State of Colorado

MENTAL HEALTH PLAN

1980 - 1985

THE COLORADO STATE MENTAL HEALTH PLAN (1980 - 1985)

VOLUME I

JULY 1980

Prepared By

COLORADO DIVISION OF MENTAL HEALTH

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VOLUME I

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THE COLORADO MENTAL HEALTH PLAN

CHAPTER I. INTRODUCTION

A. PURPOSE

The Colorado Mental Health Plan provides direction for the delivery of mental health services which will improve the quality of life of clients. More specifically, the purposes of the Plan are to assist in: 1) determining the needs of each region of the state and setting priorities based on those needs; 2) encouraging program growth and fiscal viability; 3) emphasizing local availability, accessibility, appropriate utilization of resources, high quality care, continuity of care, and reasonable costs; 4) coordinating the planning and delivery of services with other human service agencies; and 5) evaluating services to ensure high quality client care, effective functioning of the elements of the system and protection of the rights of patients.

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 ensure high 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 impact the planning and delivery of mental health services to such an extent that they must be incorporated into the Plan.

B. ORGANIZATION AND SCOPE

The 1980 update of the State Mental Health Plan replaces all previous Plans. This Plan, which addresses the requirements of Public Law 94-63 (the Community Mental Health Centers Act of 1975), as amended, and state statutes, consists of two volumes. In Volume I the Colorado mental health system looks at its current alternatives in terms of the future. The information in this Volume will be used to address the major decisions confronting the mental health system. Volume II contains specific information which describes the current mental health system in Colorado.

The following is a summary of the two volumes that make up the Colorado Comprehensive Five-Year Mental Health Plan.

VOLUME I

a. Chapter I - Introduction: This chapter provides an overview of the Plan and the planning process. It also includes a fact sheet which gives an outlined description of the Colorado mental health system.

b. Chapter II - Concepts in Mental Health: The key concept for the Colorado Division of Mental Health (DMH) is quality of life. This concept is defined in terms of the factors that are used to determine whether the quality of one's life is good or bad. This chapter also includes the principles of mental health care which are reflected throughout the Plan. These principles are categorized under the headings of quality, human dignity and clients' rights, availability and accessibility of services, continuity of care, service needs and appropriate utilization, reasonable costs, and accountability.

c. Chapter III - Trends and Issues: This chapter has been included to identify national, state and specific mental health trends and the issues they generate for the mental health system. To plan effectively, it is necessary to explore the future from current trends, capabilities, and expectations. Once the desired future is determined, resources can be allocated such that programs and trends are changed or created accordingly. Although frequent revisions and additions to the information in this chapter will be necessary, it provides a way of focusing the thinking in the mental health system.

d. Chapter IV - Statewide Goals and Objectives: Chapter IV 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 concepts and principles detailed in Chapter II. They also have been developed in response to the trends and issues identified in Chapter III.

    This chapter is revised annually. The goals in this section have not changed. Some objectives have been revised to reflect more accurately the directions of the Colorado mental health system. The five-year goals are separated into three main categories. Status goals are those that directly impact the system's clients in terms of improving their quality of life. Service goals relate to the direct provision of services and are consistent with the status goals and objectives. The system goals address those changes in the system that must take place if the status and service goals are to be successfully achieved.

    All objectives are reviewed in terms of the resource requirements necessary to carry them out. Objectives for which resources clearly will not be available are excluded. New objectives replace 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.

The second part of this chapter focuses on the objectives for fiscal year 1980-81. Specific accomplishment measures for each objective are included. The budgetary process of the state mental health system mandates planning on an annual basis. Chapter IV, therefore, translates into specific planned actions the purpose, philosophy, and thrust of the state mental health system for the current fiscal year and the overall thrust of the system for the next five years.

e. Chapter V - Financial Summary for Fiscal Year 1980-81: This chapter includes a summary of the appropriations for FY 1980-81. It also describes the fiscal plan for expenditures by operational unit.

f. Chapter VI - Report on the Accomplishment of State Plan Objectives for Fiscal Year 1979-80: The annual report on the accomplishment of State Plan objectives is included in this section. The information provided in this report is designed to give a picture of the status of State Plan objectives for the previous fiscal year. Length of reports relating to the accomplishment of many objectives makes their inclusion in the State Plan impractical. Specific information on objectives, as indicated in the report, is available from the Division of Mental Health.

VOLUME II

a. Appendix I - Administrative Information: The State Mental Health Advisory Council is identified in this section. Brief descriptions of the membership, functions, and activities of the Council are included. The membership roster, Council bylaws and minutes of Council meetings have been placed in this section, as required by the federal guidelines for state plans.

The procedures for the annual review of the State Plan and the administration of Public Health Service Act funds (314g) are detailed. The required federal assurances are included in this section, as are personnel standards relating to the State Personnel System, equal employment, and affirmative action.

Workforce issues including available resources, training programs, and the protection of employees' rights are addressed. Statements concerning fiscal support of mental health services and the requirement for volunteer services are also included.

b. Appendix II - The State Mental Health Program: A description of the state mental health program constitutes the content of this section. The mental health services and service facilities in Colorado are identified. Background information has been provided to give an overview of the development of the mental health system in Colorado.

All standards/rules and regulations promulgated by the state mental health authority are identified in this section. The Standards/Rules and Regulations for Mental Health Centers and Clinics, required by Public Law 94-63, as amended, are not included, as they have been published and distributed as a separate document.

This section was developed in accordance with the planning guidelines used by the State Health Planning and Development Agency in the development of the State Health Plan.

c. Appendix III - State Hospitals and the Catchment Area Mental Health Program: This section describes the state mental hospitals and the present services and service needs of the communities served by the twenty-three centers/clinics.

Requirements for preadmission screening are defined in this section. There is also a focus on the discharge of clients from inpatient and other more intensive forms of care, and the procedures to insure appropriate follow-up.

The catchment area concept and changes in services in some catchment areas are reflected in this section. Revised population figures and the ethnic composition of each area are also included, as are the need rankings of the catchment areas.

d. Appendix IV - Coordination of Planning: Coordination of mental health services with other human service planning and care-giving agencies is the focus of this section.

The State Mental Health Plan must be carefully integrated with the State Health Plan, the Alcohol and Drug Abuse Plan, and the planning process and documents of many other agencies and organizations. This section provides 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 structures mandated by Public Law 96-79 (the law which extends and amends the National Health Planning and Resource Development Act) is an important part of this section.

C. PLANNING PROCESS

A primary focus of the Division of Mental Health is on developing an integrated planning process. Many steps have been taken in the past two years.

One major change has been to consolidate the federal planning requirements and the state planning requirements. In the past the Division of Mental Health prepared an Operating Plan, which included financial information for the current fiscal year. The objectives in that Plan were consistent with those in the Five-Year Mental Health Plan. Last year, however, the Division developed one Comprehensive Operational Five-Year Mental Health Plan which included the specific planned actions and the financial information and data for that fiscal year.

Another major accomplishment was the development of a formalized planning process within the Department of Institutions which involved all three Divisions.

As indicated earlier, sections of this Plan are developed in accordance with the planning guidelines used by the State Health Planning and Development Agency and the Health Systems Agencies to integrate federal health and mental health planning requirements.

In the Division of Mental Health program planning, budgeting, and reporting have been refined as part of a single planning cycle. The treatment and support system model has been advanced as a basis for planning and developing services for mental health service areas. A five-year plan entitled the Colorado Treatment and Support System for Mental Health Services was prepared by the Division and was widely distributed.

The major planning accomplishment for this year has been the implementation of a formal planning process at the local level. The Division of Mental Health, the State Mental Health Advisory Council, and the Colorado Association of Community Mental Health Centers and Clinics jointly established criteria for the development of mental health catchment area plans. Each of the twenty catchment area mental health centers submitted a plan for their area to the State Mental Health Advisory Council and to the appropriate Health Systems Agency. The State Plan Committee of the Council reviewed all of the plans and determined how they would be integrated into this Plan.

The State Mental Health Plan and future revisions will continue to be based on catchment area plans and will continue to reflect the recommendations and comments of a wide variety of interested and concerned agencies, organizations, and individuals across the state. The focus in the coming year will be on further integration of state and local planning efforts with the goal of emphasizing mental health system management at the catchment area level.

D. FACT SHEET

COLORADO DIVISION OF MENTAL HEALTH

BRANCH OF GOVERNMENT: Executive Branch

DEPARTMENT: Department of Institutions

STATUTORY AUTHORITY:
FEDERAL: 42 United States Congress, 246
STATE: Colorado Revised Statutes 1973, Title 27

LOCATION: 3520 West Oxford Avenue
Denver, Colorado 80236

CENTRAL OFFICE STAFF: 39 Full-Time Employee Positions

STATE HOSPITALS:
Colorado State Hospital
Fort Logan Mental Health Center

PURCHASE OF SERVICE CONTRACTS:
Twenty Comprehensive Catchment Area Centers
Three Specialty Clinics

ADMISSIONS SYSTEM-WIDE (FY 1978-1979):
CENTERS AND CLINICS: 46,778
HOSPITALS: 3,040 (excludes drug, alcohol, and general hospital)
TOTAL: 49,818

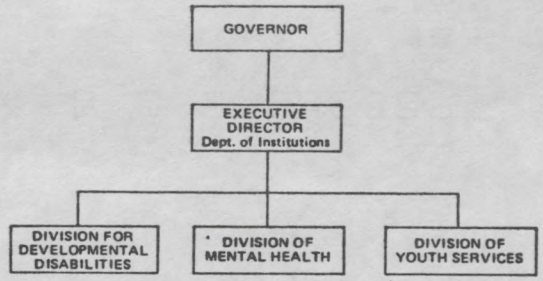
ESTIMATED CLIENTS SERVED SYSTEM-WIDE (Hospitals, Centers, and Clinics):

	FY 1978-1979
CHILDREN	5,464
ADOLESCENTS	9,067
ADULTS	59,906
ELDERLY	2,487
TARGETED*	58,232
NON-TARGETED**	18,692
TOTAL	76,924

*Targeted: moderately and severely psychiatrically disabled
**Non-Targeted: minimally and mildly psychiatrically disabled

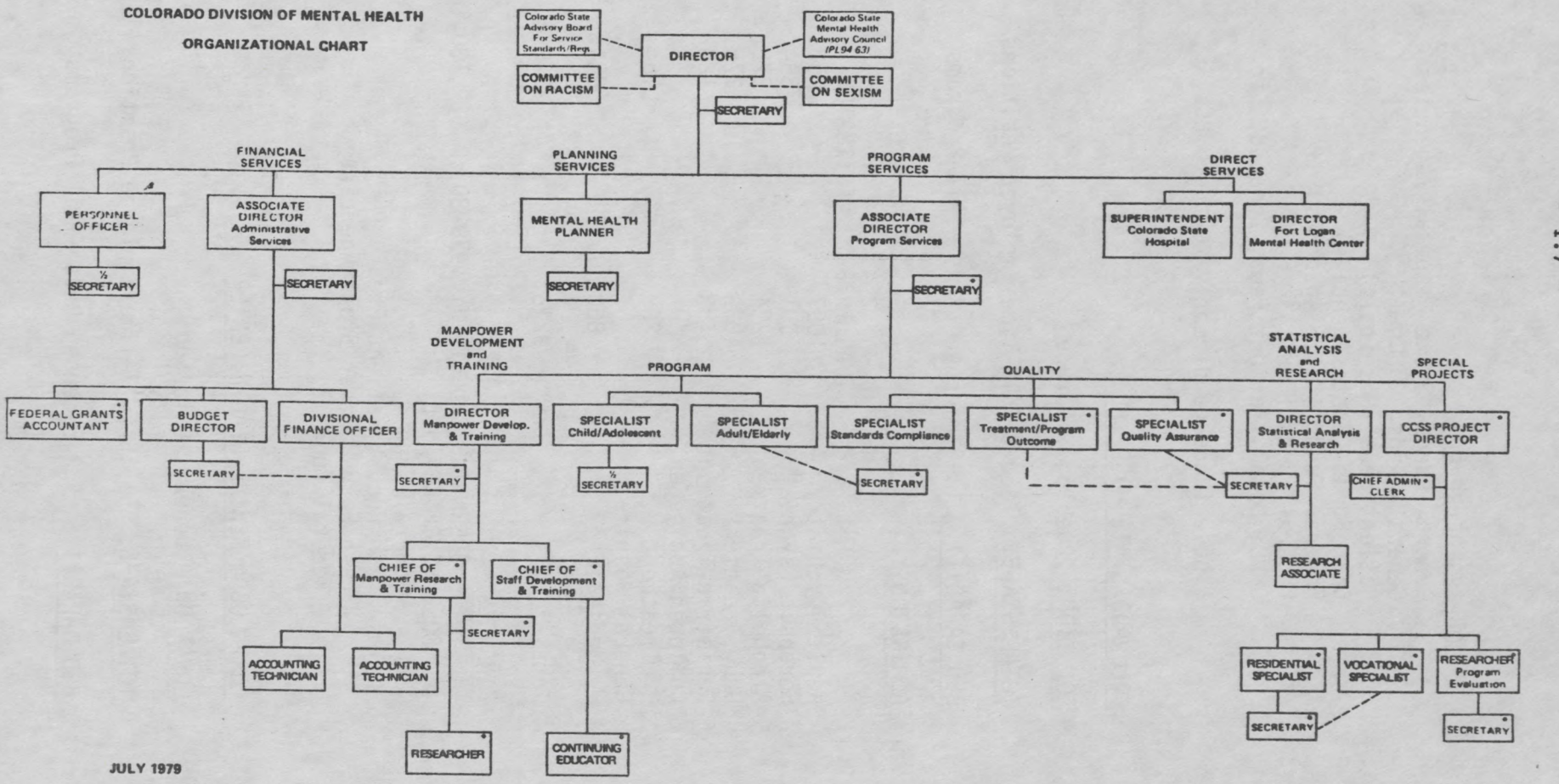
FINANCES:
TOTAL OPERATING BUDGET (FY 1979-80): $78,138,621

COLORADO DEPARTMENT OF INSTITUTIONS



COLORADO DIVISION OF MENTAL HEALTH

ORGANIZATIONAL CHART



JULY 1979

* FEDERAL GRANTS

SOURCES OF REVENUE:

General Funds, State Hospitals/Agencies	$ 24,662,237
General Funds, CMHCs	16,396,141
Patient Fees (Hospitals)	11,462,238
Cash Funds (State Agencies)	4,762,579
Federal Funds (State Agencies)	855,426
Federal Funds (CMHCs)*	5,000,000 (est.)
CMHC, Local, Patient Fees, Donated, Etc.*	15,000,000 (est.)

*These funds go directly to the CMHCs.

COLORADO STATE HOSPITAL

LOCATION: Pueblo, Colorado

TOTAL STAFF: 1360.6 Full-Time Employee Positions

BED CAPACITY: 1113 Licensed Beds - All Programs

ADMISSIONS:

	ACTUAL 1978-79	ESTIMATED 1979-80	PROJECTED 1980-81
Adult Psychiatry	1097	1252	1200
Forensic Psychiatry	391	384	400
Alcoholic Treatment	284	272	280
Drug Treatment	239	276	270
Geriatric Treatment	136	188	180
Children/Adolescent Treatment	209	164	200
General Hospital/ Medical	860	984	950
Total	3216	3520	3480

FINANCES:

TOTAL OPERATING BUDGET (FY 1979-80): $29,130,162

SOURCES OF REVENUE:

General Fund	$ 18,005,447
Cash Funds, Patient Fees	7,208,043
Cash Funds, Other State Agencies	3,651,395
Federal Funds	265,277

FORT LOGAN MENTAL HEALTH CENTER

LOCATION: Denver, Colorado

TOTAL STAFF: 515.5 Full-Time Employee Positions

BED CAPACITY: 333 Licensed Beds - All Programs

ADMISSIONS:

	ACTUAL 1978-79	ESTIMATED 1979-80	PROJECTED 1980-81
Adult Psychiatry	654	650	650
Alcohol Treatment	282	292	292
Geriatric/Deaf/ Aftercare	151	153	153
Children/Adolescent Treatment	250	263	263
Children	93	103	103
Adolescent	157	160	160
Vocational Services	4	4	4
Total	1341	1362	1362

FINANCES:

TOTAL OPERATING BUDGET (FY 1979-80): $11,369,515

SOURCES OF REVENUE:

General Funds	$ 5,978,858
Cash Funds, Patient Fees	4,254,195
Cash Funds, Other State Agencies	1,111,184
Federal Funds	25,278

COMMUNITY MENTAL HEALTH CENTERS/CLINICS

TOTAL STAFF:

FULL-TIME STAFF: 1303

PART-TIME STAFF: 243

CONTRACTED SERVICES (Statewide, FY 1979-80):

ADMISSIONS BY AGE, SEVERITY, AND ETHNIC MINORITY (excluding alcohol and drug admissions)

	PERCENT	NUMBER
CHILDREN (0-11 years)	10.0	4,778
ADOLESCENTS (12-17 years)	12.6	6,047
ADULTS (18-64 years)	72.0	34,504
ELDERLY (65+ years)	5.4	2,593
TOTAL	100.0	47,922
TARGET GROUP (Moderately and Severely Disabled)	71.9	34,449
ETHNIC MINORITIES	23.1	11,075

FINANCES:

TOTAL OPERATING BUDGET (FY 1978-79): $34,930,169

SOURCES OF REVENUE:

State Funds	$14,587,376
Federal Funds	5,500,242
Fees, Titles, Insurance	3,908,410
County/Municipal	5,174,381
Donated and In-Kind	3,875,832
School Districts	562,396
Other	1,321,532

COLORADO COMMUNITY MENTAL HEALTH CENTERS AND CLINICS

COLORADO STATE HOSPITAL SERVICE AREA:

Centennial Mental Health Center, Inc. (Region 5)
Colorado West Regional Mental Health Center, Inc. (Region 11)
Midwestern Colorado Mental Health Center, Inc.
Pikes Peak Mental Health Center
San Luis Valley Comprehensive Community Mental Health Center
Southeastern Colorado Family Guidance and Mental Health Center, Inc.
Southwest Colorado Mental Health Center, Inc.
Spanish Peaks Mental Health Center
West Central Mental Health Center, Inc.

FORT LOGAN MENTAL HEALTH CENTER SERVICE AREA:

Adams County Mental Health Center, Inc.
Arapahoe Mental Health Center, Inc.
Aurora Community Mental Health Center
Bethesda Community Mental Health Center
Mental Health Center of Boulder County, Inc.
Centennial Mental Health Center, Inc. (Region 1)
Colorado West Regional Mental Health Center, Inc. (Region 12)
Health and Hospitals Mental Health Program
Jefferson County Mental Health Center, Inc.
Larimer County Mental Health Center
Park East Comprehensive Community Mental Health Center, Inc.
Southwest Denver Community Mental Health Services, Inc.
Weld Mental Health Center, Inc.

Specialty Clinics:

Children's Hospital Mental Health Clinic
Denver Mental Health Center, Inc.
Servicios de la Raza

CHAPTER II. CONCEPTS IN MENTAL HEALTH

A. QUALITY OF LIFE

The purpose of the Colorado Division of Mental Health is to maximize the clients' capacity to improve their quality of life. The ability to function in areas such as work or school, family and social relationships, recreation and other daily living activities impacts the quality of life. The efforts of the mental health delivery system are designed to prevent or relieve emotional suffering and to help people achieve higher levels of functioning in areas that enhance their quality of life.

Economic, social and cultural factors, along with each individual's unique set of experiences, determine how each of us defines the critical requirements of our quality of life. For most people, however, there are a handful of important factors that determine the quality of life. These factors include a pleasant place to live, family and friends, a good job or school experience, and a chance to have fun. These activities and the people close to us support our leading a normal life. Success in these areas is just as crucial for the mentally disabled person. Without them, there would be no return to a normal existence. The specific factors and the amount of weight given to each factor in assessing one's quality of life vary. Nevertheless, certain factors that impact the quality of life have been identified and can be used to further define this concept.

Food and shelter are considered to be basic necessities for life. Material possessions and certain comforts and luxuries contribute to a sense of material well-being. Financial security is typically an important factor. For most people, the filling of these needs through their own efforts enhances their quality of life.

Physical and mental well-being are considered to be critical requirements of a person's quality of life. Good health has always been an important factor; however, there is increasing emphasis on physical fitness and freedom from emotional suffering. All people experience stress around common events such as losses due to separation, divorce or death, moving, changes in schools or jobs, and other changes in lifestyle. The ability to perceive and to handle stress experienced in such situations impacts the quality of one's life. Problems relating to disease, alcohol, drugs, and aging are included in this area.

Interpersonal relationships are extremely important quality-of-life components. A variety of relationships need to be considered. First are relationships with another person (e.g., spouse, boyfriend, or girlfriend) that are characterized by love, companionship, sexual satisfaction and understanding. Relationships that involve watching children grow, helping them to learn, and learning from them influence the quality of life for many people. Relationships with other relatives may also have significance. There are many beliefs, attitudes, and values that are based upon the concept of family and family relations. The fourth type of relationship has to do with friends.

The number and variety of friends and the level of intimacy established are variables. Meaningful friendships involve feelings of acceptance, support, trust, and enjoyment.

Social ties and involvement in community activities are factors impacting the quality of life. Many people become members of organizations that direct their efforts toward helping others and provide socialization opportunities. Churches, clubs, civic organizations, volunteer organizations, and special interest groups are included in this area. There is also a need to influence or, at a minimum, keep informed of local, state, and national issues through various media or discussions with others.

Productivity is a factor. Interesting, rewarding work in a job or at home is important. For many, especially children, attending school is a primary focus. Hobbies or special interests allow individuals to express themselves, to expand their learning, and to gain additional knowledge.

Personal development and understanding are factors in the life of Americans. More people are adopting the attitude of needing to take charge of themselves and of events that have an impact on them. Increased attention to personal nutrition and physical fitness, as well as increased sensitivity to environmental issues reflect this attitude. Learning, acquiring desired knowledge and mental abilities, gaining understanding and acceptance of one's strengths and limitations, and making decisions are activities that have been associated with these factors. For some people, religious or spiritual experiences and activities are part of this component.

A final factor in the quality of life is recreation. It is important to have fun and enjoy leisure time. Socializing may include attending parties, meeting new people, or interacting with others. Recreational activities may be of a passive and observational nature such as listening to music, reading, going to the movies, or going to sports events. Hunting, fishing, camping, skiing, hiking, dancing, and vacation travel are examples of recreational activities that involve a more active role.

The factors that have been identified include most of those that can be used to determine whether an individual's quality of life is good or bad. An individual's level of functioning in these areas changes from time to time. Most people have the capacity to improve their functioning in these areas to enhance their quality of life. Mental health prevention and education services are efforts to help persons or organizations acquire knowledge, attitudes, and behavior patterns that help prevent mental illness and foster mental well-being. There are other people, the mentally disabled for example, who do not have the necessary knowledge, skills, resources, or support to improve their functioning in these various domains of life. Mental health direct care services are provided to these individuals who need assistance in improving their capacity to function better and, where possible, to lead a more independent life. The quality of life factors are just as meaningful, if not more so, to psychiatrically disabled persons as to the rest of society.

If a child, adolescent, adult, or elderly person requires mental health services, a variety of resources may be needed. The resources and programs differ as the individual progresses back to a normal life. During the course of an individual's care, such issues as housing, employment, interpersonal relationships, social involvement, recreation, and general community survival skills may need to be addressed. Individual or group therapy may buttress all of these activities. The main point is that care is delivered through a system that supports the individual's return to a normal life and maximizes his or her quality of life.

B. PRINCIPLES OF MENTAL HEALTH CARE

1. Quality
   a. Mental health services should maximize the clients' capacity to improve their quality of life by helping clients achieve higher levels of functioning.
   b. Mental health services should ensure the delivery of high quality client care through the effective functioning of the elements of the mental health system.
2. Human Dignity, Privacy, and Clients' 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 a release of information without the client's consent is specifically permitted by statute. In those instances, an effort shall first be made, when practicable, to obtain the written consent of the client.
3. Availability and Accessibility of Services
   a. Mental health services should be provided, when possible and/or when the client's condition permits, in the local community, as close as possible to the client's home, and in the most normal or home-like setting available.
   b. Each client should be treated in the least intensive or restrictive setting consistent with the client's clinical needs and with the needs of the community. Each client should be given the least amount of treatment that is still maximally

effective.

c. Entry into the mental health system should be through the local mental health center.

d. 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.

e. The mental health system should determine which mental disabilities can be prevented and should implement the programs which have been demonstrated to be effective in preventing those disabilities and promoting mental well-being.

f. The mental health system should develop linkages with other human service agencies to assure that a full range of mental health services is available and accessible to the citizens of Colorado.

4. Continuity of Care

a. Mental health care should ensure that there is a continuity of relevant care from the initiation of services until the client terminates from services and that there are no gaps in service that will be detrimental to the welfare of the client.

b. Planning and service delivery for care to children, adolescents, adults, and elderly should be coordinated and linked with existing treatment and support networks.

5. Service Needs and Appropriate Utilization

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.

d. Needed resources should be developed in the most cost effective, efficient, and comprehensive manner.

e. If resources cannot adequately meet the mental health service needs of the residents of Colorado, priorities should be established that are based on client populations most in need of services.

6. Reasonable Costs

a. Mental health services should be provided at a reasonable cost to the client and purchased at a reasonable cost by the state.

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 insurance benefits.

7. Accountability
   a. There should be a continuous effort to measure the impact and results of mental health services. Agencies and programs which provide effective services at low cost will receive special recognition through the development of an incentive program.
   b. The focus of the state mental health system should be to maximize contracting for specific outcomes, with emphasis on quality and community responsibility, and to minimize regulation.
   c. The results of ongoing evaluation of mental health services should be reflected in the planning process.
   d. The people of Colorado must be assured that their tax dollars are providing quality care at reasonable cost for the citizens most in need of services.

CHAPTER III. TRENDS AND ISSUES

Proper planning requires knowledge and understanding of the trends and forces that impact the quality of life and the ability of the mental health system to enhance the quality of life of the residents of Colorado. Strategic planning begins with looking at trends and identifying the issues generated by those trends. In this way it becomes possible to examine current alternatives in terms of the future.

A. GENERAL TRENDS

1. Public Attitudes

- Demand for reduced taxation and spending.
- Demand for less government regulation.
- Demand for increased accountability.
- Demand for the return of tax dollars and reduced spending on public services.
- Concern over high costs.
- Concern over the energy crunch, including spiraling prices for gasoline, spot shortages of fuel, and on-and-off government allocation.
- Concern over lack of personal services.
- Focus on personal health care, including increased attention to physical fitness and mental well-being.
- Concern over environmental conditions, such as pollution.
- Concern over funds being diverted from programs and projects that have an immediate, observable impact to ones that have less visible, more indirect, and more future-oriented results.
- Concern over the slowness with which advancements in health care filter down to the public.
- Concern over the health care industry's ability to be self-corrective.

2. Consumer Attitudes

- Far more sophisticated, as evidenced by the acknowledgment of a "consumer movement."

- Increased health care expectations.

- Demand for quality merchandise and services.

- Demand for increased personal services and personal attention.

- Only willing to pay for what they get, resulting in categorical funding and a single product orientation.

- Demand accountability both in terms of the manner in which funds are spent and how care is delivered - accessibility and quality.

- Increased attention to quality of life factors (personal health care, increased spending for life-style goods, more thought to wise investing).

3. Legislation

- Legislation that reduces taxation (such as California's Proposition 13) and/or limits government spending reflects public sentiment throughout the country.

- Legislation that would impose mandatory cost controls on all hospital revenues is imminent if the industry's voluntary efforts are not successful in containing costs.

- National Health Insurance will increase expectations, demands for services, and costs. The additional public and private expenditures for improved health care benefits and coverage should be offset by savings from greater efficiency in the health care system.

- Planning legislation has become critical to the overall strategy for directing the future of health care. The roles of federal, state, and local government, cost containment, coordination, prioritization of health care issues, and standards for the system fall within the framework of health planning legislation.

- The Mental Health Systems Act will further the movement toward more effective mental health systems management, including increased attention to developing performance contracts and establishing linkages among human care-giving agencies. This legislation will reform the nation's mental health program and will tie it more closely to the health planning process.

4. Economy

National Trends:

- The change in the consumer price index will continue at a double-digit rate. This is expected to be the result of such factors as: (a) OPEC raising the price of world oil and other domestic energy prices rising as well; (b) business labor costs (compensation minus productivity gains) again on the rise; (c) food prices going up significantly further; (d) minimum wage and social security taxes increasing; and (e) the depreciated dollars resulting in higher import prices.

- The real gross national product will show negative growth, and thus a recession will appear.

- Consumer spending (which comprises roughly two-thirds of the gross national product) will decline. The decline will come primarily from the durable goods area (automobiles, furniture, and appliances), as the "buy-to-beat-inflation" psychology and huge consumer credit advances of the past two years have caught up with the consumer. The decline of consumer incomes relative to prices and the increased monthly debt load have put consumers in a cash-flow bind.

- Health care expenditures will continue to exceed 9 percent of the gross national product. The Carter administration has stated that it will seek legislation that would impose mandatory cost controls if voluntary efforts are not successful.

Colorado Trends:

- Inflation will continue to surpass the national rate. Factors contributing to this have included increases in food costs, housing costs (especially utility bills), and transportation costs. Both food and energy prices will continue to put pressure on budgets. Housing price increases are expected to begin approaching the national average.

- Payrolls and personal income will slow from the record 1978 rate of growth (near 16 percent) to a more moderate expansion of approximately 11 percent. The average Colorado resident gained 2 percent in real purchasing power in 1976, almost none in 1977, about 3 percent in 1978, and in 1979 only a one percent real gain.

- Taxable sales will grow more slowly as homebuilding continues to decline, income gains are reduced, the saving rate slightly rises, and auto sales weaken.

- Consumer and business spending will slow down, as the consumer psychology of buying to beat inflation becomes less of a factor.

Retail sales expansion of approximately 11 percent is expected in 1980, compared with 16 percent in 1979 and only 7 percent in 1975.

- The energy industry will continue to be the driving force in Colorado's economy, while residential construction declines, consumer attitudes worsen, and non-residential construction begins tapering off.

- Overall, no actual decline in the Colorado economy is anticipated.

(Sources: Colorado State Office of Planning and Budgeting
Economic Research Department #0010, United Banks
of Colorado, Inc.)

5. Employment

National Trends:

- The average unemployment rate will move up from 6 percent in 1979 to 7.5 percent in 1980. Rising unemployment will complicate workers' attempts to regain the declines in purchasing power which they absorbed in 1979.

- Wage gains and benefit (or compensation) gains have exceeded productivity gains. This contributes to inflation, since business raises prices in order to pay for increased labor costs. In 1980, compensation gains are expected to be close to 1979's; however, productivity should improve as business lays off workers and reduces the use of obsolete equipment, thus lowering unit labor costs.

Colorado Trends:

- Total employment, a good indicator of overall economic activity, will expand by approximately 2 percent, or 25,000 jobs. This gain will be the smallest since 1975, when jobs rose by only 0.4 percent, but will still be substantially better than national performance.

- Increases in employment are strongest in the mining, construction, and finance and services industries, though all employment sectors contribute somewhat to the increase.

- The national recession will take its toll on employment, as every major employment category is expected to experience slower growth.

(Sources: Colorado State Office of Planning and Budgeting
Economic Research Department #0010, United Banks
of Colorado, Inc.)

6. Population

National Trends:

- Falling birth rates have caused the rate of increase in the U.S. population to decline steadily from one percent per year in 1976 to the current rate of 0.7 percent annually.

- In 1970, 20 million of the U.S. population were age 65 or above. During the 1980s, this age group should reach a total of 30 million people.

Colorado Trends:

- Population growth will continue to be more rapid than that of the nation.

- Increased job opportunities in energy-oriented markets, as well as in its new and expanding businesses, will continue to attract population to the state.

- The growth rate will be between 1.5 percent and 2.0 percent, which is slower than experienced in the 1970s.

- Greatest growth will be in the 18-44 age group (post-war babies are reaching adulthood and middle-age), with the over-65 age group experiencing the second largest increase.

- From 1970 to the year 2000, the over-65 age group will double in the population.

- Several counties in Colorado are experiencing rapid growth due to the development of coal, oil, oil shale, and electric power generation facilities in the area. This growth will be accelerating at an increased rate over the next five to ten years because of current national energy policies.

7. Family Issues

- One out of three marriages is ending in divorce.

- There are three million more female heads of households than in 1975. Half of these are divorced or separated, and the other half are single or widowed.

- The number of two-person households has doubled and continues to increase. This includes younger couples without children and older couples whose children have left home.

- Life expectancy for both men and women is increasing.

- There is a gradual reduction in the average number of work hours

per week for those employed in non-agrarian occupations. Leisure time, therefore, is increasing.

- Two-worker families will continue to increase. The number of women in the labor force has almost doubled in the past two decades.

- Increased awareness of and attention to family violence, assault, and abuse are reflected throughout the country.

B. MENTAL HEALTH TRENDS

1. Financing

- Mental health service costs will continue to increase because of such things as increases in the number of patient care episodes, inflation, population growth, high labor costs, and new technologies.

- There is concern over the economic costs (direct costs plus loss of output) resulting from mental disorders, which were last estimated (1975) to be around $31 billion. These costs consist of loss of human resources or deficit production. There are also indirect costs such as loss of wages (in 1975 mental disorders were ranked tenth as a cause for days of work lost) and loss of life by premature death (mental disorders ranked twelfth as a cause of years of life lost by premature death).

- More emphasis is being placed on containing costs related to diagnosis, treatment, and rehabilitation rather than on prevention of illness and maintenance of health, as prevention and maintenance are viewed as less responsible for the increasing costs of care.

- The rate of funding for mental health will continue to decline.

- There is general concern over the lack of flexibility of funding resources. Current restrictions on the use of Title XX, housing, vocational rehabilitation, and other funds keep them from being applied adequately to the needs of mental health clients.

- There is concern over the lack of mainstream funding, i.e., Medicaid and Medicare, for mental health.

- New programs and new dollars for mental health are in jeopardy at both the federal level and the state level. Increases in mental health funding generally will come from non-governmental sources.

- Available funds will be precisely targeted with strict performance contracts.

- Support from federal funds for housing for psychiatrically disabled persons is gradually increasing in emphasis.

- There is concern over the lack of adequate funding for case management, which is the key element of a community support system.

- Major corporations are resisting increases in Blue Cross/Blue Shield rates.

- Congress and state legislatures are resisting increases in appropriations for Medicare and Medicaid.

- In Colorado, the legislature has recognized that there are vast differences (based on historical events and tradition rather than on population and need) in funding resources for mental health areas in the state. A redistribution of funding to be based on population and need has been initiated and is expected to continue.

- Mental health funds from all sources will be more closely monitored, making it far less possible to use them for a variety of purposes.

- Efficacy issues will play an increasing role in reimbursement for mental health services.

- The President's Commission on Mental Health confirmed the nation's need to devote greater fiscal resources to mental health (only 12 percent of general health expenditures are devoted to mental health).

2. Service Settings

- Emphasis on establishing treatment and support systems in the community will continue.

- Relations between hospital and community settings will continue to improve and will enhance the quality and continuity of care.

- Admissions to community mental health centers in Colorado increased through 1977, after which they began to decline. This decline will continue as centers shift resources to services for the moderately and severely disabled population.

- Admissions to community mental health centers in areas experiencing rapid growth from energy development will continue to increase due to the increase in social stress and the lack of alternative resources.

- Immediate, short-range control of symptoms and protection of the

patient will continue to be a major hospital function, but only when less intensive treatment or less supportive residential placements will not meet the clinical needs of the client.

- Hospitals will continue to be the least intensive and restrictive setting for some clients. (In Colorado, admissions have increased over the past few years.)

- The role of the hospitals as training centers for professionals working with very difficult patients will become more established.

- More research will be focused on examining the effectiveness of hospital and non-hospital residential settings for certain patient sub-groups.

- The mental health system is becoming increasingly pluralistic as patients have more options regarding the type of treatment they will receive and the setting in which the treatment is provided.

- The availability of third-party insurance will continue to influence the utilization of private practitioners and private mental health care facilities.

- The roles of supportive social networks outside the formal mental health framework for people who either don't require or don't seek formal mental health services will be recognized for their importance.

- The capability of community support systems in families, schools, neighborhoods, and similar settings will be maximized.

- More intermediate care facilities, halfway houses, supportive residences, and other group living arrangements will have to be developed to meet the needs of mental health patients.

- As decentralized service systems are developed, the requirements for case management and explicit inter-agency linkages will be paramount.

3. Work Force

- The problem of maldistribution of mental health personnel will continue. Rural areas, small towns, and poor urban areas will continue to have difficulty in recruiting properly trained mental health professionals.

- There is a lack of professionals trained specifically to work with children, adolescents, and the elderly.

- Ethnic minorities continue to be underrepresented in the mental health disciplines. This is especially true of psychiatry and psychology.

- Ethnic minorities and women are not adequately represented in managerial and top administrative positions in the mental health system.

- Psychiatrists and nurses are not entering the field at an adequate rate to meet the needs. This shortage will continue to impact rural areas.

- Primary care physicians lack adequate training in dealing with mental health problems of their patients.

- The delivery of psychiatric services to primary care patients will be improved as mental health professionals become more integrated into comprehensive medical care settings, such as neighborhood health centers and emergency rooms of general hospitals.

- Physicians and psychiatrists in the public mental health system continue to assume much larger administrative and diminished direct patient care functions. Recruiting psychiatrists for state hospitals will become much more difficult as the patient population becomes more chronic, longer staying, and less rewarding.

- Third-party insurance contributes to the greater utilization of private therapists, and thus the increased numbers of professionals going into private practice.

- "Burn-out" in the mental health system will continue to be a major problem.

- There will be more emphasis on providing good training and appropriate supervision of paraprofessionals.

- Volunteer programs in mental health will become much more important due to the role of volunteers in the client support system concept. There will be greater emphasis on the proper training and the appropriate supervision of volunteers.

- There is a need for increased availability of educational programs and training for managers and administrators in order to promote a positive approach toward mental health care systems management and to explain management techniques and tools for achieving quality of care and cost-effectiveness.

4. Patient Care

- Purchases of services will demand that patient care is funded from dollars designated for care.

- There will be continued increase in the use of mental health care resources.

- The general public will gradually become more sophisticated about mental health care.

- Performance contracts will allow providers greater flexibility in planning for mental health care in their communities while providing a mechanism for increased accountability.

- Treatment and support systems will be developed in each community by the agencies which have responsibility for case management, advocacy, and development of client support systems and linkages among mental health and related human services for the chronically mentally disabled.

- Services to children, adolescents, the elderly, the moderately and severely disabled, racial and ethnic minorities, and women will continue to be inadequate until funding for mental health is increased.

- The number of people with mental health problems and the demand for mental health services will continue to increase with the deepening recession and economic downturns.

- The focus on services to be provided and/or expanded in geographic areas identified as unserved, underserved, or inappropriately served will continue.

- Mental health and health problems will increase in areas experiencing the impact of energy development.

- Emphasis on improving the client's capacity to achieve higher levels of functioning will continue. The importance of social relatedness outside of the client's residence and of work and other types of productivity will be emphasized.

- There will be more attention focused on the interdependent nature of health and mental health.

- There is increased public awareness of the lack of appropriate services for women and for such groups as Vietnam veterans, the deaf, the developmentally disabled, and others with physical handicaps.

5. Prevention of Mental Illness and Promotion of Mental Health

- Prevention of mental illness and promotion of mental health will become more visible parts of national policy.

- Prevention efforts relating to children and their families will receive the most support.

- The demand for research that can document the impact of mental health prevention programs will continue.

- Funding for prevention programs will continue to be very limited, with gradual increases as the interface of health and mental health becomes more evident.

- Private industry will continue to financially support prevention.

- The focus of prevention strategies will shift from attempts to impact individuals to attempts to influence and change social environments.

- In energy development impacted areas, prevention strategies may prove useful in communities forced to deal with social disruption.

6. Research

- Funding for research in mental health will increase over the next ten years.

- Research related to the incidence of mental health problems and the utilization of services will experience the most rapid rate of growth. Particular attention will be focused on population groups known to have special needs, i.e., children, adolescents, the elderly, women, and racial and ethnic minorities.

- Research related to prevention will also have a more rapid rate of growth than research related to direct treatment.

- Funds allocated to research will be carefully monitored to insure that they are spent on research rather than on patient care.

- More dollars will go to targeted research with some immediate payoffs than to other less focused kinds. The relation of research to mental health care must be very evident.

- More dollars will be awarded through contracts than through grants.

- Limited resources will result in more inter-agency sharing of data and efforts to develop and disseminate the information effectively, efficiently, and in a comprehensive manner.

7. Legal

- The Rights Protection and Advocacy movement will continue. The balance between external and internal advocacy systems will receive more attention. Patients, ex-patients, and families of patients will continue to become more involved in this area.

- There will be increasing conflict generated between the social concern about protecting the community from the violent mental client and concern for ensuring rights protection of other clients in the mental health system.

- The judicial system's involvement in mental health will continue to put increased pressures on the system and will result in higher costs.

- The inflexibility of many laws and regulations and their unrelatedness to the realities of service delivery will work against the development of the mental health service delivery system. The trend toward increased and conflicting controls seems inexorable.

8. Service Relationships

- The public sector and the private sector will develop a much stronger relationship.

- There will be increased coordination and collaboration between different human service agencies in terms of planning, service delivery, research, training, and program development, implementation, and evaluation.

- The relationship between various service settings, such as hospitals and community mental health centers, will be stronger.

- Cooperative agreements, contracts, and affiliation agreements will be monitored more closely in terms of implementation and results.

C. ISSUES

The issues that have implications for the mental health system have been extracted from the trends in the nation and in the state to provide a background against which future planning can take place. The key issues for mental health appear to be the following:

- Accountability
- Service Needs
- Prevention
- Quality
- Management of the System
- Patient Care
- Resource Distribution
- Linkages With Other Systems
- Funding Mechanisms
- Cost Containment
- Work Force
- Advocacy

1. Accountability

The trends indicate that the citizens' revolt against taxes, spending, high costs, and regulation will continue unabated. Closely tied to these trends is the issue of accountability. Citizens want to know where their tax dollars are going and want to be assured of getting their money's worth. A sense of public skepticism and cynicism has become more apparent. Legislation to reduce taxation was generated by the public and continues to be a direct response to public pressure.

The mental health system will be held accountable for the public dollars at the legislative level and for high quality care at the treatment level. The taxpayer not only wants to know what is being done with tax dollars, but is demanding to know whether or not those dollars are having an impact on the population. In the past, mental health provided a description of what was being done in the system. The second level of accountability was to describe the activity related to what was being done, such as providing information on the services that were being provided and the cost of those services. Today the mental health system must move beyond these two levels by producing information related to the impact of those services and the reasonableness of those costs. The key point is that results or outcome, rather than activity, must be measured.

Mental health measures should not only include the direct impact of services on the client, but should also address the impact upon society. Rehabilitation often leads to increased revenues generated through taxes, as clients improve their level of functioning in areas such as productivity and reenter the work force. The costs of rehabilitation have been the focus of fiscal documentation. The mental health system now needs to provide documentation reflecting the economic benefits that result from clients returning to the mainstream of society.

In the past, research has been viewed as a luxury to be deferred because of the higher priority of patient services. The trends indicate that this will change. Increased demands for accountability are resulting in research being viewed as a necessity.

2. Service Needs

The primary issue for mental health today is that the mental health service needs of the citizens are much greater than the resources available to meet those needs. The increase in the population will increase the number of people needing mental health services. A 4% increase over two years would bring approximately 9,400 more severely and moderately disabled persons into the current pool of persons needing services that cannot be adequately served because of limited resources.

Population trends by age also provide information to be used in determining the distribution of mental health resources in terms of age groups. The number of elderly persons, for example, will grow more rapidly than the population as a whole over the next ten years. Children, adolescents and the elderly comprise more than half of the nation's population, but they are among those receiving the fewest mental health services.

The types of mental health programs that are offered will also be influenced by population trends. Unemployment among younger adults is likely to subside as a problem, since the numbers of those 18-24 years of age are dropping. Changes in the American family result in changes

for mental health programming. Services for single parent families, for couples experiencing conflict because of change in roles, for the elderly population, and for family members experiencing stress related to economic trends are examples of services that are often requested from the mental health system. Stress will increase with a recession and will increase the demand for mental health services. Programs for battered spouses and other victims of domestic violence are seen as needs in some areas. The cultural and linguistic backgrounds of clients must also be recognized. The effect of these influences on clients' problems and on the delivery of services has been a major development in mental health in recent years. The problems experienced by the population depend upon the age of that population and their critical requirements for the quality of life.

Energy source and other natural resources development will result in rapid population growth and the creation of many boom towns, especially in western Colorado. Historically, this situation has created severe stress for both the individuals involved and the social fabric of the community, and has resulted in a disproportionate increase in incidents of disruptive social behavior. Demand for reactive mental health services will soon exceed capacity unless the community, its service agencies, and the impacting industries ally to promote an environment which encourages the development and re-establishment of human support systems and a positive sense of community.

3. Prevention

The concepts of prevention of mental illness and promotion of mental health clearly deserve more attention. That programs designed to prevent disease and promote good health can be effective and economical has been evidenced throughout the past century by the public health sector. The issue for the mental health field, however, is that it has not used its available knowledge in a comparable effort. Research needs to be done to determine methods of providing prevention and promotion programs that will be effective. The reasonableness of costs and the impact of these programs must also be determined.

The trends that relate to a greater focus on personal health care also impact this issue. Physical fitness and mental well-being are important quality-of-life factors. The interest of the public in these factors provides many opportunities for the mental health system. Prevention programs, that are known to be effective, and other such services should be developed at the local level and provided to a wide variety of agencies, industries, businesses, clubs, etc. Local support for mental health could certainly be enhanced through efforts that can be shown to have a positive impact on the general taxpaying public.

4. Quality

The consumer movement is expected to continue at a steady pace. Demands for quality and greater expectations for service will not subside. The issue of quality is more important now to the health care industry than ever before. The mental health system must not only provide high quality care, but it must also be able to define and measure the quality of the care that is provided. Reimbursement for mental health services will depend upon the quality of that care and its results. Research may again be emphasized, as it is needed to evaluate the quality of direct and prevention services and their impact on the population. Research

offers the hope that the mental health system will be able to meet the press of patient services effectively by developing better methods of care.

The trends identified under public and consumer attitudes generate some issues that may create confusion. Demands for reduced spending and increased accountability are expressed along with demands for increased expectations, personal services, and high quality. It is no small part of the struggle for quality to make certain the public and the consumer understand the full implications of wanting more done with less.

5. Management of the System

Increased measures of accountability and demands for quality require better management of the system. A new era of health care systems management is being experienced. The state mental health authority at the state level and the governing boards of community mental health centers at the local level must view themselves as mental health system managers and must take responsibility for effectively and efficiently managing the system. The limitations on state spending will result in the need to increase local support for mental health services. The community mental health centers' responsibility for planning, assessing needs, and coordinating mental health services in their respective catchment areas is reflected in the annual plan developed by each center. These plans are used as the management plans at the catchment area level and as the basis for the State Mental Health Plan. The key decision-makers may continue to serve as consultants, representatives and advocates of the people as to where and how mental health services are provided. They must, however, now add emphasis to their roles as the managers responsible for assuring that the "product" they provide meets the quality demands of the consumer and the accountability demands of the taxpaying public.

6. Patient Care

Treatment by professionals has primarily been conceptualized as taking place in specific physical locations. The physical location might have changed (i.e., from an isolated hospital to a community mental health center); however, treatment by mental health professionals is still thought of as taking place in a structure. For many of the system's clients, treatment is being perceived of as the total daily life of the client. The trends toward developing support systems for clients are based on the belief that psychiatrically disabled individuals must have the same opportunities as others to lead a normal life. "Treatment" in the community may include services to increase the individual's productive involvement (vocational rehabilitation), to increase socialization skills and interpersonal relationships (social clubs), to develop daily living skills (residential settings), to learn to deal with emotional problems (mental health agencies), to improve physical fitness (health clubs), to encourage individuals to have fun (community parks), to control symptoms or dangerous behavior (hospitals), to improve family relationships (home), etc. Assuring the accessibility, provision and coordination of such varied services leads to the need for effective case management systems. The important issues for mental health include changing perceptions about what treatment is or is not and about the types of service settings or, more appropriately, the settings in which that treatment takes place.

7. Resource Distribution

Various population groups have been targeted because of their unmet and/or unique service needs; however, the lack of resources clearly prohibits the mental health system from meeting all of those needs. Current fiscal constraints and previously identified trends are the reasons for this dilema. The issue, then, becomes one of prioritization of needs. Community mental health centers must establish priorities relating to needs of catchment area residents and utilization of resources. Joint state and local planning, based upon local need assessments, will result in the distribution of resources to the citizens determined to be most in need in each catchment area. Written plans describing the distribution system to be used for the allocation of state dollars to catchment areas based on identified needs will be submitted to the Joint Budget Committee of the State legislature.

There are two approaches that can be considered in addressing resource distribution. The first approach is to expand the resources available for mental health. Some prefer to view the current restrictions on resources for mental health care as a reflection of political priorities rather than immutable economic forces. The mental health system could certainly increase its involvement in and ability to influence social, economic and political policies. Despite the public cynicism about the motives of professionals who seek additional resources for mental health, professionals have a continuing obligation to be advocates for clients to ensure that high quality services are accessible and available.

The second approach is to make the best use of the resources that are available. This calls for more creative and innovative uses of limited resources that result in high quality levels of care without jeopardizing budgetary considerations.

8. Linkages With Other Systems

The issue of coordination becomes more and more important as resources become more limited. Coordination and collaboration among human service oriented agencies and organizations help to ensure that there is no duplication, that there is continuity and quality of care, and that limited resources are effectively and efficiently utilized.

Stronger linkages among human services and caregiving agencies need to be developed to meet the demands of multi-needy individuals and to reduce the stressfulness of life events. In some cases, support systems need to be developed, as trends related to increased mobility and moves away from one's own family or natural environment often create stress and disrupt natural support systems. Treatment and support systems for clients require integration among human service delivery systems if they are to be successful in maximizing the client's capacity to function better.

9. Funding

The public's perception of the role of state government is to return tax dollars to the citizens, rather than provide public services. In addition to documenting the results of services, the mental health system also must demonstrate the ways in which its efforts reduce expenses and generate economic benefits that impact all citizens.

The economic trends indicate that inflation will continue at a double-digit rate while the 7% limitation on state spending remains stationary. The spending limitations are creating the need to look for additional

local support from city and county governments. Increased local control should accompany increases in local funding.

Appropriate utilization of resources can maximize the use of current dollars; however, it is also necessary to expand other financial resources. Mainstream funding, such as Medicaid and Medicare, needs to be increased, as this source of funding may well become the major funding alternative to state general funds. The failure of third-party reimbursement programs to permit payment for ambulatory care and the resistance of third-party reimbursement programs, major corporations, and legislatures to the increasing costs of health care, have given public prominence to the cost issue and continue to put pressure on the health care system with regard to this issue.

The limitations on spending can create more competition for the funds that are available at a time when monetary and other resource sharing is so important.

10. Cost Containment

Medical costs have continued to climb and are considered to be the key that could open the way to lowering the Consumer Price Index. The average cost of a hospital stay has risen from $533 in 1969 to $1,634 in 1979 and is projected to reach $2,660 in 1984 if present trends continue. Hospital costs are the number one problem of the health care industry.

Mental health costs are not rising at the same rate. The mental health field does not experience the climbing costs of equipment needed in other health care fields. In Colorado, mental health costs have been kept below inflationary figures. One reason for this has been that Colorado is one of the few states in the country which has a sophisticated unit cost system. This system has not only tightened up the management of mental health facilities, but has brought costs closer together and more in line. The mental health system needs to continue to work on reducing the range of unit costs, expanding the number of cost reimbursement categories, and improving the reliability of cost information and management.

The most constructive response to the resistance to increased funding would be action to mitigate and control rising costs and to determine and document the reasonableness of cost categories within the unit cost system.

11. Work Force

The emphasis on work force issues will continue to receive increased attention. Currently, there are thirty-six states with the capacity for mental health work force planning and development. The significance of this thrust is apparent when compared to the fact that approximately six states had such a capacity only three years ago.

Colorado's job expansion continues to surpass that of the nation, although it will moderate significantly in almost every category. The exception will be in the area of mining employment. Energy-impacted areas are growing because of the employment opportunities. This expansion is especially significant in Western Slope regions. During 1977, coal-related jobs rose 181 percent in Moffat County, 182 percent in Delta County, and 101 percent in Mesa County. Oil shale jobs were up 49 percent in Rio Blanco County. A commitment to hiring local people first reduced the unemployment rate; however, that rate increases as

the labor force expands. These counties are experiencing severe social stress related to the impact of energy development, a situation which will significantly increase as the oil shale industry moves toward a production-level capacity. The need for community-wide prevention programs and the demand for mental health services have increased, and will continue to increase disproportionately with the rapid growth.

The issue of work force shortages is very real for the mental health system in Colorado. Recruiting and maintaining qualified mental health professionals is a primary problem for some agencies in the state.

Those who provide care to children, adolescents, women, and the elderly need to have highly specialized knowledge and skills. Professionals' understanding of the cultural and linguistic backgrounds of clients must be maximized. Additional personnel to meet the needs of minority groups is necessary. The importance of taking a socio-cultural approach to mental disabilities requires increasing emphasis within training programs.

The training of primary care physicians should be addressed. The size of the patient population requiring psychiatric care in general medical practice far exceeds the capacity of the mental health system to take it over; moreover, in many cases the care is best provided within the context of primary practice. For this reason, the skills of internists, pediatricians, and family practitioners need to be improved in order to enhance their ability to appropriately deal with the psychiatric and psychosomatic problems in primary practice.

The "burn-out" rate in the mental health field is expected to continue, as demands for accountability and expectations increase amidst fiscal constraints and limited resources. The turnover of personnel at all levels in mental health is high. A key issue for the mental health system, therefore, will be to provide high quality leadership that generates challenge and re-establishes a dynamic, active field that is open to new ideas.

Trends in the structure of the American family will impact volunteerism in mental health. Volunteers serve as one of the unlimited resources available to the mental health system. For both men and women, and especially young people and students, volunteering offers an opportunity to develop new skills and serves as a career builder. For others, serving as a volunteer may offer a chance to work, learn, and become involved in areas other than those in which one works on a daily basis. Because of the increase in two-person households, there may be a shift towards recruiting couples to volunteer, rather than individuals. The increase in leisure time is also a factor. There is a need to recruit more senior volunteers, as this population increases. Many of the quality-of-life components are related to volunteerism. Men, for example, often seek service oriented volunteer experiences while women look for administrative volunteer opportunities that will enhance their employability.

12. Advocacy

Patient rights protection and advocacy are receiving increased attention from the legislative level to the treatment level. Legislators, providers of mental health care, and consumers of mental health services (including patients, ex-patients and families of patients) are emphasizing the need for formal rights protection and advocacy programs which are independent of the service delivery system (external programs), as

well as programs which are components of the mental health service system (internal programs).

There are two primary thrusts in the advocacy movement. The first thrust involves ensuring that patients' rights are vigorously protected and that the services of an advocate are available to patients. Direct patient advocacy services should include procedures for effectively and efficiently addressing patient problems and grievances. The second major approach to advocacy has been identified as systems change. The purpose of systems advocacy is to initiate, support and monitor changes in the service delivery system which are needed to protect and assure the rights of clients. These changes may involve the creation or revision of legislation, administrative policies and procedures, regulations and standards, or general practices. Advocacy is tied into politics and policy. Advocacy groups, both internal and external, keep the pressure on through changes in government, cabinet-level posts, insurance directors, and representatives to legislatures and to Congress. Advocates will continue to play a key role in educating major decision makers about the needs of the patient and the needs of the mental health system which serves the patient.

Rights protection and advocacy programs should be viewed on a continuum which involves several activities. Trends related to consumer attitudes, patient care, and changes in the legal system impact this issue.

CHAPTER IV. STATEWIDE GOALS AND OBJECTIVES

A. INTRODUCTION

The goals and objectives have been developed in congruence with the congressional intent embodied in Public Law 94-63, as amended. This act focuses on: (1) the availability and accessibility of a full range of mental health services in local communities; (2) special efforts to meet the mental health service needs of children, the elderly, the chronically mentally ill, and minorities; (3) pre-admission screening to ensure use of the least restrictive setting; (4) the development of halfway houses and other alternatives to inpatient care; (5) follow-up care for persons who have been discharged from formal mental health treatment programs; and (6) services directed towards the prevention of mental illness.

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

An annual report on the fiscal year 79-80 objectives is included in Chapter VI to facilitate a review of the system's accomplishments. Lack of accomplishment is attributable to the lack of adequate funding, organizational changes, and 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 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 Colorado mental health system with input from public, private, and voluntary agencies, organizations, and groups concerned with the quality of life for citizens in their communities. The five-year goals which were established in 1979 were reaffirmed by the State Mental Health Advisory Council. The statewide objectives have been reviewed and revised, as necessary, to ensure that key issues generated by the objectives in the catchment area mental health plans are included.

The mental health system goals are interrelated and interdependent; therefore, the order of listing does not indicate relative priority.

B. FIVE-YEAR GOALS AND OBJECTIVES

(*New funds are required if the objective is to be accomplished.)
(**The objective was included in last year's Plan, but was not funded.)

1. MENTAL HEALTH STATUS GOAL #1.

> TO MAXIMIZE THE CLIENTS' CAPACITY TO IMPROVE THEIR QUALITY OF LIFE THROUGH ACHIEVING HIGHER LEVELS OF FUNCTIONING IN AREAS SUCH AS WORK OR SCHOOL INVOLVEMENT, FAMILY AND SOCIAL RELATIONSHIPS, DAILY LIVING ACTIVITIES, AND RECREATION.

Objective 1: To have determined if clients in the state mental health system are achieving higher levels of functioning and improving their quality of life, by implementing a client outcome evaluation system which includes quality-of-life and level-of-functioning measures by July 31, 1980.

Objective 2: To have determined the impact of the Colorado Community Support System (CCSS) by comparing treatment outcome of CCSS and non-CCSS clients using existing statewide level-of-functioning measures and proposed quality-of-life data by March 1, 1981.

Objective 3: To have collaborated with the Western Interstate Commission for Higher Education (WICHE) and with the National Institute of Mental Health (NIMH) in a preliminary assessment of the uses and limitations of outcome/quality-of-life data at the local agency level by March 31, 1981.

Objective 4: To have collaborated with the Western Interstate Commission for Higher Education (WICHE) and with the National Institute of Mental Health (NIMH) in determining the degree to which outcome/quality-of-life data can be both responsive to local needs and compatible across the state by March 31, 1981.

Objective 5: To have evaluated the impact of S.B. 26 on the mental health system in terms of patients served and programs offered by June 30, 1981.

Objective 6: To have developed a method for integrating Client Status Report data that provides cost/outcome data by June 30, 1981.

Objective 7: To have determined if clients in the state mental health system are achieving higher levels of functioning and improving their quality of life by analyzing data generated by client outcome evaluation systems by July 31, 1981.

Objective 8: To conduct a pilot study for determining which mental health agencies are most cost-effective in improving the level of functioning and quality of life of the system's clients by January 31, 1982.

Objective 9: To have implemented statewide the cost/outcome methodology which integrates cost and client outcome data by June 30, 1982.

Objective 10: To have analyzed client outcome information for two special target groups to determine if clients in those groups are achieving higher levels of functioning and improving their quality of life by June 30, 1982.

Objective 11: To have analyzed client outcome information for two additional target groups to determine if clients in those groups are achieving higher levels of functioning and improving their quality of life by June 30, 1983.

Objective 12: To have analyzed client outcome information for all target groups to determine if clients in those groups are achieving higher levels of functioning and improving their quality of life by June 30, 1985.

2. MENTAL HEALTH SERVICE GOAL #1.

TO SERVE MODERATELY AND SEVERELY PSYCHIATRICALLY DISABLED CLIENTS AND/OR CLIENTS WITH THE LEAST ABILITY TO PAY TO THE MAXIMUM DEGREE THAT THE RESOURCES ALLOW AND IN A MANNER THAT ENSURES THE PROVISION OF ADEQUATE SERVICES TO GROUPS THAT HAVE BEEN UNDERSERVED OR INAPPROPRIATELY SERVED, SUCH AS CHILDREN, THE ELDERLY, ETHNIC MINORITIES, RURAL RESIDENTS, AND WOMEN.

Objective 1: To have contracted with comprehensive mental health centers for outreach programs for at least 250 chronically mentally ill nursing home residents by October 1, 1980.

Objective 2: To have determined, with the State Mental Health Advisory Council, the adequacy of existing mechanisms for ensuring that clients with the least ability to pay are served to the maximum degree that the resources allow, by March 31, 1981.

[1]Objective 3: To have admitted and provided services to 4,604 children in FY 1980-81 by June 30, 1981.

([1]The numbers of clients to be served may be revised after all DMH/Center contracts have been finalized.)

[1]Objective 4: To have admitted and provided services to 6,654 adolescents in FY 1980-81 by June 30, 1981.

[1]Objective 5: To have admitted and provided services to 3,275 elderly in FY 1980-81 by June 30, 1981.

[1]Objective 6: To have admitted and provided services to 11,656 ethnic minorities in FY 1980-81 by June 30, 1981.

[1]Objective 7: To have admitted and provided services to 40,174 targeted moderately and severely disabled clients in FY 1980-81 by June 30, 1981.

[1]Objective 8: To have decreased the number of children served out of state from 125 in 1978-79 to 75 in 1980-81 by June 30, 1981.

Objective 9: To have achieved 70% prescreening of all admissions to the two state hospitals by June 30, 1981.

Objective 10: To have developed a plan, based on Fort Logan Mental Health Center's Princeton House Model, to increase the capacity of community living facilities for serving 40 senior citizens by June 30, 1981.

Objective 11: To have developed a plan for opening a second adult psychiatry halfway house in the Denver metropolitan area to serve as a transitional facility for Fort Logan Mental Health Center's patients by June 30, 1981.

Objective 12: To have developed a plan for increasing the capacity to serve moderately and severely disabled clients in intermediate care facilities by 50 beds per year for the next four years by June 30, 1981.

Objective 13: To have obtained funds for establishing two model programs for providing effective services to the elderly by June 30, 1981.

Objective 14: To have obtained funds for establishing two model programs for Spanish-speaking migrants and their families by June 30, 1981.

Objective 15: To have obtained funds for establishing relationships between two community mental health centers and two women's agencies and their respective programs that jointly provide services to women who are victims of abuse by June 30, 1981.

([1]The numbers of clients to be served may be revised after all DMH/Center contracts have been finalized.)

Objective 16: To have obtained funds for the provision of additional treatment programs in the areas of Colorado heavily impacted by energy development by June 30, 1981.

[2]Objective 17: To have admitted and provided services to 7,874 children in FY 1981-82 by June 30, 1982.

[2]Objective 18: To have admitted and provided services to 7,588 adolescents in FY 1981-82 by June 30, 1982.

[2]Objective 19: To have admitted and provided services to 9,243 elderly in FY 1981-82 by June 30, 1982.

[2]Objective 20: To have admitted and provided services to 11,656 ethnic minorities in FY 1981-82 by June 30, 1982.

[2]Objective 21: To have admitted and provided services to 48,497 targeted moderately and severely disabled clients in FY 1981-82 by June 30, 1982.

[2]Objective 22: To have decreased the number of children served out of state from 100 in 1979-80 to 50 in 1981-82 by June 30, 1982.

[2]Objective 23: To have increased the number of children served in the community, as opposed to institutions, from 94.4% in 1978-79 to 97.2% in 1981-82 by June 30, 1982.

Objective 24: To have achieved 90% prescreening of all admissions to the two state hospitals by June 30, 1982.

*Objective 25: To have expanded the capacity to provide mental health services to sex offenders committed under state statutes by 35 beds by June 30, 1982.

**Objective 26: To have established 50 new intermediate care facility beds for moderately and severely disabled clients by June 30, 1982.

**Objective 27: To have established two model programs for providing effective services to the elderly by June 30, 1982.

**Objective 28: To have established two model programs for Spanish-speaking migrants and their families by June 30, 1982.

**Objective 29: To have established relationships between two community mental health centers and two women's agencies and their respective programs that jointly provide services to women who are victims of abuse by June 30, 1982.

([2]The numbers of clients to be served are based upon DMH projections of need.)

*Objective 30: To have established additional treatment programs in the areas of Colorado heavily impacted by energy development by June 30, 1982.

*Objective 31: To have established two community residential facilities, based on Fort Logan Mental Health Center's Princeton House Model, with the capacity for serving 40 senior citizen residents by June 30, 1983.

*Objective 32: To have opened a second adult psychiatry halfway house, based on the plan developed by Fort Logan Mental Health Center, by June 30, 1983.

*Objective 33: To have established 50 additional intermediate care facility beds for moderately and severely disabled clients by June 30, 1983.

*Objective 34: To have doubled the size of the Developmental Disabilities/ Fort Logan Psychiatric Service by June 30, 1983.

*Objective 35: To have established 50 additional intermediate care facility beds for moderately and severely disabled clients by June 30, 1984.

*Objective 36: To have established 50 additional intermediate care facility beds for moderately and severely disabled clients by June 30, 1985.

*Objective 37: To have established a program for forensic psychiatry in the Denver metropolitan area by June 30, 1985.

*Objective 38: To have specialized programs for children, the elderly, ethnic minorities, and women available in all catchment areas by June 30, 1985.

3. MENTAL HEALTH SERVICE GOAL #2.

TO PROVIDE PRIMARY PREVENTION SERVICES BASED ON PROGRAMS THAT HAVE DEMONSTRATED EFFECTIVENESS IN PROMOTING MENTAL WELL-BEING OR PREVENTING MENTAL ILLNESS.

Objective 1: To have disseminated information to centers/clinics on primary prevention programs which have been demonstrated to be effective by July 1, 1980.

Objective 2: To have provided 77,884 units (staff hours) of Consultation and Education to citizens and agencies throughout the state by June 30, 1981.

Objective 3: To have developed a five-year plan for providing primary prevention services (based on programs that have been demonstrated to be effective) throughout the state by June 30, 1981.

Objective 4: To have obtained funds for establishing two primary prevention models for children and their families based on programs that have been demonstrated to be effective by June 30, 1981.

**Objective 5: To have contracted for two primary prevention models for children and their families based on programs that have been demonstrated to be effective by June 30, 1982.

Objective 6: To have provided 85,672 units (staff hours) of Consultation and Education to citizens and agencies throughout the state by June 30, 1982.

*Objective 7: To have contracted for two additional primary prevention programs by June 30, 1983.

*Objective 8: To have expanded the number of catchment areas that provide primary prevention programs by June 30, 1984.

*Objective 9: To have primary prevention programs available in at least ten catchment areas by June 30, 1985.

4. MENTAL HEALTH SYSTEM GOAL #1.

TO ENSURE THE DELIVERY OF HIGH QUALITY CLIENT CARE THROUGH THE EFFECTIVE FUNCTIONING OF THE ELEMENTS OF THE MENTAL HEALTH SYSTEM.

Objective 1: To monitor the program quality assurance systems for 23 centers/clinics by September 30, 1980.

Objective 2: To monitor the clinical quality assurance systems for 23 centers/clinics by September 30, 1980.

Objective 3: To have evaluated the program quality assurance systems in the centers, clinics, hospitals, and DMH Central Office by September 30, 1980.

Objective 4: To have implemented an individual patient outcome review in the centers and clinics by September 30, 1980.

Objective 5: To have implemented a Medicaid review of individual patients' treatment by September 30, 1980.

Objective 6: To have evaluated the clinical quality assurance systems in the centers, clinics, and hospitals by June 30, 1981.

Objective 7: To have analyzed existing data to evaluate the mental health services provided to rural residents by June 30, 1981.

Objective 8: To have quality criteria for guiding programs in serving minorities in the 23 centers/clinics by June 30, 1981.

Objective 9: To have quality criteria for guiding programs in serving the elderly in the 23 centers/clinics by June 30, 1981.

Objective 10: To have quality criteria for guiding programs in serving women in the 23 centers/clinics by June 30, 1981.

Objective 11: To have developed a plan for a closed circuit television conference network by June 30, 1981.

Objective 12: To have integrated individual patient outcome reviews with Medicaid reviews of individual patients' treatment and with other required patient review procedures by September 30, 1981.

Objective 13: To have evaluated and appropriately revised the statewide program quality assurance system by June 30, 1982.

Objective 14: To have evaluated and appropriately revised the statewide clinical quality assurance system by June 30, 1982.

*Objective 15: To have established a comprehensive internal data system integrated with ADP-DI, including CRTs and a micro-computer, for use Division-wide (Fort Logan Mental Health Center, Colorado State Hospital, and the Central Office) by June 30, 1982.

*Objective 16: To have established a research and evaluation program at Fort Logan Mental Health Center by June 30, 1982.

*Objective 17: To have implemented a closed circuit television conference network to reduce gasoline consumption and ensure effective functioning of the mental health system by June 30, 1982.

Objective 18: To have ensured community responsibility by contracting for specific outcomes including the development of local plans and a coordinated service system through linkages and agreements with other agencies, as negotiated with the service providers, by June 30, 1983.

Objective 19: To have developed a mechanism jointly with the service providers to evaluate the delivery of high quality client care by June 30, 1984.

Objective 20: To have ensured the delivery of high quality client care by contracting for specific outcomes including the number of people served in groups with high need and the number of those people rehabilitated and/or significantly improved, as negotiated with the service providers, by June 30, 1985.

*Objective 21: To have implemented a Program Analysis System statewide by June 30, 1985.

5. MENTAL HEALTH SYSTEM GOAL #2.

> TO REGULATE AGENCIES PROVIDING PSYCHIATRIC CARE WHERE THEIR PROGRAMS BEAR ON THE PUBLIC INTEREST, INCLUDING THE PROTECTION OF PATIENTS' RIGHTS.

Objective 1: To have designed a data collection system to measure the impact of SB 26 in the mental health system by September 30, 1980.

Objective 2: To have reviewed the affirmative action plans of the 23 centers/clinics by December 31, 1980.

Objective 3: To have monitored compliance with the Standards for the Care and Treatment of the Mentally Ill for 30 designated facilities by January 1, 1981.

Objective 4: To have certified to the Department of Health that the centers/clinics are in compliance with state standards by January 1, 1981.

Objective 5: To have analyzed service components of HUD Section 8 and 202 programs by March 23, 1981.

Objective 6: To have reviewed the data collection system for 27-10 to determine alternatives for its integration with the Division's information system by March 31, 1981.

Objective 7: To have revised the Standards/Rules and Regulations for Mental Health Centers by March 31, 1981.

Objective 8: To have developed plans for establishing a law library at Colorado State Hospital for patients' rights purposes by June 30, 1981.

Objective 9: To have developed plans for establishing an internal advocacy program for mental health clients by June 30, 1981.

Objective 10: To have certified to the Department of Health that the

centers/clinics are in compliance with state standards by January 1, 1982.

Objective 11: To have revised the DMH Management Services Audit Manual in accordance with the revised Standards/Rules and Regulations by March 31, 1982.

**Objective 12: To have established a law library at Colorado State Hospital for patients' rights purposes by June 30, 1982.

*Objective 13: To have established an internal advocacy program for mental health clients by June 30, 1982.

Objective 14: To have integrated all monitoring functions within the Division of Mental Health by June 30, 1983.

Objective 15: To have evaluated the impact of performance contracting on the mental health delivery system by June 30, 1983.

6. MENTAL HEALTH SYSTEM GOAL #3.

TO HAVE COST-EFFECTIVE TREATMENT AND SUPPORT SYSTEMS FOR THE DELIVERY OF MENTAL HEALTH SERVICES TO MODERATELY AND SEVERELY DISABLED CLIENTS OF ALL AGES AVAILABLE STATEWIDE.

Objective 1: To have submitted an implementation plan, developed in accordance with the recommendations in the "Client Employment Review," to the Department of Institutions by August 1, 1980.

Objective 2: To have drafted a State Mental Health Advisory Council position on the responsibilities of Fort Logan Mental Health Center and the mental health centers in the Fort Logan Service Area regarding long-term clients by September 30, 1980.

Objective 3: To have developed an operational definition for identifying Community Support System (CSS) clients, including the difficult-to-place clients, using data available in the information system by March 31, 1981.

*Objective 4: To have provided specific quarterly Community Support System training through the two local Community Support System sites for centers around the state by April 30, 1981.

Objective 5: To have provided technical assistance for the development of a rural Community Support System model by April 30, 1981.

Objective 6: To have developed guidelines and criteria for socialization programs for long-term clients by April 30, 1981.

Objective 7: To have developed liaison relationships with existing and potential statewide support groups for families and friends of clients by April 30, 1981.

Objective 8: To have performed a cost-benefit analysis of community support services for long-term clients in three selected sites by April 30, 1981.

Objective 9: To have increased by four the number of community mental health center programs having essential components for treatment and support systems for adults by June 30, 1981.

Objective 10: To have evaluated the impact of Colorado Community Support Systems on state-level policies (e.g., case management) and programs (e.g., specialty long-term client teams) by June 30, 1981.

Objective 11: To have established additional elements of a statewide Psychiatric Vocational Rehabilitation System by June 30, 1981.

Objective 12: To have addressed further the unique needs of ethnic minority community support system clients by June 30, 1981.

Objective 13: To have provided consultation, upon request, to community mental health centers regarding residential programs for the elderly through Colorado State Hospital by June 30, 1981.

Objective 14: To have determined the need for establishing a short-term inpatient service at Fort Logan Mental Health Center for use by the community mental health centers in replacing costly short-term community inpatient services by June 30, 1981.

Objective 15: To have determined the interest of community mental health centers in the development of a training program at Fort Logan Mental Health Center for the severely and moderately disabled to successfully function in the community by June 30, 1981.

Objective 16: To have obtained alternate funding for the Patient Hospital Community Library at Fort Logan Mental Health Center by July 15, 1981.

Objective 17: To have established a consortium, involving Colorado State Hospital and Spanish Peaks Mental Health Center, for moderately and severely disabled adults who no longer require hospitalization by July 31, 1981.

Objective 18: To have established a training program through Fort Logan Mental Health Center for the moderately and severely mentally disabled for successful functioning in community programs by September 30, 1981.

Objective 19: To have established a short-term inpatient service at Fort Logan Mental Health Center for use by community mental health centers in replacing costly short-term community inpatient services by September 30, 1981.

**Objective 20: To have established a self-contained Mental Health Services for the Deaf Residential Program at Fort Logan Mental Health Center by December 31, 1981.

**Objective 21: To have established additional elements of a statewide Psychiatric Vocational Rehabilitation System by June 30, 1982.

Objective 22: To have expanded the Mental Health Services for the Deaf to become a Region VIII program by June 30, 1982.

*Objective 23: To have increased by four the number of community mental health center programs having essential components for treatment and support systems for adults by June 30, 1982.

*Objective 24: To have established a separate open adolescent program at Colorado State Hospital for the 16 and 17-year-old patients by June 30, 1982.

*Objective 25: To have increased housing availability for an additional 100 psychiatric clients, including difficult-to-place clients, by June 30, 1982.

*Objective 26: To have increased by four the number of community mental health programs having essential components for treatment and support systems for adults by June 30, 1983.

*Objective 27: To have integrated services provided by the state-funded system with those offered within the private sector for community support system projects by June 30, 1983.

Objective 28: To have established a statewide housing policy by June 30, 1983.

*Objective 29: To have increased by four the number of community mental health programs having essential components for treatment and support systems for adults by June 30, 1984.

*Objective 30: To have established agriculturally-oriented living/working facilities for the moderately and severely disabled in rural areas of the state by June 30, 1984.

*Objective 31: To have a fully established statewide Psychiatric Vocational Rehabilitation System by June 30, 1985.

*Objective 32: To have implemented Colorado Community Support System program components statewide by June 30, 1985.

7. MENTAL HEALTH SYSTEM GOAL #4.

TO ENSURE THE APPROPRIATE UTILIZATION OF ALL AVAILABLE RESOURCES BY CLIENTS MOST IN NEED.

Objective 1: To have evaluated utilization patterns for various client groups using unit-of-service data obtained from the Client Status Report by August 31, 1980.

Objective 2: To have developed recommendations, based on survey data, related to clients responsible for violent crimes by September 1, 1980.

Objective 3: To have implemented an acceptable system for the allocation of state hospital beds in the Fort Logan Service Area on a catchment area basis, dependent on local needs and resource availability by September 30, 1980.

Objective 4: To have developed an implementation plan for addressing the recommendations which result from the Governor's Executive Order dated April 14, 1980, related to violence committed by former mental patients, by December 15, 1980.

Objective 5: To have developed an implementation plan for addressing the recommendations which result from the Senate Resolution regarding the legislative study of the Colorado laws concerning the mentally ill, by December 15, 1980.

Objective 6: To have revised the Client Admission Form to reflect changes in data needs since the introduction of the form in 1974 by January 31, 1981.

Objective 7: To have evaluated resource utilization patterns based upon the Client Status Report and samples drawn from priority client populations by February 28, 1981.

Objective 8: To have developed documentation to clarify the operation and interrelationships of the various components of the information system, including fiscal by April 30, 1981.

Objective 9: To have established a mechanism for distributing the DMH licensed psychiatric beds, based on needs and resource availability by April 30, 1981.

Objective 10: To have data available to comply with ongoing requests for the newly developed Department of Institutions Information System by June 30, 1981.

Objective 11: To have begun implementing a long-range plan for research in forensic psychiatry at Colorado State Hospital by June 30, 1981.

Objective 12: To have addressed with the Legislature a plan which would permit Colorado State Hospital and Fort Logan Mental Health Center to retain an incentive percentage of revenues realized above the appropriated level and to use these revenues to improve service delivery by June 30, 1981.

Objective 13: To have developed plans for a new psychiatric rehabilitation workshop facility for use in the Denver metropolitan area by June 30, 1981.

Objective 14: To have developed a complete Management Information System which fully integrates the billing and reporting systems for the centers/clinics by July 31, 1981.

Objective 15: To have revised the system for allocating state hospital beds on a catchment area basis, dependent on local needs and resource availability by September 30, 1981.

*Objective 16: To have refunded a separate specialty treatment program at Colorado State Hospital for the Chicano ethnic group by June 30, 1982.

Objective 17: To have made specific recommendations on the needs for a forensic treatment program in the Denver metropolitan area by June 30, 1982.

*Objective 18: To have remodeled multiple buildings, as designated in Fort Logan Mental Health Center's 20-year construction plan, to meet current clinical demands by June 30, 1982.

*Objective 19: To have completed the capital construction project for the Geriatrics Treatment Center at the Colorado State Hospital, to meet the safety, heating, lighting, and environmental needs of elderly psychiatric patients, as well as meet the JCAH standards by June 30, 1982.

*Objective 20: To have completed the capital construction project for the Drug and Alcohol Treatment Center at Colorado State Hospital, to better meet the needs of these patients as well as the JCAH standards by June 30, 1982.

*Objective 21: To have completed the capital construction project to improve the recreation facilities of the Child and

Adolescent Treatment Center at Colorado State Hospital by June 30, 1982.

*Objective 22: To have established a solid waste boiler plant at the Colorado State Hospital by June 30, 1982.

*Objective 23: To have completed the capital construction project to establish an open adolescent program at Colorado State Hospital by June 30, 1982.

*Objective 24: To have completed installation of sprinkler systems in three of the five cottages of the Child and Adolescent Treatment Center at Colorado State Hospital by June 30, 1982.

*Objective 25: To have completed construction of a Denver Metropolitan Forensic Psychiatry Facility by June 30, 1984.

Objective 26: To have obtained funding for an office building on the grounds of Fort Logan Mental Health Center to be used by the Department of Institutions and the Divisions of Mental Health, Youth Services, and Developmental Disabilities by June 30, 1984.

*Objective 27: To have opened new child and adolescent psychiatric facilities at Fort Logan Mental Health Center, to replace inadequate facilities for children and to permit existing buildings used by adolescent psychiatry to be used for adult services, by June 30, 1985.

8. MENTAL HEALTH SYSTEM GOAL #5.

TO PROVIDE MENTAL HEALTH SERVICES TO THE CITIZENS MOST IN NEED IN EACH CATCHMENT AREA THROUGH JOINT STATE AND LOCAL PLANNING, INCLUDING NEEDS AND RESOURCE DISTRIBUTION.

Objective 1: To have jointly revised the guidelines for developing mental health catchment area plans with the centers and the State Mental Health Advisory Council by September 30, 1980.

Objective 2: To have revised the social indicators model for community need assessment and recalculated the estimates of populations in need to be consistent with the revised social indicators by September 30, 1980.

Objective 3: To have each mental health center submit a plan, which has been reviewed by the area HSA, for mental health

services in its catchment area to the State Mental Health Advisory Council by December 31, 1980.

Objective 4: To have developed a funding formula for FY 1982-83 that employs population-in-need estimates and resources utilization data by February 28, 1981.

Objective 5: To have the first draft of the State Mental Health Plan Update for 1981, based on catchment area plans and HSA plans, available for review by April 1, 1981.

Objective 6: To have provided the members of the Statewide Health Coordinating Council involved with mental health planning with information on the mental health planning process and the key issues for the Colorado mental health system by April 30, 1981.

Objective 7: To have worked with the State Health Planning and Development Agency in making the necessary revisions of the mental health component of the State Health Plan, based upon the Comprehensive State Mental Health Operating Plan and the HSA's mental health plan sections by April 30, 1981.

Objective 8: To have participated in the development of community surveys in catchment areas performing such surveys by June 30, 1981.

Objective 9: To have applied for federal funds to support local need assessment surveys which will impact on the social indicators methodology by June 30, 1981.

Objective 10: To jointly have revised, as necessary, the guidelines for developing mental health catchment area plans with the centers and the State Mental Health Advisory Council by September 30, 1981.

Objective 11: To have each mental health center submit a plan, which has been reviewed by the area HSA, for mental health services in its catchment area to the State Mental Health Advisory Council by December 31, 1981.

Objective 12: To have revised mental health need assessment data based on local need data, the social indicators model, and the 1980 U.S. Census data by March 31, 1982.

Objective 13: To have provided the members of the Statewide Health Coordinating Council involved with mental health planning with information about the key issues for the Colorado mental health system by April 30, 1982.

Objective 14: To have worked with the State Health Planning and Development Agency in making the necessary revisions of the

mental health component of the State Health Plan, based upon the Comprehensive State Mental Health Operating Plan and the HSA's mental health sections by April 30, 1982.

*Objective 15: To have completed local need assessment surveys in all catchment areas by June 30, 1985.

9. MENTAL HEALTH SYSTEM GOAL #6.

TO MAXIMIZE LIMITED RESOURCES BY COORDINATING THE PLANNING AND DELIVERY OF MENTAL HEALTH SERVICES WITH OTHER HUMAN SERVICE AGENCIES.

Objective 1: To have developed a specialized cooperative agreement with the Division of Criminal Justice (DCJ) to ensure coordination in planning, data exchange, and training resources by September 30, 1980.

Objective 2: To have identified areas of need for cooperative agreements from the results of the community survey conducted with Social Services, the judiciary, and county commissioners by October 31, 1980.

Objective 3: To have conducted a survey of agencies that interact with the Division of Mental Health in order to gain their perceptions of the working relationship and to solicit their recommendations on how the relationship might be enhanced by November 30, 1980.

Objective 4: To have developed a plan with the Denver Juvenile Court to address the problems which exist for the juvenile court vis-a-vis the mental health system and vice versa by December 31, 1980.

Objective 5: To have revised, as necessary, the specialized cooperative agreements with the Division of Alcohol and Drug Abuse, Criminal Justice, Medical Assistance, Rehabilitation, and Services to the Aging by January 31, 1981.

Objective 6: To have developed recommendations surrounding further integration of services between mental health and alcohol and drug abuse agencies by March 1, 1981.

Objective 7: To have developed a uniform set of guidelines to facilitate the sharing of client information between affiliated mental health and alcohol and drug abuse agencies by May 1, 1981.

Objective 8: To have implemented the Colorado VR-MH Cooperative Agreement at the local level throughout the state by June 30, 1981.

Objective 9: To have studied the feasibility of a uniform fee schedule for mental health and alcohol/drug abuse clients who are being seen for similar or related services by June 30, 1981.

Objective 10: To have addressed the need of district courts in the Denver metropolitan area for psychiatric evaluations for deferred prosecution and conditions of probation by June 30, 1981.

Objective 11: To have developed a plan to establish a Fort Logan psychiatric team to provide evaluation services to Metropolitan Denver area district courts by June 30, 1981.

Objective 12: To have established a combined Developmental Disabilities/ Fort Logan treatment unit to provide specific treatment for the mentally disordered Developmental Disabilities client by June 30, 1981.

Objective 13: To have developed a plan for providing psychiatric services through the Fort Logan Mental Health Center for other agencies of the Department of Institutions in the Denver metropolitan area by June 30, 1981.

Objective 14: To have revised, as necessary, the specialized cooperative working agreements with the Divisions of Alcohol and Drug Abuse, Criminal Justice, Medical Assistance, Rehabilitation, and Services to the Aging by June 30, 1982.

**Objective 15: To have established psychiatric services for other agencies of the Department of Institutions in the Denver metropolitan area through Fort Logan Mental Health Center by June 30, 1983.

**Objective 16: To have established a team at Fort Logan Mental Health Center to work with all other courts in the Metropolitan Denver area for evaluations, including deferred prosecution and conditions of probation by June 30, 1983.

*Objective 17: To have begun providing medical services through Fort Logan Mental Health center to all agencies of the Division of Youth Services in the Denver metropolitan area by September 1, 1983.

10. MENTAL HEALTH SYSTEM GOAL #7.

> TO INCREASE FUNDING, INCLUDING BUT NOT LIMITED TO MEDICAID AND MEDICARE, TO MENTAL HEALTH AND TO ESTABLISH CRITERIA FOR THE REGULATION OF THAT FUNDING BY THE STATE MENTAL HEALTH SYSTEM.

Objective 1: To have improved the Medicaid plan to maximize the benefits to eligible mentally disabled clients at both centers and hospitals by June 30, 1981.

Objective 2: To have increased Medicaid dollars for the community mental health system from $400,000 in FY 1978 to $2,500,000 by June 30, 1981.

Objective 3: To have maintained patient revenues in 80-81 at a level proportionate to revenue-producing patient workload of 79-80 compared to 80-81 by June 30, 1981.

Objective 4: To have identified specific methods for expanding the sources of funding for the mental health system by June 30, 1981.

Objective 5: To have increased patient fee collections by 10%, as compared to the previous fiscal year, in community mental health centers by June 30, 1981.

Objective 6: To have established eligibility for Colorado State Hospital to become the representative payee for federal benefits accruing to individuals who are patients of the hospital as a result of criminal court actions by July 1, 1981.

Objective 7: To have developed appropriate overhead rates from various federal or third-party reimbursement sources in cash funding from the two hospitals in order to completely fund the operation of the DMH Central Office by December 31, 1981.

Objective 8: To have implemented a system to improve patient fee collections by an additional 10% in community mental health centers by June 30, 1982.

Objective 9: To have increased Medicaid dollars for the community mental health system from $400,000 in FY 1978 to $4,500,000 by June 30, 1982.

Objective 10: To have increased HUD dollars for mental health clients from $2,000,000 in FY 1978 to $2,500,000 by June 30, 1982.

Objective 11: To have improved the Medicaid plan to maximize the benefits to eligible mentally disabled clients at both centers and hospitals by June 30, 1982.

11. MENTAL HEALTH SYSTEM GOAL #8.

> TO PROVIDE SERVICES TO TARGET POPULATION CLIENTS AT REASONABLE COSTS THROUGHOUT THE STATE MENTAL HEALTH SYSTEM.

Objective 1: To have implemented the first year of a resource distribution system for the allocation of state resources to catchment areas by July 31, 1980.

Objective 2: To have completed a feasibility study for fully integrating the mental health centers and the two state hospitals financially to ensure that funding follows the clients, by January 1, 1981.

Objective 3: To have submitted a report detailing costs of the non-hospital 24-hour patient care programs to the Joint Budget Committee by January 1, 1981.

Objective 4: To have implemented the use of SCOPE as a management measure for the two state hospitals, if adequate staffing is available, by June 30, 1981.

Objective 5: To have begun implementation of a short and long-term capital construction and controlled maintenance program at Colorado State Hospital and Fort Logan Mental Health Center that will insure a safe, modern physical environment for all modalities of patient treatment by June 30, 1981.

Objective 6: To have developed a five-year division-wide plan for energy conservation by June 30, 1981.

Objective 7: To carry out energy conservation steps, within available resources, at Fort Logan Mental Health Center which have been determined, by previous studies, to be effective by June 30, 1981.

Objective 8: To further develop and refine energy concepts for the production of all power equipment requirements at Colorado State Hospital by June 30, 1981.

Objective 9: To have reduced the miles driven by state employees by an additional 5% as compared with the base year of 1978-79 by June 30, 1981.

Objective 10: To have reduced the gallons of fuel used by state vehicles by an additional 5% as compared with the base year of 1978-79 by June 30, 1981.

Objective 11: To have implemented the second year of a resource redistribution system for the allocation of state resources to catchment areas by July 31, 1981.

*Objective 12: To have completed a feasibility study of cash funding the state hospitals by June 30, 1982.

Objective 13: To have revised DMH accounting, cost accounting, and auditing guidelines by June 30, 1982.

Objective 14: To have implemented the first year of the five-year division-wide plan for energy conservation by June 30, 1982.

Objective 15: To have reduced the miles driven by state employees by an additional 5% over the previous fiscal year by June 30, 1982.

Objective 16: To have reduced the gallons of fuel used by state vehicles by an additional 5% over the previous fiscal year by June 30, 1982.

**Objective 17: To have implemented a short and long-term capital construction and controlled maintenance program at Colorado State Hospital and at Fort Logan Mental Health Center that will insure a safe, modern physical environment for all modalities of patient treatment by June 30, 1982.

Objective 18: To have implemented the third year of the resource redistribution system for the allocation of state resources to catchment areas, based on local needs and resource availability, by July 31, 1982.

Objective 19: To have fully integrated the mental health centers and the two state hospitals financially, through implementation of an acceptable plan which ensures that funding follows the clients, by January 31, 1983.

Objective 20: To have implemented the fourth year of the resource redistribution system for the allocation of state resources to catchment areas, based on local needs and resource availability, by July 31, 1983.

Objective 21: To have redistributed state resources to catchment areas based on local needs and resource availability by July 31, 1984.

Objective 22: To have completed all activities for energy conservation

outlined in the five-year division-wide plan for energy conservation by June 30, 1985.

12. MENTAL HEALTH SYSTEM GOAL #9.

> TO DEVELOP THE STATE'S CAPACITY FOR MENTAL HEALTH WORK FORCE PLANNING AND DEVELOPMENT TO ENSURE THAT THE APPROPRIATE STAFF ARE AVAILABLE AND BEING UTILIZED EFFECTIVELY THROUGHOUT THE STATE MENTAL HEALTH SYSTEM.

Objective 1: To have completed the staffing standards study for all clinical support and administrative staff at Colorado State Hospital and Fort Logan Mental Health Center by September 30, 1980.

Objective 2: To have submitted an analysis and justification of the differences in administrative and support staff-to-client ratios between institutions of the Division of Mental Health and those of the Division for Developmental Disabilities to the Joint Budget Committee by November 1, 1980.

Objective 3: To have revised the plans for on-site activities and internal reviews of centers/clinics by November 1, 1980.

Objective 4: To have recommended changes in affirmative action plans for centers/clinics based on a review of current criteria by December 31, 1980.

Objective 5: To have had the Committee on Sexism submit specific recommendations to the State Mental Health Advisory Council for improving services to women including treatment and program planning and the administrative status of women in mental health agencies by January 31, 1981.

Objective 6: To have established a comprehensive data base of the mental health work force in Colorado by February 1, 1981.

Objective 7: To have provided technical assistance to the Mental Health Association on the survey of the private sector by February 1, 1981.

Objective 8: To have assembled information on mental health training programs and institutions of higher learning by February 1, 1981.

Objective 9: To have developed a comprehensive state plan for mental health work force development by April 30, 1981.

Objective 10: To have conducted studies of the mental health work force requirements for carrying out the service goals in this Plan (i.e., services to specific client groups - targeted clients, minorities, children, elderly, women, and rural residents) by June 30, 1981.

Objective 11: To have implemented strategies to correct problems in the work force identified by evaluation studies and the Work Force Advisory Committee by June 30, 1981.

Objective 12: To have provided training programs for specific treatment methods identified by the mental health centers and hospitals by June 30, 1981.

Objective 13: To have provided training programs focusing on appropriate program models for serving priority client populations by June 30, 1981.

Objective 14: To have provided training sessions for each of the following: children, adolescents, elderly, minority, and women populations by June 30, 1981.

Objective 15: To have provided training programs focusing on management issues by June 30, 1981.

**Objective 16: To have ensured sufficient physician coverage at both state hospitals to meet psychiatric standards by June 30, 1981.

Objective 17: To have addressed with the State Legislature a plan for providing 40 hours per year of continuing education time for each staff member with appropriate FTEs and dollars (at a 102% level) to assure the availability of the time by June 30, 1981.

Objective 18: To have developed a plan for providing an employee meal service at Fort Logan Mental Health Center in the hospital cafeteria on a non-profit corporation basis by June 30, 1981.

Objective 19: To have ensured that clinical support and administrative staffing assignments in both state hospitals are consistent with the staffing standards developed for these areas by June 30, 1981.

Objective 20: To have developed a training program for community mental health centers' personnel on how to provide effective aftercare services to patients released from the Institute of Forensic Psychiatry at Colorado State Hospital by July 1, 1981.

Objective 21: To have re-established the Employee Cafeteria Service at

Fort Logan under a non-profit corporation format by September 30, 1981.

**Objective 22: To have re-established the Psychiatric Technician Training Programs at both state hospitals by December 31, 1981.

Objective 23: To have revised the State Plan for Mental Health Work Force Development by March 31, 1982.

Objective 24: To have implemented work force evaluation studies as needed relevant to carrying out the service goals of this Plan by June 30, 1982.

Objective 25: To have implemented corrective work force strategies indicated in the State Plan for Work Force Development by June 30, 1982.

Objective 26: To have evaluated the effectiveness of corrective work force strategies by June 30, 1982.

*Objective 27: To have provided training programs to assist in achieving the goals and objectives of this Plan for the staffs of the centers, clinics, and hospitals by June 30, 1982.

**Objective 28: To have established an effective, comprehensive employee relations program at Fort Logan Mental Health Center, including all aspects of a progressive, productive personnel system, to improve employee satisfaction by June 30, 1982.

**Objective 29: To have brought clinical staffing up to acceptable levels in both state hospitals by implementing SCOPE staffing standards by June 30, 1982.

Objective 30: To have provided training designed to meet the needs identified in the work force evaluation studies and specified in the revised State Plan for Work Force Development by June 30, 1983.

Objective 31: To have significantly reduced the gap between mental health personnel needs and the availability of mental health personnel, especially in rural areas, by June 30, 1985.

Objective 32: To have increased the number of professionals specifically trained to work with children, adolescents, the elderly, ethnic minorities, targeted clients, and women by June 30, 1985.

C. COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : To improve clients' quality of life through effective and high quality services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
Status Goal #1. TO MAXIMIZE THE CLIENTS' CAPACITY TO IMPROVE THEIR QUALITY OF LIFE THROUGH ACHIEVING HIGHER LEVELS OF FUNCTIONING IN AREAS SUCH AS WORK OR SCHOOL INVOLVEMENT, FAMILY AND SOCIAL RELATIONSHIPS, DAILY LIVING ACTIVITIES, AND RECREATION.	(1) To have determined if clients in the state mental health system are achieving higher levels of functioning and improving their quality of life by implementing a client outcome evaluation system which includes quality-of-life and level-of-functioning measures.	7/31/80	-System in place on a pilot basis in three sites. (WICHE)	Program Services ($10,000)	The combination of quality-of-life and level-of-functioning should provide adequate outcome data. The quality-of-life can be matched to local needs and data uses while the level-of-functioning is standard across agencies.
	(2) To have determined the impact of the Colorado Community Support System (CCSS) by comparing treatment outcome of CCSS and non-CCSS clients using existing statewide level-of-functioning measures and proposed quality-of-life data.	3/1/81	-Written report	Program Services ($2,000)	This target group has been the focus of special programming. The impact of those programs on clients' lives needs to be examined.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(3) To have collaborated with the Western Interstate Commission for Higher Education (WICHE) and the National Institute of Mental Health (NIMH) in a preliminary assessment of the uses and limitations of outcome/quality-of-life data at the local agency level.	3/31/81	-Final report of WICHE/NIMH/DMH quality of life study	Program Services ($1,000)	Increased emphasis is needed on the usefulness of data collection efforts at the local level. This feasibility study will be used to determine the uses and limitations of outcome/quality-of-life data at the local agency level.
	(4) To have collaborated with WICHE/NIMH in determining the degree to which outcome/quality-of-life data can be both responsive to local needs and compatible across the state.	3/31/81	-Final report of WICHE/NIMH/DMH quality-of-life study	Program Services ($2,000)	The study will be used to determine whether this type of client outcome evaluation system can be implemented on a statewide basis and also be responsive to local needs.
	(5) To have evaluated the impact of SB 26 on the mental health system in terms of patients served and programs offered.	6/30/81	-Written report	Program Services ($2,000)	This is an important new piece of legislation with considerable ramification for the way the mental health system deals with children. The first stage in the evaluation should examine process variables.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(6) To have developed a method for integrating Client Status Report data that provides cost/outcome data.	6/30/81	-Written report	Program Services ($2,000)	The development of a measure to determine cost-effectiveness of treatment can be used as a management tool to improve the efficiency of the mental health system.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : To improve clients' quality of life through effective and high quality services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #1. TO ENSURE THE DELIVERY OF HIGH QUALITY CLIENT CARE THROUGH THE EFFECTIVE FUNCTIONING OF THE ELEMENTS OF THE MENTAL HEALTH SYSTEM.	(1) To monitor the program quality assurance systems for 23 centers/clinics.	9/30/80	-Monitoring review completed	Program Services ($1,000)	The Program Quality Assurance System which was required of the 23 centers/clinics during FY 79-80 will have been monitored and reviewed as a statewide quality control measure.
	(2) To monitor the clinical quality assurance systems for 23 centers/clinics.	9/30/80	-Monitoring review completed	Program Services ($5,000)	The Clinical Quality Assurance System also will have been reviewed as a statewide quality control measure.
	(3) To have evaluated the program quality assurance system in the centers, clinics, hospitals and DMH Central Office.	9/30/80	-Written report with recommendations	Program Services ($1,000)	Program quality assurance has been deleted from the DMH/center contracts for FY 80-81, but it has not been deleted as a quality control measure for the system and will need to be evaluated for its usefulness.
	(4) To have implemented an individual patient outcome review in the centers and clinics.	9/30/80	-Reviews completed	Program Services ($8,000)	In addition to the treatment outcome data provided by each agency, a sample of individual patients' treatment will be reviewed in the centers and clinics.
	(5) To have implemented a Medicaid review of individual patient's treatment.	9/30/80	-Reviews completed	Program Services ($10,000)	The Division of Mental Health has assumed the responsibility for reviewing individual cases of Medicaid clients in accordance with an agreement with the Division of Medical Assistance of the Department of Social Services.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : _____

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(6) To have evaluated the clinical quality assurance systems in the centers, clinics and hospitals.	6/30/81	-Written report with recommendations -Systems in both hospitals integrated with JCAH quality assurance	Program Services CSH FLMHC ($5,000)	The impact of this program should be assessed to determine if the results justify the effort expended.
	(7) To have analyzed existing data to evaluate the mental health services provided to rural residents.	6/30/81	-Written report	Program Services ($1,000)	The unique problems of rural centers have been raised repeatedly. There is now sufficient information to address such issues as adequacy, accessibility and quality of service.
	(8) To have quality criteria for guiding programs in serving minorities in the 23 centers/clinics.	6/30/81	-Visits to 23 centers/clinics	Program Services ($3,000)	(8)-(10) The Division of Mental Health has identified clearly minorities, the elderly, and women as groups who have traditionally been underserved or inappropriately served. Mental health services to meet the needs of these priority groups must be expanded at all levels. One way to insure that these issues are being addressed in a quality manner is to provide quality criteria for guiding the programs for these special populations.
	(9) To have quality criteria for guiding programs in serving the elderly in the 23 centers/clinics.	6/30/81	-Visits to 23 centers/clinics	Program Services ($3,000)	
	(10) To have quality criteria for guiding programs in serving women in the 23 centers/clinics.	6/30/81	-Visits to 23 centers/clinics	Program Services ($3,000)	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(11) To have developed a plan for a closed circuit TV conference network.	6/30/81	-Written plan	Finance Services Program Services FLMHC CSH ($500)	Such a network would permit significant savings of staff time and gasoline now spent in traveling to and from meetings. The mental health system covers the whole state and the travel distances are great.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : To serve clients most in need as the highest priority.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
Service Goal #1. TO SERVE MODERATELY AND SEVERELY PSYCHIATRICALLY DISABLED CLIENTS AND/OR CLIENTS WITH THE LEAST ABILITY TO PAY TO THE MAXIMUM DEGREE THAT THE RESOURCES ALLOW AND IN A MANNER THAT ENSURES THE PROVISION OF ADEQUATE SERVICES TO GROUPS THAT HAVE BEEN UNDERSERVED OR INAPPROPRIATELY SERVED, SUCH AS CHILDREN, THE ELDERLY, ETHNIC MINORITIES, RURAL RESIDENTS, AND WOMEN.	(1) To have contracted with comprehensive mental health centers for outreach programs for at least 250 chronically mentally ill nursing home residents.	10/1/80 *****	-Signed contracts	Finance Services Program Services ($100,000)	This objective is based upon Footnote 83 of the 1980 Long Bill.
	(2) To have determined, with the State Mental Health Advisory Council, the adequacy of existing mechanisms for ensuring that clients with the least ability to pay are served to the maximum degree that the resources allow.	3/31/81	-Data submitted to SMHAC -SMHAC minutes	SMHAC Finance Services ($1,000)	The State Mental Health Advisory Council has requested a review of existing mechanisms to ensure that clients with the least ability to pay are receiving services paid for by the state.
	(3) To have admitted and provided services to 4,604 children in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($2,300,000)	(3)-(7) The Division of Mental Health negotiates with each community mental health center/clinic a contract which records specific expectations concerning the agency's provision of services during the coming fiscal year. The contract specifies a minimum number of admissions by age (children, adolescents, adults, and elderly), severity (moderately and severely psychiatrically disabled), and ethnic background (Chicano, Black, Asian, American Indian, and total ethnic minorities). The disbursement of funds is contingent upon the agency's successful completion of these and other terms of the contract.
	(4) To have admitted and provided services to 6,654 adolescents in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($5,200,000)	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	[1](5) To have admitted and provided services to 3,275 elderly in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($3,300,000)	
	[1](6) To have admitted and provided services to 11,656 ethnic minorities in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($11,500,000)	
	[1](7) To have admitted and provided services to 40,174 targeted moderately and severely disabled clients in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($52,000,000)	
	[1](8) To have decreased the number of children served out of state from 125 in 1978-79 to 75 in 1980-81.	6/30/81 *****	-Admission data	DMH Centers/ Clinics Hospitals (included in Objective 3)	Increasing the number of children served in-state is a mental health system priority.
	(9) To have achieved 70% prescreening of all admissions to the two state hospitals.	6/30/81 *****	-Admission data that reflects at least 70% prescreened entries	CSH FLMHC Centers/ Clinics ($40,000)	Increasing the percentage of prescreened admissions is a priority of the Division and the community mental health centers.

([1]The numbers of clients to be served may be revised after all DMH/Center contracts have been finalized.)

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(10) To have developed a plan, based on FLMHC's Princeton House model, to increase the capacity of community living facilities for serving 40 senior citizens.	6/30/81	-Plan developed -Budget request for the state share prepared for FY 82-83	FLMHC Centers/ Clinics ($1,000)	The Vine Street and Princeton House I residences have proved their value. Expansion of these facilities is required. They are a specialized service to the elderly of the metropolitan area.
	(11) To have developed a plan for opening a second Adult Psychiatry Halfway House in the Denver metropolitan area to serve as a transitional facility for Fort Logan Mental Health Center's patients.	6/30/81	-Plan developed -Budget request for the state share prepared for FY 82-83	FLMHC Centers/ Clinics ($1,000)	As the Adult Psychiatry population becomes more chronic, more transitional facilities are required.
	(12) To have developed a plan for increasing the capacity to serve moderately and severely disabled clients in intermediate care facilities by 50 beds per year for the next four years.	6/30/81	-Plan developed by 1/31/81 -Budget request prepared for FY 81-82	Program Services Finance Services FLMHC and CSH Centers/ Clinics ($5,000)	Fort Logan Mental Health Center has had a waiting list for over a year. Colorado State Hospital has been operating at capacity. The community mental health centers, in their catchment area plans, clearly stated a need for increasing the capacity to serve the targeted population. The transition of care between the state hospital setting and the community programs would be enhanced with ICF's.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(13) To have obtained funds for establishing two model programs for providing effective services to the elderly.	6/30/81	-Written grant proposal by 10/30/80 -Budget request prepared for FY 81-82	Program Services Finance Services ($1,000)	The elderly have been identified as an underserved population. Although their mental health needs are generally greater than other age groups, program models for treating them have not been developed sufficiently. New techniques and skills are required, as well as new linkages with the aging network, in order to provide adequate mental health services.
	(14) To have obtained funds for establishing two model programs for Spanish-speaking migrants and their families.	6/30/81	-Written grant proposal by 10/30/80 -Budget request prepared for FY 81-82	Program Services Finance Services ($1,000)	With the mental health system, there are several programs designed to provide special services to Chicanos, but none of them are focused on isolated, rural, impoverished populations. How to reach these people, what their specific mental health needs are, and how to treat their emotional problems are not well known.
	(15) To have obtained funds for establishing relationships between two community mental health centers and two women's agencies and their respective programs that jointly provide services to women who are victims of abuse.	6/30/81	-Written grant proposal by 10/30/80 -Budget request prepared for FY 81-82	Program Services Finance Services ($1,000)	There is a lack of appropriate services for women. Rapid social changes in the status of women have created serious mental health problems. Women are assuming new roles which create new tensions; on the other hand, old abuses such as sexism and victimization are increasingly exposed. Reporting of abuse, rape, and other violent crimes against women has increased dramatically.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(16) To have obtained funds for the provision of additional treatment programs in the areas of Colorado heavily impacted by energy development.	6/30/81	-Funding resources for energy-impacted areas identified -Written grant proposal	Program Services Finance Services ($1,000)	In areas experiencing rapid growth due to the development of coal, oil, oil shale, and electric power generation facilities, the admissions to community mental health centers have been increasing. This increase, which is expected to continue, is due to the increase in social stress and to the lack of alternative resources.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
Service Goal #2. TO PROVIDE PRIMARY PREVENTION SERVICES BASED ON PROGRAMS THAT HAVE DEMONSTRATED EFFECTIVENESS IN PROMOTING MENTAL WELL-BEING OR PREVENTING MENTAL ILLNESS.	(1) To have disseminated information to centers/clinics on primary prevention programs which have been demonstrated to be effective.	7/1/80	-Information disseminated	Program Services ($500)	State dollars for prevention should go to programs which have been demonstrated to be effective. Effective programs in mental health have been difficult to find because of the problems in translating abstract concepts into operational programs and because of the difficulties in defining what the areas are where mental health as a discipline has knowledge and skills that bear on this topic.
	(2) To have provided 77,884 units (staff hours) of Consultation and Education to citizens and agencies throughout the state.	6/30/81	-Signed contracts -C & E data	Program Services Finance Services Centers/Clinics ($1,500,000)	Staff hours are a measure of workload and provide a consistent system for reimbursement. The objective has been written to be consistent with data from the DMH/center contracts.
	(3) To have developed a five-year plan for providing primary prevention services (based on programs that have been demonstrated to be effective) throughout the state.	6/30/81	-Five-year plan	Program Services ($2,000)	Prevention programs will have to be phased in as funding and knowledge about mental health prevention increase.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(4) To have obtained funds for establishing two primary prevention models for children and their families based on programs that have been demonstrated to be effective.	6/30/81	-Written grant proposal by 10/30/80 -Budget request prepared for FY 81-82	Program Services Finance Services ($500)	There are two broad areas which hold promise for mental health in primary prevention: analysis and modification of social environments and competence building. Of the two, competence building is the area where knowledge and skill are the highest. There are programs with children which have clearly demonstrated success.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : To serve clients most in need as the highest priority.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #5. TO PROVIDE MENTAL HEALTH SERVICES TO THE CITIZENS MOST IN NEED IN EACH CATCHMENT AREA THROUGH JOINT STATE AND LOCAL PLANNING, INCLUDING NEEDS AND RESOURCE DISTRIBUTION.	(1) To have jointly revised the guidelines for developing mental health catchment area plans with the centers and the State Mental Health Advisory Council.	9/30/80	-Written guidelines for FY 1981-82	Planning Services Centers/ Clinics SMHAC ($2,000)	Guidelines were first established for catchment area plans in 1979. The guidelines will need to be reviewed and revised as a result of the first year's experience with the development of local plans.
	(2) To have revised the social indicators model for community need assessment and recalculated the estimated of populations in need to be consistent with the revised social indicators	9/30/80	-Revised model (written)	Program Services ($3,000)	The updated estimates will help insure that services are provided to those most in need.
	(3) To have each mental health center submit a plan, which has been reviewed by the area HSA, for mental health services in its catchment area to the State Mental Health Advisory Council.	12/31/80	-20 catchment area plans submitted to the SMHAC	Centers/ Clinics Planning Services SMHAC ($15,000)	Catchment area plans will continue to serve as the basis for the State Plan and the DMH/Center contract negotiations, as well as the management plan for the catchment area. Catchment area plans also have been added as a requirement of the DMH/Center contract.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(4) To have developed a funding formula for FY 1982-83 that employs population-in-need estimates and resource utilization data.	2/28/81	-Published estimates and formula	Program Services Finance Services Centers/ Clinics ($5,000)	Population in need estimates are continually updated and the model revised to produce increased meaningfulness. A methodology using population-in-need estimates and resource utilization will have to be developed and agreed upon by DMH and the Centers' Association.
	(5) To have the first draft of the State Mental Health Plan Update for 1981, based on catchment area plans and HSA plans, available for review.	4/1/81	-Draft available for review	Planning Services SMHAC ($6,000)	The draft of the update of the State Mental Health Plan needs to be available by April 1, 1981, to allow for sufficient review of the draft within the ADAMHA time frame.
	(6) To have provided the members of the Statewide Health Coordinating Council involved with mental health planning with information on the mental health planning process and the key issues for the Colorado mental health system.	4/30/81	-Presentation provided	Planning Services ($500)	Now that the SHCC performs a formal review of the State Mental Health Plan and makes a recommendation to the Secretary regarding its approval, it is important that the SHCC members involved in this process understand the mental health planning process and the key issues for mental health.

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(7) To have worked with the State Health Planning and Development Agency in making the necessary revisions of the mental health component of the State Health Plan, based upon the Comprehensive State Mental Health Operating Plan and the HSA's mental health plan sections.	4/30/81	-Written revisions	Planning Services ($1,500)	The DMH and the SHPDA have agreed to work together in reviewing and revising, as necessary, the mental health component of the State Health Plan to ensure that it is consistent with the Comprehensive State Mental Health Plan and the HSAs' mental health plan sections.
	(8) To have participated in the development of community surveys in catchment areas performing such surveys.	6/30/81	-Minutes/notes on Division of Mental Health participation	Program Services ($1,000)	The Division of Mental Health will encourage local community survey need assessment studies that will result in high quality comparable estimates of need that will be useful at the statewide level.
	(9) To have applied for federal funds to support local need assessment surveys which will impact on the social indicators methodology.	6/30/81	-Completed funding application	Program Services ($1,000)	If funded, data from such studies would improve and validate the social indicators methodology and would be useful to local communities for mental health planning.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # III : To provide clients with the most effective and least intensive care and treatment through a continuum of services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #3. TO HAVE COST-EFFECTIVE TREATMENT AND SUPPORT SYSTEMS FOR THE DELIVERY OF MENTAL HEALTH SERVICES TO MODERATELY AND SEVERELY DISABLED CLIENTS OF ALL AGES AVAILABLE STATEWIDE.	(1) To have submitted an implementation plan, developed in accordance with the recommendations in the "Client Employment Review", to the Department of Institutions.	8/1/80	-Written implementation plan submitted to the Dept. of Institutions	Program Services ($1,000)	The "Client Employment Review" project was conducted through a contract between the Colorado Department of Labor and Employment, the Office of Manpower Planning and Development, and the Colorado Department of Institutions. Each division within the Department of Institutions will develop an implementation plan in accordance with the recommendations for improving service delivery.
	(2) To have drafted a State Mental Health Advisory Council position on the responsibilities of Fort Logan Mental Health Center and the mental health centers in the Fort Logan Service Area regarding long-term clients.	9/30/80	-Position statement	SMHAC Program Services Centers/Clinics FLMHC ($500)	The SMHAC agreed to review the issue of the responsibilities of FLMHC and the centers in the FLMHC Service Area regarding long-term clients, as a result of issues raised during the Council's review of the State Plan.
	(3) To have developed an operational definition for identifying Community Support System (CSS) clients, including the difficult-to-place clients, using data available in the information system.	3/31/81	-Operational definition	Program Services ($1,000)	Such a definition will facilitate the planning of CSS programs statewide.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # III : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(4) To have provided specific quarterly Community Support System training through the two local Community Support System sites for centers around the state.	4/30/81	-Training schedule and evaluation results	Program Services ($5,000)	This will be a major thrust of third-year CCSS activities with joint involvement among DMH, Southwest Denver MHC, and Boulder MHC. Federal funds have been requested for this objective.
	(5) To have provided technical assistance for the development of a rural Community Support System model.	4/30/81	-Record of contacts	Program Services ($2,000)	Without additional dollars, the actual development cannot be assured. The need is significant enough to recognize the technical assistance efforts.
	(6) To have developed guidelines and criteria for socialization programs for long-term clients.	4/30/81	-Documented guidelines and criteria	Program Services ($2,000)	Socialization programs for chronic clients are scattered in focus as they currently exist around the state. An accepted framework is necessary for further program development.
	(7) To have developed liaison relationships with existing and potential statewide support groups for families and friends of clients.	4/30/81 *****	-Record of contacts	Program Services ($2,000)	Support groups for family and friends groups are part of a growing national movement, another essential component of Colorado Community Support Systems, and a necessary element in Colorado for further funding of programs for the chronically disabled.
	(8) To have performed a cost-benefit analysis of community support services for long-term clients in three selected sites.	4/30/81	-Feasibility statement of cost-benefit study	Program Services ($2,000)	The recognition of costs involved in providing CCSS services is important for planning and future program development. The Colorado Community Support System Project has a federal contract to complete this objective. CCSS has sub-contracted for the analysis which will involve the two Colorado CSP sites and Community Corporation.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # III : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(9) To have increased by four the number of community mental health center programs having essential components for treatment and support systems for adults.	6/30/81	-CCSS final report -Components in place in four mental health centers	Program Services ($200,000)	The treatment and support system model has been advanced as the basis for planning and developing services for mental health service areas. The Division must continue to fill in the gaps where the complete support system is not in place. The commitments through HUD 202 and Section 8 programs will facilitate this.
	(10) To have evaluated the impact of Colorado Community Support Systems on state-level policies (e.g., case management) and programs (e.g., specialty long-term client teams).	6/30/81	-Evaluation report	Program Services ($1,000)	CCSS has employed a number of different approaches to improve services to the long-term client. The results of this evaluation will facilitate future federal and state planning of the CSS program.
	(11) To have established additional elements of a statewide Psychiatric Vocational Rehabilitation System.	6/30/81	-CCSS final report -Elements in place	Program Services CSH FLMHC ($5,000)	These programs are a major treatment resource for the severely psychiatrically disabled.
	(12) To have addressed further the unique needs of ethnic minority community support system clients.	6/30/81	-Report of activities	Program Services ($1,000)	Recognized needs of ethnic minority clients require unique approaches and program development.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # III : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(13) To have provided consultation, upon request, to community mental health centers regarding residential programs for the elderly through Colorado State Hospital.	6/30/81	-Consultation provided	CSH ($2,000)	CSH has expertise in the area of residential programs for the elderly and will respond to requests for consultation from centers in the CSH Service Area.
	(14) To have determined the need for establishing a short-term in-patient service at Fort Logan Mental Health Center for use by the community mental health centers in replacing costly short-term community in-patient services.	6/30/81	-Determine usefulness by 10/31/80 -Obtain certificate of need by 4/30/81 -Establish agreements with community mental health centers for FY 1981-82 by 5/31/81	FLMHC Centers/ Clinics ($2,000)	Community mental health centers buy short-term in-patient services from a variety of private facilities. Fort Logan believes it can provide comparable services at a lower cost to the centers individually and overall to the State.
	(15) To have determined the interest of community mental health centers in the development of a training program at Fort Logan Mental Health Center for the severely and moderately disabled to successfully function in the community.	6/30/81	-Determine interest and usefulness by 11/30/80 -Formulate program in conjunction with CSS and mental health centers by 4/30/81 -Establish contracts by 5/31/81	FLMHC Centers/ Clinics ($500)	Many severely and moderately disabled people can live in the community with continuing psychiatric support if they have been trained in the skills necessary to function successfully in the community. Economically, it makes sense to centralize this training program rather than have each community mental health center establish its own small program. Fort Logan has a reservoir of staff skilled in working with these people.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : To maximize limited resources through coordinated public and private delivery systems and through accessing all available funding.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #6. TO MAXIMIZE LIMITED RESOURCES BY COORDINATING THE PLANNING AND DELIVERY OF MENTAL HEALTH SERVICES WITH OTHER HUMAN SERVICE AGENCIES.	(1) To have developed a specialized cooperative agreement with the Division of Criminal Justice (DCJ) to ensure coordination in planning, data exchange, and training resources.	9/30/80	-Written agreement	Planning Services Program Services ($500)	A close cooperative working relationship with the Division of Criminal Justice is a high priority within the Division for the coming fiscal year.
	(2) To have identified areas of need for cooperative agreements from the results of the community survey conducted with Social Services, the Judiciary, and County Commissioners.	10/31/80	-Survey report	Program Services Planning Services ($1,500)	A survey to identify problems and recommend solutions is being developed with these three groups. A follow-up strategy for using the information generated will be appropriate.
	(3) To have conducted a survey of agencies that interact with the Division of Mental Health in order to gain their perceptions of the working relationship and to solicit their recommendations on how the relationship might be enhanced.	11/30/80	-Written summary report	Program Services ($1,000)	This survey would provide needed feedback for the Division of Mental Health on the status of linkages and coordination with other agencies.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(4) To have developed a plan with the Denver Juvenile Court to address the problems which exist for the juvenile court vis-a-vis the mental health system and vice-versa.	12/31/80	-Written plan	FLMHC ($1,000)	The Denver Juvenile Court faces many questions of psychiatric evaluations and psychiatric treatments. Because they are inadequately linked to the mental health system, they don't get the assistance they need to handle these questions. A written plan to address problems would smooth the interface of the juvenile court and the mental health system and would lead to improved services for clients.
	(5) To have revised, as necessary, the specialized cooperative agreements with the Division of Alcohol and Drug Abuse, Criminal Justice, Medical Assistance, Rehabilitation, and Services to the Aging.	1/31/81	-Written agreements, if necessary	Program Services Planning Services ($2,000)	Updating the intent of specialized cooperative agreements will help maximize the benefits for service delivery for the systems involved.
	(6) To have developed recommendations surrounding further integration of services between mental health and alcohol and drug abuse agencies.	3/1/81	-Written report	Program Services ($1,000)	Even though several issues related to the integration of services between the mental health system and substance abuse system have been resolved, additional areas still need to be explored.
	(7) To have developed a uniform set of guidelines to facilitate the sharing of client information between affiliated mental health and alcohol and drug abuse agencies.	5/1/81	-Written guidelines	Program Services ($1,000)	Difficulties have arisen in the mental health/substance abuse system concerning the exchange of client information.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(8) To have implemented the Colorado VR-MH Cooperative Agreement at the local level throughout the state.	6/30/81	-Operationalization of Cooperative Agreements	Program Services ($3,000)	For viable vocational programming, an essential Colorado Community Support System component, this implementation is critical.
	(9) To have studied the feasibility of a uniform fee schedule for mental health and alcohol/drug abuse clients who are being seen for similar or related services.	6/30/81	-Written study	Finance Services Program Services ($1,000)	Some community mental health centers have contracts for providing mental health and alcohol/drug abuse services. Many of the clients served cross over into both of these areas, and are currently being charged fees based upon different fee schedules. It would be appropriate, therefore, to have one ability-to-pay schedule for these clients.
	(10) To have addressed the need of district courts in the Denver metropolitan area for psychiatric evaluations for deferred prosecution and conditions of probation.	6/30/81	-Documentation of meetings with district court judges	FLMHC ($1,000)	The district court faces many questions requiring psychiatric data. It is inadequately linked to the mental health system. Because of this, many people are improperly referred for psychiatric treatment. This interface can be profitably smoothed and coordinated.
	(11) To have developed a plan to establish a Fort Logan psychiatric team to provide evaluation services to Metropolitan Denver area district courts.	6/30/81	-Plan written by 5/31/81 -Budget request prepared for FY 82-83	FLMHC ($1,000)	A single psychiatric team which provided evaluations and handled liaison to the extent not covered by community mental health centers would very much enhance the services available to the district courts and would provide for appropriate use of mental health services.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(12) To have established a combined Developmental Disabilities/Fort Logan treatment unit to provide specific treatment for the mentally disordered Developmental Disabilities client.	6/30/81	-Funding possibilities clarified by 11/30/80 -Unit and program established	FLMHC ($5,000)	The need for this program has been clearly established. The general plan is completed. Only the funding source needs to be settled, as no new funds were requested.
	(13) To have developed a plan for providing psychiatric services through Fort Logan Mental Health Center for other agencies of the Department of Institutions in the Denver metropolitan area.	6/30/81	-Plan developed -Budget request prepared for FY 82-83	FLMHC Program Services ($1,000)	Many of the agencies do not currently have psychiatric services. Economies of centralization and scale could be realized and better integration with the mental health system achieved.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : To maximize limited resources througn coordinated public and private delivery systems and through accessing all available funding.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #7. TO INCREASE FUNDING, INCLUDING BUT NOT LIMITED TO MEDICAID AND MEDICARE, TO MENTAL HEALTH AND TO ESTABLISH CRITERIA FOR THE REGULATION OF THAT FUNDING BY THE STATE MENTAL HEALTH SYSTEM.	(1) To have improved the Medicaid plan to maximize the benefits to eligible mentally disabled clients at both centers and hospitals.	6/30/81	-Changes reflected in the State Medicaid Plan	Finance Services ($2,000)	This is needed to assure that both hospital and community programs are taking full advantage of available reimbursement benefits, and to offset general funding programs.
	(2) To have increased Medicaid dollars for the community mental health system from $400,000 in FY 1978 to $2,500,000.	6/30/81	-Increased Medicaid dollars	Finance Services ($4,000)	Increased Medicaid dollars would provide additional non-general fund dollars for maintenance and expansion of programs in the community.
	(3) To have maintained patient revenues in 80-81 at a level proportionate to revenue producing patient workload of 79-80 compared to 80-81.	6/30/81	-Level of patient revenues	CSH FLMHC	Patient revenues are a major element of funding.
	(4) To have identified specific methods for expanding the sources of funding for the mental health system.	6/30/81	-Written report	Finance Services Centers/ Clinics Program Services ($3,000)	The primary issue for mental health today is that the mental health service needs of the citizens are much greater than the resources available to meet the needs. New sources of funding need to be identified.
	(5) To have increased patient fee collections by 10%, as compared to the previous fiscal year, in community mental health centers.	6/30/81	-Patient fee collection data	Finance Services Centers/ Clinics ($5,000)	Patient revenues are a major element of funding for community mental health centers and clinics.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : To provide services efficiently.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #2. TO REGULATE AGENCIES PROVIDING PSYCHIATRIC CARE WHERE THEIR PROGRAMS BEAR ON THE PUBLIC INTEREST, INCLUDING THE PROTECTION OF PATIENTS' RIGHTS.	(1) To have designed a data collection system to measure the impact of SB 26 in the mental health system.	9/30/80	-Forms and instructions	Program Services ($1,000)	All children in out-of-home placement must be reviewed by the court if it appears they will not be out-of-home more than 90 days. This includes both voluntary and involuntary patients.
	(2) To have reviewed the Affirmative Action Plans of the 23 centers/clinics.	12/31/80	-Monitoring reviews completed	Program Services ($2,000)	These reviews are included in the Division of Mental Health's regulatory responsibilities.
	(3) To have monitored compliance with the Standards for the Care and Treatment of the Mentally Ill for 38 designated facilities.	1/1/81	-Monitoring reviews completed	Program Services ($20,000)	Monitoring compliance with these standards is included in the Division of Mental Health's regulatory responsibilities.
	(4) To have certified to the Department of Health that the centers/clinics are in compliance with state standards.	1/1/81	-Compliance reviews completed for 23 centers/clinics	Program Services ($5,000)	These reviews are required for compliance with Statute 24-1-201.
	(5) To have analyzed service components of HUD Section 8 and 202 programs.	3/23/81	-Monitoring reviews completed	Program Services ($1,000)	Accomplishment of this objective is necessary for determining that services are being adequately provided to maintain clients in the community.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(6) To have reviewed the data collection system for 27-10 to determine alternatives for its integration with the Division's information system.	3/31/81	-Written statement of alternatives.	Program Services ($500)	The 27-10 data collection has been occurring outside of the standard reporting mechanism of DMH. This integration will result in increased efficiency and will eliminate duplication.
	(7) To have revised the Standards/Rules and Regulations for Mental Health Centers.	3/31/81	-Revised Standards	Program Services Governor's Board for Service Standards and Regulations ($1,000)	The Standards/Rules and Regulations for Mental Health Centers and Clinics are being revised by the Governor's Board for Service Standards and Regulations to ensure a focus on quality, community control, services to those most in need, accessibility, and coordination among care givers.
	(8) To have developed plans for establishing a law library at Colorado State Hospital for patients' rights purposes.	6/30/81	-Written plans	CSH ($500)	Current trends indicate that it is only a matter of time before this type of library will be mandated. Lack of funds delayed the accomplishment of this objective in the previous Plan.
	(9) To have developed plans for establishing an internal advocacy program for mental health clients.	6/30/81	-Written plan for program, including a funding proposal	Program Services Planning Services CSH FLMHC ($500)	Patient rights protection and advocacy are receiving increased attention from the legislative level to the treatment level. Legislators, providers of mental health care, and consumers of mental health services are emphasizing the need for formal rights protection and advocacy programs which are independent of the service delivery system (external programs), as well as programs which are components of the mental health service system (internal programs).

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : To provide services efficiently.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #4. TO ENSURE THE APPROPRIATE UTILIZATION OF ALL AVAILABLE RESOURCES BY CLIENTS MOST IN NEED.	(1) To have evaluated utilization patterns for various client groups using unit-of-service data obtained from the Client Status Report.	8/31/80	-Utilization report(s)	Program Services ($2,000)	Such a study will address whether mental health resources are equitably and appropriately distributed, and will indicate areas for improvement.
	(2) To have developed recommendations, based on survey data, related to clients responsible for violent crimes.	9/1/80	-Written recommendations	Program Services CSH FLMHC Centers/Clinics ($1,000)	A survey related to clients responsible for violent crimes has been distributed to the two state hospitals and to the mental health centers/clinics.
	(3) To have implemented an acceptable system for the allocation of state hospital beds in the Fort Logan Service Area on a catchment area basis, dependent on local needs and resource availability.	9/30/80	-Allocation system accepted by DMH and the Centers' Association -Allocation system implemented	Program Services Planning Services CSH; FLMHC Centers' Association ($5,000)	The Centers' Association and the DMH have agreed that DMH would begin the process of seeking a rational method for allocating Fort Logan's beds. It also was agreed that DMH would collect the necessary data and then would work with the Association to reach a mutually acceptable plan.
	(4) To have developed an implementation plan for addressing the recommendations which result from the Governor's Executive Order dated April 14, 1980, related to violence committed by former mental patients.	12/15/80	-Written implementation plan	Program Services ($5,000)	(4) and (5) The Governor's Executive Order and the Legislature's Resolution resulted from a series of violent crimes committed by former mental patients. This and the issue of laws concerning the mentally ill have generated the studies reflected in these objectives. Plans for addressing the recommendations proposed in these studies will need to be developed.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(5) To have developed an implementation plan for addressing the recommendations which result from the Senate Resolution regarding the legislative study of the Colorado laws concerning the mentally ill.	12/15/80	-Written implementation plan	Program Services ($5,000)	
	(6) To have revised the Client Admission Form to reflect changes in data needs since the introducing of the Form in 1974.	1/31/81	-New admission forms	Program Services ($2,000)	The Form needs to be revised to improve the efficiency and information gathering capabilities of the information system.
	(7) To have evaluated resource utilization patterns based upon the Client Status Report and samples drawn from priority client populations.	2/28/81	-Utilization report(s)	Program Services ($5,000)	The collection of such utilization data will greatly enhance the capacity of the existing information system and will impact on need assessment, treatment outcome studies, and fiscal management.
	(8) To have developed documentation to clarify the operation and interrelationships of the various components of the information system, including fiscal.	4/30/81	-Procedure manual	Program Services Finance Services ($2,000)	The purpose of this objective is to improve user training and accuracy of the information system.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(9) To have established a mechanism for distributing the DMH licensed psychiatric beds, based on needs and resource availability.	4/30/81	-Mechanism established	Planning Services CSH FLMHC Program Services ($2,000)	Bed needs vary between the two state hospitals based on their current inpatient population, demands for service, etc. A mechanism which would allow the beds to be distributed between the hospitals based on needs and resource availability would result in more effective and efficient utilization of the Division's limited resources.
	(10) To have data available to comply with ongoing requests for the newly developed Department of Institutions Information System.	6/30/81	-Written responses for Department of Institutions requests	Program Services ($2,000)	This system will improve the compatability of divisional data at the Departmental level.
	(11) To have begun implementation of a long-range plan for research in forensic psychiatry at Colorado State Hospital.	6/30/81	-Progress report	CSH ($1,000)	CSH staff members assigned to research activity are developing a forensic data base which is to be used in future research efforts. The long-range plan has been submitted to the Director of DMH.
	(12) To have addressed with the Legislature a plan which would permit Colorado State Hospital and Fort Logan Mental Health Center to retain an incentive percentage of revenues realized above the appropriate level and to use these revenues to improve service delivery.	6/30/81	-Written agreement	CSH FLMHC Finance Services ($1,000)	Such a plan would provide great incentive to maximize revenues and would provide an appropriate reward for doing so.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(13) To have developed plans for a new psychiatric rehabilitation workshop facility for use in the Denver metropolitan area.	6/30/81	-Program and rough architectural plans completed	FLMHC ($2,000)	Work therapy is a key modality in the treatment of the severely and moderately disabled. Increased capacity is necessary to accommodate the numbers of people in this category.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #9. TO DEVELOP THE STATE'S CAPACITY FOR MENTAL HEALTH WORK FORCE PLANNING AND DEVELOPMENT TO ENSURE THAT THE APPROPRIATE STAFF ARE AVAILABLE AND BEING UTILIZED EFFECTIVELY THROUGHOUT THE STATE MENTAL HEALTH SYSTEM.	(1) To have completed the staffing standards study for all clinical support and administrative staff at CSH and FLMHC.	9/30/80	-Study completed	Finance Services CSH FLMHC ($2,000)	This study is needed to determine the adequacy of clinical support and administrative staffing at both state hospitals. It also is needed to enable the accomplishment of the next objective.
	(2) To have submitted an analysis and justification of the differences in administrative and support staff to client ratios between institutions of the Division of Mental Health and those of the Division for Developmental Disabilities to the Joint Budget Committee.	11/1/80	-Report submitted to the JBC	Finance Services ($5,000)	This objective is based upon Footnote 80 of the 1980 Long Bill.
	(3) To have revised the plans for on-site activities and internal reviews of centers/clinics.	11/1/80	-Implementation of plans	Program Services ($1,000)	A consistent method for internally reviewing centers/clinics and for on-site activities needs to be developed within the Division's limited resources for performing these responsibilities.
	(4) To have recommended changes in Affirmative Action plans for centers/clinics based on a review of current criteria.	12/31/80	-Contract negotiations	Program Services ($500)	The Affirmative Action plan for each center/clinic is reviewed during the DMH/center contract negotiation.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(5) To have had the Committee on Sexism submit specific recommendations to the State Mental Health Advisory Council for improving services to women, including treatment and program planning and the administrative status of women in mental health agencies.	1/31/81	-Written recommendations submitted to SMHAC	Committee on Sexism SMHAC	In setting goals for the provision of services to the system's clients, it is important 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 work force. Efforts to demonstrate pay equalization where discrepancies exist and professional advancement opportunities for women are essential. The provision of adequately trained staff to meet the needs of women consumers and providers must be expanded throughout the system. The SMHAC has requested specific recommendations from the Committee on Sexism to address these issues.
	(6) To have established a comprehensive data base of the mental health work force in Colorado.	2/1/81	-Questionnaire -Computer printout	Program Services ($15,000)	Basic minimal mental health work force data in Colorado are needed. This is a refinement of initial data base efforts begun in 1979-80.
	(7) To have provided technical assistance to the Mental Health Association on the survey of the private sector.	2/1/81	-Minutes -Survey instrument -Printout	Program Services ($10,000)	The Division of Mental Health is cooperating with the Colorado Mental Health Association-sponsored survey of private sector providers, so that both public and private-sector mental health work force data will be available.
	(8) To have assembled information on mental health training programs and institutions of higher learning.	2/1/81	-Written report	Program Services ($15,000)	There is a need for assembling information on types of students' curriculum, core disciplines and paraprofessional training available in Colorado.

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(9) To have developed a comprehensive state plan for mental health work force development.	4/30/81	-Written plan	Program Services ($10,000)	There is a need for integrating work force data with higher education data to develop comprehensive planning implications.
	(10) To have conducted studies of the mental health work force requirements for carrying out the service goals in this Plan (i.e., services to specific client groups - targeted clients, minorities, children, elderly, women and rural residents).	6/30/81	-Written reports	Program Services ($40,000)	Studies need to be completed to assess the extent to which the work force possesses the skills to serve priority client groups.
	(11) To have implemented strategies to correct problems in the work force identified by evaluation studies and the Work Force Advisory Committee.	6/30/81	-Minutes -Written plans	Program Services ($10,000)	Mental health work force data should be used to plan and carry out corrective strategies.
	(12) To have provided training programs for specific treatment methods identified by the mental health centers and hospitals.	6/30/81	-Training programs take place -Training summaries	Program Services ($20,000)	Training provides and sharpens the skills needed to serve clients better.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(13) To have provided training programs focusing on appropriate program models for serving priority client populations.	6/30/81	-Training programs take place -Training summaries	Program Services ($25,000)	Training on innovative and effective program models is needed to provide quality care to priority client populations such as the moderately and severely disabled.
	(14) To have provided training sessions for each of the following: children, adolescents, elderly, minority and women populations.	6/30/81	-Training programs take place -Training summaries	Program Services ($25,000)	Those who provide care to children, adolescents, the elderly, minorities, and women need to have highly specialized skills and knowledge.
	(15) To have provided training programs focusing on management issues.	6/30/81	-Training programs take place -Training summaries	Program Services ($20,000)	This training will be offered to enhance the management of Colorado's mental health system.
	(16) To have ensured sufficient physician coverage at both state hospitals to meet psychiatric standards.	6/30/81	-Physician coverage consistent with standards	CSH FLMHC ($600,000)	Both state hospitals have lacked sufficient physician coverage, which was due primarily to inadequate salaries for physicians in the state system.

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(17) To have addressed with the State Legislature a plan for providing 40 hours per year of continuing education time for each staff member with appropriate FTE's and dollars (at a 102% level) to assure the availability of the time.	6/30/81	-Written agreement	FLMHC CSH Finance Services ($1,000)	Continuing education is essential to maintaining quality services, to retaining skilled staff, to decreasing turnover costs, and to enhancing recruitment potential. Business has long recognized this value and has provided such education (time and costs), and the Legislature has concurred in its value by agreeing that it is a deductible business expense. It is equally valuable to the State and its employees.
	(18) To have developed a plan for providing an employee meal service at Fort Logan Mental Health Center in the hospital cafeteria on a non-profit corporation basis.	6/30/81	-Written plan	FLMHC ($500)	Savings of time and gasoline are expected to be realized and the overall atmosphere of the employee cafeteria improved.
	(19) To have ensured that clinical support and administrative staffing assignments in both state hospitals are consistent with the staffing standards developed for these areas.	6/30/81	-Staffing assignments	Finance Services CSH FLMHC ($2,000)	The Division and the two hospitals are committed to using these standards. The hospitals may be limited in their ability to implement these standards if staffing is inadequate and funding for additional staff is not available.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # VI : To ensure that services are provided at a reasonable cost.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #8. TO PROVIDE SERVICES TO TARGET POPULATION CLIENTS AT REASONABLE COSTS THROUGHOUT THE STATE MENTAL HEALTH SYSTEM.	(1) To have implemented the first year of a resource distribution system for the allocation of state resources to catchment areas.	7/31/80	-System implemented -DMH/Center contracts	Finance Services Program Services ($500,000)	The Centers' Association and the DMH agreed to implement the first year of a resource redistribution system based upon per capita.
	(2) To have completed a feasibility study for fully integrating the mental health centers and the two state hospitals financially to ensure that funding follows the clients.	1/1/81	-Feasibility study completed	Finance Services CSH FLMHC Centers/Clinics ($10,000)	The mental health centers and the two state hospitals suffer when they are perceived as separate from each other financially. A method needs to be selected which is acceptable within the mental health system. The study will examine the many alternatives for this fiscal integration.
	(3) To have submitted a report detailing costs of the non-hospital 24-hour patient care programs to the Joint Budget Committee.	1/1/81	-Report submitted to the JBC	Finance Services CSH ($1,000)	This objective is based upon Footnote 81a of the 1980 Long Bill.
	(4) To have implemented the use of SCOPE as a management measure for the two state hospitals, if adequate staffing is available.	6/30/81	-82-83 budget request submitted using SCOPE -81-82 Operating Plan formulated by using SCOPE	CSH FLMHC ($10,000)	The Division and the two hospitals are committed to using SCOPE, as it represents the best available system for determining staffing requirements.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # VI : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(5) To have begun implementation of a short and long-term capital construction and controlled maintenance program at Colorado State Hospital and Fort Logan Mental Health Center that will insure a safe, modern physical environment for all modalities of patient treatment.	6/30/81	-Plan developed by 3/31/81 -Implementation according to funds available by 6/30/81	CSH FLMHC ($10,000)	Capital construction and controlled maintenance programs are necessary to meet the safety, heating, lighting, environmental, and program needs of patients, as well as to meet JCAH standards.
	(6) To have developed a five-year Division-wide plan for energy conservation.	6/30/81	-Written plan	Finance Services CSH FLMHC ($5,000)	(6)-(8) Energy conservation is a Division of Mental Health priority.
	(7) To carry out energy conservation steps, within available resources, at Fort Logan Mental Health Center which have been determined, by previous studies, to be effective.	6/30/81	-Steps specified in previous studies -Resources obtained	FLMHC ($3,000)	
	(8) To further develop and refine energy concepts for the production of all power equipment requirements at Colorado State Hospital.	6/30/81	-Refinements completed	CSH ($2,000)	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1980-81 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # VI : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(9) To have reduced the miles driven by State employees by an additional 5% as compared with the base year of 1978-79.	6/30/81	-Reduction reflected in mileage reports	Finance Services ($500)	Reduced mileage may be sufficient to partially offset the additional cost for gasoline and miles driven.
	(10) To have reduced the gallons of fuel used by State vehicles by an additional 5% as compared with the base year of 1978-79.	6/30/81	-Reduction in gallons of fuel	Finance Services ($500)	Reduction in vehicle fuel utilized will reduce partially the increased cost in gasoline and oil.

CHAPTER V. FINANCIAL SUMMARY FOR FISCAL YEAR 1980-81

OPERATING PLAN
DIVISION OF MENTAL HEALTH
INCOME & VARIANCE FOR 1980-1981

	Federal	Cash Fund Patient Revenue	Cash Fund Other	General Fund	Non-Appropriated	Total Income
PERSONAL SERVICES:						
Appropriation		$12,612,357	$1,228,939	$17,073,075		$30,914,371
Potted Funds Anticipated				4,872,714		4,872,714
Supplemental Anticipated				1,074,148		1,074,148
OPERATING EXPENSE:						
Appropriation			720,451	2,546,085		3,266,536
Supplemental Anticipated				141,809		141,809
TRAVEL:						
Appropriation				32,195		32,195
CAPITAL OUTLAY:						
Transfer from D. of I.				543,346		543,346
SPECIAL PURPOSE:						
Alcohol & Drug Appropriation			2,301,639			2,301,639
Alcohol & Drug Pots Anticipated				401,401		401,401
Alcohol & Drug Supplemental				338,175		338,175
Utilities Appropriated			71,749	1,297,700		1,369,449
Utilities Supplemental				95,700		95,700
Vocational Rehabilitation			579,851			579,851
Federal Grants Appropriated	$1,169,240					1,169,240
Federal Grants Non-Approp.					$ 83,000	83,000
ESEA Appropriated			58,140			58,140
ESEA Non-Appropriated					110,613	110,613
Manpower Program			253,800			253,800
School District Program			24,000			24,000
NIDA			58,800			58,800
WICHE				15,000		15,000
Community Centers/Clinics			2,080,000	17,114,876		19,194,876
CETA					54,000	54,000
Health Dept. Trng. Proj.					12,915	12,915
TOTAL	$1,169,240	$12,612,357	$7,377,369	$45,546,224	$260,528	$66,965,718
Less: Appropriation	1,230,651	12,612,357	7,318,569	37,552,054	-0-	58,713,631
TOTAL VARIANCE	($61,411)	-0-	$58,800	$7,994,170	$260,528	$8,252,087

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1980-1981

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					CHILDREN'S PSYCHIATRY					
			499,609	755,501	Personal Services	1,255,110	310,011	315,033	315,033	315,033
				25,925	Operating Expense	25,925	6,481	6,481	6,482	6,481
				373	Travel	373	97	97	89	90
				7,630	Capital Outlay	7,630	1,907	1,907	1,908	1,908
	24,123	19,186			Special Purpose	43,309	10,826	10,827	10,828	10,828
	24,123	19,186	499,609	789,429	TOTAL 58.35 FTE	1,332,347	329,322	334,345	334,340	334,340
					ADOLESCENT PSYCHIATRY					
			1,397,074	2,423,087	Personal Services	3,820,161	947,393	957,633	957,633	957,502
				61,890	Operating Expense	61,890	15,472	15,473	15,473	15,472
				1,119	Travel	1,119	287	288	272	272
				30,518	Capital Outlay	30,518	7,629	7,630	7,629	7,630
	86,490	38,954			Special Purpose	125,444	31,386	31,385	31,387	31,286
	86,490	38,954	1,397,074	2,516,614	TOTAL 177.95 FTE	4,039,132	1,002,167	1,012,409	1,012,394	1,012,162
					ADULT PSYCHIATRY					
			1,924,355	3,327,660	Personal Services	5,252,015	1,302,057	1,316,653	1,316,652	1,316,653
				131,320	Operating Expense	131,320	32,831	32,830	32,830	32,829
				4,027	Travel	4,027	1,017	1,017	997	996
				36,234	Capital Outlay	36,234	9,058	9,058	9,059	9,059
309,452					Special Purpose	309,452	77,363	77,363	77,363	77,367
309,452			1,924,355	3,499,241	TOTAL 253.60 FTE	5,733,048	1,422,326	1,436,921	1,436,901	1,436,900
					FORENSIC PSYCHIATRY					
			1,652,362	3,839,038	Personal Services	5,491,400	1,372,850	1,372,850	1,372,850	1,372,850
				122,543	Operating Expense	122,543	30,636	30,635	30,636	30,636
				1,200	Travel	1,200	300	300	300	300
				44,273	Capital Outlay	44,273	11,069	11,068	11,068	11,068
					Special Purpose	-	-	-	-	-
			1,652,362	4,007,054	TOTAL 257.80 FTE	5,659,416	1,414,855	1,414,853	1,414,854	1,414,854
					GERIATRIC PSYCHIATRY					
			1,094,945	1,957,596	Personal Services	3,052,541	757,654	764,962	764,963	764,962
				220,195	Operating Expense	220,195	55,048	55,049	55,049	55,049
				2,702	Travel	2,702	690	689	662	661
				18,245	Capital Outlay	18,245	4,561	4,561	4,561	4,562
	35,000				Special Purpose	35,000	8,750	8,750	8,750	8,750
	35,000		1,094,945	2,198,738	TOTAL 138.20 FTE	3,328,683	826,703	834,011	833,985	833,984

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1980-1981

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					GENERAL HOSPITAL AND MEDICAL SERVICES					
		522,803	1,332,790	2,248,619	Personal Services	4,104,212	1,023,014	1,027,066	1,027,066	1,027,066
		172,866		380,023	Operating Expense	552,889	138,222	138,222	138,222	138,223
				743	Travel	743	192	191	181	179
				81,951	Capital Outlay	81,951	20,488	20,488	20,488	20,487
					Special Purpose	-	-	-	-	-
		695,669	1,332,790	2,711,336	TOTAL 156.10 FTE	4,739,795	1,181,916	1,185,967	1,185,957	1,185,955
					DRUG/ALCOHOL TREATMENT					
	58,800	1,898,078	403,561	739,576	Special Purpose	3,100,015	771,930	776,027	776,027	776,031
	58,800	1,898,078	403,561	739,576	TOTAL 137.20 FTE	3,100,015	771,930	776,027	776,027	776,031
					COMMUNITY CENTERS/CLINICS					
		[1] 2,080,000		17,114,876	Special Purpose	17,114,876	3,765,273	3,765,273	4,792,165	4,792,165
		2,080,000		17,114,876	TOTAL 0 FTE	17,114,876	3,765,273	3,765,273	4,792,165	4,792,165
					TREATMENT SUPPORT SERVICES					
		352,354	2,867,921	4,843,313	Personal Services	8,063,588	2,004,048	2,019,846	2,019,846	2,019,848
		352,605		1,010,750	Operating Expense	1,363,355	340,838	340,839	340,838	340,840
				11,553	Travel	11,553	3,006	3,006	2,770	2,771
				107,812	Capital Outlay	107,812	26,953	26,953	26,953	26,953
36,503	36,315	579,851			Special Purpose	652,669	163,166	163,168	163,167	163,168
36,503	36,315	1,284,810	2,867,921	5,973,428	TOTAL 458.25 FTE	10,198,977	2,538,011	2,553,812	2,553,574	2,553,580
					ADMINISTRATION & GENERAL					
		353,782	1,843,301	3,625,123	Personal Services	5,822,206	1,453,463	1,456,248	1,456,247	1,456,248
		194,980		735,248	Operating Expense	930,228	232,557	232,557	232,556	232,558
				10,478	Travel	10,478	2,660	2,660	2,578	2,580
				216,683	Capital Outlay	216,683	117,381	43,539	27,881	27,882
847,885	54,000	349,549		1,408,400	Special Purpose	2,659,834	661,505	668,412	668,411	661,506
847,885	54,000	898,311	1,843,301	5,995,932	TOTAL 279.75 FTE	9,639,429	2,467,566	2,403,416	2,387,673	2,380,774
					TOTAL PROGRAMS					
		1,228,939	12,612,357	23,019,937	Personal Services	36,861,233	9,170,490	9,230,291	9,230,290	9,230,162
		720,451		2,687,894	Operating Expense	3,408,345	852,085	852,086	852,086	852,088
				32,195	Travel	32,195	8,249	8,248	7,849	7,849
				543,346	Capital Outlay	543,346	199,046	125,204	109,547	109,549
1,193,840	294,728	[2] 2,885,618	403,561	19,262,852	Special Purpose	24,040,599	5,490,199	5,501,205	6,528,098	6,521,097
1,193,840	294,728	4,835,008	13,015,918	45,546,224	TOTAL 1917.20 FTE	64,885,718	15,720,069	15,717,034	16,727,870	16,720,745

[1] Amount reverts

[2] Reversion Amount of 2,080,000 not included

OPERATING PLAN
DIVISION OF MENTAL HEALTH - CENTRAL OFFICE
INCOME & VARIANCE FOR 1980-1981

	Federal	General Fund	Cash Fund	Transfers	Total Income
PERSONAL SERVICES:					
Appropriation		554,501			554,501
Potted Funds Anticipated		57,272			57,272
Supplemental Anticipated		-0-			-0-
[1]OPERATING EXPENSE:					
Appropriation		9,300			9,300
TRAVEL:					
Appropriation		6,289			6,289
CAPITAL OUTLAY:					
Appropriation				2,000	2,000
SPECIAL PURPOSE:					
Other - WICHE		15,000			15,000
[2]Continuing Education	38,500				38,500
[2]Manpower	246,936				246,936
[2]CSS	545,449				545,449
TA Grants	17,000				17,000
Community Centers/Clinics		17,114,876	[3]2,080,000	2,000	17,114,876
TOTAL	847,885	17,757,238	2,080,000	2,000	18,607,123
Less: Appropriation	909,296	17,699,966	2,080,000	-0-	18,609,262
TOTAL VARIANCE	(61,411)	57,272	-0-	2,000	(2,139)

[1]Excludes services supplied without fee by Fort Logan and Colorado State Hospital

[2]Includes roll forwards from prior years

[3]Cash fund appropriation to revert

OPERATING PLAN FOR 1980-81
CENTRAL OFFICE - DIVISION OF MENTAL HEALTH

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					COMMUNITY CENTERS/CLINICS					
		2,080,000		17,114,876	Special Purpose	17,114,876	3,765,273	3,765,273	4,792,165	4,792,165
		2,080,000		17,114,876	TOTAL 0 FTE	17,114,876	3,765,273	3,765,273	4,792,165	4,792,165
					ADMIN. & GENERAL SERVICES					
				611,773	Personal Services	611,773	152,943	152,943	152,943	152,944
				9,300	Operating Expense	9,300	2,325	2,325	2,325	2,325
				6,289	Travel	6,289	1,572	1,572	1,572	1,573
				2,000	Capital Outlay	2,000	-0-	1,000	500	500
847,885				15,000	Special Purpose	862,885	215,721	215,721	215,721	215,722
847,885				644,362	TOTAL 38.0 FTE	1,492,247	372,561	373,561	373,061	373,064
					TOTAL ALL PROGRAMS					
				611,773	Personal Services	611,773	152,943	152,943	152,943	152,943
				9,300	Operating Expense	9,300	2,325	2,325	2,325	2,325
				6,289	Travel	6,289	1,572	1,572	1,572	1,573
		[1]		2,000	Capital Outlay	2,000	-0-	1,000	500	500
847,885		2,080,000		17,129,876	Special Purpose	17,977,761	3,980,994	3,980,994	5,007,886	5,007,887
847,885		2,080,000		17,759,238	TOTAL 38.0 FTE	18,607,123	4,137,834	4,138,834	5,165,226	5,165,228

FTE Gen. Funds 21.5
Fed. Funds 16.5
Total 38.0

[1] Amount reverts

OPERATING PLAN
COLORADO STATE HOSPITAL
INCOME & VARIANCE FOR 1980-1981

	FTE	Federal	Cash Fund Patient Revenue	Cash Fund Other	General Fund	Total Income
PERSONAL SERVICES:						
Appropriation	1206.7		$7,842,259	$1,228,939	$12,193,862	$21,265,060
Transfer from DMH	20.0				351,251	351,251
Central Pots Anticipated					3,373,963	3,373,963
Supplemental Anticipated	2.0				1,074,148	1,074,148
OPERATING EXPENSE:						
Appropriation				720,451	1,455,799	2,176,250
Supplemental Anticipated					141,809	141,809
TRAVEL:						
Appropriation					15,906	15,906
CAPITAL OUTLAY:						
Transfer from Dept. of Institutions					436,189	436,189
SPECIAL PURPOSE						
Utilities Appropriation				71,749	952,374	1,024,123
Utilities Supplemental Anticipated					95,700	95,700
Vocational Rehabilitation Appropriation	8.0			181,906		181,906
Manpower Program Appropriation				253,800		253,800
School District Program Appropriation				24,000		24,000
Chicano Inpatient Grant Appropriation	13.5	$309,452				309,452
Library Grant Non-Appropriated	1.0	24,600				24,600
Alcohol & Drug Programs Appropriation	94.4		403,561	1,385,262		1,788,823
Central Pots Anticipated					302,554	302,554
Alcohol & Drug Supplemental Anticipated	8.8				181,426	181,426
NIDA Statewide Services Contract				58,800		58,800
ESEA Non-Appropriated	7.0			90,613		90,613
TOTAL:	1361.4	$334,052	$8,245,820	$4,015,520	$20,574,981	$33,170,373
Less Appropriated	(1309.1)	(309,452)	(8,245,820)	(3,866,107)	(14,617,941)	(27,039,320)
VARIANCE	52.3	$ 24,600	-0-	$ 149,413	$ 5,957,040	$ 6,131,053

OPERATING PLAN FOR 1980-1981
COLORADO STATE HOSPITAL

Cash (C) and Federal (F)	Cash Fund Patient Rev.	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
			CHILD PSYCHIATRY					
	133,905	311,111	Personal Services	445,016	111,254	111,254	111,254	111,254
		14,475	Operating Expenses	14,475	3,619	3,619	3,619	3,618
		180	Travel	180	45	45	45	45
		7,630	Capital Outlay	7,630	1,907	1,907	1,908	1,908
18,123 C			Special Purpose	18,123	4,530	4,531	4,531	4,531
18,123	133,905	333,396	TOTAL 22.15 FTE	485,424	121,355	121,356	121,357	121,356
			ADOLESCENT PSYCHIATRY					
	654,585	1,520,840	Personal Services	2,175,425	543,856	543,856	543,856	543,857
		35,390	Operating Expenses	35,390	8,847	8,848	8,848	8,847
		720	Travel	720	180	180	180	180
		30,518	Capital Outlay	30,518	7,629	7,630	7,629	7,630
72,490 C			Special Purpose	72,490	18,123	18,122	18,123	18,122
72,490	654,585	1,587,468	TOTAL 103.15 FTE	2,314,543	578,635	578,636	578,636	578,636
			ADULT PSYCHIATRY					
	921,549	2,141,092	Personal Services	3,062,641	765,660	765,661	765,660	765,660
		100,985	Operating Expenses	100,985	25,247	25,246	25,246	25,246
		3,500	Travel	3,500	875	875	875	875
		36,234	Capital Outlay	26,243	9,058	9,058	9,059	9,059
309,452 F			Special Purpose	309,452	77,363	77,363	77,363	77,363
309,452	921,549	2,281,811	TOTAL 156.30 FTE	3,512,812	878,203	878,203	878,203	878,203
			FORENSIC PSYCHIATRY					
	1,652,362	3,839,038	Personal Services	5,491,400	1,372,850	1,372,850	1,372,850	1,372,850
		122,543	Operating Expenses	122,543	30,636	30,635	30,636	30,636
		1,200	Travel	1,200	300	300	300	300
		44,273	Capital Outlay	44,273	11,069	11,068	11,068	11,068
			Special Purpose					
	1,652,362	4,007,054	TOTAL 257.80 FTE	5,659,416	1,414,855	1,414,853	1,414,854	1,414,854
			ALCOHOL AND DRUG					
			Personal Services					
			Operating Expenses					
			Travel					
			Capital Outlay					
1,444,062 C	403,561	483,980	Special Purpose	2,331,603	582,901	582,901	582,901	582,900
1,444,062	403,561	483,980	TOTAL 103.20 FTE	2,331,603	582,901	582,901	582,901	582,900

OPERATING PLAN FOR 1980-1981
COLORADO STATE HOSPITAL

Cash (C) and Federal (F)	Cash Fund Patient Rev.	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
			GERIATRIC PSYCHIATRY					
	588,601	1,367,533	Personal Services	1,956,134	489,034	489,033	489,034	489,033
		63,431	Operating Expenses	63,431	15,857	15,858	15,858	15,858
		2,000	Travel	2,000	500	500	500	500
		18,245	Capital Outlay	18,245	4,561	4,561	4,561	4,562
			Special Purpose					
	588,601	1,451,209	TOTAL 91.30 FTE	2,039,810	509,952	509,952	509,953	509,953
			GENERAL HOSPITAL & MEDICAL					
522,803 C	1,052,039	1,921,465	Personal Services	3,496,307	874,077	874,077	874,077	874,076
172,866 C		251,059	Operating Expenses	423,925	105,981	105,981	105,981	105,982
		450	Travel	450	113	112	113	112
		81,951	Capital Outlay	81,951	20,488	20,488	20,488	20,487
			Special Purpose					
695,669	1,052,039	2,254,925	TOTAL 135.85 FTE	4,002,633	1,000,659	1,000,658	1,000,659	1,000,657
			TREATMENT SUPPORT SERVICES					
352,354 C	1,713,277	3,628,213	Personal Services	5,693,844	1,423,461	1,423,461	1,423,461	1,423,461
352,605 C		652,245	Operating Expenses	1,004,850	251,212	251,213	251,212	251,213
		5,656	Travel	5,656	1,414	1,414	1,414	1,414
		107,812	Capital Outlay	107,812	26,953	26,953	26,953	26,953
24,600 F			Special Purpose	206,506	51,626	51,627	51,626	51,627
181,906 C								
911,465	1,713,277	4,393,926	TOTAL 323.45 FTE	7,018,668	1,754,666	1,754,668	1,754,666	1,754,668
			ADMINISTRATION & GENERAL					
353,782 C	1,125,941	2,263,932	Personal Services	3,743,655	935,914	935,914	935,913	935,914
194,980 C		357,480	Operating Expenses	552,460	138,115	138,115	138,115	138,115
		2,200	Travel	2,200	550	550	550	550
		109,526	Capital Outlay	109,526	27,381	27,382	27,381	27,382
349,549 C		1,048,074	Special Purpose	1,397,623	349,406	349,406	349,405	349,406
898,311	1,125,941	3,781,212	TOTAL 168.20 FTE	5,805,464	1,451,366	1,451,367	1,451,364	1,451,367
			ALL HOSPITAL PROGRAMS					
1,228,939 C	7,842,259	16,993,224	Personal Services	26,064,422	6,516,106	6,516,106	6,516,105	6,516,105
720,451 C		1,597,608	Operating Expenses	2,318,059	579,514	579,515	579,515	579,515
		15,906	Travel	15,906	3,977	3,976	3,977	3,976
		436,189	Capital Outlay	436,189	109,046	109,047	109,047	109,049
334,052 F								
2,066,130 C	403,561	1,532,054	Special Purpose	4,335,797	1,083,949	1,083,950	1,083,949	1,083,949
4,349,572	8,245,820	20,574,981	TOTAL 1361.40 FTE	33,170,373	8,292,592	8,292,594	8,292,593	8,292,594

OPERATING PLAN
FORT LOGAN MENTAL HEALTH CENTER
INCOME & VARIANCE FOR 1980-81

	CASH FUND PATIENT REVENUE	CASH FUND APPROPRIATION	GENERAL FUND TRANSFER FROM DMH & DI	GENERAL FUND	FEDERAL	NON-APPROP.	TOTAL INCOME
PERSONAL SERVICES							
Appropriation	4,770,098			3,797,835			8,567,933
Transfer from DMH			175,626				175,626
Potted Funds Anticipated				1,441,479			1,441,479
OPERATING EXPENSE							
Appropriation				1,080,986			1,080,986
TRAVEL							
Appropriation				10,000			10,000
CAPITAL OUTLAY							
Transfer from D. of I.			105,157				105,157
SPECIAL PURPOSE:							
Alcohol Treatment Program-Appropriated		512,816					
Potted Funds-Needed				98,847			
Supplemental - Request				156,749			
Total Alcohol Treat. Prog.							768,412
FSEA - Appropriated		58,140					
Carry-over 79/80						20,000	78,140
Vocational Rehabilitation-Approp.		397,945					397,945
Utilities - Appropriated				345,326			345,326
Federal Funds Appropriated					11,903		11,903
CETA-Non-Appropriated						54,000	54,000
Adult Basic Education Grant-Non-Approp.						35,000	35,000
Library Grant - Non-Approp.						23,400	23,400
Health Dept. Trng. Proj.						12,915	12,915
TOTAL	4,770,098	968,901	280,783	6,931,222	11,903	145,315	13,103,222
Less: Appropriation	4,770,098	968,901	-0-	5,234,147	11,903	-0-	(10,985,049)
TOTAL VARIANCE	-0-	-0-	280,783	1,697,075	-0-	145,315	2,123,173

OPERATING PLAN FOR 1980-81
FORT LOGAN MENTAL HEALTH CENTER

Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	Gen. Fund		Total Budget	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.
				CHILDREN'S PSYCHIATRY					
		365,704	444,390	35.2 Personal Services	810,094	198,757	203,779	203,779	203,779
			11,450	Operating Expense	11,450	2,862	2,862	2,863	2,863
			193	Travel	193	52	52	44	45
				Capital Outlay					
6,000	19,186			1.0 Special Purpose	25,186	6,296	6,296	6,297	6,297
6,000	19,186	365,704	456,033	TOTAL 36.2 FTE	846,923	207,967	212,989	212,983	212,984
				ADOLESCENT PSYCHIATRY					
		742,489	902,247	71.0 Personal Services	1,644,736	403,437	413,777	413,777	413,745
			26,500	Operating Expense	26,500	6,625	6,625	6,625	6,625
			399	Travel	399	107	108	92	92
				Capital Outlay					
14,000	38,954			3.8 Special Purpose	52,954	13,263	13,263	13,264	13,164
14,000	38,954	742,489	929,146	TOTAL 74.8 FTE	1,724,589	423,532	433,773	433,758	433,526
				ADULT PSYCHIATRY					
		1,002,806	1,186,568	97.3 Personal Services	2,189,374	536,397	550,992	550,992	550,993
			30,335	Operating Expense	30,335	7,584	7,584	7,584	7,584
			527	Travel	527	142	142	122	121
				Capital Outlay					
				Special Purpose					
		1,002,806	1,217,430	TOTAL 97.3 FTE	2,220,236	544,123	558,718	558,698	558,697

OPERATING PLAN FOR 1980-81
FORT LOGAN MENTAL HEALTH CENTER

Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	Gen. Fund		Total Budget	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.
				ALCOHOLISM TREATMENT PROGRAM					
				Personal Services					
				Operating Expense					
				Travel					
				Capital Outlay					
	512,816		255,596	34.0 Special Purpose	768,412	189,029	193,126	193,126	193,131
	512,816		255,596	TOTAL 34.0 FTE	768,412	189,029	193,126	193,126	193,131
				GERIATRICS/AFTERCARE/DEAF PROG.					
		506,344	590,063	45.1 Personal Services	1,096,407	268,620	275,929	275,929	275,929
			156,764	Operating Expense	156,764	39,191	39,191	39,191	39,191
			702	Travel	702	190	189	162	161
				Capital Outlay					
35,000				1.8 Special Purpose	35,000	8,750	8,750	8,750	8,750
35,000		506,344	747,529	TOTAL 46.90 FTE	1,288,873	316,751	324,059	324,032	324,031
				GENERAL HOSPITAL & MEDICAL SERV.					
		280,751	327,154	20.25 Personal Services	607,905	148,937	152,989	152,989	152,990
			128,964	Operating Expense	128,964	32,241	32,241	32,241	32,241
			293	Travel	293	79	79	68	67
				Capital Outlay					
				Special Purpose					
		280,751	456,411	TOTAL 20.25 FTE	737,162	181,257	185,309	185,298	185,298

OPERATING PLAN FOR 1980-81
FORT LOGAN MENTAL HEALTH CENTER

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	Gen. Fund		Total Budget	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.
					TREATMENT SUPPORTING SERV.					
			1,154,644	1,215,100	119.60 Personal Services	2,369,744	580,587	596,385	596,385	596,387
				358,505	Operating Expense	358,505	89,626	89,626	89,626	89,627
				5,897	Travel	5,897	1,592	1,592	1,356	1,357
					Capital Outlay					
11,903	36,315	397,945			15.2 Special Purpose	446,163	111,540	111,541	111,541	111,541
11,903	36,315	397,945	1,154,644	1,579,502	TOTAL 134.80 FTE	3,180,309	783,345	799,144	798,908	798,912
					ADMINISTRATION & GENERAL SERV.					
			717,360	749,418	67.55 Personal Services	1,466,778	364,606	367,391	367,391	367,390
				368,468	Operating Expense	368,468	92,117	92,117	92,116	92,118
				1,989	Travel	1,989	538	538	456	457
				105,157	Capital Outlay	105,157	90,000	15,157		
	54,000			345,326	6.0 Special Purpose	399,326	96,378	103,285	103,285	96,378
	54,000		717,360	1,570,358	TOTAL 73.55 FTE	2,341,718	643,639	578,488	563,248	556,343
					TOTAL HOSPITAL PROGRAM					
			4,770,098	5,414,940	456.0 Personal Services	10,185,038	2,501,441	2,561,242	2,561,242	2,561,113
				1,080,986	Operating Expense	1,080,986	270,246	270,246	270,246	270,248
				10,000	Travel	10,000	2,700	2,700	2,300	2,300
				105,157	Capital Outlay	105,157	90,000	15,157		
11,903	145,315	968,901		600,922	61.8 Special Purpose	1,727,041	425,256	436,261	436,263	429,261
11,903	145,315	968,901	4,770,098	7,212,005	GRAND TOTAL 517.8 FTE	13,108,222	3,289,643	3,285,606	3,270,051	3,262,922

COLORADO DEPARTMENT OF INSTITUTIONS

WORKLOAD
1980-81

DIVISION OF MENTAL HEALTH

	Actual FY 78-79 Avg. Daily Attend. (Weighted)	Est. FY 79-80 Avg. Daily Attend. (Weighted)	Projected 80-81 Av. Daily Attendance (Weighted) Projected	Year-to-Date	Variance
Colorado State Hospital					
Children	12	13	13		
Adolescents	83	80	83		
Adults	177	172	169		
Elderly	91	93	89		
Forensic	297	298	301		
General Hospital	72	74	70		
Total M. H. Programs	732	730	725		
Alcohol	10	25	25		
Drug	36	43	48		
Total Other Programs	46	68	73		
TOTAL ALL PROGRAMS	778	798	798		
Fort Logan Mental Health Center					
Children	72	68	68		
Adolescents	37	32	32		
Adults	72	77	77		
Elderly (includes Deaf)	72	72	72		
Vocational Services	5	17	17		
Total M. H. Programs	258	266	266		
Alcohol *	27	27	27		
TOTAL ALL PROGRAMS	285	293	293		

*Inpatient Rehabilitation Treatment

Average Daily Attendance: Includes In-Patient and other Treatment Modalities which are weighted on the basis of time and cost. Formula gives In-Patient a weight of 1; Other 24 Hour .4; Partial Care .4; and Outpatient .167.

COLORADO DEPARTMENT OF INSTITUTIONS

WORKLOAD
1980-81

DIVISION OF MENTAL HEALTH

	Actual FY 78-79	Estimated 79-80	Projected 80-81
Colorado State Hospital	Total	Total	Total
Clients Admitted	3,216	3,783	3,640
Fort Logan Mental Health Center			
Clients Admitted	1,341	1,394	1,191

Centers and Clinics	Actual FY 78-79		Estimated 79-80		Projected 80-81	
	Number	Percent	Number	Percent	Number	Percent
I. Clients Admitted						
Children	3,328	7	4,133	8.4	4,585	9.4
Adolescents	5,203	12	5,856	11.9	6,306	12.9
Adults	34,941	78	37,152	75.5	34,966	71.4
Elderly	1,368	3	2,067	4.2	3,060	6.3
TOTAL	44,840	100	49,208	100	48,917	100
II. Targeted Clients Admitted (Moderate/Severe)						
TOTAL	24,339	74	38,579	78.4	37,457	76.6
III. Minority Persons Admitted	9,230	20.5	10,777	21.9	10,459	21.4

COLORADO DEPARTMENT OF INSTITUTIONS

COSTS & RATES

DIVISION OF MENTAL HEALTH	1978-79 Actual Costs	1979-80 Estimated Costs	1980-81 Projected Daily Rates	1979-80 Cost Per Client Served-Estimated
Colorado State Hospital				
Daily Costs and/or Rates INPATIENT ONLY				
Children	104.68	156.00	171.00	16,690
Adolescents		124.00	136.00	14,205
Adult Psychiatry	76.41	91.00	100.00	3,297
Forensic Psychiatry	70.31	86.00	94.00	12,833
Geriatrics	94.60	107.00	117.00	12,466
General Hospital	161.60	171.00	174.00	8,477
General Hospital - Rehab Unit		122.00	-	-
Alcohol Program	115.80	123.00	135.00	3,101
Drug Program	94.16	106.00	116.00	5,933
Cost Per Client Served	4,361.00	-	Not Available	7,252
Fort Logan Mental Health Center				
Daily Costs and/or Rates INPATIENT ONLY				
Children	146.00	190.00	199.00	20,268
Adolescents	146.00	169.00	169.00	11,356
Adult Psychiatry	107.94	127.00	146.00	4,659
Geriatrics (includes Deaf/Aftercare)	135.00	147.00	142.00	5,126
Alcohol Program	89.00	117.00	135.00	3,223
Cost Per Client Served (Total all programs)	5,078.00	-	7,229.00	5,713

Mental Health Centers & Clinics — Average Daily or Per Contact Rate - Based on Unit Costing

		Av. Rate	Av. Rate	Upper Limit	
Inpatient (Per Day)	129.88	129.53(net)		212.64	
Other 24-Hour Care (Per Day)	42.55	43.83(net)		62.37	
Partial Care (Per Contact)	36.89				
Short Day	-	33.88		44.81	
Long Day	-	50.16	Not	67.21	
Outpatient (Per Contact)	29.16	-	Available		
Individual	-	43.47		54.40	
Group	-	21.75		28.20	
Individual Brief	-	17.39		21.43	
Case Management/Contact	-	23.56		23.84	
Sheltered Workshop	-	33.19		44.87	
Consultation & Education (Per Staff Hour)	23.35	23.63		32.84	
Cost Per Client Served	**470.00**	**497.00**	**Not Available**		

CHAPTER VI. REPORT ON THE ACCOMPLISHMENT OF STATE PLAN OBJECTIVES FOR FISCAL YEAR 1979-80

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : To improve clients' quality of life through effective and high quality services.

***** Indicates objectives that are included in the Department of Institutions 1979-80 Operating Plan.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT *Indicates written reports or other written materials are available	COMMENTS
Status Goal #1. TO MAXIMIZE THE CLIENTS' CAPACITY TO IMPROVE THEIR QUALITY OF LIFE THROUGH ACHIEVING HIGHER LEVELS OF FUNCTIONING IN AREAS SUCH AS WORK OR SCHOOL INVOLVEMENT, FAMILY AND SOCIAL RELATIONSHIPS, DAILY LIVING ACTIVITIES, AND RECREATION.	(1) To analyze existing treatment outcome data to determine if clients in the state mental health system are achieving higher levels of functioning.	11/30/79 *****	-Written treatment outcome analysis	Program Services	Accomplished* - An Evaluation Report entitled "Preliminary Analysis of FY 78-79 Treatment Outcome Data/Hospital & Community Programs by Age and Sex" has been published and widely distributed.	
	(2) To develop operational definitions of quality of life, appropriate to diverse client populations (e.g., children, elderly, ethnic minorities, rural residents, and women).	1/31/80 *****	-Written definitions	Program Services	Accomplished* - Colorado bid for and received designation as the test state for a WICHE/NIMH study on Quality of Life, using the Oregon measure. For operational definitions of QOL, the Division has adopted the conceptual framework developed by Bigelow & Bradslay in Oregon. It is based on an interplay of role performance and satisfaction modified by environmental factors.	
	(3) To develop a cost-effective methodology to assess the quality of life of the system's clients.	6/30/80	-Written methodology	Program Services	Accomplished* - A work plan has been developed with WICHE to carry out the testing of the Oregon Quality of Life methods in three Colorado community mental health centers which agreed to serve as the local test sites for the WICHE/NIMH study.	
System Goal #1. TO ENSURE THE DELIVERY OF HIGH QUALITY CLIENT CARE THROUGH THE EFFECTIVE FUNCTIONING OF THE ELEMENTS OF THE MENTAL HEALTH SYSTEM.	(1) To have developed parameters for clinical quality assurance systems for use by the 23 centers/clinics.	10/31/79	-Parameters distributed to 23 centers/clinics	Program Services	Accomplished* - The Guidelines providing the paramaters have been widely distributed. A copy is available from the Division.	
	(2) To have the program quality assurance systems operational in the 23 centers/clinics.	10/31/79 *****	-Dry run evaluation forms	Program Services	Accomplished* - The QAP program is operational in all 23 CMHCs. The DMH QAP file contains quality assurance materials for each of the centers/clinics.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # I : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(3) To have the program quality assurance system operational in the DMH Central Office.	1/31/80	-Dry run evaluation forms	DMH Director's Office	Accomplished* - The QAP program is operational in the Central Office. The DMH QAP file contains quality assurance materials for each of the Management Units.	
	(4) To develop examples of model criteria for clinical quality assurance.	1/31/80	-Written examples	Program Services	Accomplished* - Copies of the "Guidelines" have been widely distributed.	
	(5) To have the program quality assurance system operational in the two state hospitals.	6/30/80	-Dry run evaluation forms	CSH FLMHC	Accomplished* - The QAP program is operational in both state hospitals. Each hospital has a QAP file which contains the quality assurance materials for their programs.	
	(6) To have developed quality criteria for programs serving children, the elderly, ethnic minorities, and women.	6/30/80	-Written criteria	Program Services	Not Fully Accomplished - A committee to address this objective was established during the first quarter. Minimum requirements for the criteria were determined. Specific action steps and a time frame were established for the accomplishment of this objective; however, the objective was not accomplished within that timeframe. The criteria for programs serving women were drafted by the Committee on Sexism. This objective will be fully accomplished by August 31, 1980.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : To serve clients most in need as the highest priority.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
Service Goal #1. TO SERVE MODERATELY AND SEVERELY PSYCHIATRICALLY DISABLED CLIENTS AND/OR CLIENTS WITH THE LEAST ABILITY TO PAY TO THE MAXIMUM DEGREE THAT THE RESOURCES ALLOW AND IN A MANNER THAT ENSURES THE PROVISION OF ADEQUATE SERVICES TO GROUPS THAT HAVE BEEN UNDERSERVED OR INAPPROPRIATELY SERVED, SUCH AS CHILDREN, THE ELDERLY, ETHNIC MINORITIES RURAL RESIDENTS, AND WOMEN.	(1) To increase admissions of children from 8.01% (3925) in FY 1977-78 to 9.97% (4778).	6/30/80 *****	-Signed contracts -Admission data	DMH Centers/Clinics	First 9 months admissions of children = 8.77%[1]	Signed contracts completed with 22 centers/clinics.
	(2) To increase admissions of adolescents from 12.19% (5968) in FY 1977-78 to 12.62% (6047).	6/30/80 *****	-Signed contracts -Admission data	DMH Centers/Clinics	First 9 months admissions of adolescents = 12.06%[1]	Signed contracts completed with 22 centers/clinics.
	(3) To increase admissions of elderly from 2.89% (1414) in FY 1977-78 to 5.14% (2593).	6/30/80 *****	-Signed contracts -Admission data	DMH Centers/Clinics	First 9 months admissions of elderly = 4.54%[1]	Signed contracts completed with 22 centers/clinics.
	(4) To increase admissions of targeted moderately and severely disabled clients from 59.15% (28,968) in FY 1977-78 to 71.89% (34,449).	6/30/80 *****	-Signed contracts -Admission data	DMH Centers/Clinics	First 9 months admissions of targeted clients = 78.25%[1]	Signed contracts completed with 22 centers/clinics.
	(5) To increase admissions of ethnic minorities from 20.70% (10,136) in FY 1977-78 to 23.11%(11,075).	6/30/80 *****	-Signed contracts -Admission data	DMH Centers/Clinics	First 9 months admissions of ethnic minorities = 22.09%[1]	Signed contracts completed with 22 centers/clinics.
	(6) To have increased services to rural residents through special DMH funding to Southwestern Colorado.	6/30/80 *****	-Signed contracts -Admission data	DMH Southwest Colo. MHC	Accomplished	Signed contract completed adding $98,340 in special DMH funding to this catchment area.

([1]Most recent admission data available)

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(7) To have reduced the number of forensic patients in Maximum Security at Colorado State Hospital by 7.5%.	6/30/80	-Reduction of six patients	CSH	Accomplished - Seven patients of the hard-core group have been assigned to a less secure area.	
	(8) To have achieved 50% prescreening of all admissions to the Child/ Adolescent, Adult, and Geriatric Divisions at Colo. State Hospital through assistance to the service area centers.	6/30/80 *****	-Admission data that reflects at least 50% prescreened entries	CSH Centers/Clinics	Accomplished* - Admission figures (July through May, 1980) show that 63% of the designated patient population has been prescreened prior to admission to CSH.	
System Goal #5. TO PROVIDE MENTAL HEALTH SERVICES TO THE CITIZENS MOST IN NEED IN EACH CATCHMENT AREA THROUGH JOINT STATE AND LOCAL PLANNING, INCLUDING NEEDS AND RESOURCE DISTRIBUTION.	(1) To have jointly established criteria for the development of mental health catchment area plans with the State Mental Health Advisory Council and the centers/clinics.	9/30/79	-Written criteria	Planning Services SMHAC Centers/Clinics	Accomplished* - Copies of the "Guidelines for 1980-81 Catchment Area Mental Health Plans" are available from the Division of Mental Health.	
	(2) To estimate the number of target group individuals residing in each catchment area by modifying the existing needs assessment with social indicators methodology.	10/31/79	-New estimates	Program Services Centers/Clinics	Accomplished* - The new estimates are included in Appendix III of the State Mental Health Plan.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # II : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(3)To develop a distribution system for the allocation of state dollars to catchment areas based on identified needs.	12/1/79 *****	-Mathematical model and allocation figures -Submittal of written plan to the Joint Budget Committee	Program Services Centers/Clinics	Accomplished* - A written plan for Redistribution of Resources was submitted to the Joint Budget Committee on 12/10/79.	
	(4) To have each mental health center/clinic submit a plan, which has been reviewed by the area HSA, for mental health services in their catchment area to the State Mental Health Advisory Council.	12/31/79 *****	-20 catchment area plans submitted to the SMHAC	Centers/Clinics SMHAC Planning Services	Accomplished* - Copies of the local plans may be obtained from the catchment area mental health centers or from the Division of Mental Health.	
	(5) To have the first draft of the State Mental Health Plan Update for 1980, based on catchment area plans and HSA plans, available for review.	4/1/80	-Draft available for review	Planning Services SMHAC	Accomplished* - The first draft of the State Mental Health Plan Update for 1980 was available for review on March 25, 1980.	
	(6) To have prepared, with the assistance of the State Health Planning and Development Agency, the draft of the mental health component of the State Health Plan based upon the Comprehensive State Mental Health Plan and the HSA's mental health plan sections	4/15/80	-Written draft	Planning Services SHPDA	Not Accomplished - The preparation of the draft of the mental health component of the State Health Plan has been delayed by the Southeastern Colo. HSA's decision to base the mental health section of their HSP on the catchment area mental health plans. Preparation of the mental health component of the State Health Plan will begin after the plan section from the SECHSA has been submitted to the SHPDA.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # III : To provide clients with the most effective and least intensive care and treatment through a continuum of services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
System Goal #3. TO HAVE COST-EFFECTIVE TREATMENT AND SUPPORT SYSTEMS FOR THE DELIVERY OF MENTAL HEALTH SERVICES TO MODERATELY AND SEVERELY DISABLED CLIENTS OF ALL AGES AVAILABLE STATEWIDE.	(1) To assess the availability and accessibility of treatment and support systems for minorities.	8/1/79	-Written reports	Program Services	Accomplished* - A copy of the "CCSS Minority Report," prepared by the Colorado Community Support System Project, is available from the Division of Mental Health.	
	(2) To examine the availability and accessibility of treatment and support systems in rural areas.	11/1/79	-Written reports	Program Services	Accomplished* - A written report was completed and submitted to the National Institute of Mental Health in November 1979.	
	(3) To expand and develop the availability of residential alternatives through the use of Section 8 rent subsidies in 14 sites throughout the state.	1/1/80 *****	-Written reports detailing expansion	Program Services	Accomplished* - All of the 90 units which were received in 1979 have been allocated to 11 sites, have been filled, and are being utilized across the state.	
	(4) To provide technical assistance to the HUD 202 sites in the development of vocational opportunities for chronic clients.	3/1/80	-Written reports	Program Services	Accomplished* - Technical assistance was provided following the site assessments of the HUD 202 and Section 8 sites. Individual site reports are available.	
	(5) To identify new funding sources for treatment and support systems for adults for seven projects.	4/1/80	-Report on funding sources	Program Services	Accomplished* - Colorado was selected to participate in the year 03 HUD/HEW 202 Demonstration Project which provides new funding sources for a number of projects. A VR grant application for Boulder Mental Health Center also has been approved and funded.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # III : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(6) To establish a training program through Fort Logan Mental Health Center for the moderately and severely mentally disabled for successful functioning in community programs.	6/30/80	-Funding sources obtained -Program established	FLMHC	Not Accomplished - This objective was based on the premise that mental health centers would purchase this service from Fort Logan. Exploration with the Metropolitan centers indicated that they would not have funds for such a purchase of service this fiscal year. This issue will be explored again in FY 80-81 for possible implementation in FY 81-82.	
	(7) To establish a short-term "private practice model" Adult Psychiatry Service at Fort Logan Mental Health Center.	6/30/80	-Service functioning	FLMHC	Not Accomplished - Fort Logan was not able to obtain funding for this objective for this fiscal year. This issue will be explored again in FY 80-81 for possible implementation in FY 81-82.	
	(8) To offer consultation to community mental health centers/clinics regarding residential programs for the elderly through Colorado State Hospital.	6/30/80	-Four consultations provided	CSH	Accomplished - Four consultations have been provided: (1) to the Arkansas Valley Interagency Council, involving the Southeastern Colorado Mental Health Center; (2) to the Senior Speakout Program in Lamar, Colorado; (3) to the Senior Resource Development Agency (SRDA) in Pueblo; and (4) to the Spanish Peaks Mental Health Center.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : To maximize limited resources through coordinated public and private delivery systems and through accessing all available funding.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
System Goal #6. TO MAXIMIZE LIMITED RESOURCES BY COORDINATING THE PLANNING AND DELIVERY OF MENTAL HEALTH SERVICES WITH OTHER HUMAN SERVICE AGENCIES.	(1) To develop individualized, pertinent agreements with each center/clinic in the Colorado State Hospital service area to insure an optimum working relationship.	9/1/79	-Written agreements	CSH Centers/Clinics	Accomplished* - Eight agreements were completed by 9/1/79. The ninth agreement was signed on 10/5/79. These agreements are available for review.	
	(2) To develop a routine method for obtaining input on important alcohol/drug and mental health issues from providers of substance abuse and mental health services and other concerned agencies and citizens.	10/1/79	-Description of method	Program Services	Accomplished* - An open public meeting was held on 2/28/80. A list of DMH/ADAD Workshop Recommendations and a list of participants were developed following the public meeting.	
	(3) To develop guidelines for cooperative provision of emergency services for DMH and ADAD funded agencies.	10/31/79	-Guidelines distributed	Program Services	Accomplished* - The "Guidelines for Cooperative Provision of Emergency Services" was distributed in January, 1980.	
	(4) To develop a plan for implementing the cooperative agreement between the Divisions of Mental Health and Rehabilitation to ensure coordination in planning, service delivery, data exchange, and training resources.	10/31/79	-Written plan	Program Services Planning Services	Accomplished* - The state-level implementation plan (a provision of the Cooperative Agreement) and guidelines to be used for developing local agreements were completed and disseminated by 10/31/79.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(5) To establish a liaison between the HUD/HEW Section 202 Denver sites and the HUD Regional Office and DMH.	11/1/79 *****	-Written report	Program Services	Accomplished - Continuing communications and meetings have established a solid liaison relationship.	
	(6) To address Denver Juvenile Court problems within the mental health system and with the Juvenile Court through Fort Logan Mental Health Center.	12/31/79	-Minutes of Region 3 Directors' Council reflect planning on this issue -Documentation of meetings and agreements with Denver Juvenile Courts	FLMHC Region 3 Centers/ Clinics	Not Accomplished - An extended due date of 3/31/80 was established first quarter, as the amount of time needed to coordinate activities with the agencies involved was underestimated. After work began on the objective, Fort Logan determined that the current system was working reasonably well and that the objective was no longer necessary for this year. This objective will be addressed in FY 1980-81.	
	(7) To develop a written plan between the Divisions of Mental Health, Developmental Disabilities, and Youth Services which will address the service needs of clients with overlapping problems.	1/31/80 *****	-Written plan	Program Services CSH FLMHC	Not Fully Accomplished* - The DMH/DYS statement has been completed and distributed. The DMH/DD plan was not completed and has been reassigned to the DD/DMH Coordinator for completion.	
	(8) To develop a proposal, to be submitted to the State Council on Criminal Justice, for a program that will impact the availability, accessibility, and quality of services to assault victims.	3/1/80	-Proposal submitted to the State Council on Criminal Justice	Committee on Sexism	Accomplished* - The DMH Committee on Sexism and the Division of Criminal Justice jointly developed guidelines for a sexual assault program. The proposal was approved by the State Council on Criminal Justice. The Division of Criminal Justice anticipated the dissemination of RFPs early in April 1980; however, the program was abandoned due to the termination of Federal LEAA funding.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(9) To work with the Department of Institutions to analyze the vocational service needs and resources of Community Support System clients statewide to identify gaps in service and to design programs to fill the gaps.	4/1/80	-Written report	Program Services	Accomplished* - A final report of these activities is available from the Department of Institutions.	
	(10) To coordinate a review and recommend a system of payment for those clients who cross over between ADAD and DMH treatment systems.	6/30/80	-Written recommendations	Financial Services	Not Accomplished - Due to time constraints, the necessary information from the agencies was not received on time. This objective will be accomplished by 9/30/80.	
	(11) To have developed a plan for establishing a team at Fort Logan Mental Health Center to work with the Juvenile Court, providing all Juvenile Court evaluations and as much on-site treatment as is necessary in conjunction with the Division of Youth Services.	6/30/80	-Completed plan	FLMHC	Not Accomplished - The current system is working reasonably well at the present time; therefore, this objective was not accomplished as written. This issue will be addressed further with the juvenile courts in FY 1980-81.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(12) To have developed a plan for establishing a team at Fort Logan Mental Health Center to work with courts, where appropriate, in the Metropolitan Denver area for evaluations, including deferred prosecution and conditions of probation.	6/30/80	-Completed plan	FLMHC	Not Accomplished - Fort Logan underestimated the time and resources involved in accomplishing this objective; therefore; it was not accomplished by 6/30/80. A similar objective has been proposed in the FY 1980-81 DMH Operating Plan.	
	(13) To have developed a plan for providing medical services through Fort Logan Mental Health Center to Division of Youth Services and Department of Corrections agencies in the Metropolitan Denver area.	6/30/80	-Completed plan	FLMHC	Not Fully Accomplished - The Medical Services Committee of the Department of Institutions is approaching this objective in a manner that will not result in the written plan by 6/30/80. Subcommittees have been established to review the recommendations of the Medical Services Survey and to develop implementation strategies. Central medical services for the Division of Youth Services will be established. This objective will continue to be addressed at the Departmental level.	
	(14) To co-sponsor a training program with the Division of Alcohol and Drug Abuse and the DMH Manpower, Development, and Training Section.	6/30/80	-Training program provided	Program Services	Accomplished - "The Art of Training Design and Delivery," was co-sponsored and completed October 22-24, and November 8-9, 1979. In addition, the DMH/ADAD Forum was held on 2/28/80.	
	(15) To provide a forum to develop a continuity of care system pertaining to services to women.	6/30/80	-System developed	Committee on Sexism	Accomplished - The Committee on Sexism formed a Continuity of Care Subcommittee to address this objective. The development of a continuity of care "system" was determined to have been overly ambitious. The Committee itself will provide the forum for this objective.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # IV : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
System Goal #7. TO INCREASE FUNDING, INCLUDING BUT NOT LIMITED TO MEDICAID AND MEDICARE, TO MENTAL HEALTH AND TO ESTABLISH CRITERIA FOR THE REGULATION OF THAT FUNDING BY THE STATE MENTAL HEALTH SYSTEM.	(1) To obtain an 1115 Waiver from the Department of Social Services, if necessary, to obtain additional Medicaid dollars at centers with HUD programs.	3/31/80	-Joint agreement with DMH and DSS on 1115 waiver, if needed	Financial Services	Accomplished* through implementation of the Medicaid program (S.B. 36), effective 10/1/79. The 1115 Waiver is no longer necessary, as all services that would have been available to Medicaid clients under this waiver are now available.	
	(2) To implement a Medicaid plan that maximizes the Medicaid benefits to eligible mentally disabled clients at centers and hospitals.	6/30/80 *****	-Dollars received from Medicaid in FY 80 compared to those received in FY 79	Financial Services	Accomplished*- SB 36, providing payment to centers under the Medicaid Clinic Option program, was implemented 10/1/79. Rates increased at both hospitals. Several programs not previously approved by Medicaid at CSH are being negotiated, as are attempts to obtain higher rates for persons over age 65 for CSH and FLMHC.	
	(3) To implement a Medicaid plan that maximizes the Medicaid benefits to eligible hospital patients served at Colorado State Hospital.	6/30/80	-Dollars received from Medicaid in FY 80 compared to those received in FY 79	CSH	Not Accomplished - The figures for the first eight months of FY 79-80 showed an increase over the first eight months of FY 78-79. However, during the past four months, CSH has experienced a significant collection problem with the Medicaid program. The number of patient days billed to Medicaid for payment has been reduced by 15%. Additionally, the Medicaid Management Information System of the Colorado Department of Social Services has continued to create a backlog of claims for processing, and subsequent payments received by CSH.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : To provide services efficiently.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
System Goal #2. TO REGULATE AGENCIES PROVIDING PSYCHIATRIC CARE WHERE THEIR PROGRAMS BEAR ON THE PUBLIC INTEREST, INCLUDING THE PROTECTION OF PATIENTS' RIGHTS.	(1) To have promulgated a standard on patients' rights to refuse prescription medication.	9/1/79	-Standard promulgated	Program Services	Accomplished* - The rule was promulgated; however, a Colorado Supreme Court decision requires that this rule be amended. The amended rule will be promulgated by 6/30/80.	
	(2) To evaluate the compliance with state standards of the 23 centers/clinics.	10/31/79	-Audit reports -Written certification	Program Services	Accomplished* - The results of these evaluations will be presented during the contract negotiations with each of the centers/clinics. DMH certificates are being issued.	
	(3) To develop and implement a plan for DMH internal review of centers and clinics.	10/31/79	-Reviews occurring	Program Services	Accomplished - The internal review process is completed for each center/clinic prior to the contract negotiation with that center/clinic. The expected completion date is July 30, 1980.	
	(4) To develop and implement a plan for DMH on-site activities at centers/clinics to include monitoring contracts, 27-10 compliance, quality assurance, and program and fiscal consultation.	10/31/79	-On-site activitics occurring	Program Services	Accomplished* - The 1980 site visit schedule for 27-10 site visits and the 1980-81 contract agreements between DMH and the Centers Association are available for review.	
	(5) To have designed and implemented a system for licensing community mental health centers/clinics in conjunction with the Department of Health.	12/1/79 *****	-Licensing process implemented	Program Services	Accomplished* - The licensing process has been implemented through the Department of Health. The Department of Health has licensed 20 free-standing mental health centers plus three which are with hospitals that come under the hospital's license.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(6) To determine the effectiveness and cost benefit of using a single auditor concept to evaluate the administrative and fiscal operations of the 23 centers/clinics based upon the individual audits for FY 1979.	1/31/80	-Completion of study of the results of FY 79 audits -Recommendation to DMH Director	Financial Services	Accomplished* - Based on a review of the audits submitted by the community mental health centers for the year ending 6/30/79, the Division will continue the present practice of using audits performed by private audit firms for one more fiscal year. At the end of that year, the completeness and usefulness of the audits submitted will be evaluated to determine the effectiveness and cost benefit of using a single auditor.	
System Goal #4. TO ENSURE THE APPROPRIATE UTILIZATION OF ALL AVAILABLE RESOURCES BY CLIENTS MOST IN NEED.	(1) To refine the uniform cost accounting system between Fort Logan Mental Health Center and Colorado State Hospital.	10/31/79	-Submittal of updated cost allocation procedures and uniform reporting formats to the two hospitals	Financial Services CSH FLMHC	Accomplished* - Cost reports were submitted for each quarter of FY 1979-80.	
	(2) To conduct a study of the children and adolescents who have been placed out of state for the purpose of planning in-state treatment.	11/30/79 *****	-Analysis of data -Recommended plan	Program Services	Accomplished* - The study was originally intended to be based on DSS data. That data has been analyzed and a report has been written. Subsequently, the study was expanded to include social worker interviews, analysis of state hospital assessments by outside consultants, and visits to out-of-state treatment facilities.	
	(3) To combine general hospital and geriatric resources for the treatment and care of neurologically handicapped patients at Colorado State Hospital.	1/1/80	-Combined service established	CSH	Accomplished in that the objective was explored and, as a result, a decision was made not to combine resources. The combined General Hospital/Geriatric Program was not considered feasible or practical. The diversity of patients involved prevents their mixture, and an effective treatment program cannot be developed.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(4) To complete a data collection and billing project to determine the feasibility of an individual client billing system for centers/clinics.	1/31/80 *****	-Written report to the Joint Budget Committee	Financial Services Program Services	Accomplished - The original intent of the study was changed by the JBC. A task force was established to recommend the number and type of units of service to be used by the mental health system. The task force completed its work, and a final report will be published in July 1980.	
	(5) To propose service elements which are appropriate in the provision of treatment and support systems for certain priority groups, such as children, elderly, and minorities.	2/29/80	-Written proposals to DMH Director	Program Services	Not Accomplished - This objective was determined to be a duplication of objectives (9) and (10) under System Goal #3. The Joint Units of Service Task Force, however has completed final recommendations for the data reporting aspect of this objective.	
	(6) To refine the operational definitions of clients qualifying for the severity target group.	3/31/80	-New operational definitions	Program Services	Not Accomplished - It has been decided to maintain the current operational definitions, but to consider major deviations on an agency-by-agency basis.	
	(7) To refine the billing and reporting system to achieve a higher degree of integration between the two.	3/31/80	-Recommendation for systems modification	Financial Services	Accomplished* - As of October 1, 1979, the two reporting systems were integrated (i.e., ten reporting categories).	
	(8) To have a plan developed to address the adult psychiatric waiting list at Fort Logan Mental Health Center.	3/31/80	-Written plan	FLMHC	Accomplished* - The written plan was completed and implemented as of 5/19/80.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(9) To determine if the unit of service cost system creates problems in billing for program components and, if so, to recommend solutions.	4/30/80	-Analysis of current system -Recommended solutions, if needed	Program Services	Accomplished - The Joint Units of Service Task Force had its last meeting on April 25 to recapitulate the recommended changes. DMH approved those changes which will be published by August 1, 1980.	
	(10) To develop and implement a long-range plan for research in forensic psychiatry at Colorado State Hospital.	6/30/80	-Plan implemented	CSH	Accomplished* - The CSH Institute for Forensic Psychiatry data system has been completed.	
	(11) To recommend appropriate treatment programs for children and adolescents with mental health needs who are currently being sent out of state.	6/30/80 *****	-Program recommendations	Program Services	Not Fully Accomplished - A report has been written. The Department of Institutions is currently working on developing recommendations and finalizing the report.	
	(12) To increase the patient collections at Colorado State Hospital by 7% and at Fort Logan Mental Health Center by 12% over FY. 1977-78 collections.	6/30/80	-Patient collections data	CSH FLMHC	Accomplished - CSH: A 7% increase is $7,604,810. CSH's projection as of 6/30/80 was $8,155,000 or a 14% increase. FLMHC: A 12% increase is $4,515,000. FLMHC's projection as of 6/24/80 was $4,959,000; consequently, Fort Logan also is running ahead of projections.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
System Goal #9. TO DEVELOP THE STATE'S CAPACITY FOR MENTAL HEALTH MANPOWER PLANNING AND DEVELOPMENT TO ENSURE THAT THE APPROPRIATE STAFF ARE AVAILABLE AND BEING UTILIZED EFFECTIVELY THROUGHOUT THE STATE MENTAL HEALTH SYSTEM.	(1) To organize a broadly-based advisory committee to the Colorado Mental Health Manpower Development Program.	12/31/79	-Committee minutes	Program Services	Accomplished* - The membership roster and minutes from meetings of the Advisory Committee are available for review.	
	(2) To analyze the affirmative action plans for both hospitals and the 23 centers/clinics for the purpose of setting statewide goals for affirmative action specifically related to ethnic minorities, the over-50 age group, the physically handicapped, and women.	1/31/80 *****	-Statewide goals for affirmative action established	Affirmative Action Committee	Accomplished* - The plans for the 23 centers/clinics have been reviewed. Affirmative Action Guidelines have been developed.	
	(3) To establish the beginning of a comprehensive data bank on the mental health work force in Colorado.	6/30/80 *****	-Data summary report	Program Services	Accomplished* - The survey of the private mental health sector, in cooperation with the MHA, was designed and mailed with a return date of 6/30/80. The data will be analyzed this summer, and a written report will be available in the fall. The next focus will be on the public sector survey.	
	(4) To conduct studies of the mental health manpower requirements for carrying out the service goals in this Plan.	6/30/80	-Written studies	Program Services	Accomplished* - The continuation grant proposal outlined two pilot studies to assess skills needed to work with priority client groups - chronic clients and minority clients.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # V : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(5) To organize and conduct training programs around the service goals of this Plan for the staff of hospitals, centers, and clinics.	6/30/80	-Training summaries	Program Services	Accomplished* - Summaries of the training programs that were offered during each quarter of FY 1979-80 are available from the Division.	
	(6) To have developed a plan for establishing an effective, comprehensive employee relations program at Fort Logan Mental Health Center, including all aspects of a progressive, productive personnel system, to improve employee satisfaction.	6/30/80	-Plan developed	FLMHC	Accomplished* - A plan was submitted to the Director of Fort Logan by 6/1/80.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # VI : To ensure that services are provided at a reasonable cost.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
System Goal #8. TO PROVIDE SERVICES TO TARGET POPULATION CLIENTS AT REASONABLE COSTS THROUGHOUT THE STATE MENTAL HEALTH SYSTEM.	(1) To implement the use of SCOPE as a management measure for the two state hospitals.	10/31/79 *****	-Draft of FY 80-81 budget request reflects SCOPE -Documentation in minutes of review of staffing based on SCOPE -Personnel assignment accomplished in accordance with SCOPE data	Financial Services CSH FLMHC	Not Fully Accomplished* - The DMH FY 80-81 Budget Request reflected SCOPE data. It is desirable to use SCOPE data as a management tool; however, that process is not feasible at this time due to the fact that clinical areas show rather significant minuses in the number of FTEs required. Nevertheless, staffing adjustments which partially reflect SCOPE findings have been made at both hospitals.	
	(2) To conduct a feasibility study of using a uniform ability-to-pay client fee schedule for community mental health centers and clinics.	12/31/79	-Written report to DMH Director	Financial Services	Not Accomplished* - Discussions on this issue were included at the Client Fee Workshop held on March 6-7, in Granby, Colorado, with no conclusions reached. A representative of OSPB, who is coordinating a statewide study on this issue, also was present at the Workshop. The study has begun. A written report on this issue was submitted to the Director of DMH.	
	(3) To recommend interim staffing standards for administrative and clinical support positions at Colorado State Hospital and Fort Logan Mental Health Center.	1/31/80 *****	-Written recommended standards for each area area not covered by SCOPE	CSH FLMHC	Accomplished* - An interim report was submitted to the JBC on January 2, 1980. A final report will be submitted to the JBC after follow-up work to set standards for activities not included in either SCOPE or these standards is completed.	
	(4) To revise DMH Accounting and Auditing Guidelines to consolidate addenda issued during the past three years.	1/31/80	-Submission of revised guidelines to centers/clinics	Financial Services	Accomplished* - A draft of the Revised Guidelines was disseminated to centers/clinics on March 24, 1980. The comments received on the draft will be considered before final revisions are made.	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1979-80 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS GOAL # VI : (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1979-80	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	ACCOMPLISHMENT	COMMENTS
	(5) To expand outpatient billing at Colorado State Hospital to include services for all outpatients.	1/31/80	-All outpatients billed	CSH	Accomplished*- All outpatients are billed at CSH who have an ability to pay or insurance benefits. A report was submitted to the Director of DMH on April 10, 1980.	
	(6) To establish criteria for determining what are reasonable unit costs, for reimbursement purposes, at community mental health centers and clinics.	2/29/80 *****	-Written listing of criteria used in reviewing unit cost worksheets	Financial Services	Accomplished* - A report has been submitted to the Director of DMH.	

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APPENDIX I. ADMINISTRATIVE INFORMATION

A. 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 provided on page 4 of this appendix.

2. Functions, Responsibilities, and Procedures

The State Mental Health Advisory Council functions as the official advisory body to the Division of Mental Health (DMH). The Council is responsible for approving the State Mental Health Plan and for approving priorities for the allocation of state mental health dollars. 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 the service priorities of the Division of Mental Health and to approve changes in priority areas.
b. The Council meets as often as necessary, but not less than quarterly, to consult with the state agency on the development, revision, 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 annual review and approval of the State Mental Health Plan.
d. The Council establishes task panels 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 on a monthly basis since its formation. Minutes have been kept of all meetings (copies of the minutes of the meetings held this past year are included in this 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 also included in this 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 function of the mental health system and how the various staff activites 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.

In its second year the SMHAC continued to become better acquainted with the state mental health system. Many members of the Council attended the annual state mental health conference. The SMHAC 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 that year and participated in the presentation of the division's request to the Joint Budget Committee of the state legislature. The SMHAC also became a charter member of the Governor's Advisory Council on the Handicapped.

In its third year, the SMHAC became much more involved in approving the priorities and directions of the Division of Mental Health. The entire Council reviewed the division's budget request prior to the presentation to the Joint Budget Committee of the state legislature. Council members attended and participated in the presentation of the division's request to the Joint Budget Committee. The SMHAC established task panels to serve as a resource and to provide for more thorough reviews of issues addressed by the Council. The four task panels include the Children/Adolescent Task Panel, the Elderly Task Panel, the Rural Task Panel, and the Minority Task Panel. A permanent State Plan Subcommittee also was appointed. Members of the Council carefully considered over 100 communications received from various agencies, organizations, and individuals concerning the update of the State Plan. The final draft was prepared and was approved by the Council for submission to the Department of Health, Education, and Welfare.

In the past year, the SMHAC has focused its attention on the State Mental Health Plan, the division's budget, public awareness issues, and division grants.

Following a review of the Work Force Development Grant, the Council passed a motion requesting that division staff keep the Council informed of significant (involving $10,000 or more) grant applications to provide the Council with information and an opportunity for input.

There is a dearth of media material to inform the general public about the Colorado mental health system. The Council has considered several alternatives. A slide presentation developed by the Colorado Association of Community Mental Health Centers and Clinics will be made available to the Council and the division. The Council will continue to identify possible sources of funding which could support the development of a film or other media presentations on the state mental health system.

Members of the Council were involved in developing the guidelines for the catchment area mental health plans. The State Plan Committee

reviewed the twenty catchment area mental health plans and determined how the plans would be integrated into the State Plan.

During the next year, the Council will continue to be very involved in the mental health planning process. The budget, as a companion document to the State Plan, also will continue to receive a great deal of attention from the Council.

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	
Guidotta Bates 9/81	X						X	Brush	X			X				Consumer
Colleen Casagram 9/80	X						X	Arvada			X	X				Consumer
Lucy May Dame 9/81	X						X	Denver		X		X				Senior Citizens Board
Dorothea Dolan 9/80	X						X	Denver		X		X				Retired
Melanie Fairlamb 9/80	X						X	Delta	X			X				Consumer
Peter Garcia 9/81		X			X			Lafayette			X		X			Boulder MH Center; HSA Member
Jerry Goebel 9/80		X					X	Boulder			X		X			UCHSC, Div./Child Psychiatry
Fred Lane 9/80		X					X	Aspen	X			X				Mental Health Association
John Marshall 9/81		X					X	Boulder			X	X				Jefferson County Legal Aid
Isabelle Medchill 9/80	X					X		Monument	X				X			**Indirect Provider**
Luis Medina 9/81		X			X			Alamosa	X				X			San Luis Valley MH Center
Katherine Money 9/81	X						X	Montrose	X			X				Real Estate
John Nagle 9/81		X					X	Denver		X					X	Dept. of Health/SHPDA
Jack Quinn 9/81		X					X	Pueblo		X		X				Pueblo Housing Authority
Roger Richter 9/80		X					X	Denver		X		X				Insurance and Real Estate
Nancy Sanford 9/80	X			X				Colorado Springs		X			X			Southeastern Colorado HSA
Patrick Smid 9/80		X					X	Denver		X		X				Consumer
Marge Taniwaki 9/80	X		X					Denver		X		X				Student
Michael Weissberg 9/80		X					X	Littleton			X				X	UCHSC, Dept. of Psychiatry
Robert Young 9/81		X					X	Boulder			X				X	DSS, Div. of Rehabilitation
Cece Zavala 9/81	X				X			Rocky Ford	X				X			Otero Juvenile Diversion Counselor

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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. (See attached amendment.)

(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.

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(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.

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

ARTICLE IV-OFFICERS

Each year the members of the Council will elect a Chairperson and Vice-Chairperson from the Council membership. A recording secretary may be designated by the Chairperson. The Chairperson and Vice-Chairperson shall be elected by the Council at its Annual Meeting. (See attached amendments.)

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

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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.

STATE MENTAL HEALTH ADVISORY COUNCIL

BYLAWS

AMENDMENT

ARTICLE IV - OFFICERS of the bylaws of the State Mental Health Advisory Council was amended at the November 1978 meeting of the Council to read as follows:

"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 or as replacement becomes necessary by a majority vote at a regular meeting, following two weeks' notice of the vote to members.

In the absence of both the Chairperson and Vice-Chairperson, a majority vote of the members present will be used to select an acting Chairperson to preside at the meeting."

Amendment passed by State Mental Health Advisory Council on November 9, 1978.

Sally Oglesby

Sally Oglesby, Recording Secretary
State Mental Health Advisory Council

11-78

STATE MENTAL HEALTH ADVISORY COUNCIL

BYLAWS

AMENDMENT

ARTICLE II - PURPOSES AND FUNCTION, Section (a) of the bylaws of the State Mental Health Advisory Council was amended at the July 1979 meeting of the Council to read as follows:

"(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 be responsible for approval of the State Mental Health Plan."

Amendment passed by State Mental Health Advisory Council on July 12, 1979.

Sally Oglesby

Sally Oglesby, Recording Secretary
State Mental Health Advisory Council

7-79

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: January 10, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Jerry Goebel
John Marshall
Isabelle Medchill
Luis Medina
Jack Quinn
Roger Richter
Nancy Sanford
Marge Taniwaki
Robert Young

Absent:

Colleen Casagram
Fred Lane
John Nagle
Michael Weissberg

Staff Present:

Lynn Dawson
Sutherland Miller

Guests:

Fred Garcia

* * * * * * * *

Approval of Minutes - Mr. Richter moved that the minutes of the December Council meeting be approved. Ms. Dame seconded the motion. The motion passed.

Director's Report - Dr. Miller reported that the Governor-appointed Advisory Board for Service Standards and Regulations has begun reviewing the service rules and regulations for mental health centers/clinics to ensure quality of care and to be certain that agencies are responsive to the communities in which they exist. Two letters have been sent to the community mental health centers/clinics requesting recommendations for revisions of the standards. Very little input has been received.

WICHE has been awarded a federal grant to investigate the possibility of replicating, and perhaps improving, the State of Oregon's methodology for measuring quality of life. Colorado has been selected as a test state by the federal government. DMH will be working with WICHE.

The Division received the recommendations from the JBC staff analyst. Included were recommendations for staff cuts at Fort Logan Mental Health Center and the Colorado State Hospital. These were based on the analyst's use of staffing standards in Alabama related to the Wyatt vs. Stickney case. SCOPE data in Colorado, however, shows Fort Logan to be down 37 staff and Colorado State Hospital down 76 staff.

Dr. Miller then explained the issues related to the legal problem of dual commitment. This involves commitment to the Department of Corrections (for criminal acts) and to the Department of Institutions (for persons adjudicated not guilty by reason of insanity). The law is unclear in cases of dual commitment, and the Division has not received clarification from the Attorney General's Office on this issue.

Ms. Dolan read to the Council a letter from Dr. Pardes regarding the question of 314(g) funding.

Budget Committee Report - Mr. Richter reported that the Budget Committee did not meet during the past month.

State Plan Committee Report - Mr. Richter reported that the Division has received 15 catchment area plans. Each member of the Committee has been given copies of the plans to review. An all-day meeting has been scheduled for January 28th to discuss the plans. The Committee will comment on each plan, review staff analyses of the plans, and identify the key issues for mental health that are generated by the plans. The Committee also will address the issue of how to integrate the plans into the State Plan. The possibility of creating a separate volume which would incorporate the catchment area plans was discussed.

Public Awareness Committee Report - No Public Awareness Committee report was given, as Ms. Casagram was absent.

Child/Adolescent Task Panel Report - Mr. Goebel said that there was no report from the Child/Adolescent Task Panel.

Elderly Task Panel Report - Ms. Dame reported that no money has been forthcoming from either the State or the City of Denver for day care for the elderly.

Minority Task Panel Report - Mr. Garcia said that migrant workers want health services, including mental health services, near where they are living, rather than using catchment area services. The question of working out an agreement with the State Health Department was discussed. Mr. Richter moved that the Council request the Division to make contact with the appropriate state officials to arrange a meeting with the Division and the Council to explore the feasibility of incorporating mental health in their work with migrants. Ms. Medchill seconded the motion. Discussion followed on the need to develop a model program incorporating both the Division of Mental Health and the Department of Health. Ms. Fairlamb called for the question; the motion was passed.

Rural Task Panel Report - Ms. Fairlamb reviewed for the Council the Report on Rural Issues in the Development of Community Support Systems. The report deals with specific issues for rural Colorado in terms of community support systems. The need for a newsletter regarding rural issues was discussed.

Election of Council Officers - Although the agenda had called for the election of officers later in the meeting, the election was held earlier at the request of some of the members who had to leave early. Mr. Richter was elected Chairman of the Council, and Ms. Medchill was elected Vice-Chairman. At Ms. Dolan's insistence, Mr. Richter immediately took over the chair.

Mr. Quinn moved that a vote of thanks be given Ms. Dolan for her work in chairing the Council. Ms. Fairlamb seconded the motion; the motion passed unanimously.

Mr. Richter showed members of the Council a newspaper clipping of an article by Dr. Edmund Casper, Director of the Health and Hospitals Mental Health Programs, regarding the community support system. The article will be copied and distributed with the minutes to members of the Council.

Workforce (Manpower) Development Grant Report - Paul Myers, Director of the Division's Statistical Analysis and Research Section, and Dr. Carolie Coates, Chief of Manpower Research, described the Colorado Five-Year Workforce Project, which is known at the Federal level as the "Manpower" Project. The thrust of the Workforce Project is on mental health workforce planning and development. To carry out this thrust, the Project has identified a number of activities for this year:

(1) developing a workforce data base;
(2) conducting two pilot studies, one focusing on the skills needed to work with the chronically mentally ill and one on the skills needed to work with minorities;
(3) establishing contact with colleges and universities in the area; and
(4) identifying need and intervention strategies (including training), with the assistance of the Workforce Advisory Committee.

Luis Medina is a member of the Workforce Advisory Committee, and will serve as a link between that Committee and the Council.

The Division will be working with the Mental Health Association, WICHE, and the universities and colleges.

Dr. Coates invited members of the Council to provide input to the Project. Mr. Richter asked Mr. Myers and Dr. Coates if they would keep the Council up-to-date with the information which they acquire.

New Business - Ms. Dawson announced that the three vacancies on the Council, one for a provider and two for consumers, are in the process of being filled. We are waiting for the Governor to issue an Executive Order appointing the new members. The question of whether board members should be regarded as providers or consumers was discussed. Ms. Sanford pointed out that the Federal health legislation recently changed, and now allows for board members to be considered as consumer representatives on HSA boards. Dr. Miller stated that the Division continues to view mental health board members as providers, since they are responsible for the total operation of the center/clinic.

Mr. Richter said that he would soon be making appointments for the position of chairperson of the State Plan Committee and for the position of chairperscn

of the Budget Committee, as he will not be able to continue chairing those committees.

Respectfully submitted,

Virginia Kelly
Recording Secretary

Distribution:

SMHAC Members
Executive Director
Board Presidents
John Aycrigg
Gayle Briggs
Dave Bustos
James Ciarlo
Ernest Ficco
Fred Garcia
Donald Glasco
Bob Hawkins
David Harrod
Haydee Kort
Ron LaScala
Raymond Leidig
Earl McCoy
Grace Patston
Charlotte Redden
Lenore Rosenblum
Elinor Stead
Maryellen Waggoner
Andrew Wallach
Leon Willis
Carol Barbeito Thompson
DMH Staff

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: February 14, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Colleen Casagram
Dorothea Dolan
Peter Garcia
Jerry Goebel
Fred Lane
John Nagle
Jack Quinn
Michael Weissberg
Robert Young

Absent:

Guidotta Bates
Lucy May Dame
Melanie Fairlamb
John Marshall
Isabelle Medchill
Luis Medina
Roger Richter
Nancy Sanford
Marge Taniwaki

Staff Present:

Lynn Dawson
Tom Lewis
Ambrose Rodriguez

* * * * * * * *

In the absence of both the chairman, Mr. Richter, and the vice-chairman, Ms. Medchill, Ms. Dolan conducted the meeting.

Approval of Minutes - Mr. Young moved that the minutes of the January meeting be approved. Mr. Lane seconded the motion. The motion passed.

Mr. Garcia brought up the issue of patient fee collections. Mr. Lewis told the Council that the Division will be sponsoring a fee collections workshop on March 6th and 7th. It is hoped that a uniform schedule for determining ability to pay will be developed.

Director's Report - Mr. Rodriguez reported that the Joint Budget Committee has decided to partially fund the supplemental request for the two state hospitals. Colorado State Hospital is short $510,000, and Fort Logan Mental Health Center is short $290,000. If the request is not fully funded, 148 employees at CSH and 70 employees at Fort Logan will receive lay-off notices. Mr. Rodriguez also said that clinical units at both hospitals would have to be closed, which would require the discharge or transfer of approximately 168 patients. The Office of State Planning and Budgeting is asking for additional supplemental funds. Mr. Lewis explained that the $800,000 is needed to cover the rest of this fiscal year. The Division was advised by the Joint Budget Committee to hire at the appropriated level of FTEs throughout the year with the understanding that if more money were needed, a supplemental could be requested. The JBC made it clear that it was their intention to fund the positions fully; therefore, they were filled at the funded level. Fort Logan and CSH will prepare reports on the impact of the Joint Budget Committee's decision on the Division. If the problem remains unresolved, lay-off notices will be issued

on March 1st, to be effective April 1st.

Mr. Rodriguez explained that the federal administration has not and will not request 314(g) funds for this year. In Colorado these funds have been used for special projects such as this Council, the migrant mental health project, and the Committees on Sexism and Racism, and for salaries of three Division staff positions.

Members of the Centers Association were to have submitted contract items to be negotiated by the end of November. In a meeting with representatives of the Division and the Centers Association, the following items were discussed for inclusion in the 1980-81 DMH/center contracts: (1) more flexibility to allow the contracts to be altered to meet the needs of individual centers; (2) better counting of clients by adding unenrolled clients and clients already enrolled to admissions; (3) the addition of incentives to the contracts; (4) the addition of new factors that would impact on rates; (5) the stipulation that each agency will submit a catchment area plan annually; and (6) the addition of community support program activities as part of the master contract rather than a separate contract. There was general agreement on all of the above items with the exception of the factors impacting on rates. The schedule for the contract negotiations with the centers will be made available to the Council. Council members are invited to attend the contract negotiations to observe the contracting process.

Mr. Rodriguez also announced that Dr. Miller has sent a letter to the centers indicating that the Division's preference is to contract for specific outcomes rather than to regulate the internal activities of centers.

Mr. Rodriguez has talked with Charles Stout, Director of the Colorado Migrant Health Program. Mr. Stout has offered to meet with members of the Council and Division staff to discuss how mental health concepts might be introduced into the Program. Mr. Garcia and Dr. Medina will represent the Council.

Budget Committee Report - Since Mr. Richter was not present, there was no report from the Budget Committee.

State Plan Committee: Ms. Dawson reported that Mr. Richter has appointed Ms. Medchill to chair the State Plan Committee. The Committee held an all-day meeting on January 28th to review the catchment area mental health plans. The Committee's comments and recommendations on the local plans were summarized. Ms. Dawson handed out copies of the summary to members of the Council. The summary will be discussed at the next Council meeting.

Public Awareness Committee Report - Ms. Casagram had no report from the Public Awareness Committee. She suggested that someone else be appointed to chair the Committee, as she has become very involved in work with Colorado Women Forward, the group which is seeking the reinstatement of the Colorado Commission on Women.

Child/Adolescent Task Panel Report - Mr. Goebel did not have a report from

the Child/Adolescent Task Panel. The Child/Adolescent Steering Committee will hold its regular meeting on February 15th. Mr. Goebel will give a status report on Senate Bill 26, regarding out-of-state placement of children, at the March meeting of the Council.

Elderly Task Panel Report - No report was given, as Ms. Dame was absent.

Minority Task Panel Report - Mr. Garcia had no report from the Minority Task Panel. He will provide the Council with a report on the Colorado Migrant Health Program at the next meeting.

Rural Task Panel Report - Since Ms. Fairlamb was not present, there was no report from the Rural Task Panel.

New Business - Mr. Nagle called for a quorum. Since a quorum was not present, no new business was conducted.

Ms. Dawson reported that all Council membership vacancies have been filled. The Governor has appointed three new members. Patrick Smid and Katherine Money are consumer representatives, and Cece Zavala has been appointed as a provider representative. The new members will be attending the March meeting.

Noel Nesbitt, the Community Support Systems Project Director, has aked to be on the agenda for the March meeting to update the Council on the Colorado Community Support System Program.

The State Division of Rehabilitation has requested that the Division of Mental Health be represented on its Citizen Advisory Committee. Ms. Dawson announced that the Division would like to nominate a Council member, since the Committee is to be a citizens' advisory group. Mr. Young will talk with the Director of the Division of Rehabilitation, as his understanding is that the Director would like a staff member to represent the Division.

Ms. Dolan suggested that the Council submit a nomination for the Victor I. Howery Mental Health Award in rural mental health. Nominations must be received before March 1st. Ms. Dolan has copies of the nomination form.

Ms. Dolan announced that a new State Office of Voluntary Citizen Participation has been established. Ms. Dawson said that the Division staff will be meeting with Jerry Bagg, the new Director of that Office, to discuss coordination with mental health.

Mr. Nagle suggested that the State Plan Committee meet with the State Health Coordinating Council at their meeting on March 10th, as members of the SHCC have not been able to attend a regular meeting of the State Plan Committee. Mr. Nagle will contact Mr. Richter on this matter.

Attention was drawn to Dr. Weissberg's three consecutive absences. No action

was taken, for lack of a quorum.

The question of whether or not the boards of directors are truly representative of the people in the areas served by mental health centers was brought up by Mr. Garcia. This issue relates to Standards for centers; therefore, Mr. Garcia will talk with Al Sanchez of the Division.

Respectfully submitted,

Virginia Kelly
Recording Secretary

(Standard SMHAC Distribution)

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: March 13, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Fred Lane
Luis Medina
Katherine Money
John Nagle
Jack Quinn
Roger Richter
Marge Taniwaki
Michael Weissberg
Robert Young
Cece Zavala

Absent:

Colleen Casagram
Jerry Goebel
John Marshall
Isabelle Medchill
Nancy Sanford
Patrick Smid

Staff Present:

Lynn Dawson
Sutherland Miller

* * * * * * * *

Introduction of New Members: Mr. Richter introduced Ms. Money and Ms. Zavala to the other members of the Council. An orientation meeting for the new members, Ms. Money, Ms. Zavala, and Mr. Patrick Smid, will be held on April 10th, from 10 a.m. to 12 noon, in room B-106 at Fort Logan Mental Health Center. Other members who are interested are invited to attend.

Approval of Minutes: It was moved and seconded that the minutes of the February meeting be approved. The motion passed.

Director's Report: Dr. Miller reported that the Division's supplemental request to the Joint Budget Committee was approved. For the last several years the Division has had permission from the JBC to fill positions up to the allocated number (even though adequate funds were not appropriated), with the provision that supplemental funds could be requested later in the fiscal year. The same arrangement was in force for this fiscal year; however, the Division's supplemental request was not fully funded. Dr. Miller emphasized that the Division was not asking for additional funds per se, but only for permission to use funds that had been generated through patient billings. The supplemental funds which have now been appropriated were not allocated directly to the Division, but were given to the Governor's Office of State Planning and Budgeting. With this appropriation the Division has averted the necessity of laying off approximately 200 employees, which would have severely impacted the Colorado mental health system.

The press has been giving a great deal of attention to the violent client lately. The Public Information Officer for the Department of Institutions has delivered to the media a position paper which has been developed by the Division in an effort to clarify the issues involved.

Dr. Miller reported that the physicians' salary bill, sponsored by Senator Hughes and Representative Durham, is expected to pass this year.

The Joint Commission for Accreditation of Hospitals visited Fort Logan Mental Health Center last month. The results of the survey have not been received. Colorado State Hospital also had a Medicaid/Medicare survey. No major deficiencies were noted; however, all surveys point out the deficiencies in the staffing of both state hospitals.

A delegation from the People's Republic of China visited Fort Logan recently, as a part of the observation of the Year of the Child (1979). All the delegates were women who hold high positions and are very involved in the area of issues pertaining to children. Fort Logan was the only stop they made where they were given an opportunity to observe children in trouble and facilities providing care for such children. The PRC has no facilities or programs of this kind for children.

The Division is attempting to reach an agreement with the Colorado Association of Community Mental Health Centers and Clinics to look into some way of handling the problem of the waiting list at Fort Logan. The question has been raised as to whether or not a system for allocating state hospital beds should be adopted. The centers which refer clients to Fort Logan are most anxious that this issue be explored. The Division has begun to address this issue for the Fort Logan Mental Health Center Service Area.

Dr. Miller announced that on July 1st he will be leaving the Division to work in Washington, D.C. He will be joining the Staff College for NIMH and will be working in the area of management issues for mental health agencies across the United States.

State Plan Committee Report: In Ms. Medchill's absence, Dr. Medina gave the report for the State Plan Committee. The monthly meetings of the Committee will begin at 9:30 a.m. hereafter, rather than at 9 o'clock. The Committee anticipates having a draft copy of the State Plan by their next scheduled meeting (April 10th). The draft will go to the printer before the first of April, and it will be mailed to centers and organizations within about a week after that. Some sections of the local catchment areas' plans will be incorporated in the State Plan. The DMH staff is working on data which will go into the Plan. A review of the goals and objectives in the local plans indicates that they are consistent with State Plan goals and objectives. The State Plan Committee will meet on Wednesday, May 7th, from 1 to 5 p.m., in addition to the regularly scheduled Committee meeting in May (9:30 a.m. to 12 noon, May 8th) to review the draft. An all day meeting has been scheduled for May 30th from 9:30 a.m. to 5 p.m., to review all comments that are received on the draft. Council members who are not on the State Plan Committee are invited to participate in these reviews.
Dr. Medina reported that the Fort Logan Mental Health Center Advisory Council had presented objectives to the Committee for inclusion in the State Plan. Fort Logan's Council would like to increase the number of adult beds by July 1, 1981. The waiting list for beds continues to be long. According to

that Council, 50 to 100 persons could make use of additional beds. The local plan prepared by the Health and Hospitals Mental Health Program stated that 100 psychiatric beds need to be developed in the catchment area at a cost of approximately $1,250,000. Another objective proposed by the Advisory Council is to develop a plan for correctional patients who are now underserved or unserved. It is hoped that the Division will be able to establish a separate high-risk treatment center for 30 patients.

In regard to the question of a Certificate of Need for additional beds, Dr. Miller pointed out that CSH did not give up licensed beds when it tore down some buildings. The Division is exploring the possibility of redistributing licensed beds to fit needs, thus obviating the need for a Certificate.

The question of including objectives in the Plan with resource requirements was discussed. Dr. Miller pointed out that each program which came out of the Plan had a dollar amount attached to it. Ms. Dawson explained that only those objectives for which resources are available are included in the objectives for the current fiscal year. The objectives preceded by asterisks indicate items that will be included in the next fiscal year's budget request and future requests. This system allows readers of the Plan to see how program priorities drive the budget for mental health.

Mr. Nagle suggested that, in view of limited resources, present programs be evaluated. Ms. Fairlamb questioned the use of money for evaluation of services when that money might be spent on direct patient services. It was recommended that the Budget Committee and representatives from the State Plan Committee schedule a meeting prior to the next Council meeting to review the planning/budgeting process and to review Division outcome data and costs as they relate to proposed State Plan objectives.

Mr. Richter read a letter from the State of North Carolina, praising the State Plan, especially the sections on the principles under which the Plan is developed and on trends and issues. Mr. Richter said that the Division has a good Plan due to the work of Ms. Dawson and her staff.

Mr. Garcia expressed concern with the Plan for those who are not receiving services. Mr. Richter asked Mr. Garcia to attend the State Plan Committee meetings to discuss his concerns.

Public Awareness Committee Report: There was no report from this Committee, since Ms. Casagram was not present.

Child/Adolescent Task Panel Report: There was no report from this Task Panel, since Mr. Goebel was not present.

Mr. Richter said that he had made no changes in the membership of task panels and committees. After the orientation meeting, he will discuss committee and/or task panel assignments with the new members.

Elderly Task Panel Report: Ms. Dame said that there was no report from this

Task Panel.

Minority Task Panel Report: Mr. Garcia, Dr. Medina, and Ambrose Rodriguez met with the director of the Colorado Migrant Health Program. A meeting has been scheduled for April 8th to discuss an assessment of the needs for this population. There is hope that interagency agreements may be developed to integrate health and mental health services.

Rural Task Panel Report: Ms. Fairlamb reported that the Rural Task Panel is recruiting new members.

The problems of the rural centers in regard to reimbursement rates and productivity were brought up by Ms. Fairlamb. She expressed concern about some of the items proposed for the DMH/center contracts. Dr. Miller explained that the rate paid to the centers by the Division is presently determined by their costs. State statutes require the Division to set rates. The content of the contracts with the centers is negotiated by the Division and the Colorado Association of Community Mental Health Centers and Clinics.

New Business: Ms. Taniwaki announced that a meeting of the Asian Human Service Association will take place on March 19th and 20th.

Respectfully submitted,

Virginia Kelly
Recording Secretary

(Standard SMHAC Distribution)

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: April 10, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Lucy May Dame
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Jerry Goebel
Fred Lane
Isabelle Medchill
Luis Medina
Katherine Money
John Nagle
Jack Quinn
Roger Richter
Nancy Sanford
Marge Taniwaki
Robert Young
Cece Zavala

Absent:

Colleen Casagram
John Marshall
Patrick Smid
Michael Weissberg

Staff Present:

Lynn Dawson
Sutherland Miller

Guest:

David Bustos

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Committee Participation: Sign-up sheets were passed around for the various Council Committees. Mr. Richter will be making individual contacts for Committee membership. Although each Council member will have a primary Committee assignment, there is no limit to the number of Committees members can be on.

Approval of Minutes: It was moved and seconded that the March 13 minutes be approved. The motion passed. Under the Rural Task Panel Report, Ms. Fairlamb stated that she would like last month's minutes to reflect that she was expressing concern specifically about the Division's proposed factors impacting on reimbursement rates for rural centers.

Director's Report: Dr. Miller expressed the Division's appreciation to the Council for their efforts in working with the Legislature during the budget appropriation.

Interest in the violent client and the mental health laws continues by the newspapers and other organizations. A resolution has been passed by the Legislature to study issues related to the Colorado laws concerning the care and treatment of the mentally ill and the related criminal laws. The Mental Health Center of Boulder County brought in consultants to examine mental health in Colorado. It was their feeling that the issues of how to handle the difficult client and how to interpret mental health laws was a national concern and not just an issue in Colorado.

The Division and the Centers' Association reached agreements on the 1980-81 contracts. Contract negotiations with centers started last week. If a center wants to change the basic contracting format, the Division and center can change it together. As part of the contract, there is a requirement that centers have a utilization and peer review procedure, and the Division will review no more than 40 Medicaid clients. This will take place in order to determine the quality of clinical care. The Division is not requiring the quality assurance program as part of the contract. Dr. Miller stated the program is for managers, and after a year the managers should know whether or not the program is a benefit for them. The Management Services Audit will not be included this coming year. Agencies will submit fee collection objectives and quarterly reports.

The submission of local catchment area plans will be part of the contract. This year the Division is placing a greater emphasis on outcome and less on the internal procedures of centers.

Ms. Dolan asked Dr. Miller to comment on the unenrolled client. The Division only pays and counts clients admitted to a center. Unenrolled clients are those clients not admitted to a center. Of the priority groups, two of them, children and elderly are not always admitted or enrolled by the center. The Division has told centers it will count an unenrolled emergency visit as one admission; for other unenrolled clients, three contacts will equal one admission. Mr. Garcia felt it was very important for mental health programs to count these clients.

Child/Adolescent Task Panel Report: Mr. Goebel gave his report at this time since he had to leave early. At the Task Panel's last meeting Mr. Ambrose Rodriguez was present to discuss the Panel's concern for replacing Dr. Connie Olson on the DMH staff. The Panel felt someone should be hired to focus their efforts on child/adolescent services; Mr. Goebel recommended this be a Council priority. Dr. Miller stated that the job has been posted and the position will be filled.

The University of Colorado and Region VIII Office of HEW are working on a program to look at partial care programs for children/adolescents. This is being done in light of uncertain funding. It is felt that partial care programs are needed for children and adolescents.

Mr. Goebel's report on SB 26 was postponed until the next Council meeting (May 8).

Budget Committee Report: Mr. Young reported that the Long Bill for FY 81 was back in the conference committee. Both state hospitals had experienced position cuts (CSH 65, FLMHC 44). During the House caucus both CSH and FLMHC's positions were put back in the Long Bill with funding. At the Senate caucus the CSH FTEs were incorporated back in the Long Bill, but the Senate failed to review FLMHC. Funding to the centers was suppose to be for the federal decline and salary increases; however, there is not enough money to do both. Centers will have to collect from Medicaid in order to receive salary increases. The net result is a loss of 19 positions and $342,000 in general fund cash funds.

Mr. Quinn and Mr. Garcia felt the Council should write a letter and send it to the JBC and media. After discussion the motion was made and seconded for the Council to go to the public through the media expressing alarm and concern regarding the inadequate funding. The motion passed. Responsibilities of this motion were delegated to the Budget Committee by Mr. Richter.

The physicians' salary bill may be passed, but it is doubtful whether there will be enough money to fund it.

State Plan Committee Report: Ms. Medchill reported that Dr. Tony Linder from the Colorado Commission on Children and Families met with the State Plan Committee. The Commission has been functioning for three years, with this year being their last. They are looking for alternate funding sources in order to keep functioning, or would like other agencies to pick-up issues they have identified and try to deal with them. The Commission has placed emphasis on interagency agreements and the development of standards/guidelines for child/adolescent programs, particularly for RCCFs. The Commission would like to have a contact person from the Advisory Council. It was moved and seconded that the chairperson of the Child/Adolescent Task Panel act in liaison with the Commission. Mr. Goebel agreed to do this. Motion passed.

Dr. Jim Ciarlo met with the Committee and discussed needs assessment: what data is technically available in Colorado and ways of assessing need by examining utilization,

social indicators, conducting indirect and direct surveys, and asking for expert opinions on needs. Ms. Medchill requested that a representative of the Centers' Association be present at a Council meeting to explain why they support the current equalization of funds. Dr. Miller commented that in the Long Bill, the Legislature has accepted the plan jointly developed by the Division and the Centers' Association on resource redistribution. Resource redistribution will not be based on need until the third year.

The draft of the State Mental Health Plan has been distributed. It is based on the center catchment area plans. There have been changes in the objectives but none in the goals. Ms. Medchill requested members to review the Plan in its entirety, and then address their area of concern in writing and submit comments to her by May 7th. Mr. Richter encouraged Council members to attend the State Plan Committee meeting the morning of May 8th for discussion on the Plan rather than using the Advisory Council meeting time. If after discussion with the State Plan Committee there are still differences, these differences will be dealt with at the Council meeting.

Mr. Young and Ms. Medchill stated that the State Plan Committee and the Budget Committee need to coordinate in order to determine what is realistic in terms of the budget when developing the State Plan. Since the plan and budget are part of the same planning process, it was felt that coordination between these two Committees could greatly benefit the Council.

Public Awareness Committee Report: Ms. Casagram was not present to give a report. Mr. Richter told the Council that Mr. Roger Smith from Fort Logan MHC has a copy of the slide presentation which was developed by the Centers' Association with special funding from the Division.

Elderly Task Panel Report: Ms. Dame said this Committee has not been able to meet. The Committee will meet by the next Council meeting.

Minority Task Panel Report: Mr. Garcia reported that this Committee also has not met. Mr. Garcia is trying to set up a meeting with the Migrant Health Council, the State Health Department and the Division of Mental Health. He asked Dr. Miller to explain a letter regarding outreach and family therapy. Dr. Miller explained that some time ago the Division developed a unit cost system which breaks down the costs of all mental health services into ten areas that have a reimbursement rate attached. Dr. Miller said there was no encouragement to provide two services which are essential for minorities and children; that is, there are no home visits or family therapy units. The Centers' Association has a Unit Cost Committee, and Dr. Miller has asked them to review this.

Rural Task Panel Report: Ms. Fairlamb asked Dr. Miller about contract negotiations, particularly negotiations and reimbursement factors impacting on rural center rates. Dr. Miller stated that if an individual center has a counter proposal for the negotiations, the Division will discuss this with them.

Mr. Richter read a letter from Mr. Marshall requesting that the rule for absences be waived even though he has had three absences. Mr. Marshall stated he was very interested in the Council's activities. The motion was made and seconded to accept Mr. Marshall's letter and to retain his membership on the Council. Motion passed.

Council members received a letter from Dr. Weissberg regarding emergency room medical clearance issues and were asked to review the letter in order to discuss it at the next meeting.

Respectfully submitted,

Nancy Gonzales

Nancy Gonzales
Recording Secretary

(Standard SMHAC Distribution) 4/21/80

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: May 8, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Lucy May Dame
Melanie Fairlamb
Peter Garcia
Fred Lane
John Marshall
Isabelle Medchill
Luis Medina
John Nagle
Roger Richter
Patrick Smid
Marge Taniwaki
Cece Zavala

Absent:

Colleen Casagram
Dorothea Dolan
Jerry Goebel
Katherine Money
Jack Quinn
Nancy Sanford
Michael Weissberg
Robert Young

Staff Present:

Lynn Dawson
Sutherland Miller
Ambrose Rodriguez

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Budget Committee Report - In the absence of Mr. Young, the Committee Chairman, Mr. Richter gave the Budget Committee report.

The state budget for the coming fiscal year will lead to a reduction of ten staff members at Colorado State Hospital. Since insufficient funds were appropriated for the remaining staff and for operating expenses, a request for supplemental funds must be made later in the year. Sufficient funds for Fort Logan Mental Health Center's operating expenses were appropriated; however, five staff positions were cut. At the joint meeting of the State Plan Committee and the Budget Committee on May 30, the Committee will discuss the possibility of making a public statement of concern about the inadequate funding for mental health.

Approval of Minutes - In the absence of any additions or corrections, it was ruled that the minutes of the meeting of April 10 stand as written.

Director's Report - Dr. Miller reported that the Governor issued an Executive Order on April 14, requiring a report on some of the issues surrounding the violence committed by former mental patients. Admissions, discharges, and follow-up will be among the issues to be reviewed. Centers, clinics, and hospitals have been asked to provide information in these areas.

Two representatives of the Division of Mental Health attended a conference in Washington, D.C., at which additional ways of funding programs were explored. Efforts are under way to use Medicaid and Medicare money more effectively. Many states regard Colorado as being in the forefront in these areas. The Mental Health Systems Act, which would fund the mental health centers and a number of special programs, was discussed at the conference.

The National Association of State Mental Health Program Directors worked with the National Council of Community Mental Health Centers and the National Mental Health Association to draft a bill for creation of an Act which favors a more integrated mental health delivery system. At one point, proposed language in the bill would have eliminated the state mental health authority's responsibility for the State Mental Health Plan, as well as the State Mental Health Advisory Council. Senate committee staff, however, restored these items to the proposed legislation.

Mental health centers throughout the state soon will submit their applications for HUD funding for demonstration projects for housing for the mentally ill. Colorado received 1.8 million dollars last year from HUD for this purpose.

The Department of Institutions and the Division of Mental Health have responded to a request for a proposal for a contract with the federal government in the area of internal advocacy. Ms. Dawson has devoted a great deal of time to the preparation of a proposal which would deal with setting up a more effective system of advocacy for patients within the mental health system and which would attempt to discover whether or not expanded advocacy services make a difference in the patients' environment and result in better outcome for those patients. Dr. Miller emphasized that this would be a contract, rather than a grant.

The contracting process with the centers and clinics is going well. Some facilities, however, did not submit their budget information on time, which may result in delays in their funding for the new fiscal year. In the area of quality control, new standards with regard to peer and utilization reviews have been developed jointly by the Division and the centers and clinics. The question of emergency services in the City and County of Denver also was discussed.

Mr. Richter introduced Mr. Patrick Smid to the other members of the Council.

The list of Council committees and task panels was passed around. Members were asked to make final revisions.

Child/Adolescent Task Panel Report - Since Mr. Goeble was absent, no report was given.

Emergency Room Medical Clearance Issues - Mr. Richter noted that, since Dr. Weissberg was unable to attend the meeting, no report would be given.

Elderly Task Panel Report - Ms. Dame said that the Elderly Task Panel had no report.

There was discussion regarding the hiring of the Division Director. Ms. Fairlamb moved that representatives of the Council serve on both the screening committee and the oral board for candidates for the position of

Division Director. Mr. Nagle seconded the motion. After discussion, the motion passed. It was suggested that Dr. Leidig be invited to attend the next meeting of the Council to discuss the hiring process and the Council's involvement in that process. Mr. Richter will contact Dr. Leidig.

Minority Task Panel - Mr. Garcia reported that this task panel will review the State Plan and prioritize objectives dealing with minority issues. The panel will ask for suggestions from the Division's Committee on Racism and the Committee on Sexism, as well as the Chicano Coalition.

Rural Task Panel - Ms. Fairlamb suggested that the due date on Objective 29, under System Goal 9 of the State Plan, be changed to an earlier date for completion. This objective deals with mental health personnel needs in rural areas.

State Plan Committee Report - Ms. Medchill reported that the Colorado Association of Community Mental Health Centers and Clinics will provide the State Plan Committee with a statement on its position regarding equalization of funds.

The Committee spent yesterday afternoon and this morning reviewing the Draft of the State Plan. The Committee suggested that the State Plan give special emphasis to accountability. The Committee has recommended that a statement related to the Division's focus on outcome rather than internal management of agencies be added under the section on accountability in Chapter II. The Committee also agreed that an objective which addresses clients with the least ability to pay be added to the State Plan.

The State Plan Committee has scheduled two all-day meetings in May. The first meeting will be held on May 29 from 9:30 a.m. to 5 p.m. in room B-108 at Fort Logan Mental Health Center. The purpose of this meeting is for the State Plan Committee to complete its review of the draft and to begin reviewing all of the input received as of May 15 from other agencies, individuals, and organizations. Ms. Medchill emphasized that all members of the Council are invited to participate in this review.

The second all-day meeting will be held on May 30, from 9:30 a.m. to 5 p.m. in room B-108 at Fort Logan Mental Health Center. This will be a joint meeting of the State Plan Committee and the Budget Committee.

Mr. Garcia moved that a letter be sent to all members of the Council asking that they attend the May 30 meeting of the State Plan Committee. Dr. Medina seconded the motion, but, for lack of a quorum, no vote was taken. Mr. Richter clarified that the two Council Committees and other members of the Council present at the May 30 meeting will have the authority to approve the State Plan and to set priorities for the 1981-82 objectives, which will serve as the basis for next year's budget request. A letter will be sent to the centers/clinics, the two state hospitals, and the Mental Health Association, among

others, requesting their participation in the May 30 meeting.

Mr. Richter noted that in the past the Division held the hearing, in which the Council participated, to consider the State Plan and set budget priorities for the coming year. This year the hearing is being held by the Council in relation to its charge to approve the State Plan.

The Budget Committee will meet on June 4, from 1:30 to 4:30 p.m., in room A-200 at Fort Logan Mental Health Center, to review the budget priorities established at the May 30 meeting.

Ms. Fairlamb asked that the minutes reflect the Council's recognition of Ms. Dawson's fine work.

New Business - Ms. Dawson reminded the Council that the state fiscal rules require receipts for reimbursement of all expenditures, including cab fare, travel, and lodging. If members must stay overnight or if they leave home before 5 a.m. and return after 8 p.m., they will be reimbursed for meals.

It was noted that Ms. Casagram has had three consecutive absences. Mr. Nagle moved that a letter be sent to Ms. Casagram requesting her to either indicate her desire to continue membership on the Council or to relinquish her membership. The motion was passed.

Mr. Richter appointed a Task Force to consider outcome data. Mr. Nagle was appointed chairman. Other members are Mr. Garcia, Ms. Medchill, and Dr. Ciarlo, of the State Plan Committee.

The meeting was adjourned at 4:30 p.m.

Respectfully submitted,

Virginia Kelly
Recording Secretary

(Standard SMHAC Distribution)

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: June 12, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Lucy May Dame
Peter Garcia
Jerry Goebel
Fred Lane
John Marshall
Isabelle Medchill
Luis Medina
John Nagle
Jack Quinn
Roger Richter
Nancy Sanford
Patrick Smid
Marge Taniwaki
Michael Weissberg

Absent:

Guidotta Bates
Colleen Casagram
Dorothea Dolan
Melanie Fairlamb
Katherine Money
Robert Young
Cece Zavala

Staff Present:

Bruce Berger
Lynn Dawson
Rene Grosser
Sutherland Miller
Ambrose Rodriguez

Guests:

David Bustos
James Ciarlo
David Harrod
John Levine
Eleanor Stead

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Mr. Richter announced that the order of the agenda would be changed, as Ms. Medchill needed to leave the Council meeting early. He also invited all Council members to attend a reception for Dr. Miller following the Council meeting.

State Plan Committee Report - Ms. Medchill, Committee Chairperson, reported that the Committee had met all day on May 29 to review the input which had been submitted on the State Plan and to make appropriate revisions. The State Plan Committee and the Budget Committee held a public meeting all day on May 30 to discuss input on the State Plan and to prioritize the issues for the FY 1981-82 budget request.

Ms. Medchill announced that the following objectives had been added to the State Plan:

> "Service Goal 1, Objective 2: To have determined, with the State Mental Health Advisory Council, the adequacy of existing mechanisms for ensuring that clients with the least ability to pay are served to the maximum degree that the resources allow, by March 31, 1981."

> "System Goal 3, Objective 2: To have drafted a State Mental Health Advisory Council position on the responsibilities of Fort Logan Mental Health Center and the mental health centers in the Fort Logan Service Area regarding long-term clients by September 30, 1980."

This objective was added as a result of input to the State Plan Committee from representatives of Park East Comprehensive Community Mental Health Center on the issue of the state hospitals' responsibilities for treating long-term clients.

> "System Goal 9, Objective 5: To have had the Committee on Sexism submit specific recommendations to the State Mental Health Advisory Council for improving services to women, including treatment and program planning and the administrative status of women in mental health agencies, by January 30, 1981."

Ms. Medchill stated that the Council would have primary responsibility for the foregoing objectives during the coming year.

The following objectives regarding energy-impacted areas also were added:

> "Service Goal 1, Objective 16: To have obtained funds for the provision of additional treatment programs in the areas of Colorado heavily impacted by energy development by June 30, 1981."

> "Service Goal 1, Objective 30: To have established additional treatment programs in the areas of Colorado heavily impacted by energy development by June 30, 1982."

The State Plan Committee did not have resolution on the request for basing resource redistribution on need in the next fiscal year (1981-82) and, therefore, brought the issue to the Council. A member of the Committee, Dr. James Ciarlo, had recommended that the date for basing resource redistribution on need in addition to population be moved up one year. The objective in question, System Goal 8, Objective 19, presently reads, "To have implemented the third year of the resource redistribution system for the allocation of state resources to catchment areas, based on local needs and resource availability, by June 30, 1983." Dr. Ciarlo, who represents Health and Hospitals Mental Health Program, spoke in favor of distribution of the FY 81-82 budget on the basis of both population and need. Mr. David Harrod, representing the Colorado Association of Community Mental Health Centers and Clinics, spoke in favor of retaining the current date which had been established in an agreement signed by the Association and the Division in December 1979. Mr. Nagel moved that the objective remain as presently stated, but that the Council ask for a report on the status of the need assessment methodology every six months. Ms. Dame seconded the motion, and, after discussion, Mr. Quinn called for the question. The motion as finally stated was to leave the objective as it stands, and to ask the Division and the Colorado Association of Community Mental Health Centers and Clinics to report to the Council at least twice a year on progress in

regard to developing the need assessment methodology. The motion was passed.

On behalf of the State Plan Committee, Ms. Medchill recommended that the State Plan be approved as amended. Mr. Medina moved to accept the recommendation; Mr. Quinn seconded the motion. The motion passed unanimously. Mr. Garcia, however, asked that the minutes reflect that his approval of the State Plan was conditional. He stated that if the budget items as prioritized are not funded, his approval will be rescinded.

Budget Committee Report - Mr. Richter pointed out that the State Plan Committee and the Budget Committee, during the special Council meeting on May 30, had set budget priorities for Fiscal Year 1981-82. Ms. Dawson passed out the list of prioritized issues which included the major areas of emphasis and the estimated costs for each issue. After a review and discussion of the list, Mr. Nagle moved that the Council accept the prioritized issues. Ms. Dame seconded the motion; the motion was passed.

Approval of Minutes - Mr. Nagle moved that the minutes of the May 8, 1980, meeting of the Council be approved. Mr. Garcia seconded the motion, and it was passed.

Mr. Richter expressed the Council's appreciation for the work done by Dr. Miller as Director of the Division. Dr. Miller will leave the Director's position effective July 1, 1980. Ambrose Rodriguez, Associate Director for Program Services, will serve as Acting Director until a new Director has been hired.

Director's Report - Dr. Miller reported that the process of contracting with the centers and clinics is nearly complete.

With regard to funding cuts to the state hospitals, Dr. Miller announced that cuts have been made in a manner which will keep the impact on patient care at a minimum. A possibility exists that the alcohol programs may have to be closed. The Joint Budget Committee has been asked for a written commitment to fund these programs through the Department of Health.

The Division's response to the Governor's Executive Order regarding violently mentally ill persons has gone to the Governor. Dr. Miller will meet with the Governor on June 16 to discuss the report. Mr. Richter told the Council that copies of the report will be sent to all members of the Council as soon as it is released by the Governor.

Mr. Richter had written a letter to Dr. Leidig requesting that the Council be permitted to assume joint responsibility in the selection of the new Director of the Division. Subsequently, members of the Executive, Budget, and State Plan Committees of the Council met with Dr. Leidig. Mr. Richter explained that the Director's position is under the state civil service system, that national recruitment has been instituted, that the position requires a Ph.D.

or M.D., and that the salary has been raised to a maximum of $43,000. When all resumes have been received by Phil Reynolds, Personnel Officer for the Division, each will be reviewed with regard to eligibility. An oral board examination will follow. Statutorily, Dr. Leidig is required to make the ultimate decision, but he has assured the Council that it will be involved in all phases of the selection process. Selection of members to represent the Council will be made at the next Council meeting.

Mr. Richter wrote to Ms. Casagram to remind her that she had missed three meetings of the Council. Ms. Casagram intends to resign her membership, since she has become increasingly involved in statewide women's issues. Mr. Lane moved that Ms. Casagram's resignation be accepted with regret. Ms. Dame seconded the motion, and the motion was passed. Mr. Richter will appoint a new Chair to the Public Awareness Committee and, after Ms. Casagram's written resignation has been received, a recommendation will be made to the Governor for a new appointee to membership.

Child/Adolescent Task Panel - Mr. Goebel has arranged for a presentation on Senate Bill 26 at the August meeting of the Council.

Elderly Task Panel - Ms. Dame had no report on the Elderly Task Panel.

Minority Task Panel - Mr. Garcia reported that the Task Panel has had no recent meeting.

Ms. Taniwaki distributed a report on "Indochinese and Other Asian Populations in Colorado," which was prepared by Laurence Aylesworth, Director of the Indochinese Development Center of the Park East Comprehensive Community Mental Health Center. Copies will be mailed to those Council members who were absent. Ms. Taniwaki asked that the Council endorse the requests for re-funding of the Indochinese Project, which will expire in September. The Council will discuss the report at the July meeting.

Rural Task Panel - No member of this Task Panel was present.

Outcome Data Task Panel - Mr. Nagel reported that he had met with Nancy Wilson, Specialist in Treatment and Program Outcome for the Division, to discuss the current status of the outcome data. They will meet again during the week of July 7 to pursue the question of how better to get data from the terminal in Pueblo.

Mr. Richter quoted Dr. Leidig as supporting the increased involvement of the Council. Mr. Richter said that if the Council accepts this obligation, it will need to be composed of active working committees which will prepare recommendations upon which the Council as a whole will act. Each committee would have its counterpart in the Division such as the State Plan Committee, the Budget Committee, a Personnel Committee, a Program Committee, and a Membership Committee. He suggested that the membership of the Council be increased from 21 to 30 in which case a revision of the bylaws would be

necessary.

Mr. Nagle moved that the Council direct the Executive Committee and other members who are interested to set up an Ad Hoc Committee to revise the Bylaws and prepare a draft which would be considered at the July meeting of the Council. Ms. Dame seconded the motion, and the motion was unanimously approved. Mr. Richter suggested that the Committee should include Mr. Rodriguez. The following members volunteered to serve with Mr. Richter: Mr. Nagle, Ms. Sanford, Mr. Smid, Mr. Garcia, and Ms. Dame.

Mr. Lane moved that the Council express thanks to Ms. Medchill for the work she has devoted to the State Plan Committee. Ms. Dame seconded the motion, and the motion was passed.

Mr. Smid moved that the minutes reflect the Council's appreciation of Dr. Miller's work during his tenure as Director of the Division. Mr. Nagle seconded the motion, and the motion was passed.

The meeting was adjourned at 4:30 p.m.

Virginia Kelly
Recording Secretary

(Standard SMHAC Distribution)

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: July 10, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Dorothea Dolan
Peter Garcia
Fred Lane
Isabelle Medchill
Luis Medina
Katherine Money
John Nagle
Nancy Sanford
Marge Taniwaki
Robert Young

Staff Present:

Lynn Dawson

Absent:

Lucy May Dame
Melanie Fairlamb
Jerry Goebel
John Marshall
Jack Quinn
Roger Richter
Patrick Smid
Michael Weissberg
Cece Zavala

Guests:

Laurence Aylesworth
Ernest Hamburger
Dodie Ramirez

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In the absence of the Chairperson, Mr. Richter, the Vice-Chairperson, Ms. Medchill, presided.

Approval of Minutes - Ms. Sanford moved that the minutes of the last meeting be approved. Mr. Nagel seconded the motion, and it was passed.

Ms. Medchill announced a change in the agenda in order to accomodate a presentation by Ms. Taniwaki's guest, Dr. Laurence Aylesworth, Director of the Indochinese Development Center of the Park East Mental Health Center. This agency has applied to the Office of Refugee Resettlement under the Department of Health and Human Services for a grant of $250,000 per year for each of three years, to provide mental health services to Asians in Colorado. Dr. Medina moved that the Council send a letter of support for this application to the Office of Refugee Resettlement, Department of Health and Human Services. Mr. Garcia seconded the motion, and it was passed.

Director's Report - In the absence of Ambrose Rodriguez, the Acting Director of the Division of Mental Health, Ms. Dawson gave the director's report. Dr. Miller's report on Violence and the Mentally Ill, which was prepared in response to the Executive Order issued by Governor Lamm on April 14, 1980, will be sent to 250 to 300 agencies and individuals. Recipients will be asked to submit comments to the Governor's Office by August 1, 1980.

Receipt of applications for the position of Director of the Division of Mental Health closed on July 2. Applications were reviewed by a screening committee on July 8. Mr. Nagle represented the Council on the screening committee. The oral board will be held on July 24, and on July 25 the top three candidates will be interviewed. Members of the Council's Executive Committee will participate in the interviews of the final candidates.

Negotiations for performance contracts have been completed with the centers and clinics, with the exception of Children's Hospital and Denver Health and Hospitals. Over half of the contracts have been mailed out, and the remainder are in the process of being typed for signatures.

The City Council has passed a resolution, which it forwarded to the Governor, expressing concern over the formula used for the allocation of state funds for mental health programs within the City and County of Denver. The Denver Health and Hospitals Mental Health Program has stated that their funds are being cut, since they are not getting an inflationary increase, and they have therefore closed their Northwest Counseling Service. The Division of Mental Health views the closing of the Northwest Counseling Service as a management decision of that agency. The state funding for the Health and Hospitals Mental Health Program for fiscal year 80-81 will be at the same level as the past year, with an additional $15,000 special contract for the provision of emergency services to non-Northwest Denver service area clients. The state's system for the allocation of mental health funds has not changed from last year.

Ms. Dawson also reported that a survey had been sent to community mental health centers for the purpose of developing a process for allocating beds at Fort Logan to the centers and clinics in the Fort Logan Service Area. The Division will meet with the Colorado Association of Community Mental Health Centers and Clinics to discuss the results of the survey and to develop the process for allocating beds.

Budget Committee Report - Mr. Young reported that the request for potted funds for fiscal 1981 is due from the Division on July 14. These funds are necessary for employee fringe benefits, the salary survey, and so forth.

The FY 81-82 request for capital construction funds for upgrading buildings to meet client safety, program, and environmental requirements also is due on July 14. The Budget Committee and the State Plan Committee will meet jointly on July 22, from 9 to 10 a.m., in room A-200 at Fort Logan Mental Health Center, to review the Division's budget issue papers.

Child/Adolescent Task Panel - In the absence of Mr. Goebel, Ms. Sanford reported that Ms. Dawson, Nancy Maron, Dave Benson, and others will be asked to speak at future meetings of the Child/Adolescent Steering Committee. The Committee is trying to reach all centers which have programs specifically for children to ask them to send speakers.

Elderly Task Panel - Since Ms. Dame was absent, no report was given.

Minority Task Panel - Mr. Garcia reported that the Task Panel has had no recent meeting. With regard to migrant farm workers, he reported that the migrant population is now close to 15,000 workers actually in the fields.

Rural Task Panel - Since Ms. Fairlamb was absent, no report was given.

Outcome Data Task Panel - Mr. Nagle reported that he had met with Nancy Wilson,

Program Specialist for Outcome Data. The Department of Health has offered to assist the Division in analyzing outcome data. The Task Panel is interested in discovering if there is any clustering of clients with similar diagnoses within certain populations. It will probably be a year or two before the Panel will have anything substantial to offer in this area.

State Plan Committee Report - Ms. Medchill emphasized that the State Plan Committee meets regularly on the second Thursday of each month, from 9:30 a.m. to noon, in room B-108 at Fort Logan Mental Health Center. All members of the Committee are encouraged to attend.

The Council's first priority for the 81-82 budget request is to increase mental health services to the underserved or inappropriately served, i.e., the elderly, ethnic minorities, and women. Mr. Richter would like Council members to send letters supporting this priority to him on or before July 28, when the budget issue papers will go to Dr. Leidig. After discussion, it was also agreed that the Council members would solicit letters of support from agencies and individuals who have expressed an interest in this priority area. Ms. Money will represent the Rural Task Panel in reaching people on the Western Slope. Ms. Bates will represent the Elderly Task Panel. Ms. Sanford will contact centers and clinics in the Southeast Colorado Health Systems Agency area asking that they solicit support from their constituent groups. Ms. Medchill will ask the Committee on Sexism to participate. Mr. Garcia, on behalf of the Minority Task Panel, will contact the Colorado Migrant Council and the Committee on Racism. The letters should be addressed to the Council in the care of Mr. Richter, and should be submitted by July 28.

Ad Hoc Committee for Bylaw Revisions - Since several members of the Council had left the meeting, a quorum was no longer present. Mr. Nagle moved that discussion of the bylaws be tabled until the next meeting of the Council on August 14.

Ms. Bates said that the Council would be put on the mailing list for the newsletter from Centennial Mental Health Center.

Ms. Dawson reported that reimbursement rates for travel of state employees, which also apply to members of the Council, were adjusted, effective July 1, 1980, as follows: 20 cents per mile for use of personal auto; $3.00 for breakfast, $4.00 for lunch, and $9.00 for dinner, for a total per diem of $16.00; and "actual and reasonable" costs for lodging. Travel funds available for Division advisory committees will be reduced substantially due to continued loss of 314(d-g) funds and a reduction of federal grant overhead funds.

Mr. Nagle moved that the meeting be adjourned. Dr. Medina seconded the motion; motion passed.

Virginia Kelly
Recording Secretary

(Standard SMHAC Distribution)

B. ASSURANCES

1. Reports and Records

The Division of Mental Health (DMH) has annually reported 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 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, as amended.

C. ANNUAL REVIEW

1. Procedure for Annual Review
   a. In November of each year the State Mental Health Advisory Council notifies all recipients of the Plan that the annual review is under way. 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 Statewide 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 is prepared. This document is submitted to the ADAMHA Regional Office after it has been approved by the Council.
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 updated, 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 one month after final approval, the Plan is widely distributed throughout the state.

D. 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 Orders No. 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, handicap, 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 three-year affirmative action plan.

E. ADMINISTRATION OF 314(g) 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." In the past, fifteen percent of Colorado's

annual allotment was made available to the Division of Mental Health (DMH) for mental health services. The amount of funds available per year was approximately $170,000. Up to thirty percent of the DMH allocation was used for administration of the program. The remaining seventy percent was used by community programs for various demonstration and start-up programs.

Several legislative changes have occurred affecting the funding of grants to state health and mental health authorities under Section 314(d). First, the Health Services and Centers Amendments of 1978 (PL 95-626), which was effective October 1, 1979, amended Section 314(d) by eliminating the mandatory requirement that at least fifteen percent of the funds were to be set aside for use by the state mental health authority. Second, the Community Mental Health Centers Extension Act of 1978 (PL 95-622), which also was effective October 1, 1979, established a formula grant entitled "State Mental Health Programs," under Section 314(g) of the Public Health Service Act. Grants would be made directly to state mental health authorities under this program. Congress appropriated funds for 314(d) in the 1980 budget; however, no funds were appropriated for Section 314(g). There is no provision for funding anticipated for fiscal year 1980-81 from either 314(d) or from 314(g). If 314(g) funds are appropriated in the future, the Division of Mental Health will use a portion of the funds for administration of the program, and will make the majority of the funds available to community agencies for projects which are consistent with federal guidelines.

F. WORK FORCE (MANPOWER/WOMANPOWER)

1. Summary of Current Work Force (Manpower/Womanpower)

Following are summaries of the current work force 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, & 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 & Ground 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	15	13
M.D. Physician (non-psychiatrist)	8	2
Nurse, M.S.	3	0
Nurse, B.S.	15	1
Nurse, A.A.	205	1
Nurse, Practical	19	0
Mental Health Worker, B.S.	5	0
Mental Health Worker, A.A.	143	1
Mental Health Worker	0	0
Social Worker, D.S.W.	0	0
Social Worker, Masters	39	2
Social Worker, Bachelor	4	0
Psychologist, Ph.D.	16	0
Psychologist, Masters	14	0
Psychologist, Bachelor	0	1
Other Doctorate Level	8	0
Other Masters Level	97	0
Other Bachelor Level	112	1
Other A.A.	13	0
Psychiatric Technician	311	0
Other (includes all other staff)	855	53
TOTAL	1882	75

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	22	56
M.D. Physician (non-psychiatrist)	0	6
Nurse, M.S.	29	11
Nurse, B.S.	49	8
Nurse, A.A.	5	4
Nurse, Practical	4	2
Mental Health Worker, B.S.	74	10
Mental Health Worker, A.A.	22	3
Mental Health Worker	34	5
Social Worker, D.S.W.	5	0
Social Worker, Masters	210	27
Social Worker, Bachelor	6	1
Psychologist, Ph.D.	88	18
Psychologist, Masters	116	20
Psychologist, Bachelor	23	1
Other Doctorate Level	13	0
Other Masters Level	70	7
Other Bachelor Level	77	6
Other A.A.	17	2
Psychiatric Technician	27	0
Other (includes all other staff)	412	56
TOTAL	1303	243

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. In addition, as centers and clinics are contracting to serve specific numbers of targeted client groups (ethnic minorities, moderately and severely disabled clients, and designated age groups), there may be changes needed in organization and personnel mix to serve particular groups of clients. From information on difficulty of recruitment, it appears that psychiatrists, nurses, and ethnic minorities of all disciplines remain in inadequate supply. Rural centers have cited particular difficulties in the recruitment of certain categories of professional personnel.

Training needs in the past have been identified with the assistance of a continuing education grant from the National Institute of Mental Health (NIMH) to train the staff of mental health centers to provide the twelve services required by agencies funded under Public Law 94-63, as amended. An effort has been made to make training congruent with the service goals of the State Mental Health Plan. In addition, the Continuing Education Committee, comprised of inservice directors/coordinators of individual service agencies, has been extremely helpful in identification of training needs. Although this grant will terminate on June 30, 1980, it is anticipated that the Continuing Education Committee will continue to function. The division will continue its commitment to continuing education within available resources.

The State Education Committee, which is co-chaired by the executive director of the Department of Institutions and the department chairperson of the University of Colorado's University Hospital, is made up primarily of representatives from Colorado's institutions of higher learning who are involved in training mental health professionals. This committee has been actively involved in identifying training needs and programs at the level of higher education.

The Division of Mental Health has received a new planning and development grant from NIMH entitled The Colorado Mental Health Manpower Development Program. This grant, which began in July 1979, provides five years of declining federal support to assist DMH in developing its capacity for mental health manpower planning and development. In the early years of this project, considerable effort is being expended to establish a data base of relevant staff work force data for centers and hospitals, the private service providers, and training programs in higher education in Colorado. With the assistance of a broad-based Work Force Advisory Group, it is anticipated that this data will be used to establish needs and to implement creative work force strategies. These strategies may include recruitment, higher education programs, training, staffing pattern changes, and many others not as yet identified. The expected outcome is to have designed and implemented a Colorado work force plan to address the special problems of developing and maintaining a competent mental health work force in the state.

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

The activities of the Division of Mental Health Work Force Project

and the Work Force Advisory Group (both outlined above) will be instrumental in developing a comprehensive plan for mental health manpower development. A variety of groups will particpate in this process. The public and private providers of service, the educational institutions of the state, the State Education Committee, the Continuing Education Committee, legislators, regulatory and licensing agencies will be among those working toward a comprehensive approach to developing and maintaining a mental health work force in Colorado with skills relevant to the needs of the population of the state.

4. Procedures for Protecting Displaced Employees' Rights

The state hospitals have, for all practical purposes, completed the deinstitutionalization of clients, and at present it appears that the hospitals' employment will remain at the current level. If some unforeseen circumstance should develop and a reduction of state employees at the state hospitals should become necessary, the primary protection for the employees in the reduction would be through 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-three 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 department, 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. A major concern of state hospital employees who wish to transfer to 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. The state employees would remain on the state hospital payroll, and the center would reimburse the state hospital for the employee's salary and other benefits. The employees would have to be acceptable to the center concerned and would be under the administrative control of the center director. This proposal is fraught with many problems, such as differences in salaries, fringe benefits, classification, etc., between the state system and individual centers.

Another important need which will be dealt with should the need arise is training of displaced employees for new jobs in centers 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.

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, 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 has been aggravated by the fact that the eight-year federal staffing grants began to expire about the same time that the state funding for program expansion began to decline. The state is currently limiting increases in expenditures to 7% per year.

Despite these problems, state support of mental health services has increased each year. Actual increases in state support to community programs during the past several years have been well above the consumer price index figures. Funding of the two state hospitals, however, has not kept up with inflationary increases in costs.

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 recent enactment of the "Clinic Option" program under Medicaid will increase substantially the number of clients covered in community programs. The two state hospitals are now receiving close to fifty percent of their funding from patient fees, health insurance, and federal entitlements. The DMH and the centers are, with legislative encouragement, studying ways to increase revenues 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.

APPENDIX II. THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF SERVICE

1. State Mental Health Authority

Mental health services are available to the residents of Colorado through a number of service facilities located throughout the state. The service facilities which comprise the spectrum of available services include state-owned facilities, agencies that contract with the state, private treatment resources, and voluntary mental health resources.

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 administers such grants in accordance therewith (CRS 27-1-106, 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.

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.

Address: Ambrose Rodriguez, Acting Director
Division of Mental Health
3520 West Oxford Avenue
Denver, Colorado 80236

The Department of Institutions has delegated to the Division of Mental Health the authority to operate the two state mental hospitals, to purchase services from community mental health centers/clinics and other human service oriented agencies, to regulate facilities designated as 72-hour treatment and evaluation facilities, and to otherwise plan for and direct the mental health program. The Division of Mental Health is responsible for coordination which 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.

The exercise of authority as an agent of the State Executive, including the establishment and enforcement of policies, rules and regulations, is encompassed in the Division's responsibility for executive direction. The Division of Mental Health has responsibility for regulating designated agencies and for monitoring the programs and services of the state mental hospitals and the community mental health centers and clinics to ensure compliance with standards, to assess the quality of services, and to assist the agencies in improving services.

Program and financial management are primary functions of the Central Office of the Division. Finance Services has responsibility for budget development and administration, grants management, development of unit costs and reimbursement rates for centers and clinics, accounting and auditing, contract administration, and Central Office expenditures. The finance function is part of administrative services, which also manages the support needs and facility operations of the Division.

Program Services assesses statewide mental health service needs, determines how those needs might best be met, and ensures that agency contracts are designed to address the identified service needs. Assessing agencies' compliance with standards, regulations and contract commitments is a function of Program Services. The Division emphasizes evaluation and accountability of mental health services and provides, through Program Services, necessary leadership in the development of methodologies for measuring the impact of treatment efforts and in the management of quality control systems. Two areas highly interrelated with program concerns are training/work force development and data-systems operational studies. Those two sections, one making it possible to implement program directions and the other providing the data base for decision-making, are under Program Services.

Within the Division there are special grants for workforce (manpower) development and for establishing a range of treatment and support systems for severely disabled adults. The Community Support Project enables the state to more actively put in place a framework for care that is the heart of rehabilitating the emotionally disabled.

Another central function of the Division is planning. This function involves not only statewide planning for mental health, but also focuses on integrating planning efforts at the local level and with other human service and health planning agencies. Planning Services also analyzes new state or federal legislation and policies for their impact on mental health. Planning is a process intricately involved with the State Mental Health Advisory Council and with other agencies.

The two state hospitals are actively involved in Division policy development. They play a key role in the process of integrating services and continue to increase their responsibilities related to continuity of care and coordination of services.

The Division provides consultation on planning, programming, funding and evaluation to all components of the system, to the Governor's office and to other state offices and agencies. There is also a focus on advocacy functions which involve initiating and promoting the development of high quality, reasonable cost mental health programs to serve clients most in need in a manner that protects their privacy, dignity and rights.

The Division's goals at this time are to target funds to the people most in need, to ensure the delivery of high quality care through effective functioning of the elements of the system, to regulate agencies providing psychiatric care where their programs bear on the public interest including the protection of patients' rights, to have cost-effective treatment and support systems for clients of all ages available statewide, to integrate state and local planning, to develop the state's capacity for mental health work force planning and development, and to establish a more equitable distribution of resources. Accomplishment of these system goals is designed to facilitate achievement of the primary goal for the state mental health system: to maximize the clients' capacity to improve their quality of life.

2. Definitions

a. Mental Health Services: services designed to ameliorate or prevent mental illness. Such services include, but are not limited to, inpatient, 24-hour emergency, outpatient, screening and referral, follow-up care, consultation and education, partial hospitalization and other 24-hour care.

b. Emergency Services: services, available by telephone and in face-to-face contact with professional staff, as appropriate, 24 hours a day.

c. Preadmission Screening: the process of evaluating persons believed to be in need of mental health care to determine what type or intensity of care, if any, is appropriate.

d. Outpatient Services: treatment services which are generally less intensive and of shorter duration per treatment episode than partial care (hospitalization). Services include, but are not limited to, diagnostic evaluations and treatment with special emphasis on populations most in need; diagnostic, screening and referral services for courts and other appropriate agencies and organizations; and follow-up and aftercare for residents from the area released from inpatient facilities and other treatment programs.

e. Partial Care (Hospitalization) Services: treatment services which are generally of a more intensive nature than outpatient services, and which involve more than two hours, but less than 24 hours of care per daily therapeutic episode, with the exception of sheltered workshop contacts which may be of any length.

f. Other 24-Hour Care: twenty-four hour care or supervision not provided in a hospital setting (e.g., community homes, nursing homes, or other alternative living facilities). Residential care on a hospital campus, in a non-licensed unit, and night care are also considered to be other 24-hour care.

g. Inpatient Services: in-hospital, 24-hour care at a hospital licensed by the Colorado Department of Health, including services for diagnosis, emergency, and short-term crisis care which cannot be provided in a less restrictive and expensive setting.

h. Aftercare (or Follow-Up Care): care provided to a client after discharge from a formal treatment program. Aftercare may take the form of ongoing outpatient contacts, medication

checks, rehabilitation activities or other supportive services.

i. Consultation Services: assistance given to other human service agencies, health care professionals, and human service-oriented groups to assist them in better meeting the mental health service needs of their clients.

j. Education Services: efforts to inform professionals and lay-persons about any aspect of mental health, mental health problems, and mental health services.

k. Prevention Services: efforts to help persons or organizations acquire knowledge, attitudes, and behavior patterns that help prevent mental illness and foster mental well-being. There is no universally accepted definition of primary prevention for mental health. Primary prevention embraces a broad range of activities which often are considered to include efforts to prevent problems before they occur and attempts to eliminate the causes of mental disabilities or disorders.

l. Catchment Area: a geographic mental health service area designated by the state mental health authority.

m. Catchment Area Community Mental Health Center: a community mental health center designated by the Division of Mental Health as the center responsible for providing comprehensive community mental health services in a specified geographic area. A center provides a range of mental health services which include at least inpatient, 24-hour emergency, outpatient (includes screening and follow-up), other 24-hour care, partial care, and consultation and education services. The catchment area center may provide comprehensive community mental health services directly or through agreements with affiliates.

n. Affiliate: any agency or alternate treatment facility which contracts with a center/clinic approved under the Division of Mental Health Standards/Rules and Regulations for Mental Health Centers and Clinics.

o. Specialized (Specialty) Clinic: a community mental health clinic, approved by the Division of Mental Health for the purchase of services, which does not serve a specific catchment area.

p. Community Support System: a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community.

q. Case Management: services performed by an individual or a team which include responsibility for reviewing cases, setting treatment goals, designing treatment plans, coordinating the necessary components of the plan, monitoring the treatment, and retaining responsibility for the enrolled clients' treatment. Case managers may be mental health professionals, paraprofessionals, or volunteers.

3. Geographical Area for Planning

The Division of Mental Health is responsible for statewide mental health planning. Federal mental health legislation requires that mental health service or "catchment" areas be established in every state. A catchment area is defined as "a geographic area for which there is a

designated responsibility for community mental health services." Colorado has designated 20 catchment areas. A specific community mental health center has been designated the catchment area center. The catchment area center 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 or by an affiliate of the catchment area center.

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

a. Health Service Area: Colorado has three Health Service Areas (see map, page AII.6). The Health Systems Agency (HSA) which has been designated in each Health Service Area has the overall responsibility for health planning in that area.

b. Colorado Planning Regions: There are 13 State Planning Regions (see map, page AII.7). These regions were in existence prior to passage of Public Law 93-641, as amended, 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.

c. Counties: Colorado's 104,247 square miles and 2.7 million population are distributed over 63 counties (see maps, pages AII.6 and AII.7).

d. Catchment Areas: Each of the 20 catchment areas is comprised of one or more counties, with the exception of Denver, which is divided into four catchment areas. The chart on page AII.8 shows the relationships among Health Service Areas, Colorado Planning Regions, counties, and catchment area mental health centers.

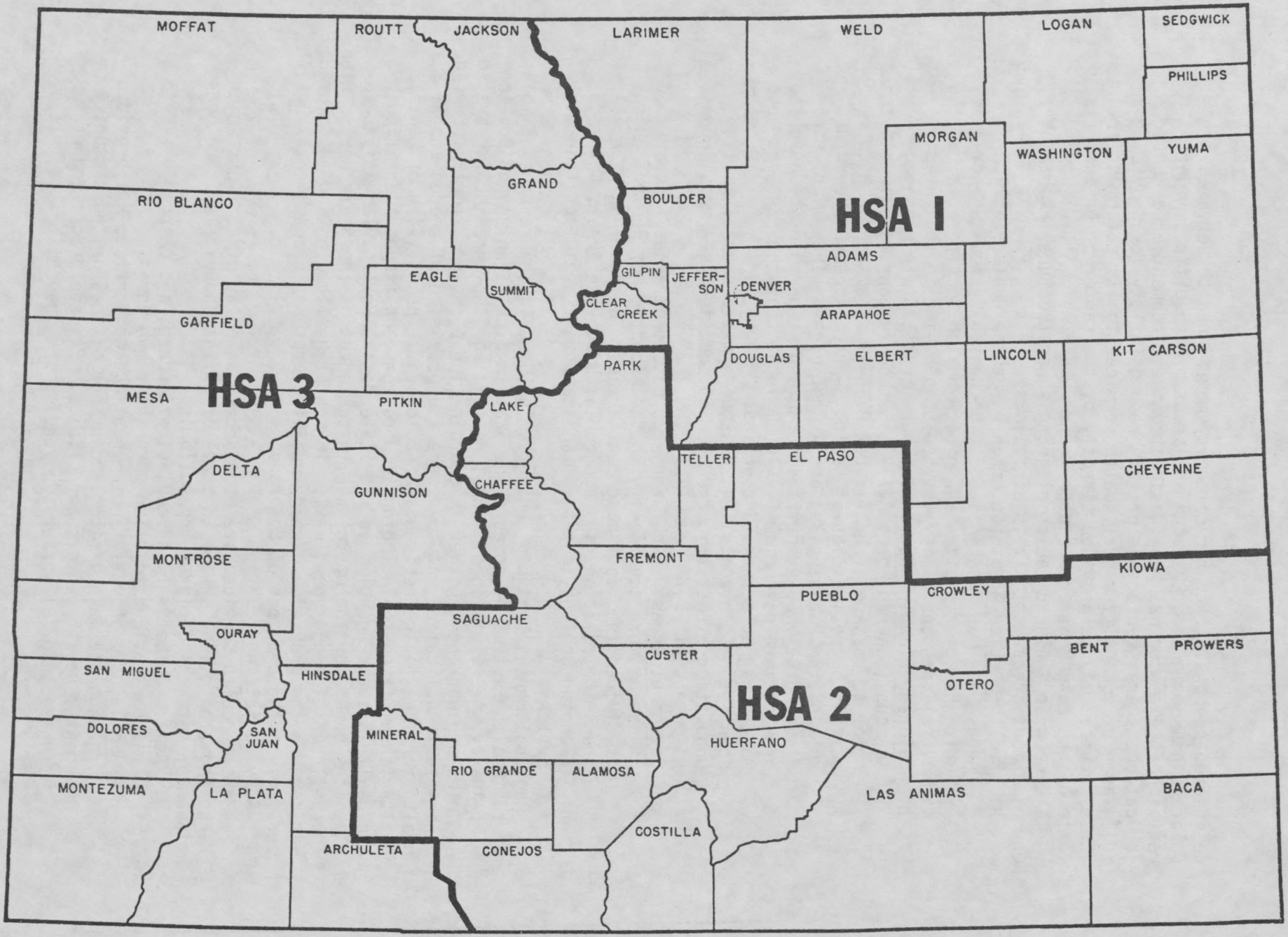
Regional mental health planning is included in the responsibilities of the Health Systems Agencies. The State Health Planning and Development Agency, the Division of Mental Health, and the three Health Systems Agencies are working together in coordinating planning efforts to avoid unnecessary duplication and to assure the provision of needed mental health services to the residents of Colorado. The Division of Mental Health is committed to including the problems and issues identified by the Health Systems Agencies in the State Mental Health Plan which provides the basis for the mental health component of the State Health Plan. The collaboration and coordination in mental health planning in Colorado will ensure the provision of high quality, reasonable cost mental health services to the citizens of Colorado.

4. Service Settings

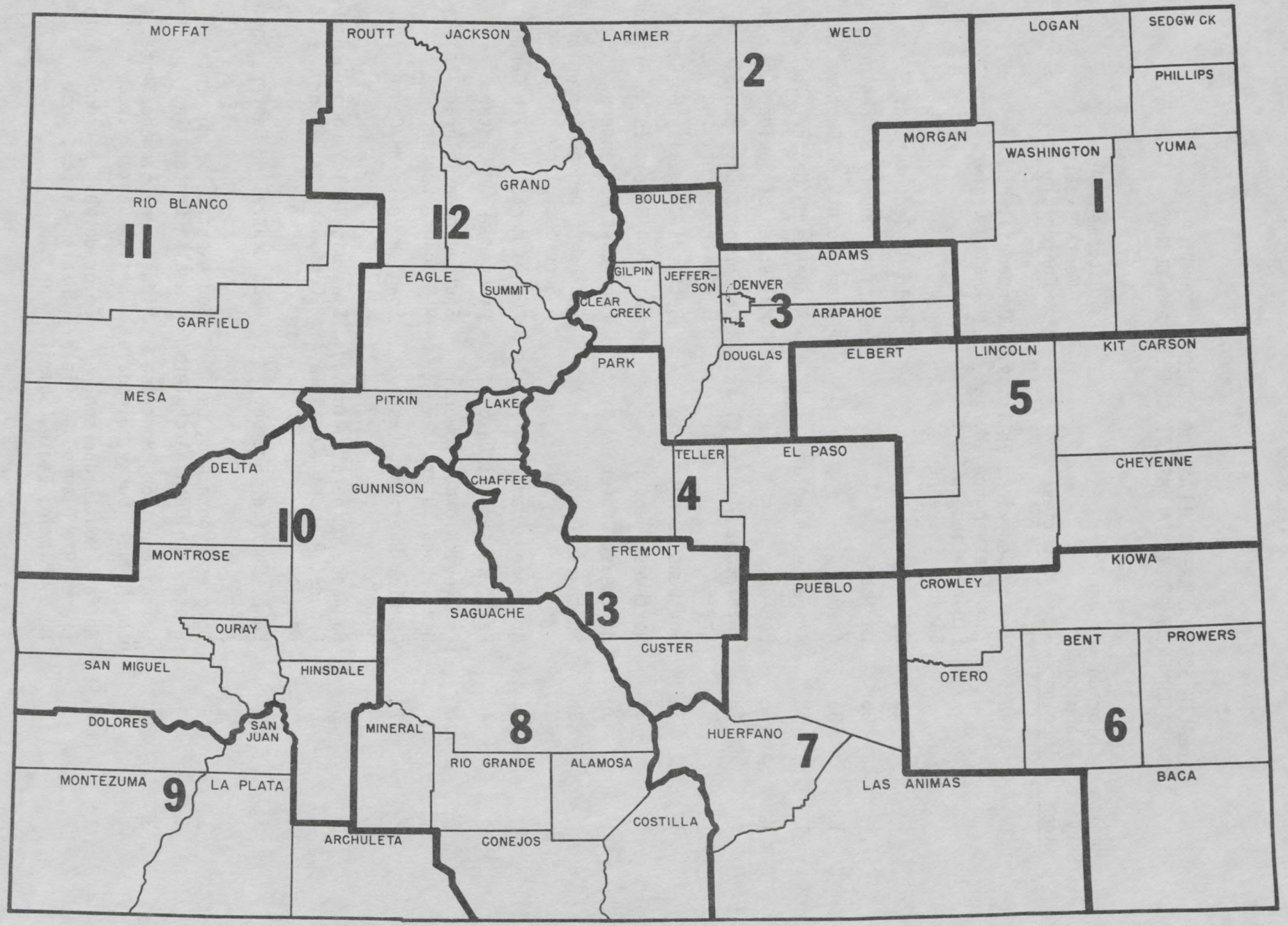
Mental health services are provided in an array of settings which range from the client's home to state or private hospitals. The continuum of settings includes the following:

a. Home: Outpatient, screening, aftercare, and emergency services may be provided to clients in their own homes.

b. Ambulatory: A variety of mental health services are provided through the main offices and branch offices of the community mental health centers and clinics. Private practitioners (nurses, social workers, psychologists, psychiatrists, etc.)



COLORADO HEALTH SERVICE AREAS



COLORADO PLANNING REGIONS

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 & 5	Logan, Sedgwick, Phillips, Yuma, Washington, Morgan, Elbert, Lincoln, Kit Carson, Cheyenne	Centennial Mental Health Center, Inc.
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	Health & Hospitals MH Programs
1	3g	Northeast Denver	Park East MH Center
1	3h	Southwest Denver	Southwest Denver Community MH Services, Inc.
1	3i	Arapahoe, Adams	Aurora Mental Health Center
2	4	Park, Teller, El Paso	Pikes Peak MH Center
2	6	Crowley, Kiowa, Prowers, Bent, Baca, Otero	Southeastern Colorado Family Guidance Center
2	7	Pueblo, Huerfano, Las Animas	Spanish Peaks MH 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 MH 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.

provide services to clients in offices located in all areas of the state. Other community facilities, such as churches, health centers, schools, etc., are used in the provision of mental health services.

c. Non-Institutional: A number of therapeutic residential settings are available which differ in terms of intensity of treatment, levels of supervision, and the client's ability to function independently. Such settings include skilled nursing homes, intermediate care facilities, personal care boarding homes, halfway houses, family care homes, group homes, foster homes, and cooperative apartments.

d. Inpatient: Services are provided in hospitals licensed by the Department of Health. The clinical needs of the client determine whether acute inpatient services and long-term inpatient services are more appropriately provided in a hospital or in an alternative residential treatment facility.

e. Community: Community support services can be provided in a wide variety of community settings, including but not limited to educational, vocational, recreational, and social settings.

B. BACKGROUND

The concept of community mental health is not a recent development. During ancient times, the noted Greek philosopher, Plato, advocated humane treatment of the mentally ill in their own communities. He wanted to keep the mentally ill within their families, as he believed that it was the family's responsibility to care for them. The history of treatment for the mentally ill in American must address itself to those responsible for their care. Since colonial times, there has been a pendular swing both between the private and public sectors and between care in the community and removal from community life. To understand the rationale for the current thrusts in mental health, a knowledge of the events in mental health, both in Colorado as well as throughout the country, that have occurred over the past twenty years is necessary.

In the late 1950s and early 1960s, the ineffectiveness of custodial methods plus the interest of the medical profession in mental illness led to the belief that it was possible to empty out the back wards of the large institutions and return the mentally ill to their communities. Isolation in state hospitals was seen as injurious to the patients, economically wasteful, and morally distasteful. State hospitals were primarily custodial. Once returned to their homes, patients might well recover. In addition, federal, state, and local communities would share the costs of their care. Community mental health centers appeared cheaper to operate than state hospitals. When the family and community assumed the responsibility for care, the mental health movement would shift from an "unnatural" institutional setting to a more normal or "natural" community setting. Improved medication was available to control "bizarre" behaviors. These beliefs and circumstances precipitated the development of community mental health centers. Community mental

health is viewed as the hallmark of the last two decades and was officially initiated with the passage of the Federal Community Mental Health Centers Act of 1963 (Public Law 88-164).

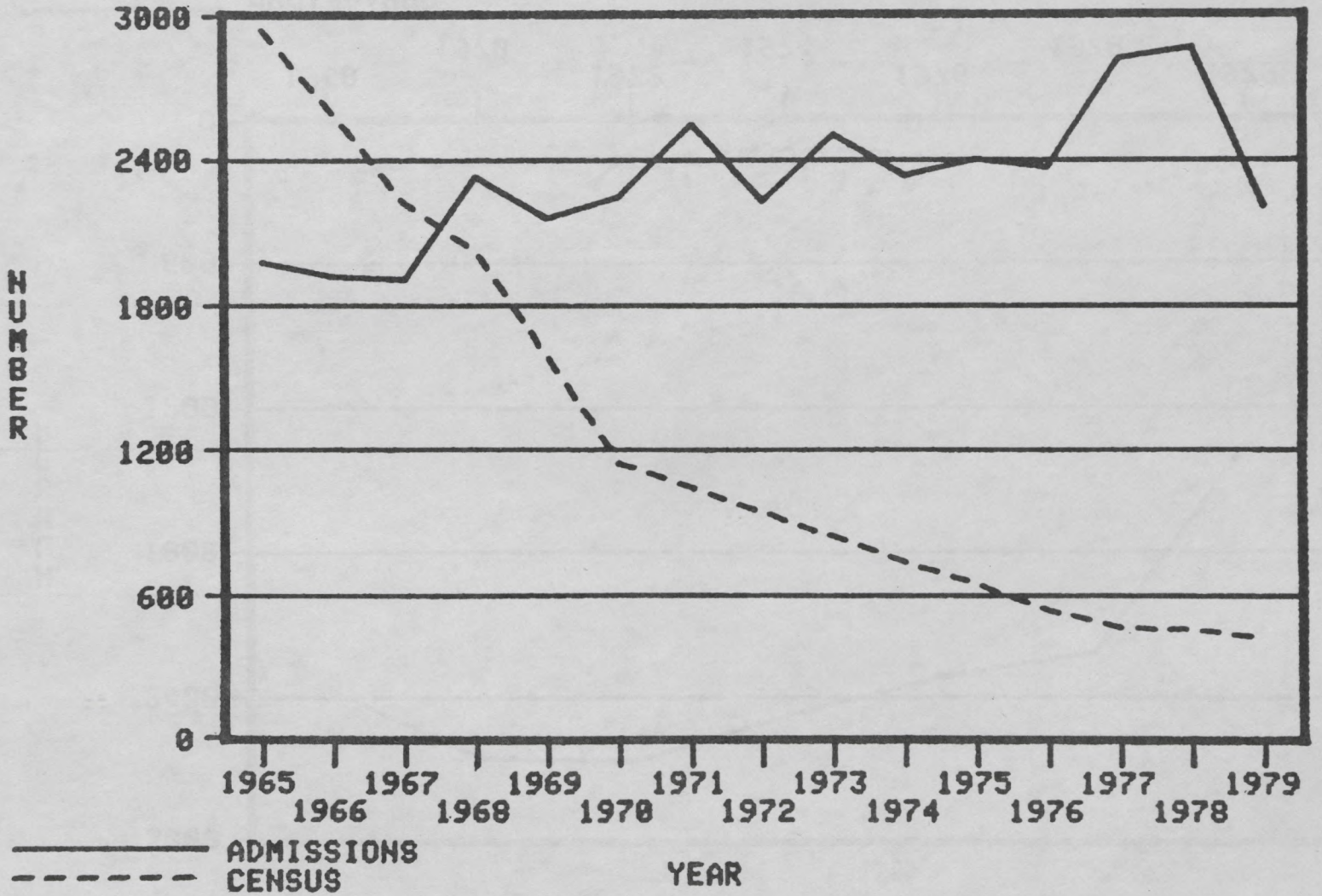
With the Community Mental Health Centers Act, the federal government began accepting some responsibility for funding and overseeing the provision of mental health services in the communities. The construction and staffing of mental health centers moved forward briskly after 1963. By mid-1966, however, federal grants totaling only $57 million had been made in contrast to billions of state dollars spent on mental health. There was, nevertheless, a drop in the census of state mental hospitals, down to 408,000 from a high of 558,000 in 1955. Many patients once confined in locked wards in state hospitals were treated at outpatient clinics, in day hospital programs, or lived in nursing homes, halfway houses, and quarterway houses. The forces of the sixties also set in action reforms which were successful in establishing patients' rights in many states' statutes or set in action judicial decrees which were helpful in abolishing abuses. These forces also helped bring about programmatic development by introducing changes, such as individual treatment plans for each patient and the geographic unit system. The result of these national efforts has been a decrease in state hospital populations from the 558,000 noted above in 1955 to 171,000 in 1976, according to the most recent National Institute of Mental Health statistics.

It was during this decade that Colorado created the Fort Logan Mental Health Center. This second state hospital was established in 1961, with two features considered to be unique at the time. First, it was a modern facility, located at the edge of the central population site. Its second unique feature was that it had a community-oriented approach which implemented all the advanced thinking of the time. Fort Logan drew national acclaim to itself and to Colorado. A short time later, following the planned transition to community-based services, Colorado State Hospital (established October 12, 1879) received similar recognition. For years, both state hospitals were actively involved in "deinstitutionalizing" their chronic populations. Tables I and II show the state hospital populations in Colorado which reflect their long commitment to returning clients to their communities. Because of their successful efforts, the two Colorado mental hospitals have completed "deinstitutionalization" and are now focusing on preventing inappropriate hospitalization of new admissions and returning appropriately hospitalized clients to their normal living environments, after intensive psychiatric treatment.

The residential populations in the two state hospitals have decreased drastically, showing an average daily census of only 641 inpatients as of July 1978. It appears, however, that this rate of decline is slowing down. Several factors seem to be involved. First of all, admissions have remained stable or have even increased over time (2625 admissions to CSH in 1964-65 as compared to 3914 in 1977-78). This increase in admissions mirrors the state's population, which has gone from an estimated 2,025,934 in 1966 to 2,751,415 in 1978, which amounts to an increase of approximately 35%. The hospitals continue to see as many or more patients today as they did several years ago. Reductions in populations have been achieved by decreasing the length of stay of patients (see

TABLE I

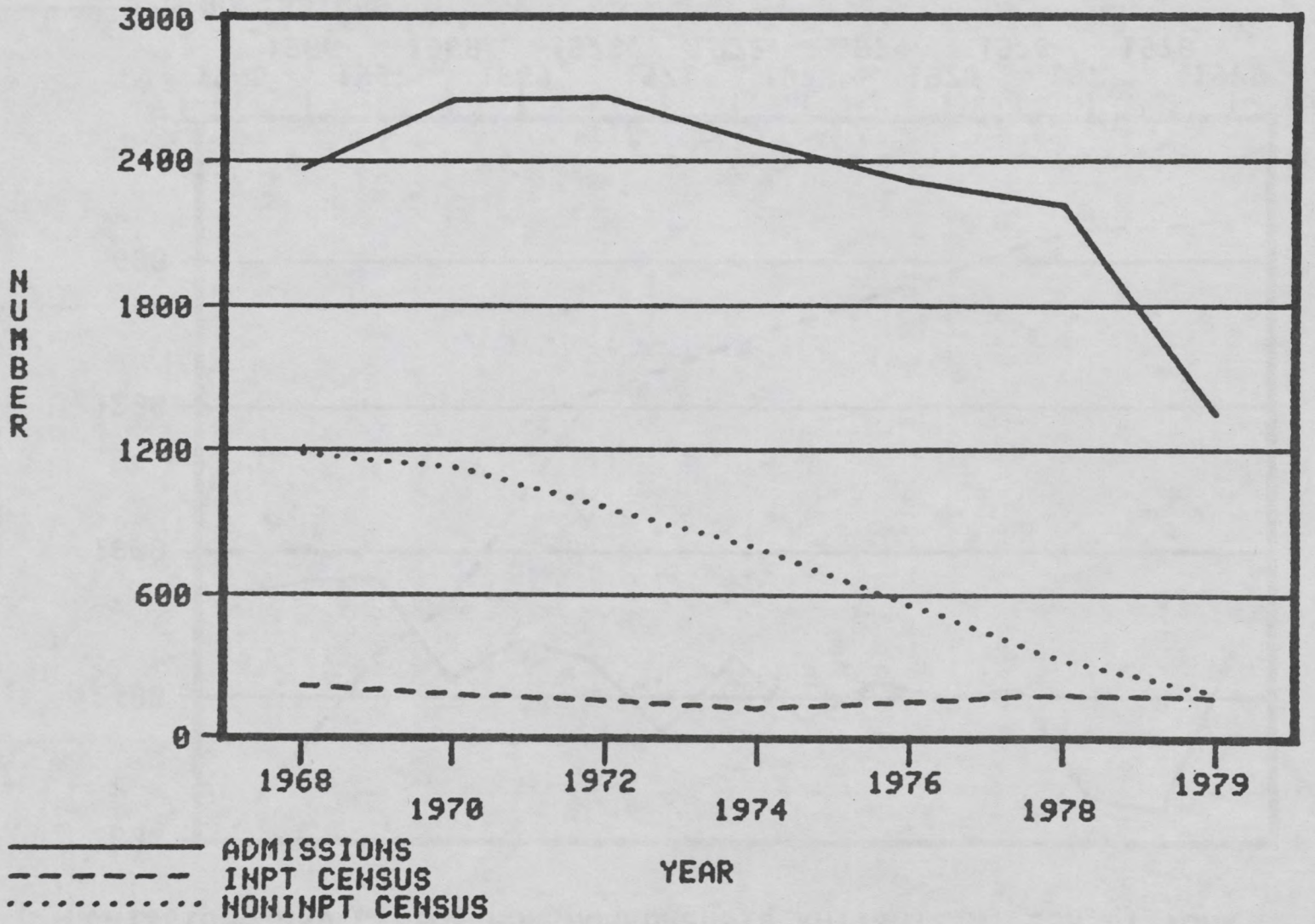
ADMISSIONS AND CENSUS FOR NONFORENSIC PATIENTS AT CSH BY YEAR



Note: In FY 78-79 the Alcohol and Drug Abuse Division began to require that alcohol treatment services be recorded as "Other 24-Hour Care," rather than as "Inpatient"; therefore, alcohol admissions to CSH during 78-79 were not counted in admissions to realized census.

TABLE II

ADMISSIONS AND CENSUS FOR PATIENTS AT FLMHC BY YEAR



Note: In FY 78-79 the Alcohol and Drug Abuse Division began to require that alcohol treatment services be recorded as "Other 24-Hour Care," rather than as "Inpatient"; therefore, alcohol admissions to FLMHC during 78-79 were not counted in admissions to realized census.

Tables III and IV). Secondly, most of the "easy" placements have been made. The third factor is that hospitals are now having to treat a population of extremely difficult patients.

Changes in public policies and attitudes may have "fueled" reforms for the treatment of the mentally ill by professionals. This treatment by professionals, however, was often conceptualized primarily as taking place in a specific physical location. The physical location might have changed (i.e., to the community from the isolated institution), but treatment by mental health professionals is still, by and large, conceptualized within a structure. Seldom is treatment thought of as being the total daily life of the client within the community.

How far we can go in avoiding the buildup of institutional populations is a question that cannot be answered until the issue of how the family and/or community can be helped to deal with the problems encountered daily with the mentally ill. While mental health ideology may be coherent, services provided to clients in the community can often be sporadic and fragmentary. All too frequently the burden that had been the hospital's has been shifted to the family and the community with only a limited attempt to provide solutions.

A recent cost-benefit study of a community mental health program in another state went so far as to consider burdens imposed by clients on family members and others in the community as a "cost" of conducting the program. The mental health system is designing programs to minimize family and community burden by providing clients with the support they need to survive and support to the families of these clients. A key to the success of any type of community program for chronically mentally disabled individuals is aggressive and timely intervention before client problems become devastating. Colorado has been addressing this issue for some time and has developed a foundation for building programs which are of high quality, meet the needs of the clients, are cost effective, protect the clients' rights and their families, and are designed to fit into the community with the community's consent and involvement.

Since the passage of the Community Mental Health Centers Act in 1963, all federal legislation has continued to be a mandate for continuing and intensifying federal, state, and community cooperation in the prevention and treatment of mental illness. Passage of such legislation ("The Community Mental Health Centers Amendments of 1975" - Public Law 94-63 and "The Community Mental Health Centers Extension Act of 1978" - Public Law 95-622) has been due in large part to the depth and strength of citizen support.

C. STANDARDS AND QUALITY ASSURANCE

1. Standards

Authority for the Department of Institutions to promulgate rules and regulations relating to community mental health services is contained in CRS 1973, 27-1-202(b), 27-1-204(1), and 27-1-205(3). The Standards/Rules and Regulations for Mental Health Centers and Clinics were adopted by the Executive Director of the Department of Institutions in March 1977, following a duly noticed public hearing

TABLE III

LENGTH OF STAY FOR NONFORENSIC PATIENTS AT CSH BY YEAR OF CENSUS

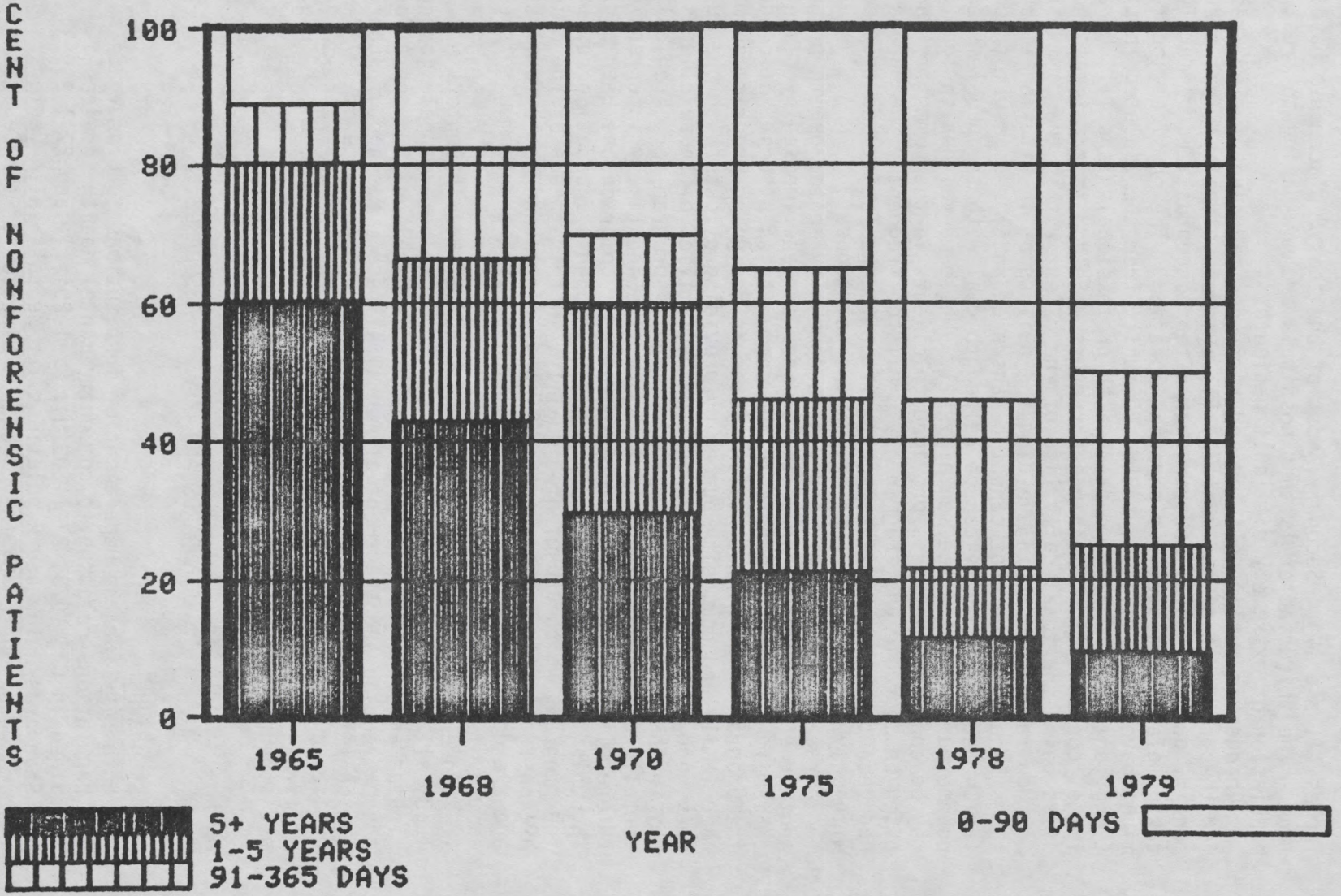
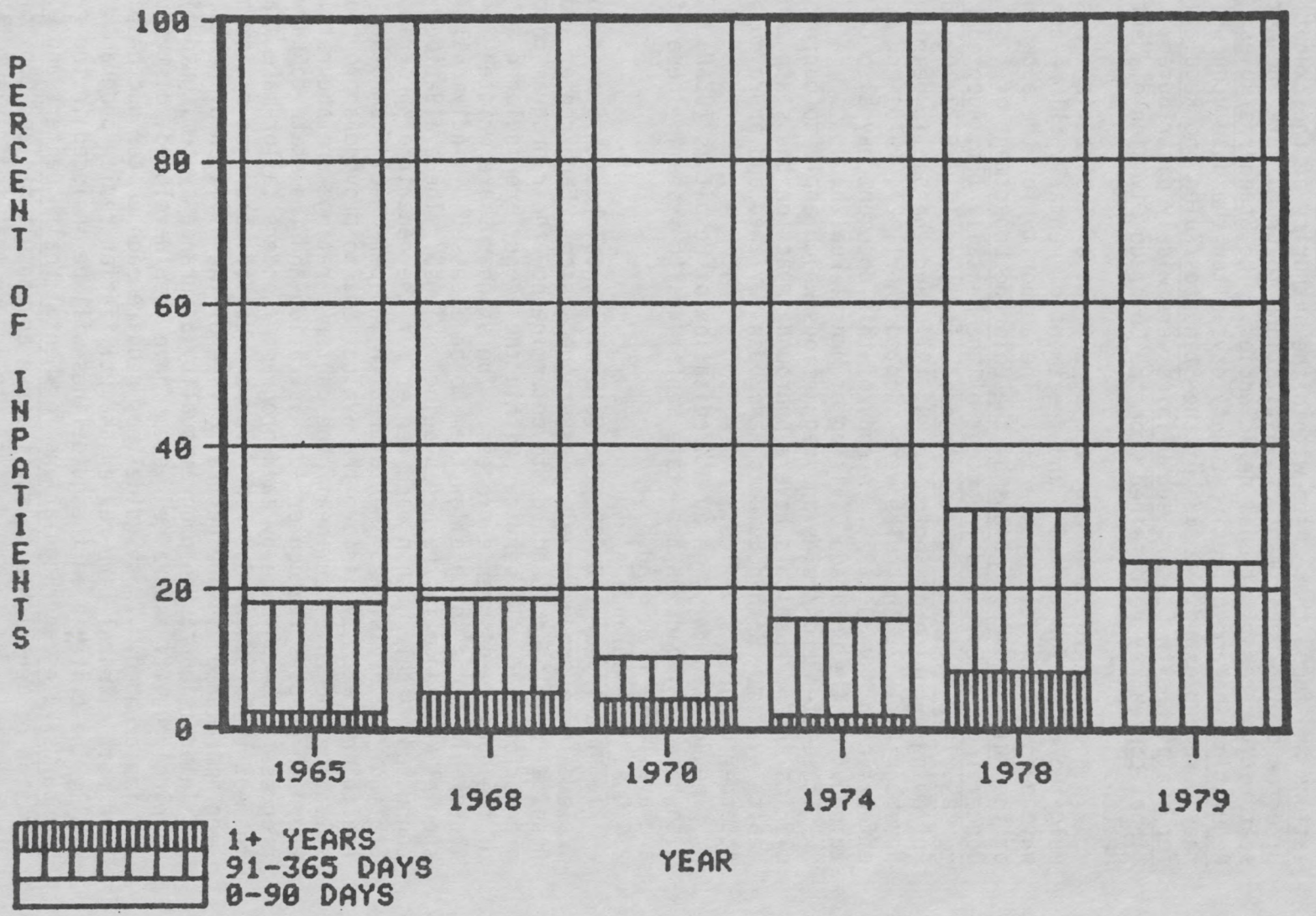


TABLE IV

LENGTH OF STAY FOR INPATIENTS AT FLMHC BY YEAR OF CENSUS



held on October 13, 1976, pursuant to 24-4-103, CRS 1973. The Colorado Attorney General's Office reviewed the Standards/Rules and Regulations and found them to be within the authority of the Executive Director of the Department of Institutions to promulgate and without statutory or constitutional deficiencies. The Standards/Rules and Regulations became effective twenty days after the date upon which they were published. Copies of the Standards/Rules and Regulations for Mental Health Centers and Clinics were widely distributed. Additional copies may be obtained from the Colorado Division of Mental Health.

In addition to the above, the Department of Institutions has promulgated rules for the care and treatment of mentally ill persons who have been detained involuntarily. The authority for the promulgation of the Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill, Adopted Pursuant to CRS 27-10-101, et seq., as Amended, is found in CRS 27-10-126. Following a notice of September 29, 1977, and the public hearing on November 4, 1977, the rules were adopted (April 21, 1978) and became effective on May 30, 1978. A copy of this document may also be obtained from the Colorado Division of Mental Health.

These standards/rules and regulations which apply to centers/clinics and/or hospitals have a profound impact on the state mental health system. Both documents have been reviewed and approved by the Attorney General's Office.

The Joint Commission on Accreditation of Hospitals (JCAH) Standards also have an impact on the state mental health system. These standards are available from JCAH.

2. Quality Assurance

In fiscal year 1979-80, the Colorado mental health system fully implemented a program quality assurance system. Each center and state hospital developed standards to determine how their program components are performing. All services within the agency are included as part of the quality assurance process. The standards are written in measurable terms which allow them to be assessed by individuals without special knowledge in the areas being reviewed. The evaluations are conducted monthly within each center for the benefit of program managers. Staff of the Division of Mental Health and personnel from other mental health programs may perform the evaluations to provide appropriate consultation and to determine if the center's ratings are accurate. This approach enables the center administration and the state to know what progress is being made by each program. Centers tailor-make standards to meet their own needs. The program quality assurance system also has been implemented in the central office of the Division of Mental Health.

In addition to the program quality assurance system, guidelines for clinical quality assurance systems have been developed, distributed, and implemented. These guidelines require each center and hospital to have both clinical care review and utilization review programs. Eventually the criteria in the guidelines will be included in the revised Standards/Rules and Regulations for Mental Health Centers and Clinics. Division of Mental Health staff serve as consultants and monitor the implementation of the guidelines, to insure that the reviews take place and meet the requirements. Several centers and hospitals had existing

systems that met many of the requirements included in the present guidelines.

D. DESCRIPTION OF THE PRESENT SYSTEM

1. Inventory

The full range of mental health services may be considered to include:

a. inpatient, outpatient, 24-hour emergency, partial hospitalization, and consultation and education services;
b. preadmission screening and referral;
c. aftercare or follow-up services;
d. other 24-hour care (i.e., residential alternatives to inpatient care);
e. case management services;
f. services to children, adolescents, adults, and the elderly;
g. services to ethnic, racial, and other minorities;
h. services to mildly, minimally, moderately, and severely disabled individuals;
i. appropriate vocational, activity, recreational, and occupational therapies;
j. 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);
k. services to perpetrators and victims of sexual assault;
l. other services determined by local needs and the requirements of federal, state, and other funding agencies.

Mental health service providers obviously vary in their ability to provide the above services. The service facilities which provide this array of mental health 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 is located in Pueblo, and serves forty-one counties in the southern and western portions of the state.
b. Fort Logan Mental Health Center is located in southwest Denver. It serves the Denver metropolitan area, northeastern Colorado, and eight counties in north-central Colorado.
c. There are twenty-three mental health centers and clinics from which the state purchases mental health services. Twenty centers 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. All centers and clinics are private, non-profit corporations except the Larimer County Mental Health Center and the Denver Health and Hospitals Mental Health Program, both of which are county agencies.

d. The University of Colorado's University Hospital is located in Denver on the University of Colorado Health Sciences Center campus. In addition to serving as a resource for complex medical/psychiatric services throughout the state, it 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.

2. Utilization

Two factors must be considered in reviewing the utilization data provided in this section. First of all, this data represents only those services provided by state-funded agencies. The Division of Mental Health does not have an estimate of the number of individuals being served in non-state hospitals on an inpatient basis; however, it does have the number of inpatient admissions to these hospitals (see Table V). Estimates of individuals being served on an outpatient basis by private practitioners or other organizations will be obtained this year through a survey of the private sector which is being developed by the Mental Health Association of Colorado, the Division of Mental Health, the Health Systems Agencies, and a number of professional organizations. The second factor is that utilization data for mental health needs to be improved and expanded. Currently, the Division of Mental Health can produce the number of admissions and terminations from

TABLE V

Psychiatric Hospital Inpatient Admissions
for Public and Private Agencies
(Excluding CSH and FLMHC)
FY 1974-75 *

Public Hospitals	No. of MH Inpatient Admissions
Colorado Psychiatric Hospital	682
Poudre Valley Memorial	333
Denver Veterans Administration	1,370
Ft. Lyon Veterans Administration	1,485
Weld County General	698
Total Public	4,568

Private Hospitals	
Bethesda	657
Emory John Brady	456
Mt. Airy	1,147
Parkview Episcopal	296
Penrose	426
St. Anthony	492
St. Joseph	900
St. Mary Corwin	509
Total Private	4,883
GRAND TOTAL	9,451

*Source: NIMH MH Facilities Inventory (1976)

state-funded facilities. The amount of service provided in between has not been determined; however, the Division is in the process of developing this type of data.

Table VI looks at community mental health centers admissions and clients served by year. Both admissions and clients served appear to have increased and peaked and are beginning to decline. This decline could be attributed to at least two factors. First, the percentage of admissions to centers and clinics of clients who are moderately and severely psychiatrically disabled has been rising since 1974 (see Table VII). Secondly, resources for mental health services also increased, peaked, and began to decline. The primary problem for mental health in Colorado today is that the mental health service needs of the residents are greater than the resources available to meet those needs.

Division of Mental Health estimates show that there are approximately 230,354 severely and moderately psychiatrically disabled persons in Colorado in need of mental health services. This figure includes 31,789 children, 30,637 adolescents, 130,611 adults, and 37,317 elderly persons in need. Of the total figure only 78,543 citizens can be cared for now. The funds which pay for the services provided to the 78,543 are only partially state funds. Although the services provided to the 78,543 persons are based on data from the Division of Mental Health which include only services provided by state-owned or state-funded facilities, it can be assumed that the need for services is still much greater than all of the resources available, including those of the private/voluntary sector.

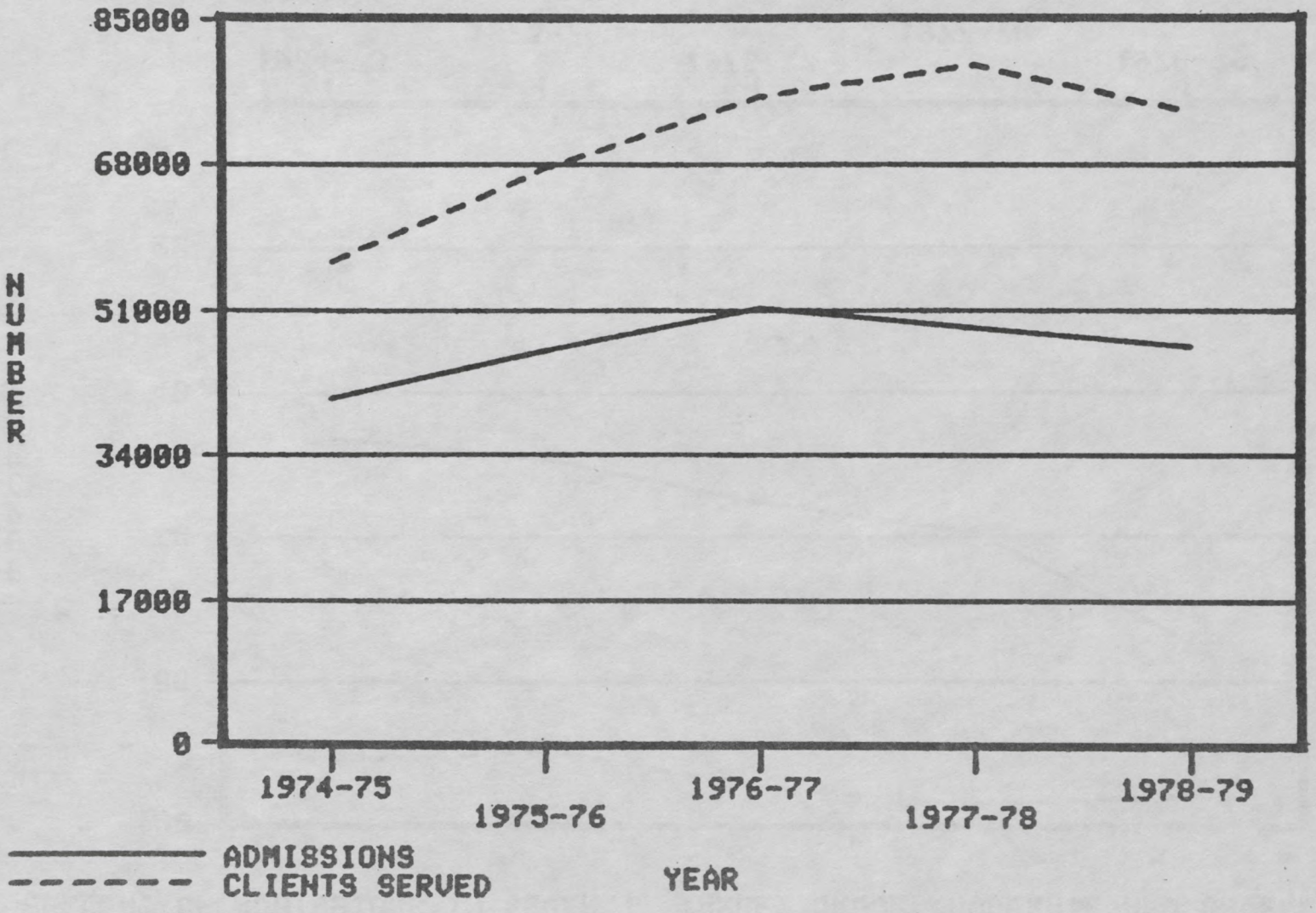
Table VIII shows how the target population (the moderately and severely disabled) is distributed by age. This table also reflects how the age representation in the target group population has changed and will continue to change. The adult (18-64 years of age) and the elderly (65 or over) populations are proportionately increasing, while the child (0-11 years of age) and the adolescent (12-17 years of age) populations are proportionately decreasing.

It is also important to look at the percentage of those in need in each age group who receive care in the state system. Table IX shows the percent admissions by age groups in the mental health centers and clinics. The distribution of age groups among the center and clinic admissions has been rather stable, with a slight increase in admissions of the elderly and a corresponding decrease in admissions of children and adolescents. It is clear that children and the elderly are the most underserved populations. The greatest area of growth in the target population is anticipated to be in the elderly age group - those currently receiving the least care. The percent of admissions by age groups for the two state hospitals is reflected in Table X. In the past two years, the percent of elderly and adolescent clients admitted to the hospitals has increased with admissions of children remaining relatively stable and admissions of adults decreasing.

The Division of Mental Health is committed to the concept that the purpose of treatment is to get people "back on their feet." This means that the person is able to be a part of his or her family, go to school, work, etc. These activities occur at home and in the patient's community. Utilization data indicate that 94.4 percent of the persons served through the Division of Mental Health's resources are seen by community

TABLE VI

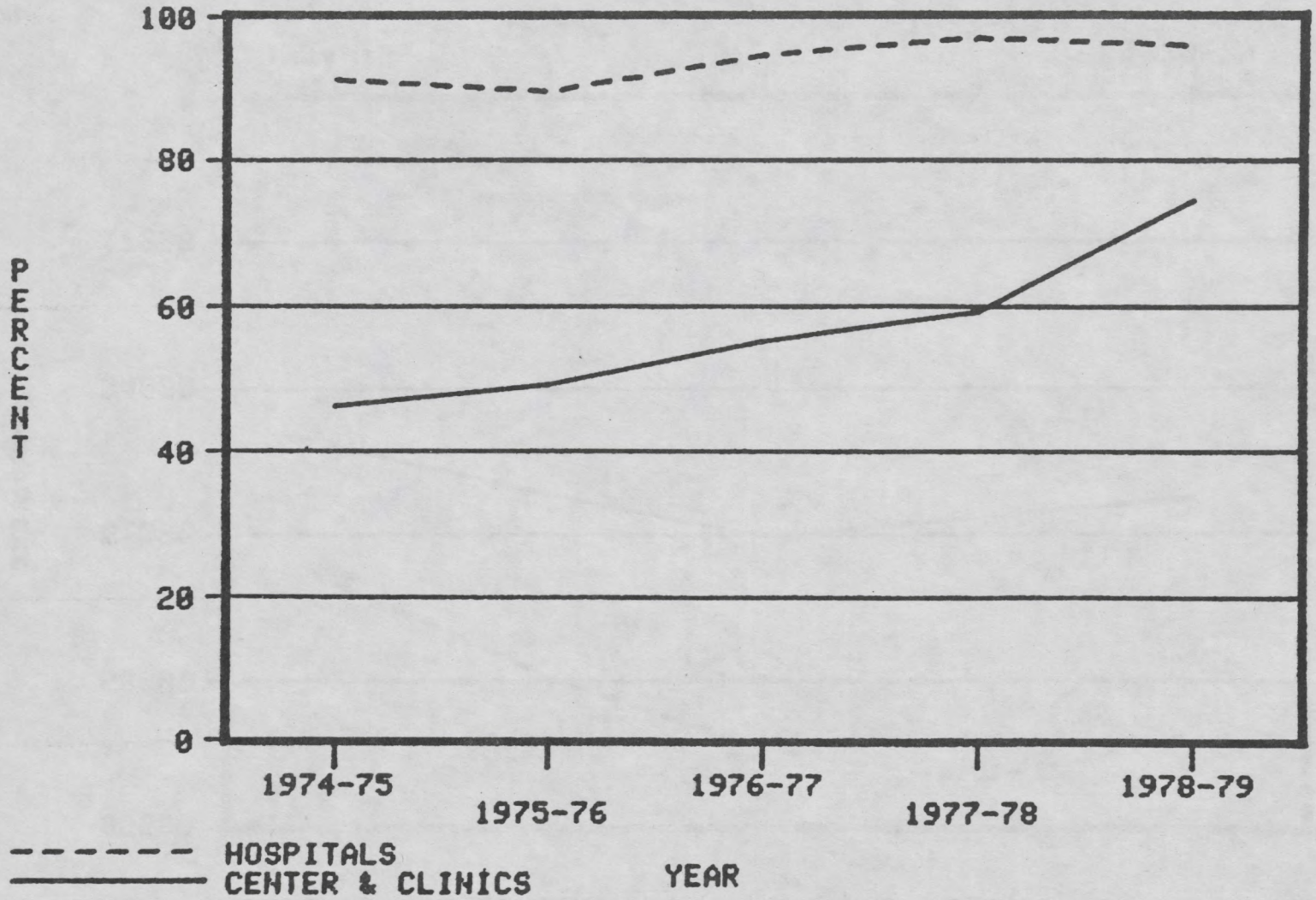
COMMUNITY MENTAL HEALTH CENTERS ADMISSIONS AND CLIENTS SERVED BY YEAR



Source: Division of Mental Health

TABLE VII

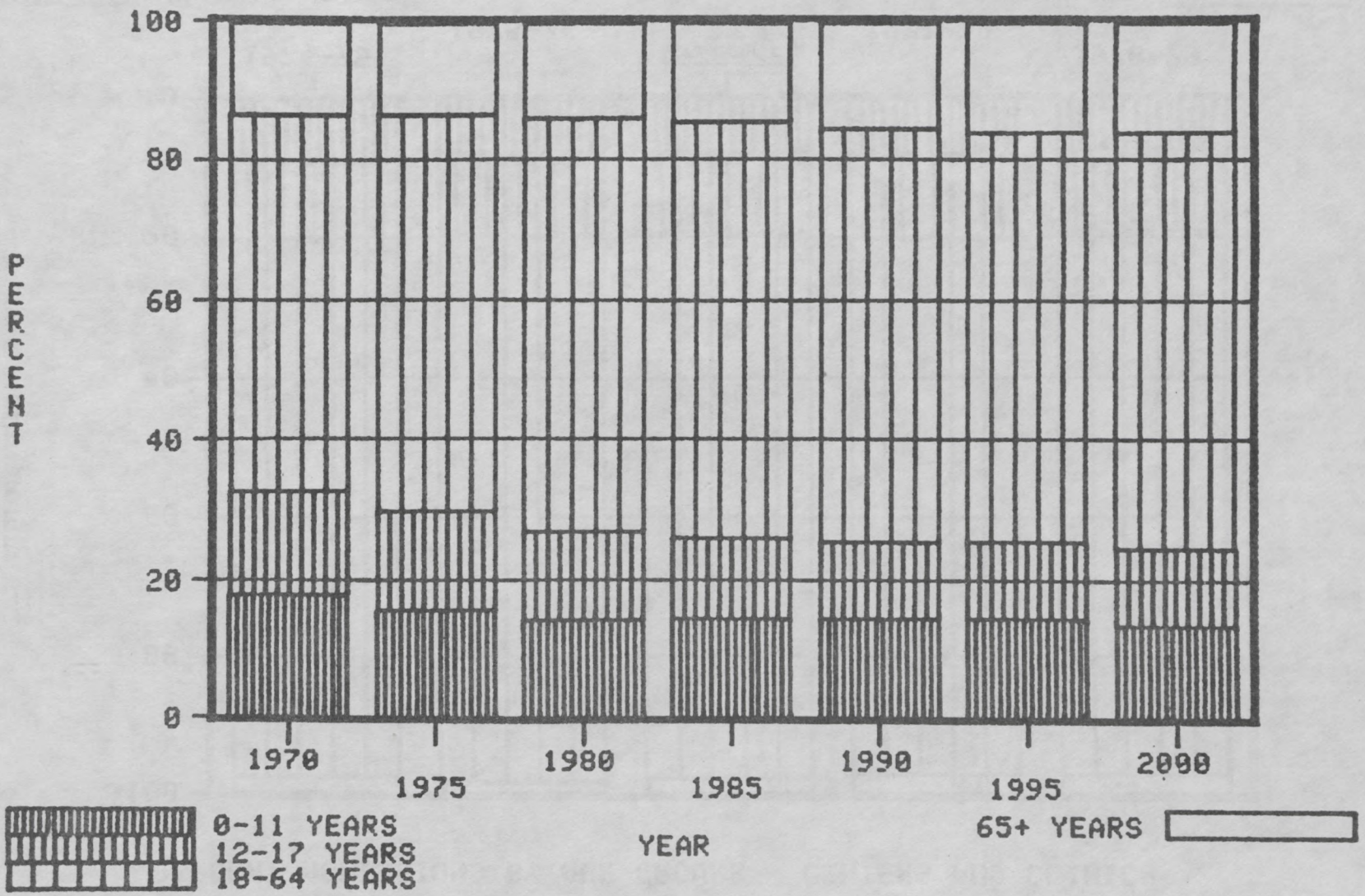
PERCENT OF ADMISSIONS IN SEVERITY TARGET GROUP (MODERATE AND SEVERE)



Note: New target group definition went into effect in FY 78-79.

TABLE VIII

PERCENT OF TARGET GROUP POPULATION BY AGE GROUPS PROJECTED 1970-2000



Source: Illustrative Projections of State Populations by Age, Race, and Sex: 1975 to 2000 U.S. Dept. of Commerce, Bureau of the Census, Population Estimates and Projections, Series P-25, No. 796, Projection Series II-A, pp. 36-37. Target group population determined by applying 'President's Commission' prevalence percentages to total population by age group.

TABLE IX

PERCENT ADMISSIONS BY AGE GROUPS - CENTERS AND CLINICS

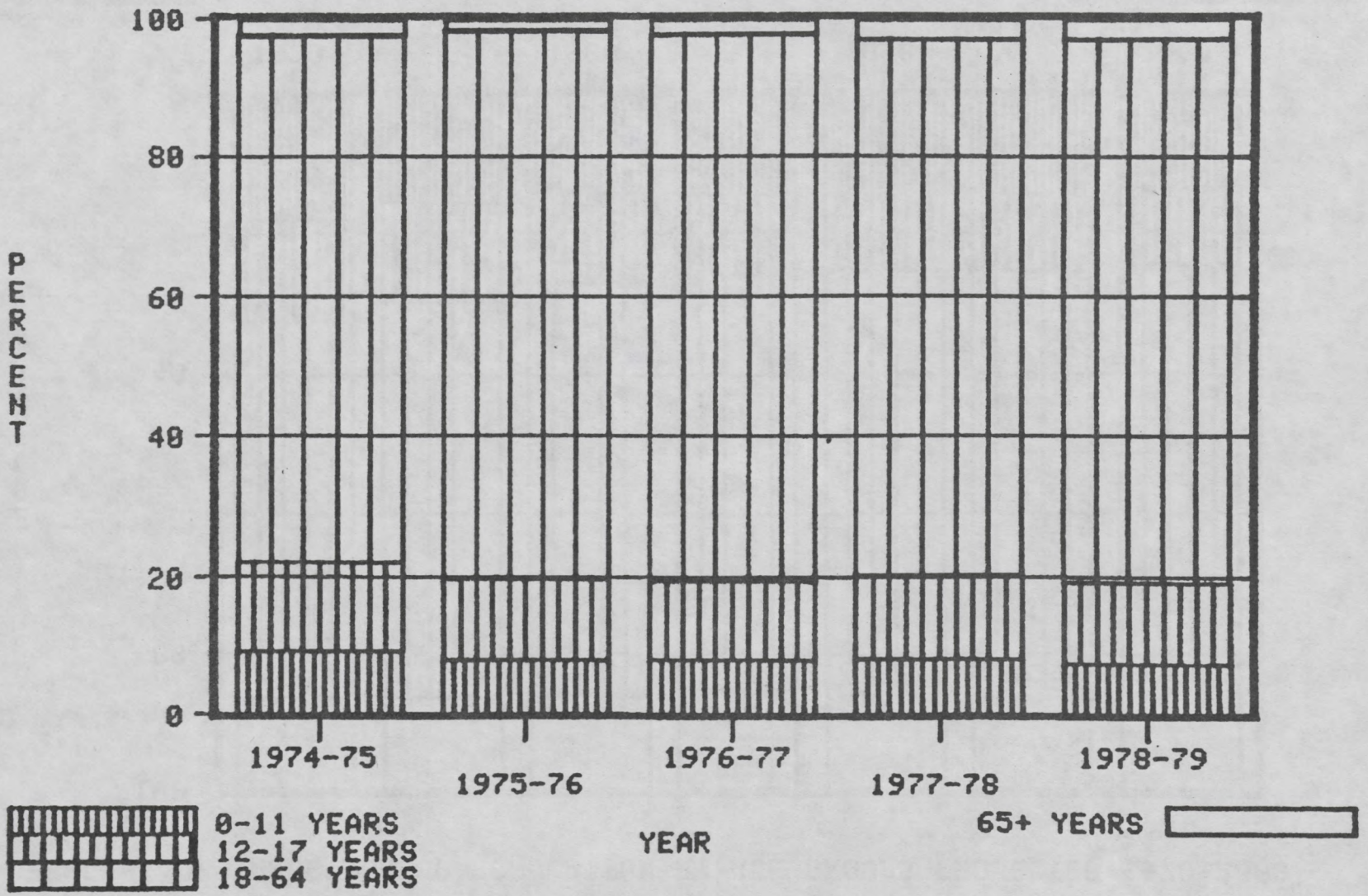
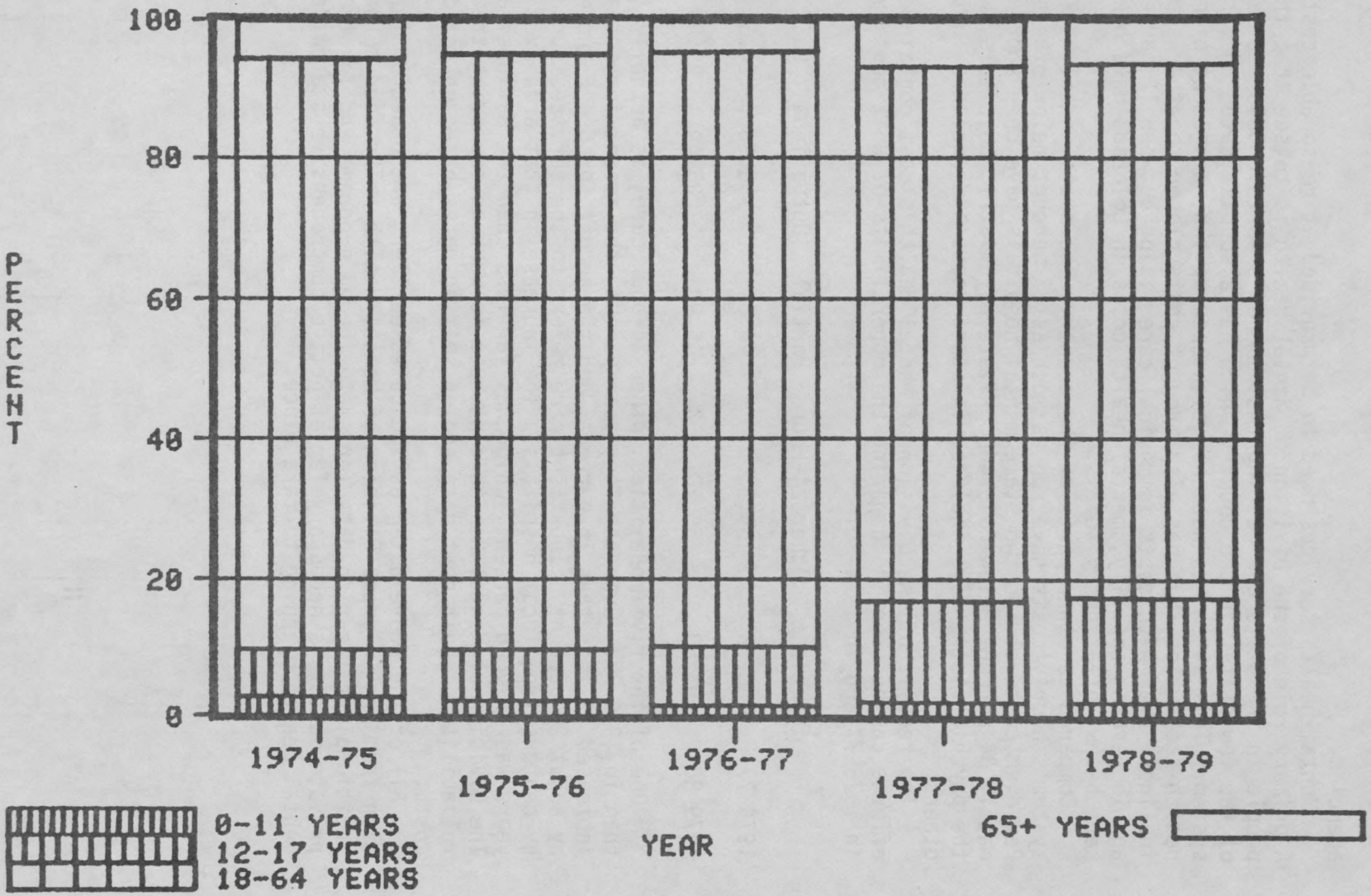


TABLE X

PERCENT ADMISSIONS BY AGE GROUPS - HOSPITALS



agencies.

Mental health services need to be provided at reasonable costs. A primary role of the Division of Mental Health is to see that the people in the state are getting their money's worth. Colorado is one of the few states in the country which has a sophisticated unit cost system. This sytem has not only tightened up the management of mental health facilities, but has also brought costs closer together and more in line. Even with costs in medical care rising between 12 percent and 15 percent annually, mental health costs in Colorado have been kept below inflationary levels.

Compared to other parts of the country, the state mental health system's hourly costs have run as much as 37 percent below others. Per diem costs at the two state mental hospitals have been approximately 34 percent below Colorado private psychiatric hospitals, with the psychiatrist's care included in state costs and excluded in the others.

The results of the Division of Mental Health's cost containment efforts can be seen in comparing the upper limits of unit costs paid in 1976-77 and in 1979-80:

	Inpatient	Other 24-Hour	Partial	Outpatient	C&E
1976-77	160.36	59.33	44.84	30.58	24.34
1979-80	193.50	56.70	45.90	35.40	29.85

One of the five modalities, other 24-hour care, is actually less than in 1976-77. Over the four-year period, the amount for outpatient increased by less than 16 percent, and the amount for C & E increased by about 20 percent. Inpatient care refers to the services purchased by centers from local hospitals. The increase in that area over four years was only 20 percent, which was far less than the national average. The Division of Mental Health continues to work on improving the reliability of unit cost data and on setting rates based on reasonable costs.

All of the above data, as indicated earlier, are based on information from the Colorado Division of Mental Health. The need to produce additional utilization data for state-funded programs and for the private sector is necessary for effective comprehensive statewide mental health planning to take place.

APPENDIX III. STATE HOSPITALS AND THE CATCHMENT AREA MENTAL HEALTH PROGRAM

A. PREADMISSION SCREENING

1. Role of Hospitals and Centers

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 have been formed in each hospital service area. The two state hospitals developed criteria for admission to inpatient care. The Committees adopted those criteria and developed guidelines for facilitating easy movement and continuous care for clients within the system. Policy statements based on the Committees' work have been prepared and issued by the DMH Central Office. 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 preadmission screening of youth is also the primary responsibility of the centers; however, the Colorado Children's Code specifies that the courts may use their discretion in bypassing centers 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 is to have the preadmission 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, clients under court order, and deaf clients. Both state hospitals' roles currently include inpatient services to persons in the four age groups (children, adolescents, adult, elderly).

2. Procedure for Preadmission Screening by Centers

   a. All catchment area centers shall inform the district courts, social service departments, and other major referral sources in the catchment area of the center's responsibility for preadmission screening of all potential inpatient clients.
   b. Each catchment area agency shall develop a written procedure for preadmission 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 judgement, 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 preadmission 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 preadmission screening.

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

e. If the client is admitted to the center, 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.

f. In those instances where a person who should have been evaluated by a catchment area center bypasses the center and appears at CSH or FLMHC to be admitted, the hospital may refer the individual to the appropriate center, 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 of the admission. The center shall contact the agency which directed the client to the hospital to clarify the referral process.

Each catchment area center is designated the preadmission screening agency for its respective catchment area.

B. ALTERNATIVES TO TREATMENT IN A HOSPITAL SETTING

1. Need Within Each Catchment Area

Each community mental health center has the responsibility for ascertaining on an ongoing basis the need for alternatives to treatment in hospital settings within its catchment area. A survey of existing resources should be conducted as a cooperative effort between such agencies as: the social services department of each county within the catchment area; developmental disabilities 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 treatment in a hospital setting for mental health clients and/or potential mental health clients rests with centers. 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 treatment in institutional settings 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 Treatment in a Hospital Setting

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

The DMH has placed increased emphasis on the elimination of inappropriate hospitalization through the stepped-up preadmission screening outlined above, and expanded use of residential and other alternatives

to inpatient hospitalization. A specific category of service ("other 24-hour care") was 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 and recommended for adoption by the Department of Health.

6. Case Management

Severely mentally disabled clients who are residing in the community require a wide variety of services often delivered from a number of public or private agencies. The Division of Mental Health is committed to assuring that clients in the community receive the necessary services and that they not be "lost" as they cross agency lines. This commitment to delivering integrated community based services has led the Division to emphasize the need for effective case management systems in the Centers across the State. Consistent with this direction is the inclusion of case management as a reimbursable unit of service.

C. 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.

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. 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 multidisciplinary team of well-trained professionals and paraprofessionals. 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 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. Psycho-surgery is not used at all.

2. Efforts to Improve Quality of Institutional Care

a. Quality Review Program (QRP)

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

(1) admission review. Within one working day of admission, one hundred percent review of admissions for: appropriateness of admission and assigned level of care according to seven critical criteria as defined on the Admission Summary and justification of diagnosis. Incomplete or inadequate documentation is investigated, referred to the physician advisor when necessary and corrective action is initiated.

(2) continued stay review. Initial continued stay review on all patients on the 10th day after admission. All patients with an approved initial and second subsequent continued stay review are reviewed on the 40th and 70th day after admission. All Medicaid recipients continuing approved hospitalization after the second subsequent continued stay review will be reviewed every 90 days thereafter for the duration of hospital stay.

(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, diagnoses, 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 and aftercare 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. Review data are evaluated to determine hospital-wide educational needs with recommendations made to the Psychiatric Care Audit and Utilization Review Committee.

(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. Patient Care Audits

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 QRP, 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. Staff Development and 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. Colorado State Hospital is now approved for two full years of continuous education by the Council on Professional Education of the Colorado Medical Society. Through the Continuing Education Committee, CSH is offering educational programs for their own staff, as well as mental health professionals in their catchment area.

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: Child and Adolescent Treatment

Center, Geriatric Treatment Center, General Adult Psychiatric Services, Drug and Alcohol Treatment Center, Institute for Forensic Psychiatry, and General Hospital Services.

The first three program divisions serve forty-one counties of the southern and western portions of the state (see map on page AIII.10 for CSH service area), with a total population of some 800,000 persons. The Drug and Alcohol Treatment Center, the Institute for 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 high quality care, alternatives to hospitalization, and methods to prevent or eliminate institutional dependency and apathy in treatment programs. Discharge planning begins at the time of admission and becomes more specific with each review of the treatment plan. There are no wards for chronic patients (except the neurologically disabled in the General Hospital), and the philosophy of "maximum mixture" of all types of clients is followed in assigning clients to treatment units.

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

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

5. Provision of Social and Recreational Stimulation

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

Activities are conducted on the ward or in other division facilities, in the hospital's central gymnasium or off the grounds. There are dyadic, small group and large group events involving both staff-client and client interaction of both a formal and informal nature. All divisions, except Forensic, provide coeducational 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 and inpatient 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, the Family Practice Residency Training Program, the Department of Institution's Automated Data Processing offices, the Division of Rehabilitation Pueblo office, and offices of the Civil Rights Commission. 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 Health Sciences 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, as well as continuing medical education.

It is planned that CSH will continue to provide emergency, adult inpatient, and transitional partial hospitalization services for selected patients of the Pueblo community. Clients in the adult partial care Programs are transferred to programs at the Spanish Peaks Mental Health Center. CSH does not admit clients directly to adult partial care services. These are transitional services which are provided to clients who are in the process of going from inpatient care to outpatient or partial care in the community, but for whom a direct transfer is not clinically advisable. Maximum use will be made of local general hospitals and alternatives to hospitalization by Western Slope centers and clinics and other centers and clinics in the CSH service area which are located a considerable distance from CSH. However, the impact on CSH will be gradual, because of the time necessary to develop alternate treatment facilities and affiliation agreements with local hospitals.

It 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 the person's home as possible. By emphasizing prescreening at the community mental health center 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 is being achieved. As stated previously, however, utilization of the existing beds will change from time to time based on the inpatient needs of various sub-populations. The average daily attendance (ADA) should be allowed

to fluctuate in response to legitimate demand. 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. The Colorado State Hospital drug and alcohol programs will provide back-up services for community alcohol, drug abuse, and mental health programs. The range of services will be jointly determined by Colorado State Hospital and ADAD.

Every effort will be made to treat adolescents and children in their own communities. 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, the General Adult Psychiatric Services and its Forensic and Geriatric treatment programs. Colorado State Hospital also has responsibility for the evaluation and treatment of the female criminal court cases from the entire state. 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.

CSH has implemented a pilot program for the specialized psychiatric treatment of Chicano clients. This is a research program designed to assess the effectiveness of special treatment approaches with Chicano clients. This pilot program is being funded by a grant from the National Institute of Mental Health contingent upon the availability of special funding.

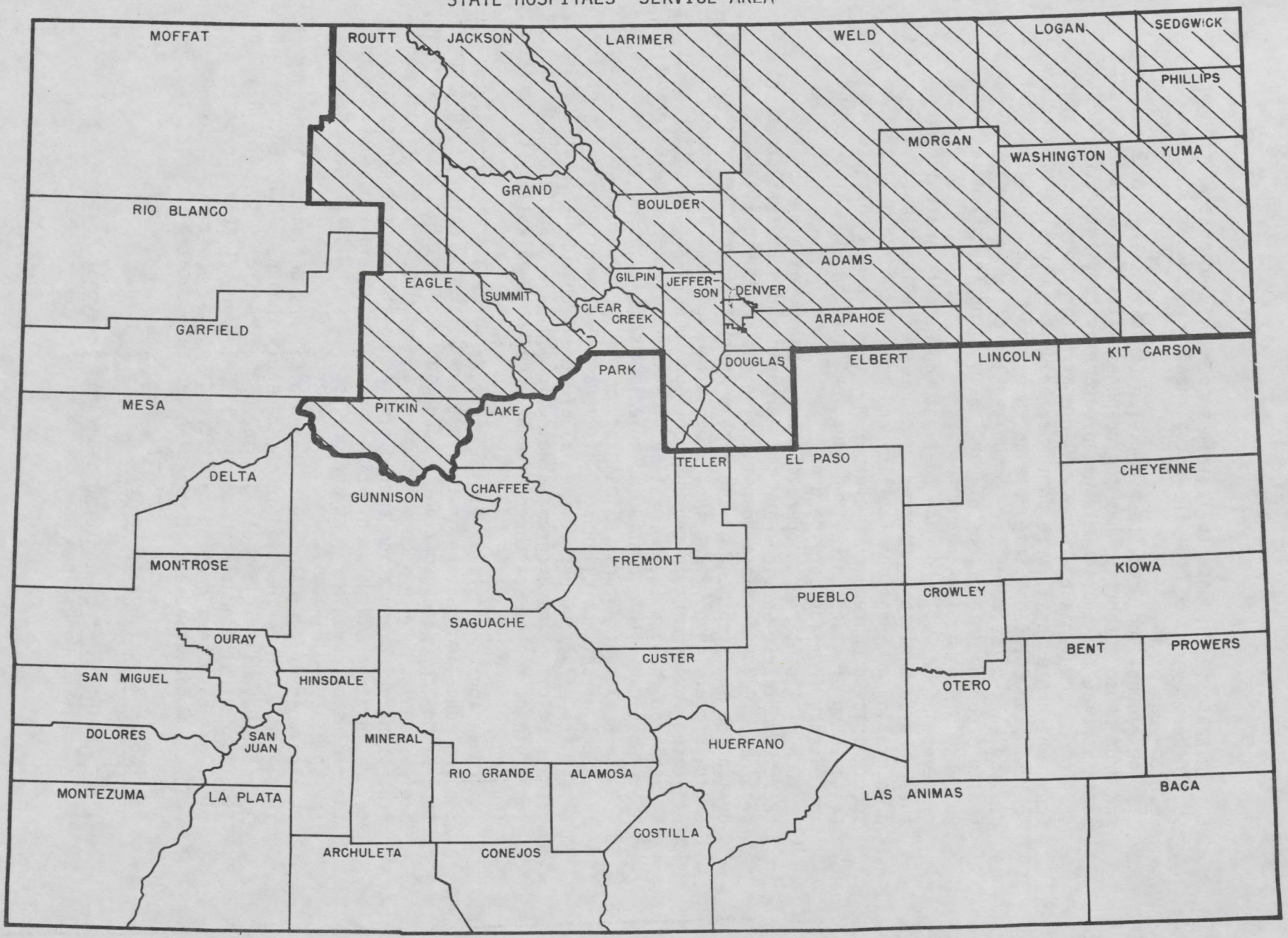
Educational activities for CSH include serving as a regional continuing education center for the southern Colorado region of the state to provide accredited continuing education programs for health services professionals. CSH has been designing and submitting to national and state continuing education 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.

The role of the Colorado State Hospital has definitely increased in this area. CSH is involved in the recently funded SEARCH Program. The American Psychiatric Society 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.

Fort Logan Mental Health Center

1. Description of Living Conditions and Treatment Resources
   a. Living Conditions

STATE HOSPITALS' SERVICE AREA



Colorado State Hospital Service Area

Fort Logan Mental Health Center Service Area

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 accommodations, 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 for 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 Health Sciences 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 to nearly competitive employment shops, and through individual and group placement of clients in private industry settings. Vocational counseling for eligible clients of the mental health centers is provided through funding from the Division of 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. Social skills learning programs are utilized. Chemotherapy is available as prescribed by the team psychiatrist. Electro-convulsive therapy is used sparingly.

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.

c. Adult Psychiatry Treatment Resources

Since February of 1977, when the Adult Psychiatry Service was expanded, the resources for the treatment of Adult Psychiatry patients have been inadequate. There has been a waiting list for all but one or two months of that period of time. The waiting list is larger now than it has ever been before and continues to

grow. This reflects the loss of nursing homes in the community willing to take psychiatric patients, and the closure of boarding homes as alternative living placements for people. This has caused tremendous stress on the Fort Logan Service Area mental health system and much less than adequate service to many people who require inpatient treatment. There is a very clear-cut need for increased Adult Psychiatry Service capacity at Fort Logan. Until this need is met, this will continue to be a major problem for the residents of the service area.

2. Efforts to Improve Quality of Institutional Care

   a. 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.

   b. The Psychiatric and Medical Audit Committee and the Utilization Review Committee conduct 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. These Committees are 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 always in progress. These Committees as well as the key managers of the center are involved in implementing the Quality Assurance Standards of the Joint Commission on Accreditation of Hospital's new Consolidated Standards.

   c. 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.

   d. 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.

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

f. 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.

g. 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-aged people and people with alcohol problems who have a wide variety of severely and moderately disabling psychiatric 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 inpatient treatment and early return of the patient to community living. With the changing role of Fort Logan in the mental health system and the assumption by the mental health centers of much of the short-term work, as well as much of the aftercare, the focus of Fort Logan's treatment has shifted much more to long-term treatment both within the hospital and in aftercare.

The Adult Psychiatry Service was re-organized during 1978-79 to find a more effective way of delivering the services and to find ways to reduce the waiting list. The service is being further modified at this time by shifting resources from other parts of the Center to Adult Psychiatry to increase its capacity to address the inordinate demand for Adult Psychiatry Services and to further attempt to reduce the waiting list. It continues to be organized as three teams: one specializing in admissions and evaluation; one specializing in very long-term treatment, with a behavioral modification - social learning focus; and one specializing in very long-term treatment for more verbal patients. The shift of resources will permit the implementation of an intermediate intensity hospital service of 20 beds. The movement of some of the very long-term people from the more intense treatment units to this intermediate intensity service will permit more rapid movement through the three intensive treatment inpatient teams and hopefully affect the waiting list favorably.

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 (see map on page AIII.10 for FLMHC service area).

Within the area served by the hospital are thirteen community mental health centers and three mental health specialty clinics. Short-term, acute care for adults is provided in local communities whenever possible. The hospital provides acute care for adult patients from the Arapahoe Mental Health Center Catchment Area, the Aurora Mental Health Center Catchment Area, Northeast Colorado (Region 1), and Northcentral Colorado (Region 12), and on contract with some local centers. Currently, the basic responsibility of Fort Logan Mental Health Center is inpatient services to children, adolescents, adults, geriatrics,

alcoholics, 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 help 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.

Despite all the efforts to avoid chronicity, a cohort of very chronic patients is gradually building up at Fort Logan and in the community. Some of these people, if given the benefit of very long-term active treatment, will be able to return to and function in the community. Some of the people who are now in the community have proven that they are simply unable to cope with the stresses of living in the community and need an intermediate intensity active treatment program on grounds at Fort Logan. In discussions between the mental health centers and Fort Logan, it is estimated there are between 50 and 100 people currently either in the community or at Fort Logan who fit into this group. This group is growing constantly, a major current factor in this growth has been the loss of nursing and boarding home resources for the residential services for these people. The Adult Psychiatry Services at Fort Logan must be enlarged and the community treatment and support systems will have to be augmented in order to provide reasonable treatment and living situations for these people. Fort Logan is also developing a small group of extremely refractory people who not only are refractory but are exceedingly difficult to treat, having propensities to assault other patients and staff, set fires, etc. Resources and programs must be provided for these people, and it must be recognized that these programs must be highly staffed programs because of the degree of disorder and disability of these people. They cannot simply be custodial programs.

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 activities 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 the role of Fort Logan will evolve into that of the primary provider of intermediate and long-term inpatient care, short-term inpatient care for the catchment areas in the Denver metroplex, and a purveyor of specialized services to various groups of citizens needing psychiatric treatment such as the mentally ill deaf, the chronically mentally ill who require a constant tie to one institution in order to avoid re-hospitalization, and other such groups. This inpatient care responsibility will include the development of long-term residential treatment units for people who cannot be handled in the community. There will have to be an increase in the size of the inpatient service at Fort Logan as well as an increase in the availability of residential facilities in the various catchment areas. The balance between these two will depend on the ability of centers to treat more seriously disturbed clients in non-hospital programs. Each catchment area center in the Denver Metropolitan area, except Arapahoe, Aurora, Jefferson, has an identified inpatient service within its catchment area. As Federal staffing grants expire, and private hospitalization costs soar, cost considerations will make it advisable to centralize inpatient services for those catchment areas close to Fort Logan Mental Health Center at Fort Logan.

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 prescreening 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. Adequate funding should be provided to meet the actual need for Fort Logan Mental Health Center services on a year-to-year basis.

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 Health Sciences 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 paraprofessionals 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. ADAD has indicated they would like to expand the Hospital Intensive Residential Treatment service at Fort Logan, and it is anticipated that this service will expand.

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 Health Sciences Center.

D. 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. However, in specific cases, follow-up care may be provided by CSH or FLMHC if the responsible center and the hospital agree that such is in the best interest of the client.

1. Predischarge Planning Procedure
   a. Initial planning for follow-up care takes place at the time of admission to inpatient care or during the preadmission process. Community mental health center 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. At the conclusion of the transitional follow-up, the client may exit the system, be followed up by the responsible center, 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 are responsible to help the client avoid the return to inpatient care. This is 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 are 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 is placed in the facility which provides that level of care which meets the individual's clinical needs. Every effort is 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 are 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 helps to 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 is fully advised as to who has responsibility for follow-up care (center, 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 are to be documented in each client's chart. These charts are 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 are maintained by both hospitals. These lists 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.

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

2. Responsible Center/Clinic in Each Catchment Area

The responsible community mental health center in each catchment area is designated in this section.

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 ensures adequate monitoring of hospital and center follow-up programs for quality and cost effectiveness.

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

The state hospitals are also responsible for informing the Division of gaps in follow-up service. CSH and FLMHC will cooperate fully with centers in the follow-up planning process.

Increased attention has been focused on aftercare services during the past three years. The DMH state budget request has 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 has responded by appropriating funds for services to such clients. The Mental Health Association of Colorado and the Colorado Association of Community Mental Health Centers and Clinics have been instrumental in gaining legislative approval for such 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 will make recommendations to DMH concerning needed revisions in the policy and procedures.

E. CATCHMENT AREA MENTAL HEALTH PROGRAM

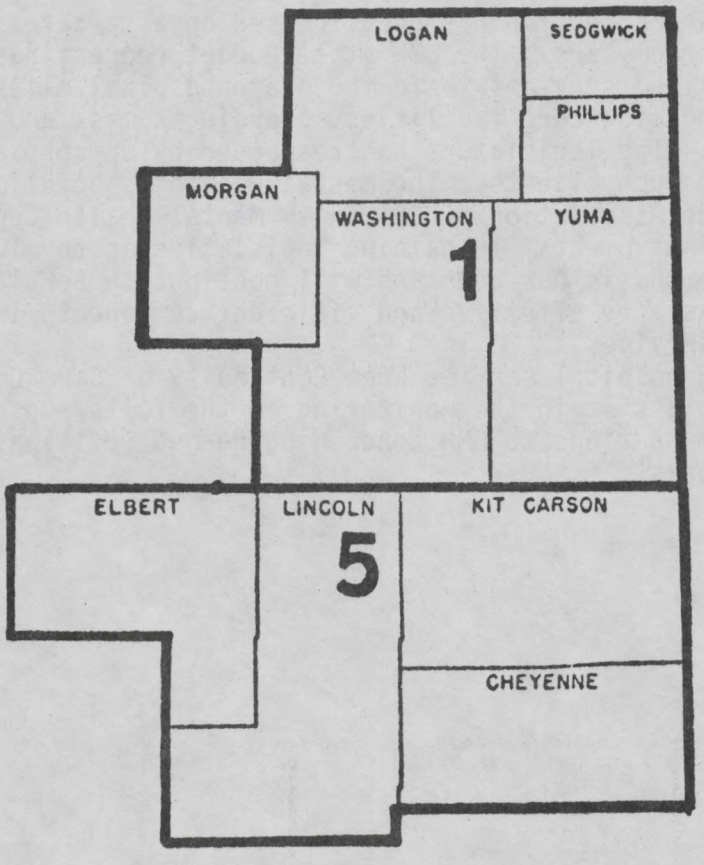
A catchment area is a geographic area for which there is a designated responsibility for community mental health services. Colorado has designated 20 catchment areas. All twenty areas are served by comprehensive community mental health centers.

The catchment areas conform with the boundaries of the thirteen state planning regions and with the boundaries of the three Health Service Areas. The following is a brief description of each region by Health Service Area, the services provided by the center serving each region, and the priorities and program needs of each center. The descriptions were adopted from the catchment area mental health plans submitted by each of the comprehensive community mental health centers.

The population data preceding the descriptions are based on projections by the State Division of Planning, Department of Local Affairs. All data are as of January 1, 1981.

1. HEALTH SERVICE AREA I

REGIONS 1 AND 5



Area: 17,696 square miles
Population: 93,643

a. Description of Area

Regions 1 and 5 have been combined into one mental health catchment area. The area is composed of 10 counties: Logan, Morgan, Phillips, Sedgwick, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne. The area is bounded by the Nebraska and Kansas state lines to the north and to the east. The Crowley and Kiowa county lines form the southern boundary of the catchment area. Weld, Adams, Arapahoe, Douglas, and El Paso Counties form the western boundary. The region's land area of 17,696 square miles represents over 17 percent of the total land area of the state.

The population is unevenly distributed, with two counties accounting for about 50 percent of the population and 20 percent of the geographical spread. The remaining eight counties include 80 percent of the land area and 47,583 people. This vast section of the total area to be served defines the most sparsely populated geographical region of the State of Colorado (about 2.5 persons per square mile). The Centennial area is also designated as a poverty area (13.8 percent of families are below the poverty level). Fourteen percent of the people living in the area are elderly. The population is most stable in terms of out-migration; consequently, the persons becoming chronically mentally ill do not "drift" out of the area, and increasingly define a population at risk. This cluster of age, poverty, chronicity, and rurality contributes the most weight to the unique mental health problems experienced by the residents of the catchment area serving Regions 1 and 5.

b. Existing Services

The Centennial Mental Health Center was incorporated as a merger of the Northeast and East Central Mental Health Clinics. The "new" center was awarded an initial operations grant by the Department of Health, Education, and Welfare in July of 1979, to establish and provide a comprehensive range of mental health services throughout the catchment area. The administrative offices for the center are located in Sterling. Outpatient services are delivered through a network of branch offices located in Sterling, Yuma, Fort Morgan, and Flagler. Each of these offices serves one to four counties, with staff allocated in proportion to the projected population in need and, in the case of the Yuma and Flagler offices, further distributed by satellite offices according to the distances involved. The satellite offices of the Flagler branch are located in Burlington, Limon, and Elizabeth, with outreach stations in many of the "smaller" towns. The satellite offices coordinated by the Yuma branch office are located in Julesburg, Holyoke, Wray, and Akron.

The existing services have been developed by target group and include programs for children and adolescents, for adults, for the elderly, and for substance abusers. The service area is divided into four geographical sub-catchment areas, and services are distributed on a per capita/space ratio. Minority concerns, the problems of women, and consultation and education are addressed on a center-wide basis. Program managers, in partnership with branch office coordinators, are responsible for delivering services in a balanced, effective, and equitable manner

throughout the catchment area.

The delivery structure for children and adolescents defines the most comprehensive range of services. They include: (1) inpatient services through affiliation with the Colorado State Hospital in Pueblo for the "east central" counties and through the Fort Logan Mental Health Center for the "northeast" counties; (2) 24-hour residential care provided by a nine-bed crisis-diagnostic center and an eight-bed long-term treatment center for adolescents (a combination crisis-treatment center for adolescents is being developed in the southern half of the area, and a crisis-nursery is planned for children); (3) separate out-patient, screening, and consultation services are available in every geographical center; (4) early intervention and evaluation are provided to the majority of the 36 school districts, with collaborative partial care available in three schools; (5) a developmental-evaluation clinic with a diagnostic team approach is managed in close coordination with High Plains Rehabilitation; (6) juvenile justice diversionary programs are in operation in 75 percent of all areas; and (7) a program of consultation and direct services for the developmentally disabled is provided through affiliation contracts with the two regional center boards.

The location of twelve geographically distributed offices with full-time staff makes it possible to provide the entire range of outpatient services to adults according to the unique needs of each rural community served. These services, while varying in adequacy from community to community, include: (1) a continuum of inpatient services provided through affiliations with the two state hospitals and through operational agreements with several local hospitals; (2) case management and residential planning provided in a majority of the locations, as well as day treatment, vocational evaluation, training, and placement. Six Section 8 units are operational in Fort Morgan. The construction of a multi-dimensional living complex is approaching final development in Sterling.

The service delivery system for the elderly is approaching a balanced distribution. Activities in this area include: (1) partial care programs available in three locations and four nursing homes, regularly scheduled meetings held with all activity directors in most nursing homes, and an extensive inservice program provided to all 17 nursing homes; (2) an ongoing "task force" composed of representatives from all agencies concerned with aging; (3) outreach activities (home visits) provided in every community; (4) "single senior" recreational and socialization clubs piloted in some of the branch offices; and (5) center staff participation in a "well oldster" clinic.

Substance abuse programs include screening and evaluations for the Highway Safety Alcohol and Drug Driving Program, outpatient counseling, awareness meetings, educational programs, and follow-up. Medical detoxification is provided in local hospitals and non-medical detox through affiliation with Weld ARC in Greeley.

The number of minority admissions and services are proportionate to the distribution of minorities throughout the area. Special minority staff are available in all branch offices.

c. Priorities and Program Needs

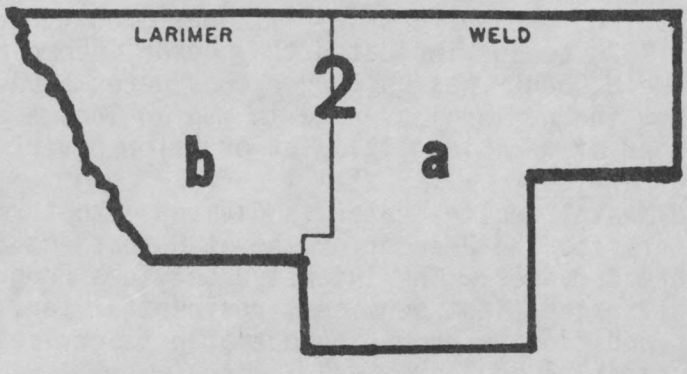
The operations grant proposed (in an eight-year plan of action) the development of a well-distributed system of age-specific services and resources responsive to a wide variety of needs. The first initiative

has been, and remains, the development of a uniform distribution of services and supportive programs. A second priority is two-fold: (1) to expand and balance the utilization of services by the elderly; and (2) to provide timely services, effectively linked to whatever resources already exist in the communities, to the vulnerable and underserved chronically mentally ill. The shortage of well-managed individual programs for the long-term care of this disability group remains one of the most serious problems facing this large rural center. A third priority is defined by the minimal availability, throughout the region, of resources and professional persons to screen and evaluate moderately and severely disturbed persons.

Special program priorities include the need for small, high quality emergency residential services for adolescents within 50 miles of their home communities. Two such additions are necessary. The minimal cost is estimated at $45,000 to $50,000 each. A second need is for a crisis nursery to serve the entire area. The cost of this nursery would be somewhat higher, based on the need for more intensive short-term care. Finally, specialty programs need to be developed within the most rural counties that are identified as having unusually high proportions of elderly and/or chronically disturbed persons and a minimum of resources. The development of adequate case management, residential alternatives, socialization and vocational activities is estimated to be at least 50 percent higher than costs of treating similar problems within communities offering a greater number of supportive services.

Rural program needs vary in each community. While none of the thirty to forty small rural communities is totally unique, they are isolated from each other and from the variety of socio-economic supports available in larger communities. Mental health problems and fiscal needs increase in relation to the distance from the two urban centers. Programs and staff cannot be distributed based on uniform projections of incidence varying only by the percentage of age groups throughout the geographic sub-areas. The complicating effects of space also are important. Service delivery constantly has to be shaped to meet the demand for services and the availability of resources.

REGION 2



Region 2a

Area: 4,033 square miles
Population: 140,000

a. Description of the Area

The Weld Mental Health Center serves Weld County, located in north-central Colorado, directly north of Denver. Weld County is one of the largest counties in the United States, with a geographical area of 4,033 square miles. At the present time, the county has a population of an estimated 140,000. Greeley is the county seat and commercial center for the county, with a population of approximately 60,000, an increase of 50 percent over 1970.

Agriculture is the major economic base for Weld County. The areas surrounding Greeley, approximately one-third of the county, are intensive farming areas, very productive in sugar beets, corn, and vegetables. 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 rangeland. Because of the difference in land use, 95 percent of the Weld County population is located within 25 miles of Greeley.

Manufacturing and light industry are also present in Weld County. Kodak of Colorado, located in Windsor, now has a work force of close to 3,000. Other farm-related manufacturing is also represented in the Greeley area. The University of Northern Colorado, located in Greeley, has a student enrollment of approximately 10,000.

There are two identifiable ethnic groups in the Weld County community. The largest group is Russian-born Germans, whose families came to the Weld County area in the early part of the Twentieth Century. This economic group is composed largely of farmers and businessmen. Only the older members of this group are still identifiable through German as their primary language. The second major ethnic group is Mexican-Americans who have come to Weld County primarily as seasonal agricultural workers. The population of Spanish-surnamed in Weld County numbered 13,752 in the 1970 census, or 15.4 percent of the total population. It should be noted that the number of migrant farmworkers has declined in recent years because of the expansion of mechanized agriculture.

Weld County was designated as a poverty area by the Department of Health, Education, and Welfare in 1971, based on figures from the 1960 census. The 1970 census indicated the median income had risen to the extent that Weld County was no longer considered a poverty area, but it is still below the national average in median income and has a substantial number of families living at or below poverty levels.

b. Existing Services

The Weld Mental Health Center is divided into three program areas: Children's Services and Prevention, Adult Outpatient Services, and Intensive Care Services. The Intensive Services Program is responsible for coordinating inpatient services, residential services, partial care services, in addition to providing outpatient services to severely and chronically disabled adults.

Inpatient care is provided through a contractual arrangement with Weld County General Hospital. The Intensive Care Program also provides residential services through contractual arrangements with Windsor Health Care, an extended care facility with 60 psychiatric beds, and the Krieger Boarding Home, a privately operated adult group home in Greeley. In addition to these residential services, the center has five units from the Department of Housing and Urban Development for subsidized housing for mentally ill individuals. Day care services to chronically mentally ill individuals include a variety of group activities, including group therapy, occupational therapy, and recreation programs.

The Adult Outpatient Program provides a variety of group, individual, and marital counseling services to citizens over 18 years of age. Specialized programs for battered women, sexual offenders, and various skill-enhancement programs are included under the Adult Outpatient Program.

The elderly Peer Counselor Program is also under the Adult Outpatient Services. Currently, there are 15 elderly Peer Counselors, retired citizens who have undergone training and counseling and act as paraprofessional counselors to the elderly in the community. In the past year, this program has increased 23% over the previous year. Further expansion of this program remains one of the priorities of this center.

The Children's and Prevention Services provide a variety of services to Weld County citizens under the age of 18. Family therapy is the preferred treatment modality with this program; however, a wide variety of group therapy, play therapy, and individual therapy programs are available for children and adolescents. In addition to the outpatient services provided, the Children's Program is responsible for much of the consultation and prevention programs that are carried on by the center. Coordinated services are currently being provided to two school districts, the Department of Social Services, the juvenile justice system, various pre-school and day care programs, and other community agencies. Additionally, a coordinator of primary prevention services has been named. Prevention services are currently being developed in the area of preschool services and parenting.

The In-Touch Counseling Clinic in Fort Lupton is a part of the Children's Services. This program provides outpatient counseling to the southern part of Weld County, as well as consultation with schools and other community agencies. Also under the children's program is Horizons, which is a drug crisis counseling program. This program serves primarily late adolescents and young adults with various drug-related emotional problems. Consultation and drug information services are a function of Horizons. The program also provides services to sex-offenders referred by the courts.

The center provides both walk-in and telephone emergency services 24 hours a day, 7 days a week. A substantial number of clients initiate this service by walking into the mental health center and requesting an appointment. After hours, the center staff are available by telephone for consultation or for direct interview.

All the above-described programs are available to both English and Spanish-speaking residents. Every team maintains at least one clinical

staff person who is bilingual (Spanish). Programs with a higher concentration of Spanish-speaking clients, e.g., the In-Touch Counseling Center in Fort Lupton, have more than one bilingual staff person. Additionally, a service contract has been developed with the Plan de Salud del Valle Rural Health Clinic in Fort Lupton, which provides psychiatric and psychological services to minorities and other rural residents.

c. Priorities and Program Needs

The increase in inpatient and residential care and the increased commitments to more intensive services are indicative of a growing presence of severe and moderately disturbed individuals in the community. It is expected that this trend will continue into the future and become more pronounced; therefore, increased services to moderate and severely disturbed individuals is a major center priority. Likewise, continued increases in services to children and the elderly are and will continue to be Weld Mental Health Center service priorities.

The southern part of the county continues to grow more rapidly than the rest of the county; therefore, this will be watched closely during the coming years. The area impacted by the Kodak Manufacturing Plant near Windsor is an area which is seen as potentially underserved. Another specific concern regards the Windsor Health Care Facility. Windsor Health Care represents an important resource to Weld Mental Health Center in providing services to clients, most of whom have some community base in Weld County. Without that program, Weld would be hard-pressed to continue to keep people out of Fort Logan Mental Health Center and relieve the pressure on that agency. There is a concern, however, with a program like Windsor Health Care attracting patients throughout the state. Weld has become increasingly alarmed at the demise of comparable programs in other parts of the state and the pressure that has been created, increasing the number of chronically mentally ill patients at Windsor Health Care. The concern is that Weld County will become the permanent home for many of these people because of the existence of the service, and they will eventually be transferred to Weld Mental Health Center programs. This concern will be monitored closely during the coming year.

The major immediate program need identified by the Board of Directors is the addition of a second full-time psychiatrist to the mental health center staff. Programmatically, the major needs focus in the area of the chronically mentally ill. A vocational program for this target population has been identified as the first program priority for the citizens of Weld County. It is estimated that such a vocational program, to include both sheltered workshop and independent vocational programs, will cost approximately $60,000 in the first year of operation. The center is also looking at the facility needs of the Stepping Stone Program, the partial care program for the chronically mentally ill, which has outgrown the space of its present building. The building also represents less than fully satisfactory working conditions. Costs for a new facility are currently being investigated. Other identified program needs for future consideration include increased partial care services for both children and elderly and the development of a contractual arrangement with Eastside Health Clinic similar to the one currently maintained with Plan de Salud del Valle. This would provide additional services

to minorities and rural areas.

Region 2b

Area: 2,640 square miles
Population: 156,100

a. Description of Area

Larimer County is located in the northcentral area of Colorado, on the northern end of the Front Range. The county is bordered on the north by the Wyoming border, on the east by Weld County, and the south by Boulder County. The western boundaries of the county are shared with Jackson County. The terrain ranges from rolling plains to the high mountain country of the Rocky Mountain National Park. Major watersheds are the Big Thompson River and the Cache La Poudre River, which flow to the east to the South Platte River. The county is heavily populated on the Front Range, but areas of extremely low density population occur in the northwestern and western portions of the county. The land area of 2,640 square miles has an overall population density of 53 persons per square mile; however, 75 percent of the population of the county live within the six incorporated areas.

The county has experienced phenomenal growth over the past two decades, particularly since 1974. A growth rate of 78 percent from 1970 to 1980 has been recorded by the County Planning Office. Assessed valuation has increased by 126 percent from 1973 to 1979, a rate of growth that far exceeds inflationary factors. New light industry continues to seek to relocate in the county. Eastman Kodak established a major facility in Windsor, Colorado, and a large number of those employees chose to live in Larimer County. Hewlett-Packard is completing a new major facility. It has been announced that NCR is seeking to relocate in the area, bringing some 600 new jobs and families. A $250,000,000 coal-fired electrical plant is slated for construction beginning in 1980 and will be completed in 1984. It is not known how many construction workers will be involved, but county planners liken the potential impact to the Western Slope problems surrounding the "energy boom." Growth has been the byword in Larimer County for the past twenty years.

With growth came major problems. In a year when the major crime rate has decreased slightly, it has increased in Fort Collins, the county seat; assaults have increased by 105 percent; rape has increased by 62 percent; robbery is up 50 percent; burglary is up 67 percent. The sociopolitical scene in the county is changing rapidly from a conservative, rural, agriculturally-based economy, to an urban, suburban, more liberal and urbane society, with a multifaceted economy based on production of light goods and products and services. As intimated above, the construction trades are a major industry in the county.

b. Existing Services

Larimer County Mental Health Center provides outpatient services, inpatient services, partial care services, transitional care services, medical and psychiatric consultation, public education and consultation, volunteer services, crisis intervention, intake, referral and screening

services and outreach services to all age groups at all levels of severity. The center's special target groups include patients whose primary language is Spanish, sexual assault victims, substance abusers, child abuse, county jail inmates, nursing homes, and combative patients. The center, therefore, provides a full range of services with only minor gaps. Certain services are available, but are provided through other agencies, particularly Fort Logan Mental Health Center. The "gaps" are briefly reviewed in the following paragraphs.

Children: Inpatient services are provided through Fort Logan Mental Health Center. During FY 78-79, six children were referred. The cost-effectiveness ratio may preclude the development of a specialized local inpatient facility. A halfway house is not available; however, placement in foster homes and similar cooperative arrangements with other agencies has been used. Again, the issue is one of funding a specialized program for relatively few numbers.

Adolescents: Some inpatient services are provided through local inpatient programs. Some service is provided through Fort Logan Mental Health Center. The local facility does not specialize in adolescents, but close coordination between center staff and hospital staff is provided when an adolescent is placed in the local hospital. Partial care is provided periodically through a number of specialized groups and activities. The existing halfway house has provided services to adolescents, but the program is not specialized.

Elderly: The existing halfway house can serve the needs of some elderly citizens. A local nursing home has been used in this capacity. A specialized halfway house for the elderly has not been established.

Special Target Groups: Partial care groups are available to all center clients. In the past, some special interest groups for Spanish-speaking clients have been provided. However, the programming has not been consistent due to the lack of interest of this minority population. Thus, minority clients are included in the usual services. The halfway house does not have a specialized program for the Spanish-speaking, but the service is available when needed. Public education efforts around mental health issues of the Spanish-speaking person have been carried out in the past. However, a new staff member has been hired to develop a stronger outreach and education effort in the Chicano community.

Specialized services for the substance abuser are partly available. The county contracts with the detox center in Greeley for alcohol detoxification services, and Fort Logan Mental Health Center provides some inpatient care. Some alcoholics are served through the local inpatient facility. In drug abuse services, some detoxification takes place in the local inpatient program. In the non-toxic state, halfway house services are available. This service is considered "partly available" because it is not a totally "specialized" service. The need for such appears questionable at this time.

As in most areas of the state, the combative, assaultive patient presents an extreme program difficulty, owing to the need for security as well as treatment. The center has recently mounted a pilot project with Fort Logan Mental Health Center to address this need, in which Fort Logan has allocated one emergency bed to Larimer County for use without regard to the waiting list. However, the bed can be occupied for only

seven working days, at which time Larimer County must provide an alternative treatment program. During the seven days, Fort Logan staff will provide their particular expertise in working with the patient. This program was necessary because of the lack of suitable facilities in Larimer County to deal successfully with this type of patient.

c. Priorities and Program Needs

Needs assessment data, in the strict, research-oriented sense, are not available for Larimer County. However, a community survey was completed in September, 1979, which served the purpose of evaluating the visibility of the center in the county. Respondents were asked to identify the areas in which they believed the mental health center "should be providing services." Respondents were then asked to rank those areas as to their relative importance. This survey was, essentially, a repeat of a similar survey completed in 1978, and the similarities were striking. The "most important" area in which the mental health center should be providing services, according to 24 percent of the 1,643 persons surveyed, was in alcohol and drug abuse services. The second and third "most important services needed" were in marital and family counseling and in services for children and teenagers. Services for the elderly were seen as "needed," but were considered less important than services to help people "cope with job-related stresses." In fact, only 3 percent of the respondents judged services to the elderly as the "most important services needed."

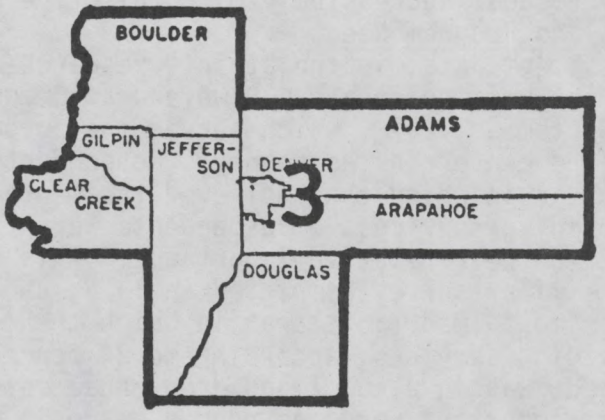
The following are the specific program needs in the area of Adult Services: (1) funding for a medium-security residential treatment program for assaultive and/or combative patients, for both short-term and longer-term placements; (2) greater support for preventive programs in assault cases (child abuse, sexual assaults, spouse-battering); and (3) greater support for establishing and maintaining mental health programs in the jail settings.

Program directions for Children and Family Services will be addressed as follows: (1) greater emphasis will be placed on consultation with other agencies, including schools and the juvenile justice and welfare systems, to create joint responses to children in need; (2) there will be continued exploration of the use of partial care programs for children; and (3) there will be continued involvement in local planning for a general community program for children under "Senate Bill 26."

For the past six years, the center has attempted to obtain significant specialized funding to meet the needs of the elderly citizens. A number of significant factors impact on meeting the needs of this special group: (1) the county has 13 nursing homes providing 1,149 licensed beds (the fourth highest number in the state); and (2) in addition to these private practice resources, the several municipalities and the county provide a number of agencies that address the needs of the elderly. These include the Area Council on Aging, Neighbor to Neighbor Services, Inc., the Fort Collins Housing Authority, and numerous church-sponsored efforts in counseling and general assistance. The center intends to focus on the following issues: (1) continued outreach into the nursing homes via specific contracts for specific services; (2) development of a general "package" of modulated services for short-term training of nursing home staffs; and (3) development of further liaison with the Council on Aging

as part of program development within the entire county.

REGION 3



Area: 5,075 square miles
Population: 1,687,600

Region 3 is a 5,075-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 on the east by Washington County, on the south by Elbert, El Paso, Teller, and Park Counties, and on 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 principle 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 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 University Hospital (a component of the University of Colorado Health Sciences Center), two psychiatric hospitals, several general hospitals, many private practitioners (psychiatrists, social workers, psychologists, nurses, pastoral counselors, etc.), as well as voluntary agencies.

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

Adams County Mental Health Center, Inc.

Area: 1,218 square miles
Population: 219,494

a. Description of the Area

The Adams County Mental Health Center's catchment area encompasses all of Adams County, with the exception of the Adams County portion of the City of Aurora, and areas south and west of Irondale Road, Box Elder Creek, and the line of 56th Avenue. The population of the catchment area is 213,063 (DRCOG Notations, July 1979).

The heavily populated western quarter of Adams County includes the municipalities of Northglenn, Westminster, Thornton, Commerce City, and part of Broomfield. The county seat, Brighton, remains an exception, in that it has retained much of its rural character. The major industrial activities (oil refining, heavy equipment sales and service, steel warehousing, etc.) are concentrated in the Commerce City area. The eastern three-quarters of the catchment area is a sparsely populated farming/ranching area.

Adams County ranks low on many socio-economic indicators. Per capita income in 1970 was $2,833 (1970 Census Data Mental Health Demographic Profile System), with 6.8 percent of the population living at or below the poverty level (State of Colorado Mental Health Plan 1979-1984). Other major economic factors include an unemployment rate of 5.52 percent (State of Colorado Mental Health Plan 1979-1984). Many residents work in Denver, and are directly affected by the economic conditions in that city. A large number of residents are employees of the federal, state, and municipal governments. Adams County has a lower tax base than most other Denver metropolitan area counties.

Significant characteristics of the catchment area and/or sub-areas that impact the need for the delivery of mental health services include: (1) there are many families in which both parents are working; (2) there is a significant number of single-parent families, especially households headed by women; (3) there is a large number of public assistance recipients; (4) Adams County has the second highest number of child abuse reports in the state - 699.1 per 100,000 population (State of Colorado Mental Health Plan 1979-1984); (5) the unemployment rate is 5.52 percent (State of Colorado Mental Health Plan 1979-1984); and (6) the incidence of suicides is 15.5 per 100,000 population (State of Colorado Mental Health Plan 1979-1984).

b. Existing Services

The Adams County Mental Health Center is a comprehensive community mental health center which provides directly or through contractual arrangements outpatient, 24-hour emergency, inpatient, other 24-hour care and partial care services to catchment area residents of all ages.

In addition to providing direct services to individuals and families, the center also provides community education programs and mental health consultation to other agencies in the county. To ensure accessibility, the center has offices in Commerce City, Westminster, Northglenn, and Brighton. Staff in each office provide outpatient and patient care coordination services. Structured partial care is provided at the Commerce City office, and hospital care is provided as needed at Denver metropolitan hospitals. Included in the center's array of services are specialized programs for high-risk and special needs groups.

The center provides a variety of programs for the chronically mentally ill. The core of this system is the Partial Care Team, which consists of the social development program and case managers who coordinate services for the chronically mentally ill. Additional contracted services are provided in conjunction with Community Corporation. They include the Adams Work and Evaluation Center (ADWEC), and the Adams Pre-Vocational and Life Adjustment Program (ADPLA). Intermission House, Community House, the Triplex and independent living apartments provide a range of living facilities from highly supervised and structured to independent.

The center has a child and adolescent program coordinator whose responsibilities include the center-wide coordination of services to children and adolescents, identifying unmet needs for this population and developing new programs. All outpatient teams have at least one clinician who is a child and adolescent specialist. Two specific programs, the Child Advocacy Team in School District #14 and the District #50 School Team, provide specialized services to children and adolescents. Day treatment services are provided in the summer for severely disturbed children by the center's Behavioral and Emotional Skill Training (BEST) Program.

The center has a seniors' program coordinator whose responsibilities include the center-wide coordination of services to the elderly, identifying unmet needs for this population, and developing new programs. The seniors' program has emphasized building upon existing services in the center and community. Current specialized services for the elderly include individual and family therapy, group meetings in nursing homes and seniors' centers, and consultation to senior centers, well-oldster clinics, and other groups in the community.

The center has a minority services specialist whose responsibilities include the center-wide coordination of services to minorities, identifying unmet needs for this population and developing new programs. All clinical teams have minority clinicians who are qualified to provide specialized services to minorities. The primary thrust of the minority services program is outreach and community education services. Significant effort is devoted to increasing utilization of direct mental health services to Chicanos.

c. Priorities and Program Needs

The center has established priorities for the delivery of mental health services that reflect the needs of the catchment area and the mandates and requirements of funding sources. The ranking of needs in the various sub-catchment areas is not sufficiently dissimilar to justify different priorities for each sub-area. However, the single most needy area in terms of mental health service needs is the Commerce City area.

Commerce City and Brighton have the highest percentage of Hispanic residents. (The priorities obviously are not mutually exclusive.)

The priorities are as follows: (1) emergency mental health services; (2) services to clients being evaluated or treated pursuant to the Care and Treatment of the Mentally Ill Act (CRS 27-10); (3) services to the severely and moderately emotionally disabled; (4) services to the following special-needs groups: children (ages 0-11), adolescents (ages 12-17), elderly (ages 65+), and minorities (American Indians, Asian Americans, Black American, Spanish Americans); (5) short-term outpatient services for clients not included in the above categories; and (6) non-emergency mental health evaluations and case-related consultation for other agencies.

There is a need to provide more comprehensive services to the severely disturbed and difficult to manage children and adolescents in Adams County. At present, a large number of children and adolescents are placed in residential child care facilities outside the county, because they cannot be maintained in the community. A broader range of community services is needed. One specific need is a year-round day treatment program for children and adolescents. The estimated annual cost of such a program is $200,000.

There is a need to increase community education and outreach services to the elderly. Elderly persons often demonstrate a reluctance to avail themselves of traditional mental health care and are, therefore, better served when services are delivered in community settings. To adequately increase the center's outreach efforts would cost approximately $40,000 per year.

For many Hispanic persons, mental health services are optimally provided by Hispanic clinicians. In this way many unnecessary barriers to service are removed. In addition to making bi-cultural clinicians available, active outreach is needed to further overcome barriers to receiving services. A separate Hispanic mental health team with a strong emphasis on outreach is needed. Such a team would cost $130,000 per year.

Arapahoe Mental Health Center, Inc.

Area: 1,597 square miles
Population: 201,029

a. Description of the Area

Arapahoe Mental Health Center serves the suburban areas of Arapahoe County and Douglas County, located in the southeast quadrant of the Denver metropolitan area. Within Arapahoe County, the center has service responsibility for about 87 percent of the county area and 57.9 percent of the county population, excluding the area bounded by the City of Aurora and School District 28-J. This latter area has been served by the Aurora Mental Health Center since July 1, 1975. Arapahoe Mental Health Center serves a mix of older established suburban communities (Littleton, 34,100; Englewood, 33,000; Sheridan, 5,600; Cherry Hills Village, 5,500; and Greenwood Village, 5,400), the rural eastern portion of Arapahoe County (Byers, 1,000; Deer Trail, 700), and the rapidly expanding incorporated and unincorporated crescent south of Orchard Road and east of

Broadway.

The rapid growth in relatively low-paying retail and service occupations is offset, in part, by substantial growth in higher paying manufacturing, construction, wholesale, and finance-insurance-real estate employment. Just as for other suburban counties, sizable numbers of area residents are employed across county boundaries in the City and County of Denver and in adjoining counties.

While only 6.8 percent of Arapahoe and 10.6 percent of Douglas households were classified as "in poverty" in 1970, sizable pockets of disadvantaged and impoverished residents occur in the older urban Sheridan-Englewood-Littleton triangle and in eastern Arapahoe and rural Douglas Counties.

The average adjusted gross income per worker has climbed in both Arapahoe County and Douglas County between 1969 and 1978, and may be over $17,000 per worker in 1979. This was up from about $7,800 in 1969. However, average wages in retail employment ($7,100), service industries ($10,800), agriculture ($8,030), and public employment ($5,160) indicate a large number of non-affluent residents who are easily overlooked when county-wide averages are used as "typical" (Source: Colorado Division of Employment, U.I. Research and Analysis). Colorado State Employment projects 4,360 economically disadvantaged persons in 1980.

The most significant factor affecting both need and delivery of services has been the rapid growth of population in Arapahoe and Douglas Counties. That part of Arapahoe County served by the center has increased in population from about 111,200 in 1970 to about 159,000 in January, 1979, and is projected to be about 169,570 on January 1, 1980 (DRCOG). The 52.5 percent increase since 1970 has occurred primarily along the outer suburban fringes of Littleton and Englewood, and most heavily in the southeastern crescent bounded by Broadway on the west and Orchard Road on the north. Douglas County, with only 8,400 residents in 1970, is estimated to have had 23,300 on January 1, 1979, and is projected to be near 25,000 on January 1, 1980 (DRCOG). The growth in Douglas County has been predominantly in the northern and central parts of that county.

Other factors which impact on need are: (1) the large number of children (0-11) and adolescents (12-17), a product of the heavy in-migration of younger families still in the child-bearing (0-6) and child-rearing (6-17) stages; (2) the community instability due to continuing in-migration and mobility within and the accompanying stresses associated with the disruption of family, neighborhood, and community ties; (3) the high proportion of women age 16 and over in the labor force, and its contribution to problems of child-bearing and child-rearing; (4) the relative concentration of a sizable population (7,000) of Hispanics in the Sheridan and North Englewood areas; (5) the relatively high proportion of households where, due to separation and divorce, the head of household is a woman who has her own children under 18; (6) the relatively high proportion of trailers and mobile homes for year-round housing, and the transient population who are dependent on such mobile living; (7) pockets of rural isolated populations in eastern Arapahoe County and Douglas County; (8) the rapid growth of the number of elderly age 65 and over, from about 6,100 in 1970 to possibly 13,000 (January 1, 1980), a 109 percent increase, poses added problems of delivery mental health services; and (9) the

continuing use and perception of the center, by residents and agencies alike, as one which serves low-income clientele, with the characteristics of the center's client often differing sharply from the "affluent" averages for the population as a whole.

b. Existing Services

The center directly provides a wide range of outreach, crisis, outpatient, partial care, and 24-hour care services to several target populations. These services include: (1) diagnostic, testing, evaluation, outpatient, and consultation services to children; (2) diagnostic, testing, evaluation, forensic, outpatient, partial care, consultation, and education services to adolescents; (3) evaluation, forensic, outpatient, partial care, 24-hour care, and consultation and education services to adults; (4) evaluation, outreach, outpatient, and consultation and education services to the elderly; (5) day crisis, night emergency services, crisis 24-hour care, aftercare, medications, case-management services, long-term outpatient, partial day and evening care, other 24-hour care, to moderately and severely disturbed targeted clients, including also continuity of care services to hospitalized clients; (6) outreach, case-management, outpatient, and specialized school services to ethnic minorities; (7) outpatient, partial care, other 24-hour care, day crisis services, night emergency services, community organization and consultation around victim-abuse of women; (8) special discussion groups, in addition to other services already listed, to rural residents; (9) forensic services for juvenile and adult court cases; (10) specialized evaluation, testing, counseling, and consultation for law-enforcement agencies; (11) specialized evaluation, testing, placement and counseling services for youth (10-17) as a component agency of the Arapahoe Youth Diagnostic Team (formerly CHINS Intervention Team); and (12) special education services team for Sheridan School District II.

c. Priorities and Program Needs

The catchment area continues to face problems of substance abuse (alcohol and drugs) for both youth and adults; problems with children and the law, at school and at home; marital problems related to divorce, separation, and a highly mobile community; problems that affect the aged and, to a lesser extent, adults, related to a combination of loss, isolation, safety, transportation, and housing.

A partial list of mental health priorities by age and geographic sub-areas includes the following: (1) drug and alcohol services for adults; (2) crisis 24-hour care for adults; (3) specialized evaluation, testing, counseling, placement, and forensic services for older children (10-11) and adolescents (12-17) in trouble with the law, schools, or parents; (4) outpatient services for couples and families with severe marital, family disruption, and separation problems; (5) outreach services to Hispanic residents, all ages, of the Englewood-Sheridan area; (6) transitional, community living services for moderately and severely disturbed adults leaving inpatient hospitalization or other 24-hour care; and (7) evaluation, case-consultation, and program consultation related to elderly residents of nursing homes.

The special program needs that exist, by priority and estimated cost, are: (1) consultation services to foster homes for placement of emotionally disturbed children and adolescents, needing temporary out-of-home placement, at $20,000 per year; (2) services to battered women in

safe houses, at $45,000 per year; (3) specialized services, outpatient and case-management, for Hispanics and ethnic minorities, at $30,000 per year; (4) mental health home visit services for the elderly, at $20,000 per year; and (5) outpatient services for the eastern rural residents of Arapahoe and Douglas Counties, at $23,000 per year.

Aurora Mental Health Center, Inc.

Area: 60 square miles
Population: 157,977

a. Description of Area

The Aurora Community Mental Health Center catchment area includes the City of Aurora and the area south to Belleview Avenue extended east of the City of Aurora in Arapahoe County to the boundary of the Aurora Public Schools district. In Adams County the catchment area border is the county line. The northern border of the catchment area is the line of 56th Avenue extended and a small enclave known as Eastwood Estates. The western boundary of the catchment area is the city line of Aurora. The northern part of the catchment area is characterized by light industrial districts, mostly undeveloped, and the farming districts surrounding Bennett, Strasburg, and Watkins. North Aurora has older residential units, with progressively newer ones towards the southeast in Arapahoe County. There are three major military facilities in the catchment area: Fitzsimmons Army Medical Center, Lowry Air Force Base, and Buckley Air National Guard Base. The catchment area abutts two other military facilities, the Rocky Mountain Arsenal and the Air Force Bombing Range, and two recreational facilities, the Cherry Creek Reservoir Park and the Plains Conservation Center. In 1976, the U.S. Census Bureau found the City of Aurora to be the fastest growing city in the United States for those of sizes between 100,000 and 200,000 people. Aurora also experiences a large amount of migration into, out of, and within the city. Housing, real estate, and retail trade are large economies in Aurora, as witnessed by the presence of two large shopping centers, the Aurora Mall and Buckingham Square. Apportionment of county totals for Adams and Arapahoe Counties estimated by the State of Colorado Division of Planning and Local Affairs by means of census tract estimates developed by the Denver Regional Council of Governments were used to establish local population estimates. The catchment area was considered to have 148,367 people as of January 1, 1980. Local estimates cite up to 175,000 people. Colorado Employment Service data indicate that 3.3 percent of the population are "economically disadvantaged."

The North Outpatient Team serves the portion of Aurora bounded by the western and northern boundaries of the city, by Sixth Avenue on the south, and by Potomac Street on the east. The area contains many small, single family homes, many apartment houses, and a few trailer courts.

According to the survey done by the center's Program Evaluation Department, the north area is signficantly different from the areas served by the other outpatient teams. It has a much higher percentage of elderly than the other areas. The average income is markedly lower, as is the average amount of education. The area has fewer married people and more singles,

more widowed, and more divorced people proportionately than the other areas.

The Central Counseling Clinic is located on the corner of South Uvalda and Mississippi. It is between two large shopping centers in Aurora, the Aurora Mall and Buckingham Square. The Aurora Mall area is considered the new "city center" area of Aurora.

The Central Counseling Clinic serves those persons living between Sixth Avenue and Iliff Avenue from the western edge of the catchment area to Potomac Street and those persons living east of Potomac Street and north of Sixth Avenue, in the northeast portion of the catchment area. This includes the rural towns of Watkins, Bennett, and Strasburg.

The South Outpatient Clinic is located at 2600 South Parker Road. The clinic is situated in the northwest part of its catchment area. It serves Aurora residents south of East Iliff Avenue to Belleview extended east. This catchment area includes both Aurora Public Schools and the Cherry Creek Public Schools, where 55 percent of its student population are Aurora residents. Rapid growth in southeast Aurora and resulting pressures from the increased number of families have made the placement of a clinic in that area necessary.

Several pressures which are prevalent among many families living in the growing number of subdivisions in southeast Aurora are: (1) the demands of attempting to maintain a higher standard of living, worsened by problems that occur when both parents are employed outside the home; (2) higher expectations placed on the children in these families to excel in school and eventually become college graduates; (3) problems caused by school children who are forced to change schools often by the upward mobility trend of American families who change jobs or accept transfers and promotions which require moves from one city to another. These problems are compounded by a higher than average divorce rate in this area.

b. Existing Services

The Specialized Services Division of the center consists of the Child and Family Team, the Community Living Program, the Older Persons Team, the Inpatient Team, and Off-Hours Emergency Services.

The Child and Family Team is responsible for providing direct consultation and education services. The Community Living Program provides intensive day treatment and follow-up care for those adult clients requiring more services per day than can be provided in an outpatient setting. The Services to Older Adults staff provides outreach services, direct treatment, and consultation and education to other catchment agencies serving this age group. The Inpatient Team is responsible for providing services to clients hospitalized, disposition planning, supervision of local short-term center residential facility staff and program, and consultation to hospital personnel. Contracted employees provide off-hours emergency services coverage for the center.

c. Priorities and Program Needs

The citizen board of directors of the center has planned to deliver services that are accessible to all parts of the catchment area. This is to be done with attention to special need areas as well. The current organizational structure reflects these priorities. There are three geographically based outpatient teams providing services to north,

central, and south areas and four special services: Child and Family Team, Community Living Program providing intensive day treatment, Older Persons Team, and an Inpatient Team which also provides non-hospital-based residential services.

Services to adolescents need to be enhanced relative to other age groups. The rate of hospitalization should be decreased. The Inpatient Team maintains a very low length of stay for its patients, but there are few alternatives to hospitalization available. These should be increased. Data indicate that the current structure of outpatient services does well in providing services to minorities, and should be maintained. The outstanding program need center-wide is to be able to maintain the current rates of service delivery.

Within the Specialized Services Division, the following programming needs have been identified: (1) additional training for child and family staff specific to working with incestuous families; (2) a group to address the emancipation issues of adolescents; (3) expansion of the Chrysalis Program, an educational approach to adolescent issues concerning family and adult responsibilities; (4) a viable intensive day treatment program for older clients; and (5) additional clinical resources to increase direct services to the older adult population.

Bethesda Community Mental Health Center, Inc.

Population: 136,798

a. Description of Area

Bethesda Community Mental Health Center's catchment area covers the southeast section of Denver County (118 square miles). The population was estimated to be over 149,000 for 1979. In 1970, the population was 125,000; this represents the fastest growth of the four service areas in Denver. Most of this growth has occurred in the south and east portions of the area. These sections are on the borders of the city limits and have the most room for future growth. People moving into this area are likely to be young, and many have children in the elementary-junior high school age range. In 1970, the southeast Denver area had the smallest percentage of individuals under fifteen years of age of any area in Colorado. Although precise estimates will be difficult until 1980, the center is quite certain that the percentage of children in the area has increased substantially. In 1970, the percentage of individuals over 65 in this area was 11.5 percent. This was slightly over the national average, and the center estimates that the total number of individuals over 65 has not decreased since then.

Economic status in the area is estimated to be high moderate, with a high percentage of individuals employed in high status jobs. There is a limited amount of large industry within the area, and small businesses are more prevalent. The percentage of individuals in poverty, according to the 1970 census, was 7.1 percent.

The percentage of Blacks and Chicanos within the area is currently estimated to be 5.7 percent and 6.2 percent respectively. While these percentages are not large, they have increased substantially since 1970.

In comparison to other areas in the state, Bethesda's catchment area

is high in: (1) the percentage of individuals over 65, (2) the number of children not with parents, (3) the number of divorced or separated individuals, (4) the amount of residential instability, and (5) the amount of population growth.

The relatively high mobility of the population also provides some potential emotional problems, such as isolation and loneliness. The high number of aged residents and the high number of post-child rearing families point to potential problems associated with changing roles and life-styles. These role changes are often accompanied by stress and the emotional problems associated with an inability to handle stress.

b. Existing Services

A full range of treatment services are offered to all clients within each of four different programs: (1) Child-Adolescent; (2) Alcohol; (3) Short-Term Treatment; and (4) Continued Treatment. The range includes hospitalization, a hospital-alternative program, a halfway house, partial care, outpatient care (including individual, couple, and family therapy), intake and emergency, program evaluation, and consultation and education services.

Bethesda has several specific programs for certain targeted populations. These programs include: (1) a child partial care program (for children and adolescents); (2) a professional drug treatment program (aimed at professionals with drug problems); (3) an alcohol program offering education/information services and treatment; (4) an adult foster care program in conjunction with the halfway house; (5) HUD housing for the chronically mentally disabled; (6) a specialized program for chronic psychiatric patients; (7) a recently-hired geriatric coordinator to develop programs for the elderly in the area; (8) a doctoral level psychology intern training program; and (9) other specialized services are available for women, late adolescents, young adults, and vocationally disabled clients.

Several other programs are currently being pursued. Bethesda submitted a three-year research demonstration grant for treating children of disruptive families. The center also submitted a grant to study the impact of severely disturbed parents on their children. Bethesda is pursuing funding for a Vietnam veterans' program. The center will soon be at the decision point regarding employee assistance programs.

c. Priorities and Program Needs

Bethesda's priorities and program needs include the following: (1) develop and increase services to the elderly; (2) develop more programs and services for the severely disturbed; (3) expand the Child-Adolescent Partial Care Program; (4) develop a continuum of housing alternatives for the severely disturbed; (5) develop a full range of vocational programming; (6) develop an evening partial care program for alcoholics; (7) increase services to Chicanos in the west section of the catchment area; (8) develop employee assistance programs; and (9) develop services for Vietnam veterans.

Mental Health Center of Boulder County, Inc.

Area: 758 square miles
Population: 206,600

a. Description of Area

Boulder County constitutes the entire Mental Health Center of Boulder County catchment area. The county is northwest of Denver 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.

Boulder County is becoming highly urbanized, with a few remaining agricultural pockets. The socio-economic mix is shifting to include a broader range of income levels. The University of Colorado and federal research installations are the dominant "industries"; however, there is a rapidly expanding manufacturing sector in the Boulder economy bringing about a significant socio-economic change. The center's recent needs assessment revealed that 24.4 percent of the county households are below the poverty level of income.

The Boulder social environment is dominated by the presence of a major university. This creates a number of special impacts relative to mental health service needs. The population is extremely mobile, i.e., there is a high frequency of in-and-out migration. Many C.U. graduates elect to remain in the community, albeit unemployed or underemployed. 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 growth management, excess socio-economic pressures have been placed on the lower economic groups, i.e., those primarily served by the center.

The county's major population concentrations include the cities of Boulder, Longmont, Lafayette, and Louisville. Each of these sub-communities has unique characteristics that necessitate special de-centralized programming. Significant numbers of Chicanos live in the east county area, requiring the presence of bi-lingual staff. Divorce and separation in Boulder County occur at twice the national rate. This problem alone leaves thousands of adults and children in need of some psychological aid.

b. Existing Services

Services offered by the Mental Health Center of Boulder County 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 and an intensive 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 Boulder, Longmont, and Lafayette. A broad range of outpatient treatment modalities is available, including individual, group, family, and couple therapies, with emphasis on short-term, goal-oriented treatment. Specialized services to the elderly are provided through the center's geriatrics program.

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

The Drug Abuse Services Program of the mental health center, 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.

Special programming and outreach to Chicanos is provided through the center's Chicano Outreach Services Program.

c. Priorities and Program Needs

The Mental Health Center of Boulder County recently completed a catchment-wide scientifically-designed mental health needs assessment. Over 1,000 households were randomly sampled and a comprehensive instrument administered to capture demographic social functioning and other indicators of need. Over 90 percent of the sample completed the interview, providing highly reliable results. An important feature of the survey was the utilization of the same social functioning instrument as that used for the Colorado treatment outcome research. Given descriptive statistics for both client and community populations permits a unique ability to determine the extent of "need" in the community, when the client group scores serve as a reference point for defining need. The results of the center's needs study are quite extensive. Basically the need to serve members of disrupted families, minority group members, low-income individuals, and highly mobile persons is indicated.

The center gives first priority to clients who are chronically disturbed and need the range of intensive treatment and community support services provided by the center. Children, adolescents, and young adults are those in the community with the greatest unmet need.

The rapidly growing east county area has the need for a fully-staffed branch office to serve that geographical area. Additionally, some attention will need to be paid to the residents of mountain communities west of Boulder during the coming years.

Boulder County continues to need a public, community-oriented psychiatric inpatient facility. The mental health center's Long Range Planning Committee has studied and documented this need.

The re-establishment of a fully-staffed branch office in the Tri-City (Lafayette, Louisville, Broomfield) is another high priority special program need.

Children's Hospital
Department of Behavioral Science Mental Health Clinic

a. Description of Area

This is a non-catchmented, specialty program.

b. 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.

c. Priorities and 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.

a. Description of Area

This is a non-catchmented, specialty program.

b. Existing Services

The clinic's special individual psychotherapy program is provided for children, adolescents, adults, elderly, targeted clients, ethnic minorities, and women on a graduated fee scale. A special program of consultation, staff development, patient evaluation, and some direct treatment is provided to the Park Avenue Baptist Nursing Home, a large near-by nursing home that houses many elderly with chronic, severe mental health problems. Clinic staff have provided excellent supervision for mental health professionals who work in other agencies in the community, such as welfare. An important service of the clinic, although not a separate treatment program, is the provision of treatment service to people in the community who work in the human services field, where stress is high.

c. Priorities and Program Needs

Program needs by priority for the clinic are: (1) the continuation of individual, intensive outpatient psychotherapy on a graduated fee scale for individuals in the Denver metropolitan area; (2) continued consultation, staff development, patient evaluation, and treatment for the Park Avenue Baptist Nursing Home with patients having chronic mental problems; and (3) provision of excellent supervision for mental health professionals who work in other community agencies.

Health and Hospitals Mental Health Program

Population: 155,365

a. Description of Area

The catchment area is entirely within the City and County of Denver and is bounded on the east by York Street, on the west and north by the city limits, and on the south by West Sixth Avenue and the east bank of the Platte River down to West Mississippi Avenue.

The population of approximately 155,000 is characterized by severe economic, occupational, and educational handicaps, ranking "low" or "extremely low" in terms of national norms (NIMH Mental Health Demographic Profile Data). The two largest ethnic minorities in the area are Hispanic and Black, representing about four-tenths of the catchment population.

The population has high concentrations of residents in the 15-through-29 and 50-through-74 age ranges. There are about 58,000 children aged 0-through-19.

There is a very high proportion of non-families (42.6 percent), and 23 percent of the population is divorced.

b. Existing Services

The main administrative office is located in Denver General Hospital. All 12 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 Comprehensive Alcoholism Rehabilitation and Evaluation Services (CARES). Major treatment methods are individual, group, and family therapies. These services are provided at all units, including the hospital inpatient service.

In addition to the above services, there are special services for children, adolescents, and elderly patients.

Outpatient children and adolescent mental health services are available on each of four outpatient mental health teams. On each of these teams there are child clinical specialists whose training and experience are in the area of diagnosing and treating children and adolescents and their families. These clinicians offer a range of services including play therapy, group therapy, family therapy, parenting classes, parent groups, and education, developmental, and psychological testing. They are also available to community caregivers to give various indirect services ranging from consultation on cases to giving workshops on parenting, child development, etc. The Hospital Clinic and Consultation Service also provides inpatient and outpatient pediatric consultation as well as direct services to children and adolescents.

The geriatric program provides both direct and indirect services to individuals and groups. These services are provided by each of the generic and specialized teams, the geriatric coordinator, and a part-time mental health worker. There is a geriatric mini-team comprised of one representative from each generic team and selected specialized teams. Each representative is assigned to spend one quarter of their time working with geriatrics. The team meets monthly, and is chaired by the geriatric coordinator. A portion of some of the meetings is used for in-services and other workshops and seminars related to aging.

The center cooperates and participates with a wide variety of community agencies concerned with the development of and carrying out programs for the aged. Some of these agencies are the Visiting Nurse Service, Seniors, Inc., the Community Homemaker Service, the Denver Commission on Aging, the Denver Housing Authority, the Institute on Gerontology at Denver University, the Department of Parks and Recreation, Senior Centers, the Catholic Community Program for Seniors, Senior

Nutrition Sites and the Department of Social Services, and the Alcohol and Drug Abuse Division of the Department of Health.

c. Priorities and Program Needs

The high need of the catchment area, as predicted by social indicators and utilization data, has resulted in an emphasis on adult targeted patients. Priority needs to be placed on services to children, adolescents, and elderly patients.

The center's floors at Park Heights Nursing Home have closed, as have numerous other nursing home and boarding home beds in the Denver metropolitan area. The Boarding Home Licensing Board indicates that 1,234 beds have closed since 1972, and approximately 320 nursing home beds have become unavailable to psychiatric patients since 1976. Previously, these displaced patients found places to live such as hotels and cheap buffets; however, the changing Capitol Hill and core city economy now prevents this option. With the closing of Park Heights, hospitalizations will increase because of the shortage of supervised beds. Many of these patients are a danger to themselves and/or to others.

There is a serious crisis developing for severely ill, chronic patients. The center's estimates are that 100 state hospital beds and 100 low-intensity beds in the metropolitan area are needed immediately.

Jefferson County Mental Health Center, Inc.

Area: 1,324 square miles
Population: 416,500

a. Description of Area

From its inception in January, 1963, Jefferson County Mental Health Center has served the three counties which lie directly west of Denver. The catchment area contains the largest population (400,000 people) of any catchment area in the state of Colorado. The main administrative offices are located at Ken-Caryl Ranch in south Jefferson County, while the emergency/inpatient service and the community support program are headquartered in Lakewood. Outpatient offices serving both adults and children are located in Arvada, Wheat Ridge, Lakewood, South Jeffco, Evergreen, and Idaho Springs. Jefferson County includes the five incorporated cities of Lakewood, Arvada, Wheat Ridge, Edgewater, and Golden, as well as parts of Westminster and Broomfield. There are large amounts of unincorporated areas in such places as Bailey, Kittredge, Columbine, Morrison, Evergreen, Lookout Mountain, Applewood, and Pleasant View. Major industries within the area include the Rocky Flats Plant of Rockwell Industries, Coors Industries, Martin-Marietta, and Johns-Manville. The federal government is a major employer, with the huge Federal Center in Lakewood and the Solar Energy Research Institute near Golden.

Clear Creek and Gilpin Counties are located in mountainous terrain from 8,000 feet to the high peaks of the Front Range, and contain the towns of Rollinsville, Black Hawk, Central City, Idaho Springs, Dumont, Empire, Georgetown, and Silver Plume. Amax, Inc., a mining corporation, is a major employer, and mining and tourism are the primary economic activities in both counties. These largely rural counties do not have the social service organization resources that exist in the Metropolitan

Area, are one to two hours' drive from psychiatric inpatient facilities, and have special isolation-related problems such as alcoholism and "cabin fever."

Although the catchment area is one of high employment and general affluence (about 3.4 percent of the population lives at or below federal poverty levels (U.S. Census Data, 1970)), the large population has placed growing stress on the center to meet basic service demands, and presents problems comparable to or greater than many other catchment areas in the state. An estimated 14,000 persons in the area are living at or below the poverty level, and the Division of Mental Health needs assessment methodology estimates that 26,000 persons in the area are in need of mental health services, which is about five times the number served by the mental health center last year. The percentage of admissions who are severely and/or chronically mentally disturbed has been steadily increasing over the past year and a half. The amount of funding from the State of Colorado and from other sources has not kept up with the growth in population; the center is now one of the lowest in the state with respect to per capita funding.

Jefferson County Mental Health Center's catchment area population is well beyond the federal guidelines for maximum population of a catchment area. The center administration has dealt with this problem by structuring the catchment area into three sub-catchment areas, each with the responsibility for needs assessment, budgeting, and program development within its area. A central governing board composed of citizens from the three sub-catchment areas and a strong internal communications system provide the local community input and control essential to the community mental health concept, while assuring a well-managed, centralized evaluation and monitoring of the center as a whole.

b. Existing Services

Jefferson County Mental Health Center supplies the traditional inpatient, outpatient, emergency, partial care, and other 24-hour services. The center also provides specialized programs for the chronically mentally ill, a child and adolescent program, and a geriatric program. Staff members include bi-lingual and bi-cultural professionals who are specially assigned to do community outreach and individualized therapy and crisis intervention where indicated. In addition, the center has special rural clinical services in Clear Creek and Gilpin Counties. Community outreach work in this area involves, along with many other activities, coordination of services with both the visiting nurse services and a rural health clinic in Gilpin County.

Jefferson County Mental Health Center has a centralized inpatient program which utilizes Fort Logan for long-term placements and St. Anthony's and Colorado Psychiatric Hospital for shorter term placements. Coordination and continuity of care are assured by the assignment of two inpatient specialists and the ongoing consultation and supervision of a staff psychiatrist. As part of this system, there is a six-bed crisis unit to help avoid hospitalizations or to aid in the transition from inpatient to outpatient. Persons admitted to this crisis unit attend the center's Community Support Program.

Community Support Program is an extensive community base system of care for the chronically mentally ill which includes skill survival

training classes, a residential component, evening activities, and coordination of vocational rehabilitation services. Patients involved in the center's Community Support Program are followed clinically by either partical care clinicians or by a designated outpatient therapist. The delivery of clinical services is coordinated via a centralized triage-emergency team. This team supplies 24-hour emergency service and the screening of all requests for clinical services to determine the appropriate level and type of care needed.

The center's outpatient offices are decentralized and have clinicians who are either assigned regular outpatient duties or specialized crisis intervention responsibilities. Each outpatient office has clinicians who specialize in the treatment of children and adolescents. This is coordinated centrally through a Children and Family Program Manager. In addition to the specialized Children and Family services, the center has two geriatric coordinators assigned program responsibility for the elderly program, which includes such services as outreach, C&E to nursing homes and other elderly programs, direct treatment, and staff development both to other agency personnel and the clinical staff of the center.

c. Priorities and Program Needs

Age priorities in rank order are age 0 to 11, age 65 and over, and ages 12 to 17.

The Lakewood catchment area has designated the following priorities: to continue to develop specialized treatment approaches for those chronically mentally ill clients appropriate for outpatient programming, to continue to focus on services to the geriatric population, to develop more staff expertise in the treatment of developmentally disabled clients, and to improve quality of care and degree of professionalism among staff through peer review and quality assurance program. The south catchment area's priorities include expanding clinical services to the mountain geriatric population, increasing visibility of the mountain emergency/crisis/triage services, determining the viability of staffing grants to expand Gilpin County and possibly Clear Creek County services, and to continue monitoring requests for services from the south Jefferson County area. The Children and Family Team has established the following priorities: increased services and admissions for the age group 0-to-11, the implementation of a family intake form, which will expedite family admissions, continuing assessment and planning for a partial care/hospital alternative program, and to continue serving moderately and severely disturbed children and adolescents in the catchment area. The Emergency/Inpatient Team's priorities for the coming year include increasing minimum average of direct service hours per week for each emergency clinician, enhancing continuity of staff and clients on the day shift, increasing collections and inpatient revenues, and providing for more frequent hospital face-to-face contacts.

Geriatric services are a major need of the catchment area. 5.7 percent of the population served by Jefferson County is over the age of 65. However, the geriatric population for the catchment area is not evenly distributed. For example, 17.2 percent of the population of Gilpin County is age 65 and over. In addition, there are 22 nursing homes in the Jefferson County area. This requires a significant amount

of outreach effort in order to provide the C&E, inservice training, evaluations, and treatment to assure that mental health services are not unnecessarily duplicated. As a result of this tremendous need to both coordinate and provide geriatric services for the catchment area, the center has hired two geriatric coordinators.

Another special program need of the catchment area is day care programming for children and adolescents. This service should be designed to provide for treatment alternatives to hospitalizations. Because Jefferson County Mental Health Center does not have a child/adolescent inpatient unit in the catchment area, services designed to keep the children in the community and to provide treatment to prevent long-term hospitalizations is essential. At this time, it would be difficult to estimate the cost of such a service. However, it is certain that the center would require additional supplemental funding in order to accomplish such a task.

Park East Comprehensive Community Mental Health Center, Inc.

Population: 115,869

a. Description of Area

Park East Comprehensive Community Mental Health Center, Inc., 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 community and those parts of the Swansea and Cheesman 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 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 University of Colorado's University Hospital in the central sector, and numerous small businesses and shopping centers throughout.

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 predominantly Chicano. This diversity makes the mission to provide adequate mental health services for all especially challenging and difficult, given current funding restraints.

b. Existing Services

There are currently three locations for the main administrative office and treatment teams in the catchment area. Services include inpatient care in either a hospital or other 24-hour community setting, day treatment, outpatient services, emergency services, and consultation and education services. In addition, Park East has specialized service delivery teams which provide mental health care to children, adolescents, senior citizens, victims of rape, and victimized women. Special programs are continuously being developed to meet the mental health needs of

ethnic people of color. These include the Park East Chicano Outreach Service (PECOS) and the Park East Asian Concern (PEAC). Park East also provides mental health training and services to persons from Southeast Asia through the Park East Indochinese Development Center. In addition, various members of the Park East staff who are bi-lingual enable the center to serve monolingual persons or bi-lingual persons whose linguistic preference is one of several English dialects, one of several Spanish dialects, one of several Indochinese dialects, Japanese, French, German, Dutch, Indonesian, or Javanese. Park East is presently in its seventh year of a federal staffing grant. With declining federal funds, the center relies heavily on state support and the generation of local funds.

c. Priorities and Program Needs

The most outstanding need of the center at this time is the expansion of the 24-hour transitional care services.

Servicios de La Raza

a. Description of Area

This is a non-catchmented, specialty program.

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

c. Priorities and 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: 32,968

a. Description of Area

Southwest Denver Community Mental Health Services, Inc., provides services to community members 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, Sixth Avenue to the north, and the Denver city limits on the west, generally following Sheridan Boulevard. The catchment area is economically and ethnically diverse. The catchment area is composed predominantly of lower middle class families. Children constitute approximately 40 percent of the total population. Ethnically, the Spanish-surnamed population has increased dramatically, from 6 percent of the total populace in 1960 to 18 percent in 1970, and to an estimated 27 percent in 1975. In contrast, the percentage of Black

residents is relatively low, estimated in 1970 at less than one percent of the total catchment area.

According to 1970 federal census data, the median income of families and unrelated individuals is slightly higher for Southwest Denver in comparison with the county and state. However, this higher median income is due primarily to the significantly larger percentage of families in Southwest Denver in which both adults are working. The percent of the population in Southwest Denver with income levels below the poverty level is 6.9 percent, according to the 1970 census data.

Single detached dwelling units predominate in Southwest Denver, with homeowners being overrepresented and renters under-represented. There is an overcrowding problem in these dwelling units, chiefly intact families; in 1970, there were very few single person households in Southwest Denver.

b. Existing Services

Southwest Denver Mental Health Center provides a full range of services for adults, children, and adolescents. In addition, through a contract with the Division of Mental Health and the National Institute of Mental Health, Southwest Denver is serving as the local demonstration site for the Colorado Community Support Project. This project entails the provision of a special program tailored to the needs of chronically disabled clients. This program is coordinated by the PINE (Persons In New Environments) Team.

The Barnum outpost was established to serve the needs of Spanish-surnamed/Chicano clients.

The innovative system of alternatives to hospitalization, which has been an integral part of Southwest Denver since its inception, has been broadened and strengthened with the past seven years' experience. This system has reduced the use of hospital beds in Southwest Denver to approximately 1.5 per 100,000 population.

c. Priorities and Program Needs

As reflected in the contractual agreement with the Division, Southwest Denver has made the expansion of services to children and adolescents and elderly clients a major priority. These client sub-populations will continue to be a priority.

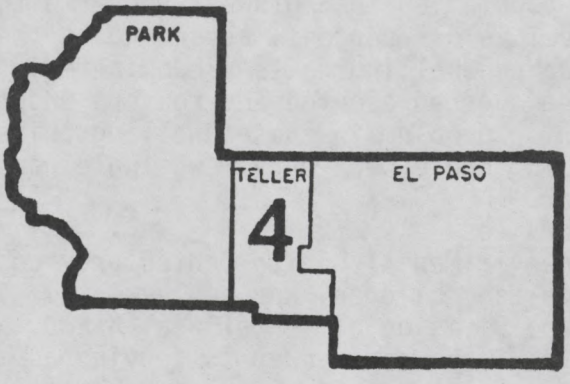
In terms of geographic areas, neighborhoods and persons with the lowest income levels and greatest social disruption are the center's first priority. Each year the Research and Evaluation Department carries out a study of admissions to the center by neighborhood. The results of this annual study are reported to the board of directors and to the management advisory group. Of particular interest is the ranking of each neighborhood in the catchment area by "percent underserved." This ranking is then compared with a ranking of these same neighborhoods by income level. Generally, these studies have found that the neighborhoods with the lowest average income level are the least underserved, indicating that the center is serving those neighborhoods and persons most in need of these services.

The major special program need at Southwest Denver Mental Health Center is to develop and implement a comprehensive system of alternatives to hospitalization for children and adolescents. A considerable amount of time and energy has already gone into the development of the system.

At this juncture, the center is seeking funding to implement the system.

2. HEALTH SERVICE AREA II

REGION 4



Area: 4,892 square miles
Population: 339,289

a. Description of Area

Pikes Peak Mental Health Center serves a current population of approximately 339,289 citizens in a three-county area in central Colorado, along the eastern slope and central plateau of the Colorado Rockies. El Paso County is primarily urban, while Teller and Park Counties are primarily mountain rural.

El Paso County, with a population of 326,250, covers 2,157 square miles and stretches east from and along the edge of the Rampart Range. The metropolitan areas of Colorado Springs, Manitou Springs, and Palmer Lake are near the foothills, with Fountain, Security, Widefield, Calhan, and Ramah located in the arid plains east and south of the range.

Teller County has a population of 6,400 and covers 553 square miles of foothills and mountain country east of Colorado Springs. It includes Pikes Peak and many small mountain towns, among them Cripple Creek and Woodland Park.

Park County is also a mountainous region, with a population of 4,850 and covering 3,260 miles. Within this county are farms, ranches, and small towns, including Fairplay, Hartsel, and Bailey (about 130 mountain miles from Colorado Springs).

The catchment area includes three large military installations. In addition, there are plans for a major "Space Center" located east of Colorado Springs for 1982. The large number of military installations support the fact that over 40 percent of the area's population is active or retired military or their dependents.

The average income level for the area is moderately low. El Paso County, which accounts for 330,000 of the estimated 339,000 in the catchment area (Park and Teller Counties remain small counties in terms of population) had a median income (excluding incomes too low to require

state filing) of $16,370. In 1976 the adjusted gross household income for El Paso County was $10,627, the lowest of the nine largest counties in the state.

In the second quarter of 1979 the percent of unemployed was only 4 percent, although 40 percent of the population are identified as maintaining a low occupational status. Military activity still accounts for over 50 percent of the area's employment. However, industry (particularly electronics), amateur sports centers, and local government services become of increasing prominence in the catchment area's economy. Tourism also remains important, although the unpredictable future of energy resources (especially gasoline) makes its role as a major contributor to the economy unknown.

A primary factor impacting on the need for expanded services is the growth factor within Region 4. Overall, the catchment area has grown at a rate of 6 percent per year. By nature of certain natural barriers (the mountains to the west and the large amount of federal reservation), most of the urban growth has been noted in the northeast section of Colorado Springs, and in the southwest sector of the metropolitan area. Projections for future growth of the area indicate a continued moderate to high growth rate, with possibly some reduction in the southeast sector and continued growth in the northeast sector and in the Ute Pass area.

Another factor dictating the need for expanded services is the high mobility rate: 62 percent of the households in the area move at least once every five years, and 44 percent have moved into or out of the catchment area during the last five years. This high instability rate is attributed largely to the disproportionate military population in the area, and is indicative of a correspondingly high degree of social isolation, separation from extended family, and lack of permanent economic and social ties experienced by many residents.

b. Existing Services

The Geographic Outpatient Services consist of three major team offices, with several satellite offices. The Colorado Springs downtown office, referred to as Team I, is located in the central part of the city in a major human service complex, housing CETA Employment Services, the Social Security Administration, and the Department of Social Services. Because of this unique location, services are provided in a coordinated manner with other human service resources. Specialized services to meet the varying needs of the poor and ethnic minorities are provided through a staff sensitive to these issues. The Fountain Valley office (Team 2) is located in Fountain, southeast of Colorado Springs, in close proximity to Fort Carson. By nature of the location, many of the services provided are directed toward families of military personnel. In addition, this program unit provides consultation services to several schools in the Fountain Valley area. Another service area supervised by this program unit is rural services to Teller and Park Counties. Services provided include direct service to individuals and families, as well as consultation to schools, nursing homes and hospitals, local physicians, law enforcement agencies, and the Department of Social Services. Emphasis is on coordination of services and developing program models viable within a rural setting. An important effort was

recently established in rural Park County, where several alternative homes have been established for short-term residential care. The Northeast Outpatient Office (Team 3) is located in the fastest population growth area within Colorado Springs. Providing general mental health services to individuals and families, this program unit also provides school consultation to communities in eastern El Paso County. The team, through flexible staffing and hours of availability, attempts to provide a high level of mental health services generic in nature.

The CARES Crisis Intervention, Adult Day Treatment, Residential, and Emergency Services program provides 24-hour emergency services and adult day treatment (including evening and weekend programs). A range of residential services is available beginning with inpatient and including a transitional care program, nursing homes, as well as supportive living environments to moderately and severely disturbed adult and elderly clients. In addition, the 24-Hour Crisis Unit has approximately 1,000 contacts per month, which include the majority of court and police related referrals for commitment under the Care and Treatment of the Mentally Ill Act. This program unit works as part of a community support system with the moderately and severely disturbed psychiatric client. A small component within CARES provides elderly outreach and evaluation services.

The Alcohol Services Unit, funded by federal, state, and local resources, operates a comprehensive service model consisting of non-medical detoxification (with appropriate hospital detoxification), a Community Intensive Residential Program (CIRT), a halfway house for clients attempting to re-establish themselves within the community, and general outpatient services in El Paso and Teller Counties. This program also works closely with other alcohol service agencies within the community.

The Youth Treatment Center offers residential and day treatment services for adolescent youth. The program receives referrals from the juvenile court, schools, Department of Social Services, and other community agencies. At present the program maintains 12 residential beds and 20 spaces for day treatment youth. The program is at capacity and is faced with a demand for expanding services.

The Consumer Credit Counseling Unit provides counseling regarding debt liquidation to families and individuals with financial problems, as well as community education programs to prevent such problems.

In regard to overall minority services, a position was created within the program office for FY 79-80 which established the role of a Program Development Manager who concentrates a major percentage of his time attempting to insure that services are sensitive to members of the various racial and ethnic communities within Colorado Springs. Workshops, in-service training, as well as a strong affirmative action program, are vehicles to achieve this end.

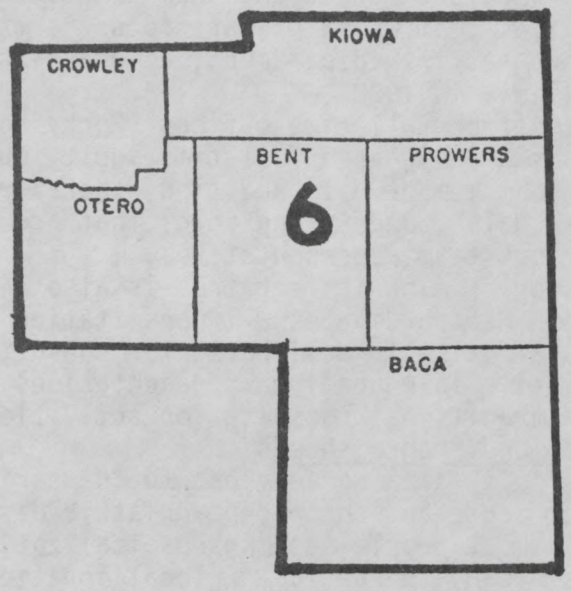
c. Priorities and Program Needs

In November, 1979, the board of directors of Pikes Peak Mental Health Center engaged in a planning process which attempted to identify the mental health priorities which needed to be addressed by Pikes Peak Mental Health Center. The board was provided with needs assessment data and was asked to prioritize the four service areas by client age (children, 0-11 years old; adolescents, 12-17 years old; adults, 18-64 years

old; and elderly, 65 years and older) and by intensity (inpatient, other 24-hour care, partial care, outpatient, consultation and education, and alcohol) which they felt were most important in the center's operation.

The board process indicated the need to intensify services in the least restrictive setting to children, adolescents, adults, and elderly. Recognition of cost was critical in attempting to capitalize on the least restrictive setting. The prioritization was based on an exercise in which it was assumed that additional funds for programs would be available.

REGION 6



Area: 9,626 square miles
Population: 62,628

a. Description of Area

Region 6 is located on the high plains of southeastern Colorado, encompassing the counties of Baca, Bent, Crowley, Kiowa, Otero, and Prowers. There are over 60,000 persons living in 9,626 square miles, an area almost twice the size of Connecticut. The area is rural, with most towns having a population of under 5,000 persons. Thirty-four percent of all persons live outside towns.

Region 6 is a designated poverty area. Eighteen of the 23 census tracts have an average income that is classified as "extremely low" on national norms. Twenty-three percent of the population lives in poverty. Economic indicators not only show high unemployment, but a significant amount of "under-employment" among persons in the region.

The area is ethnically mixed. In some towns, Spanish-surnamed persons comprise between one-third and one-half of the residents. In other towns, less than 10 percent are Spanish-surnamed. Overall, 26 percent of the region is Spanish-surnamed.

As with many rural areas, there is a high concentration of elderly.

b. Existing Services

There are no formal mental health services in the region other than the Southeastern Colorado Family Guidance and Mental Health Center. Schools, churches, and physicians attempt to handle mental health problems, but are often overwhelmed or lack important skills. Consequently, there need to be services to all persons in the region. In the second year of a federal community mental health center grant, the center is doing just that.

There are four treatment departments. The children's team serves children and adolescents. The high-risk team runs two partial care programs (in La Junta and Lamar), focuses on pre-care, partial care, and aftercare, and has a full-time staff to work with the geriatric population. The adult outpatient team treats adults. There is a minority services team whose primary focus is treatment of the monolingual client. A fifth department, a local inpatient service, should become operational in 1980.

Each of the four full-time offices (Rocky Ford, La Junta, Las Animas, and Lamar), has a designated full-time adult, outpatient clinician and a children's team member. In addition, there are four part-time offices (Ordway, Eads, Walsh, and Springfield) that are staffed at least one day a week by various team representatives.

The director of minority services is also director of consultation and education. He coordinates all consultation and education. Ten percent of all staff time is designated for consultation and education. This includes time in educational presentations, inservice training programs, and traditional consultation activities.

c. Priorities and Program Needs

A high priority area is services to the seriously impaired persons suffering from acute and chronic psychiatric disturbances.

Currently, most people needing hospitalization are sent to Colorado State Hospital (CSH) in Pueblo. A local inpatient facility is a necessity to serve as a short-term alternative to CSH to treat people closer to home and to reduce the cyclical process that characterizes treatment in most large state hospitals.

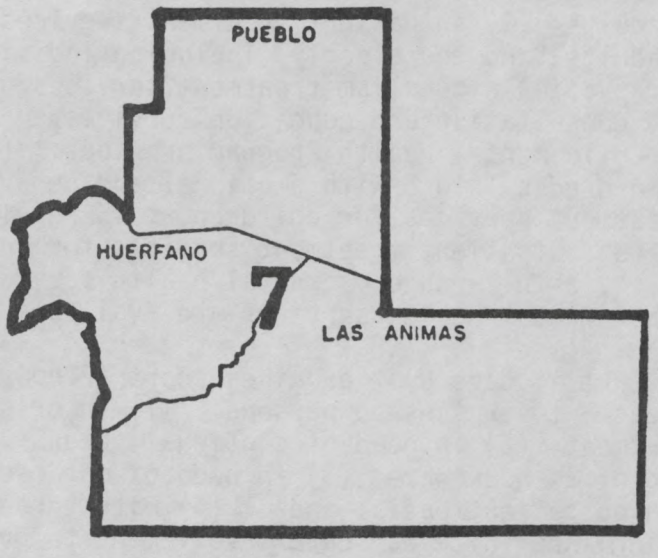
Until the start of the Community Mental Health Center grant, the Southeastern Colorado Family Guidance Center had four clinical staff for the entire region. The historical pattern was for persons to go directly to CSH for admission, without being seen at the center first. Currently only half of all admissions are pre-screened, primarily because the historical pattern still exists with agencies other than the center. From the center's perspective, there needs to be an increase in the prescreening through increased cooperation from the Colorado State Hospital, which will require a major change in policy by the administration of Colorado State Hospital.

Another priority area is services to the elderly population. In the past, roughly 3 percent to 4 percent of all admissions were from this group, while 13 percent of the population was elderly. There needs to be continued effort to close this gap between needs and resources.

A third priority area of the center is services to children. There needs to be a program available for intensive treatment for children,

in addition to outpatient care. Coordination with the local Department of Social Services is being undertaken to determine the feasibility of local residential child care programs, both 24-hour and partial care.

REGION 7



Area: 8,792 square miles
Population: 154,465

a. Description of Area

The Spanish Peaks Mental Health Center catchment area consists of Huerfano, Las Animas, and Pueblo 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 are farming and ranching in some portions of the region, but they are not the major sources of income for the area.

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. 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 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.

b. Existing Services

The Huerfano Alcoholism and Mental Health Unit provides: (1) 24-hour emergency and crisis services, admission screening services, and

aftercare services; (2) partial care services for adults; (3) outpatient treatment services for children, adolescents, adults, and the elderly, including individual, family, and group therapy; (4) alcoholism treatment services on an outpatient basis; and (5) consultation and education services.

The Las Animas Alcoholism and Mental Health Unit provides: (1) preadmission screening services and aftercare services; (2) partial care services for adults; (3) outpatient treatment services for children, adolescents, adults, and the elderly, including individual, family, and group therapy; (4) alcoholism treatment services on an outpatient basis; and (5) consultation and education services.

The Rural Child Mental Health Program provides: (1) partial care for children in grades 1 to 5 with emotional and behavioral problems; (2) outpatient treatment services for children at 16 rural schools on a weekly basis; (3) outpatient treatment services for children and their families; and (4) a full range of mental health services for adults, because no other mental health services are available in rural Pueblo County.

The Adult Partial Care Unit provides short (2 hours) and long (4 hours) day treatment services to persons: (1) in crisis who need brief intensive treatment; (2) in need of continual intensive treatment but no longer in need of 24-hour care; (3) in need of more services than can be provided on an outpatient basis; and/or (4) with chronic mental disorders requiring indefinite day care involvement to prevent re-hospitalization.

The Adult Outpatient Program provides: (1) 24-hour emergency and crisis services, preadmission screening services, and aftercare services; (2) evaluation and development of treatment programs; (3) individual and group therapy; and (4) law enforcement liaison including pre-screening of offenders for hospitalization, services for jail inmates, and supportive care for released offenders.

The Child/Adolescent Program provides: (1) individual, family, and group therapy; (2) assessment and evaluation for referrals to EKOS House facilities; and (3) partial care for persons between the ages of 12 and 17 in the Educational Day Care Project, which includes academic instruction and guidance, individual and family therapy, and training and consultation for teachers and employers of project participants.

The EKOS Houses provide non-hospital 24-hour residential care services for persons between the ages of 12 and 17 referred by the courts and social service agencies.

The Comprehensive Alcohol Treatment Program provides: (1) physical examinations; (2) psychiatric evaluations; (3) individual, family, group, and marital therapy; (4) collateral counseling; (5) chemotherapy; and (6) life management services.

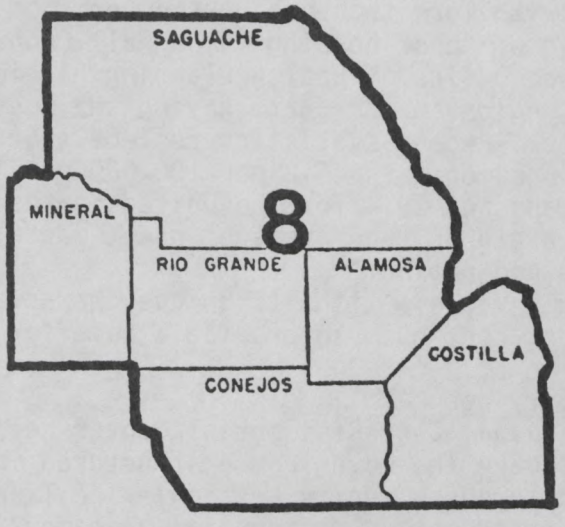
c. Priorities and Program Needs

Catchment area priorities, according to the Community Need for Services Survey conducted in October, 1979, are: (1) alcohol and drug abuse treatment; (2) children's treatment services; (3) help with marital and family problems such as child abuse, divorce, and effective parenting; (4) help with problems relating to low income and unemployment; and (5) treatment services for the developmentally and physically disabled.

Program needs, according to the Community Need for Services Survey conducted in October, 1979, are: (1) family counseling; (2) alcohol and drug programs; (3) child/adolescent programs; (4) programs for women, including divorce, rape, and abuse counseling; (5) public education and awareness programs; and (6) transportation and availability of services.

The need for increased financial support for new and existing programs in all these areas was expressed in the survey.

REGION 8



Area: 8,202 square miles
Population: 43,776

a. Description of Area

The San Luis Valley is the largest mountain valley in the world, and lies in the southern part of Colorado. Its boundaries include the New Mexico border on the south and high mountain ranges on the east, north, and west. The valley includes six counties: Alamosa, Conejos, Costilla, Rio Grande, Mineral, and Saguache.

The San Luis Valley contains the highest concentration of Chicanos in the state of Colorado (47.67 percent of the 41,900 population in the region in 1980). Geographically, the San Luis Valley is the most isolated region of the state.

The population of the valley is generally stable, with little migration in or out of the region and with the migrant population declining during the last few years due to modernization of farming technology.

For its economy, the valley is largely dependent on agriculture, although the sportsman/tourist trade of this mountainous region attracts fishermen and small and big game hunters as well as skiers, photographers, vacationers, and nature seekers.

Academically, the San Luis Valley is served by Adams State College. This institution has a combined faculty and student population of approximately 2,500.

The San Luis Valley has been identified by the state as the area having the most ingrained poverty. In comparison to the 63 counties in the state, Conejos County ranked first in percentage of families with an income less than the federally established poverty level; Saguache County ranked second; Costilla County ranked third; and Rio Grande County ranked ninth. This area also has the highest per capita expenditure for welfare assistance.

Closely related to poverty is poor housing in overcrowded conditions. The counties of Conejos, Costilla, and Saguache, for example, are ranked first, third, and fourth among counties with the percentage of housing units with more than one person per room. The same holds true for the ranking of "poor housing" among all counties in Colorado.

The Colorado Office of Health Planning has identified the San Luis Valley as the region in the state having the most critical shortage of health manpower. Recent statistics reflect that the rate of death for influenza and pneumonia is 45.2 per 100,000 population, compared to 29.7 for Colorado and 29.4 for the United States. Five of the six counties have a higher than average infant mortality rate as compared with the state and nation.

The San Luis Valley, with its unique characteristics and limited local resources, continues to provide a home for a population of 41,900 (1980).

b. Existing Services

The Transitional Care Residential Center helps emotionally handicapped clients make the move from a structured institutional setting to a less structured community setting. The Transitional Care Center is also used for temporary residential placement for patient crisis problems.

Outpatient services to children, adolescents, adults, and elderly are provided via a two-team approach. The Southeast Team provides services to Alamosa, Conejos, and Costilla Counties, whereas the Northwest Team services Rio Grande, Mineral, and Saguache Counties. Referrals to the Colorado State Hospital are pre-screened by the outpatient component.

Child and adolescent services consist primarily of individual therapy, group therapy, play therapy, and family therapy. Child specialists, as well as a coordinator of children's services, involve significant family members in the child's treatment plan, which accounts for increased adult enrollment.

Outpatient geriatric services are coordinated through a geriatrics coordinator. These services are directed at assisting elderly clients to adjust to old age, as well as to solve problems of every day life.

Outpatient services are provided in the mental health center's offices, schools, Head Start programs, nursing homes, adolescent group homes, as well as in the client's home if necessary.

Partial care services are provided in four locations in the catchment area by a partial care team. The partial care team is directly supervised by a coordinator. These services are available in San Luis, Alamosa, and Monte Vista twice per week. The Saguache partial care program is held once a week, and is directed at children, whereas the other programs see adult chronic patients. The partial care program has developed a physical fitness program for the elderly. This program

involves elderly clients in a closely monitored exercise schedule. The partial care program also provides aftercare services to chronic patients living in the community.

The center mans a 24-hour emergency/crisis program on a walk-in and/or call-in basis. The center contracts with a telephone answering service for evenings, weekends and holiday coverage. This provides accessible services 24 hours a day, seven days a week. In addition, the center is presently using a Code-a-Phone call system from the Alamosa and Monte Vista offices in an attempt to capture all incoming calls after working hours, on weekends, and on holidays.

There are four hospitals in the catchment area: Alamosa Community Hospital, Monte Vista Community Hospital, St. Joseph Hospital, and the Conejos County Hospital. These hospitals are readily available to provide immediate and short-term care. Local hospitalization is determined on an individual basis, and is advisable only when the client is seen as profiting from local hospitalization, thus precluding hospitalization at Colorado State Hospital.

The Colorado State Hospital is also available for short and long-term hospitalization. All efforts are taken to avoid any hospitalization by providing an intensive outpatient and partial care program.

Consultation and education services continue to emphasize prevention through education as a means of promoting mentally healthy attitudes. Early identification and intervention are also seen as important to avoid the rapid and very progressive movement into more serious problems. The consultation and education services provided through the center are closely integrated into the total service delivery system.

A comprehensive alcoholism program continues to provide services in the area through three components: a detoxification and evaluation center, a 24-hour residential facility, and outpatient services in all counties of the valley.

The primary treatment objective is to provide services that are visible and accessible. Outpatient counselors maintain close working relationships with the court system and continue to maintain an effective court referral system for persons with alcohol-related problems. A closely monitored Antabuse program as an adjunct to therapy is also important.

In addition to the three major components of the alcoholism program, services are provided via a traffic offender program designed to curtail abusive drinking and driving by increasing the general knowledge of the identified drinking driver.

Special programs include a summer camp, a diagnostic and evaluation clinic, and the Section 8 Housing Assistance Program. Each summer, approximately 55 valley children and adolescents participate in a week-long therapeutic camping experience sponsored by the center. The San Luis Valley Diagnostic and Evaluation Clinic is an inter-disciplinary team approach to the identification and evaluation of handicapped children from birth to age 21. Through the Department of Institutions, the center has recently received five units under the Section 8 Housing Assistance Program. The purpose of this HUD-sponsored program is to enable individuals and families to live in decent housing facilities by assisting with rent subsidies.

c. Priorities and Program Needs

The San Luis Valley Comprehensive Community Mental Health Center has identified various target populations as needing priority mental health services. These include children, adolescents, elderly, minorities, and moderately and severely disabled individuals.

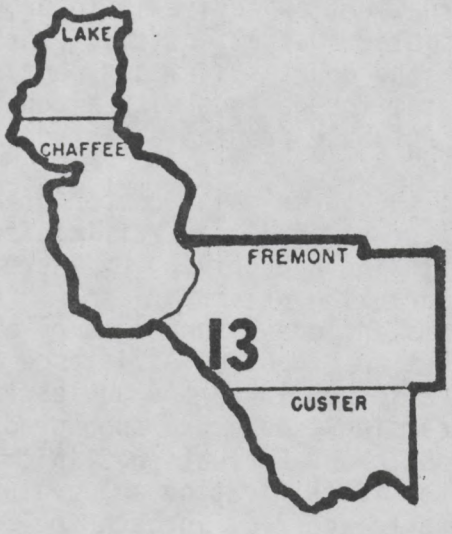
The San Luis Valley Comprehensive Community Mental Health Center is in its seventh year of federal funding. As of August 31, 1980, the center will lose its initial staffing grant, resulting in a 26 percent loss of total mental health funds. This loss will be realized in all areas of mental health programming, but will be less for target populations that have been identified by the center as needing priority mental health services.

Services to children and adolescents will be slightly reduced or will remain at the same level. This age category has been a center priority, since many problems of adulthood can be avoided by reaching out to this population. It has also been the center's experience that any work done with children usually involves the family, thus a sizable number of adults is also involved in therapy.

The San Luis Valley Comprehensive Community Mental Health Center does not foresee the development of mental health programming specifically for Chicanos. However, the center has bilingual/bicultural staff in all clinical and administrative positions. The center's employment of bilingual/bicultural staff at all levels in the organizational structure is important, since the catchment area has such a large Chicano population.

The partial care program will be expanded proportionately for the purpose of increasing the total number of severely and moderately disabled clients served.

REGION 13



Area: 3,724 square miles
Population: 55,249

a. Description of Area

West Central Mental Health Center serves a four-county catchment area composed of Fremont, Chaffee, Lake, and Custer Counties, comprising Region 13 of the state of Colorado. This area is geographically bounded on the east and south by the prairies of eastern Fremont County and mountain meadows of Custer County. As one proceeds north and west, one enters the mountainous areas of the region, which are bounded by the Wet Mountains, the Sangre de Cristos, the Collegiate Peaks, and the Park Range. The western boundary of the region is in fact the Continental Divide.

The estimated population for Region 13 for 1981 is 55,249. The area is largely rural and widely dispersed. Public transportation is at a minimum. Based on information from the Division of Mental Health, 14.6 percent of the Region 13 population is considered to be in poverty.

The vastness of the region is underscored by the fact that it is approximately 120 miles between the center's main office and its northernmost full-time satellite operation in Leadville. The low density and wide dispersion of population, as well as the lack of any viable public transportation, have accentuated the need for accessibility to center services. Consequently, the center operates three full-time offices in Canon City, Salida, and Leadville, and maintains four part-time satellite offices in Westcliffe, Florence, Cotopaxi, and Buena Vista.

b. Existing Services

West Central Mental Health Center is committed to providing the twelve essential services as mandated by Public Law 94-63, as amended, through direct services, through affiliation agreements, or through referrals. These programs and services are described below.

Screening services include initial assessment, diagnosis, and preliminary treatment planning regarding which services are most appropriate. Inpatient care refers to mental health care within a hospital setting, including referrals to local hospitals (by admission by center psychiatrist or community physician), referrals to Colorado State Hospital, or referrals to private psychiatric units. Aftercare services are provided upon discharge from a hospital setting and are designed to improve community living skills and reduce potential for rehospitalization. Partial hospitalization services are provided through affiliation agreements, referrals to schools, day care programs, and Developmental Training Services, Inc. The center provides transitional care services which include 24-hour home care and utilization of private homes in the community under contract to the center. Private homes are used for those individuals needing either a "halfway" setting between hospital care and independent community living or an alternative, while in crisis, to hospitalization.

Individual and group psychotherapy, chemotherapy, home visits, and other outreach services are offered to persons experiencing problems in living who do not require a more restricted or more intense setting for service. Outpatient individual, family, and group services are provided to children and their families. Outpatient services, consultation, and direct services within nursing homes, outreach with community agencies serving senior citizens, and home visits are part of the center's services for the elderly.

Immediate mental health care is provided via phone or face-to-face on a 24-hour basis, seven days a week. The center works directly with community groups, allied professionals, and community agencies for purposes of inservice training, workshops, public information presentations, early identification and prevention efforts, and coordination of services.

Alcohol treatment services include outpatient services to alcoholics and their families, chemotherapy, Antabuse monitoring, coordination of effort with employers, and community self-help groups. These services apply to Lake County only. All other counties are served by Drug and Alcohol Abuse, Inc. Drug abuse treatment services to Lake County residents involve outpatient counseling services to patients and their families and coordination of effort with employers. Again, all other counties are served by Drug and Alcohol Abuse, Inc.

The services described above are available to residents of the catchment area. Because of the unique concentrations of certain populations in sub-areas, some of these programs are more accentuated in one area than another.

c. Priorities and Program Needs

The mental health priorities for Region 13 have been identified by age group and by geographic sub-area. It is anticipated that admissions of children(0-11 years of age) will increase, admissions of adolescents (12-17 years of age) will remain the same, admissions of adults (18-64 years of age) will increase, and admissions of elderly (65 years or older) will remain constant, for a total annual admissions rate of 1200. These projections may be variously impacted by significant population growth and/or economic constraints.

Priorities for Fremont County include increasing services to the elderly and monitoring the impact and location of growth due to mining. The demands for services in Custer County are anticipated to increase due to more consistent delivery of services and deployment of personnel in that area. Potential growth from the development of winter recreation facilities will also impact Custer County. Because of the high utilization of existing services, development of projections for expansion of services and manpower will be needed in Chaffee County. The primary emphasis for Lake County will be upon optimal deployment of existing manpower, with more concentration on liaison and consultation efforts with industry.

Program needs which will be implemented only if there are additional resources available include the following: Psychiatric time needs to be expanded in the Fremont County area to one additional day a week, to provide more psychiatric services for the geriatric and chronic psychiatric populations. This would cost $15,000 annually.

Physical facilities throughout the region and equipment need to be upgraded to meet various fire, safety, and handicapped accessibility standards. This includes leasing other facilities, renovating existing facilities, purchasing different facilities, and/or any combination of these alternatives. Compliance with standards required to meet Medicaid regulations and standards resultant from Public Law 93-112 pertaining to serving the handicapped is of paramount concern. Costs are not currently available, due to the configuration of plans which could be implemented, as well as to the degree to which the center can make do with

what it has and meet essential standards.

Increased manpower and the development and/or expansion of satellite operations are important particularly in Chaffee and Fremont Counties. This is a situation where growth, the geographic location of that growth, and the potentiating effect on mental health needs of unplanned growth on existing community services are not sufficiently clear to provide hard data for planning or for cost projections.

3. HEALTH SERVICE AREA III

REGION 9

Area: 6,573 square miles
Population: 54,830

a. Description of Area

Southwest Colorado (Region 9) is part of the Four Corners Area, which adjoins New Mexico to the south and Utah to the west. To the north and east lie the San Juan Mountains, which form a natural boundary that tends to isolate the region from the rest of Colorado, especially in the winter. The five counties included in the catchment area are Archuleta, Dolores, La Plata, Montezuma, and San Juan Counties. It is estimated that nearly 50,000 people live in southwest Colorado.

Southwest Colorado is a designated poverty area, and has the highest unemployment rate of any region of the state. There is no heavy industry in the region. The major employers are in the fields of agriculture, lumbering, mining, and tourism. The growing tourism industry provides many low-paying seasonal jobs, such as motel maids and restaurant help. Frequent and lengthy closings of lumber mills and mines create work force lay-offs which impact heavily on Archuleta and San Juan Counties. Economic conditions are expected to improve when southwest Colorado's coal reserves are opened up for development, and this may bring the additional problems associated with an energy boom.

Both of Colorado's two Indian reservations are located in southwest Colorado. The Southern Ute Reservation is centered around the tri-ethnic town of Ignacio in La Plata County. The Ute Mountain Ute Reservation is located south of Cortez in Montezuma County, and only Ute

people live in the reservation town of Towaoc. The Indian Health Service has mental health workers on each reservation, but the Southwest Colorado Mental Health Center is seen as the primary provider of mental health services. There are problems in the area of involuntary holds and certifications to be resolved because of tribal court jurisdiction.

The center is now conducting a study of the characteristics and needs of the minority population in southwest Colorado. Preliminary indications are that the Hispanic population (17.1 percent) is stable. There is a preponderance of long-term residents, and extended family support systems are a strong influence. Southwest Colorado has few if any migrant farm workers. It is predicted that, as the population of southwest Colorado grows, the influx of people will be predominantly Anglo, and the percentage of minorities will decline. This process may have begun already. The results of the study will have a great influence on future policy decisions.

Alcoholism and unemployment affect the Native American population more than other ethnic groups in southwest Colorado. Alcoholism treatment centers at both reservations are characterized by high staff turnover rates. Innovation and perseverance will be important factors in designing service delivery strategies for the Native Americans at the reservations.

b. Existing Services

Because Southwest Colorado was determined to be in need of the full range of mental health services, the center began work on its initial operations grant application in 1978. Federal funding began on January 1, 1980. During 1979-1980, the additional state funding of $98,000 assisted the center greatly in preparation for the comprehensive center.

Given its limited financial resources over the past twelve years, the center has given priority to those most seriously disturbed, the ex-State Hospital clients, and other chronically disabled mentally ill. Center services have included outpatient, emergency, aftercare, and consultation and education. A drug abuse project, funded by the Alcohol and Drug Abuse Division, is now in its eighth year. In September, 1979, the center began a partial care program.

Like most other mental health centers in Colorado, the Southwest Colorado Mental Health Center has served disproportionate numbers of adults and Anglo-Americans. This situation is being corrected with significant increases in the numbers of children, adolescents, elderly, and minority clients served. The center has developed planning committees of professional staff members under the headings (1) Children and Adolescents, (2) Elderly, (3) Minorities, and (4) Chronically Disabled Mentally Ill. Each of these four committees designs and implements programs to increase services to these groups. The committee members come from the three outpatient centers at Durango, Cortez, and Pagosa Springs. As new professionals are added to the staff, each is assigned to a planning committee.

With a full-time satellite office having opened in Pagosa Springs in January, 1980, the center now has services accessible to all residents of the region within less than an hour's drive. In the fall of 1979, one major objective was accomplished in that the center hired at least one bilingual, bicultural direct-service staff member for each of the three outpatient offices.

Services at the Southwest Colorado Mental Health Center have been available to all the residents of southwest Colorado since the center's inception. Programs have been slow in developing, because staff have been overwhelmed with crisis work. However, during the past year new things have happened, and prior programs have been strengthened.

What used to be the center's aftercare program, which included a monthly staff meeting with health nurses, social service case workers, and other professionals, has evolved into the Community Support System, which has a broader purpose, includes more agencies, and is designed for more specific client planning. The system has developed in Durango, but will be replicated in Cortez and, to a certain extent, in Pagosa Springs.

For the past four years, the center has worked in close affiliation with the Sheltering Oak Group Home, which is a residential facility which houses more than 14 chronically disabled mentally ill adults. This program is a long-term (average stay is about two years) program designed to prevent the return of clients to the Colorado State Hospital. The center provides group therapy, consultation, and medical-psychiatric services to Sheltering Oak.

The center's new partial care program serves about 15 chronically disabled mentally ill adults, more than half of whom reside at the group home. The center is also affiliated with the Four Corners Sheltered Workshop, where a number of chronic patients are employed. Both types of partial care services will expand in 1980.

In the area of children's services, the center has been an active member of the Children's Developmental Evaluation Committee for over a decade and part of the Child Protection Team for the past four years. These programs are evaluative and consultative respectively, but both provide avenues for treatment at the center. Just beginning, now that the center has more staff, is a closer working relationship with the public schools, which has allowed a group counseling program at Durango High School, and means involvement in the Cortez schools.

In Cortez, one psychiatric social worker provides services to the residents at the Vista Grande Nursing Home. In Durango, the center bilingual, bicultural psychiatric social worker works with minority clients at Eventide. Through the center's affiliative agreement with Region 9 Community Services, the center is also providing services to elderly at the various nutrition sites throughout the region.

After several years of effort, southwest Colorado now has a secure holding room for involuntary evaluations and treatment of those clients who are believed to be dangerous to self or others or gravely disabled. Mercy Medical Center, where the room is located, has provisional designation as a 72-hour holding facility. The center has a 24-hour emergency answering service in Durango and Cortez.

c. Priorities and Program Needs

As the center phases in its new services, the top priority remains unchanged: services to the chronically disabled mentally ill. This is a region-wide priority. Because the groundwork has been laid in Durango and La Plata County, these services will be developed fully in this largest county before full development in Cortez and Montezuma County.

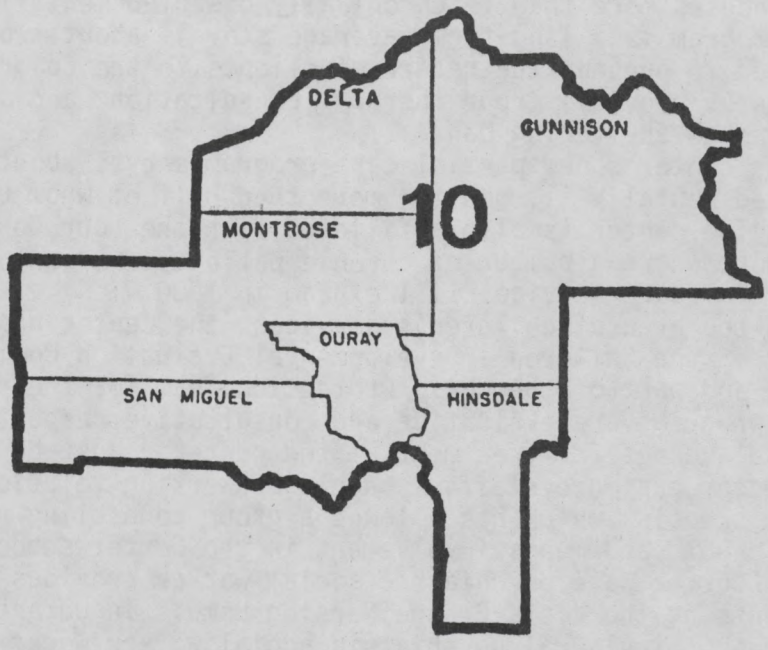
In regard to the age groups, priorities begin with the elderly, who are at present those served in the fewest numbers. This is especially true in the most rural parts of the region. Accordingly, adolescents

are next, then children, and finally adults, who are still somewhat disproportionately overserved.

Of higher priority than any of the age categories is the minority population of all ages. The Hispanic and Native American populations comprise almost 25 percent of the total region's population, but less than 20 percent of cases opened in past years.

The staff planning teams are working to define special program needs for children and adolescents, the elderly, minorities, and the chronically disabled mentally ill. These plans will encompass programs for all five counties.

REGION 10



Area: 9,530 square miles
Population: 75,022

a. Description of Area

The catchment area of the Midwestern Colorado Mental Health Center encompasses the six counties which comprise Region 10 (Delta, Gunnison, Hinsdale, Montrose, Ouray, and San Miguel), in central western Colorado. The 1980 population is estimated to be 70,600. The major industries are mining, ranching, and farming. The six counties encompass 9,530 square miles of mountainous terrain. The geography clearly has an impact on the delivery and accessibility of services, travel costs, multi-office space costs, and isolation of staff.

There is a significant lack of alternate mental health resources in some respects. There are no psychiatric inpatient facilities or even a locked nursing care facility for psychiatric patients.

The center's catchment area is a designated (HEW) poverty area. Approximately 16.2 percent of the population is considered to be in poverty.

There are a number of factors which are impacting the need for mental health services. There has been continued growth in the coal extraction industry in Delta County in recent years. The western portion of Montrose County is experiencing significant growth in the wake of increased mining activities, particularly uranium. Gunnison County is anticipating a rapid increase in population with the entry of a massive AMAX mining operation into the Crested Butte area.

b. Existing Services

The Midwestern Colorado Mental Health Center provides a full range of comprehensive services to catchment area residents. One psychologist, on contract with the school district part-time as a school psychologist, is the designated coordinator of child and adolescent services. The center employs a youth counselor part-time in an outreach effort to adolescents in the Montrose area. During the past two years the center has recruited, employed, and trained two part-time elderly peer counselors, one based in Delta and one in Montrose. These peer counselors are outreach workers in nursing homes and in the community, and are supervised by a staff psychologist. The center employs a bilingual, bicultural (Hispanic) CETA outreach worker for the minority community. Efforts continue to fill a vacancy for a professional Hispanic staff person. At this time minority outreach efforts are supervised by a part-time minority staff person on contract to the center. Latest available data indicate that approximately 40 percent of center clients have an income under $5,000 per year, and as many as 70 percent report a family income under $10,000 per year.

Midwestern Colorado Mental Health Center is a rural center serving residents in a sparsely populated six-county area involving some 20 small communities.

c. Priorities and Program Needs

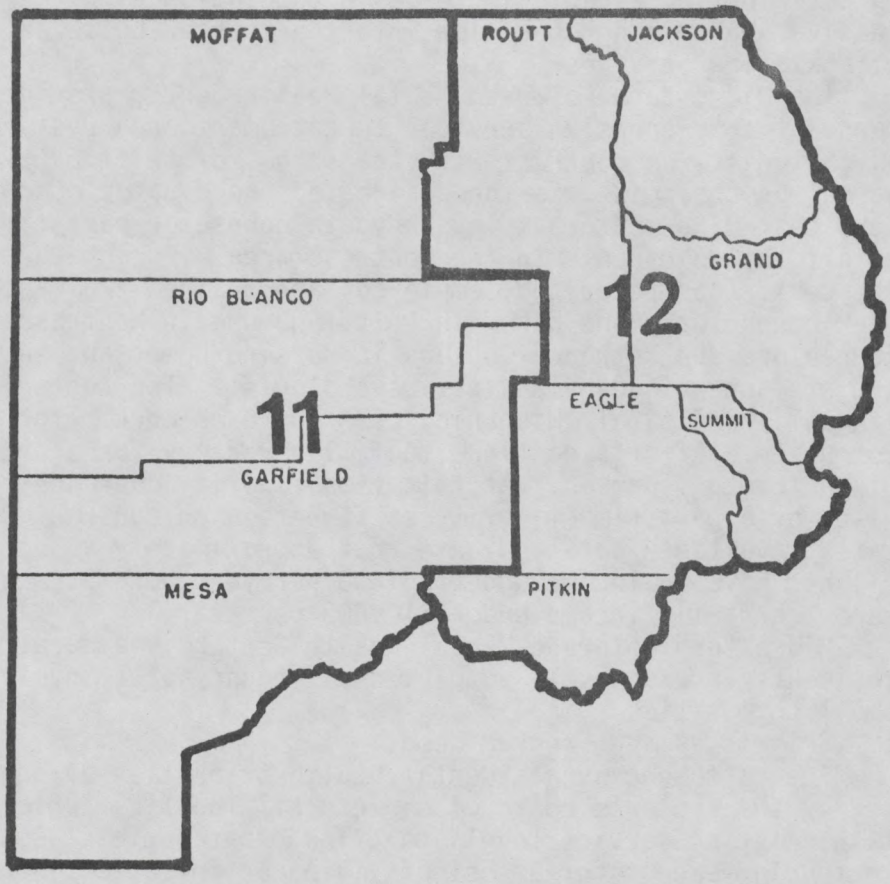
The catchment area's mental health priorities by age group were set by the center's board of directors. The first priority is to maintain existing service levels to all age categories, assuming no increase in funding except for a cost-of-living or inflation increase. The second set of priorities would include increased prevention efforts (consultation and education) for children and their parents, increased services to the elderly, increased prevention efforts (consultation and education) for adolescents and their parents, and increased services to adults. This second set of priorities is dependent upon the center's receiving an increase in funding greater than a cost-of-living or inflation increase. The priorities are the same for all geographical sub-areas of the catchment area.

Clearly, the priorities of the center board reflect a concern for the treatment and prevention of mental illness in families, as units which impact services both to children/adolescents and to adults. In fact, such an emphasis for young children probably would involve greater services to adults.

Special program needs by priority include having professional staff specialists for children and adolescent services, particularly in the area of consultation and education, but also in terms of treatment. The center needs a full-time psychiatrist or part-time resident psychiatrist in addition to the present medical director. Inpatient psychiatric beds are needed in Region 10, or significant additional funding

which would permit greater utilization of present psychiatric beds at St. Mary's Hospital in Grand Junction.

REGIONS 11 AND 12



Area: 23,464 square miles
Population: 190,148

a. Description of Area

The Colorado West Regional Mental Health Center serves the 10 counties of Planning and Management Regions 11 and 12. The catchment area is characterized as having a widely scattered population and rugged terrain. It extends from the Continental Divide on the east to the Utah border on the west. On the south, the area is bordered by Regions 10 and 13. On the north lies the Wyoming border.

The population of the area has grown rapidly since the inception of the mental health center in 1972. This trend can be expected to continue as the impact of energy development activities increases and as new resort developments are completed. During 1980, the population can be expected to approach 200,000 persons.

The composition of the population is as follows: Anglo/Other 91.83 percent; Asian 0.2 percent; Black 0.2 percent; Chicano 7.68 percent; and Native American 0.1 percent. According to the Division of Mental

Health, 13.7 percent of the population is in poverty.

In addition to the rapid rate of population growth, the known socio-psychological impacts associated with boom growth will weigh heavily on communities in the area. The vicinities of Rangely, Hayden, Rifle, and Meeker are expected to begin and/or continue this phenomenon. Craig will continue to grow rapidly. The resort areas of Vail, Steamboat Springs, Summit County, and the Roaring Fork Valley will gain population at relatively rapid rates. As the commercial and trade center of western Colorado, Grand Junction will feel the impact and side effects of much of the activity in the smaller communities.

b. Existing Services

The primary service philosophy of Colorado West is the provision of basic services at the community level. The entire area is rural in nature, consisting of small communities. Therefore, a number of small offices (13) provide general services. Population sparsity and limitation of resources prohibit the cost-effective development of highly specialized services in most areas. Emergency, outpatient services, and consultation and education are available in all communities served. More intensive and specialized services are much more limited in scope and area served.

In spite of the limitations described above, several special programs do exist. These include the following: (1) attention to youth - a residential facility for adolescents in Grand Junction; (2) special partial care programs for the elderly and for chronically disabled adults in Glenwood Springs and Steamboat Springs; (3) extensive volunteer services in the Summit County and Grand County areas; (4) services to the moderately and severely disabled adults in Grand Junction, including inpatient, halfway house, partial care, and subsidized apartment units; and (5) a minority service team housed in Grand Junction, but serving the entire area.

c. Priorities and Program Needs

As outlined in the Health Systems Plan of the Western Colorado Health Systems Agency, a major need exists in all the programs in the region for improved emergency evaluation capacity. Small community hospitals do not have the staffing or physical facilities to serve acutely disturbed clients. These clients must often be transferred to one of the two state hospitals.

The only hospital service within the region offering emergency evaluation capacity is St. Mary's Hospital in Grand Junction. Continued availability of this facility is now open to serious question. In early 1979, the district court in Grand Junction stated that it would no longer assume jurisdiction for non-Mesa County residents admitted to the hospital under the provisions of CRS 27-10.

More recently, St. Mary's Hospital has indicated that they may seek to drop designation under the provisions of CRS 27-10. This move primarily stems from perceived financial and legal liability associated with such designation. Should this occur, the two state hospitals would become the only emergency inpatient services available to the entire region.

Keeping these concerns in mind, the following priorities exist for the center: (1) Availability of emergency evaluation capacity in a hospital or other 24-hour care facility in every affiliate area. The estimated cost is $20,000 per affiliate. (2) Expansion of emergency, outpatient, and prevention services in energy development-impacted areas.

An estimated $100,000 will be needed for such service. (3) Increased services to children in the emergency, outpatient, and prevention areas. Present staff will be utilized to accomplish this increase. Therefore, cost will be limited to obtaining the necessary training for the staff. (4) Increased basic services in rapid growth areas which are not directly experiencing energy impact growth. A full-time professional position in Vail and an additional full-time position in Grand Junction are recommended.

F. 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.

G. RANKINGS OF CATCHMENT AREAS

1. Estimates of Population in Need by Catchment Area

A two-step procedure is used to estimate the number of target group individuals residing in each catchment area. The first step involves applying percentage estimates of the prevalence of mental disability for each of the four age groups to data on the population of these age groups for each catchment area. The numbers of persons in need obtained through these calculations are then summed across the four age groups to arrive at a total number of persons in need.

The second step involves modifying the estimates obtained in the procedure above with indicators of social disruption in order to take into account better the differences that exist in the prevalence of mental disability among catchment areas.

The prevalence percentages employed in this analysis are identical to those reported in the previous State Plan and are based on material contained in the Report of the President's Commission on Mental Health (1978). The percent of individuals in each age group estimated to meet the target group criteria (moderately and severely psychiatrically disabled) are as follows:

Age	% Target
0 - 11	6%
12 - 17	10%
18 - 64	7%
65+	13%

The population figures by age groups to which these percentages are applied are based on the most recent Colorado Division of Planning population projections for 1981. (The total population figures are from Colorado Population Reports, Population Estimates and Projections, Series CP-25, No. 79 (A-1), High Series - 1981, Colorado Division of Planning, March 1979. The percentages used for the age breakout are based on Colorado Population Projections 1970-2000, High Series - 1980, Colorado Division of Planning, April 1976.) The 1981 total population estimates are shown in the section of this Plan describing each catchment area. The figures for total population in need computed using this method are shown in the first column of Table 1.

The social indicators data used in this analysis and their sources are shown in Table 2. These include rates for suicide, child abuse and neglect reports, divorce, ethnic minorities, poverty, and unemployment. These and similar measures have been demonstrated in previous research to be useful in predicting the prevalence of mental disability by geographic area. A diligent effort was made to obtain the most current data available, and all measures with the exception of poverty rate (based on 1970 Census) are from 1977 or later.

A composite social indicators scale score was computed for each catchment area. This was accomplished by:

(a) transforming the social indicators into standardized score values (see Table 3),
(b) computing the mean of the six standardized score values for each catchment area, and
(c) recomputing the resulting distribution into standardized scores.

These composite social indicators standardized scores are shown in the second column of Table 1. (A score of -1.0 may be interpreted to mean that the corresponding catchment area is one standard deviation below the mean on overall social disruption; positive scores indicate greater than average social disruption.)

The composite social indicators standardized scores (z) were employed to modify the population-in-need figures based on prevalence percentages (x) to result in new population-in-need estimates (P) according to the following formula:

Table 1. Estimates of Population in Need by Catchment Area

	Unmodified Population in Need 1981[1]	Composite Social Indicators Standardized Scores	Modified Population in Need 1981[2]	Percent Total Population in Need[3]		
Community						
Adams	16296	- .46340	14786	6.74		
Arapahoe	15245	-1.01044	12164	6.05		
Aurora	11890	- .66352	10312	6.53		
Bethesda	10913	.04139	11003	8.04		
Boulder	15888	- .16430	15366	7.44		
Centennial	7448	-1.20629	5651	6.03		
Child/Adol.	-	-	-	-		
Colorado W.	14542	- .45788	13210	6.95		
Denver H&H	12394	2.67766	19031	12.25		
Denver MHC	-	-	-	-		
Jefferson	31481	-1.41423	22577	5.42		
Larimer	12054	-1.12624	9339	5.98		
Midwestern	5917	- .45894	5374	7.16		
Park East	9242	1.02656	11139	9.61		
Pikes Peak	25368	- .00036	25366	7.43		
San Luis	3405	1.18841	4214	9.63		
Servicios	-	-	-	-		
SE Colorado	4976	- .41734	4561	7.28		
SW Colorado	4254	.99193	5098	9.30		
SW Denver	6619	.80705	7687	9.27		
Spanish Pks.	12153	1.09198	14807	9.59		
Weld	10729	- .67701	9276	6.63		
W. Central	4362	.23499	4567	8.27		
Total	235176		225528	7.38		

[1]Note: Unmodified Population in Need calculated by multiplying catchment area population for each age group by "Presidents Commission" prevalence rates for each age group.

[2]Note: Modified Population in Need calculated by adjusting unmodified figure by 20% of the catchment area composite Social Indicator Standardized Score.

[3]Note: Percent Total Population in Need calculated by dividing Modified Population in Need by total population.

Table 2. Social Indicators Raw Scores for Catchment Areas

	Suicide Rate per 100,000 Population 1978[1]	Abuse & Neglect Reports Rate per 100,000 C & A 1978[2]	Divorce Rate per 1000 Married Couples 1978[3]	% Minority Population 1977[4]	% Population in Poverty 1970[5]	% Labor Force Unemployment 1980[6]
Community						
Adams	15.25	750.6	19.63	21.0	6.8	4.92
Arapahoe	18.49	465.1	23.02	7.3	6.2	3.24
Aurora	18.31	562.3	24.28	6.4	5.9	4.39
Bethesda	18.04	965.3	30.54	12.3	7.1	3.82
Boulder	10.79	1136.8	23.96	8.1	10.1	4.81
Centennial	9.04	622.8	13.92	7.6	16.8	3.51
Child/Adol.	-	-	-	-	-	-
Colorado W.	16.50	304.3	23.67	8.2	13.7	5.34
Denver H&H	35.08	965.3	30.54	53.8	24.0	7.21
Denver MHC	-	-	-	-	-	-
Jefferson	18.25	205.4	20.81	5.0	5.5	3.31
Larimer	9.66	248.3	21.90	8.3	13.6	3.91
Midwestern	9.51	289.8	20.46	10.8	20.2	5.97
Park East	20.41	965.3	30.54	47.1	10.4	4.75
Pikes Peak	16.36	492.9	27.44	15.8	11.6	5.61
San Luis	32.18	129.3	17.46	48.9	29.3	6.73
Servicios	-	-	-	-	-	-
SE Colorado	3.34	637.3	16.84	27.7	22.8	4.75
SW Colorado	21.01	678.2	26.01	24.5	18.1	7.32
SW Denver	26.03	965.3	30.54	35.2	6.9	4.36
Spanish Pks.	22.06	887.6	20.89	39.7	16.5	7.10
Weld	16.84	365.3	16.48	20.6	17.3	4.05
W. Central	21.65	339.8	26.01	12.6	14.6	6.59
STATEWIDE	17.68	576.7	23.41	18.55	9.1	4.77

[1]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1980.
[2]Source: Colorado Department of Social Services, Protective Services Program, 1980.
[3]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1980. Number of married couples estimated by applying percent population married from 1970 census to current population estimates and dividing result by 2.
[4]Source: Colorado Division of Planning, Demographics Section, Report Series CP-26, No.78(B)-1, 1978.
[5]Source: Mental Health Demographic Profile System (U.S. Census Data - 1970).
[6]Source: Colorado Division of Employment and Training, Research and Analysis Section, 1980.

Table 3. Social Indicators Standardized Scores for Catchment Areas

	Suicide Rate per 100,000 Population 1978[1]	Abuse & Neglect Reports Rate per 100,000 C & A 1978[2]	Divorce Rate per 1000 Married Couples 1978[3]	% Minority Population 1977[4]	% Population in Poverty 1970[5]	% Labor Force Unemployment 1980[6]
Community						
Adams	- .36190	.50955	- .73157	- .00292	-1.06918	- .12600
Arapahoe	.07400	- .44911	- .04591	- .89196	-1.15991	-1.41281
Aurora	.04978	- .12273	.20894	- .95036	-1.20528	- .53196
Bethesda	.01345	1.23048	1.47508	- .56749	-1.02381	- .96856
Boulder	- .96194	1.80635	.14421	- .84004	- .57013	- .21026
Centennial	-1.19738	.08042	-1.88648	- .87249	.44309	-1.20600
Child/Adol.	-	-	-	-	-	-
Colorado W.	- .19373	- .98905	.08556	- .83355	.02571	.19570
Denver H&H	2.30598	1.23048	1.47508	2.12557	1.53193	1.62805
Denver MHC	-	-	-	-	-	-
Jefferson	.04171	-1.32114	- .49291	-1.04121	-1.26577	-1.35919
Larimer	-1.11397	-1.17709	- .27244	- .82706	- .04083	- .89962
Midwestern	-1.13415	-1.03774	- .56370	- .66483	.95727	.67826
Park East	.33231	1.23048	1.47508	1.69079	- .52476	- .25621
Pikes Peak	- .21257	- .35576	.84807	- .34036	- .34329	.40251
San Luis	1.91582	-1.57667	-1.17048	1.80760	2.33343	1.26039
Servicios	-	-	-	-	-	-
SE Colorado	-1.96425	.12911	-1.29588	.43186	1.35046	- .25621
SW Colorado	.41303	.26644	.55884	.22421	.63969	1.71230
SW Denver	1.08841	1.23048	1.47508	.91856	-1.05405	- .55494
Spanish Pks.	.55430	.96958	- .47673	1.21058	.39773	1.54379
Weld	- .14799	- .78422	-1.36869	- .02888	.51871	- .79239
W. Central	.49914	- .86985	.55884	- .54802	.11040	1.15315
Total						

[1]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1980.

[2]Source: Colorado Department of Social Services, Protective Services Program, 1980.

[3]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1980. Number of married couples estimated by applying percent population married from 1970 census to current population estimates and dividing result by 2.

[4]Source: Colorado Division of Planning, Demographics Section, Report Series CP-26, No. 78(B)-1, 1978

[5]Source: Mental Health Demographic Profile System (U.S. Census Data - 1970).

[6]Source: Colorado Division of Employment and Training, Research and Analysis Section, 1980.

$$P = x\ (1 + .20\ z)$$

Thereby a catchment area which is one standard deviation above the mean on social disruption would receive a 20% increase in its population-in-need figure, or a catchment area that is one-half a standard deviation below the mean on social disruption would receive a 10% decrease in its population-in-need figure. The new population-in-need figures computed using this methodology are shown in the third column of Table 1. The percentages of a catchment area's total population that the population-in-need estimates represent also are shown in Table 1.

The model used to calculate population in need is based on the format used in FY 1979-80 with some minor modifications. Much of the data used as input to the model have been revised and updated. Unmodified population in need is based on 1981 population estimates as opposed to the 1980 estimates that were used last year. The data for three of the indicators, suicide rate, child abuse and neglect rate, and unemployment rate, have been updated for this recalculation. In addition, a new indicator, divorce rate, has been substituted for one of the previous indicators, S.S.I. psychiatric recipient rate, because of the demonstrated usefulness of divorce as a predictor of need for mental health services. Despite these changes, there is a strong correlation between last year's composite social indicator scores and those calculated this year ($r = .93$), attesting to the stability and reliability of the indicators used. These changes also brought about an increased level of inter-item consistency among the indicators ($\alpha = .71$). Furthermore, the weight assigned to the social indicators in calculating the modified population in need has been increased from 10% last year to 20% this year. This change was made because of increased confidence in the social indicators as predictors of need for mental health services and to further differentiate the population-in-need figures from total population data.

2. Inventory of Mental Health Resources by Catchment Area

The resources inventory contains resource information on three separate levels: facilities, personnel, and funding allocations. The facilities data, shown in Table 4, were obtained from the 1977 Colorado Department of Health Facilities Survey. This information was collected during 1978 and reflects a facility's status on December 31, 1977. The measures employed include the following:

(a) inpatient hospital beds licensed for psychiatric treatment,
(b) census of residents at licensed nursing homes whose primary diagnosis is psychiatric or emotional (may be interpreted as an approximate indicator of nursing home capacity for psychiatric clients),
(c) client census at licensed residential care facilities (RCFs),
(d) client census at licensed residential child care facilities (RCCFs), and
(e) the number of hospital-based, 24-hour, psychiatric emergency units.

Table 4. Resources Inventory - Facilities

	Inpatient Psychiatric Hospital Beds[1,2]	Nursing Homes Psychiatric Census[1]	RCF Census[1]	RCCF Census[1]	Psychiatric Emergency Units[1]	
Community						
Adams	0	237	33	15	0	
Arapahoe	0	47	0	139	0	
Aurora	0	23	0	12	0	
Bethesda	103	56	0	0	1	
Boulder	28	22	0	140	2	
Centennial	0	51	12	54	0	
Child/Adol.	-	-	-	-	-	
Colorado W.	2	82	0	34	1	
Denver H&H	96	113	11	175	4	
Denver MHC	-	-	-	-	-	
Jefferson	6	319	0	33	1	
Larimer	9	177	0	24	1	
Midwestern	0	18	0	8	0	
Park East	112	61	4	111	1	
Pikes Peak	109	177	0	153	2	
San Luis	0	40	0	16	0	
Servicios	-	-	-	-	-	
SE Colorado	0	21	68	97	0	
SW Colorado	6	3	12	0	1	
SW Denver	(208)0	5	11	53	1	
Spanish Pks.	(701)56	140	8	106	3	
Weld	18	69	0	27	1	
W. Central	0	96	0	14	0	
Total	(909)545	1757	159	1211	19	

[1]Source: Colorado Department of Health Facilities Survey, 1977
[2]State hospitals shown in parentheses.

The personnel data, shown in Table 5, include the following measures:

(a) number of physicians who stated on their licensing applications that their primary specialty is psychiatry or child psychiatry and who live and/or work in Colorado,

(b) number of psychologists who were listed in the National Register of Health Service Providers in Psychology who are licensed to practice in Colorado and who show Colorado as their preferred mailing address, and

(c) the total number of full-time equivalent employees (FTEs) who were reported to work in the catchment area centers/clinics.

The funding allocations data, shown in Table 6, include the number of state and federal dollars and state hospital resources which have been allocated to catchment area centers. The federal allocations do not include monies set aside for special projects or grants.

3. Priority Rankings Based on Needs vs. Resources

In order to arrive at the priority rankings which take into account the combined effect of individuals in need and resources available, it is necessary first to arrive at a composite resources score. There are substantial difficulties in employing the facilities and personnel data as they presently exist for this purpose. Many of the facilities, which may be located in a specific catchment area, are accessible to and utilized by residents of a much broader geographic area. Furthermore, the different facilities are not unidimensional in function and purpose, i.e., the existence of a certain number of nursing home beds for psychiatric patients cannot "substitute" for a psychiatric emergency unit. Also, the personnel data as yet do not reflect a sufficiently broad range of mental health professionals and paraprofessionals. Therefore, a simple additive scale combining all of these measures would not result in meaningful data for establishing overall Division priorities.

For these reasons the Division of Mental Health has chosen the measure of combined state, federal, and state hospital FY 80-81 funding allocations as the most sound overall index of total resources available to each catchment area. While this measure may not adequately account for private mental health resources, it does provide an accurate and readily interpretable gauge of the overall distribution of mental health resources from the public sector.

Population in need is combined with resources available by dividing the total state and federal dollar allocations to each catchment area by the number of target group individuals estimated to reside in that catchment area, producing a "population in need per capita allocation" figure. The results of this procedure and the resulting priority rankings are shown in Table 7.

The individual facilities and personnel resources measures may prove quite useful for the purpose of specialized mental health planning and are published here for public information.

4. Methodological Note

In the months ahead the Division of Mental Health will continue to work on refining the methodology employed in this need assessment. Part of this process will involve the implementation of several community need assessment surveys, to be conducted in several areas of the state, to validate and improve upon the social indicators model. Additional

Table 5. Resources Inventory - Personnel

	Licensed Psychiatrists[1,2]	Licensed Psychologists[2,3]	Center Staff[4]			
			Full-Time Staff	Part-Time Staff		
Community						
Adams	2	3	71	11		
Arapahoe	21	18	59	13		
Aurora		8	56	16		
Bethesda	55.5	19.5	31	20		
Boulder	33	18	81	31		
Centennial	0	0	75	9		
Child/Adol.	-	-	18	12		
Colorado W.	6	10	66	10		
Denver H&H	55.5	19.5	88	7		
Denver MHC	-	-	2	10		
Jefferson	20	22	91	13		
Larimer	6	14	64	9		
Midwestern	1	1	19	8		
Park East	55.5	19.5	44	6		
Pikes Peak	28	16	215	18		
San Luis	1	0	54	7		
Servicios	-	-	7	1		
SE Colorado	2	0	41	5		
SW Colorado	1	0	18	9		
SW Denver	55.5	19.5	58	5		
Spanish Pks.	25	6	70	16		
Weld	3	5	48	2		
W. Central	1	1	27	5		
Total	272	200	1303	243		

[1]Source: Colorado Department of Health, 1978
[2]Shown for Denver catchment areas is ¼ of Denver County total
[3]Source: National Register of Health Service Providers in Psychology, 1979
[4]Source: DMH, 1980.

Table 6. Resources Inventory - Funding Allocations

	80-81 Contracted State Dollars (1,000's)	80-81 Federal Dollars (1,000's)	80-81 State & Federal Dollars (1,000's)	79-80 Catchment Area Hospital Utilization	Total State, Fed. & Hospital Resources (1,000's)	
Community						
Adams	1,265	48	1,313	258	1,571	
Arapahoe	855	-0-	855	451	1,306	
Aurora	399	538	937	417	1,354	
Bethesda	874	-0-	874	106	981	
Boulder	1,248	30	1,278	43	1,321	
Centennial	320	638	958	153	1,112	
Child/Adol.	60	-0-	60	-0-	60	
Colorado W.	889	-0-	889	435	1,325	
Denver H&H	1,976	919	2,895	786	3,680	
Denver MHC	88	-0-	88	-0-	88	
Jefferson	1,856	-0-	1,856	651	2,507	
Larimer	457	498	955	127	1,082	
Midwestern	400	38	438	227	664	
Park East	1,017	291	1,308	366	1,673	
Pikes Peak	1,874	-0-	1,874	1,596	3,470	
San Luis	417	131	548	149	697	
Servicios	131	-0-	131	-0-	131	
SE Colorado	154	607	761	242	1,003	
SW Colorado	224	473	697	165	863	
SW Denver	936	-0-	936	250	1,186	
Spanish Pks.	640	236	876	1,798	2,674	
Weld	805	61	866	52	918	
W. Central	115	345	460	351	811	
Total	17,000	4,853	21,853	8,623	30,476	

Table 7. PRIORITY NEED RANKING

CSH Service Area	Per Capita in Need; State, Fed., & Hosp. Allocation	Priority Ranking By Region	Priority Ranking Statewide			
Midwestern	117.71	2	9			
Pikes Peak	136.80	3	11			
San Luis	165.51	4	14			
SE Colorado	219.87	8	20			
SW Colorado	169.34	5	15			
Spanish Peaks	180.61	7	17			
West Central	177.61	6	16			
Colo. West	100.27	1	4			
Average	158.46					
FLMHC Service Area						
Weld	98.97	3	3			
Larimer	115.89	7	8			
Adams	106.22	4	5			
Arapahoe	107.36	5	6			
Boulder	85.97	1	1			
Jefferson	111.04	6	7			
Bethesda	89.13	2	2			
Denver H. & H.	193.39	11	18			
Park East	150.24	9	12			
SW Denver	154.25	10	13			
Aurora	131.30	8	10			
Centennial	196.73	12	19			
Average	128.37					
Total State	132.30					

technical information on the data presented in this section may be obtained from the Colorado Division of Mental Health.

H. DATA FOR DIVISION/CENTER CONTRACT NEGOTIATIONS

The Colorado Division of Mental Health (DMH) supports community-based mental health treatment by purchasing services from local community mental health centers/clinics. As budget constraints increase and funding declines it is essential to identify service priorities and to insure that those persons with the greatest mental health needs and the fewest resources receive services with state dollars. For this reason, the Division has implemented a system of performance contracting which forms the basis for the purchase of services in the community.

Every spring, DMH negotiates individually with each community mental health center/clinic a contract which records specific expectations concerning the agency's provision of services during the coming fiscal year. The contract specifies a minimum number of admissions by age (children, adolescents, adults, and elderly), severity (moderately and severely psychiatrically disabled), and ethnic background (Chicano, Black, Asian, American Indian, and total ethnic minorities). The disbursement of funds is contingent upon the agency's successful completion of these and other terms of the contract.

Many factors are taken into consideration in negotiating the contract terms to ensure that the specified provisions best meet the needs of each community. These include the demographic composition of the catchment area population, estimates concerning the population in need, the agency's previous workload trends, the existence of other mental health resources in the community, and the agency's capacity for effecting change in its workload. Both DMH and the agencies prepare for the negotiation sessions by compiling information that is relevant to these concerns. The following pages display data that were compiled by DMH for the 1980-81 contract negotiations. These data were published previously in Orchid 25 ("Data Relevant to Agency/DMH Contract Negotiations - Spring, 1980"). They are included because of their usefulness for other planning applications throughout the year.

I. FACILITIES

1. Plans for Comprehensive Services

As previously indicated, the state is divided into twenty catchment areas. All twenty of these areas now are served by comprehensive centers.

The goal of the Division of Mental Health has been to have all catchment areas covered by comprehensive centers. This goal has been fully accomplished during the past four years, four clinics (Aurora, West Central, Larimer County, and Southeastern Colorado) were awarded initial operations grants. Two clinics (Northeast Colorado and East Central Colorado Mental Health Clinics) were awarded an initial operations grant in July of 1979, which allowed them to merge to form one strong, well-staffed center (Centennial Mental Health Center). The goal of merging the two clinics was reflected in the State Plan for the past four years.

Percent Population in Each
Age Group
- 1981 -

	Children	Adolescents	Adults	Elderly	Total Population
Community					
Adams	21.42	11.68	62.10	4.80	219494
Arapahoe	18.29	11.52	63.18	7.01	201029
Aurora	19.16	11.52	63.11	6.21	157977
Bethesda	14.42	8.88	62.45	14.25	136798
Boulder	16.12	10.75	64.31	8.82	206600
Centennial	18.03	9.91	58.12	13.94	93643
Child/Adol.	-	-	-	-	-
Colorado W	16.82	9.52	64.82	8.84	190148
Denver H&H	14.42	8.88	62.45	14.25	155365
Denver MHC	-	-	-	-	-
Jefferson	18.55	10.80	63.65	7.00	416500
Larimer	15.54	9.89	64.89	9.68	156100
Midwestern	18.03	10.95	58.72	12.30	75022
Park East	14.42	8.88	62.45	14.25	115869
Pikes Peak	20.22	9.72	63.60	6.46	339289
San Luis	20.95	11.60	56.80	10.65	43776
Servicios	-	-	-	-	-
SE Colorado	20.27	10.38	55.41	13.94	62628
SW Colorado	18.99	10.44	59.99	10.58	54830
SW Denver	14.42	8.88	62.45	14.25	82968
Spanish Pks.	18.78	10.74	58.26	12.22	154465
Weld	17.30	10.12	63.70	8.88	140000
W Central	17.79	9.44	59.61	13.16	55249
Hospitals					
CSH	-	-	-	-	-
FLMHC	-	-	-	-	-
Totals					
Community	-	-	-	-	-
Hospital	-	-	-	-	-
Grand Totals	17.86	10.30	62.50	9.34	3057750

Source: Number in poopulation are from Colorado Div. of Planning Population Estimates and Projections (June 1979). Age percentages are from earlier Div. of Planning data for 1980 (April 1976).

Percent Population in Each
Ethnic Group
- 1981 -

Community	American Indian	Asian American	Black American	Spanish American	Anglo American/Other
Adams	0.6	1.2	1.1	18.1	79.0
Arapahoe	0.3	1.2	1.3	4.5	92.7
Aurora	0.3	0.5	3.6	2.0	93.6
Bethesda	0.2	0.2	5.7	6.2	87.7
Boulder	0.28	0.90	0.65	6.27	91.90
Centennial	0.14	0.38	0.11	7.00	92.37
Child/Adol.	-	-	-	-	-
Colorado W	0.10	0.20	0.20	7.68	91.83
Denver H&H	1.0	2.3	14.1	36.4	46.2
Denver MHC	-	-	-	-	-
Jefferson	0.20	0.68	0.26	3.88	94.99
Larimer	0.27	0.87	0.31	6.89	91.67
Midwestern	0.79	0.36	0.15	9.50	89.19
Park East	0.7	1.9	34.0	10.5	52.9
Pikes Peak	0.35	1.48	5.73	8.55	84.18
San Luis	0.17	0.44	0.18	47.67	51.54
Servicios	-	-	-	-	-
SE Colorado	0.17	0.62	0.36	26.53	72.33
SW Colorado	6.90	0.37	0.12	17.08	75.54
SW Denver	0.2	0.2	1.4	33.4	64.8
Spanish Pks.	0.12	0.39	1.66	37.55	60.27
Weld	0.17	0.93	0.23	19.28	79.39
W Central	0.33	0.34	0.54	11.43	87.36
Hospitals					
CSH	-	-	-	-	-
FLMHC	-	-	-	-	-
Totals					
Community	-	-	-	-	-
Hospital	-	-	-	-	-
Grand Totals	0.45	0.90	3.73	13.51	81.45

Source: 1977 Division of Planning Estimates and DMH Estimates for Metropolitan Denver Catchment Areas.

Percent of Targeted Population in Each Age Group
(Moderately and Severely Disabled)
- 1981 -

	Children	Adolescents	Adults	Elderly	Total Percent	Total Number of Targeted Persons
Community						
Adams	17.3	15.7	58.6	8.4	100	15541
Arapahoe	14.5	15.2	58.5	11.8	100	13705
Aurora	15.1	15.2	58.6	11.1	100	11101
Bethesda	10.8	11.1	54.9	23.2	100	10958
Boulder	12.6	14.0	58.5	14.9	100	15627
Centennial	13.6	12.5	51.1	22.8	100	6550
Child/Adol.	-	-	-	-	-	-
Colorado W	13.2	12.4	59.4	15.0	100	13876
Denver H&H	10.8	11.1	54.9	23.2	100	15713
Denver MHC	-	-	-	-	-	-
Jefferson	14.7	14.3	59.0	12.0	100	27029
Larimer	12.1	12.8	58.8	16.3	100	10696
Midwestern	13.7	13.9	52.1	20.3	100	5645
Park East	10.8	11.1	54.9	23.2	100	10191
Pikes Peak	16.2	13.0	59.6	11.2	100	25367
San Luis	16.2	14.9	51.1	17.8	100	3810
Servicios	-	-	-	-	-	-
SE Colorado	15.3	13.1	48.8	22.8	100	4768
SW Colorado	14.7	13.5	54.1	17.7	100	4676
SW Denver	10.8	11.1	54.9	23.2	100	7153
Spanish Pks.	14.3	13.6	51.9	20.2	100	13480
Weld	13.5	13.2	58.3	15.0	100	10003
W Central	13.5	12.0	52.8	21.7	100	4465
Hospitals						
CSH	-	-	-	-	-	-
FLMHC	-	-	-	-	-	-
Totals						
Community	-	-	-	-	-	-
Hospital	-	-	-	-	-	-
Grand Totals	13.8	13.3	56.7	16.2	100	230354

Source: President's Commission Rates Modified by Social Indicators.

The award of their initial operations grant was considered to be a significant achievement for the Colorado mental health system.

With the above actions, only one catchment area (Southwest Colorado) was without comprehensive services. The goal then was to promote initiation of an initial operations grant application for this catchment area. This goal also was accomplished. The Southwest Colorado Mental Health Center began receiving initial operations grant funds in January, 1980.

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 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 P.L. 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.

J. 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, as amended, 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 & 5	Centennial	5
3f	Health and Hospitals	6
2a	Weld	7
7	Spanish Peaks	8
13	West Central*	9
2b	Larimer	10

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

APPENDIX IV. 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: health care, housing, organization and financing, reforming the personnel system, growth impacted communities, employment and vocational education, aging, and children.

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 Statewide Health Coordinating Council (SHCC) was appointed by the Governor (October 1977). In addition to federally mandated responsibilities, the Council focuses 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. The SHCC also selected the area of health prevention and promotion as an additional area of focus. 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 was designated as the State Health Planning and Development Agency (SHPDA) under PL 93-641, with these functions centered in the Division of Policy, Planning and Regulation. 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 under the aegis of the three Health Systems Agencies (HSAs) in the state, all of which have been designated, funded, and staffed. Subarea advisory councils 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 address specific health services, including the various mental health services, indicate to the extent feasible "how much" of each service is needed in the area and will designate guidelines for the provision of each service. The three Health Systems Plans will in turn form the basis for the State Health Plan which is developed by the SHPDA and the SHCC.

Mental health involvement in health planning was enhanced through the enactment of the Health Planning and Resources Development Amendments of 1979 (PL 96-79). These Amendments, which went into effect last fall, extend the national program begun in 1974 for three years. The new law mandates that at least one mental health consumer and one mental health provider be on the governing boards of the health systems agencies, and that their staffs include experts in mental health services. Another provision of the law states that the local health systems agencies and the statewide coordinating councils must consult with "persons knowledgeable about such services" when developing the mental health components of the health plans. Unlike the old law, the Amendments allow consumer members of the governing boards of community mental health centers to serve as consumer members of the health systems agencies boards.

Public Law 96-79 includes the delivery of appropriate mental health care in the national goals of the program. Three specific national priorities concerning mental health care were added to the list of

general health care goals. Two of them emphasize outpatient mental health care and the elimination of inappropriate institutionalization, while recognizing the need to upgrade the quality of care for those who do need inpatient treatment. The third priority emphasizes greater coordination between physical and mental health care.

Staff of the DMH, the SHPDA, and the HSAs have determined ways in which the Health Systems Plans, the State Health Plan, and the State Mental Health Plan should be coordinated. Attempts are being made to develop the plans of these agencies around the same planning taxonomies. These agencies are also sharing data and other information as necessary in the development of their respective plans. To further facilitate coordination in planning, the guidelines for the Catchment Area Mental Health Plans stipulate that each mental health center is to submit a copy of their local plan to the appropriate Health Systems Agency. The HSAs review the local plans and provide the Division of Mental Health with written comments on the plans.

Each of the Health Systems Agencies has developed a Health Systems Plan and an Annual Implementation Plan for their area. Two of the HSAs have included a mental health component in the past year's HSPs. The Central-Northeast Colorado Health Systems Agency and the Western Colorado Health Systems Agency both have completed mental health sections. The Health Systems Agency for Southeastern Colorado is developing a single plan section that will address mental health, alcohol, and drug abuse.

The Central-Northeast Colorado HSA has established the following goal for mental health for their Health Service Area: "A continuum of high quality mental health services should be available through the public and private sectors to meet the mental health service needs of Health Service Area I." Mental health priorities reflected in this HSP include: increasing services to moderately and severely psychiatrically disabled clients; increasing services to children, adolescents and the elderly; encouraging the development of private mental health resources; increasing training opportunities for mental health professionals (especially in the areas of services to children and minorities); coordinating public and private mental health efforts; assessing the adequacy of third party reimbursement for the treatment of psychiatric disabilities; and increasing primary and secondary mental health prevention programs with measurable outcomes in the public and private sectors.

The mental health section of the Western Colorado HSA Health Systems Plan is limited to an examination of the following services: inpatient care, provided in a general hospital psychiatric unit; transitional care; partial care; outpatient services; and screening and evaluation services in 72-hour treatment and evaluation facilities. These services were evaluated in the HSP in terms of defined criteria for availability and accessibility. As a result of this evaluation, the mental health priorities for the Western Colorado Health Service Area were determined to be the need for increased availability of 72-hour treatment and evaluation facilities in Regions 10, 11 and 12, and the need for increased accessibility of short-term inpatient and 72-hour evaluation services to the residents of Region 10.

The Southeastern Colorado Health Systems Agency formed a rather large task force of providers representing the public and the private sectors. This task force identified priority problems in the areas of mental

health, alcohol and drug abuse. The problem areas are categorized under the following headings: (1) programs for children and youth, (2) domestic violence programs, (3) adequate funding, (4) rural health concerns, (5) culture-specific programs for minorities (the task force agreed that all programs and services should include specific attention to the special needs of minority populations), and (6) services to the elderly. The priority problems and needs identified by the mental health/alcohol and drug abuse task force and the catchment area mental health plans submitted by the mental health centers in Health Service Area 2 will serve as the basis for the mental health section of the HSP for this area.

The State Health Planning and Development Agency and the Statewide Health Coordinating Council have been developing plan sections for the State Health Plan. They are working closely with the Division of Mental Health in the development of the mental health component which will be based on the plans of the three HSAs and on this Plan. DMH, SHPDA, and the HSAs are all 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 participate 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 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.

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 planning the State Alcohol and Drug Abuse (or substance abuse) system as expressed in their Colorado State Plan for Alcohol and Drug Abuse Treatment Prevention and Quality Assurance.

ADAD does not directly provide treatment services, but purchases services from licensed agencies across the state. In fiscal year 1979-80, the state general fund appropriation to ADAD totaled $7,804,140. In addition, ADAD was allocated $2,939,500 in federal funds.

Mental health agencies continue to be actively involved in providing substance abuse services. During fiscal year 1978-79, ADAD had 20 contracts with mental health centers to provide drug and alcohol services. During this same period of time, federal and state general funds of approximately 2.9 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 an earlier state legislature requirement, ADAD continues to maintain direct control of the two state hospitals' alcoholism services funds, so a contractual agreement for services has been established. ADAD's comprehensive statewide substance abuse plan includes specific recommendations for the substance abuse programs at the two state hospitals and the community programs.

The close working relationship between ADAD and DMH has resulted in several positive achievements during fiscal year 1979-80. Accomplishments for the past year are as follows:

a. Representatives from ADAD and DMH have met on a quarterly basis to review policies and procedures for resolving specific service delivery issues. The participation at the meetings continues to include staff from the substance abuse programs at the two state hospitals.

b. Staff from both Divisions have developed, solicited input, and distributed the document entitled "Guidelines for Cooperative Provision of Emergency Services by DMH and ADAD Funded Agencies." The purpose of the document is to insure that clients have access to appropriate services from either the mental health or substance abuse system dependent on the nature of the problem which should be given primary attention.

c. ADAD continues to contract with DMH for the Hospital Intensive Residential Treatment (HIRT) Programs at Colorado State Hospital and Fort Logan Mental Health Center. This treatment model provides services to individuals with alcohol abuse problems who would benefit from a comprehensive inpatient approach. In addition, ADAD continues to maintain a service delivery contract with the Drug Treatment Center at Colorado State Hospital.

d. Each Division continues to actively solicit input into each other's State Plan. Joint objectives are established and included in both plans.

e. Attention continues to be directed towards joint reviews by ADAD and DMH staff of clinical and programmatic quality assurance issues.

f. For the third consecutive year, an open public meeting was conducted by representatives of ADAD and DMH. The meeting offered providers of substance abuse programs and concerned citizen organizations an opportunity to discuss continuing issues relevant to coordinated service delivery. Issues identified at the public meeting were formally presented to the ADAD and DMH for potential policy recommendations.

g. When appropriate, staff from ADAD and DMH have provided joint on-site consultation to service delivery agencies.

h. ADAD and DMH's fiscal staff have jointly worked together on the following issues:
   (1) Negotiating the service delivery contracts at CSH and FLMHC.
   (2) Coordinating a review and recommending a system of payment for those clients who cross over between ADAD and DMH treatment systems.
   (3) Information has been shared regarding Title XIX funding for the two systems.

(4) Joint problem solving related to third party reimbursement funding resulting from the change of licensure at the two state hospitals.
(5) Consulting on responses to requests regarding fiscal issues from the Colorado legislature.

During the coming year, close interdepartmental planning and coordination will continue with an emphasis on the objectives listed in Volume I. 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 eight Divisions within the Department. These are: Division of Social Services, Division of Income Maintenance, Division of Services to the Aging, Division of Medical Assistance, Division of Food Assistance, Division of Child Support Enforcement, Division of Veterans Affairs, and Division of Rehabilitation. These programs provide a myriad of social and medical assistance programs for families and individuals of all ages.

The 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.

DSS programs can provide, in some instances, reimbursement for mental health services to emotionally disabled children, adolescents, adults, and aged persons. For instance, Colorado State Hospital (CSH) and Fort Logan Mental Health Center (FLMHC) receive Title XIX (Medicaid) funds from DSS. Mental health centers and clinics were recipients of Medicaid funds for services to eligible clients; however, Colorado had designed a State Medicaid Plan which prohibited the most seriously disabled psychiatric clients who were eligible for Medicaid from receiving care. Legislation was passed in 1979 which makes it possible for the centers and clinics, as significant community service providers, to be reimbursed. This is a very significant change for the centers and clinics.

In contrast to 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 has been developed between the Department of Social Services and the Division of Mental Health. The DMH and the Division of Rehabilitation, for example, joined forces to develop a cooperative service agreement which is used as a model in developing and planning coordinated services at the community level. Statewide implementation of the cooperative services agreement has progressed successfully. The liaison activities include the following: exchange of necessary statistical and agency information; collaboration in research and training activities; consultation in planning activities of the other agency in areas such as budget, policy, and program planning that affects clients in common; promotion of activities describing the total program of services required for the rehabilitation of the mentally disabled; and the review and analysis of legislation, agency regulations

and policies that impact mental health and rehabilitation. The Division of Rehabilitation currently has Third Party Cooperative Programs with the Colorado State Hospital, Fort Logan Mental Health Center, and the Denver Health and Hospitals Mental Health Program. Through the agreements Rehabilitation provides professional and support personnel expenses to make possible the provision of rehabilitation services to eligible clients within the two mental hospitals and the community mental health centers in the Denver Metroplex area. The Division of Mental Health and the Division of Rehabilitation view the cooperative agreement as a means for a practical and effective working relationship to facilitate and expand coordination of services to persons disabled by mental health problems for whom responsibility is shared.

Staff members from the Division of Mental Health, the Division of Social Services, and the Division of Services to the Aging met on a monthly basis to develop an affiliate agreement to promote the delivery of comprehensive, coordinated services to the elderly. This agreement serves as the basis for cooperative efforts at both the state and local levels.

Outcomes of the increased coordination between DSS and DMH, as well as between the centers and county social service departments are expected to include: improved coordination and facilitation of referrals for services; expanded 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.

An area of planning that has been 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 considered:

a. a representative of the mental health system should be included in the membership of the State Special Education Advisory Committee. At the present time, however, the Department of Institutions has a staff member on this committee who represents all three Divisions;

b. a coordinating group, representing the Division 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 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. Most people who enter the correctional system leave it at some point and return to society. The output of the correctional system should be individuals who make a non-criminal adaptation after their correctional experience. The goal of mental health services should be to facilitate the individual's ability to make a non-criminal adaptation to society upon leaving the correctional system.

There is a need for a plan to provide mental health services to the total population of the Department of Corrections' clients whether they are in institutions, on parole, or in another status. The role of DMH in relation to the correctional system is an area that is being addressed. 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. The philosophy of the Department of Institutions is as follows:

> "The majority of the clients of the Department of Institutions share a common inability to successfully meet the behavioral expectations and stresses of modern society. The purpose of the Department is to ensure treatment, training, education, custody, and rehabilitation services, to improve the quality of life for clients, and to serve the interests of society. To fulfill these purposes, these services are to be provided through the coordinated, efficient, and effective utilization of all resources in the state. These services will be based on client need and skillfully and humanely administered with full respect to individual dignity and personal integrity. In all instances possible services shall be delivered in the most effective, least intensive treatment setting closest to each client's home. Programs aimed at treating the inter-related problems of emotional disturbance, mental incapacity, and anti-social behavior shared by so many Department clients are developed by staff with a combination of disciplinary training."

The Department of Institutions has implemented a formalized planning process that involves planning staff from the Department and from each of the three Divisions. The purpose of the Departmental Planning Process is to ensure defined, coordinated planning for the Department. The philosophy stated above and the establishment of five year goals (see Volume I, Chapter IV) reflect the results of this process.

The Divisions of Mental Health and Developmental Disabilities have and plan to continue to engage in a variety of joint activities to increase and improve the quality of mental health services to the developmentally disabled. In 1979, the Colorado Developmental Disabilities Council Task Force on Mental Health/Developmental Disabilities received grant funds to facilitate cross-training activities among professionals in both mental health and developmental disabilities programs. The Task Force coordinated implementation of the one year (January through December, 1979) project. A model was selected which supported and augmented local processes and projects aimed at achieving the overall goals of the grant. Additionally, during 1979, the Colorado Developmental Disabilities Council funded a Department of Institutions program designed to augment the foregoing training activities to enhance planning of mental health services to the developmental disabilities client, and to develop a long-range plan for providing mental health services to the developmentally disabled client.

During the next year the Divisions of Mental Health and Developmental Disabilities need to continue to address the following areas:

- -Facilitating face to face meetings between individual community mental health centers and community-centered board directors and DD program directors.
- -Assessing service needs in terms of types of client problems and types of services needed to address the problems.
- -Assessing the amount of services needed in terms of the numbers of clients needing specific types of service.

The Division of Mental Health will continue to work with the Divisions of Developmental Disabilities and Youth Services to develop and revise written plans which will address the service needs of clients with overlapping problems. Problems between DMH and the Division of Youth Services

have primarily revolved around which division should have 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 completed. This accomplishment was the result of joint efforts between DMH and the Division of Youth Services. Fort Logan Mental Health Center has recently agreed to provide medical services to all agencies of the Division of Youth Services. These services will 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. Fort Logan also has plans to establish a team to work with the Juvenile Court to provide Juvenile Court evaluations and as much on-site treatment as is necessary in conjunction with the Division of Youth Services. In the latter part of 1979, the Division of Youth Services and DMH agreed to a policy/procedure statement that outlined how referrals would take place from DYS to DMH. Both DMH and Youth Services want coordination to continue in the direction of the above accomplishments.

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, the Health Systems Agencies, and the region's mental health centers. Approximately 15 of the state's 23 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 are involved in most communities in community planning for the total human services delivery system.

3. Municipal Planning

All community mental health centers are expected to coordinate planning activities with the municipalities within their catchment area. Financial support to centers from municipalities has enabled those mental health agencies to better serve their local residents. Coordinated planning with police and fire departments and other human service agencies at the municipal level has also improved the delivery of high quality mental health services.

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 centers. 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 volun-

tary and state-supported agencies, and voluntary agencies often provide additional supportive services for clients of other agencies.

The Mental Health Association of Colorado (MHAC) 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. 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. The Mental Health Association has established the following goals for 1980: (1) "To effect and expand the resources for prevention and treatment of mental illness of the children/youth of Colorado," and (2) "To apply MHAC resources for the benefit of all age groups for protection of patients' rights, development of appropriate services for the chronically mentally ill, and shaping, through planning, the mental health service delivery system."

A variety of cooperative relationships exist among agencies receiving governmental funds, voluntary and private mental health services. In the past year, emphasis has been placed on the need to increase the level of cooperation among these agencies and programs to coordinate planning and service delivery. The need for a survey of the mental health services provided by the private sector was identified as a planning priority by all of these groups. This issue is being addressed under the leadership of the Mental Health Association. Representatives of the Mental Health Association, the Division of Mental Health, the Health Systems Agencies, and a majority of the professional societies in Colorado will have completed a survey of the private sector within the next year. This is a significant step in efforts to integrate the mental health system and to determine directions for the future.