state of colorado

77-78 Supplement

to the

Mental health plan

1977-78 SUPPLEMENT
TO THE
COLORADO MENTAL HEALTH PLAN

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

(This Supplement is not complete unto itself, but must be used in conjunction with the State Mental Health Plan dated August 1976.)

PREPARED BY
COLORADO DIVISION OF MENTAL HEALTH

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Director

June 1977

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1977-78 SUPPLEMENT
TO THE
COLORADO MENTAL HEALTH PLAN

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CHAPTER 1

INTRODUCTION

1977-78 SUPPLEMENT TO THE COLORADO MENTAL HEALTH PLAN

I. INTRODUCTION

A. PURPOSE

The purpose of this supplement is to update the State Five Year Mental Health Plan. The annual updating of the Plan is necessary to reflect the impact of funding and policy decisions by legislative and executive bodies and the accomplishment or non-accomplishment of the previous year's objectives. Changes in roles and relationships among agencies, organizational and structural changes, the enactment of new statutes and the amendment or repeal of existing statutes also make necessary a periodic updating process. The publication of rules and standards for the implementation of statutes or the regulation of mental health related activities affect the planning and delivery of mental health services to such an extent that they must be incorporated into the Plan. Changes in priorities, and the results of research and pilot projects have little meaning unless they are appropriately and currently recorded in the State Plan, which is the written record of the planning process.

B. ORGANIZATION AND SCOPE

The 77-78 Supplement does not alter the thrust of the Plan; viz, the provision of high quality mental health services close to the home of the client and in the least restrictive setting. Also, the principles set forth in Chapter I of the basic document remain in effect. These principles, which embody the philosophy of the Division of Mental Health, are summarized under the following four headings: human dignity, privacy and client's rights; least restrictive setting; availability of services close to home; and funding and accountability.

The Supplement is to be used in conjunction with the basic document; thus, no attempt has been made to repeat the parts of the Plan which are not being superceded or altered, unless the readability of sentences, paragraphs or pages of the Supplement will be enhanced by repeating some material.

New and revised material is organized in a manner which will facilitate cross-reference with the appropriate chapter, section, page and paragraph in the basic document.

A summary of the major changes in each chapter follows:

CHAPTER I - INTRODUCTION

The process by which the Plan was updated is included in the initial chapter to indicate to the reader the Division's efforts to obtain input from as many sources as possible and the mechanism for ensuring careful review of all suggestions for updating the Plan.

CHAPTER II - ADMINISTRATIVE INFORMATION

The State Mental Health Advisory Council has become operational since the basic Plan was published. A brief description of the activities of the Council, including its participation in the review process, is included in this chapter. The updated Division of Mental Health organizational chart also will be found in Chapter II of this Supplement.

CHAPTER III - STATEWIDE GOALS AND OBJECTIVES

The objectives have been completely revised. New objectives have replaced those that have been accomplished, the target dates for some have been made more realistic, and others have been rewritten to indicate more clearly what is to be achieved.

An important change in the objectives is the requirement that each catchment area center/clinic develop a plan for increasing services to children, adolescents, the elderly and chronically disabled persons. The previous approach was to require all agencies to achieve the same fixed percentage increase in services, or to tie the percentage of each target group served to its percentage in the general population. The new approach recognizes that local needs, problems and resources differ from community to community. The process in each catchment area will involve (1) determining service needs of children, adolescents, the elderly, and the chronically disabled and other groups; (2) developing an inventory of resources (services, facilities, funds) available to meet the identified needs; (3) identification of gaps in service; (4) setting priorities; (5) developing a plan for, and providing services with existing resources; (6) evaluation of success in achieving the objectives; and (7) longer range program and fiscal planning. The planning process must also provide for input from local citizens, other service and planning agencies, client advocacy groups and elected representatives.

This chapter continues to be the "heart" of the Plan as it translates into specific planned actions the purpose, philosophy and thrust of the state mental health system.

CHAPTER IV - THE STATE MENTAL HEALTH PROGRAM

Chapter IV of the Supplement basically updates the descriptive information in the basic document. Important changes in funding of substance abuse services at the state hospitals are reported as are the reorganization of Fort Logan Mental Health Center and the publication of the Standards/Rules and Regulations for Mental Health Centers and Clinics. Statements concerning fiscal support of mental health services and the requirement for volunteer services have also been added.

CHAPTER V - COORDINATION OF PLANNING

The State Mental Health Plan must be carefully integrated with the State Health Plan, the Alcohol and Drug Abuse Plan and the planning process and documents of many other agencies and organizations. Chapter V is a current statement of the changes in the relationships, roles and structures of the various agencies with which the DMH interfaces in the planning and/or delivery of mental health services. A summary of the status of the health planning apparatus mandated by PL 93-641 (the National Health Planning and Resource Development Act) is an important part of the updated material.

CHAPTER VI - CATCHMENT AREA MENTAL HEALTH PROGRAM

This chapter reflects a number of changes in the services available in some catchment areas and the rankings (based on indicators of need) of catchment area community mental health centers and clinics. The revised population figures and the ethnic composition of each catchment area are also included.

APPENDIX

The appendix of the 77-78 Supplement includes a number of documents not found in the basic Plan. These are:

(1) Standards/Rules and Regulations for Mental Health Centers and Clinics (not included in all copies of the Plan, as the document has already been widely distributed);

(2) Rules and Regulations for the Care and Treatment of the Mentally Ill;

(3) Standards for Mental Health Care in Health Care Facilities;
(4) Availability of Comprehensive Community Mental Health Services in the 21 Catchment Areas (per PL 94-63);
(5) Minutes of the State Mental Health Advisory Council meetings;
(6) Bylaws of the State Mental Health Advisory Council;
(7) The roster of the State Mental Health Advisory Council;
(8) Report of Accomplishment of Objectives in 76-77 State Mental Health Plan.

A current report from the Chicano Mental Health Symposium is also available in the appendix.

C. PROCESS BY WHICH THE SUPPLEMENT TO THE STATE MENTAL HEALTH PLAN WAS PREPARED

This Supplement is the result of the first annual review of the State Mental Health Plan. The process followed in the development of this update for fiscal year 77-78 was as follows:

1. In November 1976, a notice of the coming review of the Plan was sent to all agencies and organizations on the regular distribution list. Those wishing to make input into the Supplement were asked to submit their recommendations and suggestions by January 31, 1977.
2. Members of the State Mental Health Advisory Council were asked to assist the State Mental Health Plan Committee in reviewing the input from various agencies and organizations and drafting some recommended changes.
3. The State Mental Health Plan Committee was reconvened. The process to be followed in the updating was discussed, and Committee members were assigned the responsibility for reviewing the input on various sections and chapters of the Plan, and, in collaboration with the agencies and organizations they represent, draft proposed changes and new material for the Supplement.
4. The Division of Mental Health staff were asked to review the input from various agencies and organizations along with the basic document and draft recommended changes in their individual specialty areas. Staff were asked to collaborate with State Mental Health Advisory Council and State Mental Health Plan Committee persons wherever possible.

5. A draft of the supplement was forwarded to ADAMHA and to the agencies and organizations on the mailing list for review and comment.
6. The draft was reviewed by the State Mental Health Advisory Council, with particular attention to the objectives. Representatives from private, voluntary, and other community agencies participated in the discussion of the draft and offered suggestions concerning various sections of the documents.
7. The A-95 review process was initiated.
8. Preparation of the Supplement, incorporating appropriate suggestions from the various agencies and organizations and other reviewers, was accomplished.
9. The Supplement was submitted to the Region VIII ADAMHA Office.

CHAPTER II

ADMINISTRATIVE INFORMATION

II. ADMINISTRATIVE INFORMATION

B. STATE MENTAL HEALTH ADVISORY COUNCIL

1. Membership

The State Mental Health Advisory Council (SMHAC) was appointed in September 1976 by Governor Richard Lamm. The Council consists of 21 members. The roster of Council members with information as to sex, ethnic background, place of residence, class of membership and expiration of term is included in the appendix.

2. Activities of the SMHAC

The SMHAC has met monthly since its formation. Minutes have been kept of all meetings (a copy of the minutes of each meeting is included in the appendix). The activities of the Council to date have included the election of officers, the development of bylaws (a copy of the bylaws is included in the appendix) and review of the State Plan. Council members have also appointed two permanent subcommittees, the Executive and Budget Subcommittees, and several ad hoc committees including one on children/adolescent services and one to review the interface between mental health and substance abuse services, with a view toward improving the integration of services.

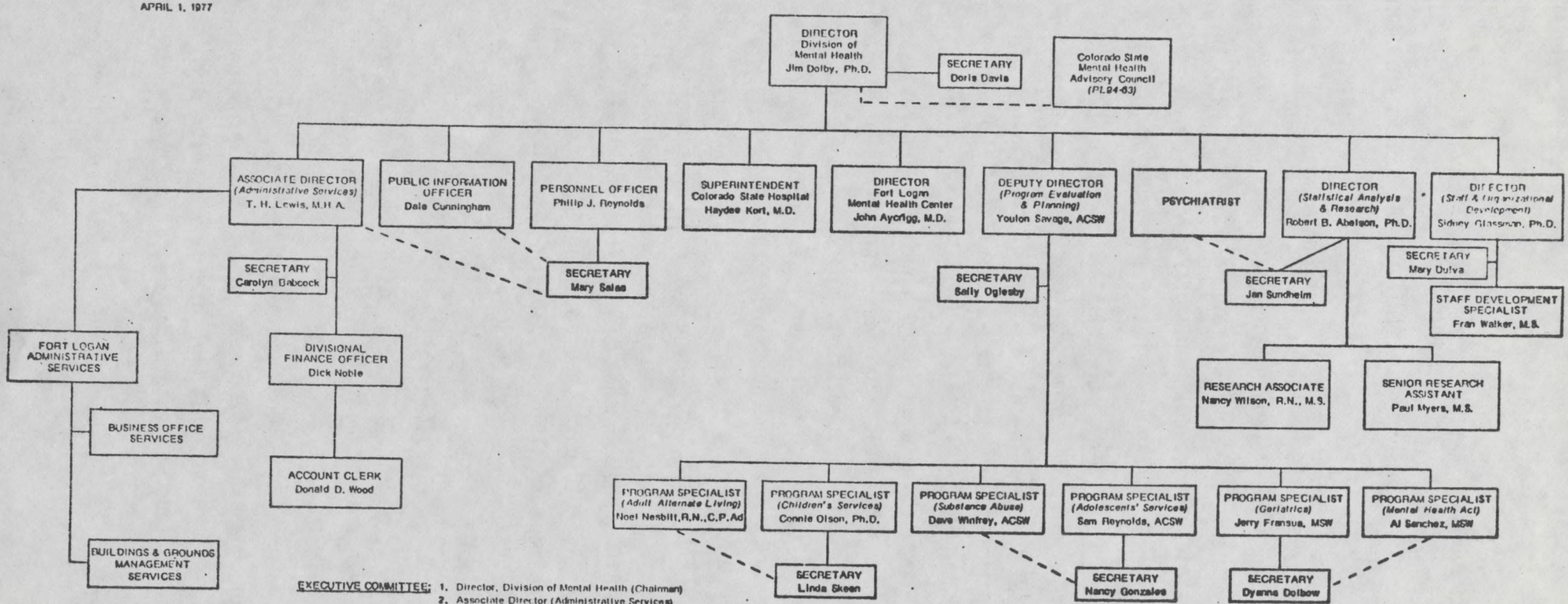
The Council has begun hearing presentations by various DMH staff specialists to gain a better understanding of the functions of the mental health system and how the various staff activities relate to the State Plan. SMHAC gave special attention to a legislatively mandated study of placement facilities for disturbed children, and requested and received a presentation from the Colorado Association of Community Mental Health Centers and Clinics. The Budget Subcommittee participated in a detailed review of the Division's recommendations for funding, following which the Council directed letters to the Governor and the Joint Budget Committee of the State Legislature concerning the funding needed for mental health services.

Council members reviewed the suggestions received from various agencies and organizations concerning the update of the State Plan. The draft of the update material was carefully studied with particular attention to the various target groups identified in the Plan.

DIVISION OF MENTAL HEALTH
ORGANIZATIONAL CHART

COLORADO DIVISION OF MENTAL HEALTH

APRIL 1, 1977



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

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 caregivers, 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) preadmission 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 goals in the 77-78 Supplement are the same as those in the basic State Mental Health Plan, with the exception that "high-risk" replaces "chronically disabled" in Goal #3. The high-risk category includes the chronically disabled in all age groups who are receiving or who require inpatient, other 24-hour, partial, or intensive outpatient care. Since there are specific objectives relating to each age group, the objectives for the high-risk category are primarily focused on former state hospital clients who require ongoing care, and other chronically psychiatrically disabled persons.

For the purpose of this document, ethnic minorities are: Asians (including Pacific Islanders), Blacks, Chicanos and Native Americans.

Quarterly reports on the fiscal year 76-77 objectives are included in the appendix to facilitate a review of the system's successes and failures. Some failures are attributable to faulty formulation of objectives; others are the results of organizational changes, the lack of adequate funding, the absence of systemwide commitment to serve the target populations, and failure to take into consideration the great diversity among catchment areas as to local needs, available resources and priorities.

The objectives in the Plan are product, rather than process oriented. In those instances where the objectives require meetings, conferences and joint activities between elements of the public mental health system and other agencies and organizations, the product will be the progress made toward resolution of the problems identified in Chapter V, as well as other current interagency problems.

It is not expected that each mental health center/clinic and hospital will become the sole provider of the myraid mental health and related services which should be available in all catchment areas. However, mental health agencies are expected to mobilize, and facilitate the use by clients of the various community resources available. These resources include a variety of alternate living facilities, health agencies, social service programs and other caregivers, activities and organizations in the public, private and voluntary sectors. Affiliation and contractual arrangements between mental health and other agencies are strongly encouraged.

The availability of adequate funding is a crucial variable in the accomplishment of the objectives in this Plan. In this connection, it

is of concern that federal funding for the maintenance of existing programs is declining and income from the state and local governments and other funding sources is not sufficient to support, on an ongoing basis, programs initiated with federal funds. These fiscal problems are further aggravated by general inflationary trends.

With service demands staying well ahead of dollar resources, increasing emphasis must be placed on full utilization of other community resources as indicated above, and re-examination of needs and priorities at the local and state levels to ensure that available dollars are used in the areas of greatest service need. Scaling down of the anticipated outcome of some objectives, and extending the timetable for the accomplishment of other objectives are viable options that must be considered.

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. preadmission 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/sexual abuse victims
- ethnic minorities
- rural residents
- economically disadvantaged persons
- women
- high risk persons

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 ethinc 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/sexual abuse 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, 1978, comparable cost-finding data will be available for all centers/clinics.

(2) By July 1, 1978, DMH will develop a model uniform chart of accounts for centers/clinics.

(3) By July 1, 1978, DMH will develop a comprehensive uniform management reporting system for the two state hospitals.

(4) By July 1, 1978, DMH will develop and implement a prospective unit reimbursement mechanism for centers/clinics.

(5) By July 1, 1978, DMH will have determined the estimated cost of implementation of the State Mental Health Plan.

(6) By January 1, 1979, the financial reporting systems for centers/clinics and the two state hospitals will be comparable.

b. Audit Guidelines:

(1) By October 1, 1977, the initial audit of all centers/clinics based on the financial audit 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, 1979, the two state hospitals will begin a planned and orderly retrofitting of buildings and heating/cooling systems to maximize energy conservation. This will include insulation programs, storm windows, caulking of buildings, changing fixed windows to moveable, installing 24-hour automatic controls on heating/cooling/ventilating systems.

(3) 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 January 1, 1978, DMH will recommend hospital staffing patterns based on SCOPE/COLO '77 for legislative consideration.

(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, a summary of the salary and classification survey will be made available to all mental health centers/ clinics.

(4) By July 1, 1978, the annual update of the personnel needs and resources of the mental health system will be accomplished.

e. Treatment Outcome Evaluation:

(1) By December 1, 1977, a statewide plan for treatment outcome evaluation will be designed.

(2) By December 1, 1977, a pilot to test possible methodological approaches to be incorporated into this plan will be completed.

(3) By July 1, 1978, DMH will be ready to implement a data collection system on treatment outcome evaluation.

f. Coordination With Other Agencies: (See Chapter V for discussion of interrelationships and issues involved in these meetings.)

(1) By October 1, 1977, the State Mental Health Advisory Council will have established a mechanism to secure input concerning the State Plan and the entire mental health system from the various private/voluntary agencies that are involved in mental health care.

(2) By January 1, 1977, the DMH will facilitate a series of meetings between mental health agencies and agencies and organizations concerned with services to developmentally disabled clients.

(3) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with the State Health Planning and Development Agency.

(4) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with Colorado Psychiatric Hospital.

(5) By July 1, 1978, DMH will have had at least four meetings (since July 1, 1977) with divisions of the Department of Social Services.

(6) By July 1, 1978, DMH will have had one meeting (since July 1, 1977) with the State Health Coordinating Council.

(7) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with the Department of Education.

(8) By July 1, 1978, DMH will have had at least two meetings (since July 1, 1977) with the Judicial Department.

(9) By July 1, 1978, DMH will have had at least four meetings (since July 1, 1977) with units of the Department of Health.

g. Need Assessment:

(1) By January 1, 1978, a comprehensive inventory of specialized services for ethnic minorities offered by state hospitals and mental health centers/clinics will be produced.

(2) By March 1, 1978, an annual inventory of existing facilities will be performed.

(3) By July 1, 1978, the preliminary need assessment data on high-risk populations will be further refined and expanded.

h. Standards and Evaluation:

(1) By July 1, 1978, the first review and update of the revised State Standards/Rules and Regulations for Mental Health Centers and Clinics will be accomplished.

(2) By July 1, 1978, each mental health center/clinic will have been evaluated using the new on-site evaluation instrument to lead to approval for purchase of services for a one-year period.

(3) By July 1, 1981, the State Standards/Rules and Regulations for Mental Health Centers and Clinics will be completely revised.

i. Management Information System Master Plan:

(1) By July 1, 1978, the MIS Master Plan will be developed.

j. Volunteer Services:

(1) By November 1, 1977, all centers and clinics will have a documented orientation and training program for volunteers.

(2) By January 1, 1978, all centers and clinics will have an identifiable volunteer service.

(3) By January 1, 1978, DMH will develop, in collaboration with the ADAMHA coordinator of volunteer services and the coordinators of

volunteer services in centers/clinics and hospitals, a mechanism for the exchange of information and input into the program planning process.

(4) By June 30, 1978, guidelines will have been developed for volunteer services in mental health centers/clinics and hospitals.

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, 1978, the combined average daily attendance (ADA) at the two state hospitals will be stabilized at the FY 75-76 level.

(2) By July 1, 1978, Fort Logan Mental Health Center will be established as a primary agency for the provision of adult inpatient services to the Denver metro area.

(3) By July 1, 1978, there will have been a 6% reduction from FY 1975-76 in the proportion of systemwide 24-hour ADAs attributable to the state hospitals.

(4) By July 1, 1979, there will have been an 18% reduction from FY 1975-76 in the proportion of systemwide 24-hour ADAs attributable to the two state hospitals.

(5) By July 1, 1981, there will have been a 24% reduction from FY 1975-76 in the proportion of systemwide 24-hour ADAs attributable to the two state hospitals.

b. Center/Clinic-Hospital Integration:

(1) By July 1, 1978, guidelines recommended by Continuity of Care Committees and approved by DMH will be fully operational.

c. Services Close to Home:

(1) By March 1, 1978, DMH will have developed a management plan which will specify, by catchment area, the residential treatment alternatives required.

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

(3) By July 1, 1979, guidelines for alternate treatment facilities not covered by existing standards will have been developed and implemented.

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

(5) By July 1, 1981, the four catchment area clinics (Southeastern Colorado, Southwest Colorado, East Central and Northeast Colorado) will be comprehensive centers offering the five services. These services will be furnished directly or through affiliate agencies.

d. Continuing Education:

(1) By October 1, 1977, a training program for the training of house parents to work in youth group homes will be developed.

(2) By April 1, 1978, DMH will have developed training program models for increasing staff sensitivity to ethnic minority mental health needs and ways of meeting these needs.

(3) By July 1, 1978, the DMH will conduct at least one minority awareness training program.

(4) By July 1, 1978, the DMH will facilitate and/or provide training programs in support of the implementation of services mandated by PL 94-63.

(5) By July 1, 1978, the DMH, with the assistance of the Continuing Education Committee, will review and update the Standards for Continuing Education.

(6) By July 1, 1978, the Staff Development Section of the DMH will review and update training resource inventories for dissemination.

(7) By July 1, 1978, the Staff Development Section of the DMH will collect and disseminate information on the various licensure and continuing education requirements of mental health professions.

(8) By July 1, 1978, the Staff Development Section of the DMH will disseminate information regarding the collections of specialized educational materials within mental health resource centers.

(9) By July 1, 1978, the DMH will provide at least one workshop for business managers and finance staff of centers and clinics in the use of Division Accounting and Auditing Guidelines and related unit cost reimbursement system.

(10) By July 1, 1978, the DMH will provide at least one workshop for center directors in the use of Division Accounting and Auditing Guidelines and related unit cost reimbursement system.

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

(12) 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).

(13) By July 1, 1979, the DMH, with the assistance of the Continuing Education Committee, will develop a proposal for the 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/sexual abuse victims
- ethnic minorities
- rural residents
- economically disadvantaged persons
- women
- high risk persons

a. Children (Ages 0-11 years):

(1) By October 1, 1977, each center/clinic will submit a plan to DMH for services to children which must be approved by DMH in accordance with the annual contract.

(2) By October 1, 1977, educational and experiential standards for child clinical staff will be developed by DMH.

(3) By January 1, 1978, at least one clinician, trained in mental health evaluation and treatment of children and their parents, shall be providing and coordinating such services at each mental health center/clinic and shall meet the standards developed by DMH regarding adequacy of training.

(4) By January 1, 1978, an identifiable children's evaluation and treatment program shall be established in each mental health center/clinic, with a program description, goals and objectives being submitted to DMH, to include written agreements as to the relationship with and involvement in local schools, social services (with special attention to child abuse and neglect), the juvenile justice system and public health agencies.

(5) By July 1, 1978, the first annual review shall be conducted by both state hospitals in cooperation with appropriate mental health centers/clinics and DMH, to determine the size and types of programs each hospital needs to provide for children within each hospital service area.

(6) By July 1, 1978, the child program of each center/clinic will be mutually agreed upon between that center/clinic and DMH.

(7) By July 1, 1978, DMH will have worked jointly with other appropriate state agencies and organizations to attempt to develop a common classification system for problems and behaviors of troubled children, as well as a system to classify all facilities (public and private) which provide 24-hour care for such children in the state.

(8) By October 1, 1978, each mental health center/clinic shall have written agreements with local school administrative units as to the provision of mental health services to mentally and physically handicapped children, in compliance with PL 94-142 (Education of the Handicapped Act).

(9) By July 1, 1979, each child program shall have been evaluated during the annual site visit, according to the Standards/Rules and Regulations for Mental Health Centers and Clinics, and the goals and objectives set forth by each center/clinic.

(10) By July 1, 1979, DMH shall have worked jointly with other appropriate state agencies and organizations toward the development of standards for mental health services in all 24-hour programs for children not currently under the jurisdiction of the Department of Institutions or their parents.

(11) By July 1, 1979, each catchment area mental health center/clinic will provide mental health services to children requiring partial and 24-hour care, whether or not the facilities therefor are operated by the mental health center/clinic or by another agency or organization. Where such facilities are operated by another agency or organization, there must be a written agreement as to how the center/clinic shall provide mental health services to the facility.

b. Adolescents (Ages 12-17 years):

(1) By October 1, 1977, each center/clinic will submit a plan to DMH for services to adolescents, which must be approved by DMH in accordance with the annual contract.

(2) By October 1, 1977, educational and experiential standards for adolescent clinical staff will be developed by DMH.

(3) By January 1, 1978, at least one clinician, trained in mental health evaluation and treatment of adolescents and their parents, shall be providing and coordinating such services at each mental health center/clinic and shall meet the standards developed by DMH regarding adequacy of training.

(4) By January 1, 1978, an identifiable adolescents' evaluation and treatment program shall be established in each mental health center/clinic, with a program description, goals and objectives being submitted to DMH, to include written agreements as to the relationship with and involvement in local schools, social services (with special attention to adolescent abuse and neglect and teenage pregnancies), the juvenile justice system and public health agencies.

(5) By July 1, 1978, the first annual review shall be conducted by both state hospitals in cooperation with appropriate mental health center/clinics and DMH, to determine the size and types of programs each hospital needs to provide for adolescents within each hospital service area.

(6) By July 1, 1978, the adolescent program of each center/clinic will be mutually agreed upon between that center/clinic and DMH.

(7) By July 1, 1978, DMH will have worked jointly with other appropriate state agencies and organizations to attempt to develop a common classification system for problems and behaviors of

troubled adolescents, as well as a system to classify all facilities (public and private) which provide 24-hour care for such adolescents in the state.

(8) By October 1, 1978, each mental health center/clinic shall have written agreements with local school administrative units as to the provision of mental health services to mentally and physically handicapped adolescents, in compliance with PL 94-142 (Education of the Handicapped Act).

(9) By July 1, 1979, each adolescent program shall have been evaluated during the annual site visit, according to the Standards/Rules and Regulations for Mental Health Centers and Clinics, and the goals and objectives set forth by each center/clinic.

(10) By July 1, 1979, DMH shall have worked jointly with other appropriate state agencies and organizations toward the development of standards for mental health services in all 24-hour programs for adolescents not currently under the jurisdiction of the Department of Institutions or their parents.

(11) By July 1, 1979, each catchment area mental health center/clinic will provide mental health services to adolescents requiring partial and 24-hour care, whether or not the facilities therefor are operated by the mental health center/clinic or another agency or organization. Where such facilities are operated by another agency or organization, there must be a written agreement as to how the center/clinic shall provide mental health services to the facility.

c. Elderly:

(1) By October 1, 1977, each catchment area center/clinic will have developed an affiliation agreement with the Area Agency on Aging.

(2) By October 1, 1977, each center/clinic will submit a plan to DMH for services to the elderly, which must be approved by DMH in accordance with the annual contract.

(3) By July 1, 1978, those catchment areas with the highest Chicano elderly population (Northwest Denver, San Luis Valley, Southeast Colorado, Spanish Peaks, Adams County, Weld and Larimer County) will have a bilingual/bicultural service delivery capability.

(4) By July 1, 1978, at least one of the six catchment area programs with the largest elderly population (Northwest Denver, Northeast

Colorado, East Central, Southeast Colorado, Midwestern Colorado and West Central) will have developed at least one independent living group home as a pilot project as a joint effort with a local Area Agency on Aging.

(5) By July 1, 1978, the Geriatric Coordinators will hold biannual meetings.

d. Alcohol and Drug Abusers:

(1) By September 1, 1977, DMH and ADAD will issue a joint policy statement which requires all agencies with which ADAD or DMH contract for services to have an affiliation agreement with their local mental health or substance abuse counterpart.

(2) By November 1, 1977, ADAD and DMH will jointly establish standards for the evaluation of the substance abuse programs at Fort Logan Mental Health Center and Colorado State Hospital.

(3) By January 1, 1978, the ADAD-DMH work group will develop a follow-up report to the Human Services Policy Council and the State Health Coordinating Council on their progress in overcoming coordinated service delivery problems.

e. Rape/Sexual Abuse Victims:

(1) By July 1, 1978, at least one clinician of each center/clinic-hospital will attend a minimum of one workshop on the techniques for treatment of rape/sexual abuse victims and their families.

(2) By July 1, 1978, each center/clinic will provide consultation and education services for rape/sexual abuse victims in coordination with other community agencies, e.g., courts, hospitals, private physicians, public health, and ministerial alliances.

(3) By July 1, 1978, each center/clinic will provide consultation and education services to rape prevention programs within the catchment area.

f. Ethnic Minorities:

(1) By August 1, 1977, the State Mental Health Advisory Council will establish a minority mental health advisory committee.

(2) By October 1, 1977, DMH will build into the site evaluation process specific criteria for assessing the adequacy of services to minority groups.

(3) By January 1, 1978, each center/clinic will be required to include training in services to minorities represented in the catchment area as part of its ongoing services.

(4) By March 1, 1978, the Minority Mental Health Advisory Committee will have made recommendations concerning mental health services for minorities for inclusion in the State Mental Health Plan.

(5) By July 1, 1978, the Minority Mental Health Advisory Committee will have met with DMH at least three times.

(6) By July 1, 1978, each center/clinic-hospital will be required to provide some evidence that its staff has the cultural sensitivity and linguistic skill to serve the Spanish-speaking population through a program that is outreach oriented.

(7) By July 1, 1978, the DMH will fund a demonstration project which will focus on the special treatment needs of ethnic minorities.

(8) By July 1, 1978, the "talent bank" of minority mental health professionals will be updated.

(9) By July 1, 1979, DMH will fund a second demonstration project which will focus on the special treatment needs of ethnic minorities.

g. Rural Residents:

(1) By September 1, 1977, a differential funding model proposal which focuses on the unique fiscal needs for delivering rural mental health services will be presented to DMH by the Rural Mental Health Ad Hoc Committee.

(2) By October 1, 1977, the Rural Mental Health Ad Hoc Committee will present a position statement to the DMH on the need for a full-time staff position to coordinate and integrate rural mental health and health care systems.

(3) By January 1, 1978, a collaborative study will be conducted and the results presented by the University of Colorado Medical Center, Psychiatry Department and DMH pertaining to the feasibility of developing educational programs in rural mental health settings.

(4) By March 1, 1978, a pilot study will have been completed and the results presented to DMH by the Rural Ad Hoc Committee on the special needs of rural mental health emergency services.

h. Economically Disadvantaged Persons:

(1) By July 1, 1978, DMH staff will have met with the State Department of Social Services and the Federal Department of Health, Education and Welfare staff at least once since July 1977 to explore means of increasing the amount of Medicaid and other social service funds, and Medicare and CHAMPUS funds available to mental health centers/clinics and hospitals.

i. Women:

(1) By August 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.

(2) By April 1, 1978, this information will be disseminated to centers/clinics and hospitals.

(3) By July 1, 1978, a minimum of one staff member/center or clinic will attend a workshop focused on special needs of women.

(4) By January 1, 1979, 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. High Risk Persons:

(1) By January 1, 1978, each center/clinic will submit a plan to DMH for services to high risk clients, which must be approved by DMH in accordance with the annual contract.

(2) By July 1, 1978, each catchment area agency will have begun providing services to chronically psychiatrically disabled clients in nursing and boarding homes in its catchment area.

(3) By July 1, 1979, the mental health standards for health care facilities will be implemented on a pilot basis in three nursing homes.

(4) By July 1, 1979, all nursing homes which provide services to psychiatrically disabled persons will be in compliance with the mental health standards for health care facilities.

4. Goal #4

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

(1) By August 1, 1977, the Division of Mental Health will invite centers/clinics and hospitals 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.

(2) By September 1, 1977, the DMH will have completed an assessment of public education services currently being provided by centers/clinics, hospitals, DMH and the Mental Health Association of Colorado, and will have developed a catalog of such services and will have identified possible gaps and needs.

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

(4) By March 1, 1978, the DMH will develop a comprehensive plan for public education services to be provided by DMH, centers/clinics and hospitals. This plan will be coordinated with the Mental Health Association.

(5) By March 1, 1978, as part of the above plan, DMH and the Mental Health Association will begin sponsoring at least one workshop or seminar per year for centers/clinics and hospital personnel responsible for public education.

(6) By July 1, 1978, all centers/clinics and hospitals will have on file with DMH their written goals and objectives for ongoing public education services within the scope of the above plan.

5. Goal #5

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

(1) 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, school district(s) staff, social services staff and staff of other appropriate human services agencies in the catchment area such as clergymen and law enforcement agencies.

(2) By July 1, 1978, all centers/clinics will have had at least one documented 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.

(3) By July 1, 1978, all centers/clinics will have had at least one documented information sharing/mutual consultation session with the regional alcohol and drug abuse coordinator.

(4) By July 1, 1978, all centers/clinics will have had at least one documented information sharing/mutual consultation session with county social services personnel to discuss mutual concerns and ways of improving services to mutual clients.

(5) By July 1, 1978, all centers/clinics will have had at least one documented information sharing/mutual consultation session with school district staff and district and other court personnel.

CHAPTER IV

THE STATE MENTAL HEALTH PROGRAM

IV. THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF THE STATE MENTAL HEALTH SYSTEM

(No substantive changes have been made in this section.)

B. PREADMISSION SCREENING

1. Role of Hospitals and Centers and Clinics (supercedes the first paragraph of subsection B.1. in basic plan)

The DMH policy is that to the fullest extent possible, all persons who are believed to be in need of mental health services will be screened or evaluated by the appropriate catchment area center. In order to facilitate the operationalization of this policy, Continuity of Care Committees, which include representatives of the state hospitals and centers and clinics have been formed in each hospital service area. The Committees have developed recommended criteria for admission to inpatient care at the state hospitals, and guidelines for facilitating easy movement and continuous care for clients within the system. The Committees' recommendations have been implemented on a pilot basis. Policy statements based on the Committees' work will be prepared and issued by the DMH Central Office when the trial period has expired and the procedures have been refined. The Continuity of Care Committees are permanent bodies which have the responsibility for monitoring the system and assisting in the resolution of any problems that might arise. Fort Logan Mental Health Center has established an admissions unit which greatly facilitates the referral and continuity of care process.

The assumption by centers/clinics of primary responsibility for preadmission screening has resulted in some complaints from juvenile court judges who prefer to send an adolescent who appears to require mental health services directly to a state hospital. Conferences involving the DMH, the centers/clinics, the state hospitals, the judges and other court personnel are being held to resolve this problem.

2. Procedure for Preadmission Screening by Centers and Clinics

(No substantive changes have been made in this section.)

C. ALTERNATIVES TO HOSPITALIZATION

(No substantive changes have been made in C.1-4.)

5. (added)

During the past year, the DMH placed increased emphasis on the elimination of inappropriate hospitalization through the stepped-up preadmission screening outlined above, and expanded use of residential and other alternatives to inpatient hospitalization. A specific category of service ("other 24-hour care") has been established to capture data on persons treated in residential alternatives to inpatient care, and special funding has been requested from the state legislature to pay for such care. The admissions and services review process described in the basic plan is still operational in the two state hospitals. This mechanism is designed to ensure that persons who require inpatient care receive services which are well planned, conducted and monitored. Standards for mental health services in nursing care facilities and intermediate health care facilities have been developed (a copy of the standards is included in the appendix).

D. PUBLIC MENTAL HOSPITALS

Fort Logan Mental Health Center

1. Description of Living Conditions and Treatment Resources

(No substantive changes have been made in this section.)

2. Efforts to Improve Quality of Institutional Care

e. (supercedes e. in the basic plan)
The center has established a half-time patient representative who is available to patients for discussing their concerns about the quality of care and who assists in finding remedies for the identified problem. The patient representative is accountable to the Community Coordinator, and ultimately to the Director.

g. Inservice training programs are available to all staff through the Office of Nursing and Training... (rather than the Division of Hospital Standards and Inservice Training).

3. Description of Present Fort Logan Mental Health Center Population

(supercedes this subsection in the basic plan)

Fort Logan Mental Health Center is organized to provide treatment to children, adolescents, adults, geriatric patients and alcoholics who have severe functional and behavioral disorders. A mental health service has been established for deaf and hearing impaired persons. The deaf services program serves the total state, but priority is given to clients from 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 (1976-77) the average daily attendance (ADA) of this inpatient population was:

Program Division	Requirements for Admission	Inpatient ADA
Adult Psychiatric	Severe psychiatric disability	43
Alcoholism	Severe drinking problem	15
Children/Adolescent	Severe psychiatric illness	53
Geriatric and Deaf	Severe psychiatric illness (The deaf might not be as severely psychiatrically disabled as other clients; however, this is the only psychiatric service available to many deaf persons.)	19
	TOTAL:	130

During the summer of 1976, FLMHC began a major reorganization of its treatment and support services. The reorganization was initiated specifically to reduce the cost of inpatient care. One result of the reorganization was an increase from 252 to 341 in hospital and transitional living beds. The majority of the additional beds are in the Children/Adolescent Division. This will obviously result in an increase in the inpatient ADA, which will be a critical factor in the lowering of costs. While the increase in the number of beds was a by-product of the reorganization, the beds were needed, as indicated by the present level of utilization, to help meet the special inpatient treatment needs of children and

adolescents, and to provide a lockable treatment facility for adults in the Fort Logan service area. The 75-76 session of the General Assembly mandated a study (Footnote 45 of the Appropriations [Long] Bill for the fiscal year beginning July 1, 1976) of the comparative costs and outcome of services provided by the two state hospitals and residential child care facilities (RCCFs). A report was submitted, but due to the complexity of the issue, the report did not include comparative cost and outcome data for state hospitals and the RCCFs. The 76-77 General Assembly has again mandated a study of comparative costs and outcomes. Future state funding for FLMHC's (and CSH's) children's and adolescents' services hinges on the outcome of this study.

Fort Logan is currently serving twenty-two counties, having added the six counties of Planning Region 12 to its service area in July 1976. The major portion of the population served resides in a highly urbanized area within 20-30 miles of the hospital. The population of the FLMHC service area is 1,900,000.

Within the area served by the hospital are twelve community mental health centers and four community mental health specialty and catchment area 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 or limit institutionalization.

4. Plans for Avoiding Chronicity

(No changes have been made in this section.)

5. Plans for Providing Social and Recreational Stimulation

(No changes have been made in this section.)

6. Evolving Role of Fort Logan Mental Health Center in the Mental Health Service Delivery System (supercedes this subsection in basic plan)

It is planned that over the next five year period the FLMHC will evolve into the role of a 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. The adult inpatient and transitional ADA is expected to increase over the

next year, then stabilize at about 90 to 95 ADA. Whether there is a further increase or decline will be determined by the availability of residential alternative facilities in the various catchment areas, and the ability of centers and clinics to treat more seriously disturbed clients in non-hospital programs. Each catchment area center in the Denver metropolitan area, except Arapahoe, has an identified inpatient service within its catchment area. However, as federal staffing grants expire, cost considerations might make it advisable to centralize inpatient services for those catchment areas close to FLMHC, at FLMHC.

FLMHC will continue to provide long-term inpatient care for all age groups, and short-term inpatient care for children, adolescents and the elderly. For the foreseeable future, the Tertiary Aid and Prevention (TAP), the Lodge, family care and supervised boarding homes programs will be continued. The hospital's vocational services program for non-DVR eligible clients will also be continued.

A decision by the legislature has, for the first time, given ADAD control over state funds for alcoholism services provided by FLMHC and Colorado State Hospital. Thus, the future of the alcoholism program at FLMHC will be determined by ADAD. In that DMH and ADAD have forged a close working relationship, DMH's participation in the decision making process around FLMHC's role in the delivery of alcoholism services is ensured.

Colorado State Hospital

1. Description of Living Conditions and Treatment Resources

(No substantive changes have been made in this section.)

2. Efforts to Improve Quality of Institutional Care

(No substantive changes have been made in this section.)

3. Description of Present Residential Population

(supercedes this subsection in basic plan)

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 (1976-77) the average daily attendance of this inpatient population based on daily midnight bed count was:

Program Division	Requirements for Admission	Inpatient ADA
Alcoholic Treatment Center	Severe drinking problem	49
Drug Treatment Center	Severe drug abuse	35
Children/Adolescent Treatment Center	Severe psychiatric illness through age 16	69
Geriatric Treatment Center	Severe psychiatric illness for patients over age 60	157
General Adult Psychiatric Services	Acute and severe psychiatric illness for patients age 17-64	122
Division of Forensic Psychiatry	Criminal court evaluations and criminally insane	282
General Hospital Services	Medical-surgical problems	63
	TOTAL:	777

The first five program divisions serve forty-one counties of the southern and western portions of the state, with a total population of some 800,000 persons. 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.

The 34% decrease in the ADA for the Geriatrics Division is the result of a deliberate plan by CSH to transfer from the inpatient service those geriatrics patients who are capable of functioning in a less restrictive setting. The clients are carefully prepared for relocation, and appropriate arrangements are made for follow-up care as required.

4. Efforts to Avoid Chronicity

(No substantive changes have been made in this section.)

5. Provision for Social and Recreational Stimulation

(No substantive changes have been made in this section.)

6. Evolving Role of Colorado State Hospital in the Mental Health Service Delivery System (supercedes the fifth paragraph which reads "CSH will phase down its alcohol and drug abuse treatment programs...")

The Alcohol and Drug Abuse Division (ADAD), as the state alcohol and drug abuse authority, has the responsibility for planning and administering the substance abuse programs in the state. The (1976-77) session of the legislature has, for the first time, given ADAD control of the substance abuse funds which previously were administered by the Division of Mental Health. Therefore, the future of the alcohol and drug abuse programs at

CSH will be determined by ADAD. The DMH's close working relationship with ADAD ensures that DMH will have input into the decisions concerning CSH's role in the provision of substance abuse services.

E. FOLLOW-UP CARE

1. Pre-Discharge Planning Procedure

(No substantive changes have been made in this section.)

2. Responsible Center/Clinic in Each Catchment Area

(No substantive changes have been made in this section.)

3. Policies for Discharge from State Hospitals

(No substantive changes have been made in this section.)

4. Methods for Assuring Availability of Follow-Up Care

The following paragraphs are added:

Increased attention has been focused on aftercare services during the past year. The DMH state budget request included funds for specialized services to former state hospital clients who are presently living in nursing care facilities, boarding homes and other group living facilities. The legislature responded by appropriating $720,000 for services to such clients and the reduction of admissions to the state hospitals. The Mental Health Association of Colorado and the Colorado Association of Community Mental Health Centers and Clinics were instrumental in gaining legislative approval of these funds. Increased emphasis has been placed on sheltered workshops as very effective and efficient components in the array of follow-up services.

The two hospital service area Continuity of Care Committees will assist in the monitoring of the follow-up process, and will make recommendations to DMH concerning needed revisions in the policy and procedures.

F. WORKFORCE (MANPOWER/WOMANPOWER)

1. Summary of Current Workforce (Manpower/Womanpower)

The following is a summary of the current staff of mental health centers, clinics and state hospitals in Colorado:

Discipline	Full-Time Staff	Part-Time Staff
M.D., Psychiatrist	48	70
M.D., Physician (non-psychiatrist)	10	62
Nurse, M.S.	24	4
Nurse, B.S.	109	6
Nurse, A.A.	158	5
Nurse, Practical	23	2
Mental Health Worker, B.S.	128	8
Mental Health Worker, A.A.	178	1
Mental Health Work	93	16
Social Worker, D.S.W.	1	2
Social Worker, Masters	245	33
Social Worker, Bachelor	29	4
Psychologist, Ph.D.	130	19
Psychologist, Masters	117	13
Psychologist, Bachelor	16	1
Other Doctorate Level	12	2
Other Masters Level	103	2
Other Bachelor Level	152	6
Other A.A.	12	
Psychiatric Technician	357	
Other	1241	176
Total	3186	432

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
Pipefitters
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 and Meatcutters
Dietitians
Laundry Workers & Supervisors
Barbers
Beauticians
Custodial Workers & Supervisors

2. Projection of Personnel Needs (supercedes the last paragraph which reads: "The Division of Mental Health...")

The Division of Mental Health is engaged in a statewide effort to upgrade the skill of the staff of centers, clinics, hospitals, the DMH Central Office and other mental health caregivers, administrators and lay board members through a series of workshops, seminars and other training techniques. The DMH applied for and received a continuing education grant to train the staff of mental health centers/clinics to provide the twelve services required by agencies funded under Public Law 94-63.

3. Development and Maintenance of an Adequate Supply of Mental Health Personnel (supercedes this subsection in basic plan)

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 postgraduate or continuing education of mental health professionals and paraprofessionals.

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 that the necessary staff skills are available to effectively implement program goals and objectives. Therefore, resources for the continuing education of mental health professionals and paraprofessionals must be built in as an integral part of the service delivery system.

The term "continuing education" is used to include all those educational activities following academic professional training, whether provided by professional societies, universities, or service agencies themselves. Continuing education is distinct from "consultation and education." Whereas continuing education is aimed at the ongoing education of mental health professionals and paraprofessionals, consultation and education is 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 terms "staff development" and "inservice training."

It includes a diverse range of activities such as: formally organized inservice classes, seminars or workshops; case conferences and clinical consultations which are primarily oriented towards staff training; sending staff to attend externally sponsored education offerings; and development of organizational policies, structures and resources in support of the ongoing professional development of agency personnel.

The responsibility for continuing education is shared by the Division of Mental Health, the service delivery agency, and the individual mental health professional:

The role of the Division is carried out by the Staff Development Section and includes identifying statewide training needs and priorities, setting minimum standards for continuing education, establishing and administering enabling mechanisms, and developing resources needed to support the role of service agencies.

The role of the indiviudal agency includes assessing agency training needs, and providing the continuing education (staff development) services required by their staff.

The role of the individual mental health professional includes the maintenance of his/her knowledge and skills in keeping with the requirements and expectations of his/her respective profession.

The implementation of these roles is enhanced through the joint efforts of the Office of Staff Development, Division of Mental Health, and the inservice directors/coordinators of the individual service agencies who together comprise the Continuing Education Committee (CEC). The CEC serves as an advisory committee to (1) the Continuing Education Grant, "Comprehensive Services Development Project" and (2) the Division of Mental Health regarding educational and training issues.

4. Procedures for Protecting Displaced Employees Rights (add the following)

No state hospital employees have been discharged or laid-off because of DMH's efforts to eliminate inappropriate hospitalization.

5. Volunteer Services (added)

Volunteer services are an important part of the history of mental health care. Modern day volunteers provide a variety of services from transporting clients to professional clinical services. Volunteers enable agencies to provide additional services, and help keep the cost of mental health care within reasonable limits. Equally as important is the community involvement and community support which the volunteers represent. They help "spread the word" about the availability of

preventive and corrective mental health care. Their presence in mental health agencies and the linkages they facilitate between the mental health center, clinic or hospital and various community organizations help breakdown the stigma often associated with mental health. It is the policy of the Division of Mental Health that all centers, clinics and hospitals have an active volunteer program.

6. Fiscal Support of the State Mental Health Program (added)

The State of Colorado has a history of strong support of its mental health programs. This state was one of the first to pass legislation which permitted state support of community mental health centers and clinics. The two state hospitals are regarded as two of the most progressive in the country. This is attributable in a large measure to the excellent fiscal support received from the legislature, especially during the 60s and early 70s.

In recent years, primarily because of poor economic conditions, it has become increasingly difficult to obtain sufficient state funding to maintain the desired level of program growth. In respect to federally funded centers, the funding problem was aggravated by the fact that the eight year federal staffing grants began to expire about the same time the economic fortunes of the state began to decline.

Despite the problems cited above, state support of mental health services has increased each year. For example, even though the state was experiencing an economic downturn, along with the rest of the country, in 1976 state support of mental health programs increased by 7.2% from FY 75-76 to FY 76-77.

In addition to actively pursuing state support, the DMH, hospitals and community agencies are attempting to find ways to maximize income from Medicaid, Medicare, CHAMPUS and other third party sources. The DMH and the centers and clinics are, with legislative encouragement, developing an incentive system which will hopefully result in an increase in income from local governments and other non-state sources.

One of the new objectives in the Plan is the development of an estimate of the cost of implementation of this Plan. It is acknowledged that it will be difficult to accurately "cost out" the Plan; however, the best talent available will be used to develop cost estimates.

7. Standards, Rules and Regulations (added)

The following standards, rules and regulations which apply to centers/clinics and/or hospitals, have been promulgated during fiscal year 76-77. These documents will have a profound impact on the public mental health system:

a. Standards/Rules and Regulations for Mental Health Centers and Clinics (distributed under separate cover, if not included in your copy of this document)
b. Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill, Pursuant to CRS 1973, 27-10-101, et seq., as amended (copy in appendix)
c. Health Care Facility Standards for Persons with Mental Health Problems (copy in appendix)
d. Joint Commission on Accreditation of Hospitals (JCAH) Standards (available from JCAH).

CHAPTER V

COORDINATION OF PLANNING

V. COORDINATION OF PLANNING

A. INTERDEPARTMENTAL COMPREHENSIVE PLANNING

1. Human Services Policy Council

(There are no substantive changes in this section.)

2. Office of State Planning and Budgeting

(There are no substantive changes in this section.)

3. Health Planning (supercedes this section in the basic plan)

As a result of the implementation of the National Health Planning and Resources Development Act of 1974 (PL 93-641), the Colorado Health Planning Council (previously created under the former comprehensive health planning legislation) is no longer functional and the Division of Comprehensive Health Planning of the Department of Health has been phased out. The Statewide Health Coordinating Council (SHCC), which will replace the Health Planning Council, has not yet been appointed by the Governor; but indications are that it will become functional by the early summer of 1977. The Colorado Department of Health has been designated as the State Health Planning and Development Agency (SHPDA) under PL 93-641, with these functions centered in the newly created Office of Medical Care Regulation and Development.

Health planning and development at the local level is now under the aegis of the three health systems agencies (HSAs) in the state, all of which have now been designated, funded and staffed. Approximately one-half of the former areawide Health Planning Councils have formed the nuclei of subarea advisory councils, which serve as local advisory groups to their respective HSAs. A primary task with which each of the HSAs is currently involved in a coordinated way with each other, is the development of a Health Systems Plan for each area. Each of these will address specific health services, including the various mental health services, will indicate to the extent feasible "how much" of each service is needed in the area and will designate guidelines and standards for the provision of each service. The three Health Systems Plans will in turn form the basis for the State Health Plan to be developed by the SHPDA and the SHCC.

Staff of DMH, SHPDA and one of the HSAs have discussed ways in which the Health Systems Plans, the State Health Plan and the State Mental Health Plan can be coordinated. An attempt will be made to develop the plans of these agencies around the following major categories:

a. Precare: This is the level at which health promotion and protection services, including mental health consultation and education services, are provided.

b. Primary Care: This is the level at which clients generally enter the health care delivery system. Outpatient, 24-hour emergency and prescreening services are primary level mental health services.

c. Intermediate Care: This level of care is more intensive in nature, and is generally utilized less frequently that primary care. Persons treated at this level have already received primary care. Partial hospitalization (day care, evening care and night care) and inpatient care are the intermediate level services provided by mental health agencies.

d. Tertiary Care: This is the most intensive and specialized level of care, and is the one most likely to be centralized or regionalized because of cost and the utilization rate. Examples of tertiary care are highly specialized services to children and the elderly which are provided in a hospital.

The federal guidelines for health planning include the following categories which are compatible with, and can be easily integrated into the precare, primary, intermediate and tertiary care model:

a. Community health promotion and protection services
b. Prevention and detection services
c. Diagnostic and treatment services
d. Habilitation and rehabilitation services
e. Maintenance services
f. Support services
g. Health system enabling services

Since the HSA and State Health Plans have not been written, the State Mental Health Plan will follow the present format during this first update year. The 1978-79 update will involve a complete rewriting of the State Mental Health Plan. That document will mark the beginning of the shift from the present format to the taxonomy for the State Health Plan developed pursuant to PL 93-641. Since July 1, 1976, there have been quarterly meetings between DMH and SHPDA staff. A SHPDA staff member participated in the writing of this section of the Plan, and the reivew of the total Plan.

4. Health Facilities Advisory Council

(There are no substantive changes in this section.)

B. INTERDEPARTMENTAL PROGRAM PLANNING

1. Alcohol and Drug Abuse Division (supercedes this section in basic plan)

The Alcohol and Drug Abuse Division (ADAD) within the State Department of Health is, by statute, the state alcohol and drug abuse authority. ADAD is responsible for formulation of the State Alcohol and Drug Abuse (or substance abuse) Plan.

ADAD does not directly provide treatment services, but purchases services from approved agencies across the state. In fiscal year 1976-77, the state general fund appropriation to ADAD was $2,976,941.00. In addition, ADAD was allocated $3,710,984.00 in federal funds.

Mental health agencies are becoming increasingly involved in providing substance abuse services. During fiscal year 1976-77, ADAD had 29 contracts with mental health centers/clinics (including the Drug Treatment Center at Colorado State Hospital) to provide drug and alcohol services. During this same period of time, state general funds of approximately 1.35 million dollars were appropriated to the alcohol treatment programs at Colorado State Hospital (CSH) and the Fort Logan Mental Health Center (FLMHC), and CSH received an additional 0.63 million dollars for drug treatment services.

At the request of ADAD and DMH, the state legislature (76-77 session) gave ADAD direct control of the two state hospitals' alcoholism services funds. This will enable ADAD to develop a truly comprehensive statewide substance abuse plan and program. It is expected that DMH will have input into the decision concerning the role of the two state hospitals in the substance abuse program.

The close working relationship between ADAD and DMH has resulted in a number of solid achievements during fiscal year 1976-77. These include:

a. Representatives from DMH and ADAD have met monthly since September 1976 to discuss ways of resolving the service delivery issues raised in the State Plan.

b. A letter of agreement has been signed by the two Division Directors which supports joint annual evaluations of the substance abuse programs in the two state hospitals and the community mental health centers/clinics.

c. DMH and ADAD have coordinated procedures for the use of compatible data forms.

d. Each division has taken steps to facilitate increased input into its State Plan by the other division.

e. DMH and ADAD have jointly conducted continuing education efforts related to substance abuse issues for mental health agency staff.

During the coming year, close interdepartmental planning and coordination will continue with an emphasis on the objectives listed in Chapter III. This will ensure the establishment of specific standards, which will be used for the evaluation of the substance abuse programs at CSH and FLMHC by DMH and ADAD staff.

2. Department of Social Services (supercedes this subsection in basic plan)

The Department of Social Services (DSS) is responsible for the provision and/or fiscal administration of a host of social and medical assistance programs. DMH and DSS have many common interests and concerns, including mutual responsibilities for clients receiving services from both agencies. Through DSS, social services and financial assistance are provided to many clients of the mental health agencies. Additionally, DSS programs make possible 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 XIX (Medicaid) and vocational rehabilitation funds from DSS. Mental health centers and clinics are recipients of Medicaid funds for services to eligible clients. Unpredictable and severe reductions in vocational rehabilitation funding have resulted in major changes and periods of uncertainty in the vocational rehabilitation programs in the hospitals and several centers. Differing interpretations as to which services of centers and clinics are eligible for Medicaid reimbursement, and restrictive Medicaid requirements (such as the physician on the premises requirement) which are difficult and fiscally impractical at least in some non-urban areas, severely limit the income to centers and clinics. Also, in contrast to the practice in many other states, the Title XX funds are virtually unavailable for the purchase of mental health services because of the prior commitment of these funds for child care and other services provided by agencies other than mental health centers and clinics. Continuing efforts are being made to include mental health services in the Title XX plan at a more viable level.

Increased coordination in planning will be developed between DSS and DMH, as well as between the centers/clinics and county social service departments. Outcomes to be expected include: improved coordination and facilitation of referrals for services; expanded vocational rehabilitation services for mental health clients; additional funds, available with a minimum of obstacles, for mental health services to persons eligible for medical assistance under Medicaid; and coordinated provision of services for the elderly.

3. Department of Education (supercedes this section in the basic plan)

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.

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. A General Accounting Office audit team recently visited the CSH ESEA program and expressed concern that the ESEA funds appear to be the primary funding for the program rather than supplemental funds, as they were intended to be.

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 Divisions of Mental Health, Developmental Disabilities, Youth Services, the Department of Social Services and 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 and/or residing in residential treatment facilities and have 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;

d. the child with multiple handicaps (such as mental retardation and mental illness) must receive services for each handicap by the agency with the primary responsibility to deliver that service. This will require joint treatment planning and joint service provision. No child should be denied the appropriate treatment for a "secondary diagnosis."

4. Department of Corrections (added)

The 1976-77 session of the Colorado General Assembly has enacted legislation which elevates Correctional Services from divisional to departmental status. Thus, Correctional Services, which was a sister division to DMH, becomes a peer of the Department of Institutions. It is generally acknowledged that mental health services for persons in the correctional system are inadequate. The role of DMH (particularly Colorado State Hospital, which has provided a variety of services to the Penitentiary and Reformatory) will be discussed with Corrections officials when the restructuring of the new department has been completed.

C. INTERDIVISIONAL PLANNING - DEPARTMENT OF INSTITUTIONS
(supercedes this section in the basic plan)

During the past year, legislative action has resulted in the shift of the Division for the Deaf and Blind from the Department of Institutions to the Department of Education, and the elevation of the Division of Correctional Services to departmental status. Thus, the Department of Institutions is now comprised of three divisions: Developmental Disabilities, Youth Services and Mental Health. All three of the divisions have "institutional" residential facilities, and all utilize community based facilities which they operate directly or through contractual arrangements with other agencies. Each of the three divisions has a strong commitment to the provision of services in the least restrictive setting, and the prevention of inappropriate institutionalization.

The Divisions of Mental Health and Developmental Disabilities plan to engage in a variety of joint activities to increase and improve the quality of mental health services to the developmentally disabled including:

1. Facilitating a face to face meeting between individual community mental health centers/clinics and community center board directors and DD program directors.
2. Assessing service needs in terms of types of client problems and and types of services needed to address the problems.
3. Assessing the amount of services needed in terms of the numbers of clients needing specific types of service.
4. Defining and planning inservice training programs which mental health centers/clinics can provide to community centered boards.
5. Defining and planning inservice training which community centered boards can make available to mental health centers/clinics.
6. Defining and planning inservice training either or both types of agencies may seek from an outside training or consultation resource.

The Divisions will be supported in this effort by the Developmental Disabilities Council, the Colorado Association for Retarded Citizens and the Mental Health Association of Colorado.

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 interface between the DMH and the Division of Youth Services has been carried on primarily through the Interdivisional Placement Team. Problems between the two divisions have primarily revolved around which division should have the primary responsibility for the treatment of especially difficult clients. The problems have been exacerbated by judicial actions which sometimes result in inappropriate placement in a youth service or mental health facility. The problems are further compounded by the lack of definitive criteria for determining the most appropriate placement for pre-delinquent and delinquent youth, some overlap between the treatment functions of mental health and youth services facilities, and differences in treatment philosophies, approaches and expectations. The DMH recently took steps to initiate a dialogue between the Division of Youth Services and Fort Logan Mental Health Center with a view toward facilitating collaborative action on the problem areas. The Division has also initiated a series of conferences involving the juvenile judges and representatives of the centers/clinics, the Judicial Department, Social Services, as well as FLMHC and the Division of Youth Services. The purposes of the conferences include finding ways to reduce the time required to respond to the courts' requests for diagnostic assessments, to gain a clear understanding of the various statutes involved, and to attempt to remove - or reduce - the barriers to humane, efficient and effective services for delinquent and pre-delinquent youth.

The Interdivisional Medical Services Committee, which has representatives from all three divisions, 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.

D. LOCAL GOVERNMENTAL PLANNING AND REGIONAL PLANNING

(No substantive changes have been made in this section.)

E. PUBLIC, VOLUNTARY, AND PRIVATE MENTAL HEALTH SERVICES

(No substantive changes have been made in this section.)

CHAPTER VI

CATCHMENT AREA MENTAL HEALTH PROGRAM

VI. CATCHMENT AREA MENTAL HEALTH PROGRAM

A. DESCRIPTION OF CATCHMENT AREAS

(No substantive changes in pages 1-4.)

On page 5, add the following after the paragraph which reads "Following is a brief description of each region, the services provided by the centers/clinics serving the region and program needs." (See Appendix IV for a chart showing the availability of the twelve PL 94-63 services in the 21 catchment areas.)

The population data are based on projections by the State Division of Planning, Department of Local Affairs. The data do not include military personnel and their dependents. Excluded military personnel and dependents are as follows: Adams - 5,287; Arapahoe - 10,460; Denver - 14,253; El Paso - 80,000. All data are as of January 1, 1978.

REGION I

(supercedes the description in the basic plan)

Area: 9,228 square miles

Population: 67,155

Composition of Population:		
	Anglo	93%
	Asian	-0-
	Black	-0-
	Chicano	7%
	Native American	-0-
	Other	-0-

1. Existing Services

The region is served by the Northeast Colorado Mental Health Clinic with headquarters in Sterling and branch offices in Fort Morgan, Yuma and Holyoke. 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, counseling services, and residential treatment programs; and consultation and education services to other community agencies. A grant is being submitted for a multi-agency diversion project

for pre- and post-adjudicated adolescents. Emergency services are available 24 hours a day. A contract with the Alcohol and Drug Abuse Division (Department of Health) supports client counseling, public education, community organization efforts and training programs in alcoholism in the region. A partial care program has been initiated in one local nursing home, while ten 24-hour alternative beds have been established in a second one.

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.

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 staffed for treating such disturbances other than on a limited emergency basis. There is a need for specialized inpatient services and additional alternative treatment facilities in the catchment area.

A planning grant application was submitted and approved by 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. No monies were available and the grant has been resubmitted. 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.

The ADAMHA Regional Office has approved the merger of the two regions; however, that office is aware of the careful planning that must take place to accomplish a merger of two established agencies. As previously indicated, the planning grant has not been funded; therefore, action on the merger has been delayed. The two agencies and the two catchment areas are maintaining their separate identities until the planning process has been properly completed.

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.

Thus far, there is joint utilization by the two clinics of a child/adolescent crisis center and of a juvenile residential treatment program. They have also jointly hired an accountant.

REGION 2a

(supercedes the description in the basic plan)

Area: 4,004 square miles

Population: 123,412

Composition of Population:		
	Anglo	82.1%
	Asian	.8%
	Black	.3%
	Chicano	16.0%
	Native American	.2%
	Other	.6%

1. Existing Services

The county is served by the Weld Mental Health Center. The center received a federal staffing grant in November 1967, and the grant terminated in October 1975. 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. Fort Logan Mental Health Center is the state hospital serving this region.

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 alternative living program for the alcoholic.

A specialized program for children and families provides emergency care, long-term therapy, evaluation services, and a child partial care treatment program, as of 3-1-77. A drug treatment/drug preventative program, "Horizons," for teenagers and young adults is well utilized as a drop-in center in the community. A conversion grant, beginning 7-1-76, has supported the development of transitional care and peer counseling (home visits, etc.) for the elderly.

2. Program Needs

The Weld Center provides basic services for all categories of clients with the exception of 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 department 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

Area: 2,614 square miles

Population: 132,806 (supercedes figure in basic plan)

Composition of Population:		
	Anglo	91.9%
	Asian	-0-
	Black	.3%
	Chicano	6.7%
	Native American	.1%
	Other	1.0%

1. Existing Services

(No substantive changes have been made in this section.)

2. Program Needs (supercedes description in basic plan)

Program needs include alternative treatment facilities for the high-risk/high resource users for all ages, increased services to outlying areas, and increased outreach to the elderly, to the Chicano population and services in relation to crime and law enforcement. 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 has received a contract for counseling services to surviving disaster victims and the families of those who did not survive.

REGION 3

Area: 5,045 square miles

Population: 1,422,393 (supercedes figure in the basic plan)

Add the following paragraph on page 14 before the paragraph which reads: "A brief description of the centers and clinics in Region 3 follows."

In 1974, the state legislature mandated the development of a plan for coordinating mental health services in the City and County of Denver. The agencies concerned, with considerable input and assistance from the Mental Health Association, the Region VIII ADAMHA Office, the Denver Department of Health and Hospitals and the Division of Mental Health, developed a plan which was accepted by the legislature. The Denver Mental Health Plan provided for the formation of a citizens' advisory group, to be known as the Denver Mental Health Advisory Board, to oversee the implementation of the Plan.

The primary thrust of the Plan is the provision of coordinated comprehensive mental health services in Denver. The Plan provided for a number of changes including the centralization of some services to eliminate unnecessary duplication, and the funnelling of state and federal funds for all Denver mental health agencies through a central fiscal agent.

The Denver Mental Health Advisory Board, the Department of Health and Hospitals, and the centers and clinics have made some progress towards the achievement of the goals. Many legal and other problems have been encountered, but all parties have invested a considerable amount of time and effort into the project and are determined to implement the Plan in the best possible way.

Adams County Mental Health Center, Inc.

Population: 190,630 (supercedes population figure in basic plan)

Composition of Population:	
Anglo	77.7%
Asian	-0-
Black	2.0%
Chicano	18.0%
Native American	.9%
Other (includes Asian)	1.4%

(No substantive changes have been made in the description.)

Arapahoe Mental Health Center, Inc.

Population: 141,968 (supercedes population figure in basic plan)

Composition of Population:	
Anglo	92.64%
Asian	.32%
Black	.96%
Chicano	4.48%
Native American	1.12%
Other	.48%

1. Existing Services

(No substantive changes have been made in this section.)

2. Program Needs (supercedes the description in the basic plan)

This center is placing major emphasis on further refinement of its alternatives to inpatient care program, and on increasing services to children and adolescents, the elderly and the Chicano residents of its catchment area.

Aurora Mental Health Center, Inc.

Population: 105,733 (supercedes population figure in basic plan)

Composition of Population:	
Anglo	94.5%
Asian	.6%
Black	1.9%
Chicano	1.6%
Native American	.5%
Other	.9%

1. Existing Services

This center is the most recently developed catchment area program in the state mental health system. The new operations grant has allowed for the development of comprehensive services in inpatient, outpatient, consultation and education, other 24-hour care, partial care and pre-hospital screening. Services which are in the process of being activated include: children/adolescents, elderly, hospital follow-up and substance abuse.

2. Program Needs

Emphasis will be placed on crisis intervention and alternatives to hospitalization. Also, increased attention will be given to services to the more rural eastern end of the catchment area.

Bethesda Community Mental Health Center

Population: 126,683 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	94.3%
	Asian	-0-
	Black	.4%
	Chicano	4.5%
	Native American	.2%
	Other	.6%

1. Existing Services

(No substantive changes have been made in this section.)

2. Program Needs (the following supercedes paragraph 2)

The center recognizes the need for increased services to members of ethnic minorities in its catchment area and is taking steps to meet this need. Efforts are also underway to increase services to the elderly and substance abusers.

Mental Health Center of Boulder County, Inc.

Population: 168,923 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	91.0%
	Asian	<1%
	Black	<1%
	Chicano	6.2%
	Native American	<1%
	Other	<1%

1. Existing Services

This is a comprehensive center which serves a diverse catchment area including both urban and rural areas. Programs are therefore geared to these specific populations (e.g., many bilingual therapists are on the center's staff). Services in all parts of the catchment area emphasize services to young adults (including a large drug-abusing population) and to families. Services in rural areas are highly accessible with good utilization by all demographic subgroups, especially the poor and minorities.

2. Program Needs

This center has a great need to provide more services for children and the elderly. Boulder is a county with a highly transient population. This rapid growth and transience creates needs for mental health services that are not fully indicated by the usual socio-demographic indicators. A transitional care facility for reducing hospital admissions is also a priority need in the county. Additional services are also needed in rural areas of the county.

Children's and Adolescents' Mental Health Services (supercedes the description in the basic plan)

(This is a non-catchmented, specialty program.)

1. Existing Services

This program provides mental health services in a medical facility which specializes in providing comprehensive physical and mental health services to children and adolescents. The mental health services are provided by professionals with specialized training in the evaluation, care and treatment of children, adolescents and their parents. The services are inpatient, outpatient and consultation and education. A unique service is the specialized outpatient services which are provided children while in the hospital for serious diseases with secondary emotional problems.

2. Program Needs

This agency will continue to play an important role in the mental health system because of its specialized services and its professional quality of care. The outpatient services were expanded in FY 76-77 and an inpatient psychiatric unit was opened in early 1977. Continued funding

and support will be required to maintain this service which will continue to expand and grow with the statewide demand for service.

Denver Mental Health Center, Inc. (supercedes the description in the basic plan)

(This is a non-catchmented, specialty program)

1. Existing Services

The clinic complements other mental health services in the Denver metropolitan area by providing longer term therapy for people of middle and lower incomes.

2. Program Needs

The clinic plans to continue expanding its outpatient services to the elderly, high-risk, and lower income populations of the Denver metropolitan area. The clinic also recognizes its need to continue expanding its availability of specialized services and collaboration with other centers.

Northwest Denver Mental Health Center

Population: 168,861 (supercedes population figure in basic plan)

Composition of Population:	Anglo	58.7%
	Asian	.7%
	Black	10.1%
	Chicano	29.5%
	Native American	1.0%
	Other	-0-

(No substantive changes have been made in the description.)

Jefferson County Mental Health Center, Inc. (supercedes description in basic plan)

Population: 316,028

Composition of Population:	Anglo	91%
	Asian	1%
	Black	.6%
	Chicano	7%
	Native American	.4%
	Other	

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 in Clear Creek County.

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 has been required to maximize efficiency. Services to Clear Creek County have been expanded, and efforts are underway to provide increased services to Gilpin County. The development of alternative residential facilities is being pushed, and increased services to the residents of nursing homes is another primary need in this catchment area. Expansion of the partial care program is presently underway.

This catchment area is well beyond the federal guideline for maximum population of a catchment area. The board and staff have been actively developing, in collaboration with ADAMHA staff, a plan for the resolution of this problem. The plan, as tentatively approved by ADAMHA provides for the formation of three semi-autonomous subcatchment areas. Each subcatchment area will have an Area Governing Board, however, governance of the total center will continue to be vested in a central governing board. The Area Boards will be composed of representatives of the Center Board who live in the various subcatchment areas.

The Area Boards will have the authority to hire and fire the Area Coordinator, with the concurrence of the Executive Director. The Area Boards will also carry out need assessment, will develop their own budget requests, and will be able to develop their own method of raising funds. This authority, and the other powers delegated to the Area Boards appear to provide the local community input and control essential to the community mental health concept.

The integration and cohesiveness of the total program will be assured by a strong internal communications system and ongoing centralized evaluation and monitoring of the center as a whole. A sixteen step implementation timetable has been developed to facilitate orderly movement to the new structure.

Servicios de La Raza (supercedes the description in the basic plan)

(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 entering its third year and is currently enjoying increasing utilization by the target group it is programmed to serve. Since it is a non-catchmented program, it is important for this staff to carefully coordinate its activities with the nearby catchment area programs as well as other community agencies.

2. Program Needs

This program needs to expand its services to elderly and children whose primary language is Spanish. In addition, the provision of consultation and education to other agencies concerning the special cultural factors involved in working with Chicano clients continues to be an area of need.

Southwest Denver Community Mental Health Services, Inc.

Population: 90,461 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	75.3%
	Asian	-0-
	Black	.2%
	Chicano	24.5%
	Native American	-0-
	Other	-0-

(No substantive changes have been made in the description.)

Park East Comprehensive Community Mental Health Center (supercedes description in basic plan)

Population: 113,106

Composition of Population:		
	Anglo	65.4%
	Asian	-0-
	Black	24.4%
	Chicano	8.5%
	Native American	-0-
	Other*	1.7%

*Native American and Asian included in Other.

1. Existing Services

The center provides a wide range of programs which continue to be developed in the areas of children, adolescents, families, elderly and

other groups. These programs reflect the conscious effort to recognize the importance of specific life, cultural and ethnic backgrounds. The multi-lingual staff can provide services to clients who speak the following languages: Spanish, English, Japanese, German, Vietnamese, Dutch, Indonesian.

2. Program Needs

The center recognizes the need for increased services to families, children, adolescents and elderly. Alternatives to 24-hour inpatient care is a high priority, as is the establishment of an outpost in Montbello.

REGION 4

(supercedes the description in the basic plan)

Area: 4,878 square miles

Population: 248,128

Composition of Population:

Anglo	82.4%
Asian	-0-
Black	5.6%
Chicano	10.5%
Native American	-0-
Other*	1.5%

*Native American and Asian included in Other.

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 consist 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 have been incorporated into an emergency services unit, providing 365 day, year-round emergency services.

The special services are 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, 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. Consumer Credit Counseling provides counseling to families and individuals with financial problems, as well as an extensive education program to prevent such problems.

The alcohol services offer 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. Although services to elderly have recently improved, 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. In addition, the center hopes to

expand its emergency services to include a crisis and screening residential center as resources become available.

The center is encountering some funding problems in its Alcoholism and Adult Forensic Services Programs. Despite a considerable financial outlay for improvement in the Youth Treatment Center (YTC), there is some uncertainty as to how long the YTC facility will meet minimum standards for accreditation by the Joint Commission on Accreditation of Psychiatric Facilities. Every effort is being made to maintain the above much needed services, but the center might have to consider dramatically reducing or terminating these activities if sufficient funding is not available to adequately maintain them.

The population of this catchment area (including military personnel and dependents) exceeds the allowable federal maximum of 250,000. During the past year, the center has engaged in a careful study of a variety of alternatives for the resolution of this problem. Conferences have been held with the several subcatchment area advisory boards, an out-of-state consultant was engaged to analyze the make-up of the community and to make recommendations for consideration by the board. Consultative input has also been sought from a number of other sources including Mr. Dan Townsend of the National Institute of Mental Health, the Georgia Consortia for Mental Health Services, Jefferson County and Colorado West Mental Health Centers in Colorado, and the ADAMHA Regional Office. After carefully considering the information and advice from the many sources and resources, the center has decided to request a waiver of the 250,000 maximum population requirement.

The waiver request will be accompanied by a plan for the delegation of increased authority to Area Boards. The central governing board will maintain overall responsibility for governance. However, the various subcatchment areas will be represented on the central governing board. The Area Boards' authority will embrace:

a. assessment of local needs;
b. budget planning for the local unit;
c. evaluation of the local program;
d. evaluation of the operational effectiveness of the local unit;
e. evaluation of the impact of services on need; and
f. participation in the selection of unit directors.

The responsibility for the development of the plan and a timetable for implementation has been assigned to a very capable board member. Board action on the proposal is expected within the next several weeks.

REGION 5

(supercedes the description in the basic plan)

Area: 8,401 square miles

Population: 21,173

Composition of Population:

Anglo	96%
Asian	-0-
Black	-0-
Chicano	4%
Native American	-0-
Other	-0-

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 in a previously unserved catchment 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 limited basis. Although the area has limited mental health facilities, arrangements have been developed for utilization of a child/adolescent crisis center and of a juvenile residential treatment program in Region 1 and of a sheltered workshop primarily for the developmentally disabled in Burlington. Clients are now screened and transported to Colorado State Hospital with follow-up care provided by the clinic.

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 was submitted and approved by the Department of Health, Education and Welfare to facilitate the development of comprehensive services for this region. No monies were available and the grant has been resubmitted. Under this grant concept, Region 1 and Region 5 could be combined so that comprehensive

services to this large, isolated area would become feasible. The two clinics have, thus far, jointly hired an accountant.

The area needs emergency services for the citizens of this region. Local facilities for short-term care and alternative residential facilities would avoid extended absence at Colorado State Hospital 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 their staffing patterns.

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

REGION 6

Area: 9,526 square miles

Population: 59,417 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	80.97%
	Asian	-0-
	Black	.35%
	Chicano	17.81%
	Native American	.15%
	Other	.72%

(No substantive changes have been made in the description, other than the addition of Prowers County to page VI.28, line 3.)

REGION 7

Area: 8,773 square miles

Population: 151,785 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	57.5%
	Asian	.4%
	Black	.8%
	Chicano	39.1%
	Native American	.1%
	Other	2.1%

(No substantive changes have been made in the description.)

REGION 8

Area: 8,180 square miles

Population: 43,490 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	51.6%
	Asian	.4%
	Black	.15%
	Chicano	47.0%
	Native American	.15%
	Other	.7%

(No substantive changes have been made in the description.)

REGION 9

(supercedes description in the basic plan)

Area: 6,563 square miles

Population: 46,126

Composition of Population:		
	Anglo	76.2%
	Asian	-0-
	Black	.1%
	Chicano	18.2%
	Native American	5.5%
	Other	-0-

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, coal, uranium, sand and gravel. The mining of coal is developing into a major industry with a rapid growth anticipated. 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 five years ago. The staff consists of 12 full-time equivalent positions, and provides services at full-time offices in Durango and Cortez. Satellite offices are located at Pagosa Springs, Dolores and Dove Creek, which are staffed on a part-time basis. Local hospitals in Durango are utilized for inpatient care for some clients who are eligible for Medicare 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. A pilot project has resulted in the development of a halfway house, adult psychiatric clients and other adult clients who require a 24-hour residential care facility, and 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. The need for bilingual staff has been seen as a need to serve this multi-cultured catchment area, so staff fluent in Spanish have been hired.

The center continues to pursue a planning grant application under PL 94-63, the objective being to plan for the provision of comprehensive mental health services for the region.

Some additional specific program needs are: (a) more local inpatient psychiatric beds; (b) expansion of the center's adult, adolescent and children's outpatient services; (c) a treatment program to meet the needs of elderly people; and (d) expanded consultation and education services.

REGION 10

(supercedes description in the basic plan)

Area: 9,369 square miles

Population: 48,691

Composition of Population:		
	Anglo	89 %
	Asian	.5%
	Black	.1%
	Chicano	9.2%
	Native American	.9%
	Other	.3%

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 between 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. The North Fork area of Delta County is a major energy impact area for coal mining. There also are several sizeable food processing plants. The region's trade centers are Gunnison, Montrose and Delta. Approximately one-sixty 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 twelve essential mental health services, including a comprehensive partial care program and specialized programs for children and the elderly. The center has arrangements with three local hospitals to provide beds for psychiatric patients; some inpatients are sent to Colorado State Hospital. Transitional residential care is provided through contractual arrangements with local nursing and boarding homes. There are full-time staff members in Delta, Gunnison, Norwood and Montrose. Part-time service is provided in Telluride, Nucla, Crested Butte, Paonia and Ouray by staff traveling to these areas. 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, family and marriage counseling agency in the catchment area.

The center currently has two federal grants which have enabled it to increase staffing and expand its services to more residents in previously underserved and unserved communities. The center has also received a federal construction grant for a new facility in Delta. As the federal grants decline, increased funding must come from fees, local and state sources if services are to be maintained at the current level.

2. Program Needs

There is need for more adequate psychiatric inpatient facilities within the catchment area in order to limit the number of patients sent to Colorado State Hospital. Other needs include an expanded high quality mental health program for alternate residential care facilities for adults, and further expansion of the partial care program.

REGIONS 11 & 12

(supercedes description in the basic plan)

Area: 23,386 square miles

Population: 146,022

Composition of Population:

Anglo	91.6%
Asian	-0-
Black	.3%
Chicano	8 %
Native American	.1%
Other	-0-

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 Hayden, Eagle, Breckenridge, Aspen, Craig, Rangely, and Meeker. The affiliates provide outreach services on a regular basis in Dinosaur, 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.

Fort Logan Mental Health Center provides state hospital inpatient services for children, adolescents, adults, alcoholics and geriatrics patients in Region 12. Region 11 receives these services from Colorado State Hospital.

The center has been remarkably effective in obtaining financial support from local governments and has also been successful in its pursuit of special funding to help deal with the mental health needs of the counties affected by the development of coal and oil shale resources.

2. Program Needs

Two primary service needs in this catchment area are additional local inpatient beds and non-hospital 24-hour care beds. The center has requested funding for these services. One impact of the availability of these services will be a reduction in inpatient admissions to Colorado State Hospital and a reduced average length of hospital stay.

REGION 13

Area: 3,715 square miles

Population: 48,321 (supercedes population figure in basic plan)

Composition of Population:		
	Anglo	87 %
	Asian	-0-
	Black	.8%
	Chicano	11 %
	Native American	.2%
	Other	1.0%

(No substantive changes have been made in the description.)

B. REVIEW PROCESS FOR CATCHMENT AREAS

(No substantive changes have been made in this section.)

C. RANKINGS OF CATCHMENT AREAS

(No substantive changes have been made in this procedure.)

LISTING OF CATCHMENT AGENCIES IN RANKED ORDER

(supercedes rankings in basic plan)

Rank*	Agency
1	SE Colorado
2	SW Colorado
3	NW Denver
4	Midwestern
5	San Luis
6.5	Park East
6.5	West Central
8	Spanish Peaks
9	NE Colorado
10	Weld
11	Adams
12.5	Larimer
12.5	Colorado West
14.5	Pikes Peak
14.5	East Central
16.5	Bethesda
16.5	SW Denver
18.5	Boulder
18.5	Jeffco
20	Aurora
21	Arapahoe

*Rank of "1" indicates greatest need.

D. PROGRAM FOR DEVELOPMENT OF COMMUNITY MENTAL HEALTH RESOURCES

(This section is eliminated as the content has been incorporated into Chapter IV.)

E. FACILITIES

(No substantive changes have been made in this section.)

F. POVERTY AREAS

(added)

(For use in application for federal grants only.)

The catchment areas listed below qualify for poverty area designation, as each meets the following criteria set forth in Public Law 94-63 and related regulations:

"A poverty catchment area is a catchment area which has one or more subareas which are characterized as subareas of poverty. A subarea of poverty is one in which 15% or more of the population is in poverty. These subareas should constitute 35% or more of the catchment area's population."

These poverty designations are relevant only to the following types of federal grants: initial operations, consultation and education, facilities assistance.

Designated Poverty Catchment Areas

Region	Center/Clinic	Rank
8	San Luis Valley	1
10	Midwestern	2
6	SE Colorado	3
9	SW Colorado	4
1	NE Colorado	5
3f	NW Denver	6
5	East Central	7
2a	Weld	8
7	Spanish Peaks	9
2b	Larimer	10

APPENDICES

Appendix I - State Mental Health Advisory Council Information
. Roster
. Bylaws
. Minutes

Appendix II - Report of the Colorado Chicano Mental Health Planning Symposium

Appendix III - Updated Need Rankings of the Catchment Areas

Appendix IV - Availability of Comprehensive Community Mental Health Services in the 21 Catchment Areas (per PL 94-63)

Appendix V - Inventory of Existing Facilities

Appendix VI - Health Care Facility Standards for Persons with Mental Health Problems

Appendix VII - Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill

Appendix VIII - Report of Accomplishment of Objectives in 76-77 State Mental Health Plan

APPENDIX I

STATE MENTAL HEALTH ADVISORY COUNCIL INFORMATION

State Mental Health Advisory Council Roster

COMPOSITION OF STATE MENTAL HEALTH ADVISORY COUNCIL

Name & Term* (# of years)	Sex: Female	Sex: Male	Ethnic Background: Asian Amer.	Ethnic Background: Black	Ethnic Background: Chicano	Ethnic Background: Native Amer.	Ethnic Background: White	Place of Residence	Type of Residence: Rural	Type of Residence: Urban	Type of Residence: Suburban	Class of Membership: Consumer	Class of Membership: Provider	Class of Membership: Nongov't Org.	Class of Membership: State Agency	Occupation & Type Of Employment
Magdaleno Avila (1)		X			X			Denver		X		X				Exec. Director, Colo. Migrant Council
Colleen Cook (1)	X						X	Denver			X		X			Director, Community Corporation
Richard Daetwiler (2)		X					X	Denver		X			X			Region III Alcohol & Drug Abuse Coord.
Lucy May Dame (1)	X						X	Denver		X		X				Chairman, Senior Citizen's Board
Dorothea Dolan (2)	X						X	Denver		X		X				Retired
Melanie Fairlamb (2)	X						X	(WS) Delta	X			X				Housewife
Peter Garcia (1)		X			X			Boulder			X		X			Boulder MHC - HSA Member
Carolyn Huber (1)	X						X	Denver		X		X				CMHC Volunteer
James Lauer (2)		X					X	Denver		X			X			Child Psychiatrist
Colores Leone (1)	X						X	Denver			X				X	MH/MR Nursing Consultant-Health Dept.
Karen Litz (2)	X						X	Lakewood			X	X				Mental Health Association
Luis Medina (2)		X			X			(SE) Pueblo		X			X			Asst. Exec. Director-Spanish Peaks MHC
Pete Mirelez (2)		X			X			Adams County			X	X				County Commissioner - Adams
Josie Johnson (2)	X			X				Denver			X	X				Executive Assistant to Lieutenant Gov.
Herbert Pardes (2)		X					X	Denver		X					X	Professor & Chairman, Psychiatry, UCMC
Jack Quinn (1)		X					X	(SE) Pueblo		X		X				Exec. Dir.-Pueblo Housing Authority
Roger Richter (2)		X					X	Denver		X		X				Insurance and Real Estate
Steve Schmitz (1)		X					X	(WS) Rifle	X			X				Asst. Director, Colorado West COG
James Syner (1)		X					X	Denver		X					X	Medical Consultant-Dpt. of Social Serv.
Marge Taniwaki (2)	X		X					Denver		X		X				Student
Clarence VanDeren (1)		X					X	Denver		X		X				Denver Area Labor Federation

*terms beginning September 1976

State Mental Health Advisory Council Bylaws

STATE MENTAL HEALTH ADVISORY COUNCIL

State of Colorado

BY-LAWS

ARTICLE I-NAME

The name of this organization shall be the State Mental Health Advisory Council of the State of Colorado.

ARTICLE II-PURPOSES & FUNCTION

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 Mental Health Plan. In that role, it will function as a collective voice for the mental health client, provider, planner, administrator and concerned citizen.

Among the Council's responsibilities are the following:

(a) The Council shall review the State Mental Health Plan each year to ascertain its relevance and responsiveness to changing mental health needs and to insure its coordination with other planning efforts. The Council shall make recommendations for changes and/or additions.

(b) The Council shall 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.

(c) The Council shall serve as a standing committee of the State Health Coordinating Council with the approval of that body.

(d) The Council shall establish ad hoc groups for special assignments deemed necessary by the Council or the Director of the Division of Mental Health.

(e) The Council shall develop and maintain by-laws and appropriate operating guidelines to insure smooth and continous operation.

ARTICLE III-MEMBERSHIP

The State Mental Health Advisory Council shall consist of twenty-one members who will be residents of Colorado. Only nine members of the council shall be direct or indirect providers of mental health services. The membership shall include representatives of those elements of the mental helath service delivery system and the community which it serves, whose decisions impact the goals of:

(a) Health care cost containment.

(b) Access to health care services.

(c) Appropriate placement.

(d) Continuity of care.

The Council shall be appointed by the Governor. For the first year of the Council's existance, ten members shall be appointed for one year terms and eleven 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 insure appropriate representation of the various geographic areas of the state, as well as the social econimic and ethnic groups residing in the state.

State Mental Health Advisory Council
State of Colorado By-Laws
page 3-continued

ARTICLE IV-OFFICERS

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. The Chairperson and Vice-Chairperson shall be elected by the Council at its Annual Meeting.

ARTICLE V-MEETINGS

The Council shall meet regularly at least on a quarterly basis, the dates, times and places of which shall be set by the Council and reflected in the minutes of the regular meetings and any other such time as agreed upon by the Council. Meetings of the Council will be open to the public. The first regular meeting of the calendar year shall be known as the Annual Meeting.

ARTICLE VI-ATTENDANCE

Regular attendance by members is important. Members of the Council shall advise the Chairperson or designee in advance of non-attendance. A member who has three consecutive absences shall be requested to submit his/her resignation unless the Council, by majority vote, votes to allow the person to retain his/her membership.

There shall be no alternates designated to attend meetings in place of members.

ARTICLE VII-QUORUM

A quorum will consist of a majority of the members. With a quorum present at any Council meeting, a majority vote will decide all questions.

ARTICLE VIII-COMMITTEES

The Chairperson shall appoint as many standing and other committees as are necessary to carry on the work of the organization and membership in such committees may be composed of both members and non-members of the Council. The Chairpersons of such

committees must be members of the Council, however, and the Director of the Division of Mental Health shall be an ex-officio member of all committees.

One such standing committee shall be an Executive Committee which shall consist of the Council Chairperson, Vice-Chairperson and Chairperson of the Budget Committee plus at least two other Council members. This Committee shall meet as needed.

Another standing committee shall be the Budget Committee which shall consist of five or more members.

ARTICLE IX-STATE MENTAL HEALTH PLAN

The Council, at all times, shall operate under the scope of the State Mental Health Plan and follow its rules, guidelines and directives.

ARTICLE X-PARLIAMENTARY AUTHORITY

The rules contained in the "Robert's Rules of Order, revised" shall govern this Council and to all cases to which they are applicable and are consistent with these By-laws.

ARTICLE XI-AMMENDMENT OF BY-LAWS

These By-laws may be altered, amended or repealed and new By-laws be adopted by majority vote of Council Members at any regular meeting of the Council and following written notice to all members at least two weeks prior to such meeting. Such changes, however, shall be consistant with the authority granted the Council under the State Mental Health Plan.

Minutes of the State Mental Health Advisory Council

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: October 28, 1976
1:30-4:00 p.m.

PLACE: Division of Mental Health
Pavilion Conference Room

Committee Members Present:

Mr. Magdaleno Avila
Ms. Colleen Cook
Dr. Richard Daetwiler
Ms. Lucy May Dame
Ms. Dorothea Dolan
Ms. Melanie Fairlamb
Mr. Peter Garcia
Ms. Carolyn Huber
Dr. James Lauer
Ms. Dolores Leone
Mr. Luis Medina
Ms. Edna Mosley
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Roger Richter
Mr. Steve Schmitz
Dr. James Syner
Ms. Marge Taniwaki

Absent:

Ms. Karen Litz
Mr. Pete Mirelez
Mr. Clarence VanDeren

Guests Present:

Dr. Capen Farmer
Mr. Armando Pollack
Ms. Elinor Stead
Mr. Lee White

Staff Present:

Dr. James Dolby
Dr. Raymond Leidig
Mr. Youlon Savage

* * * * * * * * *

Dr. James Dolby, Director of the Division of Mental Health, opened the meeting welcoming the Council members and guests and expressed his appreciation of their interest. At the request of Dr. Dolby, Dr. Herbert Pardes, Chairman of the Department of Psychiatry of the University of Colorado Medical Center, acted as Chairperson for this meeting; and, upon agreement of the Council, will continue to do so until January when officers will be elected.

Dr. Dolby discussed the purpose of the Council as set forth in PL 94-63 and the implementing regulations. He also expressed his personal appreciation for the existence of the Council for purposes such as: a forum for input, a corporate body to formulate recommendations, a monitor of State Plan progress, State Plan input and a systematic, careful, thoughtful group to give the Division of Mental Health counsel through the years.

Mr. Lee White of the Governor's Office shared with the group that the Governor is extremely pleased that the members are participating in this function. He stated that there is often confusion as to who this type of council is to report to – in this instance, the Council is to work with the DMH, the key contact persons being Dr. Dolby and Mr. Savage. He urged the Council to be initiative-seeking and also to be consensual in their decision making process. This group represents the state and the mental health needs of the citizens of the state. Mr. White spoke briefly of the talk he delivered for Governor Lamm at the Alcohol, Drug Abuse and Mental Health Administration conference, a copy of which was distributed to Council members.

Dr. Dolby explained the organizational charts of the Department of Institutions and the Division of Mental Health (copies of which are included in Chapter II of the State Plan). Section B of Chapter II, which deals with membership, selection process and functions, responsibilities and procedures of the SMHAC was also reviewed, with the reference to the Council possibly serving as a standing committee of the State Health Coordinating Council (SHCC) (with approval of that body) being noted as very important. Upon request, Mr. Savage elaborated on this, explaining the SHCC's responsibility for development of the total health plan for the state, and the importance of mental health being included in this plan. The SHCC will not be formed until approximately January of 1977.

Discussion moved to a widely shared concern regarding the actual function of the Advisory Council. Members expressed their wish for worthwhile participation and to be heard. Dr. Pardes concluded the discussion with the comment that the opportunity for important contributions exists, and it is up to the Council to take advantage of it.

Mr. Savage reviewed the State Mental Health Plan chapter by chapter, pointing out key sections. The Plan has been reviewed by numerous agencies and organizations. The Plan should have been reviewed by the Council; however, the Plan had to be submitted in June, well before the Council was appointed. Some Council members did have an opportunity to make input into the final Plan through other agencies/organizations. The Standards for Mental Health Centers and Clinics, which will be a part of the State Plan, have undergone a public hearing, and are in the process of finalization by the Attorney General's Office and the Division. If there are any questions regarding the State Plan, members should contact Dr. Dolby or Mr. Savage.

Dr. Leidig spoke briefly to the group. He emphasized the importance of citizen input, and urged the group to focus on meaningful issues rather than getting caught-up in an interminable search for identity.

Roger Richter, Peter Garcia and Jim Syner volunteered to draft some by-laws for consideration.

The Council voted to use the State Fiscal Rules as the basis for reimbursement for travel associated with Council functions.

The Advisory Council requested a tour of some of the mental health facilities and participation in some on-site evaluations. (A schedule of on-site evaluations will be distributed to all members.) The possibility of holding meetings at different locations was also discussed. Members expressed interest in meeting with boards of the centers and clinics and with the Mental Health Association.

The Advisory Council will initially meet on a monthly basis. Members were requested to indicate in writing those days during the month when they cannot meet. An attempt will be made at the next meeting to set a regular meeting time.

The next meeting of the State Mental Health Advisory Council will be at Fort Logan Mental Health Center on Tuesday, November 23, from 2-4 p.m. in Room B-106. Possible agenda items include: base line figures used in the State Plan, budget and key DMH issues. Prior to this meeting, a tour of Fort Logan will be held from noon to 2 p.m. Members desiring to participate in the orientation and tour should meet in Room B-106.

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: November 23, 1976
2:00-4:00 p.m.

PLACE: Division of Mental Health
Conference Room B-106

Committee Members Present:

Ms. Colleen Cook
Ms. Judy Casados (for Mr. Avila)
Dr. Richard Daetwiler
Ms. Lucy May Dame
Ms. Dorothea Dolan
Mr. Peter Garcia
Ms. Carolyn Huber
Dr. James Lauer
Ms. Karen Litz
Ms. Dolores Leone
Dr. Luis Medina
Ms. Edna Mosley
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Roger Richter
Mr. Steve Schmitz
Dr. James Syner
Ms. Marge Taniwaki
Mr. Clarence VanDeren

Guests Present:

Dr. Capen Farmer
Mr. Ernest Ficco
Mr. Armando Pollack
Ms. Elinor Stead
Dr. Thomas Windham

Staff Present:

Dr. Robert Abelson
Mr. Dale Cunningham
Dr. James Dolby
Mr. Jerry Fransua
Dr. Sid Glassman
Mr. Tom Lewis
Mr. Paul Myers
Ms. Noel Nesbitt
Mr. Sam Reynolds
Mr. Youlon Savage
Mr. David Winfrey

Absent:

Ms. Melanie Fairlamb
Mr. Pete Mirelez

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Dr. Pardes welcomed those in attendance and asked those not present at the previous meeting to introduce themselves.

Minutes of the October 28 meeting of the State Mental Health Advisory Council were approved as written and distributed.

Mr. Savage addressed the first agenda item, Baseline Figures Used in the State Plan, which was included on the agenda in response to a request of a Council member. A two-page document entitled "Baselines for State Plan Objectives Which Are Based on Changes in Workload" was distributed and explained by Mr. Savage. He noted that unless otherwise indicated, the objectives pertain to the total public mental health system.

Dr. Dolby introduced Noel Nesbitt, a Program Specialist on the DMH staff. Ms. Nesbitt's specialty area is Adult Alternate Living Facilities, which is a high DMH priority area for new funding. The thrust of this area of programming is the development of a series of alternative residential treatment facilities.

The facilities will be utilized by persons who do not need hospital care, but require ongoing care in a residential setting. A matrix of residential alternatives to inpatient care was distributed and explained by Ms. Nesbitt. (Copy enclosed) In response to Dr. Syner's question, Ms. Nesbitt explained that a narrative will be written for each cell in the matrix.

Ms. Nesbitt informed the Council that mental health standards for nursing homes are scheduled to be developed by the end of January. These standards will be appropriately included in the matrix developed by Ms. Nesbitt and her committee.

Dr. Lauer asked if a similar matrix will be prepared for children and adolescents. He was advised that Dr. Olson and Mr. Reynolds, DMH child and adolescent specialists, respectively, are in the process of determining the various residential treatment needs of children and adolescents and how these can best be met.

Mr. Lewis, DMH Associate Director for Administrative Services, gave the Council a brief explanation of the budgeting process, emphasizing that this process is a year-round activity. The two-page budget summary (distributed with October 28 minutes) was explained by Mr. Lewis.

Ms. Leone suggested that the Council form an ad hoc subcommittee to review the budget document in more detail. The members of this ad hoc budget review subcommittee are Lucy May Dame, Peter Garcia, Jim Lauer and Roger Richter.

The fourth agenda item was reviewed. Dr. Lauer suggested adding the general areas of psychiatry, psychology and social work (and presumably nursing) to the list of possible issues for discussion and/or presentation at future meetings.

Mr. Savage called attention to the memo in the Council members' packets regarding updating of the State Mental Health Plan. He encouraged Council members to review the Plan and provide input on the form provided. Council members were also reminded that they will be reviewing and analyzing the input received in respect to possible changes in the State Plan.

The next meeting of the State Mental Health Advisory Council will be on December 10 at Colorado State Hospital in Pueblo. The first part of the day will be devoted to a tour of CSH, beginning at 10:00 a.m.; the second part of the day will be set aside for a meeting of the SMHAC from 1-4 p.m. (Lunch will be provided for all members at 12:00.) Members were asked to let Ms. Oglesby know which portion they are interested in attending for purposes of coordinating transportation.

Future meetings of the State Mental Health Advisory Council will be held on the second Thursday of each month.

Sally Oglesby
Sally Oglesby
Recording Secretary

Distribution: SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
John Aycrigg
Carol Barbeito
John Bliss
Ernest Ficco
Henry Frey
Charles Meredith
Steve Jordan
Raymond Leidig
Elinor Stead
Lee White
Staff - DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: December 10, 1976
1:15-3:30 PM

PLACE: Colorado State Hospital

Committee Members Present:

Ms. Lucy May Dame
Ms. Dorothea Dolan
Mr. Peter Garcia
Dr. James Lauer
Ms. Karen Litz
Dr. Luis Medina
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Clarence VanDeren

Guest Present:

Dr. Ronald C. Werner

Staff Present:

Dr. James R. Dolby
Dr. Connie Olson
Mr. Sam Reynolds
Mr. Youlon D. Savage

Absent:

Mr. Magdaleno Avila
Ms. Colleen Cook
Dr. Richard Daetwiler
Ms. Melanie Fairlamb
Ms. Carolyn Huber
Ms. Dolores Leone
Mr. Pete Mirelez
Ms. Edna Mosley
Mr. Roger Richter
Mr. Steve Schmitz
Dr. James Syner
Ms. Marge Taniwaki

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Several Council members participated in a mini-tour and presentation of Colorado State Hospital from 10 AM-12 Noon.

1. Minutes: Dr. Pardes called the meeting to order. A motion was made that the minutes of the previous meeting be approved; the motion was seconded and carried.

2. Residential Child Care Facilities (RCCF): Dr. Connie Olson, Program Specialist in the area of children's services for the Division of Mental Health, presented background information on the study of RCCF's which was mandated by footnote 45 in this year's Long Bill. The mandate was that "By January 1, 1977, the Department of Social Services, Department of Institutions, and the Office of State Planning and Budgeting are to provide a report comparing cost and treatment effectiveness and program evaluation of residential programs with those at Fort Logan and Colorado State Hospital."

A task force was established with representatives from the three state departments and the RCCF's. The State Office of Planning & Budgeting (SOPB) assumed over-all responsibility for the study. There is some concern that the study will not be well-designed, and the misleading results could prove destructive to existing children's programs. Dr. Dolby recommended that SOPB contract with staff from the Department of Child Psychiatry at the University of Colorado Medical School. It is not known what action SOPB will take in respect to Dr. Dolby's recommendation.

A meeting was held this week between the designated departments and the Joint Budget Committee (JBC). Dr. Dolby again expressed his dissatisfaction with the methodology of the study. The Executive Director of SOPB maintains that the study will be done, and that it will be a "good" report. The JBC extended the deadline to March 1, 1977, with interim reports due between January and March.

Because of the significance of this study, the Council members discussed various ways they might assist in influencing the staff of SOPB to design and conduct the study in such a way as to ensure valid results. Dr. Pardes suggested the formation of an ad hoc committee to study the entire subject in depth and bring back a report and suggestions to the next meeting. Mr. Quinn made this motion, Mr. Garcia seconded, and motion carried. The subcommittee members are: Dr. Lauer who will chair the group (he asked that he be removed from the budget subcommittee), Ms. Litz, and Dr. Medina.

3. Child and Adolescent Mental Health Services: The presentation was postponed to the February meeting. However, Mr. Sam Reynolds, Program Specialist in the area of adolescent services, gave a brief outline of the Division's extensive involvement in child and adolescent services. Dr. Lauer commented that this was the first year that DMH has actively promoted children's and adolescents' services to this extent.

4. Review of Process for Establishing Goals and Objectives in the State Plan:

Postponed for a future meeting.

5. Presentation by Colorado Association of Community MH Centers & Clinics (CACMHCC):

Dr. Ronald C. Werner, Executive Director of the West Central Mental Health Center in Canon City, was introduced. He explained that CACMHCC is an organization of twenty-four community agencies which receive funding from the DMH. All but two of these facilities are private, non-profit corporations. CACMHCC is comprised of both professional and private citizen representatives of individual centers and clinics. The Association has an Executive Committee which includes representatives from the two state hospitals who are associate members. There are several functioning committees which have been actively working with staff of DMH on such matters as budgeting concerns, unit cost, and program evaluation. The organization has one part-time employee who is quite effective as a legislative consultant and representative. The Association is funded by membership dues which will be increased in the near future. There have also been grant awards from 314(d) funds for specific projects, one of which is a salary and classification study of centers and clinics.

While the Association is an independent corporation, it endeavors to work with DMH and others on a cooperative basis, and is systems oriented. At this point Dr. Pardes emphasized the concept of a "total mental health system" and mentioned the problems which can develop when one segment attempts to undermine another part of the system. This is an area which may require more attention. Dr. Werner stated he would carry this message back to the Association. He added this is one reason for having representatives from each of the state hospitals on their Executive Committee. Dr. Dolby stated that one of his great pleasures when he came to Colorado was to find that the Association was so active. The cooperation is about as good as could be hoped for, and the Association is a real ally to the Division.

Thanks was expressed to Dr. Werner for his comprehensive presentation.

6. Announcement: The Division of Mental Health will have its JBC hearing the afternoons of January 6 and 7, and these are open to the public. Council members will still have an opportunity for input into the budget process as negotiations take place.

According to Mr. Garcia, the budget subcommittee has not met yet, but will probably do so prior to the next meeting.

7. Next Meeting: The next meeting will be on January 13, 1976, in the Pavilion Conference Room (where the first meeting was held), second floor of the E Building, 4150 South Lowell Boulevard, Denver. Because of the extensive agenda, the members decided to convene at 1 PM rather than 2 PM and, if necessary, go later than the four o'clock schedule.

The agenda is as follows:
a) Report from subcommittee on RCCF Study
b) Report from budget subcommittee
c) Bylaws
d) Election of officers

Doris D. Davis
Recording Secretary

Distribution:
SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
John Aycrigg
Carol Barbeito
John Bliss
Ernest Ficco
Henry Frey
Robert Herrmann
Steve Jordan
Raymond Leidig
Elinor Stead
Lee White
Staff-DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: January 13, 1977
1-4 p.m.

PLACE: Division of Mental Health

Committee Members Present:

Dr. Richard Daetwiler
Ms. Dorothea Dolan
Ms. Melanie Fairlamb
Ms. Carolyn Huber
Dr. James Lauer
Ms. Dolores Leone
Ms. Karen Litz
Dr. Herbert Pardes (Chairperson)
Mr. Jack Quinn
Mr. Roger Richter
Mr. Steve Schmitz
Ms. Marge Taniwaki
Mr. Clarence VanDeren

Absent:

Mr. Magdaleno Avila
Ms. Colleen Cook
Ms. Lucy May Dame
Mr. Peter Garcia
Dr. Luis Medina
Mr. Pete Mirelez
Ms. Edna Mosley
Dr. James Syner

Staff Present:

Mr. Dale Cunningham
Dr. James Dolby
Mr. Tom Lewis
Mr. Youlon Savage

Guest:

Ms. Elinor Stead

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Approval of Minutes - Dr. Pardes

The meeting was called to order by Dr. Pardes. The minutes of the December 10 meeting were approved as written.

Report of the Budget Subcommittee - Mr. Richter

The Budget Subcommittee felt that their role was unclear; as they view it, the primary purpose of this subcommittee is to make recommendations as to the Council's role in the DMH budget process and to carry out this role in the continuous budget cycle.

Because of the late establishment of this Council, they could not participate effectively in the budget process this year. However, the subcommittee did have the opportunity to review the material for the JBC presentation.

It was recommended by the Subcommittee that a standing budget committee be formed to function throughout the year, beginning at this time. This committee would be the most active section of the Council; it will require participation in the year-round budget process.

Dr. Lauer asked for clarification of the Council's role in the fiscal area, in that involvement in the budget could be seen as going far beyond the State Plan. After some discussion, it was decided that the Budget Subcommittee is very relevant to the Plan, as the budget is a statement of the resources necessary to implement the Plan. A standing Budget Subcommittee will be formed. The committee will consist of the present members of the Subcommittee (Mr. Richter, Ms. Dame and Mr. Garcia) and two

additional Council members. Mr. Lewis will be the staff person assigned to the Subcommittee.

Mr. Richter will draft a letter to be sent to the Governor and the JBC expressing the Council's support of the 14.5 million dollar budget initially recommended by DMH. The letter will point out how the objectives in the State Plan relate to the 14.5 million. It was noted that the 14.5 million dollar budget is consistent with the recommendations of the Mental Health Association of Colorado and the Colorado Association of Community Mental Health Centers and Clinics. The second portion of the letter will address the Council's awareness and concern over the serious deficit which is developing in the Colorado State Hospital budget. Some causative factors are:

1. reduction in geriatrics inpatients;
2. over-estimation of third party income;
3. central collecting agency not successful in collecting bad debts;
4. accounting system changed from a cash basis to an accrual basis;
5. expected increase in Medicaid and Medicare rates did not occur.

The short-fall is $1,600,000; however adjustments will be made within the DMH which will reduce the supplemental request to around $800,000. The hearings on supplemental requests will be held at the end of January or the beginning of February. The presence of Council members is desirable.

DMH staff mentioned an important policy and budget request issue that the Council should be aware of: DMH is taking a risk in asking for an increase in funding only for community mental health centers and clinics, rather than in each of the state hospitals and the centers/clinics. The decision to request that all new state general funds for mental health services be appropriated for centers and clinics was based on the following assumptions:

1. that the practice of padding budgets is irresponsible management; and
2. that the budget request should relate directly to the State Plan; and
3. that since the main thrust of the State Plan is local availability of mental health services, new state dollars should be directed to meet the needs of high risk clients as close to their homes as possible; i.e., in community mental health centers and clinics; and that
4. the Joint Budget Committee and other members of the legislature are aware of the DMH's efforts to contain costs, follow a well-developed plan and otherwise exercise good management; and that
5. the pay-off for good management should be increased funding for needed services.

The increase sought by DMH is less than 5%.

Report of the Subcommittee on the Residential Child Care Facilities Study (Footnote 45)
Dr. Lauer

Footnote 45 is an effort on the part of the JBC to obtain comparable information about the cost and effectiveness of children's services in the state hospitals and residential child care facilities (RCCF). Dr. Lauer summarized his Subcommittee's meeting with the State Office of Planning and Budgeting. Some highlights of the report are as follows:

1. The study has revealed the need for a better means of classifying children in need of mental health services;
2. Most child patients are placed on the basis of what facility is available rather than on the basis of the child's specific service needs;
3. The study has dramatically increased the cooperation and collaboration between the RCCFs and DMH;
4. Dr. Coppolillo of the University of Colorado Medical School has agreed to assist with the study, and has already initiated a contact with Fort Logan.

Dr. Lauer believes progress is being made. He will keep the Council apprised of new developments.

By-laws - Mr. Richter

The proposed by-laws for the State Mental Health Advisory Council were reviewed by the Council. They were adopted as changed by the Council. (An updated copy is being distributed to all members with the minutes. Additional copies of the by-laws are available at DMH.)

Election of Officers

The results of the election of officers is as follows:

Dr. Herbert Pardes - Chairperson
Mrs. Dorothea Dolan - Vice-Chairperson

Sally Oglesby will continue as the recording secretary. Roger Richter will serve as Chairperson of the Budget Subcommittee.

Update of the State Plan

Input to the update of the State Mental Health Plan is due by January 30. A time-table for completion of the update is being developed. Once the input has been assembled and organized by chapter, copies will be sent to SMHAC members. It was suggested that two Council members meet with the State Mental Health Plan Committee, which will be responsible for the actual updating of the Plan.

Next Meeting

The next meeting of the State Mental Health Advisory Council will be on February 10 from 1:30-3:30 p.m. at Fort Logan Conference Room B-108. (Agenda enclosed.)

Sally Oglesby
Sally Oglesby
Recording Secretary

Distribution:
SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
Carol Barbeito
John Bliss
Ernest Ficco
Henry Frey
Steve Jordan
Elinor Stead
John Aycrigg
Robert Herrmann
Raymond Leidig
Lee White
Staff - DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: February 10, 1977
1:40-4:00

PLACE: Division of Mental Health
B-108

Committee Members Present:

Colleen Cook
Richard Daetwiler
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Carolyn Huber
James Lauer
Dolores Leone
Karen Litz
Luis Medina
Herb Pardes (Chairperson)
Jack Quinn
Roger Richter
Steve Schmitz
James Syner
Marge Taniwaki
Clarence VanDeren

Absent:

Magdaleno Avila
Pete Mirelez
Edna Mosley

Guests:

Sandy Farmer
Sophia Sanderson (for Mr. Avila)

Staff Present:

James Dolby
Pat Horton
Dick Noble
Sam Reynolds
Youlon Savage
Dave Winfrey

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Approval of Minutes: Dr. Pardes, Chairperson, called the meeting to order at 1:40 p.m. A motion was made and passed approving the minutes of the January 13 meeting.

Discussion of Relationship Between Division of Mental Health and Alcohol and Drug Abuse Division: Mr. Dave Winfrey, Substance Abuse Program Specialist of the DMH staff, gave a presentation on the relationship between DMH and ADAD. The letter of agreement between DMH and ADAD and the memo co-signed by Ken Kirkwood (Acting Director of ADAD) and Dr. Dolby to David Foote of the Human Services Policy Council (entitled, "Progress Report on Collaborative Efforts Between DMH and ADAD) were discussed. (These two items were distributed to Council members at the January meeting.)

A subcommittee was formed to take a closer look at the interface between DMH and ADAD as it relates to funding, services, monitoring, etc. The members of the subcommittee are:

Dolores Leone, Chairperson
Dorothea Dolan
Dick Daetwiler
Colleen Cook
Karen Litz

Mr. Winfrey will be available to the subcommittee as needed.

RCCF Study Update: Dr. Lauer reported that work continues on the attempt to develop a uniform classification system. When it reaches a useable stage, this system will probably be piloted in RCCFs.

Report of the Budget Subcommittee: Mr. Richter reported that the letters regarding the Council's stand on the budget requests were sent to the Governor and to the JBC. DMH and the subcommittee are prepared for a hearing on the CSH supplemental request. However, the hearing may not be necessary, as the Governor may use revenue sharing funds for the supplemental or the JBC may make a decision without a presentation by the Division.

Mr. Steve Schmitz will fill the vacancy on the Budget Subcommittee.

Continuation of Discussion on Children and Adolescents: Mr. Sam Reynolds, Adolescent Program Specialist of the DMH, continued his presentation which began at the December 10 meeting. This presentation consisted of review of the packet of material regarding child and adolescent services, which Council members received.

Ms. Dolan requested that data be obtained from the DMH statistical section as a means of determining how well the objectives in the State Plan are being met. This data will include the total number of admissions of children, adolescents and elderly, and the percent increase/decrease in admissions in FYs 75-76 and 76-77.

State Mental Health Plan Committee: The Council members who will work with the State Plan Committee and the areas they will review are as follows:

Peter Garcia - minorities
Jim Lauer - children/adolescents
Lucy May Dame - geriatrics
Dolores Leone - chapter on objectives
Dorothea Dolan - priority listings
Colleen Cook - total plan

The State Mental Health Plan Committee will begin meeting in a couple of weeks.

Executive Committee: The complete Executive Committee of the SMHAC consists of:

Herb Pardes
Dorothea Dolan
Melanie Fairlamb
Luis Medina

Items for Discussion at Future Meetings: The following items were suggested for discussion at future meetings:

Report of Alcohol & Drug Abuse Subcommittee
Feedback on State Plan
Data Requested from DMH
Status of State Health Coordinating Council
Presentation from the Mental Health Association

Next Meeting: The next meeting of the SMHAC will be held on March 10 from 1:30-4:00 p.m. at the Division of Mental Health Conference Room B-106. The entire meeting will be devoted to review of the State Plan. Members are requested to bring their individual copies of the Plan to this meeting.

Sally Ogilesby
Recording Secretary

Distribution:

SMHAC Members
Executive Directors
Board Presidents
Board Contact Person
Carol Barbeito
John Bliss
Ernest Ficco
Henry Frey
Steve Jordan
Elinor Stead
John Aycrigg
Haydee Kort
Raymond Leidig
Lee White
Staff-DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: March 11, 1977
1:45-3:30

PLACE: Division of Mental Health
B-106

Committee Members Present:

Dorothea Dolan
James Lauer
Herb Pardes, Chairman
Luis Medina

Staff Present:

Dale Cunningham
James Dolby
Sid Glassman
Sam Reynolds
Youlon Savage

Absent:

Magdaleno Avila
Colleen Cook
Richard Daetwiler
Lucy May Dame
Melanie Fairlamb
Peter Garcia
Carolyn Huber
Dolores Leone
Karen Litz
Pete Mirelez
Edna Mosley
Jack Quinn
Steve Schmitz
Roger Richter
James Syner
Marge Taniwaki
Clarence VanDeren

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The meeting began at 1:45. The approval of minutes was deferred until the next meeting, since so few members were present.

Dr. Pardes gave a brief summary of the Senate HEWI Committee hearing on Senate Bill 221 (physicians' salaries). The general feeling was that the hearing went quite well.

Dr. Dolby updated the group on the legislative process of figure setting for the state hospitals and the centers/clinics. Although several figures have been considered, no definite decisions have been made. It is expected that the Long Bill will be out by the first of April. When we know the specific recommendations, we can decide what further action, if any, should be taken.

Dr. Pardes reviewed the report on the meeting involving representatives of the Handicapped Advisory Councils, which was sent to SMHAC members. It appears that the role of this group is very unclear. It was decided that further investigation should be made regarding the purpose of such a group before we decide if the SMHAC will be a participant.

Review of the State Plan was postponed until the next meeting, when the members of the State MH Plan Committee will be present to review suggested revisions of the State Plan. Council members will be mailed copies of the proposed update material prior to the next meeting.

The next meeting of the SMHAC will be on April 14 at the Division of Mental Health in Conference Romm B-108. The Alcohol and Drug Abuse Subcommittee will hold a meeting, before the Council meeting, at 12 noon in the Fort Logan cafeteria. (The last meeting was cancelled.)

Sally Oglesby
Recording Secretary

Distribution:

SMHAC Members	John Bliss	John Aycrigg
Executive Dir.	Ernest Ficco	Haydee Kort
Board Pres.	Henry Frey	Raymond Leidig
Board Contact	Steve Jordan	Lee White
Carol Barbeito	Elinor Stead	Staff-DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: April 14, 1977
1:45-4:45 p.m.

PLACE: Division of Mental Health
B-108

Committee Members Present:

Colleen Cook
Richard Daetwiler
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Carolyn Huber
James Lauer
Karen Litz
Luis Medina
Herbert Pardes (Chairman)
Jack Quinn
Roger Richter
Steve Schmitz
Marge Taniwaki

Staff Present:

Bob Abelson
James Dolby
Sid Glassman
Paul Myers
Sam Reynolds
Al Sanchez
Youlon Savage
Fran Walker
Dave Winfrey

Absent:

Magdaleno Avila
Dolores Leone
Pete Mirelez
James Syner
Clarence VanDeren

Guests:

John Aycrigg
Richard Cripe
John DeHaan
Myles Edwards
Sandy Farmer
Ursula Garcia
Jerry Grossfeld
Bob Hawkins
Ernest Martinez
Floyd Martinez
Terry McGrann
Eugene Meeks
Larry Osaki
Robert Rabinowitz
Vicki Robbins
Elinor Stead
Phillip Swihart
Elaine Ulibarri
Chuck Vorwaller
Harry Walters
Fred Wells
Ron Werner

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The meeting was called to order at 1:45 p.m., and the minutes of the previous meeting were approved.

Dr. Dolby informed the group of the current budgetary situation. At the present time, there are five critical issues:

1. elimination of staff positions and reduction of budget in children and adolescent programs at Fort Logan
2. insufficient funds for sprinkler system at Fort Logan (could cause loss of accreditation for programs housed in affected buildings)
3. only 12.3 of the 13.5 million requested for centers/clinics has been recommended by the JBC. The way in which the funds are appropriated severely limits the DMH's flexibility in allocating the dollars.
4. insufficient funds for utilities at CSH
5. structural weakness in the Maximum Security Unit at CSH

In response to these issues, the Committee will send two letters: the first addressed to Members of the Colorado State Legislature urging reconsideration of above items 1, 2 and 3. The second addressed to Senator Strickland (Chairman, Senate Appropriations Committee) and Representative Herzberger (Chairman, House Appropriations Committee) calling attention to supplemental funding requests, above items 4 and 5. The first memo will be distributed Friday; the second, Monday.

Committee members were urged to speak personally with legislators regarding these matters.

Elinor Stead updated the Committee on what is currently happening at the legislature in regard to mental health funding.

The review of the draft of the update of the State Plan constituted the agenda for the last half of the meeting. Representatives of centers/clinics and voluntary agencies, such as Human Services, Inc. and Jewish Family and Children's Services, were also present to offer their input. A chapter by chapter review was begun with major emphasis on the objectives. Recommendations were made for additional objectives, alteration of existing objectives, etc. Mention was made of the need for stronger coordination between the public sector and the voluntary/private sector. In the final writing of the update, the Division will keep in mind the concern that the system is being driven beyond its capacity, and that while statewide priorities are necessary, agencies must have some latitude to address local needs. Council members and others were encouraged to use the forms developed by the Division to record their recommendations. The detailed review of the objectives and the balance of the Plan will be continued at the next meeting.

Ms. Fairlamb recommended that the review be continued at the next regular meeting to allow adequate time for Council members to individually review the document.

The next meeting of the State Mental Health Advisory Council will be held on May 12 from 1:30-4:30 p.m. in DMH Conference Room B-108. Since there is a large volume of material to be covered, the meeting will begin promptly at 1:30.

The Substance Abuse Subcommittee will meet at 12 noon in the Fort Logan cafeteria, prior to this Council meeting.

Sally Ogilesby
Recording Secretary

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Haydee Kort
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Maryellen Waggoner
Staff - DMH

MINUTES:

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: May 12, 1977
1:30-4:00 PM

PLACE: Division of Mental Health
B-108

Committee Members Present:

Richard Daetwiler
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Carolyn Huber
James Lauer
Dolores Leone
Luis Medina
Herbert Pardes (Chairman)
Jack Quinn
Roger Richter
Steve Schmitz
James Syner
Clarence VanDeren

Absent:

Magdaleno Avila
Colleen Cook
Peter Garcia
Karen Litz
Pete Mirelez
Marge Taniwaki

Guests:

Sandy Farmer
Bob Hawkins
Paul Isenstadt
Earl McCoy
Larry Osaki
Elinor Stead
Maryellen Waggoner

Staff Present:

Bob Abelson
James Dolby
Sid Glassman
Connie Olson
Sam Reynolds
Al Sanchez
Youlon Savage

* * * * * * *

Dr. Pardes called the meeting to order. He announced that Ms. Mosley had resigned from the Council recently because of illness. Any recommendations for replacement should be made to the Governor.

Legislative Review: Dr. Dolby gave an update on the five budgetary issues listed at the last meeting: 1) he understands that funds have been reinstated for the children's and adolescents' program at Fort Logan; 2) funds for the Fort Logan sprinkler system are not in the Long Bill at this time; 3) there are no new funds for community programs - there are still the two categories: continuation and high risk; 4) there has been $100,000 restored for utilities at CSH, and hopefully the remainder will be forthcoming; 5) funds to secure the Forensic Unit at CSH are not in the bill at the present time. He stated that everyone's efforts in these funding requests have been well received. Dr. Pardes expressed appreciation to the staff, members of the Council, and to Ms. Stead.

Review of State Plan: The members continued their review of the Plan, starting with Goal #3. Discussion centered around some issues on children, adolescents, elderly, and rural residents. It was suggested that a statement at the beginning of Chapter III, such as a Preamble, be included to give an overall view about the development of resources, working with other agencies, availability of funds, and the matter of transportation. This would perhaps relieve some of the anxieties which have been expressed during the review process. Mr. Savage agreed that this would be done. He stated that the next step was a review by DMH staff in terms of the total input from the various organizations, etc., in preparation for the final document.

Next Meeting: June 9, 1977, 1:30-4:00 PM, Conference Room B-108.

The agenda is:
1. Drug and alcohol report
2. Discussion of two committees, corrections and minority
3. Site visit process
4. Council's program for year
5. Membership issues
   a. Absentee members
   b. Membership terms
6. Public education regarding support for mental health

Doris D. Davis
Recording Secretary

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Raymond Leidig
Maryellen Waggoner
Staff-DMH

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: June 10, 1977
1:30-4:00 p.m.

PLACE: Division of Mental Health
B-108

Committee Members Present:

Richard Daetwiler
Dorothea Dolan
Peter Garcia
Carolyn Huber
Josie Johnson
Dolores Leone
Karen Litz
Luis Medina
Herbert Pardes (Chairman)
Jack Quinn
Roger Richter
Steve Schmitz
Marge Taniwaki

Absent:

Magdaleno Avila
Colleen Cook
Lucy May Dame
Melanie Fairlamb
James Lauer
Pete Mirelez
James Syner
Clarence VanDeren

Guests:

Sandy Farmer
Bob Hawkins

Staff Present:

Dale Cunningham
James Dolby
Noel Nesbitt
Connie Olson
Sam Reynolds
Youlon Savage
Dave Winfrey

* * * * * * *

Dr. Pardes called the meeting to order and the minutes of the May 12 meeting were approved as written.

Dr. Pardes introduced Ms. Josie Johnson, a new Council member appointed to fill the vacancy left by Ms. Mosley. Ms. Johnson is the Executive Assistant to the Lieutenant Governor.

Ms. Leone, Chairperson of the Substance Abuse Subcommittee, summarized the minutes of their two meetings (minutes previously distributed to Council members). The Council reviewed the recommendations submitted by the Subcommittee. These recommendations were responded to favorably by the Council, and the Subcommittee was asked to begin implementation of their recommendations and make a progress report to the Council in approximately four months. Dr. Dolby invited all those interested to attend the monthly meetings between DMH and ADAD.

Formation of an ethnic minority mental health task force was discussed. It was recommended that the present Minority Mental Health Task Force (ad hoc committee to DMH) be the base for establishment of an ethnic minority standing committee to provide input to the Council concerning mental health needs of ethnic minorities. Ms. Litz urged that Council members and consumers be included in the composition of this subcommittee. Dr. Pardes will speak with Ms. Taniwaki about chairing this subcommittee.

Regarding the development of a subcommittee on corrections issues, it was decided that Dr. Aycrigg and someone from the Department of Corrections should visit with the Council to discuss the mental health service needs of persons in the corrections system, and ways of meeting these needs. A decision concerning possible action by the SMHAC will be made following the presentation.

The issue of absentee members was discussed. It was pointed out that Mr. Avila and Mr. Mirelez have three consecutive absences. In accordance with the bylaws of the Council, a letter will be sent to Mr. Avila and Mr. Mirelez requesting that they submit their resignations.

A request will be made to the Governor that all active members who were appointed for a one-year term and are willing to serve another term, be reappointed for a two-year term.

Mr. Savage briefly reviewed the policy on participation in on-site evaluations, a copy of which was distributed. Ms. Nesbitt discussed the Revised On-Site Evaluation Instrument (ROSEI II) which should be finalized for typing next week. This document was established in accordance with the Standards/Rules and Regulations for Mental Health Centers and Clinics. The document was sent to all centers/clinics for review, but little response has been received. Suggestions were made for continued improvement in the site visit process.

The Council sent a letter (drafted by Mr. Schmitz) to the Presidential Commission on Mental Health, endorsing five candidates (Roberto Quiroz, Karen Litz, Charles Vorwaller George Bachik and Robert McKeown) for testimony before the Commission in Tucson on June 20.

Ms. Dolan informed the Council that she has been appointed to President Carter's Rural Task Panel. (She pointed out that President Carter prefers "task panel" to "task force".)

Public education to increase public support for adequate funding for mental health services was discussed. The structuring of a public education effort was assigned to the Budget Subcommittee, which will work in collaboration with DMH staff. Dr. Dolby mentioned that the Public Information Officer position has been abolished by the legislature as of July 1, 1977.

Suggestions for agenda items and activities from September on are as follows:

- presentation by the Mental Health Association
- visits to programs
- review of plans submitted by centers/clinics for services to children, adolescents and elderly
- review of partial report on the first quarter objectives
- review data reports ("Orchid Reports") in terms of the State Plan
- discuss 314(d) proposals
- review progress on Footnote 45 Study
- presentation on new federal mental health initiatives
- evaluation of Council's progress during its first year
- presentation on unit cost; its advantages and disadvantages
- review of Standards/Rules and Regulations for MH Centers and Clinics
- presentations from and discussions with representatives of the private and voluntary sectors

The next meeting of the State Mental Health Advisory Council will be held in conjunction with the Annual Mental Health Conference in Vail on Sept. 16, from 5-7:30 PM (tentatively). This date will take the place of the regular "second Thursday of the month" date this time only. Dr. Dolby will check into the possibility of funds from the Annual Mental Health Conference being used to supplement Council member's attendance. Mr. Schmitz and Ms. Fairlamb will arrange a social "get together" to provide an opportunity for Council members to mingle after the meeting. Mr. Winfrey, the DMH representative on the Executive Committee of the Conference, will be asked to assist in finding a site for the meeting and social function.

The agenda for this meeting will include discussion of the State Plan and the Budget.

The Substance Abuse Subcommittee will meet at 11:30, Thursday, August 11 at Fort Logan in Room A-200. Everyone is invited to attend.

Sally Oglesby
Recording Secretary

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More information on the meeting place and social gathering will be forthcoming.

APPENDIX II

REPORT OF THE COLORADO CHICANO MENTAL HEALTH PLANNING SYMPOSIUM

COLORADO CHICANO MENTAL HEALTH PLANNING SYMPOSIUM

Preliminary Summary of Proceedings

Colorado State Hospital
Pueblo, Colorado

March 25, 1977

Sponsored by

Chicano Symposium Committee
Mental Health Center of Boulder County, Inc.
Boulder, Colorado

Members of the Colorado Chicano Mental Health Planning Symposium met on Friday, March 25, 1977 at the Colorado State Hospital in Pueblo, Colorado. The purpose of the meeting was to discuss and agree on revisions to the State of Colorado Mental Health Plan '76 - '81 regarding goals and objectives for ethnic minorities, focusing on Chicanos. For this purpose, the following persons attended the meeting:

Participant	City
Criselda Mondragon Cole	Denver
Grady Dale	Colorado Springs
Ed Espinoza	Pueblo
Ursula Garcia	Denver
Gregorio Kort, M.D.	Pueblo
Haydee Kort, M.D.	Pueblo
Anita Martinez	Boulder
Floyd H. Martinez, Ph.D.	Boulder
Richard Martinez	Cañon City
John Ortega	Pueblo
Roberto Quiroz	Pueblo
Mario R. Rodriguez	Florence
Albertino Salazar	Pueblo
Marguerite Salazar	Cañon City
Wayne Smyer	Pueblo
Elaine Ulibarri	Denver

Anita Martinez opened the symposium by welcoming the participants and asking them to introduce themselves and provide a brief statement

concerning their activities in the mental health field. Following the introductions, Ms. Martinez discussed the purpose of the meeting. She then introduced Dr. Haydee Kort, Superintendent of the Colorado State Hospital. Dr. Kort reported that Dr. James R. Dolby, Director of the Division of Mental Health, was unable to attend the symposium because he had to attend legislative sessions in Denver to discuss issues relative to the state mental health budget. Dr. Kort related that Dr. Dolby regretted not being able to attend the meeting, but had emphasized that it was critical for the Chicano Symposium to provide input to the state Mental Health Plan by April 1, 1977.

Introduced next was Dr. Floyd Martinez who gave a brief historical background of the Chicano Symposium, and shared his views concerning the social climate existing today in American society in relation to the poor, disadvantaged, and minorities. Dr. Martinez then addressed the two major items in the Mental Health Plan which the group had met to discuss, revise, and update. The first item was Goal #3, part f, on page III.24 of the plan, dealing with the provision of mental health services to ethnic minorities; the second item was Appendix II of the plan, regarding the concerns of the Chicano Mental Health Planning Symposium.

Following protracted discussion, the group agreed to recommend to the Division of Mental Health (DMH) the establishment of a new goal under which objectives and sub-objectives would be listed in order of priority. The members felt strongly that the mental health concerns of ethnic minorities, which are included as one component of ten in Goal #3 of the present plan, needed to be elevated to a separate goal--Goal #6. Because of the tremendous needs within the minority groups, the participants agreed that a goal concerned only with "ethnic people of color" would identify this concern as requiring individual treatment. Of

course, this symposium would make recommendations specific only to the Chicano community.

Listed below is the recommended new goal; objectives and sub-objectives are arranged in order of priority, within the time frame for the accomplishment of each objective and sub-objective.

Goal #6

To insure provision and availability of special mental health services to ethnic people of color.

Chicano Objectives

1. DMH will assume the responsibility to maintain a continuing dialogue with representatives of the Chicano community through the following mechanisms:

   a. DMH will allocate a slot in its Master Plan Committee for a representative from the Chicano Mental Health Planning Symposium.

   b. 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.

   c. 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.

   Priority time frame: As soon as possible; no later than July 1, 1977.

2. DMH will allocate funds for the establishment of one or more specialized Chicano mental health resource centers.

   Priority time frame: July 1, 1977

3. DMH will build into the site evaluation format specific criteria for assessing the adequacy of services to Chicanos by community programs, clinics, and hospitals.

   a. Each center/clinic will comply or will demonstrate plans to comply with PL 94-63 pursuant to requirements for serving clients in their own language and cultural context, (Section 206, D).

   b. 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.

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

   Priority time frame: FY '77-'78

4. The staff development program will continue to develop and apply a curriculum on Chicano services for staff development on a statewide basis.

   a. 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.

   Priority time frame: FY '77-'82

5. DMH will conduct a survey of each catchment area of the State of Colorado to gather descriptive information as to the kind of efforts extant serving/meeting the diverse needs of Chicano clients.

   a. mental health centers, clinics/hospitals staffing patterns

   b. client profile

c. community demographic characteristics

d. ethnic mix of governing boards

Priority time frame: January, 1978

6. Conduct a survey of programming efforts to serve the special needs of the Chicano client.

Priority time frame: January, 1978

7. By January 1, 1978, the DMH 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.

Priority time frame: January 1, 1978

8. DMH will update the talent bank of minority health professionals and other knowledgeable people to assist in staff development functions and determine the special mental health needs of Chicanos. 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.

Priority time frame: January 1, 1978

9. In its 1978-79 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.

Priority time frame: FY '78-'79

10. During fiscal year 1978-79, DMH will fully implement the research and development projects initiated under Phase 1 (FY '76-'77).

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.

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

b. Close attention will be paid to the transportability of each model to other areas of the state.

Priority time frame: FY '78-'79

11. In light of the disproportionate number of Chicanos in the Corrections system, DMH will initiate close program collaboration with Division of Corrections on behalf of Chicano clients.

a. intramural programs

b. community programs

Priority time frame: FY '78-'79

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

a. DMH will request state funds to program for Spanish-speaking clients in their own language and cultural context in every catchment area with at least 5% Chicanos.

Priority time frame: FY '78-'79

13. DMH state budget for '79-'80 will routinely request funds for services to the Spanish-speaking population in its own language and cultural context.

Priority time frame: FY '79-'80

14. By July 1, 1980, information from the special research and demonstration projects for Chicanos will be reflected in the services provided by centers/clinics and hospitals.
Priority time frame: July 1, 1980

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

a. 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.

Priority time frame: FY '80-'81

16. By the end of FY '81-'82, every catchment area with 5% Chicano population will have developed the capacity to serve that population in its own language and cultural context.
Priority time frame: FY '81-'82

17. By 1981-82 DMH staffing pattern will reflect Chicano representation throughout all levels of administration.
Priority time frame: FY -81-'82

The meeting was adjourned at 4:45 p.m.

Note: Issues relating to other ethnic minorities (Blacks, Native Americans, Asian Americans) will be addressed in future meetings of their own.

APPENDIX III

UPDATED NEED RANKINGS OF THE CATCHMENT AREAS

UPDATED NEED RANKINGS OF THE CATCHMENT AREAS

Catchment Area		Rank on Resources Inventory	Rank on Social Indicators	Weighted Score*	FINAL RANK
1	NE Colo	4	12	28	9
2a	Weld	11	9	29	10
2b	Larimer	9	14	37	12.5
3a	Adams	7	13	33	11
3b	Arapahoe	19	20	59	21
3c	Boulder	13	17	47	18.5
3d	Jeffco	5	21	47	18.5
3e	Bethesda	8	18	44	16.5
3f	NW Denver	15	1	17	3
3g	Park East	10	8	26	6.5
3h	SW Denver	14	15	44	16.5
3i	Aurora	16	16	48	20
4	Pikes Peak	18	11	40	14.5
5	E Central	2	19	40	14.5
6	SE Colo	1	4	9	1
7	Span Peaks	21	3	27	8
8	San Luis	20	2	24	5
9	SW Colo	3	5	13	2
10	Midwestern	6	6	18	4
11,12	Colo W	17	10	37	12.5
13	W Central	12	7	26	6.5

*Weighted Score = Social Indicator Rank times 2, plus Inventory Rank

APPENDIX IV

AVAILABILITY OF COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES IN THE 21 CATCHMENT AREAS (PER PL 94 - 63)

(1)AVAILABILITY OF COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES IN THE 21 CATCHMENT AREAS (per PL 94-63)

Catchment Area and Agency	Region	HSA	inpatient	other (non-hosp) 24-hour care(2)	partial hospitalization	outpatient	24-hour emergency services	specialized serv for childrn	specialized serv for elderly	consultation & education (incl rape prevention)	assistance to courts & other public agencies (prescreening)	follow-up care	alcoholism services	drug abuse services
1 NE Colo	1	1		X	X	X	X	X	X	X	X	X	X	
2 Weld	2a	1	X	X	X	X	X	X	X	X	X	X	X	X
3 Larimer	2b	1	X	X	X	X	X	X	X	X	X	X	X	X
4 Adams	3a	1	X	X	X	X	X	X	X	X	X	X	X	X
5 Arapahoe	3b	1	X	X	X	X	X			X	X	X	X	X
6 Boulder	3c	1	X	X	X	X	X	X	X	X	X	X	X	X
7 Jefferson	3d	1	X	X	X	X	X	X	X		X	X	X	
8 Bethesda	3e	1	X	X	X	X	X	X		X		X	X	
9 NW Denver	3f	1	X	X	X	X	X	X	X	X	X	X	X	X
10 Park East	3g	1	X	X	X	X	X			X	X	X	X	X
11 SW Denver	3h	1	X	X	X	X	X	X		X	X	X	X	X
12 Aurora	3i	1	X	X	X	X	X	X	X	X	X	X		
13 East Central	5	1		X		X		X		X		X	X	
14 Pikes Peak	4	2	X	X	X	X	X	X	X	X	X	X	X	X
15 SE Colorado	6	2				X	X							
16 Spanish Pks	7	2	X	X	X	X	X	X	X	X	X	X	X	X
17 San Luis	8	2			X	X	X	X	X	X	X	X	X	X
18 West Central	13	2	X			X	X	X	X	X	X	X	X	X
19 SW Colorado	9	3		X	X	X					X	X		X
20 Midwestern	10	3	X	X	X	X	X	X	X	X	X	X	X	X
21 Colo West	11-12	3	X	X	X	X	X	X	X	X	X	X	X	X

(1) The quantity and quality of the services vary widely from catchment area to catchment area, and are related to: available funding, location (i.e., urban, rural, suburban), demographic variables, local priorities and other factors.

(2) includes transitional halfway house services

APPENDIX V

INVENTORY OF EXISTING FACILITIES

INVENTORY OF EXISTING FACILITIES

A. PROCEDURES FOR THE FACILITIES INVENTORY

In December 1976, the Colorado Division of Mental Health conducted the second 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 discussion 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 December, 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 (including last year's 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

Inventory of Existing Facilities

FINAL RANKS

Catchment Area		Final Ranks*	Final Ranks from 1976 State Plan*
1	NE Colo	4	6
2a	Weld	11	12
b	Larimer	9	13
3a	Adams	7	9.5
b	Arapahoe	19	16
c	Boulder	13	18
d	Jefferson	5	2
e	Bethesda	8	8
f	NW Denver	15	14
g	Park East	10	11
h	SW Denver	14	17
i	Aurora	16	4
4	Pikes Peak	18	20
5	E Central	2	3
6	SE Colo	1	1
7	Span Peaks	21	21
8	San Luis	20	19
9	SW Colo	3	9.5
10	Midwestern	6	7
11 & 12	Colo West	17	15
13	W Central	12	5

* The Rank 1 represents the highest need.

Inventory of Existing Facilities

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	7	5	6	7	10.2
2a	Weld	15	19	10	7	8	20.3
b	Larimer	11	6	4	13.5	15	17.8
3a	Adams	4	8	6	9	9	13.3
b	Arapahoe	16	15	16	18	19	28.5
c	Boulder	13	14	13	12	14	22.0
d	Jefferson	9	13	7	1	1	10.3
e	Bethesda	17	9	20	8	4	17.2
f	NW Denver	18	2.5	11	20	20	23.9
g	Park East	21	5	19	10	12	18.4
h	SW Denver	8	10	9	17	18	22.5
i	Aurora	10	20	18	13.5	11	25.5
4	Pikes Peak	19	17	17	15	10	27.2
5	E Central	4	2.5	2	3	3	5.0
6	SE Colo	4	2.5	2	2	2	4.2
7	Span Peaks	20	21	21	19	17	33.6
8	San Luis	4	18	15	21	21	29.4
9	SW Colo	4	2.5	2	4	5	6.0
10	Midwestern	4	11	8	5	6	11.7
11 & 12	Colo West	12	16	12	16	16	25.8
13	W Central	14	12	14	11	13	20.5

* 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 or private nonprofit ownership per 1,000 population.

Inventory of Existing Facilities

Resource Indicator Scores

Catchment Area		Indicators* 1	2	3	4	5
1	NE Colo	0	13.7	13.7	9.0	9.0
2a	Weld	15.9	56.7	29.2	10.4	10.4
b	Larimer	7.5	8.3	9.9	13.5	13.5
3a	Adams	0	18.1	18.1	10.6	10.6
b	Arapahoe	20.4	38.3	58.7	19.0	19.0
c	Boulder	8.2	33.0	33.0	12.8	12.4
d	Jefferson	5.7	31.6	25.0	2.8	2.4
e	Bethesda	27.9	21.3	97.0	10.5	6.0
f	NW Denver	35.3	0	31.4	36.1	36.1
g	Park East	82.3	4.1	86.4	11.7	11.7
h	SW Denver	3.1	24.7	25.7	16.8	16.1
i	Aurora	6.9	75.4	69.4	13.5	11.6
4	Pikes Peak	40.9	52.2	63.8	14.4	11.2
5	E Central	0	0	0	5.6	5.6
6	SE Colo	0	0	0	3.8	3.8
7	Span Peaks	47.8	101.4	139.3	23.4	15.8
8	San Luis	0	53.0	53.0	36.4	36.4
9	SW Colo	0	0	0	6.3	6.3
10	Midwestern	0	25.2	25.2	7.2	7.2
11 & 12	Colo W	7.8	43.5	32.1	15.0	15.0
13	W Central	11.0	26.4	37.4	12.3	12.3

* 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 or private nonprofit ownership per 1,000 population.

Inventory of Existing Facilities

Data for Computation of Resource Indicators

Catchment Area		1976-77 Population	Resource Indicator Data* 1	2	3	4	5
1	NE Colo	65,780	0	9	9	590	590
2a	Weld	112,893	18	64	33	1172	1172
b	Larimer	120,636	9	10	12	1623	1623
3a	Adams	210,504	0	38	38	2230	2230
b	Arapahoe	156,768	32	60	92	2986	2986
c	Boulder	181,930	15	60	60	2322	2262
d	Jefferson	347,990	20	110	87	960	820
e	Bethesda	136,069	38	29	132	1425	815
f	NW Denver	181,371	64	0	57	6552	6552
g	Park East	121,485	100	5	105	1420	1420
h	SW Denver	97,164	3	24	25	1628	1562
i	Aurora	116,756	8	88	81	1578	1358
4	Pikes Peak	318,145	130	166	203	4584	3569
5	E Central	19,903	0	0	0	112	112
6	SE Colo	60,293	0	0	0	232	232
7	Span Peaks	152,855	73	155	213	3597	2418
8	San Luis	41,484	0	22	22	1509	1509
9	SW Colo	42,507	0	0	0	266	266
10	Midwestern	47,530	0	12	12	343	343
11 &12	Colo West	140,167	11	61	45	2105	2103
13	W Central	45,397	5	12	17	560	560

* 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			9		490	36	64	441	1031
2a	18		64	508	998	134	40	711	2391
b	9		10	563	1063	330	230	286	2472
3a			38	60	1262	813	155	407	2697
b	32	84	60	2985	2114	555	317	1021	6992
c	15	15	60	1060	1605	403	314	1066	4448
d	20	23	110	375	747	97	116	372	1707
e	38	65	29	2584	987	276	162		4009
f	64			2980	4385	1280	887		9532
g	100		5	40	600	540	280		1330
h	3	2	24	514	1036	515	77	533	2675
i	8	9	88	280	1050	240	288	2916	4774
4	130	22	166	5170	2976	1232	376	2753	12507
5					112				112
6					232				232
7	73	30	155	6832	2512	857	228	1791	12220
8			22	5	1231	268	10	412	1926
9					266				266
10			12		225	91	27	107	450
11&12	11		61	38	1609	282	214	458	2601
13	5		12	80	300	120	140	80	720

Inventory of Existing Facilities

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)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Colorado State Hosp. 1600 W. 24th Street Pueblo, CO 81003	State	Psychia-tric Hospital									
-Psychiatric Clients			278	574	10	28189	26164	1344		441	240
-Medical/Surgical service			15			964	500	400		64	
Ft. Logan Mental Health Center 3250 W. Oxford Denver, CO 80236	State	Psychia-tric Hospital	46	125	92	8779	6093	503	517		1666

APPENDIX VI

HEALTH CARE FACILITY STANDARDS FOR PERSONS WITH MENTAL HEALTH PROBLEMS

5/4/77

HEALTH CARE FACILITY STANDARDS

FOR PERSONS WITH MENTAL HEALTH PROBLEMS

(proposed)

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I. GLOSSARY OF TERMS

The following glossary is intended to indicate the way in which the terms listed are used in these standards and not as general definitions of the terms.

DEPARTMENT The Department means the Colorado Department of Institutions. Licensing authority is retained by the Colorado Department of Health.

DIRECT PROGRAM SERVICE Direct program services are individual and/or group therapy programs, medication checks, and diagnostic evaluations.

FACILITY A facility for persons with mental health problems, herein after called facility, means a health care facility licensed by the Department of Health with an identifiably independent unit or an entire health care facility that provides therapeutic programs to patients and which is monitored by the Department of Institutions on the basis of these standards to provide treatment to persons with mental health problems.

INDIRECT PROGRAM SERVICE Indirect program service is all other planned activities for patients beside direct program service which have designed theraputic value.

MENTAL HEALTH WORKER A mental health worker is a person who has at least an Associate of Arts Degree in helping or human services, specialized training and one year's experience in working with persons with mental health problems.

OCCUPATIONAL THERAPIST An occupational therapist is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association.

PATIENT A patient or a person with mental health problems means a person certified as mentally ill or a person identified as having a mental health problem.

PLAN A plan is that document developed by the health care facility which is a written description of its program, facility and staffing for caring for patients and which conforms to these standards.

PROFESSIONAL PERSON Professional person shall mean a person licensed to practice medicine in the State of Colorado or a psychologist licensed to practice in the State of Colorado.

PROGRAM Mental health program, herein after called program, means a therapeutic program of services and/or functions designed, staffed and implemented by the facility for the purpose of meeting the specific needs of persons with mental health problems.

PROGRAM SUPERVISOR The program supervisor is that individual on the full time staff of the health care facility who has the responsibility of supervising and coordinating the special program staff and of implementing the inservice training program. The program supervisor shall have at least a Bachelor's Degree in a human services field and two years of experience directly related to the job function. The program supervisor shall not be the facility's Administrator or Director of Nursing.

PSYCHIATRIC NURSE — A psychiatric nurse is a registered nurse who has a Master's Degree in psychiatric nursing or two years of experience in treating persons with mental health problems.

PSYCHIATRIC SOCIAL WORKER — A psychiatric social worker is a person who is licensed in applied psychotherapy.

PSYCHIATRIC TECHNICIAN — A psychiatric technician is a person who has graduated from an accredited psychiatric technician program and licensed by the Colorado State Board of Nursing.

PSYCHIATRIST — A psychiatrist is a person licensed to practice medicine in the State of Colorado who has completed the requirements for board eligibility in psychiatry.

PSYCHOLOGIST — A psychologist is a person who is certified by the State of Colorado as a psychologist.

STATE PATIENT — State patients are all patients who are referred to a facility by a State Institution and/or community mental health center or clinic; and/or any patient who is certified to a State Institution or community mental health center or clinic. State patients shall also include all patients who are at any time referred to a facility by a State Institution or community mental health center or clinic and who are not now under the care of a private psychiatrist, certified psychologist or a psychiatric social worker.

THERAPEUTIC RECREATION SPECIALIST — A therapeutic recreation specialist is a person who is registered or eligible for registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society.

II. STATEMENT OF INTENT

Each health facility providing care for patients with mental health problems shall provide a therapeutic milieu facilitating the patient's ability to cope with a social, emotional and physical disability to reestablish independence and to attain optimum functioning. Each patient shall have the opportunity to participate in a special disability program specific to his/her needs. These standards are adopted pursuant to CRS 1973, 27-10-128, 129, and are intended to be supplemental to all other existing standards for health care facilities.

III. PLAN APPROVAL

Each facility shall submit to the Department a written description of its plan. The Department shall review the plan and, if it determines that the plan meets the needs of the population group to be served, shall issue written approval of the plan. Each facility shall comply with all requirements of its approved plan. The plan shall be evaluated and the plan amended as necessary and resubmitted annually to the Department.

A. Requirements for Plan Approval

1. Individual components of the plan shall be designed and provided to improve adaptive functioning and develop a potential for placement in a less restrictive living environment. If the facility provides services to persons with mental health problems, the requirements of these standards shall be met.

2. In order to be eligible to receive state patients a facility must submit an application and a plan which meets all the requirements set forth in these standards. Such application and plan shall be submitted first to the mental health center or clinic which has responsibility for the catchment area in which the facility is located. The mental health center or clinic shall make on-site evaluation of the facility, application and plan and shall submit its comments to the Department of Institutions and the applicant within 30 days of receipt of application.

3. When the Department determines that the plan meets the standards, it shall provide written approval of the plan to the facility.

4. Within 45 days after written approval of the plan, there shall be an on-site visit by the Department or its designee to evaluate the appropriateness of the implementation of the plan.

5. Within 90 days of the effective date of these regulations, every mental health center or clinic in conjunction with facilities in its catchment area, after thorough investigation, shall inform the Department of all state patients residing in catchment area in skilled or intermediate nursing care facilities. Such information shall also contain the names and addresses of each such patient. Any facility refusing to cooperate in the provision of information pursuant to this paragraph shall be disapproved by the Department under these standards.

6. Within nine (9) months of the effective date, the responsible mental health center or clinic shall make arrangements for evaluation of the patients and shall effectuate the transfer of appropriate patients from non-approved facilities to approved facilities.

B. Plan Requirements

The plan submitted ot the Department for approval shall include:

1. The written philosophy of the overall program and its goals.
2. A description of the procedure for evaluation of program goals and objectives.
3. A description of the population group to be served including the following:

    a. Age (chronologic and developmental when applicable)
    b. Sex
    c. Physical characteristics
    d. Emotional characteristics
    e. Behavioral characteristics
    f. Psycological characteristics (testing and measurement)
4. Number of patients to be served.
5. Provision for identification of individual patient needs, i.e., individual patient assessments. Programs which include the combining of patient groups shall be appropriate to the group needs.
6. Provision for an initial evaluation and assessment by interdisciplinary facility staff in conjunction with the area mental health center or clinic of the psychological, medical, nursing, dietetic, social and physical needs of each patient admitted within seven days of admission.
7. Provision for required program components.
8. A plan for use of community resources.
9. Provision for transportation and supervision to community resources arranged in accordance with the needs and conditions of the patients.
10. A description of the method and frequency of evaluating patient progress.
11. An organizational chart for program services staff.
12. A description of interdisciplinary professional staff by discipline and hours provided per week.
13. An example of an average patient's day.
14. Inservice training programs in effect or planned to assist staff in the recognition and understanding of the emotional problems and social needs of patients and the means of making the appropriate response in relating to such needs. Available community resources and services to be used in training shall be identified. The plan shall include provision for at least monthly in-service training and documentation thereof.
15. Provision for sufficient accommodations, including dining, recreational and program areas to meet the needs of the program for patients.
16. Provision for indoor and outdoor areas designated for programs with appropriate equipment, apparatus, and adequate supplies which shall meet the needs of patients.

C. Required Program Components

A minimum of three hours per week of direct program service, and seven hours per week of indirect program shall be provided for each patient. Any exception must be documented in the patient's record and weekly notes.

The facility shall provide, at least, all the following program services. Individual programs shall be based on the specific needs identified through the patient assessment.

1. Self help skills training, including:
   a. personal care - use of medications
   b. money management
   c. use of public transportation
   d. use of community resources
   e. behavior control, impulse control
   f. frustration tolerance
   g. mental health education
   h. physical fitness

2. Behavior control, impulse control
   a. behavior modification
   b. remotivation therapy
   c. patient government activity
   d. group counseling
   e. individual counseling

3. Interpersonal relationships, including:
   a. social counseling
   b. educational and recreational therapy
   c. socialization activity such as outings, dances, etc.

4. Prevocational separation services, including:
   a. homemaking
   b. work activities

5. Prerelease planning, including out-of-home placement.

6. Therapy
   a. individual
   b. group

D. Program Services Staffing

A program supervisor shall be on duty at least 40 hours per week.

In addition to the program director and nursing staff, each facility shall provide either through direct employment or through contractual arrangement, an interdisciplinary treatment team to develop and implement programs and to provide specific expertise to the program staff and/or provide direct patient service. The interdisciplinary team shall meet and consider each patient's treatment plan at least monthly.

The interdisciplinary treatment team shall represent at least one of each of the following categories. Every team shall have at least a psychiatrist or psychiatric nurse.

1. Psychologist, Psychiatrist, Psychiatric Social Worker
2. Psychiatric Technician, Mental Health Worker, Psychiatric Nurse
3. Occupational Therapist, Art Therapist, Dance Therapist, Recreation Therapist or Music Therapist

Each interdisciplinary treatment team member shall have a minimum of one year of experience or training in a mental health setting.

E. Compliance

1. The Department or its designee will evaluate all facilities pursuant to these regulations.

2. If the Department or its designee finds, after evaluation, that facility is not in compliance with these regulations, the Department or designee shall first, within forty-five (45) days of the review, notify the facility in writing of the specific items found to have been out of compliance.

3. The facility shall have thirty (30) days from the receipt of the notice of non-compliance in which to submit written data and/or a plan and schedule for achieving full compliance, with respect to the matter(s) not in compliance.

4. The Department or its designee, after reviewing the facility's written reply, may take action as follows:

    a. approve the proposed plan and schedule for achieving full compliance; or

    b. approve a modified plan and schedule for achieving full compliance; or

    c. upon approval of the Executive Director of the Department, revoke, suspend, annul, limit or modify the approval of the facility.

    In cases where the Department or its designee approves a proposed or modified plan and schedule for achieving full compliance, the Department or designee shall grant provisional approval for a period not to exceed ninety (90) days. A second provisional approval for a period not to exceed ninety (90) days may be granted if necessary, in the opinion of the Department or its designee, to achieve full compliance.

5. Upon a determination by the Department or its designee that the facility has failed to comply with its plan, the Department shall cause termination of referral of state patients to that facility and all appropriate state patients shall be moved to an approved facility.

6. Any referring facility which refers state patients to an unapproved facility shall itself be considered out of compliance.

F. Waiver

A waiver of the specific requirements of these regulations may be granted by the Executive Director of the Department of Institutions in accordance with this section.

1. It is the policy of the Department of Institutions that each facility shall comply in all respects with these regulations.

2. A waiver of these regulations shall be granted only upon a finding that the waiver would not adversely affect the health, safety and welfare of the patients and the further finding that application of the particular regulation would create a demonstrated financial hardship on the facility seeking the waiver. The duration of a waiver shall not exceed one year. However, a waiver may be renewed for a one-year period. The facility seeking the waiver has the burden of proof. Consideration will be given as to whether the intent of the particular regulation has been met.

3. Requests for waivers shall be submitted to the Department or its designee. The request shall contain a detailed description of the mental health services provided by the facility, the effect of the proposed waiver on the health, safety, and welfare of the patients, and the degree of financial hardship on the facility.

4. At the time of submission of each waiver requests, the facility shall be required to post notice of the request and a meaningful description of its substance in a conspicuous place on its premises. The Department or its designee shall hold no conference as described in paragraph 5 unless it has been preceded by such notice which shall be reasonably calculated to inform interested persons of the date, time and place of the conference.

5. The Department or its designee will set a date convenient to all parties for a conference to discuss the waiver request in detail. The meeting shall be conducted as an informal conference to disucss the nature of the waiver request and to exchange information concerning the factors to be considered in reviewing the request. The meeting shall be open to public attendance and participation. The facility Administrator, Program Supervisor or their designees shall attend the conference. The facility and the Department or its designee may be represented by counsel.

6. Unless additional time is required to make inspections or obtain additional information from the facility, the Department or its designee shall notify the facility, in writing, within thirty (30) days following the date of the conference of its recommendation upon the waiver request. Thereafter, with (10) days, the Executive Director of the Department shall make a final decision upon the waiver request. The decision of the Executive Director shall constitute "final agency action" of the Department of Institutions within the meaning of the Colorado Administrative Procedure Act.

IV. ADMINISTRATIVE POLICIES AND PROCEDURES

If the program in a facility is not appropriate to a patient's needs, the patient shall be referred to a facility providing the appropriate program. At least one discharge planning conference with participants from both facilities shall be held before transfer. This move shall not be made without consent of the patient or his/her legal guardian, if any. A signed copy of the consent shall be kept of file. Disputes concerning transfers shall be referred to the Department or its designee for resolution. Nothing in these regulations shall be construed to limit the freedom of any patient to be treated by a professional person and in a facility of his/her own choosing.

All patients' medication regimes shall be reviewed and approved at least monthly by a consulting psychiatrist. All medication regimes for patients whose condition shall be considered unstable shall be reviewed and approved at least weekly by a consulting psychiatrist.

V. RESTRAINT AND SECLUSION

Each facility shall develop and implement written staff procedures for managing assaultive or self-destructive behavior and for humane administering of confinement or physical restraint adequate to protect both the patient and those around him/her when a patient is determined, by a professional person, to be imminently dangerous to himself/herself or others. A facility may limit such determinations to licensed physicians, pursuant to its rules or procedures. Each facility desiring to use locked or lockable units shall also develop and implement written staff procedures specifying the patients for which such units are appropriate and the circumstances and procedures under which they may be used.

1. Physical restraint/seclusion may be used only on the express order of a professional person, except in an emergency situation.

2. In an emergency situation, only such physical restraint/seclusion as is reasonably necessary shall be used, and a professional person shall be notified as soon as possible. Any use of physical restraint/seclusion shall be justified and described in detail in the patient's record. A patient who is physically restrained/secluded shall be observed by staff not less than every thirty (30) minutes during the period of restraint/seclusion. Only upon the examination and order of a professional person may a patient be physically restrained/secluded in excess of four hours.

3. Physical restraint/seclusion procedures in excess of 24 hours shall require a new authorization by a professional person. Authorization shall be accomplished by a professional person at least every 24 hours.

4. Justification for physical restraint/seclusion procedures shall be described in the patient's record.

5. Those facilities which accept patients should have the capability to provide for physical restraint within their physical plants.

6. Unless specifically excluded by order of the professional person providing treatment to the patient, all patients including those in restraint/seclusion or in locked/lockable units shall have frequent access to exercise areas, including outdoor exercise when weather permits.

VI. PATIENT RECORDS

A. The Colorado Department of Institutions, Divison of Mental Health Standards/ Rules and Regulations for Community Mental Health Centers/Clincis shall be used as the overall charting guide.

B. There shall be a record for each patient containing sufficient information to justify a diagnosis, a treatment plan and a course of treatment.

C. The diagnosis, the treatment plan and any specific medical, psychological or psychiatric treatment shall be based on appropriate medical, psychological and psychiatric examinations.

D. Treatment plans and specific medical, psychological or psychiatric treatments shall be documented in the patient's record and signed by the responsible staff member.

E. Also to be documented in the patient's record are periodic examinations, orders for medical treatment, treatment therapies and monthly case evaluations signed by the responsible staff member.

G. The review by the responsible interdisciplinary team which assesses the treatment plan's effectiveness, the patient's status, and revises the plan as needed to maximize progress, shall be noted in the patient's record.

H. Decisions regarding the disposition of the patient shall be documented in the patient's record together with the use made of any and all resources for effecting the disposition.

I. The facility and the responsible professional person shall have the responsibility to ensure that all information obtained and records prepared shall be maintained as confidential and privileged matter and shall not be subject to public disclosure except as may be provided in section J., below.

J. Such information and records may be disclosed only: (1) in communications between professional persons in the provision of services or appropriate referrals; (2) when the patient designates persons to whom information or records may be released, but if a patient is a ward or conservatee and his guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the patient, except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney or other staff person to reveal information which has been given to him/her in confidence by members of a patient's family; (3) for claims on behalf of the patient for aid, insurance or medical assistance; (4) to appropriate courts; (5) to persons authorized by an order of court; (6) unless prohibited by law to qualified persons designated by the Department of Institutions for monitoring and evaluation the program.

K. Records shall be kept in a secure location which safeguards their confidentiality.

APPENDIX VII

RULES AND REGULATIONS OF THE COLORADO DEPARTMENT OF INSTITUTIONS CONCERNING THE CARE AND TREATMENT OF THE MENTALLY ILL

Department of Institutions
4150 South Lowell Blvd.
Denver, Colorado 80236
Telephone 761-0220

DATE: March 21, 1977

TO: All Interested Persons

FROM: Raymond Leidig, M.D., Executive Director

SUBJECT: Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill, Pursuant to C.R.S. 1973, 27-10-101, et seq., as amended.

MEMORANDUM OF ADOPTION AND PUBLICATION

I hereby adopt and publish the attached regulations as emergency rules and as permanent rules, pursuant to C.R.S. 1973, 24-4-103, effective March 22, 1977. The opinion of the Attorney General concerning these regulations is also attached.

I find that immediate adoption of these regulations is imperatively necessary for the preservation of the public health, safety, and welfare in that the current emergency designation regulations expire on March 23, 1977, and continued implementation of the Act covering the Care and Treatment of the Mentally Ill, C.R.S. 1973, 27-10-101, et seq., as amended, requires that designation regulations remain in effect continuously. Therefore, compliance with the notice requirements of C.R.S. 1973, 24-4-103 would be contrary to the public interest.

J.D. MacFarlane
Attorney General
Jean E. Dubofsky
Deputy Attorney General
Edward G. Donovan
Solicitor General

The State of Colorado

DEPARTMENT OF LAW

March 21, 1977

OFFICE OF THE ATTORNEY GENERAL
State Services Building
1525 Sherman Street
Denver, Colorado, 80202

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

Re: Rules and Regulations of the Colorado Department of Institutions Concerning The Care and Treatment of the Mentally Ill, Adopted Pursuant to C.R.S. 1973, 27-10-101, et seq., As Amended. (IN MH BBNX)

Dear Dr. Leidig:

Pursuant to your request we have examined the above-referenced emergency and permanent rules and regulations adopted by the Department of Institutions pursuant to C.R.S. 1973, 27-10-101 et seq., as amended.

Pursuant to the State Administrative Procedure Act, particularly C.R.S. 1973, 24-4-103(8)(b), this office has reviewed the rules and regulations and finds that they are within the authority of the Department of Institutions to promulgate and, further, that there are no apparent constitutional or statutory deficiencies in their form or substance.

Authority for the promulgation of these rules is found in C.R.S. 1973, 27-10-105(1), 107(1)(c), 109(1)(c), 120(1)(d) as amended, and 126 as amended. Such authority necessitates the establishment of criteria by the executive director for designating and approving facilities providing 72-hour treatment and evaluation, short-term care and treatment, and long-term care and treatment. The Department of Institutions is required to adopt rules and regulations to enforce the Act in a consistent manner. C.R.S. 1973, 27-10-126, as amended.

Your attention is directed to C.R.S. 1973, 24-4-103 which provides that the adopted rules must be approved by the Attorney General's office in regard to constitutionality and legality and that two copies of the Attorney General's opinion along with two copies of the adopted rules must be submitted to the Secretary of State. Also, you should

forward to the Secretary of State two copies of the "notice of public hearing" and the "memorandum of adoption." As provided in C.R.S. 1973, 24-4-103(8)(d), as amended, copies of all rules and regulations adopted or amended on or after July 1, 1976, and additional information related thereto should be submitted to the Legislative Drafting Office.

Therefore, you should immediately forward a copy of the rules and regulations as well as the notice and memorandum and this letter to the Legislative Drafting Office for referral to the appropriate legislative committee.

The Secretary of State has not established a Colorado regulations register, and, therefore, the publication referred to in C.R.S. 1973, 24-4-103(5) must be accomplished pursuant to the provisions of C.R.S. 1973, 24-4-103(11)(k), which provides that:

> Until the secretary of state has the facilities and funds and is fully prepared to publish each notice of rule-making and each rule as finally adopted and so notifies the agencies, each agency shall publish its own notices of rule-making and rules as finally adopted. Publication shall be by mailing a copy to each person on the agency's mailing list, which shall include the attorney general and every person who has requested to be placed thereon and who has paid any fee set by the agency for such purpose, such fee to approximate the cost of the mailing to such person, and by placing and keeping a copy on permanent file in the agency's office for inspection by any person during regular office hours.

Very truly yours,

J. D. MacFARLANE
Attorney General

JDM:JNdeR:mb

ADOPTED: March 21, 1977

EFFECTIVE: March 22, 1977

RULES AND REGULATIONS OF THE COLORADO DEPARTMENT OF INSTITUTIONS CONCERNING THE CARE AND TREATMENT OF THE MENTALLY ILL, ADOPTED PURSUANT TO C.R.S. 1973, 27-10-101, ET SEQ., AS AMENDED.

I.

STATEMENT OF POLICY, PURPOSE AND APPLICABILITY

A. APPLICABILITY OF THESE REGULATIONS; DENIAL, REVOCATION OR NONRENEWAL OF DESIGNATION.

All facilities designated hereunder as 72-hour treatment and evaluation facilities or as short and long-term treatment facilities, including those facilities specially designated, shall meet all of the applicable requirements hereof at all times. However, specially designated facilities may be excluded from the requirements hereof, in accordance with the terms of the special designation. Any designation may be denied, revoked or not renewed by the Executive Director of the Colorado Department of Institutions if a facility is found not to be in compliance herewith, pursuant to C.R.S. 1973, 24-4-104, as amended.

B. ADHERENCE TO STANDARDS.

Each designated facility shall strictly adhere to the standards, regulations and statutory requirements applicable

to that facility, such as standards of the Colorado Departments of Health and Institutions, and any other standards that may be applicable, such as those developed by Professional Standards Review Organizations and, when implemented, the "Health Care Facility Standards" of the Colorado Department of Institutions.

C. ADHERENCE TO STATUTORY REQUIREMENTS.

Each designated facility shall strictly adhere to all statutory requirements of the Act for the Care and Treatment of the Mentally Ill, C.R.S. 1973, 27-10-101 et seq., as amended. All staff shall be fully informed and periodically reinformed regarding the provisions and requirements of the Act and these regulations.

II.

GENERAL POLICIES

A. ORGANIZATION.

There shall be a single identifiable organization responsible for the operation of any facility designated hereunder. There shall be a director responsible for discharging the duties and responsibilities of the designated facility. Duties and responsibilities shall be discharged directly by the designated facility or by contractual arrangement. The name of the director shall be posted within the designated facility and shall be available to any person.

B. SERVICES.

Private facilities designated hereunder shall provide, at a minimum, inpatient services. Community mental health centers or clinics shall provide services which conform to Colorado law (C.R.S. 1973, 27-1-201 et seq., as amended) and federal law (42 U.S.C. § 2681 et seq., as amended by P.L. 94-63). State hospitals shall provide services as provided by Colorado law (C.R.S. 1973, 27-13-101 et seq. and 27-15-101 et seq., as amended). Each designated facility shall establish and maintain written policies and procedures for coordinating, integrating and ensuring continuity of medical and mental health treatment services. All designated facilities shall have ready access, at all times, to a physician and to medical services.

C. EVALUATION, CARE AND TREATMENT.

Evaluation, care and treatment shall be provided in a nondiscriminatory manner by professional staff meeting the standards of the various professions. Evaluation and treatment shall be provided in the least restrictive setting possible, consistent with the patient's needs and safety. The reasons for the choice of setting shall be documented in the patient's record. During the entire treatment process, the patient shall enjoy the maximum amount of freedom consistent with his/her treatment needs, including but not limited to those rights set forth in C.R.S. 1973, 27-10-117, as

amended. The director of a designated facility shall maintain records detailing all treatment and evaluation provided. There shall be a monthly review and update of each treatment plan.

D. PREVIOUSLY ADJUDICATED PATIENTS.

Persons previously adjudicated under the provisions of the prior Colorado mental health commitment statute, C.R.S. 1973, 27-9-101 et seq., as amended, which was repealed effective July 1, 1975, were not restored to legal capacity and competency because of the Colorado Supreme Court's decision in Estate of Phillips v. State of Colorado, ___ P.2d ___, (1976), which declared C.R.S. 1973, 27-10-114, as amended in 1975, unconstitutional. However, should any such person require further mental health treatment, he/she shall be certified and/or treated under the provisions of C.R.S. 1973, 27-10-101 et seq., as amended.

E. EMERGENCY PROCEDURES.

Each designated facility shall develop and implement written staff procedures for managing patients' assaultive or self-destructive behavior and for humane administering of confinement or physical restraint adequate to protect both the patient and those around him/her when a patient is determined, by a professional person, to be imminently dangerous to himself/herself or others. A facility may

limit such determinations to licensed physicians, pursuant to its rules or procedures.

1. Physical restraint/seclusion may be used only on the express order of a professional person, except in an emergency situation.

2. In an emergency situation, only such physical restraint/seclusion as is reasonably necessary shall be used. A professional person shall be notified as soon as possible in such cases. Any use of physical restraint/seclusion shall be justified and described in detail in the patient's record. A patient who is physically restrained/secluded shall be observed by staff not less than every thirty (30) minutes during the period of restraint/seclusion. Only upon the examination and order of a professional person may a patient be physically restrained/secluded in excess of four (4) hours.

3. Physical restraint/seclusion procedures in excess of twenty-four (24) hours shall require a new authorization by a professional person. Authorization shall be accomplished by a professional person at least every twenty-four (24) hours.

4. Justification for physical restraint/seclusion procedures shall be described in detail in the patient's record.

5. As a last resort, when dealing with a person who is an imminent danger to himself/herself or others or gravely disabled, who is being detained under the emergency provisions of C.R.S. 1973, 27-10-105, in a region where an appropriate

inpatient facility is not available, a jail may be used as a temporary placement facility. The peace officer or professional person who takes the person into custody shall contact the nearest designated facility within three hours of the initial detention of the person. Within twenty-four (24) hours, the nearest designated facility shall either accept the person for treatment and evaluation or place the person under the care of an appropriate 72-hour treatment and evaluation facility. Exceptions to this provision shall be justified and described in detail in the patient's record, and an account of each such exception shall be mailed by the nearest designated facility to the Division of Mental Health of the Colorado Department of Institutions within ten (10) days from the initial detention.

F. UNAUTHORIZED DEPARTURE.

Each designated facility shall be responsible for maintaining reasonable security capabilities to guard against the risk of unauthorized departure.

G. PATIENTS' RIGHTS.

Every patient receiving evaluation or treatment shall be furnished by the designated facility with a written copy of his/her rights, and a list of such rights (translated into Spanish or any other appropriate language) shall be posted prominently in all designated facilities.

H. RIGHT TO VOTE.

Every patient shall be given the opportunity to exercise his/her right to vote in primary and general elections. The director of each designated facility shall assist each patient in obtaining voter registration forms, applications for absentee ballots and absentee ballots and in complying with any other prerequisite for voting.

III.

CRITERIA FOR DESIGNATING & APPROVING 72-HOUR TREATMENT AND EVALUATION FACILITIES.

A. Except for special designations, which may be made by the Executive Director of the Department of Institutions or his/her designee, on a case by case basis, upon a showing that the use of the specially designated facility will be particularly beneficial to the patient, no facility shall be designated as a 72-hour treatment and evaluation facility unless it is: (1) a general hospital or a psychiatric hospital licensed by the Colorado Department of Health, or (2) a community mental health center or clinic under contract with the Colorado Department of Institutions.

B. Records shall be maintained which adequately reflect evaluation procedures and findings, as well as treatment administered, and which contain a discharge plan which adequately covers the continuing treatment needs of the patient.

C. A professional person shall be responsible for the evaluation of and treatment administered to each patient.

D. Evaluations shall be completed as soon as possible after admission. A designated 72-hour treatment and evaluation facility may detain a person for evaluation and treatment for a period not to exceed seventy-two (72) hours, excluding Saturdays, Sundays and holidays if evaluation and treatment services are not available at the facility on those days.

IV.

CRITERIA FOR DESIGNATING AND APPROVING SHORT AND LONG TERM TREATMENT FACILITIES

A. Except for special designations, which may be made by the Executive Director of the Department of Institutions or his/her designee on a case by case basis, upon a showing that the use of the specially designated facility will be particularly beneficial to the patient, no facility shall be designated as a short or long term treatment facility unless it is: (1) a general hospital or a psychiatric hospital licensed by the Colorado Department of Health, or (2) a community mental health center or clinic under contract with the Colorado Department of Institutions.

B. Every patient receiving treatment for mental illness by a designated short and long term treatment facility shall, no later than twenty-four (24) hours after admission to treatment, be placed under the care of a professional

person employed by or under contract with the designated facility. The professional person may delegate any part of his/her duties, except as limited by statute or these regulations, but he/she shall remain responsible at all times for the quality of the mental health treatment administered to the patient. The professional person shall be specifically responsible for:

1. Formulating a written treatment plan tailored to the needs of each individual patient, with the maximum feasible participation of the patient, including any provision for restrictive confinement, documenting the diagnostic basis of the plan and the progress of the treatment, and revising the plan whenever appropriate. A psychiatrist shall formulate any provision of the plan providing for psychiatric medication. The professional person or consulting psychiatrist shall not be responsible for providing nonpsychiatric medical care, but shall be reasonably alert in recommending and facilitating access to proper medical care and shall be responsible for coordinating mental health treatment with any other medical treatment provided to the patient.

2. Personally evaluating the patient at least once a month for the purpose of reassessing the appropriateness and effectiveness of the mental health treatment in promoting the patient's highest possible level of independent functioning

and ascertaining the need for continuing the patient's involuntary status, medication or restrictive confinement.

3. Personally conducting an on-site case review and evaluation session, together with regular treatment personnel, at least once a month for each patient. Medication shall be reviewed at least once a month by a psychiatrist.

4. Formulating a plan for continuing contact with and involvement of family members or the development or encouragement of other support systems.

5. Assuring that the placement alternative selected is conducive to optimum restoration of the patient's mental and physical functioning, with due regard for the safety of the patient and those around him/her and the availability of placement alternatives.

6. Monitoring the mental health treatment process.

7. If a placement facility is used, assuring that a member of the staff of the placement facility is personally responsible on an individual case basis for the mental health treatment of the patient while in that facility, under the professional supervision of the responsible professional person.

8. Assuring that all personnel who participate regularly in the mental health treatment process are identified in the patient's record.

9. Whenever clinically indicated, assuring physician visits and medical appraisal and treatment.

10. Developing a discharge plan, including provision of adequate transitional, after-care and followup services appropriate to the individual patient, calculated so as to maximally reduce the likelihood of rehospitalization or return to restrictive confinement.

11. Assuring referral for and documenting the provision of adequate support services, including but not limited to housing, social services and vocational rehabilitation services, calculated so as to maximally reduce the likelihood of rehospitalization or return to restrictive confinement.

C. The designated facility shall be responsible for the care provided by the professional person as detailed in Section IVB above. In addition, the designated facility shall be responsible for:

1. Assuring a humane psychological and physical environment for each patient.

2. Providing or arranging for vocational rehabilitation and educational services, including tutoring or other educational services to all children and adolescents.

3. Establishing contractual relationships with placement facilities, as defined in these regulations, which allow for placement of patients certified to or under the care of the designated facility, including (a) adequate provision for in-service training of placement facility staff according to a plan approved and monitored by the designated facility, (b) direct case supervision by professional

persons employed by or under contract with the designated facility, (c) necessary availability and necessary supervision of placement facility staff and (d) adherence to these regulations and the "Health Care Facility Standards" promulgated by the Colorado Department of Institutions pursuant to C.R.S. 1973, 27-10-128 and 129, as amended, when implemented. All such contractual relationships and all original or supplemental agreements and amendments shall be promptly, but in no event more than ten (10) days after the effective date of the agreement or amendment, reduced to writing and forwarded to the Division of Mental Health of the Colorado Department of Institutions for review.

D. No patient shall be transferred to any facility other than to a placement facility under contract with the transferor designated facility unless and until adequate arrangements for care by the transferee facility have been documented, including at least one discharge planning conference with participants from both designated facilities, at least twenty-four (24) hours advance notice to the patient of the impending transfer and notice to any court which has previously considered or been notified of the case. Disputes concerning transfers, including any protest or appeal by or for the patient, shall be referred to the Division of Mental Health of the Colorado Department of Institutions for resolution. No patient who is in the custody of a designated facility shall be transferred to another designated

facility unless and until adequate arrangements have been made for the transfer of the custody of the patient to the transferee designated facility.

V.

CRITERIA FOR USE OF PLACEMENT FACILITIES

A. All public and private facilities which are licensed by the Colorado Department of Health as general hospitals, psychiatric hospitals, community clinics and emergency emergency centers, convalescent centers, nursing care facilities, intermediate health care facilities or residential facilities, or community mental health centers or clinics under contract in the Colorado Department of Institutions, are hereby approved for use as placement facilities under these regulations.

B. Facilities approved for use as placement facilities may be used by any designated 72-hour treatment and evaluation facility or any designated short-and long-term treatment facility, at its discretion under the provisions of these regulations, subject to the provisions of Section IVC3 hereof, in order to provide care and security to any person undergoing mental health evaluation or treatment. Designated facilities shall not place patients in a placement facility unless all of the provisions of these regulations are met and placement in such facility is required in order to meet

the clinical needs of the patient. When a placement facility is required, the least restrictive facility possible must be used, consistent with the clinical needs of the patient.

C. A jail or other detention facility may be used as a placement facility for 72-hour treatment and evaluation: (1) when the person undergoing treatment and evaluation is ordered confined to a jail by a court pending resolution of criminal charges pursuant to C.R.S. 1973, 27-10-123; (2) when the person is confined pursuant to arrest by a peace officer, pending filing of criminal charges, and the peace officer or responsible public officer refuses to release the person to a less restrictive setting; or (3) as a last resort, when no less restrictive setting is possible for evaluation and treatment, for a maximum of twenty-four (24) hours. See Section IIE5.

D. A community clinic and emergency center, a nursing care facility, an intermediate health care facility or a residential facility may be used as a placement facility for 72-hour treatment and evaluation only if the responsible professional person finds that the use of the facility will be particularly beneficial to the patient and the patient (1) is already located in the facility, or (2) has been located in the facility within the preceding six months or (3) has been under the care of the designated 72-hour treatment and evaluation facility for at least three months preceding the evaluation and treatment.

E. Nothing contained in these regulations shall be construed to limit in any way the ability and duty of a facility to treat or evaluate persons in the least restrictive setting possible, and unrestricted community placement and out-patient evaluation and treatment shall be the preferred alternative whenever possible consistent with the patient's needs and safety.

VI.

GUIDELINES FOR TREATMENT RECORD ENTRIES

A. The Colorado Department of Institutions, Division of Mental Health "Standards/Rules and Regulations for Mental Health Centers and Clinics" (1977), as amended, shall be used as the overall charting guide.

B. There shall be a record for each patient containing sufficient information to justify a diagnosis, a treatment plan and a course of treatment.

C. The diagnosis, the treatment plan and any specific medical, psychological or psychiatric treatment shall be based on appropriate medical, psychological and psychiatric examinations.

D. Treatment plans and specific medical, psychological or psychiatric treatments shall be documented in the patient's record and signed by the responsible staff members.

E. Also to be documented in the patient's record and signed by the responsible staff members are periodic examinations, orders for medical treatment, treatment therapies and monthly case evaluations signed by the responsible professional person.

F. Observations and communications about the specific treatment goals and the patient's treatment progress shall be entered in the patient's record on a current basis, not less than once a week.

G. A patient review by the responsible professional person which assesses the treatment plan's effectiveness, the patient's status and revises the plan as needed to maximize progress, shall be noted in the patient's record on a regular basis, not less than once a month.

H. Decisions regarding the disposition of the patient shall be documented in the patient's record together with the use made of any and all resources for effecting the disposition.

I. The designated facility and the responsible professional person shall have the responsibility to ensure that all information obtained and records prepared shall be maintained as confidential and privileged matter and shall not be subject to public disclosure except as may be provided in Section VIJ, below.

J. Such information and records may be disclosed only: (1) in communications between qualified professional

persons in the provision of services or appropriate referrals; (2) when the patient designates persons to whom information or records may be released, but if a patient is a ward or conservatee and his guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the patient, except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney or other staff person to reveal information which has been given to him/her in confidence by members of a patient's family; (3) for claims on behalf of the patient for aid, insurance or medical assistance; (4) to appropriate courts; or (5) to persons authorized by an order of court.

K. Records shall be kept in a secure location which safeguards their confidentiality.

VII.

GUIDELINES FOR CONSENT FOR "SPECIFIC THERAPIES"

A. "Specific therapies" shall be considered to include all therapies or surgical procedures which may entail a substantial or catastrophic risk. Surgery, electroshock treatment, use of experimental drugs or use of drugs in extraordinarily strong dosages are examples of "specific therapies" which fall into this category.

B. The reason for the contemplated use of any specific therapy shall be fully documented in the patient's treatment

record. Specific informed consent shall be sought from the patient. No consent shall be valid for more than thirty (30) days. If the patient cannot or will not consent, consent shall be sought from the patient's legal guardian, if any.

C. The patient, and any representative designated by him/her or acting in a legal capacity for him/her, shall be informed by the attending physician as to the anticipated benefits and the risks involved in any specific therapy.

D. If the patient or his/her legal guardian refuses to consent to any specific therapy, the patient shall be offered alternative treatment, if a suitable alternative exists. If an imminent danger to the patient's life or to the lives of others exists, because of the patient's condition, the patient's physician, in consultation with the director of the designated facility or his designee, may, after careful and informed deliberation under procedures to be adopted by each designated facility, order a specific therapy without consent. Surgery may only be authorized if an imminent danger to the patient's life exists.

VIII.

EMPLOYMENT OF PATIENTS AND COMPENSATION.

A. Work, including all labor, employment or jobs involving facility operation and maintenance or used as labor-saving devices which are of an economic benefit to the

facility shall be treated as work and shall be compensated according to applicable minimum wage or certified wage rates.

B. Maintaining a minimum standard of cleanliness and personal hygiene and personal housekeeping such as making one's bed or policing one's area shall not be treated as work and shall not be compensated.

C. Patients shall not be forced in any way to perform work.

D. Training programs must comply with all applicable federal and Colorado laws.

E. All work assignments, together with a specific consent form, and the hourly compensation received, shall be noted in the patient's record.

F. Privileges or release from a designated facility shall not be conditioned upon the performance of work.

IX.

NOTIFICATION OF THE COLORADO DEPARTMENT OF INSTITUTIONS, DIVISION OF MENTAL HEALTH.

Each designated facility shall inform the Division of Mental Health of the Colorado Department of Institutions of any and all legal proceedings concerning the quality of the mental health treatment afforded to any patient or former patient, to which the facility or any of its employees is a

party, and copies of all complaints and writs issued in such proceedings shall be mailed to the Division's central office within ten (10) days of receipt by any designated facility or placement facility.

X.

APPLICATION PROCEDURE

A. Facilities seeking designation or redesignation hereunder shall apply annually to the Colorado Department of Institutions, Division of Mental Health. Those seeking redesignation shall apply at least forty-five (45) days prior to the expiration of the prior designation. All applications shall be made on forms specified by the Division of Mental Health. The Division of Mental Health shall recommend action to the Executive Director in accordance with its assessment of the facility's compliance with these regulations. Facilities making application for designation may be required to document treatment administered or any other aspect of their operations reasonably related to the application. Facilities may be required to submit and to consent to a plan and schedule for full compliance to correct any deficiencies found. Denial or non-renewal of designation may be appealed in accordance with Section IA hereof.

B. All facilities designated on Schedule A attached hereto shall be designated as both 72-hour treatment and evaluation facilities and short and long term treatment

facilities until July 1, 1977. An up-to-date list of all designated facilities and placement facilities shall be prepared by the Division of Mental Health whenever changes occur and shall be circulated to interested persons who request being placed on the mailing list.

XI.

ENFORCEMENT

A. The Division of Mental Health of the Department of Institutions shall, at least annually, evaluate all designated facilities. Evaluation of placement facilities may also be conducted yearly at the discretion of the Division, but such evaluation will be limited to those services which are provided pursuant to agreement with a designated facility.

B. If the Division of Mental Health finds, after evaluation, that a designated facility is not in compliance with these regulations, the Division shall first, within forty-five (45) days of the review, notify the designated facility in writing of the specific items found to have been out of compliance.

C. The designated facility shall have thirty (30) days from the receipt of the notice of non-compliance in which to submit written data and/or a plan and schedule for achieving full compliance, with respect to the matter(s) not in compliance.

D. The Division of Mental Health, after reviewing the designated facility's written reply, may take action as follows:

1. approve the proposed plan and schedule for achieving full compliance; or

2. approve a modified plan and schedule for achieving full compliance; or

3. upon approval of the Executive Director of the Department of Institutions, revoke, suspend, annul, limit or modify the designation of the facility, in accordance with Section 1A hereof.

In cases where the Division of Mental Health approves a proposed or modified plan and schedule for achieving full compliance, the Division shall grant provisional approval for a period not to exceed ninety (90) days. A second provisional approval for a period not to exceed ninety (90) days may be granted if necessary, in the opinion of the Division, to achieve full compliance.

XII.

WAIVER

A waiver of the specific requirements of these regulations may be granted by the Executive Director of the Department of Institutions upon the recommendation of the Division of Mental Health in accordance with this section.

A. It is the policy of the Department of Institutions and the Division of Mental Health that each designated facility shall comply in all respects with these regulations.

B. A waiver of these regulations shall be granted only upon a finding that the waiver would not adversely affect the health, safety and welfare of the patients and a further finding that application of the particular regulation would create a demonstrated financial hardship on the designated facility seeking the waiver. The duration of a waiver shall not exceed one year. However, waivers may be renewed for one-year periods. The designated facility seeking the waiver has the burden of proof. Consideration will be given as to whether the intent of the particular regulation has been met.

C. Where a designated facility provides mental health services through placement in a placement facility, and a waiver is sought for such services, the designated facility, and not the placement facility, shall request the waiver.

D. Requests for waivers shall be submitted to the Division of Mental Health, and shall be signed by the board president and the director of the designated facility. The request shall contain a detailed description of the mental health services provided by the designated facility, the effect of the proposed waiver on the health, safety, and welfare of the patients, and the degree of financial hardship on the designated facility.

E. At the time of submission of each waiver request, the designated facility shall be required to post notice of the request and a meaningful description of its substance in a conspicuous place on its premises. The Division of Mental Health shall hold no conference as described in paragraph F of this section unless it has been preceded by such notice which shall be reasonably calculated to inform interested persons of the date, time and place of the conference.

F. The Division of Mental Health will set a date convenient to all parties for a conference to discuss the waiver request in detail. The meeting shall be conducted as an informal conference to discuss the nature of the waiver request and to exchange information concerning the factors to be considered in reviewing the request. The meeting shall be open to public attendance and participation. The designated facility board president and director or their designees shall attend the conference. The designated facility and the Division of Mental Health may be represented by counsel.

G. Unless additional time is required to make inspections or obtain additional information from the designated facility, the Division of Mental Health shall notify the designated facility, in writing, within thirty (30) days following the date of the conference of its recommendation upon the waiver request. Thereafter, with ten (10) days, the Executive Director of the Department of Institutions

shall make a final decision upon the waiver request. The decision of the Executive Director shall constitute "final agency action" of the Department of Institutions within the meaning of the Colorado Administrative Procedure Act.

XIII.

DEFINITIONS

A. "Designated Facility" shall mean a facility designated under these regulations by the Executive Director of the Colorado Department of Institutions, either (1) as an 72-hour treatment and evaluation facility, pursuant to C.R.S. 1973, 27-10-105 and 106, or (2) as a short and long term treatment facility, pursuant to C.R.S. 1973, 27-10-107 and 109.

B. "Patient" shall mean a person admitted to mental health evaluation or treatment by a designated facility pursuant to C.R.S. 1973, 27-10-101 et seq.

C. "Placement Facility" shall mean a public or private facility which is licensed by the Colorado Department of Health as a general hospital, a psychiatric hospital, a community clinic and emergency center, a convalescent center, a nursing care facility, an intermediate care facility, or a residential facility or a community mental health center or clinic under contract with the Colorado Department of Institutions, which is used in order to provide care and security

to any person undergoing mental health evaluation or treatment by a designated facility, pursuant to the provisions of Sections IVC3 and V hereof. A jail may also be used as a placement facility pursuant to the provisions of Section IIE5 and VC hereof.

D. "Professional Person" shall mean a person licensed to practice medicine in the State of Colorado or a psychologist licensed to practice in the State of Colorado.

E. "Special Designation" shall mean designation of a facility as a 72-hour treatment and evaluation facility or a short and long term treatment facility by the Executive Director of the Colorado Department of Institutions or his/her designee, on a case by case basis, upon a showing that the use of the specially designated facility will be particularly beneficial to the patient. Special designations may or may not entail a waiver as provided in Section XII hereof, but special designations shall not be limited by the provisions thereof.

F. "Specific Therapy" shall mean any treatment which may entail a substantial or catastrophic risk, including major medical treatment in the nature of surgery, electroshock treatment, use of experimental drugs or use of drugs in extraordinarily strong dosages.

SCHEDULE A

The following facilities are hereby designated as 72 Hour Treatment and Evaluation Facilities and Short and Long Term Treatment Facilities, pursuant to C.R.S. 1973, 27-10-105, 107 and 109:

1. Fort Logan Mental Health Center
2. Colorado State Hospital
3. Northeast Colorado Mental Health Clinic
4. Weld Mental Health Center
5. Adams County Mental Health Center
6. Arapahoe Mental Health Center
7. Bethesda Community Mental Health Center
8. Mental Health Center of Boulder County
9. Northwest Denver Mental Health Center
10. Jefferson County Mental Health Center
11. Southwest Denver Community Mental Health Center
12. Park East Comprehensive Mental Health Center
13. Pikes Peak Family Counseling and Mental Health Center
14. Spanish Peaks Mental Health Center
15. San Luis Valley Comprehensive Community Mental Health Center
16. Southwest Colorado Mental Health Center
17. Midwestern Colorado Mental Health Center
18. Colorado West Regional Mental Health Center
19. Larimer County Mental Health Center
20. West Central Mental Health Center
21. Aurora Mental Health Center
22. Veterans Administration Hospital, Denver, Colorado
23. Veterans Administration Hospital, Fort Lyons, Colorado
24. Emery John Brady Hospital

25. University of Colorado Medical Center
    Colorado General Hospital
    Colorado Psychiatric Hospital

26. Veterans Administration Hospital, Grand Junction, Colorado

27. St. Joseph's Hospital

28. St. Anthony's Hospital

29. St. Mary's Hospital, Grand Junction

30. Porter's Hospital

31. Boulder Psychiatric Institute

APPENDIX VIII

REPORT OF ACCOMPLISHMENT OF OBJECTIVES IN 76 - 77 STATE MENTAL HEALTH PLAN

Status of
STATE PLAN OBJECTIVES
for
FIRST QUARTER
(July 1976 through October 1, 1976)

GOAL #1

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

This objective has been accomplished.

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

Preliminary Financial Audit Guidelines for Centers/Clinics were established during August 1976; final audit guidelines will be issued on or before November 1, 1976.

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

The State Health Planning and Development Agency (SHPDA) was not designated until recently. However, Division staff met with Health Department planners on September 24 to discuss coordination with SHPDA.

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

This objective was accomplished on September 15, 1976.

f. 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.

One informal meeting has been held, and there have been several telephone conversations with key people in the Division of Medical Services.

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

The SHCC will not be formed until about January 1977.

g. By October 1, 1976, DMH will produce a catalog of programs offered by its agencies.

This has been accomplished.

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

A need assessment to estimate the number and locations of severely disturbed individuals in Colorado is under way. This is the first stage of the need assessment study. The methodology for this first stage is currently being worked out with the Need Assessment Task Force.

GOAL #2

d. By July 1, 1976, a continuing education grant will have been developed for the training of center/clinic staff in the provision of 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).

This has been accomplished and the grant has been approved and funded.

d. By October 1, 1976, DMH will begin providing training to mental health agencies in the delivery of consultation services to other caregiving agencies.

This will be accomplished under the auspices of our new continuing education grant in the second or third quarter of this fiscal year.

GOAL #3

c. By September 1, 1976, DMH 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 PL 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.

The first quarterly meeting was held on September 1.

c. By September 1, 1976, DMH and the Division of Services for the Aging will begin actively promoting a statewide 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.

This matter was addressed in the first meeting with the Division of Services for the Aging (DSA). DMH and DSA are working on an implementation procedure.

d. By August 1, 1976, the DMH and DADA will have established a work group to address the problems in coordinated service delivery identified by each Division.

The initial work group, comprised of DADA and DMH staff, has met on two occasions. The agenda for the third meeting will include a discussion of the expansion of the group to include representatives of other agencies and organizations.

d. 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.

This objective has been accomplished.

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

This objective has been accomplished.

d. 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 DMH central office, and vice versa.

DADA has developed a procedure where they actively seek mental health input into their planning process. Copies of the drafts of their plans are distributed in advance to appropriate individuals within the Division of Mental Health, and also the persons designated by the Centers and Clinics Association.

h. By July 1, 1976, the DMH will use poverty as a major criteria for setting priorities for funding mental health agencies in Colorado.

This has been accomplished. A poverty factor is incorporated in the rankings set forth in the State Plan.

h. 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.

This has been accomplished by way of the budget request documents for FY 77-78.

h. By October 1, 1976, DMH staff will begin meeting with appropriate State Department of Social Services and Regional DHEW 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.

One informal meeting has been held, and there have been several telephone conversations with key staff in the Division of Medical Assistance.

GOAL #4

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

This objective has been accomplished.

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

This objective has been accomplished.

GOAL #5

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.

   This objective has been accomplished with the Division of Alcohol and Drug Abuse.

   A request for review and comment on a document from the Community Health Services Division regarding the community mental health services section of their manual received immediate attention.

10-26-76

Status of
STATE PLAN OBJECTIVES
for
SECOND QUARTER
(October 1, 1976 through January 1, 1977)

* Indicates written reports or other written materials are available

GOAL #1

a. 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.

Completion date extended to 3-30-77.

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

This objective has been accomplished.

*f. Quarterly meeting with representatives of the State Health Planning and Development Agency.

Second quarter meeting held on 11-10-76.

f. Quarterly meeting with the Department of Psychiatry, University of Colorado Medical Center.

Second quarterly meeting held on 11-19-76.

*f. Quarterly meeting with the Department of Social Services.

A total of 30 meetings were held during the second quarter.

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

The SHCC has not yet been appointed by the Governor.

*f. 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.

There were 11 contacts with the Department of Education during the second quarter. There were no contacts with the Judicial Department, but eight contacts with various courts during this period.

*f. 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.

Two scheduled joint DMH/ADAD meetings were held. One meeting was held with the Acting Assistant Director of the Office of Medical Care Regulation and Development. Two meetings have been held with State Health Planning and Development Agency staff. One meeting was held with the Division of Vital Statistics.

*g. By October 1, 1976, a methodology for performing a comprehensive need assessment will be decided upon.

The following has replaced the original objective:

By December 1, 1976, a preliminary need assessment study which estimates the number of "very disturbed people" in Colorado will be completed.

This objective has been accomplished.

GOAL #2

*b. 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.

State Hospital Continuity of Care Committees have been formed and are operational in both state hospital service areas.

d. By October 1, 1976, the DMH will begin providing training to mental health agencies in the delivery of consultation services to other caregiving agencies.

The initial workshop on consultation for mental health centers and clinics will be held in June 1977.

*d. By January 1, 1977, the DMH will have a proposed training program for increasing staff sensitivity to Chicano mental health needs.

The training program is currently being developed by the Minority Task Force.

d. 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.

The libraries of Colorado State Hospital and Fort Logan MHC will be designated the initial mental health resource centers for educational materials on Chicanos and other minorities. This designation will be accomplished by March 30, 1977.

GOAL #3

*c. Quarterly meeting with the Division of Services for the Aging.

Three scheduled meetings between DMH and the Division of Services for the Aging have been held during the second quarter.

c. By January 1, 1977, the DMH 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.

This objective has been accomplished.

*d. 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.

This objective has been accomplished.

*f. By January 1, 1977, the DMH 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.

Extension of time to March 15, 1977, approved by Director, Division of Mental Health.

*f. By January 1, 1977, the DMH 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.

This objective has been accomplished. Funds were obtained for curanderismo training program and workshop on the Chicano elderly. Additional funds are being sought through ADAMHA.

*f. 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.

The salary and classification survey is tentatively scheduled for completion in May 1977. Information on ethnicity and sex will be available when study is completed.

*h. DMH staff meeting with appropriate State Department of Social Services and Regional Department of Health, Education and Welfare staff to explore means of increasing the availability of funding for mental health services to the poor. The results of these meetings will be appropriately disseminated.

Meeting with DSS and DHEW held on 11-18-76 and 2-16-77, respectively.

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

Responsibility for accomplishment of this objective has been reassigned. A new target date of 7-1-77 has been set.

*j. 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.

This objective has not been fully realized.

GOAL #4

GOAL #5

*1. 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.

No requests for consultation have been received. However, DMH staff have met with the Alcohol and Drug Abuse Division, the Office of Medical Care Regulation and Development, the State Health Planning and Development Agency and the Division of Vital Statistics.

*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.

DMH staff have met with DSS and DE staff many times during the first two quarters as indicated elsewhere in this report and in the previous report. There have been no formal contacts with the Judicial Department.

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.

No report is available on the number of agencies which accomplished this objective.

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.

This has been accomplished.

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.

No report is available on the number of agencies which have accomplished this objective.

Status of
STATE PLAN OBJECTIVES
for
THIRD QUARTER
(January 1, 1977 through April 1, 1977)

*indicates written reports or other written materials are available.

GOAL #1

*a. By March 30, 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.

This objective has been accomplished.

*e. By March 1, 1977, a method for evaluating treatment outcome, comparable for the total system, will be decided upon by the DMH in consultation with the statewide Evaluation Advisory Committee.

This objective has not been accomplished. (Objective revised and new due date of December 1, 1977 established.)

*f. Quarterly meeting with representatives of the State Health Planning and Development Agency.

This objective has been accomplished.

*f. Quarterly meeting with the Department of Psychiatry, University of Colorado Medical Center.

This objective has been accomplished.

*f. Quarterly meeting with the Department of Social Services.

This objective has been accomplished.

*f. 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.

This objective has been accomplished.

*f. Periodic contacts with such divisions of the Department of Health as family health services, alcohol and drug abuse and health facilities will be initiated.

This objective has been accomplished.

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

This objective has been accomplished.

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

This objective has been accomplished.

GOAL #2

*d. The DMH will designate for development one or more specialized mental health resource centers for educational materials which would be available to all mental health agencies. (Designation to be accomplished by March 30, 1977.)

This objective has been accomplished.

GOAL #3

*c. Quarterly meeting with Division of Services for the Aging.

This objective has been accomplished.

*f. The DMH 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 Asians. 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. (Extension of time to March 15, 1977.)

This objective has been accomplished.

f. By April 1, 1977, the results of the study of the ethnic and sex make-up of center/clinic staffs will be made available to the agencies concerned for use in updating affirmative action plans.

This objective has not been accomplished. Due date for the study changed to June 30, 1977.

*h. Meeting with appropriate State Department of Social Services and Regional DHEW staff to explore means of increasing the availability of funding for mental health services to the poor. The results of these meetings will be appropriately disseminated.

This objective has been accomplished.

j. 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.

This objective has not been fully accomplished.

GOAL #5

*l. Periodic consultation services to Department of Health Divisions which request such services.

This objective has been accomplished.

*2. Periodic consultation services to the Department of Social Services, the Judicial Department and the Department of Education.

Consultative services available, but not requested. However, there were contacts with the three agencies during the third quarter.

*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.

This objective has been accomplished.