inpatient psychiatric beds depletes an already limited pool of inpatient resources. The private hospital system does not have a sufficient pool of inpatient beds to offset this loss. There has been a 28% drop in private hospital psychiatric beds in the past decade, from 5,350 beds in 1991 to 3,816 beds in 2010. Moreover, the loss of these beds is not evenly distributed across the state, leaving many Illinois communities without any psychiatric resources at all. Only nine rural hospitals in Illinois offer inpatient psychiatric services, and 84 Illinois counties have no psychiatric units at all. In the geographic region served by Singer Mental Health Center, there are three private hospital psychiatric units. Two are located in the Rockford area; one is in a rural community. Each is a small unit and would have great difficulty assuming responsibility for all of the patients currently served at Singer.

The loss of acute, inpatient psychiatric capacity will further exacerbate the challenges currently experienced by persons with mental illness who depend on the public system of care. It compounds budget cuts to community mental health and substance abuse services made in the past three years. Eliminating care at both ends of the continuum of

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care leaves few alternatives to persons with serious, chronic illnesses and will likely contribute to an increase in the use of hospital emergency departments, longer waits for limited inpatient private hospital psychiatric beds, and delays in treatment for all patients. Without treatment, persons with mental illness often become homeless, end up in jail, or in the worst cases, do not survive.

We cannot afford to take such risks for our most vulnerable residents, especially within the timelines suggested for such closures. A systems restructuring such as the one that has been proposed must occur within the framework of a plan that assures access to care will be preserved for those persons with serious mental illness who require acute care. IHA's Behavioral Health Steering Committee articulated such principles in 1997 and reiterated and refined them in 2005 when the state proposed that the Tinley Park Mental Health Center be closed (see attached). Such a plan should be developed with input from a broad cross section of stakeholders, including patients and families.

Persons with mental illness, like every patient, need the right care, at the right time, in the right place. The public psychiatric hospital is one setting in the continuum of care. It is designed to be a critical safety net that supports persons with serious illness who require a safe, structured environment.

As a key part of the continuum of care, private hospitals in Illinois are willing to serve and do serve hundreds of thousands of persons with mental illnesses each year. The state's private hospitals cared for close to 148,000 persons with a principal diagnosis of mental illness as inpatients in 2010; more than 750,000 persons diagnosed with a behavioral condition; and more than 190,000 patients with a principal diagnosis of mental or substance use illnesses in their emergency departments in 2009. However, private hospitals are serving these growing numbers of patients in fewer facilities and with fewer beds. The private hospital system does not have the capacity to assume responsibility for all the patients who will be displaced by the proposed state-operated hospital closures.

We recognize the state's challenging economic circumstances and the costs associated with maintaining antiquated facilities. However, we ask whether and to what extent the proposed closures will actually save money. It is critical the COGFA take into account several important factors when considering the proposed closures:

- If the closure of state hospitals contributes to an increase in homelessness and incarceration, it will cost the state more to house a person in jail than it does to provide treatment. The state would be transferring costs from one sector of the system to another, without any net savings to the state.

- Hospital Emergency Department care is very costly. Many persons using hospital emergency departments are Medicaid recipients. These state-operated hospital closures likely will cause more Medicaid recipients with mental illnesses to use EDs, especially in the absence of other alternatives.

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- State law requires funds from the closure of a state facility to be reinvested in the community. The state cannot use these funds for another purpose other than mental health services. Thus, the proceeds from a sale of a state-operated hospital property must be used for mental health purposes.

It is also important to note that in 2009, DMH eliminated $9.4 million in funding for the Community Hospital Inpatient Psychiatric Services (CHIPS) program that was designed to serve persons with mental illness who needed acute inpatient psychiatric care in a private hospital. The CHIPS program was established when the state closed the Zeller Mental Health Facility and downsized the Alton and Elgin mental health facilities as an alternative for persons who otherwise would use a state hospital. Twenty-three hospitals were participating in this program. The elimination of CHIPS has further reduced access to acute inpatient psychiatric care for a vulnerable population.

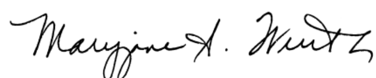
Illinois hospitals are committed to transforming health care to assure that every patient, including persons with mental and substance use illnesses, has access to the right care, at the right time, in the right place. To achieve this goal, all of us will need to work together, collaboratively, creatively and effectively, using the best of what currently exists and embracing new models.

Legislation enacted this year—House Bill 2982/Public Act 97-0381—presents one positive approach to building systems of care that capitalizes on regional strengths and encourages collaboration across systems of care. This legislation recognizes there will not be new funds but that there can be savings associated with innovative program design, elimination of redundancies and sharing of resources.

While we look forward to the opportunity to redesign the state's mental health system on a regional basis to make it more effective and efficient, we are very concerned that the proposed closures of the H. Douglas Singer Mental Health Center and other state-operated hospitals will adversely affect those efforts.

Thank you for the opportunity to provide these comments.

Sincerely,



Maryjane A. Wurth
President

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October 7, 2011

Senator Jeffrey M. Schoenberg, Co-Chair
Representative Patricia Bellock, Co-Chair
Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706

Re: Proposed Closure of Chester Mental Health Center

Dear Senator Schoenberg and Representative Bellock:

Thank you for this opportunity to comment on the proposed closure of the Chester Mental Health Center, a 240-bed maximum security forensic state-operated psychiatric hospital funded and operated by the Illinois Department of Human Services Division of Mental Health (DMH). The Illinois Hospital Association (IHA) presents the following comments on behalf of our 200 member hospitals and health systems and the patients and communities they serve.

DMH's proposed closure of Chester – and two other of Illinois' nine state-operated hospitals and the transfer of forensic patients from Chester to the remaining civil acute inpatient state-operated hospital beds – will greatly weaken an already fragile mental health system in Illinois. It will reduce the statewide existing state-operated hospital capacity from approximately 1,400 civil acute beds to approximately 200 civil acute beds. Moreover, because Chester is specially designed to serve aggressive patients who have been committed there through the courts or who are transferred there by other state-operated hospitals because of patient behavioral management issues, the loss of this facility is especially significant. It is a resource with capabilities, including staff expertise, which cannot easily or cost-effectively be transferred to another facility. Closing Chester does not make clinical or financial sense.

For individuals with serious mental illness who need the level of care provided in a hospital, the loss of close to 1,200 inpatient psychiatric beds depletes an already limited pool of inpatient resources. The private hospital system does not have a sufficient pool of inpatient beds to offset this loss. There has been a 28% drop in private hospital psychiatric beds, from 5,350 beds in 1991 to 3,816 beds in 2010. Moreover, the loss of these beds is not evenly distributed across the state, leaving many Illinois communities without any psychiatric resources at all. Only nine rural hospitals in Illinois offer inpatient psychiatric services, and 84 Illinois counties have no psychiatric units at all.

The loss of acute, inpatient psychiatric capacity will further exacerbate the challenges currently experienced by persons with mental illness who depend on the public system of care. It compounds budget cuts to community mental health and substance abuse services made in the past three years. Eliminating care at both ends of the continuum of care leaves few alternatives to persons with serious, chronic illnesses and will likely contribute to an increase in the use of hospital emergency departments, longer waits for

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limited inpatient private hospital psychiatric beds, and delays in treatment for all patients. Without treatment, persons with mental illness often become homeless, end up in jail, or in the worst cases, do not survive.

We cannot afford to take such risks for our most vulnerable residents, especially within the timelines suggested for such closures. A systems restructuring such as the one that has been proposed must occur within the framework of a plan that assures access to care will be preserved for those persons with serious mental illness who require acute care. IHA's Behavioral Health Steering Committee articulated such principles in 1997 and reiterated and refined them in 2005 when the state proposed that the Tinley Park Mental Health Center be closed (see attached). Such a plan should be developed with input from a broad cross section of stakeholders, including patients and families.

Persons with mental illness, like every patient, need the right care, at the right time, in the right place. The public psychiatric hospital is one setting in the continuum of care. It is designed to be a critical safety net that supports persons with serious illness who require a safe, structured environment.

As a key part of the continuum of care, private hospitals in Illinois are willing to serve and do serve hundreds of thousands of persons with mental illnesses each year. The state's private hospitals cared for close to 148,000 persons with a principal diagnosis of mental illness as inpatients in 2010; more than 750,000 persons diagnosed with a behavioral condition; and more than 190,000 patients with a principal diagnosis of mental or substance use illnesses in their emergency departments in 2009. However, private hospitals are serving these growing numbers of patients in fewer facilities and with fewer beds. The private hospital system does not have the capacity to assume responsibility for all the patients who will be displaced by the proposed state-operated hospital closures.

We recognize the state's challenging economic circumstances and the costs associated with maintaining antiquated facilities. However, we ask whether and to what extent the proposed closures will actually save money. It is critical that COGFA take into account several important factors when considering the proposed closures:

- If the closure of state hospitals contributes to an increase in homelessness and incarceration, it will cost the state more to house a person in jail than it does to provide treatment. The state would be transferring costs from one sector of the system to another, without any net savings to the state.

- Hospital Emergency Department care is very costly. Many persons using hospital emergency departments are Medicaid recipients. These state-operated hospital closures likely will cause more Medicaid recipients with mental illnesses to use EDs, especially in the absence of other alternatives. More important, the emergency department is not the best clinical setting for a person with mental illness.

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- State law requires funds from the closure of a state facility to be reinvested in the community. The state cannot use these funds for another purpose other than mental health services. Thus, the proceeds from a sale of a state-operated hospital property must be used for mental health purposes.

It is also important to note that in 2009, DMH eliminated $9.4 million in funding for the Community Hospital Inpatient Psychiatric Services (CHIPS) program that was designed to serve persons with mental illness who needed acute inpatient psychiatric care in a private hospital. The CHIPS program was established when the state closed the Zeller Mental Health Facility and downsized the Alton and Elgin mental health facilities as an alternative for persons who otherwise would use a state hospital. Twenty-three hospitals were participating in this program. The elimination of CHIPS has further reduced access to acute inpatient psychiatric care for a vulnerable population.

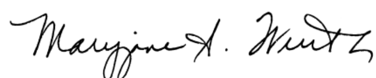
Illinois hospitals are committed to transforming health care to assure that every patient, including persons with mental and substance use illnesses, has access to the right care, at the right time, in the right place. To achieve this goal, all of us will need to work together, collaboratively, creatively and effectively, using the best of what currently exists and embracing new models.

Legislation enacted this year—House Bill 2982/Public Act 97-0381—presents one positive approach to building systems of care that capitalizes on regional strengths and encourages collaboration across systems of care. This legislation recognizes that there can be savings associated with innovative program design, elimination of redundancies and sharing of resources.

While we look forward to the opportunity to redesign the state's mental health system on a regional basis to make it more effective and efficient, we are very concerned that the proposed closures of the Chester Mental Health Center and other state-operated hospitals will adversely affect those efforts.

Thank you for the opportunity to provide these comments.

Sincerely,



Maryjane A. Wurth
President

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October 13, 2011

Senator Jeffrey M. Schoenberg, Co-Chair
Representative Patricia Bellock, Co-Chair
Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706

Re: Proposed Closure of Tinley Park Mental Health Center

Dear Senator Schoenberg and Representative Bellock:

Thank you for this opportunity to comment on the proposed closure of the Tinley Park Mental Health Center in Tinley Park, a 75 bed state-operated psychiatric hospital funded and operated by the Illinois Department of Human Services Division of Mental Health (DMH). The Illinois Hospital Association (IHA) presents the following comments on behalf of our 200 member hospitals and health systems and the patients and communities they serve.

DMH's proposed closure of Tinley Park Mental Health Center and two other of Illinois' nine state-operated hospitals and the transfer of forensic patients from Chester to the remaining civil acute inpatient state-operated hospital beds, will greatly weaken an already fragile mental health system in Illinois. It will reduce the statewide existing state-operated hospital capacity from approximately 1,400 civil acute beds to approximately 200 civil acute beds. In the regions served by the Tinley Park Mental Health Center, the loss of this psychiatric resource will further strain the psychiatric services infrastructure in hospitals and community agencies. And, it will place at risk those persons who obtained care from the Tinley Park Mental ealth Center through approximately 1900 admissions in 2010.

For individuals with serious mental illness who need the level of care provided in a hospital, the loss of close to 1,200 inpatient psychiatric beds depletes an already limited pool of inpatient resources. The private hospital system does not have a sufficient pool of inpatient beds to offset this loss. There has been a 28% drop in private hospital psychiatric beds in the past decade, from 5,350 beds in 1991 to 3,816 beds in 2010. Moreover, the loss of these beds is not evenly distributed across the state, leaving many Illinois communities without any psychiatric resources at all. Only nine rural hospitals in Illinois offer inpatient psychiatric services, and 84 Illinois counties have no psychiatric units at all.

The loss of acute, inpatient psychiatric capacity will further exacerbate the challenges currently experienced by persons with mental illness who depend on the public system of care. It compounds budget cuts to community mental health and substance abuse services made in the past three years. Eliminating care at both ends of the continuum of care leaves few alternatives to persons with serious, chronic illnesses and will likely

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contribute to an increase in the use of hospital emergency departments, longer waits for limited inpatient private hospital psychiatric beds, and delays in treatment for all patients. Without treatment, persons with mental illness often become homeless, end up in jail, or in the worst cases, do not survive.

We cannot afford to take such risks for our most vulnerable residents, especially within the timelines suggested for such closures. A systems restructuring such as the one that has been proposed must occur within the framework of a plan that assures access to care will be preserved for those persons with serious mental illness who require acute care. IHA's Behavioral Health Steering Committee articulated such principles in 1997 and reiterated and refined them in 2005 when the state proposed that the Tinley Park Mental Health Center be closed (see attached). Such a plan should be developed with input from a broad cross section of stakeholders, including patients and families.

Persons with mental illness, like every patient, need the right care, at the right time, in the right place. The public psychiatric hospital is one setting in the continuum of care. It is designed to be a critical safety net that supports persons with serious illness who require a safe, structured environment.

As a key part of the continuum of care, private hospitals in Illinois are willing to serve and do serve hundreds of thousands of persons with mental illnesses each year. The state's private hospitals cared for close to 148,000 persons with a principal diagnosis of mental illness as inpatients in 2010; more than 750,000 persons diagnosed with a behavioral condition; and more than 190,000 patients with a principal diagnosis of mental or substance use illnesses in their emergency departments in 2009. However, private hospitals are serving these growing numbers of patients in fewer facilities and with fewer beds. The private hospital system does not have the capacity to assume responsibility for all the patients who will be displaced by the proposed state-operated hospital closures.

We recognize the state's challenging economic circumstances and the costs associated with maintaining antiquated facilities. However, we ask whether and to what extent the proposed closures will actually save money. It is critical the COGFA take into account several important factors when considering the proposed closures:

- If the closure of state hospitals contributes to an increase in homelessness and incarceration, it will cost the state more to house a person in jail than it does to provide treatment. The state would be transferring costs from one sector of the system to another, without any net savings to the state.

- Hospital Emergency Department care is very costly. Many persons using hospital emergency departments are Medicaid recipients. These state-operated hospital closures likely will cause more Medicaid recipients with mental illnesses to use EDs, especially in the absence of other alternatives. More important, the emergency department is not the best clinical setting for a person with mental illness

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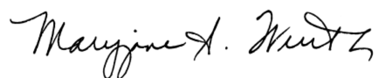
While we look forward to the opportunity to redesign the state's mental health system on a regional basis to make it more effective and efficient, we are very concerned that the proposed closures of the Tinley Park Mental Health Center and other state-operated hospitals will adversely affect those efforts.

Thank you for the opportunity to provide these comments.

Sincerely,



Maryjane A. Wurth
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Position of the Illinois Hospital Association Behavioral Health Steering Committee Regarding the Closure or Other Restructuring of the Tinley Park Mental Health Center Facility

Based on principles adopted in 1997 by the IHA Behavioral Health Steering Committee (Steering Committee) and Board regarding the privatization of state-operated mental health facilities (SOF), the Steering Committee on February 22, 2005 identified the following issues as relevant to the decisions related to whether or how the Tinley Park Mental Health Center facility should be restructured. It was their recommendation that these issues must be addressed to ensure access to an appropriate level of care for persons with mental illness:

- **The State must clearly state its vision regarding mental health services for Illinois citizens and define, publicly, its intent with regard to the role and relationship of its facilities and community resources.** The failure to define the role of the SOF in terms of its mission for the citizens of the State and relationship to community hospitals and other community providers strains the relationship between the parties, interjects ambiguity where there should be clarity, and, more importantly, does not put patients, families, and all Illinois citizens first.

- **Articulate criteria regarding which patients are most appropriate for a private hospital and which are most appropriate for a SOF.** Currently, admission and length of stay criteria are lacking or poorly defined. Admission criteria primarily are about the patient's funding source: If you are a Medicaid patient, you go to a private hospital. If you are uninsured, the SOF may accept you.
    - Clinical criteria are needed to determine before an admission whether the patient would be better served in the SOF or private hospital. Criteria are also needed to determine when a transfer is appropriate and necessary.
    - Criteria are also needed about medical services the DHS views as medically necessary and, therefore, eligible for payment.

  We believe that the SOF is appropriate for patients who are not successfully treated in community hospitals. These patients often exhibit the following characteristics: they are treatment resistant and/or have had multiple (three or more) admissions in the previous twelve months, and/or may require a longer length of stay (beyond 10 days). And, they may be unmanageably violent.

Private hospitals are appropriate for patients who present medical complexities that benefit from access to multiple specialties; patients who need to be stabilized and treated within the shortest time frame; and patients who will benefit from the diagnostic and other therapeutic resources of an acute care setting.

Patients with co-occurring disorders are caught between narrowly construed regulatory and public financing schemes that do not support access to appropriate services. For example, the state SOFs reluctantly accept patients with a primary diagnosis of substance abuse; Medicaid does not reimburse a private hospital for substance abuse treatment or rehabilitation, but only detoxification services, leaving the addicted person no access to treatment for their addiction in an acute care setting. The Illinois Department of Alcoholism and Substance Abuse licenses and pays for “sub-acute” Medicaid services, not acute services such as those needed by a substance abuse patient who has attempted suicide or has a psychiatric condition. Thus, the State financing of behavioral services lacks a comprehensive and coordinated rehabilitative focus, and thus leaves gaps that perpetuate expensive relapse and readmission.

Patients with developmental disabilities with mental illness also have few options for acute treatment available to them today. Given that the private sector cannot generally treat these individuals on an acute basis, they pose a natural population of citizens for which the State should assume responsibility. At a minimum, the State must fund, either directly or by arrangement, services that effectively meet the complex needs of these individuals.

- **Ensure patients in the private sector have community access to the same resources as are afforded patients in the SOF.** A patient upon discharge from a SOF has a firm referral to a community mental health provider. The patient being discharged from a private hospital must also have the same assurance he or she will have an appointment within the time frame dictated by his or her condition. Access to medication must also be assured, since failure to adhere to medication regimens often leads to readmission to an acute care setting.

- **Improve Medicaid rates.** Medicaid rates for inpatient psychiatric services are inadequate and vary across the state. The most vulnerable providers often have the lowest rates. Inadequate Medicaid rates coupled with burdensome administrative processes further weaken a fragile private inpatient psychiatric community. Because a large number of SOF patients are presumed to be Medicaid eligible, the adequacy of Medicaid payment is an essential variable in the shift of the locus of care to the private sector. If the private sector is not

financially viable, patients will be at risk of having no options should the SOF also be unavailable.

Moreover, the mechanisms under which the hospital either obtains DHS or Medicaid payment must also support rather than burden the provider. For example, the Community Hospital Inpatient Psychiatric Services (CHIPS) contract, which is the mechanism through which DHS contracts with private hospitals to serve a patient who otherwise may be treated in a SOF, requires a hospital to always attempt to qualify a patient for Medicaid before DHS pays the hospital. This is a costly and burdensome process, causing significant payment delays. For hospitals with low Medicaid rates, they will receive less money than they would have received from DHS, following a cumbersome administrative process, and following a lengthy period of time. Few, if any, hospitals can knowingly adopt a business model that requires them to seek out less reimbursement for services first.

Therefore, in order to ensure the private sector is able to care for the patient with mental illness:

- Medicaid rates for inpatient hospital psychiatric services must be improved. The State should at a minimum be willing to pay the private hospital with which it contracts the same per diem as it paid itself under Medicaid.
- Medicaid rates should never be less than the rate DHS pays. Ideally, both rates should be comparable and adequate to cover reasonable costs.
- The burdens associated with completing MANG applications should be shared by the State. For example, the State should provide staff support to the hospital that must complete lengthy applications. Moreover, the hospital should not be penalized if a physician does not believe a patient is disabled.

- **Make the courts more user-friendly and accessible to the private sector.** Many patients who refuse medication or admission require involvement with the judicial system. Courts are not easily accessible; there are numerous continuances; psychiatrists and staff must accompany the patient to court. There is no compensation for this. The courts must be more patient and user friendly to support the needs of patients, families and providers in the communities who must negotiate with this system. Necessary legal hearings could be conducted more creatively and efficiently. For example, a hearing could be held at the hospital, when feasible, or through the use of tele-technology that is transmitted from the courthouse or another central location. This would also assist in obtaining the support of psychiatrists to testify in such hearings.

- **Maintain in the community the funds currently allocated to the state-operated facilities.** Closure of the SOF should not reduce the overall financial support available for mental health services, i.e., there should not be a net loss of funding to the community. There is evidence that fewer funds will be available to the community, including hospitals and community mental health centers, than are currently allocated to Tinley Park SOF.

  The closure of other SOFs has resulted in a net loss to the community of mental health funding. If the community alternatives to the SOF are not strong and well financed, patients will need the safety net provided by the SOF. Moreover, the DHS fee-for-service conversion threatens the financial viability of community mental health centers. The system is being tugged at both ends of the continuum. At a minimum, the funds currently allocated to the Tinley Park SOF should continue to be available either for its operations or for a combination of state operated, private operated acute services, and community outpatient services.

- **Formally evaluate effects of reducing or eliminating SOF capacity against program goals.** Perform a formal evaluation of any program of SOF reduction or deinstitutionalization to determine whether the program's goals are truly being met, the effect of the program on all of the parties involved (community hospitals, community behavioral health providers, consumers, and Illinois citizens). Make this evaluation public and available for comment.

PRINCIPLES AND RECOMMENDATIONS REGARDING THE PRIVATIZATION OF STATE-OPERATED MENTAL HEALTH FACILITIES

- Patients first.

- Services for each patient should be delivered in the most appropriate clinical setting for that particular patient. Privatization is not the goal; rather it is a means to achieve the goal of high quality, cost effective, and accessible services for the patients.

- To the extent the private sector is able and willing to provide appropriate services to persons who otherwise would receive them in the public sector, it is a cost-effective alternative that encourages creative use of scarce resources, and offers more clinical options from which patients and families can choose.

- One rationale for shifting resources from state-operated facilities to community providers is cost-effectiveness. However, current financial resources committed to delivering services in a state-operated facility must be reserved for services used by these patients, albeit in different settings. The state must demonstrate its commitment to preserving and enhancing resources for patients, not shifting the financial responsibility onto providers or families, or diverting mental health dollars into other areas.

- Government retains the ultimate responsibility to establish performance standards and to monitor performance, a responsibility that is not diminished under a privatized system. These functions, however, should involve collaboration between government, families, consumers, advocates and providers.

- Outcomes must be measured, and against these performance measures, by an objective party.

- The state must recognize and provide accordingly that some of the patients present complex symptomology that requires long-term services that may not be appropriate for an acute care model. Provisions must be made to insure these patients receive services of an intensity, comprehensiveness, and duration that are appropriate for their needs.

- The state must define the population of persons who would be eligible for services in the private sector. Such definitions should be consistent with the Illinois Mental Health Code and should, at a minimum, include (a) persons who are uninsured and without financial means to pay for needed services; (b) patients who meet a DSM IV diagnosis of mental

illness or, if a child or adolescent, a severe emotional disturbance; and (c) exhibit functional impairment in significant life activities.

- Family involvement is critical to the success of therapy and the patient's long-term health. The services provided must include families.

- A continuum of services should be available to patients to allow for an appropriate match of needs and services. Providers, must therefore, must be able to offer a range of clinical services, including, but not limited to inpatient, partial, outpatient, and wraparound services. Where a single provider entity is unable to offer the spectrum of services a patient needs, providers should collaborate to insure such access is available.

- The state should remove existing barriers to collaboration or those which prevent flexibility in programming or training.

- The delivery of mental health services neither exists in a vacuum, nor falls under the exclusive purview and control of a single state agency. All public and private resources must be considered members of the care team to which the patient belongs. All parties must contribute to the team's success and not diminish its effectiveness (e.g. judicial system in certain parts of the state impose significant burdens on mental health patients, families, and providers who must act pursuant to law and the court's decisions.)

- Services must be culturally competent and sensitive and should respect the dignity of each patient and his/her family.