State of Colorado

MENTAL HEALTH PLAN

1985 - 1988

COLORADO STATE
MENTAL HEALTH PLAN

1985 - 1988

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3520 West Oxford Avenue
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GENERAL INTRODUCTION

The Division of Mental Health (DMH)

The Colorado Division of Mental Health provides statewide services for seriously, critically and chronically mentally ill persons of all ages. These services are delivered through two hospitals operated by DMH -- the Colorado State Hospital in Pueblo and the Fort Logan Mental Health Center in Denver -- and through contracts with three specialty clinics and 20 private non-profit community mental health centers located throughout the state. Seventy-two hour holding and emergency mental health evaluation services are provided through 27-10 designated facilities, also located statewide, which are regulated by DMH.

This service delivery network enables DMH to provide a continuum of care which ranges from intensive inpatient hospital beds to day treatment services in the clients' own communities, while they may live at home or in specialized residential facilities. All DMH services are offered to clients on an "ability to pay" basis, with state funds and federal block grant and medicaid dollars making up the costs which are greater than the available client fees and third party payments.

Figures 1-5 on pages 7-11 summarize the DMH management structure and provide summary information and statistics on each major component of the Colorado public mental health service delivery system.

The Division of Mental Health is the largest of the three divisions which comprise the Colorado Department of Institutions (DOI). The other two are the Division for Developmental Disabilities and the Division of Youth Services. The organizational structure of DOI is illustrated in Figure 6 on page 12.

The Planning Process

Each division is a strategic service delivery unit within DOI. Under this management structure, the division Directors play a major role in the formulation of strategy for their divisions as well as in the implementation and control of strategic plans.

The Executive Director of DOI in conjunction with division Directors provide overall direction and support to the strategic management process by (a) defining the mission of DOI, (b) analyzing major environmental influences, (c) interacting with key resources and funding sources, and (d) providing leadership and supervision in the strategy formulation, evaluation and implementation activities of the divisions.

Following are the Mission Statement and policies or principles of DOI which were developed by the Executive Director with the division Directors:

MISSION STATEMENT

The purpose of the Department of Institutions is to provide appropriate care and treatment to the Department's clients in a setting that assures safety to the community.

POLICIES

I. Through a continuum of services, provide treatment to clients in a decent environment which is the least intensive, least restrictive necessary to meeting their needs. When possible and/or when the client's condition permits, services should be provided in the local community in or close to the client's home and in the most normal home-like setting available.

II. Provide a secure treatment environment such that:
   1. Our clients will not be damaged physically or psychologically.
   2. Our staff is as safe as possible from physical harm.
   3. Members of the public are as free from harm as possible.

III. Manage departmental resources to take advantage of economies of scale, maximize opportunties for technology transfer between divisions and minimize unnecessary duplication of effort.

Planning is a prerequisite for the prudent use of resources and, as such, is viewed as an indispensable management process for DOI. Thus each of the three divisions within DOI participates in a structured Planning Process, the elements of which are:

1. SITUATION ANALYSIS
   A concise statement of the system's situation and conditions in the external and internal environment, indicating problems and opportunities, strengths and weaknesses; an audit of trends that can have a significant impact on accomplishment of objectives.

2. PROBLEM LIST
   A listing of the major problems and opportunities identified as a result of the situation analysis.

3. GOALS
   A target describing where we want effort directed in the future to solve identified problems.

4. OBJECTIVES
   Operate as the connecting link between goals and major tasks; are specific, realistic and measureable over a defined time period; allocate resources to target important client groups and geographic areas; detail commitment.

5. MAJOR TASKS
   Detail how each objective and strategy will be implemented during the planning period. Programs are described, priorities established and the sequence of events involving agencies, functional areas and other levels of the Department is specified.

   5a. Budget Request
   Details the specific dollar resources necessary to accomplish objectives. There are two iterations of the request: the request to

the Governor for inclusion in the overall Governor's Budget Request, and the final Legislative Budget Request which goes to the Joint Budget Committee of the Legislature and reflects the decisions made by the Governor.

6. MANAGEMENT PLAN
Determines when there will be follow-up on progress and triggers the implementation of contingency plans; contributes to the feedback loop as quarterly updates are provided. These are utilized for tracking over the year.

The annual timeframe and progression of this process is illustrated in Figure 7 on page 13. The DMH schedule for this past year's Planning Process is summarized in Figure 8 on page 14.

This document, the Colorado State Mental Health Plan 1985-88, includes all of these main elements of the Planning Process. The "Situation Analysis" and the "Problem List" are based on situation analyses and problem lists generated by staff of each program component of the mental health system, i.e., the two state hospitals and the 23 community mental health centers and clinics. These source documents are too lengthy to append to the State Plan but are available at the Division of Mental Health Central Office as well as from each program (see Fact Sheets, Figures 2-5, for program listings). This State Plan is also based on input and review provided by DMH's Management Team, on an extensive analysis of division-wide client and workload data, on review by the DOI Executive Director's Office and on outside input and review provided by the State Council, as explained below. Since the "Situation Analysis" is lengthy, it is preceded by an Executive Summary and a copy of the Final Problem List, which is the one with State Council input, on pages 16-25.

The Colorado State Mental Health Planning Advisory Council

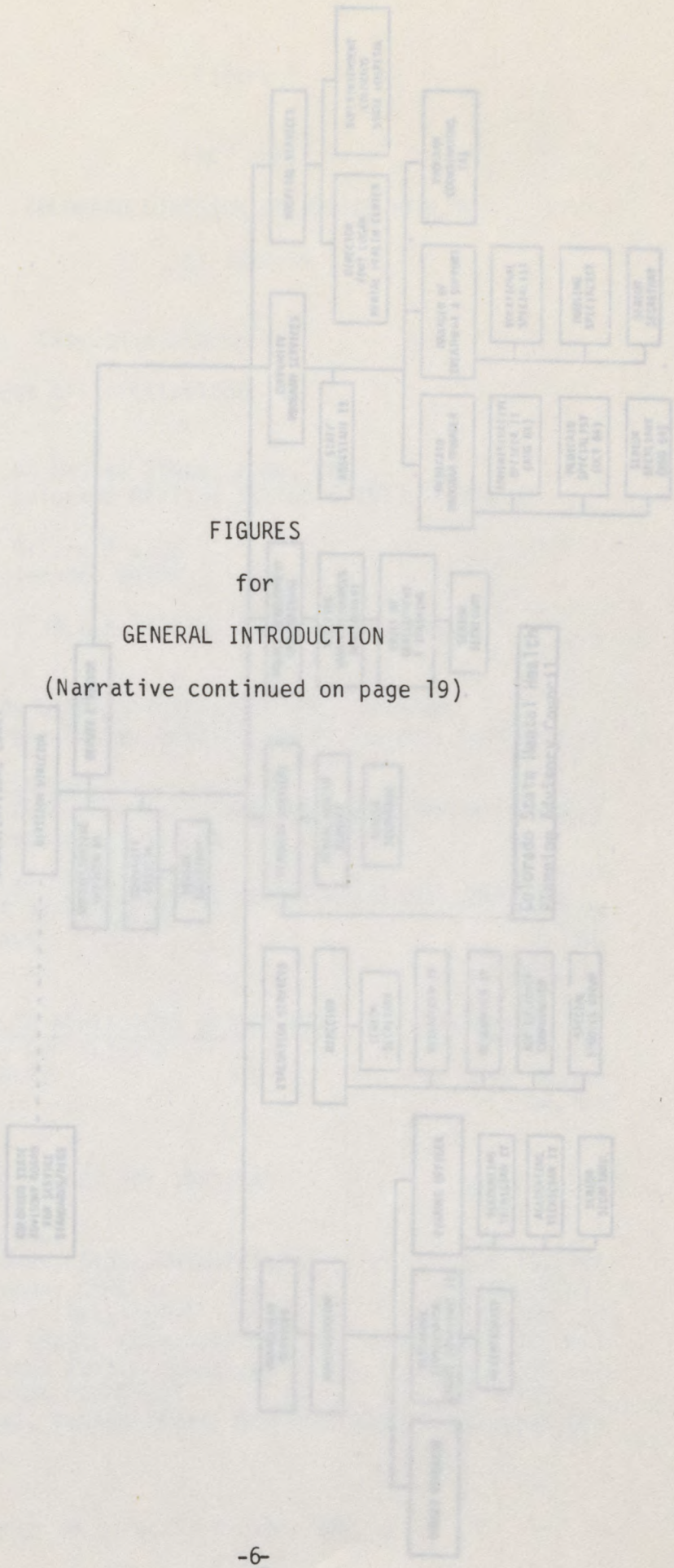
For the past 8 years Colorado has had a State Mental Health Council which serves in an advisory capacity to the Division of Mental Health. Originally this body was federally mandated through the Community Mental Health Centers Act; after that requirement ended, Colorado continued the body through appointment by the Executive Director of the Department of Institutions.

DMH currently uses the Colorado State Mental Health Planning Advisory Council as a primary mechanism for outside input into the division's Planning Process. DMH has designed the membership of this Council such that agencies or groups which represent providers, consumers, and advocates, are the standing members. It is each group's responsibility and prerogative to appoint its representative who may remain the same or change each year. The persons appointed are primary policy decision-makers, and they have a knowledge of current issues and needs relating to the delivery of public mental health services. Figure 9 on page 15 is a list of the 23 groups represented on this State Council.

Currently the duties of Council members consist of attending a 1 1/2-day annual planning meeting. This meeting has three very structured agenda items. The first is for the State Planner to provide feedback to the Council on the content and the results of the previous year's DMH Planning Process.

The second agenda item is for the members to participate in a group process to identify and prioritize "outside" problems and issues in the delivery of state mental health services. The third agenda item consists of the Council members' identification of options and strategies that DMH can pursue in order to address the top five of these problems/issues.

The input from this meeting is then used by DMH to refine and expand the problem list and priorities originally identified through the Situation Analysis. This final problem list then forms the basis of DMH's Management Plan for the coming year, the Budget Request for the year after that, and "future ongoing issues and policy initiatives." The results of each of these steps are included as separate chapters in this State Plan, except for the Budget Request which is published as a separate document.



FIGURES

for

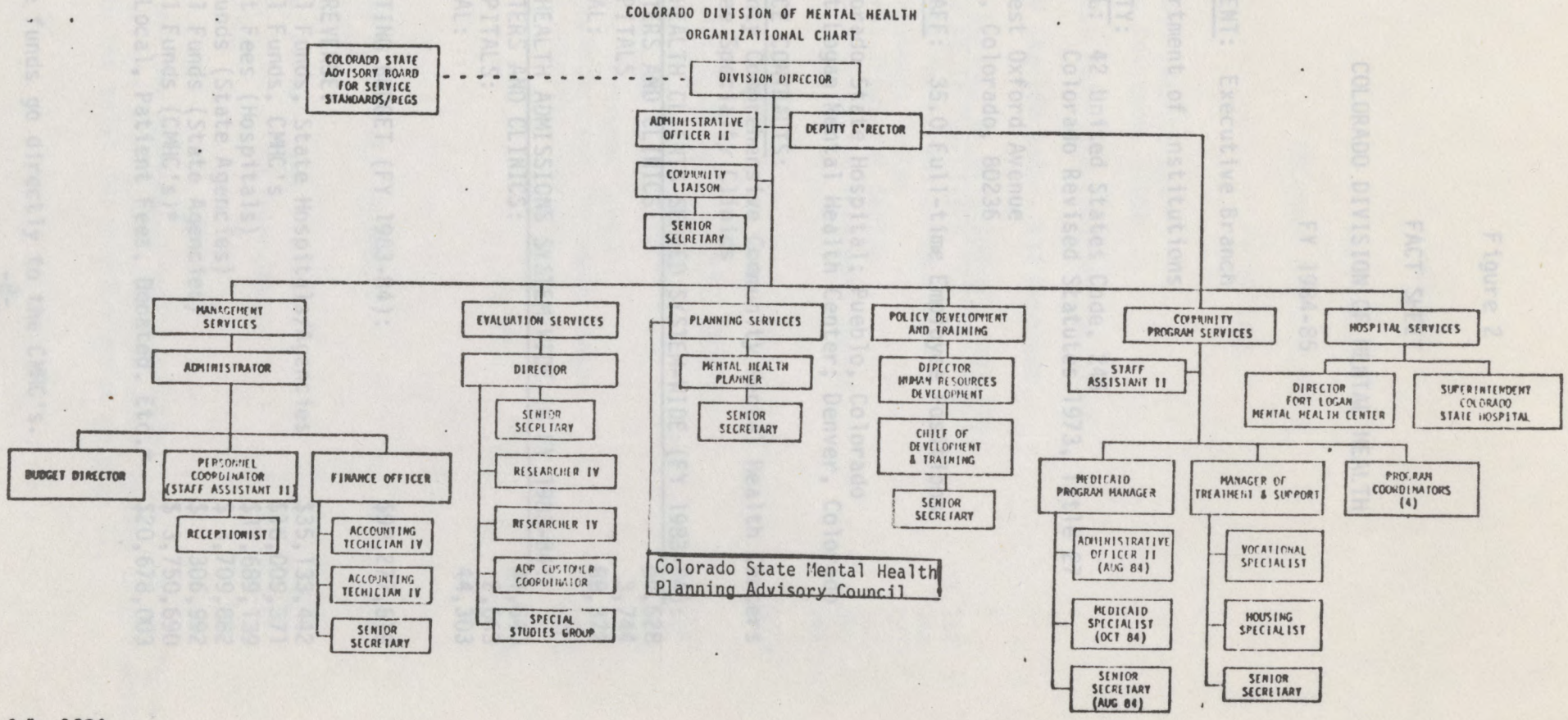
GENERAL INTRODUCTION

(Narrative continued on page 19)

Figure 1

ORGANIZATIONAL CHART

COLORADO DIVISION OF MENTAL HEALTH



July 1984

Figure 2

FACT SHEET

COLORADO DIVISION OF MENTAL HEALTH

FY 1984-85

BRANCH OF GOVERNMENT: Executive Branch

DEPARTMENT: Department of Institutions

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

LOCATION: 3520 West Oxford Avenue
Denver, Colorado, 80236

CENTRAL OFFICE STAFF: 35.0 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
Three Specialty Clinics

NUMBER OF MENTAL HEALTH CLIENTS SERVED SYSTEM-WIDE (FY 1983-84):	
CENTERS AND CLINICS:	64,628
HOSPITALS	3,744
TOTAL:	68,372

NUMBER OF MENTAL HEALTH ADMISSIONS SYSTEM-WIDE IN FY 1983-84:	
CENTERS AND CLINICS:	41,640
HOSPITALS:	2,663
TOTAL:	44,303

FINANCES:

TOTAL OPERATING BUDGET (FY 1983-84):	$99,277,519
SOURCES OF REVENUE:	
General Funds, State Hospitals/Agencies	$35,133,442
General Funds, CMHC's	$18,009,371
Patient Fees (Hospitals)	$17,689,139
Cash Funds (State Agencies)	$ 3,709,882
Federal Funds (State Agencies)	$ 306,992
Federal Funds (CMHC's)*	$ 3,750,690
CMHC, Local, Patient Fees, Donated, Etc.*	$20,678,003

*These funds go directly to the CMHC's.

Figure 3

FACT SHEET

COLORADO STATE HOSPITAL

FY 1984-85

LOCATION: 1600 West 24th Street
Pueblo, Colorado 81003

TOTAL STAFF: 1302.9 Full-time Employee Positions

BED CAPACITY: 754 Staffed Beds - All Programs

NUMBER OF CLIENTS SERVED, BY DIVISION (FY 1983-84):

General Adult Psychiatry	1,152
Institute for Forensic Psychiatry	948
Drug Treatment Center	227*
Geriatric Treatment Center	360
Children/Adolescent Treatment Center	369
General Hospital Services	944*
TOTAL:	4,000*

NUMBER OF ADMISSIONS, BY DIVISION, IN FY 1983-84:

General Adult Psychiatry	854
Institute for Forensic Psychiatry	472
Drug Treatment Center	205*
Geriatric Treatment Center	174
Children/Adolescent Treatment Center	256
General Hospital Services	956*
TOTAL:	2,917*

FINANCES:

TOTAL OPERATING BUDGET (FY 1983-84):	$ 39,854,784
SOURCES OF REVENUE:	
General Fund	$ 26,120,827
Cash Funds, Patient Fees	$ 10,449,940
Cash Funds, Other State Agencies	$ 3,284,017
Federal Funds	$ -0-

* These figures include non-mental health clients. In order to focus on the mental health client population, the non-mental health client workload is not included in the total DMH client figures on page 11.

Figure 4

FACT SHEET

FORT LOGAN MENTAL HEALTH CENTER

FY 1984-85

LOCATION: 3520 West Oxford Avenue
Denver, Colorado 80236

TOTAL STAFF: 512.9 Full-time Employee Positions

BED CAPACITY: 344 Staffed Beds - All Programs

NUMBER OF CLIENTS SERVED, BY DIVISION (FY 1983-84):

Children/Adolescent Treatment	243
Adult Psychiatry	713
Geriatric/Deaf/Aftercare	244
Vocational Services	23
UNDUPLICATED TOTAL	1,186

NUMBER OF ADMISSIONS, BY DIVISION, IN FY 1983-84:

Children/Adolescent Treatment	173
Adult Psychiatry	572
Geriatric/Deaf/Aftercare	91
Vocational Services	9
TOTAL	845

FINANCES:

TOTAL OPERATING BUDGET (FY 1983-84):	$ 16,134,236
SOURCES OF REVENUE:	
General Fund	$ 8,469,172
Cash Funds, Patient Fees	$ 7,239,199
Cash Funds, Other State Agencies	$ 425,865
Federal Funds	$ -0-

Figure 5

FACT SHEET

COLORADO COMMUNITY MENTAL HEALTH CENTERS AND CLINICS

FY 1984-85

PROGRAMS:

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.
Northwest Denver Community Mental Health Centers Services
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
Servicios de la Raza

TOTAL STAFF:	1,587
FULL-TIME STAFF:	1,286
PART-TIME STAFF:	301

NUMBER OF CLIENTS SERVED, ALL CENTERS/CLINICS (FY 1983-84): 64,628

NUMBER OF ADMISSIONS, ALL CENTERS/CLINICS, IN FY 1983-84: 41,640

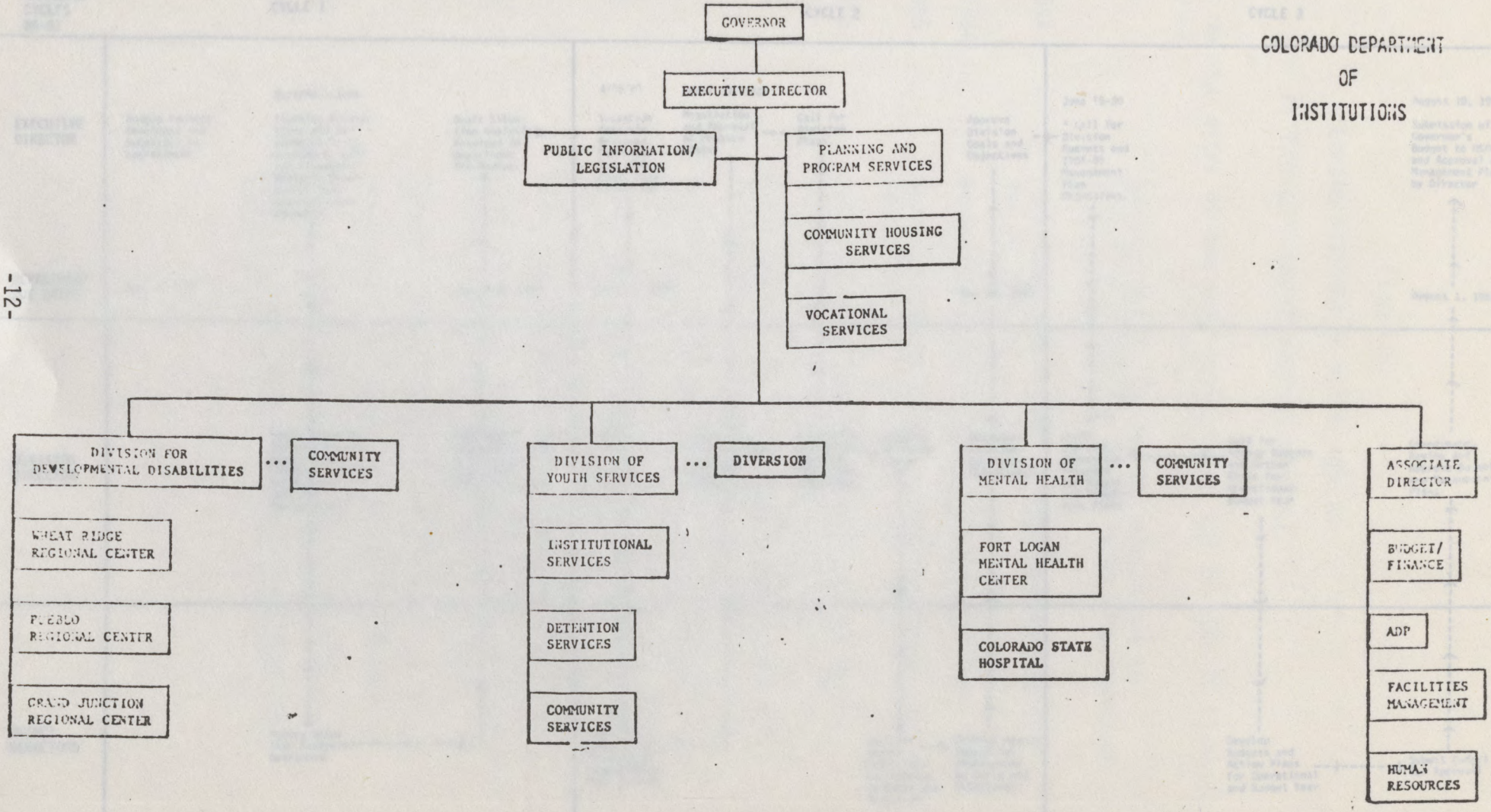
FINANCES:

TOTAL OPERATING BUDGET (FY 1983-84):	$ 42,438,064
SOURCES OF REVENUE:	
State Funds	$ 18,009,371
Federal Funds	$ 3,750,690
Fees, Titles, Insurance	$ 13,677,278
County/Municipal	$ 2,745,927
Donated and In-Kind	$ 2,306,312
School Districts	$ 208,186
Other	$ 1,740,300

Figure 6

ORGANIZATIONAL CHART

COLORADO DEPARTMENT OF INSTITUTIONS



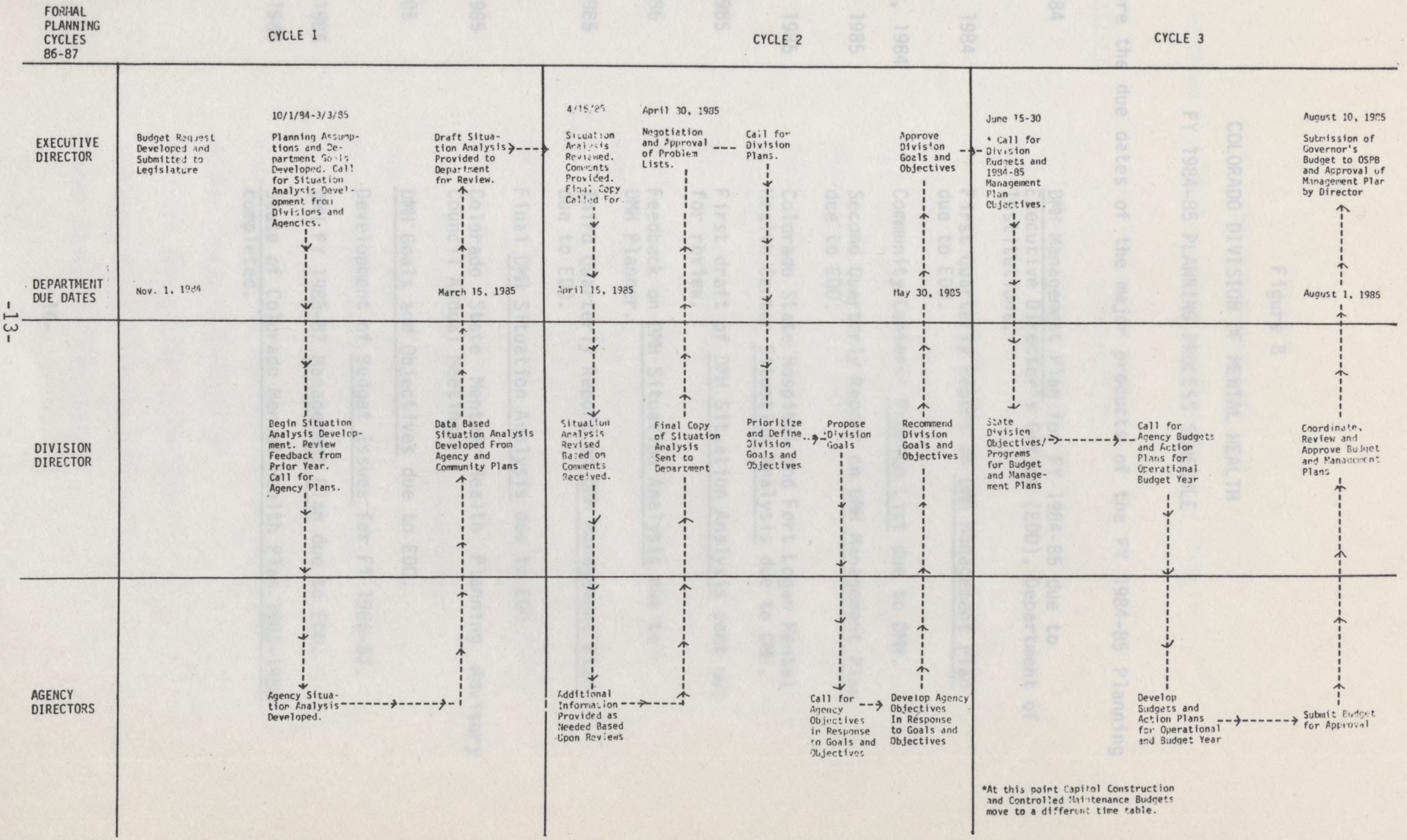
COLORADO DEPARTMENT OF INSTITUTIONS

January 1984

Figure 7

DOI Planning Process Schedule

FY 1984-85



*At this point Capitol Construction and Controlled Maintenance Budgets move to a different time table.

Figure 8

COLORADO DIVISION OF MENTAL HEALTH

FY 1984-85 PLANNING PROCESS SCHEDULE

Following are the due dates of the major products of the FY 1984-85 Planning Process:

July 31, 1984	DMH Management Plan for FY 1984-85 due to Executive Director's Office (EDO), Department of Institutions.
October 22, 1984	First Quarterly Report on DMH Management Plan due to EDO.
December 15, 1984	Community Centers' Problem List due to DMH.
January 18, 1985	Second Quarterly Report on DMH Management Plan due to EDO.
January 31, 1985	Colorado State Hospital and Fort Logan Mental Health Center Situation Analysis due to DMH.
March 15, 1985	First draft of DMH Situation Analysis sent out for review.
April 1, 1985	Feedback on DMH Situation Analysis due to DMH Planner.
April 19, 1985	Third Quarterly Report on DMH Management Plan due to EDO.
May 1, 1985	Final DMH Situation Analysis due to EDO
June 4-5, 1985	Colorado State Mental Health Planning Advisory Council Annual Meeting.
June 30, 1985	DMH Goals and Objectives due to EDO.
July, 1985	Development of Budget Issues for FY 1986-87.
August 13, 1985	DMH FY 1985-87 Management Plan due to EDO.
August 31, 1985	State of Colorado Mental Health Plan 1985-1988 completed.

Figure 9

1985 MEMBERSHIP LIST

Colorado State Mental Health Planning Advisory Council

# Representatives	Organization
1	Division of Mental Health (DMH)
2	DMH Management Team
1	Colorado State Hospital
1	Fort Logan Mental Health Center
4	Colorado Association of Centers and Clinics
1	Department of Social Services
1	Department of Education
1	Division of Youth Services
1	Division for Developmental Disabilities
1	Dept. of Health/Alcohol and Drug Abuse Division
1	Denver Department of Safety
1	Denver Mental Health Commission
1	Colorado Assn. of Homes and Service for the Aging
1	Office of State Planning and Budgeting
1	Legal Aid Society/Mental Health Law Project
1	Support Systems Consolidated
1	Mental Health Association of Colorado
1	Colorado Alliance for the Mentally Ill
1	District Attorney's Office/Victim Programs
1	Higher Education/Psychiatry
1	District Judges Assn. of Colorado
1	Emergency Psychiatric Services
1	Denver Health and Hospitals
TOTAL 27	

CHAPTER 1

EXECUTIVE SUMMARY

1985 DIVISION OF MENTAL HEALTH

SITUATION ANALYSIS and FINAL PROBLEM LIST

Following is a summary of the 1985 Division of Mental Health (DMH) Situation Analysis and the Problem List that resulted from this analysis plus the outside input of the State Mental Health Planning Advisory Council. The section headings conform to those areas addressed in the full Situation Analysis which follows on pages 27-90. The work of the Council is detailed in Chapter 3 on pages 91-99. Essentially, the following Executive Summary and Final Problem List describe the issues that the Colorado Public Mental Health System must currently face.

Target Population

The target population data show that the number of persons estimated to be in need of mental health services has been increasing and will continue to increase by an additional 5%, or 12,000 persons, by FY 1986-87. Yet in the face of these increasing demands the mental health system is serving fewer clients. It is projected that DMH will serve only 60,000 clients in FY 1986-87, which is 12% less than last year and only 25% of the total population in need. Survey results indicate that the private sector may serve as much as 24% of the population in need. Thus, the total need for mental health services is at best twice as great as the service availability.

Two reasons identified for the public mental health system's inability to serve more clients are an increase in involuntary admissions, and significant increases in the severity of adolescent and young adult clients who comprise over half of the systems' clientele. These changes have resulted in longer average lengths of stay and greater resource requirements for clients who are served, thereby reducing the numbers that can be served.

Even though Whites comprise the majority of the DMH client population, ratios of clients served to general population prevalence rates indicate that minorities are actually served at higher rates than Whites. The largest age group served is adult and prevalence rates show that the elderly (age 60+) is an underserved age group. The highest percentage of community mental health centers and clinics' (CMHCs') clients are diagnosed as "adjustment disorders" while the highest percentages of hospital clients are "schizophrenics."

Increases in indigent and unemployed clients have stressed mental health service providers' budgets at a time when emphasis is being put on populations outside the current system which need to be served. The numbers of mentally ill in jails, intersystem "grey-area" youths, dual/multi-diagnosed, mentally ill in nursing homes and the homeless mentally ill together represent thousands of persons statewide who are placed in other systems or who are unserved, but whose needs are for mental health services. Yet the mental health system is at, or in many cases over, operating capacity.

Main Services Rendered

Severe overcrowding in the two state hospitals as well as the long-standing shortage of community residential alternatives for the chronically mentally ill have resulted in a statewide shortage of inpatient resources needed for delivery of services to the mentally ill. Although the DMH bed allocation system adopted for adult hospital clients has relieved the problem somewhat,

the basic problem still remains a shortage of inpatient beds. At FLMHC this shortage is most critical in the Children/Adolescent Division; at CSH it is most critical in the Forensic Division. Aside from the new FLMHC Adolescent Unit, no additional hospital beds are requested; it is the mental health system's desire to meet this bed need with community residential alternatives. Both hospitals together, however, have been operating at 97% bed capacity since last year, with some divisions operating at over 100% capacity. Thus, the need to address this problem is reaching a crisis stage.

In addition to the difficulty which hospital overcrowding creates for CMHC's in addressing their bed needs, geographic limitations prevent the state hospitals from serving as emergency inpatient back-up to the majority of CMHC's. The necessity of contracting locally for emergency services has left some Centers without such services and others with prohibitive costs for emergency inpatient services.

The use of supervised community residential alternatives could help relieve the bed shortage as well as provide more appropriate services to patients currently in nursing homes, unsupervised boarding homes, independent living situations, or inappropriately incarcerated in jails. However, while State and local funds currently support 231 such placements, and federal HUD funds provide an additional 327 community beds, this availability falls far short of the remaining estimated statewide need for over 700 additional supervised community residential beds.

Facilities Resources

The inadequacy of facilities and program space is a major systemwide problem for DMH. CMHC budgets have been unable adequately to support current space needs, and many years of underfunding the hospitals' controlled maintenance budgets have resulted in facilities which are unsuited to client treatment needs, in ill repair, and often in violation of JCAH standards and safety codes. This year FLMHC received only 9% of its controlled maintenance budget request of $1,299,000; CSH received none of its request for $926,543.

In addition to the need for funds to maintain "useable" facilities, the hospitals are in immediate need of replacing and renovating some buildings. Capital construction needs specified by FLMHC in their facilities planning process should community-based alternatives fail to avert increases in the hospital's workload, are for a new locked adult unit in 1990, an additional adolescent locked unit in 1995, and a geriatric unit in 2005. Capital Construction needs specified by CSH in their Situation Analysis are for construction of a new coal fired power plant, renovating two Geriatrics Units, and for a new building to replace the existing Forensic medium security building.

Capital equipment funds for the hospitals have likewise fallen substantially short of needs over the past years. The two hospitals together are short approximately $1 million in capital outlay funds for the current year, a level of need which will only increase for the coming years. Specific capital equipment needs listed by FLMHC in their Situation Analysis are for replacement of the 23% capital equipment inventory that is over 20 years old and the 44% which is over 10 years old, and for ADP equipment. Needs listed by CSH in their Situation Analysis are for Pharmacy Services, the Forensic Institute,

Nutrition Services, Warehouse, Plant Operations, and ADP equipment. Furthermore, because of the major capital equipment needs of CSH General Hospital Services, which are estimated to be $852,000 in addition to the above figures, CSH is questioning whether this division should be continued in the mental health budget. Therefore, CSH is in need of funds for a feasibility study, so that "crucial decisions about the future role of the General Hospital Services including the need for major capital outlay items can be addressed before planning can be done for solving its problems" (CSH Situation Analysis, p. 2a).

Staffing Resources

Since DMH is a highly labor-intensive service delivery system, with 1,851 full-time State employees, and 1,587 CMHC employees, staffing resources deficiencies which are being experienced in the community as well as hospital components of the system, are of major import.

The majority of CMHC's listed staffing deficiencies among their top three problems in their planning process. Their staffing issues are that salaries are too low (anywhere from 18-43% below private sector and state hospital) to be competitive, which results in problems with recruitment, particularly of qualified minorities, and with retention (some centers experience staff turnover rates as high as 40% annually).

FLMHC likewise has experienced recruitment and retention problems with physicians and psychiatrists, which has resulted in a 27% annual turnover rate due to the state salary lid which prevents these salaries from being competitive with the private sector. The same problem has created a crisis situation with Registered Nurse (R.N.) positions. Of 31 R.N. vacancies last year, FLMHC was able to fill only 9 with experienced psychiatric nurses. Funds are needed to implement the FLMHC Nursing Occupational Study which would adjust the Nursing Classification System up to competitive levels.

Problems with the recruitment and retention of R.N.'s exist at the same time that CSH is in need of 66 R.N. positions (56 of them to be converted from existing positions) in order to provide 24-hour coverage on each ward, as recommended by Medicare and JCAH reviewers. CSH is in need of 15 new staff positions to correct deficiencies in the Child/Adolescent Division staffing pattern.

Finally, and ranked as highly important by both hospitals, are personal services funding deficiencies. These are non-funded personnel costs which the hospital budgets must absorb. These costs include retirement, which currently averages $340,000/year for CSH alone, vacancy savings below the assessed rate, and impacts of workers' compensation claims.

Source of Funds

Potential losses of patient fees and federal revenue sharing dollars in addition to a FY 1986-87 federal funding shortfall could result in an estimated maximum loss in funds of approximately $3.3 million, or 8% of the total CMHC budget in that year. The loss of patient fees could result in an estimated

maximum loss in funds of $2 million, or 3% of the hospital budgets over the next several years. These losses in funds would not only prevent the system from meeting increased mental health service delivery needs but also seriously erode the CMHC's ability even to maintain present core service delivery levels.

Post-Institutional Placement

Data on clients discharged from the hospitals and the CMHC's are consistent with the picture of a mental health client population that has become more disabled, in need of more security and control, and which has been impacted by the inadequate number of supervised community residential alternatives. Specifically, an increasing percentage of hospital and slightly more CMHC clients are being discharged to correctional facilities. Furthermore, an increasing percentage of hospital clients are being discharged to independent living situations which appears related to the decreasing availability, and use, of community residential placements.

Data on employment status at discharge indicate that the percentages of hospital and CMHC clients not in the labor force have increased. This may be related to the increased chronicity and severity of the clients. However, additional data and further analyses are needed to confirm this relationship and to determine what impact vocational and employment services have had and could potentially have on these discharge statistics.

Information Systems/ADP Resources

The majority of automated data processing (ADP) resources available to DMH are centralized within the DOI-ADP Section, and include two different mainframe computers (a Univac in Pueblo and an IBM in Denver). The growth in ADP applications and the proliferation of microcomputers have far exceeded the staff resources available within the DOI-ADP Section to support the total Department's ADP needs. Therefore, DMH has been forced to develop its own staff capabilities.

Due to the general lack of staff availability within DMH for ADP applications, the lack of training resources for these staff, the continued reliance on mainframe databases which are divided between two different computer systems which are difficult to link, and the lack of programmer and systems analyst resources needed to access the mainframes or create microsystem databases, DMH is having difficulty meeting its system-wide information needs.

The ADP resource needs consist primarily of policy-setting and systems coordination from the Department level; programmer and systems analyst resources for maintaining and accessing existing mainframe systems, designing and developing new micro and mainframe systems; mainframe-mainframe, micro-mainframe, and micro-micro communication networks; and staff training for DMH users.

Summary Analysis of External Influences

The most global external influences on the mental health system are currently those associated with the economics of providing care. Although the general

economic forecast for Colorado depicts a stable and positive environment within which to plan for the delivery of mental health services, some major changes are occurring within the medical arena which may greatly impact psychiatric care in the future.

One of these changes is the adoption of prospective payment systems in medical hospitals where fees/reimbursements are governed by Diagnosis Related Groupings (DRG's). One potential impact of this is that medical hospitals may be forced to transfer more clients, sooner, to the state hospitals when the insurance available to support them in the private settings runs out.

The implementation of a DRG-type system in psychiatric hospitals, which may occur as early as October 1985, could have two direct impacts on DMH. Due to the severity of DMH hospital clients, their lengths of stay currently exceed the 11-day average proposed under the DRG payment system. Therefore, reimbursements under DRG's would fall short of actual costs. Furthermore, if the DRG system is extended to other payors such as Medicaid, reductions in these revenues may be substantial. In total, DRG's could potentially increase the workloads and decrease the revenues for the two state hospitals.

Issues around provision of mental health services in Denver have focused attention on this most populous area in the statewide mental health system. Insufficient coordination of mental health services in Denver has been acknowledged. Therefore the Denver mental health service delivery system is being restructured and is currently in a transition stage. Services in the Northwest quadrant are being delivered by a consortium of Park East, Southwest Denver, and Aurora Community Mental Health Centers, and Community Support Systems, Inc. Psychiatric emergency and inpatient services are being provided by Denver Health and Hospitals. By July 1985 a Denver Mental Health Commission will be formed, which will coordinate all DMH contracts for mental health services in the entire Denver City and County. Resolving this problem has required a great deal of staff resources from the CMHC's involved, from DMH, and from many outside persons.

System-wide, it is recognized that to be effective, the public mental health service delivery system must be responsive to input from outside parties. These include families and friends of the mentally ill, other client advocates, as well as other agencies and individuals in both the public and private sectors who may need the system's services or from whom the system may need services for its clients. Specificially, outside input can supply the system with essential perspectives around program needs which differ from the providers' perspectives. These outside perspectives do not just relate to what services are needed, but how they should be provided, based on what happens in the communities where the clients return after treatment. This input also enables the mental health system to enhance coordination of services with outside persons and agencies, and enlist the commitment of those persons who are needed to identify and support areas of improvement in the system. Finally, outside involvement is needed to guard the rights of patients inside the system.

Comparison of Actual Results to DMH FY 1984-85 Management Plan

There is only one major deviation from the goals and objectives of the FY 1984-85 Management Plan. In order to address staffing deficiencies in the

CMHC's, it was DMH's listed objective to obtain a 7% cost of living increase in the CMHC FY 85-86 budget. This requested appropriation was included in the DMH Budget Request but eliminated by the Governor. Thus, the Budget Request that went to the Legislature included no cost of living increase. However, through the efforts of the CMHC's, it appears that the Joint Budget Committee will grant a cost of living increase of 1.6%.

Comparison of Actual Results to DMH FY 1984-85 Budget Request

There are two deviations in this year's Budget from the Request granted last year by the State Legislature. The appropriation for Operating Expenses was short of actual needs by $73,050 for FLMHC and $208,000 for CSH. DMH sought and was granted a $281,050 Supplemental Appropriation to cover this shortfall.

DMH also sought a Supplemental Appropriation to cover Medicaid drawdowns to the CMHC's which are estimated to exceed this year's appropriation by over $3 million. The JBC granted a Supplemental at approximately one-half of this need. This will require that the additional General Funds needed to satisfy Medicaid match requirements be transferred to the Department of Social Services from the DMH Budget at the end of FY 1984-85.

Final DMH Problem List with MH Council Input

1. The public mental health system can no longer treat as many clients.
The gap between population in need and numbers served has widened. The significantly increased severity of adolescents and young adults who, together, comprise the majority of clients, and the increased number of involuntary admissions have resulted in the need for more resources to treat the DMH Client population. Due to inflation, which has reduced spending power, there are not enough resources available even to maintain core services. Furthermore, due to a Federal funding shortfall of approximately $300,000 for FY 1986-87 and potential losses of patient fees and Federal Revenue Sharing dollars, CMHC's could lose up to $3.3 million, or 8% of their current budget. Potential losses of patient fees could result in a maximum loss in funds of $2 million, or 3% of the hospitals' budget over the next several years. Implementation of DRG's could impact first and third party payments.

2. Colorado needs to increase mental health services for the chronically mentally ill, including community treatment and support services and residential placements.
Estimates show a need for over 700 additional community residential placements for the chronically mentally ill. Hospital overcrowding may be directly related to this inadequacy of alternatives. The inadequacy of CMHC emergency service capability is also a major aspect of the system's inability to meet the needs of the chronically mentally ill population. There is a need to provide services for the homeless who are chronically mentally ill. The 1985 Benton Decision has challenged the public mental health system's response to the service needs of the chronically mentally ill.

3. The Division of Mental Health should improve methodologies for needs assessment and targeting of resources, and develop strategies to serve underserved and unserved clients.
The need to provide "more" treatment for longer lengths of stay has resulted in the system's serving fewer clients, at a time when the population in need is increasing. Furthermore, there are underserved populations such as the elderly, and unserved populations such as the homeless, the mentally ill in jails, the mentally ill in nursing homes, victims of crimes, etc., which represent thousands of persons, statewide, in need of mental health services, who do not receive them.

4. There is a need to clarify the mental health system's role in protecting society at large.
There has been a significant increase in the number of involuntary hospital admissions; the CSH Forensic Unit is severely overcrowded; adolescent clients are increasingly in need of behavior control; and increasing numbers of both hospital and CMH clients are being released to correctional facilities. Society's view of the role and nature of public mental health treatment appears to be changing.

5. The public mental health service delivery system should increase its responsiveness to outside input.
In order to be effective, the public mental health service delivery system must increase its responsiveness to outside input from client advocates,

families, and friends as well as from other agencies in both the public and private sectors.

6. Need to improve coordination of planning, budgeting, and service delivery linkages between systems, especially at the local level, and to clarify the responsibility of the public mental health service delivery sector.
There is a need to define the scope of responsibility of the public sector mental health system in relation to the private sector and to other public and private human services systems. Specialized services are needed for the multi/dual-diagnosed and for "intersystem" youths, which cross the boundaries between systems, and better coordination is needed between all systems to improve services for all clients.

7. There is no continuum of services for children and adolescents, particularly around residential programs.
The severity of adolescent clients admitted to the hospitals has increased significantly. Few community residential placements and services exist for these seriously disturbed young clients either as alternatives to hospitalization or to meet post-hospitalization needs.

8. Mental health treatment facilities and equipment are deteriorated, and there is not enough space for privacy of treatment in many community mental health centers.
Long-term underfunding of controlled maintenance for hospitals and CMHC's has resulted in substantial deterioration of facilities, some beyond repair. Many CMHC's need to move to more adequate facilities. There are immediate capital construction needs for the state hospitals. FLMHC projects the need for additional inpatient building space by 1990. CSH needs to construct a new power plant, renovate Geriatrics East and West, and modernize the Pharmacy. Unfunded capital equipment needs for the hospitals approximate $1 million this year, in addition to the need for a feasibility study of CSH General Hospital Services to determine whether an additional $852,000 in capital outlay funds that are needed should even be requested.

9. Staff salaries are too low, systemwide, and there are substantial personal services funding deficiencies in the state hospital budgets.
Inadequate salaries have caused CMHC's to have problems in the recruitment and retention of all staff. They have caused the hospitals the same problems with physicians and psychiatrists, and have resulted in a crisis situation wherein the hospitals are unable to recruit and retain enough Registered Nurses. Furthermore, non-funded personnel costs in the hospital budgets such as for retirement, vacancy savings below the assessed rate, and lost time due to workers' compensation claims diminish funds available to maintain the workforce.

10. Severe overcrowding in the state hospitals indicates a statewide shortage of public mental health inpatient resources.
The two state hospitals together have been operating at 97% of bed capacity since last year, with some divisions operating at over 100% capacity. The most critical overcrowding is in the FLMHC Children/Adolescent Division and the CSH Forensic Division. Due to the shortage of beds, CMHC's are unable to access the public inpatient resources that they need.

11. The Division of Mental Health's information systems and ADP resources are still in need of further development.
The ADP resource needs consist primarily of policy-setting and systems coordination from the Department level; programmer and systems analyst resources for maintaining and accessing existing mainframe systems, designing and developing new micro and mainframe systems; mainframe-mainframe, micro-mainframe, and micro-micro communication networks; and staff training for DMH users.

CHAPTER 2

SITUATION ANALYSIS

Introduction

The following Situation Analysis involves evaluations of external influences and internal capabilities which are likely to have a significant influence on DMH's ability to provide statewide public mental health services. The analysis of external influences establishes the nature of the environment in which DMH will operate and the size and needs of the target population. The analysis of internal capabilities is an evaluation of the ability of DMH to service the target population needs and to respond effectively to other influences from the community, the political systems, other areas of human services and other parts of the Department of Institutions.

The outcome of the Situation Analysis is a systemwide picture of the needs that must be satisfied, which leads to the identification of problems and opportunities in the service delivery areas which should be addressed by DMH. This problem/opportunity analysis is the subject of Chapter 3. It is followed by a list of all figures and tables, and by an index which lists the topics covered in this document. The Situation Analysis which is the subject of the present chapter, is divided into the following main elements:

1. Target Population: A description and analysis of the size and characteristics of the target client population served by DMH, including comments on conditions or trends which affect this group and any major impact such matters could have on DMH's ability to render services.

2. Main Services Rendered: A description of the principal types of care given to the target client population and an identification of issues which arise around providing these services.

3. Facilities Resources: A description and analysis of the types and conditions of facilities currently in use in the mental health system, including comments on their adequacy to support the services rendered.

4. Staffing Resources: A description and analysis of the numbers and qualifications of personnel currently working in the mental health system, including comments on their adequacy to provide the services needed.

5. Source of Funds: A description and analysis of the major sources and levels of funds available to render services, including comments on the adequacy of existing funds.

6. Post-Institutional Placement: A description and analysis of the alternatives available to clients who have been released from care with particular attention to the number and percentages of the total who are transferred to less and more restrictive environments.

7. Information Systems/ADP Resources: A description and analysis of the issues relative to DMH information systems and ADP needs.

8. Summary Analysis of External Influences: A description and analysis of external influences which present threats or opportunities to DMH.

9. Comparison of Actual Results to Management Plan: A report on any deviations from this present year's DMH Management Plan objectives or budget.

Since parts of the following Situation Analysis are based heavily upon Situation Analyses and Problem Lists generated by the two state hospitals and the 23 community mental health centers and clinics,* those documents will be referenced where appropriate. All division-wide client data was generated by the DMH Evaluation Services Section from its automated, integrated client database. The DMH Management Services section provided funding and staffing data, and the two state hospitals provided hospital-specific data from their respective automated management information systems. The section on Information Systems/ADP Resources is drawn from the DMH ADP Plan written by the DMH Evaluation Services Section.

*Hereinafter referred to as CMHC's.

Target Population

Population in Need

The Division of Mental Health targets its services to persons who are chronically, critically, and seriously mentally ill. In order to estimate the number of target persons in need of mental health services, DMH uses a statistical needs assessment model. This model applies age-specific national mental illness prevalence rates to age-specific Colorado general population figures. The model then adjusts these first estimates by the prevalence in Colorado of six social problem factors that have been shown to relate strongly to the need for mental health services. These factors, referred to as social indicators, are: 1) suicide rate per 100,000 population, 2) abuse and neglect reports per 100,000 children and adolescents, 3) divorce rate per 1,000 married couples, 4) percent minority population, 5) percent population in poverty, and 6) percent labor force unemployed.

As a framework for the following analysis, it should be noted that, based on the 1984 Colorado general population figure of 3,182,236 persons (Demographic Section, Colorado Division Local Government) the DMH needs assessment model estimates 230,725 persons, or 7% of the general population to be in need of mental health services. Myers et al. (1984) recently reported mental illness prevalence rates for adults in New Haven, Baltimore, and St. Louis of 13%, 13%, and 12%, respectively. Since Colorado's use of social indicator data accounts for urban differences, these outside data show Colorado's needs assessment model as providing lower, more conservative estimates of population in need.

The application of the DMH needs assessment model to Colorado general population figures results in the estimates and projections of the numbers of chronically, critically, and seriously mentally ill persons in need of mental health services provided in Table 1, page 69. For the past 3 years there have been increases in the population in need in all age groups, with an overall increase of 5%, or 10,982 persons in need of mental health services between FY 1982-83 and this year. Projections for the next two years indicate that the total population in need will continue to increase, by an additional 5%, or 12,089 persons, by FY 1986-87.

Given the limitations of public resources, it is fortunate that mental health service delivery is one area where the private sector shares in meeting the statewide need for services. A private sector survey done by DMH in collaboration with the Mental Health Association of Colorado (Thompson, Grosser, and Coates, 1980) estimated that the number of moderate to severely impaired clients served annually by the private sector was between 36,000 and 54,000. Keeping in mind that these data describe the situation five years ago, the higher estimate (assuming growth in private resources) could be applied to the population in need figure for last year (see Tables 1 and 2, page 69) to estimate that the private sector may be serving approximately 24% of the population in need. As table 2 shows, the public mental health sector served 30% of the population in need.

Although these overall figures do not control for duplication of service delivery by both private and public mental health providers, it is helpful to know that as much as half of the statewide mental health service needs may be getting met. Further analysis on more current data is needed in order ultimately to define the extent of the public mental health system's responsibility in meeting the statewide needs for mental health services.

Clients Served

Clients served are the number of open cases at the start of a fiscal year plus all admissions during that fiscal year. Table 2, page 69, shows the number of clients served by DMH last year, this year, and as projected for FY 1986-87 compared to the numbers of persons in need. These data show a decreasing trend in the total numbers served. It is projected that DMH will serve only 60,000 clients in FY 1986-87, which is 6% less than this year, and 12% less than last year. Since the population in need has been increasing, it is obvious that DMH is serving a decreasing percentage of the population in need, such that by FY 1986-87, DMH will serve only one-quarter of the persons in need of mental health services. The reasons for this, which will be illustrated under the following headings, are that the system is being called upon to serve an increasingly disabled client population which requires longer lengths of stay and more resources to treat.

Table 3, page 70, illustrates that the distributions of clients served by ethnicity, sex, and age are stable over time. The largest percentages of clients are Anglo (79%) and adults (70%). It is necessary to look at Table 4, page 71, however, to analyze the differential rates at which these clients are served. These data in Table 4 control for the general population prevalence rates of these demographics so that their prevalence rates in the DMH client population can be compared. They show that services to adolescents have increased such that they are served at a higher rate than any other age group, and that adolescents and adults are served at over twice the rate of children and elderly. National data generally show lower prevalence rates for children, so their lower rate of service may be based on lower need. However, the elderly are generally shown to have the highest prevalence of mental illness, so the elderly constitute an underserved population in Colorado.

The bottom portion of Table 4 shows that services to all minorities have increased (Hispanics stayed essentially the same) since FY 1980-81, with the greatest increase in services to Asians. This increase is consistent with DMH's funding in FY 1981-82 of the Asian Pacific Specialty Clinic. Most importantly, these data show that all minorities are now served by DMH at a higher rate than Whites.

As a final descriptor of general characteristics of the clients served by DMH, which also has remained stable over time, Table 5, pages 72 and 73 lists the most recent data on numbers and percentages of open cases by admission diagnostic category. These data show that the highest single percentage of community center clients (31.3%) are diagnosed as "adjustment disorders." The highest single percentages of hospital clients (CSH = 45.8%; FLMCH = 41.7%) are diagnosed as "schizophrenia."

Changes in the Target Population

Two major changes have occurred in the DMH client population which have serious implications for service delivery. The first of these is that the number of clients admitted on an involuntary status has increased. Table 6, page 74 shows that in FY 1979-80, 13% of admissions were involuntary. Four years later, in FY 1983-84, 19%, or almost 2,000 more clients were admitted on involuntary status.

The implications of this are that: 1) The mental health system must accept these admissions in place of other clients who are often needier and would accept treatment voluntarily, and 2) These involuntary clients are often resistive to treatment and require or are mandated to have longer lengths of stay, resulting in service delivery of low effectiveness and high cost-to-benefit ratios for the public mental health system.

This is particularly true of the hospitals. FLMHC admitted 72% of its clients on involuntary status in FY 1983-84. Figure 10, page 75, shows the increase in involuntary admissions to FLMHC since FY 1979-80 by division. "Many clinicians see the number of involuntary admissions as evidence of the role of Fort Logan as primarily a social control agency and, secondarily, a treatment agency. In terms of actual impact on services, the number of involuntary admissions increases diagnostic, assessment and accompanying paperwork requirements, especially for the Adult Admission Team which accepts 68% of all admissions to the hospital." (FLMHC Situation Analysis, p. 5)

Colorado State Hospital, where 91% of the patients are involuntary (DMH Orchid Report, Number 34), manifests this problem in the severe overcrowding of the Institute of Forensic Psychiatry, where all patients are involuntary. This problem will be discussed in more detail later under client workload issues.

The second major change in the DMH client population is that the young adults admitted to the system are significantly more severely disabled than in the past. Figure 11, page 76, graphs the admission level of dysfunction scores of young adults (age 18-40) who were admitted to the mental health system over the past five years. The increasing trend, which was shown to be statistically significant using a one-way analysis of variance, $p < .01$, shows that these clients are more dysfunctional than previously and therefore in need of more treatment resources.

The FLMHC Situtation Analysis addresses this problem as follows: "With the general population increase, the hospital is expected to see a concomitant increase in the numbers of the Young Adult Chronic Patients. This patient group has recently been described in the literature (Pepper, et al., 1982) as typically having the following characteristics:

-- Male, 18-35 years of age
-- have legal problems
-- have substance abuse problems
-- deny illness and medications
-- have significant social and living skills deficits
-- are sometimes violent, hostile and act out

...Young adult chronic patients use the psychiatric service system in a revolving door manner and move from one facility to another. These individuals have been described as being in a state of disequalibrium because they cannot adapt to the community and will not [voluntarily] remain in the hospital.

...In summary, this population group represents an emerging problem for Fort Logan as well as the CMHC's in the Denver area. Proven methods of treating this group are not readily at hand." (pp. 1-2)

Young adults, age 18-40, comprised 57% of all admissions to DMH in FY 1983-84 (special data run, DMH Evaluation Services Section).

In addition to the increase in severity of the young adult client, which is a division-wide problem, FLMHC has experienced an increase in severity of adolescent patients. Again, the FLMHC Situation Analysis (pp. 3-4) states:

"Adolescent patients admitted show generally more disturbed behavior over the last five years according to the Colorado Client Assessment Record's (CCAR) level of functioning ratings. Personal behavior problems, socio-legal difficulties, and substance abuse problems show a large to moderate increase in frequency (1983-85 Colorado State Mental Health Plan). In addition, a recent analysis by DMH Evaluation staff identified six types of adolescent patients. These types and their proportions in the public mental health system are:

-- Mildly Dysfunctional (30%)
-- Personal Distress/Interpersonal Dysfunction (21%)
-- Victim of Violence/Abuse but Mildly Dysfunctional (12%)
-- Severe Overall Dysfunction with Child & Substance Abuse (10%)
-- Severe Overall Dysfunction without Substance or Child Abuse (13%)
-- Substance Abuse and Academic Problems Otherwise Mildly Dysfunctional (14%)

Weights for severity were assigned to each type, higher weights corresponding to greater severity. Proportions of each type, weighted for severity and averaged, provide an index of case mix severity which may be useful in determining the relative dysfunction level across sectors of the Colorado Mental Health System, as is illustrated in the following table:

Comparison of CMHC's CSH and FL
Adolescent Case Mix

FY '82-83 and '83-84 (through 2/84)

	Case Mix Severity Index	% Maximum Dysfunction	Case Mix Severity Index	% Maximum Dysfunction
CMHC's	2.38	40%	2.36	39%
CSH	3.84	64%	3.58	60%
FLMHC	4.20	70%	3.90	65%

The analysis clearly shows that the two state hospitals', and particularly Fort Logan's adolescent patient group is very dysfunctional (65%-70% of maximum)."

Length of Stay

One systemwide result of the increases in involuntary admissions and in the severity of adolescents and young adults is an increase in average lengths of stay for clients in the hospitals. Table 7, page 77, shows the median lengths of stay (LOS) for currently enrolled clients by division. Lengths of stay have increased for adults (CSH: +43%, FLMHC: +8%) and elderly (CSH: +91%, FLMHC: +38%) at both hospitals, and by 55% for children/adolescents at FLMHC.

Community Center Target Population Issues

Several CMHC's, in their "Problem Lists" submitted to DMH, noted that increases in indigent and unemployed clients have added burdens to their budgets. One center indicated an increase in the number and severity of partial hospitalization clients as also requiring more resources for longer lengths-of-stay and for evening programming. One other center specified the problem of providing services in a resort area which has high seasonal fluctuations in the population-in-need. The majority of CMHC issues, however, were tied to areas other than target population changes.

Mentally Ill Persons Outside of the Mental Health System

Five target populations exist outside of the mental health system which should be considered as potential clients of the system. These are the mentally ill in jails, the "intersystem" youths, the dual/multi-diagnosed, the mentally ill in nursing homes, and the homeless mentally ill.

Mentally Ill in Jails

The National Coalition for Jail Reform (undated pamplet) estimates that of the 6.2 million persons jailed annually, nationwide, 10% or 600,000 are mentally ill persons in need of treatment. A 1981 survey (Denver Anti-Crime Council) of just the Denver County Jail revealed that 662 inmates per year were characterized by the jailers as mentally ill. Of these 459, or 69% were charged with only minor ordinance violations typically involving nothing more than nuisance behavior. The substantial numbers involved require that this issue be addressed by both the correctional and mental health systems.

"Intersystem" Youths

"Intersystem" youths are clients of the juvenile correctional (DYS), social services (DSS), and mental health systems (DMH), who do not always fall neatly into the differing types of services which each of these State systems provides, or get referred immediately into the most appropriate of the three systems. In other words, their problems cross the boundaries of these systems, and the result is that they are inappropriately placed, passed back and forth between the systems, repeatedly returned to one of the systems, or fall through the cracks between each of the three systems. These juveniles are mainly multi-problem youths who are simultaneously involved in legal, family and personal problems. They have been referred to as "intersystem" youths, or the "grey-area youths."

A survey of the juveniles who received involuntary out-of-home placement services from DSS, DMH, and DYS this past year (Wilderman, 1984) revealed that 517 of them were judged by professional staff to be inappropriate for the system in which they were placed. These "grey-area youths" were characterized by DMH and DYS as having high prevalence of such problems as suicidal tendencies, runaway, substance abuse, serious behavior disorders, had been abused or were repeated failures within the same system. They were characterized by DSS professional staff as being inappropriate for any existing DSS placement and therefore frequently passed between DSS, DMH and DYS.

The best that each system can and does do with these youths is to provide them with existing services within their systems until which time the youths can be returned home or a more appropriate placement can be found. Neither option addresses the multiple serious nature of the needs that these youths have.

Dual/Multi-Diagnosed

Although no statewide data exist on the number of dual/multi-diagnosed persons, much attention has been paid to the difficulties this population poses for service delivery systems. No one system, including mental health, can adequately meet the needs of these clients. Thus, while their numbers may not be great, they pose a significant problem to both hospitals and CMHC's in the mental health service delivery system.

Mentally Ill in Nursing Homes

It has been estimated that there are between 1,350 and 1,750 mentally ill persons residing in nursing homes statewide (Grosser, 1981). For many years, due to inadequate alternatives, the mental health system has been using nursing homes as intensive treatment facilities for clients who need 24-hour supervision, but "less than" mental hospital inpatient treatment. However,

nursing homes are intended for persons with medical problems and therefore they provide 24-hour medical staff coverage which is much more expensive and different from the 24-hour mental health staff coverage that these mentally ill clients need. Specifically, the Grosser (1981) study found that ..."40% of the chronically mentally ill residing in nursing homes have no medical or physical care needs requiring nursing home placement" (p. 1). Grosser's data showed that between 540 and 700 mentally ill persons are misplaced in nursing homes statewide and not receiving the mental health services they need, due to the mental health system's lack of appropriate supervised residential facilities. The potential closing of some nursing homes, if recently discussed regulation changes are legislated, lends further emphasis to this issue.

The Homeless Mentally Ill

National estimates are that between 25% and 50% of homeless persons are mentally ill (The Homeless Mentally Ill, 1984). Although no statewide figures are available, the Colorado Coalition for the Homeless estimates that there are from 3,000 to 3,500 homeless in the Denver metro area alone, and that of these, approximately 30%, or around 1,000 are chronically mentally ill. The 762 shelter beds in Denver which serve this entire homeless population are always full. With the additional needs of other urban areas in the State, it is clear that the residential and service needs of the homeless mentally ill are substantial.

Client Workload

Another way of analyzing DMH's target population is to examine the workload it creates for the mental health system. Many of the target population changes result in workload changes; conversely, many workload issues are barriers to the system's addressing target population changes and needs. Therefore, the following addresses client workload issues in each of the three major components of the mental health system.

The 23 CMHC's contract with DMH for the numbers of clients they will serve by age, ethnicity, chronicity, and severity. Table 8, page 78, shows that while last year the CMHC's, together, met their contract obligations, this year they are 6% or 2,304 clients below their projections at mid year. It should be noted that these totals include great variation between the CMHC's, with a few large centers that exceed their contracts carrying several others which are far below their projections.

The majority of CMHC's (14) in their Problem Lists stated that a lack of sufficient funding levels in face of the increased needs of their target populations has made it difficult, if not impossible, even to maintain previous service levels.

Fort Logan Mental Health Center (FLMHC), the state hospital located in Denver, likewise is projected to serve fewer clients this year than last year. Table

9, page 79 estimates that the hospital will serve 12%, or 144, fewer clients this year while still maintaining the same high bed occupancy rate (90% last year; 91% this year).

Colorado State Hospital (CSH), in Pueblo, has served an increased number of clients since FY 1983-84. As Table 10, page 80 shows, this is due to sharp rises in the numbers of child/adolescent and forensic clients, respectively. This has resulted in the Child/Adolescent Division being at or over capacity and the Institute for Forensic Psychiatry being severely overcrowded (see Table 11, page 81). The Forensic Institute is currently operating at 102% of bed capacity.

Main Services Rendered

Introduction

The two state hospitals and the 23 community mental health centers and clinics (CMHC's) together provide an integrated statewide network of services for the mentally ill. DMH has divided the State into 20 catchment areas and funds a community mental health center in each of these areas to provide services to persons who reside in that geographic area. In addition, DMH funds 3 specialty clinics (Childrens, Asian Pacific, Servicios) which serve clients from all areas of the State.

On a very generalized level, the hospitals provide back-up to the CMHC's for their clients who need intensive, inpatient care, and the CMHC's provide outpatient and community residential back-up services to the hospitals for all clients released back into the communities. In addition, the hospitals serve a substantial number of persons referred directly by the courts (85% of their total client population), and a small number of voluntary referrals which are from social services departments, the educational system, private medical and mental health professionals, and on personal referral (see Table 12, page 82). In contrast, the CMHC's obtain the majority of their referrals from these voluntary sources, with personal (49%) and medical/psychological (22%) referrals comprising the largest two sources (see Table 13, page 83).

Bed Allocation

The CMHC's refer clients to all divisions in the hospitals on an "as needed" basis. However, due to a geographically uneven and often too great demand on adult hospital beds, DMH in 1980 went to a bed allocation system for just this age group. Each CMHC is allocated a specific number of adult beds in the state hospitals according to an allocation formula statistically based on need. Centers work closely with hospital staff to manage this resource according to the CMHC's needs.

Although an evaluation study of the bed allocation system completed by DMH (Ellis, 1984) showed it to be successful in decreasing CMHC expenditures for non-state hospital inpatient care, increasing the numbers of adult clients served by FLMHC, increasing the appropriateness of adult clients served by CSH, and increasing the CMHC's control over their inpatient resources, several CMHC's in their Problem Lists specified a need for more beds than they were allocated. Workload data (DMH Management Services Section) also reveals slight underutilization of allocated beds for several other CMHC's. Thus, some fine tuning of the bed allocation formula is still needed.

Emergency Services

While the 2 state hospitals provide inpatient services to every CMHC, their location is too distant from all but a few CMHC's to meet emergency hospitalization needs. Thus the majority of centers must contract for this service from local hospitals and facilities, and in some areas these facilities do not exist. A number of CMHC's, in their Problem Lists, documented a lack of emergency service capability, either because no service was available or because the costs of such services were prohibitive.

Hospital Bed Capacities

Table 14, page 84 lists trends in state hospital bed occupancy rates for the past two years and for this year. The data show that the total number of public mental health inpatient hospital beds are at 97% of capacity this year which is the same as last year and up from 95% of two years ago. Most problematical at FLMHC is the increased and high occupancy rate, approaching 100%, of the adolescent beds. The FLMHC Situation Analysis, pages 6-7, states:

"The level of demand for adolescent inpatient beds by the Juvenile Courts, department of Social Services, Division of Youth Services and the thirteen Community Mental Health Centers in the FLMHC service area exceeds the resources represented by Fort Logan's 61 adolescent beds. The three existing adolescent treatment teams have averaged a 97% bed occupancy in FY '83-84 with the locked unit showing a 101% average occupancy. Although there is no single method for determining ideal occupancy rate, an 85-90% occupancy is considered the standard range for adolescent psychiatric facilities.

The adolescent teams have consistently had a waiting list for admissions over the last 2 1/2 years. Fort Logan's admission office routinely receives 8-12 inquiries monthly from Community Mental Health Centers and Social Services Departments who want to refer specific patients but do not because of the long expected wait for admission. A poll of CMHC's was conducted in August, 1984 by FLMHC's Admissions Office to determine the specific CMHC adolescent patients who would be referred for inpatient care if beds were available. The results were as follows:

Patients Needing Admission: 49 (32 need an open treatment unit and 17 would require a locked unit)

Fort Logan has pursued a formal budget request through the Division of Mental Health and the Department of Institutions in order to increase adolescent inpatient bed resources." The Joint Budget Committee and Legislature has approved DMH's request for a new 22-bed locked adolescent unit at FLMHC for FY 1985-86.

The Child/Adolescent Division at CSH is likewise just under 100% capacity, an average which masks the fact that its capacity has, for many individual months, been over 100%. However, even more problematical for CSH is the severe overcrowding of the Forensic Division, which averaged 102% occupancy last year and is maintaining that same level this year.

However, aside from the FLMHC Adolescent Unit, no new hospital beds are being requested. It is the public mental health system's desire that the hospital overcrowding be relieved by the development of community beds, as described in the following section.

Community Residential Alternatives

One of the most long-standing, widespread, and highest needs in the mental health system has been for community residential alternatives to hospitalization. Many of the chronically mentally ill do not get cured;

rather they spend a large portion of their lives in need of long-term care which includes episodes of hospitalization, moderated by various intensities of community supervision and day treatment services.

A significant, critical link in the continuum of care for the chronically mentally ill is the development of a continuum of residential alternatives. This continuum includes alternatives to hospitalization as well as alternatives to nursing home care. These alternatives are needed to fill the gaps which currently exist for the chronically mentally ill who were previously institutionalized. These alternatives are needed to complement boarding homes and other independent living situations which are also needed but do not provide sufficient structure or supervision for many persons whose functioning levels demand a more constant program of care. Without such structure and supervision, these individuals during episodes of problem behavior often become disruptive and are placed in jails, since Law Enforcement staff have nowhere else to take them.

As of June 30, 1983, DMH had open cases on 6,222 chronically mentally ill clients age 18+. Clinical data collected on these clients showed that although 1,374 were placed in inpatient or nursing home settings, 160, or 12% could have been placed in appropriate residential alternatives in the community if these were available. On the other hand, the data showed that of the 4,184 chronic patients placed in boarding homes or independent living situations, 160 or 4% were in need of more structured residential alternatives. Add to this the number of adult mentally ill who are placed in jails (459 per year in Denver alone), and it is obvious that there is a need for over 700 units of housing throughout the residential alternative continuum.

State and local funds currently support 231 units of housing/residential care in the community, and federal HUD funds provide an additional 327 units, for a total of 558 systemwide which are available to public mental health clients. However, based on the CMHC's Problem Lists which have identified the shortage of community residential facilities and alternatives for the chronically mentally ill and other special client groups (particularly children/adolescents) as their third highest problem, the need substantially exceeds the current availability of such placements.

Medical Screening

The results of several recent research projects suggest that an important proportion of mentally ill individuals may be suffering from a physical illness that either causes or exacerbates their mental illness. While the research consistently indicates that some proportion of the mentally ill suffer from these undiagnosed physical illness, the estimates of this proportion vary widely from study to study.

In order to estimate this proportion in the Colorado Mental Healath System, the Division of Mental Health in conjunction with the School of Nursing at the University of Colorado Health Sciences Center and two Community Mental Health Centers is conducting a study. In this study 175 mental health clients are receiving a physical examination from a nurse practitioner, completing a health history and providing blood and urine specimens for analysis. Following the collection of these data by the practitioner, a physician from

the School of Medicine reviews the practitioner's findings, recommending follow-up evaluation of those clients showing signs of physical illness.

In addition to the screened clients, a contrast group of clients also has been included to estimate the proportion of physical illnesses that would be discovered through routine mental health treatment. These clients may be employed to assess the treatment outcomes associated with the medical screening procedure. The Colorado Medical Screening project, therefore, will yield important information regarding the health status of mental health clients and how their physical health relates to their emotional well being.

Facilities Resources

One of the highest priorities of the Department of Institutions is to address the poor condition of a large number of its facilities throughout the three divisions. Although the main areas of concern in DMH are the two state hospitals, it should be noted that many CMHC's, through their planning process, for the past two years have highlighted the problem of insufficient program and office space. This has taken the form of clinicians being forced to provide therapy in offices that must be shared with other clinical or non-clinical staff and thus interfering with therapeutic needs for privacy. CMHC's further state in their Problem Lists that this issue relates to inadequate maintenance funding and the inability to replace, restore, or expand old or outgrown facilities.

The main issues regarding FLMHC's facilities as taken from their Situation Analysis, pp. 12-14, are:

"Space Requirements on Present Locked Units and for Future Locked Treatment Programs Exceeds Available Square Footage.

The main Fort Logan facilities were designed and constructed in the 1960's to create an open therapeutic community for treatment of relatively high functioning mentally ill persons. It was assumed that most patients would reside off campus, but would attend therapy groups and social-recreational, independent living, and vocational skills classes and workshops on the Fort Logan grounds during the day. The treatment units themselves were designed to be primarily overnight residences for only a portion of the total client population. They were not to be the site of many treatment programs or treatment staff offices; treatment staff offices were located throughout the central campus in proximity to their specialized treatment areas.

Patients were expected to cooperate with treatment on a voluntary basis; they certainly were expected to behave in a non-dangerous fashion. Accordingly, security and protection features were not included in the facilities design or staffing pattern. Units were not locked and staff were not hired or trained in the management of assaultive behavior or the daily care of gravely disabled persons.

The actual use of Fort Logan facilities departed, quite dramatically, from the designated purpose in the mid-1970's when many of the hospital treatment units were locked. This change appears to have reflected not only a general shift in society's attitude toward the mentally ill (decreased tolerance and increased fearfulness), but also a shift in the role that Fort Logan was to serve in the State's mental health delivery system. In the early 1970's the metropolitan Denver area mental health centers were assigned the role of providing treatment services for the great majority of the mentally ill. Patients who previously were the core of the Fort Logan population were now to be treated by the community mental health centers; patients who previously were excluded from treatment at Fort Logan or were transferred to the Colorado State Hospital became the core of the population for Fort Logan. The result in the [FLMHC] facilities use was that treatment units that had been designed for limited use as bedroom complexes on a short-term basis became the principal space for 24-hour residence for patients that were often here on a long-term basis. Bedroom space generally complies with licensing standards but common areas, therapeutic activities, office space and educational program

space is inadequate. Specific examples of space inadequacies [at FLMHC] include:

* The Colorado Department of Education has cited the inadequacy of the classroom space on [FLMHC] Adolescent II in their December, 1983 on-site visit.

* The dining area on [FLMHC] Adult I lacks adequate space according to a specific recommendation of the JCAH surveyors in August, 1984.

This brief history [of FLMHC] applies not just to the adult programs; it will yet be realized for children/adolescent and geriatric programs. This trend can be expected to be repeated for them in the near future. The adolescent units have experienced a chronic shortage of locked beds... The planning process for the proposed locked adolescent unit has pointed out that space which is safe and cost-effective for locked inpatient care at Fort Logan has been exhausted and new locked inpatient programs subsequent to the new adolescent unit will require new construction.

The single geriatric unit at Fort Logan is a locked admission unit. It is unknown whether there will be mandate in the near future for a locked facility for organic brain syndrome patients. The primary role for Fort Logan Mental Health Center now, and increasingly in the future, then, is to provide moderate-to-highly secure and protective treatment settings for intermediate to-long-term psychiatric patients of all ages...

Long-Range Facilities Planning Continues

Because of the increasing demands for inpatient, office and other functional areas, [FLMHC] is currently developing a long-range space utilization plan for existing, remodeled and/or new hospital facilities through 1995. [This is due to be completed by June 30, 1985]."

[To date, this facilities planning process has specified that] the need for locked treatment settings is expected to go beyond the proposed locked adolescent unit slated to open in '85-86. The planning process for the proposed unit has pointed out that the space suitable for locked inpatient care has been exhausted. Current inpatient use patterns would dictate a new locked adult unit in 1990, an adolescent locked unit in 1995 and a geriatric unit in 2005. This expected growth would indicate the need for a new building within the next five years.

Controlled Maintenance Funds are Inadequate to Keep Buildings in Good Condition.

Fort Logan is fortunate in having a fairly new physical plant (20 years old) so that [Fort Logan has] been able to "get by" when controlled maintenance funds are insufficient. Appropriations for controlled maintenance of buildings and mechanical equipment have historically been insufficient to complete all necessary repairs. The following analysis of controlled maintenance requests and appropriations illustrates the problem of increasing needs (as indicated by requested amount) and decreasing resources.

FLMHC Controlled Maintenance Requests/Appropriations
1979 - 1985

Year	Amount Requested	Amount Funded	% Funded
FY '79-80	$ 6,300	$ 6,300	100%
'80-81	35,000	3,300	9%
'81-82	464,600	302,000	65%
'82-83	194,100	194,000	100%
'83-84	527,500	47,106	9%
'84-85	1,299,000	114,170	9%
Total	$2,526,500	$666,976	26%

Historical underfunding has produced the following problems:

1. More expensive repairs are incurred when a maintenance problem is allowed to become an emergency condition. Disruption of services is often the result of emergency repairs.

2. Routine repairs if not made in a timely fashion will prove the age-old adage of "a stitch in time saves nine." For example, a leaking roof will cause interior ceiling and wall damage if left unattended.

3. Worsening building conditions will become a burden when JCAH's new (and more stringent) consolidated standards are used at Fort Logan's next accreditation survey.

4. The conditions of the living units provoke negative community reactions and project an inconsistent commitment to the care and treatment of the mentally ill.

A Critical situation is predictable within the next five years if controlled maintenance monies are not appropriated at the requested level. This is a situation that is common to state buildings in general and institutions in particular and requires long-term solutions before the buildings are beyond repair."

The main issues regarding CSH's facilities as taken from their Situation Analysis, pages 12-14, and 8-9 are:

Controlled Maintenance Funds Inadequate

"...Many years of underfinancing [controlled maintenance] requests have taken their toll on [CSH] facilities and grounds at an ever increasing and alarming rate. The litany of woes is endless: ceilings falling in on therapy rooms, rain pouring onto wards and offices, large chuck holes in roadways, etc. [CSH] will soon have to evacuate buildings unless large sums for repairs are forthcoming.

In fiscal year 1984-85, $926,543 was requested and documented. No dollars were authorized. $1,256,659 has been requested for fiscal year 1985-86 and the Governor's recommended funding line allows only $68,000 of that amount...

Capital Construction Needs

Power Plant: A capital request for $7,726,750 has been made for construction of a new, coal fired, power plant. This project is currently under concept design. Additional funds in an amount of $387,000 have been previously appropriated to complete the design. A Capital request of $7.7 million has been made for fiscal year 1985-86 for construction of the New Power Plant. This request has been approved for Fiscal Year 1985-86.

Ward Renovation: Ten patient wards in Buildings #120 and #121 are in violation of the Life Safety Code (NFPA 101), Section 13-3.6, in that there are no fire rated doors or corridor partitions in any of these wards. The recent Joint Commission on the Accreditation of Hospitals survey team has commented that this serious code violation in patient occupied areas should be corrected to maintain compliance with their established standards. Essential remedial action, which includes modifying heating and ventilation for the enclosure, is estimated to cost approximately $10,000 per ward, or $100,000.

Forensic Medium Security Building: The need for a new [CSH] Forensic Medium Security Building to replace the existing one has been well documented [by the severe overcrowding] of the Forensic Institute [and by the poor condition and inappropriate design of the building currently in use]. $390,298 has been requested in the fiscal year 1985-86 Capital Construction Budget for architectural design services...

Other Facility Needs: Very severe facilities problems for the [CSH] clincial programs have been identified by the Child and Adolescent Treatment Center and the Geriatric Treatment Center. Hospital Administration believes strongly that those problems must be resolved. During the next few months [CSH will] develop the necessary decisions about the clinical program requirements for the amount and configuration of space. In next year's Situation Analysis [CSH will] present funding [needs] for architectural design for rennovation and/or replacement of these facilities.

Capital Equipment Needs

The Colorado State Hospital was allocated approximately $250,000 for Capital Outlay items during fiscal year 1984-1985 which did not meet the total ongoing needs of the hospital. [CSH] estimates that the clinical divisions, including the necessary significant increase for the Institute for Forensic Psychiatry, need $250,000 to maintain a therapeutic environment and meet patient needs. An additional $250,000 is needed for new equipment for the Nutrition Services Department, Warehouse, Plant Operations, Automated Data Processing, the Pharmacy, and the General Hospital.

CSH General Hospital Services

"The original and inherent mission of [CSH] General Hospital Services is to care for the medical needs of Colorado State Hospital patients who once numbered over 6,000. When this size was radically reduced through deinstitutionalization, the problem of underutilization of the General Hospital Services inpatient and operating room capacities was addressed by adding a statutory responsibility to serve residents of other state institutions... At this time, the issue of cost-effective utilization is combined with rapidly increasing needs for additional resources, principally in capital equipment.

With usage going down and operating needs and costs going up, there must be a reexamination of the basic services provided. [CSH has] requested $30,000 for the fiscal year 1985-86 Budget for outside consultation to help... identify which services are needed and cost-effective and which could be contracted with private providers, given present workload and possible changes in future workload. The interrelatedness of inpatient services, clinic services, and the many support services of the General Hospital Services makes such a study extremely complex. At the same time, the urgent capital outlay needs of more than $850,000 cannot be prioritized or reformulated without some decision on the future services to be provided." The Legislature has approved the request for $30,000 for this study to be completed in FY 1985-86.

Staffing Resources

The Division of Mental Health, along with the other divisions in the Department of Institutions, is one of the most labor intensive of all state agencies. The public mental health system funds a total of 1,851 full-time state employee positions and 1,286 full-time plus 301 part-time CMHC employees. Approximately 80% of the DMH budget is allocated to personal services. Given the large numbers and proportion of the budget involved, the following issues are of major importance within DMH.

Over half of the CMHC's ranked staff salaries within their top three problems in this year's Planning Process. Their issues are that staff salaries are not competitive with those for similar positions in the private sector or in the state hospitals, and that they are inadequate to recruit and retain qualified and experienced professional staff. In addition, several CMHC's noted problems with recruiting minority staff.

The following excerpts from CMHC Problem Lists document these issues:

"According to several recent reports (Colorado Mental Health Conference, 1984) mental health salaries are about 25% lower than comparable positions in other areas... The long term implications for continuing a low salary structure are: a) low morale, b) decrease in levels of service, and c) high turnover of professional staff." (Bethesda Mental Health Center).*

"The Center is currently faced with a distressing "turnover rate" among staff. It appears in excess of 40% for the period January 1, 1984-October 31, 1984. The concentration of these positions has been in the areas of administrative support (secretarial, billing), residential counselors (essential for staffing our residential adult and adolescent programs) and nursing positions which have become more critical with our increased emphasis on services to the Chronically Mentally Ill. Comparisons of salaries provided by the Mountain States Survey (comparing similar non-profit agencies in our community) and the Centers and Clinics Association show us to be 18-36% below market wage for various administrative support positions; 30-43% below for Registered Nurses; and 30% below for residential counselors. This disparity as well as others impact on our ability to maintain quality services and attract skilled staff to PPMHC. It is incumbent upon us to be innovative in the restructuring of Center programs to generate what we feel to be in excess of $500,000 in additional revenue to address this need within the next three years." (Pikes Peak Mental Health Center).

"It is becoming increasingly difficult to recruit minorities for open positions. Jobs are sometimes advertised two or even three consecutive times in a wide variety of places in an effort to find minorities for specific positions where specific bilingual skills are needed. Center salaries are well below those for comparable education and skills in the State civil service system and the local public schools. There are few incentives for making career commitments in the Center. There is no retirement plan beyond the possibility of one percent of an employee's salary being put into an annuity if the employee makes a matching contribution. Many staff cannot afford this." (Boulder Community Mental Health Center).

* Preliminary results of additional workforce data analysis by DMH indicate that this gap in salaries may be even greater than 25%.

"Jefferson County Mental Health Center, Inc., periodically conducts salary surveys for the purpose of evaluating its compensation program. The last survey was conducted in August, 1984. The salary survey method used was the benchmark approach, whereby certain common positions' salaries (benchmark positions, hence benchmark approach) are examined and compared. The salary comparisons were made by using the results of surveys conducted by six organizations. The results of the survey clearly indicate that the Center, and Colorado Community Mental Health Centers in general, rank significantly behind other employers in the Denver area as well as other geographic areas represented in the survey.

In addition, the Center conducts an exit interview with staff upon termination. Approximately 90% of all respondents indicate they feel salaries are low and/or they are dissatisfied with their salaries. The results of the salary survey and exit interviews indicate that salary scales within the Center need to be examined. However, increased salary costs could significantly impact the Center's unit costs for services unless the number of units of service (production) can be correspondingly increased. Therefore, as part of any salary increase, it is expected that an incentive system based on productivity measures will be implemented concurrently." (Jefferson County Mental Health Center, Inc.)

FLMHC likewise ranks staffing issues within the top three problems documented in their Situation Analysis. FLMHC's specific issues, as described on pages 15-16 of their Situation Analysis are:

"Effect of Vacancy Savings on Staffing

All hospital work units have routinely maintained a designated vacancy level in order to compensate for personnel costs which are not funded including: retirement, ...worker's compensation vacancies, and extended sick leave. Fort Logan has been in operation for 20 years and many of the employees are approaching retirement age. With the aging of the Fort Logan workforce, retirement costs have begun to climb... for the first six months of FY '84-85, $85,000 has been spent for retiring employee's sick and annual leave payoffs. Non-funded personnel costs have been the driving force behind recent years' vacancy savings requirements:

Year	Vacancy Savings %
FY '81-82	1.0%
'82-83	4.0%
'83-84	4.3%
'84-85	2.8%

Since most of the vacancies occur in the direct care units, it is the treatment teams which absorb most of the vacancy savings. This situation makes team coverage and rotation of shifts difficult despite what might appear to be adequate authorized staff...

Recruitment and Retention Problems Exist at Fort Logan for Registered Nurses (R.N.'s)

Recruitment of qualified (a minimum of one year of psychiatric experience) R.N.'s was largely unsuccessful in FY 1983-84. From 7/1/83 through 6/30/84

nursing applicants were tracked through the FLMHC recruitment procedure. Few experienced R.N.'s want to be interviewed after receiving information about our patient group, rotational schedules, the salaries and lack of advancement opportunities. Of the qualified applicants who did persist, 44% took positions in other facilities after their Fort Logan interview. Therefore, last year Fort Logan was only able to hire 9 experienced psychiatric nurses into its 31 vacancies. The other positions had to be down-graded to the inexperienced R.N. 1-A level. Given that Fort Logan Staff Nurse salary was between $2,100 and $3,600 lower than the salaries quoted for the Mountain Region (AHA, 1982), the salary levels cannot be dismissed as a factor. Of the full-time nurses who resigned from Fort Logan, 39% left to pursue advancement elsewhere. In FY '83-84, twice as many experienced, full-time nurses left Fort Logan as did inexperienced nurses; two-thirds of all full-time nurses that were hired as replacements were inexperienced. Overall turnover in the R.N. category (excluding Internal Pool Staff) was 29% in '83-84.

Fort Logan's Nursing Administration has been developing a nursing retention program and the Personnel Department has been evaluating its recruitment strategies in order to improve the recruitment of R.N.'s. However, most R.N.'s see the non-implementation of the Nursing Occupational Study as the main barrier to recruiting and retaining nurses.

The total cost of limited implementation of the proposed Nursing Classification System at Fort Logan is estimated at $46,548. The cost of filling one R.N. vacancy at Fort Logan is $5,626. Using this figure, the cost of turnover last year was $174,407. If, in FY '83-84, only the nurses who left for advancement opportunities had been retained, the preceding figure could have been reduced by $68,019. The savings would have been more than the cost of limited implementation of the new, expanded series.

> [The Fort Logan Situation Analysis excerpted this from a report by Diane Igle, Nursing Service Administrator at Fort Logan, entitled "Implementation of the Nursing Series Occupational Study at Fort Logan."]

Based on these and similar difficulties experienced by other affected state departments and institutions of higher education, the Governor agreed to implement the new nursing classification system effective July 1, 1985. Thus, it is believed that this issue will be resolved over the coming year.

Recruitment and Retention of Physicians and Psychiatrists is Made More Difficult by Mandated Fiscal Restraints:

The turnover rates for the fourteen psychiatrist positions at Fort Logan was 27% in 1982-83 and 43% in 1983-84. Compensation continues to be the primary determinant of poor retention. For this reason, we are hoping that current initiatives to extend the salary scale will succeed during the current legislative session."

CSH also includes three specific staffing deficiencies among the problems identified in their Situation Analysis. These issues are described on pages 10-11 as follows:

"Registered Nurse Coverage:

Reviewing agencies such as Medicare have often recommended the addition of Registered Nurse positions to the hospital staffing pattern. The January, 1985, survey team of the Joint Commission on Accreditation of Hospitals verbally recommended that [CSH] have one Registered Nurse physically present on each ward, each shift, of every day to provide direct patient care and to supervise the paraprofessional nursing employees...Two positions are required to produce one nurse present throughout the year. By this means, then, 66 Registered Nurse positions are needed to be added to the staffing pattern to reach compliance...

Under an assumption of no new positions to be funded it might be possible to convert to 56 of the needed R.N. positions, over a period of three years, when Psychiatric Service Worker and Mental Health Worker vacancies occur through normal attrition. Even so modest an objective, however, would require an increase in personal services dollars in the amount of $7,000 to $10,000 per year, per position converted. Extensive recruiting and orientation would also be necessary to assure quality of care during the transition."

Child and Adolescent Treatment Center:

Of all the staffing deficiencies, [CSH] judges the needs of the Child and Adolescent Treatment Center to be the most critical at this time. The increasing admission work, the frequent overcrowding, the behavior and runaway problems, and the fragility and immaturity of the young patient combine to make staff shortages a critical issue on this division. The CSH Situation Analysis specifies needs for increased staffing of the child and Adolescent Treatment Center of 10 Registered Nurses, 2 Psychiatrists, 2 Clinical Therapists, and 1 clerical position.

"Retirement Pay:

During recent fiscal years, retirement costs for CSH employee vacation and sick leave have averaged $340,000 annually. These costs have had to be assumed as part of [CSH's] ongoing budget, which means that a replacement employee may not be hired until the retiring employee has exhausted vacation and sick leave benefits. This period of time may be excessive since many retiring employees have accumulated large amounts of sick leave and vacation time due to the fact that a significant number of employees exceed 25-30 years of service. At times this results in being unable to fill critical positions and adversely affects the proper functioning of the hospital. [CSH suggests]... that a separate appropriation to finance retirement pay be considered as a means to provide for the replacement of employees on an as-needed basis." (CSH Situation Analysis, p.26).

Workers' Compensation:

Over the last few years, escalating premium costs for workers' compensation insurance and increases in the numbers and size of claims have been statewide problems. In the past, payment of Worker's Compensation insurance premiums

had been centralized under the State's Department of Administration which, in turn, had authorized payment of premiums, audit adjustments, etc., to the Colorado State Compensation Fund. Essentially, due to non-involvement, the various state agencies in Colorado therefore had little to do with Workers' Compensation insurance.

In order to address the increasing costs for the Department of Institutions (DOI), the 1983 Session of the Colorado Legislature made a direct appropriation to DOI for management of Workers' Compensation. Although DOI's management of Workers' Compensation resulted in a $250,000 savings in FY 1983-84 and a $150,000 savings in the current year, DMH along with the other two divisions within DOI, is being impacted by high costs for Workers' Compensation and must continue efforts to reduce them. These costs are in the form of dollars to pay insurance premiums, as well as lost staff time which results from injuries sustained by the workforce.

Source of Funds

Following are the amounts and sources of funds for the Division of Mental Health for FY 1984-85:

DMH Central Office

General Funds	$ 603,123
Cash Funds (Block Grant and Medicaid Monitoring)	527,441
Federal Fund	94,420
Total	$ 1,224,984

State Hospitals

General Funds	$ 38,670,589
Patient Fees	18,714,085*
Payments from Other Agencies	3,217,207
Total	$ 60,601,881

Community Mental Health Centers & Clinics

General Funds	$ 17,035,371
Block Grant	3,771,818
Medicaid	9,633,253
Local	3,405,534
Patient Fees	6,269,329**
Other	2,268,114
Total	$ 42,383,419

*Comprised of $8,098,466 in 1st & 3rd party revenues plus Medicaid reimbursements.

**Comprised of $5,076,897 in 1st & 3rd party revenues plus Medicare reimbursements.

There are five main issues that relate to sources of funds:

Federal Funds Shortfall

The community mental health program began in the mid 1960's with the development of a State/Federal partnership concerning the provision of mental

health services in community settings. Under this program, the Federal Government established the community programs with "seed" money that declined in amount over time. The State Government assumed responsibility for the program by picking up the funding as the Federal portion declined. This is the program that was in effect in Colorado until the establishment of the block grants by the 1981 Federal Omnibus Reconciliation Act. The block grant awarded to Colorado reduced the funding level by approximately twenty-five percent. This shortfall was delayed through a Federal accounting adjustment until State Fiscal Year 1985-86.

Table 15, page 85 portrays the block grant expenditures from State Fiscal Year 81-82 through the projected State Fiscal Year 85-86. This analysis shows that in Fiscal Year 85-86 the Division will be short $532,479 in maintaining the current level of expenditures. This analysis also shows that there will be an additional shortfall of $285,962 in State Fiscal Year 86-87.

In Fiscal Year 84-85 the Division is spending the entire block grant award during the nine months, October 1 through June 30. This is being done in order to maintain current expenditures. This results in no funding from Federal sources being available on July 1, 1985 through September 30, 1985. This results in the shortfall of $532,479 after the roll forward balance of $285,962 is applied. Not having the roll forward of $285,962 available in Fiscal Year 86-87 results in the additional shortfall.

Therefore, DMH submitted a budget request to the Colorado Legislature for an increase in the General Fund appropriation to the CMHC's of $532,479 for FY 1985-86 to replace the Federal Funds shortfall. This request has been funded in full, but at the expense of a reduction in the requested cost-of-living increase for FY 1985-86.

Patient Fees

In both the hospitals and the CMHC's, for the past three years, patient fees from both first and third party payors has declined. These fees currently support 13% of the hospitals' and 12% of the CMHCs' budgets. The facts that private insurance is becoming more restrictive in coverage of mental health benefits, and the public mental health client population has fewer and fewer resources to pay, indicate that this decreasing trend will continue. Medicaid will likely pick up approximately half of this decline, but the eventual impact could be the loss of approximately half of the non-Medicaid patient fees, or an estimated $2 million of the hospitals' and $1 million of the CMHCs' budgets, necessitating cuts in services by those amounts.

Pueblo Regional Center Contract Changes

Approximately $3 million of the hospitals' budgets consist of payments from other agencies, and the one agency responsible for almost half of these payments is the Pueblo Regional Center (PRC). The Center currently contracts with CSH for food services, grounds and roads maintenance, pharmacy, and various inpatient and outpatient medical services.

The Pueblo Regional Center is currently embarking on a 4-year deinstitutionalization program which will of course decrease the Center's need for CSH services. This could result in reduced services to CSH clients because some of the PRC services are provided on the margin and could not be reduced without eliminating the service entirely. Negotiations are currently underway to facilitate the proper transfer of resources in such a way that CSH services will not be negatively impacted.

Federal Revenue Sharing

Approximately $2 million of the local (county and municipal) revenues going to CMHC's is federal revenue sharing dollars. If the current Reagan budget provision for the elimination of revenue sharing is passed, CMHC's would be impacted by an estimated shortfall of this amount, in addition to the federal funding shortfall discussed above.

CMHC Funding Levels

The CMHC's, in their Problem Lists, documented many concerns with present funding mechanisms. Their highest priority issue is that there is insufficient funding to maintain core services. Thus, in the face of an increasing population in need, which is more severely dysfunctional and therefore in need of more services than previously, and in the face of more attention being paid to underserved and unserved populations, the community providers are having difficulties even maintaining present service levels. The possible losses in funds, described above, would not only prevent meeting these increased needs but also make it even more difficult for CMHC's to meet the mental health systems most basic community service delivery needs.

Post-Institutional Placement

The following analysis addresses placement and treatment issues of clients discharged from CMHC's as well as from the two state hospitals. Tables 16 and 17 on pages 86 and 87 list the various alternatives available to clients released from care. These alternatives, in order of security/supervision, are: correctional facility, inpatient, nursing home, community intensive treatment facility, community residence, boarding home, HUD 202 housing, Section 8 housing, and other independent living situations. These alternatives comprise the mental health system's continuum of care. Overall, the data show that the majority of clients discharged from all components of the mental health system go to less restrictive environments.

For the hospitals (Table 16), 61% of clients discharged this year went to independent living situations, which represents an increase from 51% for the past 2 years. Although it is not possible to trace it in the data, this shift may have resulted from the decreasing percentage of clients discharged to community residences, due to these alternatives being filled with longer term patients and therefore not available to new placements. If this is true, then these clients are not receiving the level of supervision that they need in the community. Furthermore, data presented earlier on the inadequate number of existing supervised community residential alternatives impacts the hospitals' ability to discharge patients, thereby forcing the hospitals to hold clients longer and serve fewer individuals.

Also notable in Table 16 is an increase in the percentage of hospital clients who are discharged to correctional facilities (i.e., Dept. of Corrections, Division of Youth Services, and local Jails). This is consistent with admission data which shows an increase in the percentage of hospital clients referred from correctional facilities. These findings are both consistent with data presented earlier on the increasing needs of the mental health hospital client population for control and secure settings.

For the CMHC's (Table 17) there has only been a slight increase in the percentages of clients discharged to correctional facilities. The decrease in the percentages of clients discharged to inpatient is due to a policy change. Where previously the CMHC's would discharge a client when they admitted him/her to a state hospital, they now retain these clients on their caseloads until they are returned from the hospitals and complete their post institutional community treatment. All other trends in CMHC discharge placements are fairly stable, with the great majority of CMHC clients (89%) being discharged to independent living situations.

Tables 18 and 19 on pages 88 and 89 provide information on clients' employment status at discharge. Over half of the hospital clients (58% this year) are not even in the labor force, a statistic which represents an increase from 52% of hospital discharges who were not in the labor force two years ago. The percentages of CMHC clients not in the labor force have also increased, from 33% in FY 1982-83 to 37% this year (Table 19). These findings may be related to the increased chronicity and severity of the client popu- lation discussed earlier. The percentages of partand full-time employed CMHC discharges have remained stable at approximately 40%, which is much higher than hospital clients, of whom only approximately 8% are employed at dis- charge. Additional data and further analyses are needed to investigate the

possible relationship between the increased disability of the DMH client population and the increasing numbers not in the labor force at discharge. Additional data and further analysis are also needed to determine the impacts of current vocational and employment services and to project what services are needed to impact future clients' employment status at discharge.

A final descriptor of clients at discharge is their readmission rates. Table 20 on page 113 provides these data for the hospitals and the CMHC's for the past 5 years and for this year. The readmission rate for CMHC clients increased from FY 1979-80 to FY 1981-82 but then decreased such that this year it is 23% which is slightly below the FY 1979-80 rate of 24.5%. The readmission rate for hospital clients has fluctuated over these years from a high of 49.3% to a low of 43.2%. It is currently at 45.5% which is slightly higher than it has been for the past 3 years. Although there have been changes in the readmission rates, the trends have not been consistent and the variations do not appear to be significant.

Information Systems/ADP Resources

The Division of Mental Health has a long history of maintaining an extensive information system which is responsive to the needs of management for strategic planning, budget forecasting, program development and monitoring, public relations and information, and research and evaluation. The current system includes extensive client demographic and clinical data, service utilization information, financial and budget data, staffing data and limited agency descriptions.

The majority of the information is stored and maintained on one of two mainframes--a Univac at the DOI Computer Center (ICC) in Pueblo or on an IBM at the General Government Computer Center (GGCC) in Denver. While the number of systems being developed solely for microcomputers is limited at DMH's central office, this type of application is growing. The two state hospitals have a wide variety of micro systems which are internally developed, operated and maintained.

DMH's ability to expand, or even adequately maintain, the existing systems to meet ever growing demands for timely information is becoming increasingly problematic. Specifically, the current backlog of approved Requests for Data Processing Services will require an estimated 1660 hours of analyst and programmer time. This backlog grows weekly. Furthermore, the development of new systems must compete for resources with the maintenance of existing systems with the results that: 1) once undertaken, system development is running 6-8 months behind schedule, and 2) maintenance is done in a crisis mode and at times causes unintended consequences which require further patching.

Microcomputers, word processing equipment, and mainframe terminals are underutilized in part because of insufficient training and technical support for the operators and users. Inefficiency occurs because existing files have been changed to a database format which allows for user access, but the operators have not been instructed in the use of file transfer nor QLP (direct user access language).

Vendor generated software packages which are Univac compatible are virtually non-existent, thus eliminating one possible method for decreasing the demand on internal development. The task force charged with finding a cost accounting package which would prepare for Diagnostic Related Groups (DRG) prospective payment billing could find numerous existing software systems but none of them would operate in a Univac environment.

A number of external and internal factors are contributing to these problems. The DOI Automated Data Processing (ADP) Section does not have sufficient staff to support the current demand for both maintenance of the vast number of existing systems and development of new systems at the same time. The amount of maintenance required may be due in part to the age of many of the systems and the amount of crisis maintenance required.

At the present time, there are limited resources at the agency level to provide technical support to the growing number of end users. The acquisition of microcomputers with the concommitant micro-mainframe interface and micro application development has outpaced planning for training, communication

capacity, and other support functions. There is no clear policy at either the Department or Division level on where the additional resources should be located, the amount of support needed (e.g., how many trainers per number of micros) or where the responsibility rests for insuring proper utilization of systems.

As frustration grows over the inability to obtain support from the DOI-ADP Section in developing applications on the mainframe, many users are turning to micros in an effort to get something in place. Some of these applications are entirely appropriate and excellent uses of microcomputers; others are marginal and represent interim solutions; still others represent duplication of effort within and across agencies and Divisions. Again, policy statements are needed to address issues of application locus, monitoring mechanisms to ensure the consistency of data, and the avoidance of unnecessary redundancy.

The uncertainty surrounding the continued use of the Univac mainframe has added to the difficulty in planning for reasonable electronic networks. As the computer world moves closer and closer to the IBM protocol (rightly or wrongly) DMH remains tied to the Univac environment, while simultaneously having to interface with the IBM. Although recent hardware enhancements (the DCP 40) have greatly alleviated many of the communication difficulties, DMH must still master the difficulties of a split ADP environment.

A more comprehensive ADP Plan (DMH ADP Plan FY '85-86) which provides details to the above summary is available at the DMH Central Office, and has been submitted to the DOI-ADP Section.

Summary Analysis of External Influences

The preceding sections of this Situation Analysis have noted many influences external to the mental health system which are none-the-less integrally related to the client population and to service delivery. This present section, therefore, will focus on external influences of a more global, and in some cases, future orientation.

Colorado Economy

The following forecast summary of the Colorado economy provides the economic framework in which the mental health system does and will function for the years 1984 through 2009, as taken from the July, 1984 CBEF Review (University of Denver Center for Business and Economic Forecasting). Although it depicts a stable and positive environment for the state as a whole, it should be noted that some CMHC's have been impacted by depressed local economies and with rising unemployment rates, in certain catchment areas of the State.

"Since 1970 the Colorado economy has grown significantly faster than the U.S. The rapid expansion in the state was fueled by a multifamily building boom in the early 1970's, a vigorous expansion of the electronics and defense industries in the late 1970's, and burgeoning energy exploration and production lasting into the early 1980's. With the recession of 1981-82 and a weakening world oil market, Colorado's growth over the past 18 months has lagged, slowing to close to, or below, that of the nation.

The long term outlook presented here projects no future booms similar to those of the past decade. The demographic and other pressures which gave rise to surges in construction activity will be reduced over the next few years. Although forecasting energy markets is risky, the outlook calls for ample supply and stable prices through the remainder of the century. The electronics industry should remain an important source of economic growth for Colorado, but rising labor costs and the absence of a concentration of research institutions in the state will limit growth in this area.

Despite the absence of the periods of surging growth which characterized the 1970's, the outlook is a favorable one. Colorado will benefit economically from a quality labor force, an attractive living environment, and proximity to booming markets in the southwestern U.S. As the state economy emerges from the recession and the energy slowdown, growth is expected to resume at rates above the U.S., but the margin between state and national growth will be less than during the 1970's, and will narrow through most of the period as Colorado's cost and other advantages diminish. Chart 1 compares employment growth in Colorado and the nation in the 1970's and for the forecast period, while Chart 2 shows a similar comparison for population growth."

Chart 1

EMPLOYMENT GROWTH COLO & US

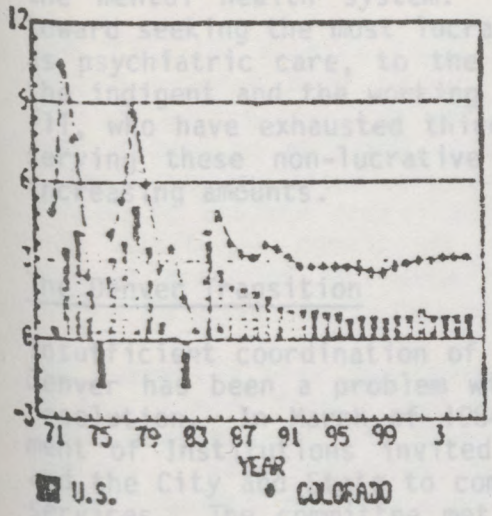
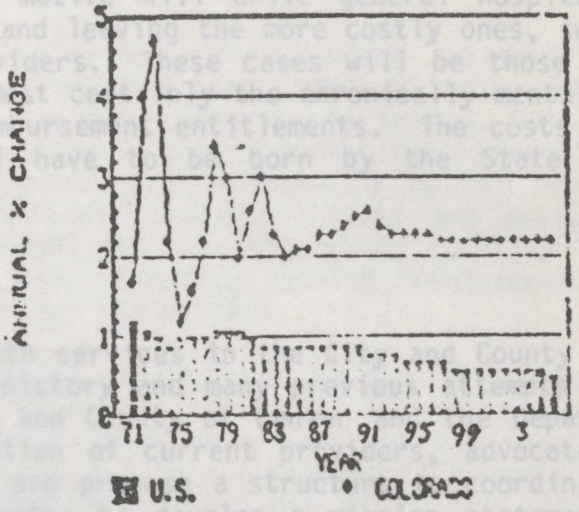


Chart 2

POPULATION GROWTH COLO & US



DRG's - Diagnosis Related Groups

The federal government, in response to escalating and uncontrolled health care costs, in October 1983 implemented a new methodology for reimbursement by Medicaid for inpatient services. This methodology, known as DRG's (Diagnosis Related Groups) is now in place for all general hospitals, with potential implementation in psychiatric hospitals as early as October of 1985. Basically, DRG's are formed by dividing all possible medical, surgical and psychiatric diagnoses into 23 major diagnostic categories, which are further sub-divided into 467 diagnostic related groups. The Government pays the hospital a flat rate set in advance according to the patient's diagnosis. Previously the payment was based on the actual cost of the service provided.

To date, the implementation of DRG's in general hospitals has resulted in significant cost savings to the federal government with attendant revenue reductions to hospitals. However, the implementation of this type of prospective payment system in the mental health system could have some negative impacts: (1) There may be, due to the severity of DMH clients, a reduction in revenue, as current client lengths-of-stay exceed the 11-day average proposed under the DRG payment system; (2) Private hospitals may be transferring clients to the state hospitals in greater numbers as the insurance available to support these clients in private settings is reduced; (3) If, due to the cost savings, this system is extended to other payors, such as Medicaid, reduction in revenues may be substantial.

The Division of Mental Health is working with other local and national organizations to try to assess the actual impacts of this new system and to try to influence the methodology which is being developed to define the psychiatric diagnoses utilized in the groupings.

Health Care for Profit

The trend toward private corporate ownership of general hospitals (such as the takeover of Presbyterian - St. Luke's Medical Center in Denver by the California-based American Medical International) will have direct impact on the mental health system. The profit motive will drive general hospitals toward seeking the most lucrative cases and leaving the more costly ones, such as psychiatric care, to the public providers. These cases will be those of the indigent and the working poor, and most certainly the chronically mentally ill, who have exhausted third-party reimbursement entitlements. The costs of serving these non-lucrative cases will have to be born by the State in increasing amounts.

The Denver Transition

Insufficient coordination of mental health services in the City and County of Denver has been a problem with a long history and many previous attempts at resolution. In March of 1984, the City and County of Denver and the Department of Institutions invited representation of current providers, advocates, and the City and State to come together and propose a structure to coordinate services. The committee met for six months to develop a mission statement, structure, and composition plan for the Denver Mental Health Commission. The committee presented the completed plan to Denver Mayor Frederico Pena on September 1, 1984. The Mayor is currently implementing the recommendations of the committee.

In October 1984, the Division awarded a contract to provide community support systems services and outpatient services for the northwest Denver catchment area to a consortium of community agencies headed by the Aurora Community Mental Health Center. Other participating members in the consortium are Park East Community Mental Health Center, Southwest Denver Mental Health Center, and Community Support Systems, Inc.

The plan is for the consortium to manage the delivery of these services from January 1, 1985 through June 30, 1985. During this period, a Policy Board representing northwest Denver will be established. The goal is for the emergence of an independent comprehensive community mental health center under a free standing Board of Directors from northwest Denver. The new Board will assume these governing responsibilities and directly contract with the Division for the provision of mental health services beginning with the 1985--86 fiscal year. As part of the restructuring of the delivery of mental health services in the City and County of Denver, the Division is also contracting with Denver Health and Hospitals for psychiatric emergency and inpatient services which are clinical resources available for each of the four Denver catchment areas. Eventually, the new Denver Mental Health Commission will coordinate all DMH contracts for mental health services in the entire Denver City and County.

Outside Input

The public mental health service delivery system functions in the context of many individuals and groups outisde of its area of direct influence, i.e., the

clients it serves. These include families and friends of the mentally ill, other client advocates, as well as other agencies and individuals in both the public and private sectors who may need the system's services or from whom the system may need services for its clients. Thus, to be effective, the public mental health service delivery system must be responsive to input from these outside parties.

Specifically, outside input can supply the system with essential perspectives around program needs which differ from the providers' perspectives. These outside perspectives do not just relate to what services are needed, but how they should be provided, based on what happens in the communities where the clients return after treatment. This input also enables the mental health system to enhance coordination of services with outside persons and agencies and enlist the commitment of those persons who are needed to identify and support areas of improvement in the system. Finally, outside involvement is needed to guard the rights of patients inside the system.

DMH currently uses the Colorado State Mental Health Planning Advisory Council as the primary formal mechanism for obtaining outside input. DMH has designed the membership of this Council such that agencies or groups are the standing members. The representatives, who are appointed by the membership groups, are primary policy decision-makers, and they have a knowledge of current issues and needs relating to the delivery of public mental health services.

The Council composition shows that particular attention has been paid to involve a wide range of interest and advocacy groups (family members of patients--the Colorado Alliance for the Mentally Ill; the Mental Health Association of Colorado; the Denver Mental Health Commission), the other state agencies with which DMH must coordinate its services (Dept. of Social Services; Dept. of Education; Division of Youth Services; Division for Developmental Disabilities; Dept. of Health/Alcohol & Drug Abuse Division), the legal/judicial community (Legal Aid Society/Mental Health Law Project; District Attorney's Office/Victim Programs; District Judges Assn. of Colorado), higher education, and the legislature (staff of the Office of State Planning and Budgeting) as well as provider groups, with a strong emphasis on the community providers (4 members from the CMHC's).

However, DMH currently has only $3,000 per year to support the Council, which is sufficient to fund only the one meeting per year for a Council of 27 members. This small membership omits many areas of essential input to the public mental health service delivery system, and limits the amount of input which can be obtained from each membership group. Specifically, the input is limited to the review and prioritization of needs. As such, the Council is extremely valuable, but does not serve the additional needed function of providing input for implementation plans, for which it could be so useful, and of providing long range perspectives.

Thus, it is recognized that there is a need to increase outside input so that the public mental health service delivery system can be more responsive to the community needs which exist. Toward that end DMH is currently applying for planning and program implementation funds from federal and private sources.

Comparison of Actual Results to Management Plan

DMH FY 1984-85 Management Plan

There is only one major deviation from the goals and objectives of DMH's FY 1984-85 Management Plan. In order to address staffing deficiencies in the CMHC's, it was DMH's listed objective to obtain a 7% cost-of-living increase in the CMHC FY 85-86 budget. This requested appropriation was included in the DMH Budget Request but eliminated by the Governor. Thus, the Budget Request that went to the Legislature included no cost-of-living increase. However, through the efforts of the CMHC's, it appears that the Joint Budget Committee will grant a cost of living increase of 1.6%.

DMH FY 1984-85 Budget Request

There are two deviations in this year's Budget from the Request granted last year by the State Legislature. The appropriation for Operating Expenses was short of actual needs by $73,050 for FLMHC and $208,000 for CSH. DMH sought and was granted a $281,050 Supplemental Appropriation to cover this shortfall.

DMH also sought a Supplemental Appropriation to cover Medicaid drawdowns to the CMHC's which are estimated to exceed this year's appropriation by over $3 million. The JBC granted a Supplemental at approximately one-half of this amount. This will require that the additional General Funds needed to satisfy Medicaid match requirements be transferred to the Department of Social Services from the DMH Budget at the end of FY 1984-85.

Problem/Opportunity Analysis

Introduction

The Situation Analysis in Chapter 2 leads to the identification and analysis of problems in the service delivery areas which may present threats to the Division of Mental Health. These may include unserved needs, new service needs, or areas of potential vulnerability. The result of this problem analysis is the Problem List which is an identification of areas where additional resources or a redirection of commitment is needed to achieve mental health system goals and objectives. The construction of this Problem List from the Situation Analysis forms the basis of the action plans for both the operational and strategic planning activities which follow in the DMH planning process. Specifically, it is the basis for Management Plans, Budget Requests, legislative initiatives, and future planning and policy development activities.

Following is a list of the problems that were identified in the DMH 1985 Situation Analysis. These problem statements have been reviewed and refined and then prioritized by the DMH Management Team. DMH will obtain outside input for this problem list from the Colorado State Mental Health Planning Advisory Council through their review of the Situation Analysis and consolidation/expansion and prioritization of the Problem List. These inputs will be used in DMH's finalization of its 1985 Problem List, which will be published in July 1985 as part of the 1985-1988 State Mental Health Plan.

Included also in this chapter is an analysis and listing of opportunities that currently exist which may help the mental health system resolve some of its problems. A list of these Opportunities follows the Problems.

Prioritized Problems

1. More treatment resources are needed for current public mental health clients.
   The significantly increased severity of adolescents and young adults who, together, comprise the majority of clients, and the increased number of involuntary admissions have resulted in the need for more resources to treat the DMH Client population. CMHC's are concerned that present funding levels are insufficient even to maintain core services.

2. There are substantial shortages of community residential alternatives needed to serve the chronically mentally ill.
   Estimates show a need for over 700 additional community residential placements for the chronically mentally ill. Hospital overcrowding may be directly related to this inadequacy of alternatives. The inadequacy of CMHC emergency service capability is also a major aspect of the system's inability to meet the needs of the chronically mentally ill population. This need for community residential alternatives also exists for seriously disturbed children and adolescents.

3. Staff salaries are too low, systemwide, and there are substantial personal services funding deficiencies in the state hospital budgets.
   Inadequate salaries have caused CMHC's to have problems in the recruitment and retention of all staff. They have caused the hospitals the same

problems with physicians and psychiatrists, and have resulted in a crisis situation wherein the hospitals are unable to recruit and retain enough Registered Nurses. Furthermore, non-funded personnel costs in the hospital budgets such as for retirement, vacancy savings below the assessed rate, and lost time due to workers' compensation claims diminish funds available to maintain the workforce.

4. The gap between population in need and numbers served has widened.
The need to provide "more" treatment for longer lengths of stay has resulted in the systems' serving fewer clients, at a time when the population in need is increasing. Furthermore, there are underserved populations such as the elderly, and unserved populations such as the mentally ill in jails, "intersystem" youths, the dual/multi-diagnosed, and mentally ill in nursing homes, which represent thousands of persons, statewide, in need of mental health services, who do not receive them.

5. Mental health treatment facilities, program space, and equipment are inadequate systemwide.
Long-term underfunding of controlled maintenance for hospitals and CMHC's has resulted in substantial deterioration of facilities, some beyond repair. Many CMHC's need to move to more adequate facilities. There are immediate capital construction needs for the state hospitals. FLMHC projects the need for additioanl inpatient building space by 1990. CSH needs to construct a new power plant, renovate Geriatrics East and West, and modernize the Pharmacy. Unfunded capital equipment needs for the hospitals approximate $1 million this year, in addition to the need for a feasibility study of CSH General Hospital Services to determine whether an additional $852,000 in capital outlay funds that are needed should even be requested.

6. Up to 8% of the CMHC and 3% of the hospital budgets are in future jeopardy.
Due to a Federal funding shortfall of approximately $300,000 for FY 1986--87 and potential losses of patient fees and Federal Revenue Sharing dollars, CMHC's could lose up to $3.3 million, or 8% of their current budget. Inadequate cost of living increases and a Medicaid drawdown shortfall will have direct General Fund impact. Potential losses of patient fees could result in a maximum loss in funds of $2 million, or 3% of the hospitals' budget over the next several years. Implementation of DRG's could impact first and third party payments.

7. There are increased demands to provide control and security for mental health clients.
Adolescent clients are increasingly in need of behavior control; increased numbers of clients are being admitted and held involuntarily; and, increasing numbers of both hospital and CMHC clients are being released to correctional facilities. The role and nature of public mental health treatment appears to be changing.

8. There is severe overcrowding in the state hospitals and therefore a statewide shortage of public mental health inpatient resources.
The two state hospitals together have been operating at 97% of bed capacity since last year, with some divisions operating at over 100% capacity. The most critical overcrowding is in the FLMHC Children/Adolescent Division and the CSH Forensic Division. Due to the shortage of beds, CMHC's are unable to access the public inpatient resouces that they need.

9. There are substantial information system/ADP resource needs.
The ADP resource needs consist primarily of policy-setting and systems coordination from the Department level; programmer and systems analyst resources for maintaining and accessing existing mainframe systems, designing and developing new micro and mainframe systems; mainframe-mainframe, micro-mainframe, and micro-micro communication networks; and staff training for DMH users.

10. There is a need to increase outside input into the public mental health service delivery system.
In order to be effective, the public mental health service delivery system must increase its responsiveness to outside input from client advocates, families, and friends as well as from other agencies in both the public and private sectors.

Opportunities

1. Advancing technology and declining costs of ADP hardware and software will enable DMH to meet more ADP resource needs at a lower cost.

2. DOI management of the Workers' Compensation system has and will continue to result in cost savings in hospital personal services budget.

3. The lead time available before implementation of DRG's provides time to develop data systems and strategies to minimize cost impacts.

4. The MOSTRA research project funded to DMH by the National Institute of Mental Health provides a sophisticated mechanism to assess, quantify, and analyze the statewide residential and service needs of the chronically mentally ill.

5. The establishment of mental health cooperative vocational programs through the Federal Jobs Bill administered by DMH has enabled approximately 150 mental health clients to obtain employment and has put in place some programs in the CMHC's which can continue and expand vocational services.

6. DMH's implementation of the Medicaid Waiver, Home and Community-Based Services - Mental Health Program (HCB-MH) in 5 CMHC's has and will continue to increase alternative services to the mentally ill who are in nursing homes or at risk of nursing home placement.

7. The implementation of the Denver Transition plan is addressing issues around the inadequate coordination of services in Denver and the availability of mental health services to residents of the City and County of Denver.

8. The stabilized U.S. and Colorado economies provide a positive economic environment in which to plan for the delivery of mental health services.

9. The movement toward public/private partnerships for provision of human services is opening up the possibility to obtain resources needed to maintain and improve the public mental health system.

10. The renewed availability of federal and private foundation funds for mental health planning and program implementation could enable DMH to address problems relating to unserved populations and to the chronically mentally ill, and to expand its ability to obtain outside input into DMH's planning process.

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TABLES AND FIGURES

for

CHAPTER 2: SITUATION ANALYSIS

(Narrative continued on page 91)

TABLE 1

POPULATION-IN-NEED ESTIMATES AND PROJECTIONS

BY AGE

FOR COLORADO MENTAL HEALTH SYSTEM

Year	AGE GROUP								
	Children 0-11		Adolescents 12-17		Adults 18-59		Elderly 60+		Pop-in-need TOTAL
	N	%	N	%	N	%	N	%	
1982-83	31,059	14.1	28,578	13.0	120,783	55.0	39,323	17.9	219,743
1983-84	32,070	14.2	29,520	13.0	124,515	55.0	40,247	17.8	226,353
1984-85	32,709	14.2	30,104	13.0	127,027	55.6	40,885	17.7	230,725
1985-86	34,230	14.4	28,963	12.2	131,929	55.4	43,085	18.1	238,205
1986-87	34,971	14.4	28,703	11.8	134,769	55.5	44,373	18.3	242,814

Source: DMH Evaluation Services Section

TABLE 2

NUMBERS OF CLIENTS SERVED BY DMH

AS PERCENTAGES OF NUMBERS IN NEED

Year	# in need	# served	# served - # in need
1983-84	226,353	68,372	30%
1984-85	230,725	63,864[1]	28%
1986-87	242,814	60,000[2]	25%

Source: DMH Evaluation Services Section

[1]Annualized figure based on July-December, 1984 data.

[2]Projected figure, using Box-Jenkins method of statistical forecasting.

TABLE 3
DEPARTMENT OF INSTITUTIONS
SITUATION ANALYSIS

CHARACTERISTICS OF THE POPULATION IN (Define Area)
Name of Division or Agency: Division of Mental Health

Segments	1983-84 Actual Service Level for (Immediate Past) #	% of total	1984-85 Estimated Service Level for Current Period #	% of total	1986-87 Estimaed Service Level for Planning Period #	% of total
By Ethnicity:						
Anglo	53,805	79%	50,456	79%	47,450	79%
Spanish Surname	9,394	14%	8,446	13%	7,908	13%
Black	3,541	5%	3,317	5%	3,115	5%
Other _____	1,597	2%	1,556	2%	1,438	2%
Missing	35	--	89	--	89	--
TOTAL	68,372	100%	63,864	99%	60,000	99%
By Sex:						
Male	30,339	44%	28,464	45%	26,742	45%
Female	37,981	56%	35,360	55%	33,218	55%
Missing	52	--	40	--	40	--
TOTAL	68,372	100%	63,864	100%	60,000	100%
By Age:						
0-11	6,620	10%	6,087	10%	5,725	9%
12-17	8,573	13%	7,934	12%	7,395	12%
18-59	47,913	70%	44,504	70%	41,863	70%
60+	5,191	8%	4,974	8%	4,652	8%
Missing	75	--	365	1%	365	1%
TOTAL	68,372	101%	63,864	101%	60,000	100%

TABLE 4

Ratio of Age Group Admissions to Adult,
Controlling Population Prevalence of Each Age Group

Year	0-11	12-17	18-59	60+
80-81	.4	1.0	1	.5
81-82	.4	1.0	1	.5
82-83	.5	1.1	1	.5
83-84	.5	1.3	1	.4
84-85	.5	1.3	1	.4

Ratio of Ethnic Group Admissions to White,
Controlling for Population Prevalence of Each Age Group

Year	Native American	Asian	Black	Hispanic	White
80-81	2.2	.6	1.3	1.3	1
81-82	2.8	.8	1.8	1.3	1
82-83	2.4	1.0	1.7	1.4	1
83-84	2.4	1.1	1.6	1.3	1
84-85	2.4	1.0	1.5	1.2	1

Notes: 1. Consider these as admissions per 100,000 of that age or ethnic group. This puts all numbers in the same metric and therefore directly comparable.

The way to think of it for example is to say in 1980-81, controlling for prevalence in the general population and assuming equal eligibility for mental health treatment, elderly were admitted at half the rate of adults.

Similarly, Native Americans were admitted at 2.2 times the rate of whites, when population prevalence is controlled.

2. To examine trends, we put the ratios within year in tables.

Source: DMH Evaluation Services Section: State Demographer, Division of Local Affairs.

Table 5

COLORADO DIVISION OF MENTAL HEALTH
JUNE 30, 1984 OPEN CASES

DSM III DIAGNOSIS CATEGORY

TYPE	AGENCY	TOTAL	MISSING		DEVEL DISABLED		ALCOHOL USE DISORDER		SUBSTANCE ABUSE		ORGANIC BRAIN SYN		DEPRESSIVE DISORDERS		SCHIZO-PHRENIA		OTHER PSYCHOSES	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
CENTERS	ADAMS	1364	0	0.0	11	.8	19	1.4	26	1.9	31	2.2	195	14.3	319	23.4	20	1.5
	ARAPAHOE	913	0	0.0	8	.9	10	1.1	0	0.0	2	.2	110	12.1	151	16.6	10	1.1
	ASIAN PACIFIC	110	0	0.0	0	0.0	0	0.0	0	0.0	2	1.8	43	38.7	2	1.8	10	9.5
	AURORA	1408	10	.7	29	2.1	0	0.0	20	1.4	10	.7	192	13.6	88	6.2	1	.1
	BETHESDA	762	31	4.1	0	0.0	0	0.0	10	1.3	20	2.6	225	29.6	156	20.4	0	0.0
	BOULDER	1429	10	.7	0	0.0	10	.7	50	3.5	20	1.4	289	20.2	94	6.6	20	1.4
	CENTENNIAL	1292	21	1.6	17	1.3	11	.8	0	0.0	68	5.2	217	16.8	107	8.3	2	.2
	CHILDRENS	408	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	20	4.9	10	2.4	10	2.4
	COLORADO WEST	1217	10	.8	101	8.3	19	1.5	9	.7	193	15.9	147	12.1	70	5.8	0	0.0
	DENVER H&H MHP	1954	21	1.1	15	.8	93	4.8	9	.5	13	.7	214	10.9	797	40.8	21	1.1
	JEFFERSON	1708	0	0.0	10	.6	1	.1	0	0.0	30	1.8	307	18.0	247	14.4	1	.1
	LARIMER	1310	10	.8	0	0.0	30	2.3	0	0.0	22	1.7	201	15.3	78	5.9	22	1.7
	MIDWESTERN	609	1	.2	0	0.0	18	3.0	1	.2	17	2.8	76	12.5	49	8.0	1	.2
	PARK EAST	845	0	0.0	31	3.6	10	1.2	10	1.2	0	0.0	145	17.1	271	32.1	31	3.6
	PIKES PEAK	2133	1	.0	2	.1	30	1.4	0	0.0	16	.7	279	13.1	344	16.1	22	1.0
	SAN LUIS	510	1	.2	26	5.1	7	1.4	7	1.4	36	7.1	63	12.3	49	9.7	1	.2
	SERVICIOS	274	0	0.0	1	.4	11	4.0	1	.4	20	7.3	11	4.0	24	8.8	0	0.0
	SE COLORADO	403	0	0.0	1	.2	10	2.5	0	0.0	15	3.7	50	12.4	45	11.2	0	0.0
	SW COLORADO	523	9	1.8	10	2.0	0	0.0	0	0.0	9	1.8	114	21.7	35	6.8	0	0.0
	SW DENVER	623	10	1.5	0	0.0	0	0.0	1	.2	12	1.9	73	11.8	136	21.8	11	1.7
	SPANISH PEAKS	1240	19	1.6	1	.1	1	.1	3	.2	31	2.5	298	24.0	356	28.7	2	.2
	WELD	1785	1	.1	54	3.0	0	0.0	0	0.0	1	.1	83	4.6	133	7.4	2	.1
	WEST CENTRAL	686	51	7.4	5	.7	11	1.6	0	0.0	19	2.8	107	15.6	81	11.8	11	1.6
TOTAL		23506	206	.9	323	1.4	291	1.2	147	.6	506	2.5	3458	14.7	3642	15.5	197	.8
HOSPITALS	CSH ADULT	164	0	0.0	0	0.0	2	1.2	1	.6	10	6.1	44	26.8	74	45.1	6	3.7
	CSH CH-ADOL	98	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	36	36.7	7	7.1	4	4.1
	CSH GERI	45	0	0.0	0	0.0	3	6.7	0	0.0	15	33.3	8	17.8	12	26.7	5	11.1
	CSH FORENSIC	374	0	0.0	1	.3	8	2.1	4	1.1	18	4.8	21	5.6	219	58.6	3	.8
		681	0	0.0	1	.1	13	1.9	5	.7	43	6.3	109	16.0	312	45.8	18	2.6
	FLMHC ADULT	117	0	0.0	2	1.7	2	1.7	2	1.7	5	4.3	22	18.8	75	64.1	2	1.7
	FLMHC CH-ADOL	74	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	12	16.2	6	8.1	3	4.1
	FLMHC GERI	98	1	1.0	0	0.0	1	1.0	1	1.0	6	6.1	43	43.9	35	35.7	4	4.1
	FLMHC VOC SRVCS	18	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	11.1	12	66.7	3	16.7
		307	1	.3	2	.7	3	1.0	3	1.0	11	3.6	79	25.7	128	41.7	12	3.9
TOTAL		988	1	.1	3	.3	16	1.6	8	.8	54	5.5	183	19.0	440	44.5	30	3.0
TOTAL		24494	207	.8	326	1.3	307	1.3	155	.6	560	2.6	3646	14.9	4082	16.7	227	.9

SOURCE: OPEN CASES SURVEY

Table 5

(Continued)

DSM III DIAGNOSIS CATEGORY

TYPE	AGENCY	TOTAL	ANXIETY DISORDER N	ANXIETY DISORDER %	PERSONALITY DISORDER N	PERSONALITY DISORDER %	PRE-ADULT DISORDER N	PRE-ADULT DISORDER %	ADJUSTMENT DISORDER N	ADJUSTMENT DISORDER %	OTHER NON-PSYCHOTIC N	OTHER NON-PSYCHOTIC %	SOCIAL MALADJUST N	SOCIAL MALADJUST %	NO MENTAL DISORDER N	NO MENTAL DISORDER %	DIAGNOSIS DEFERRED N	DIAGNOSIS DEFERRED %
CENTERS	ADAMS	1364	18	1.3	221	16.2	66	4.8	413	30.3	26	1.9	0	0.0	0	0.0	0	0.0
	ARAPAHOE	913	50	5.5	121	13.3	52	5.7	348	38.1	41	4.5	8	.9	0	0.0	0	0.0
	ASIAN PACIFIC	110	10	9.5	10	9.5	10	9.5	22	19.8	0	0.0	0	0.0	0	0.0	0	0.0
	AURORA	1408	78	5.6	279	19.8	76	5.5	536	38.0	69	4.9	10	.7	10	.7	0	0.0
	BETHESDA	762	0	0.0	94	12.3	29	3.8	76	10.0	111	14.5	10	1.3	0	0.0	0	0.0
	BOULDER	1429	30	2.1	239	16.8	31	2.1	329	23.1	277	19.4	10	.7	20	1.4	0	0.0
	CENTENNIAL	1292	56	4.3	166	12.9	32	2.5	511	39.6	74	5.8	11	.8	0	0.0	0	0.0
	CHILDRENS	408	20	4.9	10	2.4	70	17.1	119	29.3	109	26.8	0	0.0	40	9.8	0	0.0
	COLORADO WEST	1217	14	1.1	163	13.4	46	3.8	333	27.4	101	8.3	10	.8	0	0.0	0	0.0
	DENVER H&H MHP	1954	158	8.1	230	11.8	46	2.4	245	12.5	93	4.8	0	0.0	0	0.0	0	0.0
	JEFFERSON	1708	51	3.0	269	15.8	73	4.3	689	40.3	0	0.0	10	.6	20	1.2	0	0.0
	LARIMER	1310	99	7.6	348	26.6	80	6.1	410	31.3	10	.8	0	0.0	0	0.0	0	0.0
	MIDWESTERN	609	12	2.0	123	20.2	27	4.5	258	42.3	24	4.0	0	0.0	0	0.0	0	0.0
	PARK EAST	845	10	1.2	83	9.8	82	9.7	163	19.3	10	1.2	0	0.0	0	0.0	0	0.0
	PIKES PEAK	2133	43	2.0	300	14.1	138	6.5	862	40.4	68	3.2	10	.5	19	.9	0	0.0
	SAN LUIS	510	7	1.4	44	8.7	7	1.4	118	23.2	113	22.2	0	0.0	29	5.7	0	0.0
	SERVICIOS	274	0	0.0	40	14.6	30	10.9	106	38.7	30	10.9	0	0.0	0	0.0	0	0.0
	SE COLORADO	403	10	2.5	47	11.7	50	12.4	144	35.8	30	7.5	0	0.0	0	0.0	0	0.0
	SW COLORADO	523	38	7.2	77	14.7	38	7.2	88	16.9	104	19.9	0	0.0	0	0.0	0	0.0
	SW DENVER	623	20	3.3	95	15.2	10	1.5	227	36.4	29	4.6	0	0.0	0	0.0	0	0.0
	SPANISH PEAKS	1240	40	3.3	117	9.4	94	7.6	248	20.0	29	2.3	0	0.0	0	0.0	0	0.0
	WELD	1735	76	4.3	319	17.9	73	4.1	971	54.4	52	2.9	10	.6	10	.6	0	0.0
	WEST CENTRAL	686	11	1.6	76	11.0	22	3.2	150	21.9	142	20.8	0	0.0	0	0.0	0	0.0
TOTAL		23506	852	3.6	3473	14.8	1183	5.0	7367	31.3	1544	6.6	88	.4	149	.6	0	0.0
HOSPITALS	CSH ADULT	164	0	0.0	11	6.7	0	0.0	14	8.5	1	.6	0	0.0	1	.6	0	0.0
	CSH CH-ADOL	98	0	0.0	3	3.1	43	43.9	5	5.1	0	0.0	0	0.0	0	0.0	0	0.0
	CSH GERI	45	0	0.0	0	0.0	0	0.0	2	4.4	0	0.0	0	0.0	0	0.0	0	0.0
	CSH FORENSIC	374	2	.5	67	17.9	0	0.0	19	5.1	0	0.0	0	0.0	0	0.0	12	3.2
		681	2	.3	81	11.9	43	6.3	40	5.9	1	.1	0	0.0	1	0.1	12	1.8
	FLMHC ADULT	117	0	0.0	4	3.4	0	0.0	3	2.6	0	0.0	0	0.0	0	0.0	0	0.0
	FLMHC CH-ADOL	74	0	0.0	6	8.1	39	52.7	8	10.8	0	0.0	0	0.0	0	0.0	0	0.0
	FLMHC GERI	98	0	0.0	0	0.0	0	0.0	7	7.1	0	0.0	0	0.0	0	0.0	0	0.0
	FLMHC VOC SRVCS	18	0	0.0	0	0.0	0	0.0	1	5.6	0	0.0	0	0.0	0	0.0	0	0.0
		307	0	0.0	10	3.3	39	12.7	19	6.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL		988	2	.2	91	9.2	82	8.3	59	6.0	1	.1	0	0.0	1	0.1	12	1.2
TOTAL		24494	854	3.5	3564	14.6	1265	5.2	7426	30.3	1545	6.3	88	.4	149	.6	12	0.0

SOURCE: OPEN CASES SURVEY

Table 6

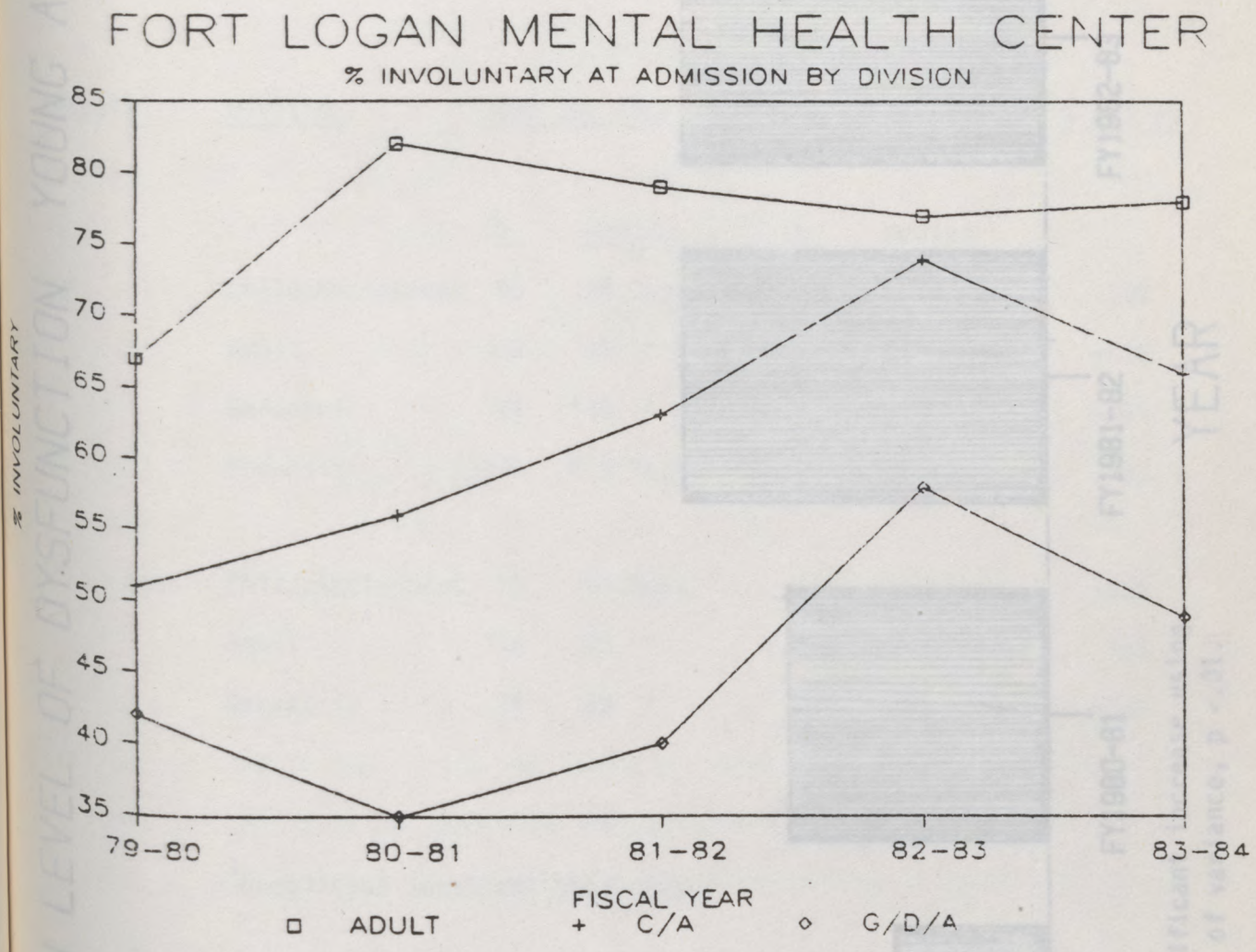
TRENDS IN NUMBERS & PERCENTAGES OF CLIENTS
BY LEGAL STATUS AT ADMISSION

Fiscal Year

	1979-80 (est.)		1980-81		1981-82		1982-83		1983-84	
Legal Status	N	%	N	%	N	%	N	%	N	%
Involuntary	6,318	13%	7,453	14%	8,756	18%	7,320	16%	8,204	18%
Voluntary	44,224	87%	46,800	86%	40,643	82%	37,305	84%	36,099	82%
TOTAL	50,542	100%	54,253	100%	49,399	100%	44,625	100%	44,303	100%

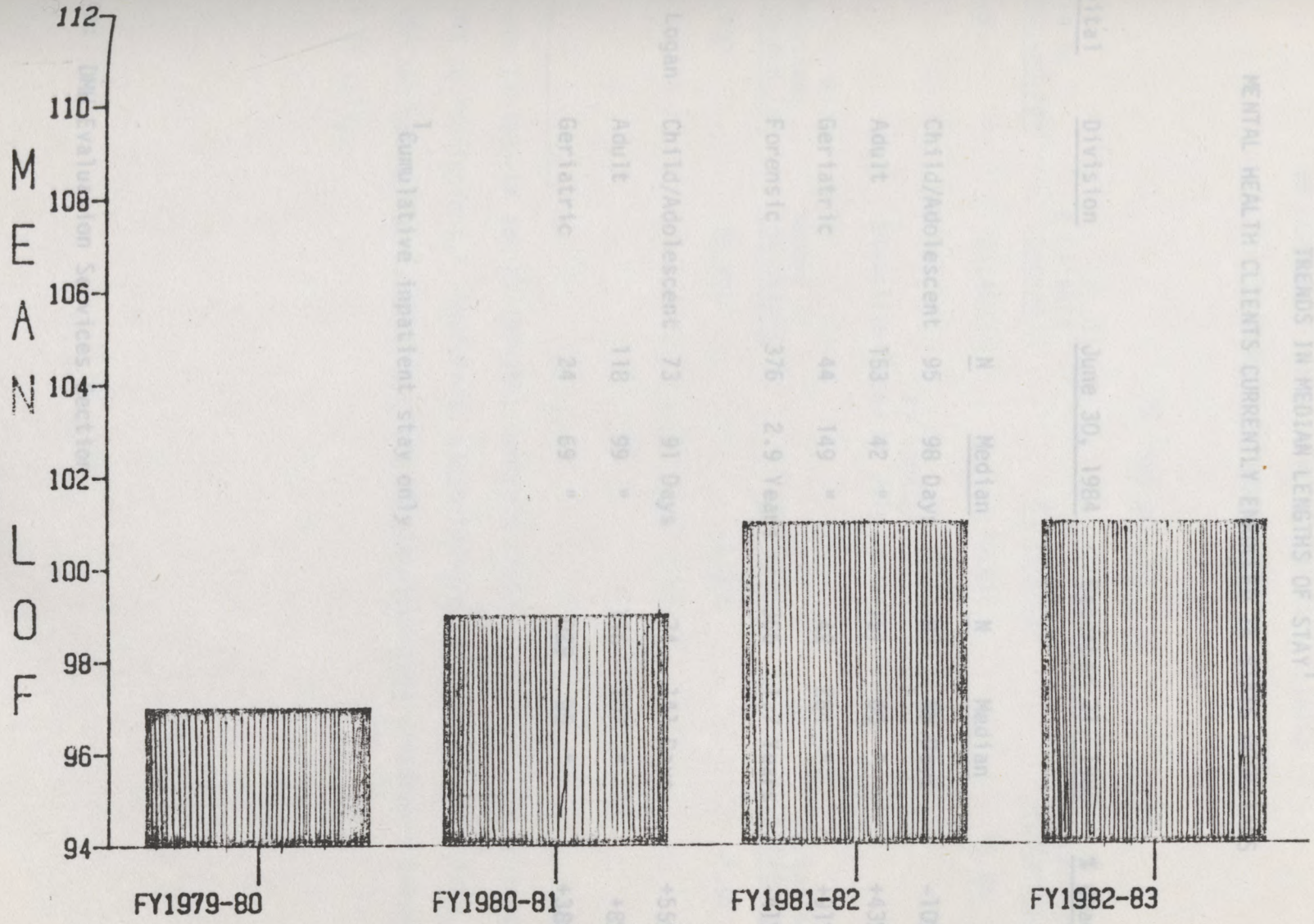
Source: DMH Evaluation Services Section

Figure 10



Source: Fort Logan Mental Health Center "Situation Analysis."

TRENDS IN LEVEL OF DYSFUNCTION YOUNG ADULT CLIENTS



Note: Statistically significant increase using a one-way analysis of variance, $p < .01$.

Table 7

TRENDS IN MEDIAN LENGTHS OF STAY[1]

MENTAL HEALTH CLIENTS CURRENTLY ENROLLED IN STATE HOSPITALS

Hospital	Division	June 30, 1984		December 31, 1985		% Change
		N	Median	N	Median	
CSH	Child/Adolescent	95	98 Days	97	88 Days	-10%
	Adult	153	42 "	151	60 "	+43%
	Geriatric	44	149 "	42	284 "	+91%
	Forensic	376	2.9 Years	366	1.7 Years	-41%
Fort Logan	Child/Adolescent	73	91 Days	74	141 Days	+55%
	Adult	118	99 "	116	107 "	+8%
	Geriatric	24	69 "	029	95 "	+38%

[1]Cumulative inpatient stay only

Source: DMH Evaluation Services Section

Table 8

NUMBERS OF CLIENTS CONTRACTED FOR

BY COMMUNITY MENTAL HEALTH CENTERS & CLINICS

COMPARED TO NUMBERS SERVED*

FY 1983-84

# Clients Contracted For	# Clients Served	Difference	Percentage Difference
60,651	64,469	+3,818	+6.3%

FY 1984-85
Annualize Based on July-December Data

# Admissions Contracted for	Number of Admissions	Difference	Percentage Difference
38,732	36,428	-2,304	-5.9%

*Between FY 1983-84 and FY 1984-85, contract criteria changed from "clients served" to "admissions." Therefore, comparisons between the numbers from year to year are not appropriate; comparison of the percentage difference between years is valid.

Table 9

WORKLOAD FIGURES

FORT LOGAN MENTAL HEALTH CENTER

	FY 1983-84	FY 1984-85[1]	Diff.	%Diff.
Carryovers (Currents)	342	331	-11	-3%
Admissions (New & Read.)	844	711	-133	-16%
Total Clients Served	1,186	1,042	144	-12%
Bed Occupancy	90%	91%	+1%	+1%

[1]Figures are annualized based on July 1984 through January 1985 data.

Source: FLMHC monthly Attendance Statistics reports.

Table 10

COLORADO STATE HOSPITAL
TOTAL CLIENTS SERVED

PROGRAM DIVISION	-- ACTUAL -- FY 82-83	FY 83-84	PRO-RATED FYTD 1/85	TREND	L.O.S.
General Adult	1,154	1,152	1,150	Stable	Up
Child/Adolescent	333	369	422	Sharp rise	Down
Geriatric	353	360	345	Fluctuating	Up
Forensic	912	948	1,048	Sharp rise	Up
General Hospital	744	944	858	Declining	No data
Substance Abuse	201	227	220	Stable	Stable
TOTAL	3,697	4,000	4,043		

Source: Colorado State Hospital Situation Analysis, p.5.

Table 11

COLORADO STATE HOSPITAL

PERCENT BED OCCUPANCY

PROGRAM DIVISION	BEDS	-- ACTUAL -- FY 82-83	FY 83-84	PRO-RATED FYTD 1/85	TREND COMMENT
General Adult	150	94.0%	96.0%	98.0%	Rising to capacity
Child/Adolescent	96	94.8	99.0	96.9	Often over capacity
Geriatric	60	93.3	90.0	85.0	Slow decline
Forensic	350	98.9	101.7	102.0	Severely overcrowded
General Hospital	68	63.2	57.4	42.6	Decline underutilized
Substance Abuse	30	76.7	76.7	76.7	Stable underutilized

Source: Colorado State Hospital Situation Analysis, p. 4.

Table 12

COLORADO DIVISION OF MENTAL HEALTH
FY1983-84 ADMISSIONS

LEGAL STATUS CATEGORY

TYPE	AGENCY	TOTAL	MISSING N	MISSING %	VOLUNTARY N	VOLUNTARY %	COURT-DIRECTED VOLUNTARY N	COURT-DIRECTED VOLUNTARY %	FORENSIC N	FORENSIC %	72 HR HOLD N	72 HR HOLD %	SHORT TERM CERTIFIED N	SHORT TERM CERTIFIED %	LONG TERM CERTIFIED N	LONG TERM CERTIFIED %	OTHER CIVIL INVOLUNTARY N	OTHER CIVIL INVOLUNTARY %
HOSPITALS	CSH ADULT	892	0	0.0	105	11.8	2	.2	28	3.1	628	70.4	102	11.4	24	2.7	3	.3
	CSH CH-ADOL	258	0	0.0	22	8.5	0	0.0	0	0.0	102	39.5	11	4.3	0	0.0	123	47.7
	CSH GERI	196	0	0.0	31	15.8	0	0.0	1	.5	147	75.0	13	6.6	3	1.5	1	.5
	CSH FORENSIC	472	0	0.0	0	0.0	0	0.0	316	66.9	144	30.5	6	1.3	4	.8	2	.4
		1818	0	0.0	158	8.7	2	.1	345	19.0	1021	56.2	132	7.3	31	1.7	129	7.1
	FLMHC ADULT	572	11	1.9	125	21.9	0	0.0	1	.2	351	61.4	78	13.6	5	.9	1	.2
	FLMHC CH-ADOL	173	2	1.2	57	32.9	0	0.0	0	0.0	76	43.9	14	8.1	1	.6	23	13.3
	FLMHC GERI	91	3	3.3	47	51.6	0	0.0	0	0.0	24	26.4	16	17.6	0	0.0	1	1.1
	FLMHC VOC SRVCS	9	0	0.0	9	100	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
		845	16	1.9	238	28.2	0	0.0	1	.1	451	53.4	108	12.8	6	.7	25	3.0
TOTAL		2663	16	.6	396	14.9	2	.1	346	13.0	1472	55.3	240	9.0	37	1.4	154	5.8
TOTAL		44303	35	.1	36099	81.5	2571	5.8	633	1.4	3880	8.8	333	.8	83	.2	669	1.5

SOURCE: PE87A & 7B

PAGE 3

Source: DMH Evaluation Services Orchid Report No. 34, p. 3.

Table 13

COLORADO DIVISION OF MENTAL HEALTH
FY1983-84 ADMISSIONS

REFERRAL SOURCE

TYPE	AGENCY	TOTAL	MISSING N	MISSING %	PERSONAL N	PERSONAL %	MEDICAL OR PSYCHOLOGICAL N	MEDICAL OR PSYCHOLOGICAL %	SOCIAL SRVCS EDUCATIONAL N	SOCIAL SRVCS EDUCATIONAL %	LEGAL N	LEGAL %	ALL OTHER N	ALL OTHER %
CENTERS	ADAMS	2388	2	.1	1078	45.1	391	16.4	437	18.3	372	15.6	108	4.5
	ARAPAHOE	1479	0	0.0	840	56.8	229	15.5	241	16.3	147	9.9	22	1.5
	ASIAN PACIFIC	154	4	2.6	21	13.6	69	44.8	27	17.5	26	16.9	7	4.5
	AURORA	2702	20	.7	1487	55.0	509	18.8	354	13.1	291	10.8	41	1.5
	BETHESDA	745	0	0.0	410	55.0	191	25.6	98	13.2	20	2.7	26	3.5
	BOULDER	1838	11	.6	1078	58.7	274	14.9	277	15.1	165	9.0	33	1.8
	CENTENNIAL	2164	1	.0	1109	51.2	255	11.8	595	27.5	179	8.3	25	1.2
	CHILDRENS	757	6	.8	116	15.3	400	52.8	69	9.1	148	19.6	18	2.4
	COLORADO WEST	2585	1	.0	1449	56.1	400	15.5	374	14.5	260	10.1	101	3.9
	DENVER H&H MHP	3536	131	3.7	1118	31.6	1711	48.4	230	6.5	290	8.2	56	1.6
	DENVER MHC	157	0	0.0	96	61.1	49	31.2	4	2.5	4	2.5	4	2.5
	JEFFERSON	3081	11	.4	1636	53.1	637	20.7	370	12.0	195	6.3	232	7.5
	LARIMER	2211	0	0.0	1412	63.9	235	10.6	254	11.5	268	12.1	42	1.9
	MIDWESTERN	1142	3	.3	601	52.6	174	15.2	230	20.1	112	9.8	22	1.9
	PARK EAST	1153	2	.2	741	64.3	315	27.3	42	3.6	39	3.4	14	1.2
	PIKES PEAK	4388	25	.6	1759	40.1	694	15.8	811	18.5	638	14.5	461	10.5
	SAN LUIS	993	0	0.0	462	46.5	193	19.4	207	20.8	90	9.1	41	4.1
	SERVICIOS	428	7	1.6	185	43.2	84	19.6	96	22.4	44	10.3	12	2.8
	SE COLORADO	971	3	.3	594	61.2	132	13.6	114	11.7	94	9.7	34	3.5
	SW COLORADO	1130	0	0.0	559	49.5	185	16.4	226	20.0	123	10.9	37	3.3
	SW DENVER	1025	4	.4	549	53.6	249	24.3	145	14.1	69	6.7	9	.9
	SPANISH PEAKS	1662	0	0.0	733	43.6	475	28.2	287	17.1	145	8.6	42	2.5
	WELD	2820	0	0.0	1595	56.6	323	11.5	536	19.0	318	11.3	48	1.7
	WEST CENTRAL	1133	0	0.0	601	53.0	251	22.2	171	15.1	106	9.4	4	.4
	DENVERHH EMER	978	9	.9	146	14.9	714	73.0	3	.3	105	10.7	1	.1
TOTAL		41640	240	.6	20375	48.9	9139	21.9	6198	14.9	4248	10.2	1440	3.5

Source: DMH Evaluation Services Orchid Report No. 34, p. 4.

Table 14

TRENDS IN STATE HOSPITAL BED OCCUPANCY RATES

Fort Logan Mental Health Center

Division	# Staffed In-Patient Beds	FY 1982-83 Ave.Occ.Rate	FY 1983-84 Ave.Occ.Rate	FY 1984-85 Ave.Occ.Rate[2]
Adult Psychiatry	121	88%	89%	89%
Geriatric/Deaf/Aftercare	30	85%	83%	85%
Children[1]	15	92%	85%	93%
Adolescent[1]	61	95%	97%	96%
Total	227	90%	90%	91%

[1]Children and Adolescents broken out separately although they are together in one division.

[2]Based on July 1984 through January 1985 data.

Source: FLMCH Monthly Attendance Statistics Report.

Colorado State Hospital

General Adult	150	94%	96%	98%
Child/Adolescent	96	95%	99%	97%
Geriatric	60	93%	90%	85%
Forensic	350	99%	102%	102%
Total	656	97%	99%	99%

Source: Reprint of Table 11, leaving out General Hospital and Substance Abuse since those divisions treat non-mental health clients.

CSH & FLMHC	883	95%	97%	97%

Source: Based on weighted means, above data.

Table 15

DIVISION OF MENTAL HEALTH
BLOCK GRANT ANALYSIS
JUNE 11, 1984

	81-82 State FY 9 Months	82-83 State FY 12 Months	83-84 State FY 12 Months	84-85 State FY 12 Months	85-86 State FY 12 Months
Grant Award 10/81-9/83	$2,905,937				
Grant Award 10/82-9/84		$3,444,623			
Grant Award 10/83-9/85			$3,400,442		
Grant Award 10/84-9/86				$3,400,442	
Grant Award 10/85-9/86					$3,400,442
Funding Available (July-Sept 1/4)	-0-	726,484	861,156	850,110	-0-
Funding Available (Oct-June 3/4)	2,179,453	2,583,467	2,550,332	3,400,442	3,400,442
Carry Forward--Prior Year	-0-	1,532,933	1,093,520	254,293	285,962
Total Funding Available	2,179,453	4,842,884	4,505,008	4,504,845	3,686,404
Less Expenditures					
Direct	501,402	3,508,188	3,842,578	3,771,818	3,771,818
Overhead	145,118	241,176	408,137	447,065	447,065
Subtotal	646,520	3,749,364	4,250,715	4,218,883	4,218,883
Balance--Carry Forward	1,532,933	1,093,520	254,293	285,962	(532,479)

Table 16

DISCHARGE PLACE OF RESIDENCE

STATE HOSPITAL CLIENTS

Residence	FY 1982-83		FY 1983-84		FY 1984-85[1]	
	N	%	N	%	N	%
Correctional Facility	155	13.4%	339	13.2%	342	15.8%
Inpatient	72	6.2%	114	4.4%	87	4.0%
Nursing Home	61	5.3%	161	6.2%	122	5.6%
Intensive Treatment Facility	40	3.5%	106	4.1%	60	2.8%
Community Residence	174	15.1%	400	15.5%	147	6.8%
Boarding Home	47	4.1%	127	4.9%	72	3.3%
HUD 202 Housing	9	.8%	9	.3%	6	.3%
Section 8 Housing	5	.4%	5	.2%	3	.1%
Other Independent	592	51.3%	1,313	51.0%	1,328	61.3%
TOTAL[2]	1,155	100.1%	2,574	99.8%	2,167	100.0%

[1]Figures for FY 1984-85 are annualized based on July 1984 through February 1985 data.

[2]Figures reflect valid N and not total numbers of discharges.

Source: DMH Evaluation Services Section.

Table 17

DISCHARGE PLACE OF RESIDENCE

CMHC CLIENTS

Residence	FY 1982-83		FY 1983-84		FY 1984-85[1]	
	N	%	N	%	N	%
Correctional Facility	311	.9%	520	1.3%	415	1.3%
Inpatient	1,431	4.2%	594	1.4%	510	1.6%
Nursing Home	783	2.3%	1,019	2.5%	933	2.8%
Intensive Treatment Facility	159	.5%	187	.5%	143	.4%
Community Residence	1,299	3.9%	1,741	4.3%	1,075	3.3%
Boarding Home	133	.4%	249	.6%	339	1.0%
HUD 202 Housing	56	.2%	127	.3%	104	.3%
Section 8 Housing	61	.2%	95	.2%	134	.4%
Other Independent	29,255	87.4%	36,358	88.9%	29,224	88.9%
TOTAL[2]	33,488	100.0%	40,890	100.0%	32,877	100.0%

[1]Figures for FY 1984-85 are annualized based on July 1984 through February 1985 data.

[2]Figures reflect valid N and not total numbers of discharges.

Source: DMH Evaluation Services Section.

Table 18

EMPLOYMENT STATUS AT DISCHARGE

STATE HOSPITAL CLIENTS

Employment status	FY 1982-83		FY 1983-84		FY 1984-85[1]	
	N	%	N	%	N	%
Employed - Full-time	52	4.7%	149	5.7%	132	6.1%
Employed - Part-time	23	2.1%	42	1.6%	36	1.7%
Homemaker	9	.8%	32	1.2%	24	1.1%
Sheltered Employment	21	1.9%	55	2.1%	45	2.1%
Not in Labor Force	579	52.0%	1,499	57.3%	1,253	57.8%
Unemployed 3 months	98	8.8%	210	8.0%	183	8.5%
Unemployed 3 months	332	29.8%	629	24.0%	491	22.7%
TOTAL[2]	1,114	100.1%	2,616	99.9%	2,164	100.0%

[1]Figures for FY 1984-85 are annualized based on July 1984 through February 1985 data.

[2]Figures reflect valid N and not total numbers of discharges.

Source: DMH Evaluation Services Section.

Table 19

EMPLOYMENT STATUS AT DISCHARGE

CMHC CLIENTS

Employment status	FY 1982-83		FY 1983-84		FY 1984-85[1]	
	N	%	N	%	N	%
Employed - Full-time	9,759	29.1%	11,847	29.0%	9,790	29.8%
Employed - Part-time	4,724	14.1%	4,467	10.9%	3,465	10.6%
Homemaker	2,479	7.4%	2,822	6.9%	2,324	7.1%
Sheltered Employment	254	.8%	305	.8%	279	.9%
Not in Labor Force	11,072	33.0%	15,204	37.2%	12,205	37.2%
Unemployed 3 months	1,654	4.9%	1,889	4.6%	1,551	4.7%
Unemployed 3 months	3,602	10.7%	4,310	10.6%	3,194	9.7%
TOTAL[2]	33,544	100.0%	40,844	100.0%	32,808	100.0%

[1]Figures for FY 1984-85 are annualized based on July 1984 through February 1985 data.

[2]Figures reflect valid N and not total numbers of discharges.

Source: DMH Evaluation Services Section.

Table 20

TRENDS IN CLIENT READMISSION RATES

	FY 1979 - 1980	FY 1980 - 1981	FY 1981 - 1982	FY 1982 - 1983	FY 1983 - 1984	FY 1984 - 1985[1]
Community Mental Health Centers						
Number of Admissions	47,220	51,537	46,827	42,206	41,640	38,408
Number of Readmissions	11,548	14,220	13,890	10,687	9,790	8,892
% Readmissions	24.5	27.6	29.7	25.3	23.5	23.1
State Hospitals						
Number of Admissions	3,293	2,716	2,572	2,419	2,663	2,601
Number of Readmissions	1,555	1,340	1,156	1,044	1,156	1,184
% Readmissions	47.2	49.3	44.9	43.2	43.4	45.5

[1]Figures for FY 1984-85 are annualized based on July 1984 through February 1985 data.

Source: DMH Evaluation Services Section.

CHAPTER 3

PLANNING COUNCIL INPUT

Introduction

The Colorado State Mental Health Planning Advisory Council met on June 4-5, 1985, to review and provide input into DMH's 1984-85 planning process. The following section includes the 24 problems which the Council identified, in order of the priorities they were assigned by Council vote, as issues that the public mental health system must face. Finally, a second section includes tasks/strategies which the Council suggested DMH follow in order to address the top five priority problems.

The top five problems which the Council identified have been incorporated into the problem list generated from the Situation Analysis (see pages 63-65), to result in the Final Problem List included on pages 97-99 and also in the first chapter, on pages 23-25. Finally, the tasks and strategies which the Council identified have been included in the DMH Management Plan in Chapter 4.

COLORADO STATE MENTAL HEALTH PLANNING ADVISORY COUNCIL

1985 PROBLEM LIST

Problem Statements

1. Problem: Need to increase community mental health programs for chronically mentally ill including community support and residential programs.
   - these inadequacies "back-up" the system.
   - look at distribution of dollars to state hospitals and community programs.
   - still need to recognize patient's need for secure/protective environment at times during their lives.

2. Problem: No continuum of services for children and adolescents, particularly around residential programs.

3. Problem: Need to improve coordination of planning, budgeting and service delivery between others systems.

4. Problem: Need for more comprehensive needs assessment to determine overall requirements for mentally ill of entire state.

5. Problem: Need to develop strategies to serve underserved and systems at the local level.

6. Problem: Need to make mental health system access easier for criminal justice practitioners.

7. Problem: There is a lack of clarity of the responsibility of the public sector to provide services to different target mental health populations.

8. Problem: Need to improve programming for non-compliant mental health clients.

9. Problem: Services should be driven by patient needs as patient is evaluated at admission. Currently, patients are forced into existing programs. This includes improved evaluation services.

10. Problem: Need to emphasize treatment outcome studies of existing programs.

11. Problem: There is a lack of early prevention and intervention programs within the mental health system, particularly with infants and children.

12. Problem: Often the least well-trained staff are treating the most disabled people which may result in lower quality care.

COLORADO STATE MENTAL HEALTH PLANNING ADVISORY COUNCIL
1985 PROBLEM LIST

Problems Statements - continued ...

13. Problem: Need to examine current policies relating to secure custody for adults and juveniles.

14. Problem: Need to accurately quantify and describe patients who are and are not being served.

15. Problem: High risk clients with substantial need for control consume a high percentage of resources.

16. Problem: Need to clarify mental health system's role to provide social control for society at large.

17. Problem: No continuum of services exists for the elderly mentally ill.

18. Problem: Need to increase cooperation between families, private sector, non-profit sector and public sector.

19. Problem: Mental health and education systems need to develop (design) long term placements for behaviorally disordered children and adolescents.

20. Problem: Need to "market" the fact that mental health problems are at the root of many other systems' problems.

21. Problem: There is a history of "over-marketing" mental health services...we shouldn't duplicate this history.

22. Problem: Need to challenge cities and counties to increase their funding contribution to mental health services.

23. Problem: Need to collect input from other agencies, private sector, others, earlier in the mental health planning process.

STRATEGIES TO ADDRESS THE TOP FIVE PROBLEMS

COLORADO STATE PLANNING ADVISORY COUNCIL

June 5, 1985

1. Need to increase community mental health programs for chronically mentally ill, including community support and residential programs.
DMH to develop a comprehensive statewide plan for provision of comprehensive community support services to all chronically mentally ill. The plan should include demographic data, client need data, and dollar figures, and will include planning for appropriate continuum of care. The plan should include strategies for implementation within 3 years.

2. No continuum of services for children adolescents, particularly around residential programs.
As a first step, DMH to define an appropriate residential continuum for children and adolescents, based on client needs. This study would take into account children/adolescents currently placed in mental health programs. Social Services (RCCFs), education and youth services -- and the service needs of these individuals. Residential programs would be designed to meet specific clusters of needs -- i.e. specialized programs as needed.

3. Need to improve coordination of planning, budgeting, and service delivery linkages between systems, especially at the local level, and to clarify the responsibility of the public mental health service delivery sector.

Step 1. Clarification - From a DMH perspective, it must be determined/clarified what they are, who they serve and how they interact with other systems in such a way that leaves no gaps in service delivery.
2. Concrete inter-agency leadership forum
3. Needs assessment
4. Plan
5. Continuum developed for each target population (which system gets them and why)
6. This filters down to the local service delivery agencies (linkage)

Statement of problem(s)

* #3. Need to improve coordination of planning, budgeting and service delivery between systems.

* #4. Need to improve service delivery linkages between systems at the local level (re: fragmentation due to funding sources).

#24. Need to clarify, etc.

*Both involve leadership.

4. Need for more comprehensive needs assessment to determine overall requirements for mentally ill of entire state.

The need assessment should be designed to capture information about the chronically and acutely mentally ill as well as their level of severity or dysfunction.

Both theoretical estimates and estimates based on sample surveys should be considered. Included in the former is the use of SSI national data and data on the SSI status of clients under care to estimate statewide numbers of CMI. Other approaches would involve applying Epidemilogical Catchment Area (ECA) figures from other state areas to Colorado and using estimates from the President's Commission on Mental Illness.

A survey approach might involve a one day count of people under treatment in the private practice sector, hospitals (public, private and VA), RCCF's, alcohol and drug programs, law enforcement facilities, CMHC's, nursing homes, etc.

5. Need to develop strategies to serve underserved and unserved clients.

Task 1

Not population parameters but what do these group members need in terms of mental health services?

Potential Groups = Victims of Violent Crime
Dual-Diagnosis Clients
Mentally Ill in Jails
Refugees
Elderly
Alcohol/Drug Abuse
Homeless

Task 2

To create and fund a position within DMH to aggressively seek out and obtain new sources of funding for these services.

DMH Problem List with MH Council Input

1. The public mental health system can no longer treat as many clients.
The gap between population in need and numbers served has widened. The significantly increased severity of adolescents and young adults who, together, comprise the majority of clients, and the increased number of involuntary admissions have resulted in the need for more resources to treat the DMH Client population. Due to inflation, which has reduced spending power, there are not enough resources available even to maintain core services. Furthermore, due to a Federal funding shortfall of approximately $300,000 for FY 1986-87 and potential losses of patient fees and Federal Revenue Sharing dollars, CMHC's could lose up to $3.3 million, or 8% of their current budget. Potential losses of patient fees could result in a maximum loss in funds of $2 million, or 3% of the hospitals' budget over the next several years. Implementation of DRG's could impact first and third party payments.

2. Colorado needs to increase mental health services for the chronically mentally ill, including community treatment and support services and residential placements.
Estimates show a need for over 700 additional community residential placements for the chronically mentally ill. Hospital overcrowding may be directly related to this inadequacy of alternatives. The inadequacy of CMHC emergency service capability is also a major aspect of the system's inability to meet the needs of the chronically mentally ill population. There is a need to provide services for the homeless who are chronically mentally ill. The 1985 Benton Decision has challenged the public mental health system's response to the service needs of the chronically mentally ill.

3. The Division of Mental Health should improve methodologies for needs assessment and targeting of resources, and develop strategies to serve underserved and unserved clients.
The need to provide "more" treatment for longer lengths of stay has resulted in the system's serving fewer clients, at a time when the population in need is increasing. Furthermore, there are underserved populations such as the elderly, and unserved populations such as the homeless, the mentally ill in jails, the mentally ill in nursing homes, victims of crimes, etc., which represent thousands of persons, statewide, in need of mental health services, who do not receive them.

4. There is a need to clarify the mental health system's role in protecting society at large.
There has been a significant increase in the number of involuntary hospital admissions; the CSH Forensic Unit is severely overcrowded; adolescent clients are increasingly in need of behavior control; and increasing numbers of both hospital and CMH clients are being released to correctional facilities. Society's view of the role and nature of public mental health treatment appears to be changing.

5. The public mental health service delivery system should increase its responsiveness to outside input.
In order to be effective, the public mental health service delivery system must increase its responsiveness to outside input from client advocates,

families, and friends as well as from other agencies in both the public and private sectors.

6. Need to improve coordination of planning, budgeting, and service delivery linkages between systems, especially at the local level, and to clarify the responsibility of the public mental health service delivery sector.
There is a need to define the scope of responsibility of the public sector mental health system in relation to the private sector and to other public and private human services systems. Specialized services are needed for the multi/dual-diagnosed and for "intersystem" youths, which cross the boundaries between systems, and better coordination is needed between all systems to improve services for all clients.

7. There is no continuum of services for children and adolescents, particularly around residential programs.
The severity of adolescent clients admitted to the hospitals has increased significantly. Few community residential placements and services exist for these seriously disturbed young clients either as alternatives to hospitalization or to meet post-hospitalization needs.

8. Mental health treatment facilities and equipment are deteriorated, and there is not enough space for privacy of treatment in many community mental health centers.
Long-term underfunding of controlled maintenance for hospitals and CMHC's has resulted in substantial deterioration of facilities, some beyond repair. Many CMHC's need to move to more adequate facilities. There are immediate capital construction needs for the state hospitals. FLMHC projects the need for additional inpatient building space by 1990. CSH needs to construct a new power plant, renovate Geriatrics East and West, and modernize the Pharmacy. Unfunded capital equipment needs for the hospitals approximate $1 million this year, in addition to the need for a feasibility study of CSH General Hospital Services to determine whether an additional $852,000 in capital outlay funds that are needed should even be requested.

9. Staff salaries are too low, systemwide, and there are substantial personal services funding deficiencies in the state hospital budgets.
Inadequate salaries have caused CMHC's to have problems in the recruitment and retention of all staff. They have caused the hospitals the same problems with physicians and psychiatrists, and have resulted in a crisis situation wherein the hospitals are unable to recruit and retain enough Registered Nurses. Furthermore, non-funded personnel costs in the hospital budgets such as for retirement, vacancy savings below the assessed rate, and lost time due to workers' compensation claims diminish funds available to maintain the workforce.

10. Severe overcrowding in the state hospitals indicates a statewide shortage of public mental health inpatient resources.
The two state hospitals together have been operating at 97% of bed capacity since last year, with some divisions operating at over 100% capacity. The most critical overcrowding is in the FLMHC Children/Adolescent Division and the CSH Forensic Division. Due to the shortage of beds, CMHC's are unable to access the public inpatient resources that they need.

11. The Division of Mental Health's information systems and ADP resources are still in need of further development.
The ADP resource needs consist primarily of policy-setting and systems coordination from the Department level; programmer and systems analyst resources for maintaining and accessing existing mainframe systems, designing and developing new micro and mainframe systems; mainframe-mainframe, micro-mainframe, and micro-micro communication networks; and staff training for DMH users.

CHAPTER 4

DMH MANAGEMENT PLAN

Introduction

The following Mangement Plan for FY 1985-86 was developed by the DMH Management Team Staff. The Final Problem List which resulted from the Situation Analysis and the State Council's input was used by the Management Team as the basis to develop goals and objectives that DMH can pursue to address these problems. The goals and objectives were then sorted out in terms of those which would be addressed by the FY 1986-87 Budget Request and those which could be addressed this coming year through management initiatives. The Management Team then specified the major tasks which will be associated with these objectives.

The following Management Plan contains the problem statements, goals, objectives, and major tasks as described above. It is the workplan DMH will be following this coming year as a result of the planning process. The Budget Request, which addresses funding for the following year, FY 1986-87, is published as a separate document.

COLORADO DEPARTMENT OF INSTITUTIONS

MANAGEMENT PLAN FY 85 to 86

DIVISION OF MENTAL HEALTH

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
1. The public mental health system can no longer treat as many clients.	1. Provide an adequate level of resources to allow services to be delivered at the rate they were being provided to clients in need during FY 1980-81, before the erosion in resources began.	a. Obtain FY 1986-87 funding from the legislature which includes replacement of at least 70% of the decline in federal funding and at least 50% of the decline in service capacity which has occurred from FY 1980-81 to FY 1985-86.	(1) Submit DMH budget request that includes replacement of the decline in Federal funds and service capacity by 8/1/85.	Bruce Berger				
			(2) Track budget request through EDO, OSPB, JCB and the legislature and advocate approval by 5/1.	Bruce Berger Mary Wiberg				
		b. Obtain funding from the legislature which includes an appropriate cost-of-living increase for the CMHC's and the hospitals for FY 1986-87, to prevent further decline in service capacity.	(1) Submit DMH budget request that includes an appropriate COL increase for the CMHC's by 8/1/85.	Bruce Berger				
			(2) Track budget request request through EDO, OSBP, JBC and the legislature and advocate approval by 5/1/86.	Bruce Berger Mary Wiberg				
2. Colorado needs to increase community mental health programs for the mentally ill, including community support and residential programs.	2. Access the necessary revenues to meet the residential, treatment and support service needs of the 6,800 CMI currently in the public mental health system as well as those outside of the system who are not receiving any assistance.	a. Complete a 3-year Master Plan to address the Needs of the Chronically Mentally Ill in Colorado.	(1) Complete tasks as specified in detailed 'work plan' which began June 14 and submit final plan to Governor's Office by 8/31/85.	Liz Wilderman Bob Glover Jack Bartleson				
		b. Obtain FY 1986-87 funding from the legislature for at least 50% of the first phase of the resources necessary to expand services to the CMI.	(1) Submit DMH budget request that includes first year of the CMI plan by 8/1/85.	Bruce Berger Liz Wilderman				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
			(2) Track budget request through EDO, OSPB, JBC and legislature and advocate approval by 5/1.	Bruce Berger Mary Wiberg				
		c. Investigate and apply for private foundation funds to expand services to the CMI.	(1) Participate in Robert Woods Johnson Foundation Advisory Board to help define funding parameters by 12/31/85.	Bob Glover Liz Wilderman				
			(2) Facilitate response to RFP by the City and County of Denver by 3/31/86.	Bob Glover Liz Wilderman				
3. The gap between population in need and numbers served has widened, creating the need for improved needs assessment and targeting of resources, and the need to develop strategies to serve underserved and unserved clients.	3A. Improve methodology for estimating number and distribution of individuals in need of mental health services.	a. Determine number and distribution by catchment area of CMI individuals.	(1) Combine zip code and census data tapes by 8/15/85.	Nancy Wilson				
			(2) Develop alternative models by using varying assumptions by 9/15/85.	Nancy Wilson				
			(3) Utilize above models to improve estimates of CMI population in need by 12/1/86.	Nancy Wilson				
		b. Assess the validity of the Colorado Need Assessment model.	(1) Obtain results of University of Denver Needs Survey and compare to Colorado model by 6/30/86.	Nancy Wilson				
			(2) Utilize results to increase the validity of the Colorado Need Assessment Model by 6/30/86.	Nancy Wilson				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
	3B. Incorporate private facility data in need assessment estimates.	a. Analyze NIMH Inventory data for private mental health facilities and general hospitals in Colorado.	(1) Review data for accuracy by 11/30/85.	Nancy Wilson				
			(2) Finalize analysis and questions by 12/31/85.	Nancy Wilson				
			(3) Publish report by 3/31/86.	Nancy Wilson				
			(4) Utilize results to improve Colorado Need Assessment Model by 6/30/86.	Nancy Wilson				
4. There is a need to clarify the mental health system's role in protecting society at large.	4A. To develop a policy statement concerning the balancing of treatment and public safety which will provide guidelines for mental health professionals and others throughout the state.	a. To have completed review and discussion by the Task Force of similar policies which have been formulated by other states and organizations, including Sutherland Miller's report to the Governor on 'Violence and the Mentally Ill' and the study by Nancy Wilson and Dave Rose entitled 'Treatment and Security.'	(1) Have Task Force members obtain, review and discuss noted reports by 9/30/85.	Haydee Kort Paul Sherman				
		b. To have implemented and completed a process whereby the Task Force will secure in-put from a variety of public and professional groups.	(1) Secure input through defined process by 12/30/85.	Haydee Kort Paul Sherman				
		c. To have discussed and agreed upon the major items to be included within the policy statement.	(1) Complete objective c by 3/30/86.	Haydee Kort Paul Sherman				
		d. To have completed an initial draft of the policy statement.	(1) Complete initial draft by 4/30/86.	Haydee Kort Paul Sherman				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
		e. To have secured for Task Force discussion, review and comments of the initial draft of the policy statement by selected groups and individuals.	(1) Complete review process of initial draft by 5/30/86.	Haydee Kort Paul Sherman				
		f. To have completed the final draft, with Task Force review and concurrence.	(1) Final draft of policy completed and approved by Task Force by 6/30/86.	Haydee Kort Paul Sherman				
	4B. To optimize placements for patients admitted to CSH Forensic Division.	a. Implement criteria re: placement of Forensic patients as to level of security needed.	(1) Complete final Task Force report by 12/31/85.	Haydee Kort				
			(2) Establish criteria by 6/30/85.	Haydee Kort				
5. There is a need to increase outside input into the public mental health service delivery system.	5A. Create processes to increase the responsiveness of the public mental health service delivery system to input from advocates, families and friends of clients and other public and private agencies.	a. In conjunction with the Superintendent of CMHS consider the feasibility and desirability of establishing an advisory board for CSH.	(1) Meet with CSH to consider this objective and present a formal recommendation to DMH Management Team by 12/30/85.	Mary Wiberg Haydee Kort				
			(2) Implement Management Team decision by 6/30/86.	Bob Glover				
		b. Work with the State Planner to support and enlarge the Planning Council.	(1) Identify new membership organizations and send letters of appointment by 10/31/85.	Liz Wilderman Mary Wiberg				
			(2) Conduct enlarged Council meeting in November 1985 to formulate list of external problems and issues.	Liz Wilderman				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
		c. Work with advocates (CAMI & MHAC) on legislation of mutual interest.	(1) Meet with advocates prior to and throughout legislative session and provide technical and lobbying support where appropriate.	Mary Wiberg				
		d. In conjunction with DMH Management Team consider the issue of the External Review Committee for patient complaints for the public mental health system.	(1) Form internal work group to review literature, critique other state systems and make preliminary recommendation to DMH Management Team by 12/30/85.	Mary Wiberg DMH Mgt. Team				
			(2) Obtain input from external groups and then make final recommendation to DMH Management Team by 6/30/86 for implementation in FY 1986-87.	Mary Wiberg DMH Mgt. Team				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
	5B. To foster linkages between DMH and higher education in order to enhance professional training of the core mental health disciplines and to increase the amount of University-based research efforts devoted to M.H. policy and practice issues.	a. Demonstrate changes in core, M.H., training curricula attributable to DMH efforts to improve the relevancy of professional training.	(1) Track nursing curriculum changes at HSC and report to DMH by 6/1/86.	Paul Sherman				
		b. To have developed arrangements between Universities designed to enable multi-university M.H. research efforts.	(1) Conduct 2 meetings of faculty interested in mental health research by 1/31/86.	Paul Sherman				
			(2) Stimulate generation of 1 collaborative research proposal by 6/1/86.	Paul Sherman				
		c. To develop a state-wide catalog of faculty M.H. interests.	(1) Contract with faculty fellow to perform this objective by 9/30/85.	Paul Sherman				
6. Need to improve coordination of planning, budgeting and service delivery linkages between systems, especially at the local level and to clarify the responsibility of the public mental health service delivery sector.	6A. Coordinate service delivery to youths held in custody under the Children's Code.	a. Form a task force of representatives from DMH, the Judiciary, DYS, DSS, and DDD to develop rules and regulations to implement H.B. 1249, concerning the provision of mental health evaluation services needed for juveniles charged with delinquency, dependency and neglect offenses.	(1) Form Task Force by 7/30/85.	Mary Wiberg				
			(2) Promulgate rules and regulations by 6/30/86.	Mary Wiberg				
		b. Coordinate the provision of inter-system training on the above rules and regulations.	(1) Provide initial training on Statute by 9/30/85.	Mary Wiberg				
			(2) Provide training to all affected by new rules and regulations once promulgated, throughout rest of fiscal year.	Mary Wiberg				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
	6B. Coordinate service delivery to youths whose needs do not fit within the present mental health, social services and youth services systems.	a. Submit a Supplemental Budget Request to the legislature to fund the Intersystem 'Gray-Area' Youth Project by December 1, 1985.	(1) Track budget request and advocate approval by 4/1/86.	Bruce Berger Liz Wilderman Mary Wiberg DSS DYS				
		b. Through the anticipated NIMH Planning Grant, complete an in-depth needs assessment and formulate statewide delivery strategies to address the needs of 'intersystem' youths.	(1) Complete needs assessment study by 4/30/86.	Liz Wilderman				
			(2) Formulate statewide service delivery strategies based on needs assessment and, if funded, first 3 months of program operations by 6/30/86.	Liz Wilderman				
	6C. Involve other systems and outside agencies in planning for the delivery of public mental health services.	a. Utilize Planning Adv. Council to develop budget and service delivery strategies for the mental health system which coordinate with the constituencies and service providers that they represent.	(1) Hold Planning Council meetings in November 1985 and July 1986 to develop budget and service delivery strategies for implementation in FY 1986-87.	Liz Wilderman				
	6D. Develop policies to clarify lead agency responsibility for each client population and then to develop mechanisms for pooling resources across systems where needed to meet multi-agency client needs.	a. Agressively pursue current MOU with DSS. (See Goal 7C)	(1) Contact EDD and DSS and mutually identify priority MOU tasks and establish a process/plan for resolution by 11/1/85.	Jack Bartleson				
			(2) Implement plan identified in (1) by 6/30/86.	Jack Bartleson				
		b. Use Leadership Forum to pursue 6D with the Department of Education.	(1) Continue to meet every 2 months and support joint lobbying and program development.	Bob Glover				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
		c. Contact ADAD, DDD, the Health Dept. (specifically on nursing home issues) to set up tailored mechanisms with each system to pursue 6D.	(1) Meet with ADAD and DDD and selected local providers from each system including State Hospital to define dual diagnosis population and system issues in disposition, establish a prioritized work plan and implement work plan by 2/1/86.	Jack Bartleson				
7. There is no continuum of services for children and adolescents, particularly residential programs.	7A. Expand residential programs for mentally ill children and adolescents.	a. Open expanded RCCF beds in current FY budget.	(1) Obtain JBC approval for use of medicaid funds and issue RFP to establish additional capacity and/or increase the program at one or both RCCF's by 3/1/86.	Jack Bartleson				
			(2) Implement new beds by 5/1/86.	Jack Bartleson				
	7B. Evaluate the overall need for services to mentally ill children and adolescents including private sector and unserved groups.	a. Analyze DMH Program Evaluation Study of RCCF initiative.	(1) Produce quarterly process evaluation reports beginning 10/30/85.	Nancy Wilson				
			(2) Produce yearly report of program process and outcome by 8/1/86.	Nancy Wilson				
	7C. Refine enrollment criteria and responsibility for RCCF programs between DSS and DMH.	a. Appoint joint task force DMH/DSS to establish criteria.	(1) Appoint task force by 10/15/85.	Mary Wiberg				
			(2) Issue formal recommendations by 6/30/86 for implementation in FY 1986-87.	Mary Wiberg				

COLORADO DEPARTMENT OF INSTITUTIONS
MANAGEMENT PLAN FY 85 TO 86

DIVISION OF MENTAL HEALTH

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
8. Mental Health treatment facilities and equipment are deteriorated and there is not enough space for privacy of treatment in many community mental health centers.	8. To maximize the effective utilization of facilities and facility resources through better facility planning, maintenance and management.	a. Start construction of the new power plant at CSH by 6/30/85.	(1) Develop a tiretable for construction of power plant by 10/1/85.	Bruce Berger				
			(2) Implement and monitor tiretable to insure completion of project by 6/30/86.	Bruce Berger				
		b. Develop an inventory of facility needs for CMHC's by 6/30/86.	(1) Develop work plan by 10/1/85.	Bruce Berger				
			(2) Complete inventory by 4/1/86.	Bruce Berger				
			(3) Complete report by 6/30/86.	Bruce Berger				
		c. Increase the efficiency of the CSH Laundry Facility.	(1) Issue RFP to lease out laundry operations by 9/30/85.	Haydee Kort				
			(2) Contract with best vendor by 2/1/86.	Haydee Kort				
		d. Update the Power Plant at CSH.	(1) Complete design of new boiler system by 11/1/85.	Haydee Kort				
			(2) Complete construction of the Bag House by 12/31/85.	Haydee Kort				
			(3) Purchase boiler equipment by 3/31/86.	Haydee Kort				
9. Staff salaries are too low systemwide and there are substantial personal services funding deficiencies in the state hospital budgets.	9A. To enable the recruitment and retention of adequate numbers and mixes of well-trained direct care and support staff in the CMHC's and hospitals to provide high quality care.	a. Obtain 100% of POTS funding and 100% of Personnel Service Budget for hospitals.	(1) Develop budget request that includes 100% of POTS need by 11/1/85.	Bruce Berger				
		b. Increase the ceiling of salary scale for psychiatrists at the hospitals by 6/30/86.	(1) In coordination with EDO, propose and advocate legislation, and develop options for contractual arrangements.	Brock Willett Haydee Kort Mary Wiberg				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
		c. Review staffing requirements on CSH Closed Adolescent Treatment Center and Housekeeping and complete report by 7/31/85.		Haydee Kort				
		d. Implement staffing changes and/or resource allocations by 6/30/86.		Haydee Kort				
		e. Review plan to reduce turnover in the rural mental health system and take actions to implement through contract negotiations in fourth quarter.						
9E. To reduce hospital personnel time due to worker compensation claims.		a. Reduce the amount of lost time due to worker compensationn claims at the hospitals by 10% by 6/30/86.	(1) Report to hospitals on accomplishment of objective each month and take corrective action as necessary.	Bruce Berger				

COLORADO DEPARTMENT OF INSTITUTIONS

MANAGEMENT PLAN FY 85 TO 86

DIVISION OF MENTAL HEALTH
EXECUTIVE DIRECTOR'S OFFICE

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
10. There is severe overcrowding in the state hospitals and therefore, a statewide shortage of public mental health inpatient resources.	10. Alleviate the overcrowding through management initiatives and resource development.	a. Examine use of forensic services for non-criminally insane patients.	(1) Determine parameters to be investigated and data available and issue report and recommendations by 1/1/86.	Nancy Wilson				
			(2) Depending on results of above, define policy changes and/or develop legislative initiative for implementation in FY 1986-87.	Bob Glover Management Team				
		b. Evaluate early impacts of H.B. 1249 on admissions to children/adolescent units.	(1) Through DMH Planning Grant, collect and analyze data and complete preliminary report by 6/30/86.	Liz Wilderman				
		c. Develop a policy concerning the need for and utilization of inpatient beds.	(1) Complete initial report by 11/1/85.	Nancy Wilson				
			(2) After review by DMH Management Team, complete final report by 1/1/86.	Nancy Wilson				
			(3) Implement policy by 6/30/86.	Bob Glover				
11. There are substantial information system/ADP resource needs.	11A. Upgrade all existing data systems.	a. Secure user oriented documentation for existing systems.	(1) Specify systems to be documented and documentation format and obtain EDD approval by 11/1/85.	Nancy Wilson				

PROBLEM	GOALS	OBJECTIVES	MAJOR TASKS	STAFF RESPONSIBLE	MONITORING DATE	ACCOMPLISHED YES	ACCOMPLISHED NO	COMMENTS
		b. Modify and streamline Seclusion and Restraint, client reporting and IRIS system.	(1) Specify changes needed and obtain DOI-ADP approval by 11/30/85	Nancy Wilson				
			(2) Make final changes by 6/30/86.	Nancy Wilson				
	11B. Develop new systems.	a. Develop a micro based agency information system for Program Services.	(1) In coordination with DOI-ADP, conduct requirements analysis, design mainframe interface for existing data bases and create Dbase III application by 6/30/86.	Nancy Wilson Paul Sherman				
		b. Ensure that 20% of the community agencies electronically transmit data this fiscal year.	(1) Survey CMHC's to identify first 6 agencies capable of transmission by 1/1/86.	Nancy Wilson				
			(2) Secure DOI-ADP approval and obtain necessary communication hardware and software by 3/30/86.	Nancy Wilson				
			(3) Electronically transmit data by 6/30/86.	Nancy Wilson				
	11C. Improve data analysis capacity.	a. Upgrade existing 7 year old micro interface with SDCC to SNA compatible high speed micro.	(1) Secure DOI-ADP approval and draw up specs and order equipment by 9/1/85.	Nancy Wilson				
			(2) Complete upgrade by 11/30/85.	Nancy Wilson				

LIST OF FIGURES AND TABLES

LIST OF FIGURES AND TABLES (Continued)

List of Topics Addressed

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(Continued)

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