State of Colorado

MENTAL HEALTH PLAN

1978 – 1983

Department of Institutions

DIVISION OF MENTAL HEALTH
3520 West Oxford Avenue
Denver, Colorado 80236
(303) 761-0220

MEMORANDUM

Date: October 31, 1978

To: Health and Other Human Service
Planning and Caregiving Agencies and Organizations

From: Sutherland Miller, Ph.D. SM

Subject: 1978-1983 Colorado Mental Health Plan

This memorandum accompanies your copy of the State Mental Health Plan. This Plan replaces the 1976 State Plan and the 1977-78 Supplement. The thrust of those plans has not been altered; viz., the provision of high quality, reasonable cost mental health services to the residents of Colorado.

The contents of the previous documents have been integrated into one document to facilitate readability. The Plan has also been updated to reflect changes that have occurred in the past two years. As was the case with the previous documents, this Plan reflects the recommendations and comments of a wide variety of interested and concerned agencies, organizations and individuals across the state.

The State Mental Health Plan is reviewed each year to ascertain its relevance and responsiveness to changing mental health needs, and to ensure its coordination with other planning efforts. The annual review and update process has been initiated at the end of November. Since the general distribution of the State Plan is occurring so close to that time, we are beginning that process now. We want to allow ample time for all interested agencies, organizations and individuals to review the State Mental Health Plan.

You are invited to send your comments and recommendations for changes and/or additions to the Colorado Division of Mental Health. Please use the format on the attached form to forward your input by January 15, 1979. All comments and recommendations will be carefully reviewed for possible inclusion in the Plan.

It is hoped that this review will be a significant activity in the planning process in your Health Service Area. The Division of Mental Health will work closely with the Health Systems Agencies and with the

State Health Planning and Development Agency and the State Health Coordinating Council to ensure that the State Mental Health Plan, developed with your assistance, is appropriately incorporated in the State Health Plan.

Please let us hear from you.

SM:LD:vk
xc: DMH Staff

State Mental Health Plan Input*

Mail to: Division of Mental Health
Attn: Lynn Dawson
3520 West Oxford Avenue
Denver, CO 80236

(Please type or print information) Date: _____

Agency/Person Providing Input: _____ Address: _____

Contact Person if Agency: _____ _____

Phone Number: _____ _____

Chapter: _____
Page: _____
Paragraph: _____

Comment/Recommendation:

*Please use a separate half-page for each comment to facilitate processing and review. Additional copies of this form may be reproduced as needed.

State Mental Health Plan Input*

Mail to: Division of Mental Health
Attn: Lynn Dawson
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THE COLORADO

MENTAL HEALTH PLAN

(1978 - 1983)

Prepared By

COLORADO DIVISION OF MENTAL HEALTH

Sutherland Miller, Ph.D.
Director

June 1978

FOREWORD

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

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THE COLORADO MENTAL HEALTH PLAN

I N D E X

Chapter I

INTRODUCTION

THE COLORADO MENTAL HEALTH PLAN

I. INTRODUCTION

A. PURPOSE

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

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

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 1978-79 State Mental Health Plan replaces the 1976 Plan and the 77-78 Supplement. This Plan does not alter the thrust of those plans; viz., the provision of high quality mental health services close to the home of the client and in the least restrictive setting.

The contents of the previous documents have been integrated into one document to facilitate readability. The Plan has also been updated to reflect changes that have occurred in the past two years.

The six chapters and appendices of the Plan address the requirements of Public Law 94-63 (the Community Mental Health Centers Act of 1975), as amended, and state statutes.

The following is a summary of each chapter with the significant changes made in each over the past two years.

CHAPTER I - INTRODUCTION

This chapter provides an overview of the Plan and includes the philosophy of the Division of Mental Health which is reflected throughout the Plan. A fifth principle which addresses the provision of mental health services based upon the needs of the population and available resources

has been added to the philosophy.

CHAPTER II - ADMINISTRATIVE INFORMATION

The State Mental Health Authority is identified in this chapter. The State Mental Health Advisory Council has become operational since the basic Plan was published. A brief description of the membership, functions, and activities of the Council, including its participation in the review process, is included in this chapter.

The procedures for the annual review of the State Plan and the administration of Public Health Service Act funds (Section 314d) are detailed. The required federal assurances are included in this chapter, as are personnel standards relating to the State Personnel System, equal employment, and affirmative action. The updated Division of Mental Health organizational chart also will be found in Chapter II.

CHAPTER III - STATEWIDE GOALS AND OBJECTIVES

Chapter III is regarded as the "heart" of the Plan as it sets forth the goals and objectives which provide both specific direction and a means of assessing progress. The goals and objectives are developed around the principles detailed in Chapter I emphasizing the use of the least restrictive setting, protection of human dignity and the client's rights, the availability of services close to home, accountability, and the provision of services based upon assessments of service needs.

This chapter has changed the most in the update process. The goals and objectives have been completely revised. The goals have been changed to reflect the elements in the delivery of mental health services, i.e., the identification, acquisition, provision, coordination, and evaluation of services. Sub-goals have been introduced to provide clarification and elaboration of the primary goal. 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. Important changes in the objectives include a focus on the assessment of service needs, establishment of objectives related to the acquisition of services, increased emphasis on providing services to specific targeted populations, and increased specificity relating to coordination with other agencies.

This chapter translates into specific planned actions the purpose, philosophy and thrust of the state mental health system.

CHAPTER IV - THE STATE MENTAL HEALTH PROGRAM

The state mental health program, as it is and as it will evolve in accordance with the Plan, constitutes the content of Chapter IV. The requirements for pre-admission screening emphasize the thrust towards avoiding inpatient hospitalization except in those instances where it is clearly indicated. Those clients who require inpatient care in a state hospital will be assured of high quality services because of the intensive and extensive quality assurance and utilization review programs in effect in both hospitals. Chapter IV also focuses on the discharge of clients from inpatient and other more intensive forms of care, and the procedures to insure appropriate follow-up.

Important changes in funding of substance abuse services at the state hospitals are reported as is the publication of the Standards/ Rules and Regulations for Mental Health Centers and Clinics.

Workforce issues including available resources, training programs, and possible displacement are addressed. The possible displacement of state hospital employees because of the emphasis on deinstitutionaliza-

tion and the use of alternatives to inpatient care is a key issue. The reasons this will probably have less harmful impact on state employees in Colorado are outlined.

Statements concerning fiscal support of mental health services and the requirement for volunteer services are also included.

CHAPTER V - COORDINATION OF PLANNING

Coordination of mental health services with other human services planning and caregiving agencies is the almost overwhelming but essential task addressed in Chapter V.

The State Mental Health Plan must be carefully integrated with 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 Division of Mental Health interfaces in the planning and/or delivery of mental health services. A summary of the status of the health planning apparatus mandated by Public Law 93-641 (The National Health Planning and Resource Development Act) is an important part of this chapter.

CHAPTER VI - CATCHMENT AREA MENTAL HEALTH PROGRAM

This chapter describes the present services and the mental health service needs of the communities served by the 24 mental health centers/clinics. The catchment area concept is supported to the extent that it allows flexibility in the sharing and centralization of services where clinically feasible and economically desirable.

Changes in the services available in some catchment areas are reflected in this chapter. Revised population figures and the ethnic

composition of each catchment area are also included.

The need rankings of the catchment areas have been updated. The major changes in the rankings this year are in the indicators used in determining both need and resources, and the calculation of unmet need by age group.

APPENDICES

Documents and materials included in the appendices consist of the following:

(1) A Listing of the Agencies and Organizations From Which Input was Requested and/or Received;

(2) State Mental Health Advisory Council Information;

(3) Availability of Comprehensive Community Mental Health Services;

(4) Report on Accomplishment of Objectives in the 1977-78 State Mental Health Plan;

(5) Supporting Material for Estimating Need for Mental Health Services by Age and Severity of Problem;

(6) Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill.

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

The Standards/Rules and Regulations for Mental Health Centers and Clinics, required by Public Law 94-63, have been published in a separate

document.

C. PHILOSOPHY

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

1. Human Dignity, Privacy and Client's Rights

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

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

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

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

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

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

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

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

client's consent is specifically permitted by statute. In those instances where a release of information is permitted by statute, an effort will first be made, when practicable, to obtain the written consent of the client.

2. Least Restrictive Setting

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

3. Availability of Services Close to Home

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

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

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

d. Closely related to the principles of the availability of services close to home and in the least restrictive setting is the concept of normalization; i.e., services should be provided in settings most like the client's normal surroundings as possible.

4. Funding and Accountability

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

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

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

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

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

5. Service Needs

   a. The provision of mental health services should be based upon the needs of the residents of the state.

   b. Needs assessments should be performed to identify target populations with special needs, unserved or underserved populations, and special needs of geographic areas.

   c. The mental health system should identify all available resources and should utilize those resources to the fullest extent possible in the provision of mental health services.

D. HOW THE PLAN WILL BE USED

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

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

Chapter II

ADMINISTRATIVE INFORMATION

II. ADMINISTRATIVE INFORMATION

A. STATE MENTAL HEALTH AUTHORITY

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

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

Address: Statutory Authority

Raymond Leidig, M.D., Executive Director
Department of Institutions
3550 West Oxford Avenue
Denver, Colorado 80236

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

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

Address: Sutherland Miller, Ph.D., Director
Division of Mental Health
3520 West Oxford Avenue
Denver, Colorado 80236

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. Functions, Responsibilities and Procedures

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

Among the Council's responsibilities are the following:

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

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

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

d. the Council establishes ad hoc groups for special assignments deemed necessary by the Council or the Director of DMH;

e. the Council is prepared to serve as a standing committee of the State Health Coordinating Council with the approval of that body.

Each year the members of the Council elect a Chairperson and Vice-Chairperson from the Council membership. A recording secretary for the Council has been designated. A quorum consists of 11 members present at any meeting. With a quorum present at any Council meeting, a majority vote decides all questions.

Meetings of the Council are open to the public.

3. 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 during the first year 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 also appointed two permanent subcommittees, the Executive and Budget Subcommittees, and several ad hoc committees.

Presentations were given by various DMH staff specialists which enabled the Council to gain a better understanding of the

functions of the mental health system and how the various staff activities relate to the State Plan. Members of the Council visited the two state hospitals, Fort Logan Mental Health Center and Colorado State Hospital. 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.

In the past year the SMHAC has continued to become better acquainted with the state mental health system. Many members of the Council attended the Annual State Mental Health Conference. During the past twelve months the SMHAC has also arranged for presentations from the voluntary sector, the Centers and Clinics Association, the Mental Health Association, and the Health Systems Agencies. The Budget subcommittee of the Council reviewed the Division's recommendations for funding needed for mental health services for the current year and participated in the presentation of the Division's request to the Joint Budget Committee of the State Legislature.

The SMHAC became a charter member of the newly formed Governor's Advisory Council on the Handicapped. The Council is currently

working on coordinating efforts related to mental health planning with the State Health Coordinating Council and will hopefully be approved by that body to serve as an official mental health advisory committee.

C. ASSURANCES

1. Reports and Records

The Division of Mental Health (DMH) annually reports in writing to the Regional Office of ADAMHA its evaluation of each facility's compliance with the Standards/Rules and Regulations for Community Mental Health Centers and Clinics and keeps such records and affords such access thereto as the Regional Office may find necessary to assure correctness, compliance, and verification of such reports.

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

2. Conflict of Interest

No full-time officer or employee of the Division of Mental Health, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs shall receive funds from any applicant directly or indirectly for payment for services provided in connection with the planning, design,

construction, equipping or operation of any projects funded under the Community Mental Health Centers Act.

D. ANNUAL REVIEW

1. Procedure for Annual Review

   a. In November of each year the Division of Mental Health notifies all recipients of the Plan that the annual review is underway. Concerned and affected agencies are invited to comment on the Plan and recommend changes and revisions.

   b. The DMH staff reviews the comments and recommendations.

   c. A draft of the proposed revisions is prepared for review by the Council.

   d. The Advisory Council is requested to study the areas of primary concern and to recommend appropriate changes and revisions in the Plan.

   e. After the Council review, the revised draft is made available for public review and for review and comment by the State A-95 Clearinghouse, the State Health Coordinating Council, the Health Systems Agencies, and the Regional Office of ADAMHA.

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

2. Procedure for Publicizing the Plan

   a. At least 30 days prior to the submission of the Plan to

the ADAMHA Regional Office, a notice is published in at least three major newspapers that the State Mental Health Plan is being up-dated, and that the proposed additions and changes are available for examination and comment.

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

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

E. PERSONNEL ADMINISTRATION

1. Personnel Standards

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

Sections 13-15 of the State Constitution provide for the establishment of a merit system. Hiring procedures, classification, compensation, fringe benefits, grievance procedures and disciplinary actions for employees of Colorado State Hospital, Fort Logan Mental Health Center and the Division of Mental Health Central Office are determined in accordance with merit system regulations.

2. Non-Discrimination

The Division of Mental Health (DMH) continues to comply with

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

The State of Colorado recognizes that a policy of nondiscrimination in itself is insufficient when attempting to reverse traditional patterns of discrimination. It has, therefore, been necessary to implement a plan of affirmative action in order to identify discriminatory practices and initiate programs designed to replace those practices with positive approaches to human and organizational development. Such a program requires support and commitment from all levels, specific goals and the monitoring and evaluation of progress in achieving affirmative action goals. The Division of Mental Health requires such affirmative action plans in its Standards/Rules and Regulations for Mental Health Centers and Clinics. The Division of Mental Health also requires the Central Office and the two state hospitals to have a specific 3 year affirmative action plan.

F. ADMINISTRATION OF 314(d) FUNDS

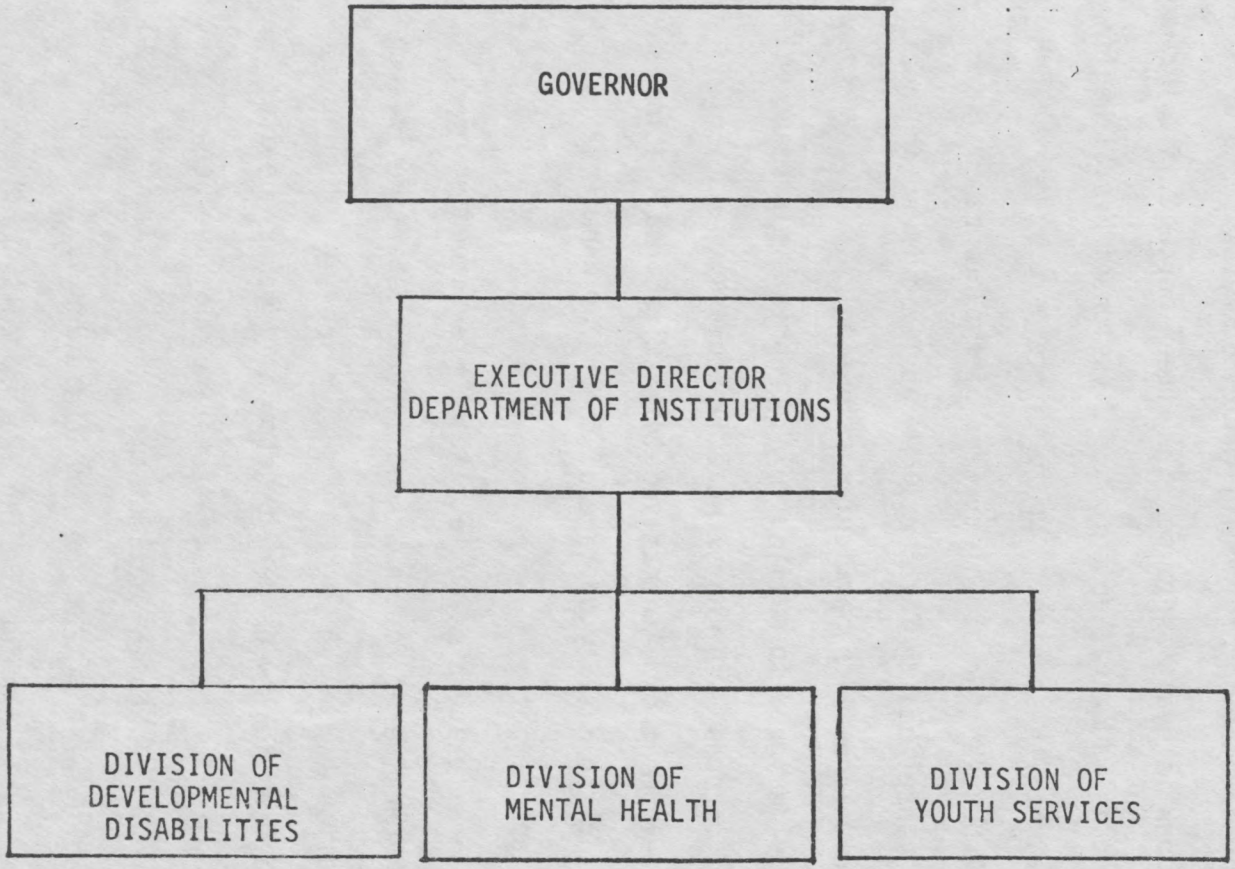
Section 314(d) of the Public Health Service Act, as amended, provides for the allocation of formula funds to states to "provide and strengthen public health services." Fifteen percent of Colorado's annual allotment is made available to the Division of Mental Health (DMH) for mental health services. Up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

1. projects designed to eliminate inappropriate placement in institutions of persons with mental health problems;
2. the development of alternatives to institutionalization;
3. improving the quality of care of those for whom institutional care is appropriate;
4. assistance to agencies to facilitate pre-screening of residents being considered for inpatient care to determine if such care is necessary;
5. provision of follow-up care by community mental health centers and clinics for residents of the state who have been discharged from mental health facilities;
6. populations such as the poor and the elderly.

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

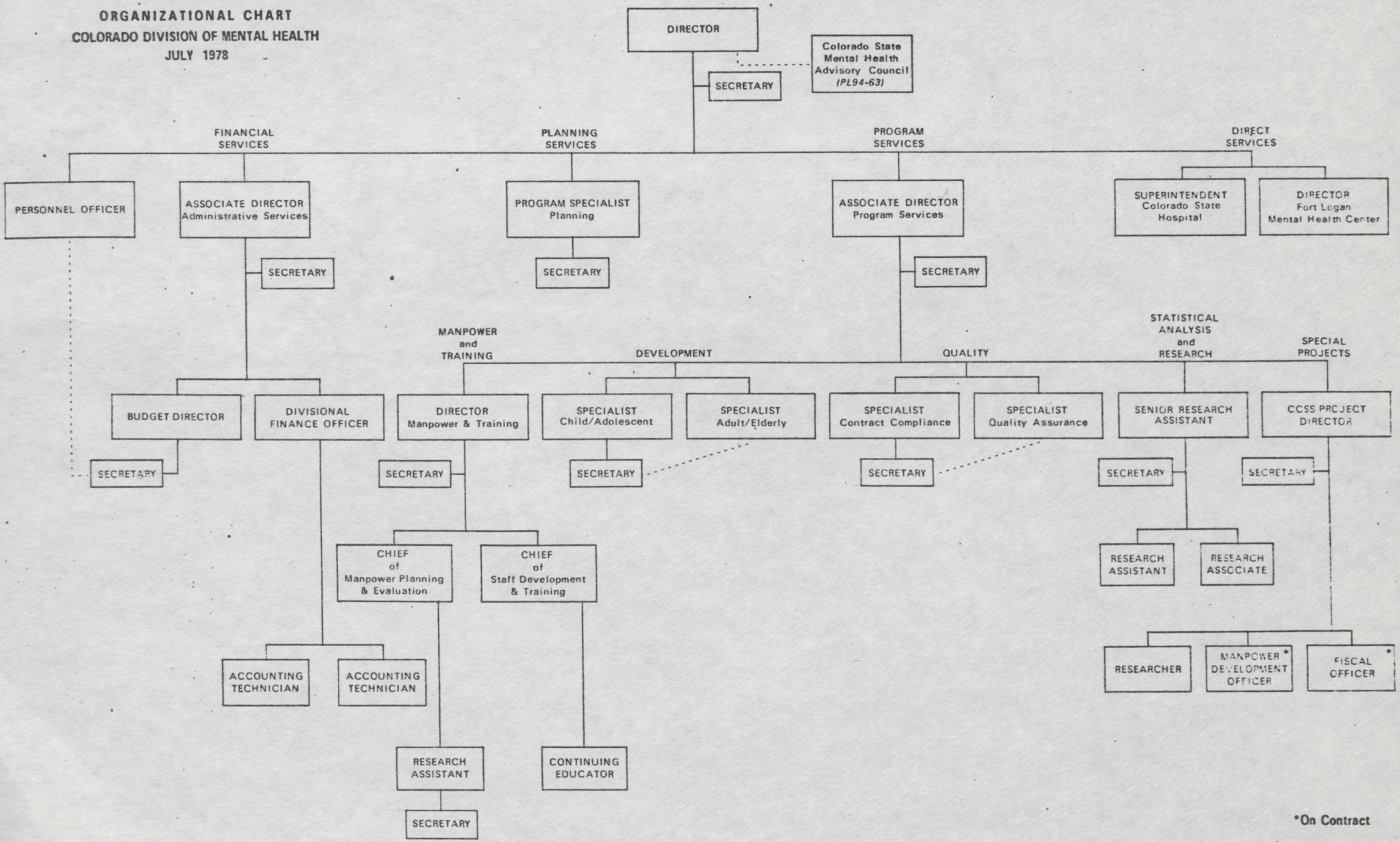
ORGANIZATIONAL CHART
DEPARTMENT OF INSTITUTIONS

FIGURE 1



1978

FIGURE 2


ORGANIZATIONAL CHART
COLORADO DIVISION OF MENTAL HEALTH
JULY 1978
DIRECTOR
SECRETARY
Colorado State Mental Health Advisory Council (PL94-63)
FINANCIAL SERVICES
PLANNING SERVICES
PROGRAM SERVICES
DIRECT SERVICES
PERSONNEL OFFICER
ASSOCIATE DIRECTOR Administrative Services
SECRETARY
PROGRAM SPECIALIST Planning
SECRETARY
ASSOCIATE DIRECTOR Program Services
SECRETARY
SUPERINTENDENT Colorado State Hospital
DIRECTOR Fort Logan Mental Health Center
MANPOWER and TRAINING
DEVELOPMENT
QUALITY
STATISTICAL ANALYSIS and RESEARCH
SPECIAL PROJECTS
BUDGET DIRECTOR
SECRETARY
DIVISIONAL FINANCE OFFICER
DIRECTOR Manpower & Training
SECRETARY
SPECIALIST Child/Adolescent
SECRETARY
SPECIALIST Adult/Elderly
SPECIALIST Contract Compliance
SECRETARY
SPECIALIST Quality Assurance
SENIOR RESEARCH ASSISTANT
SECRETARY
CCSS PROJECT DIRECTOR
SECRETARY
CHIEF of Manpower Planning & Evaluation
CHIEF of Staff Development & Training
RESEARCH ASSISTANT
RESEARCH ASSOCIATE
ACCOUNTING TECHNICIAN
ACCOUNTING TECHNICIAN
RESEARCHER
MANPOWER DEVELOPMENT OFFICER*
FISCAL OFFICER*
RESEARCH ASSISTANT
SECRETARY
CONTINUING EDUCATOR
*On Contract

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 state 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 mental health delivery system. These principles emphasize the provision of cost-effective services close to home, based upon the needs of the population, 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 the identification of service needs, the availability and utilization of needed resources, the provision of quality care, coordination with other caregivers, the roles of various components of the system, administration of the system, 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 elderly, rape victims, and substance abusers; (3) pre-admission screening to reduce inpatient care; (4) the development of halfway houses and other alternatives to inpatient care; (5) follow-up care for persons who have been discharged from a mental health facility; and (6) services directed towards the prevention of mental illness.

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. Mental health agencies, however, are expected to mobilize and to 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.

Quarterly reports on the fiscal year 77-78 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.

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 goals and objectives which follow have been developed by the Division of Mental Health with input from a number of public, private, and voluntary agencies, organizations, and groups concerned with the quality of life for citizens in their communities.

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

1. GOAL 1

TO DETERMINE THE MENTAL HEALTH SERVICE NEEDS OF EACH REGION OF THE STATE AND TO SET PRIORITIES FOR MENTAL HEALTH SERVICES ON THE BASIS OF THIS NEED ASSESSMENT.

The delivery of mental health services must be based on sound management principles which include assessing the needs of the residents of the state, identifying the resources available to meet the needs, determining utilization of the available resources, and developing needed resources in the most cost-effective, efficient and comprehensive manner. This information must then be used to impact the mental health system in relation to the acquisition, provision, coordination, and evaluation of services.

2. GOAL 2

TO ACQUIRE MENTAL HEALTH SERVICES THROUGH A SYSTEM WHICH ENCOURAGES PROGRAM GROWTH AND FISCAL VIABILITY.

The intent behind this goal is to allow the state and the agencies in the state, who serve the mental health needs of the people, increased flexibility in the purchase and the provision of services. The development of a purchase of service arrangement encourages the program growth and fiscal viability of agencies contracting for services with the state. This also enables the state to purchase as little or as much of

selected services as it deems necessary.

The agencies from which services are purchased have the right to grow and guide their own futures; however, the state has the right and the responsibility to assure quality of care, effective functioning of essential elements of the mental health system, evaluation of patient care and program management, and the protection of rights of patients.

3. GOAL 3

> TO PROVIDE MENTAL HEALTH SERVICES THROUGH A SYSTEM WHICH EMPHASIZES IDENTIFICATION OF SERVICE NEEDS, LOCAL AVAILABILITY, ACCESSIBILITY, HIGH QUALITY CARE, CONTINUITY OF CARE AND COORDINATION WITH OTHER SYSTEMS.

The provision of services should be based on identified service needs by geographical areas, on appropriate utilization and integration of resources, and on continuity and quality of care.

In keeping with the philosophy of community mental health, services should be provided as close as possible to the client's home, in the most normal or home-like setting possible, and with emphasis on utilization of the least intensive service consistent with the treatment needs of the client. Services are to be provided in the local community whenever practicable. Inpatient services are to be used only for those clients for whom inpatient services are clearly indicated. The availability of alternative treatment facilities and preadmission screening are expected to reduce the inappropriate use of inpatient beds.

Some groups have been targeted because of the need for specific programs to meet their unique mental health needs. The fact that the identified groups are not mutually exclusive must be acknowledged and considered when planning for and providing mental health services to these populations.

Utilization reports indicate that children and adolescents and the elderly are underserved. Chicanos, the largest ethnic minority group in Colorado, require a range of services which take into consideration not only the cultural factors which affect all Chicanos, but the diversity of mental health needs within the Chicano population.

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 state-funded 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 severely psychiatrically disabled, many of whom are former state hospital inpatients. The intent is to insure that the severely psychiatrically 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.

An important element in the provision of services is the area of preventive services. These are services 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 preventive services 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.

Increased use of other mental health resources such as sheltered workshops and vocational rehabilitation programs will not only be beneficial to the clients, but will increase productivity and benefit the community.

In addressing the provision of services, it is also necessary to focus on the service providers. The Division of Mental Health encourages and supports the growth and development of the individuals who make-up the workforce.

4. GOAL 4

TO COORDINATE THE PLANNING AND DELIVERY OF MENTAL HEALTH SERVICES WITH OTHER HUMAN SERVICE AGENCIES.

Coordination is essential for the planning and provision of services. The primary intent of this goal is to work toward developing a unified human service delivery system. Coordination is an ongoing process. The objectives which have been established in this section reflect relationships between DMH and other agencies that need to be established as well as relationships through which a great deal of coordination has already been attained.

Many of the objectives relating to coordination are written for the next two years rather than the next five years. Objectives for the next three to five years will primarily be dependent upon the outcome of those already established. Future objectives, as they are developed, will be included in the updates of the Plan.

5. GOAL 5

TO EVALUATE MENTAL HEALTH SERVICES TO ENSURE HIGH QUALITY CLIENT CARE, EFFECTIVE FUNCTIONING OF THE ELEMENTS OF THE MENTAL HEALTH SYSTEM AND PROTECTION OF THE RIGHTS OF PATIENTS.

Services may be determined, acquired, provided, and coordinated; however, if they are to have any meaning, they must be evaluated for their impact on the system. Evaluation measures progress, identifies

duplication and gaps in services, assesses quality, determines effectiveness and establishes direction for the future.

B. OBJECTIVES

A chart which lists the following goals and objectives by year is included at the end of this chapter.

1. GOAL 1

> TO DETERMINE THE MENTAL HEALTH SERVICE NEEDS OF EACH REGION OF THE STATE AND TO SET PRIORITIES FOR MENTAL HEALTH SERVICES ON THE BASIS OF THIS NEED ASSESSMENT.

Sub-Goal A. To identify the mental health service needs of the residents of the state.

Objective (1) The assessment of mental health service needs for each catchment area based upon the survey of need (using MHDPS social indicators and population by age group) and the resource inventory (using facility inventories and utilization of service by age group) will be reviewed and revised by December 1, 1978.

Objective (2) A method for classifying targeted populations, targeted because of the need for specific programs to meet their unique mental health needs, will be established by January 1, 1979.

Objective (3) The existing need assessment data from selected

catchment area community mental health programs will be compiled and integrated by March 1, 1979.

Objective (4) A statewide needs assessment and community readiness study will be completed by the Community Support Systems Project for severely psychiatrically disabled adults by April 1, 1979.

Objective (5) A method for performing a geographically based need assessment by age group and level of severity will be developed by May 1, 1979.

Objective (6) A geographically based need assessment, using the method developed, will be completed by November 1, 1979.

Objective (7) A statewide assessment of the special mental health service needs of women will be completed by July 1, 1980.

Objective (8) A statewide assessment of the special mental health service needs of the Chicano population will be completed by October 1, 1980.

Objective (9) A statewide assessment of the special mental health service needs of other ethnic minorities will be completed by January 1, 1981.

Sub-Goal B. To identify all mental health resources available in the state.

Objective (1) A comprehensive inventory of the mental health resources in the state, with utilization data, will be completed by July 1, 1979.

Sub-Goal C. To impact the mental health delivery system through utilization of the data obtained in the assessments of service needs.

Objective (1) Service priorities for catchment areas, based upon the revised survey of need and resource inventory and the classification of target groups, will be assigned by March 1, 1979.

Objective (2) Service priorities for catchment areas, using the geographically based need assessment and comprehensive inventory of resources, will be assigned by January 1, 1980.

Objective (3) Special programs needed for each area will be determined by May 1, 1980.

Objective (4) Plans for specific programs tailored to meet the service needs of each area will be developed by October 1, 1980.

Objective (5) The resources required to implement the special programs, the cost of implementation, and the time frames for implementation will be determined by March 1, 1981.

Objective (6) The implementation of specific programs, based on priority and available funds, will begin by July 1, 1981.

2. GOAL 2

TO ACQUIRE MENTAL HEALTH SERVICES THROUGH A SYSTEM WHICH ENCOURAGES PROGRAM GROWTH AND FISCAL VIABILITY.

Objective (1) Comparable financial reporting systems for the two state hospitals will be established by January 1, 1979.

Objective (2) A comparable methodology for computing the unit costs for the centers and clinics and the two state hospitals will be established by April 1, 1979.

Objective (3) The purchase of service arrangement by target group which is developed will be implemented by July 1, 1979.

Objective (4) A prospective reimbursement plan will be fully implemented by January 1, 1980.

3. GOAL 3

TO PROVIDE MENTAL HEALTH SERVICES THROUGH A SYSTEM WHICH EMPHASIZES IDENTIFICATION OF SERVICE NEEDS, LOCAL AVAILABILITY, ACCESSIBILITY, HIGH QUALITY CARE, CONTINUITY OF CARE AND COORDINATION WITH OTHER SYSTEMS.

Sub-Goal A. To provide mental health services tailored to the special needs of children and adolescents (ages 0-17 years).

Objective (1) An evaluation of the continuity of care process relating to children and adolescents in out-of-home placements will be completed by July 1, 1979.

Objective (2) A method of describing and classifying child and adolescent program services will be developed by July 1, 1979.

Objective (3) A data system reflecting the treatment needs of multi-handicapped children and adolescents will be developed by April 1, 1980.

Objective (4) A uniform classification system of children's disorders and degree of severity will be proposed by July 1, 1980.

Objective (5) Each catchment area agency will assure mental health services to moderately and severely disturbed children requiring partial and other 24-hour care either directly or through written agreements with affiliate agencies by July 1, 1980.

Objective (6) A coordinated child and adolescent service plan between the Departments of Social Services, Education, Health, Criminal Justice and the University of Colorado Medical Center will be developed by July 1, 1980.

Objective (7) Specialized programs for the emotionally disturbed child who is also neurologically impaired, developmentally disabled, deaf, blind, terminally ill, assaultive, a substance abuser or an abused child

will be assessed to determine service needs by July 1, 1980.

Objective (8) Prevention programs and early identification projects will be initiated by July 1, 1981.

Objective (9) The amount of service to moderately and severely disturbed children and adolescents in each catchment area which needs to be provided will be reassessed by July 1, 1981.

Sub-Goal B. To provide mental health services tailored to the special needs of adults.

Objective (1) Projects specifically funded by the General Assembly for services in rural areas will be operative in Southwest Colorado, Southeast Colorado, and East Central Colorado by August 1, 1978.

Objective (2) The DMH will submit an application for a technical assistance grant for the training of administrators of programs for chronic psychiatrically disabled adults by October 1, 1978.

Objective (3) Projects specifically funded by the General Assembly which will provide specialized services to chronic psychiatrically disabled adults will be operative in the Adams County and Jefferson County catchment areas by October 1, 1978.

Objective (4) A model community support system for chronic psychiatrically disabled adults will be operational in the Southwest Denver catchment area by

December 1, 1978.

Objective (5) Reports on the initial assessment of the projects specifically funded by the General Assembly for specialized services to chronically psychiatrically disabled adults will be submitted to DMH by Northwest Denver, Pikes Peak, Spanish Peaks, Colorado West, Adams County, and Jefferson County Mental Health Centers by December 15, 1978.

Objective (6) Reports on the initial assessment of the projects specifically funded by the General Assembly for mental health services in rural areas will be submitted to DMH by Southwest Colorado, Southeast Colorado, and East Central Colorado Mental Health Clinics by December 15, 1978.

Objective (7) A report on the projects for specialized services to chronic psychiatrically disabled adults which will include evidence of the effect of the programs and data on the size and characteristics of the population these programs are serving will be submitted to the Joint Budget Committee by January 1, 1979.

Objective (8) A report on the projects for services in rural areas which will include evidence of the need for the rural programs and the effects of these programs upon the populations served will be submitted to the Joint Budget Committee by January 1, 1979.

Objective (9) The community support system model developed in Southwest Denver will be adapted for Pueblo by CSH by March 1, 1979.

Objective (10) The HUD Section VIII rent subsidy component of the community support system model developed in Southwest Denver will be replicated in Grand Junction and Durango by March 1, 1979.

Objective (11) A comprehensive management plan for the development of community support systems for severely psychiatrically disabled adults will be developed by April 1, 1979.

Objective (12) The number of agreements between Community Mental Health Centers/Clinics and Sheltered Workshops will be increased by four by July 1, 1979.

Objective (13) The number of vocational rehabilitation counselors working in each catchment area will be increased by four by July 1, 1979.

Objective (14) The utilization of work-related rehabilitation services will be reassessed by January 1, 1982.

Sub-Goal C. To provide mental health services tailored to the special needs of the elderly.

Objective (1) An affiliation agreement with the Department of Social Services, Title XX Division, and the Division on Aging to jointly develop a model agreement to be utilized by the local county Departments of Social Services, the Area Agencies

on Aging Nutrition Sites and local community mental health centers/clinics will be developed by October 1, 1978.

Objective (2) A residential treatment home for the elderly will be opened at Colorado State Hospital by January 1, 1979.

Objective (3) A lodge for the elderly will be opened on the grounds of Colorado State Hospital by January 1, 1979.

Objective (4) The number of service arrangements between community mental health centers/clinics and nursing homes will be increased by twenty by July 1, 1979.

Sub-Goal D. To provide mental health services tailored to the special needs of targeted populations with unique mental health needs.

Economically Disadvantaged:

Objective (1) A proposal for increasing the availability of Medicaid funds for mental health services for the economically disadvantaged will be developed, in collaboration with the Department of Social Services, the Office of State Planning and Budgeting, the Centers and Clinics Association, and other appropriate agencies, by July 1, 1979.

Ethnic Minorities:

Objective (2) A model affirmative action plan for use at the

board, staff, and program levels will be developed by January 1, 1979.

Objective (3) A Standing Committee on Racism will be established by January 1, 1979.

Objective (4) A proposal for a model service delivery system for the Chicano population, including special services for Chicano youth and Chicano elderly, will be developed by July 1, 1980.

Objective (5) The percentage by which services to ethnic minorities in each area need to be increased will be determined by January 1, 1981.

Rape/Sexual Abuse Victims:

Objective (6) Each catchment area will submit a plan to DMH for services to rape/sexual abuse victims which must be approved by DMH in accordance with the annual contract by July 1, 1979.

Objective (7) Each catchment area will assure mental health services to victims of rape/sexual abuse either directly or through written agreements with affiliate agencies by July 1, 1980.

Rural Residents:

Objective (8) A pilot study which focuses on the integration of rural health and mental health service delivery systems will be developed by March 1, 1979.

Women:

Objective (9) A Standing Committee on Sexism will be established

by October 1, 1978.

Objective (10) Each catchment area will submit a plan to DMH for specific programs designed to meet the special needs of women which must be approved by DMH in accordance with the annual contract by January 1, 1981.

Sub-Goal E. To increase public knowledge of mental health services and ways of preventing mental illness.

Objective (1) At least one statewide seminar, workshop, or other public education program related to the prevention of mental illness will have been conducted or sponsored annually by July 1, 1983.

Sub-Goal F. To provide mental health services through a system which encourages and supports the growth and development of its workforce.

Objective (1) The DMH will request funds for initiating a state-funded manpower development capacity as stipulated in the Colorado Mental Health Manpower Development grant application by August 1, 1978.

Objective (2) An orientation and training program suitable for general training of volunteers working with severely disabled adults will be developed within the Community Support System Project for statewide utilization by October 1, 1978.

Objective (3) The Colorado Community Support System Project will provide at least one workshop for teams working

with the severely psychiatrically disabled adults to expand their areas of expertise necessary for effectively establishing supportive and rehabilitative services for their clients by December 1, 1978.

Objective (4) The DMH will have sponsored a consciousness-raising program on sexism in mental health by July 1, 1979.

Objective (5) Regional workshops will be provided for orientation and interpretation of the two state hospitals' Continuity of Care Policies and Procedures and the Policies and Procedures developed for the Inter-center Transfers and Placements by July 1, 1979.

Objective (6) 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 by July 1, 1979.

Objective (7) The Division of Mental Health, in collaboration with FLMHC and CSH, will have completed the refinement of SCOPE and will be using it as a basis for planning the staffing of inpatient units in the two state hospitals by July 1, 1979.

Objective (8) The DMH will provide at least one training program on the Chicano family by January 1, 1980.

Objective (9) A uniform system for reporting services provided by volunteers will be developed by January 1, 1980.

Objective (10) The DMH will sponsor a training program on women in mental health management by April 1, 1980.

Objective (11) Guidelines for volunteer services in mental health centers/clinics and hospitals will be reviewed and revised by July 1, 1982.

Sub-Goal G. To provide mental health services through a system which is based on provision of services in the client's community.

Objective (1) All catchment areas will have 24-hour emergency care available by July 1, 1979.

4. GOAL 4

TO COORDINATE THE PLANNING AND DELIVERY OF MENTAL HEALTH SERVICES WITH OTHER HUMAN SERVICE AGENCIES.

Sub-Goal A. To coordinate the planning efforts of all health planning agencies.

Objective (1) The relationship between the State Mental Health Advisory Council and the State Health Coordinating Council will be clarified and established by January 1, 1979.

Objective (2) The responsibilities of the DMH in the development of the mental health section of the State Health Plan will be determined in collaboration with the State Health Planning and Development Agency by March 1, 1979.

Objective (3) The roles and responsibilities of the DMH and the Health Systems Agencies in relation to mental

health planning will be determined by March 1, 1979.

Sub-Goal B. To coordinate interdepartmental program planning.

Objective (1) DMH, the Division on Aging, the Division of Medical Assistance, and the Title XX Division of Social Services will meet on a quarterly basis to improve communications and to facilitate and improve coordination of services at the local level beginning July 1, 1978.

Objective (2) Representatives from the Alcohol and Drug Abuse Division (ADAD) and DMH will conduct a public meeting with providers of substance abuse services and concerned citizen organizations regarding a discussion of continuing issues in coordinating service delivery by November 1, 1978.

Objective (3) Issues identified at the public meeting will be presented to the ADAD and DMH with potential policy recommendations by January 1, 1979.

Objective (4) 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 by January 1, 1979.

Objective (5) DMH and ADAD will issue a joint policy statement on client confidentiality and the procedural

guidelines to be followed by community treatment programs by March 1, 1979.

Objective (6) The DMH and the DSS will develop procedures for the coordinated provision of services for the elderly by April 1, 1979.

Objective (7) DMH and the Division of Criminal Justice (DCJ) will coordinate mutual training resources in areas of concern to both divisions, i.e., sexual assault victims and treatment of offenders by June 1, 1979.

Objective (8) DMH and DCJ will develop a plan to gather data on the mental health service needs of offenders by June 1, 1979.

Objective (9) The DMH and the Department of Social Services (DSS) will determine methods for improved coordination and facilitation of referrals for services by July 1, 1979.

Objective (10) A specific program coordination mechanism for the DMH and the Department of Education will be developed by October 1, 1979.

Objective (11) The DMH and the Department of Corrections (DC) will have reviewed DMH services to the DC and developed goals for increased coordination by October 1, 1979.

Objective (12) The DMH and the DSS will determine methods for expanded vocational rehabilitation services for

mental health clients by November 1, 1979.

Sub-Goal C. To coordinate interdivisional program planning.

Developmental Disabilities:

Objective (1) DMH and DDD will develop a listing of sources of training grant funds and application packets for training grants for DD and MH agencies and will encourage and offer technical assistance to DDD and DMH agencies which wish to make joint applications for training grants by November 1, 1978.

Objective (2) DMH and DDD will develop a joint written policy which sets forth the mental health services which should be available to DD clients as residents of a catchment area and the specialized or specific mental health services which might be provided to DD clients under contractual agreements between DD and MH agencies by March 1, 1979.

Objective (3) DMH and DDD will determine staff training needs in the developmental disabilities area for mental health agencies, and the mental health area for DD agencies by March 1, 1979.

Objective (4) DMH and DDD will jointly conduct at least one training program for staff of DMH and DDD related agencies by December 1, 1979.

Youth Services:

Objective (5) The Division of Youth Services (DYS) and the Adolescent Treatment Staff at FLMHC will have

developed and applied a baseline attitude measure to improve communications between the two programs by January 1, 1979.

Objective (6) A three-year staff exchange program between DYS and FLMHC, whereby staff members from DYS and FLMHC will exchange positions for brief periods, will have been implemented by July 1, 1979.

Objective (7) The impact of the DYS/FLMHC exchange program will be measured each year the program is in effect beginning July 1, 1979.

Objective (8) A common intake procedure for placement in either CATC or FLMHC Adolescent II will be implemented by July 1, 1979.

Objective (9) The Interdivisional Placement Team concept will be revised by July 1, 1979.

Sub-Goal D. To provide a coordinated program of appropriate consultation and education to other professionals and lay citizens.

Objective (1) Guidelines for the provision of consultation and education services will be developed by March 1, 1980.

5. GOAL 5

TO EVALUATE MENTAL HEALTH SERVICES TO ENSURE HIGH QUALITY CLIENT CARE, EFFECTIVE FUNCTIONING OF THE ELEMENTS OF THE MENTAL HEALTH SYSTEM AND PROTECTION OF THE RIGHTS OF PATIENTS

Sub-Goal A. To establish uniform means to monitor and insure quality of service delivery through systems for site assessments and other monitoring mechanisms.

Objective (1) The on-site assessment process addressing quality of client care and program effectiveness will be reviewed and revised by October 1, 1978.

Objective (2) Responsibility for assessing compliance with the standards, rules, regulations, and policies for mental health centers and clinics which are not related to clinical quality will be assigned to non-mental health professionals by January 1, 1980.

Objective (3) Each center/clinic will have been assessed using the new on-site assessment approach addressing quality of care by August 1, 1980.

Sub-Goal B. To evaluate the Standards/Rules and Regulations for Mental Health Centers and Clinics to assure quality and continuity of care in the provision of mental health services.

Objective (1) The Division of Mental Health will have developed a data base for use in revising, monitoring, and enforcing the Care and Treatment of the Mentally Ill Act by October 1, 1978.

Objective (2) The State Standards/Rules and Regulations for Mental Health Centers and Clinics will be completely revised by July 1, 1980.

Sub-Goal C. To develop a system for evaluating treatment outcome.

Objective (1) A methodology for monitoring and assessing the quality of the treatment outcome data will be devised in conjunction with the centers/clinics by January 1, 1979.

Objective (2) The various audiences who require treatment outcome evaluation information will be identified, along with their specific needs and interests by January 1, 1979.

Objective (3) A set of project descriptions will be written to provide the basis for seeking financial support of treatment outcome evaluation projects by January 1, 1979.

Objective (4) Specific needs for communication links between managers and treatment outcome evaluators will be identified, and a plan (including a budget) for meetings developed (such meetings are for the purposes of obtaining input into the evaluation research, and interpreting data results and their implications for program) by January 1, 1979.

Objective (5) The agencies' needs and desires for technical assistance for increasing their treatment outcome evaluation capabilities will be identified by July 1, 1979.

Objective (6) A plan (including a budget) for inter-agency information sharing and joint projects related to treatment outcome evaluation will be developed by

July 1, 1979.

Objective (7) Treatment outcome measures to be used on at least one target group, for which the general treatment outcome measure is inappropriate, will be pilot tested by January 1, 1980.

Sub-Goal D. To develop data systems for evaluating utilization and assuring quality control.

Objective (1) Six months cumulative data relating to admissions and exits categorized by level of severity and to cost per unit and per treatment episode will be collected by delivery system, analyzed and presented to the Joint Budget Committee by February 1, 1979.

Objective (2) Data relating to the number of contacts and clients supported by federal, state and local funds as of December 31, 1978, will be available for each mental health center/clinic by February 1, 1979.

Objective (3) A data system that relates to children and adolescent program units will be developed by July 1, 1979.

Objective (4) A uniform admission and reporting system for clients sixty years of age or older will be developed by July 1, 1979.

Objective (5) A data system which can produce information on the type, length, and cost of care for each client and which can also be used for utilization and quality review will be developed by July 1, 1979.

Objective (6) The data system which is developed to provide

information on the type, length, and cost of care for each client will have a first phase implementation by July 1, 1980.

COLORADO STATE MENTAL HEALTH PLAN

STATEWIDE GOALS AND OBJECTIVES

1978 - 1983

Fiscal Year	GOAL 1 ASSESSMENT OF SERVICE NEEDS	GOAL 2 ACQUISITION OF SERVICES	GOAL 3 PROVISION OF SERVICES	GOAL 4 COORDINATION OF SERVICES	GOAL 5 EVALUATION OF SERVICES
1978 - 1979	(1/A/1) Need assessment based on survey of need and resource inventory revised. (1/A/2) Method for classifying targeted populations established. (1/A/3) Existing need assessment data from selected catchment areas integrated. (1/C/1) Service priorities for catchment areas assigned. (1/A/4) Needs assessment and community readiness study completed by CCSS. (1/A/5) Method for geographically based need assessment by age and level of severity developed. (1/B/1) Comprehensive inventory of mental health resources completed.	(2/1) Comparable financial reporting systems for the state hospitals established. (2/2) Comparable methodology for computing unit costs for centers/clinics and state hospitals established. (2/3) Purchase of service arrangement by target group implemented.	(3/B/1) Special rural projects in SW, SE, and East Central Colorado operative. (3/F/1) Funds for initiating a state-funded manpower development capacity requested. (3/B/2) Application for T.A. grant for training of administrators of programs for chronic psych. disabled submitted. (3/B/3) Projects to provide specialized services to chronic psych. disabled in Adams Co. and Jefferson Co. operative. (3/C/1) Affiliation agreement with Dept. of Soc. Services and Div. on Aging developed. (3/D/9) Standing Committee on Sexism established. (3/F/2) CCSS orientation and training program for volunteers developed. (3/B/4) Model community support system operational in Southwest Denver. (3/F/3) Workshop for teams working with CCSS clients provided. (3/B/5) Reports on projects funded for specialized services to chronically psych. disabled submitted to DMH. (3/B/6) Reports on projects funded for services in rural areas submitted to DMH. (3/B/7) Report on projects for specialized services to chronic psych. disabled adults submitted to JBC.	(4/B/1) DMH, Div. on Aging, Div. of Medical Asst., and Title XX Div. will have met to improve coordination of services. (4/B/2) Public meeting with providers of substance abuse services and citizen organizations conducted by DMH and ADAD. (4/C/1) Training grants for DD and MH agencies assessed. (4/A/1) Relationship between SMHAC and SHCC clarified and established. (4/B/3) Issues in coordinating service delivery presented to the ADAD and DMH. (4/B/4) Follow-up report to the HSPC and the SHCC developed by ADAD-DMH. (4/C/5) Baseline attitude measure between DYS and FLMHC Adolescent Treatment Staff applied. (4/A/2) Responsibilities of DMH for the mental health section of the State Health Plan determined. (4/A/3) Relationship of DMH and the HSAs to mental health planning determined. (4/B/5) Joint policy statement on confidentiality and procedural guidelines issued by DMH and ADAD. (4/C/2) Joint written policy for mental health services to DD clients developed by DMH and DD. (4/C/3) Staff training needs in DD and MH agencies determined. (4/B/6) Procedures for coordinated provision of services for elderly developed by DMH and DSS.	(5/A/1) On-site assessment process revised. (5/B/1) Data base for CRS 27-10 developed. (5/C/1) Methodology for monitoring and assessing quality of treatment outcome data devised. (5/C/2) Audiences who require treatment outcome information identified. (5/C/3) Project descriptions for financial support of treatment outcome projects written. (5/C/4) Needs for communication links between managers and treatment outcome evaluators identified. (5/D/1) Six months cumulative data presented to the JBC. (5/D/2) Data for contact and clients supported by federal, state and local funds available. (5/C/5) Agencies' needs for technical assistance for increasing treatment outcome capabilities identified. (5/C/6) Plan for inter-agency information sharing for treatment outcome developed. (5/D/3) Data system for children/adolescent program units developed. (5/D/4) Uniform reporting system for clients sixty or older developed. (5/D/5) Data system on type, length, and cost of care for each client developed.

Fiscal Year	GOAL 1 ASSESSMENT OF SERVICE NEEDS	GOAL 2 ACQUISITION OF SERVICES	GOAL 3 PROVISION OF SERVICES	GOAL 4 COORDINATION OF SERVICES	GOAL 5 EVALUATION OF SERVICES
1979-1980	(1/A/6) Geographically based need assessment completed. (1/C/2) Service priorities for catchment areas reassigned. (1/C/3) Special programs needed for each area determined. (1/A/7) Assessment of special service needs of women completed.	(2/4) Prospective reimbursement plan fully implemented.	(3/F/8) Training program on the Chicano family provided. (3/F/9) Uniform system for reporting volunteer services developed. (3/A/3) Data system for treatment needs of multi-handicapped children/adolescents developed. (3/F/10) Training program on women in mental health management provided. (3/A/4) Uniform classification system of children's disorders proposed. (3/A/5) Mental health services to children requiring partial and other 24-hour care assured. (3/A/6) Agency coordinated child/adolescent service plan developed. (3/A/7) Service needs for specialized programs for the child with multiple disabilities assessed. (3/D/4) Proposal for model service delivery system for Chicano population developed. (3/D/7) Mental health services to victims of rape/sexual abuse assured.	(4/B/10) Coordination mechanism for DMH and DC developed. (4/B/11) Goals for increased coordination between DMH and DC developed. (4/B/12) Methods for expanded voc. rehab. services determined by DMH and DSS. (4/C/4) Training program for staff of DMH and DDD agencies conducted. (4/D/1) Guidelines for consultation and education services developed.	(5/A/2) Assessing compliance with standards not related to clinical quality assigned to non-mental health professionals. (5/C/7) Treatment outcome measures on one target group pilot tested. (5/B/2) Standards/Rules and Regs. for Centers/Clinics revised. (5/D/6) First phase of data system on type, length, and cost of care for each client implemented.
1980-1981	(1/A/8) Assessment of special service needs of Chicanos completed. (1/C/4) Plans for specific programs to meet the needs of each area developed. (1/A/9) Assessment of special service needs of other ethnic minorities completed. (1/C/5) Resources, cost, and time frames to implement special programs determined. (1/C/6) Implementation of specific programs will begin.		(3/D/5) Percentage by which services to ethnic minorities need to be increased determined. (3/D/10) Plans for specific programs for women submitted to DMH. (3/A/8) Prevention programs and early identification projects initiated. (3/A/9) Amount of service to moderately and severely disturbed children/adolescents in each area reassessed.		(5/A/3) Each center/clinic assessed using the new on-site assessment.
1981-1982			(3/B/14) Utilization of work-related rehabilitation services reassessed. (3/F/11) Guidelines for volunteer services revised.		
1982-1983			(3/E/1) One statewide public education program related to prevention conducted or sponsored annually.		

In the parentheses preceding each objective, the first number indicates the goal, the letter indicates the sub-goal, and the last number indicates the objective.

Fiscal Year	GOAL 1 ASSESSMENT OF SERVICE NEEDS	GOAL 2 ACQUISITION OF SERVICES	GOAL 3 PROVISION OF SERVICES	GOAL 4 COORDINATION OF SERVICES	GOAL 5 EVALUATION OF SERVICES
1978-1979			(3/B/8) Report on the projects for services in rural areas submitted to JBC. (3/C/2) Residential treatment home for the elderly at CSH opened. (3/C/3) Lodge for the elderly at CSH opened. (3/D/2) Model affirmative action plan developed. (3/D/3) Standing Committee on Racism established. (3/B/9) Community support system model adapted for Pueblo. (3/B/10) The HUD Section VIII rent subsidy component of CCSS model replicated in Grand Junction and Durango. (3/D/8) Pilot study on integration of rural health and mental health services developed. (3/B/11) Comprehensive management plan for CCSS developed. (3/A/1) Evaluation of continuity of care for children/adolescents in out-of-home placements completed. (3/A/2) Method of classifying child/adolescent program services developed. (3/B/12) Agreements between Centers/Clinics and Sheltered Workshops increased by four. (3/B/13) Vocational rehabilitation counselors in each area increased by four. (3/C/4) Service arrangements between centers/clinics and nursing homes increased by twenty. (3/D/1) Proposal for increasing Medicaid funds for economically disadvantaged developed. (3/D/6) Plans for services to rape/sexual abuse victims submitted to DMH. (3/F/4) Consciousness-raising program on sexism in mental health provided. (3/F/5) Regional workshops on Continuity of Care Policies and Procedures provided. (3/F/6) Proposal for funding of training needs of centers/clinics and hospitals developed. (3/F/7) Refinement and implementation of SCOPE in the state hospitals completed. (3/G/1) 24-hour emergency care available statewide.	(4/B/7) Mutual training resources coordinated by DMH and DCJ. (4/B/8) Plan to gather data on mental health needs of offenders developed by DMH and DCJ. (4/B/9) Methods for improved coordination of referrals determined by DMH and DSS. (4/C/6) Three-year staff exchange program between DYS and FLMHC implemented. (4/C/7) Impact of DYS/FLMHC exchange program measured. (4/C/8) Common intake procedure for placement in CATC or FLMHC Adolescent II implemented. (4/C/9) Interdivisional Placement Team concept revised.	

Chapter IV

THE STATE MENTAL HEALTH PROGRAM

IV. THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF THE STATE MENTAL HEALTH SYSTEM

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

Division of Mental Health

The Division of Mental Health exercises the following responsibilities.

1. Planning

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

2. Coordination

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

3. Executive Direction

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

The Division of Mental Health (DMH) has responsibility for monitoring the programs and services of the state hospitals and centers and clinics to ensure compliance with standards, to assess the quality of services, and to assist the agencies in improving services.

4. Consultation

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

5. Evaluation and Accountability

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

6. Advocacy

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

The client advocacy function includes:

a. requiring agencies to make services available to all who require mental health services, regardless of race, sex, religious beliefs, age, level of disability, etc., and requiring agencies to provide services in a manner which takes into consideration cultural and other variables;

b. publication of a handbook on patient's rights and responsibilities

which sets forth the legal rights of patients;

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

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

State-Owned Facilities and Agencies Contracting with the State

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

b. Fort Logan Mental Health Center (FLMHC) is located in southwest Denver. It serves the Denver metropolitan area, northeastern Colorado, and eight counties in north-central Colorado.

c. There are twenty-four mental health centers and clinics from which the state purchases mental health services. Seventeen centers and four clinics serve specific catchment areas and three clinics are specialty programs. A center is defined as an agency which provides at least the five "essential" services defined in State Statutes (inpatient, partial hospitalization, outpatient, 24-hour emergency care and consultation and education). A clinic provides fewer than the five essential services, but must, at a minimum, provide outpatient, consultation and education and emergency services. In actuality, some "clinics" provide the same services as some centers, but have not been

funded as comprehensive centers. All centers and clinics are private, non-profit corporations except the Larimer County Mental Health Center and Northwest Denver Mental Health Center, both of which are county agencies.

d. Colorado Psychiatric Hospital (CPH) is located in Denver on the University of Colorado Medical Center campus. In addition to serving as a resource for complex medical/psychiatric services throughout the state, CPH also serves as a back-up to many of the Metropolitan Denver area mental health centers.

Private/Voluntary Treatment Resources

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

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

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

d. Other resources include the following:

(1) volunteer agencies which provide treatment and/or personal counseling services (These include Human Services Incorporated, Jewish Family and Children's Service, Catholic Community Services and Lutheran Service Society.);

(2) other agencies whose functions include personal counseling (e.g., county departments of social services, probation and

parole departments, vocational rehabilitation programs, community centers for the developmentally disabled, public health nurses);

(3) sheltered workshops which provide such services as evaluation, work activity, short and long term work adjustment programs, sheltered employment, work stations in industry, and placement. Many of these workshops are geared specifically for psychiatric patients (e.g., Bayaud Industries, Bridge Industries, Adams County Work and Evaluation Center);

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

B. PRE-ADMISSION SCREENING

1. Role of Hospitals and Centers and Clinics

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 criteria for admission to inpatient care at the state hospitals, and guidelines for facilitating easy movement and continuous care for clients within the system. Policy statements based on the Committees' work will be prepared and issued by the DMH Central

Office as the procedures are 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 admission office which greatly facilitates the referral and continuity of care process.

The pre-admission screening of youth is also the primary responsibility of the centers/clinics; however, the Colorado Children's Code specifies that the courts may use their discretion in bypassing centers/clinics and ordering the child directly to the hospital when appropriate.

The DMH policy for having persons enter the mental health system through the catchment area center or clinic is to have the pre-admission screening function take place in the local community. Primary emphasis is on the provision of the necessary services as close to the individual's home as possible and in the least intensive setting consistent with the individual's clinical needs.

Some types of clients referred directly to CSH include forensic clients or the "criminally insane", general hospital patients, and alcoholism and drug abuse clients. CSH has statutory responsibility for forensic clients. Generally, the only clients referred directly to FLMHC are alcoholism clients and clients under court order. Both state hospitals' roles currently include inpatient services to persons in the four age groups (children, adolescents, adult, elderly).

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

   a. All catchment area centers and clinics shall inform the district courts, social service departments and other major referral sources in the catchment area of the center's/clinic's responsibility

for pre-admission screening of all potential inpatient clients.

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

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

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

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

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

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

(6) other factors, e.g., previous medical and/or psychiatric history, financial circumstances and the availability of less restrictive

alternatives, etc., should be considered.

The decision regarding the type or locus of treatment is basically a clinical judgment, in that by state statute, the treatment program must be under the overall direction of a physician. The responsible physician in each agency shall designate, to perform pre-admission screening functions, those staff members who have the requisite training, skill and experience.

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

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

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

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

contact the agency which directed the client to the hospital to clarify the referral process.

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

C. ALTERNATIVES TO HOSPITALIZATION

1. Need Within Each Catchment Area

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

2. Responsibility for Developing Alternatives

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

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

3. Efforts to Develop Alternatives to Hospitalization

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

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

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

5. Other 24-Hour Care

During the past two years, the DMH has placed increased emphasis on the elimination of inappropriate hospitalization through the stepped-up pre-admission 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 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.

D. STATE MENTAL HOSPITALS

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

Fort Logan Mental Health Center

1. Description of Living Conditions and Treatment Resources

a. Living Conditions

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

The campus of FLMHC consists of 233 acres and includes many state and community programs, in addition to psychiatric programs as follows: Central Office for the Department of Institutions, including the Executive Director's Office, Division of Mental Health, Division of Developmental Disabilities and Division of Youth Services; Intergovernmental Personnel Training Program, a division of the State Personnel Department; two CHINS Homes (Arapahoe County program); Community Corrections Residential Program (a program sponsored by Adult Parole); PEER I (a residential drug treatment program operated by the University of Colorado Medical Center).

b. Treatment Resources Available

Fort Logan has multi-disciplinary teams which are responsible for planning and delivering psychiatric treatment. Disciplines represented on teams or available for consultation include

social workers, psychiatric nurses, psychiatrists, occupational therapists, psychologists, recreational therapists, teachers and mental health workers. Psychiatric vocational services are provided in a spectrum of workshops ranging from work activity shops to nearly competitive employment shops, through programs which place clients in private industries, and by vocational counselors for eligible clients through funding from the Division of Vocational Rehabilitation of the Department of Social Services.

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

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

2. Efforts to Improve Quality of Institutional Care

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

   b. The Medical Records Committee has responsibility to review

proposals for changing the medical record, for reviewing deficiencies, for auditing the quality of documentation of medical information and assessing training and consultation needs of clinical staff.

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

d. 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.

e. The Professional Discipline Chiefs of various professional groups (psychiatrists, psychologists, social workers, nurses, activity therapists, mental health workers, vocational counselors, pastoral counselors and alcoholism counselors) within the center have major responsibilities for standards of professional practice

related to quality of patient care, for supervision of and consultation with members of their discipline and others.

f. Inservice training programs are available to all staff through the Coordinator of Training.

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

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

3. Description of Present Fort Logan Mental Health Center Population

Fort Logan Mental Health Center is organized to provide treatment to children, adolescents, adults, geriatric patients and alcoholics who have severe 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 and intensive treatment and early return of the patient to community living. With the changing role of Fort Logan in the mental health system, this commitment has remained and an additional commitment to long term treatment both within the hospital and in aftercare for certain particular people has been added. The population treated receives not only inpatient care, but in the case of the selected long term people 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.

The major reorganization of Fort Logan which was begun in 76-77 was completed and fully implemented as of the first of July. The reorganization was initiated specifically to reduce the cost per day of inpatient care and achieved an approximately 14 percent reduction not allowing for inflationary factors. The reorganization increased the total of inpatient, intermediate care, and transitional on-grounds beds to 324 from 252. Since the increased bed capacity has been implemented, a gradually growing ADA and bed occupancy has been noted such that currently the Children/Adolescent Services run around 88 to 90 percent occupancy and the Adult Service 85 to 95 percent occupancy. The workload in Adult Psychiatry has grown such that currently an additional reorganization of Adult Psychiatry is being planned so that Fort Logan can more effectively serve its adult psychiatry clients. In the 75-76 General Assembly and again in the 76-77 session, footnotes were added regarding comparisons of the Children/Adolescent Services with Residential Child Care Facilities (RCCFs). This study has been completed but aside from the study the much increased use of the services indicate that the increased beds for those age groups were quite necessary.

Fort Logan serves twenty-two counties. 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 thirteen 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 Aurora, and on contract with some local centers. Currently, the basic responsibility of FLMHC is 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

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

5. Plans for Providing Social and Recreational Stimulation

The treatment philosophy of the FLMHC is based on rehabilitating and developing social skills as a part of the treatment of people admitted. The total treatment process recognizes and encourages social interaction as a basic therapeutic strategy. The Activity Therapy Program focuses on the growth potential of the client through activities and recreational

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

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

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

It is planned that over the next five-year period the Fort Logan Mental Health Center will evolve into the role of a primary provider of short-term inpatient care for the catchment areas in the Denver metroplex in addition to its long-term inpatient care role for the 22 counties that

it serves. The centers and clinics will have input into admissions, treatment plans, and discharge decisions. This inpatient care responsibility will include the development of long-term residential treatment units for people who cannot be handled in the community. This will also include a unit for long-term residential care borderline patients. Whether there is an increase in the size of the inpatient service 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 and Aurora, has an identified inpatient service within its catchment area. However, as Federal staffing grants expire, cost considerations will make it advisable to centralize inpatient services for those catchment areas close to FLMHC at FLMHC.

It should be noted that no attempt is made in this Plan to require arbitrary increases or decreases in the average daily attendance at Fort Logan Mental Health Center during the next five years. Previous attempts to set such figures have been counter-productive. The basic principle around which the mental health system in Colorado has been developed is the provision of services in the least restrictive setting, and as close to a person's home as possible. We believe that by emphasizing pre-screening at the community mental health center/clinic level, closer collaboration with courts and other referring agencies, the development of residential alternatives to hospital care, and continued refinement of the continuity of care process, appropriate utilization of hospital beds will be achieved. However, utilization of the existing beds will change from time to time

based on the inpatient needs of various subpopulations. The average daily attendance (ADA) will be allowed to fluctuate in response to legitimate demand. The DMH, however, will monitor the ADA closely and make every effort to keep it at or below the average for the preceding three years. Adequate funding should be provided to meet the actual need for Fort Logan Mental Health Center services on a year to year basis.

For the foreseeable future, the aftercare programs including the Lodge, Family Care, and supervised boarding homes will be continued. The hospital's vocational services program will be expanded. The spectrum of workshop services and the program of employment experiences in private industry settings have proven extremely beneficial for chronic patients and for some short-term patients and should be expanded. This set of services primarily serves the non-DVR eligible client. In addition, a vocational counseling service for non-DVR eligible clients will be developed.

The hospital will continue to serve as a training site for a multitude of training programs including affiliations with schools of nursing, schools of social work, schools of occupational/recreational therapy, programs for psychiatric technician training, psychology intern training, pastoral counseling training, psychiatric residents from the University of Colorado Medical Center both in elective assignments and career residency assignments, plus a variety of other people involved in mental health programs. It is anticipated that the Alcoholism Service will continue to be an important training resource for professionals and para-professionals in that area.

A decision by the legislature gave ADAD control over State funds for alcoholism services provided by Fort Logan Mental Health Center and Colorado

State Hospital. Thus, the future of the Alcoholism Program at Fort Logan 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 Fort Logan Mental Health Center's role in the delivery of alcoholism services is insured.

Fort Logan, it is anticipated, will take on a larger role in supplying specialty services to other agencies of the Department of Institutions in the Denver area including some medical services and some psychiatric services. It also will be developing further specialized programs for low volume services such as the mental health services for deaf and hearing-impaired persons.

Fort Logan will continue to be the site of a multitude of other State agency offices and programs provided by other State entities such as the University of Colorado Medical Center.

Colorado State Hospital

1. Description of Living Conditions and Treatment Resources

a. Living Conditions

The physical facilities meet all standards of local, state and national authorities, and are fully accredited by JCAH. Bedrooms range in size from single to six-bed units, with four-bed units being the most typical arrangement. All wards open to a central nursing station and lounge area furnished with social and recreational equipment. Clients are provided with individual storage space for their personal effects, adequate clothing if they do not have their own and an allowance for personal items. Both staff and clients are encouraged to decorate rooms and halls to

help create a pleasant atmosphere. The spacious grounds surrounding the hospital buildings are available to those clients who wish to and are able to take advantage of them.

b. Treatment Resources Available

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

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

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

Treatment modalities used throughout the hospital include individual and group psychotherapy, utilizing all modern techniques ranging from transactional analysis and Gestalt therapy to behavior modification and biofeedback, occupational and recreational therapy and vocational services in addition to chemotherapy. Clients benefit from the therapeutic milieu, as well as individual attention.

Due to the wealth of therapeutic techniques available, it has been possible to use electroshock sparingly and only in short regimes. Psychosurgery is not used at all.

2. Efforts to Improve Quality of Institutional Care

a. Quality Assessment Program (QAP)

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

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

(2) concurrent review Covers one hundred percent of Medicare, Medicaid and Civilian Health and Medical Program of the United States (CHAMPUS), plus admissions and reviews of other third party admissions. Additionally, a minimum of a thirty percent random sample of all inpatient treatment episodes are reviewed on the 16th day, and every 30 days thereafter for adequacy and quality of the "data base", treatment plan, related progress notes, release plans, length of stay justification and appropriateness of level

of care and treatment intervention.

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

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

b. Medical Care Evaluation Studies

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

c. Psychiatric Care Audit and Utilization Review Committee

This committee is comprised of representatives of all disciplines and program divisions of the hospital. It acts as third level reviewer of all cases and policy questions referred from the QAP, physician advisors, physician panelists and the

natural and unnatural death committees. It reviews both cases and patterns of non-compliance and recommends policy or corrective action to the medical staff, hospital administration or other appropriate hospital committees.

d. Continuing Education

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

3. Description of Present Residential Population

The hospital groups its residents according to their functional requirements for specialized environments and clinical or rehabilitation techniques. The following groupings constitute the program divisions of the hospital organization: Alcoholic Treatment Center, Drug Treatment Center, Children/Adolescent Treatment Center, Geriatric Treatment Center, General Adult Psychiatric Services, Division of Forensic Psychiatry, and General Hospital Services.

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.

4. Efforts to Avoid Chronicity

The philosophy of the hospital has long been focused on intensive care, alternatives to hospitalization and methods to prevent or eliminate institutional dependency and apathy in treatment programs. Discharge planning begins at the time of admission and becomes more specific with each review of the treatment plan. There are no wards for chronic patients (except the neurologically disabled in the General Hospital) and the philosophy of "maximum mixture" of all types of clients is followed in assigning clients to treatment units.

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

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

5. Provision of Social and Recreational Stimulation

Activities providing this type of stimulation are of two basic types: direct therapeutic intervention for a specific behavior change or treatment objective and diversional activities for the maintenance or stimulation of social and physical assets and interests. The primary planners and providers of these activities are the recreational and occupational therapists, plus a variety of other disciplines involved in conducting special group therapy or ward community meetings. The participation of ward nursing personnel in many activities is quite extensive and absolutely essential to their operation and effectiveness.

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

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

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

The CSH campus that once housed over 6,000 clients has evolved since 1961 into a Human Services-Educational complex with CSH serving as the nucleus of the complex and providing the supporting services required. In this complex are the State Home and Training School (Resource Center for the Developmentally Disabled) at Pueblo, the emergency, inpatient and

partial hospitalization program for the Spanish Peaks Mental Health Center, an office of the Colorado Attorney General's Office, the Division of Youth Services' Pueblo office, the Division of Youth Services' Pueblo Detention Center, the Division of Wildlife's Pueblo office, the Adult Parole Pueblo office, the Department of Social Services Medical Health Unit, the State Department of Personnel Pueblo office, office of Region VII Health Planner and the Family Practice Residency Training Program. It is also projected that the Colorado State Hospital-Human Services Complex will house a correctional work release unit. It is planned that in addition to providing facilities for the above named programs, the CSH will continue to be actively engaged in participating in training a wide range of mental health professionals to include career psychiatric residents from the University of Colorado Medical Center, psychiatric technicians from the University of Southern Colorado, social work students from the University of Denver and Colorado State University, and occupational therapists plus a variety of other mental health workers.

It is planned that CSH will continue to provide emergency, adult inpatient, and transitional partial hospitalization services for the Metropolitan Pueblo Community. Adult partial care services will be phased into the Spanish Peaks Mental Health Center. Maximum use will be made of local general hospitals and alternatives to hospitalization by Western Slope centers and clinics and other centers and clinics in the CSH service area which are located a considerable distance from CSH. However, the impact on CSH will be gradual because of the time necessary to develop alternate treatment facilities and affiliation agreements with local hospitals.

Again, it should be emphasized that no attempt is made in this Plan to

require arbitrary increases or decreases in the average daily attendance at CSH during the next five years. Previous attempts to set such figures have been counter-productive. The basic principle around which the mental health system in Colorado has been developed is the provision of services in the least restrictive setting, and as close to a person's home as possible. By emphasizing pre-screening at the community mental health center/clinic level, closer collaboration with courts and other referring agencies, the development of adequate residential alternatives to hospital care, and continued refinement of the continuity of care process, appropriate utilization of hospital beds will be achieved. As stated previously, however, utilization of the existing beds will change from time to time based on the inpatient needs of various subpopulations. The average daily attendance (ADA) should be allowed to fluctuate in response to legitimate demand. DMH, however, will monitor the ADA closely and make every effort to keep it at or below the average for the preceding three years. Adequate funding should be provided to meet the actual need for CSH services on a year-to-year basis.

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 gave 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.

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

CSH will continue to operate the General Hospital and its Forensic and Geriatric treatment programs. Involvement in the Geriatric Residential Program and projected involvement in the HUD Rent Supplement Program which will be utilized through their rural service area will provide Colorado State Hospital with a continuing role in community based programs.

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

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

In the past year the role of the Colorado State Hospital has definitely increased in this area. CSH was involved in the recently funded SEARCH Program. The American Psychiatric Society recently granted CSH permission to provide APA Continuing Medical Education, Category 1, CME credit.

Colorado State Hospital has also been granted full accreditation in psychiatry by the Colorado Medical Society, Continuing Medical Education Committee. CSH will continue efforts to expand activities in the continuing education field.

E. FOLLOW-UP CARE

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

1. Pre-Discharge Planning Procedure

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

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

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

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

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

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

(4) Unless specific and documented arrangements are made for CSH or FLMHC to follow up a client discharged from inpatient care who requires long-term support and maintenance,

catchment area centers and clinics are responsible to help the client avoid the return to inpatient care. This will be accomplished by ensuring that the client is followed in a resocialization group and/or seen periodically on an outpatient basis or for medication check. Progress notes will be recorded after each contact or at least monthly.

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

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

(7) All facilities used as alternatives to inpatient care must be properly licensed if licensure is required, and must

comply with any existing standards for the care of mentally ill clients in such facilities.

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

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

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

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

2. Responsible Center/Clinic in Each Catchment Area

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

3. Policies for Discharge from State Hospitals

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

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

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

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

4. Methods for Assuring Availability of Follow-Up Care

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

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

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

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

Increased attention has been focused on aftercare services during the past two years. 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 $700,000 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 and will continue to be 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 continue to assist in the monitoring of the follow-up process, and make recommendations to DMH concerning needed revisions in the policy and procedures.

F. WORKFORCE (MANPOWER/WOMANPOWER)

1. Summary of Current Workforce (Manpower/Womanpower)

Following are summaries of the current workforce of the mental health centers, clinics, and state hospitals in Colorado. Included in "Other" categories (the last line under "Discipline" in both summaries) are the following:

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

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

A. The following is a summary of the current staff of the two state hospitals in Colorado:

Discipline	Full-Time Staff	Part-Time Staff
M.D. Psychiatrist	23	26
M.D., Physician (non-psychiatrist)	14	66
Nurse, M.S.	2	0
Nurse, B.S.	57	1
Nurse, A.A.	128	0
Nurse, Practical	16	0
Mental Health Worker, B.S.	52	0
Mental Health Worker, A.A.	115	0
Mental Health Worker	0	0
Social Worker, D.S.W.	0	0
Social Worker, Masters	45	0
Social Worker, Bachelor	5	0
Psychologist, Ph.D.	16	1
Psychologist, Masters	13	0
Psychologist, Bachelor	0	0
Other Doctorate Level	1	0
Other Masters Level	33	0
Other Bachelor Level	52	0
Other A.A.	13	0
Psychiatric Technician	307	0
Other	1,126	93
TOTAL	2,018	187

B. The following is a summary of the current staff of the mental health centers and clinics in Colorado:

Discipline	Full-Time Staff	Part-Time Staff
M.D. Psychiatrist	43	59
M.D., Physician (non-psychiatrist)	13	22
Nurse, M.S.	27	14
Nurse, B.S.	93	28
Nurse, A.A.	9	6
Nurse, Practical	20	1
Mental Health Worker, B.S.	107	20
Mental Health Worker, A.A.	105	9
Mental Health Worker	72	18
Social Worker, D.S.W.	3	1
Social Worker, Masters	189	40
Social Worker, Bachelor	14	3
Psychologist, Ph.D.	94	25
Psychologist, Masters	116	34
Psychologist, Bachelor	23	7
Other Doctorate Level	12	3
Other Masters Level	46	7
Other Bachelor Level	52	11
Other A.A.	8	4
Psychiatric Technician	46	26
Other	345	39
TOTAL	1,437	377

2. Projection of Personnel Needs

As centers and clinics take on a more comprehensive role, some changes in function of the current personnel may be required. The Division of Mental Health will take the initiative to encourage educational facilities to provide training in the clinical skills required. It appears that the mental health professionals will be in adequate supply except for psychiatrists and possibly nurses.

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 variety of training programs. The DMH applied for and received a NIMH 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.

The Division of Mental Health has submitted a new grant application to NIMH entitled The Colorado Mental Health Manpower Development Program. If funded as anticipated in 1978-79, this grant will provide five years of declining federal support to assist DMH in developing its capacity for mental health manpower planning and development. Specifically the program will consist of two major thrusts: The first of these is to establish the methodology and data base for evaluating the present and projected mental health manpower needs of the Colorado Division of Mental Health. The end product of this thrust will be a state plan for mental health manpower development. The second thrust is to develop and strengthen the necessary organizational structures, resources, and mechanisms for implementing a comprehensive approach to the education/training of mental

health personnel for Colorado's service delivery system. The end product of this latter effort will be a manpower system capable of achieving the goals of the state mental health manpower development plan.

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

The development and maintenance of an adequate supply of mental health personnel requires the joint efforts of the colleges and universities in providing the basic professional education (preservice training) and of the service delivery system in providing 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 individual 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.

The State Education Committee, which is co-chaired by the Executive Director of the Department of Institutions and the Department Chairman of Colorado Psychiatric Hospital, actively reviews manpower and education issues in mental health for the State.

4. Procedures for Protecting Displaced Employees' Rights

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

The primary protection for state hospital employees who might be affected by a reduction in the workload at the state hospitals is the State Personnel System. The rules of the State Personnel System provide for "bumping" rights, lateral transfers and preference in filling personnel vacancies which develop in state agencies. There are some thirty thousand state employees. With a turnover rate of approximately ten percent, up to three thousand existing positions plus newly funded positions become available during each year. "Bumping" rights can be exercised only within the department in which an individual is employed. The Department of Institutions, of which the Division of Mental Health is a component, employs almost five thousand persons across the state. Thus, displaced state hospital personnel would have a number of options available to them within the state system. Important considerations are the location of a vacancy and an employee's willingness to relocate. In view of the concentration of state agencies in the Denver and Pueblo areas, the importance of the relocation factor is diminished.

The twenty-four mental health centers and clinics employ some fourteen

hundred persons. All of these agencies are private, non-profit corporations, except two which are county agencies. Each has its own personnel system, none of which are related in any way to the State Personnel System. Many state hospital employees have acquired valuable skills in the treatment of the chronically ill and other difficult to treat clients. These skills can be put to good use in community agencies as they assume increasing responsibility for more seriously disabled clients. Centers and clinics will continue to send announcements of vacancies to the Division of Mental Health Personnel Officer, who is forwarding copies for posting in the state hospitals. A major concern of state hospital employees who wish to work in a center or clinic is the non-portability of retirement and other benefits from the state system to private or county agencies. While legislative relief is possible, it is not probable because of the myriad legal, funding and other problems involved. A proposed partial resolution would be placing selected state hospital employees on "detached service" at a center/clinic. The state employees would remain on the state hospital payroll, and the center/clinic would reimburse the state hospital for the employee's salary and other benefits. The employees would have to be acceptable to the center/clinic concerned and would be under the administrative control of the center/clinic director. This proposal is fraught with many problems, such as differences in salaries, fringe benefits, classification, etc., between the state system and individual centers/clinics. However, it is one avenue that is being explored.

Another important need which will be dealt with as the need arises is training of displaced employees for new jobs in centers/clinics and the state hospitals. The plan is to accomplish this through such means

as on-the-job training, regular college or university course work and/or special formal training sessions conducted as a part of the Division's continuing education program or arranged through local colleges and universities.

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

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

5. Volunteer Services

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 break down 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

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.

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.

The state mental health system will continue to stress quality of care. If fiscal support of mental health services decreases, complete programs or major sections of programs will be eliminated in an effort to maintain quality. Robbing several programs of some of their resources greatly reduces the quality of care in each; therefore, declining dollars will be paralleled with cuts in total programs or program sections.

7. Standards, Rules and Regulations

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

a. Standards/Rules and Regulations for Mental Health Centers and Clinics (distributed under separate cover)

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)

The Joint Commission on Accreditation of Hospitals (JCAH) Standards (available from JCAH) also have a profound inpact on the state mental health system.

Chapter V

COORDINATION OF PLANNING

V. COORDINATION OF PLANNING

A. INTERDEPARTMENTAL COMPREHENSIVE PLANNING

1. Human Services Policy Council

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

The Human Services Policy Council develops policies which will relate to areas of service throughout the executive branch of state government. Following recommendations to the Governor and approval of the policy statement by the Governor, the Council is responsible for implementation of the policies including coordinated planning and budgeting by the various departments. Specific agreements are developed between departments, outlining areas of program collaboration. Among the policy priorities of the Human Services Policy Council are: corrections, education and other services for the handicapped, health planning and cost containment, long term care, services to the elderly, services to youth, rural health,

and state and local governmental relations.

Information about the policies and collaboration agreements must be disseminated to agencies and sub-units within the departments. The staff of the agencies and sub-units review the policies and develop procedures for their integration into programs and service delivery. The impact of the policies developed by the Council is reflected through the collaboration and implementation efforts of the staff of the various agencies and sub-units.

2. Office of State Planning and Budgeting

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

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

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

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

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

The Division of Budgeting works with state departments and

agencies in the development of their yearly budget requests to assure that the requests reflect the Governor's policy decisions and priorities.

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

3. Health Planning

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 replaces the Health Planning Council, was appointed by the Governor in October 1977. In addition to federally mandated responsibilities, the Council will focus its planning, review, and development activities on the following areas which have been identified by the Governor as areas of major concern to the citizens of Colorado: the rising cost of medical care, medically underserved areas, and alternative living environments for the elderly. In relation to mental health, the SHCC will review and approve or disapprove the State Mental Health Plan and applications for funds made available to state government under federal health legislation.

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 office of Medical Care Regulation and Development. The SHPDA is responsible for conducting health planning activities for the State and integrating the Health Systems Agency plans into one State Health Plan to be submitted to the SHCC.

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 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 involved in a coordinated way with each other, is the development of a Health Systems Plan (HSP) and an Annual Implementation Plan (AIP) 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 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 than 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

Each of the HSAs has developed a Health Systems Plan for their area. Since the HSAs are addressing the mental health component of their plan in different ways and within different timelines, the State Mental Health Plan for this year will follow the format of the past two years. The Central-Northeast Colorado Health Systems Agency has included a community mental health section in their first year HSP and AIP. The Western Colorado Health Systems Agency has formed a mental health task force and plans to have the first draft of their community mental health section completed this Fall. The Health Systems Agency for Southeastern Colorado has been developing other plan sections and will be addressing the community mental health component within the next twelve months. Both the Western Colorado HSA and the Southeastern Colorado HSA have developed a planning section in their respective HSPs dealing with inpatient psychiatric services. DMH, SHPDA, and the HSAs are working together in coordinating planning efforts to avoid unnecessary duplication and to assure the provision of needed mental health services to the public. Staff members from SHPDA and the HSAs participated in the preparation of this section of the Plan and the review of the total Plan.

4. Health Facilities Advisory Council

The Department of Health was designated by State statutes as

the sole agency for carrying out the purposes of the Community Mental Health Centers Construction Act of 1963 and any amendments thereto. The State Health Facilities Advisory Council (HFAC) was initially appointed by the Governor to advise the Department of Health on matters involving construction of mental health and other health care facilities. In 1973 the HFAC became the State's Certificate of Public Necessity decision-making body. With that designation and with the recent expiration of the Federal Hill-Burton Act, the Council's responsibilities relating to federal grants for construction of mental health and other health facilities have virtually ended.

The Health Facilities Advisory Council is currently spending almost all of its time in reviewing Certificate of Need applications. A proposed amendment to the State Certificate of Need law would restrict activities of the HFAC to Certificate of Need project reviews.

B. INTERDEPARTMENTAL PROGRAM PLANNING

1. Alcohol and Drug Abuse Division

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

1977-78, the state general fund appropriation to ADAD totaled $6,010,367.00. In addition, ADAD was allocated $2,572,307.00 in federal funds.

Mental health agencies continue to be actively involved in providing substance abuse services. During fiscal year 1977-78, ADAD had 29 contracts with mental health centers/clinics to provide drug and alcohol services. During this same period of time, state general funds of approximately 1.92 million dollars were appropriated to the alcohol and drug treatment program at Colorado State Hospital (CSH) and the alcohol treatment program at Fort Logan Mental Health Center (FLMHC).

Pursuant to the state legislature requirement, ADAD assumed both direct control of the two state hospitals' alcoholism services funds and conducted a cost benefit study. This enabled ADAD to develop a truly comprehensive statewide substance abuse plan and program with specific recommendations for the substance abuse programs at the two state hospitals.

The close working relationship between ADAD and DMH has resulted in a number of solid achievements during fiscal year 1977-78. These include:

a. Representatives from ADAD and DMH have continued to meet monthly to develop policies and procedures for resolving specific service delivery issues.

b. A revised letter of agreement was signed by the Division Directors which supported:

   (1) collaborative contract and grant reviews;

(2) joint annual evaluations of the substance abuse programs in the two state hospitals and the community mental health centers and clinics;

(3) ADAD review of existing and proposed regulations, applications, policies, programs, and procedures of agencies providing services to substance abusers; and

(4) cooperation in educational planning and information sharing.

c. Data collection practices which resulted in duplicate reporting of data have been eliminated.

d. Specific guidelines were jointly developed by ADAD and DMH to ensure the availability of alcohol and/or drug abuse treatment services to clients of the mental health system and the availability of psychiatric services to clients of the alcohol and drug abuse service system.

e. DMH strongly encouraged substance abuse counselors within the mental health system to participate in ADAD's training/certification programs.

f. Each Division actively facilitated increased input into its State Plan by the other Division.

g. ADAD encouraged DMH input into the ADAD Cost Benefit Study which was conducted on the substance abuse programs at the two state hospitals. In addition, representatives from the Central Office staff of DMH and the two state hospitals were on the Cost Benefit Study Advisory Committee. The

study made specific recommendations on the future role of the two state hospitals in the substance abuse continuum of care.

h. Representatives of ADAD and DMH held a public meeting with providers of substance abuse services and concerned citizen organizations for an open discussion of problems in coordinated service delivery and the steps being taken to resolve the problems.

During the coming year, close interdepartmental planning and coordination will continue with an emphasis on the objectives listed in Chapter III. Continued positive results have been achieved through the joint, cooperative planning efforts of the two Divisions. ADAD and DMH plan to continue their regularly scheduled meetings.

2. Department of Social Services

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; coordinated provision of services for the elderly; and more carefully orchestrated collaboration in delivering services to emotionally disabled children.

3. Department of Education

Coordination of planning between the Department of Education

and mental health services of the Department of Institutions is included in the policy development activities of the Human Services Policy Council.

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 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. the Division of Mental Health and the Colorado Department of Education should develop administrative agreements designed to facilitate the adoption of policy statements contained in Colorado's Fiscal Year 1978 Annual Program Plan Amendment for Part B of the Education of the Handicapped Act as Amended by Public Law 94-142;

d. 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;

e. 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 person should be denied the appropriate treatment for a "secondary diagnosis."

4. Department of Corrections

The 1976-77 session of the Colorado General Assembly enacted legislation which elevated Correctional Services from divisional to departmental status. Thus, Correctional Services, which was a sister division to DMH, became 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) in relation to Corrections is an area that needs further clarification. The Department of Corrections is an agency with which DMH needs to improve and enhance their relationship to facilitate the coordination of planning.

C. INTERDIVISIONAL PLANNING - DEPARTMENT OF INSTITUTIONS

In 1977 legislative action 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 centered board directors and DD program directors.
2. Assessing service needs in terms of types of client problems 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, was initially developed to review information about hard-to-place clients, to design plans for treatment which could involve services to be provided by two or more divisions, to monitor the progress of treatment, and to make recommendations to the Executive Director about the need for new programs or revised structure of services to meet client needs. At the present time, the Interdivisional Placement Team is in the process of reviewing and evaluating their role and responsibilities and may undergo some changes in the process.

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 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.

There have been some significant accomplishments as a result of this collaboration. A comparison study between Fort Logan's Closed

Treatment Unit and the Closed Adolescent Treatment Center of the Division of Youth Services was recently completed. This accomplishment was the result of joint efforts between DMH and the Division of Youth Services. Negotiation has also started with Fort Logan Mental Health Center to provide medical services to one of the Youth Services facilities. These services would include the provision of 24-hour emergency medical back-up seven days per week, the establishment of protocol for medical and non-medical staff, and the establishment of a medical base for data collection. This collaborative effort is very significant in that it provides for improved quality of medical care in Youth Services through the support of mental health, specifically Fort Logan. Both DMH and Youth Services want coordination to continue in the direction of the above accomplishments.

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, develops and recommends policies regarding medical services to the Executive Director. An important focus of this committee has been on the standardization

of the quality of medical care within the Department of Institutions.

D. LOCAL GOVERNMENTAL PLANNING AND REGIONAL PLANNING

1. Department of Local Affairs - Division of Planning

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

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

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

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

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

2. Regional Planning

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

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

3. Municipal Planning

An example of mental health planning at the municipal level was the development of the Denver Mental Health Advisory Board, which had been sanctioned by the City and County of Denver and the seven mental health centers and clinics which provide services in Denver. The Division of Mental Health had been actively involved

in this attempt to unify the mental health delivery system in Denver. Of particular importance was the need to determine which services should be centralized to eliminate unnecessary duplication and achieve cost savings.

The overall objective of this effort was a unified mental health delivery system in Denver, involving one budget document that would provide for the distribution of mental health funds on the basis of the specific needs of the various sections of the city. Although the Denver Mental Health Advisory Board, as originally constituted, is not presently functioning, the hope is that this important collaborative planning effort will be resumed.

4. Four Corners Regional Development Commission

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

E. GOVERNMENT-FUNDED, VOLUNTARY AND PRIVATE MENTAL HEALTH SERVICES

Much of the emphasis in this Plan is on those agencies receiving federal, state, and local governmental funds for identified mental health treatment programs. Private and voluntary agencies provide a variety of mental health and counseling services in addition to those programs funded by government. Referrals are made between the voluntary and state supported agencies, and voluntary agencies often provide additional supportive services for clients of other agencies.

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

Some cooperative relationships exist between agencies receiving governmental funds, voluntary and private mental health services, but

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

Among the issues to be considered are:

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

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

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

Chapter VI

CATCHMENT AREA MENTAL HEALTH PROGRAM

VI. CATCHMENT AREA MENTAL HEALTH PROGRAM

A. DESCRIPTION OF CATCHMENT AREAS

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

The full range of community mental health services includes:

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

state alcohol and drug abuse authority.)

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

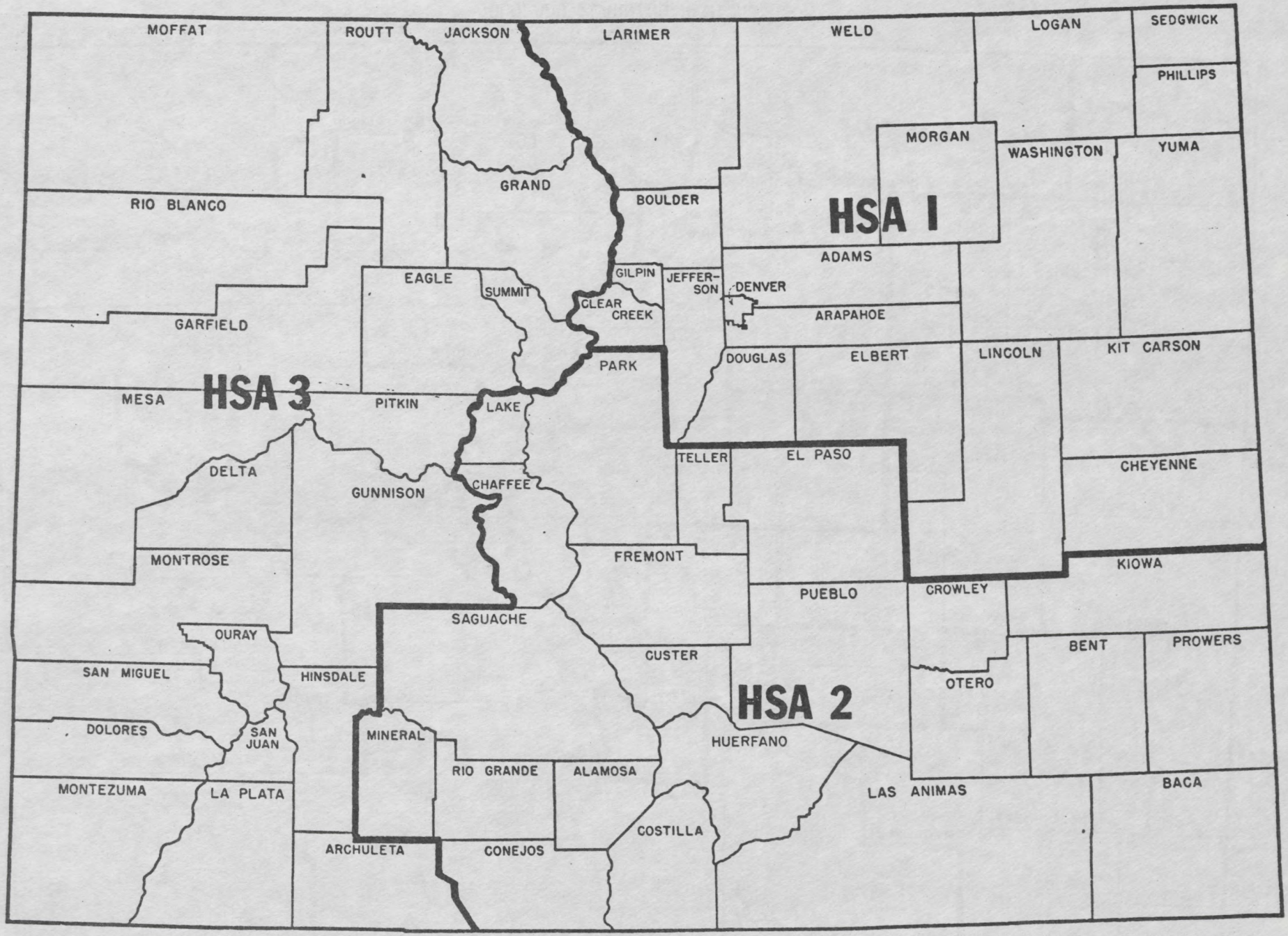
Catchment area centers and clinics obviously vary in their ability to provide the above services. The capabilities of the smaller and underdeveloped agencies will be increased through such means as differential distribution of state funds, 314(d) and other special grants, assistance in applying for federal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

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

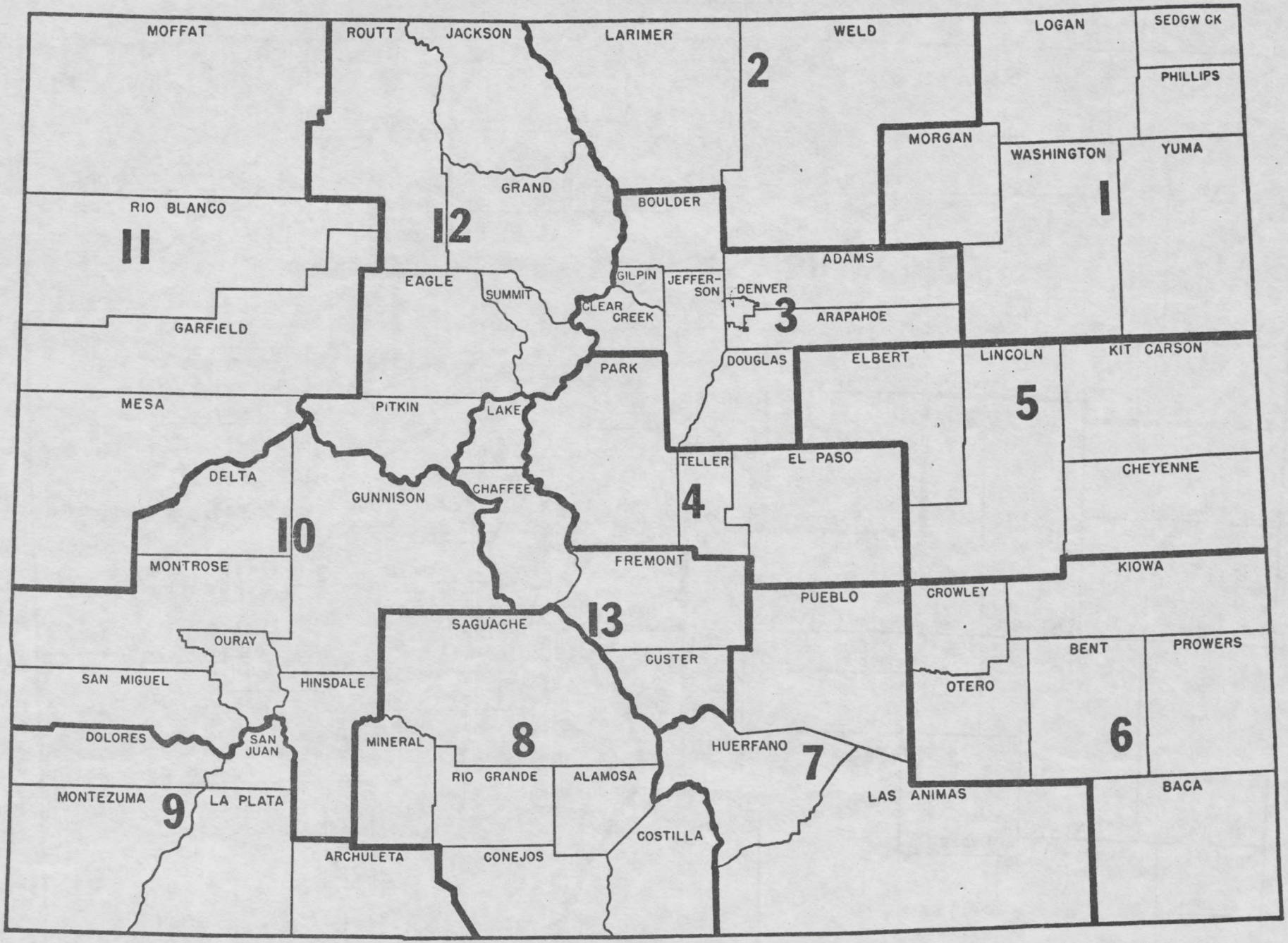
1. Health Service Area: Colorado has three Health Service Areas (see map, page 3). A Health Systems Agency (HSA) has the overall responsibility for health planning in each Health Service Area.

2. Colorado Planning Regions: There are 13 State Planning Regions (see map, page 4). These regions were in existence prior to passage of Public Law 93-641 which requires the designation of Health Service Areas. The future role of the Planning Regions is not clear. They might continue to be viable entities for planning purposes because they provide more potential for local input than the HSAs, but are more manageable than 63 counties.

3. Counties: Colorado's 104,000 square miles and 2.7 million population are distributed over 63 counties (see maps, pages 3 and 4).



COLORADO HEALTH SERVICE AREAS



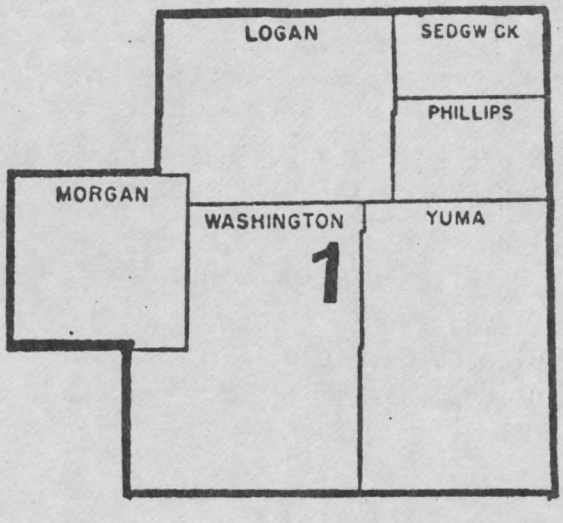
COLORADO PLANNING REGIONS

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

Following is a brief description of each region, the services provided by the centers/clinics serving each region and program needs. (See Appendix III for a chart showing the availability of the twelve Public Law 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 - 6,427; Arapahoe - 9,068; Denver - 12,356; El Paso - 82,666. All data are as of January 1, 1979.

REGION 1



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

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

Area: 9,228 square miles
Population: 67,686

Composition of Population:		
	Anglo	93.0%
	Asian	0
	Black	0
	Chicano	7.0%
	Native American	0
	Other	0

1. Description of Area

Region 1 lies in the extreme northeastern corner of Colorado and encompasses Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma Counties. The area is bounded to the north by the Nebraska state line and on the east by the Nebraska and Kansas state lines. The southern extent of the region ends at the Lincoln and Kit Carson County lines, while the Weld County and Adams County lines form the western boundary.

Northeast Colorado is characterized as a vast farming and ranching area. The majority of the population is located in the Platte River Valley; however, other small communities are located near railroads and major highways. This sparsely populated region has been designated as a poverty area and ranks high in numbers of children in poverty, aged in poverty, and low education status. The distances involved between population centers and the lack of public transportation also provide barriers to the easy provision of available, accessible, quality mental health services in this rural poverty area.

2. Existing Services

Region 1 is served by the Northeast Colorado Mental Health Clinic with headquarters in Sterling and branch offices in Fort Morgan, Yuma, Wray, and Holyoke. Outreach services are provided to other communities in the region. The clinic offers extensive outpatient services,

emergency/crisis services, and consultation and education to other community agencies. Other service modalities include residental treatment programs, partial care programs, specialized services for children and adolescents, specialized services for the elderly, prescreening, follow-up care, and alcoholism services.

Specialized services developed by the clinic include a crisis shelter which is a nine-bed facility that provides treatment, diagnosis, follow-up, emergency placement and short term shelter care for youngsters between the ages of 10 and 18 and an eight-bed juvenile shelter for long term treatment. 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. The clinic has developed affiliate agreements which provide for detoxification services and other 24-hour residential facilities for this population. The clinic has also established ten alternative treatment beds for adults in Fort Morgan.

The above-average community support generated by the Northeast Mental Health Clinic has been impressive and has enabled the clinic to offer many of the services provided by comprehensive centers without the additional funding.

3. Program Needs

Inpatient services are provided by Fort Logan Mental Health Center. 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 in the catchment area.

The lack of available, supplementary and supportive resources also provides a barrier to serving the growing elderly population and chronically disabled persons. Both the chronically disabled group and the elderly populations are located in pockets throughout the region and are not mobile groups. Providing services to these populations is a difficult task with limited resources.

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. 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. December 1, 1977 marked the starting date for the clinics to begin their planning process.

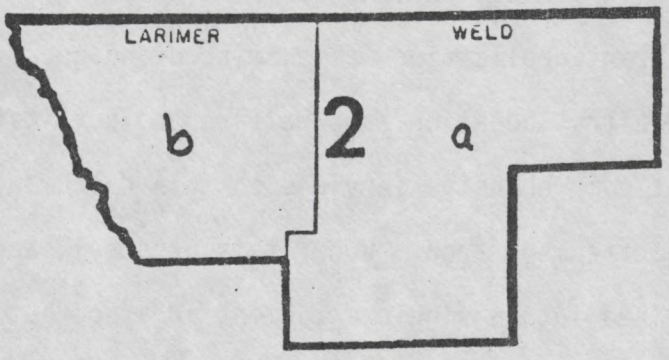
The ADAMHA Regional office has approved the merger of the two regions; however, that office is aware of the careful planning that must take place to accomplish a merger of two established agencies. The two agencies and the two catchment areas are maintaining their separate identities until the planning 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.

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

REGION 2



Region 2a

Area: 4,004 square miles
Population: 124,571

Composition of Population:	
Anglo	82.1%
Asian	0.8%
Black	0.3%
Chicano	16.0%
Native American	0.2%
Other	0.6%

1. Description of Area

Weld County is one of the two counties in Planning Region 2. The Wyoming and Nebraska state lines form the northern boundary of Region 2a; Logan and Morgan Counties form the eastern boundary; the metropolitan area of Region 3 the southern boundary; and Boulder and Larimer Counties the western boundaries. This area encompasses the far northern area of the Colorado front range corridor. The Cache la

Poudre and Big Thompson Rivers flow through the region and, coupled with efficient water resources management through the Colorado Big Thompson Project, provide this district with ample irrigation ability. The northern part of the county is a sparsely populated area dominated by the Pawnee National Grasslands.

Greeley is the County Seat and the commercial center for the county. The region surrounding Greeley, approximately one-third of the county area, is an intensive farming area. Cattle feeding and meat processing are also large industries in Weld County. The remaining two-thirds of the geographical area to the east and north is sparsely populated range land. Because of this difference in land use, 95% of the Weld County population is located within twenty-five miles of Greeley. Manufacturing and light industry are also present in this region. The University of Northern Colorado in Greeley makes education an important component of the economy in Weld County.

2. Existing Services

The county is served by the Weld Mental Health Center. The main service center and administrative offices are located in Greeley. There is a branch office in Fort Lupton, a community south of Greeley wherein a large portion of the county's Chicano population resides. The Weld Mental Health Center offers all twelve comprehensive mental health services either directly or through affiliate agencies.

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.

Effective January 1, 1978, all alcoholism services in the county were consolidated under the Weld County Health Department. The Center has an affiliation agreement for alcoholism clients with that agency.

A specialized program for children and families provides emergency care, long-term therapy, evaluation services, and a child partial care treatment program. A drug treatment/drug preventative program, "Horizons", for teenagers and young adults is utilized as a drop-in center in the community. A conversion grant which began in July 1976 has supported the development of transitional care and peer counseling for the elderly.

Fiscal support of the program will be received from the county in 1978 for the first time in several years. Additional funding comes from federal and state sources, fees, donations, modest school contract funds, and some support from the cities of Greeley, Fort Lupton, and Evans.

3. Program Needs

The Weld Mental Health 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 has been explored by the respective mental health centers.

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. The closing of the Alcoholism Halfway House in 1977, which provided some psychiatric beds, has intensified this need. The center proposes a 12 bed psychiatric halfway house facility in Greeley to reduce the use of the local hospital, nursing homes, and Fort Logan Mental Health Center.

Region 2b

Area: 2,614 square miles
Population: 135,078
Composition of Population:

Anglo	91.9%
Asian	0
Black	0.3%
Chicano	6.7%
Native American	0.1%
Other	1.0%

1. Description of Area

Larimer County comprises Planning Region 2b. The region's northern borders are aligned with Wyoming, while to the east is Weld County, to the south Boulder County, and on the west Jackson and Grand Counties. Most of Region 2b lies in the South Platte River watershed with the northwest corner of the territory comprising part of the Big Larimie River watershed. The terrain of the county ranges from mountain peaks of 14,000 feet and the Continental Divide on the west to the rolling plains of the Poudre and South Platte River Valleys.

In 1976 an unusually heavy rainfall caused the Big Thompson River, which flows across the southern part of the county, to overflow. The resulting flooding became a major disaster which claimed over 125 lives. The canyon continues to be a high risk flood area.

Fort Collins, Loveland, and Estes Park are the major communities of

the county. The major industries in Larimer County are agriculture, livestock, education (Colorado State University), and tourism.

Since 1960, Larimer County has experienced a phenomenal rate of population growth. Together, Fort Collins and Loveland comprise 75% of the population of Larimer County. The largest minority is the Chicano population which is also concentrated in the Fort Collins and Loveland areas.

2. Existing Services

The county is served by the Larimer County Mental Health Center which is a county agency. The main administrative office is located in Fort Collins with services being provided through offices in Fort Collins, Loveland and Estes Park.

In March 1976, Larimer County Mental Health Clinic applied for and received a federal operations grant which significantly altered the service provision ability and allowed the clinic to become a comprehensive community mental health center. The first grant year did not start according to plan. On the precise start-up date (August 1, 1976) the Big Thompson flood occurred, and all center efforts were diverted in that direction. By the end of September of that year, all twelve comprehensive services were operational. During the past year, the center has successfully been increasing its accessibility and service provision.

3. Program Needs

Program needs include alternative treatment facilities for the high resource users of all ages. This need is enhanced by the large number of State Hospital dischargees who were placed in

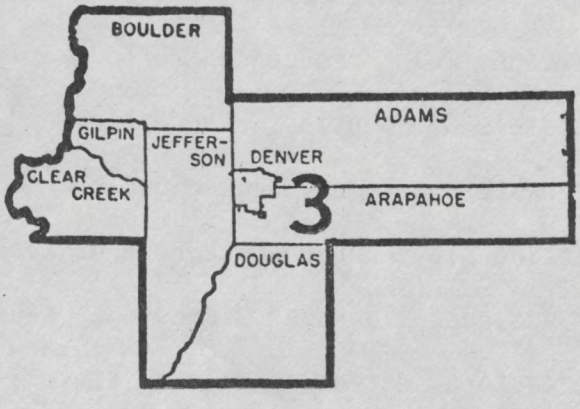
Larimer County in the late 1960s and early 1970s, many of whom still reside in the county. Larimer County ranks as one of the highest in the state as to the number of nursing home beds available.

Larimer County's rapid growth rate continues to require proportionate service expansion. The major crime rate has also increased in this county. Rapid growth is the attributing factor, according to law enforcement agencies, particularly in the areas of juvenile crimes.

Larimer County, being a retirement center for northern Colorado and southern Wyoming, has a high proportion of elderly citizens with unique needs and service requirements. There is a need for increased services and outreach to the elderly.

Other needs include increased services to outlying areas and increased services and outreach to the Chicano population.

REGION 3



Area: 5,045 square miles
Population: 1,437,944

Region 3 is a 5,045 square mile area encompassing eight counties - Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Gilpin and Jefferson. The region lies directly south of Larimer, Weld and Morgan

Counties. It is bounded in the east by Washington County, in the south by Elbert, El Paso, Teller and Park Counties and in the west by Grand and Summit Counties.

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

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

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

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

The state hospital serving Region 3 is the Fort Logan Mental Health Center. This hospital pioneered many of the approaches to community care presently being practiced in many centers and clinics in Colorado and across the country. In addition to Fort Logan and the 12 mental health

centers and clinics in Region 3, mental health services are available through Colorado Psychiatric Hospital (a component of the University of Colorado Medical Center), two psychiatric hospitals, several general hospitals, many private practitioners (psychiatrists, social workers, psychologists, nurses, pastoral counselors, etc.) as well as voluntary agencies.

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 was 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 made some progress towards the achievement of the goals. Many legal and other problems were encountered, but all parties invested a considerable amount of time and effort into the project.

The advisory group did not hold any meetings for a period of nine to twelve months. Their future direction has not yet been established.

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

Adams County Mental Health Center, Inc.

Population: 194,787

Composition of Population:	
Anglo	77.7%
Asian	0
Black	2.0%
Chicano	18.0%
Native American	0.9%
Other (includes Asian)	1.4%

1. Description of Area

This comprehensive community mental health center serves the growing suburban area to the north/northeast of the City of Denver. The majority of the catchment area population reside in the western section of the county while the eastern section of the county continues to remain a sparsely populated rural area.

2. Existing Services

Staff members provide the twelve comprehensive services through the main administrative office in Commerce City and through three branch offices which are located in Brighton, Northglenn, and Westminster. The center is utilized by residents of the community through the decentralized offices as well as a variety of specialized programs, notably, partial care, sheltered workshops and a continuum of other 24-hour residential care facilities for the chronically mentally ill. A child advocacy program offers consultation and direct services to children and adolescents in School District #14, and the Westminster School Team provides consultation and direct services to children and adolescents in School District #50.

3. Program Needs

Areas of need include expanded attention to the large number of

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

Arapahoe Mental Health Center, Inc.

Population: 145,064

Composition of Population:	
Anglo	92.6%
Asian	0.3%
Black	1.0%
Chicano	4.5%
Native American	1.1%
Other	0.5%

1. Description of Area

This center serves the suburban areas to the south of the city of Denver. It provides comprehensive services through its own decentralized facilities, Fort Logan Mental Health Center and Colorado Psychiatric Hospital.

The catchment area serves a diverse population of urban and rural communities.

Both the growth of the Chicano population and rapid expansion of suburban housing developments contribute to the growth in total population and to increases in the aged and child populations.

2. Existing Services

The main administrative office is located in Englewood. The center also has six branch offices decentralized throughout the catchment area.

The center initiated action which resulted in the passage of a county bond issue to generate funds for an alternate treatment facility. The

agency has also developed excellent consultation and education, volunteer services, children's, alcoholism and geriatric services. On July 1, 1976, the program expanded services for other 24-hour care at Santa Fe House.

3. Program Needs

The catchment area faces problems of substance abuse, alcohol and drugs, for both youth and adults; problems with children at home, at school and with the law; problems that affect the aged, that is isolation, finances, transportation, recreation, etc.; multiple problems of minorities, of the poor and of the rural and urban areas (Douglas, Glendale, East Arapahoe); and marital and family problems.

Aurora Mental Health Center, Inc.

Population: 108,039

Composition of Population:	
Anglo	94.5%
Asian	0.6%
Black	1.9%
Chicano	1.6%
Native American	0.5%
Other	0.9%

1. Description of Area

The Aurora Mental Health Center provides services to citizens of the community of Aurora. In addition, the southeast corner of Adams County is served which includes the communities of Bennett, Strasburg, and Watkins. Since the majority of the residents of Aurora live in Arapahoe County, this then constitutes over 80% of the center's catchment area population.

The catchment area contains a unique blend of industrial development, military installations, suburban growth, and agricultural

productivity. This area is one of the fastest growing population centers for its size in the nation.

2. Existing Services

This center is the most recently developed catchment area program in the state mental health system, having begun operations in 1975. The center was a result of local citizens actively soliciting support for their own mental health program. The 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, children/adolescents and elderly. Services which are in the process of being activated include: hospital follow-up and drug and alcohol abuse which will be phased in during the current year.

3. 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: 125,420

Composition of Population:	
Anglo	94.3%
Asian	0
Black	0.4%
Chicano	4.5%
Native American	0.2%
Other	0.6%

1. Description of Area

This center serves the southeast section of Denver County. The area is basically residential with the eastern half of the catchment area being the most affluent of Denver. The western part has the

lowest socio-economic grouping. The northern part is in transition, with older people moving out and younger people moving in. The south-east section is growing rapidly, and this is projected to continue for the next five years.

2. Existing Services

Bethesda provides comprehensive mental health services to the catchment area. The main administrative offices are located at 4400 East Iliff Avenue. The branch offices are Luther House and CHAP House. This program is unique, as it is affiliated with a private hospital which is utilized for inpatient care.

Day care services are also provided for children.

3. Program Needs

The catchment area is high in divorced or separated people, children not with parents, and adolescents not in school.

There are also five census tracts that need more service. 11.5% of the population are aged 65 or older, while admissions comprise some 4%.

Bethesda has the second lowest rate of consultation and education to its catchment area per staff hour, therefore requiring additional funding for consultation and education to special target groups and the western section of the catchment area.

Mental Health Center of Boulder County, Inc.

Population: 172,394

Composition of Population:		
Anglo		92.0%
Asian	Less than	1.0%
Black		1.0%
Chicano		6.3%
Native American	Less than	1.0%
Other	Less than	1.0%

1. Description of Area

Boulder County is located on the east slope of the Rocky Mountains and consists of mountainous topography in the west half of the county and plains to the east. Larimer County borders on the north, Grand County on the west, Gilpin and Jefferson Counties to the south, and Adams and Weld Counties to the east.

Major employers in Boulder County include IBM and the University of Colorado. There are a large number of medium to small manufacturing and construction firms as well as a number of federal government installations. Agriculture continues as an important but declining activity in the county.

The major population concentrations include the cities of Boulder, Longmont, Lafayette, Louisville, and Broomfield. All these communities are specifically served by branch offices of the Mental Health Center of Boulder County, Inc.

The Boulder social environment is dominated by the presence of a major university. The population is extremely mobile, i.e., there is a high degree of in-and-out migration. Boulder's "slow growth" plan has created a socio-economic environment which is unique in the state. While attempting to maintain a quality lifestyle through slow growth, excess socio-economic pressures have been placed on the lower economic groups in the county - those served primarily by the Mental Health Center of Boulder County, Inc.

2. Existing Services

The main administrative office is located in Boulder with services offered in branch offices in Boulder, Longmont, and Lafayette. Services

offered include: inpatient, partial care, outpatient services, and emergency services. Alcohol abuse services are provided by the Boulder County Department of Health, with whom the Mental Health Center of Boulder County, Inc., has an affiliation agreement. Consultation, rape education and services to victims, assistance to courts and public agencies, follow-up/aftercare services, other 24-hour services (halfway house), rehabilitation services, drug abuse services program, program evaluation, specialized services to children and adolescents, and specialized services to the elderly are available.

The center has a contract with the Boulder Psychiatric Institute, a private psychiatric hospital for the provision of adult inpatient, psychiatric bedspace, nursing, and associated services. The center operates a Residential Treatment House in Boulder for center clients from all parts of the county. Partial care programs in Boulder and Longmont serve acutely and chronically psychiatrically impaired clients. The center operates a Vocational Rehabilitation Workshop which serves clients from all over the county.

Outpatient services are provided in three locations: Boulder, Longmont, and the Tri-City Branch in the southeast part of Boulder County. A broad range of treatment modalities is available including individual, group, family and couple therapies with emphasis on short-term goal-oriented treatment.

Partial day care services for children of elementary school age are provided at the mental health center and administered conjointly with the Boulder Valley School District. Specialized services to the elderly are provided through the "Outreach to the Isolated Elderly Program" and through

a federal grant establishing the Community Care Organization for the elderly of the county.

The Rape Crisis Team consists of approximately 25 volunteers who receive training and supervision from the center.

The Drug Abuse Services Program, funded by the Alcohol and Drug Abuse Division of the Colorado Department of Health and local governments, serves drug dependent persons throughout the county with workers based in all branch offices. The center is primarily funded by federal, state, and local governments but also receives revenues from fees, third party payments, the Boulder Valley School District, the St. Vrain Valley School District, and other contributions. In recent years revenues have not increased relative to inflation.

3. Program Needs

The Mental Health Center of Boulder County continues to experience increasing demands for services from all quarters - other agencies as well as individuals in need. Unfortunately, this growing demand from a growing county population occurs at a time when the level of funding remains, at best stable. The center remains the only state-funded facility capable of delivering the full range of comprehensive mental health services in Boulder County. Therefore, the center occupies the critical central position of taking care of all those psychiatric cases that other agencies are unwilling or unable to serve.

Increased resources are needed to expand services in several areas. Additional resources are needed to provide more outpatient and consultation services to children including the addition of a child psychiatrist to the center's staff. Increased resources are needed to expand outpatient and

consultation services to adolescents. The center does not have partial care or other 24-hour programs for adolescents, and new revenues are needed to establish these programs.

Increased resources are needed to provide inpatient treatment for adolescents and children in their own community.

Children's Hospital,
Department of Behavioral Science Mental Health Clinic

1. Description of Area

This is a non-catchmented, specialty program.

2. 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.

3. 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.

1. Description of Area

This is a non-catchmented, specialty program.

2. Existing Services

The clinic complements other mental health services in the metropolitan area by providing individual insight psychotherapy for people of middle and lower incomes of all ages.

3. Program Needs

The clinic plans to continue expanding its outpatient services to the elderly, severely psychiatrically disabled 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.

Jefferson County Mental Health Center, Inc.

Population: 323,527		
Composition of Population:	Anglo	91.0%
	Asian	1.0%
	Black	0.6%
	Chicano	7.0%
	Native American	0.4%
	Other	0

1. Description of Area

The Jefferson County Mental Health Center services the three counties which lie directly west of Denver. Jefferson County is a rapidly growing suburban area with a population of well over 300,000 residents. Clear Creek and Gilpin Counties are located in mountainous areas on the eastern slopes of the Colorado Rockies. Mining and tourism

are the primary economic activities for both counties.

2. Existing Services

This comprehensive community mental health center offers a complete array of services to residents of Jefferson, Clear Creek and Gilpin Counties. This makes the center one of the largest mental health programs in the United States. The main administrative offices are located in Lakewood with branch offices in Arvada, Evergreen, Wheat Ridge/Golden, South Jefferson County and Lakewood. Part-time offices serve Idaho Springs and Georgetown in Clear Creek County.

3. 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 under way 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 under way.

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 concept has been approved by ADAMHA and provides for the formation of three sub-area committees. Each subcatchment area has a subcatchment committee; however, governance of the total center will

continue to be vested in a central governing board. The Area Committees are composed of representatives of the center Board who live in the various subcatchment areas.

The Area Committee has the authority to hire and fire the Area Coordinator, with the concurrence of the Executive Director. The Area Committees are also carrying out need assessment, are in the process of developing 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 Committee 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.

Northwest Denver Community Mental Health Center

Population: 167,177

Composition of Population:	
Anglo	58.6%
Asian	0.7%
Black	10.2%
Chicano	29.5%
Native American	0.9%
Other	0.1%

1. Description of Area

The center is a component of the City and County of Denver health system. The Northwest catchment has been officially designated as a poverty area by the Department of Health, Education, and Welfare. As the above composition of population illustrates, 41.4% of the population of the northwest area of Denver are Chicano, Black or other minorities.

2. Existing Services

The main administrative office is located in Denver General Hospital. All twelve basic services are provided: emergency services, inpatient services, outpatient services, partial day care services, rehabilitation services, alcoholism services, drug abuse services, halfway house program, children's services, services for the elderly, consultation and education, rape victim support services, and the Denver Public Inebriate Treatment Program.

Major treatment methods are individual, group and family therapies. These services are provided at all units, including the hospital inpatient service. Specialized services include a child daycare treatment program, where severely disturbed children in the first three grades of school are given classroom experience in a therapeutic environment and where family counseling is a very important aspect of the services; a consultation service to all departments of Denver General Hospital; a rape prevention research project; and the program which will seek through many innovative measures to discover and bring into treatment many chronically and severely mentally ill patients who have not previously been served in the community.

The center is funded through a combination of city, state and federal funds. The Northwest Denver Mental Health Center operates as a part of the Division of Psychiatric Services of the Department of Health and Hospitals, with all services of the agency available to all mental health clients. This includes not only Denver General Hospital and the Denver Neighborhood Health Program but also other public health departments such as Visiting Nurse, Disease Control Service, Environmental

Health, etc.

3. Program Needs

A stable basis of funding continues to be the outstanding need of the center. The geriatric program will provide perhaps the greatest challenge in attempts to expand services, since geriatric patients are more difficult to find and to involve in mental health activities than, for example, children and adolescents. The center is in the process of broadening services to children and adolescents under the supervision of the Children's Services Coordinator; this is an area which will receive much study and analysis.

One underserved area of need is services to women affected by alcoholism and services for the "battered woman".

The center programs are under constant study and analysis for the purpose of upgrading services to clients.

Park East Comprehensive Community Mental Health Center, Inc.

Population: 111,977		
Composition of Population:	Anglo	65.4%
	Asian	0
	Black	24.4%
	Chicano	8.5%
	Other*	1.7%

*Native American and Asian included in Other

1. Description of Area

Park East Comprehensive Community Mental Health Center serves the northeast quadrant of Denver bordered by Alameda Avenue on the south, York Street on the west, and on the north and east by the city limits. The service area also includes the entire Montbello neighborhood and those parts of Swansea and City Park neighborhoods which lie outside

the quadrant formed by Alameda and York Streets.

The sixteen neighborhoods or census tracts which constitute the catchment area are basically urban in character except for Montbello, which is a newly developed suburb. The catchment area is also residential in character except for the presence of Stapleton International Airport in the eastern sector, various types of industry ranging from medium to light scattered across the northern sector, City Park and Colorado General Hospital in the central sector, and numerous small businesses and shopping centers throughout.

In 1970, residents of the catchment area had a median income of $11,267, which was slightly lower than the $12,119 income for Denver as a whole. Ten percent of the residents have an income below the poverty level (U.S. Bureau of Census).

The U.S. Census Report of 1970 indicates that 29.5% of the catchment area residents are under 18 years of age, 59.5% are between 18-64 years of age, and 11% are 65 years of age or older. The Census also reports that 65% of the catchment area is White, 24% is Black, 9% is Spanish-surnamed and 2% is comprised primarily of Asians and Indians.

The catchment area is extremely diverse ethnically and economically. There are neighborhoods that could be classified as being very wealthy while others are impoverished. There are neighborhoods that are predominantly White while others are predominantly Black or Chicano. This diversity makes it particularly difficult to provide quality mental health services for all.

2. Existing Services

There are six locations for the main administrative office and branch offices in the area.

The services to children and adolescents, to the elderly, and transitional 24-hour care services are being carefully examined so that service expansion can occur. In the area of specialized services, the Continuous Care Program was developed over three years ago to provide follow-up care to those northeast Denver residents who experience long-term mental health concerns and who have, or will probably require, a long-term client relationship with the center.

The center has a long history of providing specialized services to ethnic people of color. Two examples of the specialized services are the Park East Chicano Outreach Services (PECOS) and Park East Asian Concern (PEAC).

Park East is presently in its fourth year of a federal staffing grant. With declining federal funds, the center has relied heavily upon state support and the generation of local funds. The City and County of Denver does not contribute to the center's operations.

3. Program Needs

The primary need of the center is another 24-hour transitional care facility. Based upon Park East's own survey of agencies working with the center and survey of Park East staff and Board of Directors, as well as a study conducted by the Division of Mental Health in 1976, transitional other 24-hour care ranks high in need. In addition, because of the high inpatient utilization and inpatient costs, a halfway house or facility capable of taking more severe clients is needed. Park East has reduced its hospitalization utilization from 1976-1977 to

almost half. Despite this, a large number of dollars are expended for this service area.

Park East presently serves children and adolescents and the elderly in "minimal compliance" ways. With 29.5% of the catchment area being under 18 and 11% being over 65 based upon the 1970 Census Report, increases in services in these areas are greatly needed. The outreach efforts which eventually would lead to increases in the caseload of these target groups would require additional funding. Also, services to ethnic people of color need to be expanded.

Servicios de la Raza

1. Description of Area

This is a non-catchmented, specialty program.

2. 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 activites with nearby catchment area programs as well as other community agencies.

3. 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: 89,339		
Composition of Population:	Anglo	75.3%
	Asian	0
	Black	0.2%
	Chicano	24.5%
	Native American	0
	Other	0

1. Description of Area

The Southwest Denver Community Mental Health Services, Inc., provides services to citizens who reside in the southwest area of the City and County of Denver. The catchment area is bounded on the east by the Platte River, 6th Avenue to the north, and the city limits of Denver on the west, which generally follow Sheridan Boulevard. The catchment area is economically and ethnically diverse, so providing mental health services which are responsive to a variety of needs represents a major challenge. The Fort Logan Mental Health Center lies within the boundaries of this catchment area.

2. Existing Services

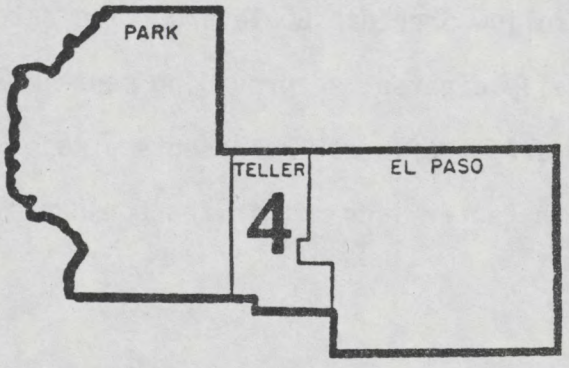
This non-federally funded center has developed a wide range of comprehensive services for its catchment area. It has placed particular emphasis on specialized services to the severely psychiatrically disabled population with a nationally known alternative-to-hospitalization program. A community treatment program continues to provide a structured residential setting for correctional offenders. Provision of services to children and adolescents has been another area of special attention. A special program designed to help meet Chicano mental health needs continues to provide a

unique array of services. This agency has a contract for alcohol abuse services with the State Alcohol and Drug Abuse Division.

3. Program Needs

The center continues to broaden its comprehensive program for alternatives to hospitalization so that need for hospitalization has been reduced even further. A newly funded federal project will allow additional focus on innovative programs for severely psychiatrically disabled clients. Services to the elderly is an area which continues to need more attention.

REGION 4



Area: 4,878 square miles
Population: 250,338
Composition of Population:

Anglo	82.4%
Asian	0.5%
Black	5.6%
Chicano	10.5%
Native American	1.0%
Other	0

1. Description of Area

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

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

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

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

The catchment area includes four large military installations: Fort Carson Army Base, the Air Force Academy, Peterson Air Force Base and Ent Air Force Base, in addition to the North American Air Defense Command Headquarters in Cheyenne Mountain. Over 40 percent of the area's population are active or retired military personnel and their dependents. Generally, the area has experienced a growth rate of approximately six percent per year, making the area one of the fastest growing in the state.

2. 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 Fountain, 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 CARES (Crisis Intervention, Adult Day Treatment, Residential and Emergency Services) Program provides 24 hour emergency service, adult day treatment services, room and board, and short-term hospitalization to individuals whose daily living is seriously disrupted by psychiatric problems. Through the CARES Program, the center has increased its services to the elderly, has established a 24 hour crisis intervention unit and a residential facility for clients who would otherwise be hospitalized.

The special services are comprised of various programs geared to the specialized needs of individuals in the catchment area. Adult Forensic Services and the Adult Forensic Women's Services are community-based mental health programs for offenders and their families. The programs' 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 adolescents in the community. Consumer Credit Counseling provides counseling and debt liquidation services to families and individuals with financial problems, as well as an education program to prevent such problems.

The Alcohol Services Unit offers a variety of programs and treatment

intensities specially designed for people with alcohol related problems.

3. Program Needs

A substantial increase in per diem reimbursement for Alcohol and Forensic other 24-hour care beds is needed. Such beds are essential if the center is to attain its objectives related to treating clients in the community.

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. The center believes it will be successful in establishing a comprehensive treatment program for children during 1978.

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.

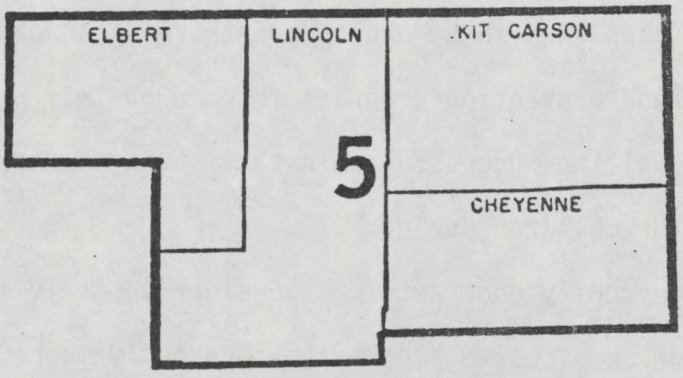
The mental health center is also under pressure to increase outpatient and consultation and education services to the rapidly expanding population in the catchment area.

The center is encountering some funding problems in its Alcoholism and Adult Forensic Services Programs. 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. In order to accommodate the unique characteristics of the area and to document a waiver request, the center revised its governance structure. As of January 1978, the advisory committees of the eight major program components of the center were changed to Program Councils and given additional areas of responsibility.

REGION 5



Area: 8,401 square miles
Population: 21,231

Composition of Population:		
	Anglo	96.0%
	Asian	0
	Black	0
	Chicano	4.0%
	Native American	0
	Other	0

1. Description of Area

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

Strong agricultural and ranching endeavors are predominant in Region 5. The distance from markets and raw materials, prevailing freight rates, and other negative factors tend to have a discouraging effect on industry in the area which is virtually nonexistent. This sparsely populated area has been designated as a poverty area. Geographical distances with numerous small population centers present many problems in the delivery of mental health services in this rural area. This area does not draw many qualified mental health professionals and travel costs are very high for the staff that do serve the area. Programs and resources are limited while the demand to develop services to meet local needs continues to increase.

2. Existing Services

Region 5 is served by a part-time clinic headquartered in Flagler. Outpatient services are provided one day per month or more in the communities of Cheyenne Wells, Stratton, Limon, Hugo, Kit Carson, Burlington, Kiowa, Simla, and Elizabeth. Telephone service is provided during daytime hours in the communities of Limon and Burlington. A 24-hour telephone answering service has been established in Flagler to handle daytime calls, as well as after-hours emergency calls. 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. In the past year an Assistant Director, who is a resident of Flagler, was appointed. There are currently five full-time clinicians and one part-time clinician who are residents of the area.

Presently, outpatient evaluation and treatment programs, alcohol and drug abuse counseling, psychological testing and evaluations, and consultation

and education services are offered. 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. Emergency mental health consultation is available on a time-limited basis at this time in the four-county area; however, there is no formal emergency mental health service.

3. Program Needs

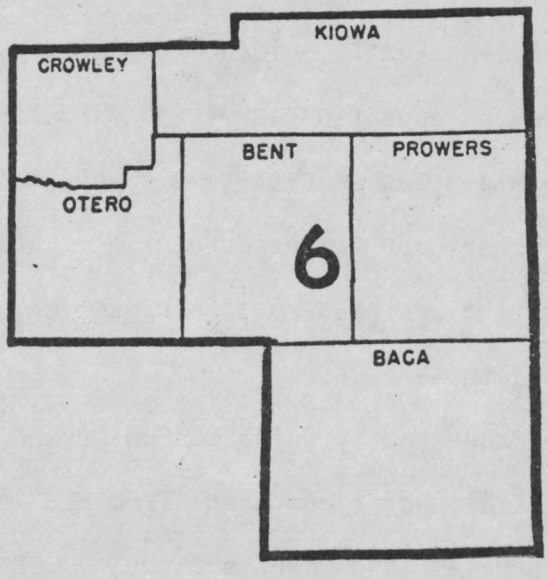
The mental health needs of this region are quite basic. Foremost is, perhaps, the availability of weekly services in all previously mentioned communities. Although the focus of the clinic has been to make services available throughout the region, the establishment of a full-time outpatient clinic would enhance the accessibility of services in this rural area. Some of the clinical positions are filled by several part-time clinicians from Region 1 due to the lack of qualified professionals residing in the area.

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 from the community when clients must be sent to the Colorado State Hospital for services. The region also lacks day care facilities for disturbed youth as well as adults. There is considerable need for mental health care of chronic predominantly 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.

A planning grant application was submitted and approved by the Department of Health, Education, and Welfare to facilitate the development of comprehensive services to this area and to the Region 1 catchment area. Under this grant concept Region 5 and Region 1 could be combined so that comprehensive services to this large, isolated area would become feasible. The two clinics began the joint planning process December 1, 1977, which will culminate in the submission of a grant application to allow the two clinics to merge into one comprehensive community mental health center. The merger would allow for the development of a stronger, comprehensive program while retaining the community identities already established.

REGION 6



Area: 9,526 square miles
Population: 60,018

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

1. Description of Area

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

Region 6 includes all of the Arkansas River drainage basin that falls outside the front range corridor. Horse Creek and the Purgatory, Big Sandy, Two Buttes and Cimmaron Rivers, tributaries of the Arkansas River, flow through the area. The Frying Pan-Arkansas Project, a water resource program, is expected to benefit the area by increasing its water resource base. The region is plagued with seasons of drought followed by severe rainfall, which are characteristic of the Great Plains Region.

The area is designated as a poverty area. The number of elderly people and Spanish speaking persons is above the state average.

2. Existing Services

The Southeastern Colorado Family Guidance Center provides only outpatient and consultation and education services. The staff consists of five clinical full-time employees, a part-time psychiatric consultant, a business manager, a director, and three secretaries. The clinic has a branch office in Lamar. The Southeast Region ranks very high in the need for additional mental health services

The Southeastern Colorado Family Guidance Center applied for and has been approved for an initial operations grant from HEW to establish comprehensive mental health services throughout the region.

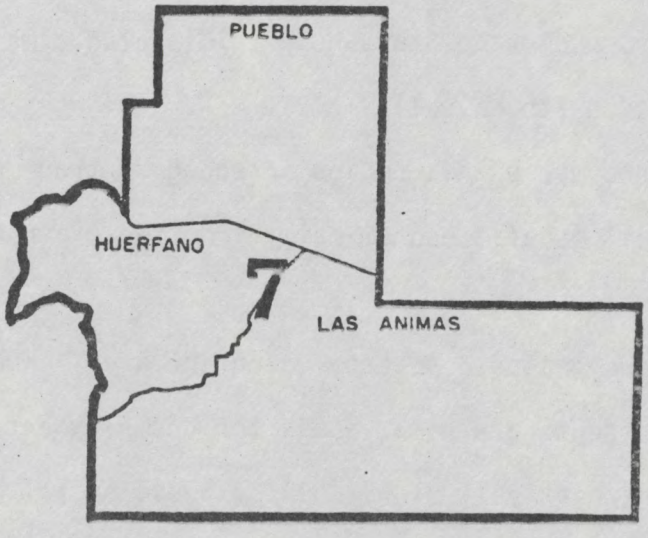
3. Program Needs

There is a serious need for increased comprehensive mental health services throughout the region. The rural communities are especially seriously under-

served due to the distances involved and the limited size of the staff.

Existing crisis services are limited. The clinic also plays a minimum role in prescreening admissions to the Colorado State Hospital. Tri-County Alcohol provides outpatient alcohol and drug treatment to Prowers, Kiowa, and Baca Counties. The Region 6 alcohol program in Las Animas provides counseling and detox/halfway house services.

REGION 7



Area: 8,773 square miles
Population: 152,968

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

1. Description of Area

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

western areas.

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

Pueblo is the major agricultural, commercial and industrial center in the region. The foremost economic asset of this city is the Colorado Fuel and Iron Corporation, which employs approximately 6,000 persons. Plans have been made to close the Pueblo Army Depot, which, in the past, has employed 2,800 persons. This event has and will have a serious economic impact on the community. Colorado State Hospital is also a major employer, with over 1,300 persons on its payroll.

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

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

2. Existing Services

The area is served by the Spanish Peaks Mental Health Center, headquartered in Pueblo. Branch offices are located in Walsenburg and Trinidad. The center provides a full array of services through affiliation with the Colorado State Hospital (CSH) in Pueblo. The center provides outpatient services, emergency services during the daytime, and consultation and education services in Pueblo. CSH provides the inpatient services, weekend

and night-time emergency services, and partial care services in Pueblo. The branch program at Walsenburg provides outpatient and partial care services to adults and outpatient services to children, while the Trinidad branch provides outpatient services for all ages and partial care services for children and school consultation services. The center has also developed a comprehensive alcoholism service program funded by an NIAAA grant. A residential child care facility, called EKOS House, is sponsored by the center. A group home in Trinidad is receiving mental health consultation from the center.

The center was originally established as a joint venture between CSH and the Spanish Peaks Mental Health Clinic. Through a construction and a subsequent staffing grant, a facility for the treatment of children in the region was established on the grounds of CSH. Cottage "D" was staffed by federal funds from the center and by state funds through CSH. Cottage "D" is now operated and funded completely through CSH, and the center is an independent non-profit agency with a working agreement with CSH, but no joint funding. The center serves children through the Rural Child Mental Health Program which provides outreach mental health services to children and families in the rural areas of Pueblo County. It is a cooperative venture with School District 70.

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

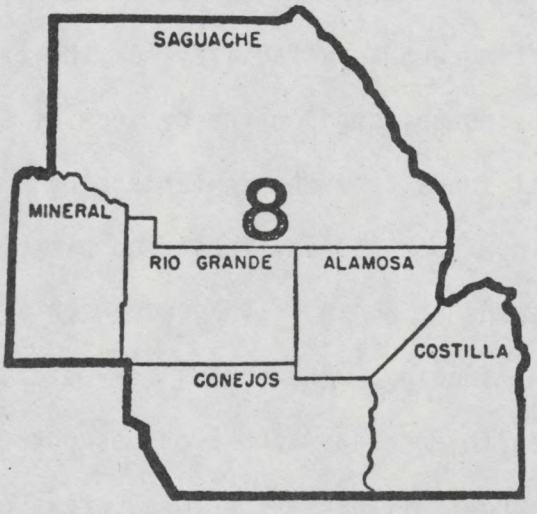
3. Program Needs

There is great need for additional resources to develop more extensive outreach services to urban and rural pockets of poverty. There is also a

large number of one-parent families that need attention.

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

REGION 8



Area: 8,180 square miles
Population: 43,922

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

1. Description of Area

Approximately the size of the State of Connecticut, the San Luis Valley

is a mountain-rimmed watershed of the upper Rio Grande River, approximately 50 miles in width and 125 miles long.

The catchment area was settled in the mid-nineteenth century by Spanish-Americans whose culture continues to predominate. This area contains by far the highest concentration of Spanish-speaking persons in the State of Colorado (47% of the population).

Region 8 consists of six counties and is a federally designated poverty area.

2. Existing Services

The San Luis Valley Comprehensive Community Mental Health Center houses the administrative offices and the main center in Alamosa. The center also has a branch office in Monte Vista and outreach components in La Jara, Antonito, San Luis, Fort Garland, Center, and Saguache.

The center offers model bilingual/bicultural partial care services, and a unique physical fitness program for the elderly.

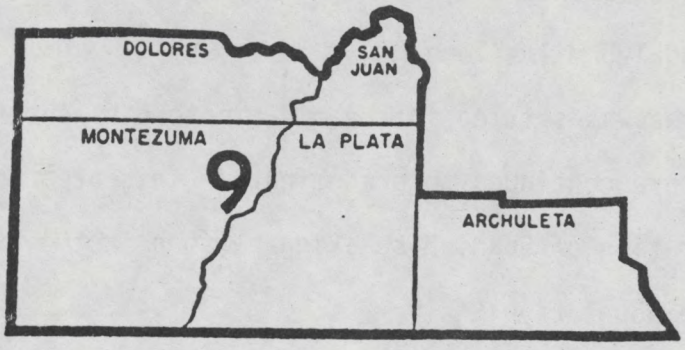
3. Program Needs

There is a need for locally available inpatient treatment of chronic disorders in children, a community corrections service, an expansion of facilities to treat the adult chronic psychiatric patients requiring hospitalization or other types of residential care.

The high incidence of poverty also contributes to alcoholism and drug abuse. The program needs to expand its capacity of crisis services to the outlying areas.

Other needs include outreach services to the elderly population.

REGION 9



Area: 6,563 square miles
Population: 46,639

Composition of Population:		
	Anglo	76.2%
	Asian	-0-
	Black	0.1%
	Chicano	18.2%
	Native American	5.5%
	Other	-0-

1. Description of Area

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. These represent the two Indian Reservations in the state.

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 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.

2. Existing Services

Southwest Colorado Mental Health Center, the only state-funded 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 center 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. Staff also provide consultation at both reservations. Local hospitals in Durango are utilized for inpatient care for some clients who are eligible for Medicare and Medicaid and other third party reimbursements.

3. Program Needs

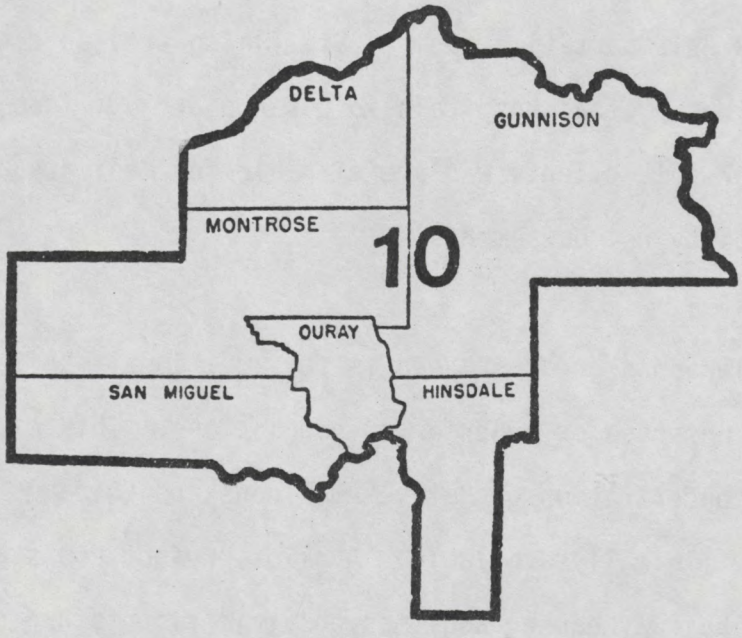
Southwest Colorado's greatest need is for additional staff to reach out to currently unserved or underserved populations. This catchment area has a high concentration of Native Americans and Chicanos for whom services are only minimally available. A pilot project assisted the development of a halfway 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. However, limited funding has meant decreased involvement by the center in these programs. 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 possible federal initial operations grant under Public Law 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



Area: 9,369 square miles
Population: 51,073
Composition of Population:

Anglo	89.0%
Asian	0.5%
Black	0.1%
Chicano	9.2%
Native American	0.9%
Other	0.3%

1. Description of Area

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 north, 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-sixth of Colorado's federal land holdings are in the region. The wealth of recreational land provides ample facilities for hunting, fishing, and skiing.

2. 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 alcohol outpatient counseling services through a contract with the State Alcohol and Drug Abuse Division. The center has arrangements with three

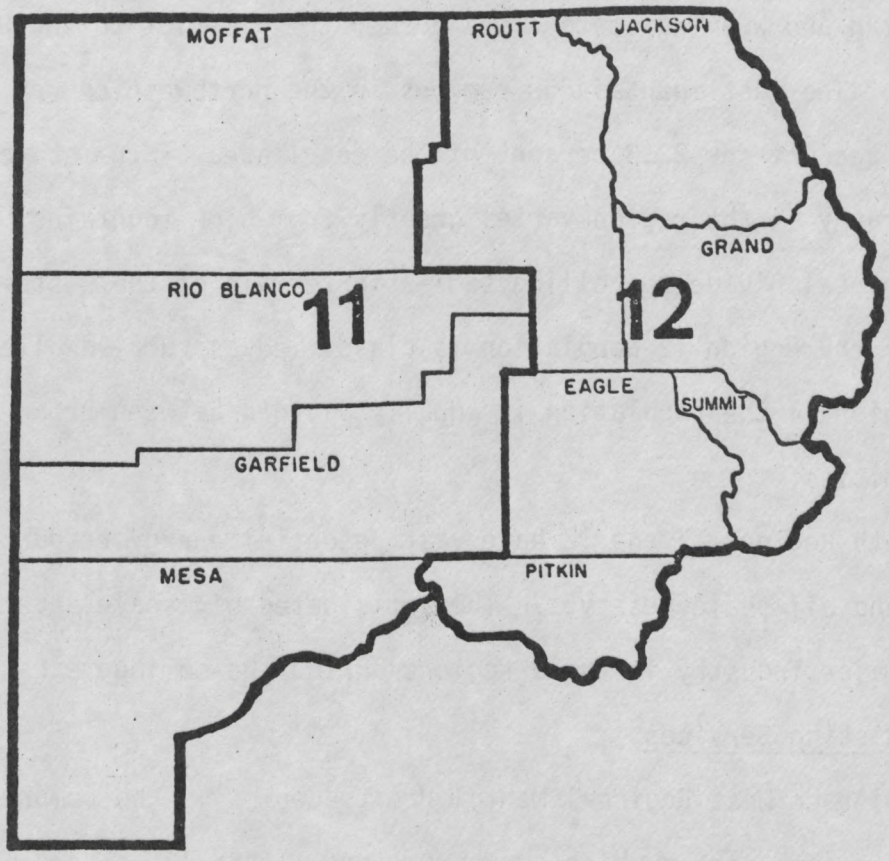
local hospitals to provide beds for psychiatric patients; some inpatients are sent to Colorado State Hospital. Transitional residential care is provided through contractual arrangements with local nursing and boarding homes. There are full-time staff members in Delta, Gunnison, Norwood and Montrose. 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 mental health, family and marriage counseling agency in the catchment area.

The center now has one federal grant which provides for 10% of the total budget. Previous federal grants allowed for increased staffing and expanded services to residents in previously underserved and unserved communities. The center has completed the construction of an office building in Delta with funding provided by a federal construction grant. As the federal grants have declined, increased funding has come from fees, local and state sources.

3. 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 AND 12



Area: 23,386 square miles
Population: 151,896
Composition of Population:

Anglo	91.6%
Asian	0
Black	0.3%
Chicano	8.0%
Native American	0.1%
Other	0

1. Description of Area

Regions 11 and 12 are combined into one mental health catchment area, which is composed of 10 counties: Moffat, Rio Blanco, Garfield, Mesa, Eagle, Grand, Jackson, Pitkin, Routt and Summit. The topographical characteristics of Regions 11 and 12 are reflected in the area's economic basis - specifically agriculture, mining, lumbering, ranching, farming, light manufacturing and recreation. The most important asset of Region

11 is the rich, fertile land of the Colorado River Valley. Stock raising plays a major economic role, with orchard crops important in Mesa County. The Utah and Wyoming state lines border the district to the west and north. The vast mountainous regions in the northwest corner of the state account for 22.3 percent of the total area of the state, and the topography of the region varies greatly from high mountains of the Continental Divide to rolling semi-arid terrain of the western area. All of the Region 12 population is classified as rural dwellers, while in Region 11 the population is equally divided between urban and rural communities.

Both Regions 11 and 12 have vast potential energy resources in their coal and oil shale reserves. The anticipated oil shale development will be a major industry in these regions during the coming years.

2. 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 Rifle, Hayden, Eagle, Breckenridge, Aspen, Craig, Rangely, and Meeker. The affiliates provide outreach services on a regular basis in Dillon, Dinosaur, Vail, Frisco, Minturn, Redcliff, 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. Outpatient substance abuse counseling services are available through a contract with the State Alcohol and Drug Abuse Division. During this past year, through the assistance of special state funds, another 24-hour care facility was staffed and began operations in Grand Junction to serve Region 11. In addition, this program has allowed for the purchase of additional inpatient services.

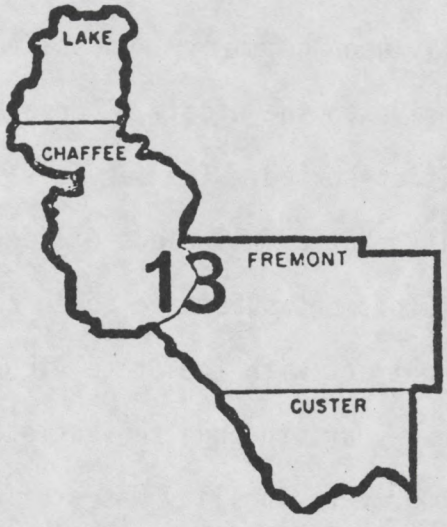
Fort Logan Mental Health Center provides state hospital inpatient services for children, adolescents, adults, alcoholics and geriatrics patients in Region 12. Region 11 receives these services from Colorado State Hospital.

The center continues to be 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.

3. Program Needs

Two primary services still needed in Region 12 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 Fort Logan Mental Health Center and a reduced average length of hospital stay.

REGION 13



Area: 3,715 square miles
Population: 48,659

Composition of Population:		
	Anglo	87.0%
	Asian	-0-
	Black	.8%
	Chicano	11.0%
	Native American	.2%
	Other	1.0%

1. Description of Area

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

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

Mining is a major industry in Region 13. Agriculture, tourism, lumbering, and recreation are other important sources of income. Approximately 80 percent of the world's supply of molybdenum is produced near

Climax by American Metal Climax Incorporated, which employs over 2,000 persons.

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

2. Existing Services

The main administrative office of the West Central Mental Health Center is located in Canon City, with branch offices in Florence, Salida, Buena Vista, Leadville, and Westcliffe.

3. Program Needs

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

B. REVIEW PROCESS FOR CATCHMENT AREAS

According to federal guidelines, the population of a catchment area is to be between 75,000 and 200,000. The upper and lower population limits can be waived by DHEW at the time of approval of a center for federal funding. After a center has been awarded a federal

grant, if any variation in the population of an area reduces it below the minimum or increases it above the maximum by more than 25 percent, a DHEW waiver must be sought or the catchment area must be enlarged or subdivided as necessary to bring it within the prescribed size.

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

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

C. RANKINGS OF CATCHMENT AREAS

1. Procedure for Determining Need Rankings of Catchment Areas

In order to determine the relative need for additional mental health

services among the various catchment areas, an updated need assessment study was performed in April 1978. As in past years, the need rankings are a reflection of unmet need, e.g., the calculated need modified by reported available resources. The major changes this year are in the indicators used in determining both need and resources, and the calculation of unmet need by age group. In addition, all values were converted to standard scores before the weighting and rank order was calculated. This will be further explained later.

A. Need - variables, items and weights

Variable	Variable Weight	Item	Item Weight
Social Indicators	2		
		Socioeconomic Distress	
		% population in poverty	2.0
		% low occupation-males	1.5
		% overcrowded households	1.5
		Family Disruption	
		% households non husband-wife	1.0
		% children not with both parents	1.0
		% divorced/separated females	1.0
		Community Change	
		% recent movers	1.25
		Ethnic Minority	
		% Chicano	0.375
		% Black	0.375
Population by Age Group	1		

B. Resources - variables, items and weights

Facility Inventory	-0.5		
		# acute inpt beds per 100,000 pop.	0.25
		# other 24-hr care beds/100,000 pop.	0.50
		# beds owned by local gov't or private nonprofit/100,000 pop.	0.10
		# wkly non 24-hr care personnel hrs. (non-private practice)/1,000 pop.	0.75
		# wkly non-personnel hrs. (non-private practice in agencies owned by local gov't or private nonprofit/ 1,000 pop.	0.10

Variable	Variable Weight	Item	Item Weight
Utilization of Service by Age Group	-1.0		
		% served with minimal distress	0.25
		% served with mild distress	0.50
		% served with moderate distress	0.75
		% served with severe distress	1.00

C. Definition of Variables

Social indicators:

Nine socioeconomic/demographic variables were selected from those available in the Mental Health Demographic Profile System (MHDPS). They were selected as indicators of socioeconomic distress, family disruption, community change, and ethnic minorities.

Indicator	Definitions	Justification	Source
A. % population in poverty	Poverty - The Federal Gov't cutoff weighted by the Census Bureau by age, farm/nonfarm, size of family unit, and sex of head of household.	NIMH factor analysis indicator. Reflects low economic status.	MHDPS 1970
B. % males 16 yrs and older in low occupation status	Low Occ. Status - Those who are operatives, service workers, and laborers including farm laborers.	Shown by NIMH factor analysis to be one of best indicators of an area's demographic and social dimensions. Reflects low socioeconomic status.	MHDPS 1970
C. % overcrowded housing	Percent household population in housing with 1.01 or more persons per room.	NIMH factor analysis indicator. Reflects stressful living condition due to overcrowding.	MHDPS 1970
D. Non husband-wife households	Household - Includes all the persons who occupy a group of rooms or a single room which constitutes separate living quarters. Husband-wife - Includes common-law as well as formal marriages.	NIMH factor analysis indicator. Reflects broken families.	MHDPS 1970

Indicator	Definitions	Justification	Source
E. % children not living with both parents	Includes stepchildren and adopted children as well as children born to a couple.	Reflection of broken homes and stressful conditions for children and remaining parent.	MHDPS 1970
F. % divorced/ separated females	Includes persons who are living apart because of marital discord, with or without a legal separation.	Reflection of one parent homes and stress of divorce.	MHDPS 1970
G. % of recent movers	Recent movers - Population who moved into present residence in 1969-1970.	NIMH factor analysis	MHDPS 1970
H.1 % Spanish heritage (Chicano)	Spanish heritage - Persons identified by: (1) having a Spanish surname when matched against a list of over 8000 names; or (2) the use of the Spanish language was reported.	Reflects stresses associated with minority group membership.	MHDPS 1970
H.2 % Black	Percent of household population that is Negro.	Same as above	MHDPS 1970

One reason for having a state mental health system is to provide services for that segment of the population which cannot afford to buy professional help from private mental health practitioners. Furthermore, low socioeconomic status has been traditionally associated with mental health problems. Therefore, the greatest weight was assigned to the indicators of socioeconomic distress with the most direct measure, percent of population in poverty, receiving the most weight among the three items.

Family disruption and community change create stressful conditions which are frequently associated with the need for mental health services.

Family disruption indicators were weighted slightly less than socio-economic indicators since the latter represents two areas of need: distress due to social factors and lowered ability to pay for service. Our indicator of community change, percent of recent movers, is based on 1970 census data. While we know that certain areas of the State have experienced rapid growth which these data do not reflect, we are unable to accurately document it at this time. Therefore, the community change indicator was given a lower weighting.

Two special target groups were identified: Chicanos and Blacks. While many of these people are also in one or more of the other social indicator categories, they are given additional weight in the rankings because of their need for specialized programs.

Population:

Catchment area figures are based on the most recent population figures published by the Department of Local Affairs, Division of Planning. The age percents from the 1975 figures were applied to the estimated 1978 populations published by the Office of State Planning and Budgeting and which are the official budget figures. (There is some disagreement as to the accuracy of these population figures, especially in areas of rapid growth.)

Exceptions to the above procedure:

The special census figures for Delta, Garfield, Mesa, Moffat, Rio Blanco, and Routt counties were used as mandated in the January 27, 1978 Executive Order.

The populations of the Denver County catchment areas were based on the age percents from the 1970 census applied to the estimated 1978

population.

The population breakout for Aurora follows the established DMH percent allocation.

While it was recognized that the more people in a given area, the greater the need for services, it was not felt to be as strong an indicator as socio-economic conditions and was, therefore, assigned half the weight.

Facility Inventory:

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

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

   This rate of non long-term beds, following Federal Inventory definitions, was selected on the basis that there would probably be beds in such facilities as general hospital psychiatric services, CMCHs, 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 State 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.

Utilization of Service:

The calculation of this variable required several steps. First, estimates of the severity of existing mental health problems by age group were made based on recent literature. Second, the percent of clients served in each catchment area with varying levels of problem severity by age group was calculated. Third, the percent of those in each level of problem severity (Step 1) was compared with those served having a similar severity rating (Step 2). This final step produced the utilization of services ratio.

Based on the belief that the existence of resources is reflected in the amount of service provided, the utilization of service index was chosen as the second indicator of resources. Further, higher weights were assigned as the severity level increased since it requires a higher level of staffing to provide service to those with severe as compared with minimal distress.

Step 1. Estimates of problem severity by age:

The most recent document addressing the mental health need issue is the Report of the President's Commission on Mental Health, 1978, where the following statements appear:

> For the past few years, the most commonly used estimate is that, at any one time, 10 percent of the population needs some form of mental health care.
>
> There is new evidence that this figure may be closer to 15 percent of the population.
>
> Of the estimated 20 to 30 million people who need mental health care, 2 million people have been or would be diagnosed as schizophrenic.
>
> A similar number, or about 1 percent of the population, suffer from profound depressive disorders.
>
> More than 1 million people have organic psychoses of toxic or neurologic origin, and other permanent disabling mental conditions from varying causes.
>
> 15 percent of patients seen in general medical practice are found to have psychiatric or emotional problems.
>
> At any given time, 25 percent of the population is under the kind of emotional stress that results in symptoms of depression or anxiety.
>
> According to the best recent estimates, 8.1 million of the 54 million children and youth of school age, or 15 percent of that population, need help for psychological disorders.
>
> Varying estimates show that anywhere from 1 to 2 million children have specific learning disabilities.
>
> One of every 3,000 children has an autistic disorder.

There are 200,000 cases of child abuse reported every year, and surveys indicate the total number may be at least ten times greater.

The incidence of mental health problems is higher among people sixty-five and older than in other age groups.

The elderly account for 25 percent of all reported suicides although they represent only 11 percent of the population.

Additional supporting material concerning the incidence of mental health problems in children and youth was found in a study conducted in 1974 by General Research Corporation under a NIMH contract. Their report entitled Assessment of Child Mental Health Needs and Programs contains a breakdown by age and severity.

Children - The percents cited by the President's Commission refer to "children of school age" and since we have included all children (0-11) the percent has been reduced from 15% to 12%. This is in line with the findings of the NIMH study which showed that the incidence increased with age.

Adolescents - Again, the President's Commission talks about "children and youth" so it is difficult to determine the exact figures for adolescents. However, due to their greater incidence of suicide, drug misuse, etc., and the findings of the NIMH study, the overall percentage is felt to be higher than for children and was set at 17%.

Adults - A baseline of 12.5% which falls between the high (15%) and low (10%) estimates mentioned above was used.

Elderly - If the incidence is higher for the elderly than for other groups, it is probably close to 20%. Over 60% of the former hospitalized patients are over 55 and the majority of those in nursing homes are also

elderly.

Summary of Step 1 Calculations

	Severe	Mod	Mild	Min
Children	2%	4%	6%	15%
	0.01% autistic 1.50% severely abused 0.49% other psychosis	Remainder of 12% baseline		Unknown stress including abuse
Adolescents	4%	6%	7%	25%
	1% schizophrenic 1% suicidal 1% depressed-psychotic 1% other severe disorders	Remainder of 17% baseline		Probably same as adult due to stress factors
Adults	3%	4%	5.5%	25%
	1% schizophrenic 1% profound depression 0.5% neurologic psychosis 0.5% other psychosis	Remainder of 12.5% baseline		Symptoms of depression and anxiety due to stress
Elderly	6%	7%	7%	25%
	2% schizophrenic and other psychosis 1% senility related 2% suicidal and deep depression 1% other severe symptoms	Remainder of 20% baseline		Certainly equal to adults and adolescents

Step 2. Severity of clients served:

	Ratings on Disruption Profile at Admission			
Diagnostic category	A	B	C	D
Psychosis	IV	IV	III	II
Neurosis, etc.	IV	III	II	II
Other	IV	III	II	I

(IV = severe; III = moderate; II = mild; I = minimal severity)

Disruption Profile Ratings

A = At least one "4" rating
B = At least one "3" rating, but no "4s"
C = A mixture of "1s" and "2s" or all "2s"
D = All "1" rating

Diagnostic Categories

Psychotic - DSM II Codes: 295-298

Neurotic, personality disorders, etc. - DSM II Codes: 290-294, 300-306, 309-315

Other - DSM II Codes 307-308, 316-318

D. Technical Note on Standard Scores

Standard scores indicate the location of a particular raw score on the normal curve or distribution of all the raw scores for a particular variable. They are calculated so that the mean is always equal to zero and the standard deviation is always equal to 1.00. A negative standard score indicates that the corresponding raw score was below the mean; a positive standard score represents a raw score above the mean (on the charts which follow this section, however, 10 was added to each column in order to eliminate negative numbers).

Because all sets of standard scores, regardless of the data they represent, have the same mean and the same standard deviation, they can be combined. This is true even when the raw scores are based on different measures that have different means, ranges, methods of scoring, etc.

E. Technical Note on Facility Inventory

The data for this section was initially collected in April 1976. 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 catchment areas, 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 information collected did not specify a breakdown of facilities by age group. The Facility Inventory will have to be updated and revised to more accurately reflect the transition to calculating unmet need by age group. State Plan objectives have been established (Chapter III) to completely update the inventory of mental health resources with revised utilization data.

2. Rankings of the Catchment Areas

The following tables show the final need rankings of the catchment areas by age group, with a rank of "1" indicating the greatest need. These rankings, or other similar data developed by or outside of the Division of Mental Health, will be shared with affected centers and clinics and with technical experts to obtain input on limitations and applicability of results, prior to use for funding decisions or recommendations.

NEED RANKINGS OF THE CATCHMENT AREAS

CHILDREN

	NEED			RESOURCES			OVERALL	
CATCHMENT AREA	Weight = 2 Social Indicators	Weight = 1 Population	Need Total	Weight = -.5 Facility Inventory	Weight = -1 Utilization of Services	Resources Total	Total Score	Rank
Adams	9.29	11.35	9.93	9.38	11.97	8.34	8.27	17
Arapahoe	8.57	10.15	7.29	10.62	9.05	10.64	7.93	18
Aurora	9.37	9.93	8.67	10.64	9.34	10.34	9.01	15
Bethesda	8.88	10.25	8.01	9.83	8.60	11.49	9.50	12
Boulder	9.34	10.36	9.04	9.89	9.83	10.23	9.27	14
Colo West	10.09	10.08	10.26	10.21	9.02	10.88	11.14	7
E Central	9.31	8.58	7.20	8.68	10.56	10.10	7.30	21
Jefferson	8.49	12.68	9.66	9.05	8.97	11.51	11.17	6
Larimer	9.77	9.74	9.28	9.51	9.67	10.58	9.86	10
Midwestern	10.37	8.96	9.70	9.24	10.09	10.29	9.99	9
NE Colo	9.66	9.19	8.51	9.18	11.22	9.19	7.70	19
NW Denver	12.96	10.95	16.87	11.45	10.71	8.56	15.43	1
Park East	10.62	10.16	11.40	10.20	8.95	10.95	12.35	2
Pikes Peak	10.02	11.65	11.69	10.66	9.85	9.82	11.51	4
San Luis	11.51	8.95	11.97	11.98	10.23	8.78	10.75	8
SE Colo	10.68	9.14	10.50	8.54	9.33	11.40	11.90	3
SW Colo	10.54	8.92	10.00	8.73	9.32	11.32	11.32	5
SW Denver	9.30	10.27	8.87	10.00	9.13	10.87	9.74	11
Sp Peaks	10.65	10.00	11.30	12.29	11.15	7.70	9.00	16
Weld	10.33	9.78	10.44	10.13	10.94	8.99	9.43	13
W Central	10.25	8.92	9.42	9.79	12.06	8.04	7.46	20

*Standard scores with mean = 0.00. 10 was added to each column to eliminate the negative numbers.

ADOLESCENTS

	NEED			RESOURCES			OVERALL	
CATCHMENT AREA	Weight = 2 Social Indicators	Weight = 1 Population	Need Total	Weight = -.5 Facility Inventory	Weight = -1 Utilization of Services	Resources Total	Total Score	Rank
Adams	9.29	11.30	9.88	9.38	12.00	8.31	8.19	19
Arapahoe	8.57	10.67	7.81	10.62	7.79	10.90	8.71	17
Aurora	9.37	9.84	8.58	10.64	9.81	9.87	8.45	18
Bethesda	8.88	9.77	7.53	9.83	8.74	11.35	8.87	15
Boulder	9.34	10.79	9.47	9.89	9.10	10.96	10.43	10
Colo West	10.09	10.25	10.43	10.21	9.73	10.17	10.60	9
E Central	9.31	8.66	7.28	8.68	10.15	10.51	7.79	20
Jefferson	8.49	12.93	9.91	9.05	9.31	11.17	11.08	6
Larimer	9.77	10.07	9.61	9.51	9.04	11.21	10.82	7
Midwestern	10.37	9.15	9.89	9.24	10.43	9.95	9.84	12
NE Colo	9.66	9.31	8.63	9.18	11.49	8.92	7.55	21
NW Denver	12.96	10.11	16.03	11.45	11.79	7.48	13.52	1
Park East	10.62	9.50	10.74	10.20	8.66	11.24	11.98	3
Pikes Peak	10.02	11.52	11.56	10.66	10.61	9.06	10.62	8
San Luis	11.51	9.06	12.08	11.98	9.87	9.14	11.22	5
SE Colo	10.68	9.23	10.59	8.54	9.21	11.52	12.11	2
SW Colo	10.54	9.05	10.13	8.73	9.14	11.50	11.63	4
SW Denver	9.30	10.53	9.13	10.00	9.77	10.23	9.36	13
Sp Peaks	10.65	10.25	11.55	12.29	10.29	8.56	10.12	11
Weld	10.33	9.98	10.64	10.13	11.32	8.61	9.25	14
W Central	10.25	8.99	9.49	9.79	10.74	9.36	8.85	16

*Standard scores with mean = 0.00. 10 was added to each column to eliminate the negative numbers.

NEED RANKINGS OF THE CATCHMENT AREAS

ADULTS

	NEED			RESOURCES			OVERALL	
CATCHMENT AREA	Weight = 2 Social Indicators	Weight = 1 Population	Need Total	Weight = -.5 Facility Inventory	Weight = -1 Utilization of Services	Resources Total	Total Score	Rank
Adams	9.29	10.93	9.51	9.38	10.27	10.04	9.55	14
Arapahoe	8.57	10.32	7.46	10.62	9.06	10.63	8.09	20
Aurora	9.37	9.88	8.62	10.64	9.39	10.29	8.91	17
Bethesda	8.88	9.93	7.69	9.83	9.45	10.64	8.32	19
Boulder	9.34	10.77	9.45	9.89	9.69	10.37	9.81	12
Colo West	10.09	10.51	10.69	10.21	9.65	10.25	10.94	7
E Central	9.31	8.67	7.29	8.68	9.10	11.56	8.85	18
Jefferson	8.49	12.78	9.76	9.05	9.91	10.57	10.33	10
Larimer	9.77	10.32	9.86	9.51	9.76	10.49	10.35	9
Midwestern	10.37	9.03	9.77	9.24	10.52	9.86	9.63	13
NE Colo	9.66	9.23	8.55	9.18	9.82	10.59	9.14	16
NW Denver	12.96	10.34	16.26	11.45	14.01	5.26	11.53	2
Park East	10.62	9.77	11.01	10.20	9.45	10.45	11.46	3
Pikes Peak	10.02	11.89	11.93	10.66	10.65	9.02	10.95	6
San Luis	11.51	8.93	11.95	11.98	9.54	9.47	11.42	4
SE Colo	10.68	9.11	10.47	8.54	9.36	11.37	11.84	1
SW Colo	10.54	9.00	10.08	8.73	9.59	11.05	11.13	5
SW Denver	9.30	9.41	8.01	10.00	10.18	9.82	7.83	21
Sp Peaks	10.65	10.02	11.32	12.29	9.81	9.04	10.37	8
Weld	10.33	10.13	10.79	10.13	10.45	9.48	10.28	11
W Central	10.25	9.02	9.52	9.79	10.34	9.76	9.28	15

*Standard scores with mean = 0.00. 10 was added to each column to eliminate the negative numbers.

ELDERLY

	NEED			RESOURCES			OVERALL	
CATCHMENT AREA	Weight = 2 Social Indicators	Weight = 1 Population	Need Total	Weight = -.5 Facility Inventory	Weight = -1 Utilization of Services	Resources Total	Total Score	Rank
Adams	9.29	9.59	8.17	9.38	10.33	9.98	8.15	17
Arapahoe	8.57	10.02	7.16	10.62	9.45	10.24	7.40	20
Aurora	9.37	8.76	7.50	10.64	9.60	10.08	7.58	19
Bethesda	8.88	10.81	8.57	9.83	9.60	10.49	9.05	15
Boulder	9.34	10.52	9.20	9.89	9.29	10.77	9.96	10
Colo West	10.09	10.55	10.73	10.21	9.40	10.50	11.23	5
E Central	9.31	8.61	7.23	8.68	8.82	11.84	9.07	14
Jefferson	8.49	11.66	8.64	9.05	9.93	10.55	9.18	13
Larimer	9.77	10.24	9.78	9.51	9.89	10.36	10.14	9
Midwestern	10.37	9.29	10.03	9.24	10.05	10.33	10.36	7
NE Colo	9.66	9.74	9.06	9.18	9.93	10.48	9.54	12
NW Denver	12.96	12.69	18.61	11.45	10.51	8.76	17.38	1
Park East	10.62	10.41	11.65	10.20	8.97	10.93	12.58	3
Pikes Peak	10.02	10.73	10.77	10.66	10.50	9.17	9.94	11
San Luis	11.51	8.91	11.93	11.98	12.81	6.20	8.13	18
SE Colo	10.68	9.59	10.95	8.54	8.94	11.79	12.74	2
SW Colo	10.54	8.92	10.00	8.73	9.73	10.91	10.91	6
SW Denver	9.30	9.00	7.60	10.00	11.72	8.28	5.88	21
Sp Peaks	10.65	10.83	12.13	12.29	9.04	9.81	11.95	4
Weld	10.33	9.91	10.57	10.13	11.83	8.10	8.67	16
W Central	10.25	9.23	9.73	9.79	9.65	10.46	10.19	8

*Standard scores with mean = 0.00. 10 was added to each column to eliminate the negative numbers.

D. FACILITIES

1. Plans for Comprehensive Services

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

The goal is to have all catchment areas covered by comprehensive centers. During the past two years, three clinics (Aurora, West Central and Larimer County) were awarded initial operations grants; one clinic (Southeastern Colorado) has recently been approved for an initial operations grant; one clinic (Southwest Colorado) applied for a planning grant; and the Division of Mental Health was awarded a planning grant for East Central and Northeast Colorado Mental Health Clinics. The plan is to merge East Central and Northeast Colorado Clinics to form one strong, well staffed agency. The rationale for combining the two catchment areas is as follows:

a. geographic contiguity and similarity of the two areas;

b. social homogeneity of populations;

c. similarity of mental health problems; and

d. when the two catchment areas are merged, they will have a total population of 89,000 and could thus meet the minimum DHEW population requirement of 75,000 without a waiver.

When planning has been completed, an application for an initial operations

grant will be submitted.

When the above actions are accomplished only one catchment area (Southwest Colorado) will be without comprehensive services. The goal is to promote initiation of an initial operations grant application for this catchment area within the next year.

2. Priorities for Federal Grant Mechanisms under P.L. 94-63, as Amended

Granting mechanisms were established under P.L. 94-63 to assist community programs in the provision of mental health services. Grants for planning community mental health center programs, for initial operations of community mental health centers, for conversion to the twelve services required to meet the definition of the Act, for financial distress, and for consultation and education programs are included under P.L. 94-63, as amended.

The Division of Mental Health will develop priorities for the twenty federal catchment areas in relation to these grants. The priorities will be submitted to the Region VIII Office of ADAMHA at least thirty days prior to the federal review of applications submitted by community mental health centers/clinics for funds under the federal granting system.

Eligibility, readiness for developing new or expanding existing programs, needs of the area, financial resources, quality of client care, and effective functioning of the program will be among the criteria used by the Division of Mental Health to determine prioritization.

3. Construction, Purchase and Remodeling of Facilities

Both existing and planned centers are required to periodically review their facilities requirements. Emphasis is placed on leasing or remodeling existing facilities rather than new construction. The criteria used

to determine priorities for construction funds have, in the past, been those incorporated in PL 88-164, Title II (Construction of Community Mental Health Centers). The need criteria to be used are those incorporated in the ADAMHA guidelines for the preparation of this Plan.

E. POVERTY AREAS

(For use in application of 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 sub-areas which are characterized as sub-areas of poverty. A sub-area of poverty is one in which 15% or more of the population is in poverty. These sub-areas should constitute 35% or more of the catchment area's population."

One method of calculating the percent used the smallest possible sub-area. If a catchment area consisted of two counties, both containing minor civil divisions (MCDs), then the population living in poverty MCDs was used. If a catchment area contained two counties, one of which was also divided by census tracts (Ts) then the population in the poverty Ts was used in that county and those in MCDs used for the other county. In no case was the percent calculated using the county as the sub-area.

The second method of calculating the percent used the sub-area giving the highest percent of population in poverty which could include the

county as a sub-area.

Since the guidelines do not clearly stipulate which type of sub-area should be used, we have ranked the poverty designations using the first method (smallest possible sub-areas) and have included the center (West Central) which became designated in 1977 based on the second method (includes the county as a sub-area).

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
13	West Central*	10
2b	Larimer	11

*(designation based on using the county as the sub-area)

APPENDICES

Appendix I - Agencies and Organizations from Which Input for the Basic Plan was Requested and/or Received

Appendix II - State Mental Health Advisory Council Information

- Roster
- Bylaws
- Minutes

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

Appendix IV - Report on Accomplishment of Objectives in the 1977-78 State Mental Health Plan

Appendix V - Supporting Material for Estimating Need for Mental Health Services by Age and Severity of Problem

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

Appendix I

AGENCIES AND ORGANIZATIONS
FROM WHICH INPUT FOR THE BASIC PLAN
WAS REQUESTED AND/OR RECEIVED

AGENCIES AND ORGANIZATIONS FROM WHICH INPUT FOR THE BASIC PLAN WAS REQUESTED AND/OR RECEIVED

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

b. American Federation of State, County and Municipal Employees

c. Chicano Mental Health Coalition (Metro-Denver)

*d. Chicano Mental Health Planning Symposium

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

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

g. Colorado Hospital Association

h. Colorado Nurses Association

i. Colorado Psychiatric Society

j. Colorado Psychological Association

k. Councils of Government

- Colorado West Area

* - Denver Regional

- District 10 Regional Planning Commission

- Huerfano-Las Animas Area

* - Larimer-Weld Regional

- Lower Arkansas Valley

- Northeastern Colorado

- Northwest Regional

- Pikes Peak Area

- Pueblo Area

* - San Luis Valley

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

*l. Denver Department of Health and Hospitals

m. Denver Mental Health Advisory Board

n. Department of Education Central Office

(1) Division of Special Education

*o. Governor's Task Force on Children

p. Department of Health Central Office

* (1) Division of Alcohol & Drug Abuse

* (2) Division of Comprehensive Health Planning

* (3) Health Facilities Division

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

* (5) Administrative Services Division (Planning Section)

q. Human Services Cabinet Council

*r. Human Services, Inc.

s. Health Systems Agencies

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

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

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

*t. Department of Institutions Central Office

* (1) Division of Corrections

(2) Division for the Deaf and Blind

(3) Division of Developmental Disabilities

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

* (a) Fort Logan Mental Health Center

* (b) Colorado State Hospital

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

* (5) Division of Youth Services

u. Joint Budget Committee

v. Juvenile Delinquent Advisory Board

*w. Legal Aid Society of Metropolitan Denver, Inc.

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

*y. Lutheran Service Society

*z. Mental Health Association of Colorado

*aa. Mile High United Way

bb. National Association of Social Workers

cc. National Council on Alcoholism

*dd. Office of State Planning and Budgeting

ee. PEAK Incorporated (alcoholism and drug outpatient program)

ff. Department of Social Services Central Office

* (1) Division of Aging

(2) Division of Medical Assistance

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

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

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

ii. State Plan Committee of Developmental Disabilities Council

jj. University of Colorado at Denver - Psychology Department

kk. University of Colorado Medical Center

(1) JFK Center

(2) Psychiatry Department

ll. Washington House (Adams County Alcoholism Treatment Program)

mm. Western Interstate Commission on Higher Education

nn. Wisconsin Department of Health and Social Services

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

Appendix II

STATE MENTAL HEALTH ADVISORY COUNCIL INFORMATION

ROSTER

BYLAWS

MINUTES

State Mental Health Advisory Council Roster

COMPOSITION OF STATE MENTAL HEALTH ADVISORY COUNCIL

Name & Term (expiration date)	Sex		Ethnic Background					Place of Residence	Type of Residence			Class of Membership				Occupation & Type Of Employment
	Female	Male	Asian Amer.	Black	Chicano	Native Amer.	White		Rural	Urban	Suburban	Consumer	Provider	Nongov't Org.	State Agency	
Colleen Cook 9-79	X						X	Adams County			X		X			Director, Community Corporation
Richard Daetwiler 9-78		X					X	Denver		X		X				Metro State College
Ben Duarte 9-79		X			X			Alamosa	X			X				Probation Officer (12th District)
Lucy May Dame 9-79	X						X	Denver		X		X				Chairman, Senior Citizen's Board
Dorothea Dolan 9-78	X						X	Denver		X		X				Retired
Melanie Fairlamb 9-78	X						X	Delta	X			X				Consumer
Peter Garcia 9-79		X			X			Boulder			X		X			Boulder MH Center - HSA Member
Josie Johnson 9-78	X			X				Denver			X	X				Executive Asst. to Lt. Governor
James Lauer 9-78		X					X	Denver		X			X			Child Psychiatrist
Dolores Leone 9-79	X						X	Franktown	X						X	MH/MR Nursing Consultant-Health Dpt.
Karen Litz 9-78	X						X	Lakewood			X	X				Mental Health Association
Isabel Medchill 9-78	X					X		Monument	X				X			Caseworker-El Paso County DSS
Luis Medina 9-78		X			X			Pueblo		X			X			Asst Exec Dir - Spanish Peaks MHC
Herbert Pardes 9-78		X					X	Denver		X					X	Professor & Chairman, Psychiatry, UCMC
Jack Quinn 9-79		X					X	Pueblo		X		X				Exec.Dir.-Pueblo Housing Authority
Roger Richter 9-78		X					X	Denver		X		X				Insurance and Real Estate
Steve Schmitz 9-79		X					X	Rifle	X			X				Director, Colorado West COG
James Syner 9-79		X					X	Denver		X					X	Medical Conslt - Dpt.of Social Serv.
Mark Tandberg 9-79		X					X	Lamar	X			X				Director, Prowers County DSS
Marge Taniwaki 9-78	X		X					Denver		X		X				Student
Clarence VanDeren 9-79		X					X	Denver		X				X		Denver Area Labor Federation

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.

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

(1978)

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: January 13, 1978
2:30-5:00 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Committee Members Present:

Colleen Cook
Richard Daetwiler
Ben Duarte
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Josie Johnson
Dolores Leone
Karen Litz
Isabel Medchill
Luis Medina
Herb Pardes (Chairperson)
Jack Quinn
Roger Richter
Steve Schmitz
James Syner
Mark Tandberg
Marge Taniwaki
Clarence VanDeren

Staff Present:

Lynn Dawson
Walter Deitchman
Jerry Fransua
Sid Glassman
Pat Horton
Ray Leidig
Noel Nesbitt
Connie Olson
Al Sanchez
Youlon Savage

Guests:

John Aycrigg
Phil Boudreau
Sandy Farmer
Bob Hawkins
Jim Miller
Shawn Raintree

Absent:

James Lauer

* * * * * * * * *

Approval of Minutes - The minutes of the November 10, 1977 meeting were approved as distributed.

Status of Recruitment Efforts for Director of DMH - Dr. Leidig was present to update the Council on the recruitment efforts for the DMH Director. At the present time there are 12 candidates. Dr. Leidig is hoping to name the Director by the first week in February; and aim towards having the Director come on board March 1.

Report from Representative of United Way/United Way Agencies - A brief presentation was made by Mr. Jim Miller, Associate Director of United Way. He described how United Way operates and how it is structured. Mr. Miller asked Council members to consider three items: (1) adding to the SMHAC a service provider from the United Way family; (2) consider the core United Way and its resources and planning and evaluation as available; (3) looking at all voluntary agencies that are providing adjunct mental health services and include them in planning.

Gerontology Programs - The DMH Geriatrics Program Specialist, Mr. Jerry Fransua, gave a presentation to the Council regarding the various projects and activities in the geriatrics area. Some of these projects and activities include workshops, mental health center affiliation agreements with Area Agencies on Aging and development of plans by mental health centers to provide services to the aged. Mr. Fransua distributed a brief, rough update on data concerning elderly patients. The Council requested updated information as more refined data becomes available.

Report from Representative of Central-Northeast Colorado Health Systems Agency - Mr. Phil Boudreau, from the Central-Northeast Colorado Health Systems Agency (HSA), explained the relationships and functions of HSAs, which were established by Public Law 93-641 (the National Health Planning and Resources Development Act). In regard to relationships, the HSA is the regional planning agency under PL 93-641; the State Health Planning and Development Agency (SHPDA) (a division of State Health) is the HSA counterpart at the state level; and the State Health Coordinating Council (SHCC) is the advisory body to the SHPDA. Functionally, these agencies are responsible for health planning and resources development. An audio-visual presentation was shown, explaining the fundamentals of HSAs. Mr. Savage reminded the Council that in the State Plan we propose that SMHAC be the mental health advisory council to the SHCC.

Division Director's Report - Mr. Savage briefly pointed out several items of interest:

1. The Joint Budget Committee will soon begin to develop their initial recommendations for appropriations to agencies. The Long Appropriations Bill is scheduled to be completed and submitted by the JBC to the legislature by March 15.
2. Council members were sent a letter requesting them to contact their legislators and urge support of the physicians' salary bill. Council members are now being asked to contact their legislators and seek their support for the mental health budget. The Division will be preparing a brief summary of budget to aid SMHAC members in composing their letters.
3. The summary reports of the four high risk projects (Northwest Denver, Colorado Springs, Pueblo and Colorado West) were distributed.
4. A summary of the SCOPE project was also distributed.
5. The unit cost report and the incentive report have been submitted to the JBC, as mandated by the legislature.
6. The status report on the accomplishment of the first quarter objectives was distributed. The second quarter report is being assembled and will be made available by the next Council meeting.

If Council members feel that clarification or further discussion on any of these items is in order, they are asked to contact Mr. Savage to have the specific item placed on the February agenda.

Report of the Budget Committee - Mr. Richter reported that the Budget Committee met three times prior to the Joint Budget Committee hearing, the last of these meetings being a coordinating meeting with the Centers' Association, the Mental Health Association and DMH. Mr. Richter concurred with Dr. Leidig and Mr. Savage that the budget presentation went extremely well.

Development of a Public Education Subcommittee - On Thursday, January 5, Mr. Richter called a meeting of representatives from the Division of Mental Health, the Mental Health Association, the Centers' Association, the state hospitals and the SMHAC for the purpose of discussing a total program designed to inform Colorado citizens of the entire mental health system in Colorado. As a result of this meeting, Mr. Richter made a motion that the Council form a public awareness committee (as a standing committee) that would become functional on a planning basis. Mr. Garcia seconded the motion. This committee is to be comprised of representatives of the above named groups, with the goal of coordinating more effective statewide information and with a direction toward development of more support. Ms. Fairlamb called for the question, and it was carried unanimously. Mr. Schmitz volunteered to represent the Council on this committee.

Absentee Issue - Dr. Pardes reaffirmed that we will take the absenteeism issue very seriously, and that Ms. Oglesby is keeping track of absences.

Evaluation Process at On-Site Assessments - This agenda item was postponed until the next meeting to allow more time for discussion.

Next Meeting - The next meeting of the State Mental Health Advisory Council will be on February 9, 1978 from 1:30-4:00 p.m. at the Division of Mental Health in Conference Room B-108. The agenda for this meeting is enclosed.

Sally Oglesby
Sally Oglesby
Recording Secretary

Distribution: SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
John Aycrigg
Carol Barbeito Thompson
Ernest Ficco
John Glismann
Bob Hawkins
Jim Kennedy
Haydee Kort
Raymond Leidig
Earl McCoy
Charlotte Redden
Elinor Stead
Linda Steggerda
Maryellen Waggoner
Staff-DMH

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: February 9, 1978
1:30-4:00 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Committee Members Present:

Colleen Cook
Richard Daetwiler
Ben Duarte
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
James Lauer
Isabel Medchill
Luis Medina
Herb Pardes (Chairperson)
Jack Quinn
Roger Richter
Steve Schmitz
Mark Tandberg
Marge Taniwaki

Absent:

Josie Johnson
Dolores Leone
Karen Litz
James Syner
Clarence VanDeren

Staff Present:

Lynn Dawson
Walter Deitchman
Pat Horton
Tom Lewis
Connie Olson
Dave Winfrey

Guests:

Boris Gertz
Elinor Stead

* * * * * * * *

Approval of Minutes - Ms. Dolan moved that the minutes of the January 13, 1978 meeting be approved as written; Ms. Fairlamb seconded the motion; motion carried.

Division Director's Report - Mr. Lewis thanked Council members for their correspondence with legislators regarding support for the mental health budget. He also announced that the legislature could begin figure setting as early as February 22, and that DMH is still receiving many questions from the JBC Analyst.

The two Program Specialist positions (Child/Adolescent Specialist and Adult Alternative Living Specialist) have not been filled yet, although interviews have taken place and a decision is expected within the next couple of weeks.

Later in the meeting it was announced that Sutherland Miller, Ph.D. is the new Director of the Division of Mental Health, his appointment to be effective immediately.

Report on Footnote 45/65c Project - Dr. Olson distributed copies of the completed report, entitled "Comparisons Between Residential Child Care Facilities and State Hospitals in the Care and Treatment of Emotionally Disturbed Children," and gave a summary of the contents. The Council will review the document further and if there are any specific points of interest, these will be looked at in more detail.

Rural Mental Health Issues - Dave Winfrey, DMH Program Specialist and Chairperson of the Rural Mental Health Ad Hoc Committee (which was developed in accordance with the State Plan) and Boris Gertz, also a member of that Committee, presented issues related to rural mental health. Mr. Winfrey briefly summarized the report "A Differential Funding Model Proposal for Rural Mental Health Programs" which was distributed prior to the meeting, pointing out special factors to be taken into consideration when

dealing with rural programs. Dr. Gertz distributed a position paper, which he prepared at the request of the Rural Mental Health Ad Hoc Committee, entitled "A Recommendation for Developing a State Level Position." He briefly reviewed the paper, leaving Council members to review it further at their convenience. A copy of Senate Bill 92, which provides for establishing a rural health institute and making an appropriation therefor, will be sent to Council members.

Evaluation Process at On-Site Assessments (with regard to clinical care) - Concerns were expressed regarding this process, i.e., the amount of time spent reviewing written information during the assessment which could be reviewed beforehand, the lack of focus on quality of care, the role of Program Specialists, the need for consultation regarding improvement of services, etc. It was agreed that this item would be carried to the next agenda, when Mr. Savage will be present to address some of these concerns.

Public Awareness Committee - Mr. Richter, Chairman of this Committee, reported that Mr. Duarte, Mr. Schmitz and himself are the representatives from the Council to this Committee.

Minority Mental Health Task Force - Ms. Taniwaki reported that this task force held a meeting on February 2 in conjunction with the Interim Task Force on Ethnic People of Color. She briefly introduced the Council to some of the concerns the task force is hearing, and will elaborate on these at a future meeting. Ms. Taniwaki also reported that there will be a Rocky Mountain Minority Mental Health Issues Conference on March 31 - April 1.

Timetable for State Plan Update - Dr. Lauer questioned the schedule for the Council's role in updating the State Plan. Ms. Dawson stated that it will be similar to last year's schedule, in that we will be starting to review the input soon.

Next Meeting - The next meeting of the State Mental Health Advisory Council will be held on March 9, from 1:30-4:00 p.m. at the Division of Mental Health in Conference Room B-108. The agenda for this meeting is enclosed.

Sally Oglesby
Sally Oglesby
Recording Secretary

Distribution:

SMHAC Members	Jim Kennedy
Executive Directors	Haydee Kort
Board Presidents	Raymond Leidig
Board Contact Persons	Earl McCoy
John Aycrigg	Charlotte Redden
Carol Barbeito Thompson	Elinor Stead
Ernest Ficco	Linda Steggerda
John Glismann	Maryellen Waggoner
Bob Hawkins	Staff-DMH

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: March 9, 1978
1:30-4:00 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Committee Members Present:

Ben Duarte
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
James Lauer
Dolores Leone
Karen Litz
Isabel Medchill
Luis Medina
Herb Pardes (Chairperson)
Jack Quinn
Roger Richter
Marge Taniwaki
Clarence VanDeren

Absent:

Colleen Cook
Richard Daetwiler
Josie Johnson
Steve Schmitz
James Syner
Mark Tandberg

Staff Present:

Lynn Dawson
Jerry Fransua
Ray Leidig
Sutherland Miller
Youlon Savage
Fran Walker

Guests:

Sandy Farmer
Bob Hawkins
Ana Mares-Montoya
Ernesto Martinez
Earl McCoy
Flora Russel
Joe Schmidt
Galen Weaver

* * * * * * * *

Introduction of Division Director - Dr. Leidig introduced and welcomed Dr. Sutherland Miller, the recently appointed Director of the Division of Mental Health.

Approval of Minutes - Mr. VanDeren moved that the minutes of the February 9, 1978 meeting be approved as written; Ms. Litz seconded; motion carried.

Division Director's Report - Dr. Miller reviewed the current status of the budget. DMH will be preparing a statement, which will be distributed to SMHAC, discussing the three major budget items we would like the Joint Budget Committee (JBC) to reconsider.

Ms. Leone moved that the Council authorize the Budget Committee to write an appropriate statement from this Council to the JBC in support of increases in the recommended appropriations for the state hospitals; motion passed.

Regarding the state pick-up of declining and expiring federal staffing grants, Mr. Savage reported that the initial JBC recommendation is 65% of the total amount needed to replace the federal dollars.

Update on Footnote 45/65c Project - After submission of the report to the JBC, monies for the last three months operation of the Fort Logan Children's Program were restored. The JBC will be reviewing the study in depth at a later date.

Update on Physicians' Salary Bill - Senate Bill 84, which allows for a general increase for state positions above Grade 82 (including physicians), is moving well through the legislative process. Senate Bill 83, the physicians' salary bill, has reportedly begun to move through the legislature. If SB 84 is approved, SB 83 will not be needed.

Presentation of the Health Planning Mechanism - Ms. Lynn Dawson, DMH Program Specialist, made a presentation to the Council on PL 93-641, the National Health Planning and Resource Development Act. Ms. Dawson explained the structural elements of the current health planning system, and how they relate to mental health. After a discussion of the importance of the PL 93-641 mechanism, it was decided that SMHAC should take the initiative in presenting to the State Health Coordinating Council (SHCC) the case for the designation of SMHAC as the mental health advisory body to SHCC. Some actions that will be pursued are: (1) Bob McKeown, a mental health center director who is a member of SHCC, will be asked to meet with SMHAC to discuss strategies for achieving our goal; (2) individual contacts with SHCC members.

Ms. Dawson discussed PL 94-63, the Community Mental Health Centers Act. She described the process for development, review and implementation of the State Plan. A flyer explaining the changes in this legislation will be sent to SMHAC.

Dr. Pardes will write a letter to the Central-Northeast Colorado Health Systems Agency nominating Ms. Dame, Ms. Dolan and Mr. Richter to fill vacant consumer positions on the HSA I board.

Site Assessment Process - This item was carried over from the February 9 meeting for further discussion. Mr. Savage assured the Council that steps are being taken to move the present assessment process toward greater efficiency and more emphasis on quality. He explained statutory and other requirements for rules and regulations and encouraged SMHAC members and others to submit suggestions for improving the process.

Update on Revision of State Plan - A schedule for the State Plan update was distributed. Ms. Dawson reported that, as of now, the staff are on target. Council members will be mailed a draft of the revision of the State Plan to review prior to the April meeting.

Report of the Public Awareness Committee - Mr. Richter reported that this Committee has been and will continue to meet regularly at 10 a.m. at DMH prior to each SMHAC meeting. Development of a catalog of resources has been identified as a first step. The immediate need is gathering of lists of resources (i.e., people, films, tapes, pamphlets) to determine what is available. Secondly, channels for wide distribution of this catalog need to be determined. Council members were requested to send in lists of known resources.

Establishment of a Subcommittee on the Chronically Mentally Ill - In response to concerns expressed by Ms. Dame, this Subcommittee was established to look into the plight of persons living in boarding homes in the Capitol Hill area, and what needs to be done for these people in terms of mental health services. The members of this Subcommittee are Ms. Dame, Ms. Leone and Ms. Russel (Northwest Denver MH Center). They are to inform the Council when the are prepared to give their input.

Dr. Pardes announced that Mr. Savage has been selected as Social Worker of the Year by the Colorado Chapter of the National Association of Social Workers. Council members offered their congratulations.

Next Meeting - The next meeting of the State Mental Health Advisory Council will be on April 13, 1978 from 1:30-4:00 at the Division of Mental Health Conference Room B-108. The agenda for the April Meeting is attached.

Sally Oglesby
Recording Secretary

Distribution: SMHAC Members
Executive Directors
Board Presidents
Board Contact Persons
John Aycrigg
Carol Barbeito Thompson
Ernest Ficco
John Glismann
Bob Hawkins
Jim Kennedy
Haydee Kort
Raymond Leidig
Earl McCoy
Charlotte Redden
Elinor Stead
Linda Steggerda
Maryellen Waggoner
Staff-DMH

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: April 13, 1978
1:30-4:00 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Committee Members Present:

Colleen Cook
Ben Duarte
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
James Lauer
Isabel Medchill
Luis Medina
Herb Pardes (Chairperson)
Jack Quinn
Roger Richter
Steve Schmitz
James Syner
Clarence VanDeren

Absent:

Richard Daetwiler
Josie Johnson
Dolores Leone
Karen Litz
Mark Tandberg
Marge Taniwaki

Staff Present:

Bob Abelson
Lynn Dawson
Walter Deitchman
Tom Lewis
Sutherland Miller
Paul Myers
Al Sanchez
Youlon Savage
Fran Walker
Dave Winfrey

Guests:

Ed Casper
Al Fontana
Bob Hawkins
Bob McKeown
Flora Russel
Al Salazar
Elinor Stead
Carol Barbeito Thompson

* * * * * * * * *

Approval of Minutes - Mr. VanDeren moved that the minutes of the March 9 meeting be approved as presented; Ms. Dolan seconded the motion; motion passed.

Division Director's Report - Mr. Lewis summarized the status of the Long Appropriations Bill for Council members, as it relates to mental health services. Mr. Richter emphasized the great need for mental health advocates in the legislature. A rough outline of the proposed DMH reorganization was presented by Dr. Miller. Some definite decisions should be made regarding the reorganization in early May. The Council requested further discussion of the plan when it is in a more finalized stage. Dr. Miller also distributed a "Proposed Purchase of Service Plan for Contract Agencies."

Discussion of Relationship of SMHAC to State Health Coordinating Council (SHCC) - Two members of the SHCC, Mr. Bob McKeown and Mr. Al Salazar, joined the Council for discussion of the relationship between SMHAC and the newly formed SHCC. Dr. Pardes will be contacting Charles Froelicher, the Chairperson of SHCC, to discuss the possibility of a direct presentation, conversation or subcommittee involvement between SHCC and SMHAC. It was felt that now is the time to be providing input to SHCC. It was recommended that HSA draft plans be submitted to DMH for review and comment, and vice versa. Dr. Pardes will speak with Mr. Froelicher about this also. It was noted that DMH staff are already actively involved with the HSAs and SHCC.

Minority Mental Health Task Force - The establishment of the Minority Mental Health Task Force was reviewed. The general feeling was that this Task Force needs to be

activated and used as a mechanism for facilitating input. Since Ms. Johnson, Chairperson of this Task Force, is out of town, Mr. Quinn was asked to contact Task Force members, and for them to contact the DMH Interim Mental Health Task Force on Ethnic People of Color and the Chicano Mental Health Workers Group to determine whether these groups would be interested in voicing their concerns to SMHAC; and if so, is expanded Task Force membership to include these groups recommended. The Task Force will present the outcome at the next meeting.

Report of the Public Awareness Committee - Mr. Richter, Chairperson of this Committee, presented one recommendation to the Council: That the SMHAC designate this Committee or another SMHAC committee to facilitate coordinated efforts among the Mental Health Association, state hospitals, centers/clinics, etc., toward the development of public support and legislative support for adequate funding of mental health services. While no formal action was taken on Mr. Richter's recommendation, the consensus appears to have been that this is a proper function of the Public Awareness Committee. The Committee will be developing a monthly bulletin, consisting of a summary of media information which it is felt would be useful in promoting public awareness of mental health. This will be distributed to centers/clinics and other interested people. A request was made for more input regarding resource materials available.

Report of Subcommittee on the Chronically Mentally Ill - Ms. Dame reported that the Subcommittee has met and has visited some boarding homes in the Denver area. Ms. Russel pointed out that the major problem is that there are not enough dollars available to adequately meet these clients' basic needs.

Review of Draft Revision of the State Plan - Ms. Dawson briefly reviewed the draft revision of the State Plan, highlighting major changes that have been made. This document replaces the basic plan and supplement; however, it does not alter their thrust. Question was raised about the possibility of having a copy of Ms. Dawson's presentation; Ms. Dawson pointed out that included in Chapter I is a summary of the contents of each chapter with the significant changes noted.

In preparation for detailed review of the Plan at the next meeting, Council members were requested to indicate areas of special interest, and to forward these items to the Chairperson, Dr. Pardes, prior to the next meeting. Ms. Oglesby will develop a check list (enclosed) to be used for this purpose. Council members are urged to meet individually with the DMH staff member responsible for a specific area, if it appears to be an area without much interest to other SMHAC members.

Next Meeting - The next meeting of the State Mental Health Advisory Council will be May 11, 1978 from 1:30-4:00 p.m. at the Division of Mental Health in Conference Room B-108. The agenda for this meeting is enclosed.

Sally Oglesby
Sally Oglesby
Recording Secretary

Distribution:
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Dwight Eisnach
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Raymond Leidig
Earl McCoy
Charlotte Redden
Roger Smith
Elinor Stead
Linda Steggerda
Maryellen Waggoner

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: May 11, 1978
1:30-3:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Committee Members Present:

Colleen Cook
Richard Daetwiler
Dorothea Dolan
James Lauer
Dolores Leone
Karen Litz
Isabel Medchill
Luis Medina
Herb Pardes (Chairman)
Jack Quinn
Roger Richter
James Syner
Mark Tandberg
Marge Taniwaki
Clarence VanDeren

Absent:

Ben Duarte
Lucy May Dame
Melanie Fairlamb
Peter Garcia
Josie Johnson
Steve Schmitz

Staff Present:

Bob Abelson
Lynn Dawson
Walter Deitchman
Sutherland Miller
Paul Myers
Fran Walker

Guests:

John Aycrigg
Sandy Farmer
Bob Hawkins
Flora Russel

* * * * * * * *

Approval of Minutes - A motion was passed to approve the minutes as distributed.

Division Director's Report - Dr. Miller identified two key items which Council members should be aware of: (1) An ongoing problem is the potential closing of Phoenix Center, a psychiatric nursing home in Jefferson County. A variety of agencies are involved in this process, and DMH is being utilized as a resource of last resort, if closure becomes necessary; (2) DMH has arrived at decisions related to how dollars will be taken away or distributed, as mandated by the JBC. Dr. Miller explained the process used for arriving at these figures.

A question was raised as to where the line item in the Long Appropriations Bill, which states that DMH and the Division for Developmental Disabilities will contribute approximately $3,500 each to the Council on the Handicapped, was initiated. DMH is not aware of how this footnote came into being. Dr. Miller and Ms. O'Hara (Director of DDD) have requested Dr. Leidig to find an alternate method for funding of this Council.

Detailed Review of Draft Revision of State Plan - Council members were asked to record their input for change on the forms provided. A chapter by chapter review of the draft of the State Plan was begun; however, discussion was soon opened to comments on any section of the Plan. Council members expressed concern about changing the dates for accomplishment of objectives which were not achieved during a previous period. There was also some concern that the new objectives were not sufficiently demanding to achieve necessary changes in the system.

The lack of input from the mental health centers/clinics was also discussed. Dr. Farmer suggested that perhaps the reason is that this Plan is much less stressful

to the centers/clinics. It was recommended that a representative of the Needs and Priorities Task Force of the Centers Association be liaison to the SMHAC. Dr. Pardes will write a letter to the Centers Association indicating our concern and asking them how this might best be handled.

The SMHAC agreed that their review of the State Plan should be an ongoing process of continual monitoring, focusing on different aspects of the Plan over the next several months; determining what has been accomplished and what direction can be realistically followed.

Minority Mental Health Task Force - Luis Medina has joined the Task Force. Dr. Pardes has been in contact with Ms. Johnson; she will activate the Task Force upon her return in the near future.

Report of the Public Awareness Committee - Mr. Richter reported that after a series of meetings, it has become evident that there is a definite need for this Committee to have staff support, and without it there is not going to be any significant move toward public and legislative support. He will put this request in writing.

Next Meeting - The next meeting of the State Mental Health Advisory Council will be June 8, 1978 from 1:30-4:00 p.m. at the Division of Mental Health in Conference Room B-108. (Agenda attached) After the June meeting, the Council will suspend meeting until September, at which time SMHAC will meet at the Annual Mental Health Conference at Keystone. At this time, the meeting for September is scheduled for Friday, September 22 from 9:30 a.m. to noon.

Sally Oglesby
Sally Oglesby
Recording Secretary

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Earl McCoy
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Roger Smith
Elinor Stead
Linda Steggerda
Maryellen Waggoner
DMH Staff

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: June 8, 1978
1:30-3:30

PLACE: Division of Mental Health
Conference Room B-108

Committee Members Present:

Richard Daetwiler
Ben Duarte
Dorothea Dolan
Karen Litz
Herb Pardes (Chairman)

Staff Present:

Tom Lewis

Guests:

Bob Hawkins
Earl McCoy
Flora Russel
Elinor Stead
Helen Voorhis

Absent:

Colleen Cook
Lucy May Dame
Melanie Fairlamb
Peter Garcia
Josie Johnson
James Lauer
Isabel Medchill
Luis Medina
Jack Quinn
Roger Richter
Steve Schmitz
James Syner
Mark Tandberg
Marge Taniwaki
Clarence VanDeren

* * * * * * * *

As the outcome of the Council's discussion at the May meeting regarding the Centers Association's involvement in the revision of the State Plan, Dr. Pardes wrote a letter to Vicki Robbins, President of the Association, indicating SMHAC's concern. Copies of this letter were previously distributed to Council members. A response is expected in the near future.

Dr. Pardes has been in touch with Mr. Froelicher of the State Health Coordinating Council (SHCC), as requested by SMHAC, and they will be meeting next week to discuss the relationship of mental health to SHCC in regard to state planning.

Dr. Pardes read a letter from Ms. Leone in which she submitted her resignation from the Council, the reason being her job relocation from the Health Department to the University of Colorado School of Nursing. Since appointments to this Council are not by specific agency affiliation, the Council will request that Ms. Leone reconsider her resignation.

Division Director's Report - Mr. Lewis distributed a one-page analysis of the budget for FY 78-79, comparing current year funding to 1978-79 funding. He announced that DMH has received formal approval from the Governor to fill up to the authorized level of FTEs at the state hospitals and request a supplemental later in the year. Mr. Lewis also informed members that the Child/Adolescent Program at Fort Logan has lost its JCAH accreditation. Fort Logan has appealed this finding. If accreditation is not regained, there is a potential loss of two million dollars in third party income. A summary statement of the reasons for this disaccreditation will be developed and sent to Council members. DMH will be preparing a list of major policy issues to be submitted to the Governor by June 23, similar to the list developed last year. Council members re-endorsed and expanded the previous year's policy issues. They also encouraged assessment of the size of the mental health program and budget, vis-a-vis the current staff. If something is to be done about the quality of care throughout the system, we must develop the wherewithal to improve it.

Care of Handicapped Patients and Epileptic Patients in the System - Helen Voorhis, Executive Director of the Colorado Epilepsy Association, related to SMHAC members the great need and concern that such people receive mental health care. Ms. Voorhis discussed the problems connected with the mental health of handicapped. The Council was requested to facilitate the training of mental health professionals regarding the problems of epilepsy, so they will be more comfortable in treating epileptics. Dr. Pardes will contact the Staff Development and Training Section of the DMH requesting that they consider this issue of training. Ms. Voorhis will also be contacting the mental health centers/clinics directly.

Report on the Handicapped Council - A report on the May 26 meeting of the Handicapped Council was mailed to SMHAC members prior to this meeting. Dr. Pardes reviewed highlights of the meeting and shared his concerns about statements that have been presented as if the Handicapped Council has agreed on them, namely that all human services should be housed under one administrative unit and that the Handicapped Council will review all federal grants coming to Colorado dealing with the handicapped. Dr. Pardes will write a letter clarifying that the SMHAC has not agreed to these statements. He will also suggest our interest in helping to orient the new director of the Handicapped Council, upon his appointment. The staff which relate to the Handicapped Council will now work under the Department of Labor and Employment.

SMHAC Membership Status Review and Discussion on Appointment of Nominating Committee - At our request, the members whose terms expired last year were reappointed for two year terms: The same will be done this year, retaining the active, involved members, as this greatly contributes to the continuity of Council activities. Ms. Oglesby will develop a record of members' attendance to assist the Governor in determining the degree of involvement; and Dr. Pardes will offer his personal impressions of individual involvement. Council members who do not wish to be reappointed should communicate this to the Governor directly.

Next Meeting - The next meeting of the State Mental Health Advisory Council will be at the Annual Mental Health Conference at Keystone on September 22 from 9:30 a.m. to noon. Additional information about this meeting will be forthcoming.

Sally Oglesby
Sally Oglesby
Recording Secretary

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Maryellen Waggoner
DMH Staff

Appendix III

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	
5	Arapahoe	3b	1		X	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	X	
8	Bethesda	3e	1	X	X	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
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	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			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	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 IV

REPORT OF
ACCOMPLISHMENT OF OBJECTIVES
IN THE 1977–78 STATE MENTAL HEALTH PLAN

Status of
STATE PLAN OBJECTIVES
for
FIRST QUARTER
(July 1, 1977 through October 1, 1977)

*indicates written reports or other written materials are available.

GOAL #1

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

Audits were received from 21 centers and clinics by December 30, 1977. Two of the remaining audits are from those centers/clinics who will be submitting audits on a calendar year basis and are expected to be in 90 days after the end of the year.

* f.(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.

This objective has been accomplished.

f.(5) By October 1, 1977, DMH will have had at least one meeting (since July 1, 1977) with divisions of the Department of Social Services.

Four scheduled meetings between DMH and the Department of Social Services were held during the First Quarter.

* f.(9) By October 1, 1977, DMH will have had at least one meeting (since July 1, 1977) with units of the Department of Health.

Two meetings between DMH and units of the Department of Health have been held during the First Quarter.

GOAL #2

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

The training program has been developed and training efforts have started.

GOAL #3

* a.(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.

Fourteen centers/clinics have submitted plans for services to children.

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

The educational and experiential standards for child clinical staff are completed.

* b.(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.

Fourteen centers/clinics have submitted plans for services to adolescents.

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

The educational and experiential standards for adolescent clinical staff are completed.

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

Three affiliation agreements have been submitted to the Division of Mental Health. The Region III Area Agency on Aging has requested an extension of time because of administrative duties. This request has effected the development of affiliation agreements for eleven centers and clinics.

* c.(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.

Twenty centers and clinics submitted a plan to DMH for services to the elderly by December 30, 1977.

* d.(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.

This objective has been accomplished.

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

This objective has been accomplished.

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

This objective has been accomplished.

* g.(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.

This objective has been accomplished. Copies of this proposal were widely distributed and received a national response.

* g.(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.

This objective has been accomplished.

i.(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.

This objective was accomplished on December 7, 1977.

GOAL #4

* (1) By August 1, 1977, the DMH 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.

Three proposals for the evaluation of Consultation and Education programs have been funded.

(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.

The Division of Mental Health and the Mental Health Association are currently conducting a survey of all mental health centers/clinics and the two state hospitals. An assessment of the data and submittal of a written report will be completed by February 15, 1978.

Status of
STATE PLAN OBJECTIVES
for
SECOND QUARTER
(October 1, 1977 through January 1, 1978)

*indicates written reports or other written materials are available.

Goal #1

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

The SCOPE/COLO '77 initial modifications, survey, and general analysis have been completed. A summary report describing the current status of the project, and the fact that the remaining problems suggest that the technique is not developed sufficiently to be used for recommending hospital staffing patterns at this time was sent to the Joint Budget Committee on December 12, 1977.

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

This objective has been accomplished.

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

This objective has been accomplished.

f.(2) By January 1, 1978, the DMH will facilitate a series of meetings between mental health agencies and agencies and organizations concerned with services to developmentally disabled clients.

This objective has been accomplished.

* f.(3) By January 1, 1978, DMH will have had at least one meeting (since July 1, 1977) with the State Health Planning and Development Agency.

This objective has been accomplished.

f.(4) By January 1, 1978, DMH will have had at least one meeting (since July 1, 1977) with Colorado Psychiatric Hospital.

Three meetings between DMH and Colorado Psychiatric Hospital were held during the second quarter.

* f.(5) By January 1, 1978, DMH will have had at least one meeting (since October 1, 1977) with divisions of the Department of Social Services.

Ten meetings between DMH and the Department of Social Services were held during the second quarter.

f.(7) By January 1, 1978, DMH will have had at least one meeting (since July 1, 1977) with the Department of Education.

Three meetings between DMH and the Department of Education were held during the second quarter.

* f.(8) By January 1, 1978, DMH will have had at least one meeting (since July 1, 1977) with the Judicial Department.

This objective has been accomplished.

* f.(9) By January 1, 1978, DMH will have had at least one meeting (since October 1, 1977) with units of the Department of Health.

Six meetings between DMH and the Department of Health were held during the second quarter.

g.(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.

This objective has not been accomplished. All centers/clinics and the State hospitals have been asked to submit information about specialized services for ethnic minorities to DMH. A comprehensive inventory will be produced by April 1, 1978.

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

Eighteen centers and clinics have a documented orientation and training program for volunteers.

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

Nineteen centers and clinics have an identifiable volunteer service.

* j.(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.

This objective has been accomplished.

Goal #2

Goal #3

a.(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.

This objective has not been accomplished. The Child/Adolescent Steering Committee is in the process of reviewing the Plans for Services to children which were submitted by the Centers and Clinics. This review process will hopefully assist in the accomplishment of this objective. The due date has been extended to July 1, 1978.

a.(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.

This objective has not been accomplished. The new due date of July 1, 1978 has been established.

b.(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.

This objective has not been accomplished. The Child/Adolescent Steering Committee is in the process of reviewing the plans for services to adolescents which were submitted by centers and clinics. This review process will hopefully assist in the accomplishment of this objective. The due date has been extended to July 1, 1978.

b.(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 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.

This objective has not been accomplished. The new due date of July 1, 1978 has been established.

d.(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.

Staff members of the Alcohol and Drug Abuse Division decided that their established monitoring standards for alcohol rehabilitation programs would apply for the review of the substance abuse programs at Fort Logan Mental Health Center and Colorado State Hospital. Those documents were used during the DMH site assessments of the three programs in October and November.

* d.(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.

This objective has been accomplished.

f.(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.

Eleven centers and clinics have included training in services to minorities represented in the catchment area. Other centers and clinics are in the process of planning for this training.

g.(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.

The information has been obtained and the written report will be completed by January 31, 1978. This objective has been fully accomplished.

j.(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.

Eleven centers and clinics have submitted a plan to DMH for services to high risk clients.

Goal #4

(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.

Twenty-one centers and clinics have conducted or sponsored a public education program which focused on the prevention of mental illness. The Mental Health Association of Colorado and DMH are sponsoring a workshop on Mental Health Education for the centers/clinics and State hospitals in February 1978.

Goal #5

(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.

Twenty-three centers and clinics have had periodic information sharing/mutual consultation sessions with staff of other human service agencies in their catchment area.

Status of
STATE PLAN OBJECTIVES
for
THIRD QUARTER
(January 1, 1978 through April 1, 1978)

*indicates written reports or other written materials are available.

Goal #1

*f.(5) By April 1, 1978, DMH will have at least one meeting (since January 1, 1978) with divisions of the Department of Social Services.

This objective has been accomplished. Five meetings between DMH and the Department of Social Services were held during the third quarter related to increasing Title XIX income to centers and clinics. Nine meetings between DMH and the Department of Social Services were also held during the third quarter which related to the coordination of services related to children.

*f.(9) By April 1, 1978, DMH will have had at least one meeting (since January 1, 1978) with units of the Department of Health.

This objective has been accomplished. Four meetings between DMH and the Alcohol and Drug Abuse Division were held during the third quarter. The DMH also had on-going contact with the State Health Planning and Development Agency during the third quarter.

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

Sixteen centers and clinics have submitted an inventory of specialized services which they offer for ethnic minorities to the DMH.

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

This objective was deleted. Public Law 95-83 requires that an inventory of existing facilities be done every five years. Insofar as such an inventory was accomplished last year, it was not necessary to include this objective in the 1977-78 Supplement to the State Plan.

Goal #2

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

This objective has not been accomplished. The residential treatment alternatives required by each catchment area will be addressed during the next year by the Colorado Community Support Systems Project in the DMH which was funded in March 1978.

*d.(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.

A conference on Minority Issues in Mental Health was co-sponsored by the DMH and WICHE on March 31 and April 1, 1978. A major conference on Mental Health Needs of Native Americans is tentatively scheduled to be held in Denver in June. A series of small inservices on Chicano mental health needs may be conducted in May and June with selected centers. Besides these demonstration projects, attempts are being made to obtain a resource who can design and disseminate training program models for use by individual agencies.

Goal #3

*f.(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.

This objective has not been accomplished by the Advisory Committee; however, a group of representatives from Chicano communities (from mental health centers/clinics) was formed and submitted objectives for inclusion in the State Plan.

*g.(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.

This objective has been accomplished.

*i.(2) By April 1, 1978, this information will be disseminated to centers/clinics and hospitals (information relating to the mental health service needs of women).

A report covering the mental health service needs of women and recommendations of ways to effectively meet those needs was completed on March 24, 1978. The report will be disseminated to centers/clinics and hospitals after it has been reviewed by the Director of DMH with the Women's Task Force.

Goal #4

(4) By March 1, 1978, 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.

The call for DMH to develop a comprehensive plan for public education services was assigned to the DMH Public Information Officer. This position was abolished by the Joint Budget Committee this year; therefore, no substantive progress has been made on this objective. The Mental Health Association, however, has agreed to assist DMH in this area in the absence of a Public Information Officer.

*(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.

This objective has been accomplished.

Status of
STATE PLAN OBJECTIVES
for
FOURTH QUARTER
(April 1, 1978 through July 1, 1978)

*indicates written reports or other written materials are available.

Goal #1

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

This objective has been accomplished.

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

This objective has been deferred indefinitely. The accomplishment of this objective would require the hiring of an outside consultant in accounting. Current staff resources are not sufficient to do the technical design and coordination required. In October, 1977, a decision was made by the Director of the Division of Mental Health to use available 314(d) funds, designated for accounting/finance purposes, for a study and implementation of a prospective reimbursement system.

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

This objective was deferred and was not accomplished due to a shortage of technical staff and the lack of funds to hire a consultant capable of designing and assisting with implementation. This objective has been revised in the 1978-1983 State Plan and in the 1978-1979 DMH Operating Plan as follows: "Comparable financial reporting systems for the two state hospitals will be established by January 1, 1979."

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

This objective has been accomplished. During May and June of this year a series of purchase of service negotiation meetings were held with the community mental health centers and clinics. Contracts have been prepared for all centers and clinics. Each contract includes the specific number of units of service to be purchased by the State which was negotiated with the community agency along with a specific unit cost (prospective rate setting mechanism) for each modality.

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

This objective was also deferred in October, 1977, by the Director of the Division of Mental Health.

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

A summary proposal for the implementation of SCOPE has been presented to the Joint Budget Committee. DMH, in collaboration with CSH and FLMHC, will have completed the refinement of SCOPE and will be using it as a basis for planning the staffing of inpatient units in the two state hospitals by July 1, 1979.

d.(3) By July 1, 1978, a summary of the salary and classification survey will be made available to all mental health centers/clinics.

This objective was not accomplished as written. A summary was not prepared in view of the fact that each mental health center/clinic received a copy of the actual classification study. The Colorado Association of Community Mental Health Centers and Clinics is in the process of doing a survey to determine the reaction of the centers and clinics to the study.

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

This objective has been accomplished.

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

This objective has been accomplished.

f.(3) By July 1, 1978, DMH will have had at least one meeting (since January 1, 1978) with the State Health Planning and Development Agency.

This objective has been accomplished. Although no official meetings have been held, there have been many contacts between DMH and the State Health Planning and Development Agency since January 1, 1978.

f.(4) By July 1, 1978, DMH will have had at least one meeting (since January 1, 1978) with Colorado Psychiatric Hospital.

This objective has been accomplished.

*f.(5) By July 1, 1978, DMH will have had at least one meeting (since April 1, 1978) with divisions of the Department of Social Services.

This objective has been accomplished. Many meetings have been held with divisions of the Department of Social Services. These meetings have included a focus on areas such as coordination of services to the elderly, coordination of services to children/adolescents, coordination of planning efforts, and interagency planning relating to state/local partnership agreements.

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

This objective has been accomplished. Staff members of DMH and members of the State Mental Health Advisory Council (SMHAC) have met with members of the State Health Coordinating Council (SHCC). A meeting with both the SMHAC and the SHCC is scheduled for early this fall to begin developing specific coordination mechanisms.

f.(7) By July 1, 1978, DMH will have had at least one meeting (since January 1, 1978) with the Department of Education.

This objective has been accomplished. Although no official meetings have been held, there have been many contacts between DMH and the Department of Education since January 1, 1978. DMH staff have also been involved with the Special Education Task Force, the Rocky Mountain Special Education Directors Study Group, and the School Health Council.

f.(8) By July 1, 1978, DMH will have had at least one meeting (since January 1, 1978) with the Judicial Department.

This objective has been accomplished.

f.(9) By July 1, 1978, DMH will have had at least one meeting (since April 1, 1978) with units of the Department of Health.

This objective has been accomplished. Several meetings have been held with units of the Department of Health.

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

This objective has been accomplished.

h.(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.

This objective has not been fully accomplished. Although a preliminary review has been performed, the Director of the Division of Mental Health has revised this objective. In lieu of an update, the State Standards/Rules and Regulations for Mental Health Centers and Clinics will be completely revised by July 1, 1980, as indicated in the 1978-1983 State Plan.

*h.(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.

This objective has been accomplished.

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

This objective has been accomplished.

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

This objective has been accomplished.

Goal #2

*a.(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.

The ADA has been increasing in both state hospitals. One explanation for this increase is related to the emphasis which has been placed on serving severely disabled clients. This emphasis has resulted in case findings which have produced more individuals in need of hospitalization. A second reason for the increasing ADA has been the closing of nursing homes for psychiatric clients, such as the closing of Phoenix Center.

*a.(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.

This objective has been accomplished.

*a.(3) By July 1, 1978, there will have been a 6% reduction from FY 75-76 in the proportion of systemwide 24-hour ADAs attributable to the state hospitals.

This objective has been accomplished. There has been a 6.1% reduction from FY 75-76 in the proportion of systemwide 24-hour ADAs attributable to the state hospitals.

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

This objective has been accomplished. Written procedures will be in final form by August, 1978.

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

Twenty-three centers and clinics provide follow-up treatment services to persons discharged from inpatient care who require such services.

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

This objective has been accomplished. A major regional conference on minority issues in mental health was held on March 31 and April 1, 1978.

*d.(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.

This objective has been accomplished.

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

This objective has been accomplished.

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

This objective has been accomplished. An updated training resource inventory on child and adolescent psychopathology was disseminated in January, 1978.

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

This objective has been accomplished. The information on continuing education requirements of different mental health professions has been written into a report which will be published and disseminated in August, 1978.

*d.(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.

This objective has been accomplished. A summary of specialized educational materials at the libraries of Colorado State Hospital and Fort Logan Mental Health Center has been written and will be disseminated in August, 1978.

*d.(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.

This objective has been accomplished. A two-day workshop was held May 11 and 12, 1977, for business managers and finance staff in Glenwood Springs.

*d.(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.

This objective has been accomplished. A workshop was held on September 26, 1977, for executive directors of centers and clinics.

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

This objective has been accomplished.

d.(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).

This objective has been accomplished. Board training has been available through DMH; however, the major responsibility for this training has been assumed by the Board Training Council of the Colorado Association of Community Mental Health Centers and Clinics through the use of 314(d) funds.

Goal #3

*a.(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.

This objective was to be accomplished by the two state hospitals in cooperation with appropriate mental health centers/clinics and DMH. The Footnote 45/65c Project and the work currently under way by the Child/Adolescent Steering Committee, however, have been substituted as the mechanisms to fully accomplish this objective.

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

This objective has not been accomplished. The initial intent was to have the child program of each center/clinic that had been mutually agreed upon between that center/clinic and DMH included in the agency's contract with DMH. It was not possible to implement this idea this past year because of the lack of resources; however, it will hopefully be implemented next year.

*a.(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.

This objective has been accomplished through the Footnote 45/65c

Project and the CYCIS Project. The systems will be further refined in the coming year.

*b.(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 adolescents within each hospital service area.

This objective has been addressed by the Footnote 45/65c Project and the work currently being done by the Child/Adolescent Steering Committee.

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

This objective has not been accomplished. It was also written for the purpose of having an agreed upon plan for adolescents in each center/clinic that would be part of the contract agreed upon by the agency and DMH; however, the objective was not implemented because of a lack of resources.

*b.(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.

This objective has been accomplished through the Footnote 45/65c Project and the CYCIS Project. The systems will be further refined during fiscal year 78-79.

*c.(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 County, and Larimer County) will have a bilingual/bicultural service delivery capability.

Larimer County Mental Health Center, San Luis Valley Mental Health Center, and Spanish Peaks Mental Health Center have a bilingual/bicultural service delivery capability for the Chicano elderly.

c.(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.

This objective has not been accomplished. A request for Title III Special Service Funds for residential programs for the elderly was submitted to the local Area Agency on Aging. The request was not granted approval.

c.(5) By July 1, 1977, the Geriatric Coordinators will hold biannual meetings.

This objective has been accomplished.

*e.(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.

This objective has been accomplished. A conference entitled "Sexual Violence: The Treatment of Rape and Incest Victims Within the Mental Health System" was sponsored by the Continuing Education Project of the Division of Mental Health on May 17 and 18, 1978. Clinicians representing the hospitals and the centers and clinics throughout the state attended this two-day conference.

*e.(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.

Twenty-one centers and clinics provide consultation and education services for rape/sexual abuse victims in coordination with other community agencies.

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

Eighteen centers and clinics provide consultation and education services to rape prevention programs within the catchment area.

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

This objective has not been accomplished. A Standing Committee on Racism will be established by January 1, 1979.

f.(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.

Eighteen centers and clinics and the state hospitals have staff members who are bilingual and bicultural to serve the Spanish-speaking population through programs that are outreach oriented.

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

This objective has been accomplished. A demonstration project was

funded at San Luis Valley Mental Health Center. Workshops on this issue were held at Park East Mental Health Center and Servicios de la Raza.

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

This objective has not been fully accomplished. The "talent bank" of minority mental health professionals is in the process of being updated through a special contract.

h.(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.

This objective has been accomplished.

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

This objective has been accomplished. In addition to the conference on "Sexual Violence", the Division of Mental Health sponsored a workshop entitled "Women in the Mental Health Spectrum" this past fall. The workshop was well attended by staff members of the mental health centers and clinics.

j.(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 the catchment area.

Twenty-one centers and clinics have begun providing services to chronically psychiatrically disabled clients in nursing homes and boarding homes in their respective catchment areas.

Goal #4

(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 (comprehensive plan for public education services).

As of July, 1978, two mental health centers and one state hospital had written goals and objectives for ongoing public education services on file with DMH. A number of centers/clinics asked for guidance in developing public education goals. The Staff and Organizational Development Section of DMH provided a half-day workshop on this issue in April for the mental health agencies. A workshop entitled "Your Key to the Community: Mental Health Education" was sponsored by DMH and the Mental Health Association of Colorado on February 2 and 3, 1978.

Goal #5

(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.

Twenty-two centers and clinics have had at least one information sharing/mutual consultation session with public health nurses and other appropriate public health personnel for purposes of 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.

Twenty-three centers and clinics have had at least one 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.

All centers and clinics have had at least one information sharing/mutual consultation session with county social services personnel.

(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.

All centers and clinics have had at least one information sharing/mutual consultation session with school district staff and district and other court personnel.

Appendix V

SUPPORTING MATERIAL FOR ESTIMATING NEED FOR MENTAL HEALTH SERVICES BY AGE AND SEVERITY OF PROBLEM

Supporting Material for Estimating
Need for Mental Health Services by Age and Severity
of Problem

Population figures by age:

Catchment area figures are based on the most recent population figures published by the Department of Local Affairs, Division of Planning. The age percents from the 1975 figures were applied to the estimated 1978 populations published by the Office of State Planning and Budgeting and which are the official budget figures. (There is some disagreement as to the accuracy of these population figures, especially in areas of rapid growth.)

Exceptions to the above procedure:

The special census figures for Delta, Garfield, Mesa, Moffat, Rio Blanco, and Routt counties were used as mandated in January 27, 1978 Executive Order.

The populations of the Denver County catchment areas were based on the age percents from the 1970 census applied to the estimated 1978 population.

The population breakout for Aurora following the established DMH percent allocation.

Severity of problem estimates:

The most recent document addressing the mental health need issue is the Report of the President's Commission on Mental Health, 1978, where the following statements appear:

> For the past few years, the most commonly used estimate is that, at any one time, 10 percent of the population needs some form of mental health care.
>
> There is new evidence that this figure may be closer to 15 percent of the population.
>
> Of the estimated 20 to 30 million people who need mental health care, 2 million people have been or would be diagnosed as schizophrenic.
>
> A similar number, or about 1 percent of the population, suffer from profound depressive disorders.
>
> More than 1 million people have organic psychoses of toxic or neurologic origin, and other permanent disabling mental conditions from varying causes.
>
> 15 percent of patients seen in general medical practice are found to have psychiatric or emotional problems.
>
> At any given time, 25 percent of the population is under the kind of emotional stress that results in symptoms of depression or anxiety.

According to the best recent estimates, 8.1 million of the 54 million children and youth of school age, or 15 percent of that population, need help for psychological disorders.

Varying estimates show that anywhere from 1 to 2 million children have specific learning disabilities.

One of every 3,000 children has an autistic disorder.

There are 200,000 cases of child abuse reported every year, and surveys indicate the total number may be at least ten times greater.

The incidence of mental health problems is higher among people sixty five and older than in other age groups.

The elderly account for 25 percent of all reported suicides although they represent only 11 percent of the population.

Additional supporting material concerning the incidence of mental health problems in children and youth was found in a study conducted in 1974 by General Research Corporation under a NIMH contract. Their report entitled Assessment of Child Mental Health Needs and Programs contains a breakdown by age and severity.

Age Group	% Severely Disturbed	% Less Severely Disturbed
0-5	2.1	12.9
6-11	2.6	17.9
12-17	3.7	18.4

Rationale for estimates of severity by age group:

Adults - Using a baseline of 12.5% which falls between the high(15%) and low (10%) estimates mentioned above, the severity was distributed as:

Severe	3%	1% schizophrenic 1% profound depression 0.5% neurologic psychosis 0.5% other psychosis
Moderate	4%	Balance of the 12.5%
Mild	5.5%	
Minimal	25%	Symptoms of depression and anxiety due to stress

Children - The percents cited by the President's Commission refer to "children of school age" and since we have included all children (0-11) the percent has been reduced from 15% to 12%. This is in line with the findings of the NIMH study which showed that the incidence increased with age.

Severe	2%	.01% autistic 1.5% severely abused .49% other psychosis
Moderate	4%	Remainder of 12%
Mild	6%	
Minimal	15%	Basically unknown stress (including abuse)

Adolescents - Again, the President's Commission talks about "children and youth" so it is difficult to determine the exact figures for adolescents. However, due to their greater incidence of suicide, drug misuse, etc., and the findings of the NIMH study, the overall percentage is felt to be higher than for children and was set at 17%.

Severe	4%	1% schizophrenic 1% suicidal 1% depressed - psychotic 1% other severe disorders
Moderate	6%	Remainder of 17%
Mild	7%	
Minimal	25%	Probably same as adult due to stress

Elderly - If the incidence is higher for the elderly than for other groups, it is probably close to 20%. Over 60% of the former hospitalized patients are over 55 and the majority of those in nursing homes are also elderly.

Severe	6%	2% Schizophrenic and other psychosis 1% senility related 2% suicidal and deep depression 1% other severe symptoms
Moderate	7%	Remainder of 20%
Mild	7%	
Minimal	25%	Certainly equal to adult and adolescents

Mental Health Needs of Children

Catchment Area/Agency	Est. need for M. H. Services: Total need	Estimated need by severity of mental health problem: Minimal 15%	Mild 6%	Moderate 4%	Severe 2%
Adams	12309	6838	2735	1824	912
Arapahoe	7403	4113	1645	1097	548
Aurora	6506	3614	1446	964	482
Bethesda	7822	4346	1738	1159	579
Boulder	8259	4588	1835	1224	612
Colorado W	7104	3947	1579	1052	526
E Central	1004	558	223	149	74
Jefferson	17734	9852	3941	2627	1314
Larimer	5729	3183	1273	849	424
Midwestern	2533	1407	563	375	188
NE Colorado	3464	1924	770	513	257
NW Denver	10652	5918	2367	1578	789
Park East	7438	4132	1653	1102	551
Pikes Peak	13512	7506	3003	2002	1001
San Luis	2500	1389	556	370	185
SE Colorado	3294	1830	732	488	244
SW Colorado	2391	1329	531	354	177
SW Denver	7883	4379	1752	1168	584
Spanish Pks	6808	3782	1513	1009	504
Weld	5912	3284	1314	876	438
W Central	2404	1336	534	356	178
TOTAL	142661	79255	31703	21136	10567

Mental Health Needs of Adolescents

Catchment Area/Agency	Est. need for M. H. Services: Total need	Estimated need by severity of mental health problem: Minimal 25%	Mild 7%	Moderate 6%	Severe 4%
Adams	10532	6269	1755	1505	1003
Arapahoe	8005	4765	1334	1144	762
Aurora	5082	3025	847	726	484
Bethesda	4847	2885	808	692	462
Boulder	8436	5022	1406	1205	803
Colorado W	6527	3885	1088	932	622
E Central	959	571	160	137	91
Jefferson	15953	9496	2659	2279	1519
Larimer	5879	3499	980	840	560
Midwestern	2658	1582	443	380	253
NE Colorado	3239	1928	540	463	308
NW Denver	6038	3594	1006	863	575
Park East	3905	2324	651	558	372
Pikes Peak	10988	6541	1831	1570	1046
San Luis	2365	1408	394	338	225
SE Colorado	2946	1753	491	421	281
SW Colorado	2322	1382	387	332	221
SW Denver	3799	2261	633	543	362
Spanish Pks	6520	3881	1087	931	621
Weld	5585	3324	931	798	532
W Central	2105	1253	351	301	200
TOTAL	118690	70648	19782	16958	11302

Mental Health Needs of Adults

Catchment Area/Agency	Est. need for M. H. Services: Total need	Estimated need by severity of mental health problem: Minimal 25%	Mild 55%	Moderate 4%	Severe 3%
Adams	43560	29040	6389	4646	3485
Arapahoe	33132	22088	4859	3534	2651
Aurora	25604	17070	3755	2731	2048
Bethesda	26433	17622	3877	2819	2115
Boulder	40813	27209	5986	4353	3265
Colorado W	36345	24230	5330	3877	2908
E Central	4679	3120	686	499	374
Jefferson	75335	50223	11049	8036	6027
Larimer	33163	22109	4864	3537	2653
Midwestern	10876	7251	1595	1160	870
NE Colorado	14404	9603	2113	1536	1152
NW Denver	33352	22234	4892	3558	2668
Park East	23558	15705	3455	2513	1885
Pikes Peak	60049	40033	8807	6405	4804
San Luis	9253	6169	1357	987	740
SE Colorado	12321	8214	1807	1314	986
SW Colorado	10450	6966	1533	1115	836
SW Denver	17429	11620	2556	1859	1394
Spanish Pks	27949	18633	4099	2981	2236
Weld	29886	19924	4383	3188	2391
W Central	10765	7177	1579	1148	861
TOTAL	579356	386240	84971	61796	46349

Mental Health Needs of the Elderly

Catchment Area/Agency	Est. need for M. H. Services: Total need	Estimated need by severity of mental health problem: Minimal 25%	Mild 7%	Moderate 7%	Severe 6%
Adams	3587	1993	558	558	478
Arapahoe	4604	2558	716	716	614
Aurora	1605	891	250	250	214
Bethesda	6491	3606	1010	1010	865
Boulder	5798	3221	902	902	773
Colorado W	5870	3261	913	913	783
E Central	1239	688	193	193	165
Jefferson	8537	4743	1328	1328	1138
Larimer	5142	2856	800	800	686
Midwestern	2865	1591	446	446	382
NE Colorado	3933	2185	612	612	524
NW Denver	10984	6102	1709	1709	1464
Park East	5542	3079	862	862	739
Pikes Peak	6300	3500	980	980	840
San Luis	1960	1089	305	305	261
SE Colorado	3579	1988	557	557	477
SW Colorado	1975	1098	307	307	263
SW Denver	2177	1209	339	339	290
Spanish Pks	6550	3639	1019	1019	873
Weld	4358	2421	678	678	581
W Central	2714	1508	422	422	362
TOTAL	95810	53226	14906	14906	12772

Appendix VI

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

State of Colorado

DEPARTMENT OF INSTITUTIONS

RICHARD D. LAMM
GOVERNOR

4150 South Lowell Boulevard, Denver, Colorado 80236
303-761-0220

RAYMOND LEIDIG, M.D.
EXECUTIVE DIRECTOR

April 21, 1978

NOTICE OF ADOPTION OF RULES AND REGULATIONS

TO ALL INTERESTED PERSONS:

Please take Notice that the Department of Institutions, pursuant to the Colorado Administrative Procedures Act, following Notice of September 29, 1977 and Public Hearing on November 4, 1977 on the Rules and Regulations of the Colorado Department of Institutions concerning the Care and Treatment of the Mentally Ill, does hereby, this date, adopt and publish as final, the rules attached hereto.

The authority of the Department to promulgate and adopt these rules and regulations is set forth in Article 10 of Chapter 27, C.R.S. 1973 as amended.

Dated this 21st day of April, 1978.

Colorado Department of Institutions

Raymond Leidig M.D.

Raymond Leidig, M.D.
Executive Director

J.D. MacFarlane
Attorney General
David W. Robbins
Deputy Attorney General
Edward G. Donovan
Solicitor General

The State of Colorado

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

STATE SERVICES BUILDING
1525 Sherman Street, 3rd. Fl.
Denver, Colorado 80203
Phone 839-3611 & 839-3621

April 28, 1978

Raymond Leidig, M.D.
Executive Director
Colorado Department of Institutions
3550 West Oxford Avenue
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 HAQF)

Dear Dr. Leidig:

Pursuant to your request, we have examined the above-referenced revised regulations adopted by you on April 21, 1978. A public hearing was held on the proposed rules and regulations on November 4, 1977. Notice of this hearing was given on September 29, 1977.

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

Authority for the above-referenced rules is specifically contained in C.R.S. 1973, §27-10-126, as amended, which states:

> Administration. The department shall make such rules and regulations as will consistently enforce the provisions of this article.

More particularly, C.R.S. 1973, §27-10-116(2), as amended, requires the Department to promulgate regulations governing the use of specific therapies and major medical treatment in the nature of surgery; and C.R.S. 1973, §27-10-118 requires the Department to promulgate regulations governing the employment and compensation of persons receiving care and treatment under the article.

In addition, C.R.S. 1973, §27-10-105(1), 107(1)(c) and 109(1)(c), all as amended, provide that facilities designated or approved by the Executive Director of the Department of Institutions shall provide care and treatment under the article.

C.R.S. 1973, §24-4-103(4), as amended, provides that a general statement of the rules' basis and purpose be incorporated by reference in the rules. The Department of Institutions has complied with this requirement on April 21, 1978.

Amendments to subsections (4) and (11)(d) of this statute further require that the agency file two copies of these rules and this opinion of the Attorney General with the Secretary of State, and that the agency maintain and make available for public inspection copies of these rules and this opinion.

In addition, a copy of all rules adopted or amended after July 1, 1976 must be submitted as provided by C.R.S. 1973, §24-4-103(8)(d) to the Legislative Drafting Office, to the appropriate committee of the General Assembly (if the General Assembly is in session) or to the Committee on Legal Services (if the General Assembly is not in session) for their opinion as to whether the rules conform with paragraph (a) of C.R.S. 1973, §24-4-103(8), as amended. All rules submitted after July 1, 1977, which have a fiscal impact, must be accompanied by a fiscal statement as described in C.R.S. 1973, §24-4-103(8)(d), as amended.

These rules as finally adopted will become effective twenty days after publication in the Code of Colorado Regulations, or on such later date as is stated in the rules, as provided by C.R.S. 1973, §24-4-103(5) and (11), as amended.

At the present time, the Secretary of State requires that the adopting agency submit to her office within ten (10) days of the date of adoption, i.e., April 13, 1978, five (5) copies of all adopted rules, including the rationale, along with the Attorney General's opinion. Three copies are necessary for the publisher; the other two copies are for statutory filing as required by C.R.S. 1973, §24-4-103(12).

Very truly yours,

J. D. MacFARLANE
Attorney General

JDM:AMB:nh

cc: AG File #IN MH HAQF

ADOPTED: April 21, 1978

EFFECTIVE: May 30, 1978

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.

INDEX

I.

STATEMENT OF POLICY, PURPOSE AND APPLICABILITY

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

These regulations govern the designation of facilities for the care and treatment of the mentally ill, pursuant to the Act for the Care and Treatment of the Mentally Ill, C.R.S. 1973, 27-10-101 et seq., as amended. 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 or a hearing officer appointed by him/her 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. Duties and responsibilities shall be discharged directly by the designated facility or by contractual arrangement. Staff privileges shall be an acceptable form of contractual arrangement. The name of a person who has been appointed to deal with complaints concerning mental health evaluations, care and treatment 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 services. Each designated facility and placement facility shall have ready access, at all times, to a physician and to medical services. Each designated facility and placement facility shall maintain records detailing all mental health services provided.

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, in the least restrictive setting possible, consistent with the patient's needs and safety and the safety of others. The reasons for the choice of setting shall be documented in the patient's record. During the entire process, the patient shall enjoy the maximum amount of freedom consistent with his/her clinical

needs, including but not limited to those rights set forth in C.R.S. 1973, 27-10-117, as amended.

D. PREVIOUSLY ADJUDICATED PATIENTS.

Any person who, by reason of a judicial decree entered by a court of this state prior to July 1, 1975, was adjudicated mentally ill, shall be deemed to have been restored to legal capacity and competency.

E. EMERGENCY PROCEDURES.

Each designated facility and placement 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 in imminent (or immediate) danger of hurting him/herself or others, and treatment of this condition is only possible with the use of seclusion and/or restraints. A facility may limit such determinations to licensed physicians, pursuant to its rules or procedures.

1. Physical restraint/seclusion may be used only when other less restrictive means cannot produce the control necessary to prevent harm to the patient or others.

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

3. 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. Only upon the examination and order of a professional person may a patient be physically restrained/secluded in excess of four (4) hours.

4. A patient who is physically restrained/secluded shall be observed by staff not less than every fifteen (15) minutes during the period of restraint/seclusion.

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

6. Justification for physical restraint/seclusion procedures shall be described in detail in the patient's record. Each designated facility and placement facility shall maintain a log showing all instances of use of seclusion, restraint or time out and the basis therefor, and such log shall be available for inspection by the Colorado Department of Institutions at all times, for a period of five years from the date of each action taken.

F. TIMEOUT PROCEDURES.

Time out is a treatment technique to allow the patient to learn to modify his/her own behavior and not a method

used to control an immediate threat. It is the brief confinement, voluntarily or involuntarily, of a patient in an unlocked or locked seclusion room for the purpose of removing the patient from potential sources of reinforcement for problem behavior and/or to provide a mild consequence for the problem behavior. Problem behavior is dangerous or disruptive behavior, potentially dangerous or disruptive behavior, or provocative violation of rules of the designated facility.

1. Time out shall not be employed as punishment or for the convenience of staff.

2. Each use of time out shall be fully documented in the patient's record by the responsible staff person and shall indicate what specific episode gave rise to the use of time out, the behavior desired to be modified, and the length of time the patient was placed in time out.

3. Each designated facility and placement facility shall establish and implement written policies and procedures for use of time out in the treatment programs of the facility. These policies and procedures shall include:

a. Time out shall only be used when less restrictive means are not appropriate to the situation involved.

b. Time out shall be as brief as possible to be effective in the situation in which it is used, not to exceed 30 minutes for each use of time out. Time out shall not be utilized more than three (3) times in any 24-hour

period without the specific written order of a professional person. Such orders must be renewed every 24 hours.

c. The patient shall always be given the opportunity to enter time out voluntarily.

d. Time out shall be clearly distinguished from seclusion and shall never be used in place of seclusion.

G. UNAUTHORIZED DEPARTURE.

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

H. 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 and placement facilities.

I. RIGHT TO VOTE.

Every patient shall be given the opportunity to exercise his/her right to vote in primary and general elections. The staff of each designated facility and placement 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 AND APPROVING 72-HOUR TREATMENT AND EVALUATION FACILITIES.

A. Except for special designations, which may be made 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, 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 employed by or under contract with the designated facility 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. Evaluation and treatment services shall be deemed to be available if a professional person employed by or under contract with the facility is "on call" to provide any mental health services on those days, unless such professional person determines and indicates in writing that additional diagnostic services, reasonably necessary for an informed certification decision, are required which are not available at the facility on Saturdays, Sundays and holidays. In such cases, the period of detention may be extended beyond 72 hours for an additional period, not to exceed a total of 84 hours from the time of admission, so that such services may be provided.

E. If at any time during a seventy-two hour evaluation of a person who is confined involuntarily, or thereafter, during involuntary short or long term treatment, the facility staff requests the person to sign in voluntarily and he/she elects to do so, the following advisement shall be given orally and in writing, and an appropriate notation shall be made in his/her medical record by the professional person or his/her designee:

"NOTICE"

"The decision to sign in voluntarily should be made by you alone and should be free from any force or pressure implied or otherwise. If you do not feel that you are able

to make a truly voluntary decision, you may continue to be held at the facility involuntarily. As an involuntary patient, you will have the right to protest your confinement and request a hearing before a judge."

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 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, no facility shall be designated as a short and 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. Staff privileges shall be an acceptable form of contractual arrangement. 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. Assuring the formulation of a written treatment plan tailored to the needs of each individual patient, with the maximum feasible participation of the patient, documenting the diagnostic basis of the plan and the progress of the treatment, reviewing and updating the plan at least monthly, and revising the plan whenever appropriate. A psychiatrist shall be responsible for 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 examining 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 or medication.

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

4. Assuring the formulation of 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. Whenever clinically indicated, assuring physician visits and medical appraisal and treatment.

9. 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.

10. 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 services to all patients and 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, 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 Colorado Department of Institutions for review.

D. No patient shall be transferred to the care of another designated or placement facility unless and until adequate arrangements for care by the receiving facility have been documented, including at least one discharge planning conference, face-to-face or by telephone, with participants from both 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 Colorado Department of Institutions for resolution. No patient who is in the custody of a designated facility shall be transferred to the care of 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.

E. Each designated facility shall forward quarterly reports detailing the status of each patient being treated under a court order for long term care and treatment to the Colorado Department of Institutions, in the format specified by the Department.

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 centers, convalescent centers, nursing care facilities, intermediate health care facilities or residential facilities, or community mental health centers or clinics under contract with 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 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 is already located in the facility, or has been under the care of the designated 72-hour treatment and evaluation facility for at least three months preceding the evaluation and treatment.

D. 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, or other established charting guidelines establishing by the Joint Commission on Accreditation of Hospitals or other accrediting bodies, 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 personnel 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 personnel 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 personnel to reveal information which has been given to them in confidence by members of a patient's family or other informants; (3) for claims on behalf of the patient for aid, insurance or medical assistance; (4) to the courts as necessary to the administration of the Act for the Care and Treatment of the Mentally Ill, C.R.S. 1973, 27-10-101, et seq., as amended; 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 TO SPECIFIC THERAPIES

A. Specific therapies shall include surgery, electro-shock treatment, the use of experimental drugs or the use of psychiatric drugs in extraordinarily large dosages and any other therapies which may entail a substantial or catastrophic risk. Specific therapies differ from general treatment in that general treatment is understood to include all treatment generally accepted for use in treating psychiatric disorders. Physical examinations, x-rays, laboratory examinations, psychotherapy, medical treatment, and generally accepted psychiatric drugs in other than extraordinarily large dosages are examples of general treatment.

B. Prior to the administration of any specific therapy, an informed consent is required to be given in writing and signed by the patient or his/her legal guardian. An informed consent means:

1. It is freely given and is expressed in writing.

2. It is preceded by the following:

a. A fair explanation of the proposed specific therapy, including identification of experimental elements in the treatment, if any.

b. The anticipated benefits.

c. The common discomforts, side effects, and risks associated, if any.

d. The probable consequences if the treatment is not permitted to proceed.

e. The availability of appropriate alternative treatment, if any, and its probable consequences.

f. An offer to answer any inquiries concerning the specific therapy.

g. An instruction that the patient or other person giving consent is free to withdraw his/her consent and to discontinue the specific therapy at any time.

C. The consent agreement entered into by the patient or other person shall not include any exculpatory language through which the patient or other person is made to waive, or to appear to waive, any of his/her legal rights, or to release the facility or any other party from liability for negligence.

D. No informed consent for a specific therapy shall be valid for more than 30 days.

E. No specific therapy shall be administered to the patient without the informed consent of the patient or his/her legal guardian, except pursuant to a court order or in an emergency situation in which the life of the patient is in imminent danger.

F. If the patient or his/her legal guardian refuses to consent to a recommended specific therapy and no suitable alternative exists, except in an emergency situation in which the life of the patient is in imminent danger, the patient's physician, in consultation with the director of the designated facility or his/her designee, may petition the court of appropriate jurisdiction for a hearing to determine whether the contemplated specific therapy shall be administered in spite of the patient's refusal of such treatment.

G. In an emergency situation in which there is imminent danger to the life of the patient because of the patient's condition, the patient is unable to grant informed consent and no legal guardian exists or can be found, and sufficient time does not exist to petition the court for an order prior to administration of the specific therapy, the patient's physician, in consultation with the director of the designated facility or his/her designee, may, after careful and informed deliberation, under procedures adopted by the facility, order a specific therapy without consent.

H. The reason for the use of any specific therapy shall be fully documented in the patient's record.

I. Each designated facility shall adopt written procedures for administration of specific therapies in accordance with these rules and regulations.

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.

Each designated facility shall inform the Colorado Department of Institutions of any and all legal proceedings

concerning the mental health treatment afforded to any patient or former patient, to which the facility or any placement facility with which it has a contract or any employee of either facility is a party, and copies of all complaints and writs issued in such proceedings shall be mailed to the Department within ten (10) days of receipt by the designated facility or placement facility.

X.

APPLICATION PROCEDURE

A. Facilities seeking designation or redesignation hereunder shall apply annually to the Colorado Department of Institutions. 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 Department. The Executive Director of the Colorado Department of Institutions shall take action in accordance with his/her 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 nonrenewal of designation may be appealed in accordance with Section IA hereof.

B. An up-to-date list of all designated facilities and placement facilities shall be prepared by the Colorado Department of Institutions monthly, if any changes occur, and shall be circulated to interested persons who request being placed on the mailing list.

XI.

ENFORCEMENT

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

B. If the Department finds, after evaluation, that a designated facility is not in compliance with these regulations, the Department 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 Department, 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. revoke, suspend, annul, limit or modify the designation of the facility, in accordance with Section 1A hereof.

In cases where the Colorado Department of Institutions approves a proposed or modified plan and schedule for achieving full compliance, the Department 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, to achieve full compliance.

XII.

WAIVER

A waiver of the specific requirements of these regulations may be granted by the Executive Director of the Colorado Department of Institutions.

A. It is the policy of the Colorado Department of Institutions 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 Colorado Department of Institutions, 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 Colorado Department of Institutions 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 Colorado Department of Institutions 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 Colorado Department of Institutions may be represented by counsel.

G. Unless additional time is required to make inspections or obtain additional information from the designated facility, the Colorado Department of Institutions shall notify the designated facility, in writing, within thirty (30) days following the date of the conference, of its recommendation upon the waiver request. Within ten (10) days thereafter, the Executive Director of the Colorado 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 Colorado 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. "Emergency situation" shall mean a situation in which there is imminent danger to the life of a patient because of the patient's condition, the patient is unable to grant informed consent and no legal guardian exists or can be found, and sufficient time does not exist to petition the court for an order prior to the administration of a specific therapy.

C. "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., as amended.

D. "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.

E. "Problem Behavior" shall mean any dangerous or disruptive behavior, potentially dangerous or disruptive behavior, or provocative violation of rules of the designated facility.

F. "Professional Person" shall mean a person licensed to practice medicine in the State of Colorado or a psychologist certified to practice in the State of Colorado.

G. "Psychiatric Medication" shall mean those medications used in the practice of psychiatry specifically for treating manifestations of psychiatric disorders.

H. "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.

I. "Specific therapy" shall include surgery, electro-shock treatment, the use of experimental drugs or the use of psychiatric drugs in extraordinarily large dosages and any other therapies which may entail a substantial or catastrophic risk. Specific therapies differ from general treatment in that general treatment is understood to include all treatment, generally accepted for use in treating psychiatric disorders. Physical examinations, x-rays, laboratory examinations, psychotherapy, medical treatment and generally accepted psychiatric drugs in other than extraordinarily large dosages are examples of general treatment.

J. "Time Out" shall mean the brief confinement, voluntarily or involuntarily, of a patient in an unlocked or locked seclusion room for the purpose of removing the patient from potential sources of reinforcement for problem behavior and/or to provide a mild consequence for the problem behavior.