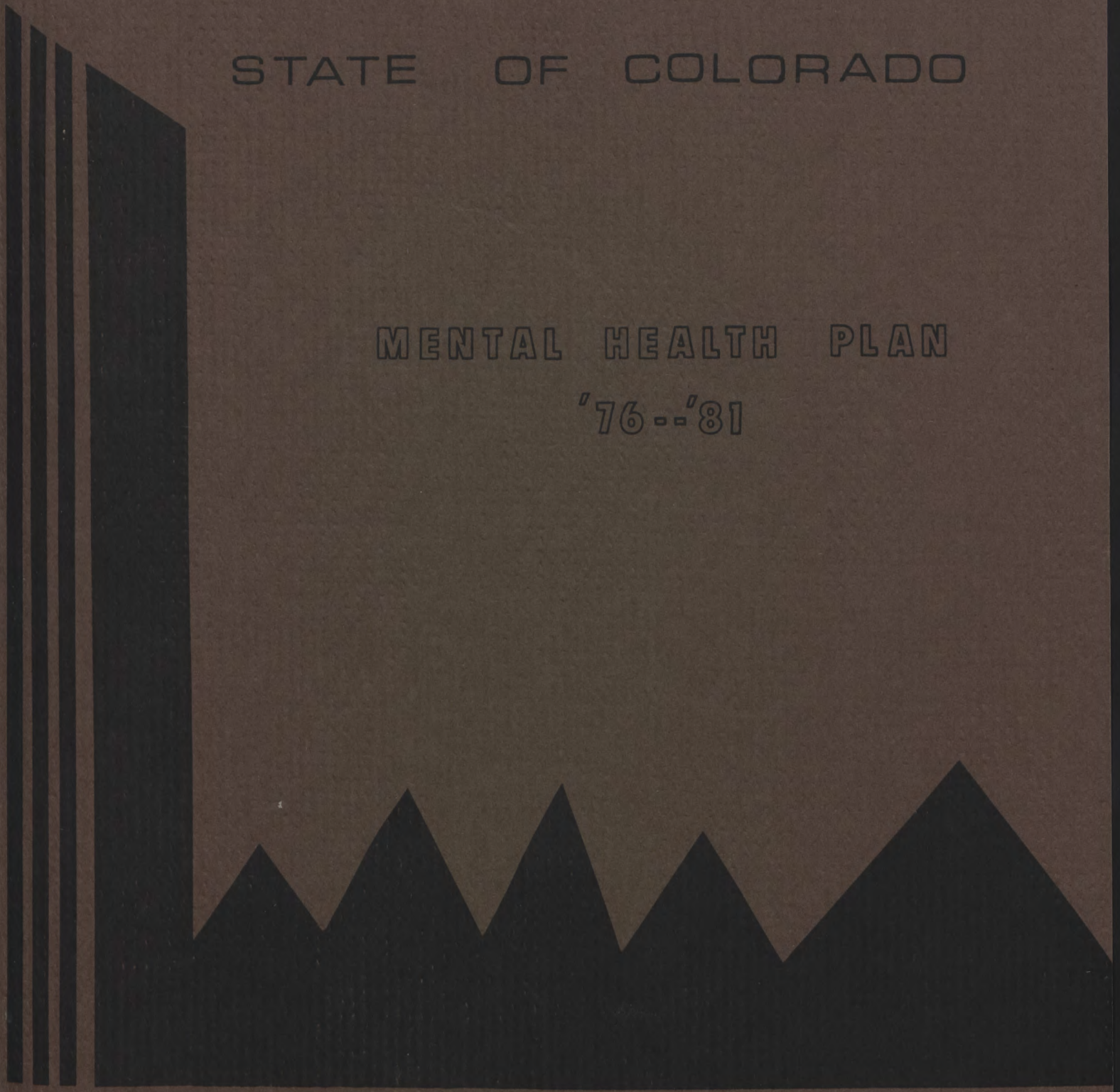
STATE OF COLORADO

MENTAL HEALTH PLAN '76--'81



THE COLORADO
MENTAL HEALTH PLAN
(1976 - 1981)

A plan based on use of the least restrictive alternative in the treatment of the mentally disabled.

August 1976

PREPARED BY

COLORADO DIVISION OF MENTAL HEALTH

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FOREWORD

The prevention and treatment of mental illness is the *raison d'etre* for the Division of Mental Health, the state hospitals and the mental health centers and clinics which comprise the public mental health services system. The basic philosophy and value system underlying this plan and the delivery of mental health services in Colorado can be summarized as follows: Persons in need of mental health services have the right to high quality services, provided close to home, without unreasonable delay. Services should be provided in the least restrictive setting, in a manner which preserves privacy and human dignity and interferes to the least extent possible with the individual's freedom. The primary objectives should be to prevent or relieve emotional suffering and to facilitate the best and most productive functioning of which the individual is capable.

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THE COLORADO MENTAL HEALTH PLAN

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2 INTRODUCTION

THE COLORADO MENTAL HEALTH PLAN

I. INTRODUCTION

A. PURPOSE

The Colorado Mental Health Plan was developed to provide direction for the planning and delivery of public mental health services during the next five years. More specifically, the purposes of the Plan are to assist in providing: systematic determination of mental health service needs, and the additional planning necessary to address these needs; the delivery of quality care by a well-organized, integrated system; and the delivery of cost-effective services.

The following requirements of a statewide mental health plan are incorporated in the purposes listed above: identify gaps in and duplication of services; determine mental health personnel needs; provide for citizen input; facilitate coordination with other agencies; develop standards to insure quality care; clarify the roles of the components of the system; provide a basis for funding; and develop goals with measurable objectives.

B. ORGANIZATION AND SCOPE

The six chapters and five appendices of the plan address the requirements of Public Law 94-63 (the Community Mental Health Center's Act of 1975), and state statutes. Following the introductory

chapter is one on the administration of the Plan. This chapter identifies the State Mental Health Authority and organizational structure, and provides for the appointment of a State Mental Health Advisory Council. The procedures for the annual review of the State Plan and the administration of Public Health Service Act funds (Section 314d) are detailed. The required federal assurances are included in this chapter, as are personnel standards relating to civil service, equal employment and affirmative action.

Chapter III is regarded as the "heart" of the Plan as it sets forth the goals and objectives which provide both specific direction and a means of assessing progress. The goals and objectives are developed around the principles detailed in Chapter I emphasizing the use of the least restrictive setting, protection of human dignity and the client's rights, the availability of services close to home, and accountability. The use of the least restricitve setting principle requires conscious effort to avoid inpatient hospitalization, when a less intensive form of treatment, such as outpatient care, will adequately meet the client's clinical needs. Implementation of this principle also requires the development of a range of locally available treatment facilities which can be used in lieu of inpatient care. Prevention and the special needs of target populations are also key foci of the goal statements and the accompanying objectives.

The state mental health program, as it is and as it will evolve in accordance with the Plan, constitutes the content of Chapter IV. The requirements for pre-admission screening emphasize the thrust towards avoiding inpatient hospitalization except in those instances where it

is clearly indicated. Those clients who require inpatient care in a state hospital will be assured of high quality services because of the intensive and extensive quality assurance and utilization review programs in effect in both hospitals.

Chapter IV also focuses on the discharge of clients from inpatient and other more intensive forms of care, and the procedures to insure appropriate follow-up. The intent is to insure that clients who require aftercare services receive such care in a pre-planned and systematic way, and that those who require living arrangements where treatment is available are properly placed.

Workforce issues including available resources, training programs and possible displacement are addressed. The possible displacement of state hospital employees because of the emphasis on deinstitutionalization and the use of alternatives to inpatient care is a key issue. The reasons this will probably have less harmful impact on state employees in Colorado are outlined. Coordination of mental health services with other human services planning and caregiving agencies is the almost overwhelming but essential task addressed in Chapter V. This chapter, and the goals and objectives speak to processes and mechanisms for constructive resolution of "boundary" problems toward the end of providing better care to more clients at the lowest possible cost.

Appropriate attention is given the complex health planning arena where, because there are many players, coordination is more difficult.

The interface between the Division of Mental Health and the Division of Alcohol and Drug Abuse is the focus of specific planning designed to increase cooperative planning which will result in better use of

available funds, additional funding, and consequently the availability of appropriate substance abuse services to more clients.

Chapter VI describes the present services and the mental health service needs of the communities served by the 24 mental health centers/clinics. The catchment area concept is supported to the extent it allows flexibility in the sharing and centralization of services where clinically feasible and economically desirable. The priorities for the funding of services and facilities in the various catchment areas will be determined, to a great extent, by the rankings of centers/clinics based on need. The rankings are indicated in Appendix III.

This chapter also deals with the development of community mental health resources and facilities for centers/clinics.

The appendices consist of a listing of the agencies and organizations from which input was sought and/or received, the Report of the Chicano Mental Health Planning Symposium, the rankings (based on need) of community mental health centers/clinics, the inventory of existing facilities, and the basis for the rankings of centers/clinics, the survey of need.

It is recognized that the implementation of this Plan is dependent, to a very large extent, upon funding. However, funding as such is not within the scope of this Plan. Specific sections of the Plan will be incorporated in annual budget requests, and the Plan itself will be a basic document available to legislators, and others with funding responsibilities, and used in budget presentations.

The Standards/Rules and Regulations required by Public Law 94-63 have been published in a separate document.

C. PHILOSOPHY

The philosophy of the Division of Mental Health is reflected throughout this Plan. This philosophy, expressed as principles, is categorized under the following four headings:

1. Human Dignity, Privacy and Client's Rights

   a. Mental health services should be provided in a manner which preserves the client's privacy and dignity.

   b. Clients have a right to know the type of treatment they will receive and the reasons for a particular type of treatment.

   c. Clients have the right to participate in setting their treatment goals.

   d. Clients have the right to receive services meeting customary standards of professional quality.

   e. Individuals have the right to refuse treatment unless they are found to be a danger to themselves or others, or are gravely disabled.

   f. Involuntary clients have the same right to goal-oriented treatment as do voluntary clients.

   g. Clients' rights should be vigorously protected. The services of an advocate should be available to involuntary clients.

   h. The written consent of the client shall be obtained before information concerning the client is released to others, except in those instances where release of information without the client's consent is specifically permitted by statute.

2. Least Restrictive Setting

Each client should be treated in the least intensive or restrictive setting consistent with the client's clinical needs (e.g., a client should not be hospitalized if a less intensive type of care will adequately meet his/her treatment needs).

3. Availability of Services Close to Home

a. Mental health services should be provided in the local community, as close as possible to the home of the client.

b. Entry into the public mental health system should be through the local mental health center or clinic. Every effort should be made to treat the client at this level on an outpatient basis before referring the client for more intensive care.

c. The mental health system should provide consultative services to other agencies such as schools, social service departments, the clergy, etc., to help increase the capabilities of these agencies and individuals in the early detection of, and effective intervention in, emotional problems.

d. Closely related to the principles of the availability of services close to home and in the least restrictive setting is the concept of normalization; i.e., services should be provided in the most normal or home-like setting possible.

4. Funding and Accountability

a. The primary responsibility for public mental health care should rest with the state; however, it is recognized that part of the financial burden should be assumed by local governments, the federal government, employers and those who receive services.

b. Clients should be billed in accordance with their ability to pay.

c. Maximum effort should be made to obtain reimbursement for services to clients, who are eligible, for Medicare (Title XVIII), Medicaid (Title XIX) and other third party mental health benefits.

d. There should be a continuous effort to measure the impact or results of mental health services. Agencies and programs which provide effective services at low cost should receive special recognition, and their methodology should be studied for possible use by other agencies.

e. The results of ongoing evaluation of mental health services should be reflected in the planning process.

D. HOW THE PLAN WILL BE USED

This Plan will be widely distributed within and outside the mental health system. It will be used within the system as a statement of policy, to clarify the roles of the various components, to unify the various agencies around common goals, for program direction, to provide a rational basis for the allocation and utilization of funds, and to assess progress.

The plan will also be used as a vehicle for improving communication between the mental health system and other agencies and organizations, and as a documented and coherent basis for funding requests.

E. PROCESS BY WHICH THE PLAN WAS DEVELOPED

1. Planning Committee

a. A planning committee was appointed by the Director, Division of Mental Health comprised of:

(1) three members of the Division of Mental Health Central Office staff;

(2) two representatives of the Colorado Association of Community Mental Health Centers and Clinics;

(3) one representative of the Mental Health Association of Colorado; and

(4) one representative from each of the two state hospitals.

b. Notification of Intent (A-95 process) was initiated.

c. The Committee reviewed a variety of approaches for preparation of a first draft. Their decision was to form a number of small task forces and to assign each the responsibility for writing a section or sections of the first draft of the Plan utilizing available input. The draft was reviewed by the Committee, the federal contact officer and others, and a second draft was prepared. The second draft was widely distributed and comments were elicited. The final draft incorporates many of the contributions of the various reviewers. (See Appendix I for a list of agencies and organizations from which input was requested and/or received.)

d. The Plan was then submitted to the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Regional Office.

CHAPTER 11

3 ADMINISTRATIVE INFORMATION

II. ADMINISTRATIVE INFORMATION

A. STATE MENTAL HEALTH AUTHORITY

The Department of Institutions is designated the official mental health and mental retardation authority and is authorized to receive grants-in-aid from the federal government under the provisions of 42 U.S.C. 246, and will administer such grants in accordance therewith (CRS 27-1-206, 1973).

The Executive Director of the State Department of Institutions is Raymond Leidig, M.D. The Executive Director is appointed by the Governor with the consent of the Senate and serves as a confidential employee of the Governor. The Department has five major Divisions: 1) Mental Health; 2) Developmental Disabilities; 3) Corrections; 4) Deaf and Blind; 5) Youth Services. (See Figure 1 for Organizational Chart of the Department of Institutions)

Address: Statutory Authority

Raymond Leidig, M.D., Executive Director
Department of Institutions
4150 South Lowell Boulevard
Denver, Colorado 80236

The Director of the Division of Mental Health is appointed by the Executive Director of the Department of Institutions. The Director of the Division of Mental Health is responsible for planning, organizing and directing the State's mental health program for the prevention and treatment of mental and emotional disorders. He has line supervision over Colorado State Hospital and Fort Logan Mental Health Center, and

the staff of the central office of the Division. He is responsible for the general effectiveness of the Division programs, activities and operations. (See Figure 2 for Organizational Chart of the Division of Mental Health)

Address: James R. Dolby, Ph.D., Director
Division of Mental Health
4150 South Lowell Boulevard
Denver, Colorado 80236

B. STATE MENTAL HEALTH ADVISORY COUNCIL

1. Membership

The State Mental Health Advisory Council will consist of 21 members who will be residents of Colorado. Only nine (9) members of the council will be direct or indirect providers of mental health services. The membership of the council should include representatives of those elements of the health service delivery system whose decisions impact the goals of: health care cost containment; access to health care services; appropriate placement; and continuity of care. Examples of sources for consumer and non-consumer members are:

a. Mental Health Association of Colorado;

b. Health systems agency boards of directors;

c. Health care payors (e.g., private insurance industry, medicaid administration);

d. League of Women Voters;

e. Child, Adolescent, and Senior Citizen Advocacy groups;

f. Ethnic Minority Advocacy groups;

g. Health manpower education and training institutions and agencies;

h. Allied health and social support providers (e.g., Nursing home industry, Community Care Organizations, etc.);

i. Health care and other human service licensure boards;

j. Former or present clients and/or family member;

k. Elected officials;

l. Board and/or staff member of mental health centers and clinics;

m. Voluntary human service agencies;

n. Private health care sector;

o. State departments and agencies;

p. School districts.

2. Selection Process

The Council shall be appointed by the Governor. For the first year of the council's existence, ten (10) members shall be appointed for one year terms and eleven (11) members for two year terms. From the second year forward, expired memberships shall be filled by the Governor for two year terms, except that appointments to fill unexpired terms of members who resign shall be for the unexpired terms of the resigned members. No council member shall serve more than five consecutive years.

Any citizen may nominate persons to serve on the council. The names of nominees may be submitted to the Governor, the Director, Division of Mental Health, or the Council.

The selection process will be implemented in such a manner as to ensure appropriate representation of the various geographic areas of the state, as well as the social, economic, and ethnic groups residing in the state.

3. Functions, Responsibilities and Procedures

The State Mental Health Advisory Council will function as an official advisory body to the Division of Mental Health concerning the development, revision, and administration of the State Plan. In that role, it functions as a collective voice for the mental health service client, provider, planner, administrator, and concerned citizen.

Among the Council's responsibilities are the following:

a. the Council will meet as often as necessary to review and critique development and implementation of the State Plan;

b. the Council will meet as often as necessary but not less than quarterly to consult with the State agency on the development and administration of the State Plan;

c. the Council will maintain a record of the dates of council meetings, issues considered, and a record of actions taken, including specific reference to the required annual review of the State Mental Health Plan for inclusion in the annual up-date of the Plan;

d. the Council will serve as a standing committee of the State Health Coordinating Council with the approval of that body;

e. the Council will establish ad hoc groups for special assignments deemed necessary by the Council or the Director of DMH;

f. the Council will develop by-laws and appropriate operating guidelines to ensure smooth and continuous operation.

Each year the members of the council will elect a Chairperson and Vice-Chairperson from the Council membership. A recording secretary may be designated by the Chairperson. A quorum will consist of 11 members present at any meeting. With a quorum present at any Council meeting, a majority vote will decide all questions.

Meetings of the Council will be open to the public.

C. ASSURANCES

1. Reports and Records

The Division of Mental Health will annually, report in writing to the Regional Office of ADAMHA its evaluation of each facility's compliance with the Standards/Rules and Regulations for community mental health centers and clinics and will keep such records and afford such access thereto as the Regional Office may find necessary to assure correctness, compliance, and verification of such reports.

The Division of Mental Health will retain on file for at least three years beyond participation in the program all documents and accounting records related to any expenditures. They will take such steps as necessary to ensure that centers/clinics retain, for at least three years after final payment of federal funds, all financial records and documents related to expenditures for projects funded wholly or in part with federal funds.

2. Conflict of Interest

No full-time officer or employee of the Division of Mental Health, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs shall receive funds from any applicant directly or indirectly for payment for services provided in connection with the planning, design, construction, equipping or operation of any projects funded under the Community Mental Health Centers Act.

D. ANNUAL REVIEW

1. Procedure for Annual Review

a. In November of each year the Division of Mental Health (DMH) will notify all recipients of the Plan that the annual review is underway. Concerned and affected agencies will be invited to comment on the Plan and recommend changes and revisions.

b. The DMH staff will review the comments and recommendations with the Advisory Council.

c. The Advisory Council will be requested to study the areas of primary concern and to recommend appropriate changes and revisions in the Plan.

d. A draft of the proposed revisions will be prepared for review by the Council.

e. After the Council review, the revised draft will be made available for public review.

f. When input generated during the public review has been appropriately considered by DMH and the Council, a final document, including the Council's comments, will be prepared for submission to the ADAMHA Regional Office.

2. Procedure for Publicizing the Plan

a. At least 30 days prior to the submission of the Plan to the ADAMHA Regional Office, a notice will be published in at least three major newspapers that the State Mental Health Plan is being up-dated, and that the proposed additions and changes are available for examination and comment.

b. Appropriate DMH staff will be available to discuss the Plan. Copies of the proposed changes and revisions will be available.

c. Within four months after final approval of the Plan a summary will be prepared for general distribution. The summaries will be made available to the Mental Health Association, centers/clinics, hospitals, and other agencies and organizations for distribution to the public.

E. PERSONNEL ADMINISTRATION

1. Personnel Standards

The State of Colorado has a merit system implemented through the State Personnel Department and governed by the State Personnel Board.

Sections 13-15 of the State Constitution provides for the establishment of a merit system. Hiring procedures, classification, compensation,

fringe benefits, grievance procedures and disciplinary actions for employees of Colorado State Hospital, Fort Logan Mental Health Center and the Division of Mental Health central office are determined in accordance with merit system regulations.

2. Non-Discrimination

The Division of Mental Health (DMH) will continue to comply with the letter and spirit of Federal Executive Order Nos. 11246 and 11375, the Civil Rights Act of 1964, as amended, the Governor's Executive Order dated April 16, 1975, the Colorado Antidiscrimination Act of 1957, as amended, the Equal Rights Amendment of 1972, and Rules and Regulations adopted by the State Personnel Board, which became effective July 1, 1975. The DMH policy in brief is to provide equal employment opportunities to all persons on the basis of individual merit without regard to race, creed, color, sex, age, national origin, marital status, family relationship, political or religious affiliations, organization membership or other non-merit factors. Compliance with this policy will be required of any agency from which the DMH purchases services.

The State of Colorado recognizes that a policy of nondiscrimination in itself is insufficient when attempting to reverse traditional patterns of discrimination. It is, therefore, necessary to implement a plan of affirmative action in order to identify discriminatory practices and initiate programs designed to replace those practices with positive approaches to human and organizational development. Such a program requires support and commitment from all levels, specific goals and the monitoring and evaluation of progress in achieving affirmative action

goals. The Division of Mental Health requires such affirmative action plans in its "Standards/Rules and Regulations for Mental Health Centers and Clinics." The Division of Mental Health is also requiring the central office and the two state hospitals to develop a specific 3 year affirmative action plan.

F. ADMINISTRATION OF 314(d) FUNDS

Section 314(d) of the Public Health Service Act, as amended, provides for the allocation of formula funds to states to "provide and strengthen public health services." Fifteen percent of Colorado's annual allotment is made available to the Division of Mental Health (DMH) for mental health services. Up to thirty percent of the DMH allocation will be used for administration of the program. The balance of the mental health funds will be utilized in accordance with federal guidelines with particular attention to:

1. projects designed to eliminate inappropriate placement in institutions of persons with mental health problems;

2. the development of alternatives to institutionalization;

3. improving the quality of care of those for whom institutional care is appropriate;

4. assistance to agencies to facilitate pre-screening of residents being considered for inpatient care to determine if such care is necessary;

5. provision of follow-up care by community mental health centers and clinics for residents of the state who have been discharged from mental health facilities;

6. high risk populations such as the poor and the elderly.

The highest priority for funding will be projects which are innovative, time limited, and which have a built-in evaluation component.

ORGANIZATIONAL CHART
DEPARTMENT OF INSTITUTIONS

FIGURE 1

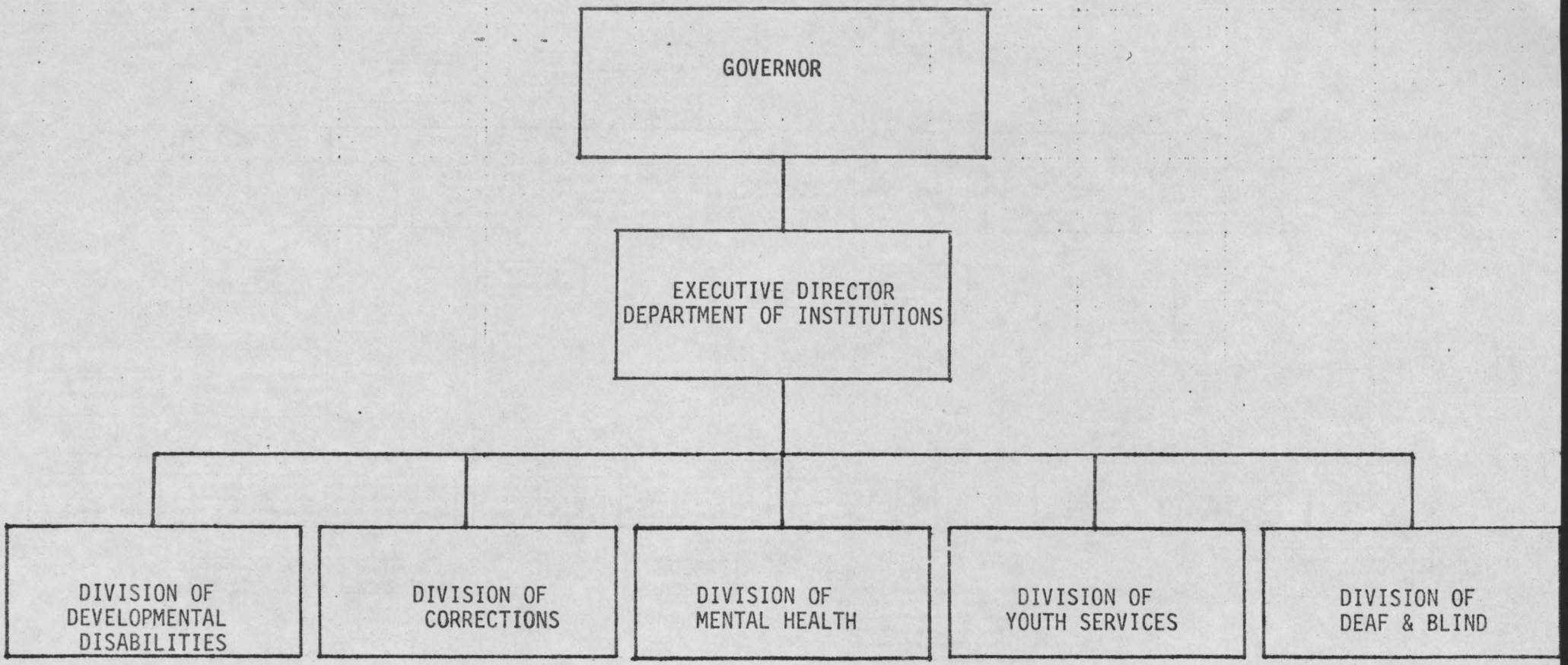

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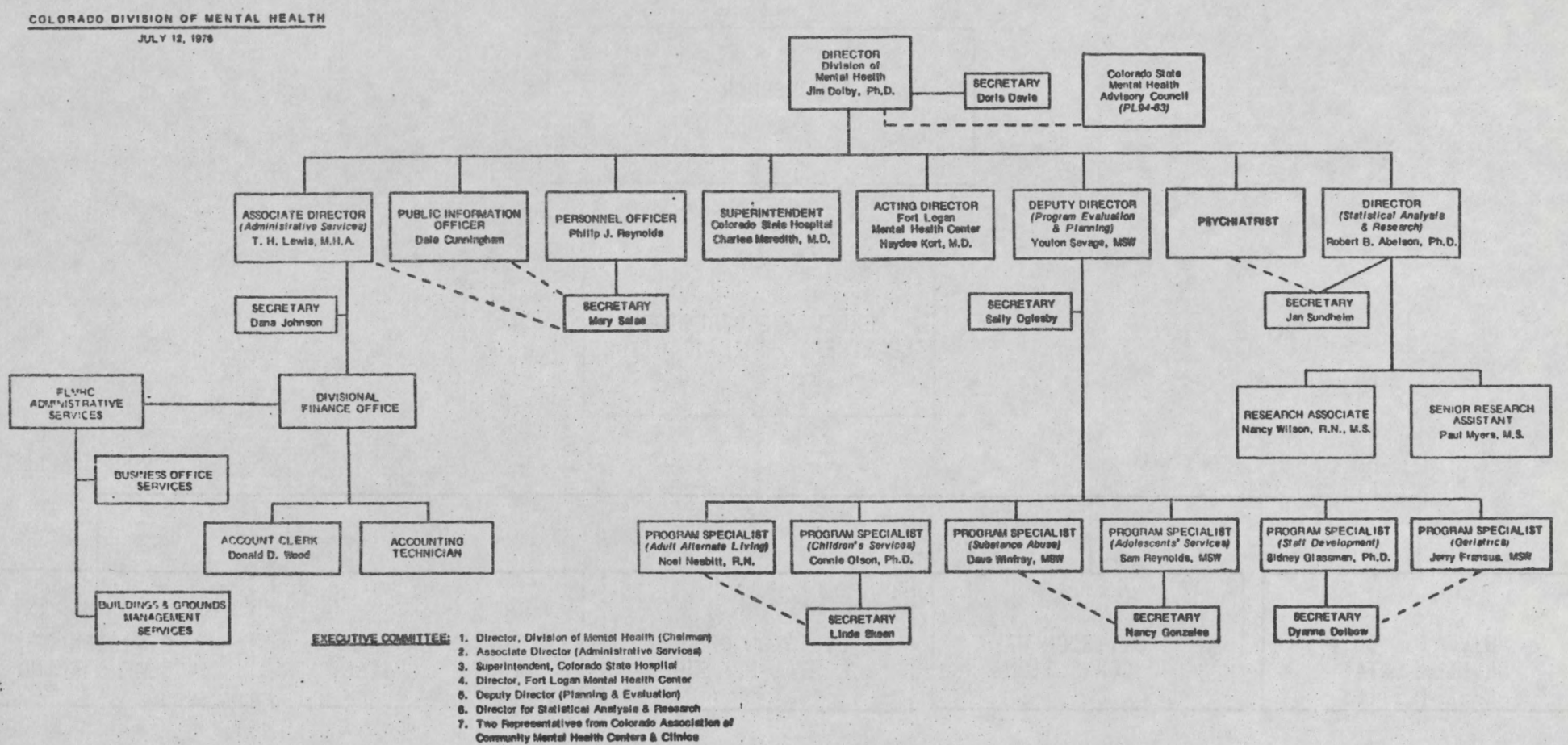
FIGURE 2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EXECUTIVE COMMITTEE:
1. Director, Division of Mental Health (Chairman)
2. Associate Director (Administrative Services)
3. Superintendent, Colorado State Hospital
4. Director, Fort Logan Mental Health Center
5. Deputy Director (Planning & Evaluation)
6. Director for Statistical Analysis & Research
7. Two Representatives from Colorado Association of Community Mental Health Centers & Clinics

CHAPTER III

4 STATEWIDE GOALS AND OBJECTIVES

III. STATEWIDE GOALS AND OBJECTIVES

A. GOALS

One purpose of the planning process is to develop procedures and mechanisms for managing the activities, tasks, and changes necessary to accomplish the mission and purpose of the organization. The setting of goals is both an essential element of the planning process and an important product. The goals in this chapter provide direction to the efforts of the public mental health system. The objectives which follow serve the dual functions of describing the steps necessary to accomplish the goals, and providing a means of assessing progress. These goals and objectives are to be our guidelines; however, they will be responsive to changing needs and other factors that evolve during the continuous planning process.

Woven into the fabric of the goals are the principles which undergird the state public mental health delivery system. These principles emphasize the provision of cost-effective services close to home, in the least restrictive setting, and in a manner which preserves human dignity, privacy and rights. The goals and objectives are the heart of the plan and serve as a unifying force which pulls together the various elements of the plan. These elements include need, special target populations, available and needed resources, coordination with other care-givers, the roles of the various components of the system, administration and accountability, and as previously indicated, the principles underlying the delivery of mental health services.

The goals and objectives are also in congruence with the congressional intent embodied in Public Law 94-63, the Community Mental Health Centers Amendments of 1975. This act focuses on: 1) the availability of a full range of mental health services (inpatient, partial hospitalization, outpatient, 24 hour emergency and consultation and education) in local communities; 2) special efforts to meet the mental health service needs of children, the aged, rape victims, and substance abusers; 3) pre-admission screening to reduce inpatient care; 4) the development of halfway houses and other alternatives to inpatient care; 5) follow-up care for persons who have been discharged from a mental health facility; and 6) services directed towards the prevention of mental illness.

The following comprehensive goals are interrelated and interdependent; therefore, the order of listing does not indicate relative priority.

1. Goal #1

> To provide mental health services through a system which:
> - is cost-effective
> - is coordinated with other agencies
> - is efficient
> - is based on the assessment of mental health needs
> - establishes and enforces quality of care standards
> - is evaluated.

The delivery of mental health services must be based on sound management principles which include determining what the needs are, obtaining the resources to meet these needs, providing effective services in the

most efficient manner and evaluating the impact of the services. Also necessary to this process are coordination with other agencies and the existence and enforcement of standards.

2. Goal #2

> To provide mental health services to the citizens of Colorado, emphasizing services which are:
> - least restrictive
> - community based
> - comprehensive
> - close to home
> - integrated
> - appropriate

The intent behind this goal is to provide services as close as possible to the client's home, in the most normal or home-like setting possible, and to emphasize utilization of the least intensive service consistent with the treatment needs of the client. The accomplishment of this goal requires:

a. recognition of the catchment area centers/clinics as the primary point of entry for clients entering the public mental health system;

b. pre-admission screening to insure that clients are not admitted to inpatient or another more intensive level of care than is required to effectively and efficiently treat them;

c. the development in each catchment area of the array of mental health services necessary to meet the service needs of the residents, including a range of alternatives to inpatient care for those clients who require 24 hour care, but not inpatient hospitalization;

d. the use of Fort Logan (the state hospital serving the Denver metropolitan area) for short term inpatient hospitalization of adults from the metropolitan Denver area in those instances where the cost of care in a general or psychiatric hospital is not competitive with the cost at Fort Logan;

e. the use of state hospitals for inpatient care for specialized inpatient services to children, adolescents and the aged who specifically require inpatient hospitalization;

f. the use of state hospitals and appropriate center/clinic services for clients requiring long term care; (This will obviously require the development of criteria to be used as the basis for selection of the appropriate treatment setting, and the movement of a client from one setting to another.)

g. the sharing of services among or between contiguous catchment area centers/clinics;

h. the provision of services through contractual or other formal arrangements with other local public, voluntary or private resources;

i. the continued use of Colorado State Hospital for the provision of adult inpatient services to the Pueblo area;

j. prior determination of the short-term adult inpatient average daily attendance for Fort Logan Mental Health Center and Colorado State Hospital to insure proper staffing of the treatment units.

In summary, this goal emphasizes the intent that the basic responsibility for the provision of mental health services rests with catchment area centers/clinics. Services will be provided in the local community whenever practicable. Inpatient services will be used only for those clients for whom inpatient services are clearly indicated.

Alternate treatment facilities, including skilled nursing homes, intermediate care facilities, residential care facilities, halfway houses, family care homes, and foster homes will be developed in the various catchment areas. The availability of these facilities and pre-admission screening are expected to reduce the inappropriate use of inpatient beds.

3. Goal #3

To provide mental health services tailored to the special needs of the following groups:

- children
- adolescents
- elderly
- alcohol and drug abusers
- rape victims
- ethnic minorities
- rural residents
- economically disadvantaged persons
- women
- chronically disabled

The indicated groups have been targeted because of the need for specific programs to meet their unique mental health needs. Utilization reports indicate that children and adolescents and the elderly are underserved. Chicanos, the largest ethnic minority group in Colorado, require a range of services which take into consideration not only the cultural factors which affect all Chicanos, but the diversity of mental health needs within the Chicano population.

Appendix II is the report of the Chicano Mental Health Planning Symposium, which took place in Denver in January 1976. This report identifies a number of issues essential to the planning and delivery of mental health services to Chicanos. Many of the symposium recommendations are incorporated in this plan.

Other ethnic minority groups, while comparatively small in number, also have a right to expect some attention to be directed to the impact of their cultural heritage on their mental health service needs. Rape

victims, rural residents and women can be better helped in treatment programs which are sensitive to their unique needs. The poor, which are also represented in some of the other groups, are the highest users of public mental health services. Treatment programs which can identify their special needs and ways of addressing these needs are essential.

An almost neglected target population is the chronically disabled, many of whom are former state hospital inpatients. The intent is to insure that the chronically disabled are identified and provided the services necessary to improve their overall functioning to the fullest extent possible, and that every effort is expended to avoid hospitalization or re-hospitalization unless such care is specifically required.

4. Goal #4

> To increase public knowledge of mental health services and ways of preventing mental illness.

Preventive services are directed at the many potential victims of mental illness, i.e., that segment of the population which, while not visibly mentally ill, function below their potential capacities. The primary thrust of this goal is the promotion of mental health by helping people acquire knowledge, attitudes, and patterns of behavior which will foster and maintain their mental well-being. Prevention-oriented mental health education must take into account the make-up of the individual communities to be served, i.e., the proportion of aged, ethnic minorities, children, etc., and the most effective ways

of reaching these groups. In this connection, there is considerable evidence to support the contention that a prevention program based on the individual, family, and small group contacts, is an effective strategy to employ in the provision of services to Chicanos. This application of the prevention concept may, for many Chicanos, be more beneficial than traditional direct service methods. A major concern to be addressed is the lack of data on the impact of preventive programs.

5. Goal #5

> To increase consultation services to other public agencies that provide services to mentally ill persons.

The term consultation services, as used in this plan, applies primarily to assisting other community service professionals improve their skills in working with mentally ill persons. Community service professionals to whom consultation services are offered include school personnel, law enforcement officials, social service workers, court personnel, public health nurses, agricultural extension workers, clergymen, physicians, and others. These individuals are the "gate-keepers" of the mental health system, for in times of trouble they are the ones to whom the average person turns for help, and they account for the largest percentage of referrals to mental health service agencies. Obviously, the more skilled the "gate-keepers" are, the more effective they will be in early detection and early intervention. Possible outcomes of the involvement of skilled "gate-keepers" include the prevention

of some serious mental health problems and more appropriate referrals to mental health centers/clinics and hospitals.

B. OBJECTIVES

1. Goal #1

> To provide mental health services through a system which:
> - is cost-effective
> - is coordinated with other agencies
> - is efficient
> - is based on the assessment of mental health needs
> - establishes and enforces quality of care standards
> - is evaluated

a. Cost-Finding System:

(1) By July 1, 1976, a uniform Chart of Accounts for the two state hospitals will be developed.

(2) By January 1, 1977, a uniform cost allocation procedure (to include cost definitions and detail methods of allocation of all fixed, variable, and step variable costs) for the two state hospitals will be developed and implemented.

(3) By July 1, 1977, a system capable of generating comparable fiscal information needed for cost-finding in centers/clinics will be developed.

(4) By January 1, 1978, the system will be fully installed in all centers/clinics.

(5) By July 1, 1978, comparable cost-finding data will be available for all centers/clinics.

(6) By July 1, 1978, the cost finding systems for centers/clinics and the two hospitals will be comparable.

b. Audit Guidelines:

(1) By October 1, 1976, financial audit guidelines for centers/clinics will be developed.

(2) By October 1, 1977, the initial audit of all centers/clinics based on these guidelines will be completed.

c. Energy Conservation:

(1) By July 1, 1979, a total energy conservation study will be done at both state hospitals.

(2) By July 1, 1981, state hospitals will begin conversion to solar heating/cooling, if proven feasible by the energy conservation study.

d. Staffing Pattern:

(1) By July 1, 1977, a classification and salary survey of centers/clinics will be completed.

(2) By July 1, 1978, the recommended staffing patterns for the state hospitals will be based on management engineering principles and normative standards.

(3) By July 1, 1978, the recommended staffing patterns for mental health centers/clinics will be developed.

e. Treatment Outcome Evaluation:

(1) By March 1, 1977, a method for evaluating treatment outcome,

comparable for the total system, will be decided upon by the Division of Mental Health in consultation with the statewide Evaluation Advisory Committee.

(2) By July 1, 1977, this method will be implemented statewide.

(3) By July 1, 1978, comparable data regarding treatment outcome will be available from all agencies.

f. Coordination with Other Agencies:

(1) By September 1, 1976, quarterly meetings with representatives of the State Health Planning and Development Agency will begin.

(2) By September 1, 1976, quarterly meetings with the Department of Psychiatry, University of Colorado Medical Center will begin.

(3) By September 1, 1976, quarterly meetings with the Department of Social Services will begin. These meetings will deal with such issues as reimbursement for mental health services under Titles XVIII, XIX and XX of the Social Security Act, and other aspects of care to persons eligible for services reimbursable by social service funds.

(4) By October 1, 1976, the Division of Mental Health will begin providing the State Health Coordinating Council with information on mental health service needs and recommended programs for meeting these needs, on an annual basis.

(5) By November 1, 1976, periodic contacts will be established with the Department of Education and the Judicial Department to deal with areas of mutual concern, such as services to children and forensic issues.

(6) By January 1, 1977, periodic contacts with such divisions

of the Department of Health as family health services, community health services, administrative services, alcohol and drug abuse and health facilities will be initiated.

g. Need Assessment:

(1) By October 1, 1976, the Division of Mental Health will produce a catalog of programs offered by its agencies.

(2) By October 1, 1976, a methodology for performing a comprehensive need assessment will be decided upon.

(3) By March 1, 1977, an annual inventory of existing facilities, as required by the State Plan, will be performed.

(4) By March 1, 1977, an annual update of the personnel needs and resources of the mental health system will be accomplished.

(5) By July 1, 1977, need assessment data to be used for program planning and budgeting purposes will be available.

(6) By October 1, 1977, a comprehensive inventory of services offered by the Division of Mental Health agencies will be produced.

(7) By July 1, 1978, need assessment data will be further refined.

h. Standards and Evaluation:

(1) By July 1, 1977, the On-Site Evaluation Instrument will be reviewed and revised.

(2) By July 1, 1977, every center/clinic will be evaluated using the 1976 version of the On-Site Evaluation Instrument.

(3) By July 1, 1977, each center/clinic/hospital will have a written Quality Assurance Program and peer review mechanisms.

(4) By July 1, 1978, the first review and update of the revised State Standards/Rules and Regulations for centers/clinics will be accomplished.

(5) By July 1, 1978, the Division of Mental Health will have developed standards for hospitals to supplement JCAH standards.

(6) By July 1, 1979, the hospitals will be evaluated using these supplemental standards.

(7) By July 1, 1981, the State Standards/Rules and Regulations for centers/clinics will be completely revised.

(8) By July 1, 1981, the Division of Mental Health will require all centers to meet Joint Commission on Accreditation of Psychiatric Facilities Standards for Centers.

2. Goal #2

> To provide mental health services to the citizens of Colorado, emphasizing services which are:
> - least restrictive
> - community based
> - comprehensive
> - close to home
> - integrated
> - appropriate

a. Use of Hospitalization:

(1) By July 1, 1977, the average daily attendance (ADA) at

the two state hospitals for FY 1976-77 will be six percent less than that for FY 75-76.

(2) By July 1, 1978, Fort Logan Mental Health Center will be established as the primary agency which provides adult inpatient services for the Denver metro area (except the Northwest Denver and Bethesda catchment areas).

(3) By July 1, 1978, the total ADA at the two state hospitals for FY 1977-78 will be seventeen percent less than that for FY 75-76.

(4) By July 1, 1979, the total ADA at the two state hospitals for FY 1978-79 will be twenty-eight percent less than that for FY 1975-76.

(5) By July 1, 1981, the ADA at the two state hospitals for FY 1980-81 will be thirty-eight percent less than that for FY 1975-76.

b. Center/Clinic-Hospital Integration:

(1) By January 1, 1977, the Division of Mental Health will form a joint center/clinic-hospital treatment planning group to formulate diagnostic, admission, treatment and discharge policies.

(2) By July 1, 1977, each center/clinic will have developed and implemented written procedures for the prescreening of potential inpatient admissions from social service departments, courts and other community agencies.

c. Services Close to Home:

(1) By July 1, 1977, the Division of Mental Health will develop in collaboration with appropriate agencies, proposed criteria and standards for admission to alternate treatment facilities.

(2) By July 1, 1978, all 14 current centers will have developed the full range of the 12 comprehensive services (inpatient, partial, outpatient, 24-hour emergency, consultation and education, pre-admission screening, halfway house, follow-up and services to children, the elderly, and alcohol and drug abusers). These services will be provided directly or through affiliated agencies.

(3) By July 1, 1978, at least eight of the catchment areas will each have available a minimum of five different types of residential treatment alternatives (e.g., nursing homes, intermediate care facilities, residential care facilities, halfway houses, family care homes, foster homes, etc.) to inpatient hospitalization.

(4) By July 1, 1978, all centers/clinics will provide follow-up treatment services to persons discharged from inpatient care who require such services.

(5) By July 1, 1979, at least 16 catchment areas will each have available a minimum of five different types of alternate treatment facilities.

(6) By July 1, 1979, all catchment areas will have 24-hour emergency care available.

(7) By July 1, 1981, the seven catchment area clinics will be comprehensive centers offering the 12 services. These services will be furnished directly or through affiliate agencies.

(8) By July 1, 1981, all centers/clinics will have available a minimum of five types of alternate residential treatment facilities.

d. Continuing Education:

(1) By July 1, 1976, a continuing education grant will have been developed for the training of center/clinic staff in the provision of the services required by PL 94-63 (inpatient, outpatient, partial care, consultation and education, emergency, prescreening, follow-up, halfway house services and services to children, the elderly and substance abusers).

(2) By October 1, 1976, the Division of Mental Health will begin providing training to mental health agencies in the delivery of consultation services to other care giving agencies.

(3) By January 1, 1977, the Division of Mental Health will have a proposed training program for increasing staff sensitivity to Chicano mental health needs.

(4) By January 1, 1977, the Division of Mental Health will designate for development one or more specialized, mental health resource centers for educational materials which would be available to all mental health agencies. The resource center will include special sections for educational materials on Chicanos and other groups with special mental health service needs.

(5) By May 1, 1977, the proposal for increasing staff sensitivity to Chicano mental health needs will have been field tested in at least three centers/clinics.

(6) By July 1, 1977, the Division will have three minority awareness training programs, including the program referred to in (4) above, available for agency use.

(7) By July 1, 1977, the Division will conduct the first of its training programs for the ongoing career development of clinical administrators.

(8) By July 1, 1977, the Division of Mental Health, with the assistance of the Continuing Education Committee, will establish standards for inservice and continuing education programs.

(9) By July 1, 1977, the Division will initiate a process for developing uniform definitions and training requirements leading to certification of employees for various levels, functions and roles in center/clinics.

(10) By July 1, 1977, the Division of Mental Health and the Division of Alcohol and Drug Abuse will have developed a training program for mental health agency staff who work with alcohol and drug abusers.

(11) By March 1, 1978, a training program for the training of parents to work in group homes will be developed.

(12) By July 1, 1978, the Division will have instituted a training program for persons who work with the chronically disabled.

(13) By July 1, 1978, the Division will have made available to each center/clinic a minimum of two board training sessions (baseline July 1, 1976).

(14) By July 1, 1979, the Division of Mental Health with the assistance of the Continuing Education Committee, will develop a proposal for the adequate funding of the training needs of the centers/clinics and hospitals.

3. Goal #3

To provide mental health services tailored to the special needs of the following groups:

- children
- adolescents
- elderly
- alcohol and drug abusers
- rape victims
- ethnic minorities
- rural residents
- economically disadvantaged persons
- women
- chronically disabled

a. Children (Ages 0-11 years):

(1) By July 1, 1977, the proportion of admissions of children to the state mental health system during the 76-77 FY will be increased by 25 percent over that of the base year, FY 1974-75.

(2) By July 1, 1978, twelve centers/clinics will have professionals trained in the treatment of children.

(3) By July 1, 1978, all catchment area programs designated as centers as of that date will have a partial care program for children

if the need in the catchment area warrants such services.

(4) By July 1, 1978, the proportion of admissions of children during the 77-78 FY will be increased by 35 percent over that of the base year, FY 1974-75.

(5) By July 1, 1978, Fort Logan Mental Health Center will add an additional unit in the Children's/Adolescent Division.

(6) By July 1, 1978, at least one group home with specially trained house parents will be established in at least each of the six catchment areas with the greatest proportion of youth. (Adams, San Luis Valley, Arapahoe, Jefferson, Southwest Denver, Southeast Colorado)

(7) By September 1, 1978, twelve centers/clinics will have a home treatment program to work with children in their own homes.

(8) By July 1, 1979, all catchment area programs will attempt to have a written agreement defining their working relationships with the school district, day care, head start and other pre-school programs which receive public funds.

(9) By July 1, 1979, the proportion of admissions of children during the 78-79 FY will be increased by a minimum of 45 percent over that of the base year, FY 1974-75.

(10) By July 1, 1979, all centers/clinics will have professionals trained in the treatment of children.

(11) By September 1, 1980, all centers/clinics will have a home treatment team to work with children in their own homes.

(12) By July 1, 1981, all catchment area agencies designated as

comprehensive centers after July 1, 1978, will have a partial care program for children if there is a need for such services in the catchment area.

(13) By July 1, 1981, all catchment area centers/clinics programs will have at least one group home with specially trained house parents.

b. Adolescents (Ages 12-17 years):

(1) By July 1, 1977, the proportion of admissions of adolescents to the state mental health system during the 76-77 FY will be increased by fifteen percent over that of the base year.

(2) By July 1, 1978, twelve centers/clinics will have professionals trained in the treatment of adolescents.

(3) By July 1, 1978, all catchment area programs designated as centers as of that date will have a partial care program for adolescents if justified by the number of adolescents requiring such services.

(4) By July 1, 1978, the proportion of admissions of adolescents during the 77-78 FY will be increased by twenty percent over that of the base year, FY 74-75.

(5) By July 1, 1978, at least one group home with specially trained house parents will be established in each of the six catchment areas with the greatest proportion of youth (Adams, San Luis Valley, Arapahoe, Jefferson, Southwest Denver, Southeast Colo.).

(6) By July 1, 1979, the proportion of admissions of adolescents during the 78-79 FY will be increased by a minimum of twenty five

percent over that of the base year, FY 74-75.

(7) By July 1, 1979, all centers/clinics will have professionals trained in the treatment of adolescents.

(8) By July 1, 1981, all catchment area centers/clinics will have at least one group home with specially trained house parents.

(9) By July 1, 1981, all catchment area centers and clinics will have a partial care program for adolescents if the number of adolescents requiring such services justifies a partial care program.

c. Elderly:

(1) By September 1, 1976, the Division of Mental Health will begin holding at least quarterly meetings with the Division of Services for the Aging with specific attention to the requirements and guidelines included in Public Law 94-63, the Community Mental Health Center Amendments of 1975, the Older Americans Act, and other federal and state statutes and directives which relate to services to the elderly.

(2) By September 1, 1976, the Division of Mental Health and the Division of Services for the Aging will begin actively promoting a state-wide field-level partnership between community mental health centers/clinics and area aging agencies with a view toward including a mental health services component in the information and referral systems of the area aging agencies, and coordinating local assessments of program needs as they relate to the elderly.

(3) By January 1, 1977, the Division of Mental Health will have begun to discuss with the Division of Services for the Aging, ways of reflecting in the FY 77-78 budget of both Divisions their joint efforts to assist older persons in maintaining themselves in independent living arrangements.

(4) By July 1, 1977, the proportion of elderly persons admissions during the 76-77 FY will be increased by 50 percent over that of the base year, FY 1974-75.

(5) By July 1, 1978, the proportion of admissions of elderly persons during the 77-78 FY will be increased 100 percent over that of the base year, FY 1974-75.

(6) By July 1, 1978, at least six catchment area programs with the largest proportion of elderly in their population (Northwest Denver, Northeast Colorado, East Central, Southeast Colorado, Midwestern, West Central) will have independent living groups, group homes, transportation networks, home industries, etc. to minimize the need for nursing home care. These services need not be directly furnished by the mental health center/clinic, but can be provided by other community agencies with support from the mental health agency.

(7) By July 1, 1980, all catchment areas will have independent living groups, group homes, transportation networks, home industries, and other similar services.

(8) By July 1, 1981, the proportion of admissions of elderly persons during the 80-81 FY will be increased by 200 percent over

that of the base year, FY 1974-75.

d. Alcohol and Drug Abusers:

(1) By August 1, 1976, the Division of Mental Health (DMH) and the Division of Alcohol and Drug Abuse (DADA) will have established a work group to address the problems in coordinated service delivery identified by each Division.

(2) By September 1, 1976, DMH and DADA will have entered into an agreement concerning coordinated on-site evaluations of alcohol and drug abuse programs at mental health centers, clinics and hospitals.

(3) By September 1, 1976, the DMH and DADA will have coordinated procedures for the use of admission forms and program data.

(4) By October 1, 1976, DADA will have developed, in collaboration with DMH, a process for insuring input into the state alcohol and drug abuse plan by mental health centers and clinics, the two state hospitals, the Division of Mental Health central office, and vice versa.

(5) By January 1, 1977, the DADA-DMH work group will present a report to the Human Services Policy Council and the State Health Coordinating Council on the proposed procedures and mechanisms for overcoming problems in coordinated service delivery.

(6) By July 1, 1977, the DMH and DADA will have jointly developed guidelines for providing appropriate alcohol and/or drug abuse services to clients of the mental health system,

and for providing appropriate psychiatric services to clients of the alcohol and drug abuse service system.

e. Rape Victims:

(1) By July 1, 1977, Colorado State Hospital (CSH) will institute a limited pilot program to identify and evaluate treatment techniques for the rehabilitation of rape offenders.

(2) By July 1, 1977, all catchment area programs will be offering consultation and education services directed toward the prevention of rape, using information from the Denver Department of Health and Hospitals (DDHH) program and other sources.

(3) By July 1, 1977, information on the techniques for treatment of rape victims and their families from the DDHH study and other sources will be available in each center/clinic and both state hospitals.

(4) By July 1, 1979, if warranted by the results, information from the CSH pilot program for rape offenders will be made available to correctional and other appropriate agencies and facilities in the state.

f. Ethnic Minorities:

(1) By January 1, 1977, the Division of Mental Health will form a talent bank of minority mental health professionals and other knowledgeable people to assist in staff development functions and determine the special mental health needs of Chicanos, Blacks, Native Americans, and Asian Americans. This group will

develop a mechanism for the exchange of expert technical information in minority services, and make recommendations regarding programs to meet the special mental health needs of ethnic minority groups.

(2) By January 1, 1977, the Division of Mental Health will be actively soliciting funds for special research and demonstration projects to determine special treatment needs of ethnic minorities and techniques for most effectively meeting these needs.

(3) By January 1, 1977, the DMH will conduct a study of the staffing pattern of each center/clinic to determine how these correlate with the ethnic and sex proportions in the client and general population.

(4) By April 1, 1977, the results of the study of the ethnic and sex makeup of center/clinic staffs will be made available to the agencies concerned for use in updating affirmative action plans.

(5) By July 1, 1980, information from the special research and demonstration projects for Chicanos, Blacks, Native Americans and Asian Americans will be reflected in the services provided by centers/clinics and hospitals.

9. Rural Residents:

(1) By July 1, 1977, the DMH will form an ad hoc committee which will identify the special mental health service needs of rural residents, the continuing education needs of mental health agency staff who serve them, and ways of effectively meeting these needs.

(2) By May 1, 1978, the report of the ad hoc committee will be available for consideration for special funding in the FY 1979-80 budget and for dissemination to appropriate agencies.

h. Economically Disadvantaged Persons:

(1) By July 1, 1976, the Division of Mental Health will use poverty resources as a major criteria for setting priorities for funding mental health agencies in Colorado.

(2) By October 1, 1976, all centers/clinics will be required to identify and prioritize the areas of poverty in their catchment areas and to indicate the efforts made, and plans to serve, these high risk populations.

(3) By October 1, 1976, DMH staff will begin meeting with appropriate State Department of Social Services and Regional Department of Health, Education & Welfare staff to explore means of increasing the availability of funding (via Medicare, Medicaid and other Social Service programs) for mental health services to the poor. The results of these meetings will be appropriately disseminated.

i. Women:

(1) By January 1, 1977, the DMH will form an ad hoc committee to gather information relating to the mental health service needs of women and ways of effectively meeting these needs. This information will be disseminated to centers/clinics and hospitals.

(2) By July 1, 1977, all centers/clinics and state hospitals which

do not have treatment programs appropriate to the special mental health needs of women will be required to develop and document such a program.

j. Chronically Disabled:

(1) By January 1, 1977, each catchment area agency will have made specific and documented efforts to identify chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

(2) By July 1, 1977, each catchment area agency will have begun providing services to chronic psychiatrically disabled clients in nursing and boarding homes in its catchment area.

4. Goal #4

> To increase public knowledge of mental health services and ways of preventing mental illness.

(1) By July 1, 1976, the DMH central office will issue monthly releases to the media on various mental health issues.

(2) By July 1, 1976, the Division of Mental Health will begin to offer consultation to one mental health agency per month on various ways of reaching the public.

(3) By July 1, 1977, the Division of Mental Health will have begun to conduct one joint public information activity with the Mental Health Association of Colorado each year.

(4) By July 1, 1977, mental health centers/clinics will be requested

to provide periodic releases to local news media on various health issues.

(5) By July 1, 1977, the DMH will invite centers/clinics to submit proposals for innovative preventive programs and evaluation of these programs. At least one proposal will be approved for funding with 314(d) funds.

(6) By January 1, 1978, all mental health centers/clinics will be required to conduct or sponsor each year, at least one seminar, workshop or other public program which focuses on the prevention of mental illness.

(7) By July 1, 1978, the DMH will initiate an assessment of consultation and education services.

5. Goal #5

> To increase consultation services to other public agencies that provide services to mentally ill persons.

(1) By October 1, 1976, the DMH will offer periodic consultation services to Department of Health divisions (e.g., family health services, community health services, alcohol and drug abuse) which request such services.

(2) By January 1, 1977, the DMH will offer periodic consultation services to the Department of Social Services, the Judicial Department, and the Department of Education.

(3) By January 1, 1977, all centers/clinics will have been requested

to have at least one information sharing/mutual consultation session with public health nurses and other appropriate public health personnel concerning areas of shared responsibility and coordination of health services.

(4) By January 1, 1977, all centers/clinics will have been requested to have at least one information sharing/mutual consultation session with the regional alcohol and drug abuse coordinator.

(5) By January 1, 1977, all centers and clinics will have been requested to have at least one information sharing/mutual consultation session with county social services personnel to discuss mutual concerns and ways of improving services to mutual clients.

(6) By March 1, 1977, all centers and clinics will have been requested to have at least one information sharing/mutual consultation session with school district staff and district and other court personnel.

(7) By January 1, 1978, all centers/clinics will be required to have periodic information sharing/mutual consultation sessions with public health nurses and other appropriate public health personnel, regional alcohol and drug abuse coordinators, court personnel, school district(s) staff, social services staff and staff of other appropriate human services agencies in the catchment area such as clergymen, law enforcement agencies, etc.

CHAPTER IV

5 THE STATE MENTAL HEALTH PROGRAM

IV. THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF THE STATE MENTAL HEALTH SYSTEM

The Colorado public mental health system consists of two state hospitals, both of which are fully accredited by the Joint Commission on Accreditation of Hospitals, twenty-one mental health centers and clinics, each of which serves a defined catchment area, and three specialty clinics. The Department of Institutions is the statutory authority for the provision of mental health services to the citizens of the State of Colorado. The Department of Institutions has delegated to the Division of Mental Health the authority to operate the two state hospitals, to purchase services from community mental health centers and clinics, and to otherwise plan for and direct the mental health program.

Division of Mental Health

The Division of Mental Health exercises the following responsibilities.

1. Planning

This includes determining need, initiating plans and/or responding to new state or federal legislation which requires statewide mental health planning efforts.

2. Coordination

This involves the facilitation of cooperative activities among and between components of the Colorado mental health services delivery system and other human service agencies to meet the various mental health service needs of the residents of the state.

3. Executive Direction

The exercise of authority as an agent of the State Executive, including the establishment and enforcement of policies, rules and regulations is encompassed in this responsibility.

The Division of Mental Health (DMH) staff includes six Mental Health Program Specialists whose primary responsibility is monitoring the programs and services of the state hospitals and centers and clinics to ensure compliance with standards and to assist the agencies in improving services. Other DMH staff also perform general monitoring functions. The primary program monitoring staff consists of one nurse, three social workers and two psychologists, all of whom have clinical and administrative experience.

4. Consultation

This would provide for consultation on planning, clinical programming, funding and evaluation to all components of the system, to the Governor's office and other state offices and agencies.

5. Evaluation and Accountability

This includes providing necessary leadership in the development of a methodology for measuring the impact of treatment and prevention efforts and relating this to cost.

6. Advocacy

Advocacy involves initiating and promoting the development of mental health programs to serve the needs of all residents of the state.

The client advocacy function includes:

a. requiring agencies to make services available to all who require mental health services, regardless of race, sex,

religious beliefs, age, level of disability, etc., and requiring agencies to provide services in a manner which takes into consideration cultural and other variables;

b. publication of a handbook on patient's rights and responsibilities which sets forth the legal rights of patients; (A copy of this document, which will be in final form within two months, will be made available to each state hospital inpatient.)

c. the establishment of a grievance mechansim which includes the availability of a designated patient advocate in each state hospital and staff assistance to clients who wish to contact legal aid organizations or private counsel.

The service facilities which comprise the spectrum of available services including the public private/voluntary sectors are identified as follows:

Public Treatment Facilities

a. Colorado State Hospital (CSH) which is located in Pueblo, serves forty-seven counties in the southern and western portions of the state.

b. Fort Logan Mental Health Center (FLMHC) is located in southwest Denver. It serves the Denver metropolitan area and northeastern Colorado. As of July 1, 1976, FLMHC will also serve six counties in north-central Colorado.

c. There are twenty-four mental health centers and clinics from which the state purchases mental health services. Fourteen centers and seven clinics serve specific catchment areas and

three clinics are specialty programs. A center is defined as an agency which provides the five "essential" services (inpatient, partial hospitalization, outpatient, 24-hour emergency care and consultation and education). By local definition, a clinic provides fewer than the five essential services, but generally at a minimum, outpatient, consultation and education and emergency services. In actuality, some "clinics" provide the same services as some centers, but have not been funded. All centers and clinics are private, non-profit corporations except the Larimer County Mental Health Clinic and Northwest Denver Mental Health Center, both of which are county agencies.

d. Colorado Psychiatric Hospital is located in Denver on the University of Colorado Medical Center campus.

Private/Voluntary Treatment Resources

a. Three private psychiatric hospitals and over a score of private general hospitals which have psychiatric wards or which will accept psychiatric patients exist.

b. Mental health clinics and other non-hospital mental health treatment facilities which do not have contractual arrangements with the Department of Institutions are available resources.

c. Private practitioners (nurses, social workers, psychologists, pastoral counselors, psychiatrists, etc.) form a multitude of resources.

d. Other resources include the following:

(1) volunteer agencies which provide treatment and/or personal counseling services; (These include Human Services

Incorporated, Jewish Family and Children's Service, Catholic Community Services and Lutheran Service Society.)

(2) public agencies whose functions include personal counseling (e.g., county departments of social services, probation and parole departments, vocational rehabilitation programs, community centers for the developmentally disabled, public health nurses);

(3) private organizations which do not fall into any of the above categories, but which are primarily oriented toward services to specific populations such as drug and alcohol abusers.

B. PRE-ADMISSION SCREENING

1. Role of Hospitals and Centers and Clinics

Mental health centers and clinics, CSH and FLMHC are engaged in pre-admission screening. In those catchment areas where centers and clinics have well established relationships with courts, social service departments and other community agencies, most of the pre-admission screening is carried out by the catchment area center or clinic. In other areas, some pre-admission screening is accomplished by CSH and FLMHC. Many clients are entering state hospitals without pre-admission screening.

The DMH policy is that persons entering the mental health system are, to the maximum extent possible, to enter through the catchment area center or clinic. The intent is to have the pre-admission screening

function take place in the local community. Primary emphasis is on the provision of the necessary services as close to the individual's home as possible and in the least intensive setting consistent with the individual's clinical needs.

Some types of clients referred directly to CSH and FLMHC include children, adolescents, elderly, seriously disturbed adults who appear to require inpatient care and, in the case of CSH, forensic clients or the "criminally insane." CSH has statutory responsibility for forensic clients. Both state hospitals' roles currently include inpatient services to persons in the four age groups (children, adolescents, adult, elderly). However, it is believed that some of the children, adolescents, adults and elderly persons referred for inpatient care could and should receive outpatient care or treatment in an alternate treatment facility in the local community. In order to reduce inpatient admissions, the procedures outlined in Section 2 which follows are being implemented.

2. Procedure for Pre-Admission Screening by Centers and Clinics

   a. All catchment area centers and clinics will inform the district courts, social service departments and other major referral sources in the catchment area of the center's/clinic's responsibility for pre-admission screening of all potential inpatient clients.

   b. Each catchment area agency shall develop a written procedure for pre-admission screening and distribute the procedures to appropriate agencies. The criteria for admission to inpatient care will take into consideration:

(1) the persons physical health; e.g., if there are such medical problems as uncontrolled diabetes, arteriosclerosis, etc., as determined by a physician, inpatient or skilled nursing home care might be indicated;

(2) the seriousness and nature of the pathology; e.g., a client who is blatantly schizophrenic and dangerous to himself/herself might be hospitalized or placed in a secure non-hospital setting;

(3) current and past medication need and drug use; e.g., if an individual requires or has been using drugs (licit or illicit) of a type or in an amount which requires a period of observation or stabilization, a more intensive form of care might be indicated;

(4) the adequacy of the individual's social support system; e.g., an individual who lives alone and has no relatives or significant others to call upon, might in a time of emotional stress require a supervised treatment setting;

(5) age and maturity; e.g., does the individual need to be in a specific setting because of precocious or retarded development;

(6) other factors; e.g., previous medical and/or psychiatric history, financial circumstances and the availability of less restrictive alternatives, etc. should be considered.

The decision regarding the type or locus of treatment is basically a clinical judgement. In that by state statute, the treatment program must be under the overall direction of

a physician. The responsible physician in each agency will designate, to perform pre-admission screening functions, those staff members who have the requisite training, skill and experience.

c. The written procedure shall designate a primary agency contact person and a back-up contact person for pre-admission screening.

d. Appropriate reports shall be provided the requesting agency, and proper documentation shall be maintained by the center/clinic.

e. If the client is admitted to the center/clinic, he/she will be asked to sign a release of information form which will authorize the obtaining of appropriate information from other agencies and the release of appropriate information to agencies which need such information in the interest of the client. (Note: The Care and Treatment of the Mentally Ill Act permits the exchange of information on certified individuals by "professional persons.")

f. In those instances where a person who should have been evaluated by a catchment area center or clinic bypasses the center/clinic and appears at CSH or FLMHC to be admitted, the hospital may refer the individual to the appropriate center/clinic, or if clinically or otherwise appropriate, the person may be admitted to the hospital. If the person is admitted, the hospital will ask the client to sign a release of information form and notify the appropriate center/clinic of the admission. The center/clinic will contact the agency which directed the client to the hospital to clarify the referral process.

All catchment area centers and clinics (see Chapter VI, Section C) are designated the pre-admission screening agency for their respective catchment areas.

C. ALTERNATIVES TO HOSPITALIZATION

1. Need Within Each Catchment Area

Each community mental health center/clinic has the responsibility for ascertaining on an ongoing basis the need for alternatives to both hospitalization and other forms of institutionalization within its catchment area. A survey of existing resources should be conducted as cooperative effort between such agencies as: the social services department of each county within the catchment area; developmental disability agencies such as the community centered boards; county health departments; courts; and private placement agencies.

2. Responsibility for Developing Alternatives

The primary responsibility for developing alternatives to hospitalization for mental health clients and/or potential mental health clients rests with centers and clinics. The two state hospitals have experience and expertise in this area and should be consulted. Alternatives assessed for potential use by mental health clients should emphasize the least restrictive alternative principle. In addition to the continuum of community based "institutional" programs which includes local psychiatric hospitals, psychiatric wards of general hospitals, nursing homes, etc., alternatives to institutionalization including sheltered workshops with supportive living

arrangements, family care homes, supervised boarding homes, group living homes, foster homes and a variety of other non-institutionalized facilities and services are being utilized. Additional such facilities are needed. Other community resources which are to be appropriately utilized include the facilities of such agencies as Human Services, Inc., Catholic Social Services, Lutheran Social Services, Jewish Family and Children's Services, as well as Vocational Services and other sections and divisions of the Department of Social Services.

3. Efforts to Develop Alternatives to Hospitalization

Intensive efforts to develop alternatives have been mounted in a number of communities. One county (Arapahoe) passed a bond issue to obtain a facility; another agency (Adams County Mental Health Center) developed boarding and sheltered workshop facilities with its own resources, then allowed the facility to become a private corporation from which it now purchases services. Still another center (Southwest Denver) has developed a series of family care homes which it uses in lieu of inpatient beds. Other centers have contracts and affiliation arrangements with boarding and nursing homes, as well as agreements for the use of other types of non-hospital alternatives.

4. Responsibility for Information and Referral Services in Each Catchment Area

Each catchment area program is responsible for providing information and referral services in the catchment area. Such services should be coordinated with the local United Way agencies and other human service organizations and groups.

D. PUBLIC MENTAL HOSPITALS

State mental hospitals began a new era in 1961 when Colorado State Hospital (CSH), then eighty-two years old, began a radical reorganization which saw it change from an overcrowded human warehouse with six thousand ill cared for clients, to a progressive treatment-oriented human services center. In the same year, Fort Logan Mental Health Center (FLMHC), a state hospital which was to pioneer many advances in mental health care, was organized. Both hospitals played important roles in the development of the state's community mental health centers.

Fort Logan Mental Health Center

1. Description of Living Conditions and Treatment Resources

   a. Living Conditions

      The physical environment at FLMHC consists of spacious, airy buildings divided by patios and lawn areas. The architectural style of FLMHC has served as a model for other psychiatric hospitals throughout the county. The patient units contain single, two and four bed accomodations with adequate individual closet and drawer space for personal belongings of the patients. All patients wear their own clothing and have access to the clothing lab to select additional wearing apparel as needed. Funds are available to meet personal needs of patients who have no other resources.

The campus of FLMHC consists of 270 acres and includes many state and community programs, in addition to psychiatric programs as follows: Central Office for the Department of Institutions, including Executive Director's Office, Division of Mental Health, Division of Corrections, Division of Developmental Disabilities and Division of Youth Services; Intergovernmental Personnel Training Program, a division of the State Personnel Department; two CHINS Homes (Arapahoe County program); offices for the Colorado Corrections Association; Community Corrections Residential Program (a program sponsored by Adult Parole.)

b. Treatment Resources Available

Fort Logan has multi-disciplinary teams which are responsible for planning and delivering psychiatric treatment. Disciplines represented on teams or available for consultation include social workers, psychiatric nurses, psychiatrists, occupational therapists, psychologists, recreational therapists, teachers and mental health workers. Vocational rehabilitation services are provided by vocational counselors, largely through funding from the Division of Vocational Rehabilitation of the Department of Social Services.

A variety of expertise in various new and traditional psychotherapy techniques exists among center staff. Both group and individual psychotherapy are utilized. Chemotherapy is available as prescribed by the team psychiatrist. Electroshock is used sparingly and no psychosurgery has ever been prescribed.

Adequate financial resources are needed to maintain the treatment programs and provide sufficient staff to meet the needs of a seriously disabled client population. Constant effort at all levels of the system is important to avoid the hospital being used as simply a depository for some of society's problems.

2. Efforts to Improve Quality of Institutional Care

a. In March 1975, Standards of Quality Treatment Services were issued describing: (1) context of the treatment program; (2) patient care; (3) treatment program; and (4) discharged planning or transfer.

b. Treatment Review Committee, an interdisciplinary group, was established by the above policy and formally reviews the required, individualized treatment plans in charts with written documentation to supervisors about treatment practices, standards and alternative approaches of equal or greater effectiveness in such or related cases. This feedback raises the awareness of treatment staff and is directed towards improved quality of treatment.

c. The Medical Records Committee has responsibility to review proposals for changing the medical record, for reviewing deficiencies, for auditing the quality of documentation of medical information and assessing training and consultation needs of clinical staff.

d. The Utilization Review and Audit Committee is responsible for conducting special audit studies and concurrent review to

meet the Standards of Care Review established by the Colorado Department of Health, an external licensing body, Joint Commission on Accreditation of Hospitals (JCAH), Professional Standards Review Organization (PSRO), Medicare, Medicaid, Civilian Health and Medical Program of the United States (CHAMPUS) and other third party payors. This Utilization Review and Audit Committee also is responsible for reviewing the variations concerning patient care and staff responsibility for standards of care. Medical Care Evaluation Studies required by PSRO through the Colorado Medical Foundation are in progress.

e. The center has established a full-time position for a Patient Representative who is available to patients for discussing their concerns about the quality of care and acts as a factor in remedying of the identified problem. The Patient Representative is accountable to the Clinical Director.

f. The Professional Discipline Chiefs of various professional groups (psychiatrists, psychologists, social workers, nurses, activity therapists, mental health workers, vocational counselors, pastoral counselors and alcoholism counselors) within the center have major responsibilities for standards of professional practice related to quality of patient care, for supervision of and consultation with members of their discipline and others.

g. Inservice training programs are available to all staff through the Division of Hospital Standards and Inservice Training.

A special focus of inservice training over the last few years has been on interethnic and sex role awareness to implement the center's affirmative action plan. Sensitivity to these issues increases staff ability to work effectively with people of different backgrounds. In addition, a climate has been fostered which encourages staff to participate in extramural programs to learn and upgrade skills. Problem-Oriented Records have recently been instituted in some units after inservice training of staff in this process. The aim of such records is to provide quality of patient treatment through improvement of documentation. The goal is to move quickly towards use of this method in all patient divisions.

h. The Program Information Analysis Department reviews program operations and goal accomplishment in patient treatment providing data and feedback to administration and clinical staff about the treatment program.

i. The use of the problem/goal-oriented record system requires the setting of specific treatment goals and the evaluation of the progress made in accomplishing the goals.

3. Description of Present Fort Logan Mental Health Center Population

Fort Logan Mental Health Center is organized to provide treatment to children, adolescents, adults, geriatric patients and alcoholics who have severe behavioral and functional disorders. A mental health service has been established for deaf and hearing impaired persons in the Denver metropolitan area.

Since its beginning in 1961, the Fort Logan Mental Health Center has had a basic commitment to short-term intensive treatment and early return of the patient to community living. This has resulted in the population receiving not only inpatient care, but graduated intensities of care in transitional living facilities on grounds and living in the community. Specialized programs provide long-term maintenance and support to many patients in community living situations who formerly would have remained in the hospital. For the first half of the current fiscal year (1975-76), the average daily attendance of this inpatient population was:

PROGRAM DIVISION	REQUIREMENTS FOR ADMISSION	ADA
Adult Psychiatric	Severe psychiatric disability	57
Alcoholism	Severe drinking problem	34
Children/Adolescent	Severe psychiatric illness	37
Geriatric and Deaf	Severe psychiatric illness	18
	FLMHC Total Inpatient Population:	146

In addition to inpatient beds, FLMHC also has ninety-four beds in on-grounds transitional living facilities.

Fort Logan serves sixteen counties, including the metropolitan Denver area and northeast Colorado. Beginning July 1, 1976, Fort Logan will also serve six counties in north-central Colorado. The major portion of the population served resides in a highly urbanized area within 20-30 miles of the hospital.

Within the area served by the hospital are nine community mental health centers and five community mental health clinics. Short-term, acute care for adults is provided in local communities whenever possible.

The hospital provides acute care for adult patients from northeast Colorado, Arapahoe County and on contract with some local centers. Currently, the basic responsibility of FLMHC is specialized inpatient services to children, adolescents, adults, geriatrics, alcoholism and long-term care for the chronically ill in programs designed to avoid institutionalization.

4. Plans for Avoiding Chronicity

The most important factor in avoiding chronicity is the availability of high quality treatment for the client. Intensive short-term hospitalization, maintenance of the person's ties to the social and cultural community of choice and early return to community living helps avoid chronicity. The FLMHC has attempted to develop multiple levels of care so clients can move toward increasing independence. In addition, FLMHC has supported and encouraged in every way possible development of adequate accessible community based services which emphasize prevention and early, effective intervention. The FLMHC vocational services program is a particularly excellent example of the hospital's efforts to avoid or limit chronicity.

5. Plans for Providing Social and Recreational Stimulation

The treatment philosophy of the FLMHC is based on rehabilitating and developing social skills as a part of the treatment of people admitted. The total treatment process recognizes and encourages social interaction as a basic therapeutic strategy. The Activity Therapy Program focuses on the growth potential of the client through activities and recreational programs. Most treatment teams have an activity therapist (academically trained as an occupational or

recreational therapist), who is responsible for both schedules and spontaneous activities. Clients utilize community facilities for swimming, bowling, movies, etc. This acquaints the client with the community and increases the likelihood that interest will continue after hospitalization. Cultural activities such as the theatre, arts and musical events are available and offer opportunities for clients to develop new interests. Active participation in camping, sports and games is encouraged. Instruction and materials are available for a wide range of craft projects such as macrame, ceramics, leather work and other crafts. The activity therapist also joins other treatment staff in improving daily living habits related to eating, grooming, manners and socializing. These help prepare the client for return to the community with an acceptable level of social skills.

Social and recreational programs are also available to clients who are not in the hospital setting, i.e., clients in boarding homes, nursing homes or other community living situations. Tickets for social and cultural events are made available, and where possible, the activity therapists links the patient into a community resource where social and recreational programs are available.

6. Evolving Role of Fort Logan Mental Health Center in the Mental Health Service Delivery System

It is planned that over the next five year period the FLMHC will evolve into the role of the primary provider of short-term inpatient care for the catchment areas in the Denver metroplex, with the centers and clinics having input into admissions and treatment policies and discharge decisions (with the exception of Bethesda and Northwest

Denver Mental Health Centers which have hospital beds immediately available to them). The adult inpatient average daily admissions is expected to decline over the next five years as pre-admission screening becomes more effective and additional alternative treatment facilities are developed. FLMHC will continue to provide long-term adult inpatient care for its catchment area, as well as geriatrics inpatient services. The Children/Adolescent Division will increase its inpatient services, and the Vocational Services and services for deaf and hearing impaired persons will expand. The alcohol abuse treatment program will be phased down to a level to be determined by the Divisions of Alcohol and Drug Abuse and Mental Health. FLMHC will continue to operate its on-grounds and community-based alternatives to inpatient care such as tertiary aid and prevention, the Lodge, supervised boarding homes, etc., as regional facilities until adequate alternate treatment facilities are available in the various catchment areas.

Colorado State Hospital

1. Description of Living Conditions and Treatment Resources

   a. Living Conditions

      The physical facilities meet all standards of local, state and national authorities, and are fully accredited by JCAH. Bedrooms range in size from single to six-bed units, with four-bed units being the most typical arrangement. All wards open to a central nursing station and lounge area furnished with social and recreational equipment.

Clients are provided with individual storage space for their personal effects, adequate clothing if they do not have their own and an allowance for personal items. Both staff and clients are encouraged to decorate rooms and halls to help create a pleasant atmosphere. The spacious grounds surrounding the hospital buildings are available to those clients who wish to and are able to take advantage of them.

b. Treatment Resources Available

Psychiatric treatment is planned and delivered by a multi-disciplinary team of well-trained professionals and para-professionals. These include psychiatrists, psychologists, social workers, occupational therapists, recreational therapists, teachers, psychiatric nurses, mental health workers and licensed psychiatric technicians. The hospital does not employ nursing attendants.

The Division of Vocational Rehabilitation (Colorado Department of Social Services) operates a rehabilitation service center on the hospital grounds and has assigned counselors to each program division to work with clients (and assist hospital staff) in developing individual educational and vocational programs.

Educational opportunities available to patients include a General Education Development Program, hospital staff teachers on several divisions, a fully accredited academic school in the Children's and Adolescents' Center and enrollment in public schools or the University of Southern Colorado in Pueblo.

Treatment modalities used throughout the hospital include individual and group psychotherapy, utilizing all modern techniques ranging from transactional analysis and Gestalt therapy to behavior modification and biofeedback, occupational and recreational therapy and vocational services in addition to chemotherapy. Clients benefit from the therapeutic milieu, as well as individual attention. Due to the wealth of therapeutic techniques available, it has been possible to use electroshock sparingly and only in short regimes. Psychosurgery is not used at all.

2. Efforts to Improve Quality of Institutional Care

a. Quality Assessment Program (QAP)

This is a CSH organized Professional Standards Review Organization (PSRO) type system operated by the Hospital Superintendent and Executive Committee. The plan is to seek full delegation of review authority from the Colorado PSRO. QAP efforts are in four main areas:

(1) admission certification Within one working day of admission, one hundred percent review of admissions for: appropriateness of admission and assigned level of care according to ten critical clinical and social criteria; and justification of diagnosis and codability. Incomplete or inadequate documentation is investigated, referred to a physician advisor when necessary and corrective action is initiated.

(2) concurrent review Covers one hundred percent of Medicare, Medicaid and Civilian Health and Medical Program of the United States (CHAMPUS), plus admissions and reviews of other third party admissions. Additionally, a minimum of a thirty percent random sample of all inpatient treatment episodes are reviewed on the 16th, 45th, 75th day and every 90 days thereafter for adequacy and quality of the "data base," treatment plan, related progress notes, release plans, length of stay justification and appropriateness of level of care and treatment intervention.

(3) inservice training Instruction on the Department of Health, Education and Welfare (DHEW) and Joint Commission on Accreditation of Hospitals (JCAH) standards and regulations, training for admitting physicians and other admissions staff includes review of admission criteria, diagnosis, presenting complaints, mental status exams and pertinent physical findings. Staff of treatment teams receive instruction on formulation and update of individualized comprehensive treatment plans which include goals, release plans, problems and assets, treatment objectives and planned interventions. All clinical staff receive training on the recording of progress notes with attention to adequacy and quality of the documentation related to the treatment plan, client's progress and treatment outcome.

(4) input to hospital policy decisions on records, formats, quality of care standards, procedures and corrective action on cases or patterns of non-compliance.

b. Medical Care Evaluation Studies

These are conducted at least once per year in each program division per PSRO and JCAH requirements.

c. Psychiatric Care Audit and Utilization Review Committee

This committee is comprised of representatives of all disciplines and program divisions of the hospital. It acts as third level reviewer of all cases and policy questions referred from the QAP, physician advisors, physician panelists and the natural and unnatural death committees. It reviews both cases and patterns of non-compliance and recommends policy or corrective action to the medical staff, hospital administration or other appropriate hospital committees.

d. Continuing Education

Each program division has its own education committee and engages in almost continuous inservice training for teaching new therapeutic techniques or improving clinical skills. Periodic hospital-wide workshops and seminars are provided to improve clinical skills. Heads of each clinical discipline hold departmental meetings to improve professional standards and clinical performance. Employees are encouraged to pursue additional academic education and financially supported when available funds permit. A special committee on continuing education is now at work developing programs for continuing education credit for licensure requirements of the various disciplines.

3. Description of Present Residential Population

The hospital groups its residents according to their functional requirements for specialized environments and clinical or rehabilitation techniques. These groupings constitute the program divisions of the hospital organization shown below. For the first half of the current fiscal year (1975-76) the average daily attendance of this inpatient population based on daily midnight bed count was:

PROGRAM DIVISION	REQUIREMENTS FOR ADMISSION	ADA
Alcoholic Treatment Center	Severe drinking problem	56
Drug Treatment Center	Severe drug abuse	36
Children and Adolescent Treatment Center	Severe psychiatric illness through age 16	67
Geriatric Treatment Center	Severe psychiatric illness for patients over age 60	238
General Adult Psychiatric Services	Acute and severe psychiatric illness for patients age 17-64	121
Division of Forensic Psychiatry	Criminal court evaluations and criminally insane	284
General Hospital Services	Medical-surgical problems	72
	CSH Total Inpatient Population:	874

The first five program divisions currently serve forty-seven counties of the southern and western portions of the state. The Division of Forensic Psychiatry and the General Hospital Services serve all sixty-three counties of the state. The General Hospital also serves non-psychiatric residents of the other state institutions.

4. Efforts to Avoid Chronicity

The philosophy of the hospital has long been focused on intensive care, alternatives to hospitalization and methods to prevent or

eliminate institutional dependency and apathy in treatment programs. Discharge planning begins at the time of admission and becomes more specific with each review of the treatment plan. There are no wards for chronic patients (except the neurologically disabled in the General Hospital) and the philosophy of "maximum mixture" of all types of clients is followed in assigning clients to treatment units.

Discharge planning gives priority to the principle of trial release at risk of failure over that of waiting for certainty of success before discharge. Frequent use is made of passes and home visits to get the client reaccustomed to his/her community environment.

Other methods to prevent institutionalization include confrontation techniques to stimulate motivation, psychodrama (rehearsal for community life by acting-out of community life situations), training in adaptive daily living skills and alternative life styles, assertiveness training, behavior modification for inappropriate or other behavior unacceptable in the community, maintenance on the lowest level of psychotropic medication necessary to control symptomatology, job and living placement counseling and the social and recreational stimulation described below.

5. Provision of Social and Recreational Stimulation

Activities providing this type of stimulation are of two basic types: direct therapeutic intervention for a specific behavior change or treatment objective and diversional activities for the maintenance or stimulation of social and physical assets and interests. The primary planners and providers of these activities are the recreational and occupational therapists, plus a variety of other disciplines involved

in conducting special group therapy or ward community meetings. The participation of ward nursing personnel in many activities is quite extensive and absolutely essential to their operation and effectiveness.

Activities are conducted on the ward or in other division facilities, in the hospital's central gymnasium or off the grounds. There are dyadic, small group and large group events involving both staff-client and client interaction of both a formal and informal nature. All divisions, except Forensic, provide co-educational living.

The central gymnasium provides facilities for an extensive client library, swimming pool and other forms of recreation, and the Department of Religious Therapies provides religious activities and counseling to all clients of CSH.

6. Evolving Role of Colorado State Hospital in the Mental Health Service Delivery System

The CSH campus that once housed over 6,000 clients has evolved since 1961 into a Human Services-Educational complex with CSH serving as the nucleus of the complex and providing the supporting services required. In this complex are the State Home and Training School (Resource Center for the Developmentally Disabled) at Pueblo, the emergency, inpatient and partial hospitalization program for the Spanish Peaks Mental Health Center, an office of the Colorado Attorney General's Office, the Division of Youth Services' Pueblo office, the Division of Wildlife's Pueblo office, the Adult Parole Pueblo office, the Department of Social Services Medical Health Unit, the State Department of Personnel Pueblo office, office of Region VII Health Planner and the Family Practice Residency Training Program. It is also projected

that the Colorado State Hospital-Human Services Complex will house a correctional work release unit and the Division of Youth Services Pueblo Detention Center. It is planned that in addition to providing facilities for the above named programs, the CSH will continue to be actively engaged in participating in training a wide range of mental health professionals to include career psychiatric residents from the University of Colorado Medical Center, psychiatric technicians from the University of Southern Colorado, social work students from the University of Denver and Colorado State University, and occupational therapists plus a variety of other mental health workers.

It is planned that CSH will continue to provide emergency and adult inpatient services for the metropolitan Pueblo community. Adult partial care services will be phased into the Spanish Peaks Mental Health Center.

Maximum use will be made of local general hospitals and alternatives to hospitalization by Western Slope centers and clinics and other centers and clinics in the CSH service area which are located a considerable distance from CSH. However, the impact on CSH will be gradual because of the time necessary to develop alternate treatment facilities and affiliation agreements with local hospitals.

It is also planned that CSH will provide very limited outpatient services. Such services will be provided in concurrence with the appropriate mental health center or clinic and only for cogent reasons.

CSH will phase down its alcohol and drug abuse treatment programs to a level to be determined by the Divisions of Alcohol and Drug Abuse

and Mental Health. As with FLMHC, hospital services will not be phased down until adequate services and facilities are available in the community.

Every effort will be made to treat adolescents and children in their own community. However, because of the inordinately high cost of operating an inpatient facility and the need for highly trained specialists to operate such a program, it is planned that CSH will continue to provide centralized inpatient services to children and adolescents from its service area.

CSH will continue to operate the General Hospital and its Forensic and Geriatric treatment programs.

It is planned that CSH will develop a number of pilot programs such as a special psychiatric treatment program for Chicano clients. Implementation of such pilot programs will of course be contingent upon the availability of special funding.

Expanded educational activities for CSH will include developing the capacity for serving as a regional continuing education center for the southern Colorado region of the state to provide accredited continuing education programs for health service professionals. Consideration will be given to designing and submitting to national and state continuing education accrediting authorities a written proposal for designating CSH as an official center for continuing education in the fields of psychiatry, psychology, social work, nursing and general and special medicine.

E. FOLLOW-UP CARE

It is the responsibility of the mental health service delivery system to assure that persons discharged from inpatient care will receive planned, adequate, appropriate follow-up care which will prevent or minimize the need for further inpatient care and promote the best possible social adjustment. Responsibility for follow-up care generally rests with the catchment area mental health center or clinic. However, in specific cases, follow-up care may be provided by CSH or FLMHC if the responsible center/clinic and the hospital agree that such is in the best interest of the client.

1. Pre-Discharge Planning Procedure

   a. Initial planning for follow-up care takes place at the time of admission to inpatient care or during the pre-admission process. Community mental health center and clinic staff and/or hospital staff responsible for evaluation will assess the client's potential for independent living after inpatient treatment. Included in this early assessment is the person's social system strengths and weaknesses, the seriousness of the person's impairment in areas where normalized living is affected and the community support system available.

   b. During treatment the client is involved to the maximum extent possible in plans for follow-up care after release.

   c. As discharge approaches, both staffs assess the person's need for follow-up care.

(1) Clients who can be discharged without need for any follow-up care exit from the mental health system and no responsibility for follow-up is assigned.

(2) For clients who can be discharged from inpatient care but need a brief transitional follow-up to be certain treatment has been completed, short-term follow-up care for a period of up to 60 days may be provided by hospital staff with the concurrence of the appropriate mental health center or clinic. At the conclusion of the transitional follow-up, the client may exit the system, be followed-up by the responsible center or clinic, or be returned to inpatient care if such is indicated.

(3) Clients being discharged from inpatient care who need ongoing supportive care are the responsibility of the local community mental health center or the referring private sector source if the client's wish is to be followed by a private therapist. Disposition planning involves the hospital and community referral sources and the client so transition from inpatient care to other care is as smooth as possible.

(4) Unless specific and documented arrangements are made for CSH or FLMHC to follow-up a client discharged from inpatient care who requires long-term support and maintenance, catchment area centers and clinics are responsible to help the client avoid the return to inpatient care. This will be accomplished by ensuring that the client is followed in a resocialization group and/or seen periodically

on an outpatient basis or for medication check. Progress notes will be recorded after each contact or at least monthly.

(5) Maximum use is to be made of alternate treatment facilities in each catchment area, including nursing homes, intermediate care facilities, boarding homes, halfway houses, family care homes and foster homes, as well as providing services to persons in their own homes. The client will be placed in the facility which provides that level of care which meets the individual's clinical needs. Every effort will be made to move persons placed in more intensive settings, such as nursing homes, to a less restrictive placement as soon as his/her condition permits. No placements will be made without the concurrence of the client and the catchment area center or clinic. Centers and clinics may not refuse aftercare services to clients who need and will accept such care.

(6) Coordination of placement activities with the social services department is essential. This will help ensure proper use of available resources and payment for services provided clients who are eligible for Social Security and other state and federal benefits.

(7) All facilities used as alternatives to inpatient care must be properly licensed if licensure is required, and must comply with any existing standards for the care of mentally ill clients in such facilities.

d. Upon discharge from inpatient care, each person who has agreed to follow-up care will be fully advised as to who has responsibility for follow-up care (center/clinic, hospital, private practitioner, etc.). When transfer of responsibility for inpatient care occurs, the person is discharged from the hospital rolls.

e. All decisions concerning aftercare will be documented in each client's chart. These charts will be randomly audited to insure proper documentation and follow-up.

f. Lists of clients transferred or discharged from CSH and FLMHC inpatient programs to aftercare or follow-up will be maintained by both hospitals. These lists will include the hospital number, the date of transfer or discharge, the client's address at the time of transfer or discharge and the name of the center/clinic.

g. Readmission to inpatient care of clients being provided follow-up care by community mental health centers/clinics will be monitored by the Division of Mental Health.

2. Responsible Center/Clinic in Each Catchment Area

The responsible community mental health center or clinic in each catchment area is designated in Chapter VI, Subsection C.

3. Policies for Discharge from State Hospitals

The quality assurance programs of both state hospitals serve as excellent tools for identifying inpatients who should be considered for discharge to the community or transfer to a less intensive level of treatment.

The goal for every client is eventual exit from the mental health system. Discharge from a state hospital occurs when the client has obtained maximum benefit from hospital programs or appropriate and adequate care is available in a less restrictive setting or no further care is indicated. Thus, discharge may take the form of total exit from the mental health system or transfer of responsibility from a state hospital to a community mental health center, clinic or other appropriate mental health resource.

The policy of the Division of Mental Health is to treat clients in the least restrictive setting. No client will be retained in inpatient care who can receive appropriate and adequate care in another setting. The preferred setting is the individual's own community. Continuing assessments will be made of the inpatient rolls at both hospitals to assure the immediate discharge or transfer from inpatient care of any client who does not specifically require inpatient care.

Information on a client will be shared only if the client has signed an appropriate release of information. The only exception will be when there is a court order permitting release of information or when a state statute specifically provides for the sharing of information on certain clients.

4. Methods for Assuring Availability of Follow-Up Care

The Division of Mental Health is responsible for the overall planning for a range of follow-up services on a local, regional and statewide basis. The Division assumes responsibility for requesting adequate funding for necessary follow-up care facilities. The

Division of Mental Health will ensure adequate monitoring of hospital and center/clinic follow-up programs for quality and cost effectiveness.

Community mental health centers and clinics have the primary responsibility for developing and providing adequate basic follow-up services for clients in their catchment area. They will be expected to work in coordination and cooperation with the state hospitals. Centers and clinics will work with social services and other community agencies to develop a range of living arrangements appropriate for clients and ex-clients. They will also work toward developing healthy community attitudes toward clients and ex-clients. It will be the responsibility of community mental health centers and clinics to inform the Division of Mental Health of gaps in follow-up service resulting in increased usage of other programs.

The state hospitals are responsible for informing the Division of gaps in follow-up service. The hospitals' follow-up and aftercare responsibilities will be phased down as mental health centers and clinics increase their capacity to exercise their primary responsibility in this area. CSH and FLMHC will cooperate fully with centers and clinics in the follow-up planning process.

F. WORKFORCE (MANPOWER/WOMANPOWER)

1. Summary of Current Workforce (Manpower/Womanpower)

The following is a summary of current personnel in hospitals, centers and clinics in the state public mental health system.

DISCIPLINE	FULL TIME STAFF	PART TIME STAFF
M.D., Psychiatrist	51	64
M.D., Non-Psychiatrist	34	87
Osteopathic Physician	0	0
Nurse, M.S.	28	2
Nurse, R.N. & B.S.	132	8
Nurse, R.N.	150	1
Nurse, Practical	23	3
Mental Health Worker, A.A.	211	5
Mental Health Work	83	6
Social Worker, D.S.W.	1	2
Social Worker, Masters	234	36
Social Worker, Bachelor	56	7
Psychologist, Ph.D.	107	23
Psychologist, Masters	69	11
Psychologist, Bachelor	10	3
Other Doctorate level	11	2
Other Master level	64	7
Other Bachelor level	129	25
Other A.A. level	8	0
Other	1574	162
	2984	454

Included in the "other" category are:

Information Specialists
Librarians
Teachers
Administrative Officers
Accountants
Personnel Officers
Purchasing Agents
Clerical Entry through Secretary II
Storekeepers
Supply Officers
PBX Operators
Reproduction Equipment Operators
Physical Plant Managers
Labor & Grounds Maintenance
Carpenters
Electricians
Painters
Typefitters
Plumbers
Plasterers
Sheet Metal Workers
General Plant Mechanics
Machinists
Automotive Servicemen & Mechanics
Welders
Refrigeration Mechanics
Stationary Firemen & Engineers
Truck Drivers
Safety Inspectors
Public Safety Guards & Officers
Food Service Workers, Cooks, Bakers & Meatcutters
Dietitians
Laundry Workers & Supervisors
Custodial Workers & Supervisors
Barbers
Beauticians

2. Projection of Personnel Needs

The current staffing will be adequate for the initial phase of the plan. As centers and clinics take on a more comprehensive role, some changes in function of the current personnel may be required. The Division of Mental Health will take the initiative to encourage educational facilities to provide the clinical skills required. It

appears that the mental health professionals will be in adequate supply except for psychiatrists and possibly for nurses.

The Division of Mental Health is also involved in a statewide effort to upgrade the skill level of mental health manpower through the Division's staff development program. This effort includes an application for federal funding for training personnel in the provision of the additional services mandated by PL 94-63.

3. Development and Maintenance of an Adequate Supply of Mental Health Personnel

The development and maintenance of an adequate supply of mental health personnel requires the joint efforts of the colleges and universities in providing the basic professional education (preservice training) and of the service delivery system in providing the postgraduate or continuing education of mental health professionals and paraprofessionals. The two state hospitals and several centers and clinics actively work to strengthen the curriculum in local colleges and universities for mental health workers and provide incentives for persons with less than an AA degree to pursue further education. The goals of continuing education are both individual and organizational: to maintain and update the skills of the individual clinician; and to provide a mechanism for accomplishing planned changes in service delivery. The ongoing professional development of employees is essential to retain experienced personnel and to ensure the delivery of an adequate quantity and quality of services. Therefore, resources for the continuing education of mental health professionals and paraprofessionals must be built into the service delivery system to ensure

that the necessary staff skills are available to effectively implement program goals and objectives.

The term "continuing education" is used to include all those educational activities beyond the basic discipline training program whether provided by academic institutions, professional societies or by service agencies themselves. However, it is limited to the ongoing education of mental health professionals and paraprofessionals. Thus, the concept of continuing education is quite discrete from "consultation and education." The latter term is used to describe a range of activities directed towards the mental health education of lay citizens or non-mental health professionals such as teachers, welfare workers, clergy or law enforcement personnel.

Within the context of the service agency, continuing education is often used synonymously with the term "staff development." It would include a diverse range of activities such as: formally organized inservice classes, seminars or workshops; case conferences and clinical consultations which are primarily oriented towards an educational goal; sending staff to attend externally sponsored educational offerings; and development of organizational policies, structures and resources in support of the ongoing professional development of agency personnel.

The appropriate role of the Division of Mental Health in continuing education is to provide initiative and leadership in certain functions. These would include identifying statewide training needs and priorities, establishing and administering enabling mechanisms and developing the resources needed.

The role of the individual agencies would include developing and providing the staff development services required by their staff and ensuring that these services are congruent with the goals and objectives of the agency. These roles of the Division and the individual agency do not diminish the responsibility of each mental health professional to maintain his/her knowledge and skill in keeping with the standards of his/her respective profession.

Among the agencies of Colorado's mental health system, there is great variability in the priority and support given to continuing education. Some agencies have well developed programs; others do not. Centers and clinics in rural areas are often handicapped by the lack of availability of resources. Larger centers are handicapped by decentralized teams and geographically dispersed satellites. A great deal of effort on the part of the Division and each agency is required to develop and maintain the skills required of the mental health personnel comprising the state mental health system.

4. Procedure for Protecting Displaced Employees Rights

The primary protection for state hospital employees who might be affected by a reduction in the workload at the state hospitals is the Civil Service System. The rules of the Civil Service System provide for "bumping" rights, lateral transfers and preference in filling personnel vacancies which develop in state agencies. There are some thirty thousand state employees. With a turnover rate of approximately ten percent, up to three thousand existing positions plus newly funded positions become available during each year. "Bumping" rights can be exercised only within the department in which

an individual is employed. The Department of Institutions, of which the Division of Mental Health is a component, employs almost five thousand persons across the state. Thus, displaced state hospital personnel would have a number of options available to them within the state system. Important considerations are the location of a vacancy and an employee's willingness to relocate. In view of the concentration of state agencies in the Denver and Pueblo areas, the importance of the relocation factor is diminished.

The twenty-four mental health centers and clinics employ some twelve hundred persons. All of these agencies are private, non-profit corporations, except two which are county agencies. Each has its own personnel system, none of which are related in any way to the State Civil Service System. Many state hospital employees have acquired valuable skills in the treatment of the chronically ill and other difficult to treat clients. These skills can be put to good use in community agencies as they assume increasing responsibility for more seriously disabled clients. Centers and clinics will continue to send announcements of vacancies to the Division of Mental Health Personnel Officer, who is forwarding copies for posting in the state hospitals. A major concern of state hospital employees who wish to work in a center or clinic is the non-portability of retirement and other benefits from the state system to private or county agencies. While legislative relief is possible, it is not probable because of the myraid legal, funding and other problems involved. A proposed partial resolution would be placing selected state hospital employees

on "detached service" at a center/clinic. The state employees would remain on the state hospital payroll, and the center/clinic would reimburse the state hospital for the employee's salary and other benefits. The employees would have to be acceptable to the center/clinic concerned and would be under the administrative control of the center/clinic director. This proposal is fraught with many problems, such as differences in salaries, fringe benefits, classification, etc., between the state system and individual centers/clinics. However, it is one avenue that is being explored.

Another important need which will be dealt with as the need arises is training of displaced employees for new jobs in centers/clinics and the state hospitals. The plan is to accomplish this through such means as on-the-job training, regular college or university course work and/or special formal training sessions conducted as a part of the Division's continuing education program or arranged through local colleges and universities.

The fact that implementation of the Plan will take place over a five year period will allow some of any possible personnel displacement to be handled via normal attrition.

There will be continuous monitoring of the impact of the Plan on state hospital personnel. Specific actions will be initiated as required to prevent or hold personnel displacements to the lowest possible level.

CHAPTER V

6 COORDINATION OF PLANNING

V. COORDINATION OF PLANNING

A. INTERDEPARTMENTAL COMPREHENSIVE PLANNING

1. Human Services Policy Council

In 1975, the Governor of Colorado established the Human Services Cabinet Council (now called the Human Services Policy Council) to develop coordinated planning and implementation of human service programs in the state. Seven departments of state government participate in the Council, through representation by the Executive Director of each department. Departments involved are: Education, Health, Institutions (which includes the Division of Mental Health), Labor and Employment, Local Affairs, Social Services and State Planning and Budgeting. Also participating are representatives of the Governor's office, including the Governor's Office of Human Resources.

The Human Services Policy Council develops policies which will relate to areas of service throughout the executive branch of state government. Following recommendations to the Governor and approval of the policy statement by the Governor, the Council is responsible for implementation of the policies including coordinated planning and budgeting by the various departments. Specific agreements are developed between departments, outlining areas of program collaboration. The first human services policy priority has been services for the aging, with the goal of assisting older persons in maintaining themselves in independent living situations. Agreements between departments have specified mechanisms for coordinated planning and budgeting, as well as integrated service delivery, to implement the goal.

Other policy areas will be developed, leading to increased collaboration between programs which are provided by separate departments, and reducing barriers to comprehensive, integrated service delivery. Information about the policies and collaboration agreements must be disseminated to agencies and sub-units within the departments.

2. Office of State Planning and Budgeting

The Office of State Planning and Budgeting, through the Division of Planning, is responsible for coordination of planning in all departments of state government.

The statute establishing the Division of Planning (24-37-202, CRS 1973 as amended) specifies responsibilities for state-level review and coordination of planning:

a. coordinate the preparation and maintenance of long-range master plans which recommend executive and legislative actions for achieving desired state objectives and which include recommended methods for evaluation;

b. stimulate, encourage, and assist state agencies to engage in long-range and short-range planning in their respective areas of responsibility;

c. review and coordinate the planning efforts of state agencies, including the relationship of such efforts with federal and local government programs.

The Division is also the clearinghouse for state agency applications for federal grants subject to review under provisions of the Bureau of the Budget A-95 regulations. Within the Office of State Planning and Budgeting, the Division reviews the Executive Budget to

assure that budget requests match the established plans of state departments and agencies.

Coordination by the Division of State Planning, working with planning staffs in other state departments, divisions and agencies, will increase the coordination of services, eliminate unnecessary duplication, and develop additional programs where needs are now not met.

3. Health Planning

The Colorado Department of Health, containing the Division of Comprehensive Health Planning, was designated as the state health planning agency by the Governor of Colorado, in accordance with PL 89-749 (the comprehensive health planning legislation), in March 1973. Up to that time the Office of Comprehensive Health Planning had been located within the Governor's Office and the Department of Local Affairs. The Division was transferred at that time to the Department of Health to continue as the unit responsible for health planning. The Colorado Health Planning Council, appointed by the Governor, is the policy-making body for the Division.

In 1975, three health service areas were established in Colorado, as provided in the National Health Planning and Resources Development Act of 1974 (PL 93-641). A non-profit corporation has been created in each of the areas, and all three have applied for and received conditional designation under that Act as health systems agencies. A Statewide Health Coordinating Council is yet to be selected. The Council, a citizens group with a consumer majority, will have sixty percent of the membership selected by the Governor from nominees of the health systems agencies; the other forty percent will be designated at-large

by the Governor. To date, a board has been chosen by each of the Health Systems Agencies. The Statewide Health Coordinating Council will be appointed by January 1977. The State Health Planning and Development Agency, an agency of the state government, has not yet been designated by the Governor. Until the Council and the Agency are selected, the Colorado Health Planning Council and the Division of Comprehensive Health Planning continue to perform the state-level planning and coordinating functions.

The Division of Comprehensive Health Planning is developing a plan framework for health services, both public and private, on a statewide basis and coordinates and provides guidelines for planning by areawide comprehensive health planning councils, which are operational in the thirteen Planning and Management Regions of the state. When the structure of PL 93-641 is implemented, the thirteen areawide councils will be replaced with three Health Systems Agencies, although sub-area councils will, in many regions, continue some of the planning and coordinating roles as advisory groups of the Health Systems Agencies. The various mental health agencies in Colorado have been involved at the local level to varying degrees with the areawide health planning councils. The latter, in many regions, have had a role in the A-95 review process regarding mental health proposals.

At the state level, the Department of Institutions is represented on the Colorado Health Planning Council, and for the past two years the representative was the director of the Division of Mental Health. Mental Health volunteers have also been active in health planning, and the current

chairman of the Council was formerly the president of the Mental Health Association of Colorado and is a vice-president of the National Association for Mental Health.

Of the three areawide health planning councils in the state which currently have specific health plans in adopted form, two have directly addressed mental health, and the third has included it in its outline. In addition, the outline of the Colorado Health Systems Plan Framework includes mental health services. A staff person from the Division of Comprehensive Health Planning is participating in the development of this plan (the Five Year Mental Health Plan).

The National Health Planning and Resources Development Act (PL 93-641), and particularly the regulations resulting from it, calls for the effective planning and development of both physical and mental health services. Consequently, the functions of the various entities created by this legislation will have impact on the planning and delivery of services by the various mental health agencies. Each health systems agency (HSA) will have specific responsibilities, including the following:

a. establish a health systems plan and annual implementation plan for the area;

b. review and approve or disapprove grant requests for designated federal funds (including funds appropriated under the Community Mental Health Centers Act and the Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act);

c. implement plans through developmental grants to community agencies;

d. recommend health facilities projects to the state for funding;

e. periodically review and comment on the appropriateness of all institutional health services in the area; and

f. coordinate its activities with other planning or administrative agencies such as Professional Standards Review Organizations.

Some of these functions, particularly (b) and (c), will not be performed during the initial period (up to one year) of a given health systems agency's designation.

The Statewide Health Coordinating Council will review and coordinate planning activities of the HSA's, prepare and approve a state health plan based on the health systems plans of the HSA's, and advise the State Health Planning and Development Agency in its work of statewide health planning and implementation of the state health plan.

Mental health agencies have been involved to some extent, through representation by staff and board members, on planning committees and by election to board membership of the health systems agencies.

Implementation of the health planning and resources development program should accomplish the following:

a. enhance the development of comprehensive health service systems, including mental health, in all areas of the state;

b. increase and broaden community involvement in mental health, particularly of those providers and consumers not in the mental health field;

c. facilitate closer coordination between the public and private sectors of the mental health delivery system;

d. improve the availability of services in rural and other underserved areas; and

e. limit unnecessary duplication of services.

In order to achieve these outcomes, mental health center and clinic board members, other volunteers, and mental health professionals must involve themselves to an even greater degree in the health planning process. This can be accomplished in part by participation on the boards, committees, and task forces of the health systems agencies and on the Statewide Health Coordinating Council and its task forces. The HSA's and the Coordinating Council, in turn, must facilitate this involvement.

4. Health Facilities Advisory Council

The Department of Health is designated by state statutes as the sole agency for carrying out the purposes of the Community Mental Health Centers Construction Act of 1963 and any amendments thereto. The State Health Facilities Advisory Council (HFAC) is a statutory body appointed by the Governor to advise the Department of Health on matters involving construction of mental health and other health care facilities. Four of the 18 members of HFAC are mental health representatives: two consumers, one public service provider, and one private service provider.

There have been some communications problems among the applicants for approval and funding of projects because of the many changes which

take place during the grant review process. These applicants include HFAC, DMH, and the Regional Department of Health, Education, and Welfare Office (DHEW). This problem will be minimized by ensuring that all significant communications are documented, and all concerned agencies receive a copy of each communication.

B. INTERDEPARTMENTAL PROGRAM PLANNING

1. Division of Alcohol and Drug Abuse

The state alcohol and drug abuse authority, by statute, is the Division of Alcohol and Drug Abuse (DADA), which is a component of the Colorado Department of Health. The Department of Health, through DADA, is responsible for formulation of an annual comprehensive state plan for alcohol and drug abuse programs, supervision of the administration of the plan, and coordination of state and federal funds for alcohol and drug abuse services. By statute, DADA is the state alcohol and drug abuse authority; therefore, the DADA alcohol and drug abuse plan is the official substance abuse plan for the state. The state general fund appropriation to DADA in fiscal year 1975-76 was $1,526,910. The Division also allocated or approved the allocation of some $4,000,000 in federal funds. DADA does not operate programs directly, but purchases services from approved agencies.

Mental health agencies, operated and/or funded through the Division of Mental Health (DMH), are actively involved with alcohol and drug abuse services. Most alcohol and drug abuse services are funded through the

Division of Alcohol and Drug Abuse, utilizing both federal and state funds. In fiscal year 1975-76, DADA had 39 contracts with mental health centers/clinics (including the Drug Treatment Center at Colorado State Hospital) to provide alcohol and drug services. During the same year, state general funds in the amount of approximately 1.4 million dollars were appropriated directly to Colorado State Hospital (CSH) and Fort Logan Mental Health Center (FLMHC) for the treatment of alcoholism, and 0.5 million dollars to CSH for drug abuse services. Additionally, a substantial percentage of the approximately 9.5 million dollars in state general funds appropriated to mental health centers and clinics in FY 75-76 was used for the treatment of center and clinic clients whose diagnosis included alcohol and/or drug abuse. Finally, of the centers' and clinics' projected income of 12.4 million dollars for the year from non-state sources (federal and local governments, fees, third-party payments) some is being used to purchase alcohol and drug abuse services.

Some achievements in coordination between DADA and DMH in the funding and operation of services include: DADA contracts with DMH-related agencies; cooperation and collaboration in the preparation of budget documents to prevent duplicate requests; beginning work on a common workload data reporting system. During the coming year, as reflected in the Objectives in Chapter III, there will be a concentrated interdepartmental planning project, involving DADA and DMH, to develop procedures for coordinated planning, funding, and delivery of alcohol and drug abuse services in relation to the mental health services delivery system.

Issues that will be addressed by the two Divisions and the two Departments include:

a. a common data base and common terminology;

b. agreement as to types, levels and intensities of services to be provided;

c. interdepartmental program budgets and funding procedures;

d. provision of appropriate alcohol and drug abuse services to clients of the mental health service system, and appropriate psychiatric services to clients of the alcohol and drug abuse service system;

e. definition of the role of the mental health services delivery system in the delivery of alcohol and drug abuse services;

f. agreement on training needs and standards for all persons who treat substance abusers;

g. development of plans for research into the etiology of alcoholism and effective treatment strategies;

h. active participation of mental health agencies, including centers and clinics, in the development and revision of alcohol and drug abuse plans, and active involvement of DADA in the preparation and updating of the state mental health plan;

i. development of plans for diminishing state hospital-based alcohol and drug abuse services, and a concurrent increase

in the availability of alcohol and drug abuse services in local communities;

j. development of a methodology for determining the outcome and impact of alcohol and drug abuse services.

2. Department of Social Services

The Department of Social Services (DSS) is responsible for the administration of a host of social and medical programs. DMH and DSS have many common interests and concerns. However, the primary interface between these two human service agencies involves reimbursement for mental health and rehabilitation services to emotionally disabled children, adolescents, adults, and aged persons.

Colorado State Hospital (CSH) and Fort Logan Mental Health Center (FLMHC) receive Title XVIII (Medicare), Title XIX (Medicaid) and vocational rehabilitation funds from DSS. Mental health centers and clinics are recipients of Medicare and Medicaid funds for services to eligible clients. The vocational rehabilitation programs in the hospitals and several centers have experienced a number of major changes and periods of uncertainty because of unpredictable and severe reductions in vocational rehabilitation funding. Mental health centers and clinics have found that as little as 40 percent of Medicaid claims have been reimbursed, and they have received differing interpretations as to what charges are payable. A major problem has been the requirement that a physician must see each client for whom a Medicaid claim is submitted. This has worked a particular hardship on rural programs which have large percentages of Medicaid eligible clients and limited

physician coverage, and has dramatically reduced the potential income to all centers and clinics from this source.

The state receives some 29 million dollars in Title XX funds. However, in contrast to many other states, none of these funds are available for the purchase of mental health services. Therefore, in Colorado the mental health agencies cannot assume responsibility for developing or providing services funded by Title XX. The responsibility lies instead with county social service departments.

The coordination of planning between DSS and DMH has improved markedly during the past year. With the assistance of the executive directors of DSS and the Department of Institutions, a plan was formulated to transfer state general funds from mental health centers and clinics to DSS. These dollars were to be matched by Medicaid funds on an approximately 55 percent (federal) to 45 percent (state) basis. When it was determined that the transfer could not be accomplished without an amendment of a state statute, DSS's legal counsel drafted an amendment which was included on the legislative calendar through a successful attempt by the director of DSS. The proposed amendment was postponed indefinitely because of some uncertainty as to the possible effects of the amendment.

DSS supported the efforts of the Colorado Association of Community Mental Health Centers and Clinics and DMH to develop a new Medicaid reimbursement formula. Payments under the formula have been delayed pending completion of negotiations with the Professional Standards Review Organization, the Colorado Foundation for Medical Care.

It is anticipated that coordinated planning between DSS and DMH will continue. The expected outcomes are: increased payments for mental health services to persons eligible for medical assistance under Medicare and Medicaid; the successful negotiation of contracts between DSS and community mental health centers and clinics; expanded vocational rehabilitation services for mental health clients; and coordinated provision of services for the elderly.

3. Department of Education

Coordination of planning between the Department of Education and mental health services of the Department of Institutions is included in the policy-development activities of the Human Services Policy Council. Additionally, a representative of the Division of Mental Health has provided input to plans of the Division of Special Education of the Department of Education.

At present there are some areas of program coordination between mental health agencies and the Department of Education. Under provisions of the state Handicapped Children's Educational Act, school districts and boards of cooperative services may contract with mental health centers or clinics to purchase diagnostic evaluation services for handicapped children, teacher and parent counseling or consultation, and inservice education for school staff and volunteers. Therapy services for children are not eligible for reimbursement to mental health agencies. In 1975, sixteen centers and clinics in rural areas of the state had contracted to provide the evaluation, consultation and training services; in urban areas, these services are provided

directly by school personnel. Limited amounts of funds from the Elementary and Secondary Education Act (federal), administered through the Department of Education have been available to supplement the school programs at the two state hospitals.

An area of planning being addressed by the Human Services Policy Council is services for the handicapped. Certainly education of the emotionally handicapped will be included in the development of policies and program goals. In addition, specific program coordination mechanisms should be developed:

a. a representative of the mental health system should be included in the membership of the State Special Education Advisory Committee;

b. a coordinating group, representing the Division of Mental Health and the Division of Special Education, should be created to plan and implement programs which will provide educational services to children excluded from public schools because of emotional handicaps;

c. changes in legislation should be sought to provide that local, state, and federal funds for education of the handicapped will be available, at an adequate level, to community or residential agencies which include educational services in treatment programs for the emotionally handicapped.

C. INTERDIVISIONAL PLANNING - DEPARTMENT OF INSTITUTIONS

Within the Department of Institutions are five Divisions: Corrections, Deaf and Blind, Developmental Disabilities, Mental Health, and Youth Services. All of the Divisions include residential agencies as well as community programs operated directly by the Divisions or through contracts with non-governmental agencies. Coordination of planning between Divisions is accomplished through regular meetings of the Division Directors and the Executive Director of the Department, through special planning meetings of the Directors, and through task forces to study program areas and make recommendations to the Executive Director.

For selected issue and policy areas, a committee of Division of Planning Directors develops coordinated planning between Divisions. The Interdivisional Placement Team, with a representative from each Division, reviews information about hard-to-place clients, designs a plan for treatment which may involve services to be provided by two or more Divisions, monitors the progress of treatment, and makes recommendations to the Executive Director about the need for new programs or revised structure of services to meet client needs. The Interdivisional Medical Services Committee surveys the adequacy of medical and related services in agencies of the Department of Institutions, including laboratory facilities and pharmacy services; recommendations are presented to the Executive Director to improve the quality and efficiency of these programs. In addition to these and other Department-wide task forces, representatives of Divisions are involved in program planning within

other Divisions; e.g., representatives of the School for the Deaf and Blind participated in planning the program of mental health services for the deaf at Fort Logan Mental Health Center, and representatives of the Division of Youth Services helped in the planning of new adolescent treatment units at Colorado State Hospital and Fort Logan Mental Health Center. Mental health centers in some areas have contracted to administer community corrections programs, and to provide services to agencies within other Divisions of the Department. The Chief of Diagnostic, Medical and Mental Health Services, in the Division of Corrections, manages and administrates provision of mental health services in that Division, and coordinates the relationship of mental health services of the Penitentiary and Reformatory with the Forensic Division and other units of Colorado State Hospital.

In many aspects, coordinated planning of services between Divisions of the Department of Institutions is being accomplished, but improved integration of services is still needed. Transfer of clients between Divisions, or provisions of services concurrently by agencies of two or more Divisions, should be implemented when required to meet the needs of clients. All mental health services to state agencies should be the responsibility of the Division of Mental Health, either through contracts under which agencies of the Division of Mental Health will provide services to other agencies, or by agreement with the Division of Mental Health that mental health services should be provided directly by those other agencies.

D. LOCAL GOVERNMENTAL PLANNING AND REGIONAL PLANNING

1. Department of Local Affairs - Division of Planning

The Division of Planning in the Department of Local Affairs has the statutory authority and responsibility for coordination of planning at the local level throughout the state.

The Division of Planning plays a dual role in assisting the planning process in Colorado. County and municipal governments engage in a continuous effort to plan and manage their futures, and the Planning Division provides them with technical and financial assistance. Other planning functions - including policy-making and regulation - are performed by various State government agencies, and the Division of Planning coordinates such activities.

The State A-95 Clearinghouse for non-State applications for federal funds is the Division of Planning in the Department of Local Affairs. A-95 is a federal program that requires all requests for federal grants to be reviewed by appropriate agencies at the local, regional, and state levels. The Division coordinates the project notification and review process with eight regional councils of governments, two area councils of governments, and one regional planning commission, each of which serves as a regional or area A-95 Clearinghouse. The Division, in addition, acts as the regional clearinghouse for three of the state's thirteen regions. (The State A-95 Clearinghouse for applications from State agencies is the Office of State Planning and Budgeting.)

Appropriate local, regional, and state review of all requests for federal funds, particularly as they relate to mental health, should

avoid unnecessary duplication of services and facilitate the implementation of the State Mental Health Plan, leading to a more effective and economical service delivery system. Increased input from the Division of Mental Health into the Division of Planning relative to the latter's role as technical advisor to local governments should result in greater involvement by those governments in local planning for mental health.

2. Regional Planning

The responsibility at the regional level for coordination between regional planning and mental health planning is shared by the respective regional council of governments and the region's mental health centers and clinics. Approximately 15 of the state's 24 centers and clinics have elected officials on their boards, which should provide for a degree of coordination. In some cases the board is selected in whole or in part by the county commissioners in the counties served by the center or clinic.

In addition to the involvement of elected officials, the staff and board members of mental health centers/clinics are involved in most communities in community planning for the total human services delivery system.

3. Municipal Planning

An example of mental health planning at the municipal level is the development of the Denver Mental Health Advisory Board, which has been sanctioned by the City and County of Denver and the seven mental health centers and clinics which provide services in Denver. The Division of Mental Health has been actively involved in this attempt to unify the mental health delivery system in Denver. Of particular importance is

the need to determine which services should be centralized to eliminate unnecessary duplication and achieve cost savings.

The overall objective of this effort is a unified mental health delivery system in Denver, involving one budget document that would provide for the distribution of mental health funds on the basis of the specific needs of the various sections of the city.

4. Four Corners Regional Development Commission

The Four Corners Commission is a federally-funded agency with the specific objective of economic development and job creation, particularly in rural areas, covering the states of Colorado, Utah, Arizona, and New Mexico. In Colorado it is administered by the Office of Rural Development, Department of Local Affairs. The Commission acts as a "funding agency of last resort" and supplements grants from other federal agencies and local funds. It apparently has not been involved in any mental health projects in the past but has participated in the funding of several hospitals and clinics. The possibilities of utilizing this resource for the development of mental health services should be explored further.

E. PUBLIC, VOLUNTARY, AND PRIVATE MENTAL HEALTH SERVICES

Much of the emphasis in this Plan is on the public mental health services - those agencies receiving federal, state, and local governmental funds for identified mental health treatment programs. Private and voluntary agencies provide a variety of mental health and counseling services in addition to the publicly funded programs. Referrals

are made between the voluntary and public agencies, and voluntary agencies often provide additional supportive services for public agency clients.

The Mental Health Association of Colorado is a citizens' organization which serves as an advocate for the mentally ill, promotes mental health through educational activities and support of legislation, and participates in the monitoring of public mental health services in the state. The Association also participates in studies of needs and programs, and was instrumental in organizing the planning process which developed the Denver Mental Health Plan. The Mile High United Way, in the Denver metropolitan area, and United Way agencies in other parts of the state, have a planning and coordinating function particularly with voluntary organizations providing mental health and counseling services. Associations of mental health professionals provide significant leadership in setting professional standards, encouraging or organizing continuing education, and participating in studies of plans, policies, and issues related to mental health programs.

Some cooperative relationships exist between the public, voluntary and private mental health services, but no comprehensive plan has been developed to coordinate planning and service delivery between the public programs and other agencies. The Division of Mental Health will organize a planning group, either as a task force related to the State Advisory Council or as a separate ad hoc study group. Membership will include representatives of the state-funded mental health system, voluntary agencies providing mental health services, private practitioners, professional associations, and the Mental Health Association. The

planning group will study issues and make recommendations to the Division of Mental Health.

Among the issues to be considered are:

a. identification of the range of mental health resources available through public, voluntary and private auspices, and criteria for admission to these services;

b. development of guidelines for relationships between public and voluntary or private services, including referral processes;

c. development of guidelines for purchase of mental health services from voluntary agencies, as appropriate, by catchment area centers and/or the Division of Mental Health.

CHAPTER VI

7 CATCHMENT AREA MENTAL HEALTH PROGRAM

VI. CATCHMENT AREA MENTAL HEALTH PROGRAM

A. DESCRIPTION OF CATCHMENT AREAS

A catchment area is defined as "a geographic area for which there is a designated responsibility for community mental health services." Colorado has designated 21 catchment areas. A specific community mental health center or clinic has been designated the catchment area center or clinic. The catchment area center/clinic has primary responsibility for providing a full range of community mental health services to its catchment area. These services may be provided directly by the center/clinic, or by an affiliate of the catchment area center/clinic.

The full range of community mental health services includes:

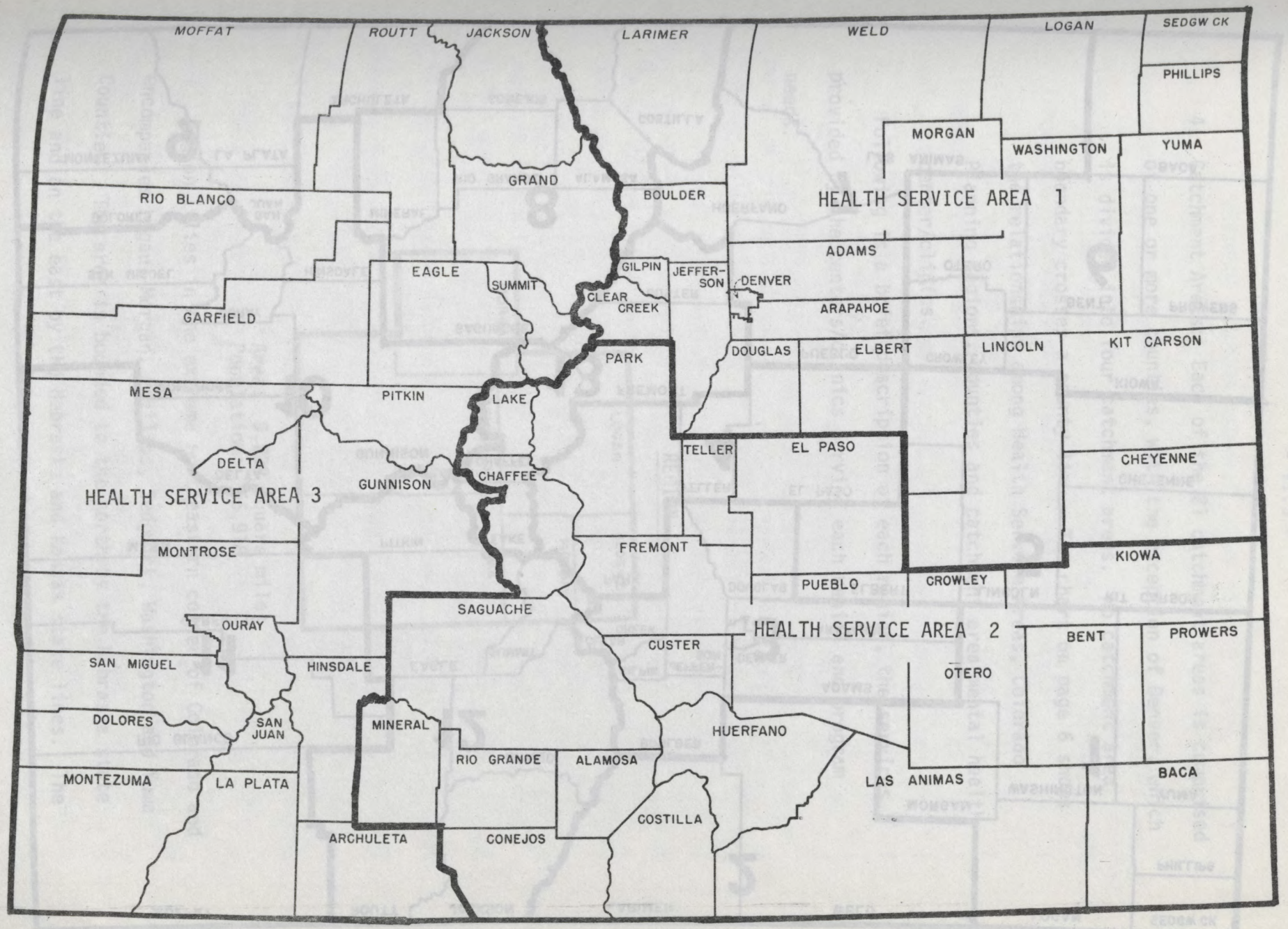
1. inpatient, outpatient, partial hospitalization, 24-hour emergency and consultation and education services;
2. other 24-hour care (i.e., residential alternatives to inpatient care);
3. services to children, adolescents, adults and the elderly;
4. appropriate vocational, activity, recreational and occupational therapies;
5. preadmission screening;
6. aftercare;
7. substance abuse services; (These services must be provided in accordance with the State Plan developed by the State Division of Alcohol and Drug Abuse, the statutory state alcohol and drug abuse authority.)

8. other services determined by local needs and the requirements of federal and other funding agencies.

Catchment area centers and clinics obviously vary in their ability to provide the above services. The capabilities of the smaller and underdeveloped agencies will be increased through such means as differential distribution of state funds, 314(d) and other special grants, assistance in applying for federal planning, initial operation and other grants, and continuing education programs for administrative and clinical staff.

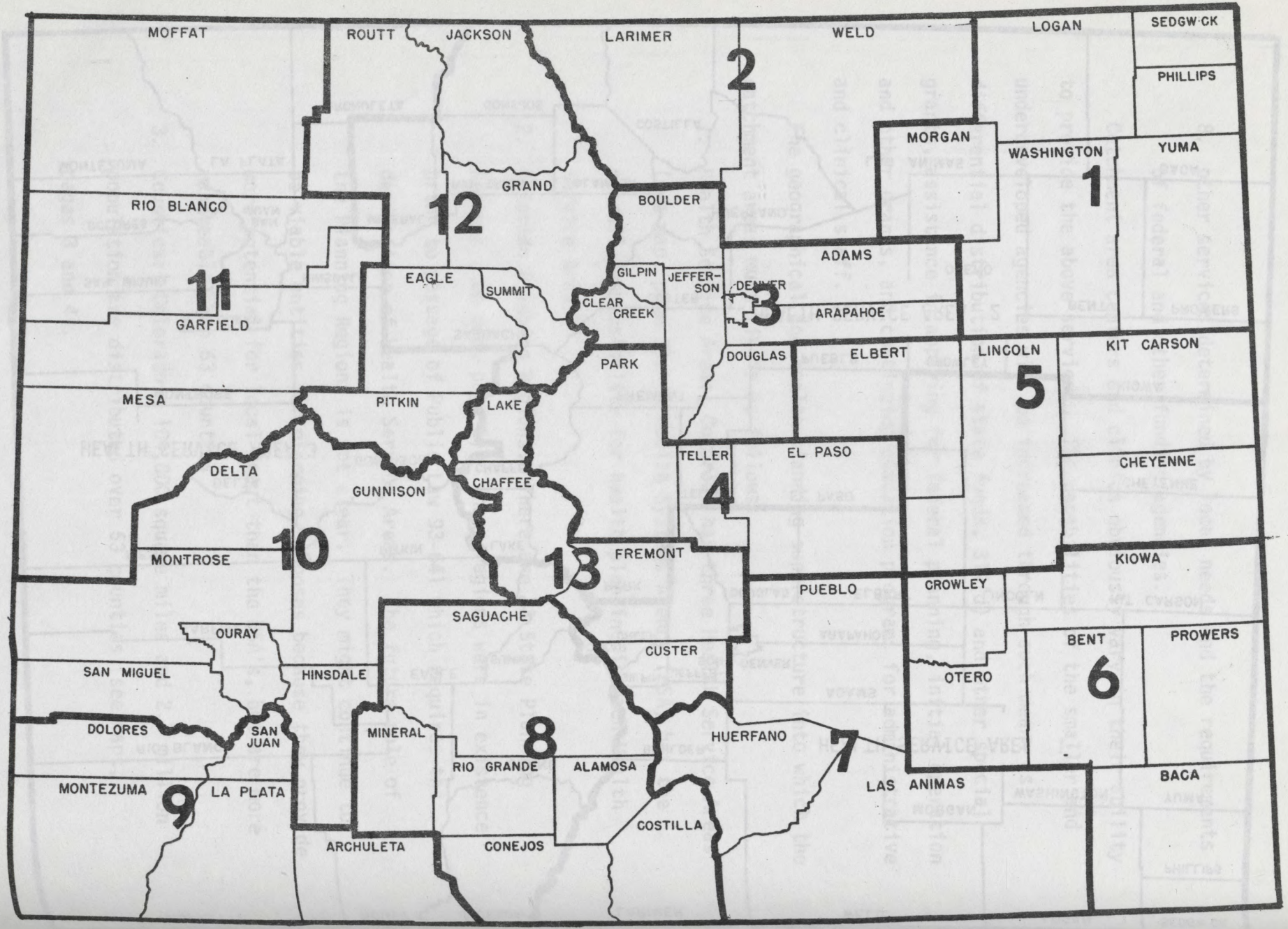
The geographical and health planning superstructure into which the catchment areas must fit is as follows:

1. Health Service Area: Colorado has three Health Service Areas (see map, page 3). A Health Systems Agency (HSA) has the overall responsibility for health planning in each Health Service Area.
2. Colorado Planning Regions: There are 13 State Planning Regions (see map, page 4). These regions were in existence prior to passage of Public Law 93-641 which requires the designation of Health Service Areas. The future role of the Planning Regions is not clear. They might continue to be viable entities for planning purposes because they provide more potential for local input than the HSA's, but are more manageable than 63 counties.
3. Counties: Colorado's 104,000 square miles and 2.7 million population are distributed over 63 counties (see maps, pages 3 and 4).



COLORADO HEALTH SERVICE AREAS

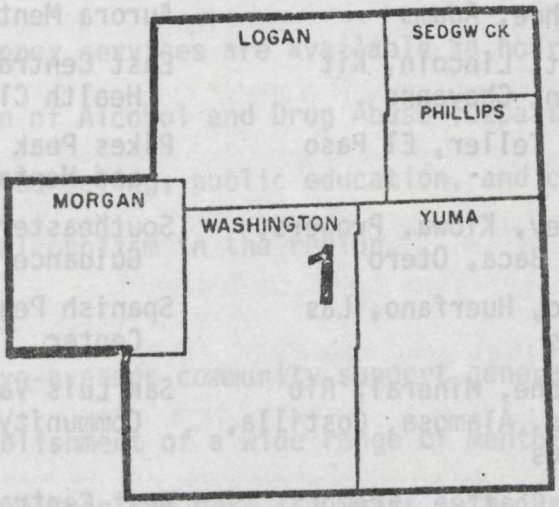
COLORADO PLANNING REGIONS



4. Catchment Areas: Each of the 21 catchment areas is comprised of one or more counties, with the exception of Denver, which is divided into four catchment areas. No catchment area boundary crosses a county line. The chart on page 6 shows the relationships among Health Service Areas, Colorado Planning Regions, counties and catchment area mental health center/clinics.

Following is a brief description of each region, the services provided by the centers/clinics serving each region and program needs.

REGION I



Area: 9,228 square miles
Population: 66,918

Region I lies in the extreme northeastern corner of Colorado and encompasses Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties. The area is bounded to the north by the Nebraska state line and on the east by the Nebraska and Kansas state lines. The

HEALTH SERVICE AREAS, PLANNING REGIONS, COUNTIES AND CATCHMENT AREA MENTAL HEALTH CENTERS AND CLINICS

Health Service Area	Colorado Planning Region	Counties	Catchment Area Mental Health Center/Clinic
1	1	Logan, Sedgwick, Phillips, Yuma, Washington, Morgan	Northeast Colorado Mental Health Clinic
1	2a	Weld	Weld MH Center, Inc.
1	2b	Larimer	Larimer County MH Center
1	3a	Adams	Adams County MH Center, Inc.
1	3b	Arapahoe, Douglas	Arapahoe MH Center, Inc.
1	3c	Boulder	MH Center of Boulder Co., Inc.
1	3d	Jefferson, Gilpin, Clear Creek	Jefferson County Mental Health Center, Inc.
1	3e	Southeast Denver	Bethesda Community MH Center
1	3f	Northwest Denver	Northwest Denver MH Center
1	3g	Northeast Denver	Park East MH Center
1	3h	Southwest Denver	SW Denver Comm. MH Services, Inc.
1	3i	Arapahoe, Adams	Aurora Mental Health Center
1	5	Elbert, Lincoln, Kit Carson, Cheyenne	East Central Colorado Mental Health Clinic, Inc.
2	4	Park, Teller, El Paso	Pikes Peak Family Counseling and Mental Health Center
2	6	Crowley, Kiowa, Prowers, Bent, Baca, Otero	Southeastern Colorado Family Guidance Center
2	7	Pueblo, Huerfano, Las Animas	Spanish Peaks Mental Health Center
2	8	Saguache, Mineral, Rio Grande, Alamosa, Costilla, Conejos	San Luis Valley Comprehensive Community MH Center
2	13	Lake, Chaffee, Fremont, Custer	West Central Mental Health Center, Inc.
3	9	Dolores, Montezuma, La Plata, San Juan, Archuleta	Southwest Colorado Mental Health Center, Inc.
3	10	Delta, Gunnison, Montrose, San Miguel, Ouray, Hinsdale	Midwestern Colorado Mental Health Center, Inc.
3	11-12	Moffat, Routt, Jackson, Grand, Rio Blanco, Garfield, Mesa, Pitkin, Eagle, Summit	Colorado West Regional Mental Health Center, Inc.

southern extent of the region ends at the Lincoln and Kit Carson County lines and the western boundary is the Weld and Adams County lines.

1. Existing Services

The region is served by the Northeast Colorado Mental Health Clinic with headquarters in Sterling and branch offices in Fort Morgan and Yuma. Outreach services are provided to other communities in the region. County fiscal support of the clinic has been impressive; over the past several years, county funds have accounted for approximately one-third of the total budget of the clinic. The major service modalities of the clinic are outpatient evaluation and treatment services, juvenile diagnostic crisis shelter and counseling services, and consultation and education services to other community agencies. Emergency services are available 24 hours a day. A contract with the Division of Alcohol and Drug Abuse (Department of Health) supports client counseling, public education, and community organization efforts in alcoholism in the region.

2. Program Needs

With the above-average community support generated by the Northeast Clinic, the establishment of a wide range of mental health services will be possible within the next few years. The region has been transferred from the Colorado State Hospital service area to that of the Fort Logan Mental Health Center. This movement provides an excellent opportunity for the clinic to plan and implement several service elements, particularly alternative inpatient services for adults.

There are no hospitals within the catchment area providing separate units, beds or professional staff to treat serious emotionally or

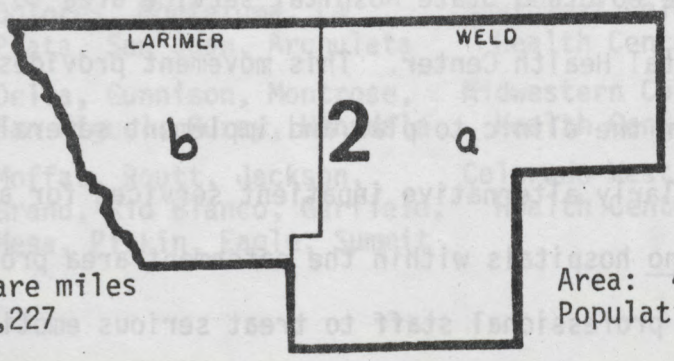
socially disturbed persons. The nine general hospitals will admit patients with a psychotic disorder or diagnosis, but they are not set up for treating such disturbances other than on an emergency basis. There is a need for specialized inpatient services and alternative treatment facilities in the catchment area.

A planning grant application has been submitted to the Department of Health, Education and Welfare to facilitate the establishment of comprehensive services to this catchment area and to the Region 5 catchment area. Under this proposal, Regions 1 and 5 would be combined into a single catchment area so that comprehensive services would be made available to both areas.

While the area of combined Regions 1 and 5 is very large, the population of these contiguous areas is quite sparse. Resources are scarce in both regions. The regions share many geographic, economic, political and social factors which increase the feasibility of amalgamation for the purposes of provision of comprehensive mental health services. Many of the Northeast Colorado Mental Health Clinic staff provide services on a part-time basis to Region 5.

As these plans are realized, catchment area changes and descriptions of services will be revised in the State Mental Health Plan.

REGION 2



Area: 2,614 square miles
Population: 124,227

Area: 4,004 square miles
Population: 116,407

Region 2a

Weld County, with a land area of 4,004 square miles, is one of the two counties in Planning Region 2. The Wyoming and Nebraska state lines form the northern boundary of Region 2a; Logan and Morgan Counties form the eastern boundary; the metropolitan area of Region 3 the southern boundary; and Boulder and Larimer Counties the western boundaries. This area encompasses the far northern area of the Colorado front range corridor. The Cache la Poudre and Big Thompson Rivers flow through the region and, coupled with efficient water resources management through the Colorado Big Thompson Project, provide this district with ample irrigation ability. The northern part of the county is a sparsely populated area dominated by the Pawnee National Grasslands. Major industries and employers include agribusiness, livestock, meat processing and education (University of Northern Colorado).

1. Existing Services

The county is served by the Weld Mental Health Center. The center received a federal staffing grant in November 1966, and the grant terminated in October 1974. Based upon the 1960 census data, the county was designated as a poverty area, and the center became eligible for poverty funding status. However, 1970 census data did not support continued poverty area designation of Weld County. No fiscal support of the program is received from the county; funding comes entirely from federal and state sources, fees, donations, and modest school contract funds and some support from the City of Greeley. The main service center and administrative offices recently moved into a new, well designed facility in Greeley.

There is a branch office in Fort Lupton, a community south of Greeley wherein a large proportion of the county's Chicano population resides. The center is attempting to increase its outreach efforts to Chicanos in the county and has made major strides, although additional resources need to be channeled into this effort.

Inpatient services are provided in the county hospital in Greeley, and the inpatient program is often filled to capacity. Adult day care services are provided through a separately organized facility called "Stepping Stone," which provides services for both chronic, longer term clients and clients in the inpatient unit. Emergency services are provided throughout the county.

A full range of services is available for the alcoholic and his family through the various center services and a specialized alcoholism outreach team. A halfway house provides an alternate living program for the alcoholic.

A specialized program for children and families provides emergency care, long term therapy and evaluation services. A drug program, "Lean-On," for teenagers and young adults is well utilized as a drop-in center in the community.

2. Program Needs

The Weld Center provides basic services for all categories of clients with the exception of geriatrics, forensic services and specialized inpatient services for children and adolescents. The possibility of some sharing of facilities and services by Weld and Larimer Counties will be explored.

Perhaps the highest priority for this region is the development of other 24-hour care services, such as a halfway house, to relieve

the growing pressure on the center's inpatient program.

There are no transitional care beds currently available for children or adolescents with chronic psychiatric problems and behavioral problems requiring intensive mental health treatment. The center proposes a 12 bed facility which would offer intensive treatment and educational oriented programs in conjunction with the local deparmtent of social services, the local school district and the local center for the developmentally disabled. This facility would make possible a reduction in the number of children being inappropriately institutionalized in both psychiatric hospitals and juvenile detention facilities.

Region 2b

Larimer County comprises Planning Region 2b. The 2b district's northern borders are aligned with Wyoming, while to the east is Weld County, to the south Boulder County and on the west Jackson and Grand Counties. Most of Region 2b lies in the South Platte River watershed with the northwest corner of the territory comprising part of the Big Laramie River watershed.

An unusually heavy rainfall recently caused the Big Thompson River, which flows across the southern part of the county, to overflow. The resulting flooding became a major disaster which claimed over 125 lives. The canyon in which the river overflowed is a major highway route, and contained many homes and businesses. Since the canyon is a high risk flood area, consideration is being given to ways of preventing future loss of life. This might result in the relocation of canyon residents to other areas of the county.

The major communities of the county are Fort Collins, Loveland and Estes Park. According to a recent survey, this area is the fourth fastest growing community in the United States. The major industries in the county are agriculture, livestock, education (Colorado State University) and tourism. The terrain of the county ranges from mountain peaks of 14,000 feet and the Continental Divide on the west to the rolling plains of the Poudre and South Platte River Valleys.

1. Existing Services

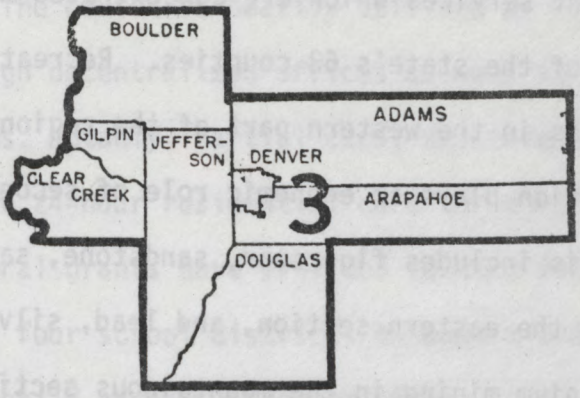
The county is served by the Larimer County Mental Health Center (LCMHC). The agency was recently awarded a federal grant which will enable it to provide a full range of community mental health services. Prior to the award of the federal grant, LCMHC had provided many services above and beyond those expected of an agency with its level of funding. These services included inpatient services, and special programs for alcoholics referred by law enforcement agencies and developmentally disabled persons with mental health problems.

2. Program Needs

Program needs include alternative treatment facilities for all ages, increased services to outlying areas, and increased outreach to the Chicano population. The federal grant and the additional state and local funding available will help meet some of these needs.

The disasterous flood referred to above created many additional demands for services beyond the capacity of the agency to meet with existing resources. The center is applying for special federal funds for counseling services to surviving disaster victims and the families of those who did not survive.

REGION 3



Area: 5,045 square miles
Population: 1,487,594

Region 3 is a 5,045 square mile area encompassing eight counties – Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Gilpin and Jefferson. The region lies directly south of Larimer, Weld and Morgan Counties. It is bounded in the east by Washington County, in the south by Elbert, El Paso, Teller and Park Counties and in the west by Grand and Summit Counties.

Region 3 is largely a metropolitan district and is the most important industrial area of the state. The topography of the territory ranges from level, fertile land in Adams County to the rugged mountains (primarily in Clear Creek and Gilpin Counties) in the western portion of the region.

The South Platte River and a few of its important tributaries – the St. Vrain River, Boulder, Clear and Cherry Creeks – flow through the area and contribute to a small amount of agricultural activity. Most of this farming is limited to Adams County and is accomplished through the use of both dry and irrigated land. There is a limited amount of farming and livestock grazing in Arapahoe, Boulder, Douglas and Jefferson Counties.

The principal economic bases of the region are manufacturing, trade and government services which are concentrated mainly in Denver, the most populous of the state's 63 counties. Recreation and tourism are major industries in the western part of the region.

Mineral extraction plays an economic role of secondary importance in the region. This includes flourspar, sandstone, sand, gravel and clay extraction in the eastern section, and lead, silver, zinc, molybdenum and uranium mining in the mountainous sections of the district.

The state hospital serving Region 3 is the Fort Logan Mental Health Center. This hospital pioneered many of the approaches to community care presently being practiced in many centers and clinics in Colorado and across the country. In addition to Fort Logan and the 14 mental health centers and clinics in Region 3, mental health services are available through Colorado Hospital (a component of the University of Colorado Medical Center), two psychiatric hospitals, several general hospitals, many private practitioners (psychiatrists, social workers, psychologists, nurses, pastoral counselors, etc.) as well as voluntary agencies.

A brief description of the centers and clinics in Region 3 follows.

Adams County Mental Health Center, Inc.

1976-77 Estimated Population: 206,561

1. Existing Services

This comprehensive community mental health center serves the rapidly growing suburban area to the north/northeast of the City of Denver.

It provides a wide range of programs for children, adults and persons in nursing homes. The center is heavily utilized by residents of the community through decentralized offices as well as a variety of specialized programs, notably, partial care, sheltered workshops and a continuum of other 24-hour residential care for the chronically ill. Specific federal grants have provided funding for direct services to children in four school districts through a school mental health program. A child advocacy program offers direct services to children and adolescents in the fifth school district.

2. Program Needs

Areas of need include expanded attention to the large number of nursing home residents who are former psychiatric patients. Additional alternative living facilities are needed because of the large number of persons within the catchment area who require long term care. Additional specialized services for Chicanos are also indicated.

Arapahoe Mental Health Center, Inc.

1976-77 Estimated Population: 153,832

1. Existing Services

This center serves the suburban areas to the south of the City of Denver. It provides comprehensive services through its own decentralized facilities, Fort Logan Mental Health Center and Colorado Psychiatric Hospital. The center initiated action which resulted in the passage of a county bond issue to generate funds for an alternative treatment facility. The agency has also developed excellent consultation and education and children's and alcoholism services.

2. Program Needs

This center will be placing major emphasis on the development of alternatives to inpatient care. Heavy emphasis will also be placed on increased services to aged persons and the Chicano residents of its catchment area.

Aurora Mental Health Center, Inc.

1976-77 Estimated Population: 114,569

1. Existing Services

This center is the most recently developed catchment area program in the mental health system. As the results of the recent approval of its application for a major grant, the center now offers a comprehensive array of mental health services. It will be several months before the center is operating at an optimal level, because of the necessary "gear-up" time.

2. Program Needs

Particular emphasis will be placed on crisis intervention, children's services and alternatives to hospitalization. Also, increased emphasis will be placed on services to the more rural eastern end of the catchment area.

Bethesda Community Mental Health Center

1976-77 Estimated Population: 127,936

1. Existing Services

This program provides comprehensive services to residents of southeast Denver. The program is unique as it is affilated with a private psychiatric hospital program which is utilized for inpatient

services. Emphasis has been placed on evaluation of treatment effectiveness within the services offered.

2. Program Needs

The center recognizes the need for development of alternatives to hospitalization within the catchment area. Also, additional services to minority persons are indicated. Efforts are underway to increase services to young people, the elderly and substance abusers.

Mental Health Center of Boulder County, Inc.

1976-77 Estimated Population: 174,413

1. Existing Services

This is a comprehensive center which serves a diverse catchment area including both urban and rural areas. Programs must therefore be geared to these specific populations. Services in the urban parts of the catchment area emphasize services to young people (including drug abuse services), families and the elderly. Services in rural areas reach the poor and minority groups. Services are readily accessible to residents of the catchment area.

2. Program Needs

This center continues to need to provide a range of services to children and young people because of the nature of its population. Alternative residential treatment facilities are needed, as are a limited number of inpatient beds to replace those previously used in a hospital which had to close its psychiatric ward. Additional services are also needed in rural areas of the county.

Children's and Adolescents' Mental Health Services

(This is a non-catchmented, specialty program)

1. Existing Services

This program provides comprehensive "child-oriented" mental health services in a "child-oriented" facility. In-hospital and outpatient services are provided to children and outpatient care is available to parents of children in treatment. Consultation and education services are also available.

2. Program Needs

This program will continue to play an important role because of its particular emphasis on services to young people in a unique setting. Continued funding and support will be required as the overall hospital program expands. At this point, the hospital is planning a private inpatient program for adolescents. The Division of Mental Health is in support of this expanded service.

Denver Mental Health Center, Inc.

(This is a non-catchmented, specialty program)

1. Existing Services

This clinic provides outpatient treatment with emphasis on individual, longer term therapy for people of middle and lower incomes.

2. Program Needs

This clinic plans to provide expanded outpatient services to the elderly and to continue emphasis on providing its services to lower income clients.

Northwest Denver Mental Health Center (Denver Department of Health and Hospitals)

1976-77 Estimated Population: 169,331

1. Existing Services

This center is a component of the City and County of Denver public health system. In some instances, physical and mental health services are available in the same facility. A wide range of physical and mental health services, plus substance abuse and vocational services are available.

2. Program Needs

This is an area of high need which can utilize virtually any additional services that can be developed. Particular needs include a range of alternative 24-hour care facilities, increased services to children and adolescents and strengthening of consultation and education programs.

Jefferson County Mental Health Center, Inc.

1976-77 Estimated Population: 337,209

1. Existing Services

This comprehensive community mental health center offers comprehensive services to Jefferson, Clear Creek and Gilpin Counties which have a total population of well over 300,000 residents, making it one of the largest in the United States. The main administrative offices are located in Lakewood with branch offices in Arvada, Evergreen, Wheat Ridge/Golden, South Jefferson and Lakewood. Part-time offices serve Idaho Springs and Georgetown.

2. Program Needs

The rapidly expanding population of these suburban and mountain counties has placed growing stress on the center to meet basic service demands. Since staffing patterns have remained more or less constant the past two years, careful utilization of staff time is required to maximize efficiency. Also, there are continuing efforts to place more services in Clear Creek and Gilpin Counties. Alternative residential facilities are a high priority for the center. Additional services to the residents of nursing homes is another primary need in this catchment area.

Servicios de La Raza

(This is a non-catchmented, specialty program)

1. Existing Services

This program provides outpatient and emergency as well as consultation and education services of a specialized nature to the Spanish-speaking community of Denver. The program is relatively new and is currently enjoying increasing utilization by the target group it is programmed to serve.

2. Program Needs

There is need for a partial care program designed to meet the needs of the monolingual client in addition to continuation of the program currently in operation. Consultation and education to other agencies concerning the special cultural factors involved in working with Chicano clients continues to be an area of need in relation to this program.

Southwest Denver Community Mental Health Services, Inc.

1976-77 Estimated Population: 90,713

1. Existing Services

This nonfederally funded center has developed a wide range of comprehensive services for its catchment area. It has placed particular emphasis on alternatives to hospitalization, and the provision of services to children and adolescents. A special program designed to help meet Chicano mental health needs is available. This agency has also pioneered a community corrections program.

2. Program Needs

The center hopes to continue and to broaden its program for alternatives to hospitalization so that need for hospitalization will be reduced even further. This includes not only services to adult clients, but adolescents and alcohol and drug abusers as well. Services to the elderly is an area which needs increased attention.

Park East Comprehensive Community Mental Health Center, Inc.
(formerly Malcolm X Center for Mental Health)

1976-77 Estimated Population: 113,321

1. Existing Services

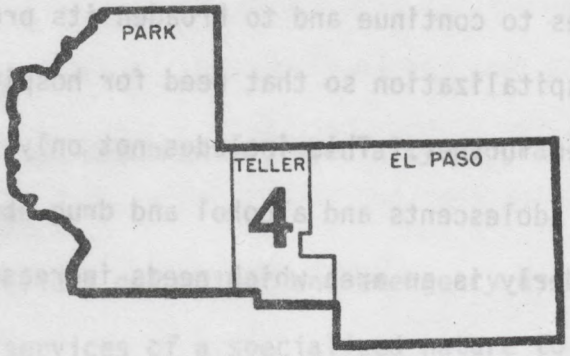
This center provides comprehensive services to the northeast section of Denver. It is the most recent center in Denver to receive federal funding. The center provides centralized intake and diagnostic services, outpatient services at two locations, non-hospital 24-hour care and a day care program. An intensive outpatient program called continuous care is available, as are consultation and education services.

Twenty-four hour care is handled through contractual arrangements with Fort Logan and other hospitals in or near the catchment area.

2. Program Needs

The center recognizes the need for increased services to the elderly, children and adolescents, as well as the Chicano residents of the area. Plans are also being made for a halfway house to serve longer term clients and to complement the short term alternative living facilities now available.

REGION 4



Area: 4,878 square miles
Population: 339,934

Planning Region 4 is composed of three counties - El Paso, Park and Teller, covering 4,878 square miles. El Paso County is primarily urban, while Park and Teller are primarily mountain rural.

El Paso County, stretching along the edge of Rampart Range, includes the metropolitan areas of Colorado Springs, Manitou Springs, Palmer Lake, Fountain, Security, Widefield, Calhan and Ramah.

Teller County consists of foothills and mountain country west of Colorado Springs, and includes Pikes Peak and many small mountain towns, among them Cripple Creek and Woodland Park.

Park County is also a mountainous region containing farms, ranches and small towns, including Fairplay, Hartsell and Bailey.

The catchment area includes four large military installations; Fort Carson Army Base, the Air Force Academy, Peterson Air Force Base and Ent Air Force Base, in addition to the North American Air Defense Command Headquarters in Cheyenne Mountain. Over 40 percent of the area's population are active or retired military personnel and their dependents.

Generally, the area has experienced a growth rate of approximately six percent per year, making the area one of the fastest growing in the state with an estimated population of 339,934, and Colorado Springs the ninth fastest growing city in the nation, with approximately 254,000 residents. Despite such rapid growth, Colorado Springs has the lowest gross household income of the state's nine largest counties, and unemployment is at or above the national rate.

1. Existing Services

This area is served by the Pikes Peak Family Counseling and Mental Health Center, which was formed in 1970 through a merger of Pikes Peak Mental Health Clinic and Family Counseling Service of Colorado Springs. The center's request for a federal staffing grant was approved, but because of presidential impoundment, was never funded. In July 1973, the State of Colorado funded a modified version of this staffing proposal.

The Geographic Outpatient Services Division consists of four major team offices with several satellite offices. Team 1 is the "core city" office and has a staff which reflects the ethnic diversity of its area. Team 2, the Fountain Valley Office, is located in Widefield,

southeast of Colorado Springs. Team 3, the Northeast Office, serves the fastest growing section of the three county area. Finally, Team 4 is located in Manitou Springs and serves all of western and northern El Paso County, as well as Park and Teller Counties. Satellite offices are located in Bailey, Fairplay, Cripple Creek and Woodland Park.

The Hospital Services Unit maintains an 11 bed psychiatric unit at Penrose Hospital. The Adult Day Treatment Unit provides a high intensity outpatient program which allows clients to remain at home and maintain their work, family and social roles. The After-Hours Emergency Services is a 365 day, year-round emergency telephone answering service.

The Special Services Division is comprised of various programs geared to the specialized needs of individuals in the catchment area. Adult Forensic Services is a community-based mental health program for offenders and their families. The program's services include alternative sentencing evaluations for the courts, consultation to staff and inmates of prisons and jails, outpatient group therapy and residential treatment for adult offenders. The Youth Treatment Center offers residential, outpatient and day treatment services to the youth in the community. Budget Counseling provides counseling to families and individuals with financial problems, as well as an extensive education program to prevent such problems.

The Alcohol Services Division offers a variety of programs and treatment intensities specially designed for people with alcohol related problems.

2. Program Needs

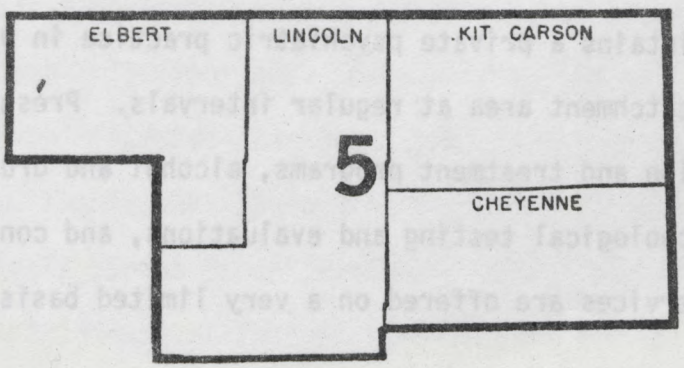
A substantial increase in other 24-hour care beds is needed. Such beds are essential if the center is to attain its objectives related to reducing the rate of inpatient hospitalization and treating clients in the least restrictive setting.

Despite the center's Youth Treatment Center (YTC), the community as a whole has a serious gap in mental health diagnostic and treatment services for children and youth. In addition, the problem of child abuse in this area continues to be acute, and there is an obvious need for both treatment and prevention programs focused on this problem. Additional funding is also needed for improvements in YTC to ensure continued accreditation.

The center is currently underserving the elderly people in its catchment area; additional resources and efforts are needed to provide outpatient and day care programs to maintain the elderly person at an acceptable level of self-sufficiency.

The mental health center is also under pressure to increase outpatient and consultation and education services to the continually expanding population in the catchment area.

REGION 5



Area: 8,401 square miles
Population: 21,158

Cheyenne, Elbert, Kit Carson and Lincoln Counties comprise Region 5, located in the mideastern portion of Colorado. Arapahoe, Washington and Yuma Counties form its northern boundary, the Kansas state line its eastern boundary, Kiowa and Crowley Counties its southern boundary, and El Paso and Douglas Counties its western boundary. The entire region straddles the ridge between the Platte and Arkansas River Valley. Strong agricultural and ranching endeavors are predominant in Region 5.

The distance from markets and raw materials, prevailing freight rates, and other negative factors tend to have a discouraging affect on industry in the area, and thus it is virtually nonexistent.

The Colorado Health Consumer Survey, published in 1971 by the Colorado-Wyoming Regional Medical Program concluded that Region 5 was "the least viable health service region in the state ... it has the most critical shortage of health manpower, and there is no potential regional health care center in the region."

1. Existing Services

At present, the region is served by a part-time clinic headquartered in Flagler. This clinic was the last to develop in the state outside the Denver metropolitan area. The clinic is headed by a part-time director who maintains a private psychiatric practice in Denver, but travels to the catchment area at regular intervals. Presently, outpatient evaluation and treatment programs, alcohol and drug abuse counseling, psychological testing and evaluations, and consultation and education services are offered on a very limited basis.

2. Program Needs

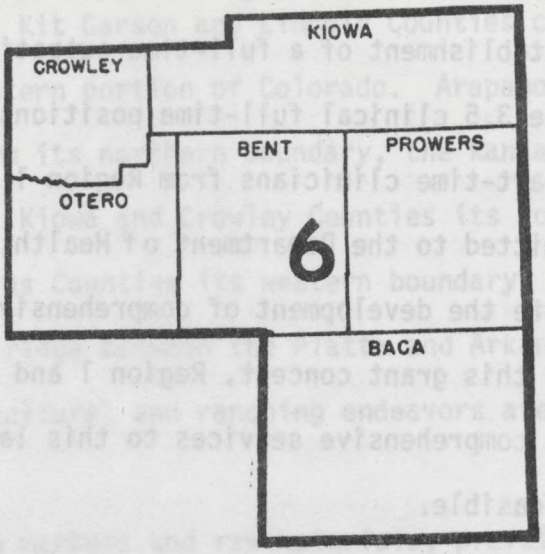
The mental health needs of the region are quite basic. Foremost is, perhaps, the establishment of a full-time outpatient clinic to serve the area. The 3.5 clinical full-time positions are primarily filled by several part-time clinicians from Region 1. A planning grant has been submitted to the Department of Health, Education and Welfare to facilitate the development of comprehensive services for this region. Under this grant concept, Region 1 and Region 5 would be combined so that comprehensive services to this large, isolated area would become feasible.

The area needs inpatient beds for emergency care within the region. Clients are now transported to Colorado State Hospital. Local facilities for short term care and alternative residential facilities would avoid extended absence from the community.

There is considerable need for mental health care of chronic, predominately aged clients. The available nursing homes are not adequately staffed to furnish quality psychiatric care. However, beds could be effectively used in existing nursing homes by upgrading of their staffing patterns.

The region lacks day care facilities for disturbed youth as well as adults.

REGION 6



Area: 9,526 square miles
Population: 57,623

The Region 6 catchment area encompasses six counties in the southeastern corner of Colorado. These are Baca, Bent, Crowley, Kiowa and Otero Counties.

Region 6 includes all of the Arkansas River drainage basin that falls outside the front range corridor. Horse Creek and the Purgatory, Big Sandy, Two Buttes and Cimmaron Rivers, tributaries of the Arkansas River, flow through the area. Other water resources include the John A. Martin, Adobe Creek, Horse Creek, Lake Meredith and Lake Henry reservoirs. The Frying Pan-Arkansas Project, a water resource program, is expected to benefit the area by increasing its water resource base. The region is plagued with seasons of drought followed by severe rainfall, which are characteristic of the Great Plains Region, but still manages to produce significant amounts of sorgham, grain, wheat, corn, broomcorn, sugar beets, alfalfa, commercial vegetables and forage. This output is accomplished through

the use of both dryland and irrigated farming techniques.

Industry has only a nominal foothold in the area, with the manufacturing that does exist primarily oriented toward food processing. Most of this industrial activity is centered around the region's main trade centers of Lamar and La Junta.

The population of the catchment area has demonstrated some decline in recent years, particularly from the rural segment. The area is designated as a poverty area. The number of elderly people and Spanish-speaking persons is above the state average.

The Region 6 catchment area is a rural, agricultural area where relatively few services are readily available. Many residents travel to Pueblo or Colorado Springs for shopping and other services. A trend in this region has been the movement of rural residents to urban areas.

1. Existing Services

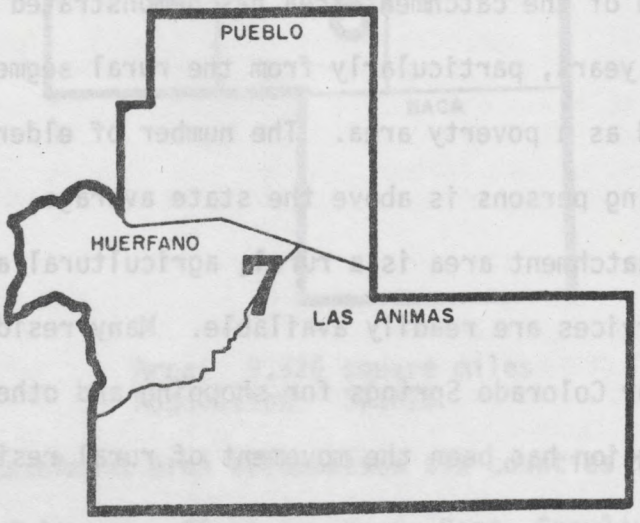
The clinic provides only outpatient and consultation and education services. The clinical staff consists of five full-time professionals, a part-time (two days per month) psychiatric consultant, a part-time nurse, and two secretaries. The clinic has a branch office in Lamar. The Southeast Region ranks first of all Colorado regions in the need for additional publicly-supported mental health services.

2. Program Needs

There is a need for increased mental health services throughout the region. The rural communities are especially seriously underserved due to the distances involved and the limited size of the staff. Need also exists for a drug and alcohol abuse counseling program. Psychological and consultation services to children, especially to

handicapped children and their parents, should be expanded. Expansion of the mental health services to the nursing homes in the catchment area is also a high priority need.

REGION 7



Area: 8,773 square miles
Population: 156,419

The Region 7 catchment area consists of Pueblo, Huerfano and Las Animas Counties. It encompasses fertile valley land, broken prairie and rolling hills in the eastern portion and plateaus and mountains in western areas.

Much of the area is in the Arkansas River watershed. There is farming and ranching in some portions of the region, but they are not the major sources of income.

Pueblo is the major agricultural, commercial and industrial center in the region. The foremost economic asset of this city is the Colorado Fuel and Iron Corporation, which employs approximately 6,000 persons. Plans have been made to close the Pueblo Army Depot, which, in the past, has employed 2,800 persons. This event has and will have a serious

economic impact on the community. Colorado State Hospital is also a major employer, with over 1,300 persons on its payroll.

Trinidad and Walsenburg are this region's secondary trade centers. Both of these communities will benefit economically from the expected expansion of the coal mining industry.

Region 7 has been designated a poverty catchment area. Numbers of poor and ethnic minority residents are high, as is the unemployment rate. Population growth has been relatively slow. All of these social factors have led to development of stresses and tensions in the catchment area. This, in turn, has led to demands for increased social and mental health services.

1. Existing Services

The area is served by the Spanish Peaks Mental Health Center, headquartered in Pueblo. Branch offices are located in Walsenburg and Trinidad. The center provides a full array of services through affiliation with the Colorado State Hospital (CSH) in Pueblo. The center provides outpatient services, emergency services during the daytime and consultation and education services in Pueblo. CSH provides the inpatient services, weekend and night-time emergency services and partial care services in Pueblo. The branch program at Walsenburg provides outpatient and partial care services to adults and outpatient services to children, while the Trinidad branch provides outpatient services for all ages and partial care services for children and school consultation services. The center has also developed a comprehensive alcoholism service program funded by an NIAAA grant. A residential child care facility, called EKOS House, is sponsored by the center. A group home in Trinidad is receiving mental health consultation from the center.

The center was originally established as a joint venture between CSH and the Spanish Peaks Mental Health Clinic. Through a construction and a subsequent staffing grant, a facility for the treatment of children in the region was established on the grounds of CSH. Cottage "D" was staffed by federal funds from the center and by state funds through CSH. Cottage "D" is now operated and funded completely through CSH, and the center is an independent nonprofit agency with a working agreement with CSH, but no joint funding. The center is in its eighth and last year of the staffing grant.

The center serves children through the Rural Child Mental Health Program which provides outreach mental health services to children and families in the rural areas of Pueblo County. It is a cooperative venture with School District 70.

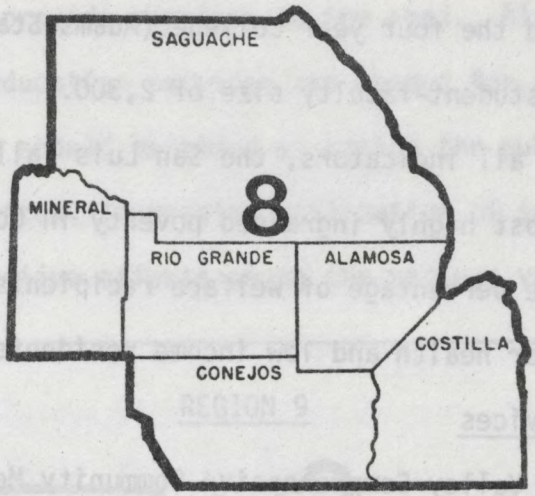
Because the area contains a large Chicano population, the center has developed effective bilingual services. Currently, the center serves as a model for this type of outreach intervention.

2. Program Needs

There is great need for additional resources to develop more extensive outreach services to urban and rural pockets of poverty. There is also a large number of one-parent families that need attention.

Other needs include the following: alternatives to inpatient services in the counties of Las Animas and Huerfano, strengthening of services to minority adult outpatient and partial care clients, provision of centerwide post-institutional follow-up services, increasing outreach mental health services to children and families at risk in areas in addition to School District 70, increasing all programs to the elderly with special emphasis on partial care and inpatient alternatives.

REGION 8



Area: 8,180 square miles
Population: 42,353

Region 8 consists of six counties in the midsouthern section of Colorado. The area consists of the San Luis Valley, the mountain rimmed watershed of the upper Rio Grande River. The valley is a broad flat plain, 50 miles in width and 115 miles long.

The catchment area was settled in the mid-nineteenth century by Spanish-Americans whose culture continues to predominate. This area contains by far the highest concentration of Spanish-speaking persons in the State of Colorado (46.1% of the population). It is also the most contained or most isolated region in the state geographically and perhaps even psychologically.

The population is unusually stable. There tends to be little migration in or out of the region.

Major population centers are Monte Vista and Alamosa. However, even these communities are small (population 4,195 and 8,615 respectively) and offer relatively few services.

The area's economy is based largely on farming, the sportsman/tourist trade and the four year college (Adams State College at Alamosa) with a student-faculty size of 2,300.

By virtually all indicators, the San Luis Valley is among the areas with the most highly ingrained poverty in Colorado. The region ranks high in the percentage of welfare recipients, poor housing, overcrowding, poor health and low income residents.

1. Existing Services

The San Luis Valley Comprehensive Community Mental Health Center is the only private or public mental health treatment facility located in the region. One outstanding feature of the center program is the extensive use of outreach centers and effective use of para-professionals who provide effective, yet economical services. The center operates full-time facilities in Alamosa and Monte Vista. Outreach offices are available in most other communities of the valley. Detoxification facilities for alcoholics are also available.

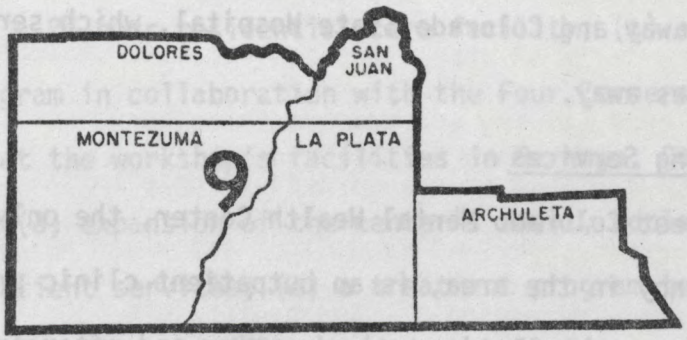
2. Program Needs

The greatest program needs are for locally available inpatient treatment of chronic disorders in children, a community corrections service and an expansion of facilities to treat the adult chronic psychiatric patients requiring hospitalization or other types of residential care.

The high incidence of poverty also contributes to alcoholism and drug abuse. There is strong need for additional resources for alcoholism and drug abuse services. The program has a limited capacity for crisis intervention in the total catchment area. A greater ability to reach out to outlying areas is a chronic need.

Other needs include development of contractual arrangements with local nursing homes to provide services to the aged. Also, strengthened consultation and education services are needed for the entire valley. These services should be aimed at making the public more aware of available services, increasing utilization of services and providing better cooperative efforts among the various valley agencies.

REGION 9



Area: 6,563 square miles
Population: 45,638

Region 9 lies in the southwest corner of Colorado and forms part of the Four Corners area. Archuleta, Dolores, La Plata, Montezuma and San Juan are the district's constituent counties. The San Miguel drainage basin bounds the area to the north, the official dividing line being the borders of San Miguel, Ouray, Hinsdale and Mineral Counties. Conejos County limits the area's eastern extent and New Mexico and Utah border the region to the south and west respectively. The Ute Mountain Indian Reservation along with the Southern Ute Indian Reservation form the southern boundary of the region.

Mineral extraction is a primary economic activity in Region 9. Mining products include pyrite, lead, zinc, silver, copper, gold, sand and gravel. Tourism and lumbering also contribute to the economy of the region with the tourist industry becoming increasingly significant. As the names of the counties suggest, the region has many Chicano and Indian residents. This region has the highest unemployment rate of any region in the state. It is relatively isolated by mountains and distance from the major Colorado cities. Denver is 332 miles away and Colorado State Hospital, which serves this region, is 271 miles away.

1. Existing Services

Southwest Colorado Mental Health Center, the only public mental health agency in the area, is an outpatient clinic providing outpatient care, consultation and education and aftercare treatment to patients of all age groups. A special outpatient drug abuse program was also funded three years ago. The staff consists of 12 full-time equivalent positions, and provides services at full-time offices in Durango, Cortez and Ignacio. Satellite offices are located at Pagosa Springs, Dolores and Dove Creek, which are staffed on a part-time basis. Local hospitals are utilized for inpatient care for some clients who are eligible for Meidcare and Medicaid and other third party reimbursements.

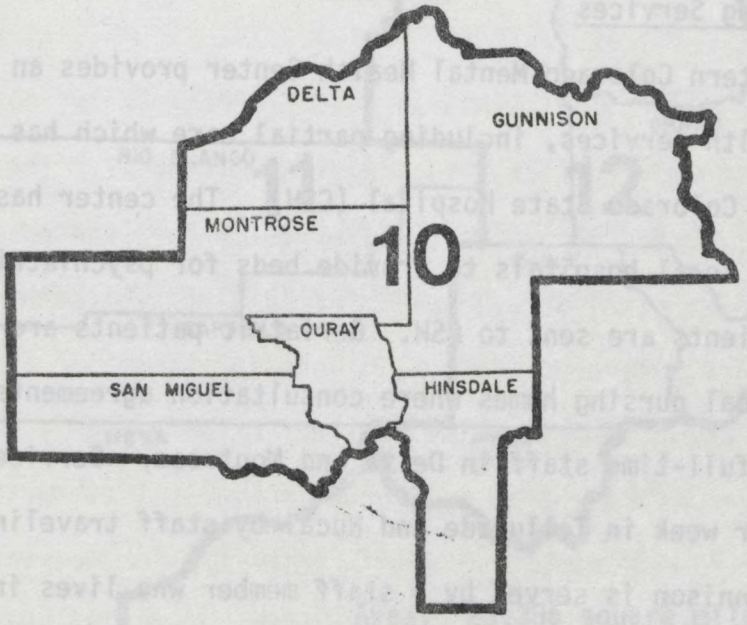
2. Program Needs

Southwest Colorado's greatest need is for additional staff to reach out to currently unserved or underserved populations. This catchment area has a high concentration of Native Americans and Chicanos for whom services are only minimally available. The need

for bilingual staff has been of continuing concern to the program. An application has been submitted under PL 94-63 for a planning grant for FY 76-77. This application has been approved but not funded. The funding of this grant will help meet the need for a plan for the provision of comprehensive mental health services in the region.

Some additional specific program needs are: (a) more local inpatient psychiatric beds; (b) a halfway house and other alternate facilities for ex-state hospital adult psychiatric clients and other adult clients who require a 24-hour residential care facility; (c) a partial care (day care) program in collaboration with the Four Corners Sheltered Workshop at the workshop's facilities in Durango, Cortez and Pagosa Springs; (d) expansion of the center's adult, adolescent and children's outpatient services; (e) a treatment program to meet the needs of elderly people, and (f) expanded consultation and education services.

REGION 10



Area: 9,369 square miles
Population: 48,737

Planning Region 10 consists of Delta, Gunnison, Hinsdale, Montrose, Ouray and San Miguel Counties. This area roughly corresponds to the drainage basins of the Gunnison, Uncompahgre and San Miguel Rivers. The Colorado River drainage basin bounds the district to the south, the official dividing line being the borders of Mesa and Pitkin Counties. The Continental Divide forms a natural boundary to the territory in the east with Chaffee County line as the agreed upon border. The State of Utah lines the region's western boundary.

Agriculture, mining and tourism form the economic base of Region 10. There are several sizeable food processing plants including Holly Sugar Corporation, Skyland Food Corporation and Russell Stover Candies Incorporated. The region's trade centers are Gunnison, Montrose and Delta. Approximately one-sixth of Colorado's federal land holdings are in the region. The wealth of recreational land provides ample facilities for hunting, fishing and skiing.

1. Existing Services

Midwestern Colorado Mental Health Center provides an array of mental health services, including partial care which has been partially staffed by Colorado State Hospital (CSH). The center has contracts with three local hospitals to provide beds for psychiatric patients; some inpatients are sent to CSH. Geriatric patients are also served through local nursing homes where consultation agreements exist. There are full-time staff in Delta and Montrose. Service is provided one day per week in Telluride and Nucal by staff traveling to these areas. Gunnison is served by a staff member who lives in the community.

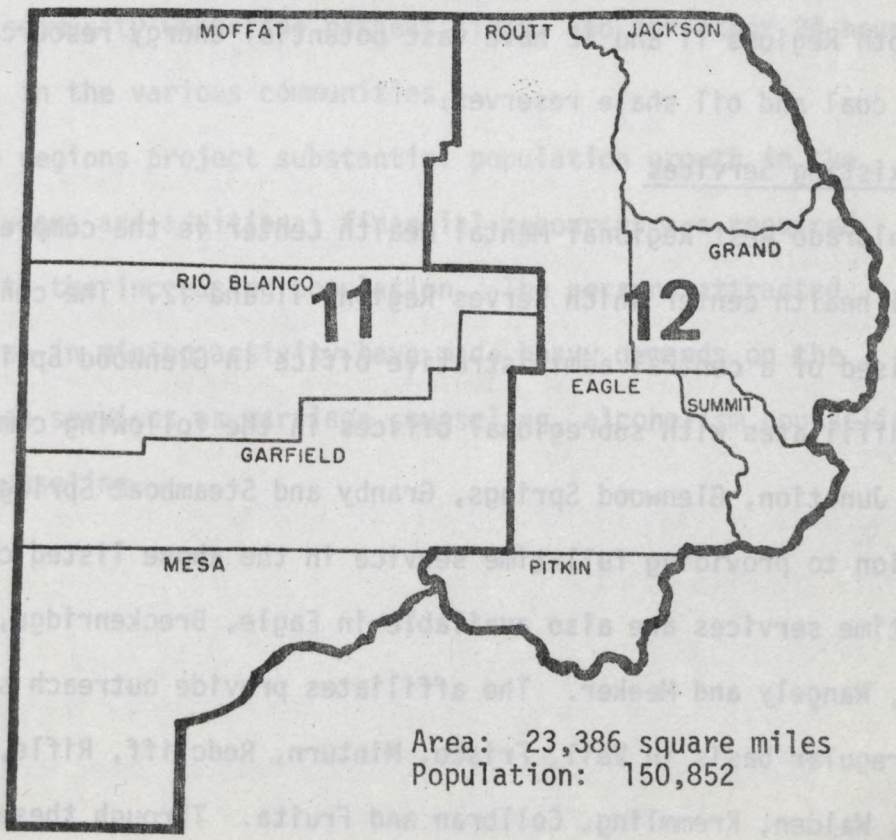
Delivering service across this vast area necessitates a sizeable travel budget. This, along with staff travel time, increases the per client cost. Midwestern is the only public mental health and marriage counseling agency in the catchment area.

The center was recently awarded a second federal grant which will enable it to increase staffing and expand its services to more residents in previously underserved and unserved communities.

2. Program Needs

There is need for more adequate hospital facilities within the catchment area in order to limit the number of patients sent to CSH. Other needs include a high quality mental health program for children and adolescents, alternate residential care facilities for adults, improved 24-hour emergency services, and an expanded partial care program.

REGIONS 11 & 12



Area: 23,386 square miles
Population: 150,852

Regions 11 and 12 are combined into one mental health catchment area, which is composed of 10 counties: Moffat, Rio Blanco, Garfield, Mesa, Eagle, Grand, Jackson, Pitkin, Routt and Summit. The topographical characteristics of Regions 11 and 12 are reflected in the area's economic basis — specifically agriculture, mining, lumbering, ranching, farming, light manufacturing and recreation. The most important asset of Region 11 is the rich, fertile land of the Colorado River Valley. Stock raising plays a major economic role, with orchard crops important in Mesa County. The Utah and Wyoming state lines border the district to the west and north. The vast mountainous regions in the northwest corner of the state account for 22.3 percent of the total area of the state, and the topography of the region varies greatly from high mountains of the Continental Divide to rolling semi-arid terrain of the western area. All of the Region 12 population is classified as rural dwellers, while in Region 11 the population is equally divided between urban and rural communities.

Both Regions 11 and 12 have vast potential energy resources in their coal and oil shale reserves.

1. Existing Services

Colorado West Regional Mental Health Center is the comprehensive mental health center which serves Regions 11 and 12. The center is comprised of a central administrative office in Glenwood Springs and four affiliates with subregional offices in the following communities: Grand Junction, Glenwood Springs, Granby and Steamboat Springs. In addition to providing full-time service in the above listed communities, full-time services are also available in Eagle, Breckenridge, Aspen, Craig, Rangely and Meeker. The affiliates provide outreach services on a regular basis in Vail, Frisco, Minturn, Redcliff, Rifle, Oak Creek, Walden, Kremmling, Collbran and Fruita. Through these programs,

service can be delivered to small communities unable to support full-time clinics and thus make service available to persons unable to travel to larger centers. The decentralized programming approach has relied heavily upon community and staff involvement in designing services responsive to the widely diverse and unique needs of the many rural communities served. The services vary in emphasis from community to community, but a full range of services is available in the catchment area.

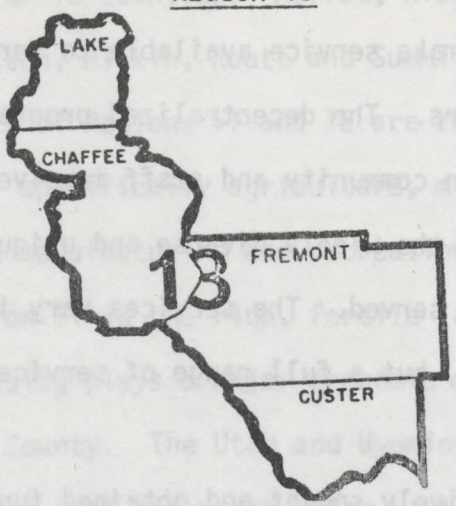
The center has actively sought and obtained funding from various sources to build a very effective program, and has made excellent use of volunteers located throughout the ten counties. As of July 1, 1976, state hospital service responsibility for Region 12 was assumed by Fort Logan. CSH continues to provide services to Region 11.

2. Program Needs

The major need is for readily available hospital beds located close to the community where the patient lives, and for other 24-hour care programs in the various communities.

These two regions project substantial population growth in the next several years and additional financial resources are required to keep up with the increasing population. The persons attracted by the increase in mining activity have made heavy demands on the center for such services as marriage counseling, alcoholism counseling and family counseling.

REGION 13



Area: 3,715 square miles
Population: 45,824

Chaffee, Custer, Fremont, and Lake Counties constitute the 3,715 square mile area designated as Planning Region 13. The mountainous counties of Regions 10, 12 and 4 (Gunnison, Pitkin, Eagle, Summit and Park) surround the northern half of the district and Regions 7 and 8 frame the southern portion of the territory.

Both the Colorado State Penitentiary and the State Reformatory are located in this catchment area.

Mining is a major industry in Region 13. Agriculture, tourism, lumbering and recreation are other important sources of income. Approximately 80 percent of the world's supply of molybdenum is produced near Climax by American Metal Climax Incorporated, which employs over 2,000 persons.

The primary trade centers of Region 13 are Canon City, Salida, Leadville and Buena Vista.

1. Existing Services

West Central Mental Health Center is the Region 13 mental health agency. The center was recently awarded a federal grant which, along

with increased state and local funding, will enable it to provide a full range of services to its catchment area.

2. Program Needs

Specific service needs which will be addressed include locally available inpatient psychiatric services, additional outpatient services throughout the region for all age groups, residential alternatives to inpatient care, day care, emergency "hot-line" services and 24-hour coverage, consultation and education services to agencies such as schools, courts, social services and law enforcement agencies, prescreening services to courts and public agencies, and expanded alcohol counseling services. This region has a high percentage of persons over age 65; special efforts are needed to reach this population.

B. REVIEW PROCESS FOR CATCHMENT AREAS

According to federal guidelines, the population of a catchment area is to be between 75,000 and 200,000. The upper and lower population limits can be waived by DHEW at the time of approval of a center for federal funding. After a center has been awarded a federal grant, if any variation in the population of an area reduces it below the minimum or increases it above the maximum by more than 25 percent, a DHEW waiver must be sought or the catchment area must be enlarged or subdivided as necessary to bring it within the prescribed size.

At least every five years the Division of Mental Health shall review catchment area boundaries to determine what adjustments are necessary. This process will be coordinated with the State Health Planning and Development Agency. The criteria to be used in conducting the review will include:

1. The sizes of catchment areas must be such that the services to be provided through centers and their satellites are promptly available and accessible.
2. The boundaries of catchment areas must conform to the extent practicable, with relevant boundaries of political subdivisions, school districts and Health Service Areas.
3. The boundaries of catchment areas must eliminate, to the extent possible, barriers to access to the services of the catchment area centers, including barriers resulting from an area's physical characteristics, residential patterns, economic and social groupings and available transportation.

C. RANKINGS OF CATCHMENT AREAS

1. Procedures Used in Ranking

In order to determine the relative need for additional mental health services among the various catchment areas, a need assessment study was performed in April 1976. This study included the following two parts:

a. an inventory of existing facilities; and

b. a need survey based on social indicators.

The inventory of existing facilities consisted of a form based on NIMH inventory definitions, and completed by the community agency responsible for each catchment area. The inventory collected data on the number and type of inpatient and other 24-hour care beds, as well as on mental health manpower available in various treatment intensities. The data were returned to the state office for compilation and analysis, and a set of indicators to assess the degree of resources available in each catchment area were chosen. A complete description of the study and the final ranks are shown in Appendix IV.

The second part of the study, the social indicator analysis, was based on the Mental Health Demographic Profile System (MHDPS). This data system provides socio-economic and other demographic information taken from the 1970 census. Eleven indicators of mental health need were chosen, and on the basis of these, the catchment areas ranked. A full description of this study along with the final ranks are shown in Appendix V.

In order to obtain a single ranking of the catchment areas, the ranks of the two studies were combined. The following formula was used: Final Score = (1/2 of the rank on the inventory survey) + (the rank on the social indicator survey). Thus, the social indicators were given twice the weight of the resources indicators. This was done for two reasons:

a. The social data were all collected in the same way (from the Census Bureau) while the inventory of resources was produced by many different people in different places. Therefore, it was felt that the latter represented less comparable data.

b. Since reporting of certain types of resources was optional on the facilities inventory, these resources were not considered in the analysis. This again led to the feeling that the inventory represented "softer" data.

2. Rankings of the Catchment Areas

The table below shows the final ranks of the catchment areas, with a rank of "1" indicating the greatest need. As mentioned above, the rankings on the facilities inventory and the social indicators survey are shown in Appendices IV and V; the combined score is shown in Appendix III. All supporting data are also included in the appendices for the reader wishing complete detail. These rankings, or other similar data developed by or outside the DMH, will be shared with affected centers and clinics and with technical experts to obtain input on limitations and applicability of results, prior to use for funding decisions or recommendations.

LISTING OF CATCHMENT AGENCIES IN RANKED ORDER

Rank*	
1	SE Colorado
2	NW Denver
3.5	Midwestern W Central
5	SW Colorado
6	San Luis Valley
7.5	Park East Spanish Peaks
9.5	NE Colorado Weld
11	Colorado West
12	Adams
13	Aurora
14.5	E Central Larimer
16	Pikes Peak
17.5	Bethesda Jefferson
19	SW Denver
20	Boulder
21	Arapahoe

*Rank of "1" indicates greatest need.

D. PROGRAM FOR DEVELOPMENT OF COMMUNITY MENTAL HEALTH RESOURCES

In keeping with the principle that mental health services must be made available to all citizens of the state, regardless of ability to pay, the Division of Mental Health will work aggressively to develop additional resources to help meet the mental health service needs of all citizens. These efforts will include well planned presentations to legislative groups, and a relentless search for alternative sources of funding.

The Division has been actively working toward a more constructive, cooperative relationship with all elements of the mental health service system and other systems such as the state and federal substance abuse authorities.

In fiscal year 1975-76 the state provided 43.5 percent of the total funds for the mental health system. Despite recent federal awards to centers, continuing emphasis must be placed on increased state fiscal participation. In order to justify increased state funding, a better system of need determination and cost accounting will be necessary. The Division has been actively developing its accounting capability and will continue to do so in the future.

The Division will aggressively pursue various potential sources of third party income, including Title XX contracts, to obtain additional funding for mental health services. A closer working relationship will be established with the Department of Social Services to insure that funds available through this department are directed, to the maximum extent possible, to mental health agencies.

There is need for legislation which will make Title XIX (Medicaid) funds more directly available for recipients of mental health services. The Division will work toward the passage of such legislation.

Each community mental health program in the state will be responsible for mounting a vigorous program to secure additional funding from counties and municipalities. In those cases where counties or cities do not participate in mental health funding, every effort will be made to educate local officials on the importance of maintaining a viable local mental health program. Close collaboration with the new Health Systems Agencies will be essential.

The Division recognizes the need for centers/clinics to reexamine their fee structure in order to insure that it is reasonable and all fees that can be collected are collected. Toward this end, special attention will be directed toward each program's fee structure and collections during annual site evaluations.

E. FACILITIES

1. Plans for Comprehensive Services

As previously indicated, the state is divided into twenty-one catchment areas. Seventeen of these areas are served by comprehensive centers, and four receive services from clinics which have achieved varying degrees of comprehensiveness. All clinics provide at least outpatient and consultation and education services, and their service offerings are supplemented by the two state hospitals.

The goal is to have all catchment areas covered by comprehensive centers. During the past month, three clinics (Aurora, West Central

and Larimer County) have been awarded initial operations grants; one clinic (Southwest Colorado) has applied for a planning grant; and the Division of Mental Health has applied for a planning grant for East Central and Northeast Colorado Mental Health Clinics. The plan is to merge East Central and Northeast Colorado Clinics to form one strong, well staffed agency. The rationale for combining the two catchment areas is as follows:

a. geographic contiguity and similarity of the two areas;

b. social homogeneity of populations;

c. similarity of mental health problems; and

d. when the two catchment areas are merged, they will have a total population of 86,000 and could thus meet the minimum DHEW population requirement of 75,000 without a waiver.

When planning has been completed, an application for an initial operations grant will be submitted.

When the above actions are accomplished, only two catchment areas (Southeastern Colorado and Southwest Colorado) will be without comprehensive services. The goal is to promote initiation of an initial operations grant application for these catchment areas within the next three years.

2. Construction, Purchase and Remodeling of Facilities

Both existing and planned centers are required to periodically review their facilities requirements. Emphasis is placed on leasing or remodeling existing facilities rather than new construction. The criteria used to determine priorities for construction funds have, in the past, been those incorporated in PL 88-164, Title II (Construction of Community Mental Health Centers). The need criteria to be used

effective July 1, 1976, are those incorporated in the ADAMHA guidelines for the preparation of this plan. The rankings of catchment areas on the basis of need are found in Appendix III.

APPENDICES

Appendix I - Agencies and Organizations From Which Input Was Requested and/or Received

Appendix II - Report of the Chicano Mental Health Planning Symposium

Appendix III - Rankings of Centers/Clinics

Appendix IV - Inventory of Existing Facilities

Appendix V - Survey of Need

8 AGENCIES AND ORGANIZATIONS FROM WHICH INPUT WAS REQUESTED AND / OR RECEIVED

AGENCIES AND ORGANIZATIONS
FROM WHICH
INPUT WAS REQUESTED AND/OR RECEIVED

*a. Alcohol, Drug Abuse & Mental Health Administration - Region VIII

b. American Federation of State, County and Municipal Employees

c. Chicano Mental Health Coalition (Metro-Denver)

*d. Chicano Mental Health Planning Symposium

*e. Citizen's Advisory Committee of the Fort Logan Mental Health Center

*f. Colorado Association of Community Mental Health Centers and Clinics

g. Colorado Hospital Association

h. Colorado Nurses Association

i. Colorado Psychiatric Society

j. Colorado Psychological Association

k. Councils of Government

- Colorado West Area

* - Denver Regional

- District 10 Regional Planning Commission

- Huerfano-Las Animas Area

* - Larimer-Weld Regional

- Lower Arkansas Valley

- Northeastern Colorado

- Northwest Regional

- Pikes Peak Area

- Pueblo Area

* - San Luis Valley

- Regions 5, 9 and 13 (see Department of Local Affairs)

*l. Denver Department of Health and Hospitals

m. Denver Mental Health Advisory Board

n. Department of Education Central Office

(1) Division of Special Education

*o. Governor's Task Force on Children

p. Department of Health Central Office

* (1) Division of Alcohol & Drug Abuse

* (2) Division of Comprehensive Health Planning

* (3) Health Facilities Division

* (4) Community Health Services Division (MH Nursing Consultant)

* (5) Administrative Services Division (Planning Section)

q. Human Services Cabinet Council

*r. Human Services, Inc.

s. Health Systems Agencies

(1) Central-Northeastern Colorado Health Systems Agency, Inc. (Area 1)

(2) Southeastern Colorado Health Systems Agency, Inc. (Area 2)

(3) Western Health Systems Agency, Inc. (Area 3)

*t. Department of Institutions Central Office

* (1) Division of Corrections

(2) Division for the Deaf and Blind

(3) Division of Developmental Disabilities

* (4) Division of Mental Health (Central Office)

* (a) Fort Logan Mental Health Center

* (b) Colorado State Hospital

* (c) Twenty-four mental health centers and clinics

* (5) Division of Youth Services

u. Joint Budget Committee

v. Juvenile Delinquent Advisory Board

w. Department of Local Affairs - Division of Planning
(Regional Clearinghouse for Regions 5, 9 and 13)

*x. Lutheran Service Society

*y. Mental Health Association of Colorado

*z. Mile High United Way

aa. National Association of Social Workers

bb. National Council on Alcoholism

*cc. Office of State Planning and Budgeting

dd. PEAK Incorporated (alcoholism and drug outpatient program)

ee. Department of Social Services Central Office

* (1) Division of Aging

(2) Division of Medical Assistance

* (3) Title XX Division (Family & Children's Section)

ff. South Dakota Department of Social Services - Office of Mental Health

*gg. State Mental Health Plan Subcommittee - Mental Health Association

hh. State Plan Committee of Developmental Disabilities Council

ii. University of Colorado at Denver - Psychology Department

jj. University of Colorado Medical Center

(1) JFK Center

(2) Psychiatry Department

kk. Washington House (Adams County Alcoholism Treatment Program)

ll. Western Interstate Commission on Higher Education

mm. Wisconsin Department of Health and Social Services

* agencies and organizations from which input into the plan was received

9 REPORT OF THE CHICANO MENTAL HEALTH PLANNING SYMPOSIUM

CHICANO MENTAL HEALTH PLANNING SYMPOSIUM

I. INTRODUCTION

The Division of Mental Health (DMH) applied for and received a small Research and Development grant from the National Institute of Mental Health in 1975. The grant was the culmination of a year of dialogue between the DMH and the NIMH Minority Center focusing on ways in which the state and federal government could cooperate in program planning and development in the area of minority mental health. It was agreed from the outset that if wide-impact minority oriented programs were to become reality, the development process must begin with minority participation in the state planning process. The Symposium Grant therefore was designed specifically to pioneer a planning process in Chicano services that would have direct impact on the State Mental Health Plan.

The Symposium was patterned to initiate that process by convening community mental health center administrators, DMH staff and Chicano experts to collectively examine the issues and produce a plan that the DMH could incorporate into the master plan. Four areas of immediate importance were addressed for the duration of the Symposium held early in 1976. Specifically those areas addressed were: (1) service programs; (2) unit cost; (3) legislation; and (4) research. The following five year plan is a compilation of the products of the Symposium sessions coupled with recommendations for other ethnic minority mental health group needs.

The largest ethnic minority in Colorado is the Chicano, comprising approximately 17% of the state's population. Although Chicanos, as a distinct cultural and ethnic group, reside in every mental health catchment area of the state, they are concentrated in the small towns of southern Colorado and in the barrios of the cities along the front range of the Rocky Mountains. The city of Denver alone contains an estimated 90,000 Chicanos most of whom reside on the westside area of the city. It makes sense then, to address the needs of the state's largest ethnic minority group as the first step to complying with PL 94-63.

The Symposium Follow-Up Committee (statewide) and the Metro-Denver Chicano Mental Health Coalition submit the following guidelines for a planned approach to meeting the special mental health needs of the ethnic minority population of the State of Colorado.

II. FIVE YEAR PLAN FOR CHICANO MENTAL HEALTH SERVICES, RESEARCH AND DEVELOPMENT.

A. Phase 1 - Fiscal Year 1976-77

Goal One: Assessment of Chicano mental health services on a statewide basis.

Interpretation: There is a critical need to conduct a statewide inventory to determine the extent and quality of services being delivered to persons of Spanish-speaking descent whose command of English is limited.

Objective 1 - Conduct a survey of each catchment area of the state to gather descriptive information as to the kinds of efforts being made to serve the limited English-speaking Chicano client.

Objective 2 - Modify the state data system currently feeding information to the Division of Mental Health (DMH) in order to gather data on Spanish-speaking clients relative to level of disruption and service delivered.

Goal Two: Develop a formalized, constructive, collaborative relationship between the DMH and representatives of the Chicano community.

Interpretation: There is a need to develop a regular liaison process between the DMH and various elements of the Chicano community in order to exchange information and expertise. Such a liaison function can be achieved through the Division's own Chicano Symposium Committee which has statewide representation.

Objective 1 - Formalize the relationship between the Director of DMH and the Chicano Symposium such that regular meetings are held to exchange information and maintain the thrust of the Chicano plan.

Objective 2 - The liaison process will serve as the central mechanism by which the Chicano plan is translated into specific action by DMH with the help of outside groups.

Goal Three: DMH will initiate plans to establish pilot research and demonstration projects designed to collect data on models appropriate for serving Chicanos.

Objective 1 - DMH support for the Chicano inpatient unit proposal for Colorado State Hospital submitted to NIMH will continue.

Objective 2 - In its 1977-78 budget request the DMH will ask for state funds to establish at least one research and demonstration project in the state designed to test out an appropriate outpatient service model for Chicano clients. A similar effort will be made to secure federal funds.

B. Phase II - Fiscal Year 1977-78

Goal One: DMH will build into the site evaluation format specific criteria for assessing the adequacy of services to Chicanos by community programs.

Objective 1 - Each center/clinic shall comply or shall demonstrate plans to comply with PL 94-63 pursuant to requirements for serving clients of limited English-speaking ability, (Section 206, D).

Objective 2 - Each center/clinic will be required to demonstrate that its staff has the cultural sensitivity and linguistic skill to serve the Spanish-speaking population through a program that is outreach oriented.

Objective 3 - Each center/clinic will be required to include training in services to Chicanos as part of its ongoing inservice training program.

Goal Two: The DMH staff development program shall develop and implement a program component aimed at Chicano client services.

Objective 1 - The staff development program will begin to develop and apply a curriculum on Chicano services for staff development on a statewide basis.

Goal Three: DMH will evaluate the model used in addressing Chicano needs to examine the needs of other minority groups.

Objective 1 - Blacks

Objective 2 - Asians

Objective 3 - Native Americans

Goal Four: During fiscal year 1977-78, DMH will fully implement the research and development projects initiated under Phase 1.

Interpretation: It is understandable that the start-up time on such programs may straddle fiscal years and/or the procurement of federal funds is often a protracted process.

Objective 1 - Each project will have a well-designed evaluation component that will yield data on its effectiveness and efficiency.

Objective 2 - Close attention will be paid to the transportability of each model to other areas of the state.

C. Phase III - Fiscal Year 1978-79

Goal One: By July 1, 1978, each community mental health program and Fort Logan will be in full compliance with PL 94-63 as it pertains to clients of limited English-speaking ability.

Objective 1 - Each center/clinic will comply with Section 201(b)(2) of PL 94-63 as it pertains to the elimination of cultural and linguistic barriers to services.

Objective 2 - Each center/clinic will comply with Section 206(c)(1)(D) of PL 94-63 as it pertains to services to clients with limited English-speaking ability.

Goal Two: DMH will be instrumental in the development of three additional research and demonstration projects on alternative models for Chicano services.

Objective 1 - Each new model will explore services in a different modality with the aim of systematically investigating all of the essential services mandated by PL 94-63.

Goal Three: The DMH will finalize plans for a forum in which the mental health needs of other significant minority groups will be assessed.

Objective 1 - DMH will assess the feasibility of conducting a combined symposium in which the needs of Blacks, Asians, and Native Americans are analyzed and a plan of action is developed.

D. Phase IV - Fiscal Year 1979-80

Goal One: DMH will request state funds for services to be directed at culturally and linguistically different clients, e.g., limited English-speaking ability, as part of the DMH request for state funds.

Objective 1 - The DMH will write into its budget request an amount sufficient to maintain research and development programs with state funds.

Objective 2 - DMH will request funds to program for clients of limited English-speaking ability in every catchment area with at least 5% Chicanos.

E. Phase V - Fiscal Year 1980-81

Goal One: By the end of the fiscal year every catchment area with 5% Chicano population will have developed the capacity to serve that population in its own language and cultural context.

Objective 1 - Each catchment area with 5% or more Chicanos will have bilingual, bicultural staff in a quantity that corresponds to the percentage of that population in the catchment area.

Goal Two: The DMH budget request for state funds will routinely contain funds for services to the limited English-speaking client.

10 RANKINGS OF CENTERS / CLINICS

RANKINGS OF CENTERS/CLINICS

The following table shows the computation of the final need rankings of the catchment areas. The "weighted score" of a catchment area was based on a combination of its rank on the resources inventory and its rank on the social indicator study. The latter was weighted twice as heavily as the former. The "weighted score" was then ranked to yield the "final ranks."

NEED RANKINGS OF THE CATCHMENT AREAS

	CATCHMENT AREA	Rank on Resources Inventory	Rank on Social Indicators	Weighted Score	FINAL RANK
1	NE Colo	6	12	15	9.5
2a	Weld	12	9	15	9.5
2b	Larimer	13	14	20.5	14.5
3a	Adams	9.5	13	17.8	12
3b	Arapahoe	16	20	28	21
3c	Boulder	18	17	26	20
3d	Jeffco	2	21	22	17.5
3e	Bethesda	8	18	22	17.5
3f	NW Denver	14	1	8	2
3g	Park East	11	8	13.5	7.5
3h	SW Denver	17	15	23.5	19
3i	Aurora	4	16	18	13
4	Pikes Peak	20	11	21	16
5	E Central	3	19	20.5	14.5
6	SE Colo	1	4	4.5	1
7	Span Peaks	21	3	13.5	7.5
8	San Luis	19	2	11.5	6
9	SW Colo	9.5	5	9.8	5
10	Midwestern	7	6	9.5	3.5
11,12	Colo W	15	10	17.5	11
13	W Central	5	7	9.5	3.5

11 INVENTORY OF EXISTING FACILITIES

APPENDIX IV

INVENTORY OF EXISTING FACILITIES

A. PROCEDURES FOR THE FACILITIES INVENTORY

In April 1976, the Colorado Division of Mental Health conducted an Inventory of Existing Facilities. Forms and instructions were distributed to the community agency recognized by the state as having responsibility for the given catchment area. These agencies collected the data for their catchments, completed the forms, and returned them to the State Division for compilation and analysis.

The form was designed to collect basic information according to NIMH Inventory definitions. The term used in Colorado for transitional/intermediate care is "other 24-hour care." This latter term appears on the form and in this dicussion for clarity to Colorado planners.

The Inventory was also used to gather additional information on beds actually utilized by the catchment community agency and on beds needed.

From the information collected by catchment areas, most of the data from Colorado's two state hospitals (Colorado State Hospital and Fort Logan Mental Health Center) were deleted from the resources of the catchment areas in which they are located (7 and 3e, respectively). This was done because the majority of resources of the two hospitals are not in fact available to these two catchment areas; i.e. the hospitals serve an area much larger than just the two catchment areas in which they are located. The present procedure, however, does include those portions of the state hospital data which are used by catchment areas 7 and 3e, respectively, since these do represent resources available within the catchments. The remainder of state hospital data appear in a separate table, not identified with any particular catchment area(s).

Also, the data used in the present rankings exclude all resources related to those facilities which were optional in completion of the Inventory. These types were excluded to assure statewide comparability, since these facilities were reported on an optional basis.

B. INDICATORS: JUSTIFICATION AND WEIGHTING

From the completed forms, indicators were selected by the Division of Mental Health for ranking Colorado's catchment areas in terms of resources. General considerations in the selection of these indicators included availability and accessibility of care, actual resources utilized by or in coordination with the catchment agency, and local (government and private) initiative in providing care.

With these considerations in mind, the following indicators were selected:

1. number of acute inpatient beds per 100,000 population (weight = .25);
2. number of other 24-hour care beds per 100,000 population (weight = .50);
3. total number of beds (inpatient and other 24-hour) with ownership by local government or private nonprofit per 100,000 population (weight = .10);
4. number of weekly non-24-hour care personnel hours (excluding private practice) per 1,000 population (weight = .75);
5. number of weekly non-24-hour care personnel hours (excluding private practice) in agencies with local government or private nonprofit ownership per 1,000 population (weight = .10).

All data used in the above rates were collected in April, 1976 by the statewide Inventory of Existing Facilities. Following are respective descriptions of these indicators and the rationale for their selection and weighting:

1. Number of acute inpatient beds per 100,000 population.

   This rate of non long-term beds, following Federal Inventory definitions, was selected on the basis that there would probably be beds in such facilities as general hospital psychiatric services, CMHC's, or the like, to which population in an area would have greater immediate access than to long-term inpatient beds.

   This rate is assigned a base weight of .25 from which the weights of the remaining four indicators are constructed.

2. Number of other 24-hour care beds per 100,000 population.

   One of the highest priorities of the Colorado Mental Health Plan is the local provision of alternatives to inpatient hospital care. Special programs to attend to this priority often employ other 24-hour care beds. Therefore, this measure of other 24-hour care beds within each catchment receives the higher weight of .50.

3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.

   This is a further refinement of the above bed-rate indicators with the additional qualification of ownership from the Inventory form. Long-term beds are included here under the assumption that with this ownership restriction, such beds would be used largely by catchment area residents.

An additional weight (.10) has been assigned because the two types of agencies here may be assumed to have the greatest accessibility and least restrictions for catchment area residents. Additionally, this rate provides an indication of local initiative and commitment for mental health services.

4. Number of weekly non-24-hour care personnel hours (excluding private practice) per 1,000 population.

This non-24-hour care personnel hours measure was selected on the basis that these treatment intensities are more readily accessible (i.e., where population in an area might first turn for services). Also, there are likely to be less personnel involved in nonpatient care activities than would be the case in 24-hour treatment intensities. Additionally, these intensities are generally closest to home and represent the least restrictive types of treatment. These data, from the Inventory forms, represent all staff providing or administering client care and exclude clerical and maintenance staff. Private practice hours are deleted, as this is an optional variable on the Inventory.

Since it is assumed that non-24-hour care services may be more easily available than 24-hour beds to a population in an area both in terms of numbers of such services and general accessibility, this rate is given a higher weight (.75) than the above indicators.

5. Number of weekly non-24-hour care personnel hours (excluding private practice) in agencies with local government or private nonprofit ownership per 1,000 population.

This final indicator qualifies the previous rate by restricting ownership to local government or private nonprofit, for the identical reasons cited in the discussion to indicator 3 above. Thus, these resources receive a little extra weight (.10) than they did in indicator number 4 above.

C. RANKING PROCEDURES

The final ranking of catchment areas is derived by summing the weighted ranks on each of the five indicators:

Catchment Area's Final Weighted Score = $\sum w_i r_i$ where i ranges from 1 to 5, r_i is the area's rank on the i_{th} indicator, and w_i is that indicator's weight.

Therefore, a Catchment Area's Final Weighted Score = $.25r_1 + .50r_2 + .10r_3 + .75r_4 + .10r_5$.

The catchment areas are then ranked on the basis of their final scores. This final ranking serves as the prioritization of the catchment areas within the Survey of Mental Health Resources.

The following tables present:

a. Final Ranks

b. Rankings on Resource Indicators and Final Weighted Scores

c. Resource Indicator Scores

d. Data for Computation of Resource Indicators

e. Regional Summary of Existing Facilities (Excluding Optional Agencies)

f. State Hospital Resources Not Assigned to Any Catchment Area

FINAL RANKS

CATCHMENT AREA		FINAL RANKS*
1	NE Colo	6
2a	Weld	12
2b	Larimer	13
3a	Adams	9.5
3b	Arapahoe	16
3c	Boulder	18
3d	Jeffco	2
3e	Bethesda	8
3f	NW Denver	14
3g	Park East	11
3h	SW Denver	17
3i	Aurora	4
4	Pikes Peak	20
5	E Central	3
6	SE Colo	1
7	Span Peaks	21
8	San Luis	19
9	SW Colo	9.5
10	Midwestern	7
11,12	Colo W	15
13	W Central	5

*The Rank 1 represents the highest need.

Rankings on Resource Indicators and Final Weighted Scores

CATCHMENT AREA		Rankings on * Indicators 1	2	3	4	5	Final Weighted Scores
1	NE Colo	4.5	9	5	9	9	13.8
2a	Weld	14	18	12	8	8	20.5
b	Larimer	10	8	6	18	19	22.5
3a	Adams	4.5	10	7	12	12	17.0
b	Arapahoe	13	14	16	15	16	14.8
c	Boulder	15	19	17	13	14	26.2
d	Jeffco	4.5	5	3	2	3	5.7
e	Bethesda	16	13	20	3.5	1	15.2
f	NW Denver	18	2.5	10	20	20	23.8
g	Park East	21	6	19	10	10	18.7
h	SW Denver	9	16	9	17	17.5	25.8
i	Aurora	4.5	7	4	5	5	9.3
4	Pikes Peak	17	20	18	16	13	29.4
5	E Central	4.5	2.5	1.5	7	6	8.5
6	SE Colo	4.5	2.5	1.5	1	2	3.6
7	Span Peaks	20	21	21	19	17.5	33.7
8	San Luis	4.5	15	14	21	21	27.9
9	SW Colo	19	2.5	15	11	11	17.0
10	Midwestern	12	11	8	6	7	14.5
11 & 12	Colo W	11	17	13	14	15	24.6
13	W Central	4.5	12	11	3.5	4	11.2

*1. Number of acute inpatient beds per 100,000 population.
2. Number of other 24-hour care beds per 100,000 population.
3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.
4. Number of weekly non-24-hour care personnel hours per 1,000 population.
5. Number of weekly non-24-hour care personnel hours in agencies with local government of private nonprofit ownership per 1,000 population.

Resource Indicator Scores

CATCHMENT AREA		Indicators * 1	2	3	4	5
1	NE Colo	0	15.3	15.3	10.0	10.0
2a	Weld	16.1	50.0	29.5	9.9	9.9
b	Larimer	7.6	11.0	18.5	17.5	17.5
3a	Adams	0	18.7	18.7	11.3	11.3
b	Arapahoe	15.2	33.0	48.1	15.1	15.1
c	Boulder	17.1	54.1	62.6	13.1	13.1
d	Jeffco	0	1.5	1.5	4.3	4.3
e	Bethesda	18.2	31.3	122.4	4.6	3.2
f	NW Denver	35.0	0	24.6	33.4	33.4
g	Park East	83.2	4.1	83.2	10.1	10.1
h	SW Denver	1.0	38.8	24.5	16.6	15.9
i	Aurora	0	10.6	10.6	5.0	5.0
4	Pikes Peak	24.5	54.8	67.1	15.2	11.8
5	E Central	0	0	0	8.7	6.7
6	SE Colo	0	0	0	3.6	3.6
7	Span Peaks	80.1	158.3	139.9	29.1	15.9
8	San Luis	0	36.1	36.1	36.3	36.3
9	SW Colo	40.2	0	40.2	10.9	10.9
10	Midwestern	12.8	21.3	21.3	8.4	8.4
11 & 12	Colo W	8.0	44.2	32.6	14.7	14.7
13	W Central	0	26.6	26.6	4.6	4.6

*1. Number of acute inpatient beds per 100,000 population.
2. Number of other 24-hour care beds per 100,000 population.
3. Total number of beds with ownership by local government or private nonprofit per 100,000 population.
4. Number of weekly non-24-hour care personnel hours per 1,000 population.
5. Number of weekly non-24-hour care personnel hours in agencies with local government of private nonprofit ownership per 1,000 population.

Data for Computation of Resource Indicators

CATCHMENT AREA	1975-76 Population	Resource Indicator Data * 1	2	3	4	5
1	65 524	-	10	10	658	658
2a	111 922	18	56	33	1108	1108
b	118 653	9	13	22	2082	2082
3a	203 607	-	38	38	2299	2299
b	151 633	23	50	73	2285	2285
c	175 620	30	95	110	2309	2309
d	333 764	-	5	5	1423	1423
e	137 248	25	43	168	627	437
f	182 944	64	-	45	6104	6104
g	122 538	102	5	102	1240	1240
h	98 006	1	38	24	1628	1562
i	112 930	-	12	12	560	560
4	302 652	74	166	203	4593	3578
5	19 818	-	-	-	172	132
6	60 187	-	-	-	215	215
7	152 258	122	241	213	4426	2418
8	41 578	-	15	15	1509	1509
9	42 330	17	-	17	460	460
10	46 889	6	10	10	394	394
11 & 12	137 955	11	61	45	2034	2032
13	45 097	-	12	12	209	209

*1. Number of acute inpatient beds.
2. Number of other 24-hour care beds.
3. Total number of beds with ownership by local government or private nonprofit.
4. Number of weekly non-24-hour care personnel hours.
5. Number of weekly non-24-hour care personnel hours in agencies with local government or private nonprofit ownership.

REGIONAL SUMMARY OF EXISTING FACILITIES
- EXCLUDING OPTIONAL AGENCIES -

CATCHMENT AREA	- Number of Beds - Inpt Acute	Inpt Long Term	Other 24-Hour	- Number of Personnel Weekly Hours - Inpt	Outpt	Partial	Emer	Oth-24	Total
1			10		462	142	54	38	696
2a	18		56	490	945	113	50	756	2354
b	9		13	1447	1554	216	312	289	3818
3a			38	60	1603	568	128	504	2863
b	23	74	50	2663	1788	360	137	858	5806
c	30	35	95	807	1621	403	285	1456	4572
d		3	5	91	1105	180	138	107	1621
e	25	100	43	1059	387	218	22	280	1966
f	64			2900	4064	1280	760		9004
g	102	1	5	40	600	600	40		1280
h	1	2	38	180	1036	515	77	705	2513
i			12	70	400		160	70	700
4	74	22	166	5170	3581	636	376	2753	12516
5					132	40			172
6					215				215
7	122	26	241	5548	3297	1257	419	1791	12312
8			15	5	1231	268	10	204	1718
9	17				460				460
10	6		10		231	130	33	113	507
11 & 12	11		61	35	1444	255	335	438	2507
13			12		189		20		209

State Hospital Resources Not Assigned to Catchment Areas

Name & Address of Resource	Ownership of Facility	Type of Facility	NUMBER OF BEDS			Mental Health Personnel Weekly Hours						
			Inpatient		Transitnl/ Intermed (Other 24-Hr Care)	Total	Facility Based					
			Acute	Long Term			Inpatnt Treatmt	Outpatnt Treatmt	Partial Treatmt	Emergcy Care	Trnsitnl/ Intermed (Other 24-Hr Care)	Priva Prct
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13
Colorado State Hospital 1600 W. 24th Street Pueblo, CO 81003	State	Psychia-tric Hospital										
-Psychiatric Clients			289	652		26,668	24,832	1,326	50	460		
-Medical/Surgical service for non-psychiatric clients of other institu-tions			15			964	500	400		64		
Fort Logan Mental Health Center 3520 W. Oxford Denver, CO 80236	State	Psychia-tric Hospital	41	109	92	8,989	5,441	625	741		2,182	

SURVEY OF NEED

A. PROCEDURES FOR NEED SURVEY

1. Task Force

In December 1975, a Need Assessment Task Force was formed from the Statewide Evaluation Advisory Committee to assist the Division of Mental Health in planning and implementing a statewide Need Assessment Survey. The members were program evaluators from four community mental health centers and one state hospital, plus central office staff. Major emphasis was placed on designing a community survey with the purpose of identifying specific target groups. In addition, local experience with social indicator studies, including but not limited to the Mental Health Demographic Profile System (MHDPS), was reviewed.

2. MHDPS

Eleven socioeconomic/demographic variables were selected from those available in the MHDPS. Four of them were suggested by the federal guidelines for State Mental Health Plans, and the task force felt they were appropriate. These were population in poverty, males in low occupational status, overcrowded housing and recent movers. We also included two ethnic groups of particular concern in Colorado: Blacks and Chicanos.

Because we wanted a direct measure of the extent of the aged and youth in the catchment area populations, the actual percent of these two groups were substituted for the dependency ratios suggested by the guidelines.

An additional category called family disruption was included since it represents an important factor in the workload of all agencies in Colorado's system. Furthermore, this factor is a major source of stress

contributing to the likelihood of mental health problems. Three MHDPS variables were chosen: non husband-wife households, children not with both parents, and divorced/separated females.

3. Community Survey

Three groups of community informants were selected for a general, open-ended need assessment survey. The first group consisted of lay people representing major occupational types in a community such as store clerks, bartenders, housewives, student leaders, farmers or ranchers, etc. In the second group were the human service workers, such as judges, public health nurses, teachers, welfare workers, ministers, family physicians, etc. The third group was made up of people directly involved in mental health activities and included board chairmen, agency heads, and Mental Health Association officials.

The returns from the survey are still being received and the data analysis is not complete. Thus these data were not considered in the need assessment rankings; however, a report containing initial impressions is included in Section D. State Plan updates in the future will contain more data of this type.

B. NEED INDICATORS USED, DEFINITIONS, JUSTIFICATIONS, AND DATA SOURCE

Indicator	Definitions	Justification	Source
A. % population in poverty	Poverty - The Federal Gov't cutoff weighted by the Census Bureau by age, farm/nonfarm, size of family unit, and sex of head of household.	NIMH factor analysis indicator Reflects low economic status	MHDPS 1970
B. % males 16 yrs and older in low occupation status	Low Occ. Status - Those who are operatives, service workers, and laborers including farm laborers.	Shown by NIMH factor analysis to be one of best indicators of an area's demographic and social dimensions. Reflects low socio-economic status.	MHDPS 1970
C. % overcrowded housing	Percent household population in housing with 1.01 or more persons per room.	NIMH factor analysis indicator. Reflects stressful living condition due to overcrowding.	MHDPS 1970
D. non husband-wife households	Household - Includes all the persons who occupy a group of rooms or a single room which constitutes a separate living quarters. Husband-wife - Includes common-law as well as formal marriages.	NIMH factor analysis indicator. Reflects broken families	MHDPS 1970
E. % children not living with both parents	Includes stepchildren and adopted children as well as children born to a couple.	Reflection of broken homes and stressful conditions for children and remaining parent.	MHDPS 1970
F. % divorced/ separated females	Includes persons who are living apart because of marital discord, with or without a legal separation.	Reflection of one parent homes and stress of divorce	MHDPS 1970

Indicator	Definitions	Justification	Source
G. % of recent movers	Recent movers - Population who moved into present residence in 1969-1970.	NIMH factor analysis	MHDPS 1970
H.1 % Spanish heritage (Chicano)	Spanish heritage - Persons identified by: (1) having a Spanish surname when matched against a list of over 8000 names; or (2) the use of the Spanish language was reported.	Reflects stresses associated with minority group membership.	MHDPS 1970
H.2 % Black	Percent of household population that is Negro.	Same as above	MHDPS 1970
I. % Aged	Percent of population who are 65 and older.	Reflects a special target group	MHDPS
J. % Youth	Percent of population who are 16 and under.	NIMH factor analysis indicator. Reflects a special target group	MHDPS 1970

C. WEIGHTS FOR NEED ASSESSMENT FACTORS

Factor and items		Weight
Socioeconomic		5.00
Poverty	2.00	
Low occupational status	1.50	
Overcrowded living situtation	1.50	
Family disruption		3.00
Non husband-wife households	1.00	
Children not living with both parents	1.00	
Divorced/separated females	1.00	
Community change		0.75
Recent movers	0.75	
Spcial target groups		1.75
Chicanos, Blacks	.75	
Aged	0.50	
Youth	0.50	

One reason for having a public mental health system is to provide services for that segment of the population which cannot afford to buy professional help from private mental health practitioners. Furthermore, low socioeconomic status has been traditionally associated with mental health problems. Therefore, the greatest weight was assigned to the indicators of socioeconomic distress with the most direct measure, percent of population in poverty, receiving the most weight among the three items.

Family disruption and community change create stressful conditions which are frequently associated with the need for mental health services. Family disruption indicators were weighted slightly less than socioeconomic indicators since the latter represents two areas of need: distress due to social factors and lowered ability to pay for service. Our indicator of community change, percent of recent movers, is based on 1970 census data and while we know that certain areas of the State have experienced rapid growth which these data do not reflect, we are unable to accurately document it at this time. Therefore, the community change indicator was given a low weighting.

Three special target groups were identified: ethnic minorities, aged and youth. While many of the people in these groups are also in one or more of the other social indicator categories, they are given additional weight in the rankings because of their need for specialized programs. The ethnic minority item was given slightly more weight than the other two target groups because it represents a combination of Chicanos and Blacks. These were combined because the distribution of the Black population is concentrated in a few catchment areas which makes ranking across the State difficult.

D. PRELIMINARY IMPRESSIONS OF COMMUNITY SURVEY (HUMAN SERVICE AND LAY PEOPLE)

While the survey questionnaires are still being returned and the formal analyses have not begun, some initial impressions can be reported. Loneliness, fear, and poor communication between parents and children and between husband and wife are common themes. Many target groups are mentioned but several are especially noteworthy because they are so consistently mentioned.

1. Divorce/broken families - the effect on children and parents, especially mothers who must take on major new responsibilities.
2. Alcoholism and other drugs - teenagers are frequently mentioned as alcoholism becomes an increasingly prevalent problem for youth.
3. Elderly - insufficient resources both in terms of money and accessible activities.
4. Welfare mothers - poor self regard and the very real problems of managing limited funds.

The response has been extremely encouraging. Even a casual reading of the forms leaves the impression that the writers gave serious thought to the mental health problems in their community before they responded. Several thanked us for the opportunity to participate, and a surprising number signed their names. Not as surprising is the 2-1 ratio of human service to lay respondents. We had hoped for a 15-20% return rate and it now stands at 17%.

REGION	COMMUNITY AGENCY	SOCIOECONOMIC INDICATORS						FAMILY DISRUPTION						CHANGE		SPECIAL TARGET GROUPS								FINAL RANKS (K)**
		POP. in POVERTY (A)		LOW OCCU. STATUS MALES (B)		OVERCROWD HSEHOLDS (C)		HSEHOLDS NOT HUS-WIFE (D)		CHILDREN NOT WITH BOTH PAR. (E)		DIVORCED OR SEP. FEMALES (F)		RECENT MOVERS (G)		CHICANO	BLACK	TOTAL*	(H)	AGED (I)		YOUTH (J)		
		%	RANK	%	RANK	%	RANK	%	RANK	%	RANK	%	RANK	%	RANK	%	%	%	RANK	%	RANK	%	RANK	
1	NE Colorado	17	7	34	11.5	16	10.5	27	12	11	18	3	20.5	25	17	7	-	7	16	12	4	35	13	12
2a	Weld	17	7	38	6.5	19	6.5	26	15	13	13	4	16.5	34	6.5	15	-	16*	8.5	8	14	35	13	9
2b	Larimer	14	11.5	30	14.5	11	15.5	29	8.5	12	15	4	16.5	40	2.5	7	-	7	16	9	12.5	30	18	14
3a	Adams	7	16.5	37	8	16	10.5	16	21	12	15	5	11.5	26	15	15	1	16	8.5	3	21	45	1	13
3b	Arapahoe	6	19.5	23	19.5	8	19.5	21	18	11	18	6	7.5	27	12.5	5	-	5	18.5	5	18	40	3	20
3c	Boulder	10	14.5	26	17.5	9	17.5	30	6	11	18	5	11.5	39	4	6	1	7	16	7	15	33	17	17
3d	Jeffco	6	19.5	23	19.5	8	19.5	20	19.5	10	20.5	6	7.5	27	12.5	4	-	4	20.5	5	18	38	5	21
3e	Bethesda	7	16.5	20	21	5	21	34	3	14	11	7	4	29	9.5	4	-	5*	18.5	11	7.5	29	19.5	18
3f	NW Denver	24	2	45	1	18	8	56	1	34	1	13	1	36	5	30	10	40	2	14	1	28	21	1
3g	Malcolm X	10	14.5	30	14.5	11	15.5	43	2	23	2	9	2	34	6.5	9	24	33	4	11	7.5	29	19.5	8
3h	SW Denver	6	19.5	34	11.5	14	13	20	19.5	14	11	7	4	21	20	18	-	18	6.5	5	18	38	5	15
3i	Aurora	6	19.5	26	17.5	9	17.5	26	15	15	8.5	7	4	40	2.5	6	1	8*	13.5	4	20	36	9	16
4	Pikes Peak	12	13	29	16	13	14	26	15	16	6	6	7.5	45	1	8	5	14*	10	6	16	35	13	11
5	E Central	16	9	31	13	15	12	25	17	10	20.5	3	20.5	22	19	4	-	4	20.5	12	4	36	9	19
6	SE Colorado	23	3	39	5	22	4	30	6	16	6	4	16.5	24	18	22	-	22	5	12	4	38	5	4
7	Span Peaks	17	7	41	3.5	24	3	31	4	18	3.5	6	7.5	20	21	34	2	36	3	10	10	36	9	3
8	San Luis	29	1	41	3.5	31	1	27	12	16	6	4	16.5	26	15	46	-	46	1	10	10	41	2	2
9	SW Colorado	18	5	35	10	25	2	27	12	18	3.5	5	11.5	28	11	18	-	18	6.5	9	12.5	37	7	5
10	Midwestern	20	4	38	6.5	20	5	28	10	14	11	4	16.5	29	9.5	10	-	10	12	12	4	35	13	6
11,12	Colorado W	14	11.5	36	9	17	9	29	8.5	15	8.5	5	11.5	32	8	8	-	8	13.5	10	10	35	13	10
13	W Central	15	10	44	2	19	6.5	30	6	12	15	4	16.5	26	15	12	1	13	11	12	4	34	16	7

*The total percent does not equal the sum of the Chicano and Black percents due to rounding.

**Derived as follows using the rank values in each column, $K = 2(A) + 1.5(B+C) + (D+E+F) + 0.75(G+H) + 0.5(I+J)$