STATE OF COLORADO

1981-82 Supplement To The

MENTAL HEALTH PLAN

STATE OF COLORADO

1981 - 82 SUPPLEMENT

TO THE

COLORADO MENTAL HEALTH PLAN

(This Supplement is not complete unto itself, but must be used in conjunction with the 1980-85 Colorado Mental Health Plan.)

COLORADO DIVISION OF MENTAL HEALTH

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July 1981

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COLORADO DIVISION OF MENTAL HEALTH

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1981-82 SUPPLEMENT TO THE

COLORADO STATE MENTAL HEALTH PLAN

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1981-82 SUPPLEMENT TO

THE COLORADO MENTAL HEALTH PLAN

CHAPTER I. INTRODUCTION

A. PURPOSE

The purpose of this Supplement is to update the 1980-85 Colorado Mental Health Plan. The annual updating of the Plan is necessary to reflect the impact of funding and policy decisions by legislative and executive bodies and the accomplishment or non-accomplishment of the previous year's objectives. Changes in roles and relationships among agencies, organizational and structural changes, the enactment of new statutes, and the amendment or repeal of existing statutes also make necessary a periodic updating process. The publication of rules and standards for the implementation of statutes or the regulation of mental health related activities 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 1981-82 Supplement does not alter the thrust of the 1980-85 Colorado Mental Health Plan; viz., the provision of high quality mental health services at reasonable costs which will improve the quality of life of the system's clients. The 1980-85 Colorado Mental Health Plan, which addresses the requirements of Federal legislation, 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 is 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.

This Supplement is to be used in conjunction with the basic document; thus, no attempt has been made to repeat the parts of the Plan which are not being superseded or altered.

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

The following is a summary of the changes that have been made in the Colorado Comprehensive Five-Year Mental Health Plan.

VOLUME I

a. Chapter I - Introduction: This chapter provides an overview of

the 1981-82 Supplement. The fact sheet, which gives an outlined description of the Colorado mental health system, has been updated.

b. Chapter II - Concepts in Mental Health: A third section, "Mental Health - A Conceptual Framework," has been added to this chapter. This section describes the general direction in which the Colorado mental health system is moving, thereby providing the framework within which mental health planning takes place.

c. Chapter III - Trends and Issues: Several factors which are putting pressure on the various components of the system have been identified in the past year. Increasing service demands, increasing severity of client disability, and decreasing resources have resulted in mental health service needs which are much greater than the resources available to meet those needs. Five of the most pressing issues for the mental health system were extracted from these factors and included in this chapter.

d. Chapter IV - Statewide Goals and Objectives: 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 1981-82. 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 four years.

e. Chapter V - Financial Summary for Fiscal Year 1981-82: This chapter includes a summary of the appropriations for FY 1981-82. 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 1980-81: 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 make 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/APPENDICES

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

b. Appendix II - The State Mental Health Program: The utilization data under the "Description of the Present System" has been updated to reflect more recent data which impacts on utilization trends.

c. Appendix III - State Hospitals and the Catchment Area Mental Health Program: Revised population estimates and the ethnic composition of each catchment area have been included. The need rankings of the catchment areas have been completely revised. 1981-82 data for Division of Mental Health/Center contract negotiations has replaced last year's data.

d. Appendix IV - Coordination of Planning: No substantive changes have been made in this chapter.

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: 25.5 Full-Time Employee Positions

STATE HOSPITALS:
Colorado State Hospital
Fort Logan Mental Health Center

PURCHASE OF SERVICE CONTRACTS:
Twenty Comprehensive Community Mental Health Centers
Three Specialty Clinics

ADMISSIONS SYSTEM-WIDE (FY 1979-1980):
CENTERS AND CLINICS: 52,362
HOSPITALS: 3,280 (excludes drug, alcohol, and general hospital)
TOTAL: 55,642

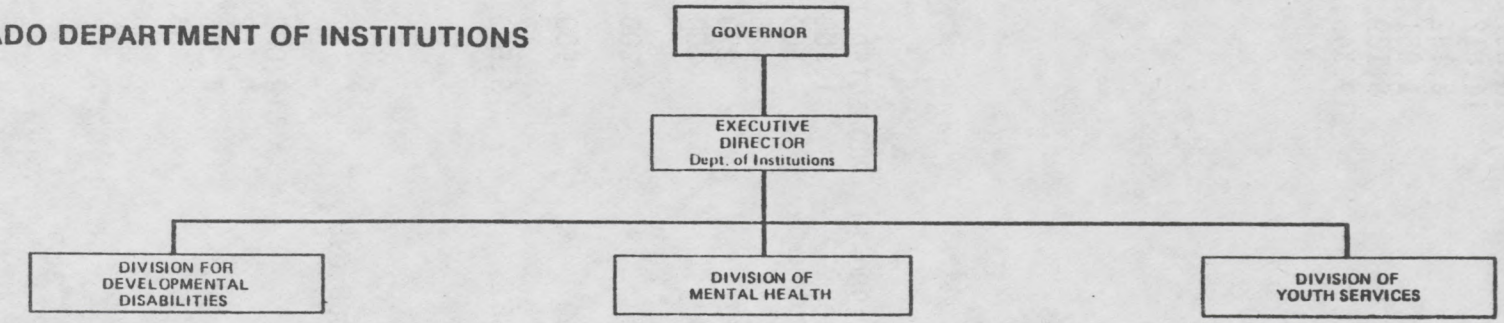
ESTIMATED CLIENTS SERVED SYSTEM-WIDE (Hospitals, Centers, and Clinics):

	FY 1979-1980
CHILDREN	7,411
ADOLESCENTS	10,578
ADULTS	62,839
ELDERLY	4,195
TARGETED*	67,660
NON-TARGETED**	17,363
TOTAL	85,023

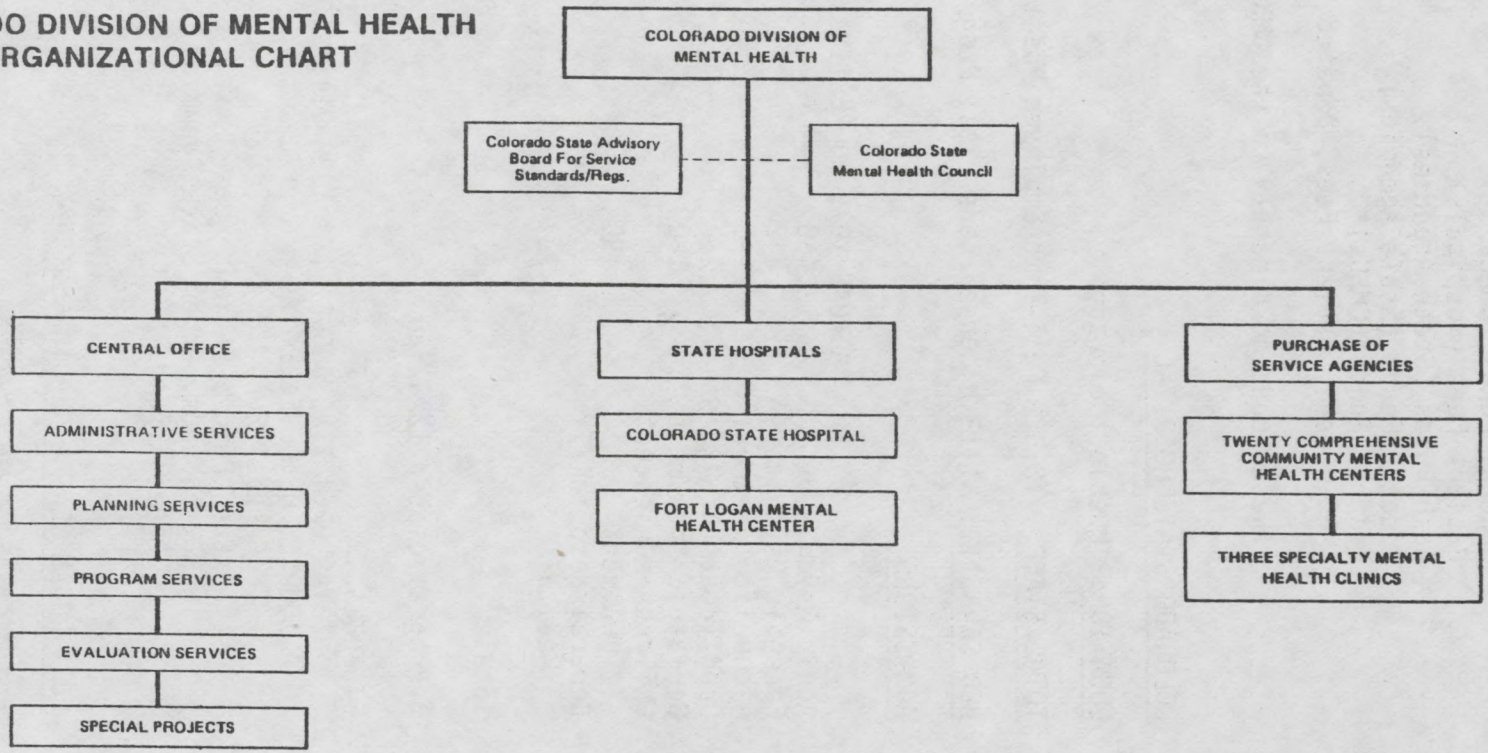
*Targeted: moderately and severely psychiatrically disabled
**Non-Targeted: minimally and mildly psychiatrically disabled

FINANCES:
TOTAL OPERATING BUDGET (FY 1980-81): $91,284,463

COLORADO DEPARTMENT OF INSTITUTIONS



COLORADO DIVISION OF MENTAL HEALTH ORGANIZATIONAL CHART



July 1981

SOURCES OF REVENUE:

General Funds, State Hospitals/Agencies	$25,895,870
General Funds, CMHCs	16,637,108
Patient Fees (Hospitals)	14,012,828
Cash Funds (State Agencies)	6,132,306
Federal Funds (State Agencies)	1,051,084
Federal Funds (CMHCs)*	5,109,931
CMHC, Local, Patient Fees, Donated, Etc.*	19,345,346

*These funds go directly to the CMHCs.

COLORADO STATE HOSPITAL

LOCATION: Pueblo, Colorado

TOTAL STAFF: 1315.8 Full-Time Employee Positions

BED CAPACITY: 1113 Licensed Beds - All Programs

ADMISSIONS:

	ACTUAL 1979-80	ESTIMATED 1980-81	PROJECTED 1981-82
Adult Psychiatry	1,468	1,500	1,600
Forensic Psychiatry	442	480	500
Alcoholic Treatment	291	116*	0*
Drug Treatment	257	270	270
Geriatric Treatment	180	180	200
Children/Adolescent Treatment	192	190	200
General Hospital/ Medical	987	900	900
Total	3,817	3,636	3,670

*(Program closed 12/31/80.)

FINANCES:

TOTAL OPERATING BUDGET (FY 1980-81): $33,008,096

SOURCES OF REVENUE:

General Fund	$19,082,830
Cash Funds, Patient Fees	9,242,730
Cash Funds, Other State Agencies	4,346,663
Federal Funds	335,873

FORT LOGAN MENTAL HEALTH CENTER

LOCATION: Denver, Colorado

TOTAL STAFF: 545.0 Full-Time Employee Positions

BED CAPACITY: 333 Licensed Beds - All Programs

ADMISSIONS:

	ACTUAL 1979-80	ESTIMATED 1980-81	PROJECTED 1981-82
Adult Psychiatry	519	376	314
Alcohol Treatment	345	368	368
Geriatric/Deaf/ Aftercare	117	93	93
Children/Adolescent Treatment:			
Children	76	68	68
Adolescent	150	135	135
Vocational Services	7	7	7
Total	1,214	1,047	985

FINANCES:

TOTAL OPERATING BUDGET (FY 1980-81): $12,735,448

SOURCES OF REVENUE:

General Funds	$6,167,804
Cash Funds, Patient Fees	4,770,098
Cash Funds, Other State Agencies	1,785,643
Federal Funds	11,903

COMMUNITY MENTAL HEALTH CENTERS/CLINICS

TOTAL STAFF:

FULL-TIME STAFF: 1567

PART-TIME STAFF: 341

CONTRACTED SERVICES (Statewide, FY 1980-81):

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

	PERCENT	NUMBER
CHILDREN (0-11 years)	9.0	4,139
ADOLESCENTS (12-17 years)	12.3	5,663
ADULTS (18-64 years)	73.0	33,473
ELDERLY (65+ years)	5.7	2,642
TOTAL	100.0	45,917
TARGET GROUP (Moderately and Severely Disabled)	76.2	35,012
ETHNIC MINORITIES	20.4	9,385

FINANCES:

TOTAL OPERATING BUDGET (FY 1980-81): $41,092,385

SOURCES OF REVENUE:

State Funds	$16,637,108
Federal Funds	5,109,931
Fees, Titles, Insurance	6,305,251
County/Municipal	5,819,880
Donated and In-Kind	4,365,295
School Districts	479,302
Other	2,375,618

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

The key theme that threads its way through this Supplement is the need for further integration of the Colorado mental health system. With this perspective, it becomes clear that if mental health status and service goals are to be achieved, then the system responsible for them must be defined and effectively managed. The Colorado Division of Mental Health is the primary system manager, and the importance of planning as a primary management tool must be recognized. Proper planning for the mental health service delivery system requires the development of a conceptual framework within which to plan. This framework should include a description of the ideal system, where the present system stands in relation to that ideal, and a description of the steps necessary to reach that ideal. For this reason, a third section has been added to Chapter II.

C. MENTAL HEALTH - A CONCEPTUAL FRAMEWORK

The purpose of the Colorado mental health system is to improve the mental health status of the residents of the state by maximizing 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.

The Colorado mental health system works to accomplish this purpose by ensuring the provision of high quality, reasonable cost mental health services to those citizens most in need of such services. The mental health system is responsible for determining the appropriate amount and mix of services needed for the treatment and rehabilitation of the mentally ill, the prevention of mental illness, and the promotion of mental health in all areas of the state.

The Division of Mental Health will assume the leadership role to ensure that progress toward this purpose and related service goals occurs within the context of a systems approach. The Division has stated clearly its commitment to viewing issues for mental health from a systems perspective, as a situation that impacts one component of the system has a ripple effect on other components. This philosophy is in keeping with the thrust of national trends which place significant importance on the states' viewing their existing and potential mental health service capabilities as "a unitary, interactive system", emphasizing local planning and resource management.

The key issue for a systems approach is integration. The system must have an integrated planning process and must be integrated both programmatically and financially. The following are the areas that require joint efforts of the service providers within the system:

(1) Systemwide Planning
(2) Systemwide Coordination
(3) Effective Management of the System
(4) Integrated Programming
(5) Regulation and Protection of Clients' and Communities' Rights
(6) Appropriate Utilization and Distribution of Financial Resources

(7) Expansion of Resources
(8) Provision of Reasonable Cost Services
(9) Appropriate Utilization and Distribution of Work Force

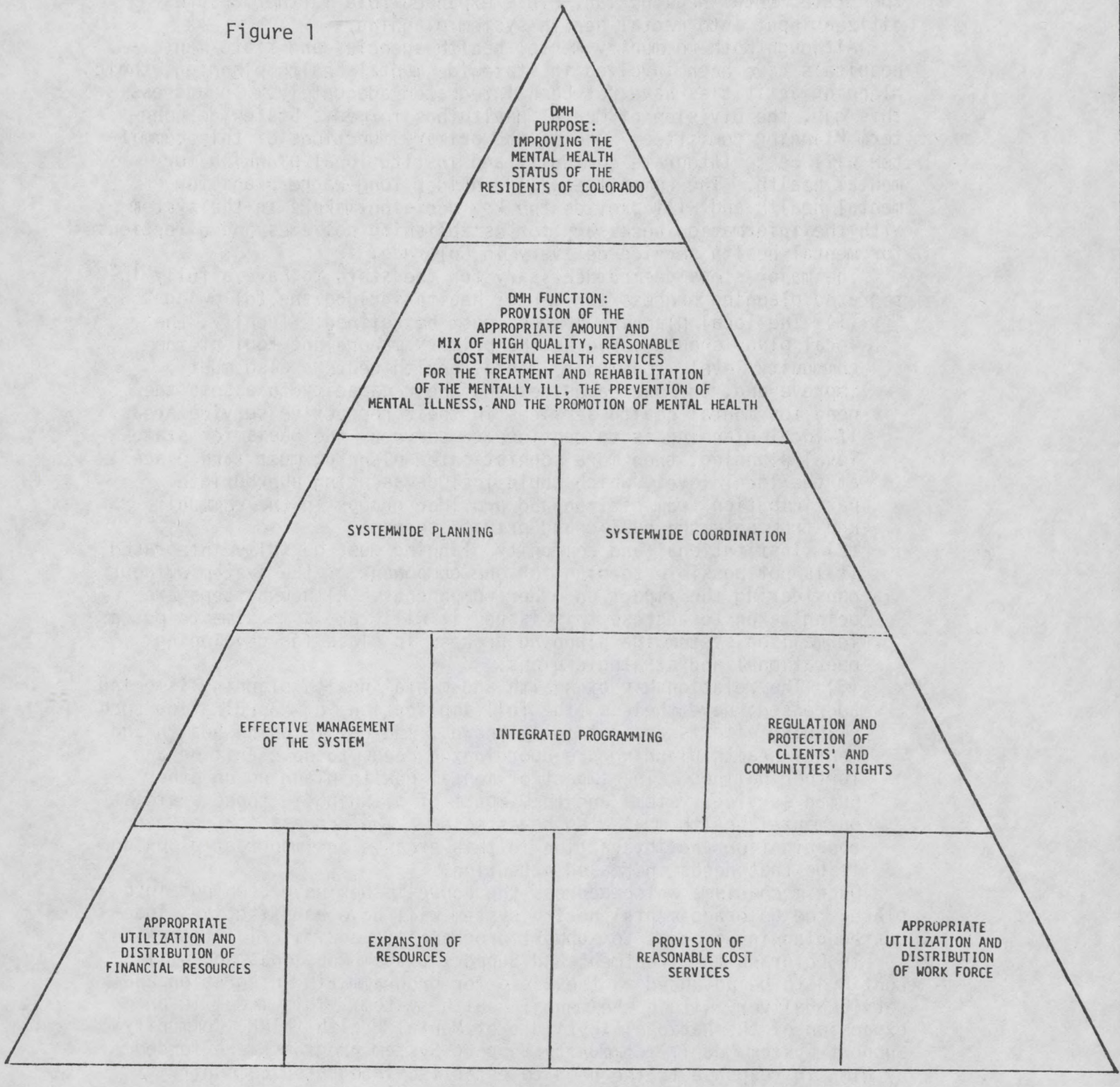
The first two areas relate to integrated planning. The next three items focus on areas that need to be given attention for integrated programming. Financial integration is encompassed in the last four areas which address resource issues. These areas interweave and overlap, i.e., planning determines programming which drives resources. Figure 1 illustrates the relationship of these areas to the mental health system purpose and to mental health service delivery.

For the purposes of planning for mental health, it is necessary to define the type of system which is most desirable for accomplishing status and service goals. If an ideal system were designed, there would be many constraints and obstacles that would have to be addressed to implement such a system. For this reason, the intent of the following is not to "realize the ideal", but rather an attempt to "idealize the real".

A system which is integrated both programmatically and financially must have an integrated planning process. There are two ways in which planning must be integrated. First, there must be effective planning at the local, state, and federal levels which is integrated. This includes assuring the participation of both providers and consumers of mental health services. The planning process also should include the public and the private sectors. The involvement of other health and human service providers also is critical, as decisions made in one area affect all other parts of mental health, health, and human service systems within each service area and throughout the state. The second way in which planning must be integrated involves integration of program planning, budgeting, and evaluation as part of a single planning cycle. Finance and program must be linked at all levels through planning.

The goal of the Division of Mental Health is to have a fully integrated planning process in place within the next four years. The framework for this type of planning process is in place. A local planning process has been implemented. Local plans for mental health services are submitted annually to the Division of Mental Health and to the appropriate Health Systems Agencies. These plans serve as a basis for the mental health components of the Health Systems Plans and as a basis for the State Mental Health Plan. Another major accomplishment in this area has been the consolidation of federal planning requirements and state planning requirements. The Division of Mental Health develops one Comprehensive Operational Five-Year Mental Health Plan which includes the specific planned actions and the financial information and data for the current fiscal year. A significant feature of the Division's planning process is the amount of provider and consumer input to state mental health planning activities. Comments and recommendations for revisions in the Division's planning document are solicited from over 250 interested agencies, organizations, and individuals. This includes the public sector, the private sector, providers and consumers of mental health services, and other health and human service-oriented agencies and organizations. The role of the Colorado Mental Health Council also has been expanded in the development, administration, and approval of

Figure 1


DMH PURPOSE: IMPROVING THE MENTAL HEALTH STATUS OF THE RESIDENTS OF COLORADO
DMH FUNCTION: PROVISION OF THE APPROPRIATE AMOUNT AND MIX OF HIGH QUALITY, REASONABLE COST MENTAL HEALTH SERVICES FOR THE TREATMENT AND REHABILITATION OF THE MENTALLY ILL, THE PREVENTION OF MENTAL ILLNESS, AND THE PROMOTION OF MENTAL HEALTH
SYSTEMWIDE PLANNING
SYSTEMWIDE COORDINATION
EFFECTIVE MANAGEMENT OF THE SYSTEM
INTEGRATED PROGRAMMING
REGULATION AND PROTECTION OF CLIENTS' AND COMMUNITIES' RIGHTS
APPROPRIATE UTILIZATION AND DISTRIBUTION OF FINANCIAL RESOURCES
EXPANSION OF RESOURCES
PROVISION OF REASONABLE COST SERVICES
APPROPRIATE UTILIZATION AND DISTRIBUTION OF WORK FORCE

the State Mental Health Plan. This expanded role further assures citizen input into mental health system planning.

Although both community mental health agencies and state mental hospitals have been involved in statewide mental health planning, their planning activities have not been integrated adequately. To address this gap, the Division of Mental Health has formed a Statewide Long-term Planning Committee. One of the primary functions of this committee will be to integrate community and institutional planning for mental health. The committee will consider long-range plans for mental health and will provide the key decision-makers in the system with the information necessary for establishing policies and directions for mental health service delivery in Colorado.

The major steps deemed necessary for the state to have a fully integrated planning process for mental health include the following:

(1) The local planning process must be refined. Ideally, the local plans should serve as the primary management tool at the community level. Community mental health centers also must improve and, in most cases, expand their capacity to assess the need for mental health services in their respective service areas. If local planning is to continue to serve as the basis for state-level planning, then more sophisticated planning must take place at the local level, which would include assuring appropriate participation from citizen and provider groups in the community and from both the public and private sectors.

(2) Institutional and community planning must be fully integrated. It is not possible to plan for one component of the system without considering the impact on other components. Although steps are being taken to address this issue, it will take some time to put a formalized systemwide planning process in place for developing operational and strategic plans.

(3) The relationship of health and mental health planning is being addressed; nevertheless, the full implications of coordinating such planning efforts are not fully known. The way in which health and mental health planning are coordinated needs to be clarified and further defined. The impact of mental health planning on other human service systems and the impact of planning in those systems on mental health must also be assessed. The process for ensuring coordination and interaction in this area is an important planning issue that needs increased attention.

Once mechanisms which address the above issues have been put into place, the Colorado mental health system will have an effective, integrated planning process to support programmatic and fiscal integration.

In Colorado the Treatment and Support System Model has and will continue to be advanced as the basis for programmatic integration and service delivery within the mental health system. This model is an expansion of the National Institute of Mental Health (NIMH) Community Support System Model. Community Support System programs were funded by NIMH in response to the need to establish integrated community-based services for the long-term severely mentally disabled mental health client. <u>The major programmatic goal of the Division of Mental Health is: To have cost-effective treatment and support systems for the delivery of mental health services to chronically and severely</u>

disabled clients of all ages available statewide.

The Division of Mental Health views issues for mental health from a systems perspective, as stated earlier, since a situation that impacts one component of the system also impacts other components. Services are provided on a continuum, as clients may need any one of a number of mental health services based upon the type of care most appropriate for their clinical needs at different times. The service continuum may be thought of in terms of levels of intensity of psychiatric care and levels of restrictiveness. It also may be thought of in terms of service settings.

The key point is that the system must be viewed as a whole. One cannot look at community-based residential facilities independent of outpatient community services and hospital inpatient services. A gap in service delivery or a backlog in one part of the system creates pressure on other parts of the system. For example, if adult residential facilities are inadequate, there are two possible alternatives. The client may be inappropriately treated in a less intensive, less restrictive setting by the community mental health center. The second option would be to serve the client in a more intensive, more restrictive setting by the hospital, which may result in a backlog, as the availability of hospital beds is limited. Both of these situations are costly and are presently occurring in Colorado.

The Treatment and Support Model has been developed for Colorado because it is a model which views the system as a whole. While the NIMH Community Support System Model is based upon the concept of establishing a full range of services in the community for the adequate care and treatment of the severely mentally disabled who, for the most part, were deinstitutionalized, the Treatment and Support System Model emphasizes the fact that for many people treatment in a hospital setting may be an important part of their total mental health treatment plan. The intent of the Treatment and Support System Model is to eliminate what has come to be viewed as a dichotomous approach to mental health care, that is, a focus on care in the community versus care in a hospital setting. Again, the key point is that services must be thought of in terms of a continuum.

Eight components have been identified as the essential programmatic components of a Treatment and Support System Model. Each of these components could be viewed on a continuum. These components include the following:

1. Community Involvement - The community has a responsibility to provide a wholesome environment for all citizens, including its emotionally disabled members. Since the client is an equal member of a community, it is essential that citizenry recognize the community involvement necessary for a meaningful life for these disabled adults. Increased citizen awareness of the need for such community involvement requires additional education of the public to expand their understanding of the mental health service delivery system. Mental health advocacy groups and organizations play a critical role in the area of public education.

This particular area of the eight programmatic components has been attended to by most mental health providers to the best of their abilities. However, it would be ideal if funds were available which

would allow each facility to acquire and maintain a community organizer of a more extensive community involvement program.

2. Crisis Intervention - For the chronically, severely, and critically disabled, this component is crucial to the Treatment and Support Model. In order to maintain effective community ties, whether in their homes or on their jobs, immediate intervention is essential. Escalation can be avoided and extensive mental health treatment avoided. Adequate and accessible crisis intervention offers both the client and the community the assurance that professional help will be available 24 hours a day, with quick response.

Facilities designed to deal with crisis intervention or with clients experiencing episodes of acute psychosis must be able to provide adequate staff personnel on a 24-hour-a-day basis, capable of extending the needed individualized services to each client. The provision of staff must include professional staff in warranted areas of service, as well as paraprofessionals and volunteers in areas appropriate to their expertise.

3. Socialization Activities - These are an integral part of the Treatment and Support System Model. They provide the disabled clients with opportunities for development of daily living skills and for expanding the range of leisure time alternatives known to them. Clients are helped to evaluate their strengths and weaknesses. They are assisted by mental health persons or trained volunteers in setting goals and utilizing appropriate services. Funding is desperately needed by mental health providers for developing community-oriented socialization training and recreational activities. Staff must be trained to analyze the benefits each specific area of the socialization program offers to individual clients. It is important to be able to develop programs of this sort that are designed for the individual needs of clients, rather than have clients participate in programs that are actually of no benefit to them because the facility is unable to offer anything better. It is necessary, therefore, to have staff capable of a variety of skills for both socialization and recreational programs.

Socialization program staff must be capable of:

- Providing community living skill training, i.e., shopping, transportation, handling money, personal hygiene, housecleaning;
- Providing social skill training, i.e., communication skills, assertiveness training, peer-related activities; and
- Organizing social/recreational activities, i.e., sports, use of community resources, dances, and potlucks.

It would be most helpful if each community center could fund positions for Director of Socialization Programs (encompassing the full spectrum as stated above). Professional and paraprofessional staff must coordinate needed inter- and intra-agency activities, as well as individualized programming for each client.

4. Medical and Mental Health Services - These services must be included in the Treatment and Support System Model in order to provide consistent health care for a particularly vulnerable population. Some of these services are diagnostic evaluations, general medical care, physical rehabilitation, prescriptions with periodic review, and regulation of psychological and counseling services.

This particular area of the eight components has probably been

attended to by mental health providers in the best manner possible. However, it is important to maintain medical and mental health professionals with the capability to attend to the areas as stated above. These areas must be attended to consistently, which means each mental health facility as it expands should have adequate staff to perform all medical and mental health needs according to their specific caseloads.

5. Vocational Services - These include vocational evaluation, pre-vocational and actual vocational opportunities, job trials, training in job-seeking skills, and work adjustment skills. Supportive work opportunities are offered for indefinite durations either in specially designed work situations in commerce and industry, in client-operated self-help businesses, or in sheltered employment. This area needs to be strengthened and staff are needed most to deal with assessing clients, developing treatment modes within this discipline, placement of clients, and follow-up on progress or regression of clients once they are placed. To really incorporate a beneficial vocational system statewide, staff must be available with expertise to assess the skills of the mental health client, to review the client's placement needs, to train in skill improvement where needed, to aide the client in work adjustment, to follow up on the client's progress or need for help in maintaining his job, to procure work within the various communities for mental health clients, and to relate with employers of mental health clients as well as prospective employers to enhance the maintenance and development of vocational services. A Director of Vocational Services is necessary for the development and coordination of these services.

6. Residential Alternatives - These are developed to provide appropriate living arrangements in an atmosphere which offers incentives and encouragement to assume increasing responsibility and to exercise self-determination. Several innovative Housing and Urban Development (HUD) programs are developing in Colorado to provide clients with independent living situations. In addition, many neighbors have opened their homes to serve as alternative families or foster care homes for persons suffering from severe emotional disabilities. Here clients become part of a healthy family group which cares about them as persons.

The first need Colorado has in this area is the building of community residential programs to the extent that they offer housing and support systems for clients with various needs.

To accommodate the various needs of mental health clients, each center needs to have a Director of Residential Services. This person could then coordinate the various components which should enhance the comprehensiveness of residential services. Depending upon their functioning levels, clients may need specialized residential services ranging from cooking to appropriate hygiene care. Some residential facilities may need staff on duty 24 hours, and other facilities may only need staff (after the client's working hours and until the client retires for bed) for a total of 8 to 10 hours. Residential services must be designed to meet the needs of clients residing within the specific facility. It would benefit the development of residential services statewide if funds were available to acquire staff in developing the complete continuum of residential alternatives.

7. Case Management - An effective system of coordinating responsibility becomes a crucial element for treatment and support systems. Case managers may function as a team or as individuals charged with assuring the accessibility and coordination of the necessary services. Case managers facilitate the movement of clients through the system by employing the network of supportive program components required. With a strong case management system, clients are assured that support will be provided indefinitely and that they will not be lost between agencies. They are guaranteed that their rights will be protected and that their dignity as human beings will be preserved.

This area of the eight components could guarantee that all of the other areas needed by each client within the system were dealt with appropriately and adequately; consequently, staff are needed by the mental health system to carry out the duties of this type of position. It is important to outline the duties of this position to ensure that beneficial changes as needed are efficiently extended to the client, that appropriate services are available as needed by the client, and that the environment is creating a stable as well as a rehabilitative atmosphere for the client.

Adequate staff in this area is a must if services are to be well coordinated and developed. Specific functional responsibilities of a case manager may include:

- intake and admission into the case management service,
- assessment of the strengths and needs of the client,
- determination of specific service and resource needs,
- linkage with and utilization of existing service delivery agencies,
- monitoring and evaluation of the client's progress,
- coordination of emergency needs,
- provision of client advocacy services to ensure equity of treatment and opportunities,
- maintenance of a continuous relationship with the client, service providers, and significant others,
- convening of case conferences, and
- termination from case management services.

8. Support for Family and Friends - This area focuses on offering back-up support, assistance and consultation to families, friends, landlords, employers, community advocacy and support groups, community agencies and community members who come in contact with mentally-disabled persons, to maximize benefits and minimize problems associated with the presence of these persons in the community.

Again, most providers within the state have realized the importance of this area; consequently, they are utilizing various staff, assigned to other important duties, to attend to this specific area. An ideal arrangement is one in which the mental health center has an identified liaison to coordinate support for a formal organized, independent group of family and friends. There would also be formal educational opportunities for the family and friends and encouragement of their advocacy for the care of the chronically mentally ill.

Many of the staff working within the Colorado mental health system wear many hats in their attempts to provide comprehensive mental health services. This type of service provision, because dedicated staff

recognize the need, can be detrimental in many cases, as is often witnessed by the "burn out" rate of employees within the mental health system, as well as constant turnover of staff.

Colorado has done a good job, with limited staff and funds, in trying to develop a high quality comprehensive program for mental health clients. The eight components have been designed for use by Colorado and its communities as a framework for developing comprehensive treatment and support systems.

It is important that the need for integrated service provision be recognized as treatment and support programs for the mentally ill are established. Utilization of all resources within the community to benefit clients of the mental health system is a must. It is not enough to have services solely available to clients of the mental health centers. These services must also be available to clients in need as residential alternatives, vocational alternatives, etc., are developed. The quality of these services must not decline as the system expands.

Having the eight programmatic components described above fully in place in each mental health service area of the state would be a major step toward realizing a prototypical mental health service delivery system. Although the intent of the Division of Mental Health is to have the eight services fully in place in each mental health service area of the state, the extent to which these services are or will be in place is impacted by several variables. First, it must be kept in mind that the programmatic components are only part of a fully integrated system. Other factors that must be in place will be described later. Secondly, criteria were developed for each program area. These criteria, however, do not specifically address the needs of each age group, even though these needs were considered when the community mental health center assessments were performed. The rating methodology used to assess the extent to which the components are in place in each service area also needs to be improved. The rating of "full", for example, for each program in order to reach an "ideal" system may differ for different service areas based upon the size of the population to be served, the resources available to that area, the unique needs of the area, and other factors that impact service delivery and service needs.

The second major step necessary to the implementation of an ideal system relates to both programmatic integration and to programmatic differentiation. The roles and relationships of the various components of the system must be clearly defined. There are ways in which the roles and responsibilities of community and hospital programs must be integrated and ways in which they must be differentiated. Currently, the roles of community mental health centers and the state mental hospitals are not clearly defined in all areas. Clarification also is needed in describing the roles and functions of the public sector and the private sector.

Programmatic integration of community and state hospital programs is necessary to ensure continuity of care for the system's clients. The Treatment and Support System Model is designed to (1) establish a service network for the severely and chronically mentally disabled, (2) provide for crisis intervention for those experiencing acute

exacerbation of symptoms which require intervention, (3) provide alternatives for treatment under existing programs based on the overall treatment objective which focuses on prevention, crisis resolution, psychosocial adjustment, habilitation/rehabilitation, or maintenance/sustenance.

The basic components of the service system have already been described. Client movement within the system, then, is a critical process which requires a clear definition of the roles of the service providers in the system. Movement begins where the client enters the system (i.e., a center or hospital) and is selected for assessment. Clients then move in and out of the programs as clinically necessary.

When a client enters the mental health system, it is important to assess the strengths and weaknesses of the individual and to determine the overall treatment objective to be accomplished. There are five broad objectives originally developed by the State of Michigan Department of Mental Health in 1980 which encompass the range of treatment objectives currently being promoted within Colorado. They include prevention, crisis resolution, psychosocial readjustment, habilitation/rehabilitation, and maintenance/sustenance, as described below:

Prevention - Programs aimed at reducing the incidence of emotional impairment or developmental disabilities by identifying and impacting on circumstances affecting the individual and environment.

Crisis Resolution - This objective is to be used: (1) in all cases in which the case is being opened in response to acute mental, emotional, or behavioral stress for the purposes of reducing the stress and ensuring the safety of the client or others; and (2) for currently open cases only in the event that the client experiences acute stress which is severe enough to cause a substantial revision in the ongoing treatment plan.

Psychosocial Adjustment - This objective is to be used in all cases in which the primary reason for intervention is to improve the client's functioning within family, school, or community life when the client is experiencing problems that are not severe enough to require removal from the family, school, or community, nor acute enough to be considered a crisis.

Habilitation/Rehabilitation - This objective is to be used in all cases in which the primary reason for intervention is to increase basic self care, daily living, and work related skills or to provide case management services to facilitate such skill attainment for the purpose of increasing the client's capacity for independent living or maximum functioning. This objective may be used for clients who are living in dependent arrangements, living alone, or those who are living with family or friends and who would require dependent care if the family or friends could no longer provide for the client.

Maintenance/Sustenance - This objective is to be used for clients who have attained optimal functioning levels through psychosocial adjustment, crisis resolution, or rehabilitation/habilitation services, and for whom continued services are required to sustain achieved functioning levels. This objective may also be used for clients who have never received other mental health services, but require services to prevent deterioration of existing functioning. The maintenance objective

should not be used for clients for whom improved functioning is a treatment goal. The client is almost completely dependent on the system to maintain the present functioning level.

All clients entering a community mental health center or a state mental hospital are screened according to a set of specific clinical criteria. The purpose of this screening is to (1) identify the specific needs of the clients, (2) eliminate those clients for whom this type of community support system is not a reasonable goal, (3) refer clients to the appropriate program, and (4) identify specific family problems relating to the client. Development of a sufficiently wide range of programs to meet client needs is a priority of the Division of Mental Health.

With Treatment and Support Programs available statewide and with the client movement process described above, the Colorado mental health system would be very close to an ideally integrated system. The differentiation of programs would be based primarily upon the needs of the client population to be served and the intensity of care to be provided. The state mental hospitals, for example, clearly are serving the most severely mentally disabled in the system.

The Statewide Long-Term Mental Health Planning Committee will have, as a primary charge, responsibility for developing written definitions of the roles of the community mental health centers and the state hospitals. The responsibility for acute care and long-term care of the system's most disabled clients needs to be clearly assigned and defined.

The Division of Mental Health has defined the population to be served through statewide treatment and support systems. The first priority of the Division is to serve the clients most in need, i.e., the chronically 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. The essential components of treatment and support system programs are designed to provide the support necessary to maintain the severely disabled of all ages, both chronic and acute, in the community when possible. Figure 5 reflects the categories of mentally disabled to be served.

Figure 5

Categories of Mentally Disabled to be Served

	Severely Mentally Disabled	
	Chronic	Acute
Child and Adolescent		
Adult and Elderly		

The Division of Mental Health is committed to and responsible for the treatment of the psychiatrically disabled in the state of Colorado. The needs of this population vary with each individual. There are, however, many needs which are common to the population as a whole.

The needs of the chronically mentally disabled adult are discussed first because it is the population which presents perhaps the greatest challenge to the system in terms of severity of disability and in terms of diversity of program needs. The other categories of the psychiatrically disabled (the acutely disabled adult, the elderly, the child, and the adolescent) are discussed largely in terms of the ways in which their needs differ from those of the chronically disabled adult.

The Chronically Mentally Disabled Adult: There are many types of clients in the mental health system, but none present a greater challenge than do the chronically mentally disabled adult clients.

Based on the first three years of the pilot Community Support Project (CSP) initiative, the National Institute of Mental Health has developed an operational definition for use in identifying CSP clients, planning service system improvements, and evaluating CSP efforts. The Colorado Division of Mental Health has adapted the National Institute of Mental Health's criteria so that chronic clients are identified by a certain combination of treatment history and problem areas.

The following is the operational definition of the chronically mentally ill client which also is compatible with the Division of Mental Health's client information system:

A. Problem duration of one year or longer

B1. Previous mental health services - inpatient, other 24-hour care, or partial care

B2. Current living arrangement - boarding home, community residence, nursing home/intermediate care facility, or other institutional setting

C1. Current employment status - sheltered employment or unemployed for more than three months

C2. Basic needs problems - at least two of the following: food, clothing, housing, finances

C3. Social skills problem

C4. Self-care management problem

C5. Inappropriate behavior likely to result in intervention - inappropriate/bizarre personal behavior problem or unable to care for self/gravely disabled problem

C6. For children only - At least two problems in the area of academic/training problems

A positive identification of chronicity would be found if a client meets criteria A and either B1 or B2 and at least two of criteria C1 through C5.

The Acutely Mentally Disabled Adult: This population of clients is seen as having the following characteristics:

1. Their illness or disability had a sudden onset;
2. They may or may not have had previous contact with the mental health system and may or may not be chronically disabled;
3. Their relationship with others is now strained because of odd or bizarre behavior;

4. Their ability to work has diminished because of their behavior;
5. They respond to treatment, including psychotropic medications;
6. They generally are motivated to seek help from mental health agencies and professionals; and
7. Their self-confidence and self-esteem have been shaken by the acute onset of the disability.

What these individuals need is a program which provides prompt:
1. Psychiatric emergency services (inpatient and outpatient);
2. Support to the "natural" support system formed by the individual prior to onset;
3. Aggressive case management, coordinating community resources to help return the individual to his/her place and role in the community.

The key concept here is prompt treatment and symptom control, coupled with support for the natural support system. Aggressive case management must be utilized to support and return the client to the natural support system as soon as possible, so as to minimize the adverse effects of the disability.

This client may be thought of as analogous to the individual who has suffered a traumatic injury. His/her capacity to function is limited during the period of recovery and may be limited thereafter to some extent, but with some minimal support nearly normal functioning is possible.

Services frequently must be short-term and transitional. In some cases, however, services must be longer-term. The longer the term, the more assistance the client will need with his/her support system. The support system must be addressed in all cases, however, so as to ensure the successful functioning of the individual in the community.

Cutting across the chronic/acute continuum is the dimension of severity. A footnote of the 1981-82 Long Bill stipulates that state funds for mental health are to "be used principally to contract for services for the serious, critical, or chronically mentally ill".

In general terms, a person with a critical mental disability will display behaviors which are potentially life threatening either to themselves or others, while a serious mental disability is one which may rapidly become critical if adequate care is not provided. To determine the extent of the Division of Mental Health's compliance with the legislative intent of the footnote, the critically and seriously disabled clients need to be identified; thus, these terms have been operationally defined as:

Critical - a severity index* score of 100 or greater plus one of the 27-10 variables, i.e., gravely disabled, danger to self, or danger to others

Serious - a severity index* score of 78 or greater

(*severity index = sum of top three Level of Functioning Scales from the Colorado Client Assessment Record (PES-7B))

The Mentally Disabled Elderly: This population of clients is seen as having the following characteristics:
1. They may or may not have had sustained contact with the mental health system;
2. Frequently they have displayed symptoms of deteriorating mental functioning over an extended period of time;
3. Their relationships with others are strained by what others view

as sustained demand for tolerance of odd behavior and idiosyncratic interests;
4. They may have episodes of disruptive, hostile, acting-out behavior which interfere with their own well-being or the well-being of others;
5. Despite treatment, including psychotropic medication, they may continue to exhibit disturbing behavior associated with severe mental illness;
6. The etiology of their mental illness may be, in part, of an organic nature;
7. They frequently have difficulty coping with mundane matters;
8. They frequently lack enough money to provide adequate food, clothing, and shelter;
9. They frequently either lack motivation or lack the ability to seek help from human service agencies;
10. The option of employment frequently is no longer available; and
11. They frequently do not have families as the core of their support system.

What these individuals need is a program which integrates:
1. Housing options;
2. Psychosocial rehabilitation programming, including social services;
3. Medical/psychiatric emergency services; with
4. Aggressive case management;
5. Community involvement with planning; and
6. Support to the "natural" support system.

Once again, the key concept is integration through case management. Particularly with the chronically mentally disabled elderly, support must be viewed as lifelong.

Because of the medical needs of this population, nursing homes and similar facilities are needed more frequently than with the other chronically mentally disabled. Nursing homes, however, should be used only when less restrictive living alternatives are not feasible.

Although regular employment is not usually needed by this population, some type of productive activity generally is very therapeutic. Volunteer activities, senior citizens' self-help groups, and individually productive activities including employment must be stimulated and encouraged.

Frequently this population must be assisted in developing leisure time interests and activities.

The Mentally Disabled Child: This population is seen as having the following characteristics:
1. They may have had prior contact with the mental health system, other service agencies, or juvenile authorities;
2. Their relationships with their families are strained because of their bizarre and odd behaviors;
3. Their episodes of disruptive, aggressive, acting-out behavior are typically seen as "unmanageable" or as withdrawn and unreachable by their families, schools, and communities;
4. They frequently have difficulty with the basic activities of family life, peer relationships, and school work;
5. They rarely have the ability to have "fun" in a socially acceptable manner;
6. They are unable to seek help for themselves from human service

agencies;
7. Their environment typically has been chaotic and crisis ridden;
8. Their view of themselves is derogatory; and
9. They have experienced a high number of traumatic events, such as losses of loved ones, physical abuse, and stress in their lives.

What these clients need is a program which integrates:
1. Psychiatric emergency services, treatment, and alleviation of symptoms; with
2. Family therapy and/or counseling;
3. Aggressive case management which supports the "natural" family and community support system of the child;
4. Housing alternatives, when the family situation demands it;
5. Psychosocial rehabilitation and education programming.

The key concept here is effective family problem solving, coupled with alleviation of symptoms and training for the child. Rarely is a child seen in treatment who does not also have accompanying family problems. Rarely, then, will treatment be successful without involvement of the family.

Many children who are identified as psychiatrically disabled have problems at home, in school, and in the community. At this stage of an individual's development, the beginnings of socially inappropriate behavior patterns are seen. If appropriate social skills are not learned at this stage, the client will have much greater difficulty in learning them later in life. This is true of all children, but much more so of psychiatrically disabled children.

The program of treatment must have the following general characteristics:
1. It must be family-oriented. The child and the family must be treated in the home environment whenever possible. Involvement of the family is essential.
2. It must be coordinated with educational services. Education is the primary "productive activity" of the "normal" child; it must be one of the basic objectives of treatment of the mentally disabled child. If treatment is successful, the child will return to normal educational pursuits.
3. It must be symptom-oriented. Alleviating symptoms must be the primary focus of the initial treatment.
4. It must be primarily non-residential. In most cases, the mentally disabled child has a family and a home. If services are designed to enhance the child's functioning in the community, services must be provided in the community, and not in an institution, wherever possible.

<u>The Mentally Disabled Adolescent</u>: This population of clients is seen as having the following characteristics:
1. They have frequently had contact with the mental health system;
2. They have frequently had contact with other agencies, such as Youth Services and Social Services;
3. Their capacity to deal with the basic activities of living, school, and community life is greatly impaired;
4. Their relationships with family, friends, and others is strained because of odd behavior and idiosyncratic interests;
5. They usually have episodes of acting-out behavior, which interferes with their own well-being and the well-being of others;

6. Despite treatment with psychotropic medication, they may continue to exhibit disturbing behavior;
7. They generally lack motivation or ability to seek out help from mental health professionals; and
8. They generally have been rejected by their families, either literally or figuratively speaking.

What these clients need is a program which integrates:

1. Psychiatric emergency services and alleviation of symptoms; with
2. Family therapy and/or counseling;
3. Aggressive case management;
4. Housing alternatives when the family situation demands it;
5. Psychosocial rehabilitation, including educational and vocational planning.

By definition, adolescence is the stage of development between childhood and adult life. Treatment of the adolescent, therefore, must consist of some elements of the treatment methods for children and those for adults.

The key concept here is integration of symptom reduction and control, family therapy, and psychosocial rehabilitation. Integration is possible only with aggressive case management, ensuring that all pertinent aspects of rehabilitation are implemented in a timely and effective manner.

In the treatment of adolescents, often it is necessary to remove them from the family home. Frequently this is the desire of the family as well as the desire of the client. When it is apparent that the family home no longer is an appropriate residence for the client, alternative housing must be secured.

Social development is the principal area of growth for the "normal" adolescent population. Every effort must be made to support this development of the mentally disturbed adolescent. Sometimes this means trying to keep the client functioning in the classroom and extra-curricular activities. Sometimes substitution of alternative support system components is appropriate.

In summary, the common elements of the needs of each category of clients are the following:

1. They all need some form of symptom alleviation.
2. They all need aggressive case management to coordinate services and efforts.
3. They all need support to any existing "natural" support system.
4. They all may need housing options on either a temporary or permanent basis.
5. They all need some form of psychosocial rehabilitation or help with returning to, or learning, productive activity.

Any comprehensive program of mental health services must address these needs in a systematic fashion. The Treatment and Support System Model is designed to do this.

For the Treatment and Support System Model to be implemented statewide, several changes must be made within the system. Programmatic and service aspects, although critical, are only part of the model system. Integrated planning, funding mechanisms, data collection, evaluation, individualized and uniform treatment planning, and integrated information systems also must be considered and addressed if an "ideal"

system is to be established. The need for integrated planning and the model service delivery system have been described. The next major step necessary for implementation of a prototypical mental health service delivery system relates to financial issues.

It is unfortunate that most available mental health programs for the chronically and severely psychiatrically disabled are designed to fit the funding mechanism and not the person. Ideally, funding should be client-based rather than program-based. The Division of Mental Health is working toward a system in which funding follows the client.

The Division of Mental Health is a national leader in the development of unit cost rates and performance contracts. It is important that the Division continue to lead the way in linking funding mechanisms to program phases and treatment outcome. The Division should be able to not only purchase services in terms of quantity, but should also be able to purchase quality services.

One of the goals of this proposed program is to demonstrate the cost-effectiveness of this model over present program models. As a starting point for the budget, an attempt was made to arrive at a total cost of operating the program and supporting the clients in the community. All the total costs of maintaining a single client in the community for one year have not as yet been isolated. It could conceivably amount to $6,000 per adult client during the first full year of a program's operation.

It is believed that cost per client (adjusted for inflation) will decrease in subsequent years. The reason for this decrease is that some clients will make progress in taking responsibility for their lives and will require decreasing amounts of service as time goes by. Also, clients will become full-time or part-time workers and require less financial support. The cost will be high during the first years of operation because clients will be "transitioning" and will require high levels of support if they are to succeed.

The cost-effectiveness analysis should begin to show the cost effect of increased independence during the second and third years of a program's operation. As the process goes on, it is expected that there will be increased caseloads at little or no increased costs. For instance, case managers (the client program coordinators) may be able to handle 20 to 40 clients requiring minimal services, whereas during the first year of programming they may only be able to handle 15 clients each, because those clients require substantial contact with staff every day.

At this point, this is all somewhat conjectural. The cost-effectiveness analysis to be designed will give solid data in the current Colorado Community Support System pilot projects, which, together with the cost-benefit analysis for this proposed system, will provide the concrete data necessary. There is no doubt that the program will work. Cost-benefit analysis will tell exactly how well, at what savings, and under what mix of expenditures the model must operate.

The Division of Mental Health has developed several innovative procedures which provide the information necessary for initial cost-effectiveness studies. These include uniform cost accounting, unit cost finding, standard outcome measurement, and service units per client. Studies are currently under way to determine the cost

effectiveness ratio for each of the Division's priority populations, including the chronic client.

Although it may still be necessary to procure more detailed information on the exact type of service provided to clients and other program variables, these innovations pave the way for estimating how changes in funding and other program inputs (e.g., mix of professional staff) will impact the effectiveness of treatment outcome. Such information will be extremely useful in deciding how to allocate scarce mental health program dollars to achieve optimal results.

All mental health service areas in Colorado have the beginnings of a treatment and support system. These support systems will be expected to grow and expand until the needs of the severely and chronically mentally disabled are met. At this time, we can only speculate on the ultimate "size" of such a system.

This beginning system is not to be mistaken for the "finished product". The centers and hospitals have a long way to go before any such system is totally comprehensive and complete; however, this is a good start in the right direction. With clear and concise mandates from (1) the legislature, (2) the Department of Institutions, and (3) the Division of Mental Health, within the next five to ten years we can see state mental health dollars supporting a system for the severely and chronically mentally disabled built on the treatment and support system concept.

It should be understood that this total system will require additional dollars over the next five years. The specific amounts required depend to a large extent on (1) the amount of dollars available through Title XIX and on the amount of dollars for housing available through HUD, and (2) the extent to which the legislature, the Department of Institutions, the Division of Mental Health, and the service providers ensure that mental health dollars only pay for such a system.

Integrated planning, financing, programming, and evaluation are the keys to the implementation of the Treatment and Support System Model. There are additional changes, however, that need to be made in the system to support the programmatic and fiscal components of the system. Data on the existing levels of mental health needs and resources are needed to ensure that public funds for mental health are distributed equitably among the catchment areas of the state. The Division's social indicators needs assessment model is being reviewed by a joint Division of Mental Health/Colorado Association of Community Mental Health Centers and Clinics Needs Assessment Task Force which will be reporting its recommendations to the Division and the Centers' Association in the fall of 1981. A significant portion of the recommendations of the Task Force will be based on the Needs Assessment Comparability Study which is currently in progress. This study will compare the findings of the community survey needs assessment studies which have been conducted in eight catchment areas in Colorado over the past few years with the results obtained from the social indicators model.

The Division of Mental Health clearly is committed to the Treatment and Support System Model. Much has been done in terms of implementing this model in Colorado; however, much more needs to be done.

Full implementation of this model will require the joint efforts of mental health system providers and consumers, health system agencies, and other human service care-giving agencies and organizations. The nine areas listed on page II.1 provide the basis for systems change. The intent of this change is to ensure that the appropriate amount and mix of mental health services are provided to the clients most in need. The end result of these efforts is to improve the mental health status of the residents of the state. The critical point is that the efforts of even an "ideal" system must be kept in the proper perspective.

The Division of Mental Health has established twelve goals which relate to status, service, and systems issues. These goals, which are the focus of Chapter IV, were 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. These five-year goals were established in 1979, and have been reaffirmed by the Colorado Mental Health Council. They are reviewed and revised annually to ensure that key issues facing the mental health system are included.

With service demands staying well ahead of dollar resources, increasing emphasis must be placed on full utilization of all resources and re-examination of needs and priorities at the local and state levels to ensure that available dollars are used to move the system toward the establishment of a prototypical mental health system.

CHAPTER III. TRENDS AND ISSUES

A. COLORADO MENTAL HEALTH TRENDS

Strategic planning begins with looking at trends and identifying the issues generated by those trends. In the past year, several factors have been identified which are putting pressure on the various components of the Colorado mental health system. Increasing service demands, increasing severity of client disability, and decreasing resources have resulted in mental health service needs which are much greater than the resources available to meet those needs.

1. Increasing Service Demands

- There are approximately 212,000 seriously psychiatrically disabled persons in Colorado in need of mental health services, with only 85,000 being cared for now through the state-funded mental health system.

- The Colorado Division of Planning is projecting that the Colorado population will grow at a rate of 2 percent to 3 percent annually over the next five years, which would bring an additional burden of approximately 30,000 more seriously psychiatrically disabled persons into the current pool of persons needing mental health services by 1985.

- Rapid growth caused by energy development has resulted in a disproportionate increase in the demand for mental health services in Colorado.

- Social changes experienced by rapid growth communities have resulted in an extensive increase in social and emotional problems, such as increases in emotional disorders, alcohol and drug abuse, family disturbances, child abuse and neglect, and crimes against property and persons.

- Inflationary factors and budget cuts for human-service oriented agencies will continue to increase stress throughout the population producing more demand for services for single-parent families, for the elderly population, for the economically disadvantaged, and for persons experiencing unemployment.

2. Increasing Client Severity

- The state-funded mental health system continues to serve more difficult clients.

- The percent of total admissions to community mental health centers and clinics of clients who are severely psychiatrically disabled has risen from 46% in FY 74-75 to 78% in FY 79-80.

- The admissions of clients who are severely psychiatrically disabled in state hospitals has risen from 91% in FY 74-75 to 96% in FY 79-80.

- The percent of clients involuntarily admitted to the state hospitals has risen from 31% in FY 75-76 to 70% in FY 79-80.

- The number of emergency admissions for the two state hospitals and the community mental health centers has risen from 8,396 in 1974 to 10,448 in 1980, a change of 24%.

- The number of "incompetent to stand trial" evaluations and the number of commitments to the Institute of Forensic Psychiatry at Colorado State Hospital are increasing.

- From 1974 to 1979, security calls at Colorado State Hospital increased by 128% and by 206% at Fort Logan Mental Health Center.

- In FY 79-80, 92% of the 519 adult patients admitted to Fort Logan Mental Health Center had prior inpatient care at Fort Logan or at another inpatient psychiatric facility.

- The length of stay for patients in both state hospitals continues to increase.

- There are more reported staff injuries from patients, more security calls, more evaluations to determine competency, more commitments, more emergency calls, and an increase in variables associated with more violent patients in community mental health centers.

- Violent crimes committed by a few mentally ill persons have raised considerable public concern.

- The shift of clients from the correctional system to the mental health system will continue as more persons with previous arrest records enter the mental health system, as the correctional system becomes more overcrowded, and as more offenders are identified as in need of mental health services.

3. Decreasing Resources

- Funding for the Colorado mental health system definitely has not kept pace with population growth, inflation, increased costs, and the decline in federal resources.

- The Colorado mental health system does not have the resources necessary to establish all the essential programs (residential, case management, socialization, vocational, medical, crisis

intervention, transportation, and support to significant others) for statewide treatment and support systems for the chronically and seriously psychiatrically disabled.

- Boarding homes and nursing homes which serve psychiatric patients continue to close with no place for the disabled patients to go.

- Fort Logan Mental Health Center, for over two years, has maintained a waiting list for admission of clients prescreened by community mental health centers as needing inpatient care; consequently, these clients are not receiving the services determined to be clinically necessary.

- The Fort Logan Service Area (the Denver metropolitan area and parts of northeast and north central Colorado) has 207 state hospital beds and an additional 388 psychiatric beds available for a population of 2,020,057, resulting in a ratio of .3 psychiatric beds per 1,000 population, which is not within the generally suggested standards (National Institute of Mental Health) of from .5 to 1.0 psychiatric beds per 1,000 population.

- The two state hospitals are understaffed in clinical areas by a total of 74 FTE which results in less than adequate care being given to the patients and in increased risks to both patients and staff.

- The rates of injury to the staff at the Colorado State Hospital due to patient contact has tripled in the past 10 years.

- Children, the elderly, ethnic and racial minorities, and women will continue to be underserved or inappropriately served if funding resources for mental health are not expanded.

- Resources are inadequate for addressing the social concern about protecting the community from the violent mental client and concern for ensuring rights protection of clients.

B. ISSUES

The trends and factors which have been identified in the past year have generated several critical issues that must be addressed by the Colorado mental health system. These issues, in addition to the eleven issues described in the 1980-85 Colorado Mental Health Plan, provide the background against which future planning should take place. The following, which have been extracted from the factors related to increased service demands and the availability of resources, are the most pressing issues for the Colorado mental health system:

- Shortage of Psychiatric Beds

- Understaffing of the Mental Health System

- Shortage of Services for Treating the Violent Mentally ill

- Inadequate Programs for the Chronically Mentally Ill

- Inadequate Programs for the Forensic Patient

1. Shortage of Psychiatric Beds

Mental health services are provided in an array of settings which range from the client's home to public or private hospitals. For some clients hospitals will continue to be the least intensive and restrictive setting. Other clients may be treated in the community with periodic treatment in a hospital setting. The majority of clients, however, can be treated in the community if adequate facilities are developed.

The need for state inpatient beds and for adult residential facility beds in the communities has intensified as service demand has increased and resources have declined. The focus for Colorado has shifted from a past concern of over-utilization of hospital beds to a concern for adequate, available, and equitable distribution of psychiatric beds. The most recent data indicate that Colorado has 617 psychiatric beds in state operated hospitals, 290 beds in psychiatric specialty hospitals, and 251 beds in psychiatric units of general hospitals to serve a total population of 2,905,000. The waiting list at Fort Logan Mental Health Center has clients who have been prescreened as needing hospital admission; consequently, these clients are not receiving the services determined to be clinically necessary. Because Fort Logan Mental Health Center is operating over capacity, court-ordered admissions cannot be served and must be placed on the waiting list. The Colorado State Hospital in Pueblo has been operating at or above capacity since July 1, 1980. The admissions to state hospitals have mirrored the State's population, which grew from an estimated 2,025,934 in 1966 to 2,905,800 in 1980, and amounted to an increase of approximately 43.5%. There has been no corresponding increase in state inpatient bed capacity to serve this increasing need.

The community mental health center catchment areas served by Fort Logan Mental Health Center have 207 state hospital beds and an additional 388 psychiatric beds available for a population of 2,020,057, resulting in a ratio of .3 psychiatric beds per 1,000 population. This ratio is not within the generally suggested standards (National Institute of Mental Health) of from .5 to 1.0 psychiatric beds per 1,000 population. To bring the Fort Logan Service Area up to a bed ratio of .5 would require the introduction of 415 additional beds into the Fort Logan Service Area.

Residential alternatives have not been developed sufficiently in the community to meet the needs of the chronically mentally ill. Boarding homes and similar residences have closed their doors due to inadequate revenues and to the conversion of these buildings to condominiums and apartments. Nursing homes also are taking fewer and fewer mentally disabled persons. Persons who have progressed to the point where they no longer need inpatient care, but cannot exist independently, need the structured environment and 24-hour care that a residential

facility in the community can provide. Many patients currently receiving inpatient care in a hospital setting could be moved to an intermediate-care facility, if available. These facilities would provide a specific type of setting in terms of clinical care and also would serve as transitional facilities for clients moving to the community from the hospital.

The critical factor related to the shortage of psychiatric beds is that a shortage in one part of the mental health system impacts the rest of the system. Services are provided on a continuum, as clients may need any one of a number of mental health services based upon the type of care most appropriate for their clinical needs at different points in time. The key point is that the system must be viewed as a whole. One cannot look at adult residential facilities independent of outpatient community services and hospital inpatient services. A gap in service delivery or a backlog in one part of the system creates pressure on other parts of the system. For example, if adult residential facilities (the middle portion of the continuum) are inadequate, there are two possible alternatives. The client may be inappropriately treated in a less intensive, less restrictive setting by the community mental health center (moves to the left of the continuum). The second option would be to serve the client in a more intensive, more restrictive setting by the hospital (moves to the right of the continuum), which may result in a backlog, as the availability of hospital beds is limited. Both of these situations are costly and are presently occurring in Colorado.

The inability of the community mental health centers to place clients in the appropriate setting causes multiple problems to the mental health care delivery system. Clients are sometimes placed in inappropriate settings (e.g. jails). Centers are forced to expend scarce resources to place clients in private hospitals with rates much higher than state hospitals. The entire system becomes backlogged and the quality of patient care suffers.

2. Understaffing of the Mental Health System

In order to provide quality patient care and satisfy the requirements of the Joint Commission on Accreditation of Hospitals, Medicaid and Medicare, the Colorado Division of Mental Health has chosen SCOPE (Staffing and Care of Patients Effectively) to determine the direct-care staff needed for a particular group of patients at the two state hospitals.

SCOPE is a system for measuring psychiatric hospital inpatient direct care workload on a time-sampling (one week) basis. (The system is an industrial engineering approach to standard staffing for patient care.) More than ten states employ some version of SCOPE. SCOPE can determine if a hospital is staffed correctly for the types of patients that are being treated in a specific unit--both in terms of the number and the type of direct-care staff. It also can indicate the amount of care patients are receiving, thus informing managers of when the structured treatment hours are inadequate. Proper staffing should lower the rapid return rate and should improve the quality of treatment given to patients while in the hospital.

The results of the latest SCOPE survey done in May of 1980 show that the two hospitals are understaffed in clinical areas by a total of 74 FTE.

This understaffing results in inadequate care being given to the patients and in increased risks to both patients and staff. The rates of injury to the staff at the Colorado State Hospital due to patient contact has tripled in the past 10 years.

In February, 1980, Fort Logan Mental Health Center was cited by the Joint Commission for Accreditation of Hospitals (JCAH) for having an insufficient number of qualified Dietitians, Food Service Workers and Housekeeping personnel. An additional 20 FTE, 7 in food service and 13 in housekeeping, are necessary to meet accreditation standards.

The community mental health centers and clinics also do not have adequate numbers of staff to meet the demands for service within the system. As the demands for service increase and, if resources are held constant, this shortfall will get worse.

There also is a concern with the maldistribution of mental health center personnel. Some rural areas, small towns, and poor urban areas have difficulty in recruiting properly trained mental health professionals. There is a lack of professionals trained specifically to work with children, the chronically mentally ill, the elderly, racial and ethnic minorities, and women.

3. Shortage of Services for Treating the Violent Mentally Ill

Violent incidents committed by a few mentally ill persons have raised public concern which must be addressed by the state mental health system. In June 1980, a report on violence and the mentally ill was prepared by the Division of Mental Health in response to an Executive Order by Governor Lamm. Although no relationship between mental illness and violent crime was found, the indirect evidence warrants further investigation by the mental health system.

Secondly, the report identified several problem areas which need to be addressed by the providers of mental health services. One factor, for example, which is impacting the mental health system is that more persons with previous arrest records are entering the mental health system. This shift of clients from the correctional system to the mental health system appears to be due, in part, to the facts that lesser crimes (e.g. vagrancy and disturbing the peace) have been declared unconstitutional because of vagueness, prisons have become over-crowded, and more criminal offenders are being considered in need of psychiatric treatment.

Another problem area for the system is that there are few effective treatment models for the violent mentally ill. The Forensic Unit at Colorado State Hospital is one of two models which exist in Colorado (the second program is the Closed Adolescent Treatment Center in the Division of Youth Services).

In mental health treatment programs there have been more staff injuries from patients, more emergency and security calls, more evaluations to determine competency, more commitments, and an increase in variables associated with more violent patients in mental health centers. Although additional procedures and practices for working with the violent client have been implemented in the two state hospitals and in the community mental health centers, more needs to be done to provide adequate and appropriate services. Good emergency care, for example, is effective in helping potentially violent mentally ill persons control themselves;

however, Colorado's emergency services do not provide consistently rapid, face-to-face responses. With some exceptions, training programs for staff in treating violent patients do not exist. Practices in the mental health centers with regard to admission, identification, treatment, release and follow-up of the violent client varied widely. New guidelines and special procedures for this population are being developed.

A third problem area is the difficult one of having definitions that are acceptable and which can be interpreted in the same manner by all systems. Differing definitions of mental illness, severity of illness and readiness for release between courts, district attorneys, the public, and the mental health providers create difficulties in determining if patients are released early. There is confusion over the terms dangerous to self, dangerous to others, and gravely disabled. Different interpretations over the use and meaning of state statutes create problems between the courts, prosecuting attorneys, and the mental health system.

In addition to improved treatment models and clarification of terms and procedures, it will be necessary for the public, the legislators, other human care givers and the mental health service providers to address several public policy issues which have been identified. The most basic question posed in the report, Violence and the Mentally Ill, is the one of preventive detention: "Under what conditions are the citizens willing to hold someone because they might commit a violent act, knowing that in 19 cases out of 20, their predictions will be wrong?"

The absolute number of mentally ill persons committing violent crimes is small. The issues involved require further investigation and lengthy consideration; nevertheless, the mental health system must continue to take steps to protect the public and care for the violent mentally ill.

4. Inadequate Programs for the Chronically Mentally Ill

The trends toward developing adequate programs for the chronically mentally ill are based on the belief that 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 settings in which that treatment takes place.

Treatment and support systems are designed to provide a support network which can actually provide for missing elements of services in the mental health services delivery system. It assists chronically disabled individuals to maintain their functional capacity in their communities and prevent them from being institutionalized due to lack of residential and supportive care alternatives. The implementation

of these services for the chronically mentally disabled is a major goal of the Division of Mental Health. The three local support system projects (located at the Mental Health Center of Boulder County, Southwest Denver Community Mental Health Center, and Centennial Mental Health Center) which are currently in place through funds from the National Institute of Mental Health contract for Community Support Systems have demonstrated that with appropriate support and programming, a significantly larger number of clients can function in the community.

Through the treatment and support program, a vocational rehabilitation unit of service has been established to assist clients in improving their employability by providing a continuum of vocational rehabilitation services from prevocational counseling to job placement. They offer supportive work opportunity of indefinite duration, either in specially designed work situations or in commerce and industry, in client-operated, self-help businesses or in sheltered employment.

The Division of Mental Health has been involved with the Department of Housing and Urban Development (HUD) Section 8 rent subsidy and Section 202 new construction projects. The HUD Section 8 Existing Housing Units for the chronically mentally ill have been expanded from 40 in FY 78 to 130 in FY 79. Seventy-five percent of last year's HUD Section 202 projects have been completed. Three new projects have been approved for funding for a total of 86 additional housing units through nine HUD Section 202 Projects. Availability of these programs has enabled the centers to increase the accessibility of services for the severely disabled. These achievements have aided in integrating the system and developing and implementing elements of treatment and support in each catchment area. Adequate programs and community facilities for those released from state hospitals are still needed.

In the Division of Mental Health report to the Governor, 1980, it was reported that each mental health planning area does not have all the essential units of service for psycho-social rehabilitation of the severely disabled. The extent to which this continuum of service exists is determined by the resources available for the centers to implement these programs. Declining resources in the metro area have contributed to the lack of adequate residential alternatives. Boarding homes and other similar housing are closing down due to reimbursement problems and to the conversion of buildings to condominiums and apartments. Nursing homes have become hesitant to accept chronic patients because payments and actual cost of services are not congruent.

As resources become available, expansion of the system will take place in areas of greatest need.

5. Inadequate Programs for the Forensic Patient

For all practical purposes the forensic patient is viewed as a potentially dangerous person. Several issues must be addressed to enhance the service being rendered to the criminally insane. First, the public must be informed of the purpose and capabilities of the Institute of Forensic Psychiatry at Colorado State Hospital. To a large extent the public is divided in its expectations of how the mental health system handles the forensic patient. One group of citizens wants them locked up while another group is adamantly opposed to any treatment that implies coercive psychiatry. The mental health system must begin to deal with this dichotomy. Second, the relationship

between the judicial system and the mental health system must be refined. The relationship must take into accord the capacity of the mental health system in the treatment of the criminally insane. Currently, Colorado State Hospital is over capacity in the Forensic Unit. Finally, the treatment process of the criminally insane must be reviewed. There are a number of issues that must be addressed. For example, a key issue relates to decision-making in the treatment of the criminally insane. How does the system move patients to less restrictive settings and plan for eventual discharge? How will the mental health system deal with the increasingly difficult issue of security? The Colorado mental health system will need to continue to address these and other problems related to forensic psychiatry.

CHAPTER IV. STATEWIDE GOALS AND OBJECTIVES

A. INTRODUCTION

The goals and objectives have been developed in congruence with the congressional intent embodied in Federal legislation. This legislation 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 community-based facilities; (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, vocational programs, 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 80-81 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 basic five-year goals which were established in 1979 were reaffirmed by the Colorado Mental Health 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 and objectives are interrelated and interdependent; therefore, the order of listing does not indicate relative priority. Various population groups have been targeted because of their unmet and/or unique service needs; however, the lack of adequate resources clearly prohibits the mental health system from meeting all of these needs. Current fiscal constraints along with increasing service demands are the reasons for this dilemma. To address this problem, the mental

health system must establish priorities relating to the needs of the residents of the state and the utilization of resources. For Fiscal Year 1981-82, the Colorado Division of Mental Health has established priorities based on three dimensions: severity of disability, age, and ethnicity. The highest priority for the state-funded mental health system is the provision of services to the severely and chronically psychiatrically disabled of all ages. The second level of prioritization, based on age groups, is as follows, with the first population subgroup serving as the highest priority: children (0-11 years), elderly (65 years and older), adolescents (12-17 years), and adults (18-64 years). In relation to the dimension of ethnicity, the higher priority for state-funded programs is the provision of services to ethnic minorities. All of these priorities are consistent with the priorities reflected in the 1981-82 local mental health plans submitted by the catchment area mental health centers.

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 analyzing data generated by client outcome evaluation systems by January 1, 1982.

Objective 2: To have analyzed client outcome information for the chronically mentally ill to determine if they are achieving higher levels of functioning and improving their quality of life by January 1, 1982.

Objective 3: To have analyzed client outcome information for the critically mentally ill to determine if they are achieving higher levels of functioning by June 30, 1982.

Objective 4: To have increased the level of functioning of clients from admission to termination of treatment an average of 25 points on the sum of the nine Division of Mental Health level-of-functioning scales by June 30, 1983.

Objective 5: To have analyzed client outcome information for four 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, 1984.

Objective 6: 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 THE MOST 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, FORENSIC PATIENTS, RURAL RESIDENTS, THE VIOLENT MENTALLY ILL, AND WOMEN.

Objective 1: To have eliminated the overflow of forensic patients on the Surgical Ward at Colorado State Hospital by July 15, 1981.

Objective 2: To have established the specialized 24-bed treatment unit for the violent mentally ill at Fort Logan Mental Health Center by October 1, 1981.

Objective 3: To have increased and enhanced the treatment capability for forensic patients in the higher security levels at Colorado State Hospital by December 31, 1981.

Objective 4: To have provided services to 7,400 children in FY 1981-82 by June 30, 1982.

Objective 5: To have provided services to 10,600 adolescents in FY 1981-82 by June 30, 1982.

Objective 6: To have provided services to 62,800 adults in FY 1981-82 by June 30, 1982.

Objective 7: To have provided services to 4,200 elderly in FY 1981-82 by June 30, 1982.

Objective 8: To have provided services to 17,700 ethnic minorities in FY 1981-82 by June 30, 1982.

Objective 9: To have provided services to 67,700 targeted and severely psychiatrically disabled clients in FY 1981-82 by June 30, 1982.

Objective 10: To have achieved 80 percent prescreening of Mental Health Act (CRS 27-10) admissions to the adult, geriatric, and child/adolescent programs of Colorado State Hospital by June 30, 1982.

Objective 11: To have established up to 100 new adult residential care facility beds for psychiatrically disabled clients in the Denver metropolitan area by June 30, 1982.

Objective 12: To have participated in the development of a program within the State of Colorado to meet the mental health needs of the children who are currently being sent out of state by June 30, 1982.

*Objective 13: To have expanded the capacity for intermediate security patients of the Institute of Forensic Psychiatry at Colorado State Hospital by adding 16 beds (GW5) to the intermediate unit and 21 full-time employees to the treatment team for the ward by September 1, 1982.

Objective 14: To have provided services to 7,400 children in FY 1982-83 by June 30, 1983.

Objective 15: To have provided services to 10,600 adolescents in FY 1982-83 by June 30, 1983.

Objective 16: To have provided services to 62,800 adults in FY 1982-83 by June 30, 1983.

Objective 17: To have provided services to 4,200 elderly in FY 1982-83 by June 30, 1983.

Objective 18: To have provided services to 17,700 ethnic minorities in FY 1982-83 by June 30, 1983.

Objective 19: To have provided services to 67,700 targeted and severely psychiatrically disabled clients in FY 1982-83 by June 30, 1983.

Objective 20: To have achieved 85 percent prescreening of Mental Health Act (CRS 27-10) admissions to the adult, geriatric, and child/adolescent programs of Colorado State Hospital by June 30, 1983.

**Objective 21: To have expanded the adult psychiatric bed capacity based upon the recommendations of the Joint Budget Committee and the first year implementation of the long-term statewide plan, developed in FY 81, for state hospital and community-based psychiatric beds by June 30, 1983.

Objective 22: To have worked with the Department of Social Services to reduce the number of children being sent to out-of-state facilities from 12 in FY 81 to no more than 3 requiring highly specialized services that would not be cost-effective if provided in-state by June 30, 1983.

**Objective 23: To have established a combined Developmental Disabilities/state hospital treatment unit to provide specific treatment for the mentally disordered Developmental Disabilities client by June 30, 1983.

*Objective 24: To have expanded the adult psychiatric bed capacity based upon the second-year implementation of the long-term statewide plan for state hospital and community-based psychiatric beds by June 30, 1984.

*Objective 25: To have expanded the adult psychiatric bed capacity based upon the third-year implementation of the long-term statewide plan for state hospital and community-based beds 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 developed a pilot prevention program for the areas of Colorado heavily impacted by energy development by June 30, 1982.

Objective 2: To have completed the pilot prevention program for the areas of Colorado heavily impacted by energy development by June 30, 1983.

**Objective 3: To have expanded the number of catchment areas that provide primary prevention programs by June 30, 1984.

**Objective 4: To have primary prevention programs available in at least five 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 have reduced the turnaround time for processing of client data from the January 1, 1981 baseline by 75 percent by October 1, 1981.

Objective 2: To have developed a management model which incorporates funding, total caseload, and new admissions for improved performance contracting with the community mental health centers/clinics by January 31, 1982.

Objective 3: To have developed recommendations on the impact of SB 26 on the mental health system by June 30, 1982.

Objective 4: To have evaluated and appropriately revised the statewide clinical quality assurance system, including appropriate revisions of the Medicaid reviews of individual patients' treatment, by June 30, 1982.

*Objective 5: To have implemented an integrated planning, evaluation, and quality assurance system at Fort Logan Mental Health Center by December 31, 1982.

Objective 6: 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 7: To have developed a mechanism jointly with the service providers to evaluate the delivery of high quality client care by June 30, 1984.

Objective 8: 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 9: 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 conducted an assessment of the 23 community mental health centers/clinics and the two state hospitals in terms of their programmatic capacity to serve the identified target groups by November 15, 1981.

Objective 2: To have monitored all community mental health centers and designated facilities for compliance with state standards, 27-10, and affirmative action requirements by December 31, 1981.

Objective 3: To have revised the Standards/Rules and Regulations for Mental Health Centers by January 1, 1982.

Objective 4: To have monitored all community mental health centers and designated facilities for compliance with state standards, 27-10, and affirmative action requirements by January 1, 1983.

Objective 5: To have integrated all monitoring functions within the Division of Mental Health by June 30, 1984.

Objective 6: To have evaluated the impact of performance contracting on the mental health delivery system by June 30, 1984.

*Objective 7: To have established an internal advocacy program for mental health clients by June 30, 1985.

6. MENTAL HEALTH SYSTEM GOAL #3.

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

Objective 1: To have developed a residential continuum for psychiatric patients to be used as the model for determining the amount and mix of state hospital and community-based adult beds needed for the Colorado mental health system by December 31, 1981.

Objective 2: To have utilized the programs of the Department of Housing and Urban Development (HUD) for expanding the development of residential alternatives throughout the state by March 3, 1982.

Objective 3: To have developed guidelines for use in the clinical evaluation of the dangerous or potentially violent patient at admission and readmission by March 31, 1982.

Objective 4: To have established parameters for residential and vocational services that will stimulate program development within the mental health system by June 30, 1982.

Objective 5: To have developed a plan for an additional psychiatric rehabilitation workshop operated by Fort Logan Mental Health Center for the severely disabled skill-deficient patient by June 30, 1982.

Objective 6: To have identified the programmatic elements necessary for meeting the unique service needs of energy impacted communities by June 30, 1982.

*Objective 7: To have improved the therapeutic activity services and the living skills services available to Fort Logan Mental Health Center's adult patient population by August 31, 1982.

Objective 8: To have developed a plan for transferring Fort Logan catchment area forensic patients from Colorado State Hospital to the Denver area to begin in FY 1983-84, based upon the forensic service recommendations developed by the statewide multi-agency Forensic Panel by December 31, 1982.

*Objective 9: To have established an additional psychiatric rehabilitation workshop operated by Fort Logan Mental Health Center for the severely disabled skill-deficient patient by June 30, 1983.

*Objective 10: To have increased the number of community mental health center programs having the essential programmatic components for treatment and support systems for chronically and seriously psychiatrically disabled adults by June 30, 1983.

Objective 11: To have refined preliminary vocational and residential systems standards for hospital and community mental health center cooperative programming by June 30, 1984.

*Objective 12: To have established Treatment and Support Systems for the chronically mentally ill in all of the mental health service areas with the essential programmatic components in place by June 30, 1985.

Objective 13: To have completed the transfer of forensic patients from Colorado State Hospital to Fort Logan Mental Health Center by June 30, 1985.

Objective 14: To have implemented an integrated forensic program incorporating both state hospitals and community mental health centers to ensure a full range of treatment alternatives for the forensic patient from inpatient settings to independent community living 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 implemented a pilot billing project with at least one center to test the feasibility of individual client billing by July 31, 1981.

Objective 2: To have implemented a system for allocating hospital beds at Fort Logan Mental Health Center on a catchment area basis, dependent on local needs, by September 30, 1981.

Objective 3: To have constructed a model for determining statewide bed need by October 1, 1981.

Objective 4: To have evaluated the appropriateness of the existing state hospitals' mental health service areas by December 1, 1981.

Objective 5: To have determined that state funds for mental health are being used principally for the provision of mental health services to the seriously, critically, or the chronically mentally ill by December 15, 1981.

Objective 6: To have completed a study investigating the need for a major remodeling of the Geriatric Treatment Center at Colorado State Hospital to ensure a safe, modern treatment facility for the geriatric population by December 31, 1981.

Objective 7: To have completed a study of the impact of the closing of the Hispanic Program, the needs of the dangerous female patient, and the violent mentally ill on the General Adult Psychiatric Service at Colorado State Hospital by March 31, 1982.

Objective 8: To have reorganized and consolidated, as necessary, the state-funded mental health service delivery system in the City and County of Denver by June 30, 1982.

Objective 9: To have established a statewide multi-agency Forensic Panel to develop specific recommendations on the needs for a forensic treatment program in the Denver metropolitan area by June 30, 1982.

Objective 10: To have developed a long-term statewide plan for state hospital and community-based adult psychiatric beds by June 30, 1982.

Objective 11: To have reviewed and revised, as necessary, the system for allocating state hospital beds on a catchment area basis, dependent on local needs and resource availability by September 30, 1982.

**Objective 12: To have implemented 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 care by June 30, 1983.

*Objective 13: To have initiated the remodeling of Building 121 for the Geriatric Treatment Center at Colorado State Hospital to meet the safety, heating, lighting, and environmental needs of elderly psychiatric patients by June 30, 1984.

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 implemented the approved recommendations of the Need Assessment Task Force for statewide uniform need assessment by October 1, 1981.

Objective 2: To have each mental health center submit a plan for mental health services in its catchment area to the Division of Mental Health by February 27, 1982.

Objective 3: To have implemented a service delivery system for the chronically mentally ill in nursing homes utilizing a Medicaid reimbursement mechanism for community mental health centers by March 31, 1982.

Objective 4: 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, 1982.

Objective 5: To have reviewed the roles and functions of the two state hospitals and the community mental health centers in the provision of mental health services to the residents of Colorado by June 30, 1982.

Objective 6: To have developed an agreed-upon methodology for estimating unmet need for mental health services in each catchment area based on estimates of population in need and clients served in different sectors of the mental health system by December 15, 1982.

Objective 7: To have each state hospital develop a plan for mental health services in their respective hospital service areas by December 31, 1982.

Objective 8: To have the first draft of the annual update of the 1982-87 State Mental Health Plan available for review by May 1, 1983.

*Objective 9: 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 cooperative agreement, addressing both community and hospital services, with the Division for Developmental Disabilities to ensure coordinated service delivery to the DD/MH client to the extent that resources allow by March 31, 1982.

Objective 2: To have worked with and developed specialized groups advocating for improved services for the mentally ill by June 1, 1982.

Objective 3: To have implemented affiliation agreements with appropriate agencies for the provision of residential and vocational services and training by June 1, 1982.

Objective 4: To have evaluated the impact of cooperative agreements between the Division of Mental Health and the Department of Corrections, the Department of Health, the Department of Social Services, and other human service agencies by June 30, 1982.

Objective 5: To have continued state-level coordination of services with the Departments of Corrections, Education, Health, Social Services, and other human service agencies by June 30, 1983.

**Objective 6: 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, 1985.

**Objective 7: 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, 1985.

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 completed a feasibility study of the cost benefit advantages/disadvantages of centralization of client billing operation of the two state hospitals by October 30, 1981.

Objective 2: To have proposed alternatives to minimize the impacts of funding cuts resulting from the state's 7 percent funding limitation, the cutback of federal NIMH grants, and the capping of Medicaid by November 30, 1981.

Objective 3: To have developed proposed uniform ability-to-pay principles and/or a schedule for use by community mental health centers by November 30, 1981.

Objective 4: To have established eligibility for Colorado State Hospital to become the representative payee for benefits accruing to individuals who are patients of the hospital as a result of criminal court actions by June 30, 1982.

Objective 5: To have developed at least two alternative funding mechanisms for the mental health system, with the emphasis on a cost-effective system and with funding following the clients by June 30, 1982.

Objective 6: To have increased Medicaid dollars for the community mental health system from $2,000,000 in FY 1980 to $3,500,000 in FY 1982 by June 30, 1982.

Objective 7: To have increased by 10 percent the rate of collections from fee-paying clients (adjusted for client workload), as compared to the previous fiscal year, in community mental health centers by June 30, 1982.

Objective 8: To have developed state budget requests, including alternative funding mechanisms, to replace critical programs which would be eliminated by federal budget cuts by September 30, 1982.

Objective 9: To have implemented at least two alternative funding mechanisms to minimize the impact of federal budget cuts and the capping of Medicaid on the mental health system by June 30, 1984.

Objective 10: To have reviewed the effectiveness of alternative funding systems by June 30, 1985.

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 conducted one training seminar for the community mental health centers concerning cash fund management, and their entire funding systems by October 30, 1981.

Objective 2: To have completed a cost-effectiveness analysis of services provided to the clients of the mental health system by January 31, 1982.

Objective 3: To have developed productivity standards for service delivery in the state hospitals and the community mental health centers by March 30, 1982.

Objective 4: To have continued the use of SCOPE as a management measure for the two state hospitals by June 30, 1982.

Objective 5: To have developed a five-year Division-wide plan for energy conservation by June 30, 1982.

Objective 6: To have implemented the first year of the five-year Division-wide plan for energy conservation by June 30, 1983.

Objective 7: 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 8: To have redistributed state resources to catchment areas based on local needs and resource availability by July 31, 1984.

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 developed training programs for staff of all agencies in the mental health system in the evaluation, diagnosis, and treatment of dangerous/violent mentally ill patients by December 31, 1981.

Objective 2: To have ensured that clinical support and administrative staffing assignments in both state hospitals are consistent with the staffing standards developed for these areas within the available resources by December 31, 1981.

Objective 3: To have provided a means whereby mental health centers can determine if they are competitive in the labor market by completing a salary and fringe study of mental health professionals in the mental health centers by April 1, 1982.

Objective 4: To have completed a feasibility study for centralized recruitment of qualified mental health professionals by May 1, 1982.

Objective 5: To have conducted statewide vocational and residential staff training in order to promote and establish expertise in these areas by June 1, 1982.

Objective 6: To have completed a study of the incidence of "the burn-out syndrome" in the mental health system for conceptualizing a broad program of preventative measures to reduce burn out by June 30, 1982.

Objective 7: To have provided training programs for serving Division of Mental Health priority client populations by June 30, 1982.

Objective 8: To have reviewed work force issues relative to forensic programs at Colorado State Hospital by June 30, 1982.

Objective 9: To have assessed work force issues relative to the impact of energy development on the Western Slope by June 30, 1982.

*Objective 10: To have completed special projects to bring about improvement in such work force areas as staff recruitment, utilization, and retention by June 30, 1983.

*Objective 11: To have provided staff training programs for the mental health system to improve the delivery of services to clients representing Division of Mental Health service priorities by June 30, 1983.

*Objective 12: To have brought both state hospitals up to SCOPE staffing standards by June 30, 1983.

Objective 13: To have implemented recommendations based on a review of comparable outside sources to achieve comparable administrative standards among institutions and divisions by June 30, 1983.

Objective 14: To have completed a series of programs at both personal and organizational levels to help to reduce job stress and burnout syndrome by June 30, 1983.

Objective 15: To have provided training and other staff support activities needed to retain and maintain qualified personnel by June 30, 1984.

Objective 16: To have assisted in recruiting staff needed to meet mental health needs in energy impact areas by June 30, 1984.

*Objective 17: To have increased state financial support for student placements in mental health service settings by June 30, 1985.

*Objective 18: To have provided staff training in services to all target populations by June 30, 1985.

C. COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY # I: Provide effective and high quality services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 analyzing data generated by client outcome evaluation systems.	1/1/82	-Report of analyses	Evaluation Services Program Services CCSS	With the change in focus of the mental health system, it is important to monitor and evaluate the outcome and impact of those changes.
	(2) To have analyzed client outcome information for the chronically mentally ill to determine if they are achieving higher levels of functioning and improving their quality of life.	1/1/82	-Report with recommendations for program managers	Evaluation Services Program Services CCSS	This study should provide direction for future planning and program development.
	(3) To have analyzed client outcome information for the critically mentally ill to determine if they are achieving higher levels of functioning.	6/30/82	-Report with recommendations for program managers	Evaluation Services Program Services	This study should provide direction for future planning and program development.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY # II: Serve clients most in need as the highest priority.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
Service Goal #1. TO SERVE THE MOST 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, FORENSIC PATIENTS, RURAL RESIDENTS, THE VIOLENT MENTALLY ILL, AND WOMEN.	(1) To have eliminated the over-flow of forensic patients on the Surgical Ward at Colorado State Hospital.	7/15/81	-No forensic patients on the Surgical Ward due to over-flow problems	CSH	In the past year, the flow of forensic patients through the system (from maximum security - medium - intermediate - minimal) was significantly slowed, resulting in an increased length of stay in maximum and medium security. The increasing length of stay created a situation whereby the admissions to maximum security exceeded the bed capacity of that unit, and created an over-flow problem. The over-flow of admissions was dealt with by placing the patients on the surgical ward, as it was the only other unit in the hospital with a high degree of security. In addition, there is a need to utilize surgical ward beds for surgical patients from the Department of Institutions and the Department of Corrections.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #II: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
Service Goal #1.	(2) To have established the specialized 24-bed treatment unit for the violent mentally ill at Fort Logan Mental Health Center.	10/1/81	-24-bed unit open	FLMHC	A specialized treatment service for the violent mentally ill within the Fort Logan system is essential.
	(3) To have increased and enhanced the treatment capability for forensic patients in the higher security levels at Colorado State Hospital.	12/31/81	-Wards 5 and 7 converted to maximum security -23-bed medium security ward opened and occupied in building 8 -Building 10 offices remodeled for use as activity and therapy rooms	CSH	The overcrowding in the forensic units will be relieved through this remodeling program by the conversion of 50 beds to maximum security, an additional 23 beds to medium security, and development of additional space in which to conduct primary and ancillary therapy programs.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY # II: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
Service Goal #1.	(4) To have provided services to 7,400 children in FY 1981-82.	6/30/82	-Signed contracts -Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	(4)-(9) 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, elderly), severity, 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. For FY 1981-82, the Division of Mental Health will contract for at least the same number of children, elderly, targeted, and ethnic minorities as contracted for in FY 1980-81. This approach allows community mental health centers to make adjustments in adolescent and adult categories.
	(5) To have provided services to 10,600 adolescents in FY 1981-82.	6/30/82	-Signed contracts -Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(6) To have provided services to 62,800 adults in FY 1981-82.	6/30/82	-Signed contracts -Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	

DEPARTMENT OF INSTITUTIONS POLICY #II: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
Service Goal #1.	(7) To have provided services to 4,200 elderly in FY 1981-82.	6/30/82	-Signed Contracts -Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(8) To have provided services to 17,700 ethnic minorities in FY 1981-82.	6/30/82	-Signed Contracts -Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(9) To have provided services to 67,700 targeted and severely psychiatrically disabled clients in FY 1981-82.	6/30/82	-Signed contracts -Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(10) To have achieved 80% prescreening of Mental Health Act (CRS-27-10) admissions to the Adult, Geriatric, and Child/Adolescent programs of Colorado State Hospital.	6/30/82	-Admission rates that reflect 80% prescreened entries, monitored on a quarterly basis	CSH CMHCs	Prescreening is needed to assure that clients are appropriately served by all elements of the mental health system in the least restrictive environment.
	(11) To have established up to 100 new adult residential care facility beds for psychiatrically disabled clients in the Denver Metropolitan area.	6/30/82	-New adult residential care facility beds established in the Denver Metropolitan area	CCSS Administrative Services Program Services Planning Services Denver Metro. CMHCs	There is currently a gap within the mental health system for appropriate residential placement facilities within the community where clients can receive the least restrictive care appropriate for their needs.

DEPARTMENT OF INSTITUTIONS POLICY #II: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
Service Goal #1	(12) To have participated in the development of a program within the State of Colorado to meet the mental health needs of the children who are currently being sent out of state.	6/30/82	-Program plan developed	Program Services Planning Services CSH FLMHC	At the present time the State of Colorado is forced to send a number of children and youth in specific diagnostic categories to other states for residential treatment. This fact is primarily due to lack of adequate programs in-state for these youth. This situation becomes problematic because of the geographic distance involved and reduces the probability of successful therapeutic outcomes for these children and youth. From a treatment, as well as a fiscal, perspective it makes sense to help these children in Colorado. This objective is consistent with the intent of SB 26 in treating children as close to home as possible.

DEPARTMENT OF INSTITUTIONS POLICY #II: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 developed a pilot prevention program for the areas of Colorado heavily impacted by energy development.	6/30/82	-Written plan	Program Services Colorado West MHC	Colorado West Mental Health Center applied for and was awarded a grant for developing a pilot prevention program for communities impacted by energy development.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY # I: Provide effective and high quality services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 have reduced the turnaround time for processing of client data from the January 1, 1981 baseline by 75%.	10/1/81	-Reduction demonstrated	Evaluation Services	DMH management requires current information for proper planning and effective management.
	(2) To have developed a management model which incorporates funding, total caseload, and new admissions for improved performance contracting with the community mental health centers/ clinics.	1/31/82	-Written model	Program Services Evaluation Services Administrative Services CMHCs	There currently is no method or process which allows for the integration of these factors in performance contracting.
	(3) To have developed recommendations on the impact of SB 26 on the mental health system.	6/30/82	-Written Report	Program Services Evaluation Services	As a follow-up to the analysis of the data collected for the evaluation of SB 26, specific recommendations should be developed to enhance service delivery.
	(4) To have evaluated and appropriately revised the statewide clinical quality assurance system, including appropriate revisions of the Medicaid reviews of individual patients' treatment.	6/30/82	-Revised guidelines	Program Services	The impact of the system should be assessed to determine if it is achieving the results intended as well as determining if revisions are necessary.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #VIII: Provide services which ensure the fullest measure of privacy, dignity, and protection of the rights of clients.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 conducted an assessment of the 23 community mental health centers/clinics and the two state hospitals in terms of their programmatic capacity to serve the identified target groups.	11/15/81	-All 25 assessments completed	Program Services CCSS	In the past year, the assessment, monitoring and Technical Assistance efforts of DMH have been primarily focused on the numbers of patients served by the mental health system. Program structure and capability have not received the attention necessary to fully understand the quality of care provided in the system.
	(2) To have monitored all community mental health centers and designated facilities for compliance with state standards, 27-10, and affirmative action requirements.	12/31/81	-Report on each center and designated facility	Program Services	Monitoring compliance in these areas is included in the Division of Mental Health's regulatory responsibilities.
	(3) To have revised the Standards/Rules and Regulations for Mental Health Centers.	1/1/82	-Revised Standards	Program Services Governor's Board for Service Standards and Regulations	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.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #III: Provide clients with the most effective, least intensive, and least restrictive care and treatment through a continuum of services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #3. TO HAVE COST EFFECTIVE TREATMENT AND SUPPORT SYSTEMS FOR THE DELIVERY OF MENTAL HEALTH SERVICES TO THE MOST PSYCHIATRICALLY DISABLED CLIENTS OF ALL AGES AVAILABLE STATEWIDE.	(1) To have developed a residential continuum for psychiatric patients to be used as the model for determining the amount and mix of state hospital and community-based adult beds needed for the Colorado mental health system.	12/31/81	-Written model -Guidelines and criteria for residental programs -Issue paper reflecting bed needs	Planning Services Evaluation Services Program Services CCSS CMHCs	The need for expanding the state psychiatric bed capacity needs to be assessed and updated to determine the appropriate amount and mix of state hospital and community-based beds required to meet the needs of the system's most disabled clients. This process will include the development of a residential continuum, a need assessment based upon that continuum, and a trend analysis related to utilization of existing resources.
	(2) To have utilized the programs of the Department of Housing and Urban Development (HUD) for expanding the development of residential alternatives throughout the state.	3/3/82	-Monthly reports of Section 8 and HUD 202 programs	CCSS	By utilizing resources other than mental health funds, appropriate and necessary residential programs can be provided and CCSS services can be developed throughout the state.
	(3) To have developed guidelines for use in the clinical evaluation of the dangerous or potentially violent patient at admission and readmission.	3/31/82	-Written guidelines	Program Services Evaluation Services	The report on "Violence and the Mentally Ill" indicated that centers need to improve the way in which they explore the issue of potential violence at the time of admission.
	(4) To have established parameters for residential and vocational services that will stimulate program development within the mental health system.	6/30/82	-Written residential and vocational criteria -Residential and vocational community program assessment	CCSS Program Services CSH FLMHC CMHCs	Consistent procedures regarding residential and vocational issues do not currently exist and are necessary for a system-wide impact on residential and vocational program development and provision.

DEPARTMENT OF INSTITUTIONS POLICY #III: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #3	(5) To have developed a plan for an additional psychiatric rehabilitation workshop operated by Fort Logan Mental Health Center for the severely disabled skill-deficient patient.	6/30/82	-Written plan	FLMHC CCSS	Many Fort Logan admissions are totally or nearly totally unhabilitated. They have never developed work habits, work site skills, or work skills. They must be started at "zero". Present workshop programs assume some preexisting habits, work site skills, etc. There are more than enough clients in the system for these programs. A program to start at a much more basic level is required.
	(6) To have identified the programmatic elements necessary for meeting the unique service needs of energy impacted communities.	6/30/82	-Written report	Program Services CMHCs	The increasing populations in energy impacted areas necessitate a reassessment of service priorities with appropriate modifications in the human service delivery system.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #V: Provide services efficiently.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #4. TO ENSURE THE APPROPRIATE UTILIZATION OF ALL AVAILABLE RESOURCES BY CLIENTS MOST IN NEED.	(1) To have implemented a pilot billing project with at least one center to test the feasibility of individual client billing.	7/31/81	-System operating	CMHCs Administrative Services Evaluation Services	There is a need to test an alternative billing system. This pilot project will test to see if improved information can be obtained with a cost savings to the system.
	(2) To have implemented a system for allocating hospital beds at Fort Logan Mental Health Center on a catchment area basis, dependent on local needs.	9/30/81	-System operating	Director's Office Evaluation Services Planning Services CMHCs FLMHC	The focus on allocation is needed to plan for FLMHC utilization.
	(3) To have constructed a model for determining statewide bed need.	10/1/81	-Report of model	Evaluation Services Planning Services CCSS CMHCs	Accomplishment of this objective would provide a basis for planning bed resources and budget projections.
	(4) To have evaluated the appropriateness of the existing state hospitals' mental health service areas.	12/1/81	-Written report	Evaluation Services Planning Services CSH FLMHC	The current service areas for CSH and FLMHC need to be reevaluated at least in terms of population served compared with psychiatric bed need.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #4	(5) To have determined that state funds for mental health are being used prinicipally for the provision of mental health services to the seriously critically, or the chronically mentally ill.	12/15/81	-Report submitted to the Joint Budget Committee	Evaluation Services Administrative Services Program Services Planning Services CMHCs	The extent to which the intent of the Joint Budget Committee has been followed should be monitored.
	(6) To have completed a study investigating the need for a major remodeling of the Geriatric Treatment Center at Colorado State Hospital to ensure a safe, modern treatment facility for the geriatric population.	12/31/81	-Submission of written report	CSH	The Geriatric Treatment Center is housed in a facility constructed in 1954. Since that time, there has been a dramatic change in the physical plant needs of the program. An initial study shall be initiated to identify the extent of changes needed to enable modernization of the building to meet current needs.
	(7) To have completed a study of the impact of the closing of the Hispanic Program, the needs of the dangerous female patient, and the violent mentally ill on the General Adult Psychiatric Service at Colorado State Hospital.	3/31/82	-Submission of written report	CSH	In view of the anticipated reduction of the Hispanic program, the continuing problems of treating the dangerous female patient as well as the violent mentally ill, and increasing admission rate of General Adult Psychiatric Services, it will be necessary to develop a plan to deal with the possible problems related to increasing workload. The first step in this process is to identify potential problem areas and possible solutions.

DEPARTMENT OF INSTITUTIONS POLICY #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #4	(8) To have reorganized and consolidated, as necessary, the state-funded mental health service delivery system in the City and County of Denver.	6/30/82	-Review of the four Denver catchment areas completed -State contracts with centers	Program Services Administrative Services Evaluation Services Planning Services	Reductions in service delivery in The Denver Health & Hospitals catchment area necessitates a review of the State-funded service delivery system for the residents of the City & County of Denver. Changes in the existing structure that would ensure the most appropriate utilization of all available resources to the clients most in need should be implemented.
	(9) To have established a statewide multi-agency Forensic Panel to develop specific recommendations on the needs for a forensic treatment program in the Denver metropolitan area.	6/30/82	-Forensic Panel established -Written recommendations submitted to the Director of DMH	Director's Office Program Services Evaluation Services Planning Services CSH, FLMHC CMHCs	The recommendations and plans should be based on a determination of need and upon the overall state philosophy concerning the forensic patient developed by the statewide multi-agency Forensic Panel.
	(10) To have developed a long-term statewide plan for state hospital and community based adult psychiatric beds.	6/30/82	-Written plan	Planning Services Evaluation Services Program Services CCSS CMHCs	The specific need for state hospital and community based psychiatric beds must be determined. After a need assessment has been completed, a plan for allocating and establishing the amount and mix of state hospital and community based psychiatric beds must be established. This plan would then serve as the foundation for future resource development and budget requests.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #II: Serve clients most in need as the highest priority.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 implemented the approved recommendations of the Need Assessment Task Force for statewide uniform need assessment.	10/1/81	-Data available for budget preparation	Evaluation Services CMHCs	These data are necessary for program planning and resource reallocation.
	(2) To have each mental health center submit a plan, for mental health services in its catchment area to the Division of Mental Health.	2/27/82	-20 catchment area plans submitted to DMH	CMHCs Planning Services Program Services	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 are a requirement of the DMH/Center contract.
	(3) To have implemented a service delivery system for the chronically mentally ill in nursing homes utilizing a medicaid reimbursement mechanism for community mental health centers.	3/31/82	-System in place	Program Services Administrative Services CCSS	The chronically mentally ill in nursing homes have long been an unserved and underserved population. A new funding mechanism which would allow a CMHC to be reimbursed by Medicaid would greatly expand the availability of services for this population.

DEPARTMENT OF INSTITUTIONS POLICY #II: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #5	(4) 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.	4/30/82	-Presentation provided	Planning Services SMHC	Since 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.
	(5) To have reviewed the roles and functions of the two state hospitals and the community mental health centers in the provision of mental health services to the residents of Colorado.	6/30/82	-Written descriptions of roles and functions of the state hospitals and the CMHCs	Statewide Long-Term Mental Health Planning Committee	As the thrusts of the mental health system change, it is necessary for each service component to clearly define its roles and functions as they relate to the roles of other components and as they relate to the needs of the population.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

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

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 cooperative agreement, addressing both community and hospital services, with the Division for Developmental Disabilities to ensure coordinated service delivery to the DD/MH client to the extent that resources allow.	3/31/82	-Written agreement	Program Services	The Division of Mental Health and the Division for Developmental Disabilities currently do not have an operational agreement. This DD/MH client population continues to be one of the populations most in need. A comprehensive service provision approach between the two Divisions is imperative.
	(2) To have worked with and developed specialized groups avocating for improved services for the mentally ill.	6/1/82	-Minutes of meetings	CCSS Program Services Planning Services SMHC	The promotion of continued dialogue with and between these groups provides a comprehensive view of the needs and gaps within the system.
	(3) to have implemented affiliation agreements with appropriate agencies for the provision of residential and vocational services and training.	6/1/82	-Report on implementation of interagency agreements	CCSS	Interagency agreements will enable DMH to access other agency expertise and minimize duplication of service efforts.
	(4) To have evaluated the impact of cooperative agreements between the Division of Mental Health and the Department of Corrections, the Department of Health, the Department of Social Services and other human service agencies.	6/30/82	-Report submitted to the Director of DMH	Program Services	Effective interagency agreements must be developed to maximize resource utilization.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

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

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 completed a feasibility study of the cost benefit advantages/ disadvantages of centralization of client billing operation of the two state hospitals.	10/30/81	-Study completed	Administrative Services	Future funding of hospital programs will depend increasingly on the success of rate-setting and client billing operations. Also, the issue of cash funding of Central Office operations may well be tied to this.
	(2) To have proposed alternatives to minimize the impacts of funding cuts resulting from the state's 7% funding limitation, the cutback of federal NIMH grants, and the capping of Medicaid.	11/30/81	-Written report submitted to the Director of DMH	Administrative Services CMHCs	Federal and state budget cuts will not only affect the mental health system, but will also affect support systems for clients. A thorough analysis is necessary to determine the overall impact of such cuts. Revenue resources from other sources will be needed in order to maintain programs at their current level of service.
	(3) To have developed proposed uniform ability-to-pay principles and/or a schedule for use by community mental health centers.	11/30/81	-Completion of principles/schedule submitted to the Centers' Association for review	Administrative Services CMHCs	This is a common practice in many states and should be considered in Colorado to comply with the intent of the Joint Budget Committee.
	(4) To have established eligibility for Colorado State Hospital to become the representative payee for benefits accruing to individuals who are patients of the hospital as a result of criminal court actions.	6/30/82	-Social Security form reflects Colorado State Hospital as a representative payee	CSH	This objective is needed to obtain additional funding for mental health services.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #IV: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #7	(5) To have developed at least two alternative funding mechanisms for the mental health system, with the emphasis on a cost-effective system and with funding following the clients.	6/30/82	-Written report to Director - reflected in 82-83 Operating Plan	Administrative Services CMHCs	Federal/state funding for mental health is declining.
	(6) To have increased Medicaid dollars for the community mental health system from $2,000,000 in FY 1980 to $3,500,000 in FY 1982.	6/30/82	-Increased Medicaid dollars	Administrative Services	Increased Medicaid dollars would provide additional non-general-fund dollars for maintenance and expansion of programs in the community.
	(7) To have increased by 10%, the rate of collections from fee paying clients (adjusted for client workload), as compared to the previous fiscal year, in community mental health centers.	6/30/82	-Patient fee collection data	Administrative Services CMHCs	Patient revenues are a major element of funding for community mental health centers and clinics.

DEPARTMENT OF INSTITUTIONS POLICY #VI: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	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 conducted one training seminar for the community mental health centers concerning cash fund management, and their entire funding systems.	10/30/81	-Seminar conducted	Administrative Services	With resources declining, it is necessary to maximize the efforts in developing new resources.
	(2) To have completed a cost-effectiveness analysis of services provided to the clients of the mental health system.	1/31/82	- Report with recommendations for statewide implementation	Evaluation Services Administrative Services CMHCs	A cost-effectiveness analysis has not been done in Colorado. A large sample of clients was drawn from the mental health centers. Using this sample, it is possible to analyze the type of service given at what cost. Comparisons can then be made among different programs and populations.
	(3) To have developed productivity standards for service delivery in the State hospitals and the community mental health centers.	3/30/82	-Standards approved by Director	Administrative Services Program Services CSH FLMHC CMHCs	All measures must be taken in order to maximize services within current resources.
	(4) To have continued the use of SCOPE as a management measure for the two state hospitals.	6/30/82	-Review of standards completed with recommended actions by 1/1/82 -Staffing consistent with SCOPE	Administrative Services CSH FLMHC	The Division and the two hospitals are committed to using SCOPE, as it represents the best available system for determining staffing standards. These standards must be reviewed annually to ensure that they are sufficient to provide for adequate staffing in the two state hospitals.

DEPARTMENT OF INSTITUTIONS POLICY #VI: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #8.	(5) To have developed a five-year Division-wide plan for energy conservation.	6/30/82	-Updated plan	Administrative Services CSH FLMHC	Energy conservation is a Division of Mental Health priority.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1981-82 OPERATING PLAN

DEPARTMENT OF INSTITUTIONS POLICY #V: Provide services efficiently.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #9 TO DEVELOP THE STATE'S CAPACITY FOR MENTAL HEALTH WORKFORCE PLANNING AND DEVELOPMENT TO INSURE THAT THE APPROPRIATE STAFF ARE AVAILABLE AND ARE BEING UTILIZED EFFECTIVELY THROUGHOUT THE STATE MENTAL HEALTH SYSTEM.	(1) To have developed training programs for staff of all agencies in the mental health system in the evaluation, diagnosis, and treatment of dangerous violent mentally ill patients.	12/31/81	-Written curricula established	Human Resources Development Program Services FLMHC CSH	It is essential that staff of the mental health system have consistent concepts of evaluation, diagnosis, and treatment of these people in order for the system to most effectively provide treatment.
	(2) To have ensured that clinical support and administrative staffing assignments in both state hospitals are consistent with the staffing standards developed for these areas within the available resources.	12/31/81	-Necessary staffing changes completed	Administrative Services CSH FLMHC	This objective is needed to assure the efficient and effective utilization of staff.
	(3) To have provided a means whereby mental health centers can determine if they are competitive in the labor market by completing a salary and fringe study of mental health professionals in the mental health centers.	4/1/82	-Results of study available to mental health centers	Personnel CMHCs	The centers need a management tool that will help them develop their staff.

DEPARTMENT OF INSTITUTIONS POLICY #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #9.	(4) To have completed a feasibility study for centralized recruitment of qualified mental health professionals.	5/1/82	-Feasibility Study completed	Personnel	The mental health system needs more efficient and effective means of recruiting as resources become more limited.
	(5) To have conducted statewide vocational and residential staff training in order to promote and establish expertise in these areas.	6/1/82	-Agenda of training sessions	CCSS	Accomplishment of this objective will enhance staff development in identified vocational and residential training need areas.
	(6) To have completed a study of the incidence of "The Burnout Syndrome" in the mental health system for conceptualizing a broad program of preventative measures to reduce burnout.	6/30/82	-Results of study to identify sources of stress in terms of individual and organizational variables (e.g. --- task, role, behavior settings, physical environment, and the characteristics which staff bring with them to the job)	Personnel Human Resources Development Evaluation Services	Professional interactions at all levels of the Mental Health System and increasing job demands with increasing limited resources arouse strong emotional feelings leading to job stress and eventually the full blown burnout syndrome. This study will identify pertinent individual and organizational factors to facilitate intervention strategies in phase II.

DEPARTMENT OF INSTITUTIONS POLICY #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1981-82	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #9.	(7) To have provided training programs for serving Division of Mental Health priority client populations.	6/30/82	-Written training summaries	Human Resources Development Section	Training is necessary to increase availability of special knowledge and skills needed to treat priority client populations.
	(8) To have reviewed workforce issues relative to forensic programs at Colorado State Hospital.	6/30/82	-Written report	Human Resources Development Section CSH	Staff selection, training and utilization all contribute to development of optimal functioning.
	(9) To have assessed workforce issues relative to the impact of energy development on the western slope.	6/30/82	-Written report	Human Resources Development Section	Population growth will increase the need for mental health services and the human resources to deliver them.

CHAPTER V. FINANCIAL SUMMARY FOR FISCAL YEAR 1981-82

OPERATING PLAN
DIVISION OF MENTAL HEALTH
INCOME & VARIANCE FOR 1981-82

	Federal	Cash Fund Patient Revenue	Cash Fund Other	General Fund	Non-Appropriated	Total Income
PERSONAL SERVICES:						
Appropriation		14,448,488	1,175,421	21,331,200		36,955,109
Transfers				469,428		469,428
Potted Funds				5,805,075		5,805,075
OPERATING EXPENSE:						
Appropriation			689,077	3,240,624		3,929,701
Transfers				9,620		9,620
TRAVEL:						
Appropriation				23,852		23,852
Transfers				5,516		5,516
CAPITAL OUTLAY:						
Transfers				163,552		163,552
SPECIAL PURPOSE:						
Drug Treatment			1,478,249			1,478,249
Drug Pots				191,085		191,085
Alcohol Program					148,000	148,000
Utilities			68,624	1,489,804		1,558,428
ESEA			47,000		100,000	147,000
ESEA Carry-over					6,661	6,661
Vocational Rehab.			554,906			554,906
Voc. Rehab. Pots				41,181		41,181
Adult Basic Ed.					12,200	12,200
Manpower Program			253,800			253,800
School District			24,000			24,000
Library Grant					18,000	18,000
Continuing Ed	8,000					8,000
Manpower Grant	193,000					193,000
CCSS	330,000					330,000
TA Grants	10,000					10,000
Community Centers			3,590,000	16,637,108		20,227,108
Group Homes				288,000		288,000
Training Grant					13,000	13,000
CETA					20,000	20,000
Chicano Grant	93,840					93,840
TOTAL	634,840	14,448,488	7,881,077	49,696,045	317,861	72,978,311
Less: Appropriation	1,014,840	14,448,488	7,917,077	43,010,588	-0-	66,390,993
TOTAL VARIANCE	380,000	-0-	36,000	(6,685,457)	(317,861)	(6,587,318)

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1981-82

Transfers	Federal Funds	Non-Approp.	Cash Fund Approp.	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					CHILDREN'S PSYCHIATRY					
			723,780	480,733	Personal Services	1,204,513	301,128	301,128	301,123	301,129
				28,156	Operating Expense	28,156	7,039	7,039	7,039	7,039
				480	Travel	480	120	120	120	120
		10,000	10,000		Special Purpose	20,000	5,000	5,000	5,000	5,000
		10,000	733,780	509,369	TOTAL 49.35 FTE	1,253,149	313,287	313,287	313,287	313,288
					ADOLESCENT PSYCHIATRY					
			2,526,264	2,091,567	Personal Services	4,617,831	1,154,457	1,154,457	1,154,457	1,154,459
				70,717	Operating Expense	70,717	17,679	17,679	17,679	17,680
				1,470	Travel	1,470	367	367	368	368
		96,661	37,000		Special Purpose	133,661	33,415	33,415	33,415	33,416
		96,661	2,563,264	2,163,754	TOTAL 187.9 FTE	4,823,679	1,205,918	1,205,918	1,205,919	1,205,921
					ADULT PSYCHIATRY					
			3,645,477	3,020,311	Personal Services	6,665,788	1,579,559	1,695,408	1,695,411	1,695,410
				152,477	Operating Expense	152,477	38,119	38,119	38,119	38,119
				4,700	Travel	4,700	1,175	1,175	1,175	1,175
	93,840				Special Purpose	93,840	23,460	23,460	23,460	23,460
	93,840		3,645,477	3,177,488	TOTAL 279.5 FTE	6,916,805	1,642,313	1,758,162	1,758,165	1,758,164
					FORENSIC PSYCHIATRY					
			2,101,770	5,350,114	Personal Services	7,451,884	1,862,971	1,862,971	1,862,971	1,862,971
				144,000	Operating Expense	144,000	36,000	36,000	36,000	36,000
				1,200	Travel	1,200	300	300	300	300
			2,101,770	5,495,314	TOTAL 318.7 FTE	7,597,084	1,899,271	1,899,271	1,899,271	1,899,271
					GERIATRIC PSYCHIATRY					
			1,511,181	1,819,740	Personal Services	3,330,921	832,730	832,730	832,730	832,731
				221,654	Operating Expense	221,654	55,411	55,411	55,410	55,422
				2,600	Travel	2,600	650	650	650	650
		12,200			Special Purpose	12,200	6,000	6,200		
		12,200	1,511,181	2,043,994	TOTAL 228.2 FTE	3,567,375	894,791	894,991	888,790	888,803
					GENERAL HOSPITAL					
			1,459,095	2,696,452	Personal Services	4,155,547	1,203,946	983,867	983,867	983,867
			165,337	455,564	Operating Expense	620,901	167,795	152,009	152,009	151,087
				550	Travel	550	138	137	138	137
			1,624,432	3,152,566	TOTAL 138.85 FTE	4,776,998	1,371,879	1,136,013	1,136,013	1,135,091

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1981-82

Transfers	Federal Funds	Non-Approp.	Cash Fund Approp.	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					DRUG/ALCOHOL TREATMENT					
		148,000	1,478,249	191,085	Special Purpose	1,817,334	565,328	417,328	417,328	417,350
		148,000	1,478,249	191,085	TOTAL 71.9 FTE	1,817,334	565,328	417,328	417,328	417,350
					COMMUNITY CENTERS/CLINICS					
			[1]3,590,000	16,925,108	Special Purpose	16,925,108	4,159,277	4,255,277	4,255,277	4,255,277
			3,590,000	16,925,108	TOTAL 0 FTE	16,925,108	4,159,277	4,255,277	4,255,277	4,255,277
					TREATMENT SUPPORT SERVICES					
			2,091,998	7,094,205	Personal Services	9,186,203	2,296,551	2,296,550	2,296,551	2,296,551
			337,248	1,176,265	Operating Expense	1,513,513	419,178	364,691	364,690	364,954
				9,552	Travel	9,552	2,388	2,388	2,387	2,389
		31,000	554,906	41,181	Special Purpose	627,087	156,795	156,795	156,795	156,702
		31,000	2,984,152	8,321,203	TOTAL 471.3 FTE	11,336,355	2,874,912	2,820,424	2,820,423	2,820,596
					ADMINISTRATION & GENERAL					
537,147			1,564,344	4,414,134	Personal Services	6,515,625	1,627,834	1,628,664	1,629,208	1,629,919
9,620			186,492	991,791	Operating Expense	1,187,903	323,580	318,576	283,674	283,673
5,516				3,300	Travel	8,816	2,204	2,204	2,204	2,204
163,552					Capital Outlay	163,552	40,888	40,888	40,888	40,888
	541,000	20,000	346,424	1,489,804	Special Purpose	2,397,228	603,881	649,696	649,696	493,955
715,835	541,000	20,000	2,097,260	6,899,029	TOTAL 267.58 FTE	10,273,124	2,598,387	2,640,028	2,605,670	2,450,639
					TOTAL PROGRAMS					
537,147			15,623,909	26,967,256	Personal Services	43,128,312	10,859,176	10,755,776	10,756,323	10,757,037
9,620			689,077	3,240,624	Operating Expense	3,939,321	1,064,801	966,924	953,622	953,974
5,516				23,852	Travel	29,368	7,342	7,341	7,342	7,343
163,552					Capital Outlay	163,552	40,888	40,888	40,888	40,888
	634,840	317,861	5,596,576	18,647,178	Special Purpose	22,026,458	5,553,156	5,547,171	5,540,971	5,385,160
715,835	634,840	317,861	21,909,565	48,878,910	TOTAL 1913.18 FTE	69,287,011	17,525,366	17,318,100	17,365,226	17,144,402

[1]Amount reverts

OPERATING PLAN
DIVISION OF MENTAL HEALTH - CENTRAL OFFICE
INCOME & VARIANCE FOR 1981-82

	Federal	General Fund	Cash Fund	Transfers	Total Income
PERSONAL SERVICES:					
Appropriation				469,428	469,428
Potted Funds Anticipated				67,719	67,719
OPERATING EXPENSE:					
Appropriation				9,620	9,620
TRAVEL:					
Appropriation				5,516	5,516
CAPITAL OUTLAY:					
Appropriation				163,552	163,552
SPECIAL PURPOSE:					
Continuing Education	8,000				8,000
Manpower	193,000				193,000
CSS	330,000				330,000
TA Grants	10,000				10,000
Community Centers/Clinics		16,637,108	3,590,000		20,227,108
Group Homes		288,000			288,000
TOTAL	541,000	16,925,108	3,590,000	715,835	21,771,943
Less: Appropriation	909,000	16,925,108	3,590,000	-0-	21,424,108
TOTAL VARIANCE	368,000	-0-	-0-	(715,835)	(347,835)

OPERATING PLAN FOR 1981-82
CENTRAL OFFICE - DIVISION OF MENTAL HEALTH

Transfers	Federal Funds	Cash Fund Approp.	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
				COMMUNITY CENTERS/CLINICS					
		[1]3,590,000	16,925,108	Special Purpose	16,925,108	4,159,277	4,255,277	4,255,277	4,255,277
		[1]3,590,000	16,925,108	TOTAL 0 FTE	16,925,108	4,159,277	4,255,277	4,255,277	4,255,277
				ADMIN. & GENERAL SERVICES					
537,147				Personal Services	537,147	133,215	134,044	134,588	135,300
9,620				Operating Expense	9,620	2,405	2,405	2,405	2,405
5,516				Travel	5,516	1,379	1,379	1,379	1,379
163,552				Capital Outlay	163,552	40,888	40,888	40,888	40,888
	541,000			Special Purpose	541,000	162,750	162,750	162,750	52,750
715,835	541,000			TOTAL 27.88 FTE	1,256,835	340,637	341,466	342,010	232,722
				TOTAL ALL PROGRAMS					
537,147				Personal Services	537,147	133,215	134,044	134,588	135,300
9,620				Operating Expense	9,620	2,405	2,405	2,405	2,405
5,516				Travel	5,516	1,379	1,379	1,379	1,379
163,552				Capital Outlay	163,552	40,888	40,888	40,888	40,888
	541,000	[1]3,590,000	16,925,108	Special Purpose	17,466,108	4,322,027	4,418,027	4,418,027	4,308,027
715,835	541,000	[1]3,590,000	16,925,108	TOTAL 27.88 FTE	18,181,943	4,499,914	4,596,743	4,597,287	4,487,999

FTE Gen. Funds 15.5
Fed. Funds 12.38
Total 27.88

[1]Amount reverts

OPERATING PLAN
FORT LOGAN MENTAL HEALTH CENTER
INCOME & VARIANCE FOR 1981-82

	CASH FUND PATIENT REVENUE	CASH FUND APPROPRIATION	GENERAL FUND	FEDERAL	NON-APPROP.	TOTAL INCOME
PERSONAL SERVICES						
Appropriation	5,974,453		4,985,143			10,959,596
Reduction in Appro.			(101,300)			(101,300)
Pots Request			1,687,937			1,687,937
Subtotal Personal Services	5,974,453		6,571,780			12,546,233
OPERATING EXPENSE						
Appropriation			1,337,599			1,337,599
TRAVEL						
Appropriation			6,475			6,475
CAPITAL OUTLAY - Included in DMH Operating Plan						
SPECIAL PURPOSE						
Utilities			458,155			458,155
ESEA		47,000				47,000
Voc Rehab		373,000				373,000
ESEA - Carryover 80/81					6,661	6,661
ADAD - Non-Appro.(2 mos.)					148,000	148,000
CETA - Non-Appro.					20,000	20,000
Adult Basic Ed.					12,200	12,200
Health Dept. Trng.Grant					13,000	13,000
Pots Request Vocational Services			41,181			41,181
TOTAL	5,974,453	420,000	8,415,190	-0-	199,861	15,009,504
Less:Appropriation	5,974,453	456,000	6,787,372	12,000	-0-	13,229,825
TOTAL VARIANCE	-0-	(36,000)	1,627,818	(12,000)	199,861	1,779,679

OPERATING PLAN FOR 1981-82
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.
					CHILDREN's PSYCHIATRY						
			574,773	101,431	26.15	Personal Services	676,204	169,051	169,051	169,051	169,051
				12,320		Operating Expense	12,320	3,080	3,080	3,080	3,080
				300		Travel	300	75	75	75	75
						Capital Outlay					
		10,000			1.0	Special Purpose	10,000	2,500	2,500	2,500	2,500
		10,000	574,773	114,051	TOTAL	27.15 FTE	698,824	174,706	174,706	174,706	174,706
					ADOLESCENT PSYCHIATRY						
			1,831,577	323,220	80.95	Personal Services	2,154,797	538,699	538,699	538,699	538,700
				32,000		Operating Expense	32,000	8,000	8,000	8,000	8,000
				750		Travel	750	187	187	188	188
						Capital Outlay					
	6,661	37,000			2.8	Special Purpose	43,661	10,915	10,915	10,915	10,916
	6,661	37,000	1,831,577	355,970	TOTAL	83.75 FTE	2,231,208	557,801	557,801	557,802	557,804
					ADULT PSYCHIATRY						
			2,642,128	466,258	130.50	Personal Services	3,108,386	690,208	806,058	806,060	806,060
				42,000		Operating Expense	42,000	10,500	10,500	10,500	10,500
				1,200		Travel	1,200	300	300	300	300
						Capital Outlay					
						Special Purpose					
			2,642,128	509,458	TOTAL	130.50 FTE	3,151,586	701,008	816,858	816,860	816,860

OPERATING PLAN FOR 1981-82
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.
					ALCOHOLISM TREATMENT PROGRAM						
						Personal Services					
						Operating Expense					
						Travel					
						Capital Outlay					
	148,000				5.0	Special Purpose	148,000	148,000			
	148,000				TOTAL	5.0 FTE(2 mos.)	148,000	148,000			
					GERIATRICS/AFTERCARE/DEAF PROG.						
			925,975	330,082	45.3	Personal Services	1,256,057	314,014	314,014	314,014	314,015
				152,260		Operating Expense	152,260	38,062	38,062	38,062	38,074
				600		Travel	600	150	150	150	150
						Capital Outlay					
	12,200				.5	Special Purpose	12,200	6,000	6,200		
	12,200		925,975	482,942	TOTAL	45.8 FTE	1,421,117	358,226	358,426	352,226	352,239
					GENERAL HOSPITAL & MED. SERV.						
				755,175	21.25	Personal Services	755,175	353,853	133,774	133,774	133,774
				157,127		Operating Expense	157,127	51,852	35,066	35,066	35,143
				100		Travel	100	25	25	25	25
						Capital Outlay					
						Special Purpose					
				912,402	TOTAL	21.25 FTE	912,402	405,730	168,865	168,865	168,942

OPERATING PLAN FOR 1981-82
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 SERVICES					
				2,963,842	134.10	Personal Services	2,963,842	740,960	740,960	740,961	740,961
				408,000		Operating Expenses	408,000	142,800	88,312	88,312	88,576
				2,425		Travel	2,425	606	606	606	607
						Capital Outlay					
	13,000	373,000		41,181	14.0	Special Purpose	427,181	106,795	106,795	106,795	106,796
	13,000	373,000		3,415,448	TOTAL	148.10 FTE	3,801,448	991,161	936,673	936,674	936,940
						ADMINISTRATIVE & GENERAL SERV.					
				1,631,772	67.75	Personal Services	1,631,772	407,943	407,943	407,943	407,943
				533,892		Operating Expense	533,892	160,077	133,473	120,171	120,171
				1,100		Travel	1,100	275	275	275	275
						Capital Outlay					
	20,000			458,155	3.0	Special Purpose	478,155	96,631	142,446	142,446	96,632
	20,000			2,624,919	TOTAL	70.75 FTE	2,644,919	664,926	684,137	670,835	625,021
						TOTAL HOSPITAL PROGRAM					
			5,974,453	6,571,780	506.0	Personal Services	12,546,233	3,214,728	3,110,499	3,110,502	3,110,504
				1,337,599		Operating Expense	1,337,599	414,371	316,493	303,191	303,544
				6,475		Travel	6,475	1,618	1,618	1,619	1,620
				-0-		Capital Outlay	-0-				
	199,861	420,000		499,336	26.3	Special Purpose	1,119,197	370,841	268,856	262,656	216,844
-0-	199,861	420,000	5,974,453	8,415,190	TOTAL	532.2 FTE	15,009,504	4,001,558	3,697,466	3,677,968	3,632,512

OPERATING PLAN
COLORADO STATE HOSPITAL
INCOME & VARIANCE FOR 1981-1982

	FTE	Federal	Cash Fund Patient Revenue	Cash Fund Other	General Fund	Total Income
PERSONAL SERVICES:						
Appropriation	1263.6		$ 8,474,035	$ 1,175,421	$ 16,346,057	$ 25,995,513
Central Pots					4,049,419	4,049,419
OPERATING EXPENSES:						
Appropriation				689,077	1,903,025	2,592,102
TRAVEL:						
Appropriation					17,377	17,377
CAPITAL OUTLAY:						
Appropriation						-0-
SPECIAL PURPOSE:						
Drug Treatment Program	66.9			1,478,249		1,478,249
Central Pots, Drug Treatment					191,085	191,085
Utilities				68,624	1,031,649	1,100,273
Vocational Rehabilitation	8.0			181,906		181,906
Manpower Program				253,800		253,800
School District Program				24,000		24,000
Chicano Inpatient Grant	4.6	$ 93,840				93,840
ESEA	9.0			100,000		100,000
Library Grant	1.0			18,000		18,000
TOTAL	1353.1	$ 93,840	$ 8,474,035	$ 3,989,077	$ 23,538,612	$ 36,095,564
Less Appropriated	(1343.1)	(93,840)	(8,474,035)	(3,871,077)	(19,298,108)	(31,737,060)
VARIANCE	10.0	-0-	-0-	$ 118,000	$ 4,240,504	$ 4,358,504

OPERATING PLAN FOR 1981-1982
COLORADO STATE HOSPITAL

FEDERAL FUNDS	CASH FUND NON-APPROP.	CASH FUND APPROP.	GENERAL FUND			TOTAL BUDGET	1st QUARTER	2nd QUARTER	3rd QUARTER	4th QUARTER
				CHILDREN'S PSYCHIATRY						
		149,007	379,302	Personal Services		528,309	132,077	132,077	132,077	132,078
			15,836	Operating Expense		15,836	3,959	3,959	3,959	3,959
			180	Travel		180	45	45	45	45
				Capital Outlay						
	10,000			Special Purpose		10,000	2,500	2,500	2,500	2,500
	10,000	149,007	395,318	TOTAL	22.20 FTE	554,325	138,581	138,581	138,581	138,582
				ADOLESCENT PSYCHIATRY						
		694,687	1,768,347	Personal Services		2,463,034	615,758	615,759	615,758	615,759
			38,717	Operating Expenses		38,717	9,679	9,679	9,679	9,680
			720	Travel		720	180	180	180	180
				Capital Outlay						
	90,000			Special Purpose		90,000	22,500	22,500	22,500	22,500
	90,000	694,687	1,807,784	TOTAL	104.15 FTE	2,592,471	648,117	648,118	648,117	648,119
				ADULT PSYCHIATRY						
		1,003,349	2,554,053	Personal Services		3,557,402	889,351	889,350	889,351	889,350
			110,477	Operating Expenses		110,477	27,619	27,619	27,620	27,619
			3,500	Travel		3,500	875	875	875	875
				Capital Outlay						
93,840				Special Purpose		93,840	23,460	23,460	23,460	23,460
93,840		1,003,349	2,668,030	TOTAL	149.00 FTE	3,765,219	941,305	941,304	941,306	941,304
				FORENSIC PSYCHIATRY						
		2,101,770	5,350,114	Personal Services		7,451,884	1,862,971	1,862,971	1,862,971	1,862,971
			144,000	Operating Expense		144,000	36,000	36,000	36,000	36,000
			1,200	Travel		1,200	300	300	300	300
				Capital Outlay						
				Special Purpose						
		2,101,770	5,495,314	TOTAL	318.70 FTE	7,597,084	1,899,271	1,899,271	1,899,271	1,899,271
				DRUG TREATMENT						
				Personal Services						
				Operating Expense						
				Travel						
				Capital Outlay						
		1,478,249	191,085	Special Purpose		1,669,334	417,328	417,328	417,328	417,350
		1,478,249	191,085	TOTAL	66.90 FTE	1,669,334	417,328	417,328	417,328	417,350

OPERATING PLAN FOR 1981-1982
COLORADO STATE HOSPITAL

FEDERAL FUNDS	CASH FUND NON-APPROP.	CASH FUND APPROP.	GENERAL FUND			TOTAL BUDGET	1st QUARTER	2nd QUARTER	3rd QUARTER	4th QUARTER
				GERIATRIC PSYCHIATRY						
		585,206	1,489,658	Personal Services		2,074,864	518,716	518,716	518,716	518,716
			69,394	Operating Expense		69,394	17,349	17,349	17,348	17,348
			2,000	Travel		2,000	500	500	500	500
				Capital Outlay						
				Special Purpose						
		585,206	1,561,052	TOTAL	82.40 FTE	2,146,258	536,565	536,565	536,564	536,564
				GENERAL HOSPITAL AND MEDICAL						
		1,459,095	1,941,277	Personal Services		3,400,372	850,093	850,093	850,093	850,093
		165,337	298,437	Operating Expense		463,774	115,943	115,943	115,944	115,944
			450	Travel		450	113	112	113	112
				Capital Outlay						
				Special Purpose						
		1,624,432	2,240,164	TOTAL	117.60 FTE	3,864,596	966,149	966,148	966,150	966,149
				TREATMENT SUPPORT SERVICES						
		2,091,998	4,130,363	Personal Services		6,222,361	1,555,591	1,555,590	1,555,590	1,555,590
		337,248	768,265	Operating Expense		1,105,513	276,378	276,379	276,378	276,378
			7,127	Travel		7,127	1,782	1,782	1,781	1,782
				Capital Outlay						
	18,000	181,906		Special Purpose		199,906	50,000	50,000	50,000	49,906
	18,000	2,611,152	4,905,755	TOTAL	323.20 FTE	7,534,907	1,883,751	1,883,751	1,883,749	1,883,656
				ADMINISTRATION AND GENERAL						
		1,564,344	2,782,362	Personal Services		4,346,706	1,086,676	1,086,677	1,086,677	1,086,676
		186,492	457,899	Operating Expense		644,391	161,098	161,098	161,098	161,097
			2,200	Travel		2,200	550	550	550	550
				Capital Outlay						
		346,424	1,031,649	Special Purpose		1,378,073	344,500	344,500	344,500	344,573
		2,097,260	4,274,110	TOTAL	168.95 FTE	6,371,370	1,592,824	1,592,825	1,592,825	1,592,896
				ALL HOSPITAL PROGRAMS						
		9,649,456	20,395,476	Personal Services		30,044,932	7,511,233	7,511,233	7,511,233	7,511,233
		689,077	1,903,025	Operating Expense		2,592,102	648,025	648,026	648,026	648,025
			17,377	Travel		17,377	4,345	4,344	4,344	4,344
				Capital Outlay						
93,840	118,000	2,006,579	1,222,734	Special Purpose		3,441,153	860,288	860,288	860,288	860,289
93,840	118,000	12,345,112	23,538,612	TOTAL	1353.10 FTE	36,095,564	9,023,891	9,023,891	9,023,891	9,023,891

COLORADO DEPARTMENT OF INSTITUTIONS

DIVISION OF MENTAL HEALTH

	COSTS & RATES			1980-81 Cost Per Client Served - Actual
	1979-80 Actual Costs	1980-81 Actual Costs	1981-82 Daily Rates	
Colorado State Hospital				
Daily Costs and/or Rates INPATIENT ONLY				
Children	161.00	164.00	183.00	28,370
Adolescents	123.00	150.00	167.00	12,699
Adult Psychiatry	91.00	104.00	116.00	3,620
Forensic Psychiatry	85.00	102.00	114.00	22,850
Geriatrics	107.00	132.00	147.00	12,550
General Hospital	159.00	182.00	203.00	5,983
General Hospital - Rehab Unit	122.00	-	-	-
Alcohol Program	125.00	153.00	-0-	3,953
Drug Program	99.00	90.00	100.00	5,896
Cost Per Client Served	-	-	Not Available	8,017
Fort Logan Mental Health Center				
Daily Costs and/or Rates INPATIENT ONLY				
Children	150.00	181.00	Not Available	13,978
Adolescents		160.00		14,413
Adult Psychiatry	121.00	150.00		13,543
Geriatrics (includes Deaf/Aftercare)	134.00	154.00		24,818
Alcohol Program	110.00	127.00		2,981
Cost Per Client Served (Total all programs)	-	-		8,857

Mental Health Centers & Clinics	Average Daily or Per Contact Rate - Based on Unit Costing			
	Av. Rate	Av. Rate	Upper Limit	
Inpatient (Per Day)	129.53(net)	159.69	238.18	
Other 24-Hour Care (Per Day)	43.83(net)	48.27	65.31	
Partial Care (Per Contact)				
Short Day	33.88	41.72	52.13	
Long Day	50.16	54.57	64.86	
Outpatient (Per Contact)				
Individual	43.47	45.26	54.38	
Group	21.75	23.87	29.93	
Individual Brief	17.39	23.29	28.36	
Case Management/Staff Hour	23.56	22.45	25.43	
Sheltered Workshop	33.19	26.05	36.94	
Consultation & Education (Per Staff Hour)	23.63	29.43	40.10	
Cost Per Client Served	497.00	Not Available		

7/21/81

COLORADO DEPARTMENT OF INSTITUTIONS

WORKLOAD

DIVISION OF MENTAL HEALTH

1981-82

	Actual FY 79-80 Avg. Daily Attend. (Weighted)	Actual FY 80-81 Avg. Daily Attend. (Weighted)	1981-82 Avg. Daily Attendance (Weighted)		
			Operating Plan Projection	Year-to-Date	Variance
Colorado State Hospital					
Children	13	13	13		
Adolescents	79	74	83		
Adults	173	170	169		
Elderly	93	86	77		
Forensic	297	291	321		
General Hospital	74	77	50		
Total M. H. Programs	729	711	713		
Alcohol (discontinued 12/31/80)	25	21	-		
Drug	44	55	57		
Total Other Programs	69	76	57		
TOTAL ALL PROGRAMS	798	787	770		
Fort Logan Mental Health Center					
Children	38	32	29		
Adolescents	37	43	38		
Adults	72	79	77/99 [1]		
Elderly (Includes Deaf)	72	69	72		
Vocational Services	21	18	17		
Total M. H. Programs	240	241	233/255		
Alcohol (Inpatient Rehab. Tr.)	27	28	27 [2]		
TOTAL ALL PROGRAMS	267	269	260/233/282[3]		

Average Daily Attendance: Includes Inpatient and other treatment modalities which are weighted on the basis of time and cost as follows:

	CSH	FLMHC
Inpatient	1.0	1.0
Other 24-Hour	.4	.33
Partial Care	.4	.5
Outpatient	.167	.31

[1] 77 from 7/1/81 through 9/30/81
99 from 10/1/81 through 6/30/82

[2] program will close 8/31/81

[3] 260 7/1/81-8/31/81
233 9/1/81-9/30/81
282 10/1/81-6/30/82

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COLORADO DEPARTMENT OF INSTITUTIONS

WORKLOAD

1981-82

DIVISION OF MENTAL HEALTH

	Actual FY 79-80	Actual FY 80-81	Projected FY 81-82
Colorado State Hospital	Total	Total	Total
Clients Admitted	2,830 + 987 gen. hosp. = 3,817	2,433 + 1,291 gen. hosp. = 3,724	2,570 + 1,100 gen. hosp. = 3,670
Fort Logan Mental Health Center			
Clients Admitted	1,214	836	520

Centers and Clinics	Actual FY 79-80 Number	Actual FY 79-80 Percent	Estimated FY 80-81 Number	Estimated FY 80-81 Percent	Projected FY 81-82 Number	Projected FY 81-82 Percent
I. Clients Admitted						
Children	4,812	9.2	4,110	8.0	3,935	9.8
Adolescents	6,482	12.4	5,857	11.4	5,059	12.6
Adults	38,524	73.6	38,945	75.8	28,710	71.5
Elderly	2,544	4.9	2,466	4.8	2,449	6.1
TOTAL	52,362	100.0	51,378	100.0	40,153	100.0
II. Targeted Clients Admitted (Moderate/Severe) TOTAL	41,024	78.3	41,052	79.9	30,752	76.6
III. Minority Persons Admitted TOTAL	11,199	21.4	11,457	22.3	7,388	18.4

CHAPTER VI. REPORT ON THE ACCOMPLISHMENT OF STATE PLAN OBJECTIVES FOR FISCAL YEAR 1980-81

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.

*****Indicates objectives that are to be included in the Department of Institutions 1980-81 Operating Plan

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished - The system is currently in place in Centennial MHC, Spanish Peaks MHC, and Aurora MHC. The preliminary results were presented at the Quality of Life Learning Committee meeting, November 14-16, 1980.
	(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)	Accomplished - A pilot collaborative study was conducted at Aurora MHC, Spanish Peaks MHC, and SW Denver MHC. This study will form the basis of a larger study to be completed during the next fiscal year.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished* - A copy of the final report is available from the Division of Mental Health.
	(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)	Accomplished* - A copy of the final report is available from the Division of Mental Health.
	(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)	Accomplished - A progress report on the status of SB 26 was submitted to the Department of Institutions in March, 1981. Additional data is being collected from both state hospitals to help in monitoring the impact of SB 26. The results of the analysis of this data will be part of the information given to the Department of Social Services to be included in their evaluation of SB 26.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished* - The work to develop the methodology to integrate these data sets has been completed.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished* - During the past year, monthly quality assurance summary reports were submitted to DMH by the centers/clinics. In addition, there were quality assurance monitoring/consultation visits to 21 centers/clinics.
	(2) To monitor the clinical quality assurance systems for 23 centers/clinics.	9/30/80	-Monitoring review completed	Program Services ($5,000)	Accomplished - As part of the Medicaid on-site monitoring reviews, the clinical quality assurance systems were extensively evaluated at each of the 23 centers/clinics. These evaluations were completed in May, 1981.
	(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)	Accomplished* - The "Report of Results of the QAP Questionnaire Evaluation Study" is available from DMH.
	(4) To have implemented an individual patient outcome review in the centers and clinics.	9/30/80	-Reviews completed	Program Services ($8,000)	Accomplished* - A pilot study was performed at 9 mental health centers. The study consisted of individual interviews with Medicaid clients and client record reviews. After the study was completed, the Medicaid format was revised.
	(5) To have implemented a Medicaid review of individual patient's treatment.	9/30/80 *****	-Reviews completed	Program Services ($10,000)	Accomplished* - The Medicaid review package has been assembled and distributed to the mental health centers. The assessment will focus on monitoring clinical records, peer and utilization review systems, and client satisfaction instruments for Medicaid clients at each center.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - The clinical quality assurance evaluations have been completed in each of the 23 centers/clinics and the two state hospitals. An evaluation report with recommendations has been written and provided to each facility.
	(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)	Accomplished* - The report analyzing the data has been completed and is in the process of being summarized and reproduced for distribution.
	(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)	Not accomplished - No further work has been done on this objective since the Quality Assurance Program is no longer required by the Division, but is used as an optional internal management tool to be utilized by individual centers based on their own needs.
	(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)	Not accomplished - No further work has been done on this objective since the Quality Assurance Program is no longer required by the Division, but is used as an optional internal management tool to be utilized by individual centers based on their own needs.
	(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)	Accomplished - The Committee on Sexism has identified criteria for guiding programs in serving women.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished* - A proposal was completed by the Division of Communications and is on file in the FLMHC audio-visual office. The proposal will be reviewed for inclusion in the Division's FY 82-83 budget request.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished* - Contracts were signed on November 1, 1980, with Spanish Peaks, Aurora, and Jefferson County Community Mental Health Centers.
	(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)	Accomplished - The State Mental Health Council reviewed the current available data and determined that state-funding only goes to pay that portion of a client's bill that the client does not have ability to pay; however, the system does not ensure that funding goes to those clients with the least absolute ability to pay. The Council will continue to address this issue.
	[1](3) To have admitted and provided services to 4,467 children in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($2,300,000)	Accomplished - DMH projection based on twelve-month estimates = 4,657
	[1](4) To have admitted and provided services to 6,766 adolescents in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($5,200,000)	Not accomplished - DMH projections based on twelve-month estimates = 6,676

[1](The number and/or percentages of clients to be admitted are based upon the DMH/Center contracts.)

DEPARTMENT OF INSTITUTIONS GOAL #II: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	[1](5) To have admitted and provided services to 3,255 elderly in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($3,300,000)	Not accomplished - DMH projection based on twelve-month estimates = 2,806
	[1](6) To have admitted and provided services to 11,256 ethnic minorities in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($11,500,000)	Accomplished - DMH projection based on twelve-month estimates = 13,073
	[1](7) To have admitted and provided services to 40,379 targeted moderately and severely disabled clients in FY 1980-81.	6/30/81 *****	-Signed contracts -Admission data	DMH Centers/ Clinics Hospitals ($52,000,000)	Accomplished - DMH projection based on twelve-month estimates = 45,783
	[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)	The Division and the centers/clinics are not directly responsible for out-of-state placements, as those placements are regulated by the Department of Social Services. This objective, therefore, should be deleted as worded, though the Division is very involved in efforts to reduce the number of children served out-of-state.
	(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)	Accomplished - The CSH cumulative report on prescreening analysis (July 1, 1980 - May 31, 1981) indicates that 73% of all GTC, CATC, and GAPs patients were prescreened. Fort Logan is running at 94-95% prescreened admissions.

[1](The number and/or percentages of clients to be admitted are based upon the DMH/Center contracts.)

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - The plan was developed; however, additional funds were not included in the FY 82-83 budget request for state support. HUD 202 funds will be used to increase the capacity for serving senior citizens.
	(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)	Accomplished - A plan was developed; however, after re-evaluation of budget priorities, expansion of inpatient beds was determined to be the higher priority.
	(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)	Not fully accomplished - The plan for establishing 60 adult residential facility beds in the Denver Metropolitan Area in FY 81-82 was submitted to the JBC. The Division also requested funding for FY 81-82 to develop a statewide plan for addressing state hospital and community-based bed needs; however, the request was not funded. The Division will continue to work on developing a long-range plan to address the need for state hospital and adult residential care facility beds.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - The Division's initial budget request for FY 81-82 included funding for model programs; however, the request was deleted from the Executive Budget. Inadequate staff resources have precluded the development of alternative grant proposals.
	(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)	Not accomplished - The Division's initial budget request for FY 81-82 included funding for model programs; however, the request was deleted from the Executive Budget. Inadequate staff resources have precluded the development of alternative grant proposals. The budget request did include funding for the Special Hispanic Program at CSH.
	(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)	Not accomplished - The Division's initial budget request for FY 81-82 included funding for Women's programs; however, the request was deleted from the Executive Budget. Inadequate staff resources have precluded the development of alternative grant proposals.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished* - On September 15, 1980, a grant was submitted to the State Department of Local Affairs. Funding was approved, and contracts have been drafted by the Department of Local Affairs for the Colorado West Mental Health Center.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished* - Materials were sent to community mental health center Executive Directors on March 11, 1981. These materials were presented May 5-11, 1981, at the WICHE Primary Prevention Conference held in Fresno, California.
	(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)	Not accomplished - DMH projection based on twelve-month estimates = 66,834
	(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)	Not accomplished - With the lack of either federal or state funding for primary prevention programs, there would be very little, if any, chance of implementing a five-year plan for primary prevention.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - This objective was not included in the Division's budget request. Alternative funding sources have been explored, and it has been determined that there are very few resources for this type of project.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished* - Copies of the Guidelines are available from the Division of Mental Health.
	(2) To have revised the social indicators model for community need assessment and recalculated the estimate of populations in need to be consistent with the revised social indicators.	9/30/80 *****	-Revised model (written)	Program Services ($3,000)	Accomplished* - The revised social indicators model is described in the 1980-85 State Mental Health Plan.
	(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)	Accomplished* - Twenty catchment area mental health plans were submitted to DMH. The Colorado Mental Health Council and DMH staff reviewed each of the plans and prepared analyses of the plans.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished* - The due date for this objective should be extended to October, 1981. DMH has established a joint DMH/ Centers Need Assessment Task Force to work on a population-in-need based redistribution formula. A letter of agreement and an invitation to participate was issued by DMH and the Centers' Association on 11/19/80. The Task Force and its committees have been meeting on a regular basis since then, and a first quarter report was submitted. This Task Force will report to DMH, the Centers' Association, and the Colorado Mental Health Council at least semi-annually.
	(5) To have the first of State Mental Health Plan Update for 1981, based on catchment area plans, HSA plans, available for review.	4/1/81	-Draft available for review	Planning Services SHMACs ($6,000)	Accomplished* - The first draft of the State Mental Health Plan was not available for review until May 1. The changing status of the Federal Mental Health Systems Act, which requires the development of the State Plan, delayed the prepareation of the first draft.
	(6) To have provided the members of the Statewide Health Coordinating Council involved with mental health planning with information on the mental planning process and the key issues for the Colorado mental health system.	4/3/81	-Presentation provided	Planning Services ($500)	Accomplished - Members of the Colorado Mental Health Council provided the SHCC with information on the mental health planning process and the key issues for the Colorado mental health system during a presentation to the members of the SHCC on March 24, 1981.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - DMH staff met with SHPDA staff regarding the mental health component of the State Health Plan. Meetings included the exchange of information regarding key issues for mental health, data, evaluation, and financing for mental health.
	(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)	Accomplished - DMH staff are working with and providing consultation to the Denver Health and Hospitals team that is conducting a survey of the City and County of Denver. Staff also anticipate working with Jefferson County MHC, which is presently considering undertaking a survey.
	(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)	Accomplished - An NIMH T.A. grant to analyze the relationship between existing survey data and social indicators has been applied for and approved.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished* - A written plan was completed July 23, 1980.
	(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)	Not accomplished - The work of the FLMHC Bed Allocation Task Force and the complexity of this issue were underestimated when the original due date for the objective was established. This objective will probably not be accomplished until next year.
	(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)	Not fully accomplished - Meetings have been held with representatives from a variety of agencies. A pre-test of a potential definition was performed at three sites, and a preliminary run through the DMH-MIS has been completed. Additional work on refining the definition is required.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - Funding for this objective was diverted; consequently, the objective will not be accomplished.
	(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)	Not accomplished - A working agreement was finalized, but a formal contract has not been developed due to modifications made in the Management Plan accepted by NIMH which requires the rural site to provide training to other centers.
	(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)	Not fully accomplished - A Socialization Workshop was held in Denver on March 26, 1981. Preliminary guidelines were developed, and a 12-member committee was formed to develop final guidelines. The committee has been meeting on a regular basis, and expects the guidelines to be completed by 7/31/81.
	(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)	Accomplished - A state conference was held, and a statewide organization, CAMI (Colorado Alliance for the Mentally Ill), was created. Members of CAMI serve on the Advisory Committee of CCSS.

DEPARTMENT OF INSTITUTIONS GOAL #III: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(8) To have performed a cost-benefit analysis of community support services for long-term clients in three selected sites.	4/30/81	-Feasbility statement of cost-benefit study	Program Services ($2,000)	Accomplished* - A copy of the final report is available from the Colorado Community Support System Project Office.
	(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)	Accomplished - Eighteen HUD Section 8 units have been allocated to five community mental health centers that have not previously participated in the program as sponsors. HUD 202 projects have expanded to include Arapahoe MHC, Aurora MHC and Seniors, Inc. These projects received new HUD 202 allocations this past summer.
	(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)	Accomplished* - A copy of the report is available from the Colorado Community Support System Project Office.
	(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)	Accomplished* - The report mentioned above indicates the changes in the availability of CSS advocated services available in each of the catchment areas. A copy of this report is available from the CCSS office.

DEPARTMENT OF INSTITUTIONS GOAL #III: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - Staff and board determinations have been made and are reflective of the catchment areas served.
	(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)	Accomplished - During FY 1980-81, the GTC Staff, at the request of the Southwest Mental Health Center, presented a workshop on the mental health needs of the elderly, including residential programming. The GTC Staff also worked closely with Spanish Peaks Mental Health Center in preparation for the transfer of the CSH residential program to the Center. Due to travel restrictions, it would have been impossible for the GTC to offer any more consultation.
	(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)	Not accomplished - It was determined that the need for a unit to serve the violent mentally ill was a higher priority than a new short-term inpatient service. The need for both short-term and long-term beds at Fort Logan continues to be addressed.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - It was determined that the responsibility for the achievement of this objective was more appropriately that of the Colorado Community Support System (CCSS) Project. CCSS staff completed a statewide assessment of training needs.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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 coordition in planning, data exchange, and training resources.	9/30/80	-Written agreement	Planning Services Program Services ($500)	Accomplished* - The written agreement was signed by the Director of the Division of Mental Health and the Director of the Division of Criminal Justice as of September 16, 1980.
	(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)	Not accomplished - No formal survey instrument has been developed. The DMH and the Division of Criminal Justice have completed a signed agreement which includes a provision to conduct a survey by September 1981.
	(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)	Accomplished - A survey of agencies that interact with the Division of Mental Health was conducted through the Department of Institutions performance auditors and management staff.

DEPARTMENT OF INSTITUTIONS GOAL #IV: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - Preliminary work has been done with the juvenile court, and further work is proceeding. Fort Logan was not successful in getting the courts to hold off on commitments of juveniles without due consideration of the constraints at FLMHC; however, it is felt that there is increased understanding on the part of the judges due to the increased dialogue.
	(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)	Accomplished* - The specialized cooperative agreements with the Division of Alcohol and Drug Abuse and the Division of Rehabilitation have been revised. The agreement with the Division of Criminal Justice was signed on 9/16/80.
	(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)	Accomplished* - The "Guidelines for Cooperative Provision of Emergency Services by DMH and ADAD Funded Agencies, Revised January, 1981" is available from DMH.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not fully accomplished - Staff of DMH and ADAD continue to study and provide consultation to agencies on federal confidentiality requirements; however, continued difficulties in their interpretations, which would make them applicable to mental health and substance abuse, prohibited the finalization of the guidelines at this time.
	(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)	Accomplished - All working agreements at the local level have been finalized, with the exception of the local agreement at Pikes Peak Mental Health Center.
	(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)	Not accomplished - Several meetings were held with the Alcohol and Drug Abuse Division; however, the feasibility study was not completed.
	(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)	Accomplished* - FLMHC has met with the Denver District Court judges. FLMHC also drafted legislation to amend existing law to allow for psychiatric evaluations for deferred prosecution and conditions of probation; however, the legislature did not pass this amendment.

DEPARTMENT OF INSTITUTIONS GOAL #IV: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - FLMHC has met with the Denver District Court judges; however, there has been no success in obtaining funding data from the State Court Administrator. This may be a more appropriate function for the centers.
	(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)	Not accomplished - A combined DD/state hospital treatment unit will be considered during FY 81-82. No funding for this program has become available to date.
	(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)	Not accomplished - This objective has been reevaluated and has been determined to be inappropriate at this time, due to limited resources.

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

DEPARTMENT OF INSTITUTIONS GOAL #IV: (cont.)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Not fully accomplished - The Office of State Planning and Budgeting has directed the Department of Social Services to expand Medicaid coverage to patients aged 21-64 for the first month of admission at CSH and FLMHC. DSS has contracted for a feasibility study with Deloitte, Haskins and Sells. Contracts providing higher retroactive Medicaid rates have been signed for both hospitals for FY 78 through FY 81.
	(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)	Accomplished - The DMH Budget Request for FY 81-82 reflects an increase from $2,000,000 to $3,000,000 in anticipated payments to mental health centers under the clinic option for FY 80-81. Current estimates are $3,157,000.
	(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	Accomplished - CSH data for the first 11 months indicates that this objective will be accomplished. Patient revenues at FLMHC are projected to be about the same as FY 79-80 before the possibility of additional Medicaid reimbursement is considered.
	(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)	Accomplished - The primary method identified for expanding funding for the mental health system at this time is through maximizing Medicaid dollars for the hospitals and the community mental health centers.

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

DEPARTMENT OF INSTITUTIONS GOAL #IV: (cont.)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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	Accomplished - Individual plans to increase fee collections have now been received from all centers/clinics. Quarterly reports have been submitted by some centers. Plans indicate that the centers will accomplish this objective. A final report will be issued upon receipt of the financial audits from the CMHCs.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished* - The Department of Social Services took the lead to develop a statewide data collection effort. DMH has been working with DOI, DDD, and DYS on this project. Early results have been summarized: DMH mailed out a questionnaire, and has analyzed the data. DOI has the lead for the Department on this project.
	(2) To have reviewed the Affirmative Action Plans of the 23 centers/clinics.	12/31/80	-Monitoring reviews completed	Program Services ($2,000)	Accomplished - All Affirmative Action Plans have been reviewed.
	(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)	Accomplished - All 27-10 designated facilities have been visited. Thirty-seven agencies are considered to be in full compliance at this time.
	(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)	Accomplished - The Division has determined that 22 centers and clinics are in full compliance with the Standards/Rules and Regulations for Mental Health Centers and Clinics. One remaining agency is Health and Hospitals Mental Health Program, regarding their emergency services. As this hospital licensure is under a general hospital license, the letter to the Department of Health will be sent prior to September 30, 1981.

DEPARTMENT OF INSTITUTIONS GOAL #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(5) To have analyzed service components of HUD Section 8 and 202 programs.	3/23/81 ***** *****	-Monitoring reviews completed	Program Services ($1,000)	Not fully accomplished - Contact has been made and 10 of the 17 mental health agencies participating in the HUD Section 8 Program have been observed. An Attendance Verification form has been developed which describes service components provided by each agency and is reported to CCSS monthly. CCSS staff are working with HUD officials and the HUD 202 Project sponsoring agencies to develop a thorough process of analyzing service components provided to clients housed in HUD 202 sites.
	(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)	Accomplished - An alternative data collection system for 27-10 has been developed. This system was presented to several non-DMH designated facilities on 9/4/80. They expressed approval. This system will utilize the existing DMH Admission Form. Use of this form will lead to integration with the DMH MIS.

DEPARTMENT OF INSTITUTIONS GOAL #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - The Governor's Advisory Board is working on these standards. Because of many issues, however, it is expected that the first draft for public review will be available no earlier than 8/1/81. Additional time will be required for the completion of this objective. The expected completion date is 1/1/82.
	(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)	Accomplished - CSH has requested that the Regional Assistant Attorney General complete a list of volumes to establish a minimal, but working, law library. CSH plans to incorporate the cost into the budget request for FY 1981-82.
	(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)	Accomplished* - A written plan, including a funding proposal, was prepared and submitted to NIMH; however, the proposal was not funded.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Not fully accomplished* - Data from two client status reports has been received and a request for data on the third client status report has been issued. Revised reports are due July 10, 1981.
	(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)	Accomplished* - The recommendations are included in the report entitled, "Violence and the Mentally Ill: A Response to an Executive Order by Governor Lamm of Colorado".
	(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)	Not fully accomplished* - An allocation system was developed by a Bed Allocation Task Force which included representatives from DMH, FLMHC, and the Centers' Association. The plan calls for a phased in implementation of the bed allocation system. The target date for implementation was changed to July 1, 1981.

DEPARTMENT OF INSTITUTIONS GOAL #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished* - A report on the status of the recommendations included in the report on violence and the mentally ill was prepared on December 18, 1980.
	(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)	This objective was not accomplished as written, as the Senate Resolution did not result in recommendations.
	(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)	Accomplished* - The form's final content and format has been developed in joint meetings with DMH, community, and hospital personnel. The implementation date is scheduled for July 1, 1981.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - Implementation of the Client Status Report has been delayed due to the ADP-Pueblo computer conversion. Stratified sampling would commence no earlier than the fourth data collection effort (7/81). Anticipated completion of this objective is 11/1/81.
	(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)	Not accomplished - DMH has an in-house computer/terminal and is developing increased resources around MIS and data processing. There are plans to consolidate various Evaluation Section and Fiscal Section files, and discussions have begun with the Fiscal Section to accomplish this. As implementation will occur in a modular fashion, so will the procedure manual.
	(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)	Accomplished - The Department of Institutions has submitted an application to the Department of Health requesting that the licensed psychiatric beds at CSH and FLMHC be shifted from the two state hospitals to the Department of Institutions. This would give the Department more flexibility in distributing beds based on needs and resource availability.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - Data is available; however, the Department of Institutions' information system is not yet operational.
	(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)	Accomplished - Plans, through research efforts, reorganization, staffing, and physician changes for the Institute of Forensic Psychiatry, have been developed and are being implemented.
	(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)	Not accomplished - DMH has received information pertinent to this issue from the National Association of State Mental Health Program Directors. The reports indicate that this is not being done in other states.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - The program and the rough architectural plans are completed.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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 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)	Accomplished* - The revised standards were sent to the state hospitals on 10/3/80. Several areas will need additional study.
	(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)	Accomplished* - A report was submitted by the Executive Director's Office to the Joint Budget Committee on January 31, 1981.
	(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)	Accomplished - A process for internal reviews of centers/clinics has been implemented.
	(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)	Accomplished - Plans from the 23 centers/ clinics have been received and accepted as part of the contract negotiations. Revised plans, where appropriate, are to be submitted on or before October 1, 1981.

DEPARTMENT OF INSTITUTIONS GOAL #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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	Accomplished* - Written materials were submitted to the Colorado Mental Health Council.
	(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)	Not fully accomplished* - The "Colorado Private Sector Mental Health Survey, 1980", has been completed and disseminated. Work Force data for the public sector has been collected and is in the process of being edited.
	(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)	Accomplished* - DMH provided expertise to conduct and analyze the study. A joint presentation was made at the Annual Mental Health Conference in October, 1980. Reports have been issued by the Division and the Mental Health Association.
	(8) To have assembled information on mental health training programs and institutions of higher learning.	2/1/81	-Written report	Program Services ($15,000)	Not accomplished - Survey instruments have been developed and distributed.

DEPARTMENT OF INSTITUTIONS GOAL #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(9) To have developed a comprehensive state plan for mental health work force development.	4/30/81 *****	-Written plan	Program Services ($10,000)	This objective has been revised. Rather than developing a separate work force plan, the statewide work force objectives will be integrated into the State Mental Health Plan.
	(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	-Preliminary reports	Program Services ($40,000)	Accomplished - A correlational analysis of minority staffing patterns and admissions is complete. At present, a therapist preference study is being conducted at rural and urban community mental health agencies. Sample data will be collected by the indicated date, and an analysis will follow.
	(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)	Accomplished - Staffing studies on ethnic minorities and women are utilized in contract negotiations. The Forensic Study at CSH was used in implementing personnel policy changes.
	(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)	Accomplished* - Training summaries for each training program are available from DMH.

DEPARTMENT OF INSTITUTIONS GOAL #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished* - Training summaries for each training program are available from DMH.
	(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)	Accomplished* - Training summaries for each training program are available from DMH.
	(15) To have provided training programs focusing on management issues.	6/30/81	-Training programs take place -Training summaries	Program Services ($20,000)	Accomplished* - Training summaries for each training program are available from DMH.
	(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)	Not accomplished - CSH has been able to hire only three psychiatrists of the eight they projected as needed to bring them into compliance with psychiatric standards.

DEPARTMENT OF INSTITUTIONS GOAL #V: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Not accomplished - This issue was not addressed with the state legislature.
	(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)	Not fully accomplished - Preliminary work has been done by assigned staff. The written plan is to be completed by August 31, 1981.
	(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)	Accomplished* - A copy of the Hospital Staffing Variance Report is available from DMH.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
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)	Accomplished* - This objective was accomplished 8/31/80 with a pro-rata allocation of $500,000 to the four lowest per capita funded centers (Arapahoe MHC, Boulder MHC, Jefferson MHC, and Weld MHC).
	(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)	Not accomplished - Discussions involving DMH staff and the Centers' Association have begun, but have not resulted in a feasibility study. The Fort Logan bed allocation plan will have some impact on this objective.
	(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)	Accomplished* - A report has been submitted to the JBC.
	(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)	Not accomplished - SCOPE has not been used as a management measure for the two state hospitals, as funding for adequate staffing is not available.

DEPARTMENT OF INSTITUTIONS GOAL #VI: (continued)

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1980-81	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - An initial ten-year capital construction plan, developed on a yearly basis, has been prepared and submitted for approval to the State Building Division, Department of Administration. The building inventory at FLMHC has been completed and will lead to the plan. FLMHC is working with the State Building Division on this objective.
	(6) To have developed a five-year Division-wide plan for energy conservation.	6/30/81	-Written plan	Finance Services CSH FLMHC ($5,000)	Not accomplished - The objective has been revised and will be included in the FY 1981-82 Operating Plan.
	(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)	Accomplished - Three projects were approved and funded. All three projects have been completed.

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	ACCOMPLISHMENT AND COMMENTS (* indicates written materials are available)
	(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)	Accomplished - Four such projects have been incorporated into the capital construction requests to be included in the five-year plan for energy conservation.
	(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)	Accomplished - The first eleven months show a cumulative 16.4% decrease as compared with the base year of 1978-79. A final report will be issued upon receipt of the last month's data.
	(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)	Accomplished - Gallons of fuel decreased during the first three quarters of FY 80-81, as compared to the same period of FY 78-79, by 4.8%. It appears that the objective will be accomplished as written. A final report will be issued upon receipt of the fourth quarter data.

APPENDIX I. ADMINISTRATIVE INFORMATION

A. COLORADO MENTAL HEALTH COUNCIL

1. Membership

The Colorado Mental Health Council was created in September, 1976, by Governor Richard Lamm. The Council consists of 21 members. The updated 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 3 of this appendix.

2. Functions, Responsibilities, and Procedures

The Colorado Mental Health Council functions as the official advisory body to the Division of Mental Health with regards to policy, operation and finances. The Council is responsible for approving the State Mental Health Plan and for assisting in the preparation of the Annual Division of Mental Health Budget Request. In that role, it functions 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 meets as often as necessary to review the service priorities of the Division of Mental Health.
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 standing committees to work with staff of the Division of Mental Health in its planning and implementation of such matters as policy, operations and finances. The Council also establishes ad hoc committees for special assignments deemed necessary by the Council or the Director of the Division of Mental Health.
e. The Council endeavors to act as a coordinating body in developing greater public and legislative awareness and support of the mental health system.

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 Council in FY 1980-81

The Council held ten monthly meetings. 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 past year included revising the Council bylaws (a copy of the revised bylaws also is included in this appendix) and re-organizing the Council's committee structure. The Council also focused its attention on the State Mental Health Plan, the Division's

budget request, public and legislative awareness issues, and program priorities for targeted populations.

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 COLORADO MENTAL HEALTH 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	
Rosita Bachmann	9/82	X				X			Fort Collins			X	X				Human Relations Officer, Ft.Collins
Guidotta Bates	9/81	X						X	Brush	X			X				Consumer
Mike Coren	9/82		X					X	Englewood			X			X		Colorado,Mental Health Association
Lucy May Dame	9/81	X						X	Denver		X		X				Senior Citizens Board
Dorothea Dolan	9/82	X						X	Denver		X		X				Retired
Frederick Dow	9/82		X	X					Denver		X		X				C.U., Asian-American Educ. Program
Melanie Fairlamb	9/82	X						X	Delta	X			X				Consumer
Ruth Fuller	9/82	X			X				Denver		X					X	UCHSC, Dept. of Psychiatry
Peter Garcia	9/81		X			X			Lafayette			X		X			HSA Member
Jerry Goebel	9/82		X					X	Boulder			X		X			UCHSC, Div. of Child Psychiatry
Leslie Hartley	9/82	X						X	Windsor	X			X				Consumer
Carol Howe	9/81	X						X	Golden			X	X				Consumer
Alma Lantz	9/81	X						X	Denver		X		X				Consumer
Luis Medina	9/81		X			X			Alamosa	X				X			San Luis Valley M.H. Center
Robert Nuffer	9/81		X					X	Glenwood Springs	X				X			Colorado West M.H. Center
Jack Quinn	9/81		X					X	Pueblo		X		X				Pueblo Housing Authority
Roger Richter	9/82		X					X	Denver		X		X				Insurance
Nancy Sanford	9/82	X			X				Colorado Springs		X			X			SE Colo. Health Systems Agency
Randy Stith	9/82		X					X	Aurora			X		X			Colo. Assn. of Comm. M.H. Centers
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

COLORADO MENTAL HEALTH COUNCIL

State of Colorado

BY-LAWS

ARTICLE I-NAME

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

ARTICLE II-PURPOSES & FUNCTION

The Council 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 will function as the official advisory body to the Division of Mental Health with regards to policy, operations and finances.

(b) The Council shall be involved with the development, revision, and administration of the State Mental Health Plan each year to ensure its relevance and responsiveness to changing mental health needs and its coordination with other planning efforts. The Council shall be responsible for approval of the State Mental Health Plan.

(c) The Council shall assist in the preparation of the Annual Division of Mental Health Budget Request and (1) be responsible for its approval prior to submission to the Department of Institutions; (2) assist in the presentation to the Department, Administration and the Legislature; and (3) be responsible for approval of the operating plan after allocations have been made.

(d) The Council shall maintain a record of dates of Council meetings, issues considered and a record of actions taken,

including specific reference to the required annual review and approval of the State Mental Health Plan for inclusion in the annual up-date of the Plan.

(e) The Council shall establish standing committees to work with staff of the Division of Mental Health in its planning and implementation of such matters as policy, operations, finances and other areas. It shall also establish ad hoc groups for special assignments deemed necessary by the Council or the Director of the Division of Mental Health.

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

(g) The Council shall endeavor to act as a coordinating body in developing greater public and legislative awareness and support of the mental health system.

ARTICLE III-MEMBERSHIP

The State Mental Health Council shall consist of twenty-five members who will be residents of Colorado. No less than forty percent of the members of the Council shall be direct or indirect providers of mental health services. A majority, but no more than sixty percent of the members, shall not be direct or indirect providers of mental health services. The membership shall include representatives of those elements of the mental health service delivery system and the geographic areas which it serves.

The Council shall be appointed by the Governor. Members shall be appointed for two-year terms. Expired memberships shall be filled by the Governor for two-year terms except that appointments to fill unexpired terms of members who resign or become ineligible for continued membership shall be for the unexpired terms of the resigned members.

Any citizen may nominate persons to serve on the Council. The names of nominees may be submitted to the Nominating and Membership Committee of the Council which will forward all nominations to the Governor with recommendations.

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 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.

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 State's fiscal year shall be known as the Annual Meeting.

ARTICLE VI-MEMBERSHIP PARTICIPATION

Regular attendance by members is required. Members of the Council shall advise the Chairperson or designee in advance of non-attendance. A member who has three consecutive absences or four absences in a twelve-month period 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.

Each member is expected to take an active part in Council and committee activities.

ARTICLE VII-QUORUM

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

ARTICLE VIII-COMMITTEES

The Chairperson shall appoint as many standing and other committees as are necessary to carry on the work of the organization and membership in such committees may be composed of both members and non-members of the Council. The Chairpersons of such committees must be members of the Council, however, and the Director of the Division of Mental Health shall be an ex-officio member of all committees.

One such standing committee shall be an Executive Committee which shall consist of the Council Chairperson and Vice-Chairperson and the Chairpersons of all standing committees.

Other standing committees shall include but not be limited to the Budget Committee, the State Plan Committee, the Nominating and Membership Committee, the Program Committee, and the Personnel Committee, each of which shall consist of five or more members.

The Council shall approve the functions and responsibilities of each standing committee.

ARTICLE IX-STATE MENTAL HEALTH PLAN

The Council, at all times, shall operate in accordance with the State Mental Health Plan.

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-AMENDMENT 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.

COLORADO MENTAL HEALTH COUNCIL

BYLAWS

AMENDMENT

ARTICLE III - MEMBERSHIP, paragraph one of the bylaws of the Colorado Mental Health Council was amended at the April, 1981, meeting of the Council to read as follows:

> "The State Mental Health Council shall consist of twenty-one members who will be residents of Colorado. No less than forty percent of the members of the Council shall be direct or indirect providers of mental health services. A majority, but no more than sixty percent of the members, shall not be direct or indirect providers of mental health services. The membership shall include representatives of those elements of the mental health service delivery system and the geographic areas which it serves."

Amendment passed by the Colorado Mental Health Council on April 9, 1981.

Virginia Kelly
Recording Secretary
Colorado Mental Health Council

4/81

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)

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: September 11, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Dorothea Dolan
Melanie Fairlamb
Peter Garcia
Jerry Goebel
Fred Lane
Luis Medina
John Nagle
Jack Quinn
Roger Richter
Nancy Sanford
Robert Young
Cece Zavala

Absent:

Lucy May Dame
John Marshall
Isabelle Medchill
Katherine Money
Marge Taniwaki
Michael Weissberg

Staff Present:

Lynn Dawson

Guests:

Annette Adler
David Bustos
Lynne Hufnagle
Youlon Savage
Elinor Stead

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Approval of Minutes: Mr. Nagle moved that the minutes of the July meeting be approved as written. Ms. Dolan 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, Lynn Dawson gave the director's report.

On September 29, Robert Glover will succeed Sutherland Miller as the Director of the Division of Mental Health. Dr. Glover has been the administrator of the Division of Community Rehabilitation in the Idaho State Department of Health and Welfare since 1976. He holds a doctorate in clinical psychology and a master's degree in developmental psychology. Dr. Glover will be present at the October meeting of the Council.

The Division has been involved in hearings before the Health, Education, Welfare, and Institutions Committee and the Judiciary Committee of the Legislature. The Judiciary Committee has been studying mental health laws and criminal laws related to mental health, and the HEWI Committee has been reviewing the mental health system.

The Legislature last year passed a bill requiring performance audits of all the State departments. The Department of Institutions volunteered to be one of the first departments to be audited, and that audit is in progress.

Mr. Richter announced that the agenda had been changed in order to allow the report by the Child/Adolescent Task Panel to be the third item on the agenda.

Child/Adolescent Task Panel Report: Mr. Goebel introduced Lynne Hufnagle, who works with the Juvenile Justice Staff Development Project. Ms. Hufnagle explained the current status of Senate Bill 26 to the Council. Senate Bill 26 is a very complicated law which attempts to control the increasing costs of out-of-home placements and to limit such placements. This bill requires that the case of any child who is in out-of-home placement for 90 days come before the court on a petition for review of need for placement. The court then determines if the child needs to remain in placement, and, if so, whether the placement in which the child is presently located is the most appropriate one. The bill also covers deinstitutionalization of children for the first time in Colorado. The "Community Organization" part of the bill permits the formation of "placement alternatives commissions" by counties who wish it. These commissions are appointed by the county commissioners and can submit plans for foster care monies, which are available to them through their departments of social services, for alternative placements in their own communities.

Ad Hoc Committee for Bylaw Revisions: Mr. Richter asked for discussion of the changes submitted by the Bylaws Committee. The Committee recommended that the Council include additional Standing Committees which would parallel functions within the Division. These would include the State Plan Committee, the Budget Committee, a Program Committee, a Nominating and Membership Committee, and a Personnel Committee. The Council would assume responsibility, not only for approval of the State Plan, but also for approval of the Division's budget request prior to its submission to the Department of Institutions. The original bylaws limited the terms of Council members to five consecutive years. This limitation would be excluded. This was recommended with the view that the Standing Committee on Membership would exercise more judgment with regard to keeping members on the Council and recommending resignations or non-renewal of terms of those who are not able to be active. In addition, after three consecutive absences or four absences in a 12-month period, a member would be asked to resign, or would have to request that the Council vote on his/her retaining membership. The Committee included in their recommendations that the election of officers be held in July to coincide with the Division's fiscal year, and that the Council be expanded in size to include 30 members, rather than 21.

Mr. Goebel moved adoption of the changes recommended by the Committee, with the addition of changing Article II, Paragraph (g), to read, "The Council shall endeavor to act as a coordinating body in developing greater public and legislative awareness and support of the mental health system". Ms. Dolan suggested that Article IX be changed to read, "The Council, at all times, shall operate in accordance with the State Mental Health Plan".

Ms. Fairlamb moved that the proposed revisions be referred back to the Committee for further consideration. After much discussion, the motion was withdrawn. Dr. Medina moved that the bylaws be adopted as revised by the Ad Hoc Committee, with the exception of Mr. Goebel's alteration of Article II and Ms. Dolan's revision of Article IX. Mr. Nagle seconded the motion. Mr. Quinn moved that the motion be amended to change the requirement for a quorum to forty percent of the membership, rather than a majority of the members. Dr. Medina and Mr. Nagle accepted Mr. Quinn's motion. Mr. Garcia moved to

sever, but his motion died for lack of a second. The motion to accept the revisions in the bylaws, with the amendments, passed.

Mr. Richter will meet with Dr. Leidig next week to discuss the revised bylaws.

State Plan Committee Report: Dr. Medina reported that the Committee discussed membership and committee structure. David Harrod, of the Colorado Association of Community Mental Health Centers and Clinics, was appointed as a member of the Committee. Membership on the Committee will be discussed again during the Committee's October meeting.

The State Health Coordinating Council has acted to approve the State Plan, although the members had some questions regarding public input and the system of funding. The Committee plans to respond to those questions in writing.

There was a discussion of State Plan objectives for which the Council is responsible. John Nagle will contact the appropriate Division staff regarding the State Plan objective which addresses long-term care, and will report on this at the next Council meeting.

Budget Committee Report: Mr. Young discussed the issue of budget priorities within the Council and within the Department of Institutions. The Council's budget priorities were submitted to the Department; however, the Council's first priority, model programs for the elderly, ethnic minorities, and women, was deleted. The Budget Committee will meet before the next meeting of the Council to discuss this change in the Division's priorities. This issue also will be included on the Council's October agenda.

Mr. Richter expressed regret at the receipt of Ms. Medchill's resignation. Ms. Medchill has accepted a full-time position with the Colorado Springs school system, and has had to resign from the Council. Mr. Richter appointed Dr. Medina acting chairperson of the State Plan Committee and acting vice-chairperson of the Council. He appointed Ms. Sanford to chair the Nominating and Membership Committee. She will be asking for volunteers to serve on that committee.

Council Membership Status: Ms. Dawson reported that Mr. Lane, whose term of membership will expire on September 15, has asked not to be renominated. The Mental Health Association has recommended a replacement. Mr. Smid has resigned. Dr. Weissberg has asked not to be renominated. Ms. Taniwaki also did not ask to be renominated. With the resignations of Colleen Casagram and Isabelle Medchill, there are vacancies for four consumer members and two provider members. The Executive Committee of the Council and Ms. Sanford will review the recommendations for new members which will be submitted to the Governor.

A fifty-dollar stipend has been awarded to the Council to send a member to the Annual State Mental Health Conference in Keystone. Mr. Garcia was designated to receive the stipend.

Mr. Dawson announced that the new travel reimbursement rules require that forms

be submitted within five working days after the end of each month and on a monthly basis.

The meeting was adjourned at 4:50 p.m.

Virginia Kelly
Recording Secretary

(Standard SMHAC Distribution)

MINUTES

STATE MENTAL HEALTH ADVISORY COUNCIL

DATE: October 9, 1980
1:30 - 4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Rosita Bachmann
Lucy May Dame
Melanie Fairlamb
Peter Garcia
Jerry Goebel
Fred Hom Dow
Luis Medina
Katherine Money
John Nagle
Roger Richter
Nancy Sanford
Randy Stith
Robert Young
Cece Zavala

Absent:

Guidotta Bates
Mike Coren
Dorothea Dolan
Ruth Fuller
Leslie Hartley
John Marshall
Jack Quinn

Staff Present:

Robert Glover

Guests:

David Bustos
Youlon Savage
Elinor Stead

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Introductions: Mr. Richter introduced Dr. Robert Glover, new Director of the Division of Mental Health. Dr. Glover gave a brief review of his background.

Orientation: Mr. Richter announced there will be an orientation meeting for new Council members and any other members who are interested from 9 to 12 noon on November 13 preceding the next Council meeting.

Approval of Minutes: Ms. Fairlamb moved to amend the minutes of September 11, 1980, to reflect that she voted against the adoption of the revised Bylaws. Minutes will be amended accordingly.

Director's Report: Dr. Glover handed out copies of an article regarding the new Systems Act just signed into law by President Carter. He said it appears Colorado has anticipated some of the directions dictated by this Act. One of these is performance contracting which will be continued by the Division. One of his initial impressions is that there seems to be a great deal of inequity geographically in Colorado in terms of the amount of mental health funds that go towards provision of services. Dr. Glover intends to represent all parts of the public sector, as he sees the Division's primary job as providing services to clients. The Division will continue to work on equalization funding formulas.

Another area of concern is the need to do system-wide planning and support building. The institutional role as it relates to the community centers and to the system on the whole needs to be addressed in the State Plan. There will be a mandate from the Division for each hospital to work on institutional planning. He wants to involve the public more in the planning for the role of the institutions, and would like to integrate this effort into the State Plan.

The Division has been asked to facilitate and resolve problems around Denver's emergency psychiatric services. Dr. Glover will meet with several center directors on this matter today at 3:30.

He mentioned several budget issues that will impact on our system. These include the 7% spending limitation; possible closing of the Alcohol Hospital Intensive Residential Treatment programs at CSH and FLMHC; development of an open adolescent unit at CSH; the amount of increase for centers for cost of living (10% vs. possibly less); and partial implementation of SCOPE figures for staffing at the two state hospitals.

Dr. Glover does not want to be perceived as in an adversary position against any part of the system. He hopes this Council, as an advisory group to himself and Dr. Leidig, will keep an objective statewide overview necessary to look at the system in total as it relates to clients.

Bylaws: A copy of the draft of the revised Bylaws was given to members. The Executive Committee presented the amended Bylaws to Dr. Leidig, who made some recommendations. Items voted on at the September meeting and approved and thus not needing consideration today include: Article II (g) and Article IX.

The first change recommended by Dr. Leidig, Article II, Section (c)(3), was suggested because the Council cannot actually approve the "final budget." Approval is the responsibility of the Legislature. A motion was made by Mr. Nagle to accept the change in Article II, Section (c)(3) to read: "be responsible for approval of the operating plan after allocations have been made." Motion was seconded by Ms. Dame. Dr. Stith then made a motion that the vote on the revision of the Bylaws as proposed by Dr. Leidig be tabled until Dr. Glover and new members of the Council have had a chance to review the proposed changes and respond. Ms. Fairlamb seconded the motion. After much discussion, including comments by Dr. Glover, a vote was taken on the motion to table the vote on the revision of the Bylaws. This motion was defeated. The original motion made by Mr. Nagle to accept the change in Article II, Section (c)(3) was then voted on and passed.

Mr. Nagle then made a motion to accept the change in Article III - Membership, to read as follows: "The State Mental Health Council shall consist of 25 members who will be residents of Colorado. No less than forty percent of the members of the Council shall be direct or indirect providers of mental health services. A majority, but no more than sixty percent of the members, shall not be direct or indirect providers of mental health services." Mr. Young seconded this motion and the motion passed.

The next proposed change was Article VII - Quorum. The motion was made by Mr. Garcia and seconded by Ms. Fairlamb to approve the following wording: "A quorum will consist of a majority of the members." After much discussion, this motion passed by a vote of 9 in favor, 4 against.

Designation of Council Committees: Mr. Richter reviewed briefly the five standing committees as established by the Bylaws, which are: State Plan, Budget, Nominating and Membership, Program, and Personnel.

Mr. Richter asked older members to sign up for membership on one of these committees. The list will be distributed to new members at the November meeting, and the Chairperson will then appoint committee members. Mr. Richter asked for volunteers to serve on the Nominating and Membership Committee specifically for the purpose of nominating officers and new members for the next year. Persons interested would begin serving on this Committee immediately.

Child/Adolescent Task Panel Report: Mr. Goebel said the following presentations will or have been made to the State Plan Committee on behalf of development of services for children: The Mental Health Association of Colorado made a presentation today; in November, the Child/Adolescent Steering Committee will make a presentation; and in December, the Colorado Commission on Children and Their Families will make a presentation. Two meetings have been scheduled regarding Senate Bill 26: Partial Care Providers for Children and Adolescents will hold a meeting at C.U. Health Sciences Center on October 20, and a meeting of the Coalition on Child Placement will take place later this month. Call Mr. Goebel for additional information.

State Plan Committee Report: Dr. Medina said the following is the agenda for the State Plan Committee meeting in November: Begin at 9:00 for orientation of new Council members; 10:00, Child/Adolescent Steering Committee; 11:00, Dr. Glover to give his reactions to the current Plan.

The following motions were made by Dr. Medina upon recommendation of the State Plan Committee: (1) That persons attending the State Plan Committee will not have voting privileges unless they are members of the State Mental Health Advisory Council. Motion was seconded by Ms. Fairlamb. After discussion, the motion was amended to read, "The only voting members of the standing committees will be members of the State Mental Health Advisory Council." The motion as amended was passed. (2) "Members of the State Mental Health Advisory Council will not have voting privileges on the committees unless officially designated as a member of that committee." This motion also passed.

Budget Committee Report: Mr. Young reported that the committee met with DMH staff yesterday to discuss the situation around the Council's #1 priority not being the Division's #1 priority. Mr. Berger discussed the relationship of the Division's budget priorities to others in the Department of Institutions and how they must meld into Departmental priorities. Mr. Rodriguez discussed current level of services to targeted groups and how Council's priorities fall in these services. The suggestion was made that in the future the Council meet with Dr. Leidig at the beginning of the budget planning process to find out what is feasible and which directions will be supported. It was agreed that the Program Committee should address this issue. Mr. Garcia made a motion that a letter be sent to Dr. Glover, with copies to the Governor and Dr. Leidig, expressing (1) the Council's dissatisfaction about the Council's #1 priority's being deleted from the budget request; (2) interest in having available discretionary money applied to this area; and (3) increased communication between the Division staff and Council to build priorities so they can be funded. The motion carried, and Mr. Richter will send a letter.

State Plan Objective Report: Mr. Nagle reported on the objective "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." The Committee recommended moving the due date to January 31, 1981.

Membership Committee Report: Ms. Sanford took over as Chairperson at the last meeting. There were 11 vacancies: Five of these were reappointments, including; Dorothea Dolan, Melanie Fairlamb, Jerry Goebel, Roger Richter, and Nancy Sanford. New appointments are: Leslie Hartley, Fred Hom Dow, Mike Coren, Rosita Bachmann, Ruth Fuller, and Randy Stith. This Committee will set up guidelines to ensure that geographic, race and economic representation is provided. Nominations for officers will be made at the November meeting.

Rural Task Panel Report: Ms. Fairlamb will get clarification on reimbursement support prior to the next Council meeting.

Outcome Data Task Panel Report: Mr. Nagle is getting access to outcome data information from the Division. The Panel will meet as soon as he has information pulled together.

Elderly Task Panel: No report.

Minority Task Panel: No report.

Mr. Richter announced the annual social will be in November. The November meeting will adjourn to his house for a social hour with dinner (dutch treat) afterward at a restaurant. Spouses of Council members are invited, and staff members from the Division who work with the Council are also invited.

Meeting adjourned at 4:40 p.m.

Carolyn Babcock

Carolyn Babcock
Recording Secretary

(Standard SMHAC Distribution)

MINUTES

COLORADO MENTAL HEALTH COUNCIL

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

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Rosita Bachmann
Guidotta Bates
Mike Coren
Fred Dow
Melanie Fairlamb
Peter Garcia
Jerry Goebel
Leslie Hartley
Luis Medina
Katherine Money
Jack Quinn
Roger Richter
Robert Young
Cece Zavala

Absent:

Lucy May Dame
Dorothea Dolan
Ruth Fuller
John Marshall
John Nagle
Nancy Sanford
Randy Stith

Staff Present:

Lynn Dawson
Robert Glover

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Approval of Minutes: Mr. Young requested that the October minutes be corrected as follows: Under Budget Committee Report, Page 3, Paragraph 1, line 10, Program Committee is corrected to read Budget Committee. Mr. Goebel requested the inclusion of a more comprehensive report on the presentation regarding Children's Mental Health in Colorado, which was made by the Colorado Mental Health Association to the State Plan Committee on October 9, 1980. Mr. Goebel obtained a report summarizing the presentation and distributed copies to members. A motion was passed that the summary be included in the minutes of October 9, 1980. A motion was then passed that the minutes be approved as amended.

Welcome to New Members: Chairperson, Mr. Richter, extended a welcome to the new members present, Leslie Hartley and Mike Coren. Mr. Coren, of Englewood, currently serves on the State Board of the Colorado Mental Health Association. Leslie Hartley, of Windsor, was asked to serve as a consumer member from Weld County.

Director's Report: Dr. Glover reported on the progress in his efforts to facilitate the resolution of the Denver General Hospital Emergency Psychiatric issue. A contract providing for emergency psychiatric services for non-catchment area clients brought to Denver General Hospital was negotiated. The effective date for those services was November 1, 1980. Medical services for these clients will be provided by Denver General Hospital.

Dr. Glover announced that the Division's 1981-82 budget request presentation to the Joint Budget Committee is tentatively set for December 9 at 2:30. He will be working with Mr. Richter in terms of the Council's role in the presentation. The Council was also informed of the current status of the management and performance audits, the new statewide long-term planning group, the Criminal

Insanity Review Task Force, and the budget allocations for advisory groups and committees of the Division.

Concerns of the Council regarding its limited budget of $4,000 for 1980/81 were discussed with Dr. Glover. As the Council is mandated to have geographical representation, it is necessary to ensure adequate funds for travel expenses of members from outlying and rural areas. Some suggestions to accomplish this and to stay within the budget included eliminating certain meetings, committee work being accomplished through standing committees rather than forming new sub-committees, and careful selection of committee membership and meeting times. This item was referred to the Executive Committee for further consideration and recommendations.

New Committees of the Council: Mr. Richter read a position paper sent to him by a newly-formed mental health coalition composed of representatives from the public and private sectors, including the Mental Health Association, the Colorado Association of Community Mental Health Centers and Clinics, the Colorado Bar Association, and the Psychiatric Society. The Council considered its role relative to this group and a motion was made and passed that a member of the Council be appointed to represent the Council in the new group. The selection of the representative will be made in the near future.

The Chairpersons and members of the Council's Standing Committees were reviewed by Mr. Richter. A list of the new Committees will be distributed with the minutes. (Attached.)

State Plan Committee Report: Dr. Medina announced that the tentative program for the December committee meeting includes presentations from the Governor's Commission on Children and Their Families and the Colorado State Chicano Mental Health Association. Also, the committee will be reviewing the guidelines for local planning. Dr. Medina encouraged Council members to attend the State Plan Committee meetings which are scheduled at 9:30 the same day as the regularly-scheduled Council meeting.

At today's meeting, Jean Williams, of Weld County Mental Health Center, gave a report from the Child/Adolescent Steering Committee. She stressed the importance of the development and implementation of a strong, effective children's program, under a state-level umbrella to facilitate coordination and continuity of all children services, which would include: a) All catchment areas having identified children and adolescent mental health programs staffed by clinicians specifically trained to work with children and adolescents; b) Both state hospitals' child/adolescent units being brought up to SCOPE staffing standards; c) A 50-bed open adolescent treatment unit at Colorado State Hospital; and d) Development of three demonstration regional mental health residential treatment programs.

Dr. Glover discussed with the committee his opinions on changes needed in statewide planning and the impact of the Mental Health Systems Act on the mental health system. There is an option for performance contracting between the State and the Federal levels under the Act which represents a major shift in terms of extensive planning by the state. He feels the Colorado State Mental Health Plan is a good one and would like to see next year's plan address

more specifically the role of the two state hospitals and their relationship to the centers. Also, he feels it is critical to develop long-term planning--ten to twenty years, with five-year planning a minimum. Dr. Glover asked the Council to name a representative to serve on the statewide long-term planning group.

Budget Committee Report: Mr. Young briefly reiterated the roles of the Budget Committee, the State Plan Committee and the Council as they relate to the internal and external budget processes of the Division and the Department of Institutions. Mr. Young suggested the possible formation of a special legislative advocacy group, composed of members from the Budget and State Plan Committees. The Council agreed, with the support of the Division, to expand its activities in this area. Council members were encouraged to read the 1981-82 budget document which was distributed to those present.

Transfer of Task Panel Activities to the Program Committee: Ms. Dawson shared with the Council the idea of the Program Committee's assuming the activities of the individual task panels. In doing this, the areas to be addressed, such as treatment outcome, children, elderly, minorities and rural issues, would parallel the functions performed by the Program Services Unit within the Division. In addition, a Division staff person would be assigned to the committee to provide a more direct link. A motion was made and passed by the Council to discontinue the task panels and transfer their activities into the Program Committee.

Rural Task Panel Report: Ms. Fairlamb reported to the Council some concerns of the Rural Task Panel. 1. There is a gap in Council membership from the rural areas. 2. Of the six members on the Council that are considered to be rural representatives, four are consumers and five of the six are women. The panel would like to see more representation of direct providers from the rural areas. 3. It is difficult for rural representatives to effectively participate in committee activities because of budgetary and time limitations. The panel requests the Council make a special effort to have committee meetings correspond with council meeting dates.

Child/Adolescent Task Panel Report: Jerry Goebel had no further report, as the presentation by the Child/Adolescent Steering Committee was discussed during the State Plan Committee Report.

Minority Task Panel Report: No report.

Membership Committee Report: The committee met today and discussed the priorities of criteria (ethnic background, geographical location, consumer-provider, male-female) to be considered in the selection of the remaining four members. As no consensus was reached, the item will be continued at their next meeting.

Meeting adjourned at 3:55 p.m.

Mary Dufva

Mary Dufva
Recording Secretary

(Standard CMHC Distribution)

MINUTES

COLORADO MENTAL HEALTH COUNCIL

DATE: December 11, 1980
1:30-4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Rosita Bachmann
Guidotta Bates
Mike Coren
Lucy May Dame
Dorothea Dolan
Fred Dow
Melanie Fairlamb
Ruth Fuller
Peter Garcia
Jerry Goebel
Leslie Hartley
Luis Medina
John Nagle
Roger Richter
Nancy Sanford
Randy Stith
Robert Young
Cece Zavala

Absent:

John Marshall
Katherine Money
Jack Quinn

Staff Present:

Lynn Dawson
Robert Glover

Guests:

Dave Bustos
Earl McCoy
Diane Rich
Elinor Stead

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Approval of Minutes: The minutes for the last meeting were amended to reflect that Jean Williams is with the Larimer County Mental Health Center, rather than the Weld Mental Health Center. Mr. Nagle moved that the minutes be approved as amended. Ms. Dame seconded the motion, and the motion was passed.

Director's Report: Dr. Glover reported on the Division's budget hearing before the Joint Budget Committee. He praised Mr. Richter's presentation, and said that the consensus among the organizations presenting was that there is a need for additional hospital beds. The number most frequently mentioned was 88 beds for Fort Logan Mental Health Center. The number of intermediate care beds advocated varied from 80 to 120.

Dr. Glover and representatives of the Colorado Association of Community Mental Health Centers and Clinics will discuss costs, numbers of beds, and kinds of services needed for community residential settings. Dr. Glover will also be discussing with the center directors the possibility of acquiring Medicaid funds, through the centers, for mental health services in nursing homes.

Dr. Glover met on December 8 with the sponsors of the Annual Mental Health Conference to discuss the site of next year's conference. Tamarron had been suggested, but after discussion of transportation, time, and budget restrictions, it was agreed that Tamarron would not be suitable.

Dr. Glover and other members of the Division staff reviewed the Mental Health Systems Act at the Region VIII Office of ADAMHA with representatives from Washington. Funds have been authorized, but not yet appropriated. Ms. Dawson pointed out that at some time in the future a statewide training program will

be arranged, and the Council will be invited to participate in that training.

Mr. Richter announced that he has appointed Ms. Dolan to represent the Council on the statewide mental health long-term planning committee.

Mr. Richter reported that the Mental Health Coalition presented a paper to the Joint Budget Committee. This group includes representatives of the Mental Health Association, the Centers Association, the Colorado Bar Association, the Colorado Psychiatric Society, the Colorado Medical Society, several social work groups, and others. The Council voted at the last meeting to appoint a representative to the group, but Mr. Richter has not yet made this appointment. The group will make a presentation at the next meeting of the State Plan Committee.

Ms. Dolan asked that the organizational chart of the Division be reviewed to be sure that the organizational function is reflected accurately.

It was agreed that the Council subcommittees would meet regularly each month at the following times: State Plan Committee, second Thursday, 9:30 a.m. to Noon, room B-108; Budget Committee, second Thursday, Noon to 1:30 p.m., room B-108 (a brown-bag lunch has been suggested); Program Committee, second Thursday, Noon to 1:30 p.m., room A-209; Executive Committee, second Thursday, 4:30 to 5:30 p.m. (immediately after the adjournment of the Council meeting), room B-108; Membership and Nominating Committee, second Thursday, Noon to 1:30 p.m., room A-112. The meeting time and place for the Personnel and Affirmative Action Committee will be determined later.

Budget Committee Report: Mr. Nagle said that, since the members of the Budget Committee were unable to meet, there was no report.

State Plan Committee Report: Dr. Medina reported on the Committee's agenda for today regarding the State Health Coordinating Council (SHCC), the guidelines for local plans, the Mental Health Systems Act, and the Governor's Commission on Children and Their Families.

The SHCC is the health planning body that approves the State Mental Health Plan. Representatives of the SHCC will be invited to meet with the State Plan Committee to discuss what kind of liaison is needed between the two councils.

The Mental Health Systems Act has many implications for the State Plan and for future mental health planning in this state. There are still many unknowns, since we probably will not receive the guidelines until about the first of March. It was noted that Colorado is already doing many things that are required by the Act. The Committee discussed the possibility of Colorado's applying for designation as "exclusive agent" under the Systems Act.

The Committee also reviewed the guidelines for local plans. There is an emphasis on some strengthening of linkages in the community. New charts have been included which were not in last year's guidelines, such as one on services provided by the private sector. At their next meeting, the State Plan Committee will discuss the process for reviewing local plans.

Bob LaCrosse gave a presentation to the Committee on the Governor's Commission

on Children and Their Families. Mr. LaCrosse addressed some general needs which the Commission has identified: a definition of standards (i.e., for staff), licensing of RCCFs, separation of the children's system, the total environment of the child, and early evaluations. The Commission would like to see expansion of interagency agreements, a comprehensive evaluation system for children, a variety of services available throughout the state, expanded short-term and crisis care for children, more emphasis on training, and early prevention and detection. The Committee identified ways in which the Commission and this Council could work together in terms of coordinating services. The Council also discussed how children's programs are funded.

Program Committee Report: Mr. Young reported that Ambrose Rodriguez has been designated Division staff person to the Committee.

Mr. Richter directed the attention of the Council to the Division Operating Plan for 1980-81, 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." He asked that the Program Committee discuss this objective and report to the full Council.

Mr. Richter said that, with regard to 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," which carries a due date of September 30, 1980, the Council will ask for an extension. This objective also will be considered by the Program Committee.

Personnel and Affirmative Action Committee Report: Mr. Goebel had to leave the meeting early, but he had told Mr. Richter that this Committee had nothing to report.

Membership and Nominating Committee Report: Ms. Sanford reported that the Committee had agreed on nominations for officers to be elected at the January meeting of the Council. These officers will serve only until July, when, in accordance with the Council's revised bylaws, new officers will be elected to serve during the new fiscal year. Since the Committee unanimously agreed that the present officers should be nominated to serve until July, the Committee's nominees are Mr. Richter for Chairperson and Dr. Medina for Vice-Chairperson. Nominations from the floor will be entertained at the January meeting.

As a result of the recent revision of the bylaws, the size of the Council will be increased to 25. The Committee considered 16 applications to fill the resulting four vacancies, and selected three to be submitted to the Governor for possible appointment. Ms. Sanford moved that the Council submit the three names to the Governor. Ms. Bates seconded the motion. Mr. Nagle asked that, in future, the Council be given the names of applicants who were not selected for possible membership. Mr. Richter called for a vote on Ms. Sanford's motion, and it was passed.

Mr. Richter also reported that he will contact Mr. Marshall, who has missed three consecutive meetings.

Ms. Dawson gave the Council a report on its budget. The Council's budget is $4,000, and as of October it had spent $1,741, leaving a balance of $2,259. The largest part of the expenditures is for transportation of members to the monthly meetings. This must be considered when increasing the number of members who have to travel great distances. Ms. Dawson asked the members to consider how they would address this issue. Mr. Richter suggested that one solution to the situation would be to eliminate one or two meetings a year.

Ms. Dolan commented that the situation is a "Catch-22", since the federal government has mandated the Council but has appropriated no funds for its expenses. Dr. Glover called attention to the fact that funds for Division councils and committees come from Division operating expenses. There is no line item in the budget to cover these expenses. The Division's travel budget has been cut ten percent over the last year and ten the year before. Ms. Dolan suggested that the Division should give direction to the Council as to how it can best adjust to its budget.

Dr. Stith suggested that the problem be assigned to one of the Council's functioning comittees. Mr. Richter referred it to the Executive Committee.

The Council discussed the amount spent on travel by members traveling from great distances. Ms. Dolan moved that the nominations not be submitted to the Governor until the Executive Committee has had an opportunity to consider what the Council can afford. Ms. Dame seconded the motion. Mr. Nagle spoke against the motion, since he feels that it will delay action by the Council. He suggested cutting the number of meetings, rather than delaying the increase in membership of the Council. Mr. Richter called the motion, and a vote was taken by a show of hands. The motion was passed by a vote of eight yeas and seven nays.

Mr. Richter announced that the Executive Committee would meet immediately following the adjournment of the Council meeting.

The meeting was adjourned.

Respectfully submitted,

Virginia Kelly

Virginia Kelly
Recording Secretary

(Standard CMHC Distribution)

MINUTES

COLORADO MENTAL HEALTH COUNCIL

DATE: February 19, 1981
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
Ruth Fuller
Peter Garcia
Jerry Goebel
Leslie Hartley
Luis Medina
John Nagle
Roger Richter
Randy Stith
Robert Young
Cece Zavala

Absent:

Rosita Bachmann
Mike Coren
Katherine Money
Jack Quinn
Nancy Sanford

Staff Present:

Lynn Dawson
Tom Lewis

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Approval of Minutes: A motion to approve the minutes of the December 11, 1981 meeting was voted on and passed.

Director's Report: In the absence of Dr. Glover, Ms. Dawson presented a status report on current issues of the Division as follows:

(1) Mental Health Systems Act: The Mental Health Systems Act is considered to be the most significant Federal legislation to impact the mental health system since the amendments in 1975 (P.L. 94-63). The Guidelines, which interpret the law and provide for implementation, should be received by the Division sometime in early March. The Division is sponsoring a training workshop on the Systems Act which will be held in the Fort Logan Mental Health Center Auditorium on March 13, from 10 a.m. to 5 p.m. Council members are encouraged to attend. The Division is currently looking at what it means to apply as an "Exclusive Agent," which Colorado will be doing. Also, the State Mental Health Plan will be called the State Mental Health Services Program. A committee, comprised of Division of Mental Health staff, representatives from the community mental health centers and clinics, and representatives from client advocacy groups, has been formed to consider the implications of the Act for the system and, more specifically, to propose criteria for ranking Title II grant applications. Rick Adamson of Montrose, and board member of the Midwestern Colorado Mental Health Center, Inc., is Chairperson of the committee.

(2) Shortage of Psychiatric Beds: The issue paper, "Colorado Mental Health System Issue: Shortage of Psychiatric Beds," distributed to members earlier, relates both to the shortage of inpatient beds and to the shortage of intermediate-care-facility beds. The paper was prepared by the Division to provide data for the Joint Budget Committee in support of the Division's request for funding 40 additional inpatient beds at Ft. Logan. Also, the possibility of adding a request for intermediate-care facilities is being pursued at this time.

(3) Long-Term-Care Task Force: The Division of Mental Health, the Center's Association, the Department of Institutions, and the Department of Social Services have been meeting to look at ways to provide mental health services to the chronically mentally ill in nursing homes. Fred Acosta of the Division may be contacted for further information.

(4) DMH Contracting with CMHC's: Contract negotiations with the centers/clinics begins in April. Currently, the general contract format is being negotiated with the Center's Association. There are few major changes from last year, and the process should be completed by the end of February.

(5) Legislation: There has been a considerable amount of legislation directly related to mental health this year. Much has been a result of the legislative interim committee work accomplished last summer. The Division has been active in analyzing, reviewing, and providing testimony regarding proposed legislation. If members have questions around specific legislation or specific bills, contact Ms. Dawson for further information.

Council Travel Budget: Mr. Richter reported that a letter was sent to Governor Lamm indicating the Council's budget limitations and the inherent problems. Although the Governor, in his response, reiterated the restrictive, far-reaching effects of budget limitations, the Council's budget from the Division of Mental Health has been increased for the fiscal year ending June 30, 1981. This is only a solution to the immediate problem. Mr. Richter was commended for his strong and persistent efforts in this matter. The Council discussed the variables and options open to them relative to the current budget and the uncertainty of funds for FY 1981/82. Major concerns of the Council included ensuring geographical representation, the expansion of the committee from 21 to 25 members as provided for in the new by-laws, and the number of meetings per year. Currently there are five vacancies, including the vacancy resulting from the resignation of John Marshall. A motion was made by Ruth Fuller to proceed with the submission of the three nominations as determined by the membership committee. The motion was seconded by John Nagle and voted on. As the motion did not carry, the matter was referred to the Executive Committee for discussion and recommendations to the Council at the next meeting. A vote will be taken by the Council at the next meeting to consider reducing the number of members on the council to 21, effective at the time of approval.

Mr. Richter requested that council members who have not completed the questionnaire regarding travel reimbursement, please do so as soon as possible.

Budget Committee Report: John Nagle reported on the joint meeting of the Budget and Program Committees with Bruce Berger of the Division. Current status of items in the budget request were reviewed. Funding appears possible for the 40 additional beds for Ft. Logan and possibly some intermediate care facilities. Division staff have been working on rationale for the inclusion of funding intermediate-care facilities. Some problem areas in the budget requests are: Colorado State Hospital Forensic Program; CSH HIRT Program; the proposed Adolescent Treatment Center at CSH; the Chicano Inpatient Program at CSH; specialty programs at Children's Hospital, the Denver Clinic and Servicios de La Raza. It also appears the request to bring staffing at both state hospitals to SCOPE standards faces

considerable difficulty. Mr. Berger considers the additional beds at Ft. Logan and the intermediate-care facilities quite an accomplishment if funded, given the current state of resources. Mr. Garcia reiterated his strong concern about minority and other specialty programs, high priorities of the Council, not being given more serious consideration for funding.

State Plan Committee Report: Dr. Medina reported that Dr. Starrett gave a presentation today on the Mental Health Coalition. Dr. Starrett sees a big gap between planning and implementation. One of the things the coalition wants to do is fill the gap and develop coordinating methods to unite the various groups in supporting issues of mutual concern.

The planning process was discussed by the Committee. The Committee plans to obtain analyses relative to the major themes, priorities, needs, finances, and other data from the centers' local plans. Division staff were asked to provide the analyses for the Committee. Also, there was some discussion as to how the Council could use the local plans to provide feedback for the centers and their boards.

Dr. Medina also reported that the Committee will be meeting with the State Health Coordinating Council on March 24, to discuss the mental health planning process and coordination between the two Councils. One specific issue which will be looked at is the needs relative to mental health that will be developing in areas impacted by energy development. The meeting is to be held at the State Health Department, March 24 at 3 p.m. Dr. Medina, Dr. Fuller and Dr. Stith will represent the Council at the meeting.

The following is the agenda for the next State Plan Committee meeting:

- Report by Rene Grosser of the Division from the Statewide Needs Assessment Committee
- Presentation by the Colorado Chicano Mental Health Association
- Timetable established for remainder of planning process from now until June
- Further discussion on the Mental Health Systems Act
- Review of the staff analyses of the local plans

Program Committee Report: The Program Committee met with the Budget Committee today in order to hear Bruce Berger's presentation. Mr. Young reported to the Council on his meetings with Division staff to discuss the objectives that involve the Council. After discussion with regard to 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," the Committee determined that clarification on the intent of the objective is needed. Possibly the objective will require reformulation.

Personnel and Affirmative Action Committee Report: Mr. Goebel urged members to review the reports published by the Colorado Commission on Children and Their Families, which he distributed to members earlier. Mr. Goebel requested a

report from the Program Committee on how needs of the task force are to be met, specifically, how the Division of Mental Health reorganization is working to meet the needs of rural, elderly, children, adolescents and minorities.

Membership & Nominating Committee Report: The Committee has three nominations for membership ready for forwarding to the governor. As the matter relates directly to budget, as previously reported, no further action was taken.

As reported at the December meeting, the Nominating Committee recommends the current officers be elected to serve until July 1, 1981, at which time new officers will be elected. Ms. Bates made a motion that the present officers continue in office until July 1, 1981. Melanie Fairlamb seconded the motion. The motion was voted on and passed.

Membership on the Central Northeast Colorado Health Systems Agency Board: Mr. Richter reported his application for membership to the Central Northeast Colorado Health Systems Agency Board has not been acted upon. Mr. Richter has applications if other members are interested in applying.

The meeting was adjourned.

Respectfully submitted,

Mary Dufva

Mary Dufva
Recording Secretary

(Standard CMHC Distribution)

MINUTES

COLORADO MENTAL HEALTH COUNCIL

DATE: March 12, 1981
1:30 - 4:30 p.m.

PLACE: Division of Mental Health
Conference Room B-108

Council Members Present:

Rosita Bachmann
Mike Coren
Dorothea Dolan
Ruth Fuller
Peter Garcia
Luis Medina
Randy Stith
Robert Young

Staff Present:

Lynn Dawson
Robert Glover

Absent:

Guidotta Bates
Lucy May Dame
Fred Dow
Melanie Fairlamb
Jerry Goebel
Leslie Hartley
Katherine Money
Jack Quinn
Roger Richter
Nancy Sanford
Cece Zavala

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Ms. Dawson extended Mr. Richter's regrets that he was unable to attend today; Dr. Medina chaired the meeting in Mr. Richter's absence.

Approval of Minutes: As a quorum was not present, approval of the minutes was postponed until the next meeting. The attendance of the last meeting was corrected to reflect that Dorothea Dolan was absent and Fred Dow was present.

Legislative Audit: Dr. Glover introduced Dan Gould of the State Auditor's office. Mr. Gould, as a member of the evaluation team conducting a performance audit of the Department of Institutions, is assigned to the Division of Mental Health. The audit is mandated by House Bill 1555 which was passed last year, and Mr. Gould will be reporting the results to the legislature and to the HEWI Committee. Primarily, the auditors are focusing on programmatic effectiveness and management efficiency. Specific areas being evaluated include reduction of costs, continuity of care, evaluation and monitoring, and planning. Mr. Gould will be interviewing several Council members to obtain their perceptions of the system and of the role of the Council as it relates to the system.

Director's Report: Dr. Glover discussed current issues facing the mental health system today. Because of increased demands stemming from population growth and other socio-economic factors, and current and future budgetary limitations, the Division of Mental Health is facing an unprecedented challenge. The current status of some major issues was given:

1) Colorado State Hospital: a) A supplemental budget request has been proposed to avoid layoff of current employees. b) Next year's budget request has been amended to provide for 23 forensic beds to alleviate the existing maximum-security overload at Colorado State Hospital. (CSH has 80 maximum-security beds and 112 maximum-security-level patients; thus, chaining of patients as recently publicized.) c) A psychiatrist, Edward Esquibel, M.D., has recently been hired as Chief of the Forensic Division.

   Increased court-ordered admissions (27-10); increased admissions resulting from the Ramos decision; transfers to CSH from the Department of Corrections

for psychiatric care, as the Department of Corrections has been forced to discontinue all contracts for psychiatric services because of budgetary restrictions; and recent increase of not-guilty-by-reason-of-insanity pleas are other factors contributing to the increased stress upon the CSH Forensic Division.

2) Fort Logan Mental Health Center: Although the Fort Logan waiting list is averaging around 107, the funding for an additional 40 beds, which looks favorable at this point, would begin to address the lack of capacity at Fort Logan.

3) Community Mental Health Centers/Clinics: The Governor has indicated his support for funding of 60 new intermediate-care beds. If accomplished, this would be a great step forward in addressing the bed shortage for intermediate care, as Centers are being forced to reduce admissions of patients in need of inpatient treatment in the community, as funds for such are very limited. Also, to address this issue, the Division of Mental Health will be requesting funds for comprehensive, long-range planning for additional psychiatric beds, looking at the total system, communities and institutions, as a network. The proposal will be submitted to the Joint Budget Committee within the next few weeks.

4) Federal Funding: Word was received from Harry Schnibbe, Executive Director of National Association of State Mental Health Program Directors, that there is an indefinite hold on the Mental Health Systems Act. It is now looking like funds for mental health, combined with funds for other human services, will be awarded in block grants to the states, with more control at the state level intended. There is a possibility of a 25% cut in National Institute of Mental Health funds this year and again next year. It also appears that Medicaid funds could be capped.

Dr. Glover stressed the importance of coming up with a reasonable mechanism to deal with priority-setting for mental health planning, and sees the Council as a very influential group in that process. He emphasized that priority-setting would have to be appropriate and "in line with reality." Issues that need to be addressed in next year's Plan include: 1) forensic beds; 2) the State's responsibility in forensic treatment and how that relates to community responsibility for forensic services, i.e., halfway-house transition, outpatient, residential; 3) clarification of the relationship between the Division of Mental Health and the Department of Corrections.

5) Legislation: Meetings are being held on Senate Bill 342, sponsored by Senator Soash, which would establish a Department of Public Safety and eliminate the Department of Institutions. The Division of Mental Health would be under the Department of Health; the Division for Developmental Disabilities under the Department of Education; and the Division of Youth Services under the Department of Corrections. Although the Department of Institutions does not oppose the establishment of a Department of Public Safety, it is opposed to the abolishment of the Department of Institutions.

The Division is conducting an analysis of SB 337 which relates to placement of children and which contains many amendments to Senate Bill 26, which was passed last year. One section, which would allow Residential Child Care

Facilities (RCCF's) to have locked residential capability, relates specifically to the Division of Mental Health, as the Division of Mental Health would be able to designate RCCF's as designated facilities under 27-10 statutes. The Division has taken a position in opposition to this provision of the bill, with recommended amendments.

Budget Committee: There was no report, as the Committee did not meet this month.

State Plan Committee Report: Dr. Medina reported the State Plan Committee discussed the revisions to be made in this year's update of the State Plan. Recommended revisions include:

Chapter 1: Update the Fact Sheet.

Chapter 2: Deals with the quality of life--include a description of the treatment and support system model as the current thrust of the system.

Chapter 3: Trends and Issues - add critical issues currently facing the system.

Chapter 4: Deals with the goals and objectives, which is the key part of the Plan. The Committee does not see any changes relative to goals specifically; however, some of the objectives will require changing.

Chapter 5: Financial summary for the current fiscal year--will be completely updated after the Long Bill is finalized.

Chapter 6: Report on last year's objectives--will be completely updated.

Appendix I: Membership and Bylaws of the Council will be revised.

Appendix III: Deals with state hospitals and catchment area mental health programs--The need assessment material will be updated.

These will be the major revisions in the 1981 Supplement to the 1980-85 State Plan.

The Committee plans to discuss how the Council should address current issues in terms of the system, i.e., the Council's role in addressing block grants. Also, the Committee will be reviewing the centers' catchment area plans with the Division, and providing feedback to the Local Boards and/or the Division. The Committee heard today from Dr. René Grosser, who reported on the progress of the Statewide Needs Assessment Committee. A needs assessment approach formula mechanism is being developed. A preliminary report should be ready for distribution October, 1981.

Ms. Dawson emphasized the critical nature of Council's role in the development of the State Plan, as the Plan reflects the issues for the mental health system, and the issues drive the budget. Other than the issue of expanding the capacity at Fort Logan, the priorities submitted to the Joint Budget Committee were those that came from the Plan. The crisis nature of the inpatient bed shortage and the violent client, plus public demand and pressures exerted on the legislature, commanded high priority. The importance of addressing current problems with a total-system perspective was emphasized.

Program Committee: There was no report, as the Committee did not meet this month.

Membership and Nominating Committee: There was no report, as the Committee did not meet this month. Ms. Dawson announced that John Nagle had resigned from the Council.

As there was no quorum, the Council postponed voting on revision of the Bylaws regarding the number of members. The consideration is to reduce the number from 25 to 21. Ms. Dawson urged the Council to proceed with the submission of their recommendations for membership to fill the two existing vacancies (required to maintain membership of 21). As the recommendations have approval of the Council, it was decided that no further vote is required before forwarding them to the Governor for consideration. The remaining issue related to the nomination of another representative from the Western Slope with the Council's limited funds for travel reimbursement. At the request of the Council, Ms. Dawson will contact Roger Richter, Chairperson, and Nancy Sanford, Chairperson of the Membership and Nominating Committee, in order to expedite conclusion of this process.

Personnel and Affirmative Action Committee: There was no report, as the Committee did not meet this month.

The meeting adjourned at 3:10 p.m.

Mary Dufva
Recording Secretary

(Standard CMHC Distribution)

MINUTES

COLORADO MENTAL HEALTH COUNCIL

Date: April 9, 1981
1:30 - 4:30 p.m.

Place: Division of Mental Health
Conference Room B-108

Council Members Present:

Rosita Bachmann
Guidotta Bates
Mike Coren
Lucy May Dame
Dorothea Dolan
Fred Dow
Melanie Fairlamb
Ruth Fuller
Peter Garcia
Luis Medina
Jack Quinn
Nancy Sanford
Randy Stith
Robert Young
Cece Zavala

Absent:

Jerry Goebel
Leslie Hartley
Katherine Money
Roger Richter

Staff Present:

Lynn Dawson
Robert Glover

* * * * * * * *

In the absence of the Chair, Mr. Richter, the Vice-Chair, Dr. Medina, presided over the meeting.

Mr. Coren moved approval of the minutes of the last two meetings. Mr. Garcia seconded the motion. The motion was passed.

Dr. Medina referred to a letter sent to the members of the Council by Mr. Richter, urging their regular attendance and participation at Council and committee meetings. He pointed out that the May meeting will be particularly important, since the draft of the State Plan will be discussed at that time.

State Plan Committee Report: Dr. Medina reported that the Committee had reviewed the local catchment area plans at this morning's meeting. The Committee reviewed the analyses of the plans prepared by Division of Mental Health staff, and concluded that the highest statewide priorities were services to the chronically and severely disabled and services to children, adolescents, and elderly. The highest programmatic priorities appeared to be community-based residential facilities and acute inpatient care for adults.

The Division of Mental Health staff held a special meeting to determine statewide issues for the State Plan. The results of that meeting were shared with the State Plan Committee. Dr. Medina stated that the DMH staff began with a list of 59 issues, which was then condensed into 13 key issues which will provide the basis for the State Plan objectives. The following 13 issues were then discussed by the Council:

(1) Treatment for violent patients
(2) Integration of the system
(3) Forensic system for the state
(4) MIS - systemwide
(5) Services for the chronically mentally disabled
(6) Maintenance of programs
(7) Planning
(8) Target populations
(9) Children out of state
(10) Funding issues
(11) Personnel
(12) Training
(13) Shortage of beds

Dr. Medina also pointed out that this year's State Plan Update will be a supplement to the 1980-85 State Plan. Changes will not be extensive.

Proposed footnotes to the Long Appropriations Bill were discussed.

Director's Report: Dr. Glover reported on the budget which has been proposed by the Joint Budget Committee. The Division has been instructed to open a 23-bed forensic unit at Colorado State Hospital. Funding for the Hispanic unit there has been deleted. Forty beds have been approved for Fort Logan Mental Health Center, but only 56 of the 93 staff positions requested have been funded. No money has yet been designated for intermediate care facilities in the community. A reduction in staff of the Division's Central Office will be necessary, due to budget cuts. No funds have been made available for the purchase of Consultation and Education Services from community mental health centers.

Because of the budgetary restrictions, the Division can no longer fund travel for the two committees which are not appointed by the Governor, the Committee on Racism and the Committee on Sexism. Dr. Glover has suggested that the chairs of these committees be nominated for membership on the Council.

The Division budget and its restrictions were discussed by the Council.

Budget Committee Report: The Committee had not met, and therefore there was no report.

Membership and Nominating Committee Report: The Committee, being without a chair, had not met, and therefore had no report. However, Ms. Dawson was able to report that two new members have been appointed to the Council by the Governor. They will fill the vacancies created by the resignations of Mr. Nagle and Mr. Marshall. They are Carol Howe, as a consumer, and Robert Nuffer, as a provider. Both will be sent letters from the Division regarding their appointment, and should be attending the next Council meeting.

Ms. Dolan moved that the Council bylaws be amended to provide for only 21

members, rather than the present 25, with the addition of new members to be achieved through attrition. After discussion, Ms. Dame seconded the motion. The motion was passed, with Dr. Fuller and Ms. Bates abstaining from voting. At Ms. Dame's suggestion, Dr. Medina directed that the record indicate that this reduction in membership is due to the present budget limitations.

Ms. Dawson brought to the attention of the Council the fact that Katherine Money has had three consecutive absences. The bylaws provide that, in this circumstance, the member must be asked to resign from the Council, or, if he/she wishes, the Council by majority vote may permit him/her to retain membership on the Council. Dr. Medina directed that Ms. Money be notified of these bylaw provisions. Ms. Dawson will be in contact with Ms. Money.

Personnel and Affirmative Action Committee Report: The Committee had not met, and therefore there was no report.

Program Committee Report: Two months ago, Mr. Richter directed the Program Committee to assess the level of services and the types of services being provided to ethnic minorities. Mr. Young reported that Mr. Garcia will meet with Nancy Wilson, of the Division's Program Evaluation staff, to get data on this issue. He will also meet with Fred Acosta, also of the Division, to find out about types of services being delivered.

Ambrose Rodriguez, the Division's Associate Director for Program Services, will meet with the Committee next month to discuss its mission.

New Business: Ms. Dolan asked that the Council be given a report on the status of the Manpower Development Grant. Dr. Medina said he would request that a progress report be given at the next meeting.

Ms. Dawson gave each member of the Council a copy of the Annual Report prepared by the Department of Institutions. She pointed out that, inasmuch as the Report includes materials regarding the Division of Mental Health, it is important for each member to review it.

Ms. Dolan moved that the meeting be adjourned. Dr. Stith seconded the motion. The motion for adjournment was passed.

Respectfully submitted,

Virginia Kelly
Recording Secretary

(Standard CMHC Distribution)

MINUTES

COLORADO MENTAL HEALTH COUNCIL

Date: May 14, 1981
1:30 - 4:30 p.m.

Place: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Mike Coren
Lucy May Dame
Dorothea Dolan
Ruth Fuller
Jerry Goebel
Carol Howe
Luis Medina
Roger Richter
Robert Young
Cece Zavala

Absent:

Rosita Bachmann
Fred Dow
Melanie Fairlamb
Peter Garcia
Leslie Hartley
Robert Nuffer
Jack Quinn
Nancy Sanford
Randy Stith

Staff Present:

Lynn Dawson
Robert Glover

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The Chair, Mr. Richter, introduced Carol Howe, the new consumer member, to the Council.

Dr. Medina moved that the minutes of the last meeting be approved as written. Ms. Zavala seconded the motion, and it was passed.

Director's Report: The Division of Mental Health has challenged Fort Logan Mental Health Center to a softball game to take place on May 20. Dr. Raymond Leidig, Director of the Department of Institutions, will serve as umpire.

Dr. Brock Willett has been named Interim Clinical Director of Fort Logan. The Division has announced a national competitive recruitment for a psychiatrist to serve as Director, since a psychiatrist is required by statute. Dr. Glover is presently acting as Director of Fort Logan. A new Interim Director will be named on Monday, May 18.

Fort Logan was not allocated any new funds or additional FTE by the State Legislature. The 40 beds originally requested will not be opened, since sufficient staff has not been funded. A 24-bed unit for the violent mentally ill will be opened and staffed with the funds and FTEs which have been allocated. After modifications have been made to the building, the unit will be opened on or about October 1. About 54 new people will be hired for staffing that ward with some additional security staff and a few other positions at Fort Logan. The budget for next year allows for funds to pay for the personnel associated with the number of FTE appropriated.

At the Division's request, the Joint Commission on Accreditation of Hospitals accreditation visit originally scheduled for May 18 and 19 has been rescheduled

for the first two weeks in August. A one-year provisional accreditation was given to Fort Logan last year. Mr. Richter remarked that this was the third consecutive year in which Fort Logan has received only a one-year accreditation.

The HIRT unit (the alcohol treatment program) is still underfunded for one month in this year, and there are enough funds for only nine months of next year. The State Division of Alcohol and Drug Abuse has agreed to provide about $60,000 to continue the HIRT program through this year. The program will be run for nine months of next year at full program capacity. After the first six months, a report will be made to the Joint Budget Committee, indicating whether the program is viable programmatically as well as economically, in order to justify either a supplemental for the rest of the year or closure of the program.

The Division has a mandate to open up a 16-bed forensic unit at Colorado State Hospital. This will necessitate closing at least one children's cottage and perhaps a geriatrics unit. The importance of adequate staffing was emphasized by the observation that staff injuries have increased 50 percent.

Ms. Dawson reported that, although 47 children are presently being treated in residential facilities out of state, only 12 children have been sent out of state in the past year. The Division is presently contracting for an assessment of the needs and characteristics of these 12 children, with a view to developing a program within Colorado. Also, a study is being done by Denver County Social Services with regard to the children who would previously have been sent out of state. In addition, the Division is looking at the characteristics of the children who are presently out of state and what sort of program would be needed in order to bring them back to Colorado for treatment. The Division is hoping to complete these studies by the end of June.

Dr. Glover reported on the present status of Senate Bill 337.

With the limitations on funding, the Division has prioritized the populations most in need of mental health services. Services to the chronically and severely mentally ill are the first priority; next are children, the elderly, adolescents, and adults, in that order; and next are ethnic minorities. Prioritization was based on three dimensions: severity, age, and ethnicity.

Contracting has been completed with 12 of the 20 community mental health centers. There is a statewide decrease in capacity of between 8 and 15 percent.

Ms. Dolan discussed the problem of patients being chained to beds in the surgical ward at Colorado State Hospital. Ms. Howe moved that the Council authorize Mr. Richter, assisted by interested members, to send a letter to Governor Lamm, with copies to members of the Joint Budget Committee, decrying the necessity for this situation and the conditions which have led to it. Ms. Dolan seconded the motion. After further discussion, the motion was passed.

A synopsis of the report of the Colorado Foundation for Medical Care on its evaluation of Fort Logan's Adult Team II was discussed by the Council.

Dr. Glover will meet tomorrow with Dr. Raymond Leidig and the directors of the other two divisions to discuss the projected layoffs of at least five or six members of the Division Central Office staff.

State Plan Committee Report: Dr. Medina reported that the Committee had reviewed the draft of the new Supplement to the State Plan this morning. He emphasized the need for members of the Council to submit input by June 5. All comments or recommendations for revisions must be submitted to the Division by the end of the day on June 5, as only input received as of that date will be considered by the Council during a special State Plan Committee meeting scheduled for June 10, from 1 to 5 p.m., at Fort Logan Mental Health Center. Mr. Richter stressed that discussion by Council members or others will have to take place during the State Plan Committee meetings of June 10 and the morning of June 11, since there will be insufficient time for further discussion of the draft during the Council meeting in the afternoon, other than discussion of approval of the Supplement itself. Dr. Medina invited all members of the Council and other organizations and interested citizens to attend the Committee meeting which will be held on the afternoon of June 10. At the regular meeting of the State Plan Committee on the morning of June 11, the Supplement will be finalized for presentation to the full Council that afternoon. Dr. Medina reminded the Council that voting will be confined to those members of the Committee who are Council members. Ms. Dawson, in giving an overview, pointed out that the Supplement is to be used only in conjunction with the 1980-85 State Mental Health Plan.

Program Committee Report: Mr. Young suggested that, since the turnout at meetings has been too low to be effective, the Committee meet on an "as needed" basis.

Budget Committee Report: Mr. Richter announced that Randy Stith has agreed to chair the Committee. Since Dr. Stith was absent, there was no report.

Membership and Nominating Committee Report: Mr. Richter announced that Ms. Dolan has agreed to chair the Committee. He reminded the Council that the election of officers will be held at the July meeting of the Council.

Personnel and Affirmative Action Committee Report: Mr. Goebel reported that he plans to meet with Phil Reynolds, Division Personnel Officer. Ms. Dawson suggested that representatives of the Committee on Sexism and the Committee on Racism be considered for membership on this Committee.

Status Report on the Human Resources Development Grant: Since Sid Glassman, who had originally planned to report on the Grant, was unable to be present, Fran Walker, Chief of Staff Development and Training, and Paul Myers, Head of Management Information Services, presented the report. The Human Resources Development Project is in its third year. The researchers are interested particularly in pre-service training and placement, recruitment issues, and affirmative action. They are attempting to build a data base concerning human resources staff. Work is being done on comparing public and private sector resources, and an analysis of clients' staff preferences with regard to ethnicity, age, sex, and so forth, which will begin perhaps as soon as mid-summer.

Mr. Richter announced that the Council will not meet in August, in keeping with the Council's decision to eliminate some meetings during the year due to budget limitations.

Mr. Young moved that the meeting be adjourned. Ms. Zavala seconded the motion, and it was passed.

Respectfully submitted,

Virginia Kelly
Recording Secretary

(Standard CMHC Distribution)

MINUTES

COLORADO MENTAL HEALTH COUNCIL

Date: June 11, 1981
1:30 - 4:30 p.m.

Place: Division of Mental Health
Conference Room B-108

Council Members Present:

Guidotta Bates
Dorothea Dolan
Ruth Fuller
Peter Garcia
Jerry Goebel
Carol Howe
Alma Lantz
Luis Medina
Bob Nuffer
Nancy Sanford
Roger Richter
Randy Stith
Cece Zavala

Guests:

Ernest Ficco
Ernest Hamburger

Staff Present:

Lynn Dawson
Robert Glover

Members Absent:

Rosita Bachmann
Mike Coren
Lucy May Dame
Fred Dow
Melanie Fairlamb
Leslie Hartley
Jack Quinn
Robert Young

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Mr. Richter, Chairperson, introduced guests, Mr. Ficco and Dr. Hamburger, of the Regional Office of ADAMHA, and new members Alma Lantz and Bob Nuffer. Dr. Lantz is a consumer representative and a member of the Division's Committee for the Status of Women in Mental Health. She is associated with a private research and development firm. Mr. Nuffer is a provider representative and is currently Director of the Sopris Branch of Colorado West Regional Mental Health Center.

The minutes of the last meeting were approved as written.

State Plan Committee Report: Dr. Medina reported that the Committee has reviewed the 81-82 Supplement to the State Mental Health Plan and all of the comments/ input received. The Committee referred the following issues to the Council for further discussion:

1. The Conceptual Framework, a new feature in the 81-82 Supplement, was agreed upon as being a positive addition to the State Plan. The new definitions for severe, critical, and chronically mentally ill, mandated by the legislature, are to be included in the Framework. The new definitions are now in draft form.

2. The Committee requested clarification by the Council of the objective in Chapter 4, Page 57 of the Operating Plan, in reference to increased fee collections. The Council agreed that the objective required rewording for clarification. The change will read, "To have increased by 10% the rate of collections from fee-paying clients (adjusted for client workload), as compared to the previous fiscal year, in community mental health centers by June 30, 1982."

3. Another change requested is to reword the statement, "shortage of mental health work force," to reflect that there is inadequate funding for staff. Understaffing in the mental health system is the issue, and will be worded as such in the Supplement.

4. Ms. Dawson outlined the five critical issues highlighted in the Supplement:

   - Shortage of psychiatric beds
   - Understaffing of the mental health system
   - Shortage of services for treating the violent mentally ill
   - Inadequate programs for the chronically mentally ill
   - Inadequate programs for the forensic patient

5. Another recommendation of the Committee is to have the Centers' Association submit objectives next year with the primary responsibility for reporting on accomplishment assigned to the centers.

Ms. Dawson reported briefly on the rationale of the 81-82 Supplement. Not knowing the status of the Mental Health Systems Act, and the uncertainty of the final outcome of new Colorado legislation, it was decided to do a supplement rather than a total re-write. Chapter IV, including the Operating Plan and Chapter VI will be cut significantly to reduce the size of the Supplement.

Dr. Medina extended the Council's appreciation for the tremendous contribution of Ms. Dawson's time and effort.

Dr. Medina made a motion to accept the Supplement as amended. The motion was seconded by Dr. Stith, voted on and passed. With the exception of Mr. Garcia, all Council members voted in favor of the motion. A letter of appreciation will be sent to those providing input to the Supplement. Letters will also be sent to groups who made presentations during the year.

Director's Report: Dr. Glover reviewed the current status of some major issues within the Division:

1. Fort Logan was funded 55 positions to open 40 beds. As the original request was for 93 staff, it is considered to be professionally and clinically irresponsible to open two wards with such a limited number of staff. The Division's proposal to open one ward sufficiently staffed, rather than two wards critically understaffed, is meeting some opposition from the Office of State Planning and Budgeting. The Council passed a motion authorizing the Chairperson to send a letter to Governor Lamm in support of the Division's position on this issue. Copies will be sent to Dr. Leidig and Ruth Stockton, Chair of the Joint Budget Committee. Dr. Stith clarified that the Council supports funding 88 additional beds, but is limited by the provision that they be adequately and humanely staffed.

2. The future of the HIRT Program for alcoholism at Fort Logan is still unknown. Currently, the Department of Health contracts with the Division of Mental Health for these services. The decision has not been made whether to continue services at Fort Logan or to transfer this service to community-based programs.

3. Completion of the new wards at Colorado State Hospital is on target. It is anticipated that the wards will be ready for occupancy by July 15. The same problem faced by Fort Logan, that of being asked to open more wards than can be adequately staffed, also exists at Colorado State Hospital. Also, the reassigning of staff to the new wards may result in some lay-offs, as staff from hospital surgery are not trained in forensic treatment.

4. Contracting with Health and Hospitals has not been completed as yet. The letter of intent from the Division is being withheld until the figures on

revenue and unit costs are received. Dr. Glover feels this will be accomplished in the near future.

5. Dr. Glover expressed his concern regarding the critical nature of the problems facing the mental health system and stressed the importance of reaching agreement on the solutions to such questions as: What to do with the chronic patient? Who has the responsibility? How is it to be provided? Within three to five years, the chronic patient population residing in the Capitol Hill area will be displaced and there must be alternatives for ensuring that they receive appropriate services.

6. Dr. Glover reported that for the next four years we are going to see up to 60% reduction of federal dollars going to the mental health system. Almost every center has proposed a reduction in total admissions and total service delivery in some form. Centers are clearly facing understaffing because of budget reductions; the majority of centers are experiencing about a 11% reduction in revenues. The ability for centers to operate within a budget is going to become more and more pertinent as time goes on. Having the expertise to capture funds other than governmental funds is becoming increasingly important.

7. Effective and careful prioritization within the State Plan is essential, as is clarifying those services we can and cannot provide. The Council has a major role to play this next year. The Council was asked to enhance its efforts in lobbying and advocating on behalf of the mental health network in total for increased resources.

Budget Committee Report: Dr. Stith, Chairperson for the Budget Committee, announced the regular meeting for the Budget Committee is at 11 o'clock, the same day as the regular monthly Council meeting. Council members were encouraged to attend. The next meeting will be held in Bruce Berger's office, room A-212 at the Division of Mental Health. Dr. Stith reported on 1981-82 funds granted to the Community Mental Health Centers by the Joint Budget Committee. General funds were the same as last year. A 2.5% increase in Medicaid dollars was given, resulting in a total increase of 2.5%. With inflation and anything else that occurs, such as trying to give raises to staff, the Division is figuring a minimum of 10% declining capacity.

Dr. Stith clarified how the high cost of hospitalization, as compared to the cost of other types of service, disproportionately affects the rate of declining admissions.

Governor Lamm has agreed to veto the footnote on a uniform fee schedule based upon the University of Colorado Medical Center's fee schedule. The Centers are committed to the establishment of a fee schedule that will be applicable throughout the system.

Program Committee Report: As Chairperson, Mr. Young, was not present, a report was not given.

Personnel and Affirmative Action Committee Report: Chairperson, Mr. Goebel, had no report at this time.

Membership and Nominating Committee Report: Ms. Dolan, Chairperson, reported that the Committee recommends the nomination of Roger Richter as Chairperson and Luis Medina as Vice Chairperson for the year 1981-82. There were no other

nominations by Council at this time. The election of officers will be held at the July meeting of the Council.

New Business: Ms. Dawson announced Leslie Hartley is planning to resign. Mr. Richter reminded Council members that the August meeting will be cancelled to reduce Council expenses.

Respectfully submitted,

Mary Dufva
Recording Secretary

(Standard CMHC Distribution)

APPENDIX II. THE STATE MENTAL HEALTH PROGRAM

D. DESCRIPTION OF THE PRESENT SYSTEM

2. Utilization

This section has been updated to reflect more recent data which impacts on utilization trends. 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 I). 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 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 II looks at community mental health centers' admissions and clients served by year. Both admissions and clients served showed a decline in FY 78-79 but have increased in FY 79-80. This increase may be due to the system for contracting with community mental health centers the Division initiated in FY 79-80. The percentage of admissions who are moderately and severely disabled is shown in Table III. This percentage for the community admissions has been rising since 1974. 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 212,000 severely and moderately psychiatrically disabled persons in Colorado in need of mental health services. This figure includes 29,256 children, 28,196 adolescents, 120,204 adults, and 34,344 elderly persons in need. Of the total figure only 85,023 citizens can be cared for now. The funds which pay for the services provided to the 85,023 are only partially state funds. Although the services provided to the 85,023 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 IV 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 and 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 V shows the percent admissions by age groups in the mental health centers and

TABLE I

Psychiatric Hospital Inpatient Admissions
for Public and Private Agencies
(Excluding CSH and FLMHC)
FY 1974-75 and FY 1976-77*

	No. of MH Inpatient Admissions	
Public Hospitals	FY 1974-75	FY 1976-77
Colorado Psychiatric Hospital	682	705
Poudre Valley Memorial	333	348
Denver Veterans Administration	1,370	1,879
Ft. Lyon Veterans Administration	1,485	**
Weld County General	698	780
Total Public	4,568	5,197***
Private Hospitals		
Bethesda	657	**
Emory John Brady	456	**
Mt. Airy	1,147	**
Parkview Episcopal	296	387
Penrose	426	158
St. Anthony	492	731
St. Joseph	900	720
St. Mary Corwin	509	496
Total Private	4,883	4,752***
Grand Total	9,451	9,949***

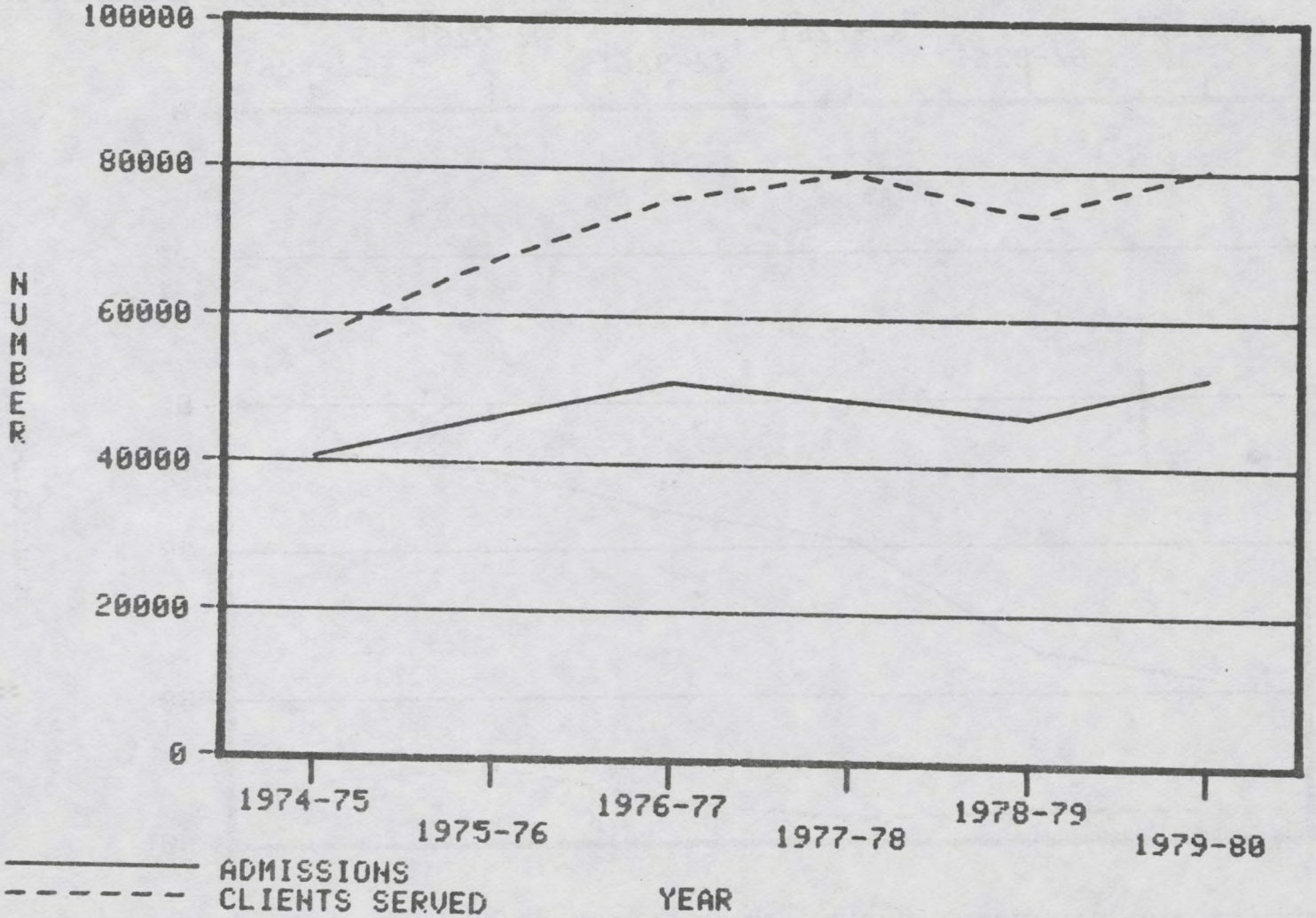
*Source: NIMH Facilities Inventory (1976 and 1978)

**Not available

***Uses the FY 74-75 number for missing data

TABLE II

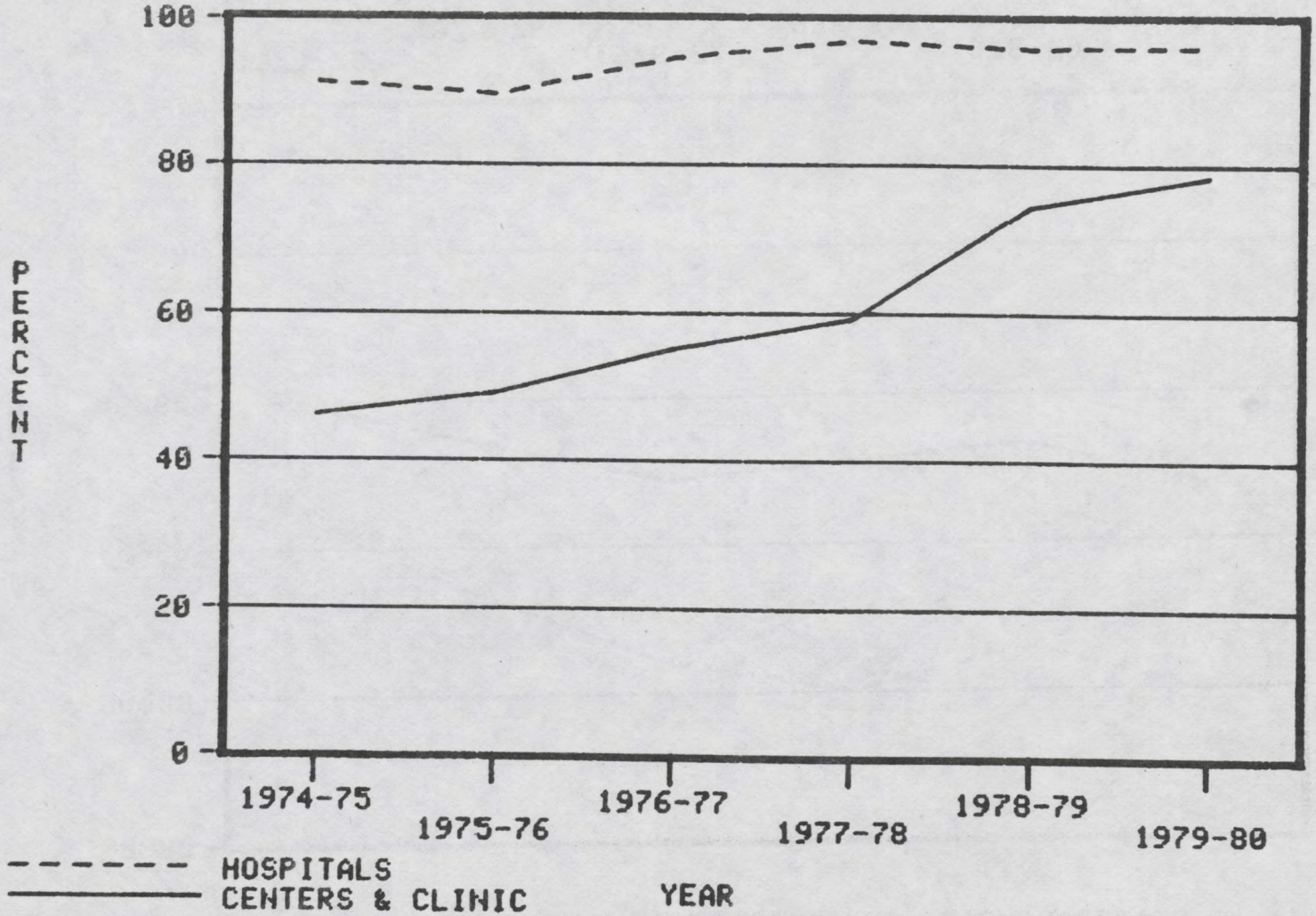
COMMUNITY MENTAL HEALTH CENTERS ADMISSIONS AND CLIENTS SERVED BY YEAR



Source: Division of Mental Health

TABLE III

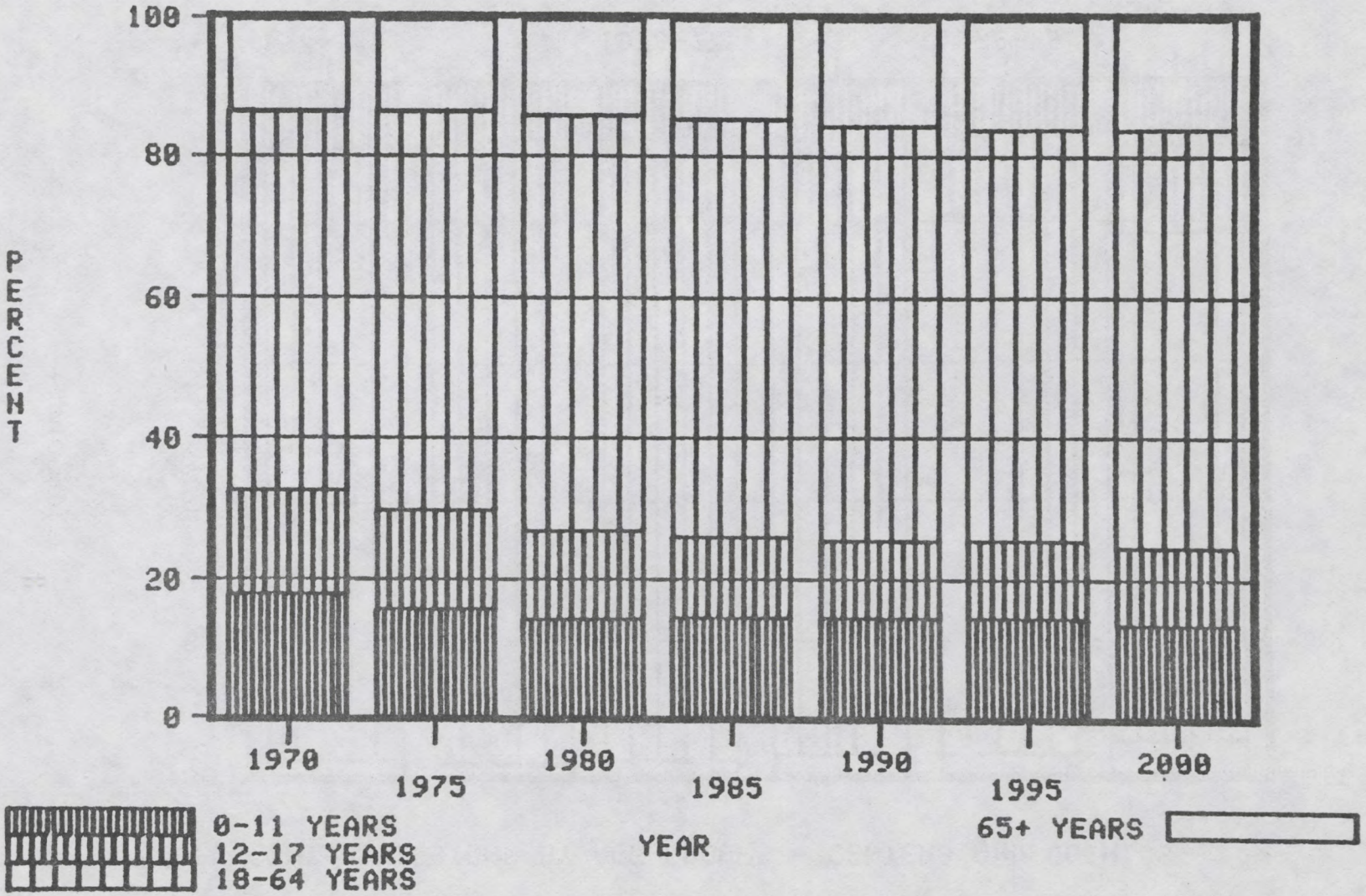
PERCENT OF ADMISSIONS IN SEVERITY TARGET GROUP (MODERATE AND SEVERE)



Note: New target group definition went into effect in FY 78-79.

TABLE IV

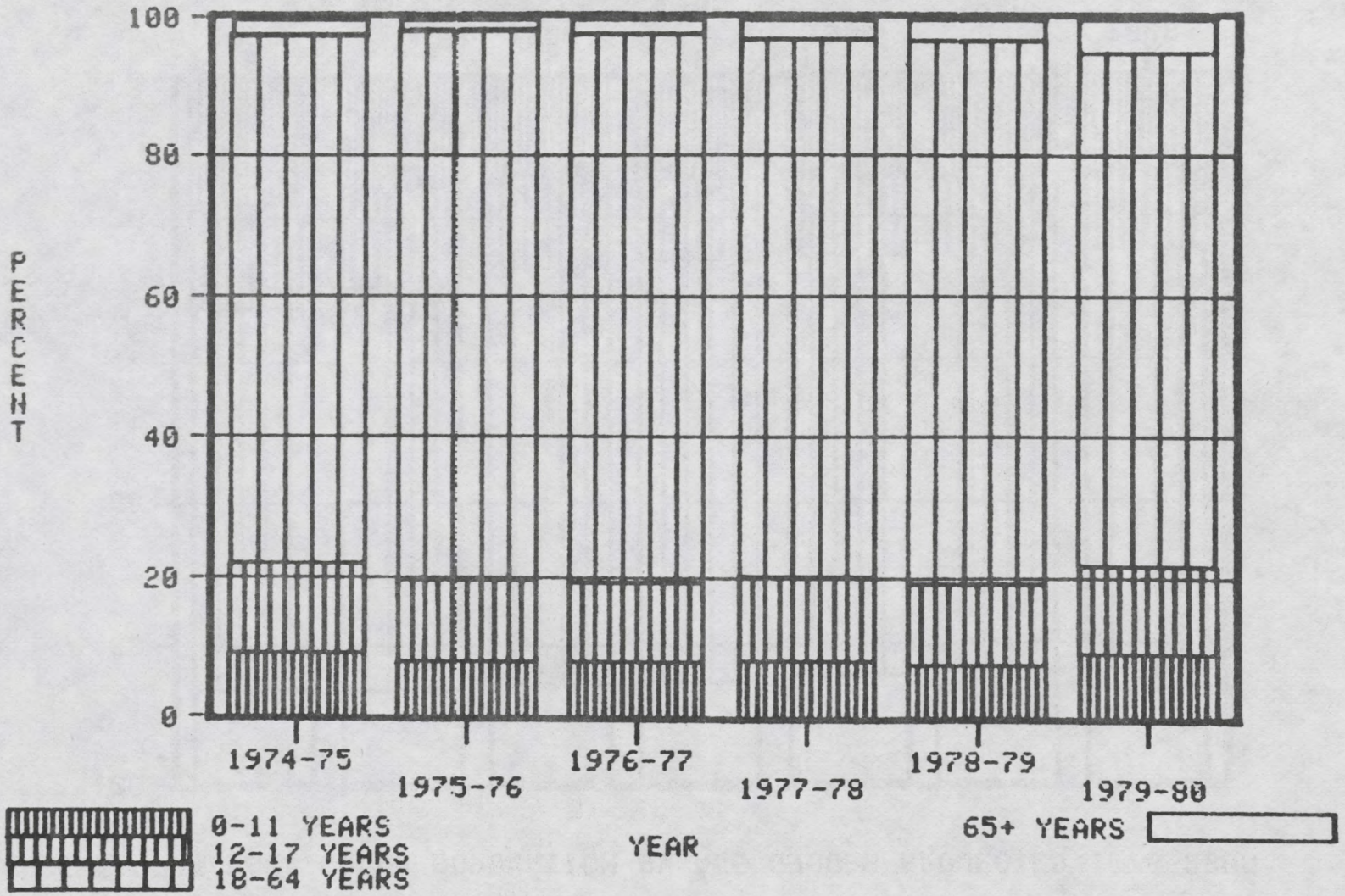
PERCENT OF TARGET GROUP POPULATION BY AGE GROUPS PROJECTED 1970-2000



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 V

PERCENT ADMISSIONS BY AGE GROUPS - CENTERS AND CLINICS



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 VI. 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 94.5 percent of the persons served through the Division of Mental Health's resources are seen by community 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 system 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.

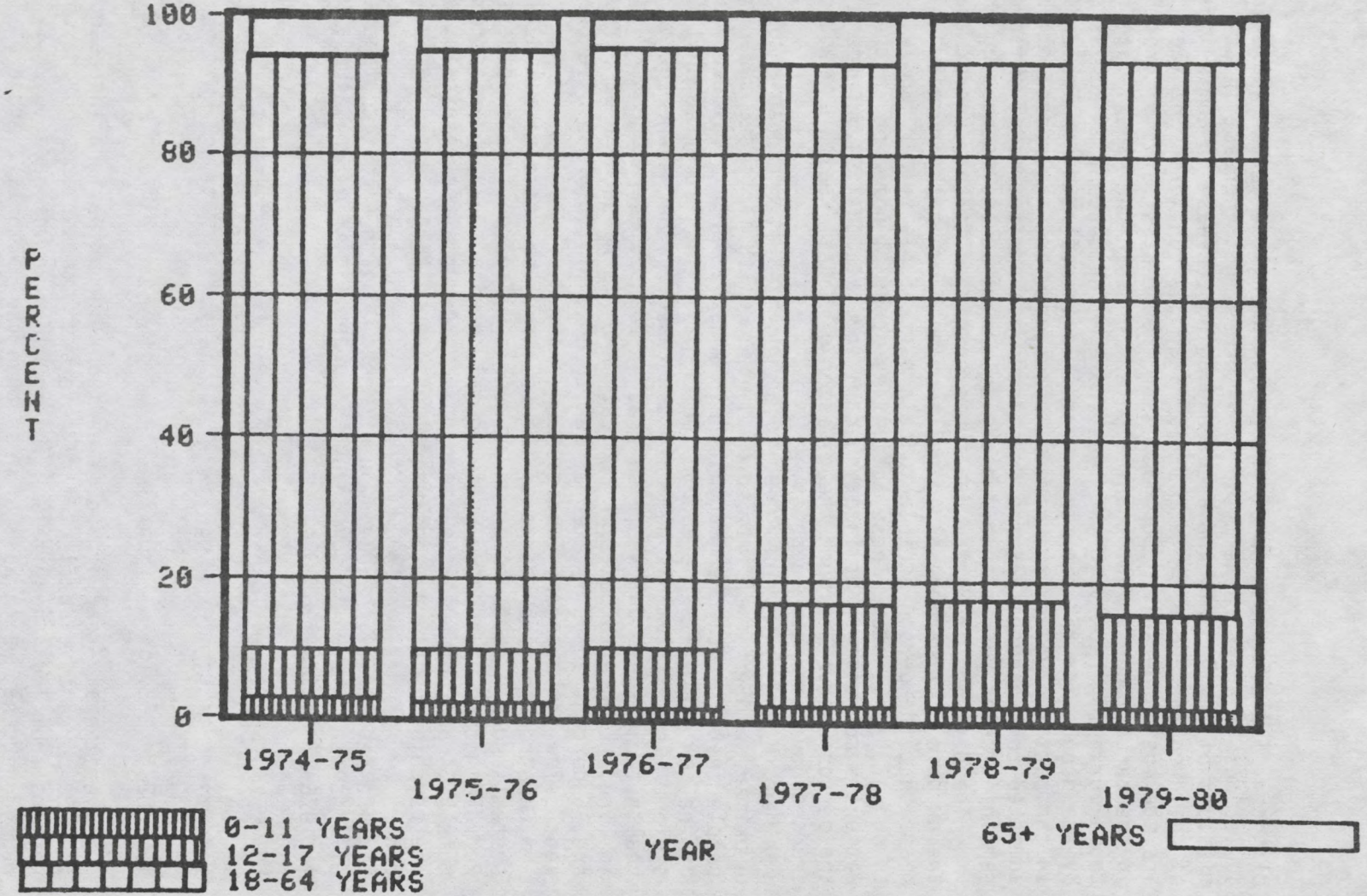
The results of the Division of Mental Health's cost containment efforts can be seen in comparing the upper limits of unit costs paid in 1976-77 and in 1981-82:

	Inpatient	Other 24-Hour	Partial	Outpatient	C&E
1976-77	160.36	59.33	44.84	30.58	24.34
1981-82	238.15	65.31	51.31	37.55	36.78

Over the six-year period, the amount for outpatient increased by less than 23 percent. Inpatient care refers to the services purchased by centers from local hospitals. The increase in that area over six years was 48 percent, which was far less than the national average of 75 percent. Partial care has increased only 10 percent while other 24-hour care has increased by only 13 percent. The Division of Mental Health continues to work on improving the reliability of unit cost data and on setting rates based on reasonable costs.

TABLE VI

PERCENT ADMISSIONS BY AGE GROUPS - HOSPITALS



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.

3. Similarities and Differences Between Public and Private Mental Health Sectors

The survey of the private mental health sector, described in the 1980-85 Colorado Mental Health Plan, was completed in December 1980. Under the impetus of the Mental Health Association of Colorado, the Division of Mental Health, the three Colorado Health Systems Agencies, all identified mental health professional societies, planning organizations interested in mental health, and representatives of private voluntary agency providers worked together to survey the private mental health sector in Colorado. The survey focused on information related to the characteristics of private mental health providers, a description of their practices, and a description of their clients. The final report, Colorado Private Sector Mental Health Survey 1980: Provider, Service and Client Characteristics, was published by the Mental Health Association and is available from that agency or from the Colorado Division of Mental Health.

For the purposes of this Supplement, the Division of Mental Health analyzed some of the similarities and differences between the public mental health sector and the private mental health sector. The following provides a summary of that analysis:

a. Number of Clients Seen - The number of clients seen annually for mental health services is probably somewhat greater in the private than in the state sector. The state mental health system sees approximately 80,000 clients annually. Respondents to the private sector survey reported seeing 68,738 clients annually. The actual number of clients seen annually in the private sector is estimated to be between 80,000 and 120,000. It is estimated than an additional 10,000 or more clients are seen annually in other settings, e.g., schools, military, etc.

b. Referral Source - For both the public and private sectors, clients are more likely to be referred within sectors than across sectors. Clients entering treatment in the public sector are more likely to be self-referred, referred by the legal system or community agencies. Clients entering treatment in the private sector are more likely to be referred by the clergy. The proportion of referrals from the medical and educational systems are about equal in the two sectors.

c. Location - Persons living in rural areas are less likely to see a therapist in the private sector than persons living in urban areas. Persons living in rural areas are equally likely to see a therapist in the public sector as persons living in urban areas.

d. Sex of Clients - The percentage of clients who are women is substantially higher in the private sector (62%) than in the public sector (49%).

e. Age of Clients - The distribution of clients seen by age groups is almost identical in the two sectors. Both sectors underserve children and elderly persons.

f. Impairment Level of Clients - A substantially greater percentage of clients seen in the public sector are moderately to severely impaired (76%) compared to the private sector (45%).

g. Ethnicity of Clients - Hispanics make up a greater proportion of public sector clients (14%) than of private sector clients (8%). Blacks are seen in approximately the same proportion in the two sectors. A greater percentage of clients seen in the public sector are ethnic minorities (21%) than in the private sector (15%).

* h. Number of Providers - A total of 670 respondents to the survey indicated they provide clinical mental health services in a private sector setting. The total actual number of private sector providers is estimated to be between 800 and 1,200. Approximately half of them work only part-time in the private sector.

* i. Sex of Providers - Overall, 43% of the providers are women. Substantially lower percentages of females were found among psychiatrists (8%) and psychologists (37%).

j. Ethnicity of Providers - There are very few ethnic minorities among the private sector clinicians (3%). About 12% of the mental health professionals in the public sector are ethnic minorities.

* k. Credentials - Most therapists in the private sector have strong credentials. Some form of licensing or certification is held by 89% of the respondents and 54.0% have earned a doctorate degree.

l. Waiting Period - The amount of time clients must wait to be seen appears to be shorter in the private compared to the public sector. Clients were reported to be seen typically within 2 weeks by 94% of the private sector respondents.

m. Duration of Course of Therapy - Responses varied greatly among respondents on the average length of a treatment episode. However, there appears to be a greater percentage of clinicians practicing long-term treatment in the private than the public sector, since 40% of the respondents indicated an average treatment length of 7 months or more. The average length of a treatment episode in CMHCs is about 3-4 months, and about 40% of all CMHC clients terminate within 30 days.

+ n. Payment Method - Results of the survey indicated that 31% of clients seen in the private sector pay for their services exclusively through individual or family means. An additional 61% have partial or full insurance coverage.

* o. Clients Seen Per Practitioner - Clinicians in the private sector reported seeing an average of 110 clients per year. The average number of clients served annually by part-time therapists is 60 compared to 159 for full-time therapists.

*Comparable data for the public sector will be available from the public provider survey.

+Comparable data for the public sector will be available from the client status report.

APPENDIX III. STATE HOSPITALS AND THE CATCHMENT AREA MENTAL HEALTH PROGRAM

G. RANKINGS OF CATCHMENT AREAS
(supersedes this section in the 1980-85 Colorado Mental Health Plan)

1. Updated Population Estimates

Table 1 reflects total population estimates based on the 1980 Census. The percent ethnic minorities in each catchment area also has been estimated from the 1980 Census.

2. 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 to which these percentages are applied are final counts from the 1980 Census. (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 figures for total population in need computed using this method are shown in the first column of Table 2.

The social indicators data used in this analysis and their sources are shown in Table 3. 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 1979 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 4),

Table 1.
1980 Census Final Population Counts and
Percent Ethnic Minorities by Catchment Area

	Total Population	Black	American Indian	Asian	Hispanic	Minority Total (not including Other)
Community						
Adams	212366	1.02	0.69	1.14	16.81	19.66
Arapahoe	188572	0.92	0.36	0.97	3.78	6.03
Aurora	163780	6.87	0.50	2.10	5.03	14.5
Bethesda	134764	2.73	0.29	1.43	3.81	8.26
Boulder	189625	0.91	0.48	1.16	5.43	7.98
Centennial	86372	0.11	0.31	0.35	6.17	6.94
Child/Adol.						
Colorado W.	178531	0.19	0.51	0.34	5.23	6.27
Denver H&H	150369	11.18	1.32	1.43	34.77	48.70
Denver MHC						
Jefferson	381490	0.51	0.39	0.95	5.20	7.05
Larimer	149184	0.42	0.43	0.92	5.87	7.64
Midwestern	61791	0.15	0.72	0.24	7.50	8.61
Park East	114634	32.94	0.62	1.67	8.83	44.06
Pikes Peak	322791	5.91	0.58	1.58	7.82	15.89
San Luis	37914	0.21	0.44	0.42	43.44	44.51
Servicios						
SE Colorado	51925	0.28	0.42	0.35	24.02	25.07
SW Colorado	50089	0.11	5.69	0.23	11.47	17.5
SW Denver	91629	1.09	0.82	1.10	26.62	29.63
Spanish Pks.	147309	1.59	0.44	0.36	34.60	36.99
Weld	123438	0.48	0.43	0.66	17.03	18.6
W. Central	52261	0.90	0.60	0.21	10.91	12.62
STATEWIDE	2888834	3.52	0.63	1.03	11.75	16.93

Source: Bureau of the Census, "Colorado Final Population and Housing Unit Counts," Report PHC80-V-7, March 1981.

Note: Population total for Aurora catchment area includes 809 from non-Aurora city portion of Arapahoe County and 4,385 from non-Aurora city portion of Adams County to reflect city/catchment area differences.

Table 2. Estimates of Population in Need by Catchment Area

	Unmodified Prevalence Estimates 1982 [1]	Composite Social Indicators Standardized Scores	Modified Population in Need 1982 [2]	Percent Total Population in Need [3]		
Community						
Adams	15766	-.49955	14191	6.68		
Arapahoe	14299	-1.01061	11409	6.05		
Aurora	12327	-.67231	10669	6.51		
Bethesda	10751	-.21355	10292	7.64		
Boulder	14582	-.53187	13031	6.87		
Centennial	6869	-1.01682	5472	6.34		
Child/Adol.						
Colorado W.	13655	-.65121	11877	6.65		
Denver H&H	11995	2.57118	18163	12.08		
Denver MHC						
Jefferson	28835	-1.09646	22512	5.90		
Larimer	11519	-1.28300	8563	5.74		
Midwestern	4873	-.44984	4435	7.18		
Park East	9145	.92057	10829	9.45		
Pikes Peak	24135	-.47485	21843	6.77		
San Luis	2949	1.28181	3705	9.77		
Servicios						
SE Colorado	4125	.36732	4428	8.53		
SW Colorado	3886	.66091	4400	8.78		
SW Denver	7310	.78044	8451	9.22		
Spanish Pks.	11590	1.51799	15109	10.26		
Weld	9459	-.65998	8210	6.65		
W. Central	4126	.46118	4507	8.62		
STATEWIDE	222196		212094			

[1] Unmodified Prevalence Estimates calculated by multiplying catchment area population for each age group by "President's Commission" age-adjusted prevalence rates. 1980 U.S. Census final counts and 1976 Division of Planning age proportions used to estimate 1982 population by age groups.

[2] Modified Population in Need calculated by adjusting unmodified estimate by 20% of the catchment area composite Social Indicator Standardized Score.

[3] Percent Total Population in Need calculated by dividing Population in Need by total population (1980 U.S. Census final counts).

Table 3. Social Indicators Raw Scores for Catchment Areas

	Suicide Rate per 100,000 Population 1979[1]	Abuse & Neglect Reports Rate per 100,000 C & A 1979[2]	Divorce Rate per 1,000 Married Couples 1979[3]	% Minority Population 1980[4]	% Population in Poverty 1970[5]	% Labor Force Un-Employment 1980[6]
Community						
Adams	16.09	937.6	15.75	19.66	6.8	5.85
Arapahoe	18.05	687.3	19.58	6.03	6.2	3.88
Aurora	14.07	803.4	20.35	14.50	5.9	5.22
Bethesda	18.36	1073.0	24.49	8.26	7.1	4.28
Boulder	15.92	1076.3	16.12	7.98	10.1	5.47
Centennial	16.35	602.0	14.35	6.94	16.8	4.08
Child/Adol.	-	-	-	-	-	-
Colorado W.	9.57	467.9	24.87	6.27	13.7	5.69
Denver H&H	31.04	1073.0	24.49	48.70	24.0	8.03
Denver MHC	-	-	-	-	-	-
Jefferson	18.94	301.2	22.15	7.05	5.5	4.07
Larimer	10.72	318.9	17.56	7.64	13.6	4.99
Midwestern	11.37	319.5	21.66	8.61	20.2	6.40
Park East	20.81	1073.0	24.49	44.06	10.4	5.30
Pikes Peak	16.83	455.0	18.32	15.89	11.6	6.42
San Luis	18.58	334.3	19.88	44.51	29.3	8.64
Servicios	-	-	-	-	-	-
SE Colorado	19.40	993.7	15.78	25.07	22.8	5.31
SW Colorado	14.12	911.6	24.40	17.50	18.1	7.62
SW Denver	27.85	1073.0	24.49	29.63	6.9	4.88
Spanish Pks.	25.85	1037.0	18.89	36.99	16.5	8.70
Weld	16.27	353.1	13.86	18.60	17.3	6.02
W. Central	19.18	211.4	29.99	12.62	14.6	7.65

[1]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1981.

[2]Source: Colorado Department of Social Services, Protective Services Program, 1981

[3]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1981. Number of Married Couples Estimated by Applying Percent Population Married from 1970 Census to Current Population Estimates and Dividing Result by 2.

[4]Source: U. S. Census Final Population and Housing Unit Counts, Report PHC80-V-7, 1981

[5]Source: Mental Health Demograph Profile System (U.S. Census Data - 1970).

[6]Source: Colorado Division of Employment and Training, Research and Analysis Section, 1981.

Table 4. Social Indicators Standardized Scores for Catchment Areas

Community	Suicide Rate per 100,000 Population 1979[1]	Abuse & Neglect Reports Rate per 100,000 C & A 1979[2]	Divorce Rate per 1000 Married Couples 1979[3]	% Minority Population 1980[4]	% Population in Poverty 1970[5]	% Labor Force Unemployment 1980[6]
Adams	- .35656	.72181	-1.14446	.02431	-1.06918	- .05111
Arapahoe	.01557	- .05529	- .23563	- .96477	-1.15991	-1.39350
Aurora	- .74008	.30516	- .05292	- .35013	-1.20528	- .48040
Bethesda	.07443	1.14219	.92947	- .80295	-1.02381	-1.12093
Boulder	- .38883	1.15243	-1.05667	- .82327	- .57018	- .31004
Centennial	- .30720	- .32013	-1.47667	- .89874	.44309	-1.25721
Child/Adol.	-	-	-	-	-	-
Colorado W.	-1.59445	- .73647	1.01965	- .94736	- .02571	- .16013
Denver H&H	2.48187	1.14219	.92947	2.13165	1.53193	1.43438
Denver MHC	-	-	-	-	-	-
Jefferson	.18455	-1.25402	.37421	- .89076	-1.26577	-1.26403
Larimer	-1.37611	-1.19907	- .71496	- .84794	- .04083	- .63712
Midwestern	-1.25270	-1.19720	.25794	- .77755	.95727	.32367
Park East	.53959	1.14219	.92947	1.79494	- .52476	- .42589
Pikes Peak	- .21606	- .77652	- .53462	- .24927	- .34329	.33730
San Luis	.11620	-1.15126	- .16445	1.82759	2.33343	1.85005
Servicios	-	-	-	-	-	-
SE Colorado	.27188	.89599	-1.13734	.41690	1.35046	- .41907
SW Colorado	- .73058	.64109	.90812	- .13243	.63969	1.15500
SW Denver	1.87621	1.14219	.92947	.74780	-1.05405	- .71208
Spanish Pks.	1.49649	1.03042	- .39936	1.28189	.39773	1.89093
Weld	- .32238	-1.09289	-1.59295	- .05261	.51871	.06473
W. Central	.23011	-1.53282	2.23459	- .48656	.11040	1.17544

[1]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1981

[2]Source: Colorado Department of Social Services, Protective Services Program, 1981.

[3]Source: Colorado Department of Health, Public Health Statistics Section, Annual Report of Vital Statistics, 1981. Number of Married Couples Estimated by Applying Percent Population Married from 1970 Census to Current Population Estimates and Dividing Result by 2.

[4]Source: U.S. Census Final Population and Housing Unit Counts, Report PHC80-V-7, 1981.

[5]Source: Mental Health Demograph Profile System (U.S. Census Data - 1970).

[6]Source: Colorado Division of Employment and Training, Research and Analysis Section, 1981.

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 2. (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:

$$P = x\ (1 + .20\ z)$$

Thereby a catchment area which is one standard deviation above the mean on social disruption would receive a 20 percent 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 percent 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 2. The percentages of a catchment area's total population that the population-in-need estimates represent also are shown in Table 2.

The model used to calculate population in need is identical to that used in FY 80-81; however, much of the population and social indicators data used as input to the model have been updated. The population prevalence estimates are based on 1980 final census counts, and more recent data for suicide, child abuse, divorce, and unemployment rates have been obtained. The percent population-in-need estimates obtained with this year's calculation of the model correlate highly ($r = .97$) with those obtained last year, attesting to the stability of the model. The population-in-need model will be recalculated throughout the year as more sociodemographic data become available from the 1980 Census.

3. 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 5, were obtained from the 1977 and 1979 Colorado Department of Health Facilities Survey. This information from the 1979 survey was collected during 1980, and reflects a facility's status on December 31, 1979. 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 5. Resources Inventory - Facilities

Community	Inpatient Psychiatic Hospital Beds[1,2]	Nursing Homes Psychiatric Census[1]	RCF Census[3]	RCCF Census[3]	Hospital Based Psychiatric Emergency Units[1]
Adams	0	187	33	15	0
Arapahoe	0	54	0	139	0
Aurora	0	10	0	12	0
Bethesda	70	68	0	0	1
Boulder	38	17	0	140	1
Centennial	0	99	12	54	1
Child/Adol.	-	-	-	-	-
Colorado W.	13	48	0	34	0
Denver H&H	94	136	11	175	4
Denver MHC	-	-	-	-	-
Jefferson	6	189	0	33	1
Larimer	9	102	0	24	0
Midwestern	0	38	0	8	0
Park East	(40)113	89	4	111	2
Pikes Peak	125	72	0	153	2
San Luis	0	14	0	16	0
Servicios	-	-	-	-	-
SE Colorado	0	10	68	97	0
SW Colorado	0	1	12	0	1
SW Denver	(203)	10	11	53	0
Spanish Pks.	(706)55	95	8	106	0
Weld	18	108	0	27	1
W. Central	0	76	0	14	0
STATEWIDE	(949)541	1423	159	1211	14

[1]Source: Colorado Department of Health Facilities Survey, 1979.
[2]State run hospitals shown in parentheses.
[3]Source: Colorado Department of Health Facilities Survey, 1977.

The personnel data shown in Table 6 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,

c. The total number of full-time equivalent employees (FTEs) who were reported to work in the catchment area centers/clinics, and

d. The total number of full-time equivalent mental health care providers (who responded to the Private Sector Survey) in private practice.

The funding allocations data shown in Table 7 include the number of state, Medicaid, 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.

4. 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, Medicaid, and state hospital FY 81-82 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 8.

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.

5. Methodological Note

In the months ahead, the Division of Mental Health will continue to work on refining the methodology employed in this need assessment.

Table 6. Resources Inventory - Personnel

	Licensed Psychiatrists[1,2]	Licensed Psychologists[2,3]	CMHC and Clinic Center Staff[4]		Private Sector Staff[5]	
			Full-Time Staff	Part-Time Staff	Full-Time Staff	Part-Time Staff
Community						
Adams	2	3	90	12	3	2
Arapahoe	21	18	67	13	27	11
Aurora		8	56	15	9	9
Bethesda	55.5	19.5	37	11	35	33
Boulder	33	18	75	75	27	26
Centennial	0	0	88	13	0	3
Child/Adol.	-	-	18	9	-	-
Colorado W.	6	10	80	19	12	10
Denver H&H	55.5	19.5	282	20	35	34
Denver MHC	-	-	3	9	-	-
Jefferson	20	22	91	13	27	29
Larimer	6	14	54	7	11	20
Midwestern	1	1	21	8	0	2
Park East	55.5	19.5	39	8	34	33
Pikes Peak	28	16	222	57	39	27
San Luis	1	0	33	4	1	3
Servicios	-	-	10	1	-	-
SE Colorado	2	0	38	3	0	2
SW Colorado	1	0	26	7	2	2
SW Denver	55.5	19.5	56	3	34	34
Spanish Pks.	25	6	86	28	8	5
Weld	3	5	48	8	3	6
W. Central	1	1	35	6	2	0
STATEWIDE	272	200	1555	349	310	296

[1]Source: Colorado Department of Health, 1978

[2]Shown for Denver catchment areas is 1/4 of Denver County total

[3]Source: National Register of Health Service Providers in Psychology, 1979

[4]Source: DMH, 1981.

[5]Source: DMH, Evaluation Report, 1980.

Table 7. Resources Inventory - Funding Allocations

	81-82 Contracted State Dollars (1,000's)	81-82 Federal Dollars (1,000's)	81-82 State & Federal Dollars (1,000's)	81-82 Medicaid Funding	80-81 Catchment Area Hospital Utilization	Total State Fed., Medicaid, Hosp. Resources (1,000's)
Community						
Adams	1,220	-0-	1,220	481	198	1,899
Arapahoe	832	-0-	832	121	357	1,310
Aurora	347	582	929	185	315	1,429
Bethesda	883	-0-	883	89	74	1,047
Boulder	1,192	30	1,222	378	133	1,734
Centennial	295	676	971	73	201	1,245
Child/Adol.	60	-0-	60	-0-	-0-	60
Colorado W.	892	-0-	892	119	348	1,358
Denver H&H	2,011	919	2,930	-0-	899	3,829
Denver MHC	88	-0-	88	6	-0-	94
Jefferson	1,855	-0-	1,855	428	362	2,646
Larimer	414	583	997	132	118	1,246
Midwestern	359	36	385	185	164	744
Park East	974	291	1,265	174	369	1,808
Pikes Peak	1,785	-0-	1,785	318	1,877	3,980
San Luis	425	97	522	58	292	871
Servicios	131	-0-	131	22	-0-	153
SE Colorado	161	616	777	106	311	1,194
SW Colorado	219	486	705	58	214	977
SW Denver	920	-0-	920	116	204	1,240
Spanish Pks.	642	130	772	367	2,327	3,466
Weld	820	61	881	141	99	1,122
W. Central	99	366	455	88	266	820

Table 8. Priority Need Ranking

CSH Service Area	Per Capita in Need; State, Fed., Medicaid, & Hosp. Allocation	Priority Ranking By Region	Priority Ranking Statewide			
Midwestern	167.79	2	12			
Pikes Peak	182.23	4	14			
San Luis	235.11	7	19			
SE Colorado	269.75	8	20			
SW Colorado	221.95	5	16			
Spanish Peaks	229.38	6	18			
West Central	181.95	3	13			
Colo. West	114.38	1	2			
Average	200.32					
FLMHC Service Area						
Weld	136.62	7	8			
Larimer	145.52	8	9			
Adams	133.82	5	6			
Arapahoe	114.79	2	3			
Boulder	133.05	4	5			
Jefferson	117.54	3	4			
Bethesda	101.72	1	1			
Denver H.& H.	210.81	11	15			
Park East	166.96	10	11			
SW Denver	146.78	9	10			
Aurora	133.95	6	7			
Centennial	227.58	12	17			
Average	147.43					
Total State	168.59					

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 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
(supersedes this section in the 1980-85 Colorado Mental Health Plan)

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, 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. Tables 1 through 12 present data that were compiled by DMH for the 1981-82 contract negotiations. The preliminary data were published previously in Orchid 29 ("Data Relevant to Agency/DMH Contract Negotiations - Spring, 1981"). They are included in this section because of their usefulness for other planning applications throughout the year.

The following tables contain the information relevant to the 1981-82 contract negotiations between the community mental health centers and the Division of Mental Health. The population totals and ethnic group percentages have been updated from their original publication in Evaluation Report (Orchid) 29.

The tables are organized as follows:

Table 1. Total Admissions
Table 2. Total Population and Total Population in Need
Table 3. Population and Admissions: Hispanics
Table 4. Population and Admissions: Blacks

Table 5. Population and Admissions: Asians
Table 6. Population and Admissions: American Indians
Table 7. Population and Admissions: Total Ethnic Minorities
Table 8. Population, Population in Need, and Admissions: Children
Table 9. Population, Population in Need, and Admissions: Adolescents
Table 10. Population, Population in Need, and Admissions: Adults
Table 11. Population, Population in Need, and Admissions: Elderly
Table 12. Severity Target Group Admissions

Contracted admissions shown reflect any agreed upon changes resulting from contract renegotiations as of April 1981. It should be recognized that the final contract figures for fiscal year 1980-81 may continue to change pending the outcome of any further contract renegotiations. The numbers of contracted and projected admissions for each priority group were calculated by multiplying the total number of admissions by the priority group percentage. Therefore, the numbers of admissions shown for each group may deviate slightly, due to rounding error, from those found in the contracts or the local plans.

The following notes are specific to the individual tables:

Table 1. This table shows the total number of admissions, actual for FY 78-79 and FY 79-80 (Orchids 26 and 28), contracted for FY 80-81, and projected by the centers for FY 81-82 as reflected in the local plans.

Table 2. Three total population estimates are shown for each catchment area: one based on 1980 final census counts, one based on 1981 Division of Planning projections (Orchid 25), and the figure reported by each agency in its local plan. The population-in-need totals include the DMH estimates (the methodology for those estimates is described on pages AIII.1 to AIII.11), and the estimates provided by the mental health centers in their local plans.

Tables 3 to 7. These tables show percent population estimates (Orchid 25 and local plans) and the number and percent of admissions (actual FY 79-80, contracted FY 80-81, and center-projected FY 81-82) for each ethnic minority group (the DMH estimates for ethnic minorities are based on 1980 Census counts by race and Spanish origin). Table 7 shows total ethnic minorities, since for contracting purposes total minorities may be greater than the sum of the individual ethnic minorities. No population-in-need percentages are shown for ethnic groups. The data reported in the catchment area plans show that most agencies assume each ethnic group is represented in the population in need in the same proportion as in the total population.

Tables 8 to 11. These tables show the same data for the four age groups as was shown for the ethnic minority groups, with the exception that DMH and mental health center estimates for percent population in need are included here as well. The DMH estimates for age groups in the population are based on 1977 Division of Planning data.

Table 12. This table shows the percent and number of severity target group admissions for FY 79-80 actual, FY 80-81 contracted, and FY 81-82 center-projected. Since the "rule of 78" measure began to be used in FY 78-79, the percent target group admissions for that year are also included in this table for comparison purposes.

TABLE 1

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

****
TOTAL ADMISSIONS
****

CATCHMENT AREA	ACTUAL 1978-79	ACTUAL 1979-80	DMH-CMHC CONTRACTED 1980-81	CMHC PLAN 1981-82
ADAMS	2572	2840	3000	3000
ARAPAHOE	1391	1791	1500	1515
AURORA	2056	3038	2700	2700
BETHESDA	853	1117	1020	1020
BOULDER	2047	1773	1657	1823
CENTENNIAL	1793	2179	2450	2400
COLO WEST	2366	3993	2900	2900
DENVER HGH	11053	9639	7640	7640
JEFFERSON	3526	3651	3675	3675
LARIMER	2406	2471	2300	2150
MIDWESTERN	1045	1222	1200	1200
PARK EAST	945	1468	1150	1100
PIKES PEAK	4520	5732	4876	0
SAN LUIS	534	596	540	540
SE COLO	898	1191	891	891
SW COLO	746	1014	1200	1200
SW DENVER	1230	1168	1250	1224
SPAN PEAKS	1579	2126	2078	4000
WELD	2536	2684	2700	2700
WEST CENTRAL	1099	1327	1200	1235
	45195	51020	45927	42913

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 2

****
TOTAL POPULATION &
TOTAL POPULATION IN NEED
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CATCHMENT AREA	TOTAL POPULATION U.S. CENSUS 1980	TOTAL POPULATION DMH 1981	TOTAL POPULATION CMHC 1982	TOTAL POPULATION IN NEED DMH 1981	TOTAL POPULATION IN NEED CMHC 1982
ADAMS	212366	219494	224678	14191	15541
ARAPAHOE	188572	201029	201029	11409	13705
AURORA	163780	157977	171290	10669	13592
BETHESDA	134764	136798	149350	10292	11914
BOULDER	189625	206600	206600	13031	18809
CENTENNIAL	86372	93643	93643	5472	6550
COLO WEST	178531	190148	190148	11877	13876
DENVER H&H	150369	155365	155365	18163	28439
JEFFERSON	381490	416500	401667	22512	26068
LARIMER	149184	156100	149205	8563	10235
MIDWESTERN	61791	75022	75022	4435	5645
PARK EAST	114634	115869	115869	10829	11123
PIKES PEAK	322791	339289	339289	21843	25367
SAN LUIS	37914	43776	43776	3705	3810
SE COLO	51925	62628	59103	4428	7093
SW COLO	50089	54830	54830	4400	4676
SW DENVER	91629	82968	88464	8451	7626
SPAN PEAKS	147309	154465	154465	15109	13480
WELD	123438	140000	140000	8210	10003
WEST CENTRAL	52261	55249	55249	4507	20916
	2888834	3057750	3069042	212096	268468

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 3

POPULATION & ADMISSIONS
BY ETHNIC GROUPS

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HISPANICS
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CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	16.8	15.6	13.1	372	13.0	390	13.0	390
ARAPAHOE	3.8	4.5	4.8	86	6.0	90	5.9	89
AURORA	5.0	2.0	3.9	118	3.8	103	3.8	103
BETHESDA	3.8	6.2	4.4	49	4.0	41	4.0	41
BOULDER	5.4	6.3	7.8	138	6.0	99	6.0	109
CENTENNIAL	6.2	7.0	7.6	166	10.0	245	0.0	0
COLO WEST	5.2	7.7	4.3	172	5.6	162	0.0	0
DENVER H&H	34.8	36.4	26.3	2535	27.0	2063	27.0	2063
JEFFERSON	5.2	3.9	3.9	142	3.9	143	3.9	143
LARIMER	5.9	6.9	5.3	131	6.1	140	6.5	140
MIDWESTERN	7.5	9.5	9.0	110	8.7	104	8.7	104
PARK EAST	8.8	10.5	8.1	119	8.3	95	6.0	66
PIKES PEAK	7.8	8.5	6.7	384	8.0	390	0.0	0
SAN LUIS	43.4	47.8	48.9	291	47.0	254	47.8	258
SE COLO	24.0	26.5	24.1	287	23.5	209	26.6	237
SW COLO	11.5	17.1	14.5	147	18.6	223	18.2	218
SW DENVER	26.6	33.4	33.7	394	30.0	375	30.8	377
SPAN PEAKS	34.6	37.6	35.8	761	35.7	742	0.0	0
WELD	17.0	19.3	16.2	435	16.7	451	16.7	451
WEST CENTRAL	10.9	11.4	6.5	86	8.0	96	8.1	100
				6923		6415		4889

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 4

POPULATION & ADMISSIONS
BY ETHNIC GROUPS

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BLACKS
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CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	1.0	1.3	1.9	54	1.3	39	1.3	39
ARAPAHOE	.9	1.3	1.5	27	1.3	19	1.3	20
AURORA	6.9	3.6	6.9	210	4.5	121	4.5	121
BETHESDA	2.7	5.7	5.2	58	4.0	41	4.0	41
BOULDER	.9	1.0	1.9	34	1.5	25	1.2	22
CENTENNIAL	.1	.1	.1	2	0.0	0	0.0	0
COLO WEST	.2	.2	.5	20	0.0	0	0.0	0
DENVER H&H	11.2	14.1	13.8	1330	14.0	1070	14.0	1070
JEFFERSON	.5	.3	.7	26	0.0	0	0.0	0
LARIMER	.4	.3	.7	17	0.0	0	0.0	0
MIDWESTERN	.1	.2	1.0	12	0.0	0	1.0	12
PARK EAST	32.9	34.0	37.6	552	36.5	420	35.9	395
PIKES PEAK	5.9	5.7	7.1	407	6.5	317	0.0	0
SAN LUIS	.2	0.0	.5	3	0.0	0	0.0	0
SE COLO	.3	.4	.5	6	0.0	0	0.0	0
SW COLO	.1	.1	.4	4	0.0	0	0.0	0
SW DENVER	1.1	1.4	2.4	28	1.9	24	2.3	28
SPAN PEAKS	1.6	1.7	1.0	21	1.5	31	0.0	0
WELD	.5	.2	1.9	51	0.0	0	0.0	0
WEST CENTRAL	.9	.5	.3	4	0.0	0	.2	2
				2866		2107		1750

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 5

POPULATION & ADMISSIONS
BY ETHNIC GROUPS

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ASIANS
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CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	1.1	1.2	.3	9	0.0	0	0.0	0
ARAPAHOE	1.0	1.2	.3	5	0.0	0	.3	5
AURORA	2.1	.5	1.0	30	0.0	0	1.5	40
BETHESDA	1.4	.2	.6	7	0.0	0	0.0	0
BOULDER	1.2	.3	.5	9	0.0	0	0.0	0
CENTENNIAL	.4	.4	.2	4	0.0	0	0.0	0
COLO WEST	.3	.2	.4	16	0.0	0	0.0	0
DENVER H&H	1.4	2.3	.2	19	0.0	0	.5	38
JEFFERSON	1.0	.7	.4	15	0.0	0	0.0	0
LARIMER	.9	.9	.4	10	0.0	0	0.0	0
MIDWESTERN	.2	.4	.4	5	0.0	0	.1	1
PARK EAST	1.7	1.9	4.4	65	2.1	24	2.3	25
PIKES PEAK	1.6	1.5	.7	40	1.6	78	0.0	0
SAN LUIS	.4	0.0	0.0	0	0.0	0	0.0	0
SE COLO	.4	.6	.3	4	0.0	0	0.0	0
SW COLO	.2	.4	.3	3	0.0	0	0.0	0
SW DENVER	1.1	.2	.4	5	0.0	0	1.5	18
SPAN PEAKS	.4	.4	.2	4	0.0	0	0.0	0
WELD	.7	.9	.5	13	0.0	0	0.0	0
WEST CENTRAL	.2	.3	.3	4	0.0	0	.2	2
				267		102		129

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 6

POPULATION & ADMISSIONS
BY ETHNIC GROUPS

****
AMERICAN INDIANS
****

CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	.7	.8	.7	20	0.0	0	0.0	0
ARAPAHOE	.4	.3	.9	16	0.0	0	.3	5
AURORA	.5	.3	.8	24	0.0	0	1.6	43
BETHESDA	.3	.2	1.0	11	0.0	0	0.0	0
BOULDER	.5	.3	.8	14	0.0	0	0.0	0
CENTENNIAL	.3	.1	.9	20	0.0	0	0.0	0
COLO WEST	.5	.1	1.0	40	0.0	0	0.0	0
DENVER H&H	1.3	1.0	3.0	289	1.5	115	1.5	115
JEFFERSON	.4	.2	1.1	40	0.0	0	0.0	0
LARIMER	.4	.3	.8	20	0.0	0	0.0	0
MIDWESTERN	.7	.8	.9	11	0.0	0	.6	7
PARK EAST	.6	.7	1.1	16	1.1	13	.8	9
PIKES PEAK	.6	.4	.6	34	0.0	0	0.0	0
SAN LUIS	.4	0.0	1.0	6	0.0	0	0.0	0
SE COLO	.4	.2	1.0	12	0.0	0	0.0	0
SW COLO	5.7	6.9	5.5	56	5.6	67	2.2	26
SW DENVER	.8	.2	.5	6	0.0	0	1.5	18
SPAN PEAKS	.4	.1	.2	4	0.0	0	0.0	0
WELD	.4	.2	.5	13	0.0	0	0.0	0
WEST CENTRAL	.6	.3	.9	12	0.0	0	.2	2
				664		195		225

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 7

POPULATION & ADMISSIONS
BY ETHNIC GROUPS

****
TOTAL ETHNIC MINORITIES
****

CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	19.6	18.9	16.0	454	16.1	483	16.1	483
ARAPAHOE	6.1	7.3	7.5	134	8.0	120	7.8	118
AURORA	14.5	6.4	12.6	383	11.4	308	11.4	308
BETHESDA	8.2	12.3	11.2	125	12.3	125	8.0	82
BOULDER	8.0	7.9	11.0	195	10.7	177	1.0	18
CENTENNIAL	7.0	7.6	8.8	192	10.0	245	0.0	0
COLO WEST	6.2	8.2	6.2	248	6.8	197	6.9	200
DENVER H&H	48.7	53.8	43.3	4174	43.0	3285	43.0	3285
JEFFERSON	7.1	5.1	6.1	223	5.8	213	3.9	143
LARIMER	7.6	8.4	7.2	178	7.6	175	9.8	206
MIDWESTERN	8.5	10.9	11.3	138	10.4	125	10.4	125
PARK EAST	44.0	47.1	51.2	752	48.0	552	45.0	495
PIKES PEAK	15.9	16.1	15.1	866	16.6	809	0.0	0
SAN LUIS	44.4	47.8	50.4	300	47.8	258	52.2	282
SE COLO	25.1	27.7	25.9	308	26.6	237	26.6	237
SW COLO	17.5	24.5	20.7	210	24.2	290	20.9	251
SW DENVER	29.6	35.2	37.0	432	31.9	399	36.1	442
SPAN PEAKS	37.0	39.8	37.2	791	38.3	796	0.0	0
WELD	18.6	20.6	19.1	513	18.1	489	18.1	489
WEST CENTRAL	12.6	12.5	8.0	106	8.5	102	8.7	107
				10722		9385		7271

TABLE 8

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

POPULATION, POPULATION IN NEED, & ADMISSIONS
BY AGE GROUPS

****
CHILDREN
****

CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT POPULATION IN NEED DMH ESTIMATE 1981	PERCENT POPULATION IN NEED CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	21.4	21.4	17.3	17.3	9.4	267	6.5	195	8.5	255
ARAPAHOE	18.3	18.3	14.5	14.5	6.6	118	9.2	138	9.2	139
AURORA	19.2	22.3	15.1	16.9	9.5	289	9.9	267	9.9	267
BETHESDA	14.4	14.4	10.8	10.9	7.5	84	7.0	71	7.0	71
BOULDER	16.1	16.7	12.6	16.5	9.0	160	8.0	133	6.0	109
CENTENNIAL	18.0	18.0	13.6	13.6	18.7	407	17.0	416	17.0	408
COLO WEST	16.8	16.8	13.2	13.2	6.2	248	7.4	215	7.5	217
DENVER H&H	14.4	14.4	10.8	12.9	5.5	530	6.0	458	6.0	458
JEFFERSON	18.5	17.5	14.7	14.7	8.5	310	6.5	239	6.5	239
LARIMER	15.5	15.5	12.1	12.1	9.5	235	8.7	200	8.7	187
MIDWESTERN	18.0	18.0	13.7	13.7	6.6	81	6.3	76	6.2	74
PARK EAST	14.4	14.4	10.8	10.9	6.4	94	6.8	78	6.8	75
PIKES PEAK	20.2	20.2	16.2	16.2	6.5	373	8.5	414	0.0	0
SAN LUIS	21.0	20.9	16.2	16.2	13.2	79	17.0	92	17.0	92
SE COLO	20.3	20.2	15.3	13.7	9.4	112	14.7	131	14.7	131
SW COLO	19.0	19.0	14.7	14.7	9.4	95	13.0	156	9.0	108
SW DENVER	14.4	14.4	10.8	10.9	11.0	128	8.6	107	8.5	104
SPAN PEAKS	18.8	18.8	14.3	14.3	12.9	274	12.4	258	10.0	400
WELD	17.3	17.3	13.5	13.5	14.2	381	13.9	375	13.9	375
WEST CENTRAL	17.8	17.8	13.5	13.5	14.4	191	10.0	120	12.1	149
						4456		4139		3858

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 9

POPULATION, POPULATION IN NEED, & ADMISSIONS
BY AGE GROUPS

****
ADOLESCENTS
****

CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT POPULATION IN NEED DMH ESTIMATE 1981	PERCENT POPULATION IN NEED CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	11.7	11.7	15.7	15.7	14.9	423	14.0	420	16.0	480
ARAPAHOE	11.5	11.5	15.2	15.2	15.3	274	14.2	213	14.2	215
AURORA	11.5	13.3	15.2	15.9	14.2	431	15.2	410	15.2	410
BETHESDA	8.9	8.9	11.1	11.1	10.2	114	9.2	94	9.5	97
BOULDER	10.8	10.5	14.0	10.6	10.5	186	10.3	171	9.0	164
CENTENNIAL	9.9	9.9	12.5	12.5	18.2	397	20.0	490	20.0	480
COLO WEST	9.5	9.5	12.4	12.4	8.7	347	10.0	290	9.9	287
DENVER H&H	8.9	8.9	11.1	9.8	6.4	617	7.0	535	7.0	535
JEFFERSON	10.8	10.0	14.3	14.3	13.9	507	12.0	441	12.0	441
LARIMER	9.9	9.9	12.8	12.8	13.4	331	13.6	313	14.1	303
MIDWESTERN	11.0	11.0	13.9	13.9	16.1	197	15.0	180	15.0	180
PARK EAST	8.9	8.9	11.1	11.1	11.1	163	9.6	110	10.3	113
PIKES PEAK	9.7	9.7	13.0	13.0	10.7	613	11.9	580	0.0	0
SAN LUIS	11.6	11.6	14.9	14.9	16.6	99	14.0	76	14.1	76
SE COLO	10.4	11.5	13.1	11.6	15.5	185	15.0	134	15.0	134
SW COLO	10.4	10.4	13.5	13.5	19.9	202	14.0	168	16.7	200
SW DENVER	8.9	8.9	11.1	11.1	15.6	182	12.4	155	12.5	153
SPAN PEAKS	10.7	10.7	13.6	13.6	17.0	361	18.8	391	15.0	600
WELD	10.1	10.1	13.2	13.2	12.4	333	12.0	324	12.0	324
WEST CENTRAL	9.4	9.4	12.0	12.0	15.9	211	14.0	168	13.8	170
						6173		5663		5362

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 10

POPULATION, POPULATION IN NEED, & ADMISSIONS
BY AGE GROUPS

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ADULTS
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CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT POPULATION IN NEED DMH ESTIMATE 1981	PERCENT POPULATION IN NEED CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	62.1	62.1	58.6	58.6	71.3	2025	74.7	2241	70.7	2121
ARAPAHOE	63.2	63.2	58.5	58.5	75.1	1345	72.6	1089	72.6	1100
AURORA	63.1	61.7	58.6	65.3	72.2	2193	70.6	1906	70.7	1909
BETHESDA	62.4	62.4	54.9	54.8	76.4	853	76.6	781	76.0	775
BOULDER	64.3	62.5	58.5	68.0	77.3	1371	77.7	1287	81.5	1486
CENTENNIAL	58.1	58.1	51.1	51.1	53.6	1168	53.0	1298	51.0	1224
COLO WEST	64.8	64.8	59.4	59.4	82.7	3302	77.4	2245	77.4	2245
DENVER H&H	62.4	62.4	54.9	59.1	82.3	7933	80.0	6112	80.0	6112
JEFFERSON	63.7	65.8	59.0	59.0	72.6	2651	76.5	2811	76.5	2811
LARIMER	64.9	64.9	58.8	58.8	71.9	1777	74.2	1707	73.0	1569
MIDWESTERN	58.7	58.7	52.1	52.1	71.9	879	72.5	870	74.6	895
PARK EAST	62.4	62.4	54.9	54.8	78.7	1155	81.0	931	81.9	901
PIKES PEAK	63.6	63.6	59.6	59.6	80.2	4597	75.5	3681	0.0	0
SAN LUIS	56.8	56.8	51.1	51.1	58.0	346	49.4	267	49.3	266
SE COLO	55.4	55.0	48.8	55.7	66.8	796	60.3	537	60.3	537
SW COLO	60.0	60.0	54.1	54.1	63.5	644	65.0	780	67.6	811
SW DENVER	62.4	62.4	54.9	54.8	70.5	823	73.0	912	73.0	894
SPAN PEAKS	58.3	58.3	51.9	51.9	65.0	1382	63.3	1315	68.8	2752
WELD	63.7	63.7	58.3	58.3	68.7	1844	69.3	1871	68.5	1849
WEST CENTRAL	59.6	59.6	52.8	52.8	66.3	880	69.3	832	66.8	825
						37964		33473		31082

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 11

POPULATION, POPULATION IN NEED, & ADMISSIONS
BY AGE GROUPS

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ELDERLY
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CATCHMENT AREA	PERCENT POPULATION DMH ESTIMATE 1981	PERCENT POPULATION CMHC ESTIMATE 1982	PERCENT POPULATION IN NEED DMH ESTIMATE 1981	PERCENT POPULATION IN NEED CMHC ESTIMATE 1982	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	4.8	4.8	8.4	8.4	4.3	122	4.8	144	4.8	144
ARAPAHOE	7.0	7.0	11.8	11.8	3.0	54	4.0	60	4.0	61
AURORA	6.2	2 7	11.1	1.9	4.1	125	4.2	113	4.2	113
BETHESDA	14.3	14.3	23.2	23.2	5.7	64	7.5	76	7.5	76
BOULDER	8.8	7.6	14.9	4.9	3.3	59	4.0	66	3.5	64
CENTENNIAL	14.0	14.0	22.8	22.8	9.5	207	10.0	245	12.0	288
COLO WEST	8.9	8.9	15.0	15.0	2.3	92	5.2	151	5.2	151
DENVER H&H	14.3	14.3	23.2	18.2	5.9	569	7.0	535	7.0	535
JEFFERSON	7.0	6.7	12.0	12.0	4.9	179	5.0	184	5.0	184
LARIMER	9.7	9.7	16.3	16.3	5.3	131	3.5	80	4.2	90
MIDWESTERN	12.3	12.3	20.3	20.3	5.4	66	6.2	74	4.2	50
PARK EAST	14.3	14.3	23.2	23.2	3.8	56	2.6	30	1.0	11
PIKES PEAK	6.5	6.5	11.2	11.2	2.6	149	4.1	200	0.0	0
SAN LUIS	10.6	10.7	17.8	17.8	12.2	73	19.6	106	19.6	106
SE COLO	13.9	13.3	22.8	19.0	8.3	99	10.0	89	10.0	89
SW COLO	10.6	10.6	17.7	17.7	7.2	73	8.0	96	6.7	80
SW DENVER	14 3	14.3	23.2	23.2	2.9	34	6.0	75	6.0	73
SPAN PEAKS	12.2	12.2	20.2	20.2	5.0	106	5.2	108	6.2	248
WELD	8.9	8.9	15.0	15.0	4.7	126	4.8	130	5.6	151
WEST CENTRAL	13.2	13.2	21.7	21.7	5.4	72	6.7	80	7.3	90
						2456		2642		2604

COLORADO DIVISION OF MENTAL HEALTH
DATA FOR PLANNING & CONTRACTING
FISCAL YEAR 1981-82

TABLE 12

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SEVERITY TARGET GROUP ADMISSIONS
(MODERATELY OR SEVERELY DISABLED)
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CATCHMENT AREA	PERCENT ADMISSIONS ACTUAL 1978-79	PERCENT ADMISSIONS ACTUAL 1979-80	NUMBER ADMISSIONS ACTUAL 1979-80	PERCENT ADMISSIONS CONTRACTED 1980-81	NUMBER ADMISSIONS CONTRACTED 1980-81	PERCENT ADMISSIONS CMHC PLAN 1981-82	NUMBER ADMISSIONS CMHC PLAN 1981-82
ADAMS	76.8	82.5	2343	75.0	2250	75.0	2250
ARAPAHOE	82.3	90.4	1619	78.0	1170	82.0	1242
AURORA	74.0	74.3	2257	73.1	1974	73.1	1974
BETHESDA	72.3	76.0	849	72.0	734	72.0	734
BOULDER	77.4	78.4	1390	76.0	1259	77.0	1404
CENTENNIAL	53.7	60.4	1316	75.0	1837	64.0	1536
COLO WEST	70.0	77.2	3083	75.0	2175	75.0	2175
DENVER H&H	84.2	80.4	7750	80.0	6112	80.0	6112
JEFFERSON	76.2	79.8	2913	79.0	2903	80.0	2940
LARIMER	75.3	86.6	2140	75.0	1725	75.0	1612
MIDWESTERN	73.0	82.1	1003	72.0	864	72.0	864
PARK EAST	71.8	81.6	1198	75.0	862	80.1	881
PIKES PEAK	74.1	77.4	4437	76.0	3706	0.0	0
SAN LUIS	56.5	78.8	470	75.0	405	75.0	405
SE COLO	75.2	75.9	904	70.7	630	70.7	630
SW COLO	81.8	82.7	839	75.0	900	75.0	900
SW DENVER	86.4	86.0	1004	80.0	1000	85.0	1040
SPAN PEAKS	76.3	82.6	1756	77.9	1619	0.0	0
WELD	72.7	71.0	1906	73.6	1987	73.6	1987
WEST CENTRAL	66.8	80.0	1062	75.0	900	75.0	926
			40239		35012		29612