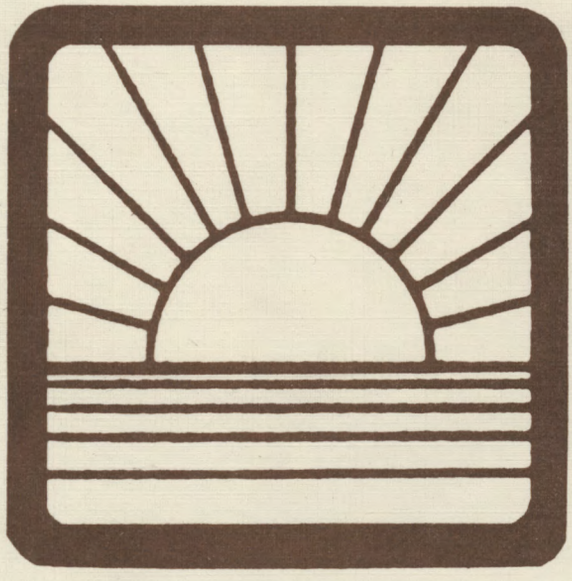
State of Colorado

MENTAL HEALTH PLAN

1982-1987



Department of Institutions

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

MEMORANDUM

Date: September 10, 1982

To: Recipients of the 1982-87 Colorado Mental Health Plan

From: Robert W. Glover, Ph.D.

Subject: The Colorado Mental Health Plan

Enclosed is a copy of the 1982-83 Update of the Five-Year Colorado Mental Health Plan. This Plan replaces all previous Plans. The information in this document is used to address the major decisions confronting the mental mental health system. This State Plan also contains specific information which describes the current mental health system in Colorado.

This revision was developed in response to input provided by a wide variety of interested and concerned agencies, organizations, and individuals across the state. The Division of Mental Health wishes to thank all of the agencies, organizations, and individuals that took the time to submit verbal and/or written comments to the Colorado Mental Health Council. All comments and recommendations for revisions were given careful consideration by the Council and by the Division. The Plan also is based upon the local mental health plans submitted to the Division of Mental Health by the twenty catchment area mental health centers in Colorado. The Colorado Mental Health Council officially approved the 1982-87 Colorado Mental Health Plan on July 8, 1982.

The Division of Mental Health and the State Plan Committee perform an ongoing review of the State Mental Health Plan to ascertain its relevance and responsiveness to changing mental health needs and to ensure its coordination with other planning efforts. Since you are a recipient of this Update of the Colorado Mental Health Plan, we are solicting your comments and recommendations.

If you have any questions or if you would like additional information, please contact Lynn Dawson, Planner for the Division of Mental Health, at 761-0220, extension 214.

RG:jr
Enclosure

STATE OF COLORADO

"COLORADO MENTAL HEALTH PLAN

1982 - 1987"

PREPARED BY

COLORADO DIVISION OF MENTAL HEALTH

SEPTEMBER 1982

STATE OF COLORADO

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THE COLORADO STATE MENTAL HEALTH PLAN

TABLE OF CONTENTS

THE COLORADO STATE MENTAL HEALTH PLAN

TABLE OF CONTENTS

APPENDICES

APPENDIX I - Division of Mental Health Residential Continuum

APPENDIX II - Scoring of the Residential Continuum Model

APPENDIX III - Vocational Continuum (Summarized Version)

THE COLORADO MENTAL HEALTH PLAN

CHAPTER I. INTRODUCTION

A. PURPOSE

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

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

The annual updating of the Plan is necessary to reflect the impact of funding and policy decisions by legislative and executive bodies and the accomplishment or non-accomplishment of the previous year's objectives. Changes in roles and relationships among agencies, organizational and structural changes, the enactment of new statutes, and the amendment or repeal of existing statutes also make necessary a periodic updating process. The publication of rules and standards for the implementation of statutes or the regulation of mental health related activities impact the planning and delivery of mental health services to such an extent that they must be incorporated into the Plan.

B. ORGANIZATION AND SCOPE

The 1982 update of the State Mental Health Plan replaces all previous Plans. This Plan consists of one volume in which 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. This document also contains specific information which describes the current mental health system in Colorado.

The following is a summary of the Chapters and Appendices that make up the Colorado Comprehensive Five-Year Mental Health Plan.

a. Chapter I - Introduction: This chapter provides an overview of the Plan. It also includes a Fact Sheet which gives an outlined description of the Colorado mental health system.

b. Chapter II - Concepts in Mental Health: The key concept for the Colorado Division of Mental Health (DMH) is the quality of life. This concept is defined in terms of the factors that are used to determine whether the quality of one's life is good or bad. This chapter also includes the principles of mental health care which are reflected throughout the Plan. These principles are categorized under the headings of quality, human dignity and clients' rights, availability and accessibility of services, continuity of care, service needs and appropriate utilization, reasonable costs, and accountability. A third section, "The Conceptual Framework", is included in 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 - Mental Health Issues: Strategic planning begins with looking at trends and identifying the issues generated by those trends. The trends and factors that have been identified as impacting mental health have generated several critical issues that must be addressed by the Colorado mental health system. These issues are discussed in this chapter.

d. Chapter IV - Statewide Goals and Objectives: Chapter IV is regarded as the "heart" of the Plan, as it sets forth the goals and objectives which provide both specific direction and means of assessing progress. The goals and objectives are developed around the concepts and principles detailed in Chapter II. They also have been developed in response to the issues identified in Chapter III.

This chapter is revised annually. Some goals and 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. The goals in this chapter reflect the overall thrust of the system for the next five years.

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. 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 for the coming fiscal year.

e. Chapter V - Financial Summary for Fiscal Year 1982-83: This chapter includes a summary of the appropriations for FY 1982-83. It also describes the fiscal plan for expenditures by operational unit.

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

All standards/rules and regulations promulgated by the state mental health authority are identified in this chapter. The Standards/Rules and Regulations for Mental Health are not included, as they have been published and distributed as a separate document.

The Colorado Mental Health Council is also identified in this chapter. Brief descriptions of the membership, functions, and activities of the Council are included.

g. Chapter VII - State Hospitals and the Catchment Area Mental Health Program: This section describes the state mental hospitals and summarizes the key issues identified in the local plans submitted by the catchment area community mental health centers.

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

Revised population estimates and estimates of population-in-need of mental health services are included, as are the need rankings of the catchment areas.

h. Appendix I - Division of Mental Health Residential Continuum

i. Appendix II - Scoring of the Residential Continuum Model

j. Appendix III - Continuum of Vocational Services for Mental Health Clients

C. 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: 31.0 Full-Time Employee Positions

STATE HOSPITALS:
Colorado State Hospital
Fort Logan Mental Health Center

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

ADMISSIONS SYSTEM-WIDE (FY 1980-81):
CENTERS AND CLINICS: 51,537
HOSPITALS: 4,560
TOTAL: 56,097

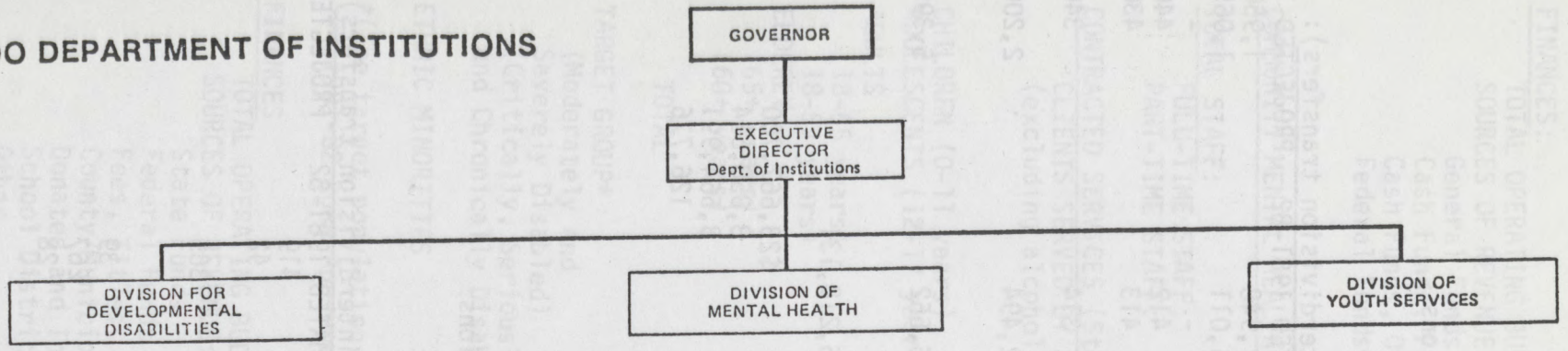
ESTIMATED CLIENTS SERVED SYSTEM-WIDE (FY 1980-81):
CENTERS AND CLINICS: 80,942
HOSPITALS: 7,131

FINANCES:
TOTAL OPERATING BUDGET (FY 1981-82): $87,427,912
SOURCES OF REVENUE:

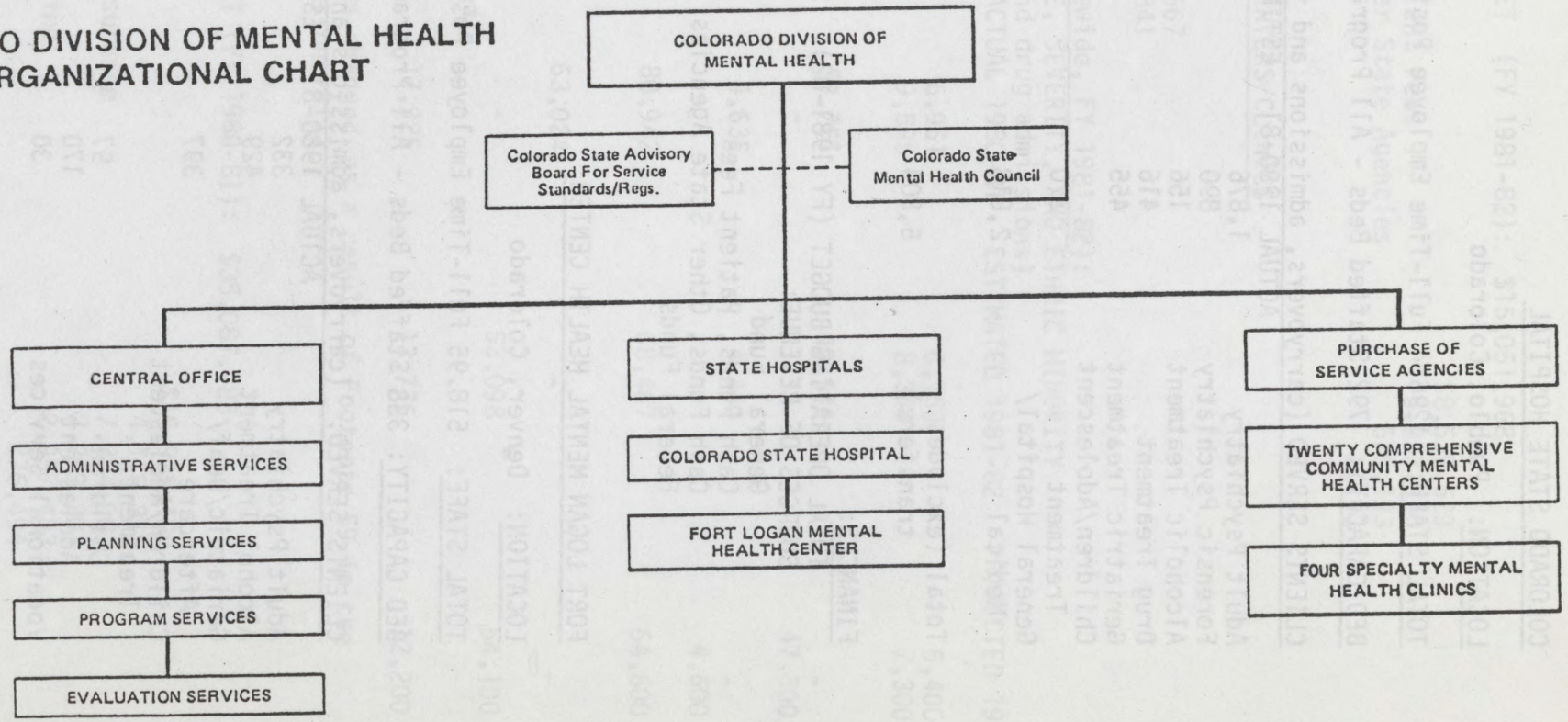
General Funds, State Hospitals/Agencies	$32,736,157
General Funds, CMHCs	16,925,108
Patient Fees (Hospitals)	14,792,617
Cash Funds (State Agencies)	4,141,184
Federal Funds (State Agencies)	669,969
Federal Funds (CMHCs)*	4,118,818
CMHC, Local, Patient Fees, Donated, Etc.*	14,044,059

*These funds go directly to the CMHCs.

COLORADO DEPARTMENT OF INSTITUTIONS



COLORADO DIVISION OF MENTAL HEALTH ORGANIZATIONAL CHART



COLORADO STATE HOSPITAL

LOCATION: Pueblo, Colorado

TOTAL STAFF: 1296.4 Full-Time Employee Positions

BED CAPACITY: 792 Staffed Beds - All Programs

CLIENTS SERVED (carryovers, admissions and interdivision transfers):

	ACTUAL 1980-81	ESTIMATED 1981-82	PROJECTED 1982-83
Adult Psychiatry	1,876	1,948	1,950
Forensic Psychiatry	890	1,011	1,065
Alcoholic Treatment	156	-	-
Drug Treatment	416	412	440
Geriatric Treatment	455	413	430
Children/Adolescent Treatment	370	314	340
General Hospital/ Medical	2,818	2,494	2,200
Total (excludes transfers)	5,804	5,562	5,395

FINANCES:

TOTAL OPERATING BUDGET (FY 1981-82): $36,218,131

SOURCES OF REVENUE:

General Fund	$23,667,700
Cash Funds, Patient Fees	8,858,664
Cash Funds, Other State Agencies	3,564,991
Federal Funds	126,776

FORT LOGAN MENTAL HEALTH CENTER

LOCATION: Denver, Colorado

TOTAL STAFF: 518.95 Full-Time Employee Positions

BED CAPACITY: 338 Staffed Beds - All Programs

CLIENTS SERVED: (carryovers, admissions and interdivision transfers):

	ACTUAL 1980-81	ESTIMATED 1981-82	PROJECTED 1982-83
Adult Psychiatry	332	419	500
Alcohol Treatment	429	42	-
Geriatric/Deaf/ Aftercare	397	365	365
Children/Adolescent Treatment:			
Children	97	39	40
Adolescent	170	267	270
Vocational Services	30	28	30
Total (excludes transfers)	1,327	1,090	1,205

FINANCES:

TOTAL OPERATING BUDGET (FY 1981-82): $15,051,968

SOURCES OF REVENUE:

General Funds	$8,539,629
Cash Funds, Patient Fees	5,933,953
Cash Funds, Other State Agencies	576,193
Federal Funds	2,193

COMMUNITY MENTAL HEALTH CENTERS/CLINICS

TOTAL STAFF:

FULL-TIME STAFF: 1,567
PART-TIME STAFF: 341

CONTRACTED SERVICES (Statewide, FY 1981-82):

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

	ACTUAL 1980-81	ESTIMATED 1981-82	PROJECTED 1982-83
CHILDREN (0-11 years)	6,961	6,159	5,400
ADOLESCENTS (12-17 years)	9,595	8,349	7,300
ADULTS			
(18-65 years)	59,751	49,519	-
(18-59 years)	-	-	47,300
ELDERLY			
(65+ years)	4,635	4,440	-
(60+ years)	-	-	4,600
TOTAL	80,942	68,467	64,600
TARGET GROUP*			
(Moderately and Severely Disabled)	63,024	-	-
(Critically, Seriously and Chronically Disabled)	-	53,098	54,100
ETHNIC MINORITIES	17,925	13,775	12,200

*(The target population was changed as a result of Footnote 59 in the FY 1981-82 Long Appropriations Bill.)

83

FINANCES

TOTAL OPERATING BUDGET (FY 1980-81): $35,087,985

SOURCES OF REVENUE:

State Funds	$16,925,108
Federal Funds	4,118,818
Fees, Titles, Insurance	7,284,083
County/Municipal	2,269,203
Donated and In-Kind	2,957,483
School Districts	276,494
Other	1,256,796

COLORADO COMMUNITY MENTAL HEALTH CENTERS AND CLINICS

Community Mental Health Centers:
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.
Colorado West Regional Mental Health Center, Inc.
Denver Health and Hospitals Mental Health Program
Jefferson County Mental Health Center, Inc.
Larimer County Mental Health Center
Midwestern Colorado Mental Health Center, Inc.
Park East Comprehensive Community 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.
Southwest Denver Community Mental Health Services, Inc.
Spanish Peaks Mental Health Center
Weld Mental Health Center, Inc.
West Central Mental Health Center, Inc.

Specialty Clinics:
Asian Pacific Development Center
Children's Hospital Mental Health Clinic
Denver Mental Health Center, Inc.
Servicios de la Raza

CHAPTER II. CONCEPTS IN MENTAL HEALTH

A. QUALITY OF LIFE

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

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

Food and shelter are considered to be basic necessities for life. Productivity also is a critical factor. Interesting, rewarding work in a job or at home is important. For many, especially children, attending school is a primary focus.

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

Interpersonal relationships are extremely important quality-of-life components. A variety of relationships need to be considered. First are relationships with another person, such as one's spouse, boyfriend, or girlfriend. Relationships with children and with other relatives also have significance. There are many beliefs, attitudes, and values that are based upon the concept of family and family relations. The fourth type of relationship has to do with friends. The number and variety of friends and the level of intimacy established are variables. Social ties and involvement in community activities also are factors impacting the quality of life. Many people become members of organizations that direct their efforts toward helping others and provide socialization opportunities.

Personal development and understanding are factors in the life of Americans. More people are adopting the attitude of needing to take

charge of themselves and of events that have an impact on them. Increased attention to personal nutrition and physical fitness, as well as increased sensitivity to environmental issues reflect this attitude. For some people, religious or spiritual experiences and activities are part of this component. A final factor in the quality of life is recreation. It is important to know how to have fun and to enjoy leisure time.

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

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

B. PRINCIPLES OF MENTAL HEALTH CARE

1. Quality
   a. Mental health services should maximize the clients' capacity to improve their quality of life.
   b. Mental health services should ensure the delivery of high quality client care.
2. Human Dignity, Privacy, and Clients' Rights
   a. Mental health services should be provided in a manner which preserves the client's privacy and dignity.
   b. Clients have a right to know the type of treatment they will receive and the reasons for a particular type of treatment.
   c. Individuals have the right to refuse treatment unless they are found to be a danger to themselves or others, or are gravely disabled.
   d. Involuntary clients have the same right to goal-oriented

treatment as do voluntary clients.

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

3. Availability and Accessibility of Services

a. Mental health services should be provided, when possible and/or when the client's condition permits, in the local community, as close as possible to the client's home, and in the most normal or home-like setting available.

b. Each client should be treated in the least intensive or restrictive setting consistent with the client's clinical needs and with the needs of the community. Each client should be given the least amount of treatment that is still maximally effective.

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

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

4. Continuity of Care

a. Mental health care should ensure that there is a continuity of relevant care from the initiation of services until the client terminates from services.

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

5. Service Needs and Appropriate Utilization

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

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

6. Reasonable Costs

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

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

7. Accountability

a. There should be a continuous effort to measure the impact and results of mental health services.

b. The focus of the state mental health system should be to maximize contracting for specific outcomes, with emphasis on quality and community responsibility, and to minimize regulation.

C. THE CONCEPTUAL FRAMEWORK

A key theme that threads its way through the State Plan 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.

The Division of Mental Health has assumed the leadership role to ensure that progress toward this purpose 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.

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 and Evaluation
(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.

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.

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. 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 disabled clients of all ages available statewide.

The Treatment and Support Model has been developed for Colorado because it is a model which views the system as a whole. This 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.

In Colorado, nine components have been identified as the essential programmatic components of the Treatment and Support System Model. These components include the following:

1. Mental Health Services - These are the basic mental health treatment services provided to clients in the Treatment and Support System Model. Such services include, but are not limited to, inpatient, 24-hour emergency, outpatient, screening and referral, follow-up care, partial hospitalization, and other 24-hour care.

This particular area of the nine programmatic components has been attended to by mental health providers in the best manner possible. The amount of service provided depends upon the availability of resources. Currently, the need for mental health services is greater than the resources available to meet that need.

2. Crisis Intervention - For the chronically, seriously, 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. Medical 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, and prescriptions with periodic review. This area must be attended to consistently, which means each mental health facility should ensure that the medical needs of their clients are met.

4. 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 have been developed 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.

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.

5. Vocational Services - These include assessment, work preparation training, work experience opportunities, job placement and related activities, and followup services. 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 at both the state and the local program levels 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 aid 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.

6. 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 nine 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.

7. Rehabilitation 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 needed by mental health providers for developing community-oriented rehabilitation activities. Staff must be trained to analyze the benefits each specific area of the rehabilitation 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 rehabilitation programs. Rehabilitation program staff must be capable of providing community living skill training, providing social skill training, and organizing social/recreational activities.

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, indepdendent 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.

9. 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.

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 nine components have been designed for use by Colorado and its communities as a framework for developing comprehensive treatment and support systems.

Having the nine 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 nine 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.

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 Treatment and Support Model also is designed to ensure that clients are treated in the least intensive, least restrictive setting consistent with their clinical needs and the needs of the community.

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.

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 an effective client movement process, 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 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 seriously, critically, and chronically 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, and clients with dual diagnoses. 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 1 reflects the categories of mentally disabled to be served.

Figure 1

Categories of Mentally Disabled to be Served

	Severely Mentally Disabled	
	Chronic	Acute
Child and Adolescent Adult Elderly		

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 presents a greater challenge than does the chronically mentally disabled adult client.

Based on the first three years of the pilot Community Support Project (CSP) initiative, the National Institute of Mental Health developed an operational definition for use in identifying CSP clients, planning service system improvements, and evaluating CSP efforts. The Colorado Division of Mental Health 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 and adolescents only - at least two problems in the area of academic/training problems

A client is considered to be chronically mentally ill if he/she meets criteria A and either B1 or B2 and at least two of criteria C1 through C6.

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.

Cutting across the chronic/acute continuum is the dimension of severity. A footnote of the 1981-82 Long bill stipulated that state funds for mental health were 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 needed to be identified, thus, these terms were 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 housing options; psychosocial rehabilitation programming, including social services; medical/psychiatric emergency services, with aggressive case management; community involvement with planning; and 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.

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 services 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 psychiatric emergency services, treatment, and alleviation of symptoms, with family therapy and/or counseling; aggressive case management which supports the "natural" family and community support system of the child; housing alternatives, when the family situation demands it; and 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.

The Mentally Disabled Adolescent: - 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 their 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 and the 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 psychiatric emergency services and alleviation of symptoms, with family therapy and/or counseling; aggressive case management; housing alternatives when the family situation demands it; and 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 commmon elements of the needs of each category of clients are the following:

- They all need some form of symptom alleviation.

- They all need aggressive case management to coordinate services and efforts.
- They all need support to any existing "natural" support system.
- They all may need housing options on either a temporary or permanent basis.
- 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 looking at possible systems 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.

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 underway 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 commprehensive 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 mental health service areas of the state.

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 and other human service care-giving agencies and organizations. The nine areas listed on page II.4 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 nine 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 updated by the Colorado Division of Mental Health. 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. MENTAL HEALTH ISSUES

Strategic planning begins with looking at trends and identifying the issues generated by those trends. In the past year, several trends 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. The major issue, then, becomes one of prioritization of needs. The Colorado mental health system must establish priorities relating to the needs of the residents of the state and the resources available to meet those needs. The trends and factors which have been identified as impacting mental health have generated several critical issues that must be addressed by the Colorado mental health system. The following issues are considered to be the highest priority for the state mental health system:

1. Maintaining the Current Level of Community Mental Health Services
2. Shortage of Psychiatric Beds for the Mental Health System
3. Inadequate Staffing for the Mental Health System
4. Inadequate Treatment and Support Systems for the Delivery of Mental Health Services to the Most Psychiatrically Disabled Clients
5. Inadequate facilities for Mental Health System Clients
6. Need to Ensure the Effective Functioning of the Elements of the Mental Health System
7. Underserved or Inappropriately Served Population Groups
8. Need to Maximize Limited Resources by Coordinating with Other Human Service Agencies

1. Maintaining the Current Level of Community Mental Health Services

The highest priority for the Colorado mental health system is to ensure that services can continue to be provided at the same level as the previous year. There are, however, several factors that impact the ability of community mental health centers to continue the same level of service provision. Mental health costs continue to increase because of such things as increases in inflation, population growth, the severity of client disability, and the number of chronically disabled patients served. At the same time that costs are increasing, resources for mental health are declining. The result over the past few years has been a decrease in the number of patients served by the community mental health centers. For example, in FY 1980-81, 78,893 clients were served by the community mental health centers, while the estimated number of clients to be served in FY 1982-83 is 63,600. The reduction in services influences not only the number of clients to be served, but also the types of services provided. The theme of survival was woven throughout the local plans submitted by the community mental health centers for FY 1982-83. Many centers question their ability to maintain the current level of service delivery unless resources for mental health are increased. Most centers plan to reduce the number of clients served in the coming year.

The primary issue for mental health today is that the mental health service needs of the citizens are much greater than the resources available to meet those needs. The increase in the population has increased the number of people needing mental health services. A four percent increase over two years, for example, would bring approximately 9,500 more severely disabled persons into the current pool of persons needing services who cannot be adequately served because of limited resources.

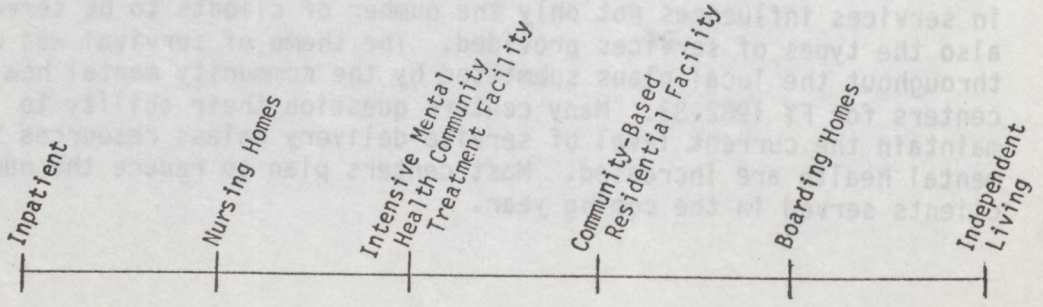
Appropriate utilization of resources can maximize the use of current dollars; however, it is also necessary to expand other financial resources if the current need is to be met. Medicaid and Medicare continue to be the focus for cuts in the federal budget. The failure of third-party reimbursement programs to permit payment for ambulatory care and the resistance of third-party reimbursement programs, major corporations, and legislatures to the increasing costs of health care have given public prominence to the cost issue and continue to put pressure on the health care system with regard to this issue. The limitations on spending can create more competition for the funds that are available at a time when monetary and other resource sharing is so important.

Significant new funding will not be available within the public system in the near future. New funding within mental health will come at the expense of other government programs or from the private sector. The system's ability to compete for limited funds will be dependent upon its ability to demonstrate cost-effective and cost-efficient services.

The public's perception of the role of state government is to return tax dollars to the citizens, rather than provide public services. In addition to documenting the results of services, the mental health system also must demonstrate the ways in which its efforts reduce expenses and generate economic benefits that impact all citizens. The key problem is that these demands for reduced spending and increased accountability are expressed along with demands for increased expectations, personal services, and high quality. It is no small part of the struggle for quality to make certain the public and the consumer understand the full implications of wanting more done with less.

2. Shortage of Psychiatric Beds for the Mental Health System

One of the most critical issues for the Colorado mental health system is the shortage of psychiatric beds, including both community-based beds and state psychiatric hospital beds. The following Residential Continuum was developed by the Colorado mental health system to address the issue of the shortage of psychiatric beds from an integrated service system perspective.



To appropriately address the issue of psychiatric bed shortages, the entire mental health system must be viewed as a whole. Few clients would move from one end of the continuum to the other and receive services in each of the six settings; however, clients clearly may be placed in several of the settings at different times based upon their clinical and service needs. The key point is that one cannot look at community-based facilities independent of outpatient community mental health center 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 community-based facilities are inadequate, there are two basic alternatives. One alternative would be that the client may be inappropriately treated in a less intensive, less restrictive setting by the community mental health center. Another alternative 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 to the client and to the system, and both are presently occurring in Colorado.

With the development of the Residential Continuum for Mental Health (see Appendix I), the system has improved its ability to determine the appropriate amount and mix of state hospital beds and community-based adult beds needed in each service area. The Continuum includes a description of the service settings, a client profile for each setting, and a description of services for each setting. This model is being used within the Colorado mental health system for short- and long-range facility planning. The Division of Mental Health began the data analysis by collecting data from a special open cases survey which identified client characteristics and living arrangements for clients within the state-funded mental health system. Using this data, the Division of Mental Health applied the Residential Continuum criteria to determine both the current and the desired/optimal residential setting for each client over the age of eighteen within the public mental health system (see Appendix II). The overall results revealed three gaps in the Residential Continuum: (1) a shortage of intensive mental health community treatment facility beds, (2) a shortage of state hospital inpatient beds, and (3) a shortage of community-based residential facility beds.

The shortages of inpatient beds and the less intensive community-based beds have been recognized as problems for the Colorado mental health system, and have been addressed to some extent. In FY 1981-82, for example, the Colorado General Assembly appropriated funds for a demonstration project that served as an initial step in establishing community-based residential facility beds for the seriously, critically, and the chronically mentally ill. This demonstration project enabled the mental health system to begin filling this gap in the continuum. Fifty-three community-based residential beds were established with these initial funds. Additional funds were appropriated for FY 1982-83 to expand the number of beds in this category to seventy-five. Although the development of these beds by no means meets the need, it does point the way toward reducing the costly treatment impacts experienced by the clients and the financial impacts

experienced by the system when clients are placed inappropriately in more intensive treatment settings. The Department of Institutions and the Department of Social Services also jointly are requesting a waiver for home and community services under the Medicaid Program as authorized under the Omnibus Reconciliation Act. Included in the mental health segment of the Waiver is a request for 130 community-based residential facility beds. A survey of the state hospitals and the community mental health centers was completed last year and indicated that there were approximately 150 community-based residential facility beds in place for use by the mental health system. Given the preceding information, the Division of Mental Health estimates that there could be approximately 355 community-based residential facility beds available through the state-funded mental health system. The client data based upon the open cases survey and the Residential Continuum criteria identifies the need for approximately 1,910 beds at a given point in time. The result is that the Colorado mental health system is meeting almost 18.6 percent of the need in this category of the Continuum.

In the category of intensive mental health community treatment facility beds, however, the mental health system is meeting only 11.5 percent of the need. The analysis of the open cases data and the Residential Continuum criteria identified approximately 2,170 clients in need of care in intensive community residential facilities. Of the 2,170 clients judged to need mental health care in an intensive treatment facility, only .6% are receiving care in that type of facility. Of the remaining clients, 8% are receiving treatment in a more intensive, more costly hospital program. Twenty-four point five percent of these clients who do not require seven-day-a-week nursing care are being inappropriately treated in a nursing home setting. The other clients who should be in an intensive mental health treatment facility are receiving less intensive care than deemed clinically appropriate in communiy-based residential facilities (6.4%), in boarding homes (12.5%), and in independent living (48.0%).

During FY 1979-80, the Colorado State Legislature mandated (Footnote 83 of the FY 1979-80 Long Bill) that the Division of Mental Health determine the number of chronically mentally ill in nursing homes. In November, 1981, the Division of Mental Health completed the first part of this study. The study used the definition of the National Institute of Mental Health community support system program population to identify residents of nursing homes who were chronically mentally ill. Based on data collected from a sample of 1,000 nursing home residents, it was estimated that 1,550 out of some 17,500 nursing home residents in Colorado were chronically mentally ill. Additionally, the second phase of the study, completed in the summer of 1981, examined clients currently enrolled in the public mental health system. That study identified approximately 1,000 nursing home residents enrolled in the system. When both of those studies are linked, it is possible to estimate that between 700 and 900 current nursing home residents meet the test of being chronically mentally ill and are capable of being better served in intensive mental health treatment facilities, community residential facilities, boarding homes, and independent living. These clients do not have significant medical

barriers to placement in alternative settings. Of these clients, approximately 531 (24.5%) should receive mental health care in an intensive treatment facility, as nursing homes are not capable of providing the psychiatric care deemed clinically appropriate for the patient population needing the psychiatric programs, staffing, and structure of a mental health treatment facility.

Although the need for state hospital inpatient beds has been addressed to some extent by the General Assembly over the past two years, there still remains a critical shortage of inpatient beds. The data shows that currently 1,134 clients need inpatient care. At a given point in time 494 patients can be cared for by the mental health system. Of the 494 inpatient beds available, 324 are state hospital beds. This can be interpreted to mean that the state has assumed responsibility for approximately 65 percent of the inpatient bed need. If this same percentage is applied to the unmet need, the state would need to develop at least 416 additional inpatient beds.

The shortage of inpatient beds also is considered to be critical because the clients needing inpatient care are clearly the most severely disabled in the system. Included in this population are those clients who are primarily diagnosed as psychotic and who are dangerous to themselves and/or others, or who are gravely disabled. More than 90% of the adult patients at Fort Logan Mental Health Center, for example, have some form of chronic mental problem. In the last two years, more than 90% of the patients admitted were judged to be long-term. These patients are not appropriate for treatment or maintenance in community based adult residential facilities. Only after intensive psychiatric hospital treatment over a long period of time can such patients be discharged to non-inpatient treatment settings. The increase in the severity and the chronicity of the patients at Fort Logan Mental Health Center has impacted the admissions and discharges which compound the critical bed shortage. In the four fiscal years from 1976-77 through 1979-80, the average number of admissions to the Adult Inpatient Division was 683.8 per year; the mean number of discharges for those same years was 658.0. In contrast, the past two years (FY 1980-81 and 1981-82) show an average number of admissions of only 201.5 and discharges of 197.0. This more than threefold decline in admissions and discharges is primarily due to the fact that patients are more chronic and must be kept in the hospital for longer stays.

The greatest need for inpatient beds at this time is for the addition of an adult long-term unit at Fort Logan Mental Health Center. All of the data point to the facts that there is an absolute and a relative shortage of adult inpatient beds at Fort Logan Mental Health Center, and that long-term patients are filling short term beds. A long-term unit would provide an increase in inpatient bed capacity and would allow for the transfer of current long stay patients to that specialized unit. This would free up beds for new admissions and make the bed allocation model much more viable. Community mental health centers would be able to exercise more placement options if there were more beds to be allocated. Length of stay in short term adult teams would be reduced while medium stay adult teams would also experience some length of stay reduction. Accessibility to the shorter

stay teams would allow for more patients who need short term treatment and stabilization to receive it and return to the community.

Community-based beds cannot substitute for inpatient beds in a state hospital. Inpatient beds are designed for the most severely psychiatrically disabled patients who require continuous medical and psychiatric diagnostic and treatment services provided under an organized medical staff in a facility licensed by the Department of Health. The primary issue is that mental health system clients are being placed in clinically inappropriate treatment settings in the community or in inpatient settings because of the critical gaps in the residential continuum.

3. Inadequate Staffing for 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 two state hospitals must be staffed adequately to provide a safe therapeutic environment for both patients and staff. The current levels of staff at Colorado State Hospital and Fort Logan Mental Health Center do not meet these requirements. Understaffing in the two state hospitals is directly impacting the quantity and quality of patient treatment which can be provided. Recent data collected on the adult divisions at Colorado State Hospital (CSH) and Fort Logan Mental Health Center (FLMHC) on the frequency and intensity of unplanned interventions required to protect patients, staff, and property from harm indicates that as the intensity and frequency of these interventions have increased, the amount of planned treatment hours per patient has declined in direct relationship. On the adult division at CSH where the direct care staffing shortages are the most acute, the percentage of patients receiving 5 hours or less planned treatment per week increased from 33% in 1979 to 52% in 1981. In this same period of time, the percentage of patients requiring the highest intensity and frequency of staff intervention increased from 5% to 13%. When there is such a high level of dangerously assaultive patients more staff are needed just to manage the ward, monitor security, and guard against patient escapes and walk-aways. The more time that staff must spend in controlling individual assaultive patients, the more difficult it becomes to manage the other patients on the ward and to provide any treatment to them. The situation which currently exists reinforces patients' escalation of assaultive behaviors in order to get staff attention. With inadequate staffing levels, less and less time is available to develop and provide planned treatment. The impact is a more custodial level of care with the emphasis on control rather than treatment.

Another impact of inadequate direct care staffing has been the increased staff injury due to patient contact. The rate of injury to staff due to patient contact has more than doubled at CSH in the preceding 10 years; the trend has continued with an increase from 121 patient contact injuries in FY 1980-81 to 139 in FY 1981-82 at CSH. Most of these injuries were reported on the Forensics and Adult Divisions, with the days lost due to patient contact injuries climbing from 143 in FY 1980-81 to 175 in FY 1981-82 on just the Forensics and Adult Divisions. In addition to the costs incurred for Workmen's

Compensation, patient care suffers from lack of staff continuity: these patients do not establish new relationships easily or quickly.

Direct care understaffing impacts are further compounded when inadequate and inappropriate facilities must be used to house patients with a history of dangerous and assaultive behaviors as is the case with the Adult Division at CSH. This is reflected in the high number of calls to hospital security: about 60% of the 7,000 calls to the security staff in FY 1980-81 came from the Adult Division which has only 20% of the total patient population. Preliminary analysis indicates that the Adult Division percent of the 7,000 total calls to security in FY 1981-82 is even greater.

Since the Forensic Division facilities have been designed and renovated to provide a more secure setting, the understaffing impact has been felt in terms of the frequent and costly use of overtime. In FY 1981-82 the Forensic Division required 69% of the entire hospital overtime budget just to provide minimal ward coverage. Approximately 392 hours/year/direct care employee are lost when CSH forensic staff are on holiday, annual and sick leave; nonetheless, coverage must be provided continuously in an inpatient setting. For the 249 direct care staff in Forensic, a total of 97,608 hours or 57.8 additional FTE are needed to cover the wards with the minimum staff. In FY 1982-83 a Relief Pool of part-time hourly employees was created as a less costly alternative than the utilization of overtime for minimal ward coverage. It is projected that 75% (12.6 FTE) of CSH's Relief Pool staff in FY 1982-83 will be used on the Forensic Division instead of overtime. Subtracting the 12.6 FTE from the needed 57.8 FTE for ward coverage leaves 45.2 FTE still needed.

The same direct relationship between the increased need for unplanned staff intervention to protect the patients from harming themselves, others, or property exists at Fort Logan Mental Health Center as well as at Colorado State Hospital. The treatment intensity level which is expected in an adult psychiatric inpatient setting is simply not possible when nursing staff must spend the bulk of their time controlling and protecting patients and themselves. Between 32% and 40% of adult patients received 5 hours or less planned treatment per week at Fort Logan from 1979 to 1981. As with CSH, increased staff interventions to manage the more assaultive patients result in increased staff injuries due to patient contact: 114 in FY 1980-81; 168 in FY 1981-82. The equivalent of 2 direct care staff for an entire year were lost due to patient-related injuries of staff at FLMHC. The highest injury rate occurred within the Adult Psychiatric Division where the direct care nursing shortage is the most acute, especially on evening, night, and weekend shifts. Such staffing shortages and increased likelihood of injuries contribute to the excessive direct care turnover rate of 54% in FY 1982-82 on the Adult Division of FLMHC (compared to the already excessive turnover rate of 43% among all of FLMHC's direct care staff for the same period). Such a high turnover rate requires additional staff coverage during the recruitment time period (an average of 224 hours per new direct care postion), and during the orientation time required to provide new staff with basic skills to treat and manage the critically, chronically, and seriously

mentally ill patients (an average of 96 hours per new direct care hire). In FY 1981-82 there were 56 direct care positions which were replaced, making a total of 17,920 hours or 10.7 FTE lost during recruitment or orientation. In past years, temporary nursing staff were hired from an outside agency as well as some overtime usage to provide coverage for these lost hours.

A number of research studies across the nation confirm Fort Logan's findings that patient care suffers when outside pool staff are used on a temporary basis. Even the most qualified and competent nursing personnel from an external agency pool lack familiarity with the hospital environment, policies, and procedures, and can seriously disrupt the continuity of patient care and team effort. Consequently, beginning in FY 1982-83 a relief pool of part-time FLMHC employees (4.9 FTE) is being used in lieu of hiring temporary nursing staff from an outside agency and to reduce the utilization of overtime at FLMHC.

The above description illustrates some of the impacts of understaffing at the two state hospitals. Unless adequate staffing is provided, these problems will continue and will increase in magnitude. A safe, therapeutic environment for both patients and staff cannot exist, and adequate treatment to patients cannot be delivered. When adequate staffing is available, a safe therapeutic environment for both patients and staff can exist, and adequate treatment to patients can be delivered.

4. Inadequate Treatment and Support Systems for the Delivery of Mental Health Sevices to the Most Psychiatrically Disabled Clients

Footnote 59 of the FY 1981-82 Long Bill states that funds from the General Assembly must be used principally for the seriously, critically or chronically mentally ill client. These individuals require a full spectrum of services within a Treatment and Support System Model in order to reach and maintain their maximum level of independence. These services include inpatient and outpatient care, emergency services, case management, residential alternatives and training in community survival skills with a strong work therapy component. All of the above compliment each other and are interdependent. A chronic client cannot be expected to secure and maintain employment if counseling services, a satisfactory place of residence, and access to community resources, inpatient care, and emergency services are not available as necessary. On the other hand, if the client's treatment does include vocational services, the client's level of independence in the areas mentioned above will often increase.

Since a full continuum of services is necessary in order to assist clients in reaching their maximum level of employability, the Division of Mental Health has developed a Vocational Continuum (see Appendix III). Some of these services are in place across the State. Programs offering pre-occupational training, however, are critically lacking. Although there are more than thirty (30) sheltered workshops in Colorado, only seven have specific programs for the mentally ill. In addition, only three community-based work experience programs exist for these individuals in Colorado. There are no regional facilities in operation which provide comprehensive assessments of mental health clients' work potential. It is essential that programs be developed to

afford these clients the opportunity to increase their productive capacity.

Reaching a maximum level of functioning in the work environment is a fundamental part of therapy. The results of a recent state hospital study in Pennsylvania showed that patients agree with this premise. Ninety-four percent (94%) of the patients questioned enjoyed working; 8% felt a greater sense of self-respect when they worked; and 90% felt that being paid to work while they were still in the hospital was the best opportunity they had had in a long time. In spite of the desire to work, less than 1,000 Colorado mental health clients served last fiscal year had an opportunity to be employed in a sheltered workshop. In addition, 5,500 (72%) of the adult chronic clients served in FY 1981-82 were unemployed or not in the labor force because of their disability or lack of skills. If appropriate services were provided, however, these clients could become more independent. The majority would require fewer services from the mental health system. For instance, the utilization of a residential treatment facility in Boulder was reduced 50% by a sample of clients who were placed in the mental health center's sheltered workshop. In addition, clients would become less dependent on public financial assistance. Those who were involved in the work experience programs would begin earning wages, perhaps for the first time. In Bayaud Industries, a Denver-based sheltered workshop/transitional employment program, 60-65% of the clients who progress through a full continuum of services are placed in various types of employment or training. An additional 21% also are usually placed in job counseling to assist them in finding work. In contrast, a publication from the U.S. Department of Health and Human Services stated that treatment in traditional settings, which do not provide such employment programming, result in post-hospital employment of only 10% to 30%. The key point is that with an increase in the availability of the occupational readiness services, identified herein for the chronically mentally ill, a significant number of the system's clients could increase their level of productivity.

Cost benefits of these kinds of services were demonstrated by a Michigan State University study. The results concluded that for every dollar spent on mental health clients who became successfully employed, a return of $3 in benefits was realized over a two-year period. Benefits were identified as increased earnings of individuals and household members, increased tax returns, decrease in economic dependence, increased satisfaction with life, and higher levels of consumer expenditures. Also, two research studies on psychiatric rehabilitation completed at Fountain House in New York City showed that the rehospitalization rate of the chronically mentally ill can be significantly reduced as a result of the client's participation in a comprehensive program which focuses on work skill development along with housing.

Cost effectiveness of some of the programs themselves can also be demonstrated. The sheltered workshop of the Mental Health Center of Boulder County, for example, is paid for primarily by income from its subcontract work; therefore, the State only covers the remaining 40%. In FY 1980-81 this meant that for approximately $50,000 of State monies, $132,000 worth of service was realized. In addition, private

industry pays for sixty-eight percent (68%) of the cost of a transitional employment placement program which is run by Bayaud Industries, Community Corporation and Fort Logan Mental Health Center. Only 32% of the program costs are provided with public monies.

The primary responsibility for providing assessments and work experience opportunities as part of the long-term treatment of chronically mentally ill clients clearly lies with the mental health agency. These services do not duplicate or replace those available through the Colorado Division of Rehabilitation (CDR). The clients who are reached through these services are ineligible for CDR services. The majority of the mental health system's chronically mentally ill clients do not possess the necessary work readiness to demonstrate an ability to benefit from services within a reasonably short period of time, as defined by the Colorado Division of Rehabilitation. The necessity of keeping services time limited and bringing about as many job placements as possible creates the tendancy of rehabilitation counselors to serve only the highest functioning mentally disabled clients. Through the development of additional assessment and work experience programs and continued interagency collaboration, the mental health system can assist chronic, low functioning clients to develop the basic work readiness necessary to access occupational training and job placement services of outside agencies, such as CDR.

5. Inadequate Facilities for Mental Health System Clients

A major problem for the mental health system is the lack of adequate facilities for mental health system clients. There are several treatment facilities and other buildings at Fort Logan Mental Health Center and at Colorado State Hospital which are being used for purposes other than those for which they were designed. There also is a major problem with lack of resources for the proper maintenance of both state hospitals.

The physical plant of Colorado State Hospital, for example, is an aging one. There has been very little new construction during the past twenty to thirty years. Many of the buildings need to be replaced or undergo major remodeling, if adequate facilities for patient care are to be maintained and meet standards established by the Joint Commission on Accreditation of Hospitals, Medicare, Medicaid, and other outside review bodies. The use and design of buildings at both state hospitals need immediate attention so that realistic workload plans may be developed for cost-effective building utilization. It must be emphasized that environmental needs are integrally involved with program development, and that the hospitals are placing major emphasis on this aspect of patient care. Since no new construction has occurred for many years, many of the facilities were constructed for vastly different functions than they now serve. Planning efforts already are addressing facility utilization and needs at hospital-wide levels. These efforts need to be expanded and continued.

There is also a major problem in the replacement of equipment throughout both state hospitals. Equipment in many areas is obsolete and does not make use of existing technology. In other areas patient needs are not being met and raise the possibility of not being in compliance with the Joint Commission on Accreditation of Hospitals, Medicare, Medicaid, and other outside review body standards. Planning

efforts are being initiated to develop overall hospital processes whereby these equipment needs are identified and prioritized.

In addition to the need for an assessment of the utilization of existing structures and the need for replacement of existing equipment, the mental health system also needs to evaluate the need for new resources and facilities. For example, a multi-agency panel has been established to analyze the need for a forensic service capability in the Denver metropolitan area. Observations and criminal court commitments under the Incompetency to Proceed and the Not Guilty by Reason of Insanity Statutes are placed at the Institute for Forensic Psychiatry at Colorado State Hospital. The appropriateness of expanding the forensic capability to the Denver metropolitan area needs to be assessed.

Both state hospitals are located on the Eastern slope of Colorado. There has been some question as to whether or not the state should develop a facility on the Western slope. This question needs to be addressed as part of an assessment of the appropriate utilization of facilities for the mental health service delivery system.

6. Need to Ensure the Effective Functioning of the Elements of the System

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

A primary method of ensuring the effective functioning of the elements of the system is to ensure that the roles and functions of those elements are clearly defined. 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. 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 the 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.

Another major factor impacting the effective functioning of the system relates to the lack of an adequate management information system. For years, the Division of Mental Health has attempted to manage a multi-million dollar operation with an inadequate and obsolete Automated Data Processing (ADP) system. The Division of Mental Health does not have any on-line communication with the main Department of Institutions computer located in Pueblo.

Currently, DMH relies upon information which is contained in a number of discrete data files stored in two non-interfaced computers and in several manual or micro-computer systems. The variability in file structure and the differing requirements of the host computers hinders our ability to cross-walk between systems in order to create work files composed of data from two or more systems. For example, in order to conduct cost outcome studies, the fiscal data must be manually transferred and entered into the client data file. In addition, the opportunities and potential of the current ADP state-of-the-art are not being utilized. Budget calculations, the testing of alternative funding formulas, comprehensive contract monitoring with projections and compliance comparisons, calculations of POTS and various personnel configurations, and the ability to conduct cost-effectiveness studies are but a few of the ADP applications which need to be developed.

During FY 1982-83, the Division of Mental Health will conduct a complete review of the existing information system comprised of cost, staffing, facilities, service, revenue and client data. The review will cover the data elements, method of collection, storage mode, location, file structure, accessibility, users, applications and other related issues. A plan will be developed for reorganization and restructuring the system to ensure ready access to all data in a cost-efficient fashion. All data applications will be prioritized and, resources permitting, some applications will be redesigned in FY 1982-83.

7. Underserved or Inappropriately Served Populations

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

The philosophy of the Division of Mental Health is that children and adolescents should be served in the least intensive, least restrictive setting, as close to home as possible, that is consistent with their clinical needs. This philosophy is in keeping with the concept of treating children in their community with maximum flexibility and local control such as the SB-26 program enacted by the Legislature. From a treatment, as well as a fiscal perspective, it is critical for programs to be developed which will allow the provision of services to these children in their communities.

Children and adolescents continue to be underserved and often inappropriately served. Preadmission screening of youth, for example,

is the primary responsibility of the community mental health centers; however, the community mental health programs often are bypassed as the child is directly referred to a state hospital or to the Juvenile Justice System. Children (ages 0-11) are not being served in proportion to their representation in the population. According to the 1980 census, children make up 18 percent of the population; however, in FY 1980-81 they represented only 9.1 percent of the population served by the community mental health centers and 1.1 percent of the population served by the state hospitals. IN FY 1981-82, the community mental health centers project that 8.1 percent of the population they serve will be children, and the hospitals project that only 0.9 percent of their population served will be children.

In addition to these indications of the mental health system's inadequate services for children, an apparent decrease in the admissions of children and adolescents also has occurred. From FY 1980-81 to FY 1981-82, there was a decrease of 1,084 admissions of children, or 25 percent. The admissions of adolescents decreased by 1,185 or 20.9 percent. The projected number of admissions to community mental health centers in FY 1982-83 is 3,283 for children and 4,055 for adolescents. This represents a maintenance of effort for children, but it again represents a decrease in admissions of adolescents of 425, or an additonal 9.5% from FY 1981-82. The reason for this decrease is twofold. The first reason for the decrease is the fact that resources have not kept pace with the increases in the costs to provide services. The second reason for the decrease appears to be related to the demand upon the community mental health system to respond to the increasing number of seriously, critically, and chronically disabled adults who need services. Increased demand for services within a static, if not declining, funding base results in program shifts within agencies along with a reduction in the services provided.

The need for increased services for children is impacting all components of the mental health system. Fort Logan Mental Health Center, for example, has had an average waiting list of thirteen children/adolescents since March of 1982. While Colorado State Hospital has not established a waiting list, virtually all admissions to the children and adolescent units are involuntary, either as a result of the state statutes (CRS 27-10) or as a result of court ordered placements under the provisions of the Children's Code. The key point is that the availability of inpatient care for children and adolescents is very limited.

Another factor impacting the need for expanding the availability of children's services is the fact that only 7 of the 20 community mental health centers operate clinical programs which are organized and staffed to respond to the needs of severely disabled children and adolescents on an outpatient basis through day treatment programs. In most respects, this also reflects the number of centers which have retained a child/adolescent clinical specialist within their staffing pattern. In addition, only 3 community mental health centers operate residential programs in their community for children or adolescents whose mental disabilities preclude treatment while living at home. As part of an effort to provide comprehensive psychiatric care and treatment for children and adolescents, day treatment programs need to

be established in more community mental health center service areas. An intensive mental health community treatment facility for severely disturbed youth also would help to reduce the current service gaps for this population.

The second population group which has been identified as being underserved and inappropriately served is the elderly. The mentally disabled elderly continue to be underrepresented in populations served by the public mental health system. It is known that a higher population in need exists; however, due to several interacting variables, they do not readily access services. These include personal value-belief systems related to the stigma of mental illness which discourages self-referral; physically related conditions which may mask psychologically based functional deficits and result in primary care in the health system; dependency related to deteriorating physical and mental capability which results in long-term care nursing home placements without mental health services; shortage of specially trained gerontological staff in the mental health system to advocate for programs which are responsive to the needs of the elderly; cost of implementing and maintaining the outreach services which may access the elderly in the face of resource limitations; and federal eligibility requirements for Medicare and Medicaid which severely limit payment for services to the elderly from outpatient community mental health settings. To counteract these influences, it is necessary for the state mental health system to advocate for services to the elderly by not only continuing technical assistance emphasis to the mental health system in order to improve and maintain appropriate, accessible services, but also to ensure services by specifically establishing minimum admission/population served levels through the existing contracting process. As with other target populations, percentages of population in need will be identified and Division of Mental Health resources will be specifically directed to this purpose.

Another very problematic population in need are those individuals with a diagnosis of mental illness in combination with another significant organic or functionally based disability such as mental retardation, substance abuse, or hearing impairment. Generally, the mental illness is secondary to the other deficit. The severity of the primary condition also tends to mask the mental illness and/or the primary condition has related behavioral characteristics that make treatment in mental health centers quite difficult due to the lack of specialized personnel and facilities.

Another factor is that the client with a dual diagnosis is primarily served by another system (e.g., Developmental Disabilities) which requires coordination and communication to achieve access for referrals and continuity of care.

Further study and evaluation are needed around the identification of dual diagnosis clients and the related task of determining which clients and what program interventions are appropriate for the mental health system. This would lead to the development of public policy affecting both the mental health system and the other related systems to assure clear direction to providers in terms of responsibility for the provision of and source of resources for necessary services.

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 has established priorities relating to the needs of the residents of the state and the utilization of resources. 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 seriously, critically, 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 (60 years and older), adolescents (12-17 years), and adults (18-59 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 1982-83 local mental health plans submitted by the catchment area mental health centers.

8. Need to Maximize Limited Resources by Coordinating with Other Human Service Agencies

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

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

CHAPTER IV. STATEWIDE GOALS AND OBJECTIVES

A. INTRODUCTION

The goals and objectives have been developed in congruence with the priorities established by the Colorado mental health system which focus 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 the chronically mentally ill, children, the elderly, and minorities; (3) pre-admission screening to ensure use of the least restrictive setting; (4) the development of community-based facilities; (5) follow-up care for persons who have been discharged from formal mental health treatment programs; and (6) programs directed towards the establishment of the treatment and support system model for the delivery of mental health services.

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 mental health service areas. Mental health agencies, however, are expected to plan for, mobilize, and facilitate the use by clients of the various community resources available. Their 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.

With service demands staying well ahead of dollar resources, increasing emphasis must be placed on full utilization of other community resources and reexamination 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 have been modified by the Colorado Division of Mental Health to reflect the most pressing issues facing the state-funded mental health system. 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. The objectives under each goal are, in fact, listed in chronological order by due date.

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 has established priorities relating to the needs of the residents of the state and the utilization of resources. For Fiscal Year 1982-83, 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 (60 years and older), adolescents (12-17 years), and adults (18-59 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 1982-83 local mental health plans submitted by the catchment area mental health centers.

An annual report on the outcome of the objectives for Fiscal Year 1981-82 is available from the Colorado Division of Mental Health. This report is prepared 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. The Division of Mental Health will continue to monitor the status of statewide objectives and local objectives included as part of the plans proposed by the community mental health centers.

B. COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1982-83 OPERATING PLAN

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
Status Goal 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 INDEPENDENT LIVING SKILLS.	(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.	6/30/83	- Report of analyses	Evaluation Services	It is important to monitor and evaluate the outcome and impact of those changes in the quality of life of the clients served by the Colorado mental health system.
	(2) To have conducted a study to determine the relationship of level of functioning to length of stay for selected populations.	6/30/83	- Written study	FLMHC	This study will help Fort Logan determine which treatment programs are most effective.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1982-83 OPERATING PLAN

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
Service Goal #1 TO SERVE THE MOST PSYCHIATRICALLY DISABLED CLIENTS WITH THE LEAST ABILITY TO PAY TO THE MAXIMUM DEGREE THAT THE RESOURCES ALLOW AND IN A MANNER THAT ENSURES THE PROVISION OF SERVICES TO GROUPS THAT HAVE BEEN UNDERSERVED OR INAPPROPRIATELY SERVED.	(1) To have identified appropriate, available placements for hearing impaired patients.	7/1/82	- Placements identified - Patient transfers accomplished	FLMHC	Completion of this objective will result in correcting inappropriate placements of hearing impaired patients.
	(2) To have conducted at least one symposium to discuss children's mental health service delivery issues.	10/30/82	- Written report describing the events and recommendations resulting from the symposium.	Program Services	The Child/Adolescent Steering Committee will conduct the symposium at the Annual Colorado Mental Health Conference in October.
	(3) To have prepared a status report on the out-of-state placements of psychiatrically disabled children.	11/1/82	- Report prepared including a description of the issues and actions needed to address the issues.	Program Services	A review of the current status of out-of-state placements is needed for effective program planning for children's services.
	(4) To have analyzed community mental health center open case data to determine if proportionate resources are reserved for priority populations.	1/31/83	- Written report	Program Services Evaluation Services Planning Services Administrative Services	The Division's practice of contracting for clients to be served needs to be assessed to assure that community mental health centers allocate resources to address the needs of priority populations in some proportion to their representation in the population.
	(5) To have identified the unmet mental health service needs and the actions necessary to supplement the mental health services available on the Southern Ute and the Mountain Ute Indian Reservations.	2/28/83	- Descriptive information regarding the two reservations submitted to DMH as part of the Center's Mental Health Service Area Plan.	Program Services Southwest Colorado MHC	The Federal Block Grant Legislation has encouraged Native Americans to seek more active participation in the state mental health system. This would appropriately require active cooperation between the Southwest Colorado MHC, tribal officials, and other service providers.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(6) To have analyzed the need for forensic service capability in the Denver metropolitan area.	6/30/83	- Final report of the Forensic Panel	Community Liaison Planning Services	Observations and criminal court commitments under ITP and NGRI are placed at the Forensic Institute at Colorado State Hospital. An analysis needs to be conducted to assess the cost effectiveness and long-range trends of forensic services.
	(7) To have provided services to 5,400 children in FY 1982-83.	6/30/83	- Signed contracts - Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	(7) - (12) 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 clients served 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.
	(8) To have provided services to 7,300 adolescents in FY 1982-83.	6/30/83	- Signed contracts - Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(9) To have provided services to 47,300 adults in FY 1982-83.	6/30/83	- Signed contracts - Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(10) To have provided services to 4,600 elderly in FY 1982-83.	6/30/83	- Signed contracts - Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(11) To have provided services to 12,200 ethnic minorities in FY 1982-83.	6/30/83	- Signed contracts - Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	
	(12) To have provided services to 54,100 seriously, critically, and chronically mentally disabled clients in FY 1982-83.	6/30/83	- Signed contracts - Quarterly data monitoring reports	DMH Centers/Clinics Hospitals	

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1982-83 OPERATING PLAN

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES.
Service Goal #2					
TO PROVIDE ADEQUATE AND APPROPRIATE RESIDENTIAL SERVICES FOR MENTAL HEALTH SYSTEM CLIENTS.	(1) To have expanded the capacity for intermediate security patients of the Institute for Forensic Psychiatry at the Colorado State Hospital by adding 18 beds (GW5) to the intermediate unit and 24 FTEs to the treatment team for the ward.	9/1/82	- Staff hired and ward in operation	CSH	The need for an increase in the number of intermediate beds had been established by a review of existing resources and projected needs. This expansion should enable the Institute to meet its various security level needs more effectively and efficiently.
	(2) To have completed an updated need assessment to determine the current and future (three to five years) demand for adult beds at Fort Logan Mental Health Center.	1/1/83	- Written report	FLMHC Evaluation Services	Fort Logan needs to do an updated assessment regarding the need for adult beds within the hospital. This assessment shall be done in conjunction with the Division of Mental Health's Evaluation Section and other efforts related to psychiatric bed needs within the state.
	(3) To have developed a plan outlining the scope and nature of the Aftercare Program at Fort Logan Mental Health Center.	2/1/83	- Written plan	FLMHC	Fort Logan has determined that the role of the Aftercare Program needs to be assessed in relation to the hospital's mission.
	(4) To have completed a process and impact evaluation of the bed allocation systems at Colorado State Hospital and at Fort Logan Mental Health Center.	3/31/83	- Written report with recommendations for revisions	Evaluation Services Program Services Planning Services CSH FLMHC CMHCs	The availability, appropriateness, and rate of utilization of state hospital beds by community mental health centers is critical to maintaining a responsive treatment and support system. An evaluation will indicate whether adjustments are needed in the process and/or in the allocation system.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(5) To have established 22 new community-based residential facility beds for psychiatrically disabled adult clients.	6/30/83	- Report of beds established and utilized by clients	Program Services CMHCs	In FY 1981-82, the State Legislature funded a residential demonstration project in which 53 community-based residential facility beds were established for psychiatrically disabled adults. The 22 beds represent an extension of that project for a total of 75 state-funded non-intensive community-based beds.
	(6) To have established 90 intensive mental health treatment facility beds, 130 community-based residential beds, and service capacity for 270 clients who are living independently.	6/30/83	- Report of beds and programs established and utilized by clients	Program Services CMHCs	The Department of Institutions, in concert with the Department of Social Services, requested a waiver for home and community-based services under the Medicaid Program as authorized under the Omnibus Reconciliation Act. The mental health segment of the Waiver will enable the mental health community programs to be able to fund alternative programs for those mentally ill clients in need of a level of care such as that provided in a nursing home utilizing the expanded definition of services provided for by the Waiver.
	(7) To have studied the different levels within the Institute for Forensic Psychiatry to determine the impact of the additional intermediate beds and to develop further recommendations.	6/30/83	- Written study completed	CSH	There is a need to evaluate the impact of the addition of intermediate beds upon the ongoing program and facility needs of the Institute for Forensic Psychiatry. This will enable the unit to develop further recommendations and planning efforts to ensure maximum efficiency and effectiveness of the unit.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(8) To have promulgated rules and regulations concerning the care and treatment of the mentally ill which include the designation of residential child care facilities as CRS 27-10 facilities.	6/30/83	- Rules and regulations promulgated	Community Liaison Program Services	July 1, 1981, the General Assembly passed Senate Bill 337, which provides for the CRS 27-10 designation of RCCFs. The existing rules and regulations permit the designation of hospitals and community mental health centers. Special designations can be made on a case-by-case basis. The RCCFs need to be included in the rules and regulations under the definition of "facility," and the rules and regulations need to be revised to address the treatment needs of children/ adolescents in a residential setting.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #1					
TO PROVIDE ADEQUATE AND APPROPRIATE STAFFING FOR MENTAL HEALTH SYSTEM PROGRAMS.	(1) To have completed a FY 1981-82 mental health training activities report.	7/30/82	- Report submitted to the Department of Institutions	Program Services	This report would summarize the training activities completed by DMH during the previous fiscal year.
	(2) To have developed a methodology to determine the staffing needs for the two state hospitals.	9/30/82	- Written methodology	Program Services Administrative Services CSH FLMHC	The Joint Budget Committee has questioned the DMH requests for additional staffing for both hospitals; consequently, a methodology for determining staffing needs should be developed in such a manner that it is acceptable to the Joint Budget Committee.
	(3) To have designed a Division of Mental Health Human Resources Development Program which includes both an analytical/planning component and a capacity building/ maintenance component.	10/1/82	- Written report	Program Services	This is a maintenance effort to assure the incorporation of necessary HRD capacity in the FY 1983-84 Division budget to replace resources previously provided under federal grants.
	(4) To have developed a FY 1983-84 training plan for mental health.	6/1/83	- Plan submitted to the Department of Institutions	Program Services	This plan will outline the proposed training activities for mental health for the coming fiscal year.
	(5) To have provided regional workshops related to collaborative activities of the mental health and the law enforcement systems.	6/30/83	- Report of completed workshops	Program Services	Relationships between mental health service system providers and law enforcement are instrumental in providing accessible and appropriate crisis services, particularly with regard to the provisions of CRS 27-10.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(6) To have provided three regional workshops on crisis intervention.	6/30/83	- Report of completed workshops	Program Services	The implementation and maintenance of a cost effective, acceptable, accessible statewide mental health emergency service system are key factors in the community mental health system. Continuing education aimed at the state of the art is a necessary activity. One workshop will be held in the Denver metropolitan area, and the other two will be held in central locations around the state.
	(7) To have provided training to mental health system staff designed to improve skills in the delivery of residential and vocational services to chronically mentally ill clients.	6/30/83	- Training summaries on file	Program Services	In the Division of Mental Health's assessment of Treatment and Support System Program needs, the two highest priorities were residential and vocational services. If these services are to be provided by mental health system staff, then the staff must receive appropriate training in these areas.
	(8) To have provided ten clock hours yearly of training for all treatment and support service staff at Fort Logan Mental Health Center.	6/30/83	- Written report on the amount and type of training delivered	FLMHC	Increasing staff knowledge, skills, and abilities should result in achieving higher levels of functioning.
	(9) To have developed a plan for hiring and retaining psychiatrists who have been trained primarily in Colorado.	6/30/83	- Written plan ready for implementation	Personnel Program Services	There is a need to reduce the turnover among psychiatrists. The Division will work to bring together the Director of the psychiatric residency program at the University of Colorado Health Sciences Center and the directors of the community mental health centers to develop a cooperative program.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #2 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 prepared an analysis of the new and existing resource requirements available for statewide implementation of the Division of Mental Health's vocational continuum.	10/1/82	- Written analysis of resource requirements and key factors facilitating or impeding progress	Program Services	Statewide implementation of the DMH Vocational Continuum as a basic mental health treatment and support system component will require either the development of new resources or the transfer of existing resources.
	(2) To have served 440 clients through the establishment of one vocational assessment center, one work preparation training program, and two work experience programs.	6/30/83	- Programs in place - Data reports on clients served	Program Services	In the Division of Mental Health's assessment of treatment and support system program needs, one of the highest priorities is vocational services. In order to initiate the statewide availability of vocational services, new programs for a demonstration effort need to be developed, and systems where limited programming exists need to be expanded.
	(3) To have adopted program and facility standards for residential and vocational services for community mental health centers.	6/30/83	- Standards adopted by DMH - Standards recommended for incorporation in the State Standards for Mental Health	Program Services	Residential and vocational services represent the two highest priorities for implementation of the treatment and support system model for mental health. DMH has developed both a residential continuum and a vocational continuum which reflect the basic treatment and support elements for these services.
	(4) To have developed an operational definition of case management for the mental health system, which is flexible and responsive to management of service activities, and which also ensures accountability.	6/30/83	- Written operational definition	Program Services	The concept of case management has been incorporated in the service activities of CMHCs; however, the variability and/or different approaches suggest lack of clarity of DMH expectations. Establishing definitions and accountability criteria would make more explicit what minimal program elements need to be in place.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(5) To have produced a workplan, identified items, and a methodology for collecting client vocational and residential data.	6/30/83	- System developed	Program Services	In the Division of Mental Health's assessment of Treatment and Support System program needs, the two highest priorities were residential and vocational services. A system for collecting client data in these areas must be developed if clients are to receive appropriate services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #3 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 implemented the provisions of the Memorandum of Understanding between the Department of Social Services and the Department of Institutions.	7/1/82	- Plan in place	Program Services	(1) - (2) A Memorandum of Understanding has been signed by the Department of Social Services and the Department of Institutions, providing for the transfer of Medicaid funding and program responsibility for those clients under the care of the Department of Institutions. The Division must implement the provisions of the agreement as it pertains to mental health clients.
	(2) To have implemented the transfer of Medicaid funds from the Department of Social Services to the Department of Institutions.	7/1/82	- Transfer of resources completed	Administrative Services	(see above)
	(3) To have developed a tentative allocation plan for the use of Federal Block Grant funds for FY 1983-84, including an impact analysis for any identified reductions in total resources for support of community mental health center treatment and support system services.	10/1/82	- Written allocation plan	Administrative Services Program Services	This plan is needed to determine how federal funds will be allocated and to assess the impact of reductions in total resources. This information will also be used as the FY 1983-84 DMH budget request is developed.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(4) To have developed a "Request for Proposals" to award the available funds for residential facilities under the Medicaid Waiver.	10/31/82	- RFP approved and submitted to the agencies	Program Services Administrative Services	The mental health segment of the Medicaid Waiver will enable the mental health community programs to fund alternative programs for those mentally ill clients in need of a level of care such as that provided in a nursing home, utilizing the expanded definition of services provided for by the Waiver.
	(5) To have developed an operating plan to control and guide the implementation of the Medicaid Waiver.	1/1/83	- Plan in place	Program Services Administrative Services	A Medicaid Waiver allowing for the spending of Medicaid funds by the community mental health programs was submitted to the federal government. The Division of Mental Health is responsible for implementing the provisions of that request.
	(6) To have submitted a report to the Colorado General Assembly detailing the cost per client served, utilization rates, and the number of clients served with Medicaid.	1/1/83	- Report submitted	Administrative Services Evaluation Services Program Services CMHCs	This report is required by a Footnote in the FY 1982-83 Long Bill. This report shall also include a listing by center of the collections from client co-pay.
	(7) To have completed a report reviewing the effectiveness of the Medicaid Waiver.	6/30/83	- Report submitted to the federal government.	Program Services Evaluation Services Administrative Services	The effectiveness of the Medicaid Waiver needs to be reviewed each year.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(8) To have reviewed the implementation of the Memorandum of Understanding and to have submitted a report concerning its effectiveness and recommending necessary changes.	6/30/83	- Report submitted	Program Services Administrative Services	The Memorandum of Understanding will need to be reviewed each year for its effectiveness.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #4					
TO ENSURE THE APPROPRIATE UTILIZATION OF FACILITIES AND FACILITY RESOURCES BY MENTAL HEALTH SYSTEM CLIENTS.	(1) To have completed a study of the utilization of all physical facilities at Fort Logan Mental Health Center.	9/30/82	- Written facilities Study	FLMHC	Fort Logan established a Long-Range Space Planning Committee to examine how the hospital's physical facilities were being used to meet the patient care requirements for the present and the intermediate future. The outcome of this project should be the development of a written facilities study.
	(2) To have developed a plan for the collaborative utilization of residential facilities at Fort Logan Mental Health Center by Fort Logan and by community mental health center clients.	6/30/83	- Written plan	Program Services FLMHC CMHCs	As the role of FLMHC has evolved toward providing primarily acute and long-term inpatient care as part of the treatment and support system, it has become apparent that innovative use of the residential capacity of FLMHC could be facilitated by a joint venture with community-based programs.
	(3) To have implemented a short- and long-term capital construction and controlled maintenance program at the two state hospitals that will ensure a safe, modern physical environment for all modalities of patient care.	6/30/83	- Controlled maintenance program in operation, dependent upon available funding.	CSH FLMHC	Various outside review agencies, including the Joint Commission on Accreditation of Hospitals, Medicare, Medicaid, and PSRO, require that various safety and environmental standards be met. By implementing such a program to achieve these goals, a major step will have been taken to meet these outside review body standards. The controlled maintenance is funded through the Department of Administration.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(4) To have developed recommendations and priorities concerning facility and capital construction needs at the two state hospitals.	6/30/83	- Recommendations and priorities established for capital construction needs at the two state hospitals	CSH FLMHC	In view of the changing of the two hospitals' patient populations, there is a need to establish priorities and cost estimates for the remodeling of various facilities. Particular areas of concern are the need for lockable facilities for children's services, remodeling of the geriatric facility at CSH, reduction of the numbers of patients on the adult wards, forensic treatment facilities, and related issues.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
System Goal #5 TO ENSURE THE DELIVERY OF HIGH QUALITY CLIENT CARE THROUGH THE EFFECTIVE FUNCTIONING OF ELEMENTS OF THE MENTAL HEALTH SYSTEM.	(1) To have established targets for patient movement (i.e., admissions, discharges, length of stay, and transfers) within Fort Logan Mental Health Center.	8/1/82	- Written targets	FLMHC	The accomplishment of these activities for the treatment units at Fort Logan should allow patients to move through the system as rapidly as possible, consistent with their treatment goals. The process for evaluating level of functioning, as it relates to the length of stay for both long-term and short-term clients, should ensure that patients do not stay in the hospital longer than required.
	(2) To have established standards for the use of seclusion and restraints for each treatment unit within Fort Logan Mental Health Center.	9/30/82	- Written standards and review procedures	FLMHC	The standards and procedures for the use of seclusion and restraints should ensure that they are used only when necessary.
	(3) To have submitted a report to the Colorado General Assembly detailing unit cost rates and usage of service by community mental health centers and clinics.	10/1/82	- Report submitted	Administrative Services Evaluation Services	The report is required by a Footnote in the FY 1982-83 Long Bill.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(4) To have completed on-site monitoring assessments of the twenty community mental health centers, the four mental health specialty clinics, and the nineteen other facilities designated as 72-hour treatment and evaluation facilities for mental health.	5/31/83	- Written assessment reports	Program Services	A consolidated on-site assessment instrument has been developed to review compliance with the "Standards/Rules and Regulations for Mental Health," The Care and Treatment of the Mentally Ill Act Rules and Regulations, and the Clinical Quality Assurance Guidelines for Medicaid. Completing these evaluations is essential in order to comply with all monitoring expectations.
	(5) To have amended CRS 27-1-201, et seq., Community Mental Health Services - Purchase, to reflect the changes in the Division of Mental Health's contracting practices and the General Assembly's appropriation practices.	6/1/83	- Legislation passed	Community Liaison	CRS 27-1-201, et seq., is outdated and no longer reflects the practices of the Legislature or the Division of Mental Health. For legal reasons, it is important to amend this law to provide for the necessary statutory authority to contract for mental health services.
	(6) To have completed a systems analysis of the Division of Mental Health fiscal, personnel, program, and evaluation data systems.	6/30/83	- Written analysis with plan	Evaluation Services DMH Management Team	The integration of the various DMH data systems requires a thorough system analysis, due to the recent changes in the Department of Institutions automated data processing hardware and software.
	(7) To have managed the budget allocation to the two state hospitals on the basis of dollars allocated, rather than FTEs.	6/30/83	- No over-expenditures for personnel services at the two state hospitals	Administrative Services CSH FLMHC	As part of the continuing efforts for effective management, changes are being implemented to assure that there is no need to depend upon supplemental budget appropriations. This should provide more stability in the management of the budget and should avoid problems associated with projecting possible supplemental needs.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY	RATIONALE FOR OBJECTIVES
	(8) To have proposed Legislation for revising the Colorado "Not Guilty By Reason of Insanity" (NGRI) Statute, if such revisions are recommended as a result of a Division of Mental Health analysis of the present NGRI Statute.	6/30/83	- Written DMH position paper - Legislation proposed, if necessary	Community Liaison	Public concern over the insanity statute has been generated as a result of the Hinckley case. It is important that Colorado not be swept away by public opinion, but that the Division of Mental Health thoroughly analyze the insanity statute and alternatives.
	(9) To have defined 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.	6/30/83	- Written descriptions of the roles and funcions of the state hospitals and the CMHCs	Planning Services Program Services CSH FLMHC CMHCs	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.
	(10) To have developed a methodology for evaluating the impact of the restructured Denver Metropolitan Emergency Service Program.	6/30/83	- Written evaluation plan submitted	Program Services Evaluation Services	The effect of restructuring the Denver Metropolitan Emergency Service Program must be evaluated to assure that expected results are realized and that corrections, if necessary, are made to achieve results.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1982-83	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 standards for more effective interaction between Fort Logan Mental Health Center's treatment teams and community facilities regarding treatment planning, discharge planning, and aftercare.	7/1/82	- Written standards	FLMHC	These standards will help to improve client movement from admission to discharge and will minimize disruption of treatment and ensure continuity of care.
	(2) To have conducted one statewide meeting with representatives from the mental health system and the criminal justice system to review service needs and system issues needing resolution.	1/30/83	- Written report of the meeting	Program Services	It is evident that there is substantial overlap of responsibility between these two systems, particularly with regard to dangerous and potentially dangerous persons. Joint planning and active collaboration at state and local levels is necessary to the efficient, appropriate provision of services.
	(3) To have developed a cooperative agreement between the Division for Developmental Disabilities, Regional Centers and the State Mental Hospitals to ensure coordination in the service delivery system for the developmentally disabled/mentally ill client.	4/30/83	- Finalized agreement	Program Services	The Division of Mental Health and the Division for Developmental Disabilities currently do not have an operational agreement. This developmentally disabled/mentally ill client population continues to be one of the populations most in need. A comprehensive service provision approach between the two Divisions is needed.

C. COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
Status Goal 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 INDEPENDENT LIVING SKILLS.	(1) To have analyzed client outcome information for four target groups to determine if clients in those groups are achieving higher levels of functioning and improving their quality of life.	6/30/84	- Written report with conclusions and recommendations	Evaluation Services	These studies will add to our knowledge of the impact of mental health services and the degree to which various client populations change during the course of treatment.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	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 SERVICES TO GROUPS THAT HAVE BEEN UNDERSERVED OR INAPPROPRIATELY SERVED.	(1) To have initiated a pilot program to provide emergency inpatient services for patients with the dual diagnosis of mentally ill/substance abuser.	9/30/83	- Program operational	Program Services Administrative Services $300,000	Inadequate resources presently exist to serve the patient population which is in need of inpatient emergency care due to substance abuse psychoses which may or may not be related to a history of mental illness. This patient oftentimes is a severe management problem because of their acting out and, at times, violent behavior. If the mental health system is to be responsive to the special physical and psychological services required to properly treat this patient, then additional resources are needed.
	(2) To have completed an analysis of the issues and barriers related to the provision of services to clients with dual diagnoses, i.e., mentally ill/developmentally disabled, mentally ill/substance abuser, and mentally ill/hearing impaired.	1/1/84	- Report submitted to the Director of DMH	Program Services FLMHC	The Division of Mental Health plans to implement initiatives addressing these underserved groups in FY 1984-85. This analysis, therefore, is necessary for program planning for that period.
	(3) To have maintained the same level of services as provided by the community mental health centers in FY 1982-83 by obtaining a maintenance-of-effort increase and funds to replace declining federal dollars.	6/30/84	- Maintenance-of-effort increase - Funds to replace declining federal dollars	Administrative Services Program Services CMHCs $2,100,000	Mental health service costs continue to increase because of such things as increases in the number of patient care episodes, inflation, population growth, and labor costs. If the mental health system is to maintain the same level of service as in the previous fiscal year, then there must be an increase as well as funds to replace declining federal dollars.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(4) To have increased services to children by expanding the availability of partial care, other 24-hour care, and in-patient programs.	6/30/84	- Programs opened and in operation	Program Services CMHCs CSH FLMHC $500,000	Mental health services for children currently are inadequate. Children are not being served in proportion to their representation in the population. Programs are especially needed for serving critically, seriously, and chronically mentally disabled youth.
	(5) To have participated in the development of needed programs within the State of Colorado to meet the mental health needs of the children who are currently being sent out of state.	6/30/84	- Program plan developed	Program Services CMHCs CSH FLMHC	At the present time the State of Colorado is forced to send 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.
	(6) To have provided in-patient services to the psychotic drug abuser by maintaining the 30-bed "Circle Program" of the Drug Treatment Center at Colorado State Hospital.	6/30/84	- Continuation of the existing program as a result of funding appropriated to CSH for the program	CSH $1,170,000 (transferred from ADAD to DMH)	There is currently a contractual agreement between ADAD and Colorado State Hospital for CSH to provide services to the psychotic abuser. The continuation of this program would be stabilized by having funding shifted to the Colorado State Hospital and more fully integrated into the hospital program. If funding is not transferred, the programs will be terminated.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(7) To have developed a plan for establishing forensic services in the Denver metropolitan area, if recommended by the multi-agency Forensic Panel.	6/30/84	- Written plan with resource recommendations, if appropriate	Community Liaison Planning Services	The Forensic Panel is analyzing the need for forensic service capability in the Denver metropolitan area. If the analysis demonstrates the cost efficiency of forensic services in the Denver area, a plan will need to be developed for establishing those services.
	(8) To have explored funding alternatives for establishing a combined Developmental Disabilities/Mental Health treatment unit to provide specific treatment for mentally ill/developmentally disabled clients.	6/30/84	- Funding possibilities clarified	Program Services	A specialized treatment unit is needed to provide treatment to clients with this dual diagnosis. Funding for the unit has been requested in the past, but no funding for this program has become available to date.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
Service Goal #2					
TO PROVIDE ADEQUATE AND APPROPRIATE RESIDENTIAL SERVICES FOR MENTAL HEALTH SYSTEM CLIENTS.	(1) To have opened a twenty-four bed unit at Fort Logan Mental Health Center to accommodate the increasing demand for adult care.	2/1/84	- New unit fully staffed and serving patients	FLMHC $745,000	There is an increasing demand for adult services at Fort Logan. An increase in bed capacity is needed to meet this demand.
	(2) To have established up to 100 new intensive adult residential care facility beds for psychiatrically disabled clients.	6/30/84	- Increased scope and number of clients served under the Medicaid Waiver - New adult residential care facility beds established	Program Services Planning Services Administrative Services CMHCs $1,402,000	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. The current Medicaid Waiver only provides for a portion of the population in need to be served. Program expansion is necessary to reach a larger proportion of those needing services.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #1					
TO PROVIDE ADEQUATE AND APPROPRIATE STAFFING FOR MENTAL HEALTH SYSTEM PROGRAMS.	(1) To have completed a FY 1982-83 mental health Training Activities Report.	7/30/83	- Report submitted to the Department of Institutions	Program Services	This report would summarize the training activities completed by DMH during the previous fiscal year.
	(2) To have developed a FY 1984-85 Training Plan for mental health,	6/1/84	- Plan submitted to the Department of Institutions	Program Services	This plan will outline the proposed training activities for mental health for the coming fiscal year.
	(3) To have achieved a level of staffing at Colorado State Hospital and at Fort Logan Mental Health Center which eliminates any shortages and which is consistent with the identified needs of both state hospitals.	6/30/84	- Staffing patterns of the two state hospitals consistent with the methodology adopted within the available resources	CSH FLMHC $1,520,400	In order to provide needed services, adequate staff must be available; however, current shortages in staffing prevent delivery of these services. The specific need for additional positions will be determined on the basis of studies conducted during the current year.
	(4) To have added 5 staff members to the Deaf Services Unit at Fort Logan Mental Health Center in order to accommodate the increased demand for patient services.	6/30/84	- Staff hired and on duty	FLMHC	The additional staff are needed to increase the capacity of Fort Logan Mental Health Center to meet more of the demand for the mental health treatment of emotionally disturbed hearing-impaired citizens.
	(5) To have developed the state's capacity for mental health work force planning and training by funding a Division of Mental Health Human Resource Development Program.	6/30/84	- Program in place and operating	Program Services $75,000	This is a maintenance effort to assure the incorporation of necessary HRD capacity in the FY 1983-84 Division budget to replace resources previously provided under federal grants. A DMH Human Resources Development Program would include both an analytical/planning component and a building/maintenance (training) component.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #2					
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 expanded the statewide availability of vocational programs, including the development of new programs for demonstration efforts and the expansion of existing programs.	6/30/84	- Programs opened and in operation	Program Services $500,000	In the Division of Mental Health's assessment of treatment and support system program needs, the second highest priority (second to the need for residential facilities) was vocational services. In order to initiate the statewide availability of vocational services, funds need to be provided to develop new programs for a demonstration effort and to expand systems where limited programming exists.
	(2) To have implemented program and facility standards for residential and vocational services for community mental health centers.	6/30/84	- Center site visit reports indicating the extent to which standards have been implemented	Program Services CMHCs	The Division of Mental Health needs to ensure that the standards developed and adopted in FY 1982-83 are being implemented in the community mental health centers.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #3					
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 revised the system and operating plan to control and guide the Medicaid Waiver, consistent with a review of the first year's operation.	7/1/83	- Revised plan in place	Program Services Administrative Services	The plan needs to be reviewed each year and revised, as necessary, to ensure consistency with system operations.
	(2) To have reviewed the transfer of Medicaid funds from the Department of Social Services to the Department of Institutions and have recommended changes consistent with the findings of the review.	7/1/83	- Written report	Administrative Services	(2) - (3) A Memorandum of Understanding has been signed between the Department of Social Services and the Department of Institutions, providing for the transfer of Medicaid funding and program responsibility for those clients under the care of the Department of Institutions. The Division of Mental Health must implement the provisions of the agreement as it pertains to mental health clients.
	(3) To have implemented the revised provisions of the Memorandum of Understanding between the Department of Social Services and the Department of Institutions.	7/1/83	- Plan in place	Program Services	
	(4) To have increased the scope and number of clients served under the Medicaid Waiver, consistent with population growth and fiscal constraints under the Waiver.	7/31/83	- Increased program approved by the federal government	Program Services Administrative Services	The current Medicaid Waiver only provides for a portion of the population in need to be served. Program expansion is necessary to reach a larger proportion of those needing services.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(5) To have completed a report reviewing the effectiveness of the Medicaid Waiver.	6/30/84	- Report submitted to the federal government	Program Services Evaluation Services Administrative Services	The effectiveness of the Medicaid Waiver needs to be reviewed each year.
	(6) To have reviewed the effectiveness and the need for changes in the revised Memorandum of Understanding between the Department of Social Services and the Department of Institutions.	6/30/84	- Written report	Program Services Administrative Services	The Memorandum of Understanding will need to be reviewed each year for its effectiveness.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal #4					
TO ENSURE THE APPROPRIATE UTILIZATION OF FACILITIES AND FACILITY RESOURCES BY MENTAL HEALTH SYSTEM CLIENTS.	(1) To have installed a bag house and completed a study for construction of a solid waste boiler plant at Colorado State Hospital.	6/30/84	- Bag house installed - Written study completed	CSH $573,000	The bag house is an air pollution control device which reduces the particulate emissions in the atmosphere. The present boiler plant was constructed in 1908, and is in need of replacement to insure the most cost-effective means of generating power, while meeting ecological standards.
	(2) To have completed a property redevelopment master plan for Fort Logan Mental Health Center.	6/30/84	- Written plan and architectural design material	FLMHC $210,000	Fort Logan established a Long-Range Space Planning Committee to examine how the hospital's physical facilities were being used to meet the patient care requirements for the present and the future. The outcome of this project was the decision that a comprehensive written facilities plan; including architectural design material, was needed for Fort Logan Mental Health Center.
	(3) To have modified the bath and toilet facilities in Building 115 at Colorado State Hospital to meet patient needs.	6/30/84	- Remodeling of bath and toilet facilities completed	CSH $184,000	The current bath and toilet facilities do not meet patient needs, in view of the current mixture of sexes in this ward setting. This remodeling would allow greater flexibility in the use of existing beds and would provide increased patient privacy.
	(4) To have replaced the telephone system at Fort Logan Mental Health Center with an up-to-date system that meets the needs of the hospital.	6/30/84	- Replacement system installed and functioning	FLMHC $78,400	The present telephone system at Fort Logan is antiquated and inadequate. No new extensions or locals are available in some areas. System failures and repairs are frequent.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(5) To have remodeled the seclusion rooms in Buildings 108, 115, and 116 at Colorado State Hospital to provide the necessary safety for patient care.	6/30/84	- Seclusion rooms remodeled	CSH $35,000	The location and design of current seclusion rooms do not provide the necessary safety for patient care. The relocation and remodeling of the seclusion rooms would result in closer staff supervision and would facilitate improved patient care. Various outside review bodies have also commented on the need for this remodeling.
	(6) To have remodeled Buildings 16 and 17 for use as treatment facilities of the Institute for Forensic Psychiatry at Colorado State Hospital.	6/30/84	- Remodeling of buildings completed	CSH $724,000	The Medium Security Unit does not have treatment facilities available to its patients. These facilities are a must if treatment programs are to be conducted and are a Joint Commission on Accreditation of Hospitals requirement.
	(7) To have completed exterior repairs and insulated Buildings 16 and 17 at Fort Logan Mental Health Center.	6/30/84	- Repairs completed - Insulation installed	FLMHC $70,000	The Joint Commission on Accreditation for Hospitals (JCAH) recommended that these patient facilities be made more habitable. The current utility costs also are extremely high and could be reduced by these actions.
	(8) To have completed elevator safety modifications at Colorado State Hospital.	6/30/84	- Elevator safety modifications in place and operating.	CSH $105,000	A variety of modifications must be made to present elevators to meet standards for elevator safety established by reviewing bodies outside of the hospital.

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal # 5					
TO ENSURE THE DELIVERY OF HIGH QUALITY CLIENT CARE THROUGH THE EFFECTIVE FUNCTIONING OF ELEMENTS OF THE MENTAL HEALTH SYSTEM.	(1) To have developed the software necessary to allow the preparation and reporting of budgetary information to enhance the financial control capabilities of the mental health system.	6/30/84	- Budget document produced	Evaluation Services Administrative Services $30,000	The latest technology should be employed whenever possible to reduce manual calculations and clerical functions.
	(2) To have generated computer contract monitoring quarterly reports which include fiscal, program, and outcome information.	6/30/84	- Quarterly reports	Evaluation Services Administrative Services Program Services $20,000	More effective and efficient management of the system will be achieved through the integration of the various DMH data systems.
	(3) To have redefined, as necessary, the roles and functions of the two state hospitals and the community mental health centers in keeping with current goals, objectives, resources, and efforts toward the integration of the state mental health system.	6/30/84	- Written definitions relating to the roles and functions of the state hospitals and the CMHCs	Planning Services CSH FLMHC Program Services CMHCs	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 1983-84 GOALS AND OBJECTIVES

DIVISION OF MENTAL HEALTH GOALS	DIVISION OBJECTIVES FY 1983-84	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
System Goal # 6					
TO MAXIMIZE LIMITED RESOURCES BY COORDINATING THE PLANNING AND DELIVERY OF MENTAL HEALTH SERVICES WITH OTHER HUMAN SERVICE AGENCIES.	(1) To have conducted at least one statewide meeting with mental health service providers and law enforcement agencies.	10/31/83	- Written report of the meeting submitted to the Director of DMH	Program Services	Relationships between mental health service system providers and law enforcement are instrumental in providing accessible and appropriate crisis services, particularly with regard to the provisions of CRS 27-10.
	(2) To have conducted at least one symposium within the state involving service providers and others interested in mental health service delivery issues for children.	11/30/83	- Written symposium report submitted to the Director of DMH	Program Services CSH FLMHC	The Division of Mental Health has identified the need for a statewide network for children's services to review children's services in-state (including the state hospitals, the community mental health centers, and the private sector), as well as children's services out-of-state.

CHAPTER V. FINANCIAL SUMMARY FOR FISCAL YEAR 1982-83

OPERATING PLAN
DIVISION OF MENTAL HEALTH
INCOME & VARIANCE FOR 1982-83

	Federal	Cash Fund Patient Rev.	Cash Fund Approp.	Cash Fund Non-Approp.	Transfers	General Fund	Total Income
PERSONAL SERVICES:							
Appropriation		16,505,945	2,265,910		517,373	21,722,326	41,011,554
Central Pots		(287,341)				3,406,958	3,119,617
Transfers from Contr.						29,424	29,424
OPERATING EXPENSE:							
Appropriation					9,262	4,191,701	4,200,963
TRAVEL:							
Appropriation					5,182	25,520	30,702
CAPITAL OUTLAY:							
Appropriation		451,505			17,500	14,477	483,482
SPECIAL PURPOSE:							
Block Grant	71,986						71,986
Medicaid Monitoring			106,326				106,326
Manpower	105,521						105,521
CSS	43,522						43,522
TA Grants	7,981						7,981
CMHC's	2,849,000		4,328,572			18,131,206	25,308,778
Group Homes						428,619	428,619
Drug Treatment			1,337,182				1,337,182
Utilities						1,947,011	1,947,011
Relief Pool						416,888	416,888
Contractual Serv.						1,210,352	1,210,352
ARB			410,000				410,000
ESEA			82,000				82,000
PL 142				29,083			29,083
WICHE					15,000		15,000
TOTAL	3,078,010	16,670,109	8,529,990	29,083	564,317	51,524,482	80,395,991
Less Appropriated	3,074,141	16,505,945	8,683,156	-0-	564,317	47,975,322	76,802,881
TOTAL VARIANCE	3,869	164,164	(153,166)	29,083	-0-	3,549,160	3,593,110

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1982-83

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					CHILDREN'S PSYCHIATRY					
			1,075,674	58,593	Personal Services	1,134,267	283,567	283,567	283,567	283,566
				24,469	Operating Expense	24,469	6,117	6,117	6,117	6,118
				235	Travel	235	58	59	59	59
					Capital Outlay					
	7,271	110,300			Special Purpose	117,571	29,392	29,393	29,393	29,393
	7,271	110,300	1,075,674	83,297	TOTAL 46.46 FTE	1,276,542	319,134	319,136	319,136	319,136
					ADOLESCENT PSYCHIATRY					
			4,498,304	21,043	Personal Services	4,519,347	1,129,837	1,129,837	1,129,836	1,129,837
				76,272	Operating Expense	76,272	19,067	19,068	19,068	19,069
				885	Travel	885	221	221	221	222
					Capital Outlay					
	21,812	381,700		1,200	Special Purpose	404,712	101,178	101,178	101,178	101,178
	21,812	381,700	4,498,304	99,400	TOTAL 181.69 FTE	5,001,216	1,250,303	1,250,304	1,250,303	1,250,306
					ADULT PSYCHIATRY					
			4,694,960	2,702,131	Personal Services	7,397,091	1,849,273	1,849,272	1,849,272	1,849,274
				156,935	Operating Expense	156,935	39,234	39,234	39,234	39,233
				3,700	Travel	3,700	925	925	925	925
					Capital Outlay					
				84,050	Special Purpose	84,050	21,013	21,013	21,013	21,011
			4,694,960	2,946,816	TOTAL 280.86 FTE	7,641,776	1,910,445	1,910,444	1,910,444	1,910,443
					FORENSIC PSYCHIATRY					
			2,042,747	5,865,214	Personal Services	7,907,961	1,976,990	1,976,990	1,976,990	1,976,991
				184,029	Operating Expense	184,029	46,007	46,007	46,007	46,008
				1,200	Travel	1,200	300	300	300	300
					Capital Outlay					
				287,982	Special Purpose	287,982	71,996	71,996	71,996	71,994
			2,042,747	6,338,425	TOTAL 346.9 FTE	8,381,172	2,095,293	2,095,293	2,095,293	2,095,293
					GERIATRIC PSYCHIATRY					
			3,284,548	11,353	Personal Services	3,295,901	823,976	823,975	823,975	823,975
				219,443	Operating Expense	219,443	54,861	54,861	54,861	54,860
				2,100	Travel	2,100	525	525	525	525
					Capital Outlay					
					Special Purpose					
			3,284,548	232,896	TOTAL 127.5 FTE	3,517,444	879,362	879,361	879,361	879,360

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1982-83

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					GENERAL HOSPITAL AND MEDICAL SERVICES					
		474,112	909,712	2,213,024	Personal Services	3,596,848	899,212	899,212	899,212	899,212
				714,197	Operating Expense	714,197	179,596	179,596	179,597	179,598
				400	Travel	400	100	100	100	100
					Capital Outlay					
				466,425	Special Purpose	466,425	116,606	116,606	116,606	116,607
		474,112	909,712	3,394,046	TOTAL 131.51 FTE	4,777,870	1,195,514	1,195,514	1,195,515	1,195,517
					DRUG TREATMENT					
		1,113,617	223,565		Special Purpose	1,337,182	334,295	334,295	334,295	334,297
		1,113,617	223,565		TOTAL 47.8 FTE	1,337,182	334,295	334,295	334,295	334,297
					COMMUNITY CENTERS/CLINICS					
2,849,000		4,328,572		18,559,825	Special Purpose	25,737,397	6,434,349	6,494,349	6,434,349	6,434,350
2,849,000		4,328,572		18,559,825	TOTAL 0 FTE	25,737,397	6,434,349	6,434,349	6,434,349	6,434,350
					TREATMENT SUPPORT SERVICES					
		1,078,349		8,588,343	Personal Services	9,666,692	2,416,673	2,416,673	2,416,673	2,416,673
				1,690,246	Operating Expense	1,690,246	422,561	422,561	422,562	422,562
				10,298	Travel	10,298	2,574	2,574	2,575	2,575
					Capital Outlay					
				283,935	Special Purpose	283,935	70,983	70,984	70,984	70,984
		1,078,349		10,572,822	TOTAL 450.99 FTE	11,651,171	2,912,791	2,912,792	2,912,794	2,912,794
					ADMINISTRATION & GENERAL					
		713,449	(287,341)	6,216,386	Personal Services	6,642,494	1,660,623	1,660,623	1,660,624	1,660,624
				1,078,482	Operating Expense	1,078,482	269,620	269,620	269,621	269,621
				11,884	Travel	11,884	2,971	2,971	2,971	2,971
			451,505	31,977	Capital Outlay	483,482	120,870	120,870	120,871	120,871
229,010				2,465,659	Special Purpose	2,694,669	673,667	673,667	673,667	673,668
229,010		713,449	164,164	9,804,388	TOTAL 251.45 FTE	10,911,011	2,727,751	2,727,751	2,727,754	2,727,755
					TOTAL PROGRAMS					
		2,595,801	15,995,039	25,676,081	Personal Services	44,266,921	11,066,730	11,066,730	11,066,730	11,066,731
				4,200,963	Operating Expense	4,200,963	1,050,240	1,050,241	1,050,241	1,050,241
				30,697	Travel	30,697	7,674	7,674	7,674	7,675
			451,505	39,977	Capital Outlay	483,482	120,870	120,870	120,871	120,871
3,078,100	29,083	5,934,189	223,565	22,149,061	Special Purpose	31,413,998	7,853,499	7,853,499	7,853,500	7,853,500
3,078,100	29,083	8,529,990	16,670,109	52,088,779	TOTAL 1865.56 FTE	80,395,991	20,099,013	20,099,014	20,099,016	20,099,018

OPERATING PLAN
DIVISION OF MENTAL HEALTH - CENTRAL OFFICE
INCOME & VARIANCE FOR 1982-83

	Federal	General Fund	Cash Fund	Transfers	Total Income
PERSONAL SERVICES:					
Appropriation				524,866	524,866
Supplemental Anticipated					-0-
(1)OPERATING EXPENSE:					
Appropriation				9,262	9,262
TRAVEL:					
Appropriation				5,182	5,182
CAPITAL OUTLAY:					
Appropriation				17,500	17,500
SPECIAL PURPOSE:					
WICHE				15,000	15,000
(2)Block Grant	71,986				71,986
Medicaid Monitoring			106,326		106,326
(2)Manpower	105,521				105,521
(2)CSS	43,522				43,522
(2)TA Grants/Other	7,981				7,981
Community Centers/Clinics	2,849,000	18,131,206	(3)4,328,572		20,980,206
Group Homes		428,619			428,619
TOTAL	3,078,010	18,559,825	(3)4,434,898	571,810	22,315,971
Less: Appropriation	3,074,141	18,559,825	(3)4,394,986	571,810	22,272,190
TOTAL VARIANCE (4)	3,869	-0-	39,912	-0- (4)	43,781

(1) Excludes services supplied without fee by Fort Logan and Colorado State Hospital
(2) Includes roll forwards from prior year.
(3) Cash fund appropriation to revert.
(4) Variance funded through rollforward of Federal funds.

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1982-83
CENTRAL OFFICE

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					COMMUNITY MENTAL HEALTH					
					Special Purpose					
2,849,000		(1)4,328,572		18,131,206	Purchase of Service	20,980,206	5,245,052	5,245,052	5,245,051	5,245,051
				428,619	Group Homes	428,619	107,155	107,154	107,155	107,155
2,849,000		(1)4,328,572		18,559,825	TOTAL 0 FTE	21,408,825	5,352,207	5,352,206	5,352,206	5,352,206
					ADMIN & GENERAL SERVICES					
				524,866	Personal Services	524,866	131,216	131,216	131,217	131,217
				9,262	Operating Expense	9,262	2,315	2,315	2,316	2,316
				5,182	Travel	5,182	1,296	1,296	1,295	1,295
				17,500	Capital Outlay	17,500	4,375	4,375	4,375	4,375
229,010		106,326		15,000	Special Purpose	350,336	87,584	87,584	87,584	87,584
229,010		106,326		571,810	TOTAL 29.8 FTE	907,146	226,786	226,786	226,787	226,787
					TOTAL ALL PROGRAMS					
				524,866	Personal Services	524,866	131,216	131,216	131,217	131,217
				9,262	Operating Expense	9,262	2,315	2,315	2,316	2,316
				5,182	Travel	5,182	1,296	1,296	1,295	1,295
				17,500	Capital Outlay	17,500	4,375	4,375	4,375	4,375
3,078,010		(1)4,434,898		18,574,825	Special Purpose	21,759,161	5,439,791	5,439,790	5,439,790	5,439,790
3,078,010		(1)4,434,898		19,131,635	TOTAL 29.8 FTE	22,315,971	5,578,993	5,578,992	5,578,993	5,578,993

FTE General Fund 14.8
Cash Funds 15.0
Total 29.8

(1) $4,328,572 reverts

OPERATING PLAN
COLORADO STATE HOSPITAL
INCOME & VARIANCE FOR 1982-83

	FTE	Federal	Cash Fund Patient Revenue	Cash Fund Other	General Fund	Total Income
PERSONAL SERVICES:						
Appropriation	1252.1	-0-	9,798,704	2,265,910	16,397,936	28,462,550
Central Pots			(183,818)		2,372,297	2,188,479
OPERATING EXPENSES:						
Appropriation					2,807,241	2,807,241
TRAVEL:						
Appropriation					18,728	18,728
CAPITAL OUTLAY:						
Transfer			347,982			347,982
SPECIAL PURPOSE:						
Drug Treatment Program	47.8			1,337,182		1,337,182
Utilities					1,448,111	1,448,111
Relief Pool	16.8				343,388	343,388
Contractual Services					842,850	842,850
Authorized Revenue Base Program				230,000		230,000
ESEA	1.3			24,000		24,000
TOTAL	1318.0	-0-	9,962,868	3,857,092	24,230,551	38,050,511
Less Appropriated	1259.0	-0-	(9,798,704)	(4,050,170)	(21,730,529)	(35,579,403)
VARIANCE	59.0	-0-	164,164	(193,078)	2,500,022	2,471,108

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1982-83
COLORADO STATE HOSPITAL

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					CHILDREN'S PSYCHIATRY					
		439,054		52,258	Personal Services	491,312	122,828	122,828	122,828	122,828
				13,500	Operating Expense	13,500	3,375	3,375	3,375	3,375
				180	Travel	180	45	45	45	45
					Capital Outlay					
		50,800			Special Purpose	50,800	12,700	12,700	12,700	12,700
		489,854		65,938	TOTAL 20.61 FTE	555,792	138,948	138,948	138,948	138,948
					ADOLESCENT PSYCHIATRY					
		2,383,621			Personal Services	2,383,621	595,905	595,905	595,905	595,906
				43,365	Operating Expense	43,365	10,841	10,841	10,841	10,842
				720	Travel	720	180	180	180	180
					Capital Outlay					
		203,200		1,200	Special Purpose	204,400	51,100	51,100	51,100	51,100
		2,586,821		45,285	TOTAL 97.04 FTE	2,632,106	658,026	658,026	658,026	658,028
					ADULT PSYCHIATRY					
		1,879,994		1,838,884	Personal Services	3,718,878	929,719	929,719	929,719	929,721
				117,331	Operating Expense	117,331	29,333	29,333	29,333	29,332
				3,500	Travel	3,500	875	875	875	875
					Capital Outlay					
				84,050	Special Purpose	84,050	21,013	21,013	21,013	21,011
		1,879,994		2,043,765	TOTAL 143.80 FTE	3,923,759	980,940	980,940	980,940	980,939
					FORENSIC PSYCHIATRY					
		2,042,747		5,865,214	Personal Services	7,907,961	1,976,990	1,976,990	1,976,990	1,976,991
				184,029	Operating Expense	184,029	46,007	46,007	46,007	46,008
				1,200	Travel	1,200	300	300	300	300
					Capital Outlay					
				287,982	Special Purpose	287,982	71,996	71,996	71,996	71,994
		2,042,747		6,338,425	TOTAL 346.90 FTE	8,381,172	2,095,293	2,095,293	2,095,293	2,095,293
					DRUG TREATMENT					
					Personal Services					
					Operating Expense					
					Travel					
					Capital Outlay					
		1,337,182			Special Purpose	1,337,182	334,295	334,295	334,295	334,297
		1,337,182			TOTAL 47.80 FTE	1,337,182	334,295	334,295	334,295	334,297

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1982-83
COLORADO STATE HOSPITAL

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
					GERIATRIC PSYCHIATRY					
		2,143,576			Personal Services	2,143,576	535,894	535,894	535,894	535,894
				74,443	Operating Expense	74,443	18,611	18,611	18,611	18,610
				1,200	Travel	1,200	300	300	300	300
					Capital Outlay					
					Special Purpose					
		2,143,576		75,643	TOTAL 82.50 FTE	2,219,219	554,805	554,805	554,805	554,804
					GENERAL HOSPITAL & MEDICAL					
		1,383,824		1,672,589	Personal Services	3,056,413	764,104	764,104	764,104	764,101
				503,489	Operating Expense	503,489	125,872	125,872	125,872	125,873
				300	Travel	300	75	75	75	75
					Capital Outlay					
				466,425	Special Purpose	466,425	116,606	116,606	116,606	116,607
		1,383,824		2,642,803	TOTAL 113.86 FTE	4,026,627	1,006,657	1,006,657	1,006,657	1,006,656
					TREATMENT SUPPORT SERVICES					
		1,078,349		5,522,166	Personal Services	6,600,515	1,650,129	1,650,129	1,650,129	1,650,128
				1,227,540	Operating Expense	1,227,540	306,885	306,885	306,885	306,885
				7,678	Travel	7,678	1,919	1,919	1,919	1,921
					Capital Outlay					
				283,935	Special Purpose	283,935	70,984	70,984	70,984	70,983
		1,078,349		7,041,319	TOTAL 313.50 FTE	8,119,668	2,029,917	2,029,917	2,029,917	2,029,917
					ADMINISTRATION & GENERAL					
		713,449		3,635,304	Personal Services	4,348,753	1,087,188	1,087,188	1,087,188	1,087,189
		(183,818)		827,362	Operating Expense	643,544	160,886	160,886	160,886	160,886
				3,950	Travel	3,950	988	988	988	986
		347,982			Capital Outlay	347,982	86,995	86,995	86,996	86,996
				1,510,757	Special Purpose	1,510,757	377,689	377,689	377,689	377,690
		1,061,431		5,793,555	TOTAL 152.05 FTE	6,854,986	1,713,746	1,713,746	1,713,747	1,713,747
					ALL HOSPITAL PROGRAMS					
		11,880,796		18,770,233	Personal Services	30,651,029	7,662,757	7,662,757	7,662,757	7,662,758
				2,807,241	Operating Expense	2,807,241	701,810	701,810	701,810	701,811
				18,728	Travel	18,728	4,682	4,682	4,682	4,682
		347,982			Capital Outlay	347,982	86,995	86,995	86,996	86,996
		1,591,182		2,634,349	Special Purpose	4,225,531	1,056,383	1,056,383	1,056,383	1,056,382
		13,819,961		24,230,551	TOTAL 1318.06 FTE	38,050,511	9,512,627	9,512,627	9,512,628	9,512,629

OPERATING PLAN
FORT LOGAN MENTAL HEALTH CENTER
INCOME & VARIANCE FOR FY 82-83

	Cash Fund Patient Rev.	Cash Fund Approp.	General Fund	Non-Approp.	Total Income	FTE
PERSONAL SERVICES						
Appropriation	6,707,241		5,324,390		12,031,631	
POTS	(103,523)		1,027,168		923,645	
Subtotal Personal Services	6,603,718		6,351,558		12,955,766	508.0
Transfer from Contractual			29,424		29,424	
			6,380,982		12,984,700	
OPERATING EXPENSE						
Appropriation			1,384,460		1,384,460	
TRAVEL						
Appropriation			6,792		6,792	
CAPITAL OUTLAY						
Appropriation	103,523		14,477		118,000	
SPECIAL PURPOSE						
Utilities			498,900		498,900	
ESEA		58,000			58,000	3.8
Authorized Revenue Base		180,000			180,000	
PL 142 Discretionary				29,083	29,083	
Relief Staff			73,500		73,500	4.9
Contractual Services			367,502		367,502	
	6,707,241	238,000	8,726,613	29,083	15,700,937	516.7
LONG BILL:	6,707,241	238,000	7,684,968	-0-	14,630,209	516.7
TOTAL VARIANCE:	-0-	-0-	1,041,645	29,083	1,070,728	

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1982-83
FORT LOGAN MENTAL HEALTH CENTER

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund	FTE		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
						CHILDREN'S PSYCHIATRY					
			636,620	6,335	24.9	Personal Services	642,955	160,739	160,739	160,739	160,738
				10,969		Operating	10,969	2,742	2,742	2,742	2,743
				55		Travel	55	13	14	14	14
	7,271	59,500			.95	Special Purpose	66,771	16,692	16,693	16,693	16,693
	7,271	59,500	636,620	17,359	25.85	TOTALS	720,750	180,186	180,188	180,188	180,188
						ADOLESCENT PSYCHIATRY					
			2,114,683	21,043	81.8	Personal Services	2,135,726	533,932	533,932	533,931	533,931
				32,907		Operating	32,907	8,226	8,227	8,227	8,227
				165		Travel	165	41	41	41	42
	21,812	178,500			2.85	Special Purpose	200,312	50,078	50,078	50,078	50,078
	21,812	178,500	2,114,683	54,115	84.65	TOTALS	2,369,110	592,277	592,278	592,277	592,278
						ADULT PSYCHIATRY					
			2,814,966	863,247	137.06	Personal Services	3,678,213	919,554	919,553	919,553	919,553
				39,604		Operating	39,604	9,901	9,901	9,901	9,901
				200		Travel	200	50	50	50	50
						Special Purpose					
			2,814 966	903,051	137.06	TOTALS	3,718,017	929,505	929,504	929,504	929,504
						GERIATRICS/AFTERCARE/DEAF PROG					
			1,140,972	11,353	45.0	Personal Services	1,152,325	288,082	288,081	288,081	288,081
				145,000		Operating	145,000	36,250	36,250	36,250	36,250
				900		Travel	900	225	225	225	225
						Special Purpose					
			1,140,972	157,253	45.0	TOTALS	1,298,225	324,557	324,556	324,556	324,556
						GEN. HOSP. & MEDICAL SERVICE					
				540,435	17.65	Personal Services	540,435	135,109	135,109	135,109	135,108
				210,708		Operating	210,708	52,677	52,677	52,677	52,677
				100		Travel	100	25	25	25	25
						Special Purpose					
				751,243	17.65	TOTALS	751,243	187,811	187,811	187,811	187,810

DIVISION OF MENTAL HEALTH
OPERATING PLAN FOR 1982-83
FORT LOGAN MENTAL HEALTH CENTER

Federal Funds	Cash Fund Non-Approp.	Cash Fund Approp.	Cash Fund Patient	General Fund	FTE		Total Budget	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
						TREATMENT SUPPORT SERVICE					
				3,066,177	137.49	Personal Services	3,066,177	766,544	766,545	766,544	766,544
				462,706		Operating	462,706	115,676	115,676	115,677	115,677
				2,620		Travel	2,620	655	655	655	655
						Special Purpose					
				3,531,503	137.49	TOTALS	3,531,503	882,875	882,876	882,876	882,876
						ADMIN/BUSINESS/PERSONNEL					
			(103,523)	1,872,398	69.6	Personal Services	1,768,875	442,218	442,218	442,219	442,220
				425,676		Operating	482,566	120,642	120,642	120,641	120,641
				2,752		Travel	2,752	688	688	688	688
			103,523	513,377		Special Purpose	616,900	154,225	154,225	154,225	154,225
			-0-	2,814,203	69.6	TOTALS	2,871,093	717,773	717,773	717,773	717,774
						STAFF RELIEF - POOL					
				73,500	4.9	Relief Staff	73,500	18,375	18,375	18,375	18,375
				73,500	4.9	TOTALS	73,500	18,375	18,375	18,375	18,375
						CONTRACTUAL SERVICES					
				367,502		Contractual Services	367,502	91,875	91,876	91,876	91,875
				367,502		TOTALS	367,502	91,875	91,876	91,876	91,875
						TOTAL HOSPITAL PROGRAMS					
			6,603,718	6,380,982	509.0	Personal Services	12,984,700	3,246,175	3,246,175	3,246,175	3,246,175
				1,384,460		Operating	1,384,460	346,113	346,114	346,115	346,118
				6,792		Travel	6,792	1,697	1,698	1,698	1,699
	29,083	238,000	103,523	513,377	3.8	Special Purpose	883,983	220,995	220,996	220,996	220,996
				367,502		Contractual Services	367,502	91,875	91,876	91,876	91,875
				73,500	4.9	Relief Staff	73,500	18,375	18,375	18,375	18,375
	29,083	238,000	6,707,241	8,726,613	517.7	TOTALS	15,700,937	3,925,230	3,925,234	3,925,235	3,925,238

CHAPTER VI. THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF SERVICE

1. State Mental Health Authority

Mental health services are available to the residents of Colorado through a number of service facilities located throughout the state. The service facilities which comprise the spectrum of available services include state-owned facilities, agencies that contract with the state, private treatment resources, and voluntary mental health resources.

The Department of Institutions is designated the official mental health and mental retardation authority and is authorized to receive grants-in-aid from the federal government under the provisions of 42 USC 246, and administers such grants in accordance therewith (CRS 27-1-106, 1973).

The Executive Director of the State Department of Institutions is appointed by the Governor with the consent of the Senate and serves as a confidential employee of the Governor. The Department has three major divisions: (1) Mental Health; (2) Developmental Disabilities; and (3) Youth Services. The Director of the Division of Mental Health is appointed by the Executive Director of the Department of Institutions. The Director of the Division of Mental Health (DMH) is responsible for planning, organizing, and directing the state's mental health program for the prevention and treatment of mental and emotional disorders.

The Department of Institutions has delegated to the Division of Mental Health the authority to operate the two state mental hospitals, to purchase services from community mental health centers/clinics and other human service oriented agencies, to regulate facilities designated as 72-hour treatment and evaluation facilities, and to otherwise plan for and direct the mental health program. The Division of Mental Health is responsible for coordination which involves the facilitation of cooperative activities among and between components of the Colorado mental health services delivery system and other human service agencies to meet the various mental health service needs of the residents of the state.

The exercise of authority as an agent of the State Executive, including the establishment and enforcement of policies, rules and regulations, is encompassed in the Division's responsibility for executive direction. The Division of Mental Health has responsibility for regulating designated agencies and for monitoring the programs and services of the state mental hospitals and the community mental health centers and clinics to ensure compliance with standards, to assess the quality of services, and to assist the agencies in improving services.

Program and financial management are primary functions of the Central Office of the Division. Administrative Services has responsibility for budget development and administration, grants management, development of unit costs and reimbursement rates for centers and clinics, accounting and auditing, the fiscal sections of contracts, and Central Office expenditures. Administrative Services also manages the support needs and

facility operations of the Division.

Program Services assesses statewide mental health service needs, determines how those needs might best be met, and ensures that agency contracts are designed to address the identified service needs. Assessing agencies' compliance with standards, regulations, and contract commitments is a function of Program Services. The Division emphasizes accountability of mental health services and provides, through Program Services, necessary leadership in the management of quality control systems. Included under Program Services are special projects for human resources development and for establishing a range of treatment and support systems for seriously, critically, and chronically disabled clients. The community support project enables the state to more actively put in place a framework for care that is the heart of rehabilitating the emotionally disabled.

Another central function of the Division is planning. This function involves not only statewide planning for mental health, but also focuses on integrating planning efforts at the local level and with other human service and health planning agencies. Planning Services is involved with short-term, functionally-oriented planning associated with the preparation of annual operating plans. This section also has responsibility for strategic planning which focuses on the development of systemwide priorities and longer range goals that serve as operating guidelines for the state mental health system. Planning is a process intricately involved with the State Mental Health Council and with other agencies.

Evaluation Services provides leadership in the development of methodologies to assess the population in need of services statewide and to measure the impact of treatment efforts. An area highly interrelated with the evaluation function is the management information system which provides the data base for decision making.

The two state hospitals are actively involved in Division policy development. They play a key role in the process of integrating services and continue to increase their responsibilities related to continuity of care and coordination of services.

The Division provides consultation on planning, programming, funding and evaluation to all components of the system, to the Governor's office and to other state offices and agencies. There is also a focus on advocacy functions which involve initiating and promoting the development of high quality, reasonable cost mental health programs to serve clients most in need in a manner that protects their privacy, dignity, and rights.

2. Definitions

a. Mental Health Services: services designed to ameliorate or prevent mental illness. Such services include, but are not limited to, inpatient, 24-hour emergency, outpatient, screening and referral, follow-up care, consultation and education, partial hospitalization and other 24-hour care.

b. Emergency Services: services aimed at the reduction of acute emotional disabilities and their physical and social manifestations.

c. Screening: the process of evaluating persons believed to be in need of mental health care to determine what type or

intensity of care, if any, is appropriate.

d. Outpatient Services: treatment services which are generally less intensive and of shorter duration per treatment episode than partial care (hospitalization). Services include, but are not limited to, diagnostic evaluations and treatment with special emphasis on populations most in need; diagnostic, screening and referral services for courts and other appropriate agencies and organizations; and follow-up and aftercare for residents from the area released from inpatient facilities and other treatment programs.

e. Partial Care (Hospitalization) Services: treatment services which are generally of a more intensive nature than outpatient services, and which involve more than two hours, but less than 24 hours of care per daily therapeutic episode, with the exception of sheltered workshop contacts which may be of any length.

f. Other 24-Hour Care: residential care for patients who need 24-hour care but clinically or medically do not require formal hospitalization.

g. Inpatient Services: in-hospital, 24-hour care at a hospital licensed by the Colorado Department of Health.

h. Follow-Up Care/Aftercare: care provided to a patient after discharge from a formal treatment program. Follow-up care may take the form of such services as ongoing outpatient contacts, medication checks, resocialization groups, and is aimed at supporting and increasing the patient's level of functioning.

i. Consultation Services: assistance given to other human service agencies, health care professionals, and human service-oriented groups to assist them in better meeting the mental health service needs of their patients.

j. Education Services: efforts to inform professionals and laypersons about any aspect of mental health, mental health problems, and mental health services.

k. Prevention Services: efforts to help persons or organizations acquire knowledge, attitudes, and behavior patterns that help prevent mental illness and foster mental well-being. There is no universally accepted definition of primary prevention for mental health. Primary prevention embraces a broad range of activities which often are considered to include efforts to prevent problems before they occur and attempts to eliminate the causes of mental disabilities or disorders.

l. Catchment Area: a geographic mental health service area designated by the Division of Mental Health.

m. Catchment Area Community Mental Health Center: a community-based agency which is designated by the Division of Mental Health as the center responsible for providing comprehensive community mental health services in a specified geographic area. A center provides a range of mental health services which include at least inpatient, 24-hour emergency, outpatient (includes screening and follow-up), other 24-hour care, partial care, and consultation and education services. The catchment area center may provide comprehensive community mental health services directly or through agreements with

affiliates.

n. Affiliate: any agency or alternate treatment facility which contracts with a center/clinic approved under the Division of Mental Health Standards/Rules and Regulations for Mental Health Centers and Clinics.

o. Specialized (Specialty) Clinic: a community mental health clinic, approved by the Division of Mental Health for the purchase of services, which does not serve a specific catchment area.

p. Community Support System: a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community.

q. Case Management: services performed by an individual or a team which include responsibility for reviewing cases, setting treatment goals, designing treatment plans, coordinating the necessary components of the plan, monitoring the treatment, and retaining responsibility for the enrolled clients' treatment. Case managers may be mental health professionals, paraprofessionals, or volunteers.

3. Geographical Area for Planning

The Division of Mental Health is responsible for statewide mental health planning. Mental health service or "catchment" areas have been established in every state. A mental health service or catchment area is defined as "a geographic area for which there is a designated responsibility for community mental health services." Colorado has designated 20 catchment areas. A specific community mental health center has been designated the catchment area center. The catchment area center has primary responsibility for providing a full range of community mental health services to its catchment area. These services may be provided directly by the center or by an affiliate of the catchment area center.

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

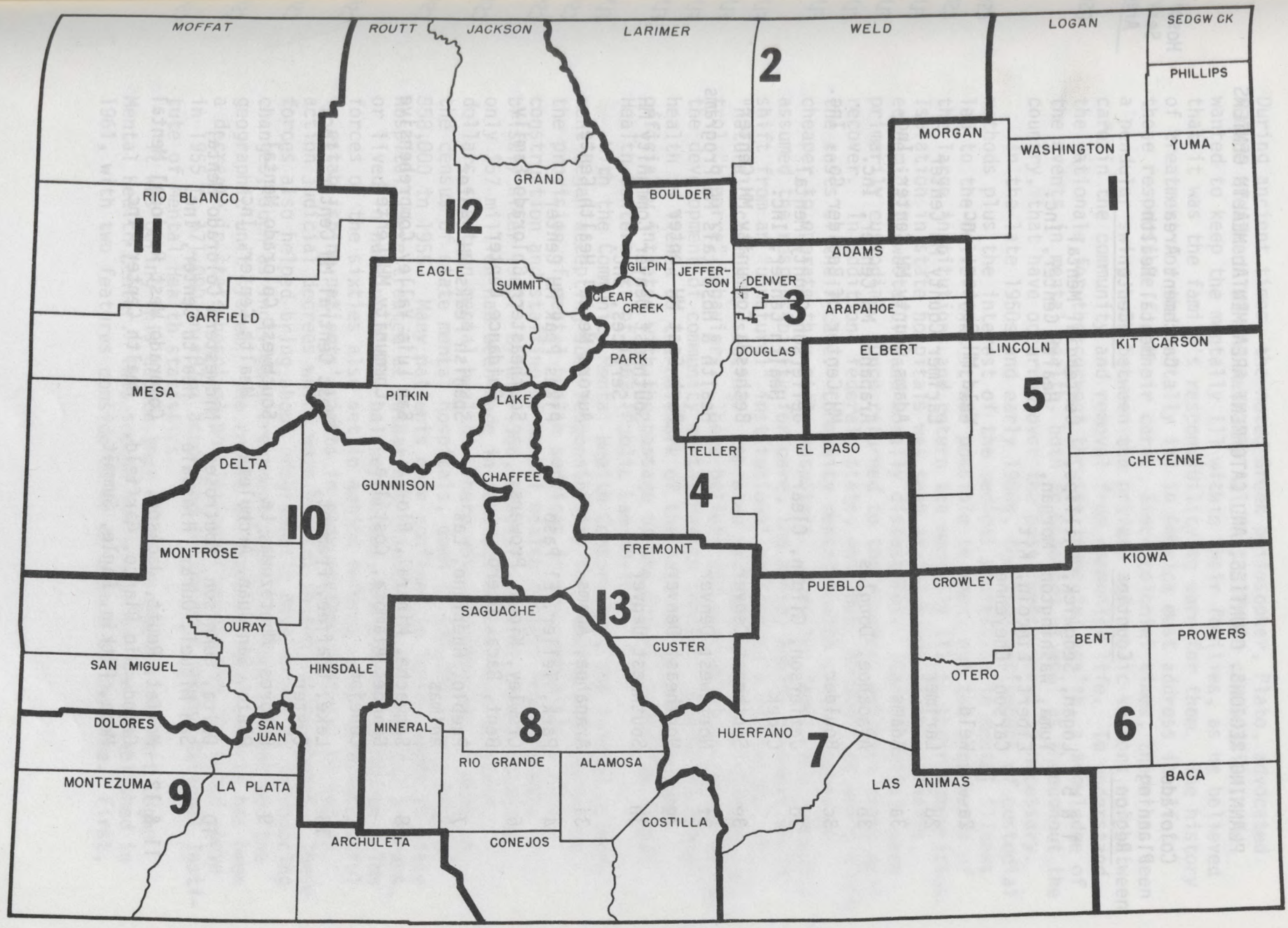
a. Colorado Planning Regions: There are 13 State Planning Regions (see map, page VI.5). These regions were in existence prior to the passage of Public Law 93-641, which required the designation of Health Service Areas. The future role of the Planning Regions is not clear. They continue to be viable entities for planning purposes because they are more manageable than 63 counties.

b. Counties: Colorado's 104,247 square miles and 2.9 million population are distributed over 63 counties (see map, page VI.5).

c. Catchment Areas: Each of the 20 catchment areas is comprised of one or more counties, with the exception of Denver, which is divided into four catchment areas. The chart on page VI.6 shows the relationships among Colorado Planning Regions, counties, catchment area mental health centers, and state hospitals.

B. BACKGROUND

The concept of community mental health is not a recent development.



COLORADO PLANNING REGIONS

PLANNING REGIONS, COUNTIES, AND CATCHMENT AREA MENTAL HEALTH CENTERS

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

During ancient times, the noted Greek philosopher, Plato, advocated humane treatment of the mentally ill in their own communities. He wanted to keep the mentally ill within their families, as he believed that it was the family's responsibility to care for them. The history of treatment for the mentally ill in America must address itself to those responsible for their care. Since colonial times, there has been a pendular swing both between the private and public sectors and between care in the community and removal from community life. To understand the rationale for the current thrusts in mental health, a knowledge of the events in mental health, both in Colorado as well as throughout the country, that have occurred over the past twenty years is necessary.

In the late 1950s and early 1960s, the ineffectiveness of custodial methods plus the interest of the medical profession in mental illness led to the belief that it was possible to empty out the back wards of the large institutions and return the mentally ill to their communities. Isolation in state hospitals was seen as injurious to the patients, economically wasteful, and morally distasteful. State hospitals were primarily custodial. Once returned to their homes, patients might well recover. In addition, federal, state, and local communities would share the costs of their care. Community mental health centers appeared cheaper to operate than state hospitals. When the family and community assumed the responsibility for care, the mental health movement would shift from an "unnatural" institutional setting to a more normal or "natural" community setting. Improved medication was available to control "bizarre" behaviors. These beliefs and circumstances precipitated the development of community mental health centers. Community mental health is viewed as the hallmark of the last two decades and was officially intiated with the passage of the Federal Community Mental Health Centers Act of 1963 (Public Law 88-164).

With the Community Mental Health Centers Act, the federal government began accepting some responsibility for funding and overseeing the provision of mental health services in the communities. The construction and staffing of mental health centers moved forward briskly after 1963. By mid-1966, however, federal grants totaling only $57 million had been made in contrast to billions of state dollars spent on mental health. There was, nevertheless, a drop in the census of state mental hospitals, down to 408,000 from a high of 558,000 in 1955. Many patients once confined in locked wards in state hospitals were treated at outpatient clinics, in day hospital programs, or lived in nursing homes, halfway houses, and quarterway houses. The forces of the sixties also set in action reforms which were successful in establishing patients' rights in many states' statutes or set in action judicial decrees which were helpful in abolishing abuses. These forces also helped bring about programmatic development by introducing changes, such as individual treatment plans for each patient and the geographic unit system. The result of these national efforts has been a decrease in state hospital populations from the 558,000 noted above in 1955 to 171,000 in 1976, according to the most recent National Institute of Mental Health statistics.

It was during this decade that Colorado created the Fort Logan Mental Health Center. This second state hospital was established in 1961, with two features considered to be unique at the time. First,

it was a modern facility, located at the edge of the central population site. Its second unique feature was that it had a community-oriented approach which implemented all the advanced thinking of the time. Fort Logan drew national acclaim to itself and to Colorado. A short time later, following the planned transition to community-based services, Colorado State Hospital (established October 12, 1879) received similar recognition. For years, both state hospitals were actively involved in "deinstitutionalizing" their chronic populations. Because of their successful efforts, the two Colorado mental hospitals have completed "deinistitutionalization" and are now focusing on preventing inappropriate hospitalization of new admissions and returning appropriately hospitalized clients to their normal living environments, after intensive psychiatric treatment.

The residential populations in the two state hospitals have decreased drastically. It appears, however, that this rate of decline is slowing down. Several factors seem to be involved. First of all, admissions have remained stable or have even increased over time (2625 admissions to CSH in 1964-65 as compared to 3086 in 1980-81). This increase in admissions mirrors the increase in the state's population. The hospitals continue to see as many or more patients today as they did several years ago. Reductions in populations have been achieved by decreasing the length of stay of patients. Secondly, most of the "easy" placements have been made. The third factor is that hospitals are now having to treat a population of extremely difficult patients.

Changes in public policies and attitudes may have "fueled" reforms for the treatment of the mentally ill by professionals. This treatment by professionals, however, was often conceptualized primarily as taking place in a specific physical location. The physical location might have changed (i.e., to the community from the isolated institution), but treatment by mental health professionals is still, by and large, conceptualized within a structure. Seldom is treatment thought of as being the total daily life of the client within the community.

How far we can go in avoiding the buildup of institutional populations is a question that cannot be answered until the issue of how the family and/or community can be helped to deal with the problems encountered daily with the mentally ill. While mental health ideology may be coherent, services provided to clients in the community can often be sporadic and fragmentary. All too frequently the burden that had been the hospital's has been shifted to the family and the community with only a limited attempt to provide solutions.

A cost-benefit study of a community mental health program in another state went so far as to consider burdens imposed by clients on family members and others in the community as a "cost" of conducting the program. The mental health system is designing programs to minimize family and community burden by providing clients with the support they need to survive and support to the families of these clients. A key to the success of any type of community program for chronically mentally disabled individuals is aggressive and timely intervention before client problems become devastating. Colorado has been addressing this issue for some time and has developed a foundation for building programs which are of high quality, meet the needs of the clients, are cost effective, protect the clients' rights and their families,

and are designed to fit into the community with the community's consent and involvement.

C. STANDARDS

Authority for the Department of Institutions to promulgate rules and regulations relating to community mental health services is contained in CRS 1973, 27-1-202(b), 27-1-204(1), and 27-1-205(3). The Standards/Rules and Regulations for Mental Health Centers and Clinics were revised and adopted by the Executive Director of the Department of Institutions in November, 1981, following a duly noticed public hearing held on September 15, 1981, pursuant to 24-4-103, CRS 1973. The Colorado Attorney General's Office reviewed the Standards/Rules and Regulations and found them to be within the authority of the Executive Director of the Department of Institutions to promulgate and without statutory or constitutional deficiencies. Copies of the Standards/Rules and Regulations for Mental Health Centers and Clinics were widely distributed. Additional copies may be obtained from the Colorado Division of Mental Health.

In addition to the above, the Department of Institutions has promulgated rules for the care and treatment of mentally ill persons who have been detained involuntarily. The authority for the promulgation of the Rules and Regulations of the Colorado Department of Institutions Concerning the Care and Treatment of the Mentally Ill, Adopted Pursuant to CRS 27-10-101, et seq., as Amended, is found in CRS 27-10-126. Following a notice of September 29, 1977, and the public hearing on November 4, 1977, the rules were adopted and became effective on May 30, 1978. A copy of this document may also be obtained from the Colorado Division of Mental Health.

These standards/rules and regulations which apply to centers, clinics, and hospitals have a profound impact on the state mental health system. Both documents have been reviewed and approved by the Attorney General's Office.

The Joint Commission on Accreditation of Hospitals (JCAH) Standards also have an impact on the state mental health system. These standards are available from JCAH.

D. DESCRIPTION OF THE PRESENT SYSTEM

1. Mental Health Services

The full range of mental health services may be considered to include:

a. inpatient, outpatient, 24-hour emergency, partial hospitalization, and consultation and education services;
b. preadmission screening and referral;
c. aftercare or follow-up services;
d. other 24-hour care;
e. case management services;
f. services to children, adolescents, adults, and the elderly;
g. services to ethnic, racial, and other minorities;

h. services to seriously, critically, and chronically mentally disabled individuals;
i. appropriate vocational, activity, recreational, and occupational therapies;
j. substance abuse services (these services must be provided in accordance with the state plan developed by the state Division of Alcohol and Drug Abuse, the statutory state alcohol and drug abuse authority);
k. other services determined by local needs and the requirements of federal, state, and other funding agencies.

Mental health service providers obviously vary in their ability to provide the above services. The service facilities which provide this array of mental health services, including the state-funded, private/voluntary sectors, are identified as follows:

2. State-Owned Facilities and Agencies Contracting with the State
   a. Colorado State Hospital is located in Pueblo, and serves fifty-five counties.
   b. Fort Logan Mental Health Center is located in southwest Denver, and serves the Denver metropolitan area.
   c. There are twenty-four mental health centers and clinics from which the state purchases mental health services. Twenty centers serve specific catchment areas, and four clinics are specialty programs. A center is defined as an agency which provides at least the five "essential" services defined in state statutes (inpatient, partial hospitalization, outpatient, 24-hour emergency care, and consultation and education). A clinic provides fewer than the five essential services, but must, at a minimum, provide outpatient, consultation and education and emergency services. All centers and clinics are private, non-profit corporations except the Larimer County Mental Health Center and the Denver Health and Hospitals Mental Health Program, both of which are county agencies.
   d. The University of Colorado's University Hospital is located in Denver on the University of Colorado Health Sciences Center campus. In addition to serving as a resource for complex medical/psychiatric services throughout the state, it also serves as a back-up to many of the metropolitan Denver area mental health centers.
3. Private/Voluntary Treatment Resources
   a. Four private psychiatric hospitals and over a score of private general hospitals which have psychiatric wards or which will accept psychiatric patients exist.
   b. Mental health clinics and other non-hospital mental health treatment facilities which do not have contractual arrangements with the Department of Institutions are available resources.
   c. Private practitioners (nurses, social workers, psychologists, pastoral counselors, psychiatrists, etc.) form a multitude of resources.
   d. Other resources include the following:
      (1) volunteer agencies which provide treatment and/or personal counseling services (These include Human Services Incorporated, Jewish Family and Children's Service, Catholic

Community Services, and Lutheran Service Society);

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

(3) sheltered workshops which provide such services as evaluation, work activity, short- and long-term work adjustment programs, sheltered employment, work stations in industry, and placement. Many of these workshops are geared specifically for psychiatric patients;

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

4. 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 State Plan, 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 that 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% 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.)

E. 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 VI.16 of this chapter.

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

The Council has met on a monthly basis since its formation. Minutes

have been kept of all meetings (copies of the minutes of the meetings held this past year are available from the Division of Mental Health). The activities of the Council during the first year included the election of officers, the development of bylaws, and review of the State Plan. Council members also appointed two permanent subcommittees, the Executive and Budget Subcommittees, and several ad hoc committees. Presentations were given by various DMH staff specialists which enabled the Council to gain a better understanding of the function of the mental health system and how the various staff activities relate to the State Plan. Members of the Council visited the two state hospitals, Fort Logan Mental Health Center and Colorado State Hospital. The Council gave special attention to a legislatively mandated study of placement facilities for disturbed children, and requested and received a presentation from the Colorado Association of Community Mental Health Centers and Clinics. The Budget Subcommittee participated in a detailed review of the Division's recommendations for funding, following which the Council directed letters to the Governor and the Joint Budget Committee of the state legislature concerning the funding needed for mental health services. Council members reviewed the suggestions received from various agencies and organizations concerning the update of the State Plan.

In its second year the Council continued to become better acquainted with the state mental health system. Many members of the Council attended the annual state mental health conference. The Council also arranged for presentations from the voluntary sector, the centers and clinics association, the Mental Health Association, and the health systems agencies. The Budget Subcommittee of the Council reviewed the Division's recommendations for funding needed for mental health services for that year and participated in the presentation of the Division's request to the Joint Budget Committee of the state legislature.

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

In its fourth year, the Council focused its attention on the State Mental Health Plan, the Division's budget, public awareness issues, and Division grants. Members of the Council also were involved in developing the guidelines for the catchment area mental health plans. The State Plan Committee reviewed the twenty catchment area mental health plans and determined how the plans would be integrated into the State Plan.

In FY 1980-81, the Council held ten monthly meetings. The activities of the Council included revising the Council bylaws and reorganizing 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 past year, the Council again focused a great deal of attention on the State Mental Health Plan, the Division's budget request, and legislative issues. The lack of adequate forensic facilities at Colorado State Hospital was a special concern addressed by the Council, especially since it resulted in the temporary chaining of patients in the surgery ward. Staff members from Colorado State Hospital attended the September Council meeting and gave a presentation on the Institute for Forensic Psychiatry. In December, members of the Council visited Colorado State Hospital.

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. The Council also will continue to focus on legislative issues which impact mental health.

COMPOSITION OF COLORADO MENTAL HEALTH COUNCIL

Name & Term (Expiration Date)	Sex: Female	Sex: Male	Ethnic Background: Asian Amer.	Ethnic Background: Black	Ethnic Background: Chicano	Ethnic Background: Native Amer.	Ethnic Background: White	Place of Residence	Type of Residence: Rural	Type of Residence: Urban	Type of Residence: Suburban	Class of Membership: Consumer	Class of Membership: Provider	Class of Membership: Nongov't. Org.	Class of Membership: State Agency	Occupation & Type of Employment
Alice Archibald 82	X						X	Durango	X				X			Director, Southwest Colorado MHC
Guidotta Bates 83	X						X	Brush	X			X				Consumer
Mike Coren 82		X					X	Englewood			X			X		Colorado Mental Health Association
Lucy May Dame 83	X						X	Denver		X		X				Senior Citizens' Board
Dorothea Dolan 82	X						X	Denver		X		X				Retired
Melanie Fairlamb 82	X						X	Delta	X			X				Consumer
Ruth Fuller 82	X			X				Denver		X					X	UCHSC, Department of Psychiatry
Jerry Goebel 82		X					X	Boulder			X		X			Boulder Psychiatric Institute
Alma Lantz 83	X						X	Denver		X		X				Consumer
Lois Moll 83	X						X	Denver		X		X				Consumer
Robert Nuffer 83		X					X	Glenwood Springs	X				X			Colorado West Mental Health Center
Jack Quinn 83		X					X	Pueblo		X		X				Pueblo Housing Authority
Roger Richter 82		X					X	Denver		X		X				Insurance
Rick Sanchez 83		X			X			Alamosa	X			X				Consumer
Patricia Schlatter 82	X						X	Salida	X			X				Consumer
Randy Stith 82		X					X	Aurora			X		X			Colo. Assn. of Community MH Centers
Richard Suinn 82		X	X					Fort Collins			X		X			CSU, Department of Psychology
Jennie Villegos 83	X				X			Denver		X			X			Servicios de la Raza
Dorothy Witherspoon 82	X						X	Denver		X		X				Consumer
Robert Young 82		X					X	Boulder			X				X	DSS, Division of Rehabilitation
Cece Zavala-Martinez 83	X				X			Rocky Ford	X			X				Otero Juvenile Diversion Counselor

CHAPTER VII. STATE HOSPITALS AND THE CATCHMENT AREA MENTAL HEALTH PROGRAM

A. INTRODUCTION

The Treatment and Support System Model has been developed and adopted by the Colorado mental health system because it is a model which views the system as a whole. While the original community mental health model was based upon the concept of establishing a full range of services in the community for the adequate care and treatment of the chronically mentally ill 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. Instead, the issues for mental health must be addressed on a systemic basis, as a situation that impacts one component of the system has a ripple effect on other components. Clients may move from one service setting and provider to another. A client, for example, may receive outpatient services at a community mental health center, experience a period of severe dysfunction and be placed in a hospital for intensive psychiatric care, then be returned to the community via a halfway house or a cooperative apartment, with outpatient services from the community mental health center. Since clients receive services from a network of service providers, the various providers must be integrated programmatically and financially and must address the issues for mental health as an integrated system. The key point is that services must be available from both the state mental hospitals and the community mental health centers. The roles and responsibilities of each of these components of the system must be defined in terms of how the roles should be integrated and in terms of how the roles should be differentiated.

B. SCREENING

1. Role of Hospitals and Centers

The DMH policy is that to the fullest extent possible, all persons who are believed to be in need of mental health services will be screened or evaluated by the appropriate catchment area center. In order to facilitate the operationalization of this policy, Continuity of Care Committees, which include representatives of the state hospitals and centers have been formed in each hospital service area. The two state hospitals developed criteria for admission to inpatient care. The Committees adopted those criteria and developed guidelines for facilitating easy movement and continuous care for clients within the system. Policy statements based on the Committees' work have been prepared and issued by the DMH Central Office. The Continuity of Care Committees are permanent bodies which have the responsibility for monitoring the system and assisting in the resolution of any problems that might arise.

The preadmission screening of youth is also the primary responsibility

of the centers; however, the Colorado Children's Code specifies that the courts may use their discretion in bypassing centers and ordering the child directly to the hospital when appropriate.

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

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

2. Procedure for Screening by Centers

   a. All catchment area centers shall inform the district courts, social service departments, and other major referral sources in the catchment area of the center's responsibility for preadmission screening of all potential inpatient clients.

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

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

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

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

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

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

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

      The decision regarding the type or locus of treatment is basically a clinical judgment, in that by state statute, the treatment program must be under the overall direction of a physician. The responsible physician in each agency shall

designate, to perform screening functions, those staff members who have the requisite training, skill and experience.

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

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

e. If the client is admitted to the center, he/she shall be asked to sign a release of information form which shall authorize the obtaining of appropriate information from other agencies and the release of appropriate information to agencies which need such information in the interest of the client.

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

Each catchment area center is designated the screening agency for its respective catchment area.

C. STATE MENTAL HOSPITALS

State mental hospitals began a new era in 1961 when Colorado State Hospital (CSH), then 82 years old, began a radical reorganization which saw it change from an overcrowded human warehouse with 6,000 ill cared for clients to a progressive treatment-oriented human services center. In the same year, Fort Logan Mental Health Center (FLMHC), a state hospital which was to pioneer many advances in mental health care, was organized.

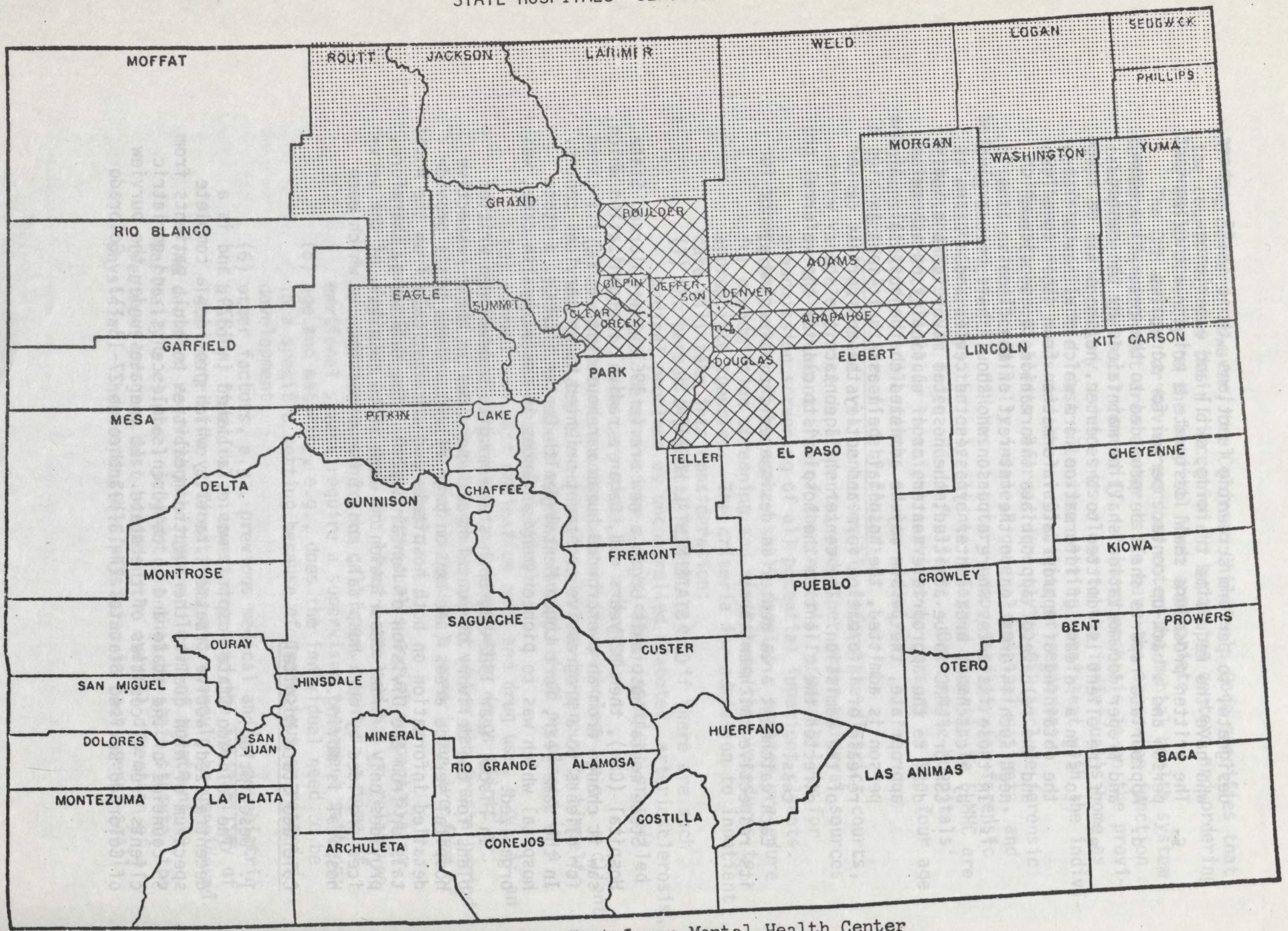
In Fiscal Year 1982-83, both state hospitals developed written plans for the delivery of mental health services in their respective hospital service areas (see map on page VII.4). These plans provide detailed information on both hospitals and are available from the hospitals or from the Division of Mental Health. The following, therefore, provides only a brief description of each state hospital, of the services provided by each hospital, and of the directions in which each hospital is moving.

Colorado State Hospital

1. Description:

The Colorado State Hospital was established in 1879, and is a decentralized, active treatment facility which provides a complete spectrum of high quality therapeutic modalities to adult patients from 55 counties of the state and to children, adolescents, and geriatric clients from 41 counties of the state. It operates under the purview of Colorado Revised Statutes 27-13-103 through 27-13-113. Colorado

STATE HOSPITALS' SERVICE AREAS



Fort Logan Mental Health Center
Service Area - All Ages
Colorado State Hospital

Fort Logan Mental Health Center
-Children, Adolescents, Geriatrics
Colorado State Hospital
-Adults

State Hospital became the first hospital in the nation to receive a full three-year accreditation from the Joint Commission on Accreditation of Hospitals. The Hospital also is licensed by the state Department of Health and is in full compliance with the rules and regulations necessary to participate in all third party reimbursement programs. A wide variety of treatment programs is provided. These treatment programs are primarily provided on an inpatient basis, and they range from intensive short-term to long-term intensive and specialized programs. In addition, there are very limited transitional services provided and very selective aftercare services. Continuity of care is provided through the working relationships with the community mental health centers. The Colorado State Hospital is a major component of the Division of Mental Health, and functions as part of the integrated public mental health system.

2. Major Programs:

a. General Adult Psychiatric Services: The General Adult Psychiatric Services unit provides psychiatric services to men and women 18 through 59 years of age. Catchment area responsibilities include 55 counties of the state. Female criminal court cases from the entire state are also the responsibility of General Adult Psychiatric Services. General Adult Psychiatric Services offers an unusually wide variety of psychiatric treatment techniques, and from these elements a specific treatment program is created to meet the needs of each individual patient. Patients are encouraged to help plan their treatment, and to participate in on-going changes as improvement occurs. The goal of treatment is to help each patient prepare for return to home, family, and productive living as efficiently and effectively as possible. With the advent of the community mental health centers providing total prescreening of individuals being considered for hospitalization and the introduction of the of the bed allocation system, a closer working relationship is being developed between the various community mental health centers and the unit.

b. Child and Adolescent Treatment Center: The Child and Adolescent Treatment Center consists of five treatment teams, is primarily an inpatient residential program, and serves 41 counties. Outpatient services are offered in a few select cases during transition from inpatient to community care. The Center utilizes a multi-disciplinary approach to treatment in a residential setting. Individual, group, family, play, recreational, and occupational therapies are part of the overall program. Medical, educational, social, and religious programs are also integral parts of treatment. Special emphasis is placed on services to the entire family. The center actively participates with community mental health centers and other community agencies in prescreening children being considered for admission.

c. Geriatric Treatment Center: The Geriatric Treatment Center provides inpatient services to individuals 60 years of age and older. The division provides primarily short-term treatment and serves a 41-county catchment area. The Center is designed to provide a short-term treatment experience to help the person

cope with his/her psychiatric, behavioral, social, and physical problems. The individual is guided to an acceptance of limitations imposed by the aging process without concomitant loss of self esteem. In addition, acceptance of loss and coping through normal grieving processes is pivotal. Patients are treated with respect and dignity. Staff approaches focus on what the person can do, rather than on what is beyond his/her capabilities. Treatment is seen as a partnership between the patient, the staff, family and significant others, and appropriate agencies. Individualized treatment plans are formulated and carried out by this partnership.

d. Institute for Forensic Psychiatry: The Institute for Forensic Psychiatry is the only psychiatric treatment unit in the State of Colorado for the treatment of the mentally disordered criminal offender. The program also receives transfers from correctional institutions for psychiatric care, observation cases from the courts, and a limited number of sexual offenders. This program is charged with both the treatment and the security of patients assigned to it for psychiatric care. It is the philosophy of the hospital that meaningful psychiatric treatment for a patient can occur within a graduated security setting. As the patient's treatment program progresses, certain external controls may gradually be lessened. The staff believes that as the patient develops more adequate understanding and insight, the more he is able to translate these into inner controls necessary for successful functioning in a complex society. In order to accomplish this self-awareness, several different treatment modalities are used in accordance with the needs of each patient.

e. Drug Treatment Center: The Drug Treatment Center serves the entire state, functioning largely as a backup service to community drug programs. The unit is composed of 30 beds and offers two distinctly different treatment services. The Circle Program serves as a drug residential inpatient program, and the Plains Addiction Recovery Clinic provides outpatient services only.

f. General Hospital Services: The General Hospital of Colorado State Hospital provides acute and convalescent medical and surgical inpatient treatment for all clients referred from within the Department of Institutions and the Department of Corrections. All outpatient and aftercare clinics, laboratory, and associated supportive services provide a complete spectrum of medical-surgical care.

g. Treatment Support Services: A variety of services is necessary to complement, supplement, and support the direct treatment services provided in a state hospital. These services include, but are not limited to, vocational services, medical records, program evaluation, living skills programs, activity therapies (occupational and recreational therapy), quality assurance and peer review, food services, housekeeping, laundry, library services, training, and volunteer services.

h. Administrative and General Services: These services provide

the overall management of the hospital, and include such areas as personnel, finance, purchasing and supply, and general administration. These services also include the physical plant operation and maintenance programs involving buildings, grounds, and vehicles.

3. Future Roles and Function:

The public in the hospital's service area has come to expect high quality inpatient care delivered by a professional and dedicated staff. The hospital has a long history of responsiveness to the needs and desires of the various communities within its service area. This has fostered a cooperative interaction within which a definition of hospital role and function has developed. Generally the public has been supportive of the hospital and has utilized hospital services and resources in an appropriate manner. The openness of the hospital and its continuing efforts to involve the community has had many positive benefits. The hospital today is accepted as a major community service and one which has a vital place in meeting community needs. The system expectations of the hospital have become increasingly defined during the years, so that today the inpatient role of the hospital within the mental health system is generally known.

In projecting future roles and functions of the hospital, it has been assumed (1) that the hospital will continue to serve as a major state facility for treatment of the seriously and severely mentally ill individual, (2) that the hospital will continue to serve the forensic type patient, (3) that admissions and average daily census will stabilize, (4) that local mental health centers will continue to serve their areas, will eliminate unnecessary admissions, and will prevent the prolonged stay of those admitted to the hospital by developing appropriate community residential facilities, (5) that funding will remain constant and that no major shifts in financial support will occur, and (6) that current trends, directions, treatment modalities, and program development will not be significantly altered.

The impact of bed allocation, the development of community beds as part of the residential continuum, the faltering economy, reduced governmental expenditures, and the significant population increase for Colorado all have direct and indirect effects upon the workload, resources and future of the hospital. To try to anticipate and adjust to these and other environmental factors will be a major focus of the planning process during the coming years.

The hospital's role and function has developed in an incremental fashion and in part has responded to local community mental health centers ability to provide increasing services, both as to type and amount, at the local level. The impact of governmental funding reductions at the local level, particularly in mental health, has yet to be measured, but will undoubtedly effect the future role and function of the hospital.

Fort Logan Mental Health Center

1. Description:

Fort Logan Mental Health Center was established in 1961, under the authority of Colorado Revised Statutes 27-15-101 through 27-15-105. In

recent years, its role and functions have evolved into those of a second state hospital. It is organizationally located in the Department of Institutions as an agency of the Division of Mental Health. It is charged with providing psychiatric treatment services to adult clients in the Denver metropolitan area, as well as to children, adolescents, and the elderly in the north central and northeastern areas of the state. The hospital's treatment program is organized around age groups, with four major divisions responsible for serving children, adolescents, adults, and the elderly. The basic design calls for long-term intensive treatment to be provided in an inpatient setting. Programs are also provided to meet the specialized mental health needs of the hearing impaired. Specialized residential programs designed to teach independent living skills and aftercare programs are provided to increase the chance of successful adjustment to community life for those patients who are about to be discharged to a less restrictive treatment setting outside the hospital.

2. Major Programs:

a. Division of Adult Psychiatric Services: The adult psychiatric population at Fort Logan includes the most severely disabled individuals from the general population who suffer from psychotic conditions rendering them gravely disabled. A high percentage of these patients suffer from some form of chronic mental problems. They are often dangerous to themselves or others. The overall goal of this Division is the restoration and maintenance of these patients to optimum levels of functioning and, for as many as possible, eventual placement in appropriate public or private community based treatment programs.

b. Division of Child/Adolescent Psychiatry: The Division of Child/Adolescent Psychiatry provides emergency, short- and long-term psychiatric treatment in an inpatient setting for the age group of seven through seventeen. The fifteen inpatient children's beds serve the seven to eleven year olds, and forty-five inpatient adolescent beds serve the fifteen through seventeen year olds. One twenty-two bed adolescent unit is locked. Children under seven years old may be accepted by special arrangement.

c. Division of Geriatric/Aftercare/Deaf Psychiatric Services: This Division provides emergency, short- and long-term psychiatric treatment in an inpatient setting for people sixty years of age and older in a thirty-bed unit. Aftercare services are also provided to a group of very chronic and disabled people eighteen and older, in a variety of supportive community settings. Limited psychiatric services are provided to the mentally ill who are severely hearing impaired. Since treatment is so heavily dependent on verbal communications, it is necessary to hire mental health professionals who are skilled in communicating with the deaf. This combination of communication and treatment skills is difficult to find for employment in this program. Thus, the number of such patients who can be accommodated by this program is small, in spite of the fact that it is the only program of its type in the state. There are two boarding homes of eighteen to twenty beds available to Fort

Logan geriatric clients through arrangements with a local non-profit corporation.

d. Hospital and Medical Services: Provides supporting medical pharmacy, laboratory, etc., services to Fort Logan clients and some other state agencies.

e. Treatment Support Services: A variety of services is necessary to complement, supplement, and support the direct treatment services provided in a state hospital. These services include, but are not limited to, vocational services, medical records, program evaluation, living skills program, activity therapies (occupational and recreational therapy), quality assurance and peer review, food services, housekeeping, laundry, library services, training, and volunteer services.

f. Administrative and General Services: These services provide the overall management of the hospital, and include such areas as personnel, finance, purchasing and supply, and general administration. These services also include the physical plant operation and maintenance programs involving buildings, grounds, and vehicles.

3. Future Roles and Functions:

Fort Logan Mental Health Center will continue to perform the basic functions of a hospital for the mentally ill, and will move from a need model to a demand model. This will be necessitated by reduced resources coupled with needs for mental health services which will continue to grow beyond the hospital's capacity to fully meet them. The hospital will be admitting only those patients for whom there are no other appropriate resources or services in the public or private sector.

The continued reduction of financial support for mental health services suggests that efforts are going to have to be intensified to manage resources in a more efficient manner. Plans are going to have to focus on doing more with less to insure that the quality of patient care does not suffer.

Fort Logan Mental Health Center will continue to be the primary state-funded psychiatric inpatient treatment facility for residents of the Denver metropolitan area, where more than half of the state's population is located. As a range of residential treatment facilities are developed statewide in the next few years (replacing the diminishing supply of nursing home and boarding home beds which were never really appropriate for the more impaired psychiatric client), Fort Logan's role will include short-term inpatient treatment for persons who can return to community based facilities rather quickly, and longer-term treatment services for persons who need more intensive or more extended treatment. Specialized services for mental health clients whose needs cannot be met in other programs, such as the mentally ill hearing impaired and the mentally ill/developmentally disabled clients, will be initiated or expanded.

Some transitional residential facilities on the Fort Logan grounds may be developed, if sufficient new funding is obtained, to provide time-limited services for patients who can leave the inpatient program but are not yet ready for available community-based facilities. Within the next five years, plans should be completed for establishment of some level of forensic service capability in the Denver area.

In recent years public expectations of Fort Logan Mental Health Center have shifted to emphasis on protection of the community by means of treatment or confinement of persons who are potentially dangerous to other persons or to property. Because of limited public funds, inpatient and community services are expected to deal primarily with persons who are more severely psychiatrically impaired and/or chronically mentally ill. Until adequate intensive residential facilities are developed as a transition from inpatient treatment, Fort Logan will be expected to maintain patients for relatively long periods in inpatient or on-grounds transitional facilities.

The mental health service system expectations for Fort Logan are somewhat broader, encompassing a variety of service requests which are sometimes incompatible within the limited resources available. Depending on the programs and facilities available in local catchment areas, Fort Logan Mental Health Center is expected to provide: (a) short-term inpatient evaluation, stabilization and treatment; (b) long-term inpatient care and treatment; and/or (c) treatment and custody for mentally ill persons considered dangerous. As community mental health centers become more involved with developing treatment and discharge criteria for patients at Fort Logan, an increasing proportion of the beds will probably be used for shorter-term treatment, allowing immediate hospitalization for community clients.

D. FOLLOW-UP CARE

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

1. Predischarge Planning Procedure

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

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

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

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

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

(3) Clients being discharged from inpatient care who need ongoing supportive care are the responsibility of the local community mental health center. Disposition planning involves the hospital and community referral sources and the client, so transition from inpatient care to other care is as smooth as possible.

(4) Unless specific and documented arrangements are made for CSH or FLMHC to follow-up a client discharged from inpatient care who requires long-term support and maintenance, catchment area centers are responsible to help the client avoid the return to inpatient care. This is accomplished by ensuring that the client is followed in a resocialization group and/or seen periodically on an outpatient basis or for medication check. Progress notes are recorded after each contact or at least monthly.

(5) Maximum use is to be made of treatment facilities in each catchment area, as well as providing services to persons in their own homes. The client is placed in the facility which provides that level of care which meets the individual's clinical needs. Every effort is made to move persons placed in more intensive settings to a less restrictive placement as soon as his/her condition permits. No placements are made without the concurrence of the client and the catchment area center or clinic.

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

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

d. Upon discharge from inpatient care, each person who has agreed to follow-up care is fully advised as to who has responsibility for follow-up care. When transfer of responsibility for inpatient care occurs, the person is discharged from the hospital rolls.

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

f. Readmission to inpatient care of clients being provided follow-up care by community mental health centers is monitored by the Division of Mental Health.

2. Responsible Center in Each Catchment Area

The responsible agency in each catchment area is the community mental health center designated by the Division of Mental Health.

3. Policies for Discharge from State Hospitals

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

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

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

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

4. Methods for Assuring Availability of Follow-Up Care

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

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

The state hospitals are also responsible for informing the Division of gaps in follow-up service. CSH and FLMHC will cooperate fully with centers in the follow-up planning process.

The two hospital service area Continuity of Care Committees will continue to assist in the monitoring of the follow-up process and will

make recommendations to DMH concerning needed revisions in the policy and procedures.

E. CATCHMENT AREA MENTAL HEALTH PROGRAM

A catchment area or mental health service area is a geographic area for which there is a designated responsibility for community mental health services. Colorado has designated 20 catchment areas. All twenty areas are served by comprehensive community mental health centers.

The Colorado Division of Mental Health purchases mental health services from the twenty catchment area mental health centers and from four specialty clinics which provide highly specialized services. The twenty service area centers provide at least the services defined in state standards (e.g., inpatient, other 24-hour care, partial care, outpatient, and 24-hour emergency). A clinic provides fewer than the essential services, but must at a minimum provide outpatient services, 24-hour emergency services, and consultation and education. All centers and clinics are private, non-profit corporations with the exception of two which are county agencies.

The mental health catchment areas range in size from 37,900 residents in the San Luis Valley Mental Health Center Area (Saguache, Mineral, Rio Grande, Alamosa, Conejos, and Costilla Counties) to almost 400,000 persons served by the Jefferson Councy Mental Health Center (Jefferson, Gilpin, and Clear Creek Counties.)

A goal of the Division of Mental Health is to have a full range of mental health services available in each catchment area. A full spectrum of services would include the above listed services for all age and minority groups in addition to preadmission screening, followup care, residential services, vocational services, activity, recreational and occupational therapies, and consultation and education services. The Colorado mental health system also is working toward establishing statewide cost-effective Treatment and Support Systems for the delivery of mental health services to chronically and severely disabled clients of all ages.

Each mental health center may not become the sole provider of the myriad mental health and related services which should be available in all catchment areas. Mental health centers, however, are expected to plan for and ensure the utilization of the various community resources available. Affiliation and contractual arrangements between mental health and other agencies also are expected as a way of ensuring the availability and utilization of all resources by clients most in need of services.

The Colorado Division of Mental Health 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 implemented a system of performance contracting which forms the basis for the purchase of services in the community.

Every spring, the Division 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 clients served 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.

The community mental health centers' responsibility for planning, assessing needs, and coordinating mental health services in their respective catchment areas is receiving increased emphasis and is reflected in the annual plan developed by each center. These local plans are used as the management plans at the catchment area level and as a basis for statewide planning for mental health by the Division. Each Mental Health Service Area Plan includes a description of the catchment area which covers the geographical boundaries of the area, major economic factors, and significant characteristics of the area that impact the need for and the delivery of mental health services. A description of existing services provided by the center is also included. To provide those reading each plan with the most accurate data available that reflects the mental health service needs of the residents of the area, each plan provides data related to the catchment area's needs. A description of the key issues facing the center, the impacts of those issues upon the center, and the center's priorities are a critical part of each plan submitted to the Division. A section on work force issues is included in each plan to provide those reading the plan with an understanding of the staffing issues that must be addressed by the service area center. Finally, each plan contains a listing of the center's goals and objectives which reflect the center's plans and directions for addressing identified needs and priorities. Following the goals and objectives for the coming year is a report on the accomplishment of catchment area plan objectives for the previous fiscal year. Submission of the Mental Health Service Area Plan is included in the Division's contract with each of the twenty catchment area centers. These plans are available for review from the community mental health centers or from the Division of Mental Health.

The Division of Mental Health reviews all of the local plans and identifies statewide trends and planning issues. In the plans submitted for Fiscal Year 1982-83, the theme that was woven throughout was maintenance of the current level of services. With reductions in government funding, rampant inflation, population growth, and the increase in the severity of client disabilities, the major challenge for the mental health centers is the maintenance of existing programs. As costs for mental health care increase, resources are declining and are resulting in the curtailment of community-based programs. A reduction in overall capacity has already occurred and the trend is continuing.

According to the local plans for FY 1982-83, the community mental health centers estimate that they will serve a total of 63,600 clients. In comparison, 78,893 clients were served by the community mental health centers in FY 1980-81.

Another major problem identified in the local plans was the problem of inadequate funding for mental health and the need for expanding alternate funding sources. The mental health centers addressed the funding issue in a variety of ways; however, the key point over and over was that more cost efficient management was needed along with exploring ways to expand the funding resources available for mental health care. The shortage of psychiatric beds and the need to maximize the utilization of residential facilities was a theme that was central to many of the local plans. The need for improving the training provided to staff to maintain the quality of care was also an issue in several of the local plans. Staff recruitment, training, and retention were mentioned more frequently in the FY 1982-83 local plans than in any of the previous sets of local plans submitted to the Division.

The population groups identified as being the most underserved or inappropriately served were children, the elderly, and adolescents. Although the inadequacy of services to the chronically mentally disabled is a key problem which is being addressed by a majority of centers, many centers are also identifying a lack of resources for serving acutely disabled adults. The need for acute inpatient beds and the need for crisis and 24-hour emergency services were mentioned in several plans.

Although many issues were identified in the local plans, there was a considerable amount of agreement and continuity related to the critical issues. The review and analyses of the Mental Health Service Area Plans formed the basis for the Mental Health Issues described in Chapter III and the related Goals and Objectives included in Chapter IV of this plan.

F. CATCHMENT AREA DEMOGRAPHIC DATA AND POPULATION-IN-NEED ESTIMATES

1. Population Data:

Tables 1 and 2 show catchment area populations by age and ethnic groups respectively. The procedures used to generate these figures have improved considerably from previous years. The data for Adams, Arapahoe, and Aurora catchment areas are based on census tract groupings, rather than the ratios employed previously. Age and ethnic breakouts (in addition to totals) are also based on 1980 Census Counts. To accommodate the transition in the definition of the elderly age group (from 65+ to 60+), a column for the 60-64 age category is shown. Catchment areas are shown grouped according to state hospital service regions, and subtotals for the regions, in addition to state totals, which are displayed. At the present time, no official population projections (based on 1980 census data) are available from the State Division of Planning. Additional information on these demographic tables is available from the Evaluation Services Section of the Division of Mental Health.

Table 1

1980 US CENSUS
TOTAL POPULATION BY AGE GROUPS
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

STATE HOSP REGION	CATCHMENT AREA	0-11 N	0-11 %	12-17 N	12-17 %	18-59 N	18-59 %	60-64 N	60-64 %	65+ N	65+ %	TOTAL
CSH												
	CENTENNIAL	16481	19.081	9016	10.439	45057	52.166	3996	4.626	11822	13.687	86372
	COLO WEST	32405	18.136	16311	9.129	110513	61.850	5624	3.148	13827	7.738	178680
	LARIMER	25026	16.775	13166	8.825	93675	62.792	4637	3.108	12680	8.500	149184
	MIDWESTERN	10936	17.698	6051	9.793	34565	55.939	2698	4.366	7541	12.204	61791
	PIKES PEAK	61013	18.902	33631	10.419	195960	60.708	10231	3.170	21956	6.802	322791
	SAN LUIS	7787	20.539	4383	11.560	19923	52.548	1587	4.186	4234	11.167	37914
	SE COLO	10102	19.455	5728	11.031	26029	50.128	2620	5.046	7446	14.340	51925
	SW COLO	9380	18.727	5260	10.501	28918	57.733	1993	3.979	4538	9.060	50089
	SPAN PEAKS	27080	18.383	15850	10.760	78890	53.554	7090	4.813	18399	12.490	147309
	WELD	23712	19.210	12660	10.256	72082	58.395	4083	3.308	10901	8.831	123438
	WEST CENTRAL	9257	17.713	5365	10.266	28242	54.040	2212	4.233	7185	13.748	52261
TOTAL		233179	18.481	127421	10.099	733854	58.161	46771	3.707	120529	9.552	1261754
FLSH												
	ADAMS	45161	20.976	24667	11.457	127824	59.370	6207	2.883	11443	5.315	215302
	ARAPAHOE	35449	18.812	22983	12.197	112846	59.885	6246	3.315	10913	5.791	188437
	AURORA	31985	19.869	15229	9.460	102175	63.471	4637	2.880	6953	4.319	160979
	BETHESDA	13504	10.020	7707	5.719	87069	64.608	6975	5.176	19509	14.476	134764
	BOULDER	29689	15.657	17555	9.258	124579	65.698	4927	2.598	12875	6.790	189625
	DENVER H&H	24803	16.389	11170	7.381	86349	57.057	6669	4.407	22347	14.766	151338
	JEFFERSON	71440	18.726	43186	11.320	232305	60.892	11889	3.116	22682	5.945	381502
	PARK EAST	19061	16.628	9836	8.580	69577	60.695	4188	3.653	11970	10.442	114634
	SW DENVER	15988	17.449	8807	9.612	54651	59.644	4086	4.459	8097	8.837	91629
TOTAL		287080	17.632	161140	9.897	997375	61.256	55824	3.429	126789	7.787	1628210
TOTAL TOTAL		520259	18.002	288561	9.985	1731229	59.905	102595	3.550	247318	8.558	2889964

SOURCE: DATA EXTRACTED FROM STF1A, US BUREAU OF THE CENSUS.
PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 05/10/82 .

Table 2 1980 US CENSUS

Table 2

1980 US CENSUS
TOTAL POPULATION BY ETHNIC GROUPS
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

STATE HOSP REGION	CATCHMENT AREA	HISP-ANIC N	HISP-ANIC %	BLACK N	BLACK %	ASIAN N	ASIAN %	AMER INDIAN N	AMER INDIAN %	TOTAL MINOR-ITIES N	TOTAL MINOR-ITIES %	TOTAL
CSH												
	CENTENNIAL	5259	6.089	95	.110	298	.345	265	.307	5917	6.851	86372
	COLO WEST	9165	5.129	342	.191	606	.339	904	.506	11017	6.166	178680
	LARIMER	8524	5.714	627	.420	1369	.918	644	.432	11164	7.483	149184
	MIDWESTERN	4566	7.389	95	.154	150	.243	443	.717	5254	8.503	61791
	PIKES PEAK	24185	7.492	19071	5.908	5093	1.578	1858	.576	50207	15.554	322791
	SAN LUIS	16389	43.227	79	.208	159	.419	165	.435	16792	44.290	37914
	SE COLO	12417	23.913	144	.277	184	.354	214	.412	12959	24.957	51925
	SW COLO	5600	11.180	54	.108	115	.230	2850	5.690	8619	17.207	50089
	SPAN PEAKS	50571	34.330	2339	1.588	524	.356	655	.445	54089	36.718	147309
	WELD	20834	16.878	597	.484	820	.664	527	.427	22778	18.453	123438
	WEST CENTRAL	5642	10.796	469	.897	108	.207	312	.597	6531	12.497	52261
TOTAL		163152	12.931	23912	1.895	9426	.747	8837	.700	205327	16.273	1261754
FLSH												
	ADAMS	35893	16.671	2197	1.020	2459	1.142	1480	.687	42029	19.521	215302
	ARAPAHOE	6921	3.673	1686	.895	1792	.951	666	.353	11065	5.872	188437
	AURORA	7702	4.784	10963	6.810	3382	2.101	821	.510	22868	14.206	160979
	BETHESDA	5014	3.721	3683	2.733	1929	1.431	395	.293	11021	8.178	134764
	BOULDER	10104	5.328	1735	.915	2191	1.155	905	.477	14935	7.876	189625
	DENVER H&H	51776	34.212	16813	11.110	2175	1.437	2001	1.322	72765	48.081	151338
	JEFFERSON	19494	5.110	1958	.513	3641	.954	1503	.394	26596	6.971	381502
	PARK EAST	9475	8.265	37756	32.936	1914	1.670	709	.618	49854	43.490	114634
	SW DENVER	24065	26.264	1000	1.091	1007	1.099	751	.820	26823	29.273	91629
TOTAL		170444	10.468	77791	4.778	20490	1.258	9231	.567	277956	17.071	1628210
TOTAL TOTAL		333596	11.543	101703	3.519	29916	1.035	18068	.625	483283	16.723	2889964

SOURCE: DATA EXTRACTED FROM STF1A, US BUREAU OF THE CENSUS.
PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 05/10/82 .

2. Estimates of Population in Need of Mental Health Services:

Over the past year a considerable amount of work has gone into reviewing and refining the social indicators model used to estimate the population in need of mental health services by catchment area. In December, 1980, the Needs Assessment Task Force was formed under the auspices of the Division of Mental Health and the Colorado Association of Mental Health Centers and Clinics, to develop and evaluate feasible needs assessment strategies for Colorado. The Task Force conducted studies and literature reviews in a number of areas including epidemiological surveys in the community, social indicators research, and the relationship of treatment resources to service utilization. The group also participated in and made use of a study (December, 1981) which analyzed data collected from community needs assessment surveys done in Colorado and compared these findings with the results of the social indicators model. Good agreement was found to exist between the community survey and social indicators approaches.

The Task Force recommended that the Division of Mental Health continue to employ a social indicators model to estimate population in need for each catchment area. While endorsing the basic structure of the current model, the group also recommended a number of modifications to it. Most importantly, the Task Force wanted to see three sets of results produced based on different assumptions relating to the weight applied to the social indicators. The midrange estimate would be produced from a weight of 14 percent, while lower-and-higher-variance estimates (using weights of 10 percent and 17 percent, respectively) should be shown to serve as confidence limits around the estimate. (The high variance estimate still was a lower weight than that used in the model published in the 1982 State Plan Supplement - twenty percent.) These recommendations have been adopted and are shown in the accompanying tables.

The Task Force also recommended that the six previously used social indicators be retained, but that reliability studies be conducted on the data and that better procedures be developed to disaggregate the county-level data. Furthermore, the Task Force sees the model as appropriate for estimating the serious and critical populations; however, it recommended that a separate estimation procedure be developed for the chronically mentally ill. The Division of Mental Health agreed with these recommendations and is proceeding to work on these areas to the extent that resources permit. The Report of the Colorado Needs Assessment Task Force is available from the Division of Mental Health.

Table 3 shows the scores for each catchment area on the six social indicators, as well as the composite standardized score need in the estimation equation. The composite score was calculated by standardizing each of the individual scores, taking the mean for each catchment area, and standardizing the resulting distribution. Each of the indicators has been updated, except population in poverty, which is not yet available from the 1980 Census. The estimate of the number of married couples, which is used in calculating divorce rate, was also updated using 1980 Census data.

The unmodified prevalence estimates, shown in Table 4, were arrived at by multiplying the following age-adjusted prevalence rates to

Table 3

COLORADO DIVISION OF MENTAL HEALTH
POPULATION IN NEED MODEL
SOCIAL INDICATORS RAW SCORES
AND COMPOSITE STANDARDIZED SCORES
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

STATE HOSP REGION	CATCHMENT AREA	SUICIDE RATE PER 100,000 POP 1980 (1)	ABUSE & NEGLECT REPORTS RATE PER 100,000 C & A 1980 (2)	DIVORCE RATE PER 1,000 MARRIED COUPLES 1980 (3)	PERCENT MINORITY POPULATION 1980 (4)	PERCENT POPULATION IN POVERTY 1970 (5)	PERCENT LABOR FORCE UNEMPLOYMENT 1981 (6)	COMPOSITE SOCIAL INDICATOR SCORE(7)
CSH								
	CENTENNIAL	9.262	953.053	17.607	6.851	16.8	3.907	-1.16211
	COLO WEST	20.707	560.390	32.000	6.166	13.7	5.551	-.16840
	LARIMER	8.044	345.622	26.700	7.483	13.6	5.506	-1.12788
	MIDWESTERN	19.420	600.459	24.028	8.503	20.2	6.611	-.06955
	PIKES PEAK	15.800	687.841	32.006	15.554	11.6	6.059	-.06482
	SAN LUIS	18.463	353.328	21.350	44.290	29.3	8.930	1.07366
	SE COLO	11.555	1383.449	21.120	24.957	22.8	5.890	.46341
	SW COLO	17.968	1031.421	29.321	17.207	18.1	6.998	.66926
	SPAN PEAKS	15.613	922.432	24.930	36.718	16.5	9.185	.98269
	WELD	11.342	486.638	19.777	18.453	17.3	5.832	-.77303
	WEST CENTRAL	34.442	294.077	31.115	12.497	14.6	7.734	.68124
MEAN		16.602	692.610	25.450	18.062	17.7	6.564	
S.D.		7.282	342.850	5.158	12.618	5.0	1.565	
FLSH								
	ADAMS	12.076	852.093	23.773	19.521	6.8	6.081	-.60108
	ARAPAHOE	9.552	694.824	23.153	5.872	6.2	3.455	-1.64977

(1) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1982.
(2) SOURCE COLORADO DEPARTMENT OF SOCIAL SERVICES, PROTECTIVE SERVICES PROGRAM, 1982.
(3) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1982. NUMBER OF MARRIED COUPLES ESTIMATED BY SUMMING COUNTS OF MARRIED AND SEPARATED INDIVIDUALS FROM 1980 CENSUS AND DIVIDING RESULT BY 2.
(4) SOURCE DATA EXTRACTED FROM SUMMARY TAPE FILE 1A, 1980 U.S. CENSUS.
(5) SOURCE MENTAL HEALTH DEMOGRAPHIC PROFILE SYSTEM (U.S. CENSUS DATA - 1970).
(6) SOURCE COLORADO DIVISION OF EMPLOYMENT AND TRAINING, RESEARCH AND ANALYSIS SECTION, 1982.
(7) COMPOSITE SOCIAL INDICATOR SCORE CALCULATED BY TAKING MEAN OF INDIVIDUAL STANDARDIZED SCORES, AND STANDARDIZING RESULTING DISTRIBUTION.

PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 05/10/82 .

Table 3 (part ii)

COLORADO DIVISION OF MENTAL HEALTH
POPULATION IN NEED MODEL
SOCIAL INDICATORS RAW SCORES
AND COMPOSITE STANDARDIZED SCORES
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

STATE HOSP REGION	CATCHMENT AREA	SUICIDE RATE PER 100,000 POP 1980 (1)	ABUSE & NEGLECT REPORTS RATE PER 100,000 C & A 1980 (2)	DIVORCE RATE PER 1,000 MARRIED COUPLES 1980 (3)	PERCENT MINORITY POPULATION 1980 (4)	PERCENT POPULATION IN POVERTY 1970 (5)	PERCENT LABOR FORCE UNEMPLOYMENT 1981 (6)	COMPOSITE SOCIAL INDICATOR SCORE(7)
	AURORA	16.772	821.790	24.168	14.206	5.9	4.916	-.76998
	BETHESDA	24.487	1150.346	35.718	8.178	7.1	4.182	.20541
	BOULDER	15.821	1024.469	29.811	7.876	10.1	4.768	-.33015
	DENVER H&H	31.717	1148.083	35.717	48.081	24.0	7.865	2.69256
	JEFFERSON	15.203	376.878	28.104	6.971	5.5	4.429	-1.28108
	PARK EAST	12.213	1148.908	35.753	43.490	10.4	5.188	.74074
	SW DENVER	18.553	1149.425	35.739	29.273	6.9	4.770	.48897
MEAN		17.377	929.646	30.215	20.385	9.2	5.073	
S.D.		6.902	269.289	5.638	16.259	5.8	1.268	
TOTAL								
MEAN		16.951	799.276	27.594	19.107	13.9	5.893	
S.D.		6.937	327.166	5.771	14.018	6.8	1.595	

(1) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1982.
(2) SOURCE COLORADO DEPARTMENT OF SOCIAL SERVICES, PROTECTIVE SERVICES PROGRAM, 1982.
(3) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1982. NUMBER OF MARRIED COUPLES ESTIMATED BY SUMMING COUNTS OF MARRIED AND SEPARATED INDIVIDUALS FROM 1980 CENSUS AND DIVIDING RESULT BY 2.
(4) SOURCE DATA EXTRACTED FROM SUMMARY TAPE FILE 1A, 1980 U.S. CENSUS.
(5) SOURCE MENTAL HEALTH DEMOGRAPHIC PROFILE SYSTEM (U.S. CENSUS DATA - 1970).
(6) SOURCE COLORADO DIVISION OF EMPLOYMENT AND TRAINING, RESEARCH AND ANALYSIS SECTION, 1982.
(7) COMPOSITE SOCIAL INDICATOR SCORE CALCULATED BY TAKING MEAN OF INDIVIDUAL STANDARDIZED SCORES, AND STANDARDIZING RESULTING DISTRIBUTION.

PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 05/10/82 .

Table 4

COLORADO DIVISION OF MENTAL HEALTH
POPULATION IN NEED MODEL
ESTIMATES OF POPULATION IN NEED
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

STATE HOSP REGION	CATCHMENT AREA	TOTAL POPU-LATION	UNMOD-IFIED PREVA-LENCE EST. (1)	COMPO-SITE SOCIAL INDI-CATOR SCORE	POP IN NEED LOW VARI-ANCE EST. (2)	% OF TOTAL POP.	POP IN NEED MEDIUM VARI-ANCE EST. (3)	% OF TOTAL POP.	POP IN NEED HIGH VARI-ANCE EST. (4)	% OF TOTAL POP.
CSH										
	CENTENNIAL	86372	6785	-1.16211	6136	7.10	5868	6.79	5663	6.56
	COLO WEST	178680	13451	-.16840	13532	7.57	13565	7.59	13591	7.61
	LARIMER	149184	11281	-1.12788	10241	6.86	9812	6.58	9485	6.36
	MIDWESTERN	61791	4807	-.06955	4885	7.91	4917	7.96	4941	8.00
	PIKES PEAK	322791	24282	-.06482	24686	7.65	24852	7.70	24980	7.74
	SAN LUIS	37914	2940	1.07366	3331	8.79	3493	9.21	3616	9.54
	SE COLO	51925	4108	.46341	4398	8.47	4518	8.70	4610	8.88
	SW COLO	50089	3831	.66926	4182	8.35	4328	8.64	4438	8.86
	SPAN PEAKS	147309	11536	.98269	12964	8.80	13554	9.20	14004	9.51
	WELD	123438	9383	-.77303	8859	7.18	8642	7.00	8478	6.87
	WEST CENTRAL	52261	4102	.68124	4483	8.58	4641	8.88	4761	9.11
TOTAL		1261754	96506		97697	7.74	98190	7.78	98567	7.81
RATIO						1.28		1.40		1.50
FLSH										
	ADAMS	215302	16066	-.60108	15451	7.18	15198	7.06	15004	6.97
	ARAPAHOE	188437	14211	-1.64977	12142	6.44	11288	5.99	10636	5.64
	AURORA	160979	11869	-.76998	11210	6.96	10938	6.79	10730	6.67
	BETHESDA	134764	10589	.20541	11058	8.21	11251	8.35	11399	8.46
	BOULDER	189625	14215	-.33015	14065	7.42	14003	7.38	13957	7.36
	DENVER H&H	151338	11841	2.69256	15379	10.16	16840	11.13	17955	11.86

(1) UNMODIFIED PREVALENCE ESTIMATES CALCULATED BY MULTIPLYING CATCHMENT AREA POPULATION FOR EACH AGE GROUP BY PRESIDENTS COMMISSION AGE ADJUSTED PREVALENCE RATES: 0-11 6%, 12-17 10%, 18-59 7%, 60+ 11%.
(2) POPULATION IN NEED LOW VARIANCE ESTIMATE CALCULATED BY ADJUSTING UNMODIFIED ESTIMATE BY 10% OF THE CATCHMENT AREA COMPOSITE SOCIAL INDICATOR STANDARDIZED SCORE.
(3) POPULATION IN NEED MEDIUM VARIANCE ESTIMATE CALCULATED BY ADJUSTING UNMODIFIED ESTIMATE BY 14% OF THE CATCHMENT AREA COMPOSITE SOCIAL INDICATOR STANDARDIZED SCORE.
(4) POPULATION IN NEED HIGH VARIANCE ESTIMATE CALCULATED BY ADJUSTING UNMODIFIED ESTIMATE BY 17% OF THE CATCHMENT AREA COMPOSITE SOCIAL INDICATOR STANDARDIZED SCORE.

PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 06/29/82 .

Table 4 (part ii)

COLORADO DIVISION OF MENTAL HEALTH
POPULATION IN NEED MODEL
ESTIMATES OF POPULATION IN NEED
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

STATE HOSP REGION	CATCHMENT AREA	TOTAL POPU-LATION	UNMOD-IFIED PREVA-LENCE EST. (1)	COMPO-SITE SOCIAL INDI-CATOR SCORE	POP IN NEED LOW VARI-ANCE EST. (2)	% OF TOTAL POP.	POP IN NEED MEDIUM VARI-ANCE EST. (3)	% OF TOTAL POP.	POP IN NEED HIGH VARI-ANCE EST. (4)	% OF TOTAL POP.
	JEFFERSON	381502	28669	-1.28108	25578	6.70	24300	6.37	23327	6.11
	PARK EAST	114634	8775	.74074	9644	8.41	10003	8.73	10277	8.97
	SW DENVER	91629	7006	.48897	7519	8.21	7732	8.44	7893	8.61
TOTAL		1628210	123241		122046	7.50	121553	7 47	121178	7.44
RATIO						1.58		1.86		2.10
TOTAL										
TOTAL		2989964	219747		219743	7.60	219743	7.60	219745	7.60
RATIO						1.58		1.86		2.10

(1) UNMODIFIED PREVALENCE ESTIMATES CALCULATED BY MULTIPLYING CATCHMENT AREA POPULATION FOR EACH AGE GROUP BY PRESIDENTS COMMISSION AGE ADJUSTED PREVALENCE RATES: 0-11 6%, 12-17 10%, 18-59 7%, 60+ 11%.
(2) POPULATION IN NEED LOW VARIANCE ESTIMATE CALCULATED BY ADJUSTING UNMODIFIED ESTIMATE BY 10% OF THE CATCHMENT AREA COMPOSITE SOCIAL INDICATOR STANDARDIZED SCORE.
(3) POPULATION IN NEED MEDIUM VARIANCE ESTIMATE CALCULATED BY ADJUSTING UNMODIFIED ESTIMATE BY 14% OF THE CATCHMENT AREA COMPOSITE SOCIAL INDICATOR STANDARDIZED SCORE.
(4) POPULATION IN NEED HIGH VARIANCE ESTIMATE CALCULATED BY ADJUSTING UNMODIFIED ESTIMATE BY 17% OF THE CATCHMENT AREA COMPOSITE SOCIAL INDICATOR STANDARDIZED SCORE.

PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 06/29/82 .

catchment area population figures:

Age	% Target
Children (0-11)	6%
Adolescents (12-17)	10%
Adults (18-59)	7%
Elderly (60+)	11%

The percentage for elderly was lowered from 13 percent to 11 percent due to the change in definition of the elderly age group that goes into effect on July 1, 1982 (from 65+ to 60+). Using 11 percent for ages 60 and older produces comparable results to the 13 percent that was previously applied to ages 65 and older.

The population in need estimates (P_i), shown in Table 4, were computed using the equation

$$P_i = x(1 + w_i z)$$

where x is the unmodified prevalence estimate, 1 is the composite social indicator score, and w_i are weights for the low (10 percent), medium (14 percent) and high (17 percent) variance estimates.

Table 5 shows the number and percentage of the population in need for each age group. Although the numbers are based on the low-variance estimates (which were used in effecting FY 83 funding allocations), the percentages would remain identical for the medium- and high-variance estimates as well. These percentages are used by the Division in contracting with community agencies for the number of clients served by age groups. Additional information about the population in need estimation procedure is available from the Evaluation Services Section.

3. Priority Rankings Based on Needs versus 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 community-based 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 82-83 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. The funding allocations data shown in Table 6 include the number of state, Medicaid, and

Table 5

COLORADO DIVISION OF MENTAL HEALTH
POPULATION IN NEED MODEL - LOW VARIANCE ESTIMATES
ESTIMATES OF POPULATION IN NEED BY AGE GROUPS
CATCHMENT AREAS GROUPED BY STATE HOSPITAL SERVICE REGIONS

STATE HOSP REGION	CATCHMENT AREA	0-11 N	0-11 %	12-17 N	12-17 %	18-59 N	18-59 %	60+ N	60+ %	TOTAL
CSH										
	CENTENNIAL	894	14.576	816	13.294	2852	46.485	1574	25.645	6136
	COLO WEST	1956	14.452	1641	12.125	7783	57.512	2153	15.910	13532
	LARIMER	1364	13.314	1196	11.674	5953	58.124	1729	16.887	10241
	MIDWESTERN	667	13.647	615	12.586	2459	50.343	1144	23.424	4885
	PIKES PEAK	3722	15.077	3419	13.850	13945	56.490	3600	14.583	24686
	SAN LUIS	529	15.884	496	14.898	1581	47.449	725	21.769	3331
	SE COLO	649	14.752	613	13.948	1951	44.352	1185	26.947	4398
	SW COLO	615	14.696	574	13.730	2209	52.832	784	18.742	4182
	SPAN PEAKS	1826	14.086	1781	13.740	6206	47.868	3151	24.307	12964
	WELD	1344	15.166	1195	13.492	4764	53.778	1556	17.564	8859
	WEST CENTRAL	607	13.530	586	13.067	2161	48.196	1130	25.207	4483
TOTAL		14173	14.507	12932	13.237	51864	53.087	18731	19.173	97697
FLSH										
	ADAMS	2606	16.868	2373	15.355	8605	55.695	1867	12.081	15451
	ARAPAHOE	1817	14.967	1963	16.171	6749	55.584	1612	13.278	12142
	AURORA	1812	16.168	1438	12.832	6755	60.258	1204	10.742	11210
	BETHESDA	846	7.649	805	7.281	6365	57.560	3042	27.510	11058
	BOULDER	1762	12.529	1736	12.346	8629	61.351	1937	13.774	14065
	DENVER H&H	1933	12.567	1451	9.433	7850	51.043	4146	26.957	15379
	JEFFERSON	3824	14.950	3853	15.065	14508	56.720	3393	13.265	25578
	PARK EAST	1257	13.037	1081	11.214	5352	55.499	1953	20.251	9644
	SW DENVER	1029	13.688	946	12.575	4106	54.610	1438	19.126	7519
TOTAL		16886	13.836	15646	12.820	68919	56.470	20592	16.872	122046
TOTAL TOTAL		31059	14.134	28578	13.005	120783	54.966	39323	17.895	219743

PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 05/10/82 .

Table 6. Resources Inventory - Funding Allocations

Community	82-83 Contracted State Dollars (1,000's)	82-83 Federal Dollars (1,000's)	82-83 State & Federal Dollars (1,000's)	82-83 Medicaid Funding (1,000's)	81-82 Catchment Area Hospital Utilization (1,000's)	Total State Fed., Medicaid, Hosp. Resources (1,000's)
Adams	1,367	-0-	1,367	367	245	1,978
Arapahoe	888	-0-	888	185	246	1,319
Aurora	403	561	964	253	189	1,405
Bethesda	955	-0-	955	115	226	1,295
Boulder	1,300	28	1,328	361	269	1,959
Centennial	358	592	950	83	108	1,140
Child/Adol.	64	-0-	64	-0-	-0-	64
Colorado W.	970	-0-	970	131	447	1,548
Denver H&H	2,162	104	2,266	-0-	571	2,837
Denver MHC	94	-0-	94	5	-0-	99
Jefferson	2,025	-0-	2,025	428	453	2,906
Larimer	501	567	1,068	142	28	1,239
Midwestern	341	33	374	291	79	744
Park East	1,027	263	1,290	260	211	1,762
Pikes Peak	1,892	-0-	1,892	382	1,444	3,718
San Luis	449	75	524	61	319	905
Servicios	129	-0-	129	40	-0-	169
SE Colorado	202	485	687	107	219	1,013
SW Colorado	229	423	652	130	137	919
SW Denver	1,005	-0-	1,005	72	254	1,331
Spanish Pks.	697	110	807	350	1,780	2,937
Weld	857	57	914	183	139	1,236
W. Central	135	331	466	86	151	703
Asian Pacific	68	-	-	40	-	108

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.

Population in need is combined with resources available by dividing the total state and federal dollar allocations to each catchment area by the number of target group individuals estimated to reside in that catchment area, producing a "population in need per capita allocation" figure. The results of this procedure and the resulting priority rankings are shown in Table 7.

Table 7. Priority Need Ranking

CSH Service Area	Per Capita in Need; State, Fed., Medicaid, & Hosp. Allocation	Priority Ranking By Region	Priority Ranking Statewide			
Midwestern	156.27	2	10			
Pikes Peak	158.03	3	11			
San Luis	265.76	8	20			
SE Colorado	231.59	7	19			
SW Colorado	217.05	6	18			
Spanish Peaks	214.99	5	17			
West Central	159.21	4	12			
Colo. West	118.53	1	3			
Average	190.18					
FLMHC Service Area						
Weld	136.79	7	8			
Larimer	120.60	4	5			
Adams	129.04	6	7			
Arapahoe	100.31	1	1			
Boulder	138.63	8	9			
Jefferson	110.63	2	2			
Bethesda	120.25	5	6			
Denver H & H	183.83	12	15			
Park East	172.38	10	14			
SW Denver	165.04	9	13			
Aurora	119.43	3	4			
Centennial	180.60	11	16			
Average	139.79					
Total State	159.95					

APPENDICES

APPENDIX I

DIVISION OF MENTAL HEALTH RESIDENTIAL CONTINUUM

RESIDENTIAL SETTING	CLIENT PROFILE	SERVICE DESCRIPTION
1. INPATIENT: In-hospital, 24-hour care at a hospital licensed by the Colorado Department of Health (i.e., private psychiatric hospitals, general hospitals, and state hospitals) characterized by continuous medical and psychiatric diagnostic and treatment services provided under an organized medical staff.	- Individuals determined to be a danger to self - Individuals determined to be a danger to others - Individuals determined to be gravely disabled - Individuals who are combative or assaultive or violent due to mental illness - Individuals who are admitted under the provisions of 27-10 and other involuntary codes - Individuals who need to be in a protective environment in order for treatment to be attempted - Individuals who have a severe disturbance of thought processes which does not permit even marginal community functioning - e.g., extensive delusions or hallucinations; bizarre behavior; destructive behavior - Individuals with psychiatric problems accompanied by severe medical or physical problems - Individuals who are seriously, critically, or chronically psychiatrically disabled	- 24-hour medical staffing - 24-hour nursing supervision - 24-hour mental health staffing - Medication stabilization - Medication monitoring - Lockable units - Physical restraints and seclusion rooms - Structured mental health programs - Continuous psychiatric services - Support services fully provided (e.g., food, clothing, laundry, etc.) - Individual and group therapy provided - Self care management skills, basic living skills, social skills, and interpersonal skills may be taught - Functional and vocational assessment may be provided - Work preparation training and/or supervised (sheltered) work opportunities may be provided - Crisis intervention - Case management - Social and recreational opportunities - Discharge planning and referral
2. NURSING HOMES: 24-hour care in a skilled nursing care facility or an intermediate health care facility licensed by the Department of Health which provides health services that are supportive and restorative in nature to patients who may require medical care and 24-hour nursing services. The major focus of this type of facility is on continuous medical, nursing, or health care supervision, with intermittent mental health and/or social care services.	- Individuals with chronic health problems who require seven-day-a-week nursing care and who have a psychiatric diagnosis - Individuals who are unable to provide their own physical care and who have a psychiatric diagnosis - Individuals who are non-combative, non-assaultive, and non-violent - Individuals who are not serious behavior management problems - Individuals who are not dangerous to themselves or others	- 24-hour medical care available - 24-hour nursing supervision - 24-hour structured programming, but not mental health care - Medication monitoring - Intermittent mental health services - Support services fully provided (e.g., food, clothing, laundry, etc.) - Discharge planning and referral - Referrals to community mental health centers for mental health care

DIVISION OF MENTAL HEALTH RESIDENTIAL CONTINUUM

RESIDENTIAL SETTING	CLIENT PROFILE	SERVICE DESCRIPTION
3. INTENSIVE MENTAL HEALTH COMMUNITY TREATMENT FACILITY: 24-hour mental health staffing and clinical supervision in a facility operated by or under contract with a mental health agency approved by the Division of Mental Health. The major focus of this type of facility is on the continuous provision of intensive mental health services and mental health support services with intermittent medical, nursing, or health care supervision. These facilities may provide long-term maintenance care to mental health clients or may be designed to provide transitional care.	- Individuals with problems in meeting basic needs - Individuals with problems in self care management - Individuals with inappropriate social skills - Individuals who are seriously and/or chronically psychiatrically disabled. - Individuals who have a primary psychiatric diagnosis and no major medical problems - Individuals who have minimal job or role performance skills - Individuals who need life planning assistance to manage personal affairs - Individuals whose personal behaviors create management problems - Individuals who may pose a potential threat to themselves or others, but not individuals who are overtly violent toward themselves or others	- 24-hour mental health staffing - Intermittent nursing supervision - Medication stabilization - Medication monitoring - Physical restraints - Continuous mental health programming - Structured mental health services - Discharge planning and referral - Basic care skills taught - Individual and group therapy - Self care management taught. - Social skills taught - Functional and vocational assessment - Work preparation training and/or supervised (sheltered) work opportunities may be provided - Crisis intervention - Case management - Support services may be provided - Social and recreational opportunities - Medical care available through the community. mental health center or an outside agency - Access to other mental health center services

DIVISION OF MENTAL HEALTH RESIDENTIAL CONTINUUM

RESIDENTIAL SETTING	CLIENT PROFILE	SERVICE DESCRIPTION
4. COMMUNITY-BASED RESIDENTIAL FACILITY: Less than 24-hour clinical supervision in a facility which may or may not be operated by or under contract with a mental health agency. The major focus of this type of facility is on the provision of less intensive mental health services and mental health support services. These facilities may provide long-term care to mental health clients or may be designed to provide transitional care.	- Individuals with few/minimal problems in self care management - Individuals with few/minimal problems in meeting basic needs - Individuals with few/minimal problems with social skills - Individuals who are in need of further job or role performance skills to move toward independent functioning - Individuals who do not create behavior management problems - Individuals who function at a higher overall level than those in an intensive mental health facility - Individuals who need a focus on rehabilitation rather than maintenance - Individuals who are in need of a structured living arrangement	- Less than 24-hour mental health staffing - Medication monitoring - On-site mental health programming with referrals to community mental health centers - Follow-up care provided by the mental health center - Less intensive mental health therapy - Emphasis on peer support - Functional and vocational assessment may be provided - Vocational services available through the community mental health center or an outside agency - Emphasis on independent social skills - Independent living skills taught - Social and recreational opportunities may be provided - Medical care available through the community mental health center or an outside agency - Individual and group therapy may be provided through the community mental health center - Crisis intervention provided through the community mental health center - Case management provided through the community mental health center - Access to other mental health center services

DIVISION OF MENTAL HEALTH RESIDENTIAL CONTINUUM

RESIDENTIAL SETTING	CLIENT PROFILE	SERVICE DESCRIPTION
5. BOARDING HOMES: A privately-owned facility which is licensed, certified, or otherwise operates according to local county requirements. These facilities provide room and two or three meals per day for four or more adults. A mental health center placing clients in this type of facility has sole responsibility for providing mental health services to the client, as the facility itself does not offer mental health services.	- Individuals who have the capability of meeting basic needs - Individuals who have inconsistent job and/or role performance skills - Individuals who are not behavior management problems - Individuals who are frequently withdrawn and socially isolated - Individuals who lack adequate interpersonal skills - Individuals who may need periodic assistance in life planning to manage personal affairs - Individuals who need a focus on maintenance rather than rehabilitation	- Community mental health centers may provide all services to clients (facility provides no mental health services) - Room plus two or three meals per day provided - No official responsibility for mental health services - Medical care available through the community mental health center or an outside agency - Mental health services may be provided by the community mental health center - Follow-up care may be provided by the community mental health center - Crisis intervention may be provided by the community mental health center - Case management may be provided by the community mental health center
6. INDEPENDENT LIVING: A publicly or privately owned residence where the client lives while obtaining mental health services or mental health support services through a catchment area community mental health center.	- Individuals who have the capability of meeting basic needs - Individuals who have no problems in self care management - Individuals who have adequate job and/or role performance skills - Individuals who possess adequate interpersonal and social skills - Individuals who need intermittent mental health intervention for rehabilitation or maintenance	- The services of a community mental health center would be available to the residents of independent living settings - Medical care available through the community mental health center or an outside agency - Follow-up care may be provided by the community mental health center - Case management may be provided by the community mental health center - Crisis intervention may be provided by the community mental health center

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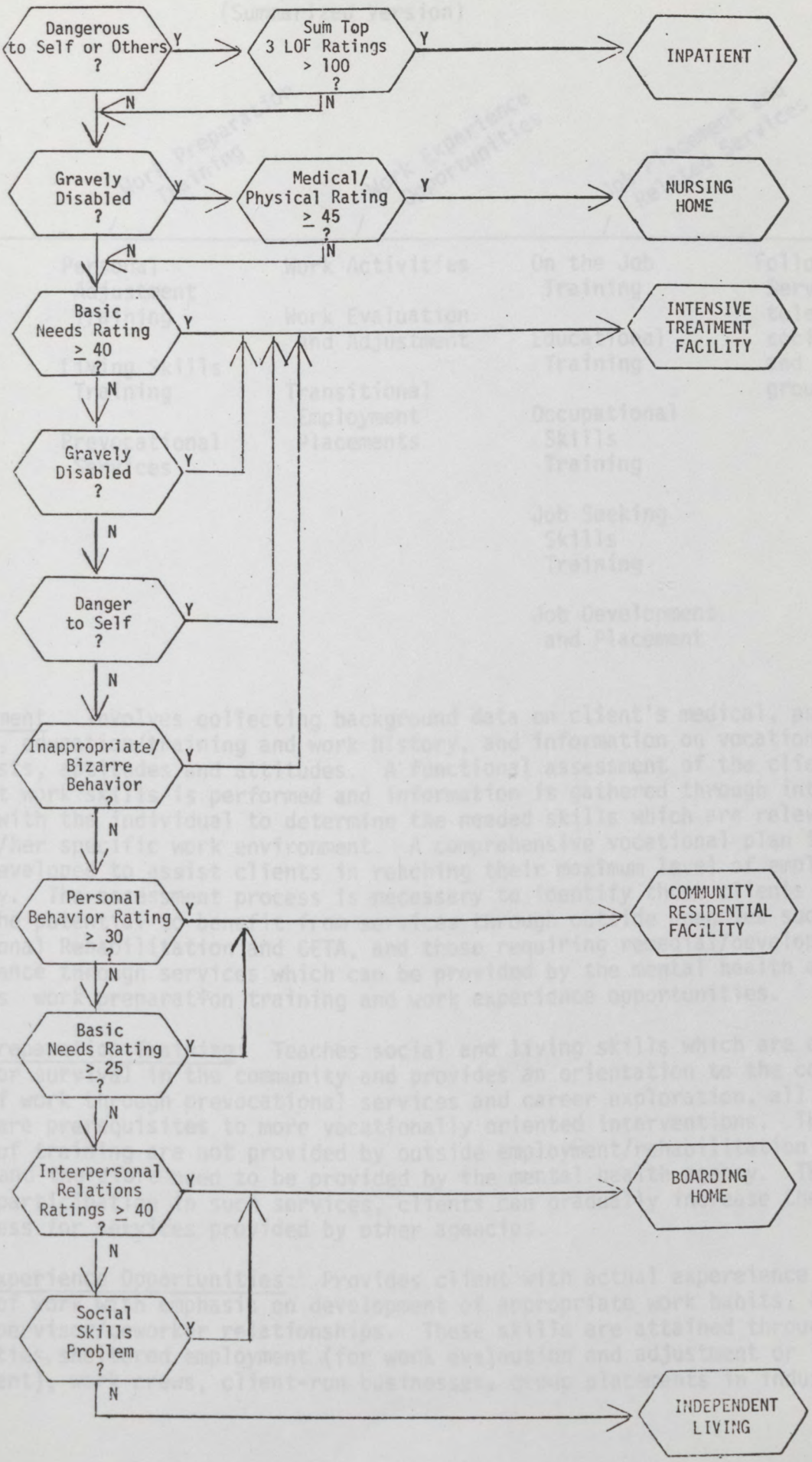
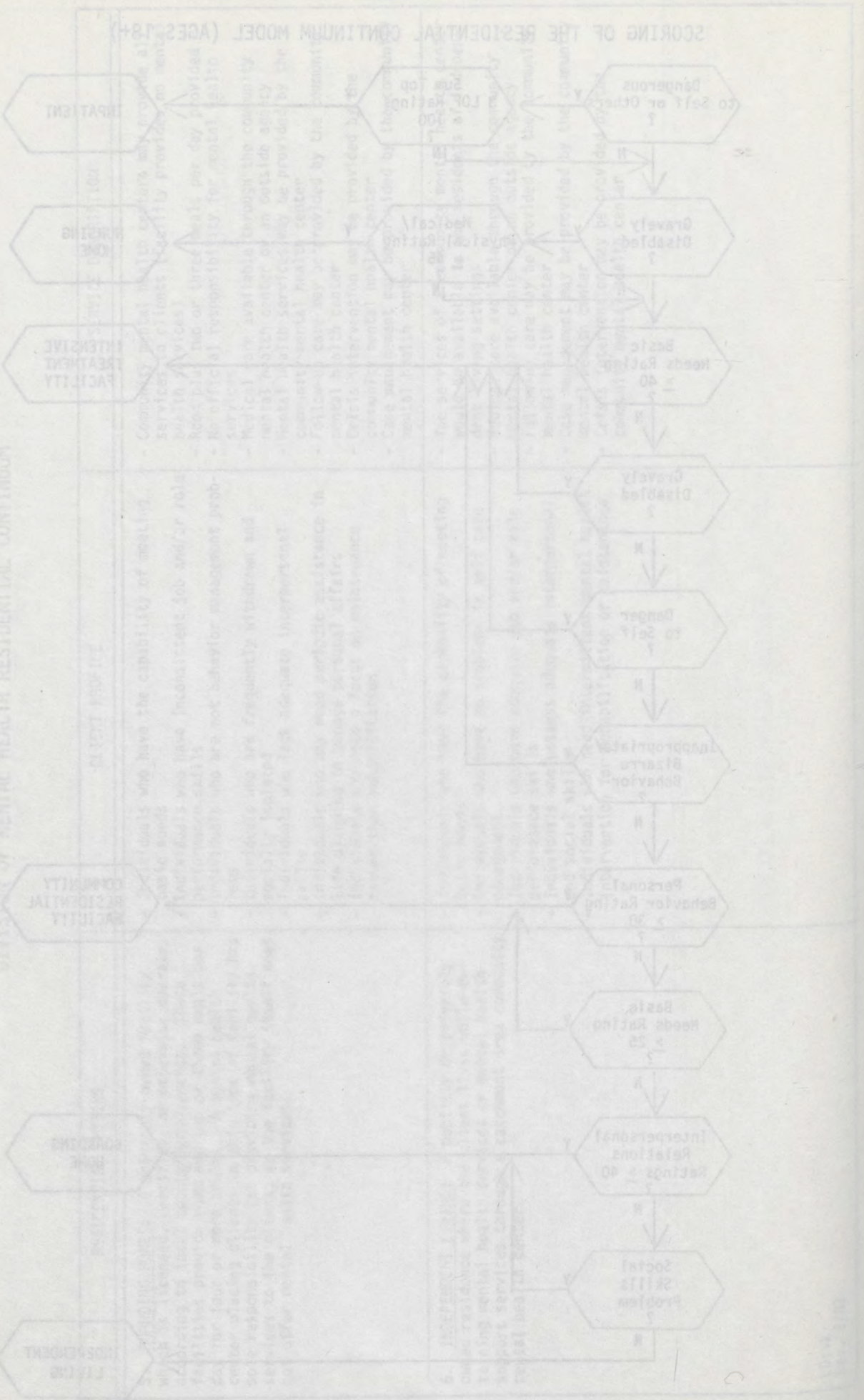
APPENDIX II

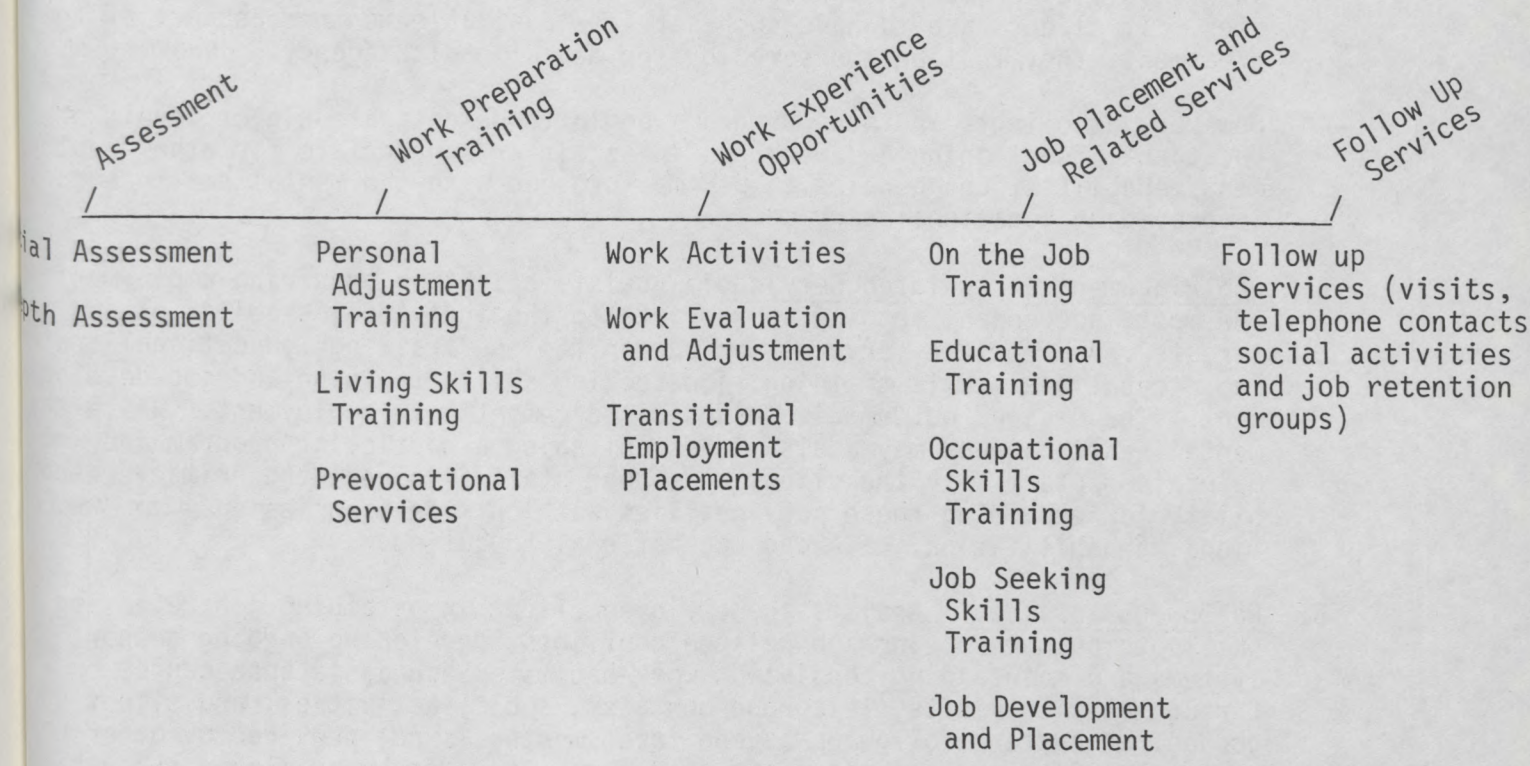
SCORING OF THE RESIDENTIAL CONTINUUM MODEL (AGES 18+)





APPENDIX III

VOCATIONAL CONTINUUM
(Summarized Version)



1. Assessment: Involves collecting background data on client's medical, psychosocial, education/training and work history, and information on vocational interests, aptitudes and attitudes. A functional assessment of the client's current work skills is performed and information is gathered through interviews with the individual to determine the needed skills which are relevant to his/her specific work environment. A comprehensive vocational plan is then developed to assist clients in reaching their maximum level of employability. The assessment process is necessary to identify those clients who have the potential to benefit from services through outside agencies such as; Vocational Rehabilitation and CETA, and those requiring remedial/developmental assistance through services which can be provided by the mental health agency such as work preparation training and work experience opportunities.

2. Work Preparation Training: Teaches social and living skills which are essential for survival in the community and provides an orientation to the concept of work through prevocational services and career exploration, all of which are prerequisites to more vocationally oriented interventions. These types of training are not provided by outside employment/rehabilitation agencies, and therefore need to be provided by the mental health agency. Through their participation in such services, clients can gradually increase their readiness for services provided by other agencies.

3. Work Experience Opportunities: Provides client with actual expereience in the world of work with emphasis on development of appropriate work habits, attitudes and supervisor/coworker relationships. These skills are attained through work activities, sheltered employment (for work evalaution and adjustment or long term placement), work crews, client-run businesses, group placements in industry and

individual transitional employment placements (TEP). A certain degree of work potential demonstrated by the client in the skills identified above is usually an eligibility criterion for services of outside employment/rehabilitation agencies. If clients are to have such services available to them as part of their treatment, they must be sponsored by the mental health agency. However, as

However, as clients in these programs begin to demonstrate higher levels of vocational functioning and work readiness, it is appropriate for other employment/rehabilitation agencies to become involved with the mental health agency in providing vocational services.

4. Job Placement and Related Services: Assists client in acquiring employment in the most independent setting appropriate to the individual's abilities and interests. Appropriate services include on the job training, educational training, occupational skill training, job seeking skills training and job development. The desired outcome is unsubsidized competitive employment. While the mental health agency may assist in establishing a particular program and will maintain contact with the client and other staff involved, the primary responsibility for providing these services lies with outside agencies such as Vocational Rehabilitation, CETA and Occupational Education.

5. Follow Up Services: Assists the employed client in attaining job retention skills through resolving job related conflicts, developing ongoing support systems and maintaining consistent work habits. Such assistance can be provided through on-site visits, telephone contacts, social activities, and client support groups. Long-term follow up beyond three months is not provided by other employment/rehabilitation agencies, and therefore needs to be available through mental health personnel as appropriate, based on the individual client's needs.