DIVISION OF MENTAL HEALTH

MASTER PLAN

1973

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Governor

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Department of Institutions

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DIVISION OF MENTAL HEALTH

COLORADO DEPARTMENT OF INSTITUTIONS

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Division of Mental Health
1973 Master Planning Committee

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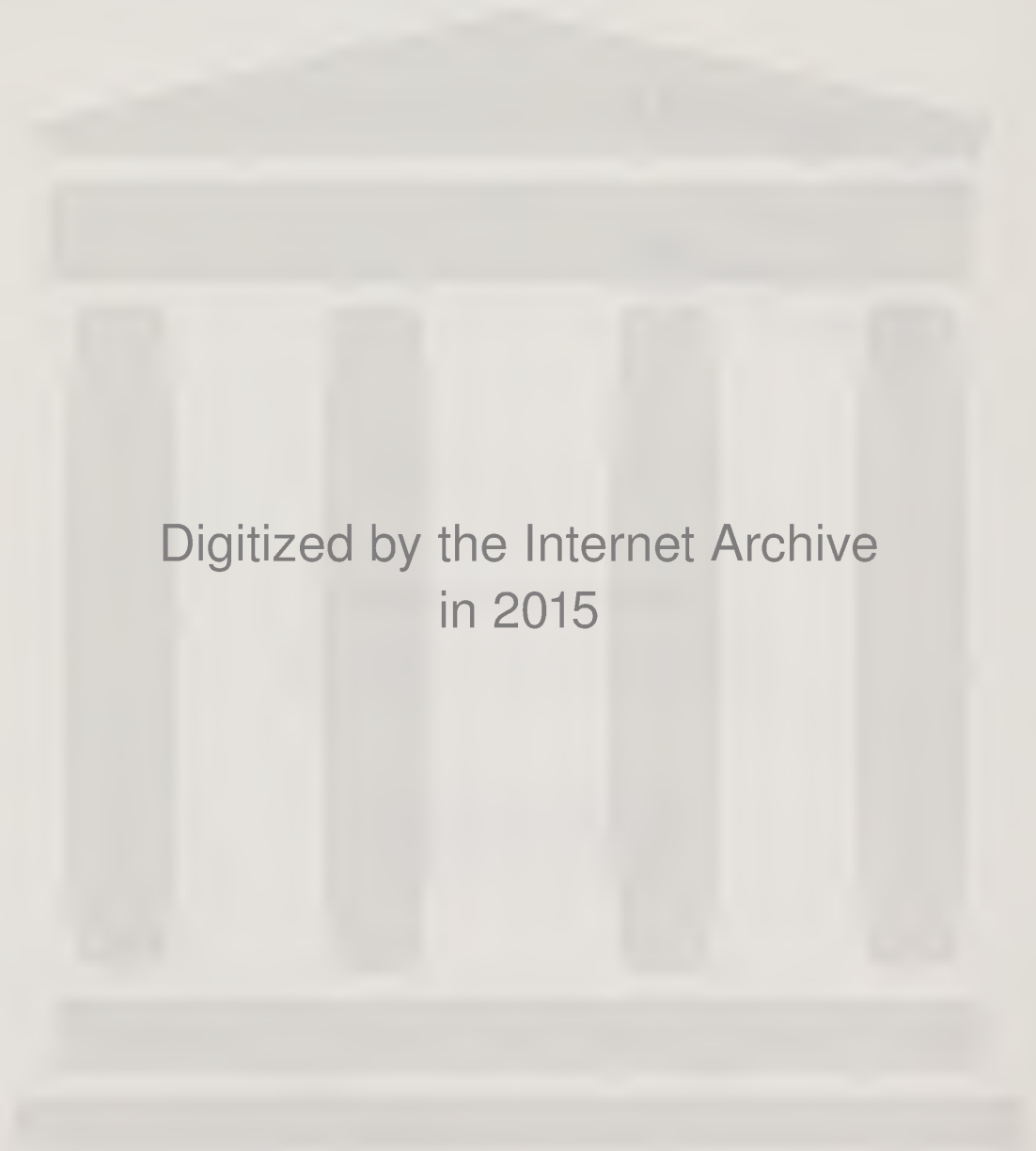

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INTRODUCTION

In 1879, just three years after gaining statehood, Colorado initiated its first public state-supported effort to be of assistance to those who were known as "insane" persons. This beginning step was the establishment of the Colorado State Insane Asylum in Pueblo for the care of approximately 30 mentally disturbed citizens, most of whom lived in the city of Denver. Today, 94 years later, Colorado is recognized as a leader in the prevention and treatment of mental disorders; it has an enviable mental health program that is emulated by most governmental units throughout the United States and Canada.

Ironically, such progress has been achieved without the benefit of any officially sanctioned or directed statewide comprehensive "Mental Health Plan," with the one exception of the 1965 two-volume report concerned with "Planning Comprehensive Mental Health Services in Colorado" by a group of citizens and professionals working on behalf of the Department of Institutions. However, it would be inaccurate to attribute this remarkable record to a "Topsy" phenomenon; many forces have been exerted during the past 12 years that were carefully and wisely coordinated in the development of the beginning stages of an integrated, geographically comprehensive mental health service delivery system. Dedicated professional and paraprofessional individuals, working closely with a concerned state legislature and federal agencies molded a program structure that called for, and received, superior personnel and facilities which form the bulk of the present Colorado Mental Health Services Delivery System.

While the general field of mental health care and treatment received a giant boost during or immediately after World War II, it is not an exaggeration to note categorically that more progress in the treatment of the entire spectrum of mental and emotional disorders has been made in the past 12 years than in all the years preceding. The introduction of so-called "psychotropic drugs", at about this time, suddenly made available to mental health practitioners, significantly accelerated the treatment process for those under some forms of therapy. Probably of more importance, these drugs helped to create within a huge, previously refractory population an opportunity to commence a meaningful therapeutic relationship. Colorado early recognized the potential for conversion of a "good" custodial program into an active treatment program by initiating creative changes within the state hospital system.

The 6,000 inpatients at the Colorado State Hospital were reorganized into small, decentralized treatment units. Fort Logan Mental Health Center was constructed in 1961, and significant numbers of professional personnel

were added to existing staffs. As the impact of active treatment programs began to appear, a noticeable decline in inpatient statistics commenced that has only now apparently plateaued at approximately 2,200 individuals at any given time among all of the facilities providing such care throughout the state.

In the mid 1960's, a federal program, the Comprehensive Community Mental Health Centers Act, provided the incentive and financial where-with-all to construct and staff mental health service delivery facilities in communities throughout the state. With the help of the established state hospitals, Colorado quickly increased its ability to provide such services within selected communities by gaining federal fiscal support for the creation and implementation of what is now a group of 14 Comprehensive Community Mental Health Centers and eight mental health clinics located throughout the state. However, now that the federal financial stimulation is winding down, the need for more state dollars has created within our legislature the need for not only accountability for dollars spent, but for a rational and carefully conceived plan for the delivery of mental health services in the future.

To help initiate and maintain a completely integrated mental health care delivery system, in 1972 the Chief of the Division of Mental Health charged a group of six members of representative components of the mental health delivery system to amplify and place in operational order the approved direction for all divisions within the Department of Institutions as published in the latter's Master Planning Program completed in November, 1971. As a first step an update of the 1971 Department of Institutions Planning Program (Appendix A) was completed (See Appendix B). Starting from and building upon these earlier efforts, this document was developed by the following individuals:

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Robert S. Herrmann, Ph. D., Assistant Superintendent for Administrative Services, Colorado State Hospital

Earl McCoy, ACSW, Chief, Community Services, Fort Logan Mental Health Center

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PHILOSOPHY

The basic philosophy of the Division of Mental Health, Colorado Department of Institutions, is that every citizen is entitled to the full range of mental health care services which facilitate his efforts to attain a sense of personal fulfillment, respect for the needs of others, and pride in his own life. The effective delivery of mental health services depends upon the knowledge of needs, capabilities, attitudes, resources and environment of each community. Therefore, it is the Division of Mental Health's belief that the provision of services should be guided by community residents who are in touch with their neighbors' needs, their frustrations and the social, economic and political forces which affect them positively and negatively.

First, mental health services should be provided on the basis of needs.

Second, the aim of the mental health delivery system is to bring assistance to people as close as possible to the situation in which the needs are manifested and at the time when those needs are expressed.

Third, the system should ensure that mental health services are provided which are acceptable and useful to its clients.

Fourth, the Division has the responsibility to coordinate the delivery of the different existing service delivery models to provide new kinds of services where existing institutions or agencies are unable to meet the residents' needs.

Fifth, the mental health system should provide citizen-oriented programs of consultation to other agencies to increase the effectiveness of their own services.

Sixth, through its educational programs, the local mental health delivery system should attempt to reinforce and enhance the positive community, social, institutional, familial and personal forces supporting mental health.

Seventh, there should be continuous evaluation of mental health services and appropriate changes in service delivery should be initiated in accordance with the results of this ongoing evaluation.

PURPOSE OF COLORADO MENTAL HEALTH PLAN

During the 1973 session of the Colorado legislature, three joint resolutions were introduced for the purpose of determining the delivery of mental health services for the future and the funding for those services.

HR-1027 noted the need for the development of a comprehensive mental health plan for Colorado to provide solid guidelines for policy formulation in the various areas of mental health services and to clarify the respective roles of those elements of government responsible for the delivery of mental health services. This resolution also called for the appointment of a bipartisan committee to study the field of mental health including alcoholism and drug abuse and to draw up a comprehensive, long-range plan for the delivery of mental health services in Colorado. This resolution would require cost effectiveness studies, clarifications for the purchase of services concept, accurate definitions of the interrelationships between the various departments and agencies delivering such services in the state, examination of the role of third party insurance as it relates to mental health, and in general, delineation of what would appear to be broad, sweeping changes and guidelines for the future mental health programs of Colorado.

JHR-1025 notes the multiplicity of institutions providing related services and calls for the establishment of a committee to study the laws governing the interrelationships. Such a study, according to the resolution, would require a recommendation showing how each facility can be best utilized in the state.

Still another legislative intent regarding the state mental health program can be found in HJR-1031, which is primarily concerned with the dollars spent for the delivery of mental health and related services. This resolution requests that a committee study the efficiency and economy of present and/or proposed programs.

Now that this united burst of energy and growth has occurred, it is apparent that a learned, professional, and above all, objective scrutiny be conducted regarding the status of mental health service delivery systems in Colorado; and that the long sought plan be introduced to provide a base to be used for the future. With all of the above-mentioned progress registered in the annals of mental health treatment, some deficiencies must be corrected before they become irreversible. This Mental Health Plan for Colorado therefore must address, but not be limited to, some of the following points:

(1) Define clearly for all to understand (consumers and providers) that "client need" is the overriding priority of the Colorado mental health program.

(2) Coordinate efforts, define roles and establish an adequate client information system. This must be accomplished simultaneously upon an inter-and intra-department basis.

(3) Develop uniform standards for each segment of the mental health care delivery system in Colorado. Quality Assurance Programs (QAP) and Professional Standards Review Organizations (PSRO) and other acceptable evaluation systems will be monitoring Colorado mental health programs.

(4) Discover a method for the funding of pilot or pioneering programs to enhance all aspects (fiscal, professional and administrative) of the mental health care programs.

(5) Establish a priority-setting process in which all agencies will participate.

(6) Conduct a professional public information program regarding mental health as a first step in an obvious effort to initiate the "prevention" phase of the mental health program.

(7) Insure that all entities of the human services delivery programs are involved, wherever possible, in the providing of mental health services.

(8) Guarantee active participation of all interested citizens in the planning process.

(9) The Division of Mental Health must exercise its leadership role in establishing guidelines for funding quotas, broad control limitations, disbursement of revenue-sharing dollars, personnel and administrative problems, autonomy versus state control matters, etc.

(10) Constant surveillance must be undertaken to insure that efficiency and economy of methods do not jeopardize quality of treatment.

(11) Sufficient guidance and justification must be provided for the vital indirect services of every delivery program; consultation and education, research, training, medical records, facilities, maintenance, etc.

(12) The roles and responsibilities must be spelled out for every component of the Colorado Mental Health System. This would include, but not be limited to, hospitals, centers, clinics, the private sector, the Division of Mental Health, and the Department of Institutions.

(13) A method is urgently needed for insuring the participation of all mental health personnel, professional and paraprofessional, in training, and research opportunities.

(14) The aftercare segments of the Colorado Mental Health Program not under any Department of Institutions authority, must be integrated in a professionally, administratively and financially acceptable manner.

(15) Initiate a phase-in schedule integrating the Division of Mental Health's priorities and those of the local communities. The implementation of this schedule will insure the equitable delivery of the mental health services based on a careful analysis of need assessment data plus the social services delivery capability. (See Appendix C.)

Delivery System

ISSUES AND CONCERNS IN STATE MENTAL HEALTH PLANNING

1. Developing Mental Health Efforts Into a Clearly-Defined System

The present mental health delivery system has been characterized as a non-system. This alludes, in part, to the fact that over the course of the past ten years each of the various sub-components (such as the clinics, centers, and state hospitals) has developed its own program and role function without an adequate mechanism, such as a master plan, for coordinating the implications and ramifications of the evolutionary program changes of other components. A strong central office, sufficiently staffed, will allow the state mental health authority to integrate the sub-components into a cohesive operation. Of course, when there is strong central leadership, there must be an adequate system of checks and balances.

The further development of mechanisms for an adequate mental health delivery system would allow each of the sub-components to be part of an open forum. In the past, as an example, centers have held periodic meetings to discuss reactions to proposed role changes at the Colorado State Hospital and at Fort Logan Mental Health Center. A strong central mental health authority must provide for inputs from agencies and citizens and for a means of discussion and sharing of new ideas about treatment modalities and administrative procedures. From these sets of discussions evolve the means for adequate planning, policy decisions, and a coordinated delivery of services, both intra and inter department. This two-way communication process will provide for the checks and balances within the division.

2. The Respective Roles of the State Hospitals and of the Community Centers and Clinics.

In the past 10 years, dramatic changes have taken place in the roles of the major mental caregivers in Colorado allowing a consistently increasing proportion of individuals and families with mental health problems to receive services close to their own homes.

The State Hospital in Pueblo was transformed from a custodial institution housing 6,000 patients to a dynamic, decentralized organization providing active treatment to an inpatient population reduced to less than 1,500. Fort Logan provided mental health services to Denver metro residents much closer to their own homes and pioneered a number of approaches to the provision of community-based mental health services such as day care, and evening care. The initiation of community mental health centers further extended these concepts, and made mental health treatment modalities such as adult psychiatric inpatient alternatives available within each of their communities.

These recent, rapid changes raise several important questions. What should the ultimate roles be for the state hospitals, clinics, and mental health centers in Colorado? If redeployment of certain services from the state hospitals to centers (or vice versa) is anticipated, should the redeployment be made on a dollar-for-dollar basis, or on some other basis? Which services and functions can be delivered most efficiently and effectively at a centralized versus a decentralized level? To what extent should services be further decentralized within each catchment area? Finally, which services, if any, might be delivered more effectively and efficiently at a setting removed from the client's home and neighborhood?

3. The Need for Clear Priorities.

The central issue of this master plan, therefore, must be the setting of priorities, both from the state level looking at all of the various indices which make up a total mental health system and from the local citizenry, vis-a-vis the independent boards, in view of the needs of that particular locale.

This master plan must address itself to criteria to insure that the priorities are set equally across the state of Colorado. Priorities should not be responsive simply to the "grantsmanship" of a particular mental health delivery sub-unit, but rather based upon firm and concrete need assessments and long-range planning processes, with input of local and regional planning groups.

If the state sets clear, specific and comprehensive standards, the citizens will receive both a high level of mental health services and a wise investment of monies. On the other hand, if the standards become too rigid and specific, there is danger that the centers and clinics will be unable to respond quickly to changing local conditions, concerns and citizen input. Local support in the form of monies and other voluntary assistance may decrease. Innovation and creative approaches to problems may be replaced by apathy and stagnation.

4. Funding Mechanisms.

The most obvious constraint imposed on any mental health system is its budget. The quantity and the quality of mental health services obviously are related to the level at which programs are funded.

Funding mechanisms for mental health services include federal formula and project grants (many of which decline to zero level over a period of years); special federal grants through Housing and Urban Development, Law Enforcement Assistance Agency, Model Cities and other federal agencies; contracts and demonstration projects. State and local governments provide funds in the form of per capita allocations (based on the size of the population served), appropriations tied to federal grants with matching requirements and project and other types of

grants for state purchase of specific mental health services.

Colorado is among those states which have been most willing to shoulder major responsibility for funding mental health services. Appropriations for the two state hospitals are based on several factors including average daily attendance, workload data and established staff to client ratios. Federally funded mental health centers receive state funds which, together with the federal funds, provide 90% of staffing grants, in addition to a state per capita allotment of $.85 per person (up from $.60 effective July 1, 1973). Mental health clinics receive a per capita allotment on the same basis as the centers. Exceptions to this practice are Denver Mental Health Center (technically a Clinic), and the Children's and Adolescent's Mental Health Service of Children's Hospital Association (another Clinic). These two agencies currently receive annual state support in the amount of $50,000 each.

Possibly the most significant breakthrough in the funding of mental health services occurred during the 1972-73 session of the General Assembly. The Legislature funded two new community mental health centers and one growth grant, all of which were approved at the federal level but not funded, from state revenue sharing and general funds. The formula applied to these programs is 82.5% of the federal eligible figure.

This precedent-setting decision suggests legislative commitment not only to the continuation of support for community based programs, but also for the assumption of the primary responsibility for funding such programs. This decision has a number of implications, among which is potentially increased state control of community mental health centers.

A number of key legislators including the author of several major mental health funding acts, in addition to center directors and the Chief of the Division of Mental Health, have expressed some dissatisfaction with the present mechanism for funding mental health centers and clinics and the state hospitals. In the absence of valid need assessment and cost-benefit data, it has not been possible to develop a funding scheme tied to need or objectively determined program impact.

A number of factors, in addition to need and outcome, should be considered in developing formulae and other mechanisms for financing mental health services. These would include the capability of county and municipal governmental units tocontribute matching funds, socioeconomic factors in the various communities, fee policies and percentages of fees collected, differences in operating costs, variations in staffing patterns, demographic and population factors, usage patterns, the availability and accessibility of other human caregiving

agencies, and variations in third party payments. All of the above should be considered within the framework of program budgeting.

Further, there do not currently exist any incentives to the service components to save money, whether public or private. If an agency is successful in reducing costs while maintaining a high quality of care, it should be allowed some benefit for its efforts. However, under the existing funding scheme, it must return the money to the state and be funded the next year at the same rate or a lower one than the agency which is either less effective or efficient or both. One suggestion is that funds left from one year should be allowed to remain with the agency to be used for special programs or improve existing programs the next year.

On the national scene, there is steady movement towards some form of universal health care plan. There are indications that national health insurance (NHI) will contain specific provisions for the treatment of mental and emotional disorders. Estimates of the amount of mental health coverage range from negligible to substantial. It also is possible that mental health coverage will initially be modest, but will increase as data on usage and cost become more available.

Special revenue sharing for health also has been discussed. However, legislation for this area has not found strong support in Congress.

Mental Health Services through Health Maintenance Organizations (HMO) is yet another possibility. A number of HMO prototypes have been funded, each with a different means of providing mental health care.

Still other possible federal sources are the continued funding of community mental health centers through an extension of the Community Mental Health Center act to permit new starts and/or extending federal participation beyond eight years, and various social service programs, such as Title IV A of the Social Security Act. The former is possible on a limited scale, and the latter holds little promise of substantial funds for mental health services in Colorado because of recent restrictions.

The constraints tied to Medicare and Medicaid (Titles 18 and 19 of the Social Security Act) reduce their potential as major sources of third party income for community mental health centers and clinics that cannot meet such requirements as having an M. D. on the premises at all times when treatment is taking place.

5. Data Base and Need for Evaluation.

The state legislature has repeatedly asked for evidence that the mental health programs in Colorado are effective in terms of meeting the needs of the citizens, providing a high quality of care, using appropriated funds wisely, and in returning the majority of clients to their communities as reasonably well-functioning people.

The responsibility for providing this information clearly lies with the central office which must obtain it either with its own resources or call upon the delivery system for specific assistance.

Isolated attempts at program evaluation have been carried out over the past ten years at various agencies. For the most part, these were funded wholly or in part with federal funds and were seen as pilot or special short-term projects. In 1969 a research/evaluator position was created in the central office to coordinate the various agency efforts and to establish a basic data collection system. This effort was partially successful; however, the position was vacated in 1971 and no attempt to fill it has been made until recently.

During the interim, a Data Task Force was created in 1972 to revise the existing data system and make it more compatible with budget procedures. This in turn required the standardizing of bookkeeping and budget preparation across the many components of the mental health delivery system. A proposed Planned Program Budget system was developed and approved by the Executive Budget Office and Joint Budget Committee in 1972. However, the machinery for implementing the system awaits the supervision of the central office evaluation coordinator and the plan has not yet become fully functional. Further, the plan addresses itself to the issues of unduplicated counts of cases seen and/or treated by the delivery system by problem categories and basic cost accounting. The questions of outcome or effectiveness and need assessment are still unresolved.

Colorado is fortunate in having several large federally-funded evaluation projects currently working on the problem of treatment outcome measures, indices of cost benefit, mental health system evaluation, and management information systems. Every attempt should be made to incorporate, adapting where necessary, the techniques and findings of these studies into the state data system. This is a large task but one which should be pursued immediately by the central office.

6. Accountability.

This issue revolves around the concern of many that the mental health agencies and/or programs are not doing what they said they were going to do with the money they were given. While tied to the evaluation issue above, it is broader in scope in that it focuses on the total agency and its impact on the community it serves. It requires a statement of purpose, goals and objectives for each agency and then a means to measure their performance in accordance with that statement. It further requires an assessment of the needs of the community served and periodic assessment of the impact of the agency related to those needs.

7. The Relationship of Mental Health to Social Services, Health, and Other Caregiving Agencies.

The concepts of mental health are slowly permeating many of the other human services; e. g., corrections, education, social services, and general health care. This trend gives rise to a current concern over the appropriate organizational location of mental health services within the state governmental structure. Some feel that a new department should be created which replaces several others and combines many state functions under the umbrella of Human Services. Others feel that mental health still is basically a health service component and should be within the Department of Health. Still others believe that things are fine the way they currently exist with the Division of Mental Health residing in the Department of Institutions where its activities can be coordinated with mental retardation, corrections, etc.

It is hoped that in resolving this issue the mental health profession does not engage in territorial battles to the detriment of the citizens it is charged with serving. While realizing that some departments and organizational structures would be more appropriate than others, it is hoped that the current ability of the mental health system to provide a wide range of services to its clients would continue unrestricted by organizational concerns and constraints.

8. Local Autonomy or State Control.

Before the passage of the 1963 comprehensive Mental Health Centers Act on the national level, Colorado had been moving ahead in its plans to deliver first rate mental health services to its citizenry. Over the years, the establishment of the federal guidelines, which call for the involvement of local citizens in the operation of centers, has been interpreted in different ways. One interpretation has been that this citizens' board become the policy-making and decision-making body for the local comprehensive mental health centers. All but one of the comprehensive centers in Colorado are non-profit corporations; therefore, the rules and regulations of these organizations are set forth by their own by-laws and articles of the corporation. The other interpretation has been that these boards should be advisory only.

Currently only the two state hospitals are under the direct control, supervision and management of the Department of Institutions. The local community mental health centers and clinics are governed by the local administration and their local boards. However, with the increased state support in terms of tax dollars allocated on a per capita basis, concern is being expressed in many quarters that the state has both a right and an obligation to exert more direct control in the local agencies. Basically, this is done through the contractual agreements between the Division of Mental Health and the local centers and clinics in which the latter agree to provide certain services according to standards drawn up by the former. The necessary control should lie in these standards; and if they are not met, the state monies should be withdrawn.

9. The Importance of Individual Client Needs Versus the Mental Health Delivery System Itself.

As within any system which purports to serve needs of individual clients or individuals suffering from various problems, mental health has established itself as an integral part of both the local and state governments. Consequently, it is imperative that all long-range plans must constantly refer back to the very basic tenets of the mental health delivery system which is to serve the individual clients. Far too often the perpetuation of a delivery of service itself seems to dictate the directionality and priorities of the system rather than respond to individual needs of individuals.

Realistic parochial interests and healthy competition can insure attention to individual client needs, not the perpetuation of a given institution or sub-element within the delivery system. Therefore, this trend or central theme will be reflected in all parts of this master plan.

10. Revisions of the State Standards.

The Division of Mental Health must soon undertake the difficult job of revising its standards for the purchase of services from mental health facilities. This process includes the definition of roles for centers, clinics and hospitals; the defining of "quality care" and the establishment of quantifiable standards for role performance and the delivery of high quality services. A nation-wide system of quality control is being established through Quality Assurance Programs (QAP) and Professional Standards Review Organizations (PSRO). Colorado State Hospital is actively involved in this process via a federal grant. It is anticipated that all hospitals and community mental health centers and clinics will eventually be monitored under one of these programs.

Before full implementation of the new standards, the Division of Mental Health must address itself to developing state-wide need assessment methods and adequate criteria for program evaluation. It is obvious that the state hospitals already are accredited, but the standards to which this master plan is alluding are firm criteria for insuring quality mental health services in each component. Each must have a uniform set of standards which is viable, yet at the same time, flexible enough to meet the needs of the citizenry in the varying locales across the state.

11. Developing a Prevention Phase of the Delivery of Mental Health Services.

Controversy has raged for a long time in the mental health profession as to whether we are truly talking about prevention or whether we are talking about intervention which reduces the intensity of the mental health problems. To insure that mental health programs in Colorado, now and in the future, do not attempt to oversell their programs, this issue must be squarely addressed. There must be measurable outcomes addressing themselves to the impact of

the programs and predicated on well thought-out model programs, which, in turn, can be evaluated on the basis of the local community and the applicability to other communities throughout the state. There also must be a viable concern and desire by the local community for this model program to take place in the confines of the area.

Knowledge about mental health has not advanced to the point of specifying the underlying causes of many so-called mental health problems or illnesses. Many advances have been made in the past 50 years in both the physical and psychological help offered those with mental health problems and this information should be disseminated so that people can better understand the current state of the art.

As we learn more about and are able to alleviate some of the social, economic and environmental factors which contribute to severe mental distress, we will benefit all citizens since these factors affect everyone. Also, it is essential that there be more acceptance among the general population so that an individual who has had a mental health problem will not be restricted in his social functioning, rejoining society or performing to the best his potential will allow.

12. Coordinated Training Programs for Mental Health Professionals.

Training programs for mental health professionals and paraprofessionals have been independently developed over the years in the state of Colorado. It is now time that we firmly address the issue of pulling together the various training programs into a more economical, efficient and coordinated effort. By this we are not suggesting that a single training system be developed and imposed upon the various training institutions, but rather that the strong leadership of the central mental health authority in the state be charged with the responsibility of overseeing all professional and paraprofessional training that takes place in institutions which are under the direct control of the Department of Institutions. The central mental health authority will also cooperate with and coordinate its training programs with the training programs of the University of Colorado Medical Center, the Denver Veterans Administration Hospital and Denver General Hospital. As within any profession, there are varying thoughts as to which is the most expeditious manner for delivering a well-coordinated training program. Consequently, the training needs must not only be thought of in terms of the existing programs in the mental health delivery system within the state today, but with a constant awareness that programs will by necessity expand and move in new directions and that the training of an individual starting today should be designed to meet adequately the needs of the mental health delivery system three to five years hence.

Training, therefore, must be coordinated not only for the state-supported schools, but also for the several private and federal institutions which supply many of the key personnel into the mental health delivery system and the manpower needs of the same.

Continuing education for all mental health professionals, both in the public and private sectors, must be included in the initial planning to insure the delivery of high quality mental health services.

13. Care of Former Hospitalized Patients.

Nursing homes have become some of the major facilities for the placement of individuals after hospitalization within the local community. This master plan must address itself to the issue of not only the physical environment an individual has within any given nursing home, but must also be concerned with the development of an adequate quality of life within that setting where the individual can feel as though he is a viable member of our society and not one who has been dehumanized and simply "put out to pasture". Nursing homes also provide an adequate alternative for structured group living for the mentally retarded as well as for those individuals who do not need full hospitalization. In reviewing the adequacy and quality of nursing home services, attention should be given to finding or developing residential facilities for persons who do not require primarily nursing care. Adequate follow-up care must be planned for the post-hospitalization needs of those persons who cannot resume independent living in the community.

14. System of Funding Pilot or Experimental Programs.

The age of program budgeting is upon us. This allows the management of each level in the mental health system to manage its programs in a fairly concise and uniform manner. However, there must be a reservoir of dollars set aside each year for pilot studies. Such a fund administered by the Chief of the Division of Mental Health, with all elements of the system encouraged to compete for dollars over and above their approved budgets, could insure that Colorado does not stagnate. These pilot programs could be in the following areas: new treatment methods, management methods, evaluation techniques and accounting procedures. Obviously, any one pilot program could have gross ramifications for any or all segments, not just for the one being funded.

As is inevitably the case, programs that start on a pilot basis may end up being permanent and funding on a continuing basis be requested. Each proposal for a pilot program should include plans for cost-benefit analysis and evaluation of the program, so that justification for future funding could be made and clearly supported with appropriate data.

GOALS AND OBJECTIVES

1. Goal: Develop an integrated mental health services delivery system.

   Objectives:

   a. By October 1973, there will be an initial plan for the assignment of specific responsibility for the provision of each element of service within each region to a community mental health center or clinic or a state hospital.

   b. By January 1974, there will be a plan for a mental health information system which will make data on admissions, discharges, etc., from each component of the mental health services delivery system available to all components.

   c. By July 1974, there will be a plan for collaborative and cooperative working relationships between Colorado Psychiatric Hospital and Mental Health Programs under the control of the Department of Institutions, and Colorado Psychiatric Hospital and Agencies with which the Department of Institutions has contractual arrangements.

   d. By July 1974, the Division of Mental Health will structure and implement a plan to insure the following:

      (1) The optimal use of input from the various mental health components, which includes a design for a forum for gathering input and disseminating it.

      (2) The development and implementation of a plan to facilitate the exchange of expertise, personnel and services among the mental health system components.

   e. By July 1974, there will be four regional Mental Health Coordinators who will provide consultation in the management, clinical, programmatic and other areas in the Mental Health agencies in their region. Regional Coordinators also will serve as policy interpreters for the central office for the programs in their region.

   f. By January 1975, the first draft of a systems wide procedures manual will be available for review by components of the mental health services delivery system.

   g. By January 1975, there will be a plan for the development of cooperative relationships with that portion of the private mental health sector with which the Department of Institutions has no contractual arrangements.

2. Goal: Bring the total mental health services delivery system to an optimal level of functioning as defined by state standards;

Objectives:

a. By January 1974, there will be an individual written treatment plan for each client in the Mental Health Services delivery system.

b. By July 1974, proposals for a series of pilot projects aimed at cost containment and the development of innovative, efficient, high-quality treatment approaches will be available for incorporation into the 1975 Department of Institutions budget request.

c. By July 1974, each center and clinic will have contacted each school district in its service area and explored the possibility of providing preventive and early interventive mental health services to the pupils in the district (see House Bill 1164, 1973).

d. By July 1974, there will be a mental health disaster plan for psychological first aid to victims of major disasters.

e. By January 1975, the first draft of the state standards for community mental health centers will be revised to include standards for quality of care in centers and clinics.

f. By January 1975, there will be a quality assurance program in effect in both state hospitals.

g. By January 1975, there will be a proposal for an incentive reimbursement system which will reward providers of high quality mental health services who work to increase their efficiency and effectiveness.

3. Goal: Ensure the availability and accessibility of the full range of quality mental health services close to persons who require such care.

Objectives:

a. By January 1975, a detailed capital construction plan for mental health facilities will be available. The major consideration in the development of this plan will be service needs in the various regions of the state.

b. By July 1976, the full range of mental health services will be available through community mental health clinics and centers, with the exceptions of those specialized services which remain (or become) the responsibility of state hospitals for clinical, economic or other cogent reasons.

4. Goal: Establish priorities for the development and expansion of mental health services as needed, throughout the state.

Objectives:

a. By July 1974, there will be a plan, with priorities, for the development of needed new centers and clinics, and for the expansion of existing community based programs.

b. By July 1975, priorities for the delivery of mental health services, based on assessment of need and including citizen input, will be submitted to the Division of Mental Health for (1) each catchment area, (2) each mental health agency, and (3) each planning region.

5. Goal: Develop a proposal for a new mechanism for the allocation of funds for mental health services.

Objective:

By July 1974, a proposal for a new mechanism for funding state hospitals and community mental health clinics and centers will be available for presentation to the General Assembly.

6. Goal: Develop a statewide management information system which includes need assessment and program evaluation capabilities.

Objectives:

a. By November 1973, the coordinator of research position in the Division of Mental Health will be filled.

b. By January 1974, the preliminary results of evaluative studies by several centers, clinics, and hospitals will be available.

c. By January 1974, there will be a statewide program evaluation and accountability advisory committee.

d. By July 1974, a proposal for state funding of a statewide need assessment and outcome survey will be available for presentation to the General Assembly.

e. By July 1975, a proposal for state funding of an ongoing need assessment and impact measuring system will be available for inclusion in the Department of Institutions budget request for 1975 - 76.

f. By July 1974, a set of guidelines will be developed for minimal evaluation and accountability procedures for all mental health components.

g. By July 1974, negotiations for needed on-line computer capabilities will be underway.

h. By July 1975, current evaluation programs in centers, clinics, and hospitals will be reviewed and evaluated in light of the above guidelines (f).

7. Goal: Reduce community and family disruptions and the loss of productive output by persons with mental health problems.

Objective:

By July 1975, there will be a plan to measure improvement in social and vocational functioning in the clients served by the three programs (centers, clinics, or hospitals).

8. Goal: Participate in attempts to ameliorate those factors in the social and physical environment that contribute to mental illness.

Objectives:

a. By January 1975, a manual will be written setting forth guidelines by which hospitals, centers, and clinics will report observed harmful or potentially harmful conditions and practices such as housing code violations, child abuse, etc.

b. By July 1975, using the established guidelines, all centers, clinics and hospitals will report the above conditions to the proper authorities.

9. Goal: Increase society's understanding, acceptance and tolerance of persons with mental and emotional disorders.

Objectives:

a. By January 1974, each center, clinic and hospital must schedule a minimum of one public education (information) program each six months on some aspect of mental health and emotional illness.

b. By January 1974, all centers, clinics and hospitals will be required to designate a public information person to inform the public of significant accomplishments in mental health in general, and the center, clinic or hospital in particular.

10. Goal: Coordinate training programs for mental health professionals and paraprofessionals.

Objectives:

a. By July 1974, there will be a cooperatively devised plan for coordinating psychiatry residency programs involving the University of Colorado Medical Center, the Denver Veterans Administration Hospital, the Division of Mental Health, Fort Logan Mental Health Center, Colorado State Hospital, and Denver General Hospital.

b. By July 1975, there will be a plan for determining the extent of the need in the state for nurses, social workers, psychiatrists, psychologists and other mental health related disciplines.

c. By January 1976, there will be a plan for determining the extent of the need for mental health professionals and paraprofessionals and a coordinated program for training such persons.

d. By July 1976, the coordinated psychiatry residency program will be operational.

11. Goal: Improve the quality of mental health services in nursing homes and other non-hospital 24-hour care facilities.

Objectives:

a. By July 1974, there will be a directory of nursing homes and other non-hospital 24-hour care facilities.

b. By January 1975, there will be at least one "model" nursing home.

c. By January 1975, there will be an initial draft of mental health standards for nursing homes.

d. By July 1975, there will be state standards for mental health services in non-hospital 24-hour care facilities, other than nursing homes.

e. By July 1975, there will be a plan for a coordinated mental health services training program for staffs of nursing homes and other non-hospital 24-hour care facilities.

f. By July 1975, there will be a procedure for regular on-site evaluation of mental health care in nursing homes and other non-hospital 24-hour care facilities.

Delivery System

STRUCTURE OF COLORADO MENTAL HEALTH

DELIVERY SYSTEM

BASIC ELEMENTS OF SERVICE

The mental health services delivery system in Colorado is comprised of public and private mental health centers, clinics and hospitals, in addition to other treatment facilities. The scope of available services is impressive; however, there are gaps in mental health services which deprive some people of needed care, and there is duplication of services which increases the cost of services to individual citizens, both directly and indirectly. There is an obvious need for a planned, systematic approach to the provision of mental health services. Such a plan embraces a unified services approach in which specific responsibilities are assigned to each component.

The Division of Mental Health is committed to the holistic or "whole person" approach. However, initially, in order to stabilize the system and establish a common base for planning and funding purposes, it will be necessary to assign responsibility for services in a manner which creates less-than-ideal continuity of care and which can result in fragmentation of service to some clients. This condition will prevail until the plan to provide all feasible mental health services through community based programs is fully implemented.

The basic elements of the Colorado mental health care delivery system are:

1. Inpatient Service (Incare):

   a. 24-hour inhospital care - a therapeutic program in which the client is in full-time care in a hospital setting. Actual treatment may take place in a location other than the hospital.

   b. 24-hour non-hospital care - a therapeutic program in which the client is in full-time care in a non-hospital setting as a specific alternative to 24-hour inhospital care. Actual treatment may take place in a location other than the full-time care facility.

2. Outpatient Service (Outcare):

   Service of up to three hours per day provided on a regular or non-scheduled basis. Outpatient services may be provided in a client's home, at the primary treatment facility, or at some other accessible location.

3. Partial Hospitalization (Intermediate/Transitional/Day Care/ Evening Care):

   A therapeutic program for those persons who require less than 24-hour (full-time) care, but more than outpatient care.

4. Emergency Service (Crisis Intervention):

   Immediate mental health care and evaluation for persons in crisis on a 24-hour-a-day, seven-day-a-week basis.

5. Consultation and Education:

Consultation - involves the provision of mental health assistance by qualified personnel to such community care givers and agencies as courts, schools, police, welfare departments, etc. The purpose is to assist these agencies in providing more effective services to their clients.

Education - activities directed toward increasing the visibility; i. e., community awareness of the program as a community resource and promotion of mental health and the prevention of emotional problems through the dissemination of information on mental health.

6. Training:

Planned staff development training activities and the provision of training experiences for students of mental health related and allied disciplines such as nurses, psychiatry residents, mental health workers, social workers, psychologists, etc.

7. Program Evaluation:

Assessment of the extent to which the program fulfills its objectives.

8. Central Administrative Services (General and Administrative):

The activities related to planning, organizing, controlling, financing, staffing, and directing the overall program of the agency.

9. Aftercare:

Followup care after receiving inpatient or partial hospitalization treatment.

10. Forensic Services:

Services to persons who enter the mental health system via a court order or pursuant to state statutes on on involuntary admission for treatment, evaluation, and/or observation.

11. Rehabilitation Services:

Services designed to reduce the residual deficits of emotional disturbance and to assist clients in attaining the highest level of social and vocational functioning of which they are capable.

12. Specialized Services:

Inpatient, outpatient, partial hospitalization, emergency, consultation and education, central administrative and the several specialized services have been established as "cost centers" or program elements in many agencies;

thus data on these services are readily available. The two state hospitals, and some centers and clinics, have internal data collection systems which facilitate the accumulation of data in other categories, e. g., forensic, program evaluation, rehabilitation, and aftercare services. Additionally, the Division of Mental Health's client admission and termination forms capture data on clients by age, primary and secondary problem, and require identification of those clients who enter the public mental health system via state statutes on care and treatment of the mentally ill. Data on consultation and education service hours and program evaluation is collected in the "group report."

Irrespective of organizational structure, all state agencies accountable to the Division of Mental Health and agencies from which the Division of Mental Health purchases services, will report such services under the following categories to facilitate comparability and assist in program planning:

Institutional:
- Inpatient Service

Transitional:
- Partial Hospitalization

Community:
- Outpatient
- Emergency

Consultation and Education:
- Consultation and Education
- Training

General and Administrative:
- Central Administrative
- Program Evaluation

Aftercare, forensic, rehabilitation, and specialized services provided will be appropriately reflected in the above listed categories. Responsibility for provision of the basic elements of service within each of the 12 planning regions will be specifically assigned to a community mental health center, clinic, or one of the two state hospitals. The ultimate goal is the local availability of the full spectrum of mental health services, with the exception of those functions which properly should be carried out on a regional or multi-regional basis by state hospitals.

ROLE OF THE DIVISION OF MENTAL HEALTH

The Division of Mental Health is the largest of five divisions of the Department of Institutions, and the latter is a statutory department of the State Government (Section 3-11-1, C. R. S. 1963). Section 3-11-4, C. R. S., provides that "the Department (Institutions) shall manage, supervise, and control the following state institutions: Colorado State Hospital at Pueblo and Fort Logan Mental Health Center." Sections 3-11-9 and 3-11-10, C. R. S., authorize the Department of Institutions to purchase mental health services from community mental health centers and clinics that have been approved by the Director, Department of Institutions.

The Division, in carrying out its responsibilities, will engage in the following activities:

1. Planning: this includes initiating and/or responding to new legislative proposals as they relate to mental health, and the development of a master plan for the delivery of mental health services in Colorado.
2. Coordination: facilitating cooperative ventures among and between components of the Colorado mental health services delivery system to meet the various and changing needs of specific populations.
3. Executive Director: the exercise of authority as an agent of the State Executive, including the establishment and enforcement of policies and standards.
4. Consultation: providing planning, clinical, fiscal, and evaluation consultation to all components within the system.
5. Evaluation and Accountability: providing necessary leadership in the development of operational indices for measuring the impact of treatment and preventive efforts and relating this to cost.
6. Advocacy: initiating and promoting the development of mental health programs to serve the needs of all residents of the state.

The Division of Mental Health will take the initiative in the development of a truly unified mental health services delivery system within which appropriate responsibilities will be assigned to the various service components. A basic tenet in the delivery of mental health services is that each client or patient is a complete, functioning human being and not just a potential psychiatric statistic.

The Division of Mental Health, recognizing the importance of comprehensive health planning in meeting total human health needs, strongly urges staff and board members of mental health centers, clinics, and hospitals to become actively involved in the comprehensive planning process in their region.

RELATIONSHIP BETWEEN THE DIVISION OF MENTAL HEALTH AND THE OTHER DIVISIONS OF THE DEPARTMENT OF INSTITUTIONS

The Division of Mental Health is one of six divisions in the Department of Institutions, the others being Mental Retardation, Youth Services, Corrections, Deaf and Blind School, and the Division of Finance. The Division Chiefs periodically meet, as a group, with the Executive Director of the Department of Institutions to discuss matters of general concern and to resolve problematic intra-departmental issues. Additionally, the Chief, Division of Mental Health meets from time to time with other Division Chiefs around issues of mutual concern. Relationships with the various components of the Department of Institutions are not unilateral, but involve a reciprocal exchange of services and information.

The following descriptions characterize the formal and informal contacts between the Division of Mental Health and the staff and/or clients of other divisions:

Division of Mental Retardation:

The Division of Mental Health provides some direct consultation services to the Division of Mental Retardation. Additionally, Colorado State Hospital provides facilities and supportive services to the State Home and Training School at Pueblo, which is located on the Colorado State Hospital grounds. Other mental health/mental retardation contacts take place at the community level, where community mental health centers and clinics, in addition to the two state hospitals provide consultation to staff or mental retardation centers, foster homes and other facilities, and direct mentalhealth services to mental retardation clients.

Division of Youth Services:

In addition to Division level consultation services provided Youth Services, Fort Logan Mental Health Center staffs two Youth Services teams, one of which serves the Closed Adolescent Treatment Center at the Mount View Girls School. Community mental health centers, clinics and hospitals provide services to Division of Youth Services clients via consultation to courts, detention centers, and other group placement facilities, and through direct services to referred youth.

Division of Corrections:

The Divisions of Mental Health and Corrections have as close a working relationship as any two Divisions in the Department. In addition to the extensive consultation provided the Division of Corrections by the Division of Mental

Health, Colorado State Hospital sends a traveling team to Colorado State Penitentiary and Colorado State Reformatory on a regular basis. Colorado State Hospital also provides minimum, medium, and maximum security facilities for inmates of Colorado State Penitentiary and Colorado State Reformatory who require in-patient care, as well as general hospital services for inmates. Community mental health centers, clinics and hospitals provide consultation services to courts, probation and parole officers, and direct services to clients in the corrections system.

Deaf and Blind School:

The Division of Mental Health consultation services to the Deaf and Blind School in Colorado Springs have been limited due primarily to distance. However, Pikes Peak Family Counseling and Mental Health Center, which is located in Colorado Springs, has provided some consultation and direct service to the Deaf and Blind program. The Division of Mental Health should seek means of expanding its services to the Deaf and Blind School.

Division of Finance:

The Division of Finance, as a supporting activity, provides fiscal consultation, automated data processing, and direct financial services to the Division of Mental Health. The Division of Mental Health services to the Finance Division consist primarily of assistance in interpreting Federal, State, and Local policies and guidelines as they relate to mental health.

Public Information:

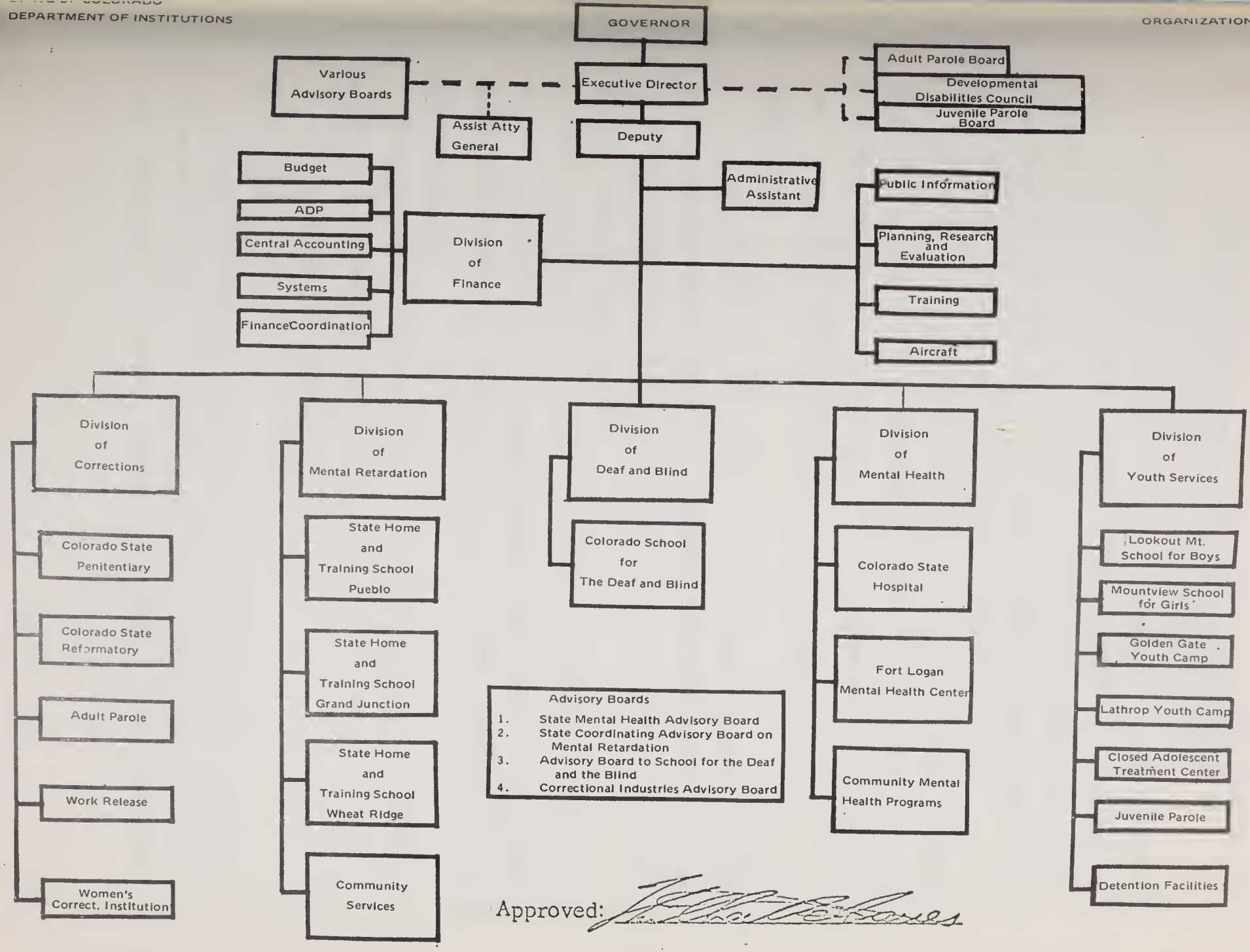
While the Public Information Office is not a Division, it is a vital part of the Department's program. This office develops news releases and other forms of publicity for the Division's programs. The Public Information Officer attempts to insure that newsworthy accomplishments are brought to the attention of the public, that incidents involving the Division of Mental Health and other Department of Institutions components are factually reported and that the visibility of mental health programs is increased.

Other Departmental Units:

The Planning, Research and Evaluation Unit is not yet staffed; it is anticipated that when staffed, this unit will have a close working relationship with the Division of Mental Health.

The TrainingUnit is in the process of transition from a Division of Youth Services activity to a consultation-oriented service serving the total department.

The Departmental aircraft provides air transportation for some traveling teams in addition to courier and emergency services, and rapid, time-saving travel for other official purposes.


GOVERNOR
Various Advisory Boards
Assist Atty General
Executive Director
Adult Parole Board
Developmental Disabilities Council
Juvenile Parole Board
Deputy
Budget
ADP
Central Accounting
Systems
FinanceCoordination
Division of Finance
Administrative Assistant
Public Information
Planning, Research and Evaluation
Training
Aircraft
Division of Corrections
Colorado State Penitentiary
Colorado State Reformatory
Adult Parole
Work Release
Women's Correct. Institution
Division of Mental Retardation
State Home and Training School Pueblo
State Home and Training School Grand Junction
State Home and Training School Wheat Ridge
Community Services
Division of Deaf and Blind
Colorado School for The Deaf and Blind
Advisory Boards
1. State Mental Health Advisory Board
2. State Coordinating Advisory Board on Mental Retardation
3. Advisory Board to School for the Deaf and the Blind
4. Correctional Industries Advisory Board
Division of Mental Health
Colorado State Hospital
Fort Logan Mental Health Center
Community Mental Health Programs
Division of Youth Services
Lookout Mt. School for Boys
Mountview School for Girls
Golden Gate Youth Camp
Lathrop Youth Camp
Closed Adolescent Treatment Center
Juvenile Parole
Detention Facilities

Approved:

RELATIONSHIPS BETWEEN THE DIVISION OF MENTAL HEALTH AND OTHER DEPARTMENTS, LEGISLATIVE COMMITTEES, PUBLIC AGENCIES OUTSIDE THE DEPARTMENT OF INSTITUTIONS, AND PRIVATE AGENCIES AND ORGANIZATIONS

The Division of Mental Health has attempted to establish cooperative relationships with other state departments, and a variety of public and private providers of mental health and mental health related services. Attention also has been given to the promotion of positive relationships with lay and professional groups which represent consumers and mental health care givers. Additionally, there are legislative committees, appointive committees, councils, and advisory groups which, by their nature, require periodic or ongoing contacts with the Division of Mental Health.

Some of the agencies and groups referred to above reviewed and commented on the initial draft of this plan, and representatives of many of these agencies and organizations will be invited to serve as resource persons to, or members of task forces to assist in accomplishing the stated objectives and developing detailed plans to meet identified service needs. A brief description of the Division's relationship with other agencies and organizations follows:

Other Departments

The Division of Mental Health, as a unit of the statutory Department of Institutions, maintains formal and informal contacts with other state departments. Because of the interrelatedness of the functions of the Division of Mental Health and the Health Department, and mental health and the Department of Social Services, the Division of Mental Health has extensive contacts with these two departments.

The Division of Mental Health has an especially close working relationship with the Division of Alcohol and Drug Abuse, with joint staff meetings and other joint ventures being frequent occurrences. There also has been a significant increase in collaborative planning between the Division of Mental Health and the Office of Comprehensive Health Planning.

Private/Voluntary Sector

Professionals and agencies in the private/voluntary sector are important components of the total mental health services delivery system. The Division of Mental Health will continue to actively seek the involvement of representatives of this sector in ongoing planning activities.

Public Institutions

The University of Colorado Medical Center and the Veteran's Administration Hospital are two major public institutions with which the Division of Mental Health engages in an ongoing dialogue. The Division and the University of Colorado Medical Center have joined forces to develop plans for coordinated training programs and collaboration in various service areas.

Other Public Agencies, Commissions, and Councils

The Division of Mental Health will continue to expand its collective planning with areawide comprehensive health planning offices, commissions and councils, major county health departments, and other similar agencies and groups which have significant impact in the planning and policy making areas.

Federal Agencies

The major Federal agency with which the Division of Mental Health relates is the Region VIII Office of Health, Education and Welfare. Both the HEW Office and the Division of Mental Health have designated liaison persons to ensure the sharing of information vital to both. The collaborative relationship between these two authorities is further manifested in extensive joint planning, joint site visits, and other activities which facilitate the coordination of Federal and State activities in the mental health services delivery area.

ROLE OF MENTAL HEALTH CENTERS, CLINICS, STATE HOSPITALS AND OTHER COMPONENTS OF THE MENTAL HEALTH SERVICES DELIVERY SYSTEM

The Division of Mental Health is committed to attempting to bring community mental health centers and clinics, state hospitals, Colorado Psychiatric Hospital, and the private sector into a coordinated system of mental health services. A clear understanding and definition of the roles of the various components of the mental health services delivery system is essential to the accomplishment of the above goal, as well as insuring the availability of quality mental health services to all who need such care, and minimizing duplication of services. For the purpose of this document, elements of the public and private mental health sectors are identified as follows:

1. Public mental health treatment facilities
   a. Colorado State Hospital
   b. Fort Logan Mental Health Center
   c. 22 mental health centers and clinics which provide mental health services by contract with the Division of Mental Health
   d. Colorado Psychiatric Hospital
   e. Denver General Hospital, Department of Psychiatry
2. Private treatment resources
   a. Private psychiatric hospitals and private general hospitals which have psychiatric wards or which will accept psychiatric patients
   b. Mental health clinics and other non-hospital mental health treatment facilities which do not have contractual arrangements with the Department of Institutions
   c. Private practitioners
3. Voluntary agencies which provide treatment and/or personal counseling services.
4. Public agencies whose functions include personal counseling (e. g. county welfare departments, probation and parole departments, vocational rehabilitation programs, mental retardation programs, public health nurses).
5. Private organizations which do not fall into any of the above categories but which are primarily oriented towards services to specific populations, such as drug and alcohol users.

A. Community mental health centers and clinics:

Ideally, each component of the public health services delivery system would provide a service or services that would not be duplicated within the service area. It follows that one agency in each service area should be the focal point for mental health services; i. e., one agency in each service area should be the primary intake point, and should have overall responsibility for the planning and provision of all mental health services within that area (see the section entitled "BASIC ELEMENTS OF SERVICE" for a listing and description of the basic elements of the Colorado mental health delivery system). The agency responsible for services to a given catchment area would provide services either directly, or through affiliate arrangements with other care givers, both public and private. This role is seen as a proper one for community based mental health centers and clinics. These local facilities already exist in some 22 communities across the state, which include over 80% of the population of Colorado. Full implementation of this plan would require that:

1. Present service (catchment) area boundaries for centers and clinics be reviewed and appropriate adjustments made.
2. Service area boundaries for state hospitals be adjusted so that those services which are the responsibility of state hospitals will be provided to local programs by the state hospital closest to the community.
3. All funds for mental health services, other than those services which are the sole responsibility of state hospitals, for a given catchment area, be appropriated to the Division of Mental Health for distribution via contractual arrangements to community programs.
4. Appropriation of funds per number 3 above, for the full range of mental health services be phased in over a period of several years in accordance with the schedule developed by the Division of Mental Health. Primary criteria for assumption of services by centers and clinics would be need, the readiness of the local program to assume services as determined by the Division of Mental Health and economic feasibility.
5. The Division of Mental Health exercises a sufficient degree of control over publicly funded centers and clinics to enable the Division, as the State Mental Health Authority, to properly direct the total mental health services effort.
6. Centers and clinics should be free to negotiate affiliation arrangements with state or private hospitals, and other facilities in or near their catchment areas. Primary considerations in such affiliation arrangements would be quality, accessibility of services, and cost.

B. State Hospitals:

1. Colorado State Hospital and Fort Logan Mental Health Center are uniquely qualified to provide certain mental health services that for clinical and economic reasons can best be provided by a regional state hospital. Both Colorado State Hospital and Fort Logan Mental Health Center should be funded at a level that will enable them to continue providing high-quality services to those individuals and agencies within their service area. The service area of the state hospital includes several planning regions and several center and clinic catchment areas. Colorado State Hospital and Fort Logan Mental Health Center are similar in many respects but differ significantly in terms of history, treatment philosophy, and special responsibilities. The future role of these institutions is outlined elsewhere in this plan, but it will be restated here for convenience.

   a. Long-term care for a limited number of clients unable to benefit from treatment in other settings.

   b. Residential treatment for limited numbers of acutely disturbed children, adolescents, adults, and older adults.

   c. Highly specialized alcohol and drug abuse treatment.

   d. Research.

   e. Continuing education.

   f. Training of health care professionals, paraprofessionals, and other mental health related disciplines.

2. Services and activities unique to Colorado State Hospital now and in the future:

   a. Maintenance of maximum, medium, and minimum security facilities for the criminally insane and Colorado State Reformatory and Colorado State Penitentiary inmates who require in-hospital care.

   b. Provision of services, via traveling teams, to Colorado State Penitentiary and Colorado State Reformatory.

   c. Provision of facilities and services on a contract basis to the State Home and Training School, Pueblo, and other agencies located on Colorado State Hospital grounds.

   d. General Hospital services for the southern part of the state (family practice residency).

   e. Career resident program.

3. Fort Logan Mental Health Center: services and activities unique to Fort Logan now and in the future:

   a. Mental health services to the Closed Adolescent Treatment Center.

   b. Intensive 24-hour psychiatric hospital care in an open setting for the severely disturbed person who cannot be handled in a general hospital or an alternative to incare.

c. Experimental, specialized programs for such groups as non-criminal sociopaths.

4. Both Colorado State Hospital and Fort Logan Mental Health Center will continue to provide for several years some basic mental health services to various communities in the state until community-based agencies are prepared and approved to assume responsibility for these services.

C. University of Colorado Department of Psychiatry (CPH, CGH and Clinics), Psychiatric Hospital and Clinics:

The primary function of the medical school's hospital and clinics will continue to be education and research. The delivery of mental health services will continue to be a major part of the educational-patient care system and these services will be coordinated with all community mental health centers and clinics, Fort Logan Mental Health Center, Colorado State Hospital, the Denver VA Hospital and Denver General Hospital. The coordination of services is essential since the medical school, through CGH, CPH, and their outpatient clinics, treats patients from all areas of the state of Colorado. The medical school could not fulfill its educational mission if it did not have a broad and varied patient population to serve.

The Schools of Medicine and Nursing will be active participants in coordinating mental health professional and paraprofessional training programs throughout the State.

D. The Private Sector:

Private hospitals and practitioners are not limited by service area boundaries and other constraints that are necessary in the public sector. However, since accessibility is a key factor in the utilization of private mental health resources just as it is for public agencies, there will be increased use of local private hospitals for persons with psychiatric problems. This will come about as a result of negotiations between centers and clinics and private hospitals for a limited number of beds in local hospitals. Thus, close-to-home 24-hour inpatient care will be available for those who require such care.

Under National Health Insurance, which is expected to be operational within the next several years, private hospitals and private practitioners will be competing with public mental health agencies for the service dollar. Nevertheless, the public and private sectors will continue to exchange referrals and enter into various contractual arrangements which will benefit the client. Some private practitioners will continue to be available for part-time or contract work with public agencies. This healthy competition for third party payment money should improve the provision of services by both private and public agencies. However, this new source of funding will not diminish the need for cooperative programs in the public and private sectors.

E. Other Agencies Which Provide Treatment and/or Personal Counseling Services:

Private and voluntary agencies will continue to serve a portion of the population at risk. Staff of such agencies will continue to make and receive referrals to and from public facilities.

Mental retardation programs, probation and parole departments, welfare agencies, and vocational rehabilitation services, etc., serve persons with special concerns, many of whom also have mental health problems. These agencies should continue to refer clients who require mental health services to public and private mental health resources rather than duplicating existing services by hiring their own mental health staff.

Preliminary indications from the Division of Alcohol and Drug Abuse are that the Division also will attempt to make full use of existing treatment resources (centers, clinics, and hospitals) in lieu of establishing a separate treatment system for persons with drug and alcohol abuse problems.

There will continue to be a large number of private programs, such as Synanon, serving specific populations with varying degrees of effectiveness. Some will survive because of dedicated leadership and a high degree of success with a limited number of clients. Others will cease operation because of funding problems, only to be replaced by new organizations seeking to mitigate human misery. All these agencies likely will continue to accept a limited number of referrals from other organizations and will likewise make referrals to existing mental health resources.

It is anticipated that the need assessment survey and special purpose legislation, such as the revision of the Act on Care and Treatment of the Mentally Ill, may dictate the need for new services. Such new services will be assigned to the appropriate element(s) of the mental health services delivery system.

STATE - WIDE PLANS

PLAN FOR DIVISION OF MENTAL HEALTH EVALUATION AND ACCOUNTABILITY CAPABILITIES

Upon filling the coordinator of program evaluation position, every effort should be made to implement the first stage of the state-wide management information system which involves comparable cost accounting techniques and some assessment of client outcome. However, this is a bare-bones effort and much work remains if we are to have adequate program evaluation and accountability in the Division.

First, each component of the mental health system should have the capacity and resources for in-house evaluation. These do not have to be elaborate nor even necessarily full-time positions if the clinic or center is small. These evaluation efforts should complement the state system while simultaneously addressing particular needs of the facility.

Second, the central office should initiate special evaluation/accountability studies either state-wide or locally which focus on special problem areas. For example, what particular difficulties and benefits are associated with the establishment of alternatives to 24-hour hospitalization in rural communities; are mental health services meeting the needs of minority groups and to what extent, etc.? Funds should be available to carry out these short-term studies either from a central pool or allocated to the individual facility.

Third, there must be devised some means of coordinating and pooling of expertise and resources for inter-agency studies or for the sharing of resources between agencies. This must not, however, impinge on the ability of the home agency to conduct its own in-house work or work for the central office. With an improvement in the communication mechanism among agencies, it would appear that most duplication of equipment, manpower, and use of money could be avoided.

Needless to say, this type of effort is expensive, particularly in the developmental stages. Additional staff will be required at the central office and in some of the agencies in the years ahead. Computer capabilities must be expanded to include several remote terminals with access not only to the Department computer at Pueblo but those at the University of Colorado, State Capitol, and University of Denver.

PHASE - IN OF THE FULL RANGE OF MENTAL HEALTH SERVICES

One of the goals of the Division of Mental Health is "to insure the availability and accessibility of the full range of quality mental health services close to persons who require such care." The accomplishment of this goal requires a determination as to which services should be provided at the community level, the setting of priorities among the services to be locally available, and the development of a schedule for the phase-in to centers and clinics of those services which they are to provide.

The provision of basic mental health services to persons in all age ranges is viewed as the responsibility of the local community mental health center/clinic with hospitals ultimately serving those clients who require highly specialized services. Highest priority has been given to the adult group, primarily because as wage earners and parents, adults' disabilities have the greatest impact on society.

All existing community mental health centers and clinics provide some adult outpatient, emergency and aftercare services. Few centers and clinics provide adult inpatient and partial hospitalization services, and they vary widely as to their level of readiness to provide such services.

Level of readiness to assume responsibility for adult inpatient and partial hospitalization services is determined by criteria which include the following:

1. Strong board support regarding sufficient funds for such assumption, as evidenced by public statements of board members and/or written resolutions, policy statements, etc.
2. Existing contracts with local hospitals and alternative care facilities, or correspondence from hospitals and alternative care facilities indicating that necessary beds and other services will be available when required.
3. The availability of facilities for partial care in the catchment area.
4. Low average monthly census of adult clients in 24-hour in-hospital care (this should be considered in relationship to catchment area population).
5. Evidence of prior planning for provision of such services by board, administration and staff.
6. Prior experience in the provision of inpatient and partial care services to adult psychiatric patients.
7. Availability of "need" data on the community concerned, and the ability to evaluate ongoing and proposed new programs.

On the basis of the above criteria, those centers considered most ready to assume responsibility for adult incare and partial care are: Adams, Southwest Denver, Boulder, Jefferson, and Northwest Denver Mental Health Centers.

These centers, along with Malcom X, are being recommended for assumption of adult incare and partial care responsibilities during the 1974 - 75 fiscal year.

The proposed schedule for assumption of adult incare and partial care responsibility for fiscal year 1974 - 75 is as follows:

July 1, 1974 – Adams, Southwest Denver, Northwest Denver, and Malcom X

January 1, 1975 – Boulder, Jefferson

(See "Plan for Assignment of Mental Health Service Responsibilities" for phase-in schedule for fiscal year 75 - 76)

Long range schedule for assignment of service responsibilities will be developed and revised in an ongoing process. Cost factors will be developed sufficiently in advance to facilitate planning and will be revised as necessary to take into consideration changes in funding, cost of living fluctuations and variations in service delivery.

Priorities for the development of new programs and the expansion of existing ones will be established by the Chief, Division of Mental Health, based on input from catchment area planning and regional planning, in conjunction with the Master Plan Committee. Additional collaborative planning will involve the private sector, other human service agencies, and official state-wide planning agencies.

A construction plan exists which outlines the development of new facilities in each region. Based on reports from each mental health facility, both the construction plan and the master plan will be revised on a yearly basis to reflect new community needs and/or state economics. In general, the Division policy is to: (1) extend basic services to communities not currently covered; (2) initiate new programs at the local level when the need for, and projected volume of that particular service, make it economically feasible; and (3) avoid new construction if possible in favor of using existing or remodeled facilities.

PLAN FOR ASSIGNMENT OF MENTAL HEALTH SERVICE RESPONSIBILITIES

This section of the Division of Mental Health Master Plan addresses the need for assignment of responsibility for the provision of mental health services within each region of the state. Clear assignment of service responsibility is essential to effective planning and management, efficient delivery of mental health services, and fiscal and programmatic accountability. The service responsibility matrices, which are integral components of this section, identify present service responsibilities and projects shifts and adjustments for the next two fiscal periods ('74-'75 & '75-'76).

Clarification of present service responsibilities, planning for assumption of new roles and transfers of functions among mental health centers, clinics, and hospitals has been, and will continue to be, a difficult task. Factors contributing to this difficulty include:

1. The variety of titles and labels applied to similar services by various agencies
2. Variations in treatment philosophy
3. Wide variations in staffing patterns and number of staff
4. Differences in local needs and priorities
5. Overlapping service area boundaries
6. Differing levels of administrative and clinical expertise
7. Resistance to change

An attempt has been made to respect local priorities while focusing on the mental health service needs of the total state.

Principles and assumptions upon which the assignment of service responsibility is based are as follows:

General

The assignment of responsibilities set forth in this document will be used as guidelines for program planning and funding requests. However, planning is a dynamic process, and continuing adjustments will be made as required by changing needs, the results of ongoing program evaluation efforts, legal decisions, new initiatives at Federal, State and Local levels, in addition to other factors which affect programming and funding.

"X" in a cell in the service responsibility matrices indicates primary responsibility. In some instances, two or more agencies may be providing the same service, but only one will have primary responsibility. What appears to be duplicated services in some instances are pilot or limited programs which should be viewed as demonstration or transitional in nature, rather than duplicated activities.

The fact that an agency has primary responsibility for a service does not imply that the service is adequately funded. As indicated in the matrices, during the next two fiscal years, some clinics will expand their services, but will maintain their clinic status, providing primarily outcare and consultation and education services. Several clinics will move towards center status through growth to meet community needs. Some centers will become more comprehensive in the scope of services provided.

Total new costs reflected in the assignment of responsibility matrices refer to state funds. These data are not complete in all instances.

Costs for fiscal year '75 - '76 have been omitted from the service responsibility matrices because of the difficulty in accurately projecting costs. Gross data presently available will be analyzed and refined prior to the next budget period.

Proposed phase-in of alcohol and drug abuse services are subject to approval by the Division of Alcohol and Drug Abuse the state alcohol and drug abuse authority.

Service Categories

As an initial step towards the development of common service categories, the following service elements are utilized (see "Basic Elements of Service" , page 29 for definitions):

a. Inpatient "A"

b. Inpatient "B"

c. Outpatient

d. Partial

e. Emergency

f. Consultation and Education

Specialized services focus on the special treatment needs of specific age groups and problem categories:

a. Children (0 - 11)

b. Adolescent (12 - 17)

c. Adult (18 - 64)

d. Geriatrics (65 +)

e. Alcoholism

f. Drug Abuse

Aftercare is recognized as an important service entity because the treatment needs of some previously hospitalized

clients are significant and unique. While aftercare data are generally reported in outpatient or consultation and education statistics, agencies are advised to collect and maintain aftercare data in such a manner that it can be retrieved for separate analysis.

Some forensic services are available in several centers; however, Colorado State Hospital is the sole treatment facility for the "criminally insane."

Data on rehabilitation clients should be reported under the appropriate service category (ies) above.

Program evaluation and general and administrative are required activities for all programs.

Role of State Hospitals

In keeping with the goal of ensuring the availability of the full range of quality mental health services close to persons who require such care, the thrust is towards the provision of basic mental health services through community mental health centers and clinics. The State Hospital's role is to provide certain specialized and other centralized services on a multi-regional basis. (See "Role of Components" for further details on roles.)

State Hospitals also will provide such basic services as adult inpatient "A" and inpatient "B", and partial services to some local communities. In most instances, these services will be assumed by centers and clinics on a phased-in basis. State Hospitals may indefinitely provide some basic services to some local communities when this approach is found to be desirable for clinical, economic, or other cogent reasons.

There is no intent to restrict State Hospitals to on-grounds operation. Colorado State Hospital and Fort Logan Mental Health Center should maintain and conduct those off-grounds facilities and activities required to carry out their assigned responsibilities. Close coordination with centers, clinics, and other care givers in the service area is required.

The Division of Mental Health intends for the state hospitals to continue as full-fledged partners in the mental health delivery system. However, changes in their functions and responsibilities in accordance with this plan, may result in some internal changes, adjustments in funding priorities, and changes in the use of some existing facilities.

Purchase of Specialized Services

The plan allows continued purchase of specialized services from Denver Mental Health Center and Children's Hospital, in addition to other private agencies. However, these and all other purchase of service agreements will be continuously evaluated in the light of the need for the service provided, quality of care, outcome and established catchment area boundaries. The Division of Mental Health will purchase specialized services directly from some private agencies. Other private agencies will provide specific mental health services through an affiliate agreement with a center, clinic, or hospital.

New Center Proposed

A new center is proposed for Aurora, which presently is being served by Adams and Arapahoe Mental Health Centers. The new Aurora center would begin operation on July 1, 1975. Support for this proposal is based on the following:

a. The proposal was citizen initiated

b. The city government has tentatively agreed to consider contributing .25 per resident annually towards the support of a local mental health center

c. General hospital facilities will be available for use as needed

d. Aurora's population is projected to be 150,000 by 1975. This is viewed as an optimal population size for a community based mental health program.

e. While Aurora lies in both Adams and Arapahoe Counties, its residents are more strongly identified with the City of Aurora than with either Adams or Arapahoe County

f. The boards of Adams and Arapahoe Mental Health Centers have been advised of this plan and the two centers have been working cooperatively with the Aurora Steering Committee.

Impact of Recent Legislation

The impact of Senate Bill 349 (revision of state stutute on care and treatment of the mentally ill), House Bill 1279 (Colorado Alcoholism and Treatment Act), and House Bill 1164 (Education of Handicapped Children), all of which were enacted during the '72 - '73 session of the General Assembly, is not yet known. As plans to implement these acts are developed, necessary adjustments will be made in this document.

On the Federal level, the impact on Colorado of the one year extension of the Community Mental Health Centers Act is unknown. Planning for mental health services in Colorado should be based on the mental health service needs of Colorado residents. However, every attempt should be made to obtain this state's share of Federal funds.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION
1

GEOGRAPHIC AREA
Logan, Morgan, Phillips, Sedgwick, Yuma and Washington Counties

COMMUNITY FACILITY:
NE Colo. Mental Health Clinic

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	NECMHC	FLMHC/CSH	NECMHC	FLMHC	NECMHC	FLMHC	
Service: Inpatient "A"							
Adult		xF		x		x	
Adolescent		xC		x		x	
Children		xC		x		x	
Geriatrics		xC		x		x	
Drug Abuse		xC		x		x	
Alcoholism		xC		x		x	
Inpatient "B"							
Adult	(2)	xF	$49,920		x		
Adolescent		xC		x	x		
Children		xC		x		x	
Geriatrics		xC		x		x	
Drug Abuse		xC		x		x	
Alcoholism		xC		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x(1)		x		x		
Alcoholism	x(1)		x		x		
Partial							
Adult	(2)	xF		x	x		
Adolescent		xC		x		x	
Children		xC		x		x	
Geriatrics		xC		x		x	
Drug Abuse		xC		x		x	
Alcoholism		xC		x		x	
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$49,920		$		

F - Fort Logan Mental Health Center
C - Colorado State Hospital

See next page for explanation of (1) and (2)

(1) Some abusers receive care through regular clinic services. However, no specific treatment programs are available in the community for these groups.

(2) This service is being developed on a pilot basis by NECMHC. However, until this service is fully implemented, the responsibility for this service lies with FLMHC.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 2

GEOGRAPHIC AREA: Larimer County

COMMUNITY FACILITY: Larimer County Mental Health Clinic

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	LCMHC	FLMHC/CSH	LCMHC	FLMHC	LCMHC	FLMHC	
Service: Inpatient "A"							
Adult	(1)	xF		x		x	
Adolescent	(2)	xC		x		x	
Children		xC		x		x	
Geriatrics		xC		x		x	
Drug Abuse		xC		x		x	
Alcoholism		xC		x		x	
Inpatient "B"							
Adult		xF	$39,300		x		
Adolescent		xC		x		x	
Children		xC		x		x	
Geriatrics		xC		x		x	
Drug Abuse		xC		x		x	
Alcoholism		xC		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	(3)	x		x		x	
Alcoholism	(3)	x		x		x	
Partial							
Adult	(4)	x	(4)	x	x		
Adolescent		xC		x		x	
Children		xC		x		x	
Geriatrics		xC		x		x	
Drug Abuse		xC		x		x	
Alcoholism		xC		x		x	
Emergency							
Adult	(5)	x	x		x		
Adolescent	(5)	x	x		x		
Children	(5)	x	x		x		
Geriatrics	(5)	x	x		x		
Drug Abuse	(5)	x	x		x		
Alcoholism	(5)	x	x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$39,300		$		

F - FLMHC
C - CSH

See next page for explanation of (1), (2), (3), (4), (5).

(1) LCMHC is developing a local ten-bed inpatient unit in a local general hospital through existing and local resources. However, until this resource is fully developed, FLMHC will maintain primary responsibility for this service.

(2) It is possible that some adolescents will be treated in the local inpatient "A" program. However, CSH will maintain service responsibility until local service is fully developed.

(3) Through regular outpatient services.

(4) LCMHC provides a minimal day-care program.

(5) The Clinic provides minimal emergency services.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 2

GEOGRAPHIC AREA: Weld County

COMMUNITY FACILITY: Weld Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	WMHC	CSH/FLMHC	WMHC	FLMHC	WMHC	FLMHC	
Service:							
Inpatient "A"							
Adult	x (1)	(2)	x		x		
Adolescent	x (1)	(2)	x		x		
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism	x (1)		x (1)		x (1)		
Inpatient "B"							
Adult	(3)	x	$46,996		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism	x		x		x		
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult	x	(4) F	x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$46,996				

(1) Available through local general hospital, but currently used to capacity.
(2) CSH also provides some inpatient services to this catchment area.
(3) Through small 314(d) grant, local resources for this service are being developed on pilot basis.
(4) FLMHC is assisting the Center in the provision of this service.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Adams County

COMMUNITY FACILITY: Adams County Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	ACMHC	FLMHC	ACMHC	FLMHC	ACMHC	FLMHC	
Service: Inpatient "A"							
Adult		x	x 183,929		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x (1)	x (1)		x		
Alcoholism		x	x(2)40,205				
Inpatient "B"							
Adult	(3)	x	x 33,479		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x	x		
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x	(4)	x		x		
Partial							
Adult		x	x 189,592		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x (1)		x (1)	x (1)		
Alcoholism		x	x (2)		x (2)		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x(5)23,355		x		
Alcoholism	x		x		x		
Total New Costs			$470,560		$		

(1) No specialized services; some services from DGH.
(2) Contingent upon approval of federal grant.
(3) Limited facilities provided by ACMHC.
(4) FLMHC provides some outpatient services.
(5) One drug educator plus operating costs.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Arapahoe County – Douglas County

COMMUNITY FACILITY: Arapahoe Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	AMHC	FLMHC	AMHC	FLMHC	AMHC	FLMHC	
Service: Inpatient "A"							
Adult		x(1)		x (1)	x		
Adolescent		x (1)		x (1)		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x(2) (1)		x(2) (1)	x		
Alcoholism		x		x	x		
Inpatient "B"							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs							

(1) CPH provides some services to residents of that part of Aurora which is in Arapahoe County.

(2) No specialized drug abuse services at FLMHC; DGH provides some services.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Aurora

COMMUNITY FACILITY: Aurora Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital					AMHC (1)	FLMHC	
Service:							
Inpatient "A"							
Adult					x		
Adolescent						x	
Children						x	
Geriatrics						x	
Drug Abuse					x		
Alcoholism					x		
Inpatient "B"							
Adult					x		
Adolescent						x	
Children						x	
Geriatrics						x	
Drug Abuse					x		
Alcoholism					x		
Outpatient							
Adult					x		
Adolescent					x		
Children					x		
Geriatrics					x		
Drug Abuse					x		
Alcoholism					x		
Partial							
Adult					x		
Adolescent					x		
Children						x	
Geriatrics						x	
Drug Abuse					x		
Alcoholism					x		
Emergency							
Adult					x		
Adolescent					x		
Children					x		
Geriatrics					x		
Drug Abuse					x		
Alcoholism					x		
Consultation & Education							
Adult					x		
Adolescent					x		
Children					x		
Geriatrics					x		
Drug Abuse					x		
Alcoholism					x		
Total New Costs							

(1) Adams and Arapahoe Mental Health Centers and FLMHC will continue to provide services if the Aurora program is not funded.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Southeast Denver

COMMUNITY FACILITY: Bethesda Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	BMHC	FLMHC	BMHC	FLMHC	BMHC	FLMHC	
Service: Inpatient "A"							
Adult	x		x		x		
Adolescent	x		x		x		
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Inpatient "B"							
Adult	x		x		x		
Adolescent	x		x		x		
Children		x		x		x	
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult	x		x		x		
Adolescent	x		x		x		
Children		x		x		x	
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs							

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Boulder County

COMMUNITY FACILITY: Mental Health Center of Boulder County

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	MHCBC	FLMHC	MHCBC	FLMHC	MHCBC	FLMHC	
Service: Inpatient "A"							
Adult	x (1)	(1)	x25,882 (2)		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Inpatient "B"							
Adult		x	x39,118 (2)		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x (3)		x (3)		x (3)	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x (4)		x (4)		x (4)		
Partial							
Adult	x (5)	(5)	x 97,000		x		
Adolescent		x		x		x	
Children	x		x		x		
Geriatrics		x		x		x	
Drug Abuse	x		x		x		
Alcoholism		x		x		x	
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$162,000		$		

(1) MHCBC for less than 14 days inpatient "A" care.
FLMHC for 14 days or more inpatient "A" care.
(2) One-half year
(3) FLMHC and other community agencies.
(4) In collaboration with local Health Dept.
(5) Minimal services; some staff assistance from FLMHC.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Denver Metro Area

COMMUNITY FACILITY: Children's and Adolescent's Mental Health Services of Children's Hospital

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	CH		CH		CH		
Service: Inpatient "A"							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Inpatient "B"							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Outpatient							
Adult							
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics							
Drug Abuse							
Alcoholism							
Partial							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Emergency							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Consultation & Education							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Total New Costs							

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Denver Metro Area

COMMUNITY FACILITY: Denver Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	DMHC		DMHC		DMHC		
Service: Inpatient "A"							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Inpatient "B"							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Emergency							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Consultation & Education							
Adult							
Adolescent							
Children							
Geriatrics							
Drug Abuse							
Alcoholism							
Total New Costs							

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Jefferson, Clear Creek and Gilpin Counties

COMMUNITY FACILITY: Jefferson County Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	JCMHC	FLMHC	JCMHC	FLMHC	JCMHC	FLMHC	
Service: Inpatient "A"							
Adult		x	x124,038 (2)		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x (1)	x (1)		x (1)		
Alcoholism		x		x			
Inpatient "B"							
Adult		x	x 66,791 (2)		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x (1)		x		x	
Alcoholism		x		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult	x	(3)	x	(4)	x		
Adolescent	x	(3)	x	(4)	x		
Children	x	(3)	x	(4)	x		
Geriatrics	x	(3)	x	(4)	x		
Drug Abuse	x	(3)	x	(4)	x		
Alcoholism	x	(3)	x	(4)	x		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$ 190,829		$		

(1) No specialized services; some services from DGH.
(2) One-half year.
(3) FLMHC also provides some services.
(4) FLMHC will provide some services for one-half year.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Northeast Denver

COMMUNITY FACILITY: Malcom X Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	MX	FLMHC	MX	FLMHC	MX	FLMHC	
Service: Inpatient "A"							
Adult		x	x 104,395		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse	x		x		x		
Alcoholism		x		x		x	
Inpatient "B"							
Adult	x		x 150,000		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse	x		x		x		
Alcoholism		x		x		x	
Outpatient							
Adult	x		x 30,000		x		
Adolescent	x		x 69,000		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult	x		x 75,000		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse	x		x		x		
Alcoholism		x		x		x	
Emergency							
Adult	x		x 50,000		x		
Adolescent	x		x 23,000		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x 40,899		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$ 542,294		$		

(1) Includes funding of staffing grant at 82.5% of federal eligible.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Northwest Denver

COMMUNITY FACILITY: Northwest Denver Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	NWDMHC	FLMHC	NWDMHC	FLMHC	NWDMHC	FLMHC	
Service:							
Inpatient "A"							
Adult	x		x 93,752		x		
Adolescent	x		x		x		
Children		x		x		x	
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Inpatient "B"							
Adult	x		x		x		
Adolescent	x		x		x		
Children		x		x		x	
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult	x		x		x		
Adolescent	x		x		x		
Children		x		x		x	
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$ 93,752		$		

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 3

GEOGRAPHIC AREA: Southwest Denver

COMMUNITY FACILITY: Southwest Denver Mental Health Services

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	SWDMHS	FLMHC	SWDMHS	FLMHC	SWDMHS	FLMHC	
Service: Inpatient "A"							
Adult		x	x 36,000		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x (1)		x (1)		x (1)	
Alcoholism		x (2)		x (2)		x	
Inpatient "B"							
Adult	(3)	x	x 126,000		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse	(4)	x (1)	(4)	x (1)	(4)	x (1)	
Alcoholism		x		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult		x	x 38,000		x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x (5)		x (5)		x (5)		
Alcoholism	x (5)		x (5)		x (5)		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$ 200,000		$		

(1) No specialized services; some services from DGH.
(2) Some services from DGH.
(3) Limited facilities provided by SWDMHS.
(4) Small pilot program for special group.
(5) Some services from DGH.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION
4

GEOGRAPHIC AREA
El Paso, Park and Teller Counties

COMMUNITY FACILITY:
Pikes Peak Family Counseling and Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	PPFCMHC	CSH	PPFCMHC	CSH	PPFCMHC	CSH	
Service:							
Inpatient "A"							
Adult	x	(1)	x	(1)	x	(1)	
Adolescent	(1)	x	(1)	x	x		
Children		x		x	x		
Geriatrics	x		x		x		
Drug Abuse	(1)	x		x	(2)	x	
Alcoholism	(1)	x		x	(2)	x	
Inpatient "B"							
Adult		x		x	x		
Adolescent	(3)	x	(3)	x	x		
Children		x		x	x		
Geriatrics		x		x		x	
Drug Abuse		x		x	(2)	x	
Alcoholism		x		x	(2)	x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x (4)		x (4)		x		
Alcoholism	x (4)		x (4)		x		
Partial							
Adult	x		x		x		
Adolescent	x		x		x		
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	(2)	x	
Alcoholism		x		x	(2)	x	
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x (4)		x (4)		x (2)		
Alcoholism	x (4)		x (4)		x (2)		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x (4)		x (4)		x (2)		
Alcoholism	x (4)		x (4)		x (2)		
Total New Costs							

See next page for explanations of (1), (2), (3), and (4).

(1) Inpatient services for adults will be implemented 11/1/73 by PPFCMHC. Drug abusers and alcoholics and some adolescents may also receive services through this unit. CSH will continue, however, to maintain primary responsibility for specialty inpatient services until these are fully implemented by PPFCMHC.

(2) PPFCMHC plans to request federal assistance in drug abuse and alcoholism staffing grants.

(3) Some adolescent inpatient "B" services are available through the "Juvenile Offender" program.

(4) This service provided to abusers through regular center services, but is not a specialized treatment program.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION 5

GEOGRAPHIC AREA: Cheyenne, Elbert, Kit Carson, and Lincoln Counties

COMMUNITY FACILITY: East Central Colorado Mental Health Clinic

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	ECCMHC	CSH	ECCMHC	CSH	ECCMHC	CSH	
Service:							
Inpatient "A"							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Inpatient "B"							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Outpatient							
Adult	x (1)		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Emergency							
Adult	x (2)		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x (3)		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs							

(1) Outpatient services are extremely minimal and require significant expansion to meet the needs.
(2) Minimal emergency services, on an outpatient basis, is available through ECCMHC, but lack of fulltime status prevents full implementation of emergency service.
(3) C & E services are minimal due to part-time status of clinic.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION
6

GEOGRAPHIC AREA
Baca, Bent, Crowley, Kiowa, Otero and Prowers Counties

COMMUNITY FACILITY:
Southeastern Colo.
Family Guidance Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	SCFGH	CSH	SCFGH	CSH	SCFGH	CSH	
Service: Inpatient "A"							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Inpatient "B"							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x (1)		x		x		
Partial							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Emergency							
Adult	(2)	x	(2)	x	x		
Adolescent	(2)	x	(2)	x	x		
Children	(2)	x	(2)	x	x		
Geriatrics	(2)	x	(2)	x	x		
Drug Abuse	(2)	x	(2)	x	x		
Alcoholism	(2)	x	(2)	x	x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x (1)		x		x		
Total New Costs			$		$		

(1) Provided as part of regular clinic services; not a specialized program.
(2) The clinic provides some emergency services, but these are minimal and limited in availability to outlying portions of the catchment area.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 7

GEOGRAPHIC AREA: Pueblo, Huerfano and Las Animas Counties

COMMUNITY FACILITY: Southern Colorado Comprehensive Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	SCCMHC	CSH	SCCMHC	CSH	SCCMHC	CSH	
Service: Inpatient "A"							
Adult	(1)	x	(1)	x	(1)	x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Inpatient "B"							
Adult		x		x	(3)	x	
Adolescent	(2)	x	(2)	x	(3)	x	
Children	(2)	x	(2)	x	(3)	x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x (4)		x (4)		x (4)		
Alcoholism	x (4)		x (4)		x (4)		
Partial							
Adult		x		x		x	
Adolescent	(5)	x	(5)	x	(5)	x	
Children	(5)	x	(5)	x	(5)	x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Emergency							
Adult	x (6)		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$		$		

See next page for explanation of (1), (2), (3), (4), (5), and (6).

Pueblo, Huerfano, and Las Animas Counties cont'd.

(1) Staffing grant provides that inpatient services are based at CSH. SCCMHC, however, will develop inpatient services outside the Pueblo area in future years.

(2) SCCMHC provides this service in Trinidad.

(3) SCCMHC plans to develop these services in Trinidad and Walsenburg.

(4) Some services to abusers are available through regular center services. However, expansion of services to these client categories is essential to meet the needs.

(5) SCCMHC provides this service in Trinidad and Walsenburg.

(6) This service is provided in conjunction with CSH. Additional support is needed to develop services outside of Pueblo area.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION
7

GEOGRAPHIC AREA
Chaffee, Custer, Fremont, and Lake Counties

COMMUNITY FACILITY:
West Central Colorado
Mental Health Clinic

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	WCCMHC	CSH	WCCMHC	CSH	WCCMHC	CSH	
Service: Inpatient "A"							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Inpatient "B"							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x (1)		x (1)		x (1)		
Alcoholism	x (1)		x (1)		x (1)		
Partial							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Emergency							
Adult	x (2)		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$		$		

(1) Services to abusers is provided through regular clinic services, but is not a specialized program.

(2) Limited emergency services are currently provided to portions of the catchment area. Plans are underway exploring means of expanding this service throughout catchment area.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 8

GEOGRAPHIC AREA: Saguache, Mineral, Rio Grande, Alamosa Conejos, and Costilla Counties

COMMUNITY FACILITY: San Luis Valley Comp. Community Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	SLVCCMHC	CSH	SLVCCMHC	CSH	SLVCCMHC	CSH	
Service: Inpatient "A"							
Adult		x		x		x	
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Inpatient "B"							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism	(1)	x	(1)	x	x		
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult	(2)	x	(2)	x	x		
Adolescent		x		x	x		
Children		x		x	x		
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$		$		

(1) Limited alcohol services are available through affiliate arrangement serving four of the six counties in catchment area.
(2) Very limited day care available locally.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION: 9

GEOGRAPHIC AREA: Dolores, Montezuma, San Juan, La Plata, and Archuleta Counties

COMMUNITY FACILITY: Southwestern Colorado Mental Health Ctr.

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	SWMHC	CSH	SWMHC	CSH	SWMHC	CSH	
Service:							
Inpatient "A"							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Inpatient "B"							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Outpatient							
Adult	x		$38,000		x		
Adolescent	x		(1)		x		
Children	x		(1)		x		
Geriatrics	x		(1)		x		
Drug Abuse	x		(1)		x		
Alcoholism	x		(1)		x		
Partial							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Emergency							
Adult	x (2)		x (2)		x		
Adolescent	x (2)		x (2)		x		
Children	x (2)		x (2)		x		
Geriatrics	x (2)		x (2)		x		
Drug Abuse	x (2)		x (2)		x		
Alcoholism	x (2)		x (2)		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$ 38,000		$		

See next page for explanation of (1), and (2).

Dolores, Montezuma, San Juan, La Plata, and Archuleta Counties, cont'd.

(1) The '74 - '75 budget request of $38,000 is to provide expansion of basic outpatient services for all ages and problem groups.

(2) Emergency service is provided on an outpatient basis but needs development on a twenty-four hour basis.

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION
10

GEOGRAPHIC AREA
Delta, Montrose, Gunnison, San Miguel, Ouray and Hinsdale Counties

COMMUNITY FACILITY:
Midwestern Colorado Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	MCMHC	CSH	MCMHC	CSH	MCMHC	CSH	
Service: Inpatient "A"							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Inpatient "B"							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$		$		

MENTAL HEALTH
SERVICE RESPONSIBILITIES

REGION
11 - 12

GEOGRAPHIC AREA
Moffat, Pitkin, Routt, Jackson, Grand, Rio Blanco, Garfield, Mesa, Eagle, and Summit Counties

COMMUNITY FACILITY:
Colo. West Regional Mental Health Center

Fiscal Year	'73 - '74		'74 - '75		'75 - '76		
Center/Clinic Hospital	CWMHC	CSH	CWMHC	CSH	CWMHC	CSH	
Service:							
Inpatient "A"							
Adult		x		x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x		x	
Alcoholism		x		x		x	
Inpatient "B"							
Adult	(1)	x	(1)	x	x		
Adolescent		x		x		x	
Children		x		x		x	
Geriatrics		x		x		x	
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Outpatient							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Partial							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse		x		x	x		
Alcoholism		x		x	x		
Emergency							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Consultation & Education							
Adult	x		x		x		
Adolescent	x		x		x		
Children	x		x		x		
Geriatrics	x		x		x		
Drug Abuse	x		x		x		
Alcoholism	x		x		x		
Total New Costs			$		$		

(1) Limited services on a pilot basis.

REGIONAL PLANS

BASIC DATA FOR THE 12 COLORADO REGIONS

In an attempt to gain an overview of the mental health service needs in each region, several indices were examined. These are among those most frequently cited in sociological and demographic studies (1) as relating to the general physical and mental health of area residents.

I.	Demographic variables	
	A. Sex	U. S. Bureau of Census 1970
	B. Age	U. S. Bureau of Census 1970
	C. Ethnic group	U. S. Bureau of Census 1970
II.	Economic variables	
	A. Percent of families under poverty level	U. S. Census 1970
	B. Percent of families over $15,000	U. S. Census 1970
	C. Median family income	U. S. Census 1970
	D. Percent families on welfare	U. S. Census 1970
	E. Percent families on Social Security	U. S. Census 1970
	F. Percent families unemployed	U. S. Census 1970
III.	Social indicators	
	A. Suicide rate per 100,000	State Mental Health Construction Plan
	B. Crime rate per 100,000	State Mental Health Construction Plan
	C. Marriage dissolution rates based on 1972 est. population	Colorado Department of Health
IV.	Health variables	
	A. Fetal death rates (1970) per 1,000 live births	Colorado Department of Health
	B. Birth rates (1970) per 1,000 population	Colorado Department of Health
	C. Percent of births with low birth weight (1970)	Colorado Department of Health

The data is presented in the following tables by catchment area where possible.

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(1) See for example: Monroe, R. R., Klee, G. D. & Brody, E. B. (Eds) Psychiatric Epidemiology and Mental Health Planning, Psychiatric research report no. 22, American Psychiatric Association, April, 1967; Redick, R. W., Goldsmigh, H. F. & Unger, E. L. (Eds) 1970 Census data used to indicate areas with different potentials for mental health and related problems. Methodology reports, National Institute of Mental Health Statistics Series C-No. 3, April, 1971.

In a few cases, the Denver County data is not divided by the four catchment areas - to do so would involve analyses by census tracts, a job beyond the resources of this committee. Also, no attempt was made to cover the multitude of variables considered to indicate need for mental health services. An analysis using census data and the procedure developed by Goldsmith and Unger (2) should be undertaken by the Division of Mental Health.

Further, because the data is presented by Region, it is possible that problem areas within a region are overlooked. For example, 26% of the residents of Costilla County are receiving some form of welfare assistance, which is twice that shown for the overall Region 8 (average of 13%). Similarly, 4.7% of the people in Gunnison County are over 65· while the average for Region 10 is 12%.

The most productive use of these tables is in recognizing the diverse nature of the population in Colorado both in terms of demographic characteristics and problem areas. Poverty exists in some parts of the core city (mainly Northwest Denver) while Southeast and Southwest Denver and the suburban counties of Jefferson and Arapahoe are the most affluent. Social disruption respects no economic barriers, i. e., high crime rate areas exist in the entire Metro area – core city and suburbs; suicide rates are high in both Adams County (a middle income group), Northwest Denver (a poor area) and Southeast Denver (an affluent area); and divorce rates are high in both rich and poor areas; conversely, the area served by San Luis Valley Community Mental Health Center is one of the poorest areas in the state, but also has one of the lowest crime, divorce, and fetal death rates.

Given this diversity of population and problems, it becomes even more crucial that each component of the mental health delivery system plan its priorities and be prepared to justify them with additional data. These data, plus more extensive analyses of additional variables combined with local input and expertise is essential for rational planning. Only in this way can the shift to community-based services really address the needs of the people to be served.

Reference to the charts should be made while reviewing the specific area plans. For example, note is made of the need for programs specifically designed to meet the needs of the large Chicano population in Weld, Huerfano, and Las Animas Counties, and the San Luis Valley. Similarly, since the highest crime rates appear in the City of Denver, it is most appropriate that Southwest Denver Community Mental Health Center has begun a program to assist people leaving the State Penitentiary with the social difficulties of returning to the community. In addition, pre-sentencing work and special programs for parolees with drug and alcohol problems are in effect or are being proposed.

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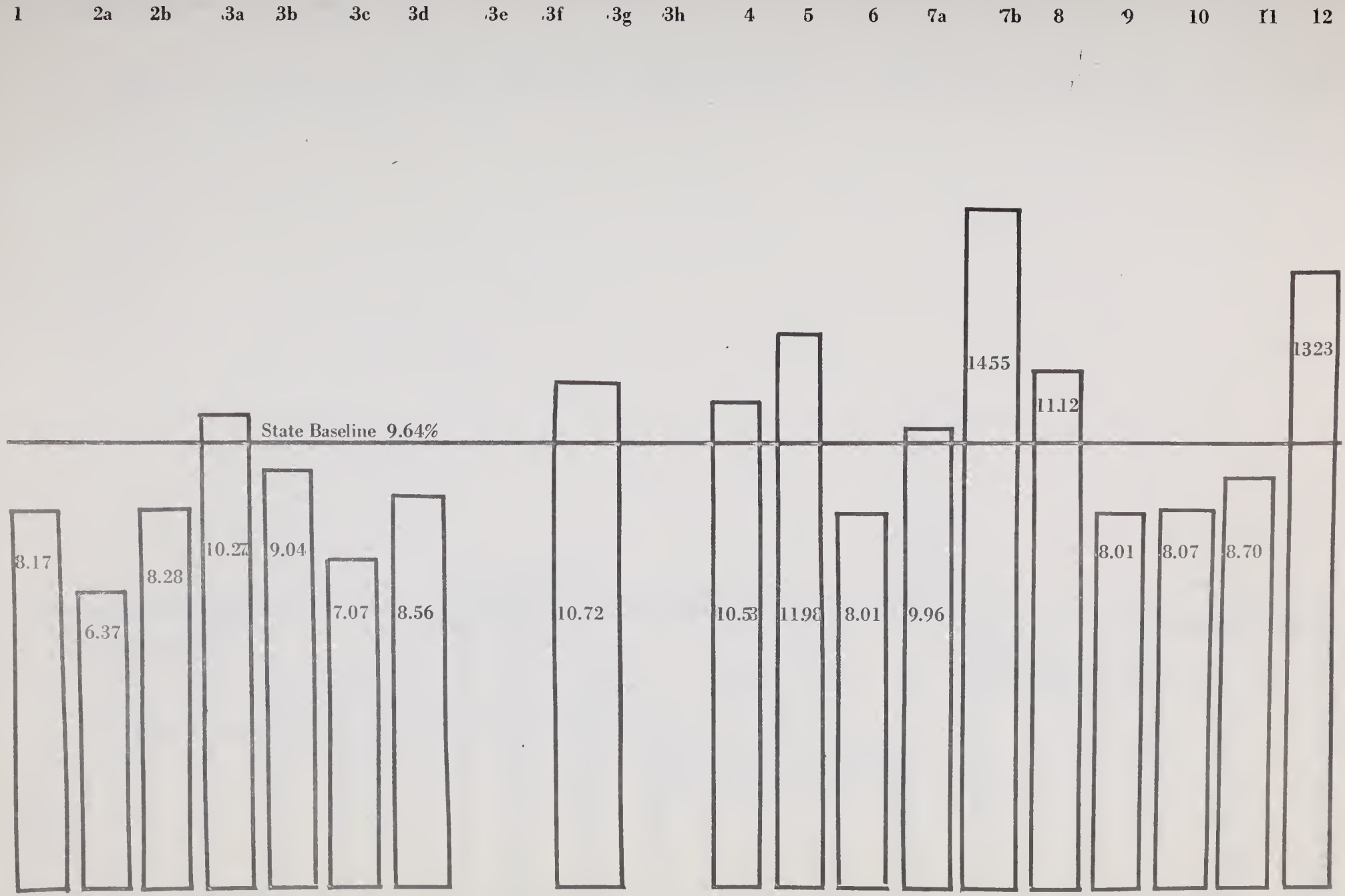
(2) Goldsmith, H. F. & Unger, E. L. Social Areas: Identification procedures using 1970 census data. Mental Health Study Center, National Institutes of Mental Health, 1972.

PLANNING REGIONS

REGION NO.	*COUNTIES*
1	*Logan, Sedgwick, Phillips, Yuma, Washington, Morgan*
2 - a	*Weld*
2 - b	*Larimer*
3 - a	*Adams*
3 - b	*Arapahoe & Douglas*
3 - c	*Boulder*
3 - d	*Jefferson, Gilpin & Clear Creek*
3 - e	*Southeast Denver*
3 - f	*Northwest Denver*
3 - g	*Northeast Denver*
3 - h	*Southwest Denver*
4	*Park, Teller, El Paso*
5	*Elbert, Lincoln, Kit Carson, Cheyenne*
6	*Crowley, Kiowa, Prowers, Bent, Baca, Otero*
7 - a	*Pueblo, Huerfano, Las Animas*
7 - b	*Lake, Chaffee, Fremont, Custer*
8	*Saguache, Mineral, Rio Grande, Alamosa, Costilla, Conejos*
9	*Dolores, Montezuma, La Plata, San Juan, Archuleta*
10	*Delta, Gunnison, Montrose, San Miguel, Ouray, Hinsdale*
11 & 12	*Moffat, Routt, Jackson, Grand, Rio Blanco, Garfield, Mesa, Pitkin, Eagle, Summit*

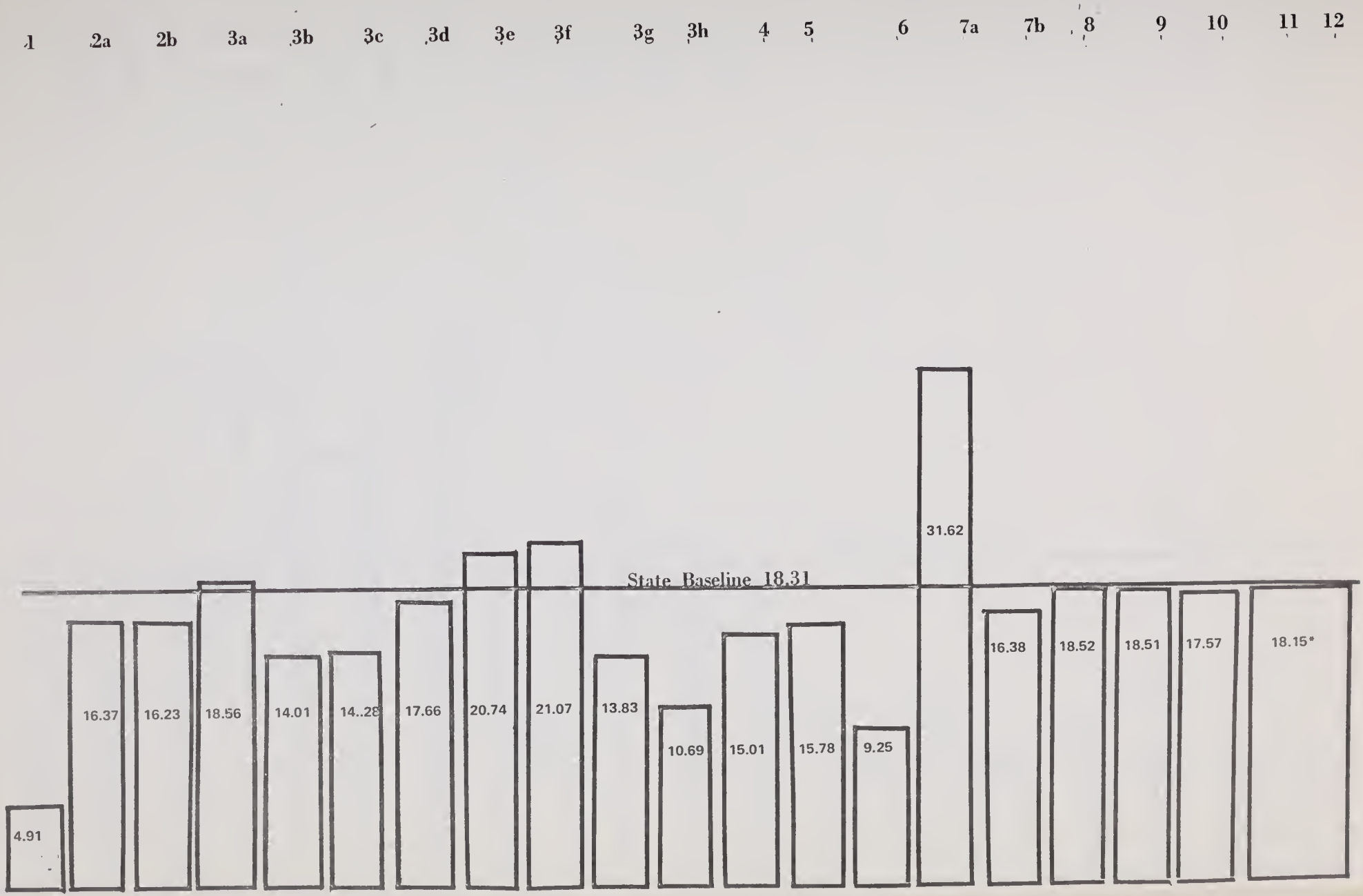
PERCENT OF BIRTHS HAVING LOW BIRTH WEIGHT
1970 Data



SUICIDE RATE per 100,000

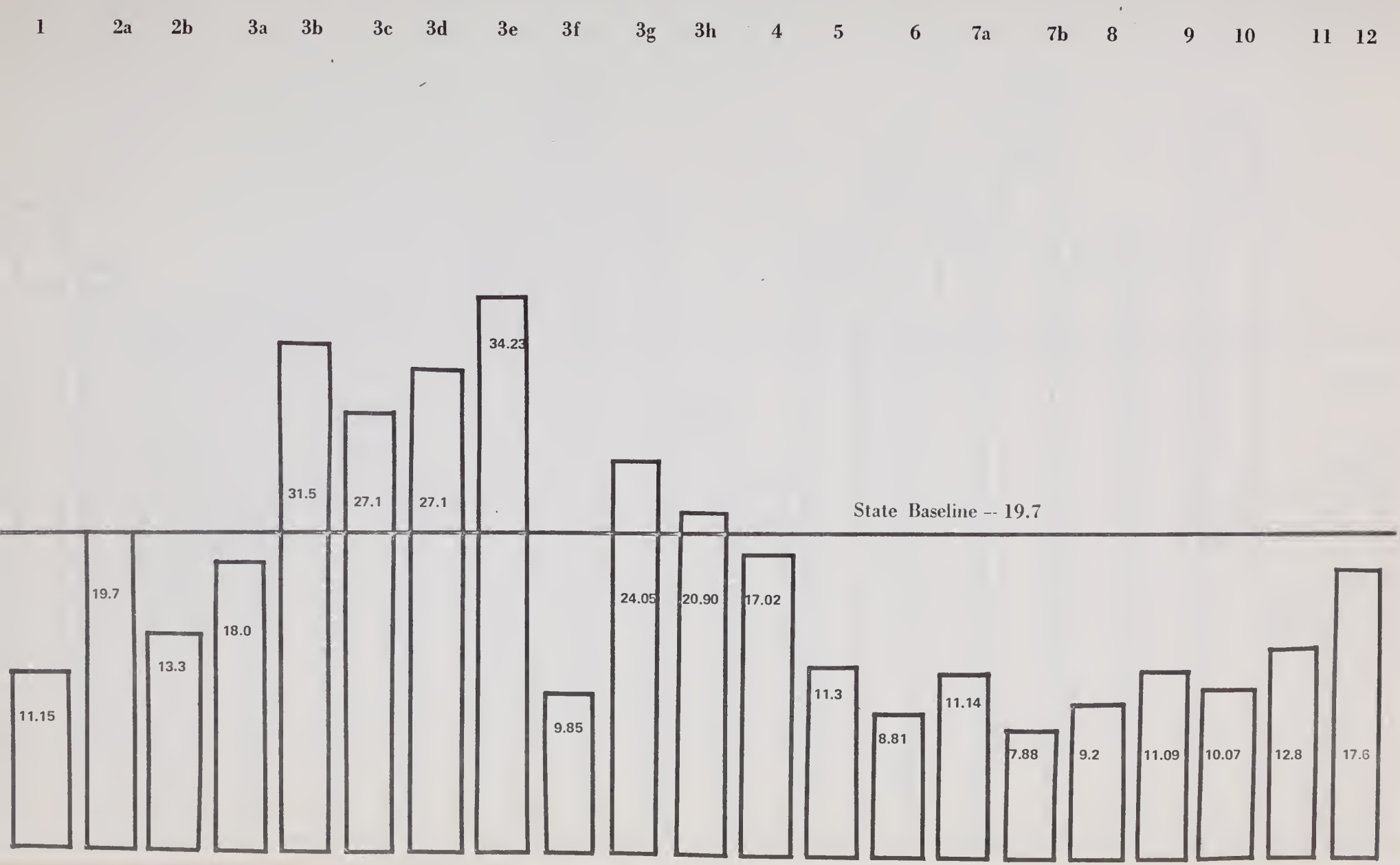
REGIONS

*Figures available only for regions 11 and 12 combined



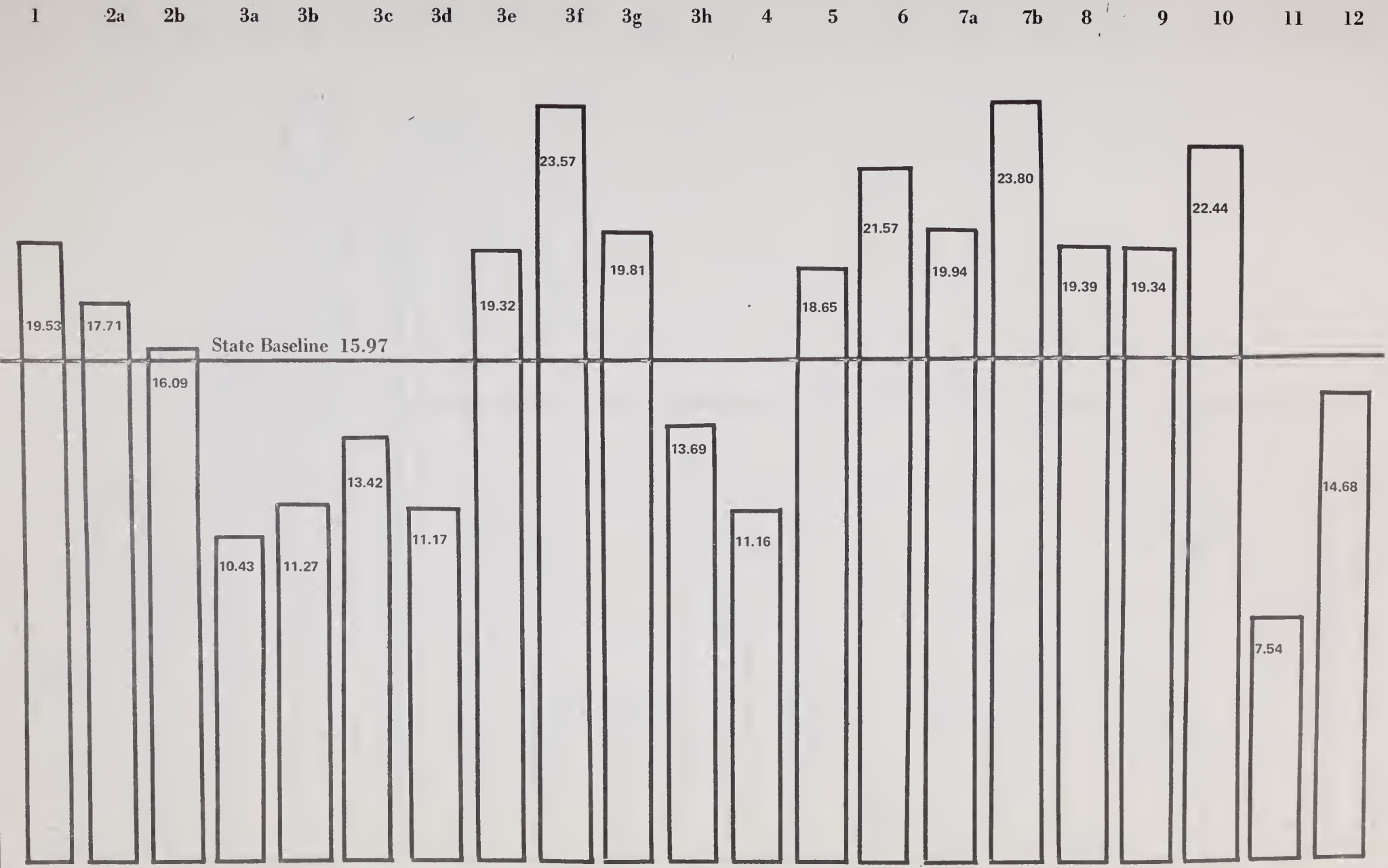
PERCENTAGE OF FAMILIES OVER $10,000

REGIONS



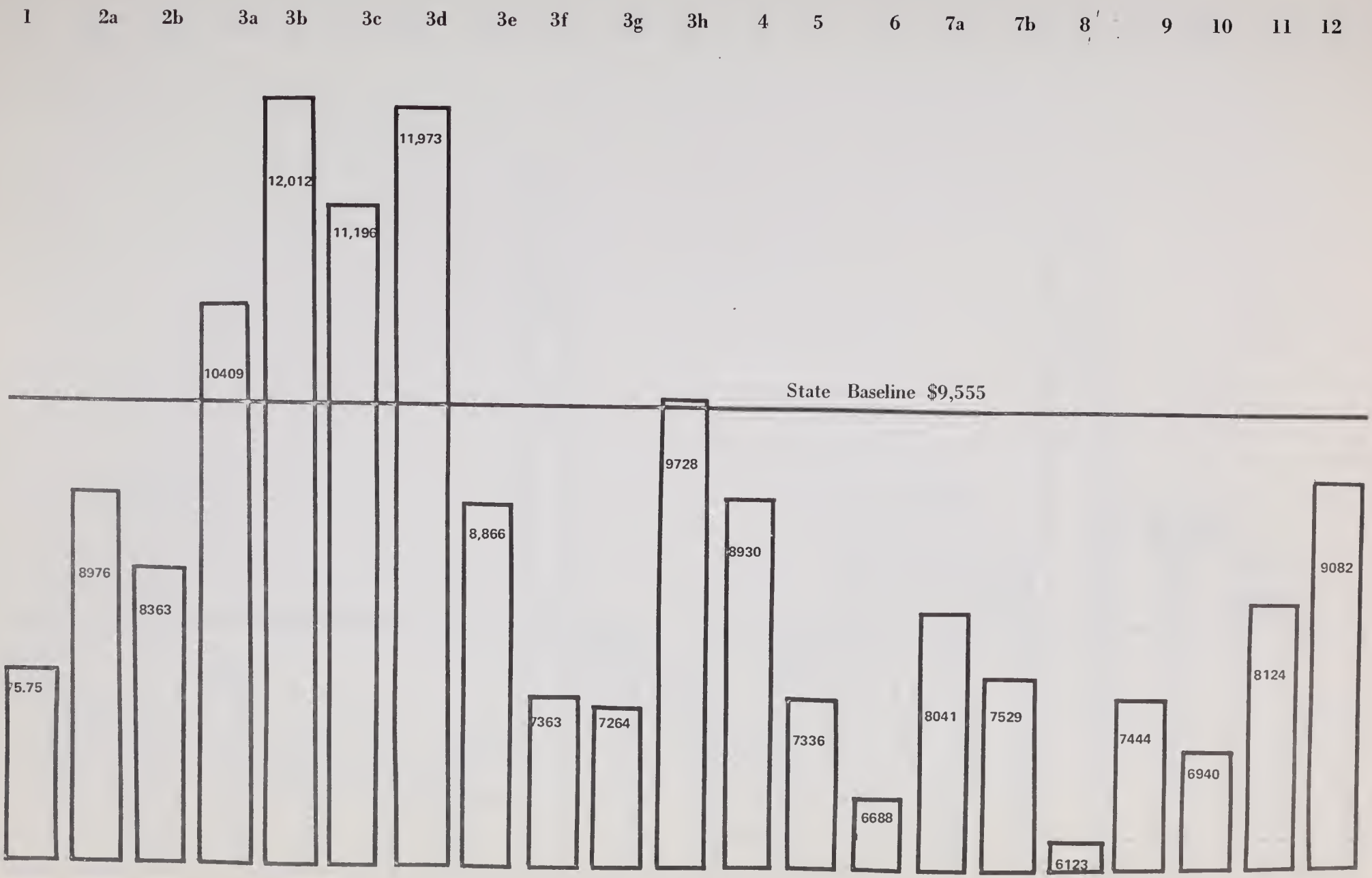
PERCENTAGE OF FAMILIES ON SOCIAL SECURITY

REGIONS



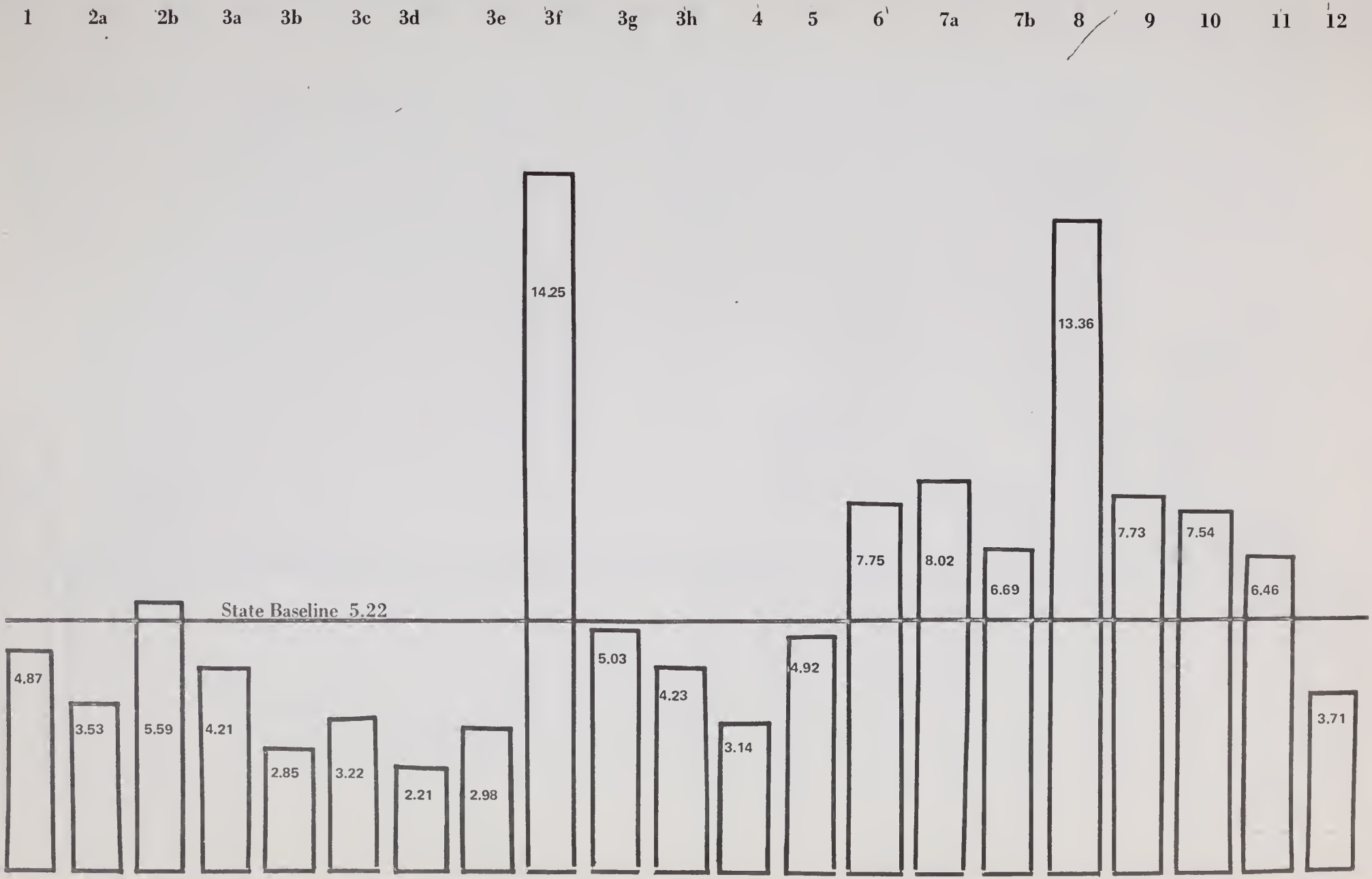
MEDIAN FAMILY INCOME

REGIONS



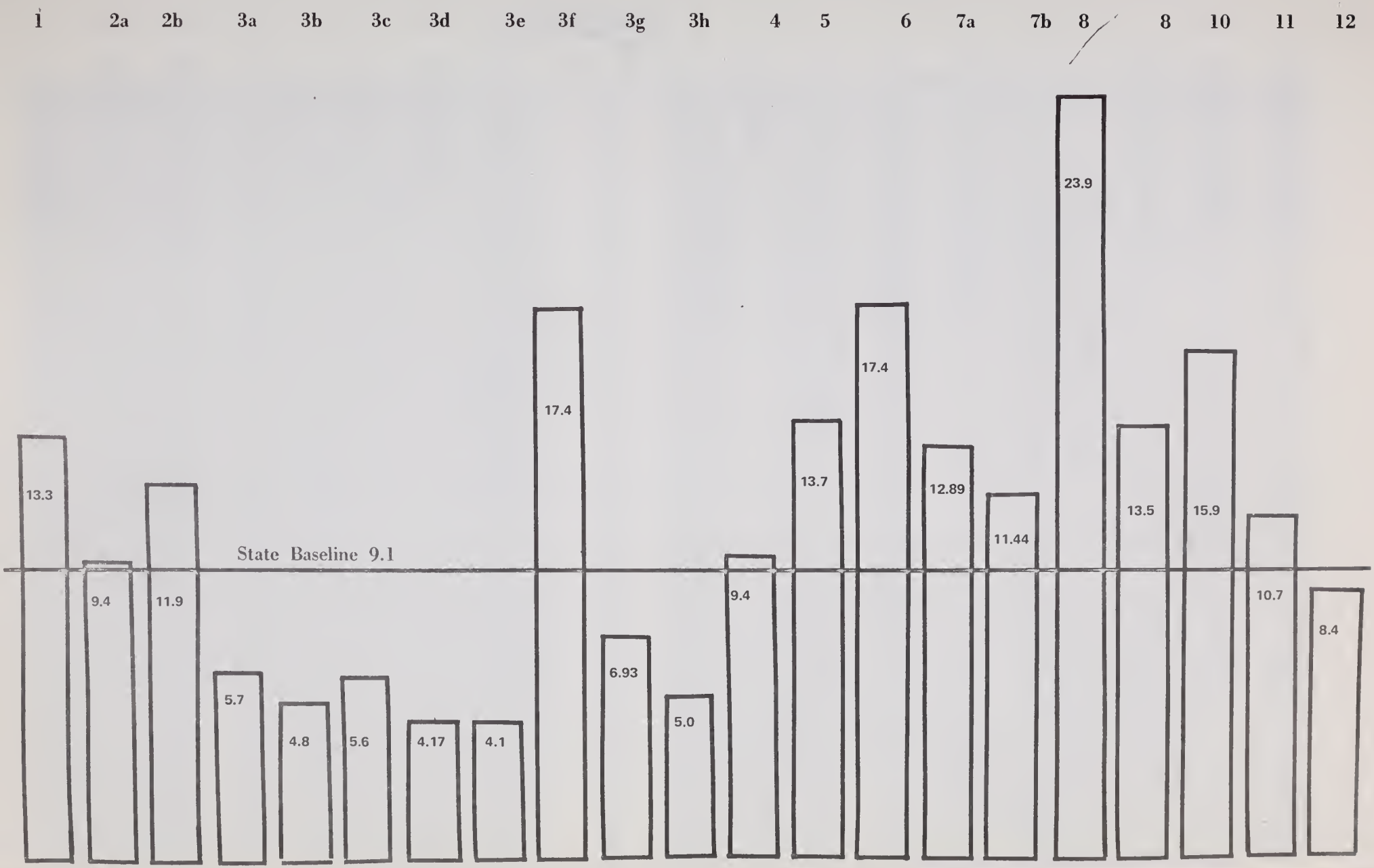
PERCENTAGE OF FAMILIES ON WELFARE

REGIONS



PERCENTAGE OF FAMILIES UNDER POVERTY LEVEL

REGIONS

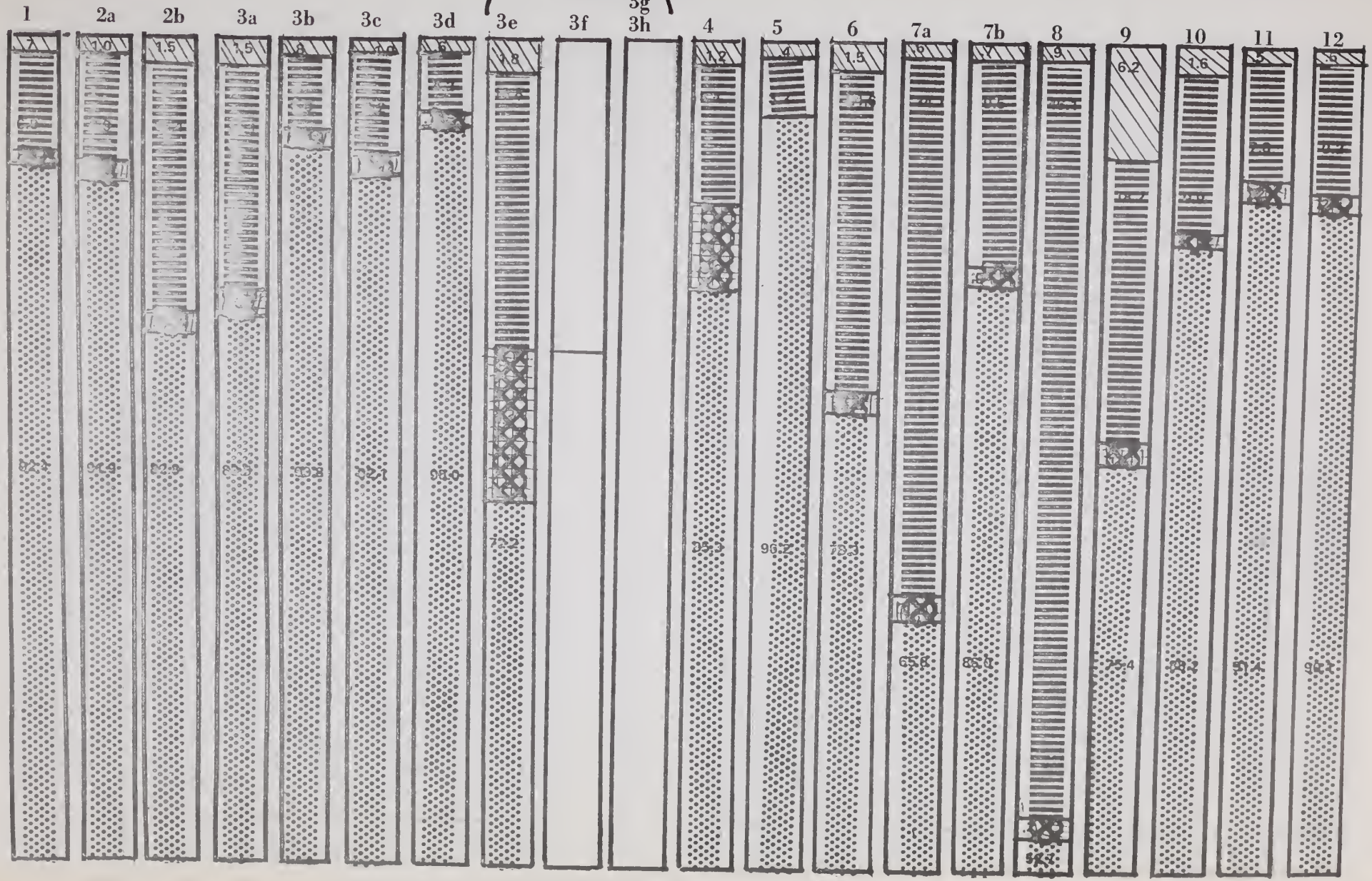


RACE DISTRIBUTION: WHERE

1970

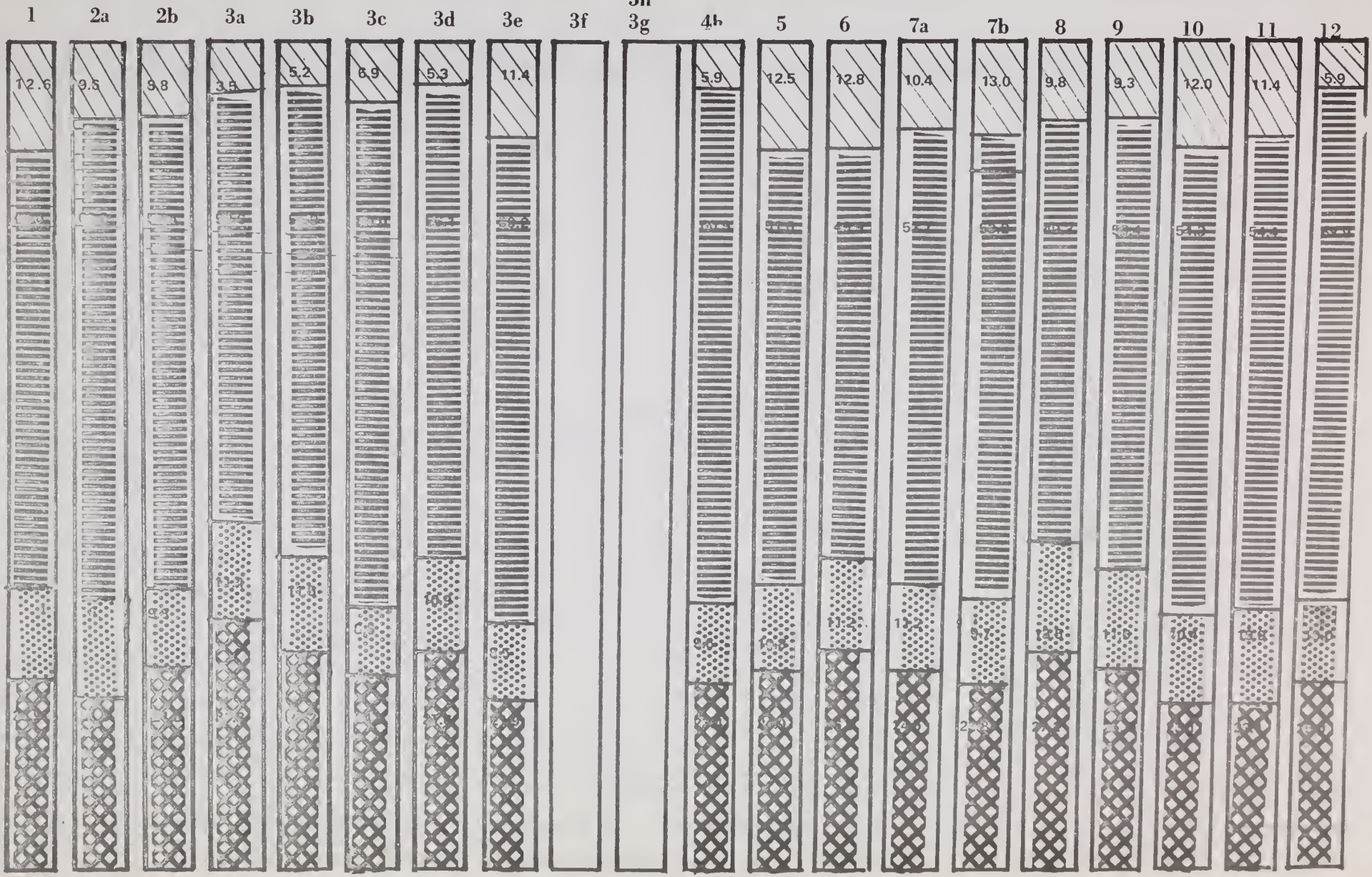
= Other
= Chicano
= Black
= White

All in Denver



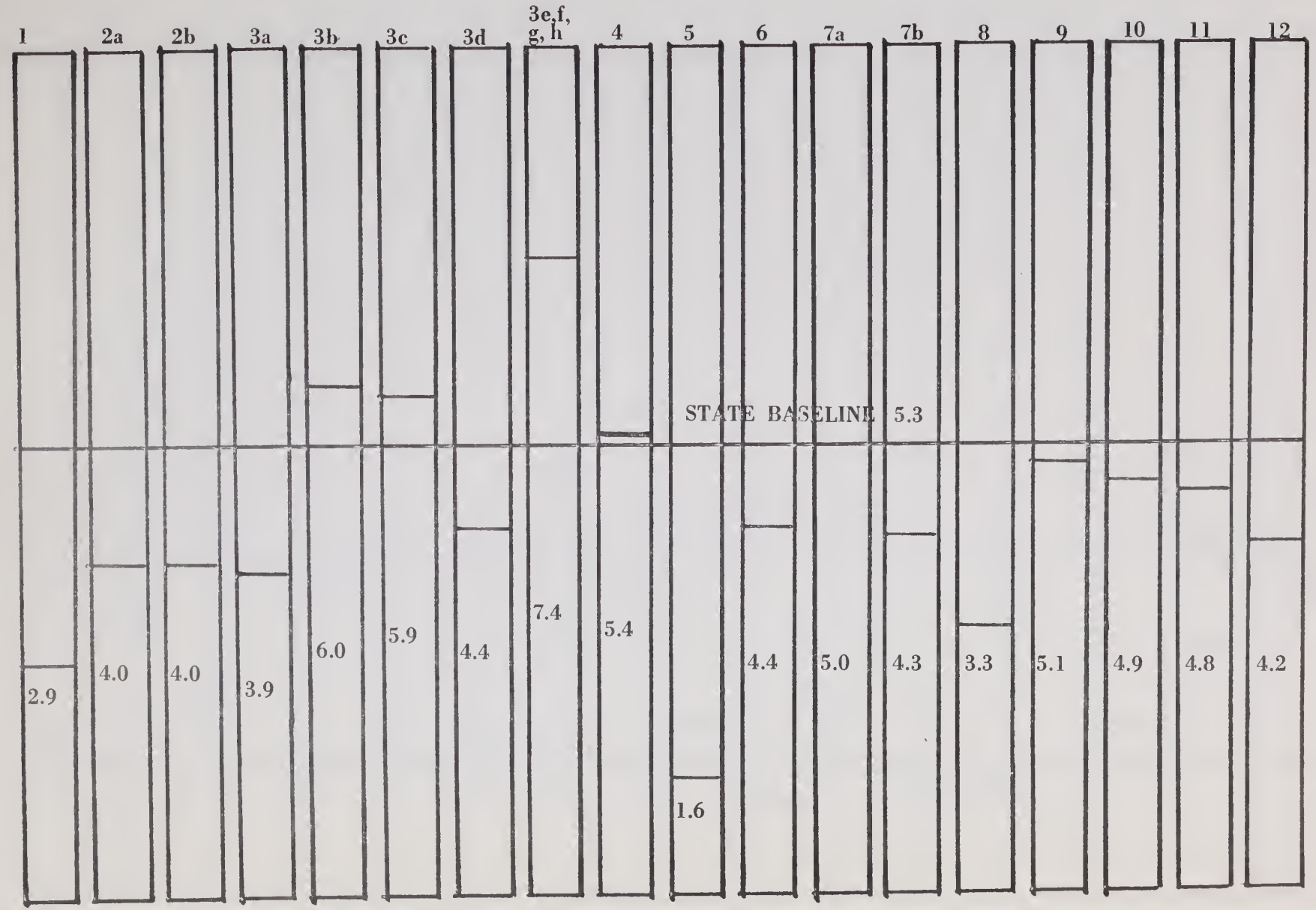
AGE DISTRIBUTION: WHERE = 18 - 64
= 13 - 17
= 0 - 12

All of Denver



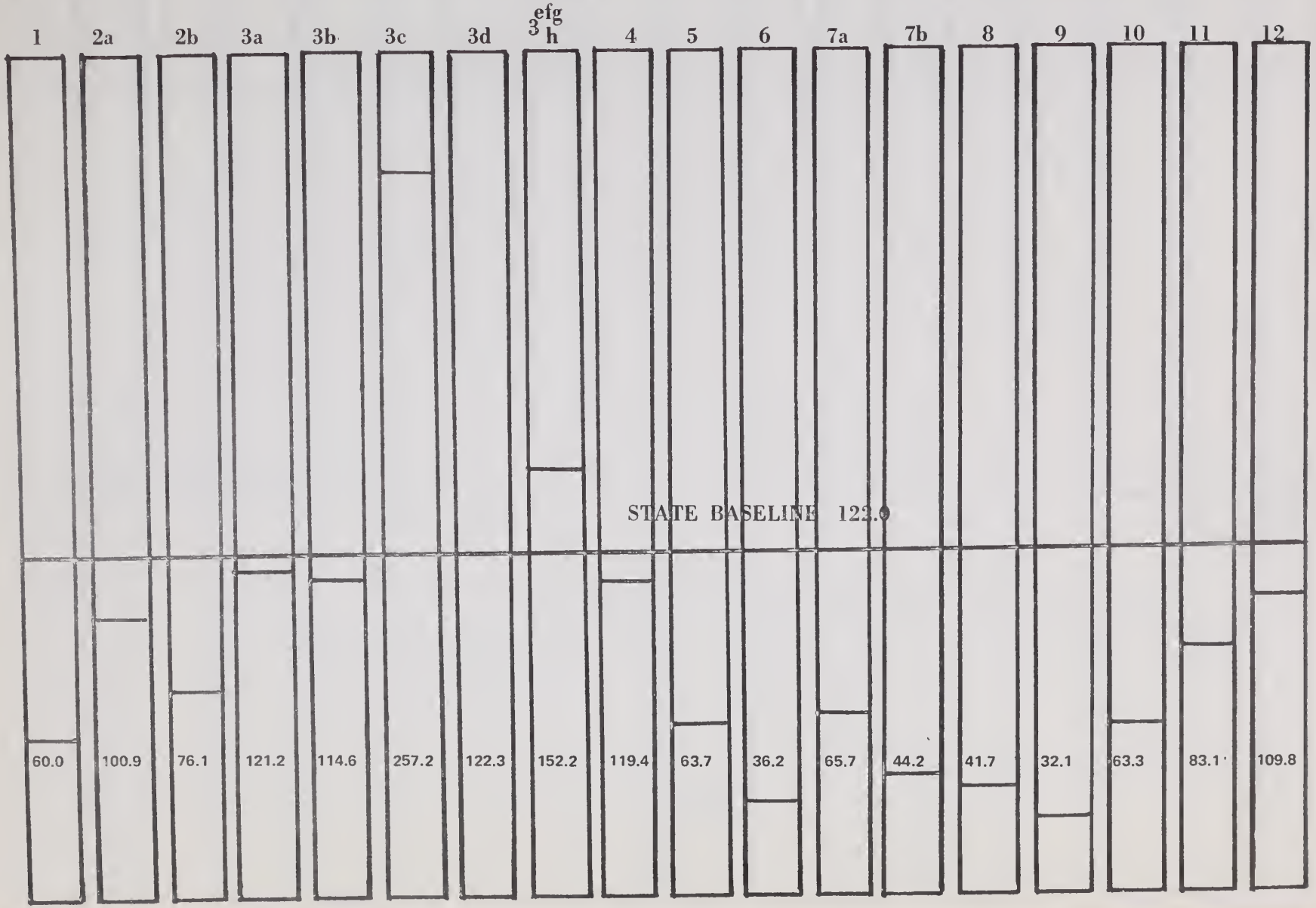
DISSOLUTION RATES BASED ON 1972 POPULATION ESTIMATE

per 1,000 Population

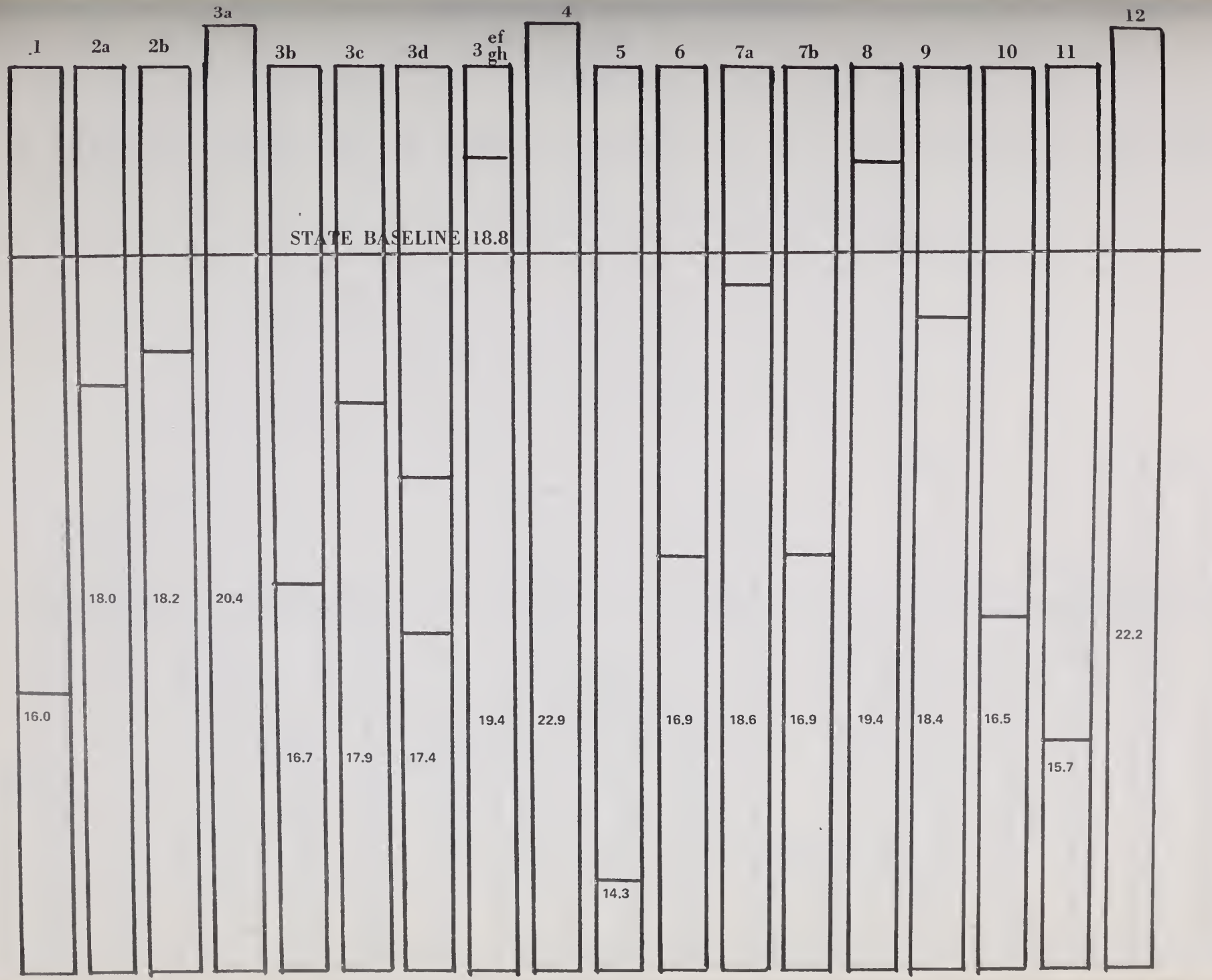


DEATH RATES – 1970

per 1,000 Live Births

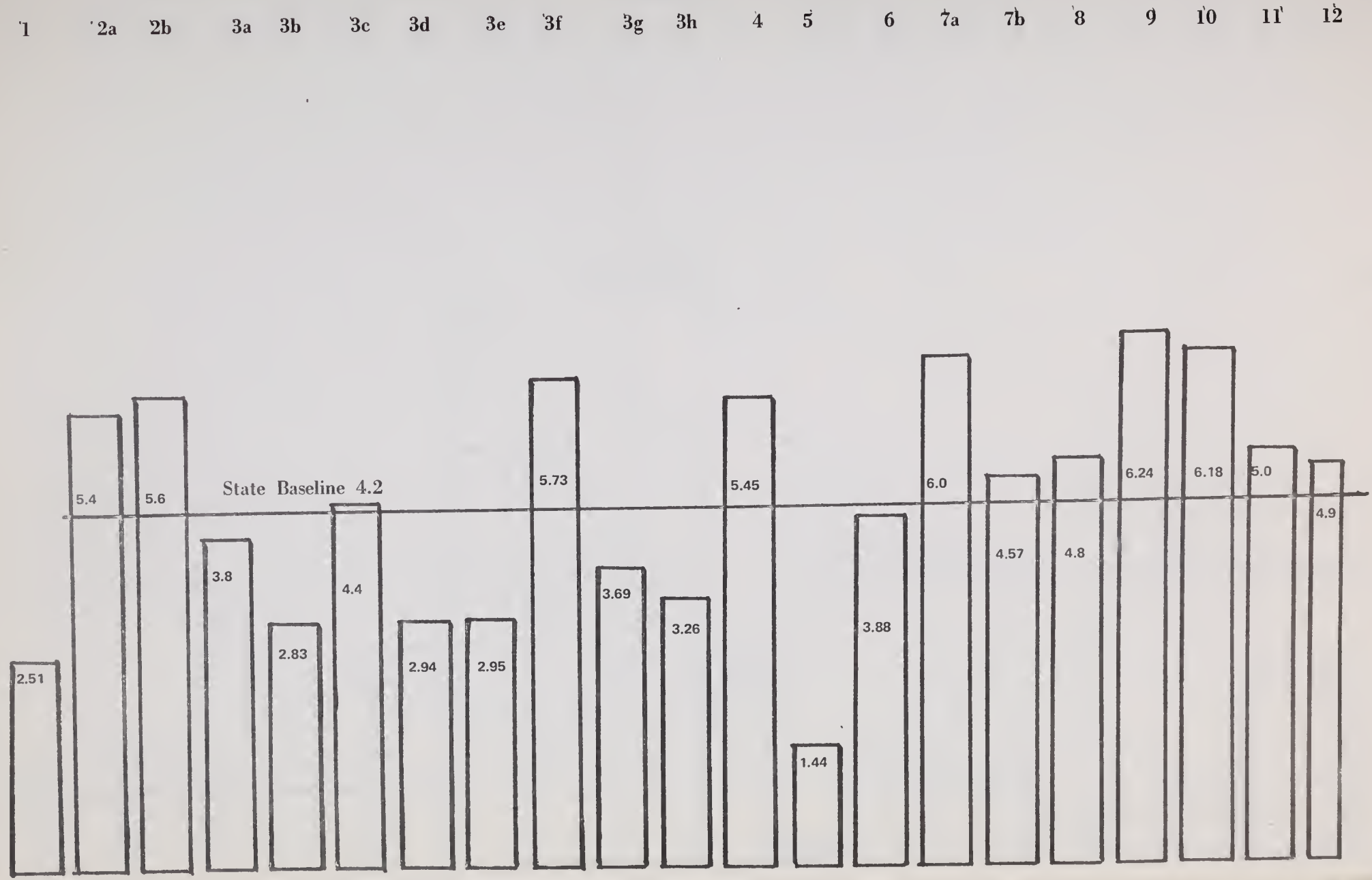


BED BED RATES — 1970 — per 1,000 Population



PERCENTAGE OF FAMILIES UNEMPLOYED

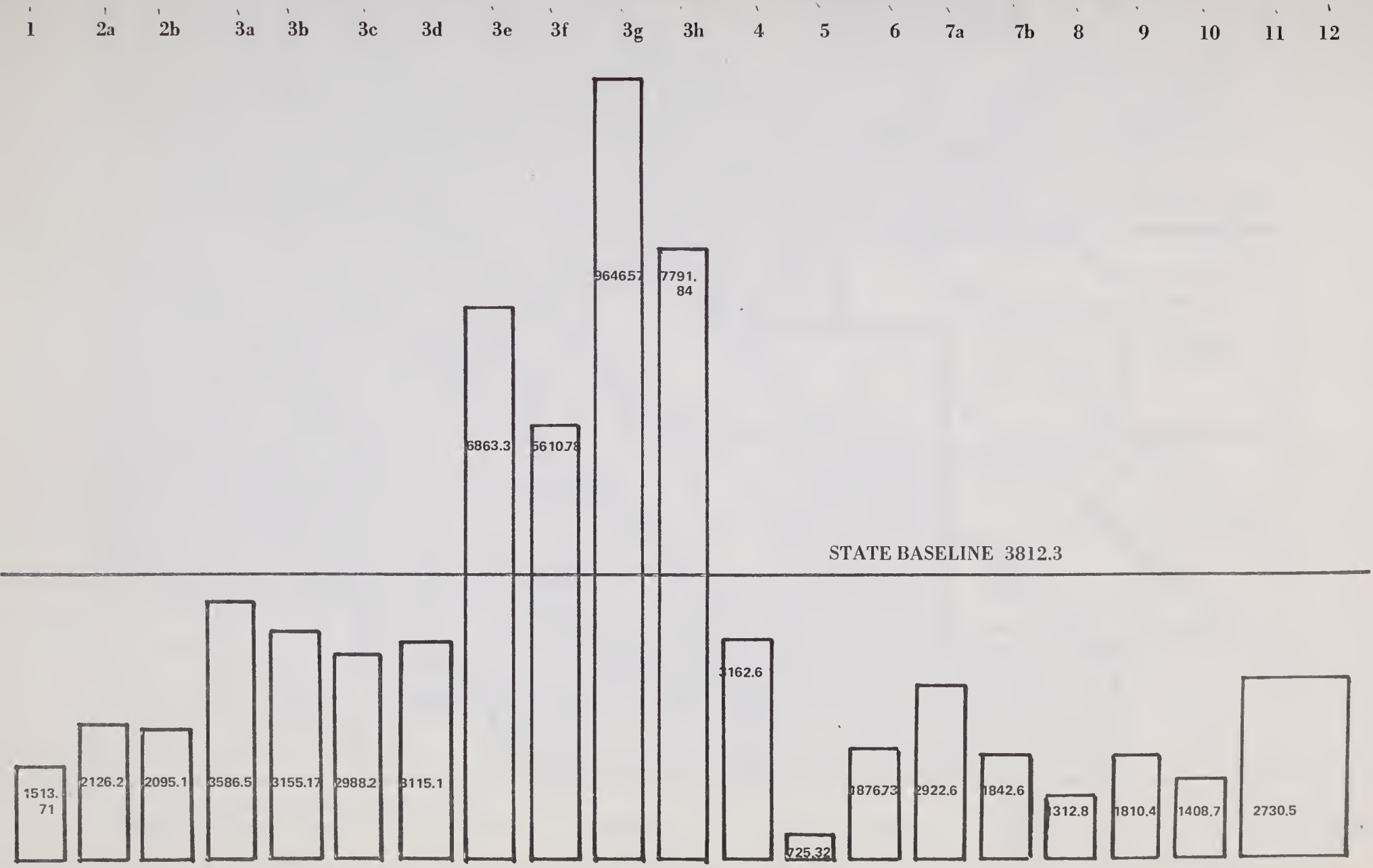
1970
REGIONS

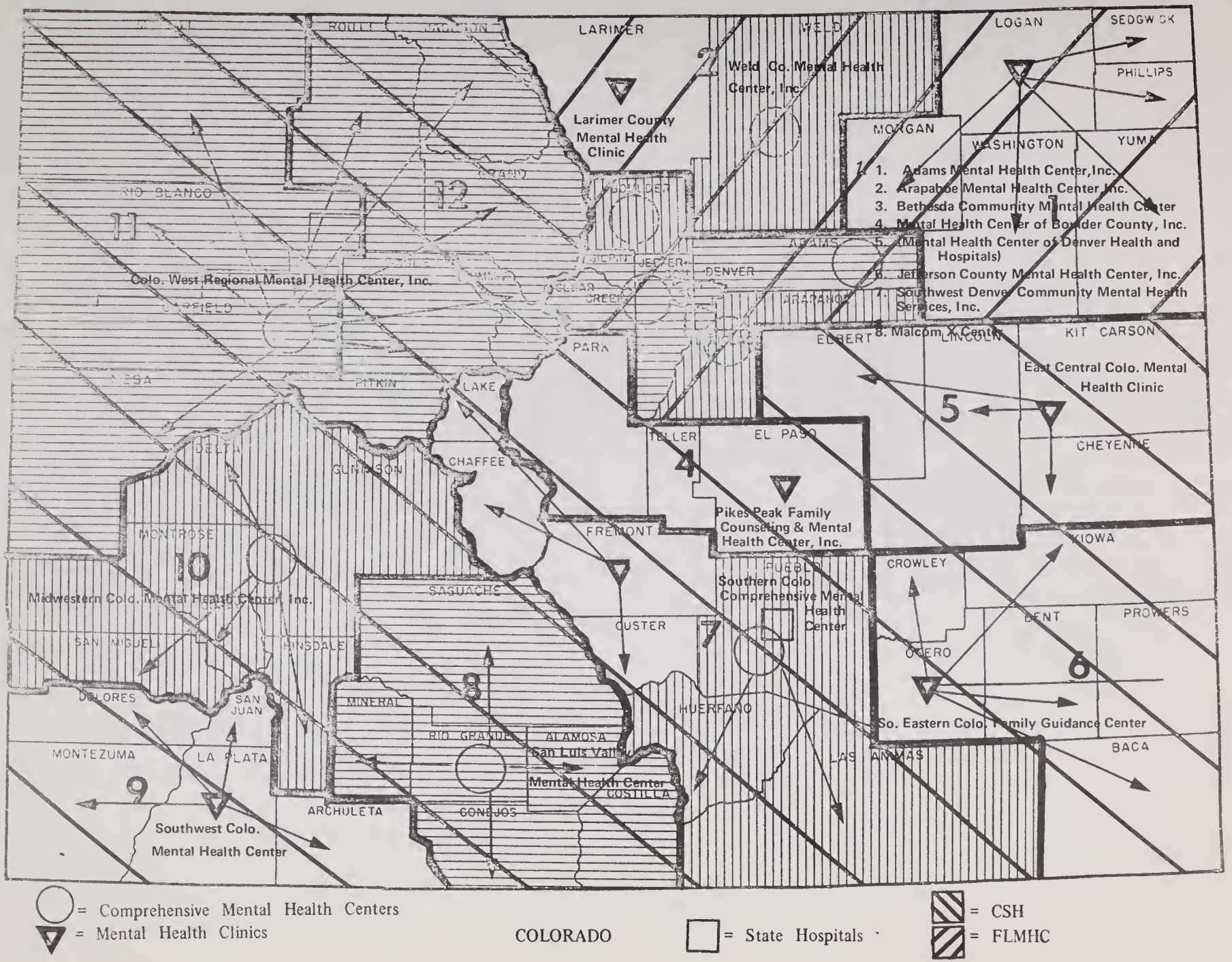


CRIME RATE per 100,000

1970

REGIONS





= Comprehensive Mental Health Centers

= Mental Health Clinics

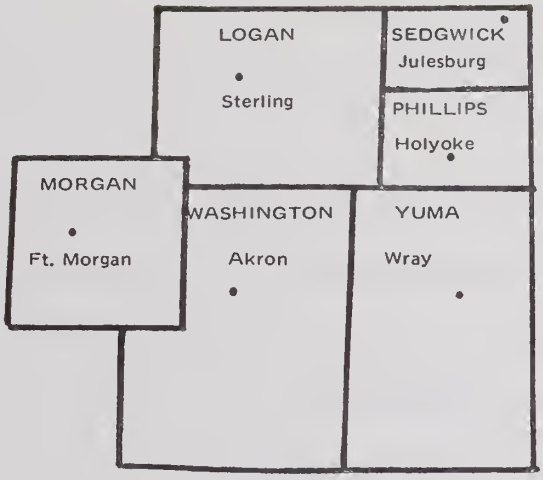
COLORADO

= State Hospitals

= CSH

= FLMHC

REGION 1



Area: 9,228 square miles
1973 Estimated Population: 62,700
1973 Clinic F.T.E.: 17.75

Region 1

The six northeastern counties of Colorado (Logan, Morgan, Phillips, Sedgwick, Washington and Yuma), with an estimated 1973 population of 62,700 persons, comprise Region 1. Over 66% of these persons live in Logan and Morgan Counties. Irrigated and dry-land agriculture and livestock are the major industries of the Region, and the two major communities are Sterling and Fort Morgan. There are nine general hospitals in the Region, and Northeast Junior College is located in Sterling. The Region is 9,228 square miles in size; distances between major population centers and outlying parts of the Region range from 50 to 100 miles.

Existing Services

The Region is served by the Northeast Colorado Mental Health Clinic headquartered in Sterling with a branch office in Fort Morgan. County fiscal support of the Clinic has been impressive; over the past several years, county funds have accounted for approximately one-third of the total budget of the clinic. The major service modalities of the Clinic are outpatient individual, group and family therapy; and education and consultation services to other community agencies. The Clinic is presently developing a day-care program in Sterling to be provided in a new building recently purchased by the Clinic's Board of Directors. A small LEAA grant provides some services for problem adolescents in Sterling. A contract with the Division of Alcohol and Drug Abuse (Department of Health) supports public education and community organization efforts in alcoholism in the Region.

The Clinic has approximately 18 FTE positions, including a part-time psychiatric consultant. During the fiscal year of 1972, when the Clinic had 9.45 FTE's, the Clinic had 5,731 visits and a caseload of approximately 1,000 clients and their families. During the same year, nearly two-thirds of the clients receiving services at the Clinic were under 18 years of age.

Program Needs

With the above-average community support generated by the Northeast Clinic, the establishment of a wide range of mental health services will be possible within the next few years. The Region is currently in the process of being transferred from the Colorado State Hospital service area to that of the Fort Logan Mental Health Center. This movement provides an excellent opportunity for the Clinic to plan and implement several service elements, particularly alternative inpatient services for adults (inpatient B). A modest 314 (d) grant from the Division of Mental Health for fiscal year 1974 provides some support for the development of alternative care services (day-care and inpatient care in a

cooperating nursing home). However, additional resources will be required to develop these services at an acceptable level.

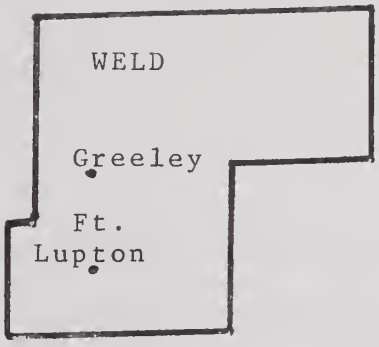
The presence of nine general hospitals in the Region, along with the support of the medical community in the Region, bodes well for the development of hospital-based inpatient services for intensive inpatient care; however, the absence of fiscal resources prevents this development; and, since federal funding for comprehensive centers is unlikely in the future, the development of hospital-based inpatient services may be dependent upon state and county resources.

The continued development of specialty services in the Region will probably be somewhat sporadic until the basic comprehensive service elements are solidified. However, alcoholism services require additional attention; the current low-level support of the Division of Alcohol and Drug Abuse will need to be expanded in order to provide the full range of services to those suffering from problems of drug abuse.

Goals:

1. Development of local inpatient services for adults.
   a. Short-term crisis-oriented, hospital-based units
   b. Alternative case services, including the use of nursing homes and crisis homes
2. Development of partial care services in conjunction with the inpatient programs
3. Development of 24-hour emergency services throughout the region
4. Development of full array of alcoholism treatment services, including detoxification, throughout the region
5. Attainment of comprehensive Center status

REGION 2a



Area: 4,004 square miles
1973 estimated population: 99,000
1973-74 Center F.T.E.: 47.95

Region 2a

Larimer and Weld Counties are designated as State Planning Region 2. Since separate mental health programs in the two counties have evolved over the years, it is desirable to study the two counties separately.

Region 2a: Weld County

Weld County has a population estimated at 99,000 in 1973, and the largest community is Greeley (about 39,000). There are a number of smaller communities located throughout the county, a majority of them located in the Southern portion. The Northern part of the county is a sparsely populated area dominated by the Pawnee National Grasslands. Major industries in Weld County include agribusiness, livestock, meat processing and education (University of Northern Colorado).

Existing Services

The county is served by the Weld Mental Health Center. The Center received a federal staffing grant in November, 1966; and the grant terminates in October, 1974. Based upon the 1960 census data, the county was designated as a poverty area; and the center became eligible for poverty funding status. The Center is staffed by nearly 48 FTE positions with an annual budget nearing $600,000. No county funds are used in support of the program; funding comes entirely from federal and state sources, fees, donations, and modest school contract funds and modest support from the city of Greeley. The Weld Center is the only community mental health program in the state that does not receive county support.

The main service center is in Greeley. There is a branch office in Fort Lupton, a community south of Greeley wherein a large proportion of the county's Chicano population resides. The center is attempting to increase its outreach efforts to Chicanos in the county and has made major strides, although additional resources may need to be channeled into this effort. Inpatient services are provided in the county hospital in Greeley, and the inpatient program is filled to capacity (258 clients during 1972 - 73). The average length of stay has increased slightly during FY 1973 to 10.3 days from 9.1 for the previous year. However, admissions to Colorado State Hospital Adult Psychiatric Services from Weld County declined by 40% from 1972 to 1973 (from 40 to 23).

Adult day care services, provided through a separately organized facility called "Stepping Stone" provides services for both chronic, longer term clients and clients in the inpatient unit. A half-way house provides services to alcoholics; and a full range of services is available for the alcoholic and his family through the various center service

elements. A modest drug abuse program, revolving around a city-provided facility named "Lean-on" and manned by one center staff member, was developed early in 1973. This program relies heavily on volunteer services.

The largest program unit is the outpatient unit, providing about 7,000 client visits for 1,372 clients during FY 1971 - 72. About one-fourth of the clients served by the Weld Mental Health Center are under 18 years of age.

A peculiarity exists with respect to the federal staffing funds for the Weld Center. Following the amendments to the original Federal Staffing Grant legislation (91-211) that allowed for differential funding of poverty centers, Weld was designated as a poverty center and thus eligible for additional federal funds at increased percentage rate. However, at the time of such designation, the Colorado General Assembly had already funded the mental health center at its non-poverty level. Additional matching funds were thus not available. The center chose to utilize other local resources and operating funds to match for the additional federal dollars, and for the past three years, the Center has operated "short" on operating funds in order to "make ends meet" for personnel.

Program Needs

The Weld Center provides basic services for all categories of clients with the exception of geriatrics, forensic services and specialized inpatient services for children and adolescents. Economic considerations dictate that the probable future course for the establishment of such services will be in conjunction with the Larimer County Mental Health Clinic in Fort Collins.

Perhaps the highest priority for this Region is the development of alternate 24-hour care services to relieve the growing pressure on the Center's inpatient program. A small 314 (d) grant from the Division of Mental Health during FY 1974 offers some alternatives through the use of crisis homes. A more permanent solution would be the development of a full-scale halfway house for psychiatric clients to provide both an entry treatment facility and an exit facility for persons leaving the hospital unit.

A second program need is the expansion of services to the Chicano community through the hiring of additional Chicano staff. The Center has addressed itself to this priority, but it has not yet been implemented.

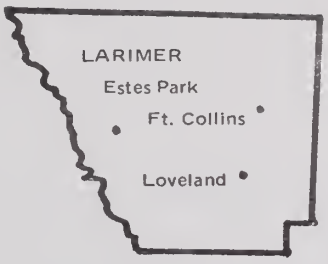
Thirdly, while services to substance abusers are available within the Center programs, these services are less than adequate. Additional resources should be addressed to the needs of alcoholics and drug abusers.

Beyond all of these goals remains the question of survival of the center itself. When the federal grant is retired, local funding support must be generated. Thus it is essential that efforts continue to develop county fiscal support as well as that of the city.

Goals:

1. Development of alternate, adult inpatient services
2. Establishment of halfway house program for adult psychiatric clients
3. Outreach of services to the Chicano community
4. Expansion of services to alcohol and drug abusers
5. Assumption of all adult psychiatric services

REGION 2b



Area: 2,614 square miles

1973 estimated population: 113,000

1973-74 Clinic F.T.E.: 14.5

Region 2b: Larimer County

The 1973 estimated population of Larimer County is 113,000 persons. The major communities of the County are Fort Collins, Loveland and Estes Park. The major industries in the County are agriculture, livestock, education (Colorado State University) and tourism. The terrain of the County ranges from a 14,000 - plus feet peak and the Continental Divide on the west to the rolling plains of the Poudre and South Platte River valleys. The southwest corner of the County is in the Rocky Mountain National Park; about 44% of the County land area is controlled by the federal, state or local governments.

Existing Service

The County is served by the Larimer County Mental Health Clinic; and for the past two years, the Clinic has provided the necessary service elements of a comprehensive center. However, the lack of clearly established affiliative agreements and formalized organization has prevented the designation of the Clinic as a center. For example, short-term placement of clients in the Poudre Valley Memorial Hospital has been a practice for several years without formal designation or description as an "inpatient program." Outpatient services are provided in Fort Collins and Loveland; day-care services are provided four days per week; consultation and education services are provided to welfare, the police, and the schools. A basic 24-hour emergency program is available through an answering service. In short, the basic "ingredients" of a comprehensive program are available in the Clinic program either as a formal program or on an "as-needed" basis. Despite the availability of these services, Larimer County is a high user of state hospital services.

The Colorado State Hospital has provided State Hospital services to Larimer County residents. Beginning September 1, 1973, however, the responsibility for adult services was shifted to the Fort Logan Mental Health Center. Additional programmatic plans will provide an opportunity for the Larimer County Clinic to "educate" other community agencies on the availability of local services which may stimulate additional treatment resources.

Program Needs

At the present writing, efforts are underway to implement a formalized psychiatric inpatient unit in the Poudre Valley Memorial Hospital. Once the relationship between the Clinic and the Hospital is established, the Clinic should apply for designation as a comprehensive center. However, alternate 24-hour non-hospital services may prove a more feasible inpatient program; and the Clinic is currently working on plans to establish such a service.

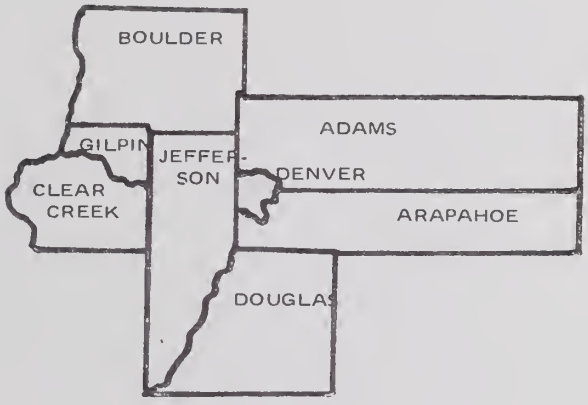
Several programmatic shortcomings require attention. First, an outreach program to the underserved Chicano

community needs to be developed. Second, although three part-time psychiatrists provide psychiatric consultation to the Clinic, additional psychiatric or medical involvement in the clinical programs, possibly hiring a full-time psychiatrist, should be considered. For economic reasons, expansion of programs to serve child, adolescent, geriatric and alcoholic clients may need to be developed cooperatively with the Weld Mental Health Center. Attention must be given to assuring that an expanded emergency service is made available throughout the County, more particularly in Estes Park.

Goals:

1. Development of inpatient services
2. Expansion of emergency service to outlying county areas
3. Outreach to Chicano community
4. Designation as a comprehensive center

Region 3


BOULDER
ADAMS
GILPIN
JEFFER-
SON
DENVER
CLEAR
CREEK
ARAPAHOE
DOUGLAS

PLANNING REGION 3

(DENVER METRO AREA)

INTRODUCTION:

Over the past ten years, major changes have taken place in mental health services in Region 3. The opening of Fort Logan in 1961 pioneered a number of new approaches to mental health care never before attempted on a large scale in any state hospital. Day care, evening care, and other forms of transitional treatment were offered as alternatives to 24-hour care, allowing Denver patients, who formerly would have been hospitalized at Pueblo, the opportunity of spending evenings and weekends at home with their families. Several of these concepts were incorporated into the national planning that later resulted in the development of community mental health centers.

Adult psychiatry services at Fort Logan were decentralized so that eventually separate teams served Adams, Arapahoe, and Jefferson Counties, and in 1971, Boulder County. Six teams in Denver served separate areas of the city. Speciality divisions were opened meeting mental health needs of children, adolescents, alcoholics, and the aged. At the same time, Colorado State Hospital continued to provide forensic and other special services to Denver area patients.

With the opening of Fort Logan, the population of patients admitted to Pueblo from Region 3 over the course of many years dropped from 888 in 1962 to 228 in 1973, at the same time that the local population of the area increased by 40%. The drop in admissions was the result of decreased admissions from Denver and dramatic shifts from custodial care to active treatment at the Colorado State Hospital in Pueblo during this time period.

In 1963, the Community Mental Health Center Act was passed and communities in Region 3 quickly availed themselves of the opportunity to provide a broad range of mental health service in the community. The Federal funding, combined with services of Fort Logan in most catchment areas, allowed the centers to begin to provide comprehensive services. The Northwest Denver Mental Health Center was funded in 1966, Arapahoe in 1967, Jefferson in 1967, Adams in 1968, Bethesda in 1971, Boulder in 1971 and Southwest Denver in 1973. Malcom X Center, serving Northeast Denver, is the only Region 3 catchment area center not yet receiving Federal or State mental health center funding based on a staffing grant.

With the exception of Denver General Hospital and Bethesda, the agencies sponsoring the new mental health center programs were outpatient clinics, which had not had extensive previous experience or resources for treating major mental illness, acute psychiatric emergencies and chronic patients. As a result, in the period from 1963 to 1968,

there was a strong tendency to send many psychiatric emergencies, many patients who were severely disturbed or difficult to manage and most chronic patients to Fort Logan for treatment.

More recently, the centers' experience, expertise and willingness to provide a broad spectrum of adult psychiatric services has increased. The centers are now asking to provide more adult services in the community, while Fort Logan feels that some services will need to continue to be provided at Fort Logan.

In addition to Fort Logan Mental Health Center and the community mental health centers and clinics in the Denver area from which services are purchased by the State through the Department of Instututions, other public and private hospitals are providing mental health services for the region. In Denver, 222 beds for psychiatric patients are available in private hospitals, in addition to 16 beds at Denver General Hospital and 79 beds at Colorado Psychiatric Hospital. Boulder Memorial Hospital also has 14 psychiatric beds.

The physical plant of Colorado Psychiatric Hospital, the inpatient facility of the Department of Psychiatry, has deteriorated. Since the inpatient treatment program is an integral part of the Department of Psychiatry and the Medical School, new inpatient facilities on the Medical School Campus are being planned for the near future. Planning is also underway for coordinating the service and training functions of the Department of Psychiatry with the total mental health system of the region and the State.

MENTAL HEALTH ISSUES IN REGION 3

1. The respective roles of Fort Logan and the Community Mental Health Centers.

   At the present time, the centers have made significant strides in the provision of the rull range of adult psychiatric services in the community and in the development of community-based alternatives to hospitalization. Fort Logan has facilitated and supported the assumption of these responsibilities by a number of centers and has reorganized its own services to produce a greater focus on chronic patients and specialized services.

   However, to a great extent, the historic roles of Fort Logan and the centers have been determined too often by the centers' assumption of responsibility for clinical problems they feel competent and interested in treating, while Fort Logan has assumed responsibility for the clinical problems that are left over, that fit within the framework of Fort Logan's philosophy.

   At the present time, the community mental health centers in Region 3 are providing few services for geriatric patients and few treatment services for alcohol problems are available in the community. Most

of the centers in Region 3 provide limited services for children and adolescents, but narcotic addiction programs are available only within the City and County of Denver, and in Boulder's newly funded program. The Denver narcotic addiction treatment programs are all clustered close to downtown Denver and are only minimally associated with community mental health centers. Several centers provide professional assistance to the courts, but the provision of community mental health services to individuals in the State and Federal correctional systems is very limited.

Fort Logan does not provide traditional closed treatment facilities. It does provide specialty services in alcohol, geriatrics, children, and adolescent treatment programs, in addition to adult psychiatry treatment programs.

2. Regional Coordination of Mental Health Services.

Region 3 encompasses eight counties in which more than half of the State's citizens reside. In this metropolitan area, with a concentration of population, are located eight mental health catchment areas – four in the City and County of Denver, and four in the suburban counties. The beginning activities to plan and implement a mental health authority for Denver are described below. In addition, attention must be given to developing viable coordination of services for the total region. As people move across city or county boundaries from their homes to places of employment or other activities, some mental health services may need to be planned and offered cooperatively by more than one catchment area center, or as a regional service. The Metro Mental Health Planning Council has offered a forum for some interchange of ideas, and the Denver Regional Council of Governments has developed regional planning which is pertinent to mental health services. Strengthened regional coordination will be needed for the future.

3. Mental Health Authority for Denver.

There is a major need in the City and County of Denver for city-wide integration and coordination of mental health programs, and the development of a Denver mental health plan that takes into account mental health needs and leads to a rational city-wide allocation of mental health resources. Unfortunately, the historical evolution of mental health services in the City has militated against the development of a city-wide approach to mental health problems.

The City Charter of Denver designated Health and Hospitals as the department which "shall exercise all administrative functions of the City and County of Denver pertaining to the physical and mental health

of the people, and the operation of municipally owned institutions for the care of the sick, aged, or mentally ill."

Originally, the City and County of Denver provided financial support for the Department of Psychiatry under Health and Hospitals, which operated an 18-bed psychiatric inpatient service at Denver General, focusing on the needs of the indigent,mentally ill. However, mental health resources in Denver County expanded rapidly in the past ten years, and Federal funding under a number of specifically different successive Federal programs added further complexity to the mental health service system of the City.

As a result of the Community Mental Health Centers Act passed in 1963, the City was divided into four mental health catchment areas serving Northwest, Southwest, Northeast, and Southeast Denver. The Northwest Center was funded through the Health and Hospitals Department of Psychiatry, while the other three centers were operated by separate private non-profit corporations governed by citizens' boards. In addition to the four centers, two non-catchmented outpatient facilities, Denver Mental Health Center and the Children's and Adolescents Mental Health Service, provided special intensive outpatient services to Denver citizens.

Further mental health funding became available through the Office of Economic Opportunity's Neighborhood Health Programs. The East Denver Neighborhood Health Center was established in 1966 and the West Denver Center in 1968. Nine smaller health stations were then added to serve specific neighborhoods. Mental health services were provided as part of a total spectrum of health care. Unfortunately, the catchment areas of the neighborhood health programs did not correspond to the mental health center catchment areas.

The Model Cities Grant to the City of Denver in 1969 provided funds for a number of special mental health projects. These projects provided mental health services in a number of low income, high problem, target areas in the City. This established still another set of geographic service boundaries which did not coincide with either the neighborhood health program boundaries or the mental health centers' catchment area boundaries.

The mental health centers serving Southeast, Northeast, and Southwest Denver were not directly involved in the Model Cities funding or the neighborhood health funding. Combined with increasing support from the City budget through Health and Hospitals to mental health services in Northwest Denver, this

resulted in an unbalanced distribution of mental health resources in the City of Denver.

Clearly, there is a major need for a Denver mental health plan which defines city-wide needs, integrates and coordinates services, and provides a retional basis for Federal, State, and City mental health funding. The establishment of a Denver Mental Health Authority would facilitate such planning and coordination, but the designation of a Denver Mental Health Authority has been made difficult by a number of factors:

a. The city administration has taken the clear position that the manager of Health and Hospitals is the Denver Mental Health Authority. However, the manager of Health and Hospitals currently has the direct responsibility of operating one of the four Denver mental health centers, which places him in a potential conflict of interest position in the Denver Mental Health Authority position, since he would simultaneously be a purchaser and a vendor of mental health services.

b. The comparative power of the Denver Mental Health Authority and of the citizens' boards are difficult to define. The citizens' boards of the mental health centers, while recognizing the need for city-wide planning and integration of mental health services, have rejected any plan that would lead to their centers becoming city agencies, rather than separate private non-profit corporations that can enter into contracts with the city for providing mental health services.

c. Attitudes of mistrust have existed between the centers and the city administration, based on the historical evolution of their relationships. Recently major steps have been taken to resolve these differences and a city-wide planning effort has been initiated.

Present Status of Planning

A city-wide Denver group representing city mental health agencies, center board members, and concerned citizens is meeting with the full support of Health and Hospitals and the Division of Mental Health to draw up a Denver County mental health plan, which will develop a mechanism for the integration and coordination of mental health services and develop a long-range mental health plan for the city.

4. Aftercare Services.

As the Colorado State Hospital and Fort Logan increased their emphasis on returning all patients who who did not require institutional care to community living, a number of chronic psychiatric patients, who normally would spend a majority of their lives in institutional care, were discharged. As has been demonstrated in other states that put an emphasis on decreasing state institutional care, such as California,

chronic patients who are discharged from the State Hospital tend to concentrate in boarding homes and nursing homes in large urban centers. Additional patients are placed in boarding homes and nursing homes by mental health centers. This trend has resulted in the accumulation of a disproportionate number of facilities for chronic patients in boarding homes in the Capitol Hill section of Denver and in nursing homes throughout the metropolitan region.

While many boarding homes and nursing homes provide a living environment that supports a good quality of life, a number of Denver nursing and boarding homes, and other facilities permit an environment that results in social isolation, de-humanized conditions, and poor quality of care. Plans for mental health services must include a systematic review of these facilities in the Denver area, with provisions for assuring that patients are placed only in boarding homes or nursing homes providing high-quality care and that appropriate supportive or treatment services are provided to those patients.

5. Adult Mental Health Services.

Most of the mental health clinics and centers in region III provide psychotherapy for adults as a major component of their mental health services. The specific treatment approaches used vary widely and include individual psychotherapy, marital counseling, family therapy, group therapy, and behavior modification. In addition, most clinics and centers place significant emphasis on preventive programs and on consultation and education to other community agencies and organizations.

Because of the major emphasis on adult outpatient programs in most clinics and centers, training programs for continued professional growth of staff members in adult psychotherapy services are extremely important. Existing training programs within each mental health agency could be significantly strengthened by making the specific expertise in some agencies available to all region III agencies in a coordinated way. A Denver-Metro Consortium on Mental Health Continuing Education has been organized to facilitate such a process.

Coordination of consultation and education programs in organizations such as schools and correctional systems is needed, especially in areas such as Denver County where several catchmented mental health agencies may be providing services to one county-wide organization. A clearer definition of the appropriate areas of involvement of mental health agencies in preventive and education programs is needed.

6. The Role of the University of Colorado Psychiatric Hospital and Clinics.

Most of the Department of Psychiatry's training and patient service programs take place in buildings constructed during the past 15 years (CGH, Adult and Child Clinic Building, Child Day Care Center, and J. F. Kennedy Center); however, the inpatient service (CPH) has increasing problems because the hospital is aged and outdated. Although not a part of the mental health system under the Department of Institutions the University of Colorado's Department of Psychiatry, through its clinical divisions, provides a significant amount of inpatient and other mental health services for residents of Denver, the metropolitan areas, and the whole state. One thousand fifty nine Region 3 residents were admitted for inpatient service at Colorado Psychiatric Hospital in 1972 - 73, and the adult and child outpatient psychiatric clinics had a total of 32,600 outpatient visits. The children's division includes the Children's Diagnostic Center, the Children's and Adolescents Mental Health Service, a day care treatment program, and the adolescent unit, and an active school consultation and teacher training program involving several Colorado school districts.

Through the Psychiatric Liaison Division, about 3,000 psychiatric evaluation and consultation visits are provided for patients in medical services of Colorado General Hospital. The Psychiatric Emergency Service of University of Colorado Medical Center provided 3,034 emergency evaluations during the year and is an important resource for residents of Denver and the surrounding counties. There is a small training-oriented alcoholic treatment program and a major drug abuse-heroin addiction treatment program. A major need exists for coordinating the hospital services provided at Colorado Psychiatric Hospital and the other psychiatric services provided at the University of Colorado Medical Center with the other mental health services available in Denver.

7. Special Problem Areas.

a. ALCOHOL

An Alcohol plan for Region 3 must be coordinated with the Alcohol and Drug Abuse Division of the Colorado Department of Health, which has the responsibility of drawing up the State Master Plan for Alcoholism.

(1) Needs

At the present time, a number of major specific alcohol problems exist in Region 3. These needs are being met either partially or not at all. They include:

(a) treatment and rehabilitation for individuals arrested for public drunkenness.

(b) detoxification facilities, both in inpatient beds and community-based residential facilities.

(c) outpatient treatment facilities for individuals and families with alcohol problems, with a special emphasis on facilities responsive to drinking problems identified early in their course.

(d) facilities specifically designed to reach and respond to women with alcohol problems and especially the suburban housewife alcoholic.

(e) facilities to treat individuals with alcohol problems in the work setting.

(f) facilities to treat individuals identified as having drinking problems as a result of drinking-driving arrests.

(g) facilities able to provide services meeting the specific needs of Region 3's Chicano, Black, and Indian population.

(2) Resources

At the present time, the major alcohol treatment facilities in Region 3 are the Fort Logan Mental Health Center's alcoholism division, which treats approximately 1000 individuals each year with a combination of one-week residential treatment and outpatient groups, and the Denver Department of Health and Hospitals, which provides detoxification beds, supporting services for the skid-row alcoholic and outpatient facilities. Evaluation, outpatient and halfway house services for alcoholics are available through the Alcoholism Service of the Boulder County Health Department. Inpatient and detoxification care is provided by the Mental Health Center of Boulder through their inpatient and crisis services. Other Region 3 centers provide some, usually minimal, outpatient alcohol problems services.

(3) Public Drunkenness

It is important to point out that very few of the existing Region 3 resources provide services pertinent to the needs of individuals arrested for public drunkenness. If treatment and rehabilitation is to be provided in place of arrest for these individuals as a result of the new state law, a significant number of new treatment settings, rather than an expansion of existing facilities, is indicated. Presently the Wazee Center is able to provide supportive services daily to as many as 300 skid-row

individuals who have high arrest rates of which as many as 50 stay overnight. The Social Brokerage Center provides antabuse and other therapies to approximately 50 individuals per week, and a small number of halfway house spaces are available in Denver. Virtually no public drunkenness oriented resources exist in Jefferson, Arapahoe, and Adams Counties, while some halfway house facilities exist in Boulder County.

(4) Detoxification

Twenty-seven alcohol detoxification beds are available in Denver General Hospital, and other inpatient detoxification beds are minimally available at the University of Colorado Medical Center and in private Denver hospitals. Community-based residential drying-out facilities, utilizing peer group assistance and having prompt and effective medical back-up and coordination with inpatient detoxification facilities, have been demonstrated to be effective. Pilot programs for community-based detoxification facilities are needed for the Region 3 area along with an increase in inpatient detoxification services.

(5) Outpatient Treatment

Although most of the Region 3 centers have some small outpatient resources for the treatment of alcohol problems, the existing outpatient resources fall far short of meeting existing needs. Major expansion of existing outpatient treatment facilities is indicated.

(6) Alcohol Problems of Women

Women with alcohol problems represent only a tiny fraction of the individuals treated in the Region 3 area's existing treatment programs. Yet, carefully conducted population surveys show that although men with alcohol problems are more numerous than women, there are substantial numbers of women with alcohol problems who are not reached by existing treatment resources. In order to reach these women, studies of treatment acceptability and pilot programs designed specifically to meet the needs of groups such as the suburban housewife with alcohol problems are indicated.

(7) Alcohol Programs in the Work Setting

A number of effective models exist for assisting problem drinkers through the direct participation of the employing organization. Although some private consulting organizations exist for this purpose, existing mental health agencies have only limited involvement with major Denver employers. Because

of the concentration of major employers in Region 3, a coordinated effort at providing work-related alcohol problems services on some type of fee-for-service basis is indicated.

(8) Treatment of the Drinking Driver

The State Health Department initiated in 1971 a project funded by the Department of Transportation to decrease the incidence of drunken driving. Individuals who were arrested for DUI and other alcohol related driving offenses were referred after evaluation to a broad range of Region 3 treatment programs with the treatment supported by a Federal demonstration grant. Treatment has, to date, resulted in a significant decrease in driving violations of the individuals treated; and since the demonstration funds terminate in 1974, a decision needs to be made on future funding of the treatment programs.

(9) Alcohol Problems of Minority Groups

At the present time, three alcohol treatment programs funded through Denver Opportunity provide services especially oriented to minority group needs. The East Side D. O. Center provides services especially geared to the black population; the Westside D. O. Center meets some of the needs of the Chicano population; and the Tepees Center provides programs especially oriented to Indians, including a residential facility at Eagle Lodge. An evaluation of the success of these programs in meeting the specific needs of minority group members with alcohol problems is indicated.

(10) Suggested Priorities

(a) evaluation of existing and proposed alcoholism treatment programs.

(b) expansion of community-based and inpatient detoxification resources.

(c) expansion of outpatient and early treatment resources.

(d) continuation of treatment programs for the drinking driver.

(e) development of specific resources for treatment and rehabilitation of individuals arrested for public drunkenness under the new law.

(f) development of treatment programs responsive to women with alcohol problems.

(g) expansion of minority group alcohol treatment programs.

(h) development and coordination of resources intervening in alcohol problems related to the work setting.

b. DRUGS

In conjunction with the Alcohol and Drug Abuse Division of the Colorado Department of Health, the Region 3 comprehensive mental health plan should provide for drug treatment services in the community mental health agencies and in other pertinent agencies.

(1) Needs

(a) treatment for heroin addicts.

(b) treatment for individuals addicted to barbiturates and sedatives.

(c) treatment for individuals with problems with hallucinogens, amphetamines, and other drugs.

(d) drug education programs.

(2) Resources

(a) Heroin Addiction Treatment Resources: At the present time, there are estimated to be 3000 opiate addicts in the Region 3 area. Jefferson County Mental Health Center, Arapahoe Mental Health Center, and Adams Mental Health Center currently have no heroin addiction treatment programs. Boulder Mental Health Center has recently received funding for a comprehensive drug treatment program including Methadone maintenance. Southwest Denver and Bethesda have small programs for Federal offenders with drug problems, and Denver General Hospital and Malcom X operate treatment programs offering Methadone maintenance.

Approximately 500 Methadone maintenance treatment slots are available in the Region 3 area. All of these programs except the new Boulder program are located in close proximity to each other in downtown Denver and are poorly accessible to addict populations in Northwest and Southwest Denver and Adams, Jefferson, and Arapahoe Counties. Methadone has become easily available as a street drug, and a significant number of individuals are becoming newly addicted to street-purchased Methadone. Greater controls must be instituted in existing Methadone programs to decrease the amount of illicitly sold Methadone now available in the community.

Drug-free treatment programs rather than Methadone maintenance should in most cases be the initial treatment offered to heroin addicts, with Methadone maintenance available as backup when drug-free treatment is unsuccessful. However, the only drug-free treatment available presently in the Region 3 area is the NARA programs at Southwest and Bethesda, the therapeutic community at the Veterans Administration, Cenikor, and the new Boulder programs. A major priority for the treatment of narcotic addicts in Region 3 should be the initiation of a significant number of drug-free treatment programs, including short-term residential facilities, long-term therapeutic communities, outpatient programs, and new experimental drug-free treatment programs.

(b) Barbiturates and Other Sedatives: A detoxification center for non-heroin drug problems has recently been opened at Denver General Hospital. Although a significant number of barbiturate addicts exist in the nursing and medical professions and among the general population, they

rarely present themselves for treatment.

(c) Other Drug Treatment Programs: A number of treatment programs exist in the Region 3 area for teenagers with drug problems, including a large number of crisis "hot lines," self-help groups, residences, and other treatment facilities. There is liaison with mental health centers, but there is a need for greater coordination of these programs and for expansion of short-term community-based residential facilities combined with drug treatment programs.

(3) Suggested Priorities

(a) Initiation of drug-free heroin addiction treatment programs, including short-term and long-term residential treatment programs and outpatient drug-free treatment programs.

(b) Coordination and redistribution of existing Methadone maintenance programs.

(c) Expansion of short-term residential facilities for teenagers with drug-free problems and coordination of so-called soft drug treatment resources.

c. CHILDREN AND YOUTH

(1) Needs

(a) direct treatment of emotionally disturbed children and youth and their families in the community setting.

(b) treatment of the more seriously disturbed children and adolescents in the community setting rather than the institutional setting when appropriate.

(c) prevention of mental health problems in children and youth.

(d) treatment and rehabilitation of autistic children.

(e) child and youth advocacy.

(f) specific programs for youth who do not fit into present services.

(2) Resources

(a) Outpatient Treatment: All Region 3 centers and clinics provide at least limited degrees of outpatient treatment for children and adolescents with mental health problems, and their families. The University of Colorado Medical Center provides a children's diagnostic center; the outpatient children's clinic, day care center and JFK Center serve children and adolescents. Outpatient psychiatric care is also available through the Adolescent Clinic at Colorado General Hospital. The Children's Hospital Children's and Adolescents Mental Health Service also provides diagnostic and outpatient service for children and adolescents. Bethesda Hospital and Mental Health Center has an outpatient program for adolescents, and plans to initiate a day care program. The Fort Logan Children's Division provides home treatment services for children from the Region 3 area who might otherwise be hospitalized and some limited community-

based service for children with serious emotional problems. Expansion of present outpatient treatment resources for children and adolescents is needed.

In addition to the mental health agencies, a variety of other community programs provide a degree of counseling and assistance, particularly for adolescents. Youth service bureaus (funded by LEAA grants), detention centers, private self-help groups with "hot-line" or "crash pad" services, and alternatives to formal schools such as "street academies" deal with youths who have a variety of problems. These programs are generally uncoordinated, and some referrals are made to mental health agencies for more serious emotional problems.

(b) Inpatient and Hospital Alternative Treatment: The Children's Division at Fort Logan has available 45 beds for the inpatient treatment of severely disturbed children and also provides outpatient treatment followup of children previously admitted, home treatment, and a limited amount of consultation and education. The Fort Logan Adolescent Division has a 12-bed inhospital treatment program, with day care for additional adolescents. The Closed Adolescent Treatment Center of the Youth Services Division, staffed by Fort Logan, provides inpatient treatment for adolescents referred through the courts. Bethesda Hospital and Center has an 18-bed inpatient service for adolescents (age 14 to 18). Colorado Psychiatric Hospital has an inpatient unit for adolescents also. There is a need for some expansion of inpatient services for adolescents, and for additional residential centers, especially for girls.

Although the Region 3 centers have made progress in the establishment of a number of community-based alternatives to psychiatric hospitalization for adults, no comparable programs for children and adolescents currently exist. There is an urgent need to develop pilot programs for community alternatives to hospitalization for children and adolescents and particularly for those with special needs, such as the aggressive child.

(c) School Consultation: Adams, Arapahoe, and Jefferson Counties provide specific consultation, education, and preventive services to their school systems through special grants. No similar grants exist in the Denver school systems although consultation and preventive services are available in Denver County target areas through Model Cities and the University of Colorado Day Care Center which provides some consultation services for Northeast Denver Schools. Centers and clinics in Denver also provide a limited degree of school consultation service. The Boulder Center, on a contractual basis, provides direct service to children and training for teachers in two school districts in their community.

(d) Autistic Children: A survey by the Children's Division at Fort Logan estimated that approximately 50 autistic children reside in Region 3. A day care program for 12 - 18 children under the age of 12 is available in Denver through a cooperative endeavor between the Denver Board

of Education, the Southwest Metropolitan Board of Cooperative Services, and Fort Logan Children's Division. A major unmet need is for 24-hour community-based facilities for autistic children and for programs available to autistic children over the age of 12.

(e) Children with Special Problems: Children with special problems such as learning disabilities, emotional disturbance, and mental retardation are to receive special attention in all school systems. Mental health agencies are cooperating to develop the plans and to provide appropriate services.

(f) Child Advocacy: Child advocacy councils are attempting to represent the needs of children through legislative and other processes.

(3) Suggested Priorities

(a) Expansion of existing outpatient treatment programs.

(b) Work with local school districts for the provision of mental health services to handicapped children under the provisions of H. B. 1164 (1973), (See Appendix C.)

(c) Continuation of existing school consultation programs and development of new programs as needed in areas not now being served.

(d) Development of community-based inpatient alternatives, as well as a limited number of additional treatment facilities for children and youth in the Region 3 area.

(e) Development of special residential, partial, outpatient, and family consultation programs for autistic children.

(f) Continued development of preventive programs, i. e., parents' education programs, school mental health curriculum, etc.

d. GERIATRICS

(1) Needs

(a) Direct treatment for aged individuals with mental health problems and their families in the community setting.

(b) Treatment of the more seriously disturbed geriatric patient in community settings rather than institutional settings, whenever appropriate.

(c) Improvement of quality of life in Region 3 nursing homes and Region 3 coordination of placement in nursing homes that takes into account zoning variations in different areas.

(d) Coordination with medical, recreational, service (Meals on Wheels, etc.) and other programs for the aged.

(2) Resources

(a) Outpatient Programs: Outpatient treatment for the aged individual with mental health problems is limited in the Region 3 area mental health centers and clinics. Fort Logan has an

enrollment of approximately 150 geriatric patients in outpatient care at any one time. The development of additional geriatric outpatient treatment resources is urgently needed.

(b) Inpatient and Community Alternative Resources: The Fort Logan geriatric division provides inpatient treatment of aged individuals with psychiatric problems. A community geriatrics team provides community consultation and support in nursing homes and other community resources. The Fort Logan geriatric division currently is operating a Federally funded pilot program on geriatric community alternatives to hospitalization. No other community alternatives to psychiatric hospitalization other than nursing homes is currently available in Region 3.

(c) Nursing Homes: Many aged individuals with psychiatric problems live in nursing homes in the Denver Metro Area. Existing standards for nursing homes insure a basic minimum standard for nursing care and building structure variables, but quality of life varies widely from one nursing home to another. As a result, some older individuals with psychiatric problems live under socially isolating and de-humanizing conditions in Denver Metro nursing homes. In other instances, psychiatric followup of patients referred to nursing homes by centers or state hospitals is poorly coordinated with nursing home procedures. Finally, available zoning allowing for the operation of nursing homes is unevenly distributed in the Denver Metro area, resulting in disproportionately high numbers of geriatric psychiatric patients in nursing homes in some catchment areas, and disproportionately low numbers in others. Metro area-wide coordination of placement and mental health followup of aged individuals with psychiatric problems in nursing is indicated with a systematic review of quality of life variables and availability of nursing home placements throughout the metropolitan area.

(3) Suggested Priorities

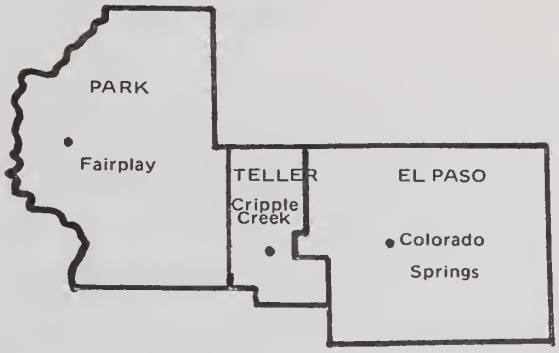
(a) Initiation of outpatient treatment resources for aged individuals with psychiatric problems within each catchment area in the Denver Metro area and expansion of existing resources where indicated.

(b) Initiation of inpatient alternative programs for geriatric psychiatric patients where indicated.

GOALS FOR REGION 3 MENTAL HEALTH PLAN

1. Define the role of Fort Logan and the role of Denver area community mental health centers more precisely so that the role of the centers is determined by the principle that those mental health services that can be delivered effectively and efficiently by the centers will be delivered in the community by the centers. Those services that can more effectively and efficiently be delivered at a more centralized level will be delivered by Fort Logan at Fort Logan or in the community with collaboration of the centers and Fort Logan.
2. Facilitate regional coordination for mental health and related services in Region 3.

3. Establish a Mental Health Authority in the City and County of Denver which:
   a. is officially designated and recognized by City and County and State,
   b. receives significant budgetary support from State and City,
   c. allows for contracting services from private non-profit community corporations from City and State, and
   d. resolves present potential conflict of interest with Health and Hospitals acting both as purchaser and vendor of mental health services.
4. Review and upgrade the treatment programs in boarding homes, nursing homes, and other aftercare facilities in the metropolitan area. Clarify and coordinate the placement and followup of clients from one component of service to another.
5. Clarify and integrate the role of Colorado Psychiatric Hospital in delivery of mental health services in the Region 3 area.
6. Establish a mental health plan for City and County of Denver acceptable to the City and the State, which provides basic mental health services in all catchment areas, equalizes and stabilizes the funding process, and reviews and possibly revises catchment area boundaries.
7. Establish a Region 3 mental health plan in conjunction with Denver Regional Council of Governments which provides for basic mental health services and special mental health services in all catchment areas.
8. Coordinate and facilitate Region 3 training programs in psychiatry, psychology, psychiatric nursing, psychiatric social work, and paraprofessional training.
9. Develop a structure through which the delivery of mental health services in Region 3 will be coordinated and integrated.



Area: 4,878 square miles
1973 estimated population: 284,000
1973 - 74 Center F. T. E.: 137.95

Region 4

El Paso, Park and Teller Counties comprise the Pike's Peak Mental Health Region. The 1973 estimated population of the Region is 284,000 persons. The major industry in the Region is tourism although livestock, manufacturing and major military installations, including Ent Air Force Base, Camp Carson, and the United States Air Force Academy, are other major sources of income. The terrain ranges from rolling plains in eastern El Paso County to high mountains and valleys in the west. The Continental Divide defines the western boundaries of the Region.

The largest community in the area is Colorado Springs in El Paso County. "The Springs" is surrounded by a number of smaller communities and foothills residences.

Existing Services

The Region is served by the Pikes Peak Family Counseling and Mental Health Center. Pikes Peak provides a comprehensive array of services as outlined in the federal staffing grant application. The application was federally approved but unfunded for over a year; the 49th General Assembly of Colorado appropriated revenue-sharing funds to provide the state formula share of the full staffing costs. This allowed the comprehensive program to get underway as of July 1, 1973. In addition to these funds, Pikes Peak has two LEAA grants, support funds from the three counties and several city governments in the Region. The total 1973 - 74 budget of the Center approaches 2 million dollars, a 134% increase over the 1972 - 73 fiscal year.

The program can be described as a combination of centralized and decentralized services. Four teams serve geographically defined areas with outpatient and partial care services, while transitional and inpatient services are centralized. Partial care services are provided through a variety of service elements, but are centralized in the Center's main building. Adult forensic and youth halfway house programs are provided, and will be highlighted below. Inpatient services are centralized at Penrose Hospital in Colorado Springs, but alternate, non-hospital 24-hour care services are presently being planned.

Unique to Pikes Peak is the development of an Adult Forensic Service Program funded, in part, by an LEAA grant. The program provides evaluation and treatment services to adult offenders and their families, including child-abusing parents, and persons referred by police, courts, probation and parole, and attorneys. The Youth Diagnostic and Halfway House program, similarly funded, provides services to juvenile offenders, and both programs offer transitional living facilities.

Program Needs

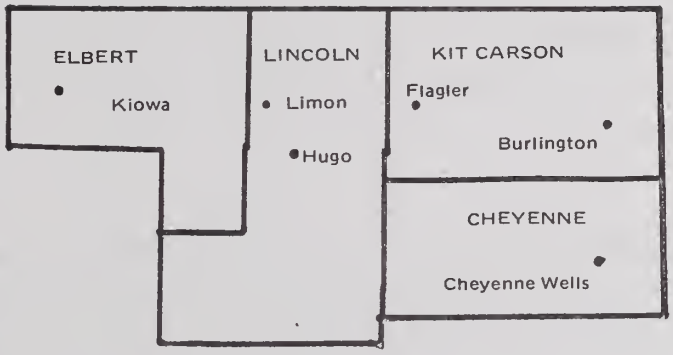
The Pikes Peak Center is a new program with the 1973 - 74 fiscal year being a period of adjustments and implementation. However, the aggressiveness in pursuing the development of services and solidarity of the entire program suggests that the Pikes Peak facility will reach programmatic maturity at an accelerated rate. It is highly likely, therefore, that Pikes Peak will be the major candidate to assume responsibility for all mental health services in the Region. Accordingly, the following goals seem in order:

1. Full assumption of adult psychiatric services.

   Development of alternative 24-hour care services.

2. Development of full range of alcohol treatment services.
3. Development of children's inpatient and partial care services beyond current levels.
4. Alternative funding for continuation and expansion of adult forensic and juvenile offenders programs.
5. Development of services for drug abusers.

Region 5



Area: 8401 square miles
1973 estimated population: 19,300
1973 - 74 Clinic F. T. E.: .75

Region 5

The East Central Colorado Mental Health Region is composed of four large, sparsely populated counties. The major industry in the Region is agriculture, chiefly livestock and wheat growing. Major communities in the Region are Kiowa, Hugo, Limon, and Burlington.

The four counties, Elbert, Cheyenne, Kit Carson, and Lincoln, have a 1973 estimated population of 19,300 persons. The collective land area is 8,401 square miles, or a population density of 2.297 persons per square mile. A further idea of the "ruralness" of the region can be seen when one realizes that 29% of the population of the Region lives in the four county seats (5,636 persons). The largest community is Burlington (2,828 persons).

The Colorado Health Consumer Survey, published in 1971 by the Colorado-Wyoming Regional Medical Program concluded that Region 5 was "the least viable health service region in the State . . . . it has the most critical shortage of health manpower, and there is no potential regional health care center in the Region." In the survey, 9.2% of the Region residents questioned reported that they believed that a Mental Health resource would be very important to their families.

Existing Services

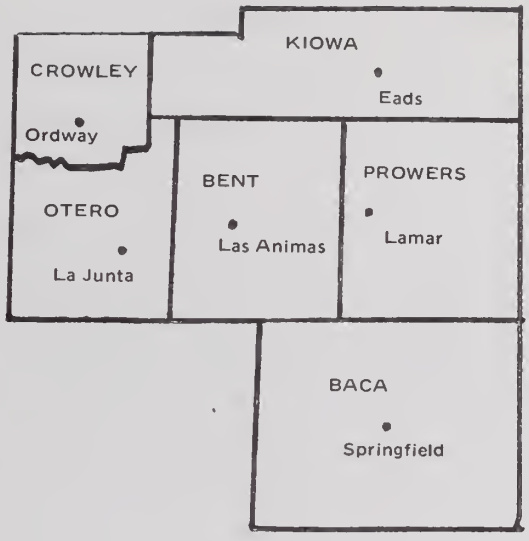
At present, the Region is served by a part-time clinic (2½ days per month), headquartered in Flagler. The clinic was the last clinic in the state to develop. The clinic derives its income from State sources (per capita funds), and local counties ($9,000 for FY 1972 - 73) and approximately $4,000 from client fees. During FY 1971 - 72, the East Central Clinic staff had a caseload of about 166 clients; 108 clients were terminated during the same period. The limitations on the provision of additional services appear to be the lack of staff and funds. For FY 1973 - 74, the clinic anticipates $15,732 from State sources, $15,500 from county and local sources, and an additional $5,000 in assistance under the 314 (d) program. The $36,232 1973 - 74 budget will not allow for full-time clinic operations, but represents a maintenance effort plus some increase in consultative services to public schools in the area. Presently, only outpatient and consultation services are provided. The 1972 - 73 Division of Mental Health Time Study shows that 14% of the clinic staff time was utilized for travel within the Region.

Program Needs

The mental health needs of the region are quite basic. Foremost is, perhaps, the establishment of a full-time outpatient clinic to serve the area. Probably some combination of centralized and traveling clinic program will need to be developed. It would seem unlikely to project a comprehensive center for the Region in the near future due to low population and high cost factors. However, through coordination of various existing resources and full-time clinic resources, much of the mental health needs of the region can be economically met.

Goal: Expansion and development of basic clinic services throughout the Region.

Region 6



Area: 9,570 square miles
1973 estimated population: 55,500
1973 - 74 Clinic F. T. E.:

Region 6

The Southeastern Colorado Region encompasses six counties: Baca, Bent, Crowley, Kiowa, Otero, and Prowers. The 1973 estimated population of the Region is 55,500 persons. However, 68% of the population resides in Otero County (24,000) and Prowers County (13,700). The terrain of the Region is rolling plains, and major income sources are livestock and agriculture. Major communities in the Region include Las Animas (3,148), Lamar (7,797), La Junta (7,938), Rocky Ford (4,859), Ordway (1,017), and Springfield (1,660). A major Veterans Administration installation for treatment of psychiatric problems is located at Ft. Lyon. The facility is noted for its treatment program for alcoholism.

The Region is served by the Southeastern Colorado Family Guidance and Counseling Center. Located in La Junta, the Clinic serves Otero, Prowers and Bent Counties while some outreach activities have been addressed to Baca and Kiowa Counties. During the past year, the Boards of Commissioners of these two counties have considered providing funds for additional Clinic staff to serve their counties.

Existing Services

The Clinic provides outpatient and consultation and education services. The latter service has been extended in Baca and Kiowa Counties, while little outpatient service has been provided. The Clinic is staffed by three full-time professional staff and a part-time (two days per month) psychiatric consultant. A part-time nurse and two secretaries complete the staff. The Clinic has a branch office in Lamar. In the 1973 Colorado Mental Health Center Construction Plan, the Southeast Region ranked third of all Colorado regions in the need for additional publicly-supported mental health services.

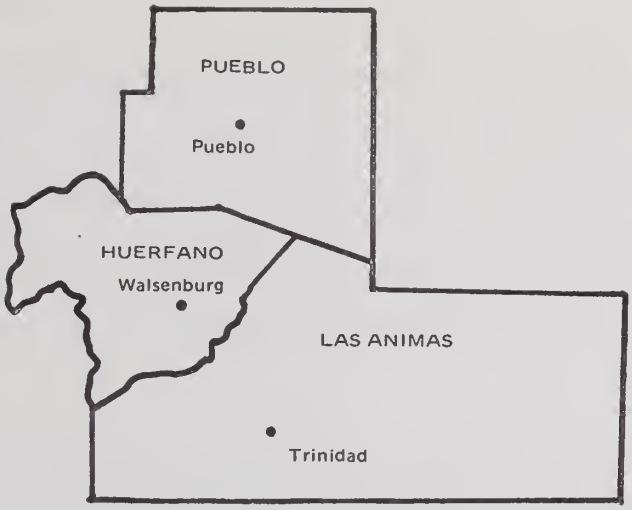
Program Needs

Expansion of basic outpatient services to Baca and Kiowa Counties appears to be of first priority. However, consistent with the general goals of the Division, the development of comprehensive service in the Region is the ultimate goal. It can be noted that, following recent thrusts by the Veterans Administration and of Congressional action, a potential service or affiliate arrangement with the Ft. Lyon Veterans Administration is a possibility for increasing mental health services to the general public. Several general hospitals in the Region provide a potential resource for local inpatient services. Expansion of services to include specialty services, i. e. children's, adolescents', etc., will of necessity, be retarded until basic services are developed beyond current levels.

Goals:

1. Development and expansion of outpatient services throughout the Region.
2. Development of inpatient services through the V. A. hospital and alternate care programs.
3. Development of partial care services.

REGION 7a



Area: 8,773 square miles
1973 estimated population: 149,195
1973-74 Center F.T.E. 43.0

Region 7

Pueblo, Huerfano, and Las Animas Counties have joined together to provide comprehensive mental health services. The remaining counties in this Region receive services through the West Central Colorado Mental Health Clinic. Thus, the Region is divided, for planning purposes, into two sub-regions.

Region 7a: Southern Colorado

Three counties comprise the sub-region of Southern Colorado: Pueblo, Huerfano, and Las Animas. The collective 1973 estimated population is 149,195 persons. Approximately two-thirds of the Region live in the City of Pueblo. Another 9% reside in the cities of Trinidad and Walsenburg. Thus, about 73% of the population of the Region live in the three communities. The Region encompasses 8,773 square miles; 73% of the population live on one-half of one percent of the land area. The terrain of the region ranges from the plains of the Eastern portion to the mountains on the West.

A high proportion of the area residents are Chicano; about one-half of the residents of Huerfano and Las Animas Counties are Chicano, which is indicative of special programmatic needs and concerns. It is also generally recognized that alcoholism is a major problem throughout the three counties. The area is designated as a poverty area and as such is especially in need of publicly supported programs and services.

Existing Services

The area is served by the Southern Colorado Mental Health Center, headquartered in Pueblo. Two branch offices are located in Walsenburg and Trinidad. The Center provides the full array of services in affiliation with the Colorado State Hospital in Pueblo. The Center provides outpatient services, emergency services during the daytime and consultation and education services in Pueblo. Colorado State Hospital provides the inpatient services, weekend and nighttime emergency services and partial care services in Pueblo. The branch program at Walsenburg provides outpatient services to adults and children, while the Trinidad branch provides outpatient services, partial care services for children and school consultation services.

The Center was originally established as a joint venture between CSH and the Spanish Peaks Mental Health Clinic. Through a construction and a subsequent staffing grant, a facility for the treatment of children in the region was established on the grounds of CSH. Cottage "D" is staffed by federal funds from the Center and by State funds through CSH. Currently, the Center is attempting to realign staff and programs to support existing services in the community. To

do so, the Center Board has proposed to redirect the federal funds from the cottage "D" program, relying upon State resources to fill the staffing void at Cottage "D". State funds are not currently available to fully staff Cottage "D", but plans are presently being drawn to provide for a resolution of this problem.

The Center is the recipient of a second staffing grant which became operative in April 1973. The program offers comprehensive service to all children and their families in the rural areas of Pueblo County.

Program Needs

Perhaps of primary concern is the delineation of service responsibilities of the Colorado State Hospital and the Mental Health Center. Whiel unnecessary duplication should be avoided, it also makes little sense to develop a patch-work of services which only serves to confuse persons seeking services. Goals for this Region should include:

1. Development of partial care services for adults in Pueblo
2. Assumption of total responsibility for emergency services in Pueblo
3. Development of full array of community-based alcoholism services
4. Expansion of children's services to include some non-hospital 24-hour care facilities and partial care programs

REGION 7b

Area: 3,850 square miles
1973 estimated population: 45,700
1973 - 74 Clinic F.T.E.: 5

Region 7b:

The West Central Mental Health Region entails four counties: Chaffee, Custer, Fremont, and Lake. The total population of the Region is estimated to be 45,700. The terrain of the Region ranges from rolling foothills in the Southeastern portion to the 14,000 ft. altitude of the Continental Divide which circumscribes the Northern and Western Regional boundaries.

The major income sources include light industry, tourism and recreation, mining, livestock, and services. Two state institutions in the Region are also major income sources: The State Reformatory in Buena Vista and the State Penitentiary in Canon City. Roughly 3,850 square miles are entailed in the Region of which 59% is owned by federal (Pike and San Isabel National Forests), state and local governments. There are three major communities in the Region: Canon City in Fremont County (9,206 population), Salida in Chaffee County (4,355 population), and Leadville in Lake County (4,314 population). Roughly 40% of the population live in these three communities. A number of smaller communities are scattered throughout the Region.

Existing Services

The West Central Region is served by an outpatient clinic that is headquartered in Canon City. Satellite services have recently been developed in Salida and Leadville. The clinic, however, functions with approximately 5 F. T. E. positions made up of 3 full time and 3 part time staff.

A crisis volunteer telephone-based intervention program operating in Fremont County functions in coordination with the clinic providing a measure of 24-hour emergency service. However, the relatively limited scope of the program requires expansion throughout the Region. The Clinic provides outpatient services and consultation and education services. A review of a sample workweek in the Division 1971 - 72 Time Study indicates that approximately 57% of the staff time is spent ind direct outpatient treatment, 3.5% in consultation and education, and 9% in travel time. These figures do not include clerical time. These figures indicate that a very large portion of the small staff time available is spent in responding to "band-aid" intervention with little time left for continued program or community development activities. During FY 1971 - 72, the West Central Clinic served approximately 600 clients, all outpatients. The mean number of interviews was eight. The primary treatment modality is one-to-one individual service with little or no group treatment. The estimated budget for FY 1973 - 74 is $71,882.00 of which $28,500.00 is projected from State sources and $22,875.00 from County sources.

Program Needs

The present clinic relies on the outpatient modality to meet pressing client demands. Thus, it would seem that additional staff and funds will need to be applied towards meeting this demand and in training and consulting with other community agencies.

Development of short-term crisis treatment modalities and day-care services using group treatment and other treatment modalities seem especially timely. Further, the potential of the area would seem to lie in the development of alternative inpatient care systems; owing to the relative proximity of the Region to Colorado State Hospital (the distances between Pueblo and the major population centers of the Region range from 39 miles from Canon City to 155 miles from Leadville), it would seem more prudent to develop intensive inpatient program affiliation with Colorado State Hospital. Intensive and short-term general hospital based inpatient services would provide emergency intake points for evaluation and treatment.

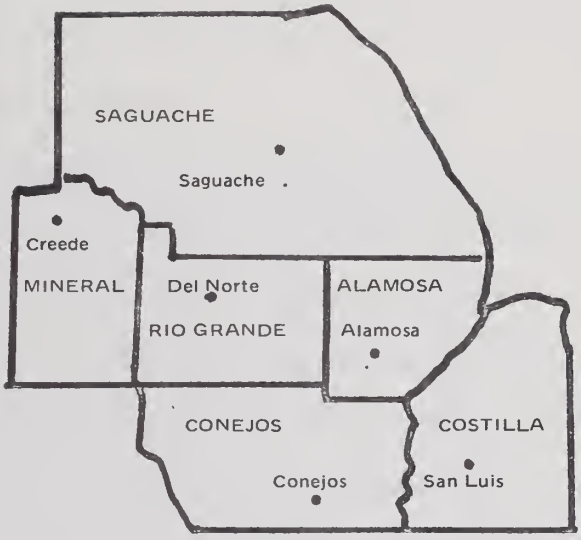
Alcoholism treatment services, including detoxification, are necessities. In short, the Region is a prime candidate for the development of a smaller scale comprehensive center based upon a combination of centralized and decentralized treatment modalities.

Goals:

1. Expansion of outpatient services

   Development of alternative clinical modalities
2. Development of alternative inpatient care system and hospital-based services
3. Development of partial care services
4. Development of alcoholism treatment services

REGION 8



Area served by

San Luis Valley Community Comprehensive Mental Health Center

Center Location: Alamose

Outreach Locations: Saguache
Center
Del Norte
Creede
Monte Vista
Fort Garland
La Jara
Antonita
San Luis

Area: 8,185 square miles.
Population[1]: 38,300
Staff Size 1973: 23.4 F.T.E.

Region 8

Region 8 is composed of six counties in South Central Colorado with the majority of the population living in the high altitude (7,500 feet) flat valley. The area is 8,185 square miles, with a population projection of 38,300 in July 1974 and a density of 5.3 persons per square mile. This Region is comparatively isolated geographically because it is surrounded by mountain ranges. It is recognized throughout the state governmental agencies as an area of persistent and chronic economic depression and ranks Number One in need among the seven poverty-designated Regions. The per capita income (1970 census) was $1,186 below the state mean of $3,106; 23.9% of the family incomes were under the poverty level; and the percentage of families receiving welfare is high although the unemployment rate did not differ significantly from that of the rest of the state.

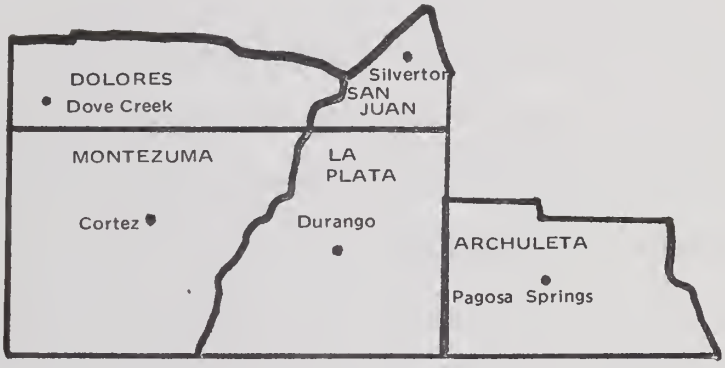
The San Luis Valley Comprehensive Community Mental Health Center serves the Region and is in its second year of providing the basic five elements of mental health services. It is the only private or public mental health treatment facility located in the Region. One outstanding feature of the Center program is the wide use of outreach centers and effective use of paraprofessionals who provide effective, yet economical service. The greatest program needs are for a detoxification center for the alcoholics, inpatient treatment of chronic disorders in children, a forensic program, and an expansion of regional provisions to treat the adult chronic psychiatric patients requiring hospitalization.

During the past year (FY '73) the Center was mainly supported by a federal staffing grant. The sources of funds were as follows: 79.5% federal, 15% state, 2.5% county, and 3.1% other local funds. The poverty of the area is reflected by the small amount of local and county contributions to the Center. State support of more alcoholism treatment programs is vital to this region.

Goals:

1. To provide alcohol and drug detoxification treatment programs.
2. To provide children's inpatient treatment program.
3. To provide a forensic treatment program.
4. Expansion of inpatient adult psychiatric facilities.

REGION 9



Area served by

Southwest Colorado Mental Health Center, Inc.

Clinic Location: Durango

Full-time service: Durango

Part-time service: Cortez

Population: 39,100

Area: 6,563 sq. miles

Size of Staff 1973: 4.8 F.T.E.

Region 9

Region 9 is composed of five counties in the Southwest corner of the state; Dolores, San Juan, Montezuma, La Plata and Archuleta. As the names of the counties suggest, the Region has many Chicano and Indian residents. The Region covers 6,563 square miles, has a projected population in 1974 of 39,100 and a density of 5.9 persons per square mile. This Region has the highest unemployment rate of any region in the state and ranks 6th in need among the seven poverty designated regions. It is relatively isolated by mountains and distance from the major Colorado cities with mental health services. Denver is 332 miles away and Colorado State Hospital in Pueblo, which serves this region, is 271 miles away.

Southwest Colorado Mental Health Center, Inc., the only public mental health agency in the area, is an outpatient clinic providing outpatient care, consultation and education and aftercare treatment to patients of all age groups which includes a day care hospital program. A special outpatient drug abuse program was funded one year ago and is well underway. An alcohol treatment grant was approved and not funded although the program is badly needed. The staff is very small (4.8 full time equivalent positions) and can provide service only on a limited basis to Durango. Although service is available, it is not accessible to approximately half of the area population. To help meet this problem, a 314 (d) Special Project Grant was awarded for the year 1973 - 74 to provide outreach pervices through a worker who would spend two days each week in Cortez to serve Montezuma and Dolores Counties, containing 40% or approximately 1,560 of the Region's population. The drug abuse program also provides one full time worker and a secretary to the Cortez area. The outpatient needs are overwhelming and will be even greater when the outreach program funded through 314 (d) is terminated in 1974 unless other resources can be found to meet these needs. During the past year the state provided 29% of the budget through per capita funding while 5.5% was provided by the county, 20.3% were local funds, and the remainder was from special grants. The Region lacks strong local resources and depends upon state and federal monies.

The mental health clinic is providing three of their five basic elements of service required of a mental health center. The Board of Directors plans for the clinic to become a Comprehensive Community Mental Health Center in 1974 - 75. It is also their plan to develop services in Cortez as well as Durango with careful attention to just which services would be best developed in each of the areas.

Goals: 1. Change the outpatient clinic program to a comprehensive community mental health program.

2. Deliver service to citizens in outlying areas where service is unaccessible.

3. Prepare for implementation of S. B. 349 (See Appendix E) and H. B. 1279 (See Appendix F).

Objectives:

1. Provide all five basic elements of service by July 1, 1975.

   Three services are provided at the present time.

   a. Develop inpatient service and/or alternatives to hospitalization by July 1974.

   b. Develop 24-hour emergency telephone service and regional netwoek by July 1974.

   c. Twenty-five percent staff time will be spent on consultation and education by July 1974.

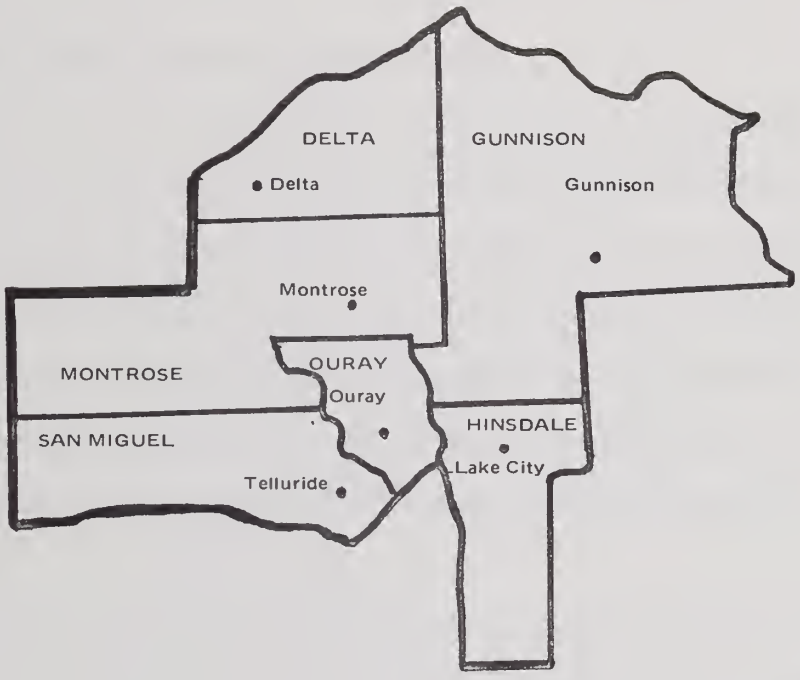
2. Increase outpatient services to reduce waiting list by 75% by 1975.

3. Establish three ongoing outreach outpatient programs to serve Montezuma and Dolores Counties by 1975.

4. In compliance with H. B. 1279, provide detoxification service and treatment of alcoholics presently put in jail.

5. In compliance with S. B. 349, provide inpatient and emergency care of patients now jailed while waiting for transportation to Pueblo.

REGION 10



Area served by

Midwestern Colorado Mental Health Center

Center Location: Montrose

Outreach Locations: Gunnison
Delta
Telluride
Nucla

Area: 9,369 sq. miles

Population: 46,100

Size of Staff 1973: 6.9 F.T.E.

Region 10

Region 10 is located in the central area of the western slope. It includes six counties, an area of 9,369 square miles and has a projected population in 1974 - 75 of 46,100 with a density of 4.9 persons per square mile. This region ranks fourth in need among the state's seven poverty designated regions.

Midwestern Colorado Mental Health Center provides the five basic elements of service including an affiliation with Colorado State Hospital to provide inpatient services for adults, adolescents, children, and geriatric service. The Center has contracts with three local hospitals to provide three beds each for psychiatric patients. Geriatric patients are also served through local Center-supervised nursing homes.

The staff consists of six full-time and two part-time professional staff, 1½ secretaries, and one part-time volunteer. The Center staff, located in Montrose, provides service four days per week in Delta, one day per week in Telluride, one day per week in Nucla, via staff traveling to these areas. Gunnison is served by a staff member who lives in the community. In 1973, it was providing direct service to 1% of the population of 15,000 who are not now accessible to service due to isolation and the distances staff would be required to travel to reach them. Delivering service necessitates a travel budget of nearly $8,000 in addition to staff travel time which increases the per-client cost of centers serving a large sparsely populated area. Midwestern is the only mental health and marriage counseling public agency in the catchment area.

In FY 1973 the Center received funds from the following sources: 45.6% federal, 28.7% state, 7.2% county, and 18.5% other funds. The continuation budget will effectively produce a reduction of service to the Region unless new money can be appropriated to replace the one-year 314 (d) federal grant awarded 1973 - 74.

Goals:

1. Develop and fund an alcohol treatment program. There is community pressure to provide an alcohol treatment program. A community-supported survey is underway to further define the specific needs. An alcohol abuse grant was approved but not funded last year.
2. Develop, coordinate and fund a drug abuse program. There is no adequate comprehensive drug abuse program but efforts are in progress to coordinate a western slope program if funds can be made available.
3. Increase staff to more adequately provide service to area.

REGIONS 11 and 12

Served by

Colorado West Regional Mental Health Center
With Affiliate and Outreach Locations

Center Office: Glenwood Springs

Affiliate Offices: Grand Junction
Granby
Glenwood Springs
Steamboat Springs

Outreach Locations:

Eagle	Craig
Vail	Hayden
Frisco	Oak Creek
Breckenridge	Walden
Minturn	Meeker
Redcliff	Kremmling
Aspen	Collbran
Rifle	Fruita

Area: 23,386 square miles
Population: 126,100
Size of Staff 1973: 34 F.T.E.

Regions 11 and 12

Regions 11 and 12 are combined into one mental health planning and service unit which is composed of 10 counties with an area of 23,386 square miles, a projected population in 1974 of 126,100 and a density of 5.4 persons per square mile. The vast mountainous region in the northwest corner of the state accounts for 22.3% of the total area of the state and the topography of the Region varies greatly from high mountains of the Continental Divide to routh and rolling semi-arid terrain of the western area. Major industries are agriculture, livestock, mining, and tourism. It is not necessary to cross any major mountain pass to travel within the Region, but distances between the major cities are great; for example, it is 263 miles between Grand Junction in the west and Granby in the eastern part of the Region.

Colorado West Regional Mental Health Center, Inc., is a newly formed enterprising comprehensive mental health center serving Regions 11 and 12. The Center is comprised of a central administrative office in Glenwood Springs and four affiliates with sub-regional offices in the following communities: Grand Junction, Glenwood Springs, Granby, and Hayden. In addition to providing full-time service in the above listed centers, the affiliates provide outreach service on a regular basis in Eagle, Vail, Frisco, Breckenridge, Minturn, Redcliff, Aspen, Rifle, Craig, Steamboat Springs, Oak Creek, Meeker, Walden, Kremmling, Collbran, and Fruita. Through outreach programs, service can be delivered to small communities unable to support full-time clinics and thus make service available to persons unable to travel to larger centers. The decentralized programming approach has relied heavily upon community and staff involvement in designing services responsible to the widely diverse and unique needs of the many rural communities served. Although the services vary in emphasis from community to community,they have been developed within the framework of the five essential services.

The Center is currently in its second year of operation as an affiliation of four small regional programs with combined resources providing comprehensive mental health services for the total region. The Center actively sought and obtained funding from various sources to build a very effective program, and now is staffed with 34 full-time equivalent positions and many volunteers located throughout the ten counties. The funds were obtained in FY 1973 according to the following breakdown: 52.9% federal funds, 24.3% state, 7.6% county, and 15.2% other local funds.

Goals: 1. To provide sufficient alcohol and drug abuse service for the regions.

A need for increased services has been documented through surveys.

2. To provide orderly growth and development of the program by development of a comprehensive program evaluation and research system.

3. To develop the capacity to support adult psychiatric services in the community to take the load off the state hospitals and provide alternative care close to the patients' homes.
4. To provide more immediate and intensive services to communities where further development has been indicated, such as Rio Blanco County.
5. To increase availability of all services presently available by increasing the staff.

RECOMMENDATIONS

OVERVIEW FOR THE FUTURE AND DIRECTION FOR NEXT THREE YEARS

RECOMMENDATIONS

Programmatic

The Committee's programmatic recommendations are implcit in the goals for the Division of Mental Health which are set forth in this document. These goals, stated as recommendations, are as follows: it is recommended that the Division of Mental Health take the necessary action to:

1. Develop an integrated mental health services delivery system;
2. Bring the total mental health services delivery system to an optimal level of functioning as defined by state standards;
3. Insure the availability and accessibility of the full range of quality mental health services close to persons who require such care;
4. Establish priorities for the development and expansion of mental health services, as needed, throughout the state;
5. Develop a proposal for a new mechanism for the allocation of funds for mental health services;
6. Develop a statewide management information system which includes need assessment and program evaluation capabilities;
7. Reduce community and family disruptions and the loss of productive output by persons with mental health problems;
8. Participate in attempts to ameliorate those factors in the social and physical environment that contribute to mental illness;
9. Increase society's understanding, acceptance and tolerance of persons with mental and emotional disorders;
10. Coordinate training programs for mental health professionals and paraprofessionals;
11. Improve the quality of mental health services in nursing homes and other non-hospital 24-hour care facilities.

The objectives which accompany the goals state specific activities which must be accomplished to achieve the goals. These objectives are set in a time frame which gives additional meaning and thrust to those goal-directed recommentations.

The recommendations implicit in the objectives address key issues in mental health including:

1. Need assessment

2. Program planning and development
3. Coordination of services
4. Definition and assignment of roles
5. Funding
6. Standards for quality of care
7. Coordinated training programs
8. Program evaluation

FUTURE PLANNING

The Division of Mental Health Master Plan is not complete unto itself, but represents a beginning point from which more specific plans for mental health services in future years will evolve. In order to facilitate this process, it is recommended that:

1. The Master Plan Committee not exceed six persons
2. Three of the present committee members be replaced in 1973, and three in 1974
3. New members be appointed to two year terms
4. New members be drawn from the public and private/voluntary sectors, and lay groups
5. Task forces be constituted from the same sources as in number 4 above to develop detailed recommendations for specific areas (e. g., children and youth services) and to accomplish the objectives identified in the plan
6. Members of the Master Plan Committee be designated as resource persons to specific task forces
7. The specific tasks which task forces are to accomplish be set forth in writing, and that time frames be established for the accomplishment of each stage of each task
8. The Master Plan be updated each year
9. Each task group working in a service area (e. g., geriatrics, children and youth) be required to specifically consider:
    a. Need
    b. Existing resources
    c. Programs required to provide needed services
    d. Where services should be located (e. g., in local communities, in a district comprised of several regions, in an existing state hospital)
    e. Projected costs over a three-year period
    f. Requirements for evaluation of proposed new and existing programs or services.

The Committee believes that this document should receive the widest possible dissemination and that written comments should be encouraged. Such comments should be directed to the Chief of the Division of Mental Health for review, then transmitted to the Master Plan Committee for appropriate consideration in the revision of the plan.

OVERVIEW FOR THE FUTURE

It will be the responsibility of the Division of Mental Health to insure that the citizens of Colorado have equal opportunities, no matter where they reside, to receive high quality mental health services appropriate to their individual and collective needs. While it is sometimes noted that idealistic goals and objectives are somehow ethereal and unattainable, it should be stated that the Division of Mental Health and its collective agencies constantly seek ways and means to decrease the incidence and prevalence of mental health problems. To develop such assurances, it is imperative that every effort be expended to maintain a completely integrated, unified system of mental health care, treatment and prevention services.

Recognition must be afforded to the fact that for the foreseeable future, the mental health services delivery system in Colorado will be comprised of public and private mental health centers, clinics, hospitals and other treatment facilities. There are gaps in mental health services that deprive some areas of needed care while simultaneously other areas enjoy a plethora of these same services. The Division of Mental Health must assume the initiative and the strong leadership required to develop a unified mental health delivery system that carries appropriate responsibility and authority to each component.

As noted earlier, care must be exercised by the Mental Health Division that energies devoted to maintaining unification of programs with all facilities do not become the energies for unit rivalry and dissent. The age-old battle, not unique to Colorado by any means, for state funds cannot be allowed to result in a disproportionate share of such funds going to any one segment or service within the Colorado mental health delivery system.

With fewer funds likely to be available to the two state hospitals, therapeutic programs must be reduced or redirected. The establishment of adequate numbers of mental health centers and clinics for the treatment in an outpatient or partial hospitalization setting of more and more people, closer and closer to their homes, has been and will continue to be the desired approach to the mental health services delivery programs within the state of Colorado. However, the hospitals cannot be stripped of resources indiscriminately or they will return to the "chronic," more "regressed" facilities they were a quarter of a century ago. State hospital professional and administrative expertise must be nurtured and utilized to the fullest in the new thrust.

A companion "must" for the future of mental health care in Colorado is the equally critical need of the Division of Mental Health to insure that comprehensive community mental health centers become literally that: comprehensive.

The stability of the community programs of the present and proposed for the future must be predicated upon such long-term planning that is sufficiently flexible to accommodate various changes in treatment modalities, funding mechanisms and political climates.

DIRECTION FOR NEXT THREE YEARS

With the introduction of this document as the state master plan for the delivery of mental health care services throughout Colorado, the first years following its acceptance and approval will be devoted to implementation and a working through the myriad of small but constant problems that are anticipated to occur. State control versus semi- to fully-autonomous facilities, functioning in a manner common to all (necessary for a state system), will pose problems not envisioned at this time.

Of early concern then will be the following as well as a host of other priorities incident to establishing key roles for each segment of the mental health services delivery system (see Goals and Objectives section):

1. Development of a procedures manual for the Division of Mental Health and the components of the mental health services delivery system;
2. Establishment of all of the proposed five regional offices in Colorado to advise and provide consultation in the management, clinical, programmatic and other areas for the agencies in each area;
3. Implement the legislative direction and intent of the new "Mental Health Act," the new civil commitment law effective July 1, 1974, that restores, at long last, the dignity of each patient irrespective of his or her legal status;
4. Insure the timely intervention into the mental illness sequence by establishing and promoting mental health care facilities throughout all of Colorado;
5. Assist in the development of a more adequate funding mechanism for mental health services;
6. Review, up-date and expand the state standards for all community mental health centers and clinics.
7. Finalize urgently needed state-wide need assessment, data gethering and program evaluation procedures;
8. Commence with public education programs necessary to increase society's understanding and acceptance of persons with emotional and mental disorders; and
9. Simultaneously with (8), reduce significant emotional and mental distress in persons with mental health problems.

It is noted that good communications do exist or are being developed between mental health service delivery facilities on all levels. There is no reason why changes in program should not be facilitated with an absolute minimum of rivalry, vested interests or "buck passing." It is, therefore, very important that state hospital programs continue to

be supported and improved rather than relegated to a low priority, second-class status; and it is absolutely essential that both community-based programs and institutional programs support and complement one another if the citizens of Colorado are to continue receiving the best possible mental health services no matter where in the state they live.

DEPARTMENT OF INSTITUTIONS
MASTER PLANNING PROGRAM

PROFILE for the TREATMENT OF MENTAL AND EMOTIONAL DISORDERS PROGRAM

	DESCRIPTION OF PRESENT PROGRAM	EVALUATION OF PRESENT PROGRAM	PROJECTION OF FUTURE PROGRAM
Y NED S	1. Restore or improve the social and vocational functioning of emotionally disturbed or mentally disordered persons to a level which permits acceptable community living. 2. Eliminate or minimize community and family disruption and the loss of productive output by those suffering from mental and emotional disorders. 3. Eliminate or minimize significant emotional and mental distress of persons suffering mental disorder. 4. Eliminate or minimize the dependence of the emotionally or mentally disturbed individual on society's social support systems. 5. Improve society's tolerance and acceptance of deviant individual behavior.	1. Almost all individuals served are able to attain at least minimal standards of acceptable community living. 2. Direct therapeutic involvement with community and family members has helped to minimize the disruptions experienced. 3. Use of psychological, social, and chemical therapies have helped to significantly reduce the level of distress in most individuals served. Major reforms in the methods of institutional care have dramatically reduced the trauma and damage formerly experienced from receiving such care. 4. Lack of system-wide data makes evaluation of the level of dependency very subjective. The greater emphasis on maintaining emotionally disturbed individuals in the community has probably placed a greater load on the rest of the systems than the previous custodial methods did.	1. Greater specificity for the goal statements, making qualitative evaluations more precise. 2. Improved quantifications of goal measures, thus refining quantitative evaluations. 3. General elevation of the quality of goals sought, as the hidden costs of the minimum goals for community adjustment becomes more evident. 4. Convergence with the goals of the other components of the social support systems, so that a unified set of goals emerges. 5. Development of goals related to the level of dependence on any part of the social support system rather than specific components of it.
Y NED CTIVES	1. Move 90% of those admitted into 24-hour care to some form of lesser dependency on the mental health systems within 90 days of admission. 2. Maintain 65% of those released in (1) above in acceptable community functioning for two years without return to further dependence on any part of the mental health system. 3. Maintain 85% of those released in (1) above in acceptable community functioning for two years without return to further dependence on 24-hour care in any part of the mental health system. 4. Move 90% of those admitted into partial hospitalization care to outpatient status or acceptable community functioning within 12 months of admission. 5. Maintain 90% of those released in (4) above in acceptable community functioning for two years without return to further dependence on any part of the mental health system. 6. Return 95% of all admissions to outpatient services to acceptable community living within 12 months of admission. 7. Maintain 80% of those released in (6) above in acceptable community functioning for two years without return to further dependence on any part of the mental health system.	1. Data to measure accomplishment of these objectives is available from some parts of the mental health system. Data on system-wide dependence are not available. 2. Performance measures on the above criteria are available from some components of the mental health system. Degree of objective attainment varies with different components of the system. No system-wide measures are available. 3. Programs on which data are available tend to run slightly below the levels set in the newly defined objectives. 4. Present objectives are oriented to program process (i.e., how rapidly clients are returned to the community) and current objective measures are appropriate. 5. Future objectives should be more oriented to the value of the output of the system and the minimization of total system dependence by the client population. Criteria measuring these aspects of system performance need to be developed.	1. Objectives will become more concerned with the value and results of mental health services. 2. Objectives will become more concerned with the lessening of client dependence. 3. Objectives will define standards of performance higher than minimal community standards and with greater emphasis on personal growth and development.

APPENDIX - A

PROFILE for the TREATMENT OF MENTAL AND EMOTIONAL DISORDERS PROGRAM (continued)

	DESCRIPTION OF PRESENT PROGRAM	EVALUATION OF PRESENT PROGRAM	PROJECTION OF FUTURE PROGRAM
LATION NG VED	1. National reports indicate that one out of ten need treatment for mental disorder during their lifetime. Therefore, the present target population in Colorado is approximately 220,000 within their lifetimes. The number of these who require immediate treatment is difficult to estimate, but it is probably larger than the nearly 50,000 persons who received services from agencies in the Colorado mental health program last year. The ages of these persons varied from very young children to elderly citizens. 2. The suicide rate and divorce rate in Colorado is 50% higher than the national average. 3. The homicide rate in the United States is the highest among all major nations.	1. The very young child is not being served. At the present time there are no consistently effective ways to identify those needing treatment before they reach school age. 2. Older adults that have never come to the attention of the mental health system are a great unmet need. Assistance to combat the barren lives and the loneliness and severe depression characteristic of the existence of many older citizens in the community is needed. 3. Ethnic minority groups and/or the poverty groups are underrepresented in many of the treatment programs. 4. Many older adolescents are still unserved. 5. Alcoholics and drug addicts are major problems for which only minimal programs have been developed. 6. Many isolated rural areas of the state are largely unreached by program unless the individual takes the initiative.	1. Increase in number of all citizens requiring services, especially children, the elderly, and disadvantaged. 2. Gradual decrease in proportion of the young population group, though not in absolute numbers, as more population control measures are implemented. 3. A rising drug abuse population. 4. Increase in "social offenders," both the criminal commitments to the State Hospital, as well as referrals and transfers from adult and juvenile correctional institutions.
RVICES VIDED	Institutional Services 1. Psychiatric hospitalization including psychotherapy, chemotherapy, social and vocational skill training. 2. Medical hospital services covering the full range of physical problems of the psychiatric patient including severe neurological damage. 3. Specialized treatment for particular problem groups such as childhood and geriatric disorders, alcoholism, drug addictions, and the criminally insane. 4. Services to comprehensive community mental health centers by contractual arrangements. 5. Full range of hospitalization services to inmates and residents of other institutions within the Department. 6. Major field training for the full range of professional, paraprofessional and ancillary mental health personnel. Transitional Services 7. Partial hospitalization including day, night, or weekend care. 8. Half-way houses and group home placements. 9. Supervised work programs for patient groups. 10. Nursing home and foster family placement with continuing follow-up treatment or supervision. Community Services 11. Outpatient care and aftercare follow-up visits. 12. Emergency crisis intervention by specialized teams. 13. Family and/or marriage counseling. 14. Consultation and educational services to other agency and professional personnel to enhance their ability to cope with mental health problems.	1. There are more treatment needs and requests than present resources are able to meet. Partial solution would be greater cooperation and coordination with other human services agencies. 2. Strengths: a. Approximately 99% of the state's population has access to some form of mental health services supported in part by public funds. b. Community programs with increasing citizen concern and input. c. Two award-winning State Hospitals. d. A spirit of innovation with new alternatives constantly being tried -- particularly in alcoholism and drug abuse areas. 3. Weaknesses: a. Effective response to the alienation of youth as symbolized by drug abuse, etc. b. Continuity of care with private sector services is a frustrating problem. c. Less successful results with non-containment treatment approaches for certain adolescent groups. d. Improvement required in coordination of state hospital based programs and clinic and center programs. 4. Duplications: a. Private sector outpatient services and psychiatric hospitals (including state). b. Some Federal programs, such as drug abuse treatment centers and minority health centers. 5. Lack of mental health system-wide integrated information network to facilitate more effective evaluation of system functioning. Eventually a network tying all social system programs together will be needed.	1. More integrated services with other human resource agencies especially for low income and culturally deprived persons. 2. Initiation of comprehensive drug treatment programs for all Colorado residents affected. 3. Agreement on common definitions of key items of information and complete interchange of such data should be facilitated within the total mental health system and with other social support systems. Institutional Services 4. More selective emphasis on 24-hour care. Transitional Services 5. More specialized programs for the very young and the very old, including therapeutic nursery care and modified work programs for the elderly. 6. Movement toward group living treatment programs on a community-centered basis. 7. Increased need for drying-out and detoxification centers. Community Services 8. More emphasis on crisis intervention on a community basis without institutionalization. 9. Increased emphasis on family treatment programs on a non-institutionalized basis. 10. Provide adequate supportive after-care programs for those who need it. 11. Greater emphasis by mental health programs on community education. 12. Since it is difficult to maintain the interest of many adolescents needing treatment - better community programs and peer-group based programs are needed. 13. Need to establish systems wherein referrals to the state hospitals are processed by existing mental health centers. 14. Increase in emphasis on community services as alternatives to 24-hour care. 15. Increased citizen involvement and participation such as volunteers, board members, primary users, and minorities. 16. Greater emphasis on outreach services. 17. Newer treatment methods suited to new forms of family and group relationships.

PROFILE for the TREATMENT OF MENTAL AND EMOTIONAL DISORDERS PROGRAM (continued)

	DESCRIPTION OF PRESENT PROGRAM	EVALUATION OF PRESENT PROGRAM	PROJECTION OF FUTURE PROGRAM
S OF ONNEL	1. Professionals with college degrees in a mental health discipline (psychiatrists, psychologists, social workers, clergymen, nurses, and mental health workers.) 2. Paraprofessionals (psychiatric technicians, occupational therapists, recreational therapists, vocational therapists, etc.) 3. Other professionals such as physicians, administrators, researchers, teachers, and social scientists. 4. Supporting services personnel. 5. Volunteers and students.	1. The chronic shortage of mental health professionals experienced in recent years is easing up now. The opportunity to bolster manpower with high quality professionals is available as soon as the temporary freeze on filling positions is lifted. 2. There is a good range of professionals involved in the program but some shifting of roles is needed. 3. Inadequate use of other social sciences personnel such as economists and sociologists in the evaluation of the program and in the design of imaginative new treatment programs.	1. Use of specially trained personnel to help neighborhoods organize to accomplish their objectives. 2. Physicians' assistants in a variety of medical care areas. 3. Greater use of community resources such as individuals in education, religion, law, friends, and neighbors to help with crisis intervention. 4. Expanded use of Behavioral Modification and other contingency management techniques in selected areas. 5. Development of a mental health career ladder to make provision for those with no formal training through the highest educational levels, truly interdisciplinary in nature and with increased emphasis on helping skills and appropriate experience.
ING RCES	(F.Y. 1970-71) — % of total budget 1. State general fund (a) State hospitals 77% (b) Community programs 7% 2. Federal funds (a) Staffing grants (p.l. 89-105) 4% (b) Partnership for Health Act (314d) 1% (c) Other Federal funds 3% 3. Local funds, including local government, school districts, United Way, donations, fees, third party payments, local fund raising efforts 8% 100%	1. A basic but flexible formula should be established for state support of mental health program. 2. Stability of local funding is inadequate and variable. Some county commissioners supply strong support to mental health, others offer very meager support. 3. The proportion of state appropriations for mental health has been steadily declining since 1962-63 (12.29%) to date (approximately 9%).	1. Greater responsibility assumed by State and local sources. 2. Increase in 3rd party payment for services, including a National Health Insurance Program. 3. Permissive legislation authorizing formation of mental health districts so citizens can tax themselves for desired mental health services. 4. If revenue sharing becomes a reality, increased share of funding from the Federal sector channeled to the local communities. 5. Possible contractual arrangements between health maintenance organizations and community mental health programs. 6. Increased efforts in resource development at all levels.
ATIONSHIP OTHER ARTMENT GRAMS	1. Limited diagnostic, consultative, and treatment services are provided other agencies. 2. Colorado State Hospital provides a psychiatric corrections team for the penitentiary and reformatory. 3. Colorado State Hospital provides basic support and assistance to the State Home & Training School at Pueblo. 4. Fort Logan provides a psychiatric team to Youth Services and some assistance to the Ridge Home. 5. No services are presently being provided the State Home & Training School at Grand Junction. 6. Some consultation has been provided to the School for the Deaf and the Blind. 7. Colorado State Hospital provides physical facilities for other agencies in the Department. 8. Colorado State Hospital provides medical and surgical, inpatient, clinic, and diagnostic services to (1) Colorado State Penitentiary (2) Colorado State Reformatory (3) Lathrop Park Youth Center.	1. Minimal relationships with probation and parole. 2. Red tape, including such things as hassling over eligibility requirements, retard provision of services across divisional lines.	1. Closer working relationships and the sharing of professional and paraprofessional personnel between all human resource agencies - integration and continuity of services and the maintaining of records. 2. Centralized human resource centers in the communities where an individual in need can receive services for any one of several problems.

PROFILE for the TREATMENT OF MENTAL AND EMOTIONAL DISORDERS PROGRAM (continued)

	DESCRIPTION OF PRESENT PROGRAM	EVALUATION OF PRESENT PROGRAM	PROJECTION OF FUTURE PROGRAM
ATIONSHIP THER E RAMS	1. Provides consultation with the Social Services Department for those over 65 under the Social Security Act. 2. Provides consultation with the Department of Health for the alcoholism unit and the drug abuse program. 3. The Department of Health is responsible for licensing of the community mental health centers, clinics, and special alcoholism programs working cooperatively with the Department of Institutions. 4. Colorado State Hospital provides physical facilities for several state agencies, including Southern Colorado State College, State Personnel Department, etc.	1. Efforts are needed to overcome the difficulties in getting other State departments (and divisions within institutions) to work effectively together in existing relationships. 2. Common, patient-oriented objectives with the Departments of Labor and Employment, Social Services, and other human resource agencies at the Federal, State, and local level are needed to support effective treatment programs. 3. Present relationships with school districts need to be improved for early identification and treatment programs. 4. There is inadequate delineation of line and staff responsibility in State government. 5. Program can be facilitated and better implemented by data flow, information exchange, and registry for multiple casualties between State programs.	1. Possibly a Human Services Commission directly under the Governor, charged with improving coordination of various State programs in this area. 2. There will be increased clarification of responsibilities and decision prerogative at all levels of State government. 3. Increased emphasis on regional government and articulation of mental health services within this new structure.
ATIONSHIP FEDERAL OGRAMS	1. The Federal Department of Health, Education, and Welfare, through the National Institute of Mental Health, provides standards for treatment and regular monitoring and assessment of ongoing programs through site visits to hospitals and community centers. The National Institute of Mental Health and Department of Health, Education, and Welfare will increase their role as more funds come from the Federal government through Medicare, National Health Insurance, etc. 2. Increasing refinement by the mental health authority of standards and methods of monitoring and enforcement. 3. The State develops priorities and a "State" plan which becomes the blueprint for State-Federal participation.	1. Problems in coordinating program development. 2. Shifting Federal guidelines.	1. Regional Office of the National Institute of Mental Health will have more authority for funding and program development. 2. A National Health Plan, including mental health services, is imminent. 3. With the coming of Health Maintenance Organizations, there will be more emphasis on prevention. 4. We will see many new programs involving children's services and the child advocacy concept in the next few years.
LATIONSHIP COMMUNITY OGRAMS	1. Provides consultation and training to many human services agencies, including mental health workshops, throughout the State. 2. Referrals to and from community agencies are increasing. 3. United Way contributes to some clinics and centers. 4. Professional consultation to local, statewide, and national programs of mental health importance as to: a. National Institute of Mental Health b. Department of Health, Education & Welfare c. Other national organizations	1. Some problems with commitment among all agencies to serving people, even if at the expense of cherished boundaries and protective barriers.	1. Greater collaboration with other helping services through both professional mental health programs and ancillary or non-professional services. 2. Unification of efforts to break down barriers, increase services, increase responsiveness, and avoid duplication. 3. Redefine the role of state hospitals, such as making a determination of which specific services, for clinical as well as economic reasons, should be delivered on a regional rather than local basis. 4. Solidify the role of community mental health centers and clinics as the primary local resources for the delivery of mental health services. 5. Community programs will need integration with the Federal government's Health Maintenance Organization programs in terms of possible common catchment areas, etc.

Treatment of Mental and
Emotional Disorders Program

- Increase specificity and quantification of goals and objectives
- Develop programs to reach those residents not adequately served
- Improve integration of services between State hospitals, community centers and clinics, the private sector and other governmental programs
- Share personnel between agencies
- Process referrals to State hospitals through community centers and clinics
- Develop more selective emphasis on 24-hour care at State hospitals
- Redefine role of State hospitals
- Establish basic but flexible formula for State support of program
- Develop community centers and clinics as primary local resource for deliver of services
- Enact legislation permitting formation of mental health districts for funding purposes
- Use specially trained personnel to help organize neighborhoods to accomplish objectives
- Develop group living treatment on a community centered basis
- Develop more drying-out and detoxification centers in community
- Increase emphasis on crisis intervention, using community resources
- Increase family treatment programs on non-institutionalized basis
- Provide better supportive after-care programs at community centers and clinics
- Develop out-reach services for greater community education, involvement and participation
- Improve relationships with school districts for earlier identification of disorders

- Develop new treatment methods more suited to new family and group relationships
- Prepare groundwork for centralized human resource centers in communities
- Involve other types of social science professionals in design and evaluation of programs
- Develop mental health career ladder for all program personnel

PROGRAM PROFILE OF MENTAL HEALTH, 1971
DEPT. OF INSTITUTIONS, MASTER PLANNING PROGRAM

NEWLY DEFINED GOALS

Description of Present Program

1. Restore or improve the social and vocational functioning of persons with mental health problems to a level which facilitates acceptable community living.

2. Eliminate or minimize community and family disruption and the loss of productive output by persons with mental health problems.

3. Eliminate or minimize significant emotional and mental distress of persons with mental health problems.

4. Eliminate or minimize the dependency of persons with mental health problems on social, mental health or other agencies.

5. Improve the physical and social environment of persons with mental health problems and their families, and participate in the amelioration of those factors in the physical and social environment that interfere with mental health.

6. Improve the quality of life of persons with mental health problems and their families.

7. Improve society's understanding of mental health problems.

8. Ensure the right of persons who enter the mental health services delivery system to quality care.

9. Develop a comprehensive five-year plan and schedule for phasing in services which meet state-wide mental health needs and reflect the changing role of state hospitals and community-based programs.

10. Decrease the incidence and prevalence of mental health problems.

Evaluation of Present Program

1. Almost all individuals served are able to attain at least minimal standards of acceptable community living.

2. Direct therapeutic involvement with community and family members, and the increasing availability of a variety of treatment resources within the community, have helped to minimize the disruptions experienced by persons with mental health problems.

3. Use of psychological, social, and chemical therapies have helped to significantly reduce the level of distress in most individuals served. Major reforms in the methods of institutional care have dramatically reduced the trauma and damage formerly experienced from receiving such care.

4. The greater emphasis on maintaining emotionally disturbed individuals in the community has probably placed a greater load on social and other agencies, such as welfare.

5. Programs aimed at improving the quality of life, and the social and physical environment, are in the initial stages of development. In some instances, the use of community resources such as boarding homes, nursing homes and other alternatives to hospitals may result in a decline in the quality of physical and social environment and the quality of life of persons with mental health problems.

6. Lack of adequate systematic data impedes the objective assessment of needs and the impact of mental health programs.

Projection of Future Program

1. Greater specificity for the goal statements, making qualitative evaluations more precise.

2. Convergence with the goals of the other components of the social support systems, so that a unified set of goals emerge.

3. The cost for all other human services support systems will be taken into account in the development and evaluation of mental health systems.

4. Refinement of goals related to quality of life.

5. Mental health service will evince its greater concern with total human needs through involvement in areas such as effecting societal change and integration and/or collaboration with other human services agencies and change agents.

6. Development of a standardized system-wide data collection and evaluation program.

7. Establishment of a statewide coordination and facilitation of well-designed and well-controlled research studies of specific areas of vital importance to state mental health programs.

8. Continued redefinition of goals as evaluative data concerning present programs becomes availabl e.

NEWLY DEFINED OBJECTIVES

Description of Present Program

1. To maintain 90% of all persons who require mental health services in the community.

2. To have 60% of the population over age 15 become aware of the availability of mental health services in their community.

3. To insure that 75% of the population will be able to have direct contact with a mental health caretaker within one hour when mental health services are needed.

4. To have a prior evaluation by the local mental health service of 90% of all admissions to state hospitals.

5. To have a written treatment plan and goals for 100% of all persons served in the mental health system.

6. To devote 20% of mental health resources to consultation and education to the various agencies in the community such as schools, welfare, churches, public health, courts and others.

7. To move 90% of those admitted to the mental health services delivery system towards less dependence on the system within 90 days of admission; e.g., transferred from 24-hour care to a day care program, or from a one-hour per week contact to one hour per month.

8. To return 95% of all admissions to mental health services to acceptable community living within 12 months of admission.

9. To maintain 80% of those returned to acceptable community living for two years without re-entry to any part of the mental health system.

Profile for the Treatment of Mental and Emotional Disorders

POPULATION BEING SERVED

Description of Present Program:

1. It is estimated that at least 10% of the population will need treatment for mental disorder during their lifetime. This target population would be at least 220,000 persons in Colorado.

2. Tens of thousands of Colorado residents have been reached via consultation and education services. These services enabled other community agencies to assist in the prevention of mental health problems as well as remediation or intervention by other support systems.

3. A large percentage of direct services hours are involved in crisis situations such as suicide attempts or gestures, and unstable family relationships.

4. More than 50,000 persons received services of varying amounts from agencies in the Colorado Mental Health Program last year.

Evaluation of Present Program:

1. The young child is not being adequately served. At the present time there are no consistently effective ways to identify those needing treatment before they reach school age, and limited referral possibilities for those who are identified.

2. The present mental health system has done little to meet the needs of older adults with problems such as loneliness and depression.

3. The present mental health system is not meeting the needs of ethnic minorities and poverty groups.

4. More mental health services are needed for adolescents and young adults.

5. Only minimal programs have been developed for alcoholics and drug abusers.

6. Residents of many isolated and rural areas of the State do not have easy access to mental health resources.

Projection of Future Program:

1. Increase in the number of citizens requiring treatment and prevention services; this will be especially pronounced in high-risk groups such as children, the elderly and the disadvantaged.

2. An increase in mental health services for the individual who exhibits criminal and anti-social behavior.

3. An increase in the provision of mental health services for drug and alcohol abusers.

4. The total population of Colorado will continue to increase. Parts of the state will experience rapid population growth while other areas will show a decline; both will require changes in the mental health delivery system.

SERVICES PROVIDED

Description of Present Program:

Institutional Services

1. Psychiatric hospitalization, including psychotherapy, chemotherapy, milieu therapy, social and vocational skill training.

2. Community based institutional services are being provided by general hospitals and 24 hour non-hospital facilities.

3. Medical hospital services, covering the full range of physical problems of the psychiatric patient, including severe neurological morbidity.

4. Specialized treatment for particular problem groups, such as children the aged, drug abusers, including alcoholics and the "criminally insane."

5. Full range of hospitalization services to inmates and residents of other institutions within the Department.

6. Major field training for professional, paraprofessional and ancillary mental health personnel.

Transitional Services

7. Partial hospitalization, including day, night or weekend care.

8. Half-way houses and group home placements.

9. Supervised work programs for patient groups.

10. Nursing home and foster family placement with continuing follow-up treatment or supervision.

Community Services

11. Outpatient care, and post hospitalization after care services.

12. Diagnostic and out patient treatment for special groups such as alcohol and drug abusers, children and others.

13. Emergency (after hours) coverage and crisis intervention by specialized teams.

14. Family therapy and marriage counseling.

15. Consultation services to other agencies and professional personnel to increase their ability to cope with mental health related problems.

16. Education programs directed to the general lay community and particularly to high-risk groups. The focus of these efforts is on the prevention and early detection of mental and emotional difficulties.

Evaluation of Present Program:

1. There are more treatment needs and requests than present resources are able to meet. Limited emphasis has been placed on outreach efforts. Partial solution would be increased cooperation and coordination with other human service agencies.

2. Strengths:

   a. Approximately 99% of the State's population has access to some form of mental health services supported in part by public funds.

   b. The continuing growth of community programs, with increasing citizen involvement and input.

   c. Two progressive State Hospitals.

   d. A spirit of innovation with continuous effort being directed towards the development of new alternatives for the delivery of mental health services.

3. Weaknesses:

   a. Marginal level of coordination of services provided by State Hospitals and community mental health centers and clinics.

   b. Lack of satisfactory alternatives to treatment in closed settings for some adolescents, including those with character disorders.

   c. Poor continuity of care between the public and private mental health sectors.

   d. Less than effective response to problems relating to the alienation of youth as symbolized by drug abuse, antisocial behavior, etc.

   e. Lack of adequate community mental health resources, especially in rural areas.

   f. Lack of mental health system-wide integrated information network to facilitate more effective evaluation of the total system and the effectiveness and efficiency of individual programs.

Projection of Future Program:

1. Better integration of services with other human care agencies.

2. Initiation of comprehensive drug and alcohol treatment programs.

3. Development of a coordinated management information system.

4. More selective use of in-hospital 24-hour care, and concurrent development of additional non-hospital 24-hour care facilities.

5. More specialized programs for the very young and the aged, including therapeutic nursery care for preschool age children and modified work programs and socialization activities for the elderly.

6. Development of more effective crisis intervention services.

7. Increased emphasis on outpatient family treatment programs.

8. Planned improvement in aftercare services.

9. Greater emphasis by mental health programs on prevention oriented community education.

10. Better community programs and peer group based activities for adolescents in need of treatment.

11. Development of a more effective triage process by local mental health agencies.

12. Increased citizen involvement and participation in the planning and delivery of services.

13. Greater emphasis on outreach services.

14. Development of relevant treatment methods for new and changing forms of family and group relationships.

TYPES OF PERSONNEL

Description of Present Program:

1. Professional with Bachelor level degrees or above in a mental health or mental health related discipline (psychiatry, nursing, social work, psychology, occupational therapy, etc.).

2. Paraprofessionals (mental health workers, psychiatric technicians, etc.).

3. Other professionals such as non-psychiatrist physicians, social scientists, administrators, researchers, and teachers.

4. Supporting services personnel (e.g., clerical).

5. Students

6. Volunteers

Evaluation of Present Program:

1. The supply of mental health professionals exceeds the demand in some areas.

2. Paraprofessionals have proven their worth and are well qualified members and leaders of clinical and administrative units.

3. Students from many disciplines are receiving training in a variety of mental health service agencies.

Projection of Future Program:

1. Use of physicians' assistants in a variety of medically related areas.

2. Greater use of community resources, including professional and lay citizens to provide care giving services.

3. Expanded programs of continuing education to enhance the skills of mental health care givers.

FUNDING SOURCES (1973-74)

	% of total budget
1. State general fund	
a. State hospitals	_____%
b. Community programs	_____%
2. State revenue sharing	_____%
3. Federal Funds	
a. Staffing grants (PL 89-105)	_____%
b. Partnership for Health Act (314D)	_____%
c. Other Federal funds	_____%
3. Local funds, including local governments, school districts, United Way, donations, fees, third party payments, local fund raising efforts	_____%
	100%

Evaluation of Present Program:

1. State support of mental health programs is not based on need.

2. Local support is variable, often unpredictable and generally inadequate. Wide variations exist among mental health agencies in respect to funds received from local governments, fees for service, contributions, and support from organizations such as United Way.

3. The level of Federal support varies widely from agency to agency. Federal funding is not based on need, although centers designated as "poverty" centers receive a larger percentage of Federal funds than non-poverty agencies.

Projection of Future Program:

1. Increased responsibility for funding will be assumed by the State.

2. There will be increasing pressure for increased support from county and municipal governments, fees and third party sources.

3. National Health Insurance will become an important source of funds for mental health services.

4. There will be a significant increase in the amount of Revenue Sharing funds made available for mental health services.

5. Some mental health services will be provided by mental health centers and clinics under contract with health maintenance organizations.

6. There will be increased Federal funding in specific areas such as Law Enforcement Assistance (LEAA), and drug and alcohol abuse.

RELATIONSHIP TO OTHER DEPARTMENT PROGRAMS

Description of Present Program:

1. Limited diagnostic, consultative and treatment services are provided other agencies.

2. A team from Colorado State Hospital provides psychiatric services to the penitentiary and reformatory.

3. Colorado State Hospital provides supportive services and physical facilities to the State Home and Training School at Pueblo.

4. Fort Logan provides psychiatric services to programs under the Division of Youth Services along with some assistance to the State Home and Training School at Wheatridge.

5. No services presently are being provided the State Home and Training School at Grand Junction.

6. Limited consultation has been provided to the School for the Deaf and the Blind.

7. Colorado State Hospital provides medical and surgical, inpatient, clinic, and diagnostic services to (1) Colorado State Penitentiary, (2) Colorado State Reformatory, (3) Lathrop Park Youth Center.

Evaluation of Present Program:

1. Mental health services to the probation and parole sections are minimal.

2. The failure of the General Assembly to appropriate adequate funds for the purchase of mental health services by other divisions has been a barrier to inter-departmental collaboration.

Projection of Future Program:

1. The trend towards community based services in all divisions will result in the development of close working relationships among Youth Services, Mental Health, Deaf and Blind, Corrections and Mental Retardation at the community level.

2. With the establishment of a research position in the Department will come coordinated program evaluation and joint research efforts.

DESCRIPTION OF PRESENT PROGRAM

Relationship to other state programs:

1. Consultation, diagnostic, and treatment services to the Court system.

2. Consultation to and collaborative planning with the Division of Alcohol and Drug Abuse of the Health Department.

3. Coordination of the licensing of community mental health centers, clinics, and other mental health care facilities with the Health Department.

4. Colorado State Hospital provides physical facilities for several state agencies, including Southern Colorado State College, State Personnel Department, etc.

Evaluation of Present Program:

1. The Division of Alcohol and Drug Abuse in the Department of Health is the State Alcohol and Drug Abuse Authority, but most public alcohol and drug abuse treatment takes place in agencies under the direction or control of the Division of Mental Health in the Department of Institutions. This results in duplication in such areas as planning, coordinating, etc., in addition to unclear lines of communication and many administrative problems.

2. Coordination between mental health programs and elements of the education system ranges from practically non-existant to fairly well developed.

3. Joint operations involving the Division of Mental Health and the Department of Social Services have not been operationalized despite extensive planning.

Projection of Future Program:

1. Reorganization of several departments and divisions into a human services umbrella agency is one possibility.

2. Formation of a human services advisory commission is another alternative.

3. Increased emphasis on regional government will probably bring about some changes in the administration of mental health and other state programs.

Relationship to Federal Programs:

Description of Present Program:

1. Federal project, formula and staffing grants are a major source of funds for mental health programs.

2. The Federal government requires the state to have a "construction" plan for mental health facilities. This plan, which relates to overall planning for mental health services, is updated annually.

3. Occasionally, local projects are funded by the Central Federal Office without approval-or knowledge-of the Division of Mental Health, and, on occasions, the Regional Federal Office.

Evaluation of Present Program:

1. Divided state responsibility for alcohol and drug abuse services makes coordination of Federally funded mental health and drug and alcohol abuse services extremely difficult.

2. A close working relationship has been developed between the Division of Mental Health and the NIMH Regional Office within which many potentially troublesome problems are quickly resolved.

3. Regional NIMH staff conduct on-site evaluations of Federally funded centers. Division of Mental Health staff have an active role in such evaluations.

Projection of Future Program:

1. As eight-year Federal staffing grants expire and state support increases, the Federal presence in the mental health area will diminish; however, NIMH staff members will be invited to participate in state on-site program evaluations.

2. State standards for community mental health centers will take precedence over Federal guidelines.

3. Revenue Sharing funds will be increasingly used to fund mental health programs.

4. Federal involvement will be increasingly reflected in development of a total health care delivery system which embraces all health services including mental health.

5. National Health Insurance will give consumers the means whereby they can purchase mental health services where they wish. This will result in improved services at the community level.

Relationship to Community Programs

Description of Present Program:

1. Community mental health centers and clinics are semi-private organizations which, in most instances, are under the control of governing boards. The Department of Institutions has statutory authority to purchase services from those centers and clinics which meet the standards set by the Department.

2. The Division of Mental Health maintains a close relationship with the Mental Health Association of Colorado, and encourages centers, clinics and hospitals to develop cooperative arrangements with the private sector as well as lay groups and local community service organizations.

3. Community based services are available to more than 80% of the state's population.

Evaluation of Present Program:

1. Coordination between public and private sector is not as well developed as it should be.

2. Community centers and clinics vary in their readiness to assume responsibility for the full range of mental health services.

3. Training for Boards and Administrators is a critical need in some centers and clinics.

4. Need to place more emphasis on program evaluation.

Projection of Future Program:

1. Specific services responsibilities will be assigned to individual centers and clinics in accordance with the needs of their service area and their ability to provide needed services.

2. Centers and clinics will become the primary mental health resources for the residents of their catchment areas.

3. Primary emphasis will be on intermediate care, outcare and non-hospital 24-hour care. The majority of those who require 24-hour in-hospital care will be hospitalized on a short term basis in hospitals located in or near their own community.

4. Community mental health centers and clinics will become part of a united mental health services delivery system which will include state hospitals and the private sector.

Treatment of Mental and
Emotional Disorders Program
Summary of Goals

1. Increase specificity and quantification of goals and objectives
2. Develop programs to reach those residents not adequately served
3. Improve integration of services between State hospitals, community centers and clinics, the private sector and other governmental programs
4. Share personnel between agencies
5. Process referrals to State hospitals through community centers and clinics
6. Develop more selective emphasis on 24-hour care
7. Redefine roles of State hospitals, community centers and clinics
8. Establish basic but flexible formula for State support of program
9. Emphasize the role of centers and clinics in the planning, coordination and delivery of mental health services
10. Promote legislation permitting county mill levy for mental health services or formation of mental health service districts for funding purposes
11. Use specially trained personnel to help organize neighborhoods to accomplish objectives
12. Develop group living treatment on a community centered basis
13. Develop more drying-out and detoxification centers in community
14. Increase emphasis on crisis intervention, using community resources
15. Increase family treatment programs on non-institutionalized basis
16. Provide better supportive after-care programs at community centers and clinics
17. Develop out-reach services for greater community education, involvement and participation
18. Improve relationships with school districts for more effective provision of preventative and other mental health services
19. Develop new treatment methods more suited to new family and group relationships
20. Prepare groundwork for centralized human resource centers in communities

Treatment of Mental and Emotional Disorders
Summary of Goals

21. Involve other types of human services and social science professionals in the design and evaluation of mental health programs

22. Develop mental health career ladders for all program personnel

23. Periodically review the accessibility and responsiveness of all mental health programs

24. Facilitate the development and evaluation of preventive programs

25. Participate in the development of programs for the community based evaluation and treatment of the criminal offender

26. Facilitate the development of community based treatment programs for problems related to drug and alcohol abuse

27. Develop new programs and/or expand existing programs to reach those residents not adequately served

28. Develop mechanism for funding mental health programs on the basis of need

. Develop a phase-in schedule for the assumption of the full range of appropriate services by community mental health centers and clinics.

STATE OF COLORADO
JOHN A. LOVE · GOVERNOR

DEPARTMENT OF INSTITUTIONS
Hilbert Schauer, Executive Director
Division of Mental Health
Harl H. Young, Ph.D., Chief
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Denver, Colorado 80203
Telephone (303) 892-2595

July 10, 1973

BULLETIN NO. 276

TO: Board Presidents of all Mental Health Centers/Clinics
Executive Directors of all Mental Health Centers/Clinics

FROM: Youlon D. Savage, ACSW, Coordinator, Community Mental Health Programs

SUBJECT: Proposed schedule for phase-in of full range of mental health services

One of the goals of the Division of Mental Health is to insure the availability of the full range of quality mental health services close to persons who require such care. We are asking your assistance in developing a proposed time table for the accomplishment of this goal and the objectives related to it.

Please complete the attached form, and return it, along with the required narrative, to this office by July 20, 1973. While this report is specifically for use in developing the Master Plan, much of it will be very useful to you in the preparation of your budget request for fiscal year 74-75.

Schedules from individual centers and clinics will be reviewed by the Division staff, the Master Planning committee, the Division of Alcohol and Drug Abuse, Comprehensive Health Planning, and other affected and concerned agencies. The final schedule will be distributed to all centers, clinics and hospitals, incorporated into the Master Plan, and presented to the Executive Budget Office and the Joint Budget Committee.

Instructions for completion of the report are attached.

YDS:pkw
Attachments

cc: Dr. Meredith
Dr. Bonn
Elinor Stead

Figure 1

INSTRUCTIONS FOR COMPLETING "PROPOSED SCHEDULE FOR PHASE-IN OF FULL RANGE OF MENTAL HEALTH SERVICES"

1. The proposed phase-in date is the date by which the center/clinic will be fully capable of assuming total responsibility for providing the service directly, or through an affiliate located in or near the catchment area.

2. The report must be accompanied by a narrative which will include the following information for each cell:

   a. Name of agency(ies) currently (as of 7-1-73) providing this service.

   b. Name of agency(ies) which will provide this service when it is phased in.

   c. Cost breakdown:

      Personnel Services
      Operating Expenses
      Travel
      Capital Outlay

   d. How were costs computed? (Please include sources of data on which costs are based.)

   e. If there are no plans to provide a service, indicate the reason.

3. Definition of Services

   a. Inpatient Service (Incare):

      1) 24-hour in-hospital care: a therapeutic program in which the client is in full time care in a hospital setting. Actual treatment may take place in a location other than the hospital.

      2) 24-hour non-hospital care: a therapeutic program in which the client is in full time care in a non-hospital setting as a specific alternative to 24-hour in-hospital care. Actual treatment may take place in a location other than the full-time care facility.

   b. Outpatient Service (Outcare):

      Service of up to three hours in duration provided on a regular or non-scheduled basis. Outpatient services may be provided in a client's home, at the primary treatment facility or at some other accessible location.

   c. Partial Hospitalization (Partial Care/Intermediate/Transitional/Day Care/Evening Care):

      A therapeutic program for those persons who require less than 24-hour (full time) care, but more than outpatient care.

d. Emergency Service (Crisis Intervention):

Immediate mental health care and evaluation for persons in crisis on a 24-hour-a-day, seven-day-a-week basis.

e. Consultation and Education:

1) Consultation: involves the provision of mental health assistance by qualified personnel to such community care givers and agencies as courts, schools, police, welfare departments, etc. The purpose is to assist these agencies in providing more effective services to their clients.

2) Education: activities directed towards (a) increasing the visibility; i.e., community awareness of the program as a community resource and (b) promotion of mental health and the prevention of emotional problems through the dissemination of information on mental health.

f. Aftercare:

Care which follows a period of inpatient or partial hospitalization.

g. Forensic Services:

Services to persons who enter the mental health system via a court order or pursuant to state statutes on involuntary admission for treatment, evaluation and/or observation. (For centers and clinics this does not include the "criminally insane" unless they have been conditionally released from CSH.)

h. Rehabilitation Services:

Services designed to reduce the residual deficits of emotional disturbance and to assist clients in attaining the highest level of social and vocational functioning of which they are capable.

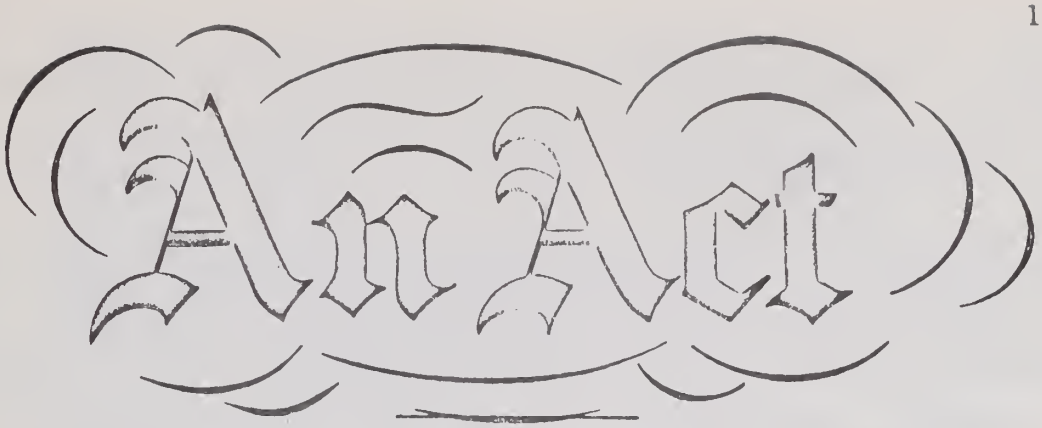
Proposed Schedule for Phase-in of Full-Range of
Mental Health Services

Center/Clinic

Date of Report

Service	Age/Special Problem Categories							
	Adults	Adolescents	Children	Geriatrics	Drug Abuse	Alcohol Abuse	Rehabilitation	Forensic
Inpatient "A" Proposed Phase-in Date Estimated Cost	Cell A-1	A-2	A-3	A-4	A-5	A-6	A-7	A-8
Inpatient "B" Proposed Phase-in Date Estimated Cost	Cell B-1	B-2	B-3	B-4	B-5	B-6	B-7	B-8
Outpatient Proposed Phase-in Date Estimated Cost	Cell C-1	C-2	C-3	C-4	C-5	C-6	C-7	C-8
Partial Proposed Phase-in Date Estimated Cost	Cell D-1	D-2	D-3	D-4	D-5	D-6	D-7	D-8
Emergency Proposed Phase-in Date Estimated Cost	Cell E-1	E-2	E-3	E-4	E-5	E-6	E-7	E-8
Aftercare Proposed Phase-in Date Estimated Cost	Cell F-1	F-2	F-3	F-4	F-5	F-6	F-7	F-8
Consultation & Education Proposed Phase-in Date Estimated Cost	Cell G-1	G-2	G-3	G-4	G-5	G-6	G-7	G-8

Figure 1-b



HOUSE BILL NO. 1164. BY REPRESENTATIVES Strahle, Arnold, Buechner, Hinman, Baer, Benavidez, Bishop, Boley, Burns, Carroll, Cooper, DeMoulin, Dittemore, Edmonds, Farley, Fentress, Frank, Fuhr, Gallagher, Gaon, Gunn, Gustafson, Hamlin, Hayes, Howe, Kirscht, Kopel, Koster, Lamm, Lloyd, Miller, Mullen, Munson, O'Brian, Quinlan, Sack, Safran, Sears, Showalter, Smith, Spano, Strang, Taylor, Valdez, Webb, Wells, Younglund, Bendelow, Bryant, Baker, Eckelberry, Friedman, Herzberger, Hybl, Lucero, McNeil, Massari, Moore, Pettie, Sonnenberg, Southworth, and Tempest; also SENATORS L. Fowler, Anderson, Cole, McCormick, Allshouse, Bermingham, G. Brown, H. Brown, Calabrese, Cisneros, Darby, DeBerard, Garnsey, Jackson, Johnson, Kinnie, Kogovsek, Locke, MacManus, Massari, Minister, Noble, Parker, Plock, Ruland, Schieffelin, Shoemaker, Stockton, Strickland, and Wunsch.

AMENDING ARTICLE 22 OF CHAPTER 123, COLORADO REVISED STATUTES 1963, AS AMENDED, CONCERNING THE EDUCATION OF HANDICAPPED CHILDREN, AND MAKING AN APPROPRIATION THEREFOR.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 22 of chapter 123, Colorado Revised Statutes 1963, as amended, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

ARTICLE 22

Education of Handicapped Children

123-22-1. Short title. This article shall be known and may be cited as the "Handicapped Children's Educational Act".

123-22-2. Legislative declaration. The general assembly, recognizing the obligation of the state of Colorado to provide educational opportunities to all children which will enable them to lead fulfilling and productive lives, declares that the purpose of this article is to provide means for educating those

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

children who are handicapped. It is the intent of the general assembly, in keeping with accepted educational principles, that handicapped children shall be educated in regular classrooms, insofar as practicable, and should be assigned to special education classrooms only when the nature of the child's handicap makes the inclusion of the child in a regular classroom impractical. To this end, the services of special education personnel shall be utilized within the regular school programs to the maximum extent permitted by good educational practices, both in rendering services directly to children and in providing consultative services to regular classroom teachers.

123-22-3. Definitions. (1) As used in this article, unless the context otherwise requires:

(2) "Administrative unit" means a school district or a board of cooperative services that is providing educational services to handicapped children and that is responsible for the local administration of this article.

(3) "Department" means the department of education.

(4) "Equipment" means that equipment used especially for the education of handicapped children which is approved by the state board. The state board shall publish a list of the types of approved equipment.

(5) "Handicapped children" means those persons between the ages of five and twenty-one who by reason of one or more of the following conditions are unable to receive reasonable benefit from ordinary education: Long-term physical impairment or illness; significant limited intellectual capacity; significant identifiable emotional or behavior disorder or identifiable perceptual or communicative disorders; or speech disorders. "Handicapped children" also means those persons between the ages of five and twenty-one whose presence in the ordinary educational program is detrimental to the education of others and must therefore receive modified or supplementary assistance and services in order to function and learn. A school district may make special educational programs and services available to persons under age five who would otherwise qualify as handicapped children under this subsection (5), and such persons enrolled in special educational programs or receiving special educational services shall be deemed to be "handicapped children" for all purposes of this article. The state board shall develop guidelines for the identification of handicapped children who may become eligible for special educational services under provisions of this article.

(6) "Instructional materials" means those materials used especially for the education of handicapped children. Consumable materials and regular textbooks shall not be considered reimbursable items if such materials and textbooks are not to be

used especially for the education of handicapped children.

(7) "Optometrist" means a doctor of optometry duly licensed to practice optometry.

(8) "Physician" means a doctor of medicine or osteopathy duly licensed to practice medicine.

(9) (a) "Psychologist" means any person who meets any one of the following requirements:

(b) He is properly certificated as a school psychologist by the state board.

(c) He is properly certified as a psychologist by the Colorado state board of psychologist examiners.

(d) He has a minimum of two years of graduate training in psychology, is supervised by a psychologist as defined in paragraphs (b) or (c) of this subsection (8), and is employed as a psychologist by an institution of higher education, hospital, or mental health clinic or agency that is supported at least in part by government funds.

(10) "School district" means a school district organized and existing pursuant to law, but shall not include a junior college district.

(11) "State board" means the state board of education.

123-22-4. Administration. (1) This article shall be administered by the department. Administration of this article shall include the recommendation to the state board of education of reasonable criteria, rules, and regulations; recommended minimum standards for facilities, materials, equipment, and personnel; and recommended assessment criteria for identifying handicapped children, their level of handicap, and the special services needed. The state board of education shall adopt appropriate recommendations following public hearings in several locations throughout the state with respect to the suggested criteria, rules, regulations, and standards. Recommendations adopted by the state board shall be in accord with the legislative declaration set forth in section 123-22-2. Any school district which provides plans, programs, or services which do not reasonably satisfy the criteria, rules, regulations, and standards recommended by the state board of education will be provided by the department of education with a detailed analysis of any discrepancies noted along with specific recommendations for their correction. Funding will be provided or continued for a reasonable period of time, as determined by the department of education, to allow the local district opportunity to satisfy the recommended criteria, rules, regulations, and standards, or to establish a claim for variance based upon conditions indigenous

to a local district.

(2) In order to assist the state board in the performance of its responsibilities for the implementation of this article, a state special education advisory committee of an appropriate size shall be appointed by the state board. The members of the advisory committee shall include at least two special education teachers, at least two administrators with experience in special education, at least two parents of children presently or formerly enrolled in special education programs, and one representative from the department of institutions. Members shall be appointed for one-year or two-year terms.

(3) The department shall submit to the governor and the education committees and the joint budget committee of the general assembly an annual report of the type and number of handicapped children served and not served, what educational services are provided to them, and the total costs incurred for the services, whether state, federal, local, or privately funded. The report shall include a measurable qualitative evaluation of the educational services rendered. The audit performed by the school district shall certify the number of pupils enrolled in special education programs and the numbers and salaries of reimbursable personnel.

(4) To comply with this section, the department shall maintain a data and information system on children, personnel, costs, and revenues.

123-22-5. Depository and retrieval network for visually and hearing handicapped children. The department will maintain a production, inventory, and depository system for those textbooks, equipment, and instructional and resource materials used in the education of visually and hearing handicapped children or in the inservice training of professional personnel. The services of said system shall be available to those administrative units which find it more economical to employ materials from a central depository than to maintain their own.

123-22-6. Special educational programs. (1) By September 1, 1973, every school district in the state shall be either an administrative unit in itself or in a board of cooperative services which shall be designated as an administrative unit. An administrative unit shall be a school district or board of cooperative services which meets criteria established by the state board governing the duties and responsibilities of the director of special education and is either a board of cooperative services which conducts special educational programs for all school districts which are members of the board of cooperative services or is a school district which meets criteria of geographic size, location, and number of pupils established by the state board to achieve maximum efficiency in administering programs of special education. Although the state board shall

define the qualifications and the general duties and responsibilities of directors of special education, such directors shall be regarded for all purposes as employees of their local administrative units and subject to the administrative direction of such units.

(2) Each administrative unit shall submit a plan to the department no later than January 1, 1974, indicating how the school district will provide for education of all handicapped children between the ages of five and twenty-one no later than July 1, 1975. Each unit plan shall include the type and number of handicapped children in the unit based upon the department's criteria of incidence, the services to be provided, and the estimated resources necessary. If any administrative unit fails to submit an acceptable plan by January 1, 1974, the state board shall provide a comprehensive plan by July 1, 1974, for the education of handicapped children within the administrative unit.

(3) Administrative units may until July 1, 1975, and shall thereafter make available special educational services for the education of any handicapped child between the ages of five and twenty-one under jurisdiction of the administrative unit.

(4) To comply with this section, an administrative unit may contract with one or more administrative units to establish and maintain special educational programs for the education of handicapped children, sharing the costs thereof in accordance with the terms of the contract agreed upon; or an administrative unit having fewer than six children who need a particular kind of special educational program may purchase services from one or more administrative units where an appropriate special educational program exists.

(5) By September 1, 1973, and thereafter, each administrative unit shall employ a director of special education. From and after July 1, 1975, no director of special education shall be employed who does not meet qualification standards as set by the state board.

(6) By July 1, 1975, and thereafter, each administrative unit shall employ a sufficient number of school psychologists and school social workers or contract for services to adequately carry out those functions that provide for teacher referral of children who may be handicapped, case finding and assessment, staffing of the special committee as provided for in section 123-22-8 (1) and (4), teacher and parent counseling and consultation, and inservice education for school staff and volunteers. In submitting that portion of the plan to comply with this subsection (6), the administrative unit may indicate how it intends to utilize the services of existing mental health clinics or centers in carrying out the functions named above in cooperation and coordination with the school psychologists and school social workers.

(7) Any administrative unit planning to utilize federal funds from any source for the education of handicapped children as provided in this article shall obtain prior approval from the department for the use of such funds. The use of such funds in the administrative unit shall be in accordance with rules and regulations as established by the department, which are not in conflict with federal law or regulations.

(8) Nothing in this section shall be construed to change the purpose and function of the school for the deaf and blind in Colorado Springs, or to change the requirements or standards for admission thereto.

123-22-7. Authority to contract with community center boards. (1) An administrative unit may contract with an institution of higher education, or a community center board, as provided in section 71-8-2, C.R.S. 1963, for the provision by the administrative unit of an education and training program for handicapped children. If such agreement is arrived at by the two agencies, the administrative unit shall place the responsibility for administering the program with the director of special education.

(2) The two agencies shall agree to an amount per child that the institution of higher education or community center board shall pay to the administrative unit for providing such services. No school district providing an education and training program for handicapped children under contract with an institution of higher education or a community center board shall count such children as regularly enrolled for the purposes of the general state school aid as provided by law. The institution of higher education or community center board shall pay to the administrative unit providing the program an amount per child as agreed upon by the institution or board and the administrative unit, but such amount shall not be less than the amount per child provided to the institution or board by the department of institutions for educational purposes pursuant to section 71-8-2 (1), C.R.S. 1963. Any school district providing an education and training program for handicapped children domiciled in that district shall not be required to provide to an institution of higher education or a community center board the amount required by section 71-8-2 (3), C.R.S. 1963, on behalf of those children; but each such school district shall expend out of its own funds at least the amount required by the said section 71-8-2 (3), C.R.S. 1963, in providing the program.

123-22-8. Determination of handicap - enrollment. (1) The determination that a child is handicapped and the recommendation for placement of that child in a special educational program shall be made by a committee of professionally qualified personnel designated by the board of education of the school district or by the governing board of the board of cooperative services if the administrative unit encompasses more than a

single school district. The composition of the committee shall be prescribed by the state board and may be composed of but not limited to the following: A psychologist, a social worker, a physician, a school administrator, and a teacher of the handicapped. The committee shall give parents of an allegedly handicapped child an opportunity to consult with the committee or representative thereof prior to determination that their child is handicapped.

(2) Before any child is given an individually administered battery of psychological tests for placement in a special educational program, the child's parent or guardian must give consent in writing.

(3) In case of appeal, the final approval of the enrollment of any eligible handicapped child in a special educational program shall be made by the board of education of the school district of the child's residence.

(4) The committee, named in subsection (1) of this section, shall review the placement of each child who is enrolled in a special educational program at least once every year.

(5) In formulating recommendations for placement of a handicapped child, the committee shall work cooperatively with the department of institutions, when applicable, and shall be guided by the legislative declaration contained in section 123-22-2.

123-22-9. Tuition. If an administrative unit cannot provide an educational program for a handicapped child because of the uniqueness of the handicap, the administrative unit may contract with another administrative unit to provide the needed program, upon approval by the department. In such an instance the administrative unit of the child's residence shall reimburse the administrative unit of the child's attendance in an amount equal to the cost of educating that child after applicable revenues from federal funds, state equalization funds, and reimbursements under the provisions of this article have been deducted. Reimbursement by the department under this section shall not be subject to proration under the provisions of section 123-22-14 (3).

123-22-10. Maintenance. For each child enrolled in a special educational program for handicapped children in an administrative unit, the department shall pay to the administrative unit of the child's residence for the maintenance in a family care home in the administrative unit of the child's attendance an amount equal to the established family care home rate of the community for a school year, as established by the division of public welfare of the department of social services, with final approval to be made by the department. Such placement shall be made only in a family care home licensed by the

department of social services, and such placements may be made in homes of relatives. Reimbursement by the department under this section shall not be subject to proration under the provisions of section 123-22-14 (3).

123-22-11. Materials and equipment. An administrative unit may purchase and be reimbursed for materials and equipment for the education of handicapped children. To be eligible for reimbursement, the administrative unit shall maintain a special education instructional materials center and may employ a special education instructional materials specialist. A qualifying center may be operated as a part of an existing instructional materials center, but such portion shall be specifically accounted for.

123-22-12. Length of school year. Administrative units may conduct special educational programs as prescribed in this article for any length of time, except that the administrative unit must meet the minimum length of time as established by law for school districts.

123-22-13. School district report. The governing board of each administrative unit which is eligible for reimbursement under any provisions of this article shall file with the department, on or before July 15, 1973, and July 15 of each year thereafter, a report which contains a statement of the reimbursable costs of approved programs as outlined in section 123-22-14 and other information as required by the state board.

123-22-14. Reimbursable costs of programs. (1) (a) Beginning in the fiscal year 1973 - 1974, an administrative unit which maintains and operates special educational programs approved by the department for the education of handicapped children shall be entitled to reimbursement for:

(b) (i) Eighty percent of that portion of the salary of the following personnel which is attributable, in accordance with regulations of the department, to special educational programs:

(ii) Administrator and assistant administrator of special education in an administrative unit, if such administrator meets the qualification standards for administrators as set by the state board;

(iii) Supervisors of special programs;

(iv) Teachers of special classes;

(v) Teachers of special resource rooms;

(vi) Teachers of special itinerant programs;

(vii) School psychologists;

(viii) School social workers;

(ix) School audiologists;

(x) Occupational therapists;

(xi) Physical therapists;

(xii) Special education instructional aides;

(xiii) Special education instructional materials specialists;

(xiv) Speech correctionists;

(xv) Mobility specialists for the blind;

(xvi) Special education secretaries;

(xvii) Registered school nurses;

(c) (i) Eighty percent of the costs of:

(ii) Special transportation provided for handicapped children only, after other funds reimbursed by the state are deducted;

(iii) Home-to-school or hospital-to-school equipment;

(iv) Consultation and evaluation services provided by psychiatrists, psychologists, and social workers employed by mental health clinics and centers approved by the department, and eighty percent of mileage expenses incurred by such personnel in traveling from their base of operations to other attendance centers in the course of fulfilling job requirements;

(v) In-service training of regular classroom teachers to provide special education services to children within regular classrooms insofar as is practicable and efficacious;

(vi) For each child so accepted, the average cost per pupil of educating children with similar handicaps in any unit which accepts a child from another administrative unit in one or more of its special education programs, such reimbursement to be made to the administrative unit of the child's residence.

(d) Fifty percent of the costs of materials for the education of handicapped children or two hundred dollars per special education teacher, whichever is less;

(e) Fifty percent of the costs of equipment used in the education of handicapped children;

(f) (i) One hundred percent of the costs of:

(ii) Maintenance of a child in a licensed family care home;

(iii) The average cost per pupil of children with similar handicaps of an administrative unit that accepts a child from another administrative unit in one of its special educational programs.

(2) Payments made under the provisions of this article shall in no way affect the amount of other state aid for which a school district may qualify.

(3) In the event appropriations shall be insufficient to cover reimbursements provided for in subsection (1) of this section, all approved reimbursements, except those for tuition and for maintenance in a family care home, which shall always be fully reimbursed, shall be prorated on the basis of total claims submitted in proportion to funds available for reimbursement.

(4) The enactment of this article shall not affect reimbursements under prior law for special educational programs conducted during the period prior to July 1, 1973.

(5) Reimbursements to any administrative unit under the provisions of this article shall in no instance exceed one hundred percent of the attributable student cost when such reimbursements are combined with all other applicable state, private, and federal resources.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated out of any moneys in the state treasury not otherwise appropriated, to the department of education, for the fiscal year beginning July 1, 1973, the sum of four million six hundred sixty thousand two hundred sixteen dollars ($4,660,216), or so much thereof as may be necessary, for the implementation of this act. Of the total amount appropriated by this section, the sum of forty-seven thousand nine hundred dollars ($47,900), or so much thereof as may be necessary, shall be used for the implementation of section 123-22-5, C.R.S. 1963; the sum of one hundred fifty-two thousand dollars ($152,000), or so much thereof as may be necessary, shall be used for the implementation of section 123-22-4 (4), C.R.S. 1963; and the sum of two million dollars ($2,000,000), or so much thereof as may be necessary, shall be used for the implementation of section 123-22-14 (1) (c) (v), C.R.S. 1963.

SECTION 3. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

John D. Fuhr
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

John D. Vanderhoof
PRESIDENT
OF THE SENATE

Lorraine F. Lombardi
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Comfort W. Shaw
SECRETARY OF
THE SENATE

APPROVED_____

John A. Love
GOVERNOR OF THE STATE OF COLORADO

An Act

SENATE BILL NO. 349. BY SENATORS Strickland, Plock, Bermingham, Cisneros, Strockton, Allshouse, G. Brown, Calabrese, Darby, Jackson, Kogovsek, MacManus, Parker, Schieffelin, and Wunsch; also REPRESENTATIVES Smith, Dittemore, Lamm, Baer, Benavidez, Bendelow, Bishop, Carroll, Cooper, DeMoulin, Faker, Eckelberry, Edmonds, Farley, Frank, Fuhr, Gallagher, Gaon, Hamlin, Hayes, Herzberger, Hinman, Howe, Hybl, Kirscht, Kopel, Koster, Lloyd, Lucero, Miller, Munson, O'Brian, Pettie, Quinlan, Ross, Sack, Safran, Sears, Showalter, Southworth, Spano, Strahle, Strang, Taylor, Tempest, Valdez, Webb, Wells, and Younglund.

CONCERNING CARE AND TREATMENT OF THE MENTALLY ILL.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 1 of chapter 71, Colorado Revised Statutes 1963, as amended, is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

ARTICLE 1

Care and Treatment of the Mentally Ill

71-1-1. Legislative declaration. (1) (a) The general assembly hereby declares that the purposes of this article are:

(b) To secure for each person who may be mentally ill such care and treatment as will be suited to the needs of the person, and to insure that such care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

(c) To deprive a person of his liberty for purposes of treatment or care only when less restrictive alternatives are

CAPITAL letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

unavailable and only when his safety or the safety of others is endangered;

(d) To provide the fullest possible measure of privacy, dignity, and other rights to persons undergoing care and treatment for mental illness;

(e) To encourage the use of voluntary rather than coercive measures to secure treatment and care for mental illness.

(2) To carry out these purposes, the provisions of this article shall be liberally construed.

71-1-2. Definitions. (1) As used in this article, unless the context otherwise requires:

(2) "Court" means the district courts of the state of Colorado and the probate court in the city and county of Denver.

(3) "Court-ordered evaluation" means an evaluation ordered by a court pursuant to section 71-1-6.

(4) "Department" means the department of institutions.

(5) "Executive director" means the executive director of the department of institutions.

(6) "Gravely disabled" means a condition in which a person, as a result of mental illness, is unable to take care of his basic personal needs or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person. A person of any age may be "gravely disabled" under this definition, but the term does not include mentally retarded persons by reason of such retardation alone.

(7) "Hospital" means a public hospital or a licensed private hospital, clinic, community mental health center or clinic, institution, or sanitarium which is equipped and staffed to provide treatment for mentally ill persons.

(8) "Mentally ill person" means a person who is of such mental condition that he is in need of medical supervision, treatment, care, or restraint.

(9) "Peace officer" means any peace officer as defined in section 40-1-1001 (3) (1), C.R.S. 1963.

(10) "Petitioner" means any person who files any petition in any proceeding in the interest of any alleged mentally ill or gravely disabled person.

(11) "Physician" means a person licensed to practice medicine in this state.

(12) "Professional person" means a person licensed to practice medicine in this state or a psychologist certified to practice in this state.

(13) "Respondent" means either a person alleged in a petition filed pursuant to this article to be mentally ill or gravely disabled or a person certified pursuant to the provisions of this article.

(14) "Screening" means a review of all petitions, to consist of an interview with the petitioner and, whenever possible, the respondent, an assessment of the problem, an explanation of the petition to the respondent, and a determination of whether the respondent needs and, if so, will accept, on a voluntary basis, comprehensive evaluation, treatment, referral, and other appropriate services, either on an inpatient or an outpatient basis.

71-1-3. Voluntary applications for mental health services. (1) Nothing in this article shall be construed in any way as limiting the right of any person to make voluntary application at any time to any public or private agency or professional person for mental health services, either by direct application in person or by referral from any other public or private agency or professional person.

(2) Notwithstanding any other provision of law, a minor who is fifteen years of age or older, whether with or without the consent of a parent or legal guardian, may consent to receive mental health services to be rendered by a hospital or a person licensed to practice medicine in this state. Such consent shall not be subject to disaffirmance because of minority. The professional person rendering mental health services to a minor may, with or without the consent of the minor, advise the parent or legal guardian of the minor of the services given or needed.

(3) Nothing in subsection (2) of this section shall be construed to require the consent of any minor to receive mental health services when the parent or legal guardian of the minor makes voluntary application for such services on his behalf, or to limit the application to minors of the provisions of this article concerning involuntary evaluation, care, and treatment.

(4) For the purpose of this article, the treatment by prayer in the practice of the religion of any church which teaches reliance on spiritual means alone for healing shall be considered a form of treatment.

71-1-4. Rights of respondents. Unless specifically stated in an order by the court, a respondent shall not forfeit any legal right or suffer legal disability by reason of the provisions of this article.

71-1-5. Emergency procedure. (1) When any person appears to be mentally ill and, as a result of such mental illness, appears to be an imminent danger to others or to himself, or appears to be gravely disabled, a peace officer or a professional person, upon probable cause, and with such assistance as may be required, may take the person into custody, or cause him to be taken into custody, and place him in a facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation. Upon an affidavit sworn to or affirmed before a judge which relates sufficient facts to establish that a person appears to be mentally ill, and as a result of such mental illness appears to be an imminent danger to others or to himself, or appears to be gravely disabled, the court may order the person described in the affidavit to be taken into custody, and placed in a facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation. Whenever in this article a facility is to be designated or approved by the executive director, hospitals, if available, shall be approved or designated in each county before other facilities are approved or designated. Whenever in this article a facility is to be designated or approved by the executive director as a facility for a stated purpose, and the facility to be designated or approved is a private facility, the consent of the private facility to the enforcement of standards set by the executive director shall be a prerequisite to the designation or approval.

(2) Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer or professional person, and further stating that the officer or professional person believes as a result of his personal observations, or as a result of information obtained from others which he believes to be reliable, that the person is mentally ill and, as a result of mental illness, an imminent danger to others, or to himself, or gravely disabled. The application shall indicate when the person was taken into custody and who brought the person's condition to the attention of the officer or professional person. The application shall be kept on file by the seventy-two-hour treatment and evaluation facility for at least five years, and a copy shall be furnished to the person being evaluated.

(3) If the seventy-two-hour treatment and evaluation facility admits the person, it may detain him for evaluation and treatment for a period not to exceed seventy-two hours, excluding Saturdays, Sundays, and holidays if evaluation and treatment services are not available on those days. If, in the opinion of the professional person in charge of the evaluation, the person can be properly cared for without being detained, he shall be provided services on a voluntary basis.

(4) Each person admitted to a seventy-two-hour treatment and evaluation facility under the provisions of this article shall receive an evaluation as soon after he is admitted as

possible and shall receive such treatment and care as his condition requires for the full period that he is held. Such person shall be released before seventy-two hours have elapsed if, in the opinion of the professional person in charge of the evaluation, the person no longer requires evaluation or treatment. Persons who have been detained for seventy-two-hour evaluation and treatment shall be released, referred for further care and treatment on a voluntary basis, or certified for treatment pursuant to section 71-1-7.

71-1-6. Court-ordered evaluation for mentally ill persons. (1) Any person alleged to be mentally ill, and as a result of mental illness to be a danger to others or to himself, or to be gravely disabled may be given an evaluation of his condition under a court order pursuant to this section.

(2) Any individual may petition the court in the county in which the respondent resides or is physically present alleging that there is a person who appears to be mentally ill and, as a result of such mental illness, appears to be a danger to others, or to himself, or appears to be gravely disabled, and requesting that an evaluation of the person's condition be made.

(3) (a) The petition for a court-ordered evaluation shall contain the following:

(b) The name and address of the petitioner and his interest in the case;

(c) The name of the person for whom evaluation is sought, who shall be designated as the respondent, and, if known to the petitioner, the address, age, sex, marital status, and occupation of the respondent;

(d) Allegations of fact indicating that the respondent may be mentally ill, and, as a result, a danger to others or to himself, or gravely disabled, and showing reasonable grounds to warrant an evaluation;

(e) The name and address of every person known or believed by the petitioner to be legally responsible for the care, support, and maintenance of the respondent, if available;

(f) The name, address, and telephone number of the attorney, if any, who has most recently represented the respondent. If there is no attorney, there shall be a statement as to whether, to the best knowledge of the petitioner, the respondent meets the criteria established by the legal aid agency operating in the county or city and county for it to represent a client.

(4) Upon receipt of a petition satisfying the requirements of subsection (3) of this section, the court shall designate a

facility approved by the executive director, or a professional person, to provide screening of the respondent to determine whether there is probable cause to believe the allegations. The respondent shall be notified by the screening facility or professional person by means of a letter that a petition has been filed for an order for seventy-two-hour evaluation, and his cooperation shall be solicited. Such letter shall be personally delivered to the respondent, if possible.

(5) Following screening, the facility or professional person designated by the court shall file his report with the court. The report shall include a recommendation as to whether there is probable cause to believe that the respondent is mentally ill, and, as a result of mental illness, is a danger to others, or to himself, or gravely disabled, and whether the respondent will voluntarily receive evaluation or treatment. The screening report submitted to the court shall be confidential in accordance with section 20 of this article, and shall be furnished to the respondent or his attorney or personal representative.

(6) Whenever it appears, by petition and screening pursuant to this section, to the satisfaction of the court that probable cause exists to believe that the respondent is mentally ill, and, as a result of such mental illness, is a danger to others or to himself, or is gravely disabled, and that efforts have been made to secure the cooperation of the respondent, who has refused or failed to accept evaluation voluntarily, the court shall issue an order for evaluation authorizing a peace officer or a court-appointed professional person to take the respondent into custody and place him in a facility designated by the executive director for seventy-two-hour treatment and evaluation. At the time of taking the respondent into custody, a copy of the petition and the order for evaluation shall be given to the respondent, and promptly thereafter to anyone designated by such respondent, and to the professional person in charge of the seventy-two-hour treatment and evaluation facility named in the order or his designee.

(7) The respondent shall be evaluated as promptly as possible, and shall in no event be detained longer than seventy-two hours under the court order, excluding Saturdays, Sundays, and holidays if treatment and evaluation services are not available on those days. Within that time, the respondent shall be released, referred for further care and treatment on a voluntary basis, or certified for short-term treatment.

(8) At the time the respondent is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative is in possession of the respondent's personal property, the person taking him into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the

respondent.

71-1-7. Certification for short-term treatment. (1) (a) If a person detained for seventy-two hours under the provisions of section 71-1-5, or a respondent under court order for evaluation pursuant to section 71-1-6, has received an evaluation, he may be certified for not more than three months of short-term treatment under the following conditions:

(b) The professional staff of the agency or facility providing seventy-two-hour treatment and evaluation has analyzed the person's condition and has found the person is mentally ill, and, as a result of mental illness, a danger to others or to himself, or gravely disabled.

(c) The person has been advised of the availability of, but has not accepted, voluntary treatment; but if reasonable grounds exist to believe that the person will not remain in a voluntary treatment program, his acceptance shall not preclude certification.

(d) The facility which will provide short-tèrm treatment has been designated or approved by the executive director to provide such treatment.

(2) The notice of certification must be signed by a physician on the staff of the evaluation facility who participated in the evaluation. The certification shall be filed with the court within five days from the date of certification. The certification shall be filed with the court in the county in which the respondent resided or was physically present immediately prior to being taken into custody.

(3) Copies of the certification shall be personally delivered to the respondent and mailed to his attorney and the department, and a copy shall be kept by the evaluation facility as part of the person's record. The respondent shall also be asked to designate any other person whom he wishes informed regarding certification. If he is incapable of making such a designation at the time the certification is delivered, he shall be asked to designate such person as soon as he is capable. In addition to the copy of the certification, the respondent shall be given a written notice that a hearing upon his certification for short-term treatment may be had before the court or a jury upon written request directed to the court pursuant to subsection (6) of this section.

(4) Upon certification of the respondent, the facility designated for short-term treatment shall have custody of the respondent.

(5) Whenever a certification is filed with the court, the court shall forthwith appoint an attorney to represent the

respondent. The court shall determine whether the respondent is able to afford an attorney, and his choice of an attorney. The court may appoint that attorney. In the event the respondent is entitled to be represented by the legal aid agency operating in the county or city and county, such agency may be requested to assist in referral of the matter to private counsel or may be appointed to represent the respondent. The attorney representing the respondent shall be provided with a copy of the certification immediately upon his appointment.

(6) The respondent for short-term treatment, or his attorney, may at any time file a written request that the certification for short-term treatment or the treatment be reviewed by the court, or that the treatment be on an outpatient basis. If review is requested, the court shall hear the matter within ten days after the request, and the court shall give notice to the respondent and his attorney and the certifying and treating facility of the time and place thereof. The hearing shall be held in accordance with section 71-1-11. At the conclusion of the hearing, the court may enter or confirm the certification for short-term treatment, discharge the respondent, or enter any other appropriate order.

(7) Records and papers in proceedings under this section and section 71-1-8 shall be maintained separately by the clerks of the several courts. Upon the release of any respondent in accordance with the provisions of section 71-1-10, the facility shall notify the clerk of the court within five days of the release, and the clerk shall forthwith seal the record in the case and omit the name of the respondent from the index or indices of cases in such court until and unless the respondent becomes subject to an order of long-term care and treatment pursuant to section 71-1-9 or until and unless the court orders them opened for good cause shown. In the event a petition is filed pursuant to section 71-1-9, such certification record may be opened and become a part of the record in the long-term care and treatment case and the name of the respondent indexed.

71-1-8. Extension of short-term treatment. If the professional person in charge of the evaluation and treatment believes that a period longer than three months is necessary for treatment of the respondent, he shall file with the court an extended certification. No extended certification for treatment shall be for a period of more than three months. The respondent shall be entitled to a hearing on the extended certification under the same conditions as in an original certification. The attorney initially representing the respondent shall continue to represent that person, unless the court appoints another attorney.

71-1-9. Long-term care and treatment of the mentally ill. (1) (a) Whenever a respondent has received short-term treatment for five consecutive months under the provisions of sections

71-1-7 and 71-1-8, the professional person in charge of the evaluation and treatment may file a petition with the court for long-term care and treatment of the respondent under the following conditions:

(b) The professional staff of the agency or facility providing short-term treatment has analyzed the respondent's condition and has found that the respondent is mentally ill, and, as a result of mental illness, a danger to others or to himself, or gravely disabled.

(c) The respondent has been advised of the availability of, but has not accepted, voluntary treatment; but if reasonable grounds exist to believe that the respondent will not remain in a voluntary treatment program, his acceptance of voluntary treatment shall not preclude an order pursuant to this section.

(d) The facility which will provide long-term care and treatment has been designated or approved by the executive director to provide such care and treatment.

(2) Every petition for long-term care and treatment shall include a prayer for a hearing before the court prior to the expiration of six months from the date of original certification. A copy of the petition shall be delivered personally to the respondent for whom long-term care and treatment is sought, and mailed to his attorney of record and the department simultaneously with the filing thereof.

(3) Within ten days of receipt of the petition, the respondent or his attorney may request a jury trial by filing a written request therefor with the court.

(4) The court or jury shall determine whether the conditions of subsection (1) of this section are met, and whether the respondent is mentally ill, and, as a result, a danger to others or to himself, or gravely disabled. The court shall thereupon issue an order of long-term care and treatment for a term not to exceed six months, or it shall discharge the respondent for whom long-term care and treatment was sought, or it shall enter any other appropriate order. An order for long-term care and treatment shall grant custody of such respondent to the department for placement with an agency or facility designated by the executive director to provide long-term care and treatment.

(5) An original order of long-term care and treatment, or any extension of such order, shall expire upon the date specified therein, unless further extended as provided in this subsection (5). If an extension is being sought, the professional person in charge of the evaluation and treatment shall certify to the court at least thirty days prior to the expiration date of the order in force that an extension of such order is necessary for the care

and treatment of the respondent subject to the order in force, and a copy of such certification shall be delivered to the respondent and simultaneously mailed to his attorney of record and the department. At least twenty days before the expiration of the order, the court shall give written notice to the respondent and his attorney of record that a hearing upon the extension may be had before the court or a jury upon written request to the court within ten days after receipt of the notice. If no hearing is requested by the respondent within such time, the court may proceed ex parte. If a hearing is timely requested, it shall be held before the expiration date of the order in force. If the court or jury finds that the conditions of subsection (1) of this section continue to be met, and the respondent is mentally ill and as a result a danger to others or to himself, or gravely disabled, the court shall issue an extension of the order. Any extension shall be for a period of not more than one year, but there may be as many extensions as the court orders pursuant to this section.

71-1-10. Termination of short-term and long-term treatment - escape. (1) An original certification for short-term treatment under section 71-1-7 or an extended certification under section 71-1-8 or an order for long-term care and treatment or any extension thereof shall terminate as soon as, in the opinion of the professional person in charge of treatment of the respondent, the respondent has received sufficient benefit from such treatment for him to leave. Whenever a certification or extended certification is terminated under this section, the professional person in charge of the facility providing treatment shall so notify the court in writing within five days of such termination. Such professional person may also prescribe day care, night care, or any other similar mode of treatment prior to termination.

(2) Before termination, an escaped respondent may be returned to the hospital or facility by order of the court without a hearing, or by the superintendent of such hospital without order of court. After termination, a respondent may be returned to the institution only in accordance with the provisions of this article.

71-1-11. Hearing procedures - jurisdiction. (1) Hearings before the court under sections 71-1-7, 71-1-8, or 71-1-9, shall be conducted in the same manner as other civil proceedings before such court. The burden of proof shall be upon the person or facility seeking to detain the respondent.

(2) The court may appoint a professional person to examine the respondent for whom short-term treatment or long-term care and treatment is sought and to testify at the hearing before the court as to the results of his examination. Such court-appointed professional person shall act solely in an advisory capacity, and no presumption shall attach to his findings.

(3) Every respondent subject to an order for short-term treatment or long-term care and treatment shall be advised of his right to appeal such order by the court at the conclusion of any hearing as a result of which such an order may be entered.

(4) The court in which the petition is filed under section 71-1-6, or the certification is filed under section 71-1-7, shall be the court of original jurisdiction and of continuing jurisdiction for any further proceedings under this article. When the convenience of the parties and the ends of justice would be promoted by a change in the court having jurisdiction, the court may order a transfer of the proceeding to another county. Until further order, if any, of the transferee court, it shall be the court of continuing jurisdiction.

(5) All proceedings shall be conducted by the district attorney of the county where the proceeding is held, or by a qualified attorney acting for the district attorney, appointed by the district court for that purpose, except that, in any county or in any city and county having a population exceeding one hundred thousand persons, the proceedings shall be conducted by the county attorney or by a qualified attorney acting for the county attorney, appointed by the district court.

71-1-12. Appeals. Appellate review of any order of short-term treatment or long-term care and treatment may be had as provided in the Colorado appellate rules. Such appeal shall be advanced upon the calendar of the appellate court and shall be decided at the earliest practicable time. Pending disposition by the appellate court, it may make such order as it may consider proper in the premises relating to the care and custody of the respondent.

71-1-13. Habeas corpus. Any person detained pursuant to this article shall be entitled to an order in the nature of habeas corpus upon proper petition to any court generally empowered to issue orders in the nature of habeas corpus.

71-1-14. Restoration of rights. Any person who, by reason of a judicial decree entered by a court of this state prior to July 1, 1974, adjudicating such person mentally ill, shall, on July 1, 1975, be deemed to have been restored to legal capacity and competency unless, before July 1, 1975, a petition for the appointment of a guardian or conservator is filed with the court which entered the adjudication. The status of persons adjudicated mentally deficient prior to July 1, 1974, shall not be affected.

71-1-15. Discrimination. No person who has received evaluation or treatment under any provisions of this article shall be discriminated against because of such status. For purposes of this section, "discrimination" means giving any unfavorable weight to the fact of hospitalization or outpatient

care and treatment unrelated to a person's present capacity to meet standards applicable to all persons. Any person who suffers injury by reason of a violation of this section shall have a civil cause of action.

71-1-16. Right to treatment. (1) Any person receiving evaluation or treatment under any provisions of this article is entitled to medical and psychiatric care and treatment. The professional person in charge of the agency or facility providing evaluation, care, or treatment shall keep records detailing all care and treatment received by such person, and such records shall be made available, upon that person's written authorization, to his attorney or his personal physician. Such records shall be permanent records.

(2) (a) The department shall adopt regulations to assure that each agency or facility providing evaluation, care, or treatment shall require the following:

(b) Consent for specific therapies and major medical treatment in the nature of surgery. The nature of the consent, by whom it is given, and under what conditions, shall be determined by regulations of the department.

(c) The order of a physician for any treatment or specific therapy based on appropriate medical examinations;

(d) Notation in the patient's treatment record of periodic examinations, evaluations, orders for treatment, and specific therapies signed by personnel involved; and

(e) Conduct according to the guidelines contained in the regulations of the federal government and the department with regard to clinical investigations, research, experimentation, and testing of any kind.

71-1-17. Rights of persons receiving evaluation, care, or treatment. (1) (a) Each person receiving evaluation, care, or treatment under any provision of this article has the following rights and shall be advised of such rights by the facility:

(b) To receive and send sealed correspondence. No incoming or outgoing correspondence shall be opened, delayed, held, or censored by the personnel of the facility.

(c) To have access to letter writing materials, including postage, and to have staff members of the facility assist persons who are unable to write, prepare, and mail correspondence;

(d) To have ready access to telephones, both to make and to receive calls in privacy;

(e) To have frequent and convenient opportunities to meet

with visitors. Each person may see his attorney, clergyman, or physician at any time.

(f) To wear his own clothes, keep and use his own personal possessions, and keep and be allowed to spend a reasonable sum of his own money.

(2) A person's rights under subsection (1) of this section may be denied for good cause only by the professional person providing treatment. Denial of any right shall in all cases be entered into the person's treatment record. Information pertaining to a denial of rights contained in the person's treatment record shall be made available, upon request, to the person or his attorney.

(3) No person admitted to or in a facility shall be fingerprinted unless required by other provisions of law.

(4) A person may be photographed upon admission for identification and the administrative purposes of the facility. Such photographs shall be confidential and shall not be released by the facility except pursuant to court order. No other nonmedical photographs shall be taken or used without appropriate consent or authorization.

71-1-18. Employment of persons in a facility. The department shall adopt regulations governing the employment and compensation therefor of persons receiving care or treatment under any provision of this article. The department shall establish standards for reasonable compensation for such employment.

71-1-19. Voting in public elections. Any person receiving evaluation, care, or treatment under any provision of this article, shall be given the opportunity to exercise his right to register and to vote in primary and general elections. The professional person in charge of each agency or facility providing evaluation, care, or treatment shall assist such persons, upon their request, to obtain voter registration forms, applications for absentee ballots, and absentee ballots, and to comply with any other prerequisite for voting.

71-1-20. Records. (1) (a) All information obtained and records prepared in the course of providing any services under this article to individuals under any provision of this article shall be confidential and privileged matter. Such information and records may be disclosed only:

(b) In communications between qualified professional persons in the provision of services or appropriate referrals;

(c) When the recipient of services designates persons to whom information or records may be released; but if a recipient

of services is a ward or conservatee, and his guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the recipient, except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information which has been given to him in confidence by members of a patient's family;

(d) To the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to which he may be entitled;

(e) For research, if the department has promulgated rules for the conduct of research. Such rules shall include, but not be limited to, the requirement that all researchers must sign an oath of confidentiality.

(f) To the courts, as necessary to the administration of justice;

(g) To persons authorized by an order of court after notice and opportunity for hearing to the person to whom the record or information pertains and the custodian of the record or information pursuant to the rules of civil procedure.

71-1-21. Treatment in federal facilities. (1) If a person is certified under the provisions of this article, and is eligible for hospital care or treatment by an agency of the United States, and if a certificate of notification from said agency, showing that facilities are available and that the person is eligible for care or treatment therein, is received, the court may order said person to be placed in the custody of the agency for hospitalization. When any person is admitted pursuant to an order of court to any hospital or institution operated by any agency of the United States within or without this state, he shall be subject to the rules and regulations of the agency. The chief officer of any hospital or institution operated by an agency and in which the person is so hospitalized shall, with respect to the person, be vested with the same powers as the superintendent of the Colorado state hospital with respect to detention, custody, transfer, conditional release, or discharge of patients. Jurisdiction shall be retained in the appropriate courts of this state to inquire into the mental condition of persons so hospitalized, and to determine the necessity for continuance of their hospitalization.

(2) An order of a court of competent jurisdiction of another state, territory, or of the District of Columbia, authorizing hospitalization of a person to any agency of the United States, shall have the same effect as to said person while in this state as in the jurisdiction in which the court entering the order is situated; the courts of the state or district

issuing the order shall be deemed to have retained jurisdiction of the person so hospitalized for the purpose of inquiring into his mental condition and of determining the necessity for continuance of his hospitalization. Consent is hereby given to the application of the law of the state or district in which the court issuing the order for hospitalization is located, with respect to the authority of the chief officer of any hospital or institution operated in this state by any agency of the United States to retain custody, to transfer, to conditionally release, or to discharge the person hospitalized.

71-1-22. Transfer of persons into and out of Colorado. The transfer of persons hospitalized under the provisions of this article out of Colorado or under the laws of another jurisdiction into Colorado shall be governed by the provisions of the interstate compact on mental health.

71-1-23. Criminal proceedings. Proceedings under sections 71-1-5, 71-1-6, or 71-1-7 shall not be initiated or carried out involving a person charged with a criminal offense unless or until the criminal offense has been tried or dismissed; except that the judge of the court wherein the criminal action is pending may request the district or probate court to authorize and permit such proceedings.

71-1-24. Application of this article. The provisions of this article do not apply to or govern any proceedings commenced or concluded prior to July 1, 1974, with the exception of section 71-1-14. Any proceeding commenced prior to July 1, 1974, shall be administered and disposed of according to the provisions of law existing prior to July 1, 1974, in the same manner as if this article had not been enacted.

SECTION 2. 71-3-5 (1), Colorado Revised Statutes 1963 (1965 Supp.), is amended to read:

71-3-5. Superintendent - employees - reports - publications. (1) The department of institutions shall appoint pursuant to article XII, section 13 of the constitution of Colorado, a superintendent for the Colorado state hospital who shall be a physician, a graduate of an incorporated medical college, and shall have at least ten years' experience in the actual practice of his profession, and at least five years' actual experience in a hospital for the treatment of the ~~insane~~ MENTALLY ILL. ~~The superintendent shall give his entire time and attention to the discharge of his duties.~~

SECTION 3. Article 4 of chapter 71, Colorado Revised Statutes 1963, as amended, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

71-4-26. Definitions. "Mentally deficient person" means a person whose intellectual functions have been deficient since

birth or whose intellectual development has been arrested or impaired by disease or physical injury to such an extent that he lacks sufficient control, judgment, and discretion to manage his property or affairs or who, by reason of this deficiency, for his own welfare, or the welfare or safety of others, requires protection, supervision, guidance, training, control, or care. The terms "idiot", "feebleminded person", "mental incompetent", "mental defective", and "weak-minded person" shall hereafter be deemed to mean and be included within the term "mentally deficient person" within the present statutes of the state of Colorado, unless the context otherwise indicates a mentally ill person.

71-4-27. Adjudication of competency. If any reputable person files in the court by which a person has been adjudicated mentally deficient a written petition setting forth that the adjudicated person is no longer mentally deficient, supported by the certificate of a doctor licensed to practice medicine, said court shall immediately appoint two reputable doctors licensed to practice medicine to examine the adjudicated person at the place where he is then physically present and to report their findings to the court. In the event that he is confined at the time the petition is filed, at least one of said doctors appointed by the court shall not be associated with the institution wherein such person is confined. If from such examination it is found by the court that the person so adjudicated is no longer mentally deficient, the court shall forthwith enter an order of competency, a copy of which shall be forwarded to the department of institutions, and, if at such time the person is confined in an institution, he shall immediately be discharged therefrom.

71-4-28. Discharge by hospital. If, in the opinion of the superintendent or chief medical officer of a hospital, any person adjudicated and committed thereto is no longer mentally deficient, the superintendent or chief officer shall file in the court by which the person was adjudicated a verified statment setting forth that the person is no longer mentally deficient and should be discharged. The court may, on its own motion in such case, enter an order of competency.

71-4-29. Administrative discharge. (1) The superintendent or director of any state home and training school may issue a conditional release to any person under his control when he believes such release to be for the best interest of such person or society. Notice of such conditional release shall be filed in the court committing the person. If any such person, to whom there has been issued a conditional release, is not returned to said institution within a period of one year thereafter, or if any such person escapes from said institution and is not returned thereto within a period of one year thereafter, the name of such person shall be dropped from the roll of patients in said institution, and such person shall be administratively discharged; entry shall be made accordingly in the records of

said institution. At the time of such administrative discharge, the superintendent or director of such state home and training school shall notify, in writing, the court by which said person was committed and the department of institutions of such administrative discharge. The superintendent or director may, without further order of court, readmit any person conditionally released and not adjudicated competent.

(2) Before the issuance of an administrative discharge, an escaped person may be returned to the institution by order of the court without a hearing, or by the superintendent or director without order of court. After the issuance of an administrative discharge, a respondent may be returned to the institution only by order of the court, after proof of need of further institutional care.

SECTION 4. Repeal. 49-3-2 (2), 71-3-3, 71-3-4, and 71-3-6, Colorado Revised Statutes 1963, are repealed.

SECTION 5. Effective date. This act shall take effect July 1, 1974.

SECTION 6. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

John D. Vanderhoof
PRESIDENT
OF THE SENATE

John D. Fuhr
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Comfort W. Shaw
SECRETARY OF
THE SENATE

Lorraine F. Lombardi
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED _____

John A. Love
GOVERNOR OF THE STATE OF COLORADO

HOUSE BILL NO. 1279. BY REPRESENTATIVES Strahle, Strang, Safran, Smith, DeMoulin, Fuhr, Herzberger, Hinman, Koster, Lamm, Tempest, Valdez, Baer, Benavidez, Bendelow, Bishop, Boley, Carroll, Cooper, Dittemore, Eckelberry, Edmonds, Frank, Gallagher, Gaon, Gunn, Howe, Hybl, Kirscht, Kopel, Lloyd, Lucero, McNeil, Miller, Mullen, Munson, Pettie, Sears, Showalter, and Taylor; also SENATORS Stockton, Shoemaker, Allshouse, Bermingham, G. Brown, Cisneros, Cole, Darby, Jackson, Johnson, Locke, Minister, and Schieffelin.

CONCERNING ALCOHOLISM AND INTOXICATION TREATMENT, AND ENACTING THE "COLORADO ALCOHOLISM AND INTOXICATION TREATMENT ACT".

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Chapter 66, Colorado Revised Statutes 1963, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 45

Alcoholism and Intoxication Treatment

66-45-1. Legislative declaration. It is the policy of this state that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society. The general assembly hereby finds and declares that alcoholism and intoxication are matters of statewide concern.

66-45-2. Definitions. (1) As used in this article, unless the context otherwise requires:

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(2) "Alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted.

(3) "Approved private treatment facility" means a private agency meeting the standards prescribed in section 66-45-6 (1) and approved under section 66-45-6 (3).

(4) "Approved public treatment facility" means a treatment agency operating under the direction and control of or approved by the division of alcohol and drug abuse or providing treatment under this article through a contract with the division under section 66-45-5 (7) and meeting the standards prescribed in section 66-45-6 (1) and approved under section 66-45-6 (3).

(5) "Department" means the department of health.

(6) "Director" means the director of the division of alcohol and drug abuse.

(7) "Division" means the division of alcohol and drug abuse within the department established under section 66-1-2.

(8) "Emergency service patrol" means a patrol established under section 66-45-13.

(9) "Executive director" means the executive director of the department.

(10) "Incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment.

(11) "Incompetent person" means a person who has been adjudged incompetent by the district court.

(12) "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol.

(13) "Licensed physician" means either a physician licensed by the state of Colorado or a hospital-licensed physician employed by the admitting facility.

(14) "Treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation, and career counseling, which may be extended to

alcoholics and intoxicated persons.

66-45-3. Powers of division. (1) (a) To carry out the purposes of this article, the division may:

(b) Plan, establish, and maintain treatment programs as necessary or desirable;

(c) Make contracts necessary or incidental to the performance of its duties and the execution of its powers, including contracts with public and private agencies, organizations, and individuals to pay them for services rendered or furnished to alcoholics or intoxicated persons;

(d) Solicit and accept for use any gift of money or property made by will or otherwise and any grant of money, services, or property from the federal government, the state, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant;

(e) Administer or supervise the administration of the provisions relating to alcoholics and intoxicated persons of any state plan submitted for federal funding pursuant to federal health, welfare, or treatment legislation;

(f) Coordinate its activities and cooperate with alcoholism programs in this and other states and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(g) Keep records and engage in research and the gathering of relevant statistics;

(h) Do other acts and things necessary or convenient to execute the authority expressly granted to it;

(i) Acquire, hold, or dispose of real property, or any interest therein, and construct, lease, or otherwise provide treatment facilities for alcoholics and intoxicated persons.

66-45-4. Duties of division. (1) (a) In addition to duties prescribed by section 66-36-2, the division shall:

(b) Develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;

(c) Coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(d) Utilize community mental health centers and clinics whenever feasible;

(e) Cooperate with the department of institutions in establishing and conducting programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in appropriate agencies and institutions and for alcoholics and intoxicated persons in or on parole from correctional institutions; and in carrying out duties specified under paragraphs (j) and (l) of this section;

(f) Cooperate with the department of education, schools, police departments, courts, and other public and private agencies, organizations, and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons and preparing curriculum materials thereon for use at all levels of school education;

(g) Prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(h) Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(i) Organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(j) Sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons and serve as a clearinghouse for information relating to alcoholism;

(k) Specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(l) Advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the state's comprehensive health plan;

(m) Review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation and

advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(n) Assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in this state;

(o) Utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(p) Cooperate with the state department of highways in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while under the influence of, or impaired by, alcohol;

(q) Encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(r) Encourage all health and disability insurance programs to include alcoholism as a covered illness;

(s) Submit to the governor an annual report covering the activities of the division.

66-45-5. Comprehensive program for treatment - regional facilities. (1) The division, with the advice and recommendations of the advisory council pursuant to section 66-36-8, shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons.

(2) (a) Insofar as funds available to the division will permit, the program of the division shall include all of the following:

(b) Emergency treatment;

(c) Inpatient treatment;

(d) Intermediate treatment;

(e) Outpatient and follow-up treatment.

(3) The division shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 66-45-9 to 66-45-12. Treatment may not be provided at a correctional institution except for inmates.

(4) The division shall maintain, supervise, and control all facilities operated by it subject to policies of the department.

The administrator of each facility shall make an annual report of its activities to the director in the form and manner the director specifies.

(5) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(6) The director shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities.

(7) The division may contract for the use of any facility as an approved public treatment facility if the director, subject to the policies of the department, considers this to be an effective and economical course to follow.

66-45-6. Standards for public and private treatment facilities - enforcement procedures - penalties. (1) The division shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility and fix the fees to be charged for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

(2) The division periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(3) The division shall maintain a list of approved public and private treatment facilities.

(4) Each approved public and private treatment facility shall file with the division, on request, data, statistics, schedules, and information the division reasonably requires. An approved public or private treatment facility that fails without good cause to furnish any data, statistics, schedules, or information, as requested, or files fraudulent returns thereof shall be removed from the list of approved treatment facilities.

(5) The division, after hearing, may suspend, revoke, limit, restrict, or refuse to grant an approval for failure to meet its standards.

(6) The district court may restrain any violation of, review any denial, restriction, or revocation of approval under, and grant other relief required to enforce the provisions of this section.

(7) Upon petition of the division and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the division authorizing him to enter and inspect at reasonable times, and

examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the division or which the division has reasonable cause to believe is operating in violation of this article.

66-45-7. Acceptance for treatment - rules. (1) The director shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In establishing the rules the director shall be guided by the following standards:

(a) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(b) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

(c) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(d) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(e) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

66-45-8. Voluntary treatment of alcoholics. (1) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he or a parent, legal guardian, or other legal representative may make the application.

(2) Subject to rules adopted by the director, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(3) If a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the division shall arrange for assistance in obtaining supportive services and residential facilities.

66-45-9. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (1) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated and to be in need of help may be assisted to his home, an approved public treatment facility, an approved private treatment facility, or other appropriate facility by the police or the emergency service patrol.

(2) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available, he shall be taken to an emergency medical service, or such other facility as may be necessary to protect his health and safety, customarily used for incapacitated persons. If neither an approved public treatment facility nor an emergency medical service is available, he may be detained in a jail or similar facility, but only for so long as may be necessary to prevent injury to himself or others or to prevent a breach of the peace. The police or the emergency service patrol, in detaining the person, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

(3) A person who comes voluntarily or is brought to an approved public treatment facility may be examined by a licensed physician as soon as possible. He may then be admitted as a patient or referred to another health facility.

(4) A person who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission may not be detained at the facility once he is no longer incapacitated by alcohol or if he remains incapacitated by alcohol, for more than one hundred twenty hours after admission as a patient, unless he is committed under section 66-45-10. A person may consent to remain in the facility as long as the physician in charge believes it appropriate.

(5) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds may be taken to his home, if any. If he has no home, the approved public treatment facility may assist him in obtaining shelter.

(6) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified

as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

(7) The police or members of the emergency service patrol who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable therefor.

(8) If the administrator in charge of the approved public treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

66-45-10. Emergency commitment. (1) An intoxicated person who has threatened or attempted to inflict or inflicted physical harm on another and is likely to inflict physical harm on another unless committed or who is incapacitated by alcohol may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(2) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment.

(3) Upon approval of the application by the administrator in charge of the approved public treatment facility, the person shall be brought to the facility by a peace officer, a health officer, the emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted or transferred to another appropriate public or private treatment facility until discharged, as provided in subsection (5) of this section.

(4) The administrator in charge of an approved public treatment facility shall refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(5) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than five days. If a petition for involuntary commitment under section 66-45-11 has been filed within the five days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until

the petition has been heard and determined, but no longer than ten days after filing the petition.

(6) A copy of the written application for commitment and of the physician's certificate and a written explanation of the person's right to counsel shall be given to the person within twenty-four hours after commitment by the administrator. Such person shall be permitted to consult with counsel at any time.

66-45-11. Involuntary commitment of alcoholics. (1) A person may be committed to the custody of the division by the district court upon the petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he has threatened or attempted to inflict or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another or that he is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition.

(2) Upon filing the petition, the court shall fix a date for a hearing no later than ten days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, one of his parents or his legal guardian if he is a minor, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(3) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall be present unless the court believes that his presence is likely to be injurious to him; in this event, the court shall appoint a guardian ad litem to represent him throughout the proceeding. The court shall examine the person in open court or, if advisable, shall examine the person out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to be examined by a court-appointed licensed physician. If he refuses and there is sufficient evidence to believe that the allegations

of the petition are true or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the division for a period of not more than five days for purposes of a diagnostic examination.

(4) If after hearing all relevant evidence, including the results of any diagnostic examination by the division, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, it shall make an order of commitment to the division. It may not order commitment of a person unless it determines that the division is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

(5) A person committed as provided in this section shall remain in the custody of the division for treatment for a period of thirty days unless sooner discharged. At the end of the thirty-day period, he shall be discharged automatically unless the division, before expiration of the period, obtains a court order for his recommitment upon the grounds set forth in subsection (1) of this section for a further period of ninety days unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the division shall apply for recommitment if after examination it is determined that the likelihood still exists.

(6) A person recommitted as provided in subsection (5) of this section who has not been discharged by the division before the end of the ninety-day period shall be discharged at the expiration of that period unless the division, before expiration of the period, obtains a court order on the grounds set forth in subsection (1) of this section for recommitment for a further period not to exceed ninety days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the division shall apply for recommitment if after examination it is determined that the likelihood still exists. Only two recommitment orders under subsection (5) of this section and this subsection (6) are permitted.

(7) Upon the filing of a petition for recommitment under subsections (5) and (6) of this section, the court shall fix a date for hearing no later than ten days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection (1) of this section if different from the petitioner for recommitment, one of his parents or his legal guardian if he is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (3) of this section.

(8) The division shall provide for adequate and appropriate

treatment of a person committed to its custody. The division may transfer any person committed to its custody from one approved public treatment facility to another if transfer is medically advisable.

(9) (a) A person committed to the custody of the division for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(b) In case of an alcoholic committed on the grounds that he is likely to inflict physical harm upon another, that he no longer has an alcoholic condition which requires treatment or the likelihood no longer exists; or

(c) In case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer appropriate.

(10) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, to be represented by counsel at every stage of any proceedings relating to his commitment and recommitment, and to have counsel appointed by the court or provided by the court if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(11) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

(12) A person committed under this article may at any time seek to be discharged from commitment by an order in the nature of habeas corpus.

(13) The venue for proceedings under this section is the county in which the person to be committed resides or is present.

66-45-12. Records of alcoholics and intoxicated persons. (1) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(2) Notwithstanding subsection (1) of this section, the

director may make available information from patients' records for purposes of research into the causes and treatment of alcoholism. Information under this subsection (2) shall not be published in a way that discloses patients' names or other identifying information.

66-45-13. Visitation and communication of patients. (1) Patients in any approved treatment facility shall be granted opportunities for continuing visitation and communication with their families and friends consistent with an effective treatment program. Patients shall be permitted to consult with counsel at any time.

(2) Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. The director may adopt reasonable rules regarding the use of the telephone by patients in approved treatment facilities.

66-45-14. Emergency service patrol - establishment - rules. (1) The division and cities, counties, cities and counties, and regional service authorities may establish emergency service patrols. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall be authorized to transport intoxicated persons to their homes and to and from public treatment facilities.

(2) The director shall adopt rules for the establishment, training, and conduct of emergency service patrols.

66-45-15. Payment for treatment - financial ability of patients. (1) If treatment is provided by an approved public treatment facility and the patient has not paid the charge therefor, the division is entitled to any payment received by the patient or to which he may be entitled because of the services rendered and from any public or private source available to the division because of the treatment provided to the patient.

(2) A patient in an approved treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability is liable to the division for the cost of maintenance and treatment of the patient therein in accordance with rates established.

(3) The director shall adopt rules governing financial ability that take into consideration the income, savings and other personal and real property of the person required to pay, and any support being furnished by him to any person he is required by law to support.

66-45-16. Criminal laws limitations. (1) No county,

municipality, or other political subdivision may adopt or enforce a local law, ordinance, resolution, or rule having the force of law that includes drinking, being a common drunkard, or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction.

(2) No county, municipality, or other political subdivision may interpret or apply any law of general application to circumvent the provisions of subsection (1) of this section.

(3) Nothing in this article affects any law, ordinance, resolution, or rule against drunken driving, driving under the influence of alcohol, or other similar offense involving the operation of a vehicle, an aircraft, or a boat or machinery or other equipment or regarding the sale, purchase, dispensing, possessing, or use of alcoholic beverages at stated times and places or by a particular class of persons.

(4) The fact that a person is intoxicated or incapacitated by alcohol shall not prevent his being arrested or prosecuted for the commission of any criminal act or conduct not enumerated in subsection (1) of this section.

(5) Nothing in this article shall be construed as a limitation upon the right of a police officer to make an otherwise legal arrest, notwithstanding the fact that the arrested person may be intoxicated or incapacitated by alcohol.

SECTION 2. Repeal. 40-9-112, Colorado Revised Statutes 1963 (1971 Supp.), is repealed.

SECTION 3. Effective date. This act shall take effect July 1, 1974.

SECTION 4. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

John D. Fuhr
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

John D. Vanderhoof
PRESIDENT
OF THE SENATE

Lorraine F. Lombardi
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Comfort W. Shaw
SECRETARY OF
THE SENATE

APPROVED _____

John A. Love
GOVERNOR OF THE STATE OF COLORADO