State of Colorado

MENTAL HEALTH PLAN

1983 - 1985

STATE OF COLORADO

COLORADO MENTAL HEALTH PLAN

1983 - 1985

PREPARED BY

COLORADO DIVISION OF MENTAL HEALTH

NOVEMBER 1983

THE COLORADO STATE MENTAL HEALTH PLAN

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THE COLORADO MENTAL HEALTH PLAN

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 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: clarify the roles of the components of the system; determine mental health personnel and facility needs; provide for citizen input; facilitate coordination with other agencies; identify gaps in and duplication of services; 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 1983-85 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 content and format of this Plan differ substantially from previous plans, as this Plan reflects an effort to integrate the Division of Mental

Health's planning process with the planning process which has been established over the past couple of years by the Department of Institutions. The primary focus of the Department's planning process is the development of a "Situational Analysis," which provides an assessment of the status of the current service system and its ability to achieve its mission and goals. Chapters Two through Nine of this State Mental Health Plan are based upon the mandated format for the Division of Mental Health's Situational Analysis. Another significant change is that the State Mental Health Plan is now a two-year plan, rather than a five-year plan. This change will be evaluated to determine if the reduced time period covered by the Plan results in planning which is more relevant and responsive to the changing mental health needs of the State of Colorado.

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

1. Introduction: This introduction provides an overview of the State Mental Health Plan. It also includes a Fact Sheet which gives an outlined description of the Colorado mental health system.

2. Chapter I - 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. This chapter also includes descriptions of the state mental hospitals and the catchment area mental health programs. The Colorado Mental Health Council also is identified in this chapter. Brief descriptions of the role, responsibilities, and membership of the Council are included.

3. Chapter II - Target Client Population: This chapter provides a description of the characteristics and size of the state-funded mental health system's target client population. The Division of Mental Health's priorities for service delivery, based upon severity and chronicity of disability, age, and ethnicity, are described in this section.

4. Chapter III - Main Services Rendered: This chapter contains a critical analysis of the services provided to the various client populations served by the state mental health system. For each of the system's client populations, there is a summary of the current situation regarding the provision of mental health services. Following this introduction is a description of the facts and trends that impact the delivery of mental health services to each respective population. The conclusions and general implications which flow from the facts and trends are then stated. Each chapter concludes with recommended strategies for addressing the problems which have been identified.

5. Chapter IV - Facilities: 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 Colorado State Hospital and at Fort Logan Mental Health Center

which are being used for purposes other than those for which they were designed. This section includes a description of these and other facility related problems. Both general and specific facility needs for the two state hospitals also are described in Chapter IV.

6. Chapter V - Staff Resources: This chapter begins by looking at the issues that impact the mental health system's human resources, then presents the conclusions and implications generated by these issues. Strategies for dealing with staff resource problems are described at the end of this section.

7. Chapter VI - Source of Funds: This chapter describes the major sources and levels of funds employed to render state mental health services.

8. Chapter VII - External Influences: Proper planning requires knowledge and understanding of the external factors that impact the ability of the mental health system to provide services to the residents of Colorado. Chapter VII looks at external trends that impact the mental health system and provides a brief summary of the issues generated by those trends.

9. Chapter VIII - Comparison of Actual Results to Operating Plan: Chapter VIII summarizes briefly the major deviations from the Division of Mental Health's FY 1982-83 Operating Plan and from the FY 1982-83 budget.

10. Chapter IX - Summary List of Problems and Opportunities: This section contains a concise list of problems and opportunities which resulted from the analyses completed in the preceding chapters.

11. Chapter X - Statewide Goals and Objectives: Chapter X is one of the most critical chapters in the Plan, as it sets forth the goals and objectives which provide both specific direction and a means for assessing progress. The goals and objectives have been developed in response to the issues and problems identified in the preceding chapters.

This chapter is revised annually. Some goals and objectives have been revised to reflect more accurately the directions of the Colorado mental health system. 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 X, 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.

C. FACT SHEET

COLORADO DIVISON 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: 29.3 Full-time Employee Positions

STATE HOSPITALS:
Colorado State Hospital; Pueblo, Colorado
Fort Logan Mental Health Center; Denver, Colorado

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

ESTIMATED ADMISSIONS SYSTEM-WIDE (FY 1982-83):
CENTERS AND CLINICS: 40,013
HOSPITALS: 2,417
TOTAL: 42,430

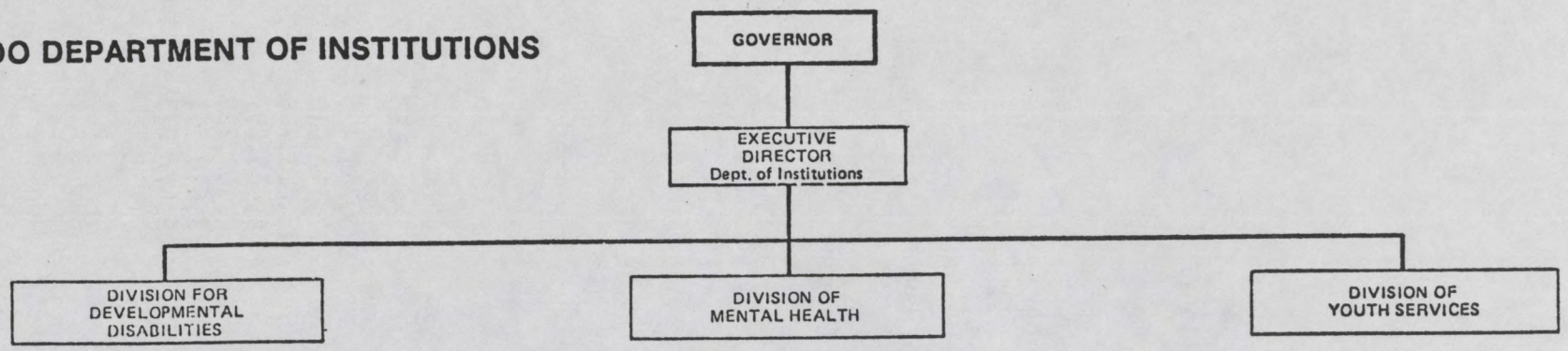
ESTIMATED CLIENTS SERVED SYSTEM-WIDE (FY 1982-83):
CENTERS AND CLINICS: 63,688
HOSPITALS: 3,249
TOTAL: 66,937

FINANCES:
TOTAL OPERATING BUDGET (FY 1982-83): $91,080,235
SOURCES OF REVENUE:

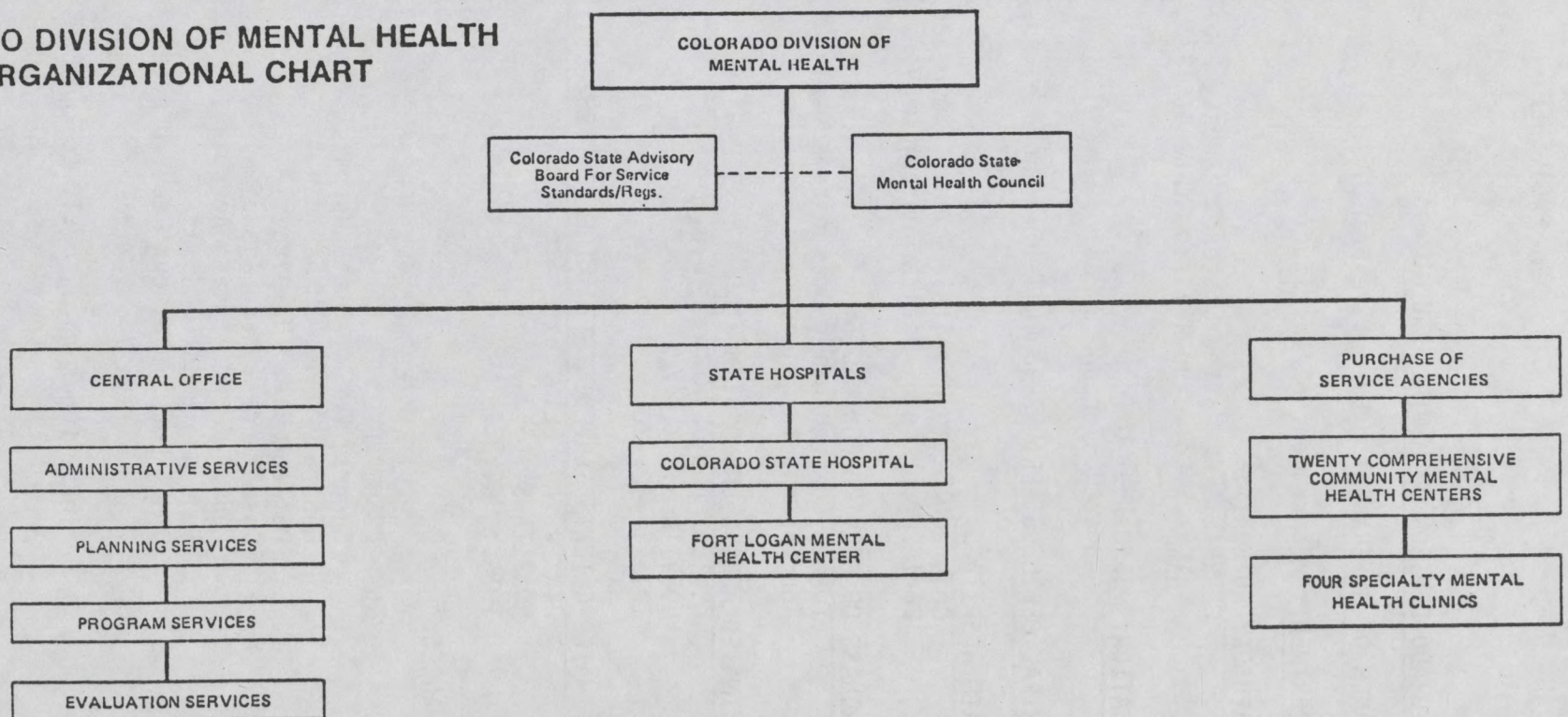
General Funds, State Hospitals/Agencies	$33,766,123
General Funds, CMHCs	17,142,918
Patient Fees (Hospitals)	15,223,760
Cash Funds (State Agencies)	4,456,691
Federal Funds (State Agencies)	302,739
Federal Funds (CMHCs)*	3,610,191
CMHC, Local, Patient Fees, Donated, Etc.*	16,577,813

*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: 1,325.0 Full-time Employee Positions

BED CAPACITY: 754 Staffed Beds - All Programs

CLIENTS SERVED (carryovers, admissions and interdivision transfers):

	ACTUAL 1981-82	ESTIMATED 1982-83	PROJECTED 1983-84
Adult Psychiatry	1,498	1,154	1,160
Forensic Psychiatry	935	1,000	1,100
Drug Treatment	392	262	200
Geriatric Treatment	401	364	300
Children/Adolescent Treatment	336	334	350
General Hospital/ Medical	2,405	2,318	2,100
Total (excludes transfers)	5,151	4,646	4,600

FINANCES:

TOTAL OPERATING BUDGET (FY 1982-83):	$38,180,681
SOURCES OF REVENUE:	
General Fund	$24,404,287
Cash Funds, Patient Fees	9,686,318
Cash Funds, Other State Agencies	4,090,076
Federal Funds	-0-

FORT LOGAN MENTAL HEALTH CENTER

LOCATION: Denver, Colorado

TOTAL STAFF: 516.7 Full-time Employee Positions

BED CAPACITY: 333 Staffed Beds - All Programs

CLIENTS SERVED (carryovers, admissions and interdivision transfers):

	ACTUAL 1981-82	ESTIMATED 1982-83	PROJECTED 1983-84
Adult Psychiatry	360	484	568
Geriatric/Deaf/ Aftercare	372	358	250
Children/Adolescent Treatment			
Children	71	38	32
Adolescent	212	249	243
Vocational Services	24	18	24
Total (excludes transfers)	997	1,073	1,037

FINANCES:

TOTAL OPERATING BUDGET (FY 1982-83):	$15,265,893
SOURCES OF REVENUE:	
General Fund	$ 9,361,836
Cash Funds, Patient Fees	5,537,442
Cash Funds, Other State Agencies	366,615
Federal Funds	-0-

COMMUNITY MENTAL HEALTH CENTERS/CLINICS

TOTAL STAFF:

FULL-TIME STAFF:	1,099
PART-TIME STAFF:	488

CONTRACTED SERVICES:

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

	ACTUAL 1981-82	ESTIMATED 1982-83	PROJECTED 1983-84
CHILDREN (0-11 years)	6,293	5,519	5,439
ADOLESCENTS (12-17 years)	8,595	7,900	7,226
ADULTS (18-59 years)	51,999	45,051	43,855
ELDERLY (60+ years)	5,686	5,218	4,870
TOTAL	72,573	63,688	61,390
CRITICALLY, SERIOUSLY, AND CHRONICALLY DISABLED	56,360	52,194	47,289
ETHNIC MINORITIES	16,017	13,459	12,064

FINANCES:

TOTAL OPERATING BUDGET (FY 1982-83):	$37,633,661
SOURCES OF REVENUE:	
State Funds	$17,142,918
Federal Funds	3,610,191
Fees, Titles, Insurance	9,076,807
County/Municipal	2,299,858
Donated and In-Kind	2,550,672
School Districts	277,234
Other	2,675,981

COLORADO COMMUNITY MENTAL HEALTH CENTERS AND CLINICS

Community Mental Health Centers

Adams Community 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

THE COLORADO MENTAL HEALTH PLAN

CHAPTER I: THE STATE MENTAL HEALTH PROGRAM

A. DESCRIPTION OF SERVICE

1. State Mental Health Authority

The Department of Institutions is designated the official mental health and mental retardation authority (CRS 27-1-101 to 27-16-105) 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). 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.
- To establish and enforce policies, rules, and regulations for the state mental health system.
- To monitor the programs and services of the state mental hospitals, the community mental health centers/clinics, and the other designated agencies to ensure compliance with standards, rules and regulations.
- To assess the quality of mental health services and to assist the agencies in improving services.
- To facilitate 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.
- To otherwise plan, organize, and direct the state's mental health program for the prevention and treatment of mental and emotional disorders.

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: any type of 24-hour care or supervision which is not provided within a hospital setting (e.g., community homes, nursing homes, etc.). Residential care on a hospital campus, in a non-licensed unit, is also Other 24-Hour Care.

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. State-Owned Facilities and Agencies Contracting with the State

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.

a. Colorado State Hospital is located in Pueblo, and services fifty-five counties.
b. Fort Logan Mental Health Center is located in southwest Denver, and services 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. All centers and clinics are private, nonprofit 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.

4. Private/Voluntary Treatment Resources

a. There are four private psychiatric hospitals and over twenty private general hospitals which have psychiatric wards or which will accept psychiatric patients.
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. Many private practitioners (nurses, social workers, psychologists, pastoral counselors, psychiatrists, etc.) are also available.
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 Services, 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.

B. STATE HOSPITALS AND THE CATCHMENT AREA MENTAL HEALTH PROGRAM

The Treatment and Support System Model has been developed and adopted by the Colorado Division of Mental Health 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 some 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,

because changes in one part of the system have a ripple effect upon the 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 and inpatient services in a state hospital. 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.

1. State Mental Hospitals

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

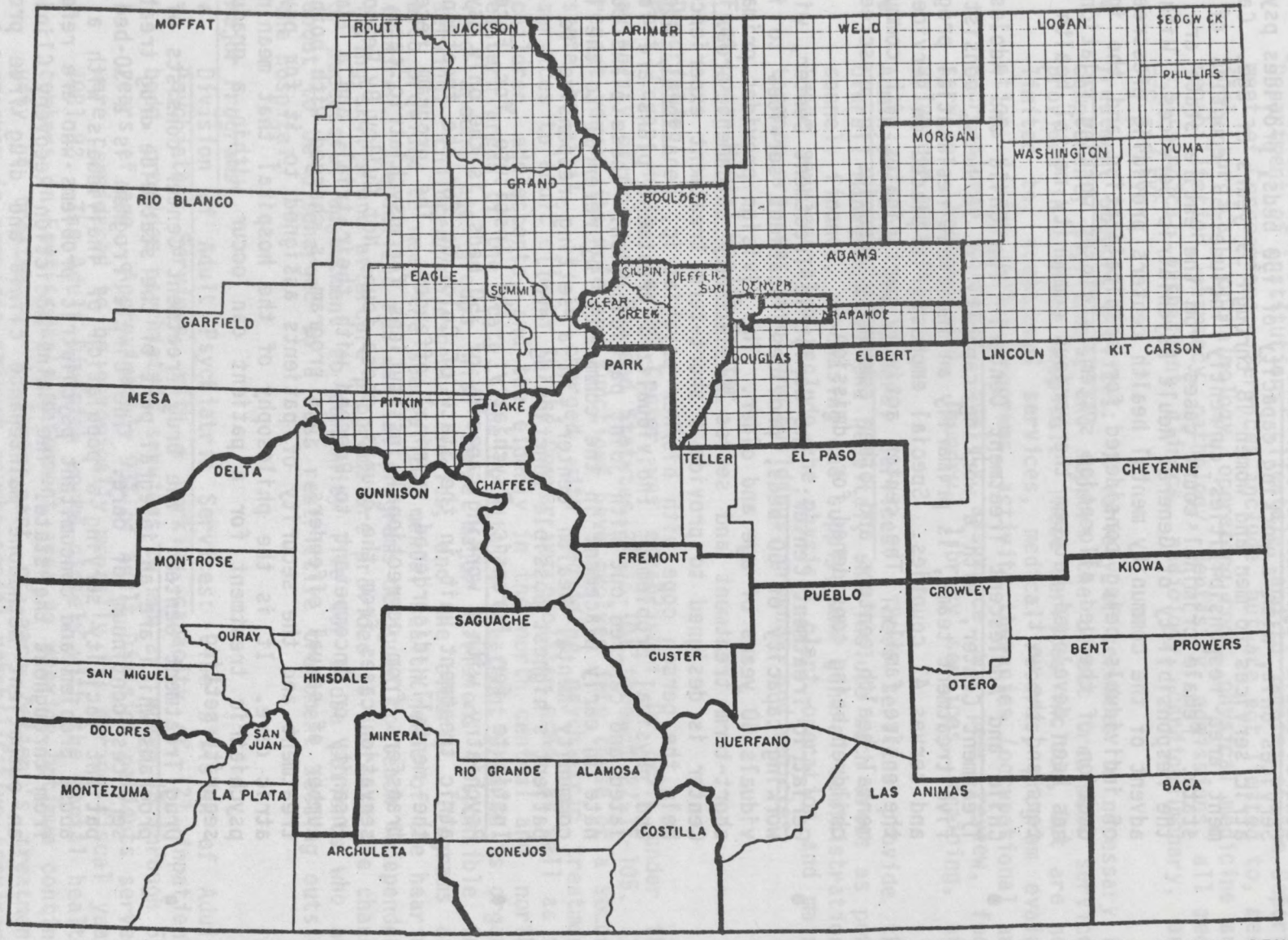
In Fiscal Year 1983-84, both state hospitals developed written plans for the delivery of mental health services in their respective hospital service areas (see map on page 6). These plans provide detailed information on both hospitals and are available from the hospitals or from the Division of Mental Health. The following, therefore, provides only a brief description of each state hospital, and of the services provided by each hospital.

Colorado State Hospital

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, adolescent, and geriatric clients from 41 counties of the state. It operates under the purview of Colorado Revised Statutes 27-13-113. Colorado 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.

DIVISION OF MENTAL HEALTH - HOSPITAL SERVICE AREAS



FORT LOGAN MENTAL HEALTH CENTER
ALL AGES

COLORADO STATE HOSPITAL
ALL AGES

FORT LOGAN MENTAL HEALTH CENTER
CHILDREN, ADOLESCENTS, GERIATRICS.
COLORADO STATE HOSPITAL
ADULTS

(12/82)

Major Programs:

- General Adult Psychiatric Services: The General Adult Psychiatric Services unit, with a working capacity of 150 beds, provides psychiatric services to men and women 18 through 59 years of age. Catchment area responsibilities currently include 55 counties of the state. Female criminal court cases from the entire state are also the responsibility of General Adult Psychiatric Services. With the advent of the community mental health centers providing prescreening of individuals being considered for hospitalization and the introduction of the bed allocation system, a closer working relationship has been developed between the various community mental health centers and the unit.

- Child and Adolescent Treatment Center: The Child and Adolescent Treatment Center, with a working capacity of 96 beds, consists of five treatment teams, is primarily an inpatient residential program, and serves 41 counties. 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.

- Geriatric Treatment Center: The Geriatric Treatment Center, with a working capacity of 60 beds, 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. Individualized treatment plans are formulated and carried out with joint participation. These plans culminate in early placement in the community, by referral to the local community mental health center, in a setting responsive to each patient's highest possible functioning level.

- Institute for Forensic Psychiatry: The Institute for Forensic Psychiatry, with a working capacity of 350 beds, is the only psychiatric treatment unit in the State of Colorado for the treatment of the mentally disordered criminal offender. The program receives transfers from correctional institutions for psychiatric care, observation cases from the courts, those found Not Guilty By Reason of Insanity or Incompetent to Proceed with their trial, 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.

- Drug Treatment Center: The Drug Treatment Center consists of two programs which are an integral part of the statewide drug treatment services continuum of care. The Circle Program is a 30-bed inpatient facility serving a population of individuals with a drug abuse problem and concomitant psychiatric problems who are referred from throughout the state. The Plains Addiction Recovery Clinic is an outpatient methadone maintenance clinic and drug free program which provides services for the southeastern part of Colorado.

- General Hospital Services: The General Hospital, with a working capacity of 68 beds, provides medical and surgical services to Colorado State Hospital psychiatric patients, to a wide variety of Department of Institutions' clientele, and to inmates of the Department of Corrections. Services include, but are not limited to, medical, surgical, opthalmology, operating room, physical medicine and rehabilitation, pharmacy, pathology, dentistry, admissions, all medical/surgical outpatient clinics, radiology, cardiopulmonary, and EEG and EKG.
- 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.
- 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.

Fort Logan Mental Health Center

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 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 three major divisions responsible for serving: children/adolescents; adults; and the elderly. 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.

Major Programs:

- Division of Adult Psychiatric Services: The Division of Adult Psychiatric Services, with a working capacity of 121 inpatient beds, provides psychiatric services to men and women 18 through 59 years of age. Approximately 93% of Adult Division patients served were considered to be chronically mentally ill during fiscal year 1981-82. The Adult Division works closely with the mental health centers in Fort Logan's catchment area to provide optimum continuity of treatment. A large part of each patient's treatment program is provided through psycho-social rehabilitative services,

such as vocational services, living skills training and occupational therapies.

- Division of Child/Adolescent Psychiatry: The Division of Child/Adolescent Psychiatry provides inpatient services to children, ages seven through eleven, and to adolescents, ages twelve through seventeen. This Division has four clinical teams with a working capacity of 76 inpatient beds: (1) Childrens I is a 15 bed unit which provides emergency, short, and long-term care. The admission of children under the age of seven is available by special arrangement. (2) Adolescent I is an open treatment unit with 23 beds. (3) Adolescent II is a locked facility with 22 beds. (4) Adolescent III is an open treatment facility with 16 beds.

  This Division has experienced high demand for services with an average bed occupancy rate of 93% for FY 1981-82 and 94% for FY 1982-83. In addition to the treatment services provided to all Fort Logan patients, patients of the Child/Adolescent Division receive educational programming through the Fort Logan School. Special emphasis also is placed upon including the patient's family in treatment.

- Division of Geriatric/Aftercare/Deaf Psychiatric Services: The Geriatric/Aftercare/Deaf Division is characterized by its diversity in patient population and treatment services provided through the following teams:
  (1) Geriatrics Inpatient Team: This is a thirty bed lockable facility which provides emergency short-term and long-term services to mentally ill persons over the age of sixty years.
  (2) Deaf Services: This is a specialty service which provides psychiatric treatment to the hearing-impaired/mentally ill of the entire state. Most patients are seen as day or outpatients. At present there are two residential treatment settings available on Fort Logan's grounds for the hearing impaired.
  (3) Aftercare: Fort Logan Mental Health Center has actively developed less structured alternatives to inpatient care in an attempt to: 1) provide residential alternatives to nursing home care for the elderly patient; 2) provide psychiatric treatment in the least restrictive setting appropriate to the patient's needs; 3) find more cost-effective alternatives to inpatient treatment for the long-term patient. At present, other twenty-four hour programs at Fort Logan focus on serving the chronic adult and elderly patient or the hearing impaired patient.

- Hospital and Medical Services: This service provides supporting medical, pharmacy, dentistry, central medical supply, and EEG services to Fort Logan patients and other state agencies, including Developmental Disabilities and the Division of Youth Services.

- 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.

- 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.

2. Catchment Area Mental Health Program

a. Catchment Areas

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. 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 11 shows the relationships among Colorado Planning Regions, counties, catchment area mental health centers, and state hospitals.

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 County Mental Health Center (Jefferson, Gilpin, and Clear Creek Counties).

b. Community Mental Health Centers and Clinics

The Colorado Division of Mental Health purchases mental health services from the twenty catchment area mental health centers and from the four specialty clinics which provide highly specialized services. A goal of the Division of Mental Health is to have a full range of mental health services available in each catchment area. 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 of 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.

PLANNING REGIONS, COUNTIES, AND CATCHMENT AREA MENTAL HEALTH CENTERS

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

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 to be served:

-By age (children, adolescents, adults, and elderly).

-By severity (serious, critical, and chronic).

-By ethnic background (Chicano, Black, Asian, American Indian, and total ethnic minorities).

The disbursement of funds is contingent upon the agencies successful completion of these and other terms of the contract.

Each year the community mental health centers and clinics submit a plan for services in their respective catchment areas. The submission of these plans is included in the Division's contract with each of the centers. The Division of Mental Health reviews all of these local plans and identifies statewide trends and planning issues. In the plans submitted for Fiscal Year 1983-84, the themes that were woven throughout, in order of priority, were as follows:

(1) Concern over declining resources; including federal, state, and local funds.

(2) Importance of maintaining the current level of services.

(3) Concern over staffing and staff issues such as low salaries, burnout, and turnover.

(4) Ensuring adequate programs for the various target client populations; especially the seriously, critically and chronically disabled and children/adolescents.

(5) Concern over the shortage of psychiatric beds, including inpatient beds and psychiatric beds in the community.

C. COLORADO MENTAL HEALTH COUNCIL

1. Role and Responsibilities

The Colorado Mental Health Council was created in September, 1976, by Governor Richard Lamm. In October of 1983, Governor Lamm transferred authority for the Council to the Executive Director of the Department of Institutions. The Council functions as the official advisory body to the Division of Mental Health with regards to the development, implementation, and evaluation of the State Mental Health Plan. In that role, it serves 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, but not less than quarterly, to consult with the state agency on the development, revision, and administration of the State Mental Health Plan to

ensure its relevance and responsiveness to changing mental health needs and its coordination with other planning efforts.

b. 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.

c. 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.

d. The Council maintains bylaws and appropriate operating guidelines to ensure smooth and continuous operation.

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.

2. Membership

The State Mental Health Council consists of 21 members who are residents of Colorado. No less than 40% of the members of the Council are direct and indirect providers of mental health services. A majority, but no more than 60% of the members are consumer representatives and consumers of mental health services. The members of the Council are most useful in their advisory capacity if diversity of geographic areas, interests, concerns, and expertise are maintained. An 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 I.14 of this Chapter.

COMPOSITION OF COLORADO MENTAL HEALTH COUNCIL

Name and Date Term Expires		Sex		Ethnic Background					Place of Residence	Type of Residence			Class of Membership				Occupation & Type of Employment
		Female	Male	Asian Amer.	Black	Chicano	Native Amer.	White		Rural	Urban	Suburban	Consumer	Provider	Nongov't. Org.	State Agency	
Alice Archibald	84	X						X	Durango	X				X			Director, Southwest MHC
Guidotta Bates	85	X						X	Brush	X			X				Consumer
James Clinton	84		X					X	Greeley		X		X				Consumer
Lucy May Dame	85	X						X	Denver		X		X				Senior Citizen's Board
Melanie Fairlamb	84	X						X	Delta	X			X				Consumer
Ruth Fuller	84	X			X				Denver		X					X	UCHSC, Dept. of Psychiatry
Jerry Goebel	84		X					X	Boulder			X		X			Boulder Psychiatric Institute
Thelma Knight	84	X						X	Littleton			X	X				Mental Health Association
Lois Moll	85	X						X	Denver		X		X				Consumer
Jack Quinn	85		X					X	Pueblo		X		X				Pueblo Housing Authority
Roger Richter	84		X					X	Denver		X		X				Insurance
Rick Sanchez	85		X			X			Alamosa	X			X				Consumer
Randy Stith	84		X					X	Aurora			X		X			Colo. Assn. of Community MHCs
Jennie Villegos	85	X				X			Denver		X			X			Servicios de La Raza
Robert Young	85		X					X	Boulder			X				X	DSS, Div. of Rehabilitation

CHAPTER II: TARGET CLIENT POPULATION

The Division of Mental Health has established priorities for service delivery based on three dimensions:

- -Severity and Chronicity of Disability
- -Age
- -Ethnicity

The highest priority for the state-funded mental health system is the provision of services to the seriously, critically and chronically mentally ill of all ages. This priority was mandated by the Colorado State Legislature in Footnote 59 of the FY 1981-82 Long Bill which states that funds from the General Assembly must be used "principally to contract for services for the seriously, critically or chronically mentally ill."

The second level of prioritization, based on age groups, is as follows, with the first population serving as the highest priority:

- -Children (0-11 years) and Adolescents (12-17 years)
- -Elderly (60 years and older)
- -Adults (18-59 years)

In relation to the dimension of ethnicity, a high priority for state-funded programs is to ensure that ethnic minorities receive an equitable distribution of services.

All of these priorities are consistent with the priorities reflected in the most recent local mental health plans submitted by the catchment area mental health centers. In order to monitor the degree to which public mental health funds are expended for these target groups, definitions for the seriously, critically and chronically mentally disabled target groups were developed. These are summarized briefly below.

Critically mentally ill individuals are defined as those persons in need of immediate care because of a life threatening condition. They are judged to be dangerous to themselves, dangerous to others and/or gravely disabled as a result of mental illness.

In contrast, **seriously mentally ill** individuals are those at risk of becoming critical if care is not provided. They may be potentially dangerous and are distinguished by functioning well below community norms.

The **chronically mentally ill** have a history of intensive treatment for mental illness. As a result of their disability, they are unable to maintain themselves in the community without considerable social and treatment support.

Below are patient profiles of these three client categories which comprise the Division's target groups.

TABLE II.1

Chronically, Seriously, and Critically Mentally Ill
Client Profiles

Chronically Mentally Ill:

previously used mental health services	94%
median length of current treatment episode	394 days
gravely disabled	29%
danger to self or to others	18%
unemployed	36%
social skills problem	91%
problems meeting basic needs	52%
lives with family or relatives	55%
severe-to-moderate personal behavior dysfunction	61%

Critically Mentally Ill:

previously used mental health services	86%
median length of current treatment episode	264 days
gravely disabled	64%
danger to self or to others	56%
unemployed	29%
social skills problem	79%
problems meeting basic needs	73%
lives with family or relatives	61%
severe-to-moderate personal behavior dysfunction	73%

Seriously Mentally Ill:

previously used mental health services	72%
median length of current treatment episode	163 days
gravely disabled	1%
danger to self or to others	2%
unemployed	19%
social skills problem	65%
problems meeting basic needs	28%
lives with family or relatives	68%
severe-to-moderate personal behavior dysfunction	34%

As would be expected from the definitions of these target groups, each group exhibits a somewhat different pattern of clinical characteristics. The chronically mentally ill, for example, are most likely to have received previous mental health treatment, have the longest treatment episodes, exhibit relatively greater problems with social skills and are most likely to be unemployed. The critically mentally ill are more likely to be gravely disabled, to be dangerous to themselves or others, to be having difficulty

in meeting their basic needs and to have severe or moderate behavioral dysfunction than those individuals in the other two groups. In contrast, those individuals who are seriously mentally ill are the least disrupted of the three target groups while still exhibiting marked problems in several areas.

In Table II.2, the utilization of state funded hospitals and community centers by target group is summarized.

TABLE II.2

Target Clients: Percentage Distribution of Open Cases Between the State Hospitals and Community Centers/Clinics

	State Hospitals	Community Centers & Clinics
	%	%
Chronic	76.1	22.9
Critical	57.6	10.9
Serious	34.6	66.6
Any one of three	95.6	78.3

The vast majority of clients served by the public mental health system meet the criteria of being either critically, seriously or chronically mentally ill.

While the information presented in Table II.2 related to open cases at the state hospitals and clinics at the end of the 1981-82 fiscal year, the information presented in Table II.3 summarizes characteristics of those patients admitted during fiscal year 1981-82.

TABLE II.3

Number of Admissions to Mental Health Centers and State Hospitals and Percentage Breakdown by Age Groups, Severity, and Ethnic Minorities, FY 1981-82

		AGE GROUPS				SEVERITY	ETHNICITY
Agency	Number of Admissions	% Children (0-11)	% Adol. (12-17)	% Adults (18-59)	% Elderly (60+)	% Critical/ Serious	% Ethnic Minorities
Community MH Centers and Clinics[1]	46,827	9.1	12.1	72.0	6.7	87.1	21.8
State Hospitals[2]	2,572	1.9	15.2	72.7	10.1	97.4	26.4
Colorado General Population		18.0	10.0	59.9	12.1	--	16.7

[1]Includes non-catchment specialty mental health clinics.

[2]Includes admissions of out-of-state residents and individuals with no permanent address.

This table describes admissions to the state mental health system during fiscal year 1981-82. The first column displays the total number of admissions for the community mental health centers/clinics and for the two state hospitals. The following columns show the percentage of these admission totals which fall into each of four age groups: children (ages 0-11), adolescents (ages 12-17), adults (ages 18-59), and elderly (ages 60 and over). The next column shows what percentage of these admissions are individuals who are critically or seriously psychiatrically disabled. The last column displays the percentage of admissions who are ethnic minorities, including Hispanics, Blacks, American Indians and Asians. Additionally, the percent of Colorado's general population in each of these groups also is presented.

In both the hospitals and community agencies, the proportion of adults and adolescents who are admitted to treatment exceeds their representation in the

general population while children and the elderly are somewhat underserved relative to their general population frequency. Similarly, minority group members represent proportionately more of the treatment group than of the general population. While discrepancies currently exist between the treatment group and general population, these are addressed each year through specific performance contracting with each community agency.

The estimated number of individuals served by various components of the mental health system is shown in Table II.4. Since individuals may be served in more than one setting, the second column in the table presents the estimated unduplicated count of clients in the mental health system. As may be clearly seen from the table, the majority of services are provided by the private practitioners and community mental health centers and clinics while the non-state funded hospitals serve the third highest proportion of clients.

TABLE II.4

Clients Receiving Mental Health Services
Statewide by Major Treatment Sector, FY 1981-82

Treatment Sector	Total # of Clients Served[1]	Estimated Unduplicated Count[2]
State Hospitals[3]		
CSH	2,354	1,954
FLMHC	997	828
Non-State Hospitals	13,000(est)	10,790
Nursing Homes	1,740(est)	1,440
Community MH Centers and Clinics	71,930	59,702
College Campus Clinics	5,380(est)	4,470
Private Practitioners	69,000-166,000(est)	57,275-137,790
Total	164,401-261,401	136,459-216,974

[1]Clients served are admissions plus carryovers (if available) from previous years.

[2]Using Regier's methodology (Regier, et al., Arch. General Psychiatry, 1978) which uses a conversion factor of 0.83 (approximately 1.2 episodes per person per year).

[3]Does not include non-mental health clients such as those in the general hospital at CSH, or alcohol or drug abuse programs. Those clients would increase the total clients served at the state hospitals by 2,797.

The graphs included in Figures II.1 and II.2 show admission trends for children/adolescents, adults, the elderly, and minorities from FY 1978-79 to FY 1982-83 (9 months of data). These graphs also show the population-in-need of services data for those same populations (see Appendix I for a technical explanation of the Division of Mental Health's Population-In-Need of Mental Health Services Model). This data very clearly presents the current situation in Colorado: **the need for mental health services is increasing while the ability of the system to serve more clients is decreasing.**

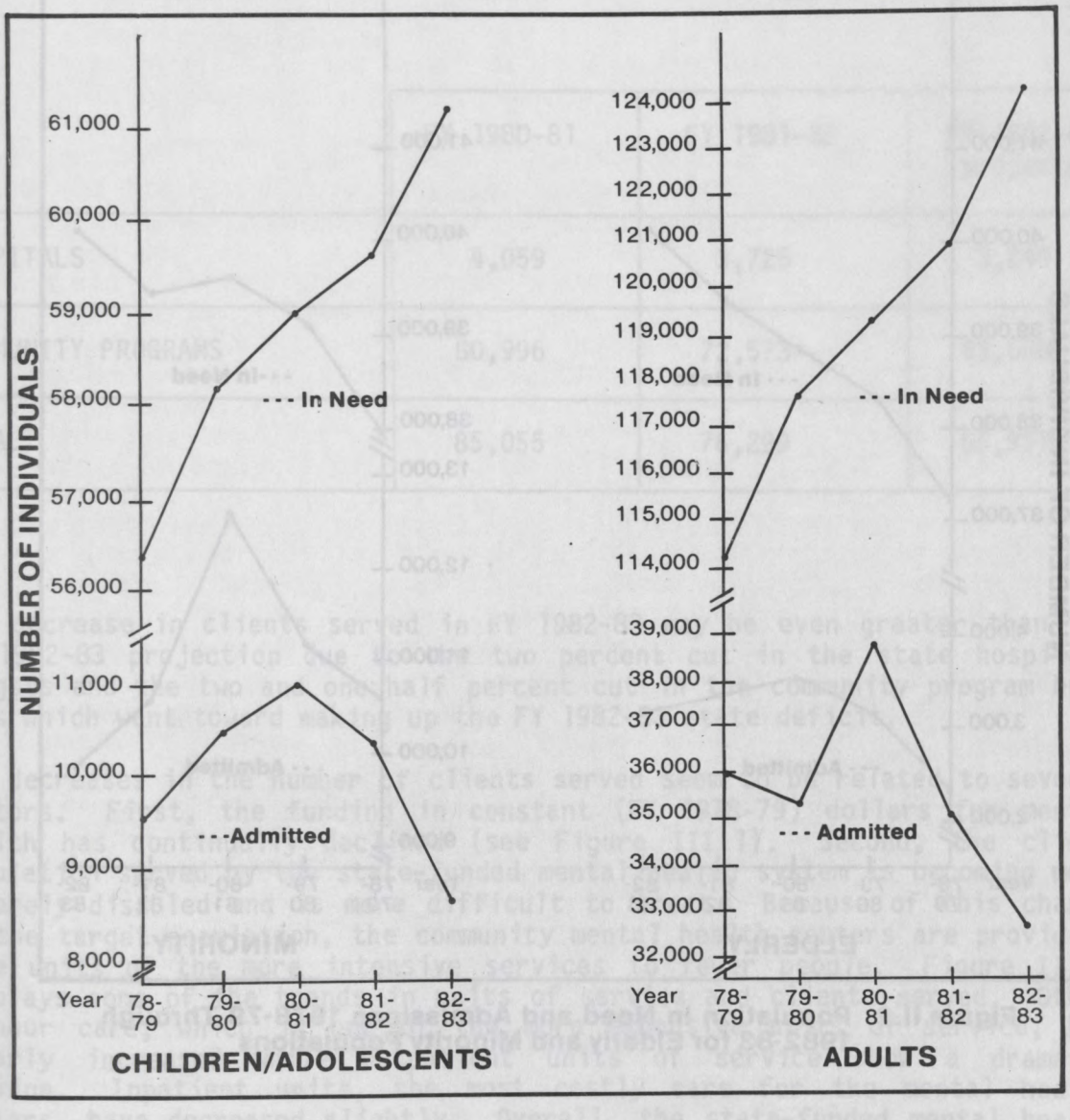


Figure II.1: Population in Need and Admissions 1978-79 Through 1982-83 for Children/Adolescents and Adults

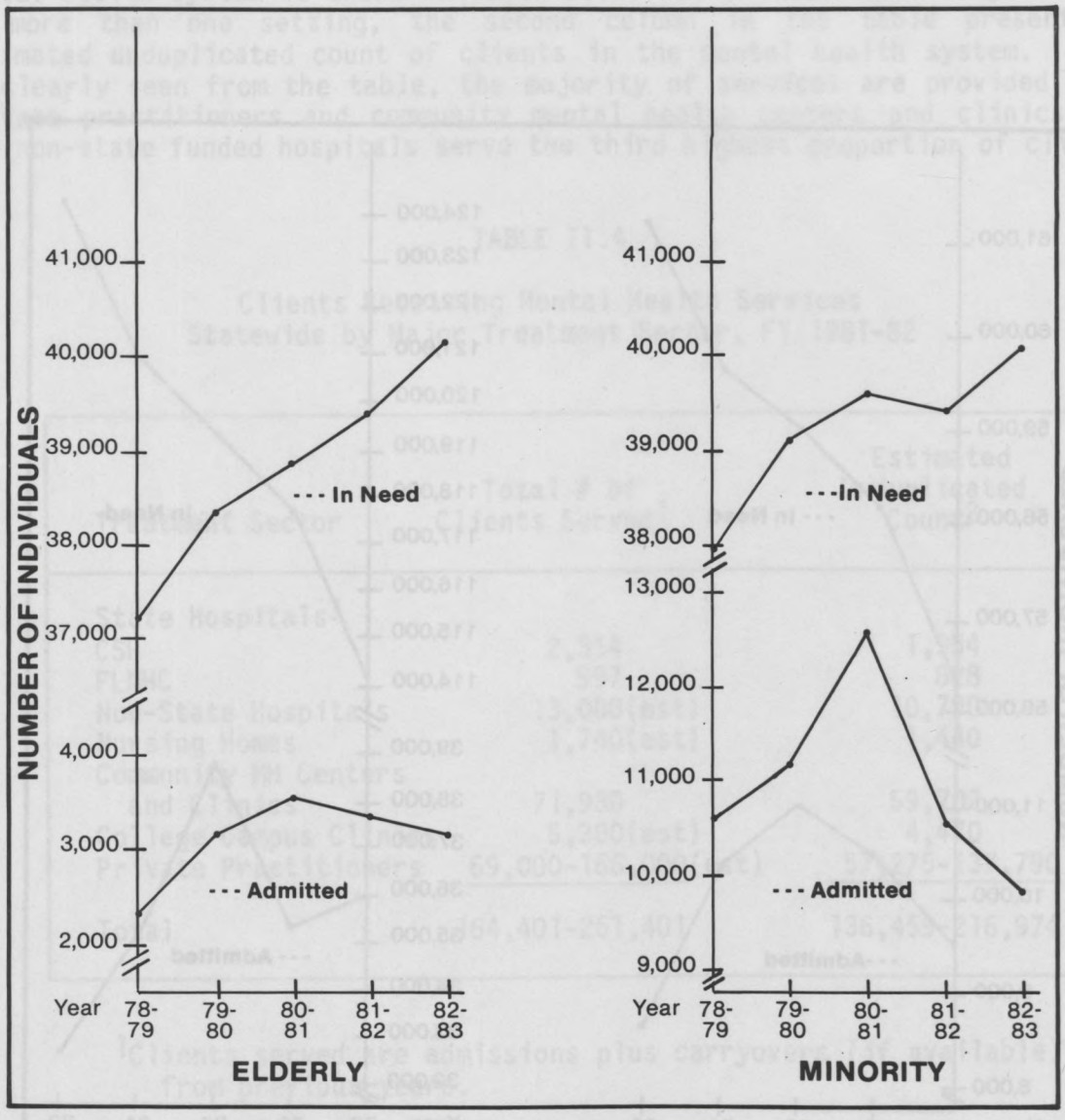


Figure II.2: Population in Need and Admissions 1978-79 Through 1982-83 for Elderly and Minority Populations

CHAPTER III: MAIN SERVICES RENDERED

The number of clients served by the Colorado mental health system (see Table III.1) has been decreasing steadily over the past few years.

TABLE III.1

Colorado Mental Health System Clients Served

	FY 1980-81	FY 1981-82	FY 1982-83 (projected)
HOSPITALS	4,059	3,726	3,249
COMMUNITY PROGRAMS	80,996	72,573	63,688
TOTAL	85,055	76,299	66,937

The decrease in clients served in FY 1982-83 may be even greater than the FY 1982-83 projection due to the two percent cut in the state hospitals budgets and the two and one half percent cut in the community program budgets which went toward making up the FY 1982-83 state deficit.

The decreases in the number of clients served seem to be related to several factors. First, the funding in constant (FY 1978-79) dollars for mental health has continually declined (see Figure III.1). Second, the client population served by the state-funded mental health system is becoming more severely disabled and is more difficult to treat. Because of this change in the target population, the community mental health centers are providing more units of the more intensive services to fewer people. Figure III.2 displays some of the trends in units of service and clients served. Other 24-hour care, which is one of the more expensive units of service, has clearly increased while outpatient units of service show a dramatic decline. Inpatient units, the most costly care for the mental health centers, have decreased slightly. **Overall, the state-funded mental health system is moving toward providing more intensive, more expensive services to fewer and fewer clients with fewer resources.**

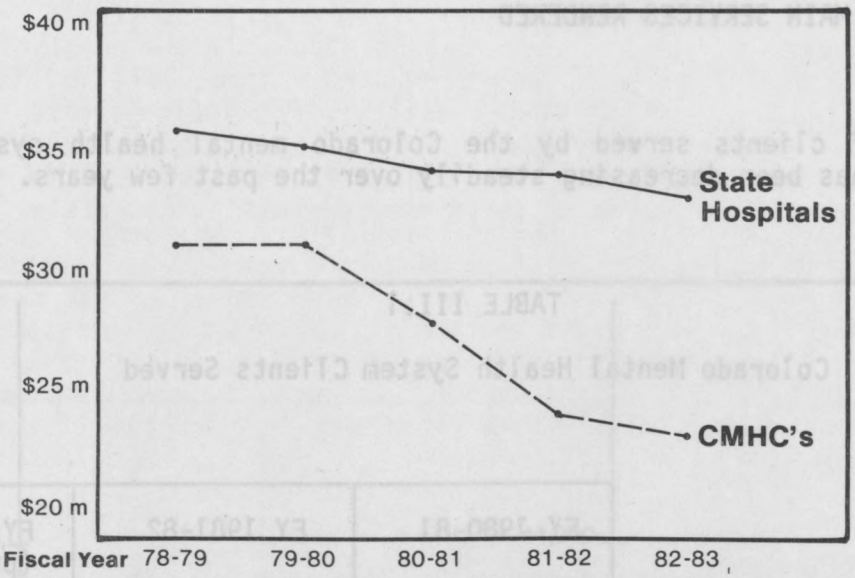


Figure III.1: Community Mental Health Center/Clinic and Hospital Funding in Constant (FY 78-79) Dollars

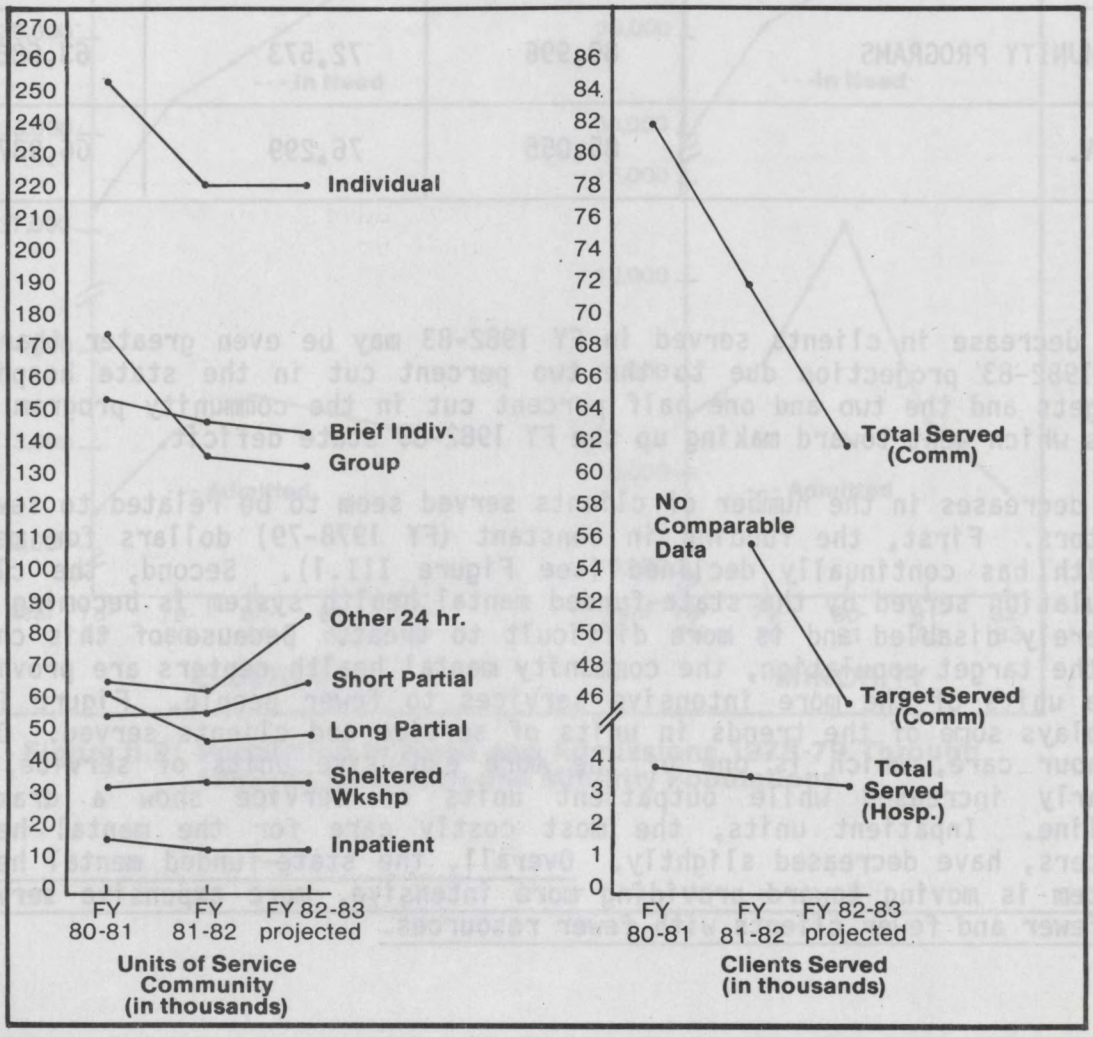


Figure III.2: Performance Indicators

A. CHILD/ADOLESCENT SERVICES

1. Introduction

There is an impending crisis in the provision of state-funded mental health services to children and adolescents. Several of the events which preceded the crisis in adult psychiatric services a couple of years ago are occurring in the area of child/adolescent services. These events include:

- A decrease in resources coupled with an increasing demand for services.
- An increase in the severity of the illness of those being served.
- The operation of state hospitals at and over capacity.
- The existence of a waiting list for state hospital inpatient services.
- An increase in the length of stay in the state hospitals.
- An increase in involuntary admissions.

Essentially what appears to be happening is that the children/adolescents in the state system are becoming more severely disabled and more difficult to treat. Associated with the increased level of severity of this patient population is an increase in their length of stay in the state hospitals. The increase in involuntary admissions also impacts the hospitals' census. These two trends are primarily responsible for the fact that both Colorado State Hospital and Fort Logan Mental Health Center have been operating at or over capacity for some time. Fort Logan Mental Health Center, for example, has had a waiting list for admission to the child/adolescent division almost continually for at least the past two years. An analysis of this waiting list over the past two years indicates that the mean wait for admission is 31 days. When the "not admitted" referrals to the waiting list are tracked for disposition, it was determined that 13.5% are placed in foster care or group homes despite the community mental health center clinician's assessment that inpatient care was the most clinically appropriate treatment. Since a backlog in one part of the state system impacts the rest of the system, both the state hospitals and the community mental health centers feel the pressure created by the shortage of state hospital child/adolescent inpatient resources.

A gap in service delivery in one part of the system also creates pressure on other parts of the system. When there is a lack of community-based intensive treatment facilities, two alternatives are utilized. One alternative is that some patients are treated inappropriately in less intensive, less restrictive settings by the community mental health centers and clinics. The other alternative is that some patients are treated in more intensive, more restrictive settings by the hospital which extends the backlog described above, as the availability of hospital beds is limited. Both of these situations are costly to the patient and to the system, and both are presently occurring in Colorado.

The need for a continuum of care which includes adequate resources for service provision in the community as well as adequate resources for

the state hospitals becomes evident as one examines the data. There clearly are differences in the patients which are treated in a hospital setting compared to those treated in a community mental health center setting. These differences are critical because they point to the fact that different patient populations need different treatment settings. In the past, some people believed that if adequate resources were available in the community, there would be no need for inpatient beds. Some still believe that resources should go to either hospitals or the community agencies. This clearly is not appropriate given the data. Resources are needed in both settings in order to meet the clinical needs of patients at different points in time, thereby ensuring an appropriate continuum of care. Although the Division of Mental Health has placed a priority on services to children/adolescents over the past couple of years, the reduction in resources has resulted in an overall decrease in admissions and in the capacity of the system to serve this population. In general, if current trends continue, it is quite clear that the resources will not be sufficient for meeting the needs of the children and adolescents in the state mental health system. By identifying this potential crisis now, the mental health system can implement strategies to avert the crisis.

2. Facts and Trends

a. SIGNIFICANT STATEWIDE DECREASE IN THE ACTUAL NUMBER OF ADMISSIONS OF CHILDREN AND ADOLESCENTS

Figure III.3 reflects a significant statewide decrease in the actual number of admissions of children and adolescents to the community mental health centers/clinics. This decrease has been attributed to the decrease in resources coupled with the increase in severity of the patients served in the state mental health system. There also has been a slight decrease in the number of admissions to Fort Logan Mental Health Center and a slight increase in the admissions to Colorado State Hospital. Also, it is of interest to note that the total number of admissions of children and adolescents to state hospitals has remained approximately the same for the past ten years.

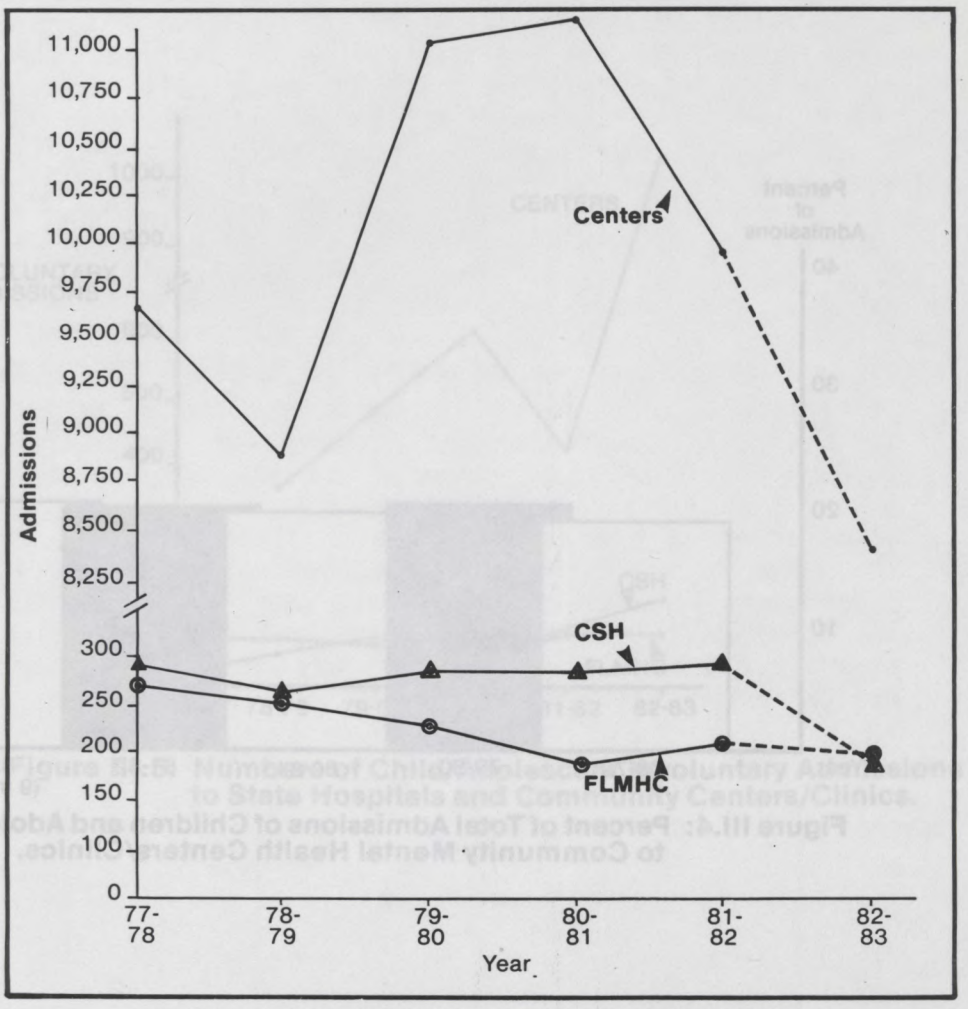


Figure III.3 Child/Adolescent Admissions.

b. EFFORTS TO INCREASE ADMISSIONS OF CHILDREN/ADOLESCENTS HAVE BEEN UNSUCCESSFUL

While Figure III.3 shows a decrease in the actual number of admissions to community mental health centers/clinics, Figure III.4 indicates that the percentage of total admissions that are children and adolescents has remained relatively stable over the past four years. This reflects the fact that although the system has tried to meet more of the needs of this target population through the performance contracting process, these efforts have been unsuccessful.

The overall decline in resources simply has precluded the system from meeting more of this need.

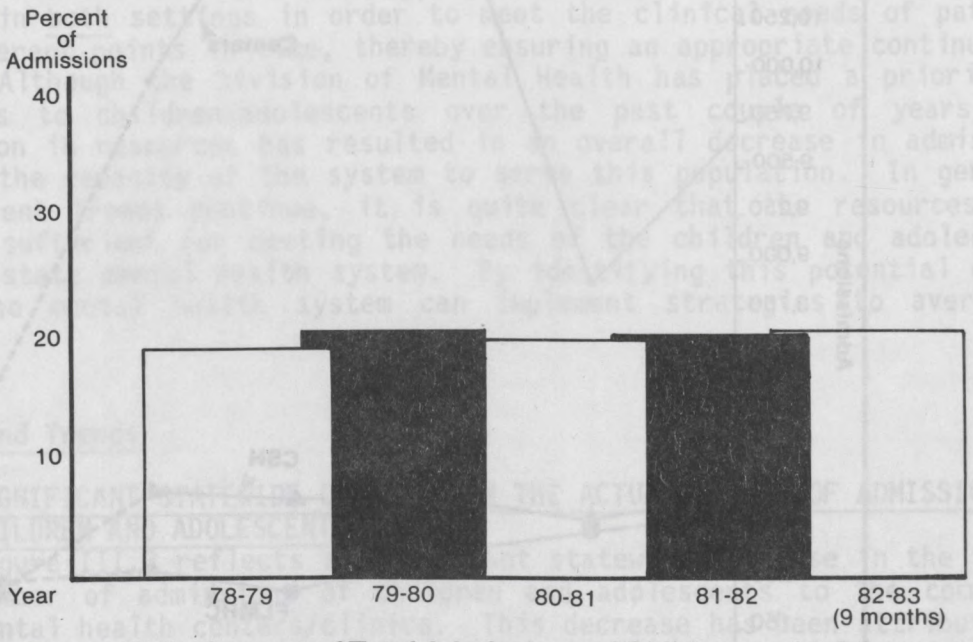


Figure III.4: Percent of Total Admissions of Children and Adolescents to Community Mental Health Centers/Clinics.

c. DRAMATIC INCREASE IN INVOLUNTARY ADMISSIONS

The significantly dramatic increase in the number of involuntary admissions of children and adolescents to the community mental health centers and clinics is reflected in Figure III.5. This increase has been attributed primarily to the increased severity of the children/adolescents being admitted to the system which has resulted in more involuntary admissions, especially through the courts.

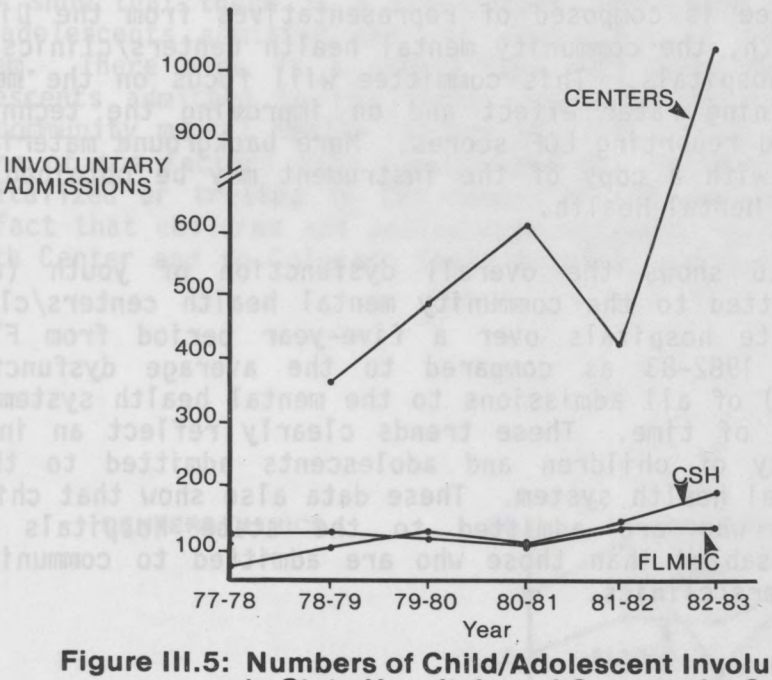


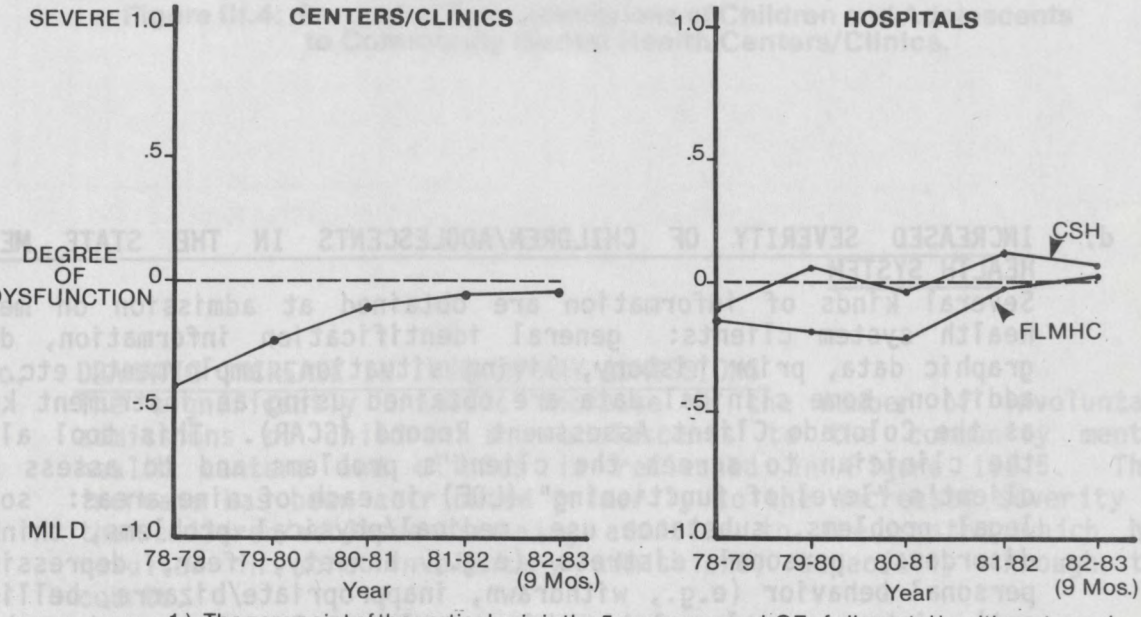
Figure III.5: Numbers of Child/Adolescent Involuntary Admissions to State Hospitals and Community Centers/Clinics.

d. INCREASED SEVERITY OF CHILDREN/ADOLESCENTS IN THE STATE MENTAL HEALTH SYSTEM

Several kinds of information are obtained at admission on mental health system clients: general identification information, demographic data, prior history, living situation, employment, etc. In addition, some clinical data are obtained using an instrument known as the Colorado Client Assessment Record (CCAR). This tool allows the clinician to screen the client's problems and to assess each client's "level of functioning" (LOF) in each of nine areas: socio-legal problems, substance use, medical/physical problems, thinking disorders, personal distress (e.g., anxiety, fear, depression), personal behavior (e.g., withdrawn, inappropriate/bizarre, belligerent), interpersonal relationships, role performance, and problems meeting basic needs. Clinician ratings always contain some rater

and organizational effect; consequently, a method has recently been developed by DMH researchers to control for it in CCAR ratings. The LOF scores and outcome results used in this document have been adjusted for these effects and are reported in a form (standard scores) that makes trends easier to interpret. A committee of the Organization for Program Evaluation in Colorado (OPEC) has been formed to further examine level of functioning measurement issues. The committee is composed of representatives from the Division of Mental Health, the community mental health centers/clinics, and the two state hospitals. This committee will focus on the methodology for determining rater effect and on improving the techniques for defining and reporting LOF scores. More background material on the CCAR along with a copy of the instrument may be obtained from the Division of Mental Health.

Figure III.6 shows the overall dysfunction of youth (ages 1-17 years) admitted to the community mental health centers/clinics and to the state hospitals over a five-year period from FY 1978-79 through FY 1982-83 as compared to the average dysfunction (the dotted line) of all admissions to the mental health system over the same period of time. These trends clearly reflect an increase in the severity of children and adolescents admitted to the state-funded mental health system. These data also show that children and adolescents who are admitted to the state hospitals are more severely disabled than those who are admitted to community mental health centers/clinics.



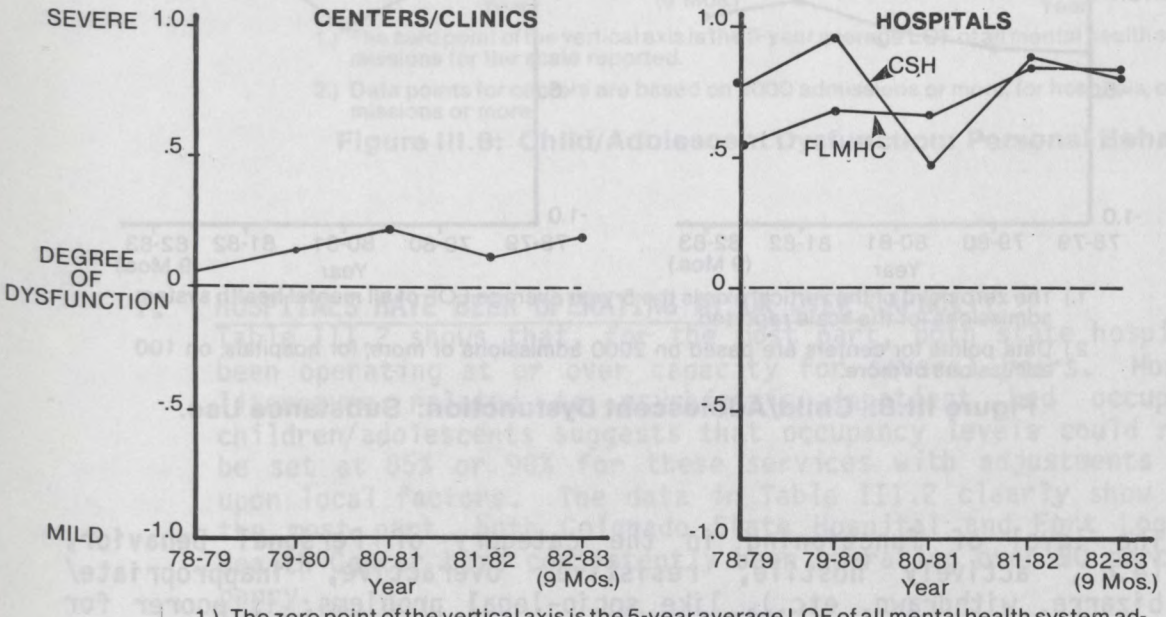
1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.6: Overall Dysfunction of Child/Adolescent Admissions.

e. DIFFERENCES BETWEEN CHILDREN/ADOLESCENTS ADMITTED TO THE STATE HOSPITALS AND THOSE ADMITTED TO THE COMMUNITY MENTAL HEALTH CENTERS/CLINICS DETERMINE THE TYPES OF TREATMENT NEEDED

Children and adolescents in the state-funded mental health system clearly differ from the general population served by the state system in the area of socio-legal problems. The data in Figure III.7 show that there is a significant difference between children and adolescents admitted and all admissions to the mental health system. There also is a significant difference between children/adolescents admitted to the state hospitals and those admitted to the community mental health centers/clinics. This clearly seems to be one of the factors that impacts whether or not an individual is hospitalized or treated in the community. These data also reflect the fact that children and adolescents admitted to Fort Logan Mental Health Center and to Colorado State Hospital are becoming more similar.

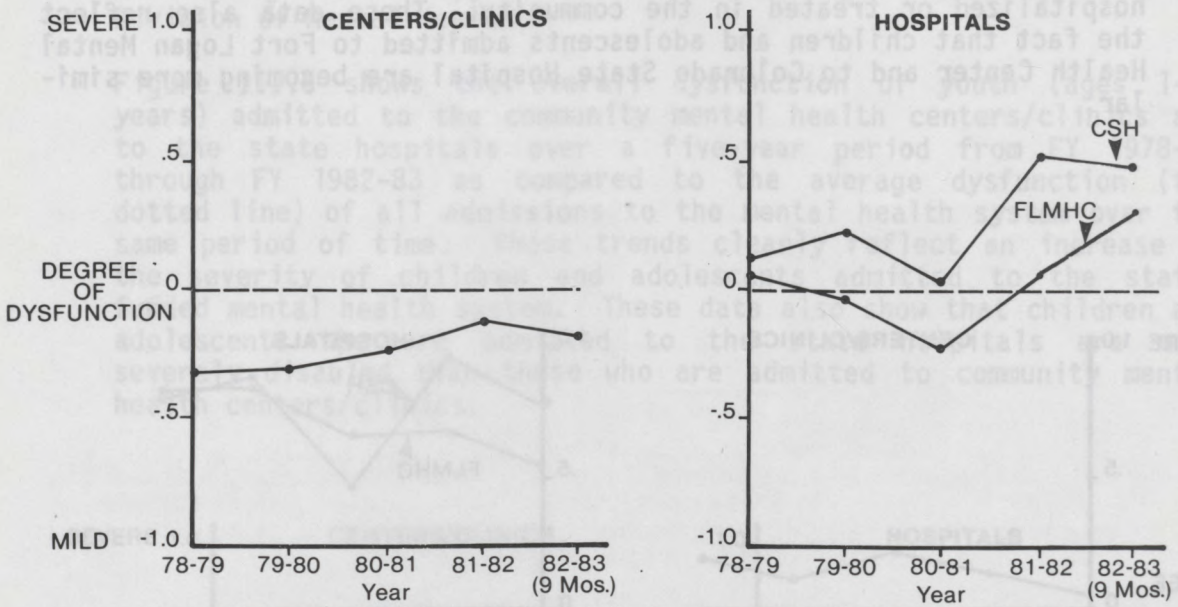


1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.7: Child/Adolescent Dysfunction: Socio-Legal

Overall, substance abuse appears to be increasing among children and adolescents admitted to the state-funded mental health system. The trend data in Figure III.8 also show that substance abuse is a factor that is more characteristic of youth admitted for treatment to a state hospital setting.

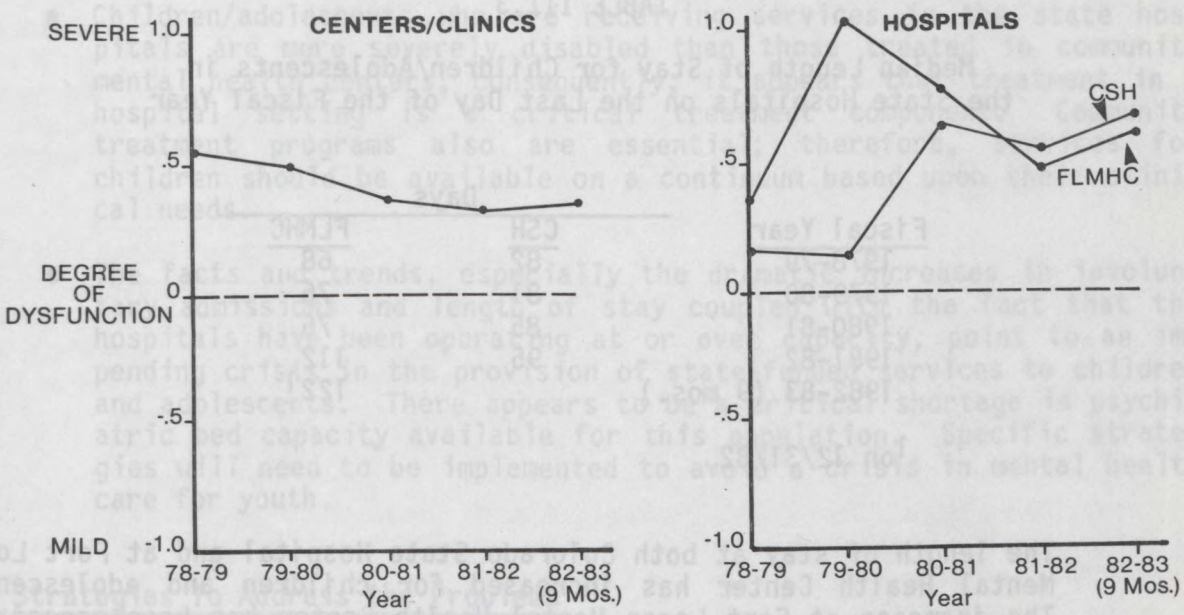


1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.8: Child/Adolescent Dysfunction: Substance Use.

The level of functioning in the category of Personal Behavior, (e.g., actively hostile, resistive, overactive, inappropriate/ bizarre, withdrawn, etc.), like socio-legal problems, is poorer for children and adolescents than for the average admission to the state mental health system. This factor also appears to be one of the determinants for inpatient care for this population. The similarities in the populations of the two state hospitals also is reflected in Figure III.9.



1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.9: Child/Adolescent Dysfunction: Personal Behavior

f. HOSPITALS HAVE BEEN OPERATING AT OR OVER CAPACITY

Table III.2 shows that, for the most part, both state hospitals have been operating at or over capacity for several years. Most of the literature related to psychiatric inpatient bed occupancy for children/adolescents suggests that occupancy levels could reasonably be set at 85% or 90% for these services with adjustments dependent upon local factors. The data in Table III.2 clearly show that, for the most part, both Colorado State Hospital and Fort Logan Mental Health Center have consistently been operating over 90 percent occupancy.

TABLE III.2

State Hospital Bed Occupancy:
Child/Adolescent

Fiscal Year	Average Percent of Beds Occupied	
	CSH	FLMHC
1979-80	92.7	80.0
1980-81	88.5	90.0
1981-82	91.7	93.0
1982-83 (9 mos.)	93.8	94.0

g. SIGNIFICANT INCREASE IN LENGTH OF STAY FOR CHILDREN AND ADOLESCENTS

TABLE III.3

Median Length of Stay for Children/Adolescents in the State Hospitals on the Last Day of the Fiscal Year

	Days	
Fiscal Year	CSH	FLMHC
1978-79	82	68
1979-80	81	76
1980-81	85	76
1981-82	95	112
1982-83 (9 mos.)		122[1]

[1]on 12/31/82

The length of stay at both Colorado State Hospital and at Fort Logan Mental Health Center has increased for children and adolescents. The increase at Fort Logan Mental Health Center has been especially dramatic.

3. Conclusions From the Data

a. Specific Conclusions

- Efforts to increase or even to maintain admission levels of children and adolescents have been unsuccessful due to a lack of resources.
- Children and adolescents in the state mental health system are becoming more severely disabled and more difficult to treat.
- Children/adolescents who are in the state mental hospitals are more severely disabled than those who are served by the community mental health centers/clinics.
- The child/adolescent populations of the two state hospitals are becoming more similar.
- The two state hospitals have been operating at or over capacity for several years.
- The length of stay for children/adolescents in the two state hospitals continues to increase significantly.
- The number of involuntary admissions for children/adolescents in the state system is increasing dramatically.

b. General Implications

- If current funding trends and patient characteristic trends continue, the resources clearly are not sufficient for meeting the needs of children and adolescents in the state mental health system.

- Children/adolescents who are receiving services in the state hospitals are more severely disabled than those treated in community mental health centers; consequently, it appears that treatment in a hospital setting is a critical treatment component. Community treatment programs also are essential; therefore, services for children should be available on a continuum based upon their clinical needs.

- The facts and trends, especially the dramatic increases in involuntary admissions and length of stay coupled with the fact that the hospitals have been operating at or over capacity, point to an impending crisis in the provision of state-funded services to children and adolescents. There appears to be a critical shortage in psychiatric bed capacity available for this population. Specific strategies will need to be implemented to avoid a crisis in mental health care for youth.

4. Strategies To Address the Problems

a. Strategies Requiring No New Resources

- **Consider bed allocation at both state hospitals to include the child/adolescent programs.** Because of the shortage of adult psychiatric state inpatient beds and because of the inequities in the distribution of those existing resources, the state went to a "Bed Allocation System" for adults in 1981. This system was designed to equitably distribute the limited state hospital beds for adults using the population in need model throughout the state. It also was designed to decrease the number of inappropriate admissions to the state hospitals, to prioritize those patients most in need of state hospital services, and to facilitate a cooperative working arrangement between the state hospitals and the community mental health centers. So far, all of these things seem to be happening to some degree. The Division of Mental Health currently is conducting a study to assess the impact of the bed allocation system for adults. This should be studied to determine if it is a viable strategy for partially addressing the shortage of psychiatric inpatient beds for children/adolescents.

- **Maximize the programs developed as alternatives to sending children out of state for treatment (Senate Bill 26).** Because of the lack of specialized programs for children/adolescents, there was a point in time when large numbers of children were being sent out of state for treatment due to the lack of appropriate treatment programs in Colorado. The number of children/adolescents served out of state has dropped dramatically in the past few years. The mental health system needs to ensure that it is taking full advantage of the programs, such as day treatment and limited residential programs, developed as a result of the passage of Senate Bill 26.

- **Expand resources for consultation and education services for children and adolescents to include all catchment areas.** In Footnote 60 of the 1981 Long Appropriations Bill, the State Legislature stated that the Division of Mental Health could purchase consultation and education services only from counties which had a population of less than 85,000. This limitation on the use of state funds for consultation and education has impacted children's programs since children/adolescents, the elderly, and minorities are considered to be the populations that benefit most from these services. By expanding consultation and education to include all catchment areas, services to children/adolescents could be increased and/or improved.

- **Increase coordination and collaboration with other human services agencies which serve children and adolescents.** 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.

- **Determine the unmet mental health need for seriously disturbed children and adolescents in the community.** This effort also will include determining the capacity and utilization of community programs for children/adolescents. The impact of Senate Bill 26 on the state-funded mental health system should be assessed, for example, to determine if it has increased or reduced the pressures related to the provision of mental health services to youth. Although the amount of data analyzed in children/adolescent programs has increased in the past year, there is still a great deal that needs to be developed and reviewed.

b. Strategies Requiring New Resources

- **Alleviate the overcrowding in the state hospital adolescent units by increasing the number of state-funded psychiatric inpatient beds for children and adolescents.** The highest priority for inpatient beds in FY 1984-85 is for a lockable 22-bed adolescent unit at Fort Logan Mental Health Center.

- **Increase services to children by designating at least one residential child care facility as an evaluation and treatment facility under State Statute (CRS 27-10).** Although residential child care facilities can become agencies designated as 72-hour mental health treatment and evaluation facilities under state statutes, not one has done so. By designating these facilities, the system would increase the resources available for children/adolescents with mental health problems.

- **Increase the number of intensive mental health community treatment facility beds for children and adolescents.** These facilities would help to fill the gap in residential services for children/adolescents in the community and could serve as a transition setting to or from the more intensive care of a state hospital.

- **Expand the availability of day treatment programs in high need communities.** Because of the severity of disability of the population being addressed, the more intensive treatment programs are the higher priority. Many of the community mental health centers and clinics have indicated a need for more day treatment programs for adolescents.

- **Offer training to mental health professionals on methods of providing day treatment for adolescents.** A top priority for the Division's Human Resource Development Section, if funding is continued, is the development of training programs related to the provision of services to children and adolescents.

- **Increase the number of vocational and occupational therapists providing services to adolescents in the state hospitals.** Vocational programs are essential for older adolescents in treatment in order to prepare them for an appropriate and more productive return to the community. Data indicate that the average adolescent at Colorado State Hospital is academically almost three years behind the age appropriate level. Furthermore, only 30% of the 16 and 17 year old adolescents return to school after discharge from CSH. Because of this educational handicap and the absence of vocational programming, they are unprepared to enter the job market at even the most basic levels.

B. ADULT SERVICES

1. Introduction

The adult population being treated by the state-funded mental health system is a very **severely disabled population** that is becoming **more difficult to treat.** The recognition of socio-legal problems as a primary characteristic of the hospitalized adult population is creating concern among mental health professionals. The expectations of the mental health system in treating this population need to be assessed, as there appears to be a shift of clients from the correctional system to the mental health system. This shift appears to be due, in part, to the facts that lesser crimes (e.g., vagrancy and disturbing the peace) have been declared unconstitutional because of vagueness, prisons have become over-crowded, and more criminal offenders are being considered in need of psychiatric treatment.

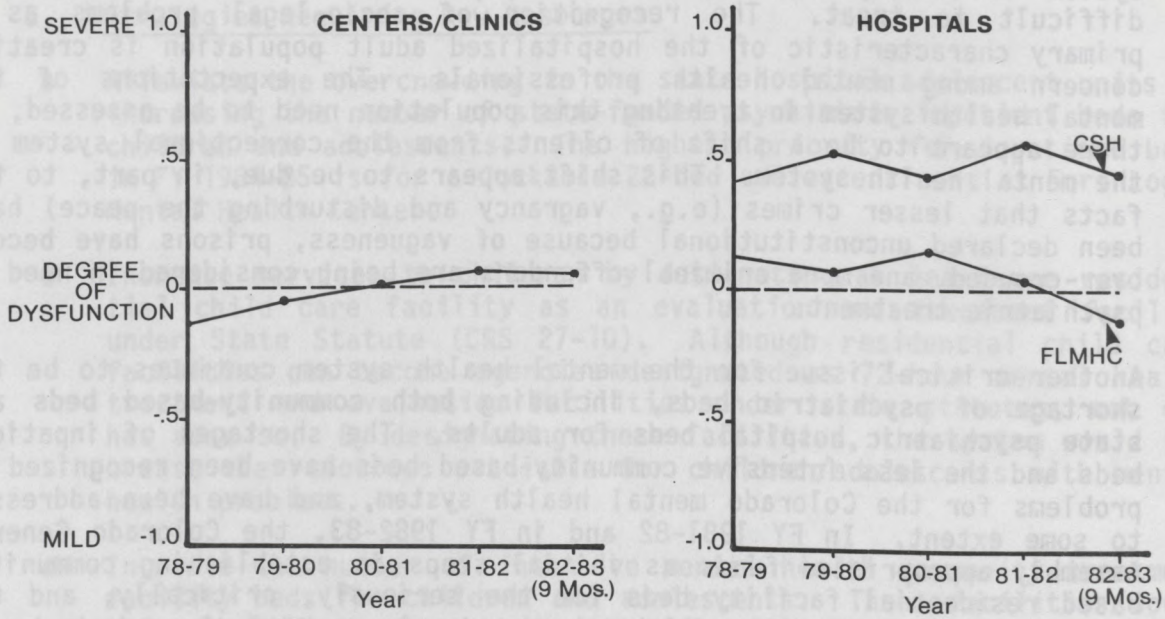
Another critical issue for the mental health system continues to be the **shortage of psychiatric beds, including both community-based** beds and **state psychiatric hospital beds for adults.** The shortages of inpatient beds and the less intensive community-based beds have been recognized as problems for the Colorado mental health system, and have been addressed to some extent. In FY 1981-82 and in FY 1982-83, the Colorado General Assembly appropriated funds as initial steps in establishing community-based residential facility beds for the seriously, critically, and the chronically mentally ill. 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. Although the need for adult state hospital inpatient beds is not as critical as the need for adolescent inpatient beds, there still remains a shortage of beds. One critical factor which may impact this shortage is the implementation of the bed allocation system for the adult programs for the state hospitals. Although both hospitals have identified the need for additional adult inpatient beds, neither plans to request new state dollars in FY 1984-85 for adult inpatient beds. Both hospitals want to allow their programs time to develop and implement necessary programmatic and administrative changes. The bed allocation system also needs time to stabilize. Both hospitals indicate that the bed allocation system has generally improved the accessibility of inpatient adult beds for mental health centers and is a step towards equity among admitting centers. Another factor which may reduce the shortage is the Medicaid Waiver; however, the impact of the Waiver is not yet known.

2. Facts and Trends

a. THE ADULT POPULATIONS DIFFER AMONG THE COMMUNITY MENTAL HEALTH CENTERS, COLORADO STATE HOSPITAL, AND FORT LOGAN MENTAL HEALTH CENTER

Figure III.10 shows the overall dysfunction of adults admitted to the state mental health system over the past five years. These trends indicate that the overall dysfunction level is increasing at the centers, and slightly decreasing at Fort Logan Mental Health Center and at Colorado State Hospital.



1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

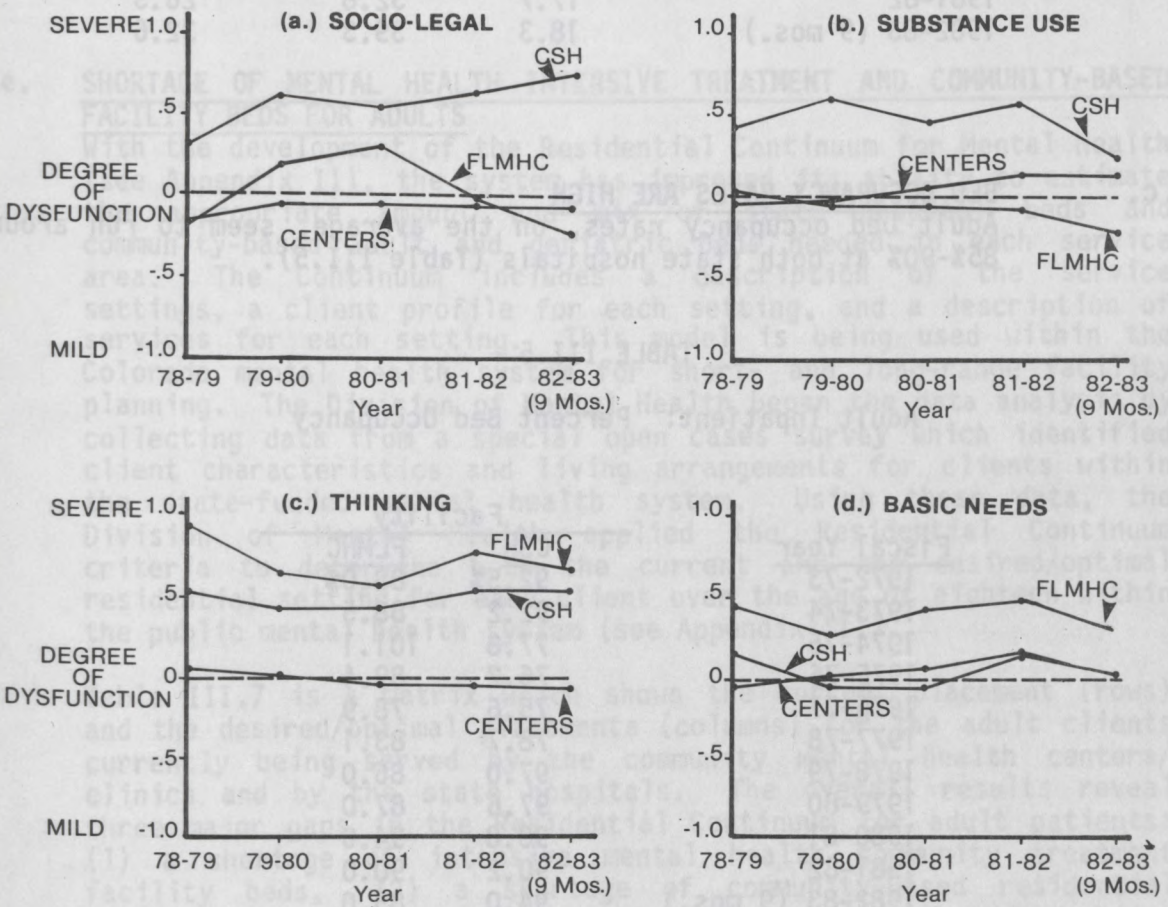
2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.10: Overall Dysfunction of Adult Admissions

One of the factors which determines whether an individual is hospitalized or treated in the community is the level of socio-legal dysfunctioning. Figure III.11 (a.) clearly shows that there is a significant difference between adults admitted to the state hospitals and adults admitted to the community mental health centers/clinics. These data also reflect the fact that the socio-legal level of functioning at the time of admission for adults is poorest at Colorado State Hospital and is getting worse.

The severity of thinking disorders is one of the factors which determines whether or not a patient is treated in a hospital environment or in the community. The adult patients admitted to Fort Logan Mental Health Center have poorer functioning in the thinking area than those admitted to Colorado State Hospital or to the centers as can be seen in Figure III.11 (c.).

Figure III.11 (d.) shows a fourth area which distinguishes the adult patient population at Fort Logan from the adult patient population at Colorado State Hospital. These data reflect the fact that patients admitted to Fort Logan function poorly in meeting their basic needs.



1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.11: Dysfunction in Four Areas: Adult Admissions to State Hospitals and Community Mental Health Centers/Clinics.

b. INCREASE IN THE PERCENTAGE OF ADMISSIONS OF ADULT PATIENTS WITH LEGAL PROBLEMS

The definite increase in the admission of adult patients with legal problems is reflected in Table III.4. The data indicate that almost one-third of the total admissions of adults to state hospitals are individuals with legal problems. The trend clearly reflects a continuing increase for both centers and hospitals.

TABLE III.4

Adult Admissions: Percent with Current Legal Problems

	Admitting Facility		
Fiscal Year	Centers	CSH	FLMHC
1978-79	16.0	23.2	17.4
1979-80	17.5	26.7	21.8
1980-81	17.5	24.6	30.3
1981-82	17.7	32.8	26.3
1982-83 (9 mos.)	18.3	39.3	32.6

c. BED OCCUPANCY RATES ARE HIGH

Adult bed occupancy rates, on the average, seem to run around 85%-90% at both state hospitals (Table III.5).

TABLE III.5

Adult Inpatient: Percent Bed Occupancy

	Facility	
Fiscal Year	CSH	FLMHC
1972-73	92.5%	88.0%
1973-74	92.2	88.5
1974-75	77.8	101.1
1975-76	76.2	89.4
1976-77	75.6	78.9
1977-78	78.7	83.1
1978-79	97.0	86.0
1979-80	97.6	87.0
1980-81	98.8	94.0
1981-82	90.2	90.0
1982-83 (9 mos.)	94.0	85.0

d. SIGNIFICANT INCREASE IN LENGTH OF STAY AT FORT LOGAN FOR ADULTS

Table III.6 shows the length of stay on the adult division at the two state hospitals during the years for which data were available. The length of stay at Colorado State Hospital has been rising slightly. The length of stay at Fort Logan, however, shows a substantial increase.

TABLE III.6

Median Length of Stay of Adult Patients in Treatment on the Last Day of the Fiscal Year

	Facility	
Fiscal Year	CSH	FLMHC
1978-79	42	47
1979-80	36	62
1980-81	54	221
1981-82	48	120

e. SHORTAGE OF MENTAL HEALTH INTENSIVE TREATMENT AND COMMUNITY-BASED FACILITY BEDS FOR ADULTS

With the development of the Residential Continuum for Mental Health (see Appendix II), the system has improved its ability to estimate the appropriate amount and mix of state hospital beds and community-based adult and geriatric 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 these 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 III).

Table III.7 is a matrix which shows the current placement (rows) and the desired/optimal placements (columns) for the adult clients currently being served by the community mental health centers/clinics and by the state hospitals. The overall results reveal three major gaps in the Residential Continuum for adult patients: (1) a shortage of intensive mental health community treatment facility beds, (2) a shortage of community-based residential facility beds, (3) a shortage of state hospital inpatient beds.

TABLE III.7

Residential Continuum Matrix - Centers and Hospitals Combined for Adult Clients

Current Residential Setting		Desired/Optimal Residential Setting: Inpatient (1)	Nursing Home (2)	Intensive Tx (3)	Comm Residen (4)	Boarding Home (5)	Indep Living (6)	Row Total
		221[1]	9	94	39	8	5	376
	Inpatient	58.7[2]	2.4	25.0	10.4	2.1	1.3	2.7
		19.9[3]	14.4	3.4	0.9	0.4	0.1	
		1.6[4]	0.1	0.7	0.3	0.1	0.0	
		44	20	109	8	9	4	195
	Nursing Home	22.8	10.3	56.0	4.1	4.8	2.1	1.4
		4.0	31.7	3.9	0.2	0.4	0.1	
		0.3	0.1	0.8	0.1	0.1	0.0	
		80	0	103	94	14	9	300
	Intensive Tx	26.8	0.0	34.3	31.3	4.6	3.0	2.1
		7.2	0.0	3.7	2.1	0.6	0.3	
		0.6	0.0	0.7	0.7	0.1	0.1	
		121	6	398	415	206	273	1419
	Comm Residen	8.5	0.4	28.1	29.2	14.5	19.2	10.1
		10.9	9.0	14.3	9.4	9.3	7.7	
		0.9	0.0	2.8	2.9	1.5	1.9	
		22	6	209	79	34	20	369
	Boarding Home	6.0	1.6	56.7	21.3	9.2	5.3	2.6
		2.0	9.5	7.5	1.8	1.5	0.6	
		0.2	0.0	1.5	0.6	0.2	0.1	
		624	22	1864	3763	1937	3208	11418
	Indep Living	5.5	0.2	16.3	33.0	17.0	28.1	81.1
		56.1	35.2	67.1	85.6	87.7	91.2	
		4.4	0.2	13.2	26.7	13.8	22.8	
Column Total		1112	63	2777	4397	2209	3518	14076
		7.9	0.4	19.7	31.2	15.7	25.0	100.0

[1] Number of Clients
[2] Row Percentage
[3] Column Percentage
[4] Total Percentage

3. Conclusions From the Data

a. Specific Conclusions

- Adults who are in the state hospitals are more severely disabled than those who are served by community mental health centers and clinics.

- More patients with poor level of functioning in the areas of socio-legal problems and substance use are admitted to Colorado State Hospital.

- More patients with poor level of functioning in the areas of thinking problems and meeting basic needs are admitted to Fort Logan Mental Health Center.

- The proportion of adult patients admitted with legal problems is almost one third of the total adult admissions to the state hospitals and is increasing for all components of the system.

- The adult populations differ among the community mental health centers/clinics, Colorado State Hospital, and Fort Logan Mental Health Center.

- There is a serious shortage of mental health intensive treatment facility beds, community-based facility beds, and psychiatric inpatient beds for adults.

b. General Implications

- The average adult patient in need of treatment in a state hospital has great difficulty functioning, especially in the areas of socio-legal problems, substance use problems, thinking problems, and problems meeting basic needs. This is a difficult client to treat. Of special concern is the large number of clients admitted with legal problems. This increase in legal problems of the adult state hospital population may require a different programmatic approach to differentiate criminal/civil clients who belong in the corrections system from those clients with mental health problems who are treatable in the mental health system.

- The differences in the patient populations of the two state hospitals and the community mental health centers should be considered as program planning takes place.

4. **Strategies To Address the Problems**

a. Strategies Requiring No New Resources

- **Continue bed allocation for the adult programs at the state hospitals.** The bed allocation system for adults was implemented in 1981. Although the impact study has not been completed, the bed allocation system, so far, has received credit for contributing to the decrease in the average daily attendance at Colorado State Hospital, to a decrease in inappropriate admissions to the state hospitals, to the prioritizing of those patients most in need of hospital services, and to the increased cooperative working relationships which have been developed between the centers and the state hospitals.

- **Maximize the home and community-based service program established as a result of the approved Medicaid Waiver.** The Department of Institutions, the Divisions of Mental Health and Developmental Disabilities, and the Department of Social Services submitted a series of "Medicaid Waivers" this past year under the provisions of the Omnibus Reconciliation Act (PL 97-35). This Act allows for the

development of community-based alternatives to institutional care provided specific mandates could be met under Section 1902 of the Social Security Act. The Home- and Community-Based Services Program (Senate Bill 138) became effective February 7, 1983. This Waiver is being implemented by the Department of Social Services as well as the county departments of Social Services. By design, the Waivers will utilize the Colorado Foundation for Medical Care's PSRO process to programmatically identify the elderly, and mental health and developmental disabilities waivered "target groups."

- **Work with the universities to encourage, obtain, and disseminate information on the latest advancements in the area of health and mental health research.** Current research in mental health increasingly is focusing on biochemical approaches to the diagnosis and treatment of mental illness. The Division of Mental Health should endeavor to enhance its relationship with the University of Colorado Health Sciences Center (UCHSC) so that community mental health centers, the state hospitals, and the system's clients can benefit from advances in this area. Electro-physiological and PETT (Positron Emission Transaxial Tomography) research also show much promise as aids in the study of the etiology of schizophrenia and the development of new diagnostic and treatment approaches. Since UCHSC is involved in these types of research, the Division of Mental Health will try to facilitate a sharing of this new knowledge and technology with the state-funded agencies. The Colorado Alliance for the Mentally Ill (CAMI) has joined others in advocating for a thorough medical screening of chronically mentally ill clients to determine if some might respond to medical as opposed to psychosocial treatment. The Division of Mental Health is following the research which is being conducted in this area in California to ensure that whatever is gained from this and other related research is made available to Colorado mental health agencies. In general, the Division's role in this area should be to focus on encouraging research when appropriate, on disseminating the results of available research, and on working more closely with the universities.

- **Assess the need for changes in treatment approaches to ensure that treatment is responsive and relevant to the changing needs of this patient population.**

b. Strategies Requiring New Resources

- **Provide training to mental health professionals related to treatment approaches (e.g., crisis intervention) and to treatment programs (The Treatment and Support System Concept) which are geared toward improving services to the seriously, critically and chronically mentally ill.** Training related to improving services to the Division's highest priority target population naturally is a training priority.

- If current management efforts to address the shortage of psychiatric inpatient beds (e.g., bed allocation) and the shortage of community facility beds (e.g., the Medicaid Waiver) are not sufficient to meet

the need of this target population, then new resources will need to be requested in the future to fill the gaps in these services.

C. GERIATRIC SERVICES

1. Introduction

Division of Mental Health studies indicate that the elderly are the most severely disabled of all population groups in Colorado. Compared to other population groups, the elderly tend to have more medical/ physical problems, more thinking disorders, and more problems meeting basic needs. They have fewer problems in the area of interpersonal relationships; however, the elderly in general also tend to have fewer relationships which may account for some of this difference.

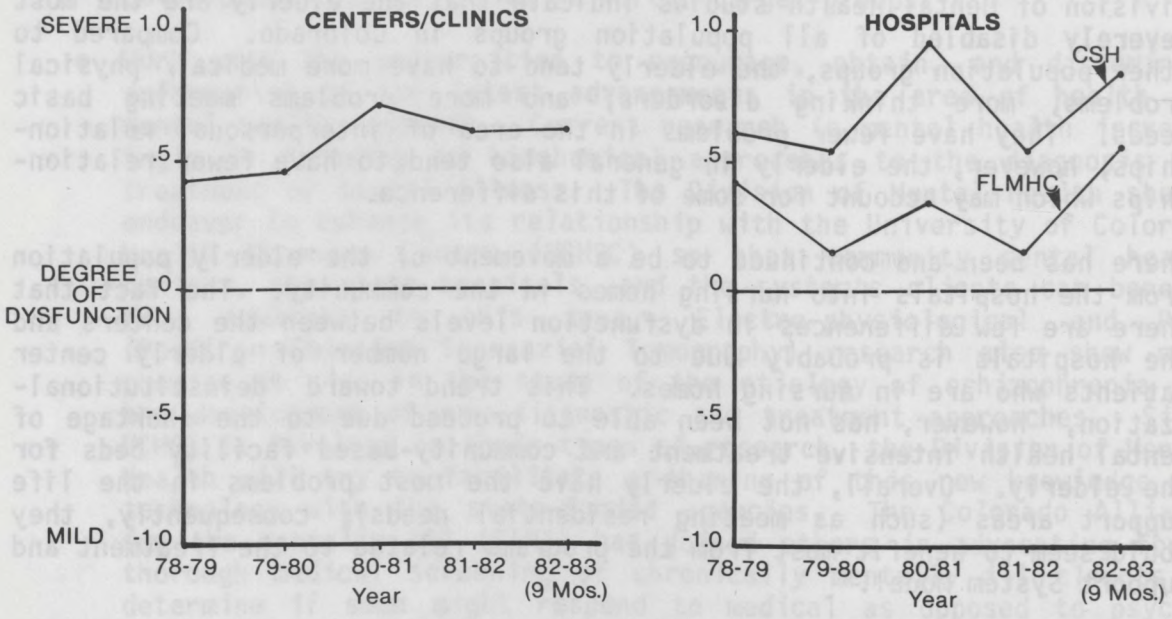
There has been and continues to be a movement of the elderly population from the hospitals into nursing homes in the community. The fact that there are few differences in dysfunction levels between the centers and the hospitals is probably due to the large number of elderly center patients who are in nursing homes. This trend toward "deinstitutionalization," however, has not been able to proceed due to the shortage of mental health intensive treatment and community-based facility beds for the elderly. Overall, the elderly have the most problems in the life support areas (such as meeting residential needs); consequently, they would seem to benefit most from the programs related to the Treatment and Support System Model.

Although the bed occupancy rates have been quite high at times for Colorado State Hospital, the hospital is reducing the average daily attendance on this unit. This decrease in census should, therefore, address the problems the Geriatric Unit has had in the past in terms of operating over capacity. Bed occupancy at Fort Logan has increased, but appears to be stabilizing. At this time, therefore, there does not appear to be a critical need to expand the availability of state inpatient beds for this population.

2. Facts and Trends

a. THE ELDERLY ARE THE MOST SEVERELY DISABLED POPULATION GROUP SERVED BY THE STATE-FUNDED SYSTEM

Figure III.12 shows the overall dysfunction of the elderly admitted to community mental health centers/clinics and to the state hospitals over a five-year period from FY 1978-79 through FY 1982-83 as compared to the average dysfunction (the dotted line) of all admissions to the mental health system over the same period of time. When compared to the overall dysfunction of children and adolescents and to the overall dysfunction of adults, the elderly clearly have the most difficulty functioning of all patients admitted to the system. The trends in Figure III.12 also indicate that the overall dysfunction level for the elderly is increasing slightly. There are few differences in dysfunction levels between the centers and the hospitals.



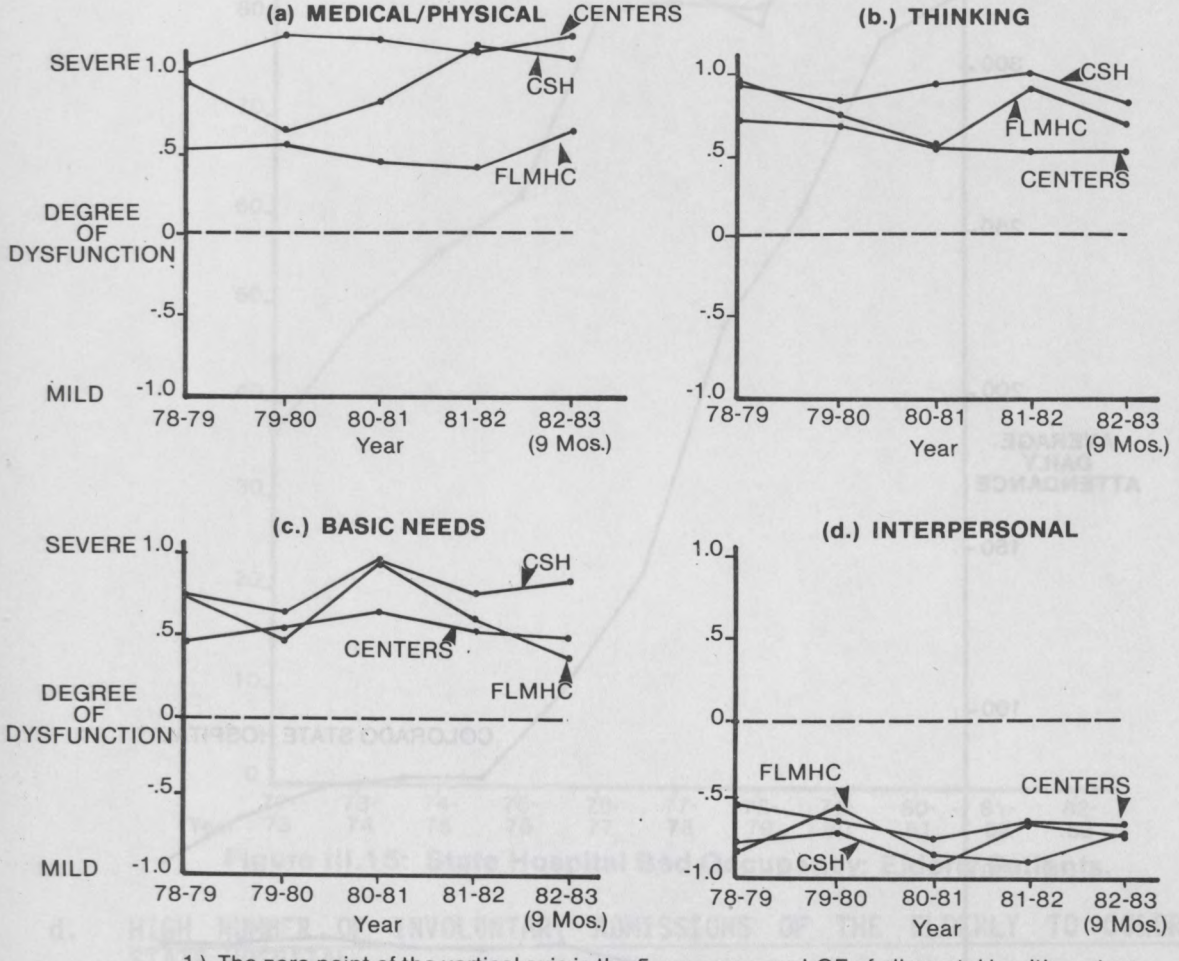
1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.12: Overall Dysfunction of Elderly Admissions.

b. THE ELDERLY HAVE MORE MEDICAL/PHYSICAL PROBLEMS, MORE THINKING PROBLEMS, AND MORE PROBLEMS MEETING BASIC NEEDS

Relative to the overall patient population, the elderly have more medical/physical problems, more thinking disorders, and more problems meeting basic needs. The data in Figure III.13 reflect the poor level of functioning in these areas of elderly patients admitted to the community mental health centers/clinics and to the state hospitals. Chart (d.) in Figure III.13 shows that the elderly have fewer problems functioning in the area of interpersonal relationships than the overall patient population; however, the elderly also generally have fewer individuals in their support system which simply may result in having fewer people with whom they relate.



1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.13: Dysfunction in Four Areas: Elderly Admissions to State Hospitals and Community Mental Health Centers/Clinics.

c. DRAMATIC DECREASE IN THE GERIATRIC POPULATION AT COLORADO STATE HOSPITAL

The average daily attendance (ADA) for the geriatric population has decreased dramatically at Colorado State Hospital as shown in Figure III.14, reflecting a trend toward deinstitutionalization. The average daily attendance at Fort Logan Mental Health Center, however, has remained relatively stable, probably reflecting the fact that Fort Logan never functioned as a long-term care program.

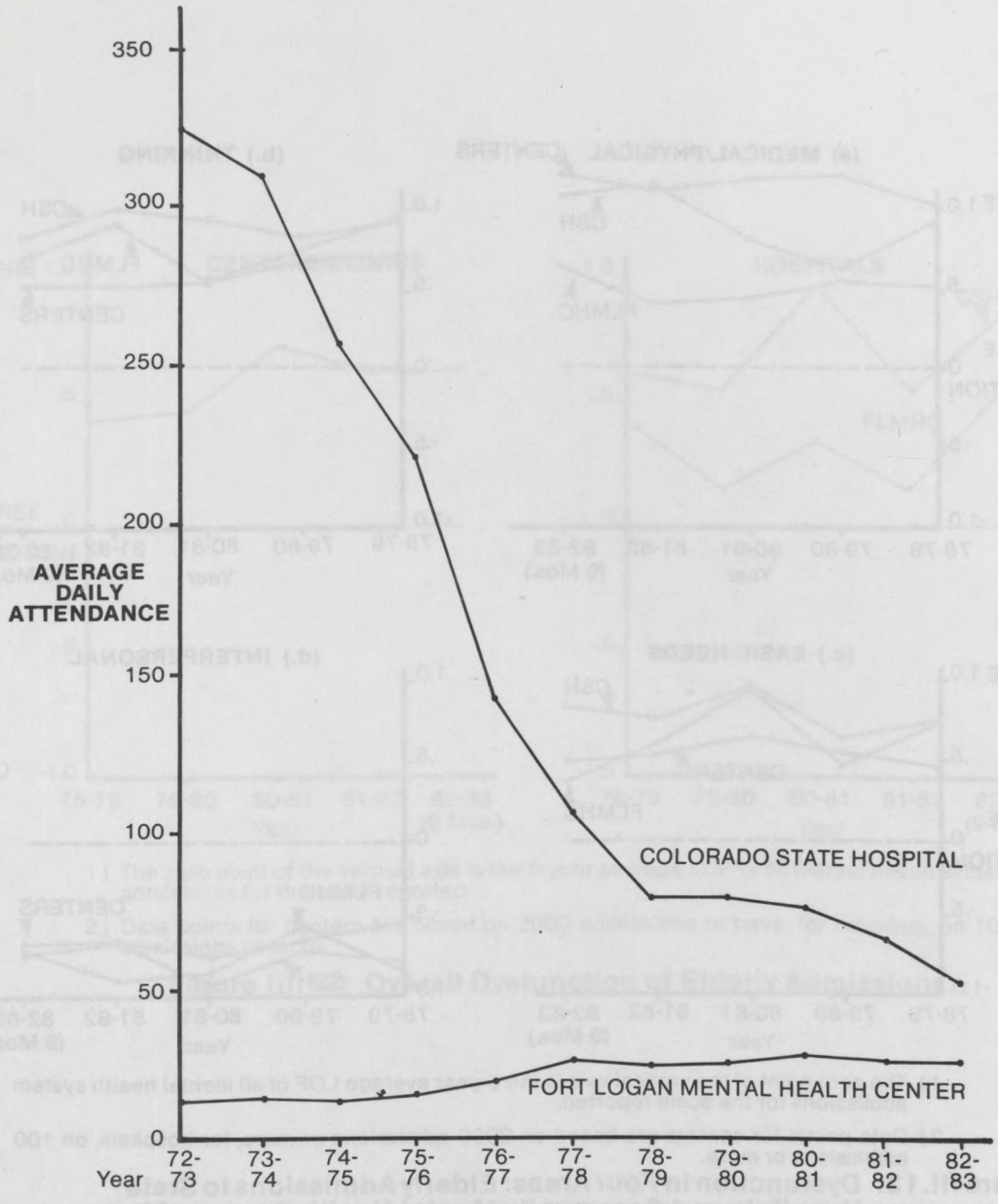


Figure III.14: Average Daily Attendance of Elderly Patients in State Hospitals.

Figure III.15 shows the occupancy rates for the elderly at the two state hospitals for the past ten years from FY 1972-73 through FY 1982-83. As can be seen, the occupancy rate at Fort Logan Mental Health Center has been climbing while the rate at Colorado State Hospital has been fairly stable. It is important to note that bed occupancy at both state hospitals consistently has remained above 80% for the past five years.

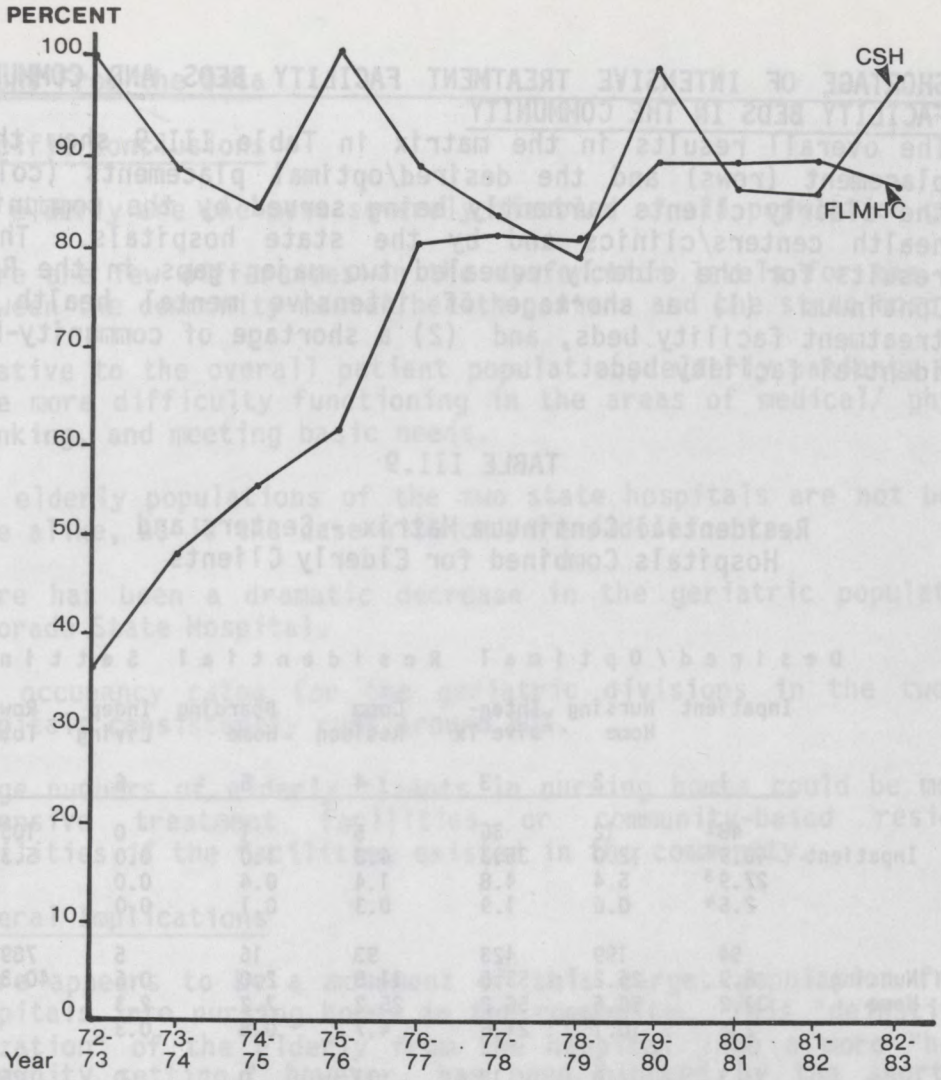


Figure III.15: State Hospital Bed Occupancy: Elderly Patients.

d. HIGH NUMBER OF INVOLUNTARY ADMISSIONS OF THE ELDERLY TO COLORADO STATE HOSPITAL

There are significant differences between the proportions of elderly involuntary patients admitted to Colorado State Hospital and to Fort Logan Mental Health Center as shown in Table III.8. The higher number of involuntary admissions at Colorado State Hospital may be related to such factors as the reluctance of patients in the Colorado State Hospital Service Area to seek voluntary treatment at a hospital which is far from home or the lack of community-based alternatives in rural areas.

TABLE III.8

Elderly Admissions: Percent Involuntary

	Admitting Facility		
Fiscal Year	Centers	CSH	FLMHC
1978-79	8.5	67.1	55.2
1979-80	4.8	77.5	50.0
1980-81	4.7	78.5	55.6
1981-82	9.2	77.7	53.1
1982-83 (9 mos.)	8.7	75.7	61.7

e. SHORTAGE OF INTENSIVE TREATMENT FACILITY BEDS AND COMMUNITY-BASED FACILITY BEDS IN THE COMMUNITY

The overall results in the matrix in Table III.9 show the current placement (rows) and the desired/optimal placements (columns) for the elderly clients currently being served by the community mental health centers/clinics and by the state hospitals. The overall results for the elderly revealed two major gaps in the Residential Continuum (1) a shortage of intensive mental health community treatment facility beds, and (2) a shortage of community-based residential facility beds.

TABLE III.9

Residential Continuum Matrix - Centers and Hospitals Combined for Elderly Clients

Current Residential Setting	Desired/Optimal Residential Setting: Inpatient	Nursing Home	Intensive Tx	Comm Residen	Boarding Home	Indep Living	Row Total
	1	2	3	4	5	6	
Inpatient	48[1]	12	36	5	1	0	103
	46.9[2]	12.0	35.3	4.8	1.0	0.0	5.3
	27.9[3]	5.4	4.8	1.4	0.4	0.0	
	2.5[4]	0.6	1.9	0.3	0.1	0.0	
Nursing Home	54	199	423	93	16	5	789
	6.9	25.2	53.5	11.8	2.0	0.6	40.3
	31.2	86.6	56.2	25.2	7.2	2.3	
	2.8	10.1	21.6	4.7	0.8	0.3	
Intensive Tx	3	0	12	11	0	0	26
	11.4	0.0	45.0	43.6	0.0	0.0	1.3
	1.7	0.0	1.6	3.1	0.0	0.0	
	0.2	0.0	0.6	0.6	0.0	0.0	
Comm Residen	14	0	50	50	73	26	214
	6.6	0.0	23.6	23.5	34.2	12.1	10.9
	8.1	0.0	6.7	13.6	32.8	12.1	
	0.7	0.0	2.6	2.6	3.7	1.3	
Boarding Home	17	16	64	15	2	2	117
	14.5	14.0	55.0	13.1	1.7	1.7	6.0
	9.8	7.1	8.6	4.2	0.9	0.9	
	0.9	0.8	3.3	0.8	0.1	0.1	
Indep Living	37	2	166	194	130	181	710
	5.2	0.3	23.4	27.3	18.4	25.5	36.2
	21.3	0.9	22.1	52.5	58.6	84.6	
	1.9	0.1	8.5	9.9	6.7	9.2	
Column Total	173	229	752	369	222	214	1960
	8.8	11.7	38.4	18.8	11.4	10.9	100.0

[1]Number of Clients
[2]Row Percentage
[3]Column Percentage
[4]Total Percentage

3. Conclusions From the Data

a. Specific Conclusions

- The elderly are the most severely disabled of all population groups.
- There are few differences in the dysfunction levels for the elderly between the community mental health centers and the state hospitals.
- Relative to the overall patient population, elderly patients tend to have more difficulty functioning in the areas of medical/ physical, thinking, and meeting basic needs.
- The elderly populations of the two state hospitals are not becoming more alike, as is the case with children/adolescents.
- There has been a dramatic decrease in the geriatric population at Colorado State Hospital.
- Bed occupancy rates for the geriatric divisions in the two state hospitals consistently runs around 80%.
- Large numbers of elderly clients in nursing homes could be moved to intensive treatment facilities or community-based residential facilities if the facilities existed in the community.

b. General Implications

- There appears to be a movement of this target population from the hospitals into nursing homes in the community. This "deinstitutionalization" of the elderly from the hospital into a more "homelike community setting," however, has been blocked by the shortage of intensive treatment facility beds and community-based facility beds in the community.
- There is a general lack of differences between the elderly population served by the centers and the elderly population served by the hospitals. The hospital populations, however, differ more than other hospital population groups. These differences may be due to the geographical differences in hospital service areas. The fact that the Colorado State Hospital has a General Hospital Service Unit may also be a factor due to the large number of medical/physical problems experienced by the elderly. In general, the differences need to be considered when program planning occurs as the hospitals may require different programs to meet the unique needs of their respective populations.

4. Strategies To Address the Problems

a. Strategies Requiring No New Resources

- **Maximize the programs of the Medicaid Waiver.** The Medicaid Waiver concept allows the provision of home and community-based services

as an alternative to nursing home placement; therefore, the PSRO both certifies nursing home admission and identifies potential clients for alternatives. Through this process, those individuals in need of mental health services will be referred to the most appropriate mental health center for assessment to determine if an alternative to nursing home placement is appropriate and available. It has been estimated that this program potentially may serve 490 nursing home clients. While some attention will be directed to the "at risk" (of nursing home admission) population, it is estimated that this will be very limited due to Federal program requirements and to the medical necessity requirements for nursing care used as an admission screen by the PSRO.

- **Expand bed allocation at both state hospitals to include the geriatric programs.** Although the need for inpatient beds for the elderly is not approaching the crisis for which children/adolescent beds seems to be heading, the equitable distribution of geriatric inpatient beds, nevertheless, should be considered. This would seem to be an important strategy for effective management of the state inpatient resources for this population.

- **Expand resources for consultation and education services for the elderly to include all catchment areas.** The restriction on Consultation and Education Services (C & E) imposed by the Colorado State Legislature continues to impede the ability of the community mental health centers to provide needed services to underserved populations (i.e., children, adolescents, the elderly, and minorities). Consultation and education is the vehicle through which many outreach efforts are mobilized. This service included a variety of efforts designed to access the underserved in an age and a culturally appropriate manner which was often through collaborative programming with non-mental health service providers. The reduction in C & E often delays mental health intervention until the onset of acute dysfunction, the point at which it frequently is necessary to utilize the most expensive program elements available.

- **Examine the need for changes in treatment programs based upon the differences and changes in the target population.** The two state hospitals and the centers should examine treatment approaches and programs to ensure that the unique needs of their respective populations are met.

b. Strategies Requiring New Resources

- **Offer training to mental health professionals on special treatment issues for the elderly.** A priority for the Division is the development of training programs related to the provision of services to the elderly.

- If the strategies not requiring new resources are not sufficient to meet the needs of this population, then new resources will have to be requested, especially to address the shortage of intensive treatment and community-based facility beds.

D. ETHNIC MINORITIES SERVICES

1. Introduction

A review of the data indicated that, for the most part, ethnic minorities do not appear to be significantly different from the rest of the population served by the state mental health system when compared on changes in percentage of admissions and on overall differences in level of functioning. Ethnic minorities in the state hospitals; however, function poorly in the socio-legal area.

Data need to be reviewed on an ongoing basis with regard to minority staffing to determine whether minority staff are adequately and appropriately represented in the mental health service delivery system.

2. Facts and Trends

a. THE PERCENTAGE OF TOTAL MINORITY ADMISSIONS IS NOT CHANGING SIGNIFICANTLY IN SPITE OF DECLINES IN THE NUMBER OF ADMISSIONS

Table III.10 shows that the percentage of minority admissions is not changing dramatically in spite of decreases in the number of total admissions. Minority admissions to the community mental health centers/clinics are relatively stable, while admissions to Fort Logan Mental Health Center are increasing slightly. The percentage of admissions to Colorado State Hospital have declined somewhat. This decline is thought to be due to the changes in the Hospital's service area to include more northern counties which have fewer minorities.

TABLE III.10

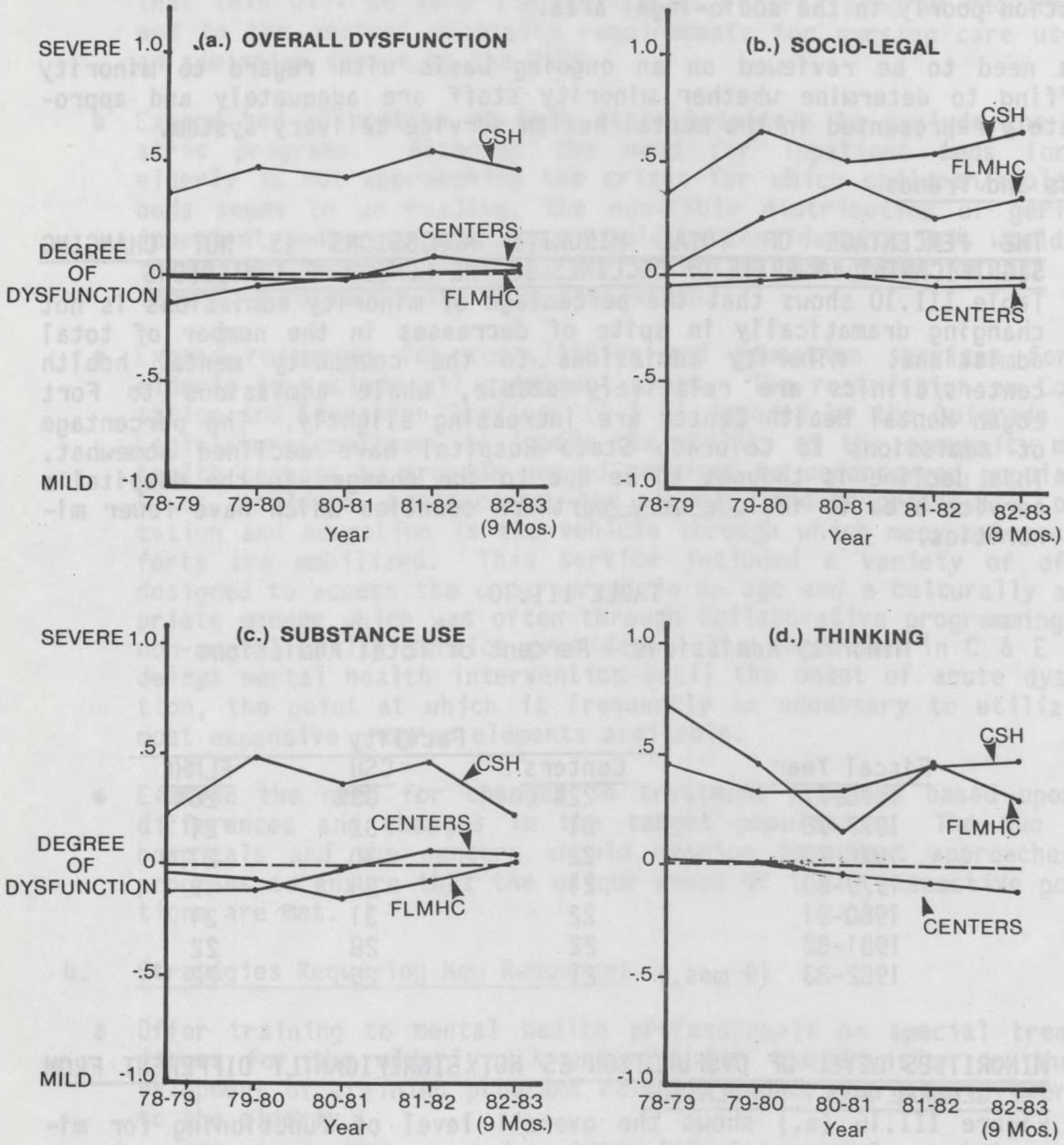
Minority Admissions: Percent of Total Admissions

	Facility		
Fiscal Year	Centers	CSH	FLMHC
1976-77	22%	33%	26%
1977-78	21	32	21
1978-79	22	30	21
1979-80	21	29	19
1980-81	22	31	21
1981-82	22	28	22
1982-83 (9 mos.)	21	25	22

b. MINORITIES LEVEL OF DYSFUNCTION IS NOT SIGNIFICANTLY DIFFERENT FROM THE GENERAL ADULT POPULATION

Figure III.16 (a.) shows the overall level of functioning for minorities. In general, minorities do not differ significantly in overall dysfunction from the general adult population. There is, however, a distinct difference between the level of functioning of minorities treated at Colorado State Hospital compared to those treated at Fort Logan Mental Health Center. Figure III.16 (b.)

seems to indicate that minorities admitted to the state mental health system function quite poorly in the area of socio-legal problems. This also clearly appears to be one of the determinants for inpatient care for ethnic minorities. Figures III.16 (c.) and (d.) show level of functioning in the areas of substance use and thinking disorders for minorities. Again, these data show that there are no critical differences in the minority population served by the state system compared to the general adult population served by the state.



1.) The zero point of the vertical axis is the 5-year average LOF of all mental health system admissions for the scale reported.

2.) Data points for centers are based on 2000 admissions or more, for hospitals, on 100 admissions or more.

Figure III.16: Dysfunction in Four Areas: Minority Admissions to State Hospitals and Community Mental Health Centers/Clinics.

3. Conclusions From the Data

a. Specific Conclusions

- The percentage of total minority admissions is not changing significantly in spite of declines in the number of admissions.
- In general, the level of functioning of minorities does not differ significantly from the general adult population.
- Minority clients admitted to the state mental health system function quite poorly in the area of socio-legal problems.

b. General Implications

- Based upon the data presented, there are no critical issues facing the system with regard to services for ethnic minorities. Most of the conclusions have implications for program planning and training efforts.

4. Strategies To Address the Problems

a. Strategies Requiring No New Resources

- **Review staffing patterns at the state hospitals and the community mental health centers with regard to ethnicity.** Staffing patterns should be reviewed to ensure that minority staffing reflects the ethnic representation in each catchment area and represents the centers' caseloads.
- **Work with colleges and universities to recruit more ethnic minorities into their mental health training programs.** They also should be encouraged to provide training which prepares students to work in the public mental health sector. This would help to ensure the availability of ethnic minorities for work in the state-funded mental health system.

b. Strategies Requiring New Resources

- **Expand resources for consultation and education services for minorities to include all catchment areas.** Minorities are among the groups that benefit most from consultation and education services. For the specialty clinics, the agencies which serve highly unique client populations (e.g., non-English speaking) and which provide highly specialized, culturally relevant services, the limitation on C & E impacts on their ability to extend their services by providing training to the catchment area community mental health centers.
- **Offer training to mental health professionals who work with ethnic minorities.** Training which enhances the ability of the mental health system to treat this population is needed and could be provided through the Division of Mental Health.

E. FORENSIC SERVICES

1. Introduction

The Institute for Forensic Psychiatry at Colorado State Hospital is running **over capacity in Maximum, Medium, and Intermediate Security.** In addition, Medium Security units are **out of compliance with State Health Department** standards regarding required square footage for patient living areas. The overcrowded conditions, especially in Medium Security, not only violate Health Department standards, but they also result in several **negative consequences:**

- There is less direct treatment time per patient (20-25 minutes per day per patient which should be 50-60 minutes per day);
- Injuries to both patients and staff tend to increase;
- There appears to be increased loss of employee productivity due to sickness and injuries incurred while on duty;
- The length of stay increases because of the decreased amount of direct treatment which results in increased costs.

The overcrowding is especially critical when one considers the fact that this unit, which was created by state statutes, is the only Forensic Unit for Colorado.

2. Facts and Trends

a. FORENSIC IS NOT IN COMPLIANCE WITH STATE HEALTH DEPARTMENT STANDARDS REGARDING REQUIRED SQUARE FOOTAGE FOR PATIENT LIVING AREAS

The Institute for Forensic Psychiatry has a licensed capacity of 350 beds. The Institute is sectioned into five distinct security/ program levels: Maximum Security, Maximum Annex, Medium Security, Intermediate Security, and Minimum Security.

Level	Number of Wards	Wards
Maximum	4	F1, F2, F3, F4
Maximum Annex	2	F5, F7
Medium	4	F9, F10, F11, F12
Intermediate	2	GW6, GW12
Minimum	3	GW11, 79N, 79W

Department of Health standards state that multiple bed dorms should provide 80 square feet of living area to each patient and that each dorm should have no more than four (4) patients. The major compliance problem in Forensic is Medium Security which has had anywhere from five to eight patients per dorm. Medium security has ranged from 46 to 75 square feet per patient; however, the average hovers around 68 square feet depending on census fluctuations. There also are compliance problems on the intermediate units, but these problems are not as serious.

b. THE INSTITUTE FOR FORENSIC PSYCHIATRY IS OPERATING OVER CAPACITY

The following table shows the ward census and occupancy rates for

the Institute for Forensic Psychiatry from October 1982 through May 1983. These dates were selected because the last ward change occurred in September, 1982 when GW-6 was opened as intermediate security for the Division. The Institute, therefore, has eight months of data under the present ward configuration. These data are consistent with the trends for the past three years, and clearly show a critical problem on the Maximum, Medium, and Intermediate Security Wards.

The Institute for Forensic Psychiatry has never had a proper vacancy factor. Most hospitals expect at least a 10% vacancy factor which would amount to 35 vacancies for Forensic. In operation, they rarely have had more than seven or eight vacant beds. Up to now, Forensic often has had only one or two vacant beds, especially over a weekend.

TABLE III.11

INSTITUTE FOR FORENSIC PSYCHIATRY
Ward Census and Occupancy Rates
(October 1982 through May 1983)

Ward	Security	Licensed Capacity	Mean Census	Occupancy Rate (%)
F-1	Maximum	20	21.2	106.0
F-2	Maximum	20	21.8	109.0
F-3	Maximum	20	20.9	104.5
F-4	Maximum	20	21.3	106.5
F-5	Max Annex	25	22.5	90.0
F-7	Max Annex	25	22.7	90.8
F-9	Medium	23	29.8	129.6
F-10	Medium	23	30.5	132.6
F-11	Medium	23	29.6	128.7
F-12	Medium	23	30.0	130.4
GW-6	Intermediate	18	20.3	112.8
GW-12	Intermediate	21	20.6	98.1
GW-11	Minimum	21	14.8	70.5
79-W	Minimum	34	25.0	73.5
79-N	Minimum	34	24.4	71.8
TOTAL		350	355.6*	

*Includes 0.5 admitted to surgical (for medical reasons).

Although most of the wards are operating over capacity, the minimum security wards are an exception. Recently, these minimum security

wards have been operating under capacity, in contrast to FY 1980-81 during which the mean census for wards 79W and 79N was 31.3 and 32.3 respectively. The difference seems to be the result of the efforts to reduce the number of escapes. Patients on these wards tended to "walk away". To reduce these walk aways/escapes, a number of "walk away prone" patients were sent back to more secure wards.

c. SECLUSION/RESTRAINT ROOMS ARE BEING USED INAPPROPRIATELY AS REGULAR PATIENT ROOMS

One significant impact of the lack of capacity has been the use of beds designated for seclusion/restraint as regular patient beds. This frequently is very disruptive to treatment and programs. For example, a patient who becomes disturbed during the night may need to be placed in a seclusion bed; however, in order for him to be put in seclusion, the patient occupying that bed must be awakened and moved in the trade-off. Another consequence of this practice is that some patients end up in more restrictive settings than clinically appropriate, since the seclusion/restraint areas are designed as more restrictive areas.

Table III.12 shows the extent to which seclusion/restraint beds are being utilized inappropriately as a result of the overcrowding in Maximum, Medium, and Intermediate Security. It is important to note that only 5 of the 30 seclusion beds are included in the Hospital's licensed capacity of 350 beds. Of the remaining 25 beds, 19 are almost constantly occupied.

TABLE III.12

Utilization of Seclusive/Restraint Beds In the Institute For Forensic Psychiatry

Security Level	Number of Seclusion/Restraint Beds	Beds Included In Licensed Count of 350	Estimated Occupancy Rate (%) for Seclusion/ Restraint Beds
Maximum	8	No	100%
Max Annex	5	Yes	100%
Medium	8	No	75%
Intermediate	3	No	100%
Minimum	6	No	0

d. LENGTH OF STAY OF FORENSIC PATIENTS HAS INCREASED SIGNIFICANTLY

When the length of stay of NGRI (Not Guilty By Reason of Insanity) patients who had been released from Colorado State Hospital was analyzed, the results showed that the median length of stay had more than doubled from 2.7 years in FY 1980-81 to 4.5 years in FY 1982-83. Data on inpatients determined incompetent to proceed with their trial also show a definite increase in length of stay (from 3.1 months in FY 1980-81 to 4.6 months in FY 1982-83).

e. REFERRALS FROM CORRECTIONS HAVE DOUBLED IN THE PAST THREE YEARS

TABLE III.13

Referrals From Corrections

Correctional Facility	FY 1980-81	FY 1981-82	FY 1982-83 (7/1/82 - 5/31/83)
Buena Vista	5	10	15
Canon City	14	13	24
Fremont	2	5	4
Total	21	28	43

3. Conclusions From the Data

a. Specific Conclusions

- There is critical overcrowding in the Maximum, Medium, and Intermediate Security Units at the Institute for Forensic Psychiatry.
- The Institute for Forensic Psychiatry is not in compliance with State Health Department standards regarding required square footage for patient living areas.
- Seclusion/restraint rooms are being used inappropriately as regular patient rooms.
- Length of stay of Forensic patients has increased significantly.

b. General Implications

The overcrowding in the Institute for Forensic Psychiatry needs to be reduced to improve the mental health care provided to forensic patients. The Institute also needs to come into compliance with State Health Department standards by expanding the physical capacity of the Forensic program.

4. Strategies To Address the Problems

a. Strategies Requiring No New Resources

- **Transfer patients, as clinically appropriate, to less secure wards such as the Minimum Security wards in a manner that ensures both the security of the patients and the safety of the community.** The staff of the Institute for Forensic Psychiatry are currently reviewing all patients to determine which patients could appropriately be transferred to a less secure setting without increasing hospital escapes.

- **Provide an inservice for staff on competency training in order to get patients in that legal category (Incompetent to Proceed With A Trial) out of the hospital as soon as possible.** Patients are sent to the Forensic Unit in order to become competent to stand trial for the crime with which they have been charged. Since hospital staff have been trained to treat patients, it is difficult for them to return the patients to court until they have made significant progress. Staff need to be trained to treat the patients for their return to court which should reduce their length of stay in the hospital.

- **Develop a matrix for forensic patients which shows the current placement of patients and the desired/optimal placement for each patient.** This concept is similar to that which formed the basis for the Division's Residential Continuum. This additional information would assist in the planning process for Forensic Services.

b. Strategies Requiring New Resources

- **Alleviate the overcrowding in the Institute for Forensic Psychiatry by opening a new 18-bed ward, fully staffed, without increasing the number of clients to be served.** This expansion also would bring the Institute in compliance with State Health Department standards for square footage for patient living areas.

- **Reduce the pressures on the Institute for Forensic Psychiatry at Colorado State Hospital by utilizing four beds in the Larimer County Jail to do competency and psychiatric evaluations on NGRI (Not Guilty by Reason of Insanity) patients.** During the past year, the Division of Mental Health reviewed the forensic services provided in Colorado, and determined that some level of forensic service capability was needed in the northern part of the state. Currently, all 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. In an effort to establish some forensic service capability in the northern part of the state, the Division of Mental Health is considering the development of a joint contractual partnership involving the Division, the Larimer County Mental Health Center, and the Larimer County Sheriff's Office for

the provision of forensic mental health holding and evaluation services on a regional basis. These services would be directed toward persons requiring court ordered or other legally mandated and controlled evaluative procedures pending legal disposition of their case. Present costs estimated by Colorado State Hospital for forensic detainees are quoted at $127 per day, with rates going much higher when greater security measures are required. Local law enforcement and detention centers also incur holding, personnel, and transportation costs when clients must be removed to Colorado State Hospital in Pueblo. It is assumed that these costs could be reduced substantially and that the service could be provided in a more appropriate, timely manner if it were available to clients in the northern section of the state. Larimer County has been selected as the potential site, since it has recently completed a new detention facility. The design of this structure allows for segregated areas for groups of detainees. This design would be particularly suitable for the evaluation and observation of the mentally ill detainee. This segregated design would provide a small unit to be used only for mental health clients. The staffing required would include the customary sheriff's personnel, who would receive special training, and one full-time certified psychologist from the Larimer County Mental Health Center. Part-time clinical (e.g., psychiatric and nursing) and part-time support (e.g., secretarial) personnel would also be provided by the Center on an as-needed basis.

F. DUALLY DIAGNOSED POPULATIONS

1. The Mentally Ill/Hearing Impaired Patient

The State of Colorado has been pursuing the goal of adequate mental health services for the hearing impaired since 1976 when the Deaf Services Team (DST) was established at Fort Logan Mental Health Center. This effort has been hampered by an incomplete understanding of the parameters of the deaf client population in Colorado. When the prevalence rate of pre-vocational deafness in the western United States is applied against state 1981 census, it is estimated that 5,752 seriously impaired deaf persons live in Colorado. Pre-vocational deafness includes those who have never had hearing (pre-lingually deaf) and those who lose their hearing before the age of 18. Other definitions of impairedness show that there are 33,986 persons with hearing loss in Colorado and 19,000 in the Denver metro area (1980 census). It is not clear from the literature what proportion of deaf persons require psychiatric care. It would appear that this population does not seek and/or has difficulty accessing service within the public mental health system.

The state funded mental health system needs to implement a planning initiative for the hearing impaired which would:

- determine the at risk population in need by both level of hearing deficit and degree of psychiatric dysfunction; and

- identify needed mental health resources, including an implementation plan which specifies the type, location, and intensity of services needed.

2. The Mentally Ill/Developmentally Disabled Patient

Issues concerning patients with dual diagnoses are ongoing. Resolution of these issues will require interagency agreements and policy development to define mutual roles and responsibilities. The Division of Mental Health will continue to work jointly with the Division for Developmental Disabilities to identify the issues and options for solutions to providing services to this population.

3. The Mentally Ill/Detained Youth

One of the most significant patient issues between mental health and youth services relates to the lack of adequate emergency mental health services for non-committed youths who are temporarily detained in detention centers. Data from the State Division of Youth Services show that during fiscal year 1982-83, there were approximately 237 of these youths who were admitted temporarily to detention centers and who were later placed in mental health facilities (i.e., Colorado State Hospital, Fort Logan Mental Health Center, and private hospitals). According to these data, the average daily attendance for these youths was 6.64 days, and the average length of stay was 9.25 days. Of the 237 youths, 64 were released within twenty-four hours, and 93 were released within 48 hours. The Division of Youth Services does not consider its resources adequate for dealing with youths who have mental health problems and who are high-risk youths, creating a danger to themselves and others. One strategy which might help to address this problem would be the CRS 27-10 designation of Residential Child Care Facilities as 72-hour treatment and evaluation facilities. The Division of Mental Health and the Division of Youth Services will continue to work together to identify the issues and options for solutions to the service needs of this dually diagnosed population.

4. The Mentally Ill/Substance Abuse Patient

Issues concerning this patient population also are ongoing. The Division of Mental Health needs to jointly review the issues and options for providing services to this dually diagnosed population with the Division of Alcohol and Drug Abuse.

G. PROGRAMMATIC PRIORITIES

1. Residential Services

One of the most critical issues for the mental health system continues to be the shortage of psychiatric beds, including both community-based beds and state psychiatric hospital beds. The specific shortage related to children/adolescents, adults, elderly, and forensic patients are described in the preceding sections.

2. Vocational Services

The second specific area where there is a critical gap in services and

where efforts are being made to capture new funds for program expansion is the area of vocational services. Since a full continuum of services is necessary in order to assist patients in reaching their maximum level of employability, the Division of Mental Health developed a Vocational Continuum. Programs offering pre-occupational training, however, are critically lacking. Although there are more than thirty sheltered workshops in Colorado, only seven have specific programs for the mentally ill. In addition, only four 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 patients' work potential.

It is essential that programs be developed to afford the system's clients the opportunity to increase their productive capacity. The Vocational Coop at the Southwest Colorado Mental Health Center in Durango, for example, has been an outstanding success. The project started on target on July 1, 1982 and maintained an active caseload of twenty clients throughout the year. The year end evaluation data indicated that 75% of clients participating in this project were placed in competitive employment. Further, **a reduction of approximately $120,000 was realized in public support systems for these clients.** Colorado is fortunate to have an effective model already in place since Congress recently passed legislation (the Job Training Partnership Act) which provides 3.5 billion dollars nationwide for training of disadvantaged citizens and "others facing serious barriers to employment," including the handicapped.

The Division of Mental Health has been appropriated $220,000 in Federal Block Grant Funds under Public Law 98-8, the Federal Emergency Jobs Bill, which will result in the expansion of vocational services in nearly half of the catchment area community mental health centers in Colorado. The designated purpose for this allocation is to address problems associated with extended unemployment. Of the eight programs to be awarded funds for a Mental Health Cooperative Vocational Program, six will be for adults in rural areas and two will focus on adolescents in an urban or suburban setting. All of these programs will be based on the model developed in Durango. To ensure staffing knowledge and expertise for service delivery, part of the appropriation will be used to train each new employee responsible for the program. The Division has arranged for a two week intensive training course with the Vocational Education Department at the University of Northern Colorado. Each participant will be given nine hours of graduate credit toward a vocational credential.

The Federal Emergency Jobs Bill appears to be the only significant source of new money for the expansion of vocational services to the system's clients. This legislation, by its very nature, requires a strong partnership and commitment from private industry. Through involvement in Local Service Delivery Areas and Private Industry Councils, local community mental health center personnel might ultimately increase their contacts and involvement with private industry in the training and employment needs of clients.

At Fort Logan Mental Health Center, older adolescents have some access to the adult work therapy program; no such option exists at Colorado State

Hospital. The impact of this deficiency is growing since both the numbers and percent of 16 and 17 year old adolescent admissions, compared to total child/adolescent admissions, have been steadily increasing at Colorado State Hospital: 55/24% in 1979-80 to 81/36% in 1982-83. Although there are school programs at Colorado State Hospital to address academic deficiencies, they do not remedy the several-year lag which the adolescents present upon admission; consequently, only about 30% of the 16 and 17 year old adolescents return to school after discharge from the hospital. The majority face the future with educational deficiencies and with a total absence of vocational programming to prepare them for even the most basic work possibilities.

H. TREATMENT/SERVICE OUTCOME

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

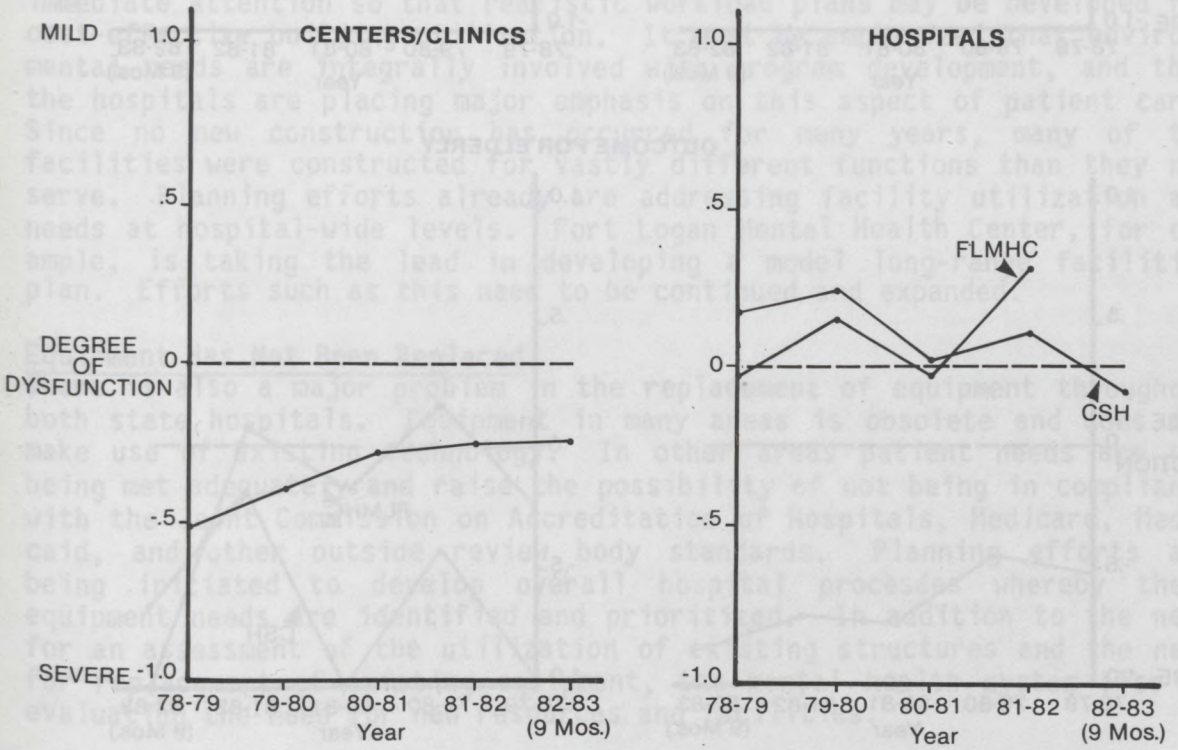
The Division of Mental Health has analyzed trends in the treatment outcome index for children/adolescents, adults, and the elderly. The outcome measures reported here are based on the relationship between admission and termination level of functioning (LOF) ratings. A file was created especially for the Situational Analysis which consisted of 29,000 records. The file was made up of 20 percent samples from each of the years from 1978-79 through 1981-82 and a 30 percent sample from 1982-83 (9months). Only clients for whom there was both an admission and discharge record within the year were included.

Ratings done in the manner of these LOF ratings often contain bias. Raters develop habitual responses with some consistently rating all scales high or low and others rating certain scales high and other scales low in a predictable pattern. Recent research has demonstrated the presence of rater-related patterns in these LOF ratings and has led to a methodology which can be used to remove them. LOF ratings done on each client in the sample at admission and termination were corrected for rater effect before outcome scores were computed.

A committee of the Organization for Program Evaluation in Colorado (OPEC) has been formed to further examine level of functioning measurement issues. The committee is composed of representatives from the Division of Mental Health, the community mental health centers/clinics, and the two state hospitals. This committee will focus on the methodology for determining rater effect and on improving the techniques for defining and reporting LOF scores.

A number of threats to the validity of outcome scores come into play when this kind of score is obtained by simply subtracting termination LOF from admission LOF. In order to avoid these, a method very similar to the one used to "take out" rater effect was used to "take out" the influence of differences between client's admission ratings on termination ratings. In other words, these outcome scores are like looking at termination ratings made on clients who had all been admitted with the same level of dysfunction.

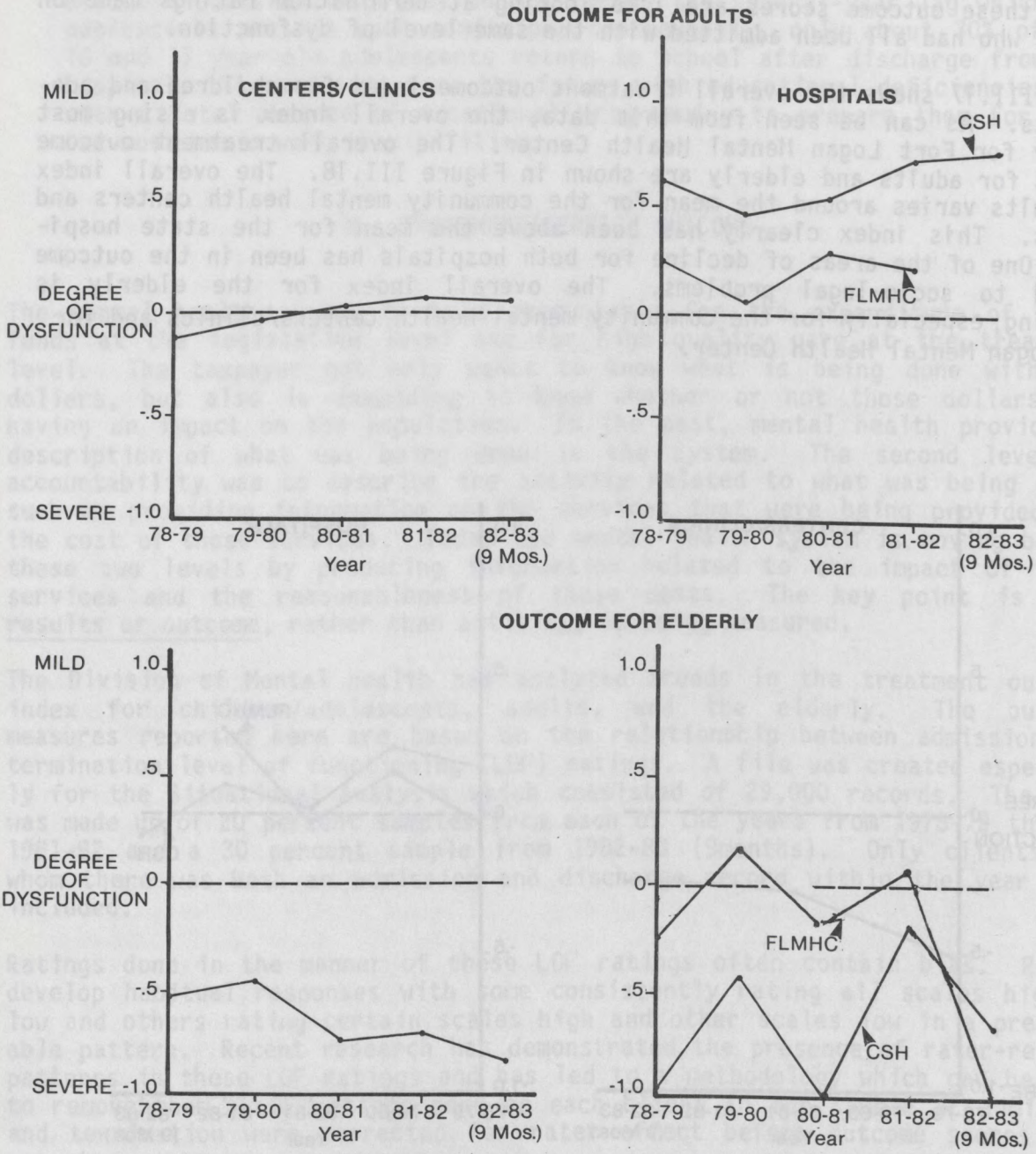
Figure III.17 shows the overall treatment outcome index for children and adolescents. As can be seen from this data, the overall index is rising most sharply for Fort Logan Mental Health Center. The overall treatment outcome indices for adults and elderly are shown in Figure III.18. The overall index for adults varies around the mean for the community mental health centers and clinics. This index clearly has been above the mean for the state hospitals. One of the areas of decline for both hospitals has been in the outcome related to socio-legal problems. The overall index for the elderly is declining, especially for the community mental health centers/clinics and for Fort Logan Mental Health Center.



1.) The zero point of the vertical axis is the 5-year average Outcome Index of all mental health system terminations for the scale reported. The Outcome Index is a termination LOF adjusted for differences among clients at admission.

2.) Data points for centers are based on 2000 terminations or more, for hospitals, on 100 terminations or more. The Index is based upon outcome for clients admitted and terminated within each fiscal year.

Figure III.17: Outcome for Children/Adolescents



1.) The zero point of the vertical axis is the 5-year average Outcome Index of all mental health system terminations for the scale reported. The Outcome Index is a termination LOF adjusted for differences among clients at admission.

2.) Data points for centers are based on 2000 terminations or more, for hospitals, on 100 terminations or more. The Index is based upon outcome for clients admitted and terminated within each fiscal year.

Figure III.18: Outcome for Adults and Elderly

CHAPTER IV: FACILITIES

A. PROBLEMS

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.

1. No New Construction Has Occurred

The physical plant of Colorado State Hospital, for example, is an aging one. There has been very little new construction during the past twenty 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 (JCAH), 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. Fort Logan Mental Health Center, for example, is taking the lead in developing a model long-range facilities plan. Efforts such as this need to be continued and expanded.

2. Equipment Has Not Been Replaced

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 adequately 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 is evaluating the need for new resources and facilities.

B. COLORADO STATE HOSPITAL

1. General Facility Needs

- Development of a long-range facilities plan. There is a need to evaluate and study overall hospital facility utilization and needs at

Colorado State Hospital to assure maximum efficiency and effectiveness in building usage. Initial efforts have been implemented; however, it appears that internal resources will not be adequate to complete the type of review needed. Outside consultation will need to be identified, secured, and reimbursed.

2. Specific Facility Needs

- **Construction of a power plant which is both economically and environmentally necessary.** The major facilities issue for Colorado State Hospital is the power plant. The Hospital's power plant was constructed in 1908 and must be replaced for economic and environmental reasons. Financially the cost of operating gas fired boilers, if coal firing is not possible, increase fuel costs by up to $800,000 per year. Environmentally there is an increasing possibility that coal firing may not be allowed utilizing the current power plant pollution control measures which, in essence, means replacement of the power plant or utilizing gas as a fuel.

- **Development of a plan for the General Hospital based upon a thorough study and needs assessment of this Unit.** Admissions to the General Hospital at Colorado State Hospital are directly related to the other hospital divisions and to the Department of Corrections. There has been a decline in average daily attendance throughout the years. Some of the reasons for this decline are the closing of the two rehabilitation wards and the decrease in the number of security patients allowed on the surgical unit. There currently is a list of approximately 20 people from Corrections waiting for surgical services. General Hospital staff also are very concerned about the critical condition of the equipment. Most of the equipment was purchased in 1965, and most of the radiology equipment is 17 years old. Useful life for x-ray equipment is 10 years, and the life of most of the other equipment has more than doubled that expected. Repairs are expensive and much of the equipment needs to be replaced. In view of the changing needs, the serious equipment problems, and other questions concerning utilization of the General Hospital Services, Colorado State Hospital needs to complete a thorough study and needs to develop a plan for the overall utilization of this unit. This study and plan will require outside consultants and additional state resources in FY 1984-85.

- **Construction of a new medium security building for the Institute for Forensic Psychiatry which is necessary for the public safety.** The Institute for Forensic Psychiatry Medium Security Unit is often overcrowded by nearly 30 patients beyond capacity and has no facilities which are readily available for recreational or occupational therapy programming, in comparison to other Forensic units. Patients in medium security must be escorted to the north unit recreation facility for ancillary programs. A new facility for medium security patients which would house approximately 120 patients will be needed. The present capacity is 92, and the unit normally runs around 120.

- **Construction of a new geriatrics facility which is necessary to safely treat the geriatric population.** The Geriatric Treatment Center at

Colorado State Hospital is housed in a six story building which was constructed in 1956. The program itself is housed on four floors which is an inappropriate arrangement for a geriatric program. The facility does not allow for patient privacy and is dehumanizing due to the fact that it was designed as a custodial center. It no longer meets the treatment and facility needs for a geriatric population, especially when the dramatic advances made in gerontology in recent years are considered. What is needed is a new facility which is architecturally compatible with the modern psychiatric treatment program of the division.

- **Construction of an adult unit which meets present day standards for treatment of the acutely mentally ill.** Colorado State Hospital also projects a need to change the facilities on General Adult Psychiatric Services (GAPS) to get the wards down to an optimum level of no more than 22 patients per ward. At the present time GAPS accommodates 40 patients per ward. In the opinion of hospital staff, the optimal standard would be 22 for an acute care service which receives the extensive admissions that are experienced on GAPS wards. Having several smaller rooms for watching T.V., etc. also would be preferable to the large day hall concept which is currently in place. This may mean that new facilities will need to be constructed since current facilities were built in the 1930's and do not lend themselves to the type of remodeling needed to accomplish these goals.

- **Construction of a closed adolescent unit and a new facility for the school program.** The Child and Adolescent Treatment Center operates at 85% - 90% capacity. The population of Colorado is increasing, and private hospitals charge close to $400 a day. Colorado State Hospital is anticipating a need for more beds in the closed unit. It would be desirable to construct a closed unit in the same area as the rest of the Children's Center. This would require capital construction monies. A new facility also is needed for the school program. The facility was originally built for three cottages, and there are now five. Colorado State Hospital would like to have Occupational Therapy and Recreational Therapy integrated into the school program. Modifications would need to be made in the cottages to provide space for this programming.

C. FORT LOGAN MENTAL HEALTH CENTER

1. General Facility Needs

- **Completion of the extensive facilties utilization and needs study and development of the long-range facilities plan.** The first facilities issue revolves around more appropriate utilization of all state owned properties on the Fort Logan grounds. A facilities analysis was completed during the summer of 1982. The Fort Logan Development Committee is actively working on role and program issues around the use of all buildings. A planning and engineering study is needed to

complete the assessment and feasibility stage of the long-range development plan. The property development effort will improve the range of residential and psycho-social rehabilitative alternatives available at the hospital and the cost-effectiveness of building maintenance and management.

2. Specific Facility Needs

- **Replacement of the 20-year old telephone system.** The current system is antiquated and does not meet the needs of the hospital.

- **Complete needed exterior repairs and remodeling for fire and safety protection.** The deterioration of Fort Logan Mental Health Center's physical plant is becoming a critical problem. Capital construction and controlled maintenance monies have been so limited as to prevent even minimal upkeep. Several of the older residential buildings (100 years old) require extensive exterior repairs. The 1981 JCAH survey recommendations for physical plant changes or improvements constituted 41% of all recommendations. Some of these recommendations addressed problems associated with using open-designed wards as locked wards.

- **Replacement of X-ray equipment.** X-ray equipment is old and in need of replacement.

- **Construction of a centrally located maintenance shop.** The Maintenance Department has long needed a centralized supply and shop area (partially planned for the Medical Services and Geriatric Building basement, and a separate shop area located adjacent to the central heating plant) which will greatly increase the efficiency of the department and reduce gas consumption caused by the present location of the shops.

- **Construction of a new school/therapeutic activities building or an upgrade of existing facilities for the same purpose.** The lack of social activities and educational areas on locked wards are especially problematic for Fort Logan. Adolescent II, for instance, is a locked facility with inadequate school and therapeutic activity areas in terms of available space and awkwardness of design. Clients of this unit cannot attend the main Fort Logan school because of the runaway risk involved in moving clients across campus. The increase in numbers of adolescent clients combined with the lockability/design issue has produced a critical situation which can only be relieved by major renovations of existing childrens/adolescents buildings or through new construction.

CHAPTER V: STAFF RESOURCES

A. INTRODUCTION

The Colorado Mental Health system is highly labor intensive; over 80% of the total budget is used for personnel. According to data collected by the Division's Human Resource and Development Section, there are approximately 1,950 persons staffing Colorado's two state hospitals and another 1,700 persons staffing the 24 community mental health centers and clinics. These 3,640 staff are referred to as the public sector mental health workforce. In addition, roughly another 800-1,200 persons are working in the private practice sector in Colorado, located almost exclusively along the population centers of the Front Range in contrast to the statewide distribution of the public sector workforce. The quality of services delivered to clients is directly dependent upon the availability, adequacy, and performance of these human resources.

B. ISSUES

1. **Staff Turnover Is High In the Public Mental Health Sector**

The following Table reflects the annual turnover of staff in the state-funded mental health system.

TABLE V.1

Annual Turnover of Mental Health Staff

	Centers	CSH	FL	Average for all State Employees
1981	34%	14%	35%	14%
1982	29%	15%	36%	12%

In industry, annual turnover rates in excess of 15-20% are usually viewed with concern. As can be seen from Table V.1, both the community mental health centers/clinics and Fort Logan Mental Health Center have extremely high turnover. Some of this high turnover can be attributed to the fact that staff from Fort Logan and other centers located in the Denver metropolitan area have more job opportunities available to them in mental health or in related fields. High turnover causes considerable disruption in treatment, as well as requiring the costly expenditure of time and money for temporary coverage, recruitment, and replacement. The high turnover rate in the state-funded system is also reflected in the average tenure of public sector staff as shown in Table V.2.

TABLE V.2

Average Tenure of Staff

Public Sector	3.5 years
Private Sector	7 years

2. **Several Factors Create Recruitment Problems**

While agencies in urban settings generally find it easier to recruit than do agencies in rural settings, the entire system has difficulty in recruiting psychiatrists and psychiatric nurses.

A second recruitment problem, especially for community mental health centers, is the movement of the mental health workforce from the public into the private sector directly following graduate training and/or after a shorter tenure in the public sector. Several factors contribute to this movement:

- salaries are not competitive with the private sector;
- the public sector targeted population of seriously, critically and chronically mentally ill are increasingly more difficult to work with;
- insufficient attention has been given to the re-education of staff to competently work with the targeted populations (nor do higher education curricula deal with the needs of the public sector clientele);
- the push for increased productivity often comes at the expense of staff development and attention to quality of performance.

The lack of a pool of new graduates from which to recruit may present another problem for the system to address. The fact that new graduates are less available has been attributed to the reduction in federal training funds and the tendency of the younger workforce to spend fewer years in the public sector before moving to the private sector.

3. **Continuing Education and Staff Development Functions Need to be Continued for State-Funded Programs**

Many of the staff in the public sector hold advanced professional degrees which require them to get continuing education in order to acquire and/or maintain licensure or certification. The Human Resources and Development Section of the Division organizes and provides continuing education programs which upgrade staff clinical skills for treating the state's target populations, ensure knowledge of and compliance with changing rules and regulations, and improve management capacity to efficiently operate the system. Using only federal funds, the Human Resources Development Section of the Division has provided approximately 570 hours of training to an average of 2,630 participants each year for the past six years. This training will not be available beyond the current fiscal year unless the state decides to provide the funding.

4. Linkages With Higher Education Need to Be Improved

Human Resource Development staff are working with the higher education programs to make their curricula more relevant to preparing the future mental health staff for work in the public mental health sector, as current curricula in the mental health disciplines don't address the targeted populations of the public mental health sector, particularly the chronically mentally ill. There needs to be more shared commitment and long range planning between Colorado's public mental health system and the graduate mental health training programs in the state.

5. Staffing Deficiencies at the State Hospitals

Turnover, especially among clinical staff at Fort Logan, is of primary concern. In FY 1982-83, 79% of all terminations occurred in clinical areas - with psychiatry and psychiatric nursing services being hit the hardest. Under such circumstances, general hiring freezes have played havoc with patient care. In order to provide minimal coverage on clinical wards, Fort Logan Mental Health Center had to resort to hiring temporary nursing staff at twice the cost of regular staff. To address this problem, Fort Logan implemented the use of an internal relief pool of part-time staff this past fall. This Nursing Relief Pool (NRP) has yielded positive results.

The internal NRP, however, is inadequate to meet current demands:

- Since January, 1983 when NRP has been close to operating at its authorized capacity, an average of seven additional shifts per week could have used NRP staff had the additional resources existed.
- When current NRP staff are not sufficient to meet the need, temporary external pool personnel must be used to provide minimum ward coverage at twice the cost of NRP staff. With the existing NRP program operating close to capacity for only the last 6 months of 1982-83, external pool temporary costs have been reduced from $137,000 in 1981-82 to $121,000 in 1982-83. Further reductions and cost savings are expected in 1983-84.
- Some additional funds will be used for expansion of the NRP in 1983-84, and the data base will be closely monitored to identify trends and needs.

6. The Mental Health System Needs to Ensure That There Are Appropriate Numbers of Ethnic Minorities and Women Represented at All Staff Levels of State-Funded Agencies

TABLE V.3

ETHNIC GROUP POPULATIONS IN COLORADO:	Hispanic	Black	Asian	American Indian
% IN COLORADO	11.4%	3.5%	1%	0.6%
*ETHNIC GROUP REPRESENTATION IN ALL CENTERS, CLINICS, AND HOSPITALS				
ALL POSITIONS	18.2%	3.8%	1.3%	0.9%
THERAPISTS	17.1%	3.8%	1.7%	0.8%
EXECUTIVE MANAGEMENT TEAM OF AGENCY	17%	4%	1.8%	0.4%
UNIT DIRECTORS	8%	5%	0.7%	0

*Colorado Public Mental Health Workforce Survey, 1983
(85% Response Rate)

As can be seen from the above Table, overall the public sector workforce is representative of Colorado's ethnic group composition. In all but five of the community mental health centers/clinics, it actually exceeds the population, and in only one case (Hispanic Unit Directors) does the discrepancy vary by more than a fraction of a percent. When these data are examined according to groupings by centers and the two hospitals, some deficiencies in excess of only 1% are noted. For example, in some centers Hispanics are not always adequately represented in the categories of therapist and unit director. It was also noted that minorities are not as well represented at Fort Logan as they are at Colorado State Hospital. Clearly, there are problems in some positions with inadequate Hispanic representation. In part, this is a reflection of a limited applicant pool, steep competition with higher salaries than the public sector offers, and agency location.

When data from the same 1983 Colorado Public Mental Health Workforce Survey are examined for women, they reveal that only five of the twenty-four centers and clinics approach proportional representation of women in all levels of management. In seventeen agencies, less than 45% of the executive management group are women; and in ten agencies, less than 45% of the management team and unit directors are women.

C. CONCLUSIONS AND IMPLICATIONS

- Generally, the mental health system needs to increase the focus on its chief resource - its people - as is evidenced in the high turnover, recruitment problems, and staff deficiencies which have been identified.
- A staff development function is essential to the operation and improvement of the mental health system and must be maintained with state funds if it is to continue.
- Without a major effort to establish substantial linkages with higher

education programs, the public mental health system faces increasing difficulty in finding appropriately trained staff to serve its targeted populations.

- Overall, the public sector workforce is representative of Colorado's ethnic group composition.
- Women in the public sector workforce are not sufficiently represented in middle and upper management positions.

D. STRATEGIES TO ADDRESS THE PROBLEMS

1. Strategies Requiring No New Resources

- Identify barriers in the state system which restrict personnel and management initiatives that could produce cost savings and improve the functioning of the human resources.
- Research and utilize human resource-focused programs which have been effective in other states.
- Use the 1983 Mental Health Public Sector Workforce data to predict future turnover and to pinpoint other workforce trends.
- As a system, focus on incentives other than money which will attract and retain high quality staff.
- Convene a task force from the mental health system and from related higher education programs to address barriers to effective communication and joint planning.
- Utilize low cost training resources and maximize sharing of expertise within the system.
- Monitor the community mental health centers/clinics and the two state hospitals to ensure that there are adequate minority staff to meet the needs of each agency's patient population.
- Monitor the community mental health centers/clinics and the two state hospitals to ensure that women are equally represented at all levels of management.
- Maximize the success of the Nursing Relief Pool at Fort Logan Mental Health Center by expanding it to meet the current hospital needs.

2. Strategies Requiring New Resources

- Request state funding for maintaining the staff development capacity at the Division of Mental Health.

CHAPTER VI: SOURCE OF FUNDS

1. General Funds: The general fund appropriation was adequate for its prescribed services prior to the state's revenue problems. The general funding is no longer adequate to support all existing projects as included in the appropriations report.

	78-79	79-80	80-81	81-82	82-83
CMHCs	$14,536,423	$16,202,651	$16,797,489	$16,424,985	$18,115,321
Hospitals	$20,756,586	$23,129,948	$26,188,584	$31,487,099	$32,693,266

2. Federal Funds: Federal funds come to the Division of Mental Health through the block grants and through a grant by NIMH for the Human Resources Development (HRD) program. The funding for the HRD program will be reduced by 50% July 1. The block grant is scheduled to end in federal fiscal year 1983. This will cause a 2.9 million dollar shortfall in FY 1984-85. It is assumed that the authorization for the block grant will be continued by Congress, causing no shortfall in funding until FY 1985-86.

	78-79	79-80	80-81	81-82	82-83
CMHCs	$5,437,263	$5,733,489	$4,165,186	$4,091,431	$3,610,191
Hospitals	$ 15,496	$ 230,604	$ 381,191	$ 124,229	$ -0-

3. City and County: The community mental health programs receive funding from counties and municipalities. This funding was reduced in FY 1981-82, thereby reducing the number of clients receiving service. The majority of this funding is federal revenue sharing. The federal authorization for revenue sharing ends September 30, 1983. It is assumed that Congress will pass legislation continuing this program.

	78-79	79-80	80-81	81-82	82-83
CMHCs	$2,283,032	$2,396,477	$2,406,208	$2,280,968	$2,299,858
Hospital's	$ -0-	$ -0-	$ -0-	$ -0-	$ -0-

4. School Districts: Many mental health centers contract with local school districts to provide services to students. This funding has been reduced and is causing reductions in service. Most of this funding comes to the school districts through PL 94-142 which has been reduced by the federal government. It is assumed that this decline will continue.

	78-79	79-80	80-81	81-82	82-83
CMHCs	$ 468,272	$ 511,691	$ 488,101	$ 354,697	$ 277,234
Hospitals	-0-	-0-	-0-	-0-	-0-

5. **Patient Fees:** With the increase in the level of severity of clients being treated has come a reduction in the number of patients who can pay for their services with direct patient fees. The more severely disabled the client, the less likely that they are able to hold a job. Funding in the communities has declined since FY 1980-81.

	78-79	79-80	80-81	81-82	82-83
CMHCs	$1,721,037	$1,828,832	$2,085,278	$1,851,969	$1,946,876
Hospitals	$ 687,525	$ 734,816	$ 891,287	$1,013,984	$1,123,916

6. **Medicare-Medicaid:** It is becoming increasingly difficult to qualify clients for Medicare or Medicaid services. Changes in federal emphasis and in federal priorities have resulted in both regulatory and attitudinal changes making qualification of these clients more difficult. The rate of increase in Medicaid has declined and will continue to decline in the future.

	78-79	79-80	80-81	81-82	82-83
CMHCs	$ 475,092	$ 1,367,257	$ 4,209,834	$ 4,442,235	$ 4,843,007
Hospitals	$8,292,623	$10,097,816	$11,214,869	$12,470,764	$11,894,618

7. **Insurance:** Insurance for patients is becoming more and more difficult to collect. Insurance companies are refusing claims for psychiatric services with more and more frequency.

	78-79	79-80	80-81	81-82	82-83
CMHCs	$ 982,484	$1,035,517	$2,552,826	$2,141,315	$2,286,924
Hospitals	$2,808,966	$3,246,431	$4,116,811	$4,417,561	$4,518,613

The highest priority for Colorado mental health system funding 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, the sources of funding 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 62,000. 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 is woven throughout the local plans submitted by the community mental health centers. Many centers question their ability to maintain the current level of service delivery unless resources for mental health are increased. Most centers will have to reduce the number of clients served in the coming year.

Reductions in support services to clients (SSI, AFDC, food stamps, etc.) also reduce the mental health system's ability to maintain clients in outpatient settings. Reductions in these services are causing increases in demand for the more intensive and expensive services.

The increasing difficulty with first and third party revenue is reflected by the problems at the two state hospitals. Both hospitals have found it necessary to establish collection review committees. Extraordinary efforts are now necessary just to maintain revenues at their current level.

Overall, the ability of the mental health system to generate resources is on the decline. Figure III.1 illustrates the hospitals and CMHCs funding levels from FY 1978-79 to FY 1982-83 in constant dollars. As the graph shows, the systems ability to serve clients has declined since FY 1978-79.

CHAPTER VII: EXTERNAL INFLUENCES

Proper planning requires knowledge and understanding of the external factors that impact the ability of the mental health system to provide services to the residents of Colorado. Strategic planning begins with looking at these external influences and the impact that they have on the mental health system.

A. TRENDS

1. Public and Consumer Attitudes
   - Demand for reduced taxation and spending.
   - Demand for increased accountability, both in terms of the manner in which funds are spent and how care is delivered - accessibility and quality.
   - Concern over high costs.
   - Demand for quality merchandise and services.
   - Concern related to protecting the community from violent mental health patients.

2. Economy
   - Total employment, a good indicator of overall economic activity, will expand by approximately 2.5 percent, or 32,000 jobs, in Colorado.
   - Although this is very slow growth compared to what Colorado has experienced in the past, it is almost double the percentage increase expected nationally.
   - The Denver Consumer Price Index is expected to rise between 5 and 9 percent next year.
   - Overall, Colorado's economic recovery is expected to be slower than the national recovery rate. Colorado's economy, however, has not suffered as much as other areas of the country; consequently, the recovery will not seem as dramatic as it may be for other states.

3. Population and Family Issues
   - Population growth in Colorado is projected to grow more slowly in 1983 than in previous years.
   - Greatest growth will be in the 18-44 age group, with the over-65 age group experiencing the second largest increase.
   - A large percentage (42% estimated nationally by the National Institute of Mental Health) of the state hospital populations will be in the 18 to 34 age group. This population is often described as sicker, more hostile, and more difficult to treat.
   - From 1970 to the year 2000, the over-65 age group will double in the population.
   - Increased awareness of and attention to family violence, assault, and abuse are reflected throughout the country.

4. Mental Health Financing
   - Mental health service costs will continue to increase because of such

things as increases in the provision of the more costly services, inflation, population growth, high labor costs, and new technologies.
- More emphasis is being placed on containing costs related to diagnosis, treatment, and rehabilitation rather than on prevention of illness and maintenance of health, as prevention and maintenance are viewed as less responsible for the increasing costs of care.
- There is general concern over the lack of flexibility of funding resources. Current restrictions on certain federal and state funds keep them from being applied appropriately to the needs of mental health clients.
- New programs and new dollars for mental health are in jeopardy at all levels. If there are to be increases in mental health resources, they will have to come from the private sector.
- Efficacy issues will play an increasing role in reimbursement for mental health services.

5. Mental Health Service Settings
- Emphasis on establishing treatment and support systems in the community will continue, but lack of resources will inhibit the mental health system's ability to implement new treatment and support system programs.
- Increased interface of system components will continue to improve and enhance the continuity of care.
- More intensive mental health community treatment facilities and more community-based residential facilities will have to be developed to meet the needs of mental health patients; yet, hospitals will continue to be the treatment facility of choice for some patients.

6. Mental Health Workforce
- Staff morale will continue to decline with the uncertainty of future funding, with the increase in client disruption, with the lack of adequate training, and with the lack of opportunities for advancement.
- The recruitment and retention of mental health professionals, especially nurses and psychiatrists, will continue to be a problem.
- Training in higher education is not preparing mental health professionals to work with the chronically mentally ill and Colorado's other target populations.
- There is also a need for increased availability of educational programs and training for managers and administrators in order to promote a positive approach toward mental health care systems management, and to explain management techniques and tools for achieving quality of care and cost-effectiveness.
- Third-party insurance contributes to the greater utilization of private therapists, and thus the increased numbers of professionals going into private practice. Professionals may also begin to bypass the public system as they graduate from school to enter the private sector for more attractive salaries.

7. Patient Care
- The number of people with mental health problems and the demand for mental health services will continue to increase, especially with population growth, economic downturns, and unemployment.
- The increase in the number of young (18-34 years of age) chronic adult clients will impact mental health programming.

- The general public will gradually become more sophisticated about mental health care.
- Biopharmacological improvements will reduce the length of stay in inpatient settings and will reduce community placement risks.

8. Legal
   - There will be continued emphasis on ensuring rights protection of patients in the mental health system.
   - The judicial system's involvement in mental health will continue to put increased pressures on the system and will result in higher costs.

B. SUMMARY OF EXTERNAL INFLUENCES

1. Focus on Accountability:
   These trends indicate that the citizens' revolt against taxes, spending, high costs and regulation will continue unabated. Closely tied to these trends is the issue of accountability. Citizens want to know where their tax dollars are going and want to be assured of getting their money's worth. A sense of public skepticism and cynicism has become more apparent. The mental health system will be held accountable for the public dollars at the legislative level and for high quality care at the treatment level. The taxpayer not only wants to know what is being done with tax dollars, but is demanding to know whether or not those dollars are having an impact on the population.

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

3. Service Needs Are Greater Than Resources Available To Meet the Needs:
   The primary issue for mental health today is that the mental health service needs of the citizens are much greater than the resources available to meet those needs. The increase in the population will increase the number of people needing mental health services. Population trends by age also provide information to be used in determining the distribution of mental health resources. 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. Changes in the American family also result in changes for mental health programming. Services for single parent families, for couples experiencing conflict because of changes in roles, for the elderly population, and for family members experiencing stress related to economic trends are examples of services that are often requested from the mental health system.

4. Focus on the Treatment and Support System Model:
Treatment by professionals has primarily been conceptualized as taking place in specific physical locations. For many of the system's clients, however, treatment is being perceived of as the total daily life of the client. The trends toward developing support systems for clients are based on the belief that psychiatrically disabled individuals must have the same opportunities as others to lead a normal life. "Treatment" in the community may include services to increase the individual's productive involvement (vocational rehabilitation), to help the individual learn to deal with emotional problems (mental health treatment), to control symptoms or dangerous behavior (hospitals), to improve family relationships (home), etc. The important issues for mental health include changing perceptions about what treatment is or is not and about the types of service settings or, more appropriately, the settings in which that treatment takes place.

5. Increased Coordination Necessary:
The issue of coordination becomes more and more important as resources become more limited. Coordination and collaboration among public and private 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 service and caregiving agencies need to be developed to meet the demands of multi-needy individuals.

6. Concern Over Workforce Shortages:
The issue of workforce shortages is very real for the mental health system in Colorado. Recruiting and maintaining certain qualified or specialized mental health professionals is a primary problem, especially for some rural area agencies. The turnover of personnel at all levels in mental health is high. A key issue for the mental health system will be to provide high quality leadership that generates challenge and reestablishes a dynamic, active field that is open to new ideas.

CHAPTER VIII: COMPARISON OF ACTUAL RESULTS TO OPERATING PLAN

A. STATUS OF OBJECTIVES

For the most part, the Division of Mental Health's FY 1982-83 Operating Plan objectives were on target. There were, however, some deviations which should be noted. First, the objectives related to the Medicaid Waiver, though still appropriate, were not on target due to the fact that Federal approval of the Waiver was received 90 days later than initially anticipated. Similarly, the objectives relating to the Memorandum of Understanding (MOU) were appropriate, but were not on target since the Memorandum had not been finalized.

Other objectives which continued to be appropriate, but which were not on target, were those related to the Automated Data Processing (ADP) System. The lack of adequate ADP capacity impacted the ability of both the Central Office and the two state hospitals to develop a Management Information System. To compensate for the lack of a smoothly functioning MIS, resources were shifted from policy impact studies (e.g., the bed allocation impact study) in order to manually retrieve data. The Division of Mental Health also has been slow in meeting the objective related to interfacing the various data bases within the Division due to the reallocation of system analysts.

B. CHANGES DUE TO BUDGET REDUCTIONS

The following were the major deviations from the Division of Mental Health's Operating Plan which were due to reductions in the budget:

1. Colorado State Hospital
   a. CSH incurred a 2% cut in General Funds from their FY 1982-83 budget. This decreased their Personal Services estimate by $344,240 and increased the cash necessary by $127,160.
   b. The capacity of the Geriatric Treatment Center was reduced from 84 to 60 beds, thereby reducing the anticipated ADA and clients served on that unit.

2. Fort Logan Mental Health Center
   a. Fort Logan also sustained a 2% cut in General Funds reducing the Personal Services estimate by $116,000. Contractual service was reduced by $32,000, and operating expenses were reduced by $22,000.
   b. The ADA and clients served in Adult Services was reduced, based upon the delay in the opening of Team 6. This delay resulted in a reduction of approximately 24 admissions.

3. Division of Mental Health Contract Agencies
   a. The Division of Mental Health reduced the contracts for purchase of service with the community mental health centers and clinics by $371,200 to comply with the 2% cut. This reduction resulted in approximately 530 clients not receiving service.

CHAPTER IX: SUMMARY LIST OF PROBLEMS AND OPPORTUNITIES

A. PROBLEM LIST FOR FY 1984-85

1. SHORTAGE OF FINANCIAL RESOURCES FOR MAINTAINING THE CURRENT LEVEL OF MENTAL HEALTH SERVICE DELIVERY

- Cost of Living: A cost of living for the community mental health centers would amount to approximately $1.5 million. A cost of living in the Medicaid to the CMHCs will cost approximately $300,000.
- Declining Federal Funds: The Division is expecting the Federal Block Grant to be continued; however, if it were to be eliminated, the replacement costs would be $3 million.
- Human Resources Development: The budget request for the HRD Grant for FY 83-84 is approximately $50,000. General Fund replacement, therefore, in 1984-85 would be approximately $50,000.

2. IMPENDING CRISIS IN COMMUNITY AND STATE HOSPITAL SERVICE DELIVERY TO CHILDREN/ADOLESCENTS

- Shortage of Inpatient Beds for Adolescents in the State Hospitals: The two state hospitals have been operating at or over capacity for several years. Dramatic increases in involuntary admissions, along with significant increases in length of stay, point to an impending crisis in the provision of services to children and adolescents. The most critical shortage of state hospital beds is in the Fort Logan Service Area; consequently, the highest priority for inpatient beds in FY 1984-85 is for a lockable 22-bed adolescent unit at Fort Logan Mental Health Center.
- Shortage of Psychiatric Beds in the Community for Children/Adolescents: Increasing the number of intensive mental health community treatment facility beds for children/adolescents would improve the ability of the centers and hospitals to move these patients through the system. Development of these facilities also would help to fill one of the gaps in the continuum of services for children/ adolescents.
- Shortage of Day Treatment Programs for Seriously, Critically and Chronically Disabled Children/Adolescents: The state-funded mental health system needs to increase services to children by expanding the availability of day treatment programs in high need communities. Mental health professionals in the state system need training in methods of providing day treatment to adolescents.
- Shortage of Vocational Services for Adolescents in Treatment at Colorado State Hospital: In order to provide appropriate vocational services to the adolescents being cared for in Colorado State Hospital's inpatient program, there is a critical need for one vocational rehabilitation therapist and two occupational therapists.

3. SEVERE OVERCROWDING IN THE DIVISION FOR FORENSIC PSYCHIATRY AT COLORADO STATE HOSPITAL

- Shortage of Inpatient Services for Forensic Patients: The Forensic Unit currently is not in compliance with State Health Department standards pertaining to required square footage for patient living areas. The

maximum and medium security units consistently have been running over capacity, as many regular patients are forced to occupy rooms that are designated for seclusion/restraint. To relieve this overcrowding, an additional 18-bed intermediate security ward needs to be added. The creation of this ward would automatically call for the formation of an additional treatment team and the necessary complement of staff to make the team operational. Total staff required would be 29 FTE.

- Lack of Training for Staff Who Work with Forensic-Type Patients: The Division has determined that training is needed in the areas of crisis intervention, working with law enforcement agencies, and implementing state statutes related to the care and treatment of the mentally ill.

4. STAFFING DEFICIENCIES AT THE STATE HOSPITALS

- Colorado State Hospital: Specific supportive areas needing increased staffing are ground maintenance (2 FTE), personnel (2 FTE), and postal services (1 FTE).
- Fort Logan Mental Health Center: Specific supportive areas needing increased staffing are safety (2 FTE) and housekeeping (2.5 FTE). In addition, Fort Logan needs to add 3 FTE to their internal nursing relief pool.

5. LACK OF INFORMATION RELATED TO MENTAL HEALTH SERVICES FOR DEAF PATIENTS

- Both providers and consumers concerned about mental health services for the deaf client have expressed a need for expanding and enhancing services for the deaf population. Program planning and staffing for deaf services, especially at Fort Logan Mental Health Center and in the community mental health centers, have been impeded by a lack of understanding of the population in need characteristics, as well as what services should be provided to respond to these needs. To answer these questions, the state system needs to complete a study related to deaf services.

6. SHORTAGE OF TREATMENT AND SUPPORT SYSTEM SERVICES FOR ADULT PATIENTS

- Shortage of Intensive Mental Health Community Treatment Facility Beds for Adults: There continues to be a critical shortage of intensive treatment facility beds in the community for adult clients. Using the Division's Residential Continuum Model, it is estimated that only 14.7% of the need is being met in this area.
- Lack of Adequate Vocational and Prevocational Services for Adults: An important need for the expansion of treatment and support system services is in the area of vocational services. We can begin to address this need by using funds created under the new Federal Emergency Jobs Bill.

7. INADEQUATE TREATMENT AND SUPPORT SYSTEM SERVICES FOR GERIATRIC PATIENTS

- Shortage of Residential Community Alternatives for the Geriatric Population: Traditionally, geriatric clients have been placed in inpatient treatment settings or in nursing homes because of medical problems which are common for this age group. Over the past few years, many of the mental health system patients in this age group were transferred from

hospitals to nursing homes. Now, these patients need to be moved (based upon their clinical condition) into intensive treatment facilities in the community, into the less intensive community-based residential facilities, and into boarding homes.

- Shortage of Consultation and Education for Geriatric Patients and for Those Who Work with Geriatric Patients: Since outreach efforts are critical to reaching this underserved population, consultation and education funds should be expanded to all catchment areas who need to increase services to the elderly. Additional training efforts also are needed for mental health professionals that work with this population.

8. SHORTAGE OF CONSULTATION AND EDUCATION FOR MINORITY PATIENTS AND FOR THOSE WHO WORK WITH MINORITY PATIENTS

- Training is Needed in the Treatment of Socio-Legal Problems: Since minorities seem to be hospitalized more for socio-legal problems, training in how to deal with such problems would be appropriate.

9. LACK OF ADEQUATE SERVICES FOR PATIENTS WITH DUAL DIAGNOSES

10. LACK OF AN ADEQUATE MANAGEMENT INFORMATION SYSTEM

- There is a pressing need to improve management effectiveness by expanding the utilization of available modern communication and computer technology.

11. INADEQUATE FACILITIES FOR MENTAL HEALTH SYSTEM CLIENTS

B. OPPORTUNITIES FOR FY 1984-85

1. Bed Allocation: Bed allocation has reduced the inequities in the system in regards to the distribution of state psychiatric inpatient beds for adults and has improved the relationships between the centers and the state hospitals.
2. Facilities Planning: A formalized facility planning process at both state hospitals should improve the utilization of state hospital facilities.
3. Alternate Sources of Funding: By working more closely with the private sector, the state mental health system may be able to fill some of the gaps in service to the most psychiatrically disabled. Private foundations, for example, offer one source of potential funding for addressing the problem of inadequate treatment and support system services for the chronically mentally ill.
4. Medicaid Waiver: The full implications of the Waiver are not yet known. Hopefully, it will turn out to be an opportunity for the system.
5. Vocational Services: The Federal Emergency Jobs Bill, which was recently passed by Congress, is providing a means for expanding vocational services to clients within the state-funded mental health system.

CHAPTER X. 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 and adolescents, 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. These resources include a variety of alternate living facilities, vocational programs, health agencies, social service programs and other caregivers, activities and organizations in the public, private, and voluntary sectors. Affiliation and contractual arrangements between mental health and other agencies are strongly encouraged.

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 have been developed 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. 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 and adolescents (0-17 years), elderly (60 years and older) 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 1983-84 local mental health plans submitted by the catchment area mental health centers.

An annual report on the outcome of the objectives for Fiscal Year 1982-83 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 1983-84 MANAGEMENT PLAN

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.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have provided services to 62,000 mental health system clients in FY 83-84 by 6/30/84.	-Signed contracts by 7/31/83. -Quarterly data monitoring reports. -Services provided by 6/30/84.	-Services provided.	Division Director CMHCs CSH FLMHC	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.
(2) To have ensured that at least 75% of the clients served by the community mental health centers and clinics are seriously, critically, or chronically psychiatrically disabled by 6/30/84.	-Signed Contracts. -Quarterly data monitoring reports. -Services provided by 6/30/84.	-Services provided. -Written report.	Program Services Evaluation Services CMHCs	The highest priority for the state-funded mental health system is the provision of services to the seriously, critically, and chronically mentally ill of all ages. This priority was mandated by the Colorado State Legislature in Footnote 59 of the FY 1981-82 Long Bill.
(3) To have determined the unmet mental health need for seriously disturbed children and adolescents by 6/30/84.	-Methodology and procedure for determining unmet need developed by 1/1/84. -Methodology implemented by 3/31/84. -Draft report prepared by 5/31/84. -Final report prepared by 6/30/84.	-Report identifying unmet need.	Program Services Evaluation Services	The state-funded mental health system has identified children and adolescents as a priority population. While experiential evidence and advocates support the need for more resources for this population, reliable objective data needs to be further developed, especially for community programs. The implementation of this objective may depend upon the feasibility of the methodology given current resource limitations.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

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.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(4) To have gained legislative support for reimbursing C&E Services in all mental health catchment areas, regardless of size, to enhance services to children/adolescents, the elderly, and minorities by 6/30/84.	-Establish a working committee with representatives from centers and specialty clinics to define the problem and to develop a methodology for studying the issue by 10/31/83. -Prepare a report on the impact of the current legislative prohibition against funding C&E in all areas by 4/1/84. -Work with Legislators regarding this issue. -Legislative restrictions on the use of C&E funds removed by 6/30/84.	-Legislative restriction on the use of C&E funds removed.	Program Services Community Liaison	In Footnote 60 of the 1981 Long Appropriations Bill, the State Legislature stated that the Division of Mental Health could purchase consultation and education services only from counties which had a population of less than 85,000. This limitation on the use of state funds for C&E has impacted programs for children/adolescents, the elderly, and minorities since these are the populations that benefit most from these services.
(5) To have provided training to staff of the Forensic Unit at CSH on the treatment of clients admitted in the legal category of incompetent to proceed with a trial by 6/30/84.	-Training provided by 6/30/84.	-Training provided.	CSH	Patients are sent to the Forensic Unit in order to become competent to stand trial for the crime with which they have been charged. Since hospital staff have been trained to treat patients, it is difficult for them to return the patients to court until they have made significant progress. Staff need to be trained to treat the patients for their return to court which could reduce their length of stay in the hospital.

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.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(G) To have developed a methodology for establishing a matrix for forensic patients at Colorado State Hospital which shows the current placement of patients and the desired/optimal placement for each patient by 6/30/84.	-Develop draft methodology by 3/31/84. -Final methodology by 6/30/84.	-Written methodology.	CSH	This concept is similar to that which formed the basis for the Division's Residential Continuum. This additional information would assist in the planning process for Forensic Services.

GOAL # 2 : TO PROVIDE ADEQUATE AND APPROPRIATE RESIDENTIAL SERVICES FOR MENTAL HEALTH SYSTEM CLIENTS.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have completed a process and impact evaluation of the bed allocation systems at CSH and Fort Logan Mental Health Center (FLMHC) by 10/31/83.	-Written report with recommendations for revisions by 10/31/83.	-Written report with recommendations for revisions.	Evaluation Services Program 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.
(2) To have developed recommendations for the State mental health system regarding the extension of bed allocation to other population groups (i.e., children/adolescents and/or geriatric clients) by 6/30/84.	-Review written study of the adult bed allocation process. -Form study committee to review the report and to identify and develop information needed for extending bed allocation by 1/31/84. -Draft report of findings and recommendations by 4/30/84. -Final written report completed by 6/30/84.	Written report.	Program Services Evaluation Services Planning Services CMHCs	General adult psychiatric beds have been incrementally placed in allocation since 1982. Based upon the outcome of this experience, it may be appropriate to implement bed allocation for other population groups.
(3) 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 by 6/30/84.	-Regulations in place by 7/1/83. -Independent clients starting to be approved by 7/15/83. -Residential clients starting to be approved by 8/1/83. -Quarterly status reports on the implementation of the	-Report of beds and programs established and utilized by clients.	Program Services CMHCs Administrative Services	The Department of Institutions, in concert with the Department of Social Services, requested and received 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 enables 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.

GOAL # 2 : TO PROVIDE ADEQUATE AND APPROPRIATE RESIDENTIAL SERVICES FOR MENTAL HEALTH SYSTEM CLIENTS.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
	Medicaid Waiver. -Report of beds and programs established and utilized by clients by 6/30/84.			
(4) To have completed a report reviewing the effectiveness of the Medicaid Waiver by 6/30/84.	-Implement the evaluation by 3/1/84. -Monitor routine data for the Waiver on a monthly basis. -Report submitted to federal government by 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.
(5) To have investigated the validity of the Resitial Continuum Model for predicting inpatient residential service needs in accordance with the grant submitted to the National Institute of Mental Health by 6/30/84.	-Establish a residential continuum task force. -Develop a case review instrument for capturing service need data from clinical staff. -Analyze data from clinical staff re: the status and residential service needs of sampled clients. -Draft final report. -Final report written by 6/30/84.	-Written report.	Evaluation Services Planning Services CSH FLMHC	In order to employ the Residential Continuum Model to plan needed residential settings, it is important that the validity of the model be investigated and its limitations understood. The accomplishment of this objective is dependent upon the approval and funding of a grant submitted by DMH to the National Institute of Mental Health.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 3 : TO HAVE COST-EFFECTIVE TREATMENT AND SUPPORT SYSTEMS FOR THE DELIVERY OF MENTAL HEALTH SERVICES TO THE MOST PSYCHIATRICALLY DISABLED CLIENTS OF ALL AGES AVAILABLE STATEWIDE.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have worked with Denver Health and Hospital's Mental Health Program to improve the mental health care provided to the chronically mentally ill in the City and County of Denver by 12/31/83.	-Convene committee of Denver mental health providers. -Develop a strategy with the Department of Institutions for addressing the mental health system in the City and County of Denver. -Written report completed by 12/31/83.	-Written report.	Division Director Program Services DOI	The pending "right to treatment" court decision will potentially shape the public responsibility for services to the chronically mentally ill. This decision may then offer an opportunity to consider reorganization of public mental health services in the City and County of Denver.
(2) To have utilized targeted "emergency jobs bill" block grant funds for developing community mental health center prevocational and work experience programs by 6/30/84.	-RFPs due to DMH by 7/27/83. -Eight centers selected for participation by 7/28/83. -Staff hired and 2-week training program implemented by 8/15/83. -First clients admitted by 10/1/83. -First agency program status reports due to DMH by 3/31/84.	-Programs in place.	Program Services Administrative Services	The Federal ADM Block Grant was recently augmented to include funds for impacting unemployment/underemployment related issues which influence mental health service utilization.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 3 : TO HAVE COST-EFFECTIVE TREATMENT AND SUPPORT SYSTEMS FOR THE DELIVERY OF MENTAL HEALTH SERVICES TO THE MOST PSYCHIATRICALLY DISABLED CLIENTS OF ALL AGES AVAILABLE STATEWIDE.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(3) To have implemented the residential, vocational, and partial care program guidelines for community mental health centers by 6/30/84.	-Draft guidelines accepted by DMH by 10/1/83. -Guidelines incorporated into DMH monitoring protocol and implemented by 1/1/84. -Quarterly reports received from contracted providers. -Guidelines utilized to determine provider conformance by 6/30/84.	-Guidelines utilized to determine provider conformance.	Program Services CMHCs	The Division of Mental Health needs to ensure that the guidelines developed and adopted in FY 82-83 are being implemented in the community mental health centers, as these guidelines define programmatic expectations for the contracted provider system.

GOAL # 4 : 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.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have implemented the provisions of the the Memorandum of Understanding between the Dept. of Social Services and the Dept. of Institutions by 6/30/84.	-Plan in place by 6/30/84.	-Plan in place.	DOI Program Services	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 responsiblity 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.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 5 : TO PROVIDE ADEQUATE AND APPROPRIATE STAFFING FOR MENTAL HEALTH SYSTEM PROGRAMS.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have developed a FY 84-85 Training Plan to support the clinical and management needs of the mental health system by 6/1/84.	-Complete an assessment of training needs. -Plan submitted to DOI by 6/1/84.	-Plan submitted to the Dept. of Institutions.	Program Services	This plan will outline the proposed training activities for mental health for the coming fiscal year.
(2) To have brought together public mental health providers and mental health higher education faculty to develop strategies to address the specific recruitment and retention problems identified in the FY 83-84 community mental health center and hospital plans by 6/30/84.	-Meet with the Higher Education Committee to discuss DMH concerns by 10/31/83. -Hold an initial meeting of DMH, providers, and higher education representatives by 2/1/84. -Report of findings and recommendations by 6/30/84.	-Report of findings and recommendations.	Program Services	Currently there is no formal mechanism for problem identification and resolution between the public mental health system and the preservice training institutions. These issues impact on recruitment, retention, and competence of the mental health workforce.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 6 : TO IMPROVE MANAGEMENT EFFECTIVENESS BY EXPANDING THE UTILIZATION OF AVAILABLE COMMUNICATION AND COMPUTER TECHNOLOGY.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have acquired a Fort Logan Mental Health Center based micro-computer system by 11/30/83.	-System operational by 11/30/83.	-System operational.	FLMHC Evaluation Services	Fort Logan needs this equipment to manage the hospital's internal data systems. Division of Mental Health required data are entered and stored in a UNIVAC computer in Pueblo. Additional data sets are not readily adaptable to that system. Critical data sets for patient seclusion and restraints, personnel, staff development, medical clinic, etc., will be resident on the requested system. The system will establish much needed communication to GGCC as well.
(2) To have developed a hospital five-year plan for the use of available communications and computer technology at CSH by 5/31/84.	-Outline and format of plan developed by 9/30/83. -First draft of plan completed by 1/1/84. -Final draft of plan completed and available to interested parties by 5/31/84.	-Written outline developed. -Written draft completed. -Final written plan approved and distributed.	CSH Evaluation Services	In order to proceed in a planned, rational and cost-effective fashion in the use of modern technology, a written plan is necessary.
(3) To have installed a new hospital-wide telephone system at Colorado State Hospital by 6/30/84.	-Develop funding mechanism to purchase or lease new system by 8/1/83. -Secure contract for installation of the system by 1/15/84. -System installed and functioning by 6/30/84.	-Funds identified. -Contract completed. -Phones in operation.	CSH	A new telephone system is needed as the present system is inefficient, prone to breakdown, and does not utilize existing technology.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 6 : TO IMPROVE MANAGEMENT EFFECTIVENESS BY EXPANDING THE UTILIZATION OF AVAILABLE COMMUNICATION AND COMPUTER TECHNOLOGY.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(4) To have developed Management Information Systems to meet the special information needs of the users in the Division's Central Office, CSH, and FLMHC by 6/30/84.	-Establish format and timetable for the development of the Management Information System by 11/15/83. -Complete first draft of Management Information System by 3/31/84. -Develop a strategic plan for information systems for the Division of Mental Health by 6/30/84. -Management Information System design completed by 6/30/84.	-Written format and timetable available. -Written draft completed. -Management Information Systems in place, approved, and functioning.	Evaluation Services CSH FLMHC	The need for Management Information Systems is obvious in view of the vast amount of data and information available to managers. If they are to utilize this data and information then it must be presented in an organized and understandable fashion.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 7 : TO MAXIMIZE THE EFFECTIVE UTILIZATION OF FACILITIES AND FACILITY RESOURCES THROUGH BETTER FACILITY PLANNING, MAINTENANCE, AND MANAGEMENT.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have developed a proposal detailing program components of the FLMHC facilities plan which would outline the roles of Fort Logan with respect to outside agencies in expanding mental health services by 1/1/84.	-Written proposal by 10/1/83. -Introduce Legislation which would give property management authority to FLMHC's property development corporation.	-Written proposal. -Legislation introduced to the General Assembly.	FLMHC Administrative Services DOI CMHCs	A mental health systems approach is essential to cooperatively identify potential uses of Fort Logan's buildings and grounds. Current information indicates that the Property Development Corporation must be an organizational entity outside of state government. This would require action by the General Assembly.
(2) To have initiated a study of the current and future utilization of the General Hospital Services at CSH, including use of the facility, equipment needs, and services provided by 8/15/83.	-Determine scope and extent of study by 7/1/83. -Develop a plan and outline to complete study by 7/15/83. -Complete initial phase of study by 8/15/83.	-Written statement of scope and extent of study. -Written outline. -Written study, with recommendations completed.	CSH Administrative Services	This will be the first phase in studying the General Hospital Services and will draw primarily on internal resources. Its purpose is to lay the groundwork for more in-depth study utilizing outside consultants proposed for FY 84-85.
(3) To have completed an engineering and architectural study for a new power plant at CSH by 6/30/84.	-Consultants hired to write the plan by 9/30/83. -Study finalized by 6/30/84.	-Contract for services. -Written study.	CSH Administrative Services DOI	This is the first step toward actual construction of a new power plant and must be completed prior to securing funding for actual construction.

GOAL # 7 : TO MAXIMIZE THE EFFECTIVE UTILIZATION OF FACILITIES AND FACILITY RESOURCES THROUGH BETTER FACILITY PLANNING, MAINTENANCE, AND MANAGEMENT.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(4) To have initiated internal planning efforts at CSH for design of a new facility for Medium Security patients by 6/30/84.	-Initial written input from the Institute for Forensic Psychiatry concerning the plan and timeframe for developing building proposal by 9/30/83. -Written proposal from the unit specifying proposed building needs by 6/30/84.	-Written statement. -Written proposal.	CSH Administrative Services DOI	Current facilities utilized in the treatment of patients are no longer acceptable to changing treatment needs and to patient/public safety. New construction is needed to continue to provide services in the most cost-effective manner.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 8 : TO ENSURE THE DELIVERY OF HIGH QUALITY CLIENT CARE THROUGH THE EFFECTIVE FUNCTIONING OF ELEMENTS OF THE MENTAL HEALTH SYSTEM.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have improved the quality, usefulness, and reliability of financial and audit reports of state funded community mental health centers by 12/1/83.	-DMH Accounting and Auditing Guidelines revised and in use by 7/1/83. -Peer Review of audit reports performed on all independent audit firms by State designated auditor by 1/31/84. -Consolidation of audited Revenue and Expense Data by State designated auditor by 12/1/83.	-Audits for 82-83 reflect the revised guidelines. -Written reports.	Administrative Services CMHCs	Revision of Accounting and Auditing Guidelines necessary to reflect numerous changes and consolidation of related issues including Medicaid regulations, ability to pay scale, changes in units of service definitions, etc. For the past two years the State Auditor's Office has recommended that audits of community programs be done by a single designated State auditor; an approved alternative was selected to use the PEER REVIEW process. If the results of the Peer Review are successful, it should not then be necessary to go to the "single state auditor" concept.
(2) To have promulgated rules and regulations concerning the Care and Treatment of the Mentally Ill by 12/31/83.	-Public hearing by 9/30/83. -Revision of rules and regulations as result of public hearing by 11/30/83. -Adoption of Rules and Regulations by 12/31/83.	-Rules and Regulations promulgated.	Community Liaison	The existing rules and regulations concerning the Care and Treatment of the Mentally Ill are dated and have not been revised since 5/31/78. The Governor's Advisory Board for Service Standards and Regulations has been working on the new rules and regulations since 12/81 and anticipates completion by the end of this year.
(3) To have implemented changes, if necessary, in the Division of Mental Health's internal advocacy system in the two state	-Complete an analysis of patient complaints at the two state hospitals to determine changes needed in the internal advocacy	-Changes in place.	Community Liaison CSH FLMHC	Patient rights protection and advocacy are receiving increased attention from the legislative level to the treatment level. Legislators, providers of mental health care, and consumers of mental health services (including patients, ex-patients, and families of

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 8 : TO ENSURE THE DELIVERY OF HIGH QUALITY CLIENT CARE THROUGH THE EFFECTIVE FUNCTIONING OF ELEMENTS OF THE MENTAL HEALTH SYSTEM.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
hospitals to ensure that patient advocacy services include procedures for effectively and efficiently addressing patient grievances and that system changes are initiated as needed by 6/30/84.	system by 2/29/84. -Recommend necessary changes based upon the analysis by 4/30/84. -Implement needed changes by 6/30/84.			patients) emphasize the need for rights protection and advocacy programs which are independent of the service delivery system (external programs), as well as programs which are components of the mental health service system (internal programs). There are two primary thrusts in the area of advocacy. The first thrust involves ensuring that patients' rights are vigorously protected and that the services of an advocate are available to patients. Direct patient advocacy services should include procedures for effectively and efficiently addressing patient problems and grievances. The second major approach to advocacy has been identified as systems change. The purpose of systems advocacy is to initiate, support, and monitor changes in the service delivery system which are needed to protect and assure the rights of clients. These changes may involve the creation or revision of legislation, administrative policies and procedures, regulations and standards, or general practices.
(4) 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 by 6/30/84.	-Establish a task force by 9/30/83. -Draft legislation by 11/30/83. -Secure legislative sponsor by 12/31/83. -Testify before appropriate legislative committees by 5/31/84. -Legislation passed by 6/30/84.	-Legislation passed.	Community Liaison Administrative Services	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.
(5) To have reviewed the Division's contracting process to determine its effectiveness in assuring accountability and focused impact of public funds on priority goals by 6/30/84.	-Form a Study Committee by 1/1/84. -Define the scope of the study by 2/28/84. -Prepare a preliminary report by 4/1/84. -Final report written by 6/30/84.	-Written report.	Program Services Administrative Services Planning Services Evaluation Services CMHCs	The contracting process is the primary method used by the Division of Mental Health to implement goals and objectives for the community service system. A careful review of the process and outcome is an important management task.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1983-84 MANAGEMENT PLAN

GOAL # 9 : TO MAXIMIZE LIMITED RESOURCES BY COORDINATING THE PLANNING AND DELIVERY OF MENTAL HEALTH SERVICES WITH OTHER HUMAN SERVICE AGENCIES.

OBJECTIVES FY 1983-84	MILESTONES	ACCOMPLISHMENT CRITERIA	STAFF RESPONSIBLE	RATIONALE FOR OBJECTIVE
(1) To have reviewed jointly with the Division for Development Disabilities (DDD), issues and options for solution in providing services to the dually diagnosed client by 1/1/84.	-Convene a meeting with DDD by 8/1/83. -Prepare a preliminary report by 12/1/83. -Final report written and approved by 1/1/84.	-Written report.	Division Director Program Services	(1) - (2) Issues concerning clients with dual diagnoses are ongoing. Resolution of these issues will require interagency agreements and policy development to define mutual roles and responsibilities.
(2) To have reviewed jointly with the Division of Alcohol and Drug Abuse (ADAD), issues and options for solution in providing services to the dually diagnosed client by 6/30/84.	-Convene a meeting with ADAD by 1/31/84. -Prepare a preliminary report by 5/31/84. -Final report written and approved by 6/30/84.	-Written report.	Division Director Program Services	
(3) To have developed necessary communication procedures to obtain technical assistance and information concerning research findings, state-of-the-art clinical practices, etc. from higher education in order to enhance quality of patient care in the mental health system by 6/30/84.	-The Division of Mental Health's Management Team identifies structure, process, and content for discussion with representatives of higher education by 10/31/83. -Convene meeting with representatives of higher education to discuss DMH concerns by 1/1/84. -Written report completed by 6/30/84.	-Written report.	Program Services Evaluation Services	Advances in state-of-the-art treatment techniques should be provided to the public mental health service system. Currently there is no predictable or structured mechanism for this knowledge transfer other than professional journals and independent technical meetings and conferences.

C. COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
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 maintained the same level of services as provided by the community mental health centers in FY 83-84 by obtaining a maintenance-of-effort increase.	06/30/85	-Maintenance-of-effort increase.	Admin. Services Program Services CMHCs $1,100,000	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.
	(2) To have maintained the same level of services as provided by the state hospitals in FY 83-84 by obtaining an appropriation sufficient to reduce the required vacancy savings to its natural level.	06/30/85	-Budget increase funded.	Admin. Services CSH FLMHC $500,000	The current appropriation requires a vacancy savings rate above that which would naturally occur through the normal attrition process.
	(3) To have maintained the same level of training provided by the Division in FY 83-84 by replacing the Human Resources Development Grant.	06/30/85	-Budget increase funded.	Admin. Services Program Services $50,000	This is a maintenance effort to assure the incorporation of necessary HRD capacity in the FY 84-85 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 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(4) To have increased services to adolescents by establishing a 22-bed treatment unit at Fort Logan Mental Health Center.	06/30/85	-New locked in-patient facility staffed and ready to receive patients.	FLMHC $1,232,200	If funded, this new team would alleviate overcrowding in Adolescent II where occupancy has averaged 98% ('82-'83 YTD) and was at 95% during FY 81-82. FLMHC serves most teens who are court-ordered into treatment or require a secure facility in the hospital's service area since there are no comparable private-sector resources. The waiting list for admission to FLMHC adolescent teams has ranged from 15 to 20 names for the last year. The estimated resource requirement is based upon personal services, operating budget, and capital outlay start-up costs. This additional adolescent unit would increase patient revenue collections by about $800,000/year.
	(5) To have increased services to children by establishing an incremental payment to designated Residential Child Care Facilities for providing the secure setting and specialized program necessary for the care of mentally ill adolescents who do not need the medical support of a hospital.	06/30/85	-Programs in place and funded.	Program Services $500,000	The mental health system needs to develop community-based intensive treatment facilities to reduce the pressure on the state hospital inpatient facilities. CRS 27-10 was amended in 1981 to allow the designation of RCCFs to accept involuntary admissions. This would allow the maintenance of a controlled setting which could provide appropriate care to adolescents. To date, only one RCCF has pursued designation. This general lack of interest is related to the additional cost of programs which meet 27-10 requirements.

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(6) To have reduced the gap in adolescent services at Colorado State Hospital by developing vocational and pre-vocational programming for adolescents as part of their inpatient treatment focus.	06/30/85	-Vocational and occupational therapists hired.	CSH $90,000	Both the numbers and percent of 16 and 17 year old adolescent admissions, compared to total child/adolescent admissions, have been steadily increasing at CSH. Although there are school programs at CSH to address academic deficiencies, they do not remedy the several-year lag which the adolescents present upon admission; consequently, only about 30% of the 16 and 17 year old adolescents return to school after discharge from the hospital. The majority face the future with educational deficiencies and with a total absence of vocational programming to prepare them for even the most basic work possibilities.
	(7) To have increased services to children by expanding the availability of day treatment programs in high need communities.	06/30/85	-Programs in place.	Program Services $450,000	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.
	(8) To have expanded the capacity for patients of the Institute for Forensic Psychiatry at Colorado State Hospital by opening a new 18-bed intermediate ward, fully staffed, without increasing the number of clients to be served.	06/30/85	-Staff hired and ward in operation.	CSH $625,800	The Institute for Forensic Psychiatry at Colorado State Hospital is critically overcrowded in Maximum, Medium and Intermediate Security. In addition, Medium Security units are out of compliance with State Health Department Standards regarding required square footage for patient living areas.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(9) To have implemented a planning initiative for the hearing impaired which would determine the at risk population in need by both level of hearing deficit and degree of psychiatric dysfunction, and identify needed mental health resources.	06/30/85	-Written report on the population in need. -Written report on the mental health resources needed for serving the at risk population.	Program Services FLMHC $25,000	The State of Colorado has been pursuing the goal of adequate mental health services for the hearing impaired since 1976 when the Deaf Services Team was established at Fort Logan. This effort has been hampered by by an incomplete understanding of the parameters of the deaf client population in Colorado.
	(10) To have developed a matrix for forensic patients at CSH which shows the current placement of patients and the desired/optimal placement for each patient by 6/30/85.	6/30/85	-Written report with matrix.	CSH	This concept is similar to that which formed the basis for the Division's Residential Continuum. This additional information would assist in the planning process for Forensic Services.
GOAL # 2. TO PROVIDE ADEQUATE AND APPROPRIATE RESIDENTIAL SERVICES FOR MENTAL HEALTH SYSTEM CLIENTS.	(1) To have implemented the recommendations for the state mental health system regarding the extension of bed allocation to other population groups (i.e., children/adolescents and/or geriatric clients).	06/30/85	-Recommendations implemented.	Program Services CMHCs CSH FLMHC	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. The results of the formal evaluation of the bed allocation systems at CSH and at FLMHC for adults should include recommendations for the extension of bed allocation to other population groups.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
GOAL #3. TO MAXIMIZE THE EFFECTIVE UTILIZATION OF FACILITIES AND FACILITY RESOURCES THROUGH BETTER FACILITY PLANNING, MAINTENANCE, AND MANAGEMENT.	(1) To have completed all phases of the Property Development Master Plan for Fort Logan Mental Center, including the implementation of a plan for the collaborative utilization of residential facilities at Fort Logan by Fort Logan and by community mental health center clients.	06/30/85	-Completion of all five phases as reflected in the written Property Master Plan. -Plan in effect with two new identified programs in operation.	FLMHC Program Services CMHCs DOI $210,000	The five phases of the Property Development Master Plan include: (1) the strategic planning phase; (2) the functional analysis stage; (3) the architectural and engineering phase; (4) the aerial photo lay-overs; and (5) the program services coordinating costs. 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. This objective is the extension of a FY 82-83 objective relating to the development of a collaborative plan.
	(2) To have started construction on a new power plant at Colorado State Hospital.	06/30/85	-Construction in process.	CSH DOI $2,000,000	A new power plant is critically needed to meet environmental standards and to provide power for the hospital in a cost efficient manner.
	(3) To have completed an engineering and architectural study at Colorado State Hospital for a new Medium Security Unit.	06/30/85	-Written report and recommendations submitted.	CSH DOI $371,000	Current facilities utilized in the treatment of patients are no longer acceptable to changing treatment needs and to patient and public safety. New construction is needed to meet these requirements and to continue to provide services in the most cost-effective manner.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
GOAL # 4. TO IMPROVE MANAGEMENT EFFECTIVENESS BY EXPANDING THE UTILIZATION OF AVAILABLE COMMUNICATION AND COMPUTER TECHNOLOGY.	(1) To have developed a cost effective Management Information System for the Division of Mental Health.	06/30/85	-Needed equipment purchased and in use.	Evaluation Services CSH FLMHC $100,000	The delivery of cost effective services depends upon clinical and managerial staff who make decisions based on current, reliable, and available information. The recent advances in information processing hardware and software provides both managers and clinicians with the tools to access and utilize the needed information in a timely, cost-effective manner.
	(2) To have developed computer and data base linkages between clinical, personnel, and fiscal information sets at Fort Logan Mental Health Center.	06/30/85	-Capacity to merge and analyze data sets.	FLMHC	This objective reflects one of the next developmental steps in the implementation of a management information system (MIS) at Fort Logan Mental Health Center.
	(3) To have begun installation of equipment in a planned and purposeful fashion based upon the five-year plan developed by Colorado State Hospital for the use of communication and computer technology.	06/30/85	-New equipment purchased on the basis of priorities established in the five-year plan.	CSH	The purchase and installation of equipment at Colorado State Hospital should be based upon the five-year plan for the use of available communications and computer technology which is to be written in FY 83-84.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
GOAL # 5. 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 reviewed the utilization of targeted "emergency jobs bill" block grant funds for developing community mental health center pre-vocational and work experience programs.	06/30/85	-Written report.	Program Services	The Federal ADM Block Grant was augmented to include funds for impacting unemployment/ underemployment related issues which influence mental health service utilization. The impact of the first year's utilization of these funds should be evaluated.
GOAL # 6. 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.	07/01/84	-Revised plan in place.	Program Services Admin. 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 implemented changes consistent with the findings of the review.	10/31/84	-Written report.	Program Services Admin. Services	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. The Memorandum needs to be reviewed each year, and the recommended revisions need to be implemented.

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(3) To have increased the scope and number of clients served under the Medicaid Waiver, consistent with population growth and fiscal constraints under the Waiver.	06/30/85	-Increased program approved by the federal government.	Program Services Admin. 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.

APPENDICES

COLORADO DIVISION OF MENTAL HEALTH FISCAL YEAR 1984-85 GOALS AND OBJECTIVES

GOALS	OBJECTIVES FY 1984-85	DUE DATE	ACCOMPLISHMENT MEASURES	RESPONSIBILITY AND ESTIMATED RESOURCES	RATIONALE FOR OBJECTIVES
	(7) To have increased the scope and number of clients served under the Medicaid Waiver, consistent with population growth and fiscal constraints under the Waiver.	06/30/85	-Increased program approved by the Federal government.	Program Services Admin. 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.

APPENDIX I

Catchment Area Demographic Data and Population in Need Estimates

Population Data

In Tables 1 and 2, the 1981 population estimates for each of the 20 mental health catchment areas are presented. Catchment areas are shown grouped according to state hospital service region for adults. Subtotals for each region, in addition to the state totals, are displayed. These estimates were calculated from county level projections developed by the Colorado Division of Local Government in August of 1982. Since these county level estimates are not disaggregated by any demographic variables, the age and ethnic disaggregation depicted in the tables was accomplished by employing 1980 census based proportions. Similarly, the population estimates for the seven Community Mental Health Centers, which serve subcounty areas, were calculated using the 1980 proportions. Additional information on these demographic tables is available from the Evaluation Services Section of the Division of Mental Health.

Estimates of Population in Need of Mental Health Services

Table 3 displays the social indicator data which is employed in calculating the population in need of mental health services. The six social indicator scores for each of the 20 catchment areas are presented in the table as well as the composite standardized score which is used in the final need estimation equation. This composite Z score may be interpreted as showing the degree to which each catchment area differs from the overall state average on the mean of the six indicators. A negative number indicates that the center is below the state average on the indicators and evidences lower levels of the social problems measured by the indicator variables. Conversely, positive composite scores are indicative of higher than average levels of the social variables which are known to be associated with needs for services. The values for each indicator which are presented in Table 3 are the most current available including the 1980 census estimates of percent population in poverty.

The unmodified prevalence estimates, shown in Table 4, were arrived at by multiplying the following age-adjusted prevalence rate by the catchment area population figures:

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

These age specific prevalence rates were adapted from the 1978 Report of the President's Commission on Mental Health

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, Z is the composite social indicater score, and w_i are weights for the low (10 percent), medium (14 percent)

and high (17 percent) variance estimates. Both this specific equation and the variables which are employed in it as well as this general approach to estimating the population in need have been jointly endorsed by the Division of Mental Health and the Colorado Association of Community Mental Health Centers and Clinics.

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 83-84 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.

1981 POPULATION ESTIMATES
TOTAL POPULATION BY AGE GROUPS
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

TABLE 1

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												
	ARAPAHOE	36760	18.812	23833	12.197	117021	59.885	6477	3.315	11317	5.791	195408
	CENTENNIAL	16601	19.081	9082	10.439	45385	52.166	4025	4.626	11908	13.687	87000
	COLO WEST	34784	18.136	17509	9.129	118628	61.850	6037	3.148	14842	7.738	191800
	LARIMER	24894	16.775	13097	8.825	93183	62.792	4613	3.108	12613	8.500	148400
	MIDWESTERN	11238	17.693	6218	9.793	35521	55.939	2773	4.366	7750	12.204	63500
	PIKES PEAK	62187	18.902	34278	10.419	199729	60.708	10428	3.170	22378	6.802	329000
	SAN LUIS	8031	20.539	4520	11.560	20546	52.548	1637	4.186	4366	11.167	39100
	SE COLO	10019	19.455	5681	11.031	25816	50.128	2599	5.046	7385	14.340	51500
	SW COLO	9700	18.727	5440	10.501	29906	57.733	2061	3.979	4693	9.060	51800
	SPAN PEAKS	26913	18.383	15752	10.760	78403	53.554	7046	4.813	18285	12.490	146400
	WELD	23801	19.210	12707	10.256	72352	58.395	4098	3.308	10942	8.831	123900
	WEST CENTRAL	9423	17.713	5461	10.266	28749	54.040	2252	4.233	7314	13.748	53200
TOTAL		274351	18.525	153578	10.370	865239	58.422	54046	3.649	133793	9.034	1481008
FLMHC												
	ADAMS	46365	20.976	25324	11.457	131231	59.370	6372	2.883	11748	5.315	221041
	AURORA	33569	19.869	15983	9.460	107235	63.471	4867	2.880	7297	4.319	168951
	BETHESDA	13686	10.020	7811	5.719	88243	64.608	7069	5.176	19772	14.476	136581
	BOULDER	30656	15.657	18127	9.258	128636	65.698	5087	2.598	13294	6.790	195800
	DENVER H&H	25137	16.389	11321	7.381	87514	57.057	6759	4.407	22648	14.766	153379
	JEFFERSON	74773	18.726	45201	11.320	243143	60.892	12444	3.116	23740	5.945	399300
	PARK EAST	19317	16.628	9968	8.580	70512	60.695	4244	3.653	12131	10.442	116175
	SW DENVER	16204	17.449	8926	9.612	55388	59.644	4141	4.459	8206	8.837	92865
TOTAL		259707	17.499	142661	9.613	911902	61.445	50983	3.435	118836	8.007	1484092
TOTAL TOTAL		534058	18.011	296239	9.991	1777141	59.935	105029	3.542	252629	8.520	2965100

SOURCE: CATCHMENT AREA POPULATION ESTIMATES EXTRACTED FROM COLORADO POPULATION REPORTS AUGUST 82.
AGE PROPORTIONS CALCULATED FROM 1980 CENSUS.
PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 07/14/83 .

1981 POPULATION ESTIMATES
TOTAL POPULATION BY ETHNIC GROUPS
COLORADO MENTAL HEALTH CATCHMENT AREAS
GROUPED BY STATE HOSPITAL SERVICE REGIONS

TABLE 2

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												
	ARAPAHOE	7177	3.673	1748	.895	1858	.951	691	.353	11474	5.872	195408
	CENTENNIAL	5297	6.089	96	.110	300	.345	267	.307	5960	6.851	87000
	COLO WEST	9838	5.129	367	.191	650	.339	970	.506	11825	6.166	191800
	LARIMER	8479	5.714	624	.420	1362	.918	641	.432	11105	7.483	148400
	MIDWESTERN	4692	7.389	98	.154	154	.243	455	.717	5399	8.503	63500
	PIKES PEAK	24650	7.492	19438	5.908	5191	1.578	1894	.576	51173	15.554	329000
	SAN LUIS	16902	43.227	81	.208	164	.419	170	.435	17317	44.290	39100
	SE COLO	12315	23.913	143	.277	182	.354	212	.412	12853	24.957	51500
	SW COLO	5791	11.180	56	.108	119	.230	2947	5.690	8913	17.207	51800
	SPAN PEAKS	50259	34.330	2325	1.588	521	.356	651	.445	53755	36.718	146400
	WELD	20912	16.878	599	.484	823	.664	529	.427	22863	18.453	123900
	WEST CENTRAL	5743	10.796	477	.897	110	.207	318	.597	6648	12.497	53200
TOTAL		172055	11.617	26052	1.759	11434	.772	9745	.658	219286	14.807	1481008
FLMHC												
	ADAMS	36850	16.671	2256	1.020	2525	1.142	1519	.687	43149	19.521	221041
	AURORA	8083	4.784	11506	6.810	3549	2.101	862	.510	24000	14.206	168951
	BETHESDA	5082	3.721	3733	2.733	1955	1.431	400	.293	11170	8.178	136581
	BOULDER	10433	5.328	1791	.915	2262	1.155	934	.477	15421	7.876	195800
	DENVER H&H	52474	34.212	17040	11.110	2204	1.437	2028	1.322	73746	48.081	153379
	JEFFERSON	20403	5.110	2049	.513	3811	.954	1573	.394	27837	6.971	399300
	PARK EAST	9602	8.265	38264	32.936	1940	1.670	719	.618	50524	43.490	116175
	SW DENVER	24390	26.264	1013	1.091	1021	1.099	761	.820	27185	29.273	92865
TOTAL		167317	11.274	77652	5.232	19267	1.298	8796	.593	273032	18.397	1484092
TOTAL TOTAL		339372	11.446	103704	3.497	30701	1.035	18541	.625	492318	16.604	2965100

SOURCE: CATCHMENT AREA POPULATION ESTIMATES EXTRACTED FROM COLORADO POPULATION REPORTS AUG 82.
ETHNIC PROPORTIONS CALCULATED FROM 1980 CENSUS.
PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 07/14/83 .

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

TABLE 3 (p.1)

STATE HOSP REGION	CATCHMENT AREA	SUICIDE RATE PER 100,000 POP 1981 (1)	ABUSE & NEGLECT REPORTS RATE PER 100,000 C & A 1982 (2)	DIVORCE RATE PER 1,000 MARRIED COUPLES 1981 (3)	PERCENT MINORITY POPULATION 1980 (4)	PERCENT POPULATION IN POVERTY 1980 (5)	PERCENT LABOR FORCE UNEMPLOYMENT 1982 (6)	COMPOSITE SOCIAL INDICATOR SCORE(7)
CSH								
	ARAPAHOE	20.470	741.009	22.851	5.872	4.5	5.033	-1.39803
	CENTENNIAL	20.690	852.704	19.179	6.851	12.9	6.664	-.88654
	COLO WEST	15.120	1464.823	29.856	6.166	8.8	9.079	-.05334
	LARIMER	18.868	468.532	25.836	7.483	11.0	7.065	-.97313
	MIDWESTERN	17.323	939.505	27.515	8.503	13.4	11.151	-.04065
	PIKES PEAK	15.502	757.788	38.103	15.554	10.4	7.894	-.01501
	SAN LUIS	12.788	565.692	23.930	44.290	24.1	11.789	.61876
	SE COLO	3.883	1146.496	21.534	24.957	19.7	8.363	-.39001
	SW COLO	25.097	1162.463	34.966	17.207	14.7	10.413	1.03645
	SPAN PEAKS	23.907	897.691	25.821	36.718	14.6	16.260	1.21611
	WELD	12.107	1216.172	25.223	18.453	14.1	7.440	-.25236
	WEST CENTRAL	26.316	544.208	25.015	12.497	10.6	15.216	.18510
MEAN		17.672	896.425	26.652	17.046	13.1	9.697	
S.D.		6.349	304.857	5.404	12.535	4.9	3.423	
FLMHC								
	ADAMS	21.715	1526.036	26.123	19.521	7.4	8.161	.18795

(1) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1983.
(2) SOURCE COLORADO DEPARTMENT OF SOCIAL SERVICES, PROTECTIVE SERVICES PROGRAM, 1983.
(3) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1983. NUMBER OF MARRIED COUPLES ESTIMATED FROM 1980 CENSUS AND UPDATED WITH 1981 POPULATION ESTIMATES PROVIDED BY THE DIVISION OF LOCAL GOVERNMENT, AUGUST, 1982.
(4) SOURCE DATA EXTRACTED FROM SUMMARY TAPE FILE 1A, 1980 U.S. CENSUS.
(5) SOURCE 1980 CENSUS SUMMARY TAPE FILE 3. PROVIDED BY THE DIVISION OF LOCAL GOVERNMENT, 1983.
(6) SOURCE COLORADO DIVISION OF EMPLOYMENT AND TRAINING, RESEARCH AND ANALYSIS SECTION, 1983.
(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, 07/14/83 .

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

TABLE 3 (p.2)

STATE HOSP REGION	CATCHMENT AREA	SUICIDE RATE PER 100,000 POP 1981 (1)	ABUSE & NEGLECT REPORTS RATE PER 100,000 C & A 1982 (2)	DIVORCE RATE PER 1,000 MARRIED COUPLES 1981 (3)	PERCENT MINORITY POPULATION 1980 (4)	PERCENT POPULATION IN POVERTY 1980 (5)	PERCENT LABOR FORCE UNEMPLOYMENT 1982 (6)	COMPOSITE SOCIAL INDICATOR SCORE(7)
	AURORA	8.878	950.516	24.041	14.206	5.5	6.527	-1.28364
	BETHESDA	16.108	1367.633	34.340	8.178	6.3	5.140	-.30521
	BOULDER	15.832	1330.381	32.861	7.876	10.1	6.612	-.09945
	DENVER H&H	35.859	1365.955	34.373	48.081	23.8	9.581	2.64330
	JEFFERSON	17.030	500.108	25.207	6.971	4.6	5.970	-1.49953
	PARK EAST	21.519	1365.886	34.387	43.490	11.4	6.360	1.01751
	SW DENVER	12.922	1364.902	34.361	29.273	10.8	5.854	.29137
MEAN		18.733	1221.427	30.712	22.200	10.0	6.776	
S.D.		8.098	334.252	4.689	16.379	6.1	1.426	
TOTAL MEAN		18.097	1026.426	28.276	19.107	11.9	8.529	
S.D.		6.912	348.787	5.401	14.018	5.5	3.113	

(1) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1983.
(2) SOURCE COLORADO DEPARTMENT OF SOCIAL SERVICES, PROTECTIVE SERVICES PROGRAM, 1983.
(3) SOURCE COLORADO DEPARTMENT OF HEALTH, PUBLIC HEALTH STATISTICS SECTION, ANNUAL REPORT OF VITAL STATISTICS, 1983. NUMBER OF MARRIED COUPLES ESTIMATED FROM 1980 CENSUS AND UPDATED WITH 1981 POPULATION ESTIMATES PROVIDED BY THE DIVISION OF LOCAL GOVERNMENT, AUGUST, 1982.
(4) SOURCE DATA EXTRACTED FROM SUMMARY TAPE FILE 1A, 1980 U.S. CENSUS.
(5) SOURCE 1980 CENSUS SUMMARY TAPE FILE 3. PROVIDED BY THE DIVISION OF LOCAL GOVERNMENT, 1983.
(6) SOURCE COLORADO DIVISION OF EMPLOYMENT AND TRAINING, RESEARCH AND ANALYSIS SECTION, 1983.
(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, 07/14/83 .

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

TABLE 4 (p.1)

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										
	ARAPAHOE	195408	14737	-1.39803	12972	6.64	12242	6.26	11686	5.98
	CENTENNIAL	87000	6834	-.88654	6373	7.33	6182	7.11	6037	6.94
	COLO WEST	191800	14439	-.05334	14696	7.66	14802	7.72	14883	7.76
	LARIMER	148400	11222	-.97313	10366	6.99	10012	6.75	9742	6.56
	MIDWESTERN	63500	4940	-.04065	5034	7.93	5073	7.99	5103	8.04
	PIKES PEAK	329000	24749	-.01501	25287	7.69	25509	7.75	25678	7.80
	SAN LUIS	39100	3032	.61876	3294	8.42	3403	8.70	3486	8.92
	SE COLO	51500	4074	-.39001	4006	7.79	3978	7.72	3957	7.68
	SW COLO	51800	3962	1.03645	4474	8.64	4686	9.05	4847	9.36
	SPAN PEAKS	146400	11464	1.21611	13157	8.99	13857	9.47	14390	9.83
	WELD	123900	9418	-.25286	9393	7.58	9383	7.57	9376	7.57
	WEST CENTRAL	53200	4175	.18510	4351	8.18	4424	8.32	4480	8.42
TOTAL		1481008	113046		113403	7.66	113551	7.67	113665	7.67
RATIO						1.35		1.51		1.64
FLMHC										
	ADAMS	221041	16493	.18795	17194	7.78	17483	7.91	17704	8.01
	AURORA	168951	12456	-1.28364	11110	6.58	10553	6.25	10129	6.00
	BETHESDA	136581	10732	-.30521	10646	7.79	10611	7.77	10584	7.75
	BOULDER	195800	14679	-.09945	14871	7.59	14950	7.64	15011	7.67
	DENVER H&H	153379	12001	2.64330	15520	10.12	16962	11.07	18093	11.80

(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, 07/14/83 .

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

TABLE 4 (p.2)

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	399300	30006	-1.49953	26100	6.54	24486	6.13	23256	5.82
	PARK EAST	116175	8893	1.01751	10026	8.63	10494	9.03	10851	9.34
	SW DENVER	92665	7100	.29137	7477	8.05	7632	8.22	7751	8.35
TOTAL		1484092	112360		112950	7.61	113191	7.63	113379	7.64
RATIO						1.55		1.81		2.03
TOTAL										
TOTAL		2965100	225406		226353	7.63	226742	7.65	227044	7.66
RATIO						1.55		1.81		2.03

(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, 07/14/83 .

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

TABLE 5

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										
	ARAPAHOE	1942	14.969	2098	16.170	7210	55.581	1723	13.279	12972
	CENTENNIAL	929	14.574	847	13.287	2963	46.488	1635	25.651	6373
	COLO WEST	2124	14.454	1782	12.127	8452	57.511	2338	15.908	14696
	LARIMER	1380	13.313	1210	11.673	6025	58.127	1750	16.886	10366
	MIDWESTERN	687	13.644	634	12.591	2533	50.324	1180	23.441	5034
	PIKES PEAK	3812	15.075	3503	13.851	14285	56.491	3687	14.582	25287
	SAN LUIS	524	15.897	491	14.908	1562	47.427	717	21.768	3294
	SE COLO	591	14.752	559	13.942	1777	44.354	1080	26.951	4006
	SW COLO	657	14.690	614	13.730	2363	52.827	839	18.753	4474
	SPAN PEAKS	1854	14.088	1808	13.739	6298	47.872	3197	24.302	13157
	WELD	1424	15.162	1268	13.495	5052	53.780	1650	17.562	9393
	WEST CENTRAL	589	13.533	569	13.078	2097	48.192	1096	25.198	4351
TOTAL		16513	14.561	15383	13.565	60617	53.453	20892	18.423	113403
FLMHC										
	ADAMS	2900	16.868	2640	15.352	9578	55.696	2078	12.084	17194
	AURORA	1796	16.169	1425	12.829	6695	60.260	1193	10.742	11110
	BETHESDA	814	7.650	775	7.277	6127	57.557	2929	27.516	10646
	BOULDER	1863	12.528	1837	12.351	9123	61.346	2048	13.775	14871
	DENVER H&H	1951	12.566	1464	9.433	7925	51.046	4185	26.956	15526
	JEFFERSON	3902	14.950	3932	15.064	14804	56.722	3462	13.264	26100
	PARK EAST	1307	13.033	1124	11.211	5565	55.504	2030	20.252	10026
	SW DENVER	1024	13.690	940	12.577	4083	54.606	1430	19.127	7477
TOTAL		15557	13.773	14137	12.516	63898	56.572	19355	17.136	112950
TOTAL TOTAL		32070	14.168	29520	13.042	124515	55.009	40247	17.781	226353

PREPARED BY EVALUATION SERVICES, DIVISION OF MENTAL HEALTH, DENVER, 07/14/83 .

APPENDIX II

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. LD:vk Rev. 6/82	- 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

APPENDIX III

SCORING OF THE RESIDENTIAL CONTINUUM MODEL (AGES 18+)