division of mental health

department of institutions

MASTER PLAN

1974–1975

2nd edition

Richard D. Lamm
Governor
1975 -

Raymond Leidig, M. D.
Executive Director
Department of Institutions

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DIVISION OF MENTAL HEALTH

COLORADO DEPARTMENT OF INSTITUTIONS

Harl H. Young, Ph. D.
Director, Division of Mental Health

Submitted by:
Division of Mental Health
1974 - 75 Master Planning Committee

Morton Flax, Chairman
Vicki Agee
Karen Cutler
J. Gary May
Terrence McGrann
Nancy C. Wilson

December 1974

DEPARTMENT OF INSTITUTIONS
RAYMOND LEIDIG, M.D. Executive Director
DIVISION OF MENTAL HEALTH
HARL H. YOUNG, Ph.D. Director
4150 South Lowell Boulevard
Denver, Colorado 80236
Telephone: (303) 761-0220

RICHARD D. LAMM
GOVERNOR

February 11, 1975

Dear Reader:

The 1973 Master Planning document was received with acclaim. For many reasons the acclaim was well deserved. We invited critical comments from all over the state and we received many responses from a wide spectrum of public opinion. Some of the major criticisms were:

1. Services to children and youth were not sufficiently addressed.

2. The document did not contain a detailed capital construction plan.

3. There was insufficient planning between the Division of Corrections and the Division of Mental Health for clients with problems in both areas.

4. The roles of the elements within the mental health system, i.e., clinics, centers, and hospitals, were not presented in sufficient detail.

5. There was little input into the planning process from the private voluntary sector, and privately practicing mental health professionals.

6. The planning input was limited to the mental health establishment.

7. The well-known difficulties in coordinating the services provided in the four catchment areas of the City and County of Denver were not addressed.

8. The much discussed Vanderhoof-Petrone plan for reorganization of state government and the proper place of the Division of Mental Health within the reorganization was not studied and, therefore, no recommendations were made in this area.

The reader will recall each year half the Master Planning Committee membership is replaced and thus a new group is constituted with the annual task of updating and improving, if possible, the planning document. It is safe to say that the new group (whose names are listed on the preceding page) took their review of the old plan and the ensuing criticisms very seriously. After a great deal of discussion, the committee felt that the magnitude and complexity of a complete revision of last year's plan, which would also be responsive to the criticisms received, would be an overwhelming task. Therefore, the committee decided to concentrate its efforts in three major areas. The first area involved a complete revision of the goals and objectives previously set forth, together with an expansion into new areas where the committee thought desirable. The second major area was to rewrite in greater detail the role statements of the various elements of the mental health system. The third major area was to conduct a community survey, hopefully including a large segment of non-mental health professionals or board members who would have a better perspective on mental health priorities in relation to other local needs.

The implications of these decisions by the committee to limit the scope of its work are two-fold:

1. This document should be used in conjunction with the 1973 volume. That is to say, some sections of the 1973 plan remain in force, most notably the sections on statewide plans and regional plans, pages 35-93.

2. Several of the criticisms of the earlier document have not been addressed and must be addressed by the new committee. For example, the section on structure of the Colorado mental health delivery system was not addressed and thus must be updated next year.

A final point - this year's committee, I think, made a wise decision in deferring a review of the complex problems within the Denver area to a later date. An independent group under the aegis of the Mental Health Association of Colorado and the Mile High United Way has worked diligently to put together a plan for the Denver area. This plan has been approved by Dr. Abraham Kauvar, the Manager of Health and Hospitals, Mrs. Fletcher Gaylord, the Mental Health Association of Colorado representative, myself, and the Joint Budget Committee. It is a good start in resolving the problems of the Denver area. Tentatively, this plan should be considered a part of the Divisional Master Plan and be given a chance to work for the coming year. It should be reviewed, of course, by the Master Planning Committee following a year's experience.

In closing, I want to offer my personal congratulations and gratitude to the present committee. They have labored hard and brought forth a meritorious product.

Not many groups demonstrate their dedication for their commitment to a quality product as this one has done by, among other things, holding meetings starting at 6:30 am. My special thanks go to the retiring members of the committee this year, Dr. Mort Flax, Chairman, Ms. Nancy Wilson, and Mr. Terry McGrann.

Sincerely yours,

Harl H. Young, Ph.D.
Director, Division of Mental Health

HHY:dd

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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, 95 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 several 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 one and one-half decades 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 now reduced to approximately 1,300 individuals at any given time in the state-supported mental health system.

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 9 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.

The Director of the Division of Mental Health created a Master Planning Committee in the early part of 1972. Instructions to the committee were to

modify and amplify the mental health section of the existing Department of Institutions Master Planning Program. The committee chose to expand that charge and developed a comprehensive document - the 1973 Master Plan. A long range master plan must be a changing document. Therefore, the 1974-75 edition modifies and updates critical portions of the previous plan and sets forth new goals, objectives, issues, and concerns. The plan should enable the Division of Mental Health to prepare for the changing and increasing demands for service. The Master Plan should provide insight into the development of the mental health system in Colorado as it strives to become a more unified and integrated system. The 1974-75 document was developed by committee members who represent various components of the mental health system plus a professional planner. The members are:

Vicki Agee, Ph.D., Director, Closed Adolescent Treatment Center, Office of Youth Services.

Karen Cutler, M.A., Senior Planner, Mile High United Way.

Morton Flax, Ph.D., Chairman; Director, Aurora Mental Health Center.

J. Gary May, M.D., Child Psychiatrist, Colorado Psychiatric Hospital; Private practice.

Terrence J. McGrann, ACSW, Assistant to the Clinical Director, Colorado State Hospital.

Nancy Wilson, R.N., M.A., Senior Research Associate, Fort Logan Mental Health Center.

PHILOSOPHY

Mental health can be considered as freedom from serious emotional or mental distress and conflict. When such a state exists within individuals, they are more likely to experience productive, satisfying and fulfilling lives in harmony with other persons and the society in which they live.

The basic philosophy of the Division of Mental Health, Colorado Department of Institutions, is to promote mental health by providing a range of services to the citizens of Colorado which are intended to combat mental distress. These services include direct treatment, consultation, education, and research.

The Division of Mental Health strongly supports the concept that service should be made available to all citizens requiring them; that a system which pursues this goal includes providers of service from the public, private, and voluntary sectors.

These elements of a total delivery system which are state administered or assisted, must be integrated, and this can only be achieved through strong and aggressive leadership at the divisional level. An integrated system requires the assignment of definite and specific responsibilities to the various elements within the system and accountability by these same elements to a higher authority. In addition, cooperation and coordination must exist between a state-supported mental health network and other providers of service, the latter comprised of agencies and groups which function under private and voluntary auspices.

While integration of the state mental health system is necessary, it is equally important that all divisions of the Department of Institutions function in close cooperation with each other. Continuous communication is essential, and at times, joint planning is necessary. Each division of the Department possesses areas of expertise which should be shared with the others.

It is the conviction of the Division of Mental Health that while services should be available to all citizens, when possible individuals also maintain the basic right to accept or refuse these services. In addition, the individual has the right to seek assistance for mental health problems through agencies most acceptable and convenient. It is also recognized that availability means that services should be provided, when possible, in the language and cultural context most appropriate to the client.

As programs are considered, planned, and implemented the Division of Mental Health and the various system components should be responsive to information provided by community residents, and no planning should be conducted in isolation of the designated population to be served.

The following are additional concepts essential to the philosophy of the Division of Mental Health.

First --Once a need has been determined, services designed to meet the need should be readily accessible to potential recipients, agencies, or other appropriate groups.

Second --Mental health services should be provided on the basis of greatest need. The division has the responsibility for assessing need, with input from all interested parties. It is recognized that needs or problems do not remain static; on the contrary, they change completely or in degree of intensity. For services to remain meaningful and effective, the Division of Mental Health must respond quickly to these changes.

Third --The system should insure that mental health services are provided which are acceptable and useful to its clients. Special needs of special target groups, including minorities, must be addressed.

Fourth --The Division of Mental Health has the responsibility to coordinate the delivery of the various existing services

and to provide leadership and direction to institutions and agencies in the development of new programs which are required.

Fifth --The mental health system should provide programs of consultation to other agencies and groups such as law enforcement, schools, the clergy, etc., as a method of supporting the efforts of these various providers of service.

Sixth --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.

Goal 1

Develop an Integrated Mental Health Service Delivery System

Issues and Concerns

The basic challenge of the service delivery system is to provide quality, effective mental health service to all citizens of the state at a reasonable cost. The Division of Mental Health has responsibilities to develop the fabric of care which extends to the mental health needs of state citizens, does not needlessly duplicate existing services or become so costly as to produce inefficient results for the dollar spent.

A major challenge is to provide care to those citizens who, by geographical circumstances, are far removed from the centers of care. The quantity and diversity of services available in the Denver, Colorado Springs, and Pueblo areas are in contrast to the paucity of services available in more remote areas of the state. On the other hand, although urban areas have a wide variety of services, there is often duplication, insufficient personnel, problems of overlap, and gaps which require careful planning.

The Division of Mental Health has a responsibility to provide mental health services to the citizens of the state. In the past, this has been the primary role of the state hospitals, but recently some of this function is being assumed by the community mental health centers and clinics. While the Division of Mental Health maintains direct responsibility for the operation of the state hospitals, it also has an ongoing responsibility for the development and maintenance of standards for the operation of the community mental health centers and clinics. The Division of Mental Health also has the responsibility to assure the provision of mental health services through purchase of service agreements, should such services not be available in the existing system.

The Division of Mental Health must also work cooperatively with other

health, education and welfare agencies in the public, private and voluntary sectors to coordinate services and programs for interrelated mental health concerns. While the division does not directly control or dictate the programs of other agencies, it must coordinate the integration of services.

The Division of Mental Health has responsibility to plan for the future delivery of service. This planning, although it affects the operation of the division directly, has many implications for all involved in the care of the mentally disturbed and all who plan for the prevention of mental health problems.

Previous 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.

Current Progress

A. Objective A, requiring an initial plan for assignment of responsibility within regions, has been accomplished.

B. Objective B, requiring the development of a mental health information system plan to make data available regarding all components, has also been accomplished. (See additional information in Goal 6 regarding the management information system.)

C. Objective C, referring to a cooperative working relationship between Colorado Psychiatric Hospital and the Department of Institutions, is in progress.

D. Objective D has not been accomplished.

E. Objective E, regarding the four Regional Mental Health Coordinators,

is incomplete. Four coordinator positions were funded by the legislature. One position is now in the process of being filled, inasmuch as the incumbent recently accepted another position.

F. Objective F is in progress.

G. Objective G is in progress.

Revised Objectives

Objective A. By July, 1975 there will be four Regional Mental Health Coordinators who will provide consultation in management, clinical, and program planning for the mental health agencies in their regions. Regional coordinators also will serve as policy interpretors for the central office for the programs in their regions.

Comments and Recommendations: As noted in Current Progress, this objective remains incomplete. The role of the regional coordinator in facilitating an integrated system cannot be overemphasized. This person serves as the communication link between the region and the central office.

It should be noted that several states have expanded the role of the regional coordinators to that of decentralized deputy directors of mental health for their regions. They would be responsible to the state director of mental health and would carry out all the functions of the central office on an area-wide, regional basis. This decentralized function may serve a useful role in the future in Colorado. It is not recommended immediately, but in planning over the next ten years it may become a major approach to management. Presently, it is considered too costly, requiring many more state and regional level staff and a more sophisticated service system than currently exists.

The date of implementation for this objective has been reluctantly changed by the Master Plan Committee. It is the committee's intent that this objective should receive priority in 1975. Delay past this deadline will

present many problems in the implementation of the rest of the Master Plan.

Objective B. By July 1975, there will be a plan for the collaborative and cooperative working relationship between Colorado Psychiatric Hospital and the mental health programs under contract with or controlled by the Department of Institutions

Comments and Recommendations: Colorado Psychiatric Hospital (including the affiliated Veterans Administration facilities) is the primary inpatient teaching facility for the University of Colorado Medical Center. Although its teaching function cannot be divorced from providing service, its primary mission will remain teaching and research. The outstanding national reputation of the Department of Psychiatry of the University of Colorado is linked to the quality of its psychiatric services. The fact that Colorado has a high per capita ratio of well-trained, American born psychiatrists is related to that training reputation.

Colorado Psychiatric Hospital is in the process of change. Its inpatient service will move to a smaller physical plant (in the Colorado General Hospital) by spring, 1975.

Cooperative relationships exist among Colorado Psychiatric Hospital, the Division of Mental Health and the community mental health centers. Colorado Psychiatric Hospital is utilized as an intensive short-term treatment facility which augments and compliments the programs of the community mental health centers.

The Colorado Psychiatric Hospital program now serves the entire state and could do so more effectively if transportation were more available. It can serve as a source of consultation and diagnostic study for complex problems requiring highly specialized techniques or skills, e.g., such as psychoneurological problems, severe psychophysiological disorders, unusual or rare diagnoses, unusual teaching cases, or those suitable for potential research

programs. Colorado Psychiatric Hospital also serves as an emergency care facility for the metropolitan area with a well organized and active psychiatric emergency service at Colorado General Hospital. The adolescent ward has functioned as an acute hospitalization facility and has served patients from many areas of the state.

Discussion should continue between Colorado Psychiatric Hospital and the directors of the state hospitals, community mental health centers and regional mental health agencies regarding effective and proper utilization of Colorado Psychiatric Hospital as an adjunct to the hospital and community program. The delay in one year of the implementation of the objective is proper, considering the changes taking place at Colorado Psychiatric Hospital which will affect its program. The close working relationship between the Division of Mental Health and the University of Colorado, Department of Psychiatry, is desirable and progress in that direction is further described under Goal 10.

Objective C. By July 1975, the Division of Mental Health will implement a plan to insure optimum opportunity for input from the various components of the mental health system, plus a forum for comprehensive information sharing on an ongoing basis.

Comments and Recommendations: The Division of Mental Health has been aware of the problems associated with this particular recommendation, and properly points out that they have been making considerable effort to gain input from various sources. It would be useful to increase periodic meetings with board presidents, regional meetings,and other approaches. There is a clear distinction between receiving input and stimulating discussion and the fact that the director of the Division of Mental Health and his designees have the ultimate responsibility for decisions regarding policy and implementation of that policy.

Objective D. By July 1975, a plan will be developed to facilitate the exchange of expertise, personnel, and services among the mental health system components operated by or contracted with the Division of Mental Health.

Comments and Recommendations: This objective can do a great deal to upgrade current facilities. It gives employees within the system an opportunity to exchange ideas and develop some understanding of and empathy with the other components of the system. The exchange process can often be very stimulating to those involved and do a great deal to integrate and upgrade the mental health delivery system.

Objective E. By January 1976, the first draft of a systems procedures manual will be available for review by components of the mental health services delivery system.

Comment: This manual will help each of the centers, clinics, and hospitals set up a formalized system to assist in the operation of their programs and work with their respective boards and committees.

Objective F. By January 1976, 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.

Comment: The traditional separation of the private practice sector and the state mental health system is changing. Although many individual private practitioners have been involved in the development of the state system. There is now a need to more fully develop a system of interaction between the two. This may be encouraged by a variety of fiscal arrangements such as

fee for service contracts, retainers, inservice training agreements, consulting services and the like.

Goal 2

Bring the Total Mental Health Services Delivery System to an Optimal Level of Functioning as Defined by State Standards

Issues and Concerns

Control is inherent in the state's authority to allocate funds. The opportunity to demonstrate creative leadership and to be a catalyst for the development of a state mental health system lies within the criteria which are utilized for resource deployment. Clear, comprehensive state standards for all components of the mental health delivery system are needed to insure integration of services, high quality care, and optimal use of resources. The improvement of standards will be pivotal in the future relationship of the central office to other components of the delivery system. Translated into contractual agreements between the state and providers of service, standards are not only the contingency for the receipt of funds, but perhaps the most important leverage with which to effect accountability and renewal of the delivery system.

The challenge is to initiate standards which will move all elements of the system in the direction of integration without unduly sacrificing individual growth. Standards must emerge which stimulate performance but are not so rigid as to divest service agencies of the flexibility to respond quickly to changing local conditions and opinions. Nationwide systems of quality control are emerging through Quality Assurance Programs (QAP) and Professional Standards Review Organizations (PSRO). Eventually, all hospitals and community mental health centers and clinics will be monitored under one of these or similar programs. In the interim, the continued development of state standards is closely tied to other accountability mechanisms - statewide needs assessment information and adequate criteria of performance evaluation.

Other prerequisites to effective standards include adequate definitions of the respective roles of centers, clinics, and hospitals, plus a clarification of the meaning of quality care which lends itself to quantification and application throughout the system.

In summary, the Division of Mental Health can best monitor the performance of facilities peripheral to the central office (i.e. community mental health centers, clinics, and hospitals in the future) through the refinement and enforcement of standards and regulations.

Previous 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 1976, the first edition of the State Standards for Licensure of Community Mental Health Centers will be revised to include official 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 1976, 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.

Current Progress

The Division of Mental Health requested that Objective A be retargeted involving individual written treatment plans for 1975. A disaster plan has been developed for Region III and a preliminary disaster response plan for the Division of Mental Health is now in effect. It is hoped that great improvement can be made in it after one year's experience. No change in progress towards Goals B, C, and E is reported. Later target dates were also requested for Objectives D, F, and G.

Revised Objectives

Objective A. By January 1976, there will be an individual written treatment plan for each client in the mental health services delivery system.

Comments and Recommendations: It is with considerable concern that the Master Plan Committee changes the date for this objective from January 1974 to January 1976. It is considered by this committee to be tantamount to adequate clinical care that individual written treatment plans be developed for each client in the near future. This is seen as a high priority objective and one which should receive the full attention of every element of service within the state mental health system. The importance of the individual written treatment plan in terms of offering solid evidence of care, appropriate documentation, and being a necessity for accreditation cannot be denied.

Objective B. By July 1975, 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 1976-77 Department of Institutions budget requests.

Comments and Recommendations: Without the necessary flexibility in the present funding mechanism, it is imperative that the various components within the mental health system have the ability to develop innovative and new programs. Obviously, it is impossible for each center, clinic, and hospital to devote or set aside a portion of their budget for projects which might be both time-consuming and expensive. Therefore, by the establishment of pilot programs, the Division of Mental Health can see the fruition of projects which are relatively low-cost and can be strategically placed around the state in areas of need. The results of these projects are models which can be modified, amplified, and adapted to other programs.

Many of the existing alternatives to hospitalization and 24-hour care in Region III developed from the model project and experience of Fort Logan.

As the inflationary spiral continues and the demand for direct service increases, the program managers find it increasingly difficult to reorder their priorities to meet these demands. Without direction and leadership from the Department of Institutions, along with the necessary funding to stimulate special pilot projects, many of these innovations will not be implemented.

It is the recommendation of the Master Planning Committee that this objective be included in each new Master Plan edition to allow centers 1) to spend time to develop long range programs, not "crash" projects; 2) to allow a series of pilot projects aimed at the cost containment and innovative high quality treatment programs to be funded in various areas around the state. This should be based on need, expertise, and local support, not on previous participation in pilot programs.

Objective C. By July 1975, 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 (House Bill 1164, 1973).

Comments and Recommendations: Many of the mental health centers and clinics around the state have endeavored to establish contact with the local school districts in their service area. However, the school districts, under the mandate of House Bill 1164, must provide a great deal of direct service. This requires highly trained manpower with knowledge of educational and remedial techniques as well as diagnostic capabilities. Preventive and early intervention mental health services require this and more. This does not mean that the school personnel themselves are being asked to become mental health professionals but, rather, that they integrate those skills and training techniques, which are part of their background, into a new and emerging model. The overriding issue, however, still remains how to most expeditiously meet the consultation and education needs of the school system plus develop an early intervention program.

Objective D. By July 1975, there will be an improved mental health disaster plan for psychological first aid to victims of major disasters.

Comments and Recommendations: Region III (metropolitan Denver) through the Metropolitan Mental Health Planning Council, has worked very closely with such agencies as the Civil Defense and the regional office of HEW to develop a mental health plan to assist victims of major disasters. This plan is now in its final stages and has been tested. This prototype, although primarily designed for metropolitan Denver, can be utilized in other regions of the state, providing that adequate training, education, and time are invested by the local communities

and/or regions. The Division of Mental Health should be responsible for coordinating all of the various mental health agencies, enabling them to work together in a smooth, organized, collaborative way.

Objective E. By January 1976, the first edition of the State Standards for Licensure of Community Mental Health Centers will be revised to include standards for quality of care in centers and clinics, and standards for appropriate planning at all levels.

Comments and Recommendations: By January of 1976 the first edition of the State Standards for Licensure of Community Mental Health Centers will be revised to include standards for appropriate planning at all levels. The role of the Division of Mental Health as a standard and regulation promulgating and review body appears to be accepted as the major vehicle for offering assurance to the citizen, taxpayer, and legislator of the State of Colorado that the community mental health centers are indeed doing a proper and thorough job. Such standards should eventually be associated with continuation of state funding with such funding being contingent upon the proper maintenance of standards by the community mental health centers and clinics. It is also strongly recommended that the community mental health centers have representation and input into the future standards which are developed.

Objective F. By July 1975, there will be a quality assurance program in effect in both state hospitals.

Comments and Recommendations: The Colorado State Hospital has developed an ongoing quality assurance program that includes review of the appropriateness of admission, length of stay, quality of records, and appropriateness of treatment.

Fort Logan has a sophisticated pilot program of assessment of treatment effectiveness and a program of record review. There is also a project to develop

a model for cost effectiveness assessment. Further progress with the quality assessment program is anticipated over the next year in both hospitals.

The quality assurance program should be developed to meet the standards as set forth in the future by the Joint Commission on Accreditation of Hospitals.

Objective G. By January 1976, 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.

Comments and Recommendations: The initial intent of the 1973 Master Plan Committee was to allow each component of the mental health system to retain a portion of funds generated at the local level, allowing for an incentive reimbursement system within that agency to promote higher quality services. Often centers, clinics, and hospitals find themselves locked into salary schedules and, with the ongoing spiral of inflation, it is impossible to set aside sufficient funds to provide incentive programs. Therefore, continued effort in providing rewards for people developing new and creative programs is essential.

Objective H. By July 1977, each mental health center will have applied for an accreditation survey.

Comments and Recommendations: The Joint Commission on Accreditation of Hospitals is in the process of developing standards for accreditation of community mental health centers. Once those standards are made available and the survey program is operational, each community mental health center in the state should apply for review and potential accreditation. The accreditation will undoubtedly have considerable influence on third party payments which will become a major aspect of the future community mental health centers fiscal survival. It is the responsibility of the Division of Mental Health to insure that each center be aware of the progress of standards development and provide technical assistance in obtaining accreditation.

Goal 3

Assure the Availability and Accessibility of the Full-Range of Quality Mental Health Services Close to Persons Requiring Such Care

Issues and Concerns

As with any system which purports to serve the needs of individual clients, mental health has established itself as an integral part of both the local and state governments. Too often the perpetuation of a delivery service system itself dictates the directionality and priorities of the system, rather than responding to needs of individuals.

The major problem which faces the mental health delivery system is how to effectively and economically provide a program which reaches out and is accessible to all individuals in need. The advent of state government regionalization will require a parallel regionalization of mental health programs. There must be an ongoing method to interface these services. The mental health system, therefore, must continue to address itself to several issues simultaneously. These are: how to increase both direct and indirect services to the clients within their respective service areas; the further development of new regional hospital settings specializing in programs which cannot be economically handled on the local level; and the continuation and development of a full range of services for all clients with the strong emphasis on comprehensive services beyond the orginial intent of comprehensive community mental health centers act of 1963. This would include the long overdue comprehensive services for children, youth, aged, as well as a full range of programs for drug and alcohol abusers; further development of a partnership with the private and voluntary sectors in order to unify the mental health delivery system throughout the state; the education of hospital and community mental health centers and advisory groups to work more closely with local units of government and the general public to stimulate and promote the further understanding of mental health services.

Previous 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 exception of those specialized services which remain (or become) the responsibility of state hospitals for clinical, economic or other cogent reasons.

Current Progress

Original Goals A and B of the 1973 Master Plan have not fully been reached.

Revised Objectives

Objective A. By January 1976, 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. (The objective time period is delayed one year.)

Comments and Recommendations: The State of Colorado does not have an adequate, sufficiently detailed capital construction plan, including priorities for mental health. Division staff each year prepares or updates a "construction plan",approved by the State Department of Health, and submits it to NIMH in order to establish eligibility for Hill Burton and MH-MR federal construction funds. This document, however, falls far short of being the useful document it should be. Because of the Divisional philosophy emphasizing "brains over bricks", i.e., program development over buildings, in practice, the document has pointed to needs and priorities of programs, with most of the initiative for construction applications

coming from the local people as their programs matured. It is now time for a more aggressive posture on the part of the Division - to actually assess construction needs for years in advance and to plan and prioritize appropriately. Thus, construction funds for mental health in recent years have been largely dependent on the availability of federal dollars which now are in question for the future. Therefore, the State likely must assume more and more responsibility for funding the new growth of the mental health system facilities.

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

Comments and Recommendations: For a detailed explanation of this objective see the Role and Function of Colorado State Hospital, Fort Logan Mental Health Center and the mental health centers and clinics.

Goal 4

Establish Priorities for the Development and Expansion of Mental Health Services as Needed Throughout the State

Issues and Concerns

Frequently, the development of new mental health centers and clinics has occurred as a function of the availability of local matching money, rather than on the basis of the need for service. Thus, many of the economically depressed, remote, rural areas of the state are still without adequate and easily accessible services and facilities.

Similarly, services to certain groups are often provided on the basis of available funding and/or staff interest, rather than on the basis of community need. The problem of alcoholism, for example, is a major one in most Colorado communities, yet very few of the community mental health centers have resources committed to the treatment and prevention of alcoholism. (Alcohol and drug services in Colorado are funded primarily through the State Department of Health.)

The provision of service is directly related to level of funding; therefore, the funding of mental health services must be based on local need and not primarily on local resources and population. The assessment of need is not an easy task but must be initiated (see Goal 6). Until more thorough and objective need data are available, the Division of Mental Health will have to continue to rely on their subjective impressions, their regional coordinators, local mental health personnel, and interested citizens.

Previous 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.

Current Progress

A. Objective A has been delayed until January 1975 due to the press of other work. Progress is being made, however.
B. Objective B is in progress based on the reports received from local agencies as part of their budget request each year.

Revised Objectives

Objective A. By July 1975, there will be an initial plan, with priorities, for the development of needed new centers and clinics, and for the expansion or consolidation of existing community based programs.

Comments and Recommendations: Given the existing data, a statement of priorities is needed so that the planning at the state, regional, and local level can be more fruitful. While realizing that some of these priorities may change, it is unlikely that general regional development will be drastically altered. Without this initial plan, it is questionable whether any local action will take place, even on a preliminary exploratory basis.

Objective B. By November 1975, priorities for the delivery of mental health services, based on the best possible assessments of need and including citizen input, will be submitted by local planning bodies, including Councils of Government as appropriate, and/or community mental health agencies to the Division of Mental Health for (1) each catchment area, (2) each mental health agency, and (3) each planning region.

Comments and Recommendations: This objective is an interim one and is an attempt to broaden the input process until such time as the Needs Assessment Study is completed. It is extremely important that more information and ideas be obtained from the citizens of each region and community, rather than relying exclusively on the opinions of the mental health establishment. The recent survey conducted by the 1974-75 Master Plan Committee asked for the names of people in each community willing to serve on local planning committees. An extensive list resulted and these local people should be contacted and their interest in mental health planning utilized. (See recommendations for 1975-76 Master Plan Committee.)

Objective C. By July 1977, the mental health service priorities will be reordered as indicated by additional data available from the Needs Assessment Study in addition to the usual subjective data.

Comments and Recommendations: By this time both the social indicator and the target group studies will be completed and should provide considerable information about the needs and priorities within each catchment area and each region of the state. While the date of July 1977 is indicated here, this refers to a completed first step and it is fully anticipated that this will be an ongoing process.

Goal 5

Develop a Proposal for New Mechanisms for Allocating Funds for Mental Health Services

Issues and Concerns

The State of Colorado historically has accepted its responsibility for the care and treatment of individuals with mental health problems. The advent of the community efforts to provide services as close to the natural environment or home of the individual as possible has shifted some of the responsibility of funding to the local communities. This places the mental health system in a dilemma, inasmuch as the general public tends to place mental health services fairly low on the list of funding priorities. Another problem is diminishing federal support, even though new legislation is pending which would stimulate the growth of new programs via Health Maintenance Organizations and/or National Health Insurance. Federal legislation alone, however, will not alleviate the need for additional state and local dollars.

Ideally, funding for mental health services should remain diverse; i.e., from multiple sources. The following factors should be considered in the development of funding for mental health services: 1) results of a needs assessment survey with input from human services agencies, related mental health providers, consumers, and the community at large, including a mechanism for periodic monitoring; 2) census and demographic data; 3) trends as demonstrated by current programs from other states and national literature; 4) utilization of mental health services throughout the state; and 5) results of pilot projects designed to determine the most effective techniques for the amelioration of mental health problems.

It should be noted here that Colorado law requires that funding for mental health programs shall be based on need. We should, of course, continue to document and refine our measures of need.

While the above data are being developed, it is recommended that the present funding mechanism be continued for one year. Hopefully, by fiscal year 1976-77 new approaches, based on criteria derived from the data, can be identified.

Previous Objectives

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.

Current Progress

This original objective has not been fully reached.

Revised Objectives

By July 1976, 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.

Comments and Recommendations: The division is designing general guidelines to be used in the preparation of the 1976-77 budget. Despite the increased cost related to maintaining existing programs, there must be some growth and new program development if community mental health centers are to continue to be effective providers of mental health services. A prime concern is the equalization of services across the state (i.e., insuring the availability of the highest quality, basic mental health services in rural as well as urban areas). Additional priorities are: alternatives to hospitalization; services to children, adolescents, and the aged; and mental health services for persons in nursing homes, boarding homes and other personal care facilities; needed programs which can generate federal funds to match state dollars; and programs which address new urgent concerns or old programs in innovative ways.

Goal 6

Develop a Statewide Management Information System which Includes Need Assessment, Outcome Measurement, Accountability and General Program Evaluation Capabilities

Issues and Concerns

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 high quality care, using appropriated funds wisely, and returning the majority of the mentally disturbed 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 their own resources or with the assistance of the delivery system.

Isolated attempts at program evaluation have been carried on over the past ten years at various agencies. For the most part, these were funded entirely or in part with federal funds and were seen as pilot or special short term projects. The leadership necessary to coordinate, adapt, and incorporate these various approaches into a statewide data system did not exist until the past year. However, since the appointment of the Chief of Program Evaluation, tremendous progress has been made in the establishment of a basic management information system for the Division of Mental Health. The system is built upon routine reporting of information from the centers, clinics and hospitals using common forms and definitions resulting in comparable data.

Additional components of the system are still being developed, such as improved measures of treatment outcome, indices of cost benefit, and need assessment. Also needed is further work in the area of accountability. While tied to the evaluation issue, accountability focuses on the total agency and its impact on the community served. It requires that the purposes, goals, and objectives of each agency be clearly stated and that their performance be measured in

accordance with those statements. 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.

As stated in the Program Evaluation Report for FY 1973-74, DMH Office of Program Evaluation;

"The ultimate Goal of the Information System is to provide the following capabilities:

(1) To provide descriptive comparisons at the level of specific treatment and other service categories.

(2) To provide data regarding outcomes, benefits, and costs for specific treatment categories and for specific types of clients.

(3) To be able to interrelate many different kinds of variables such as patient characteristics, patient problems, treatment types, outcomes, costs, etc.

(4) To have the flexibility to accommodate changes in direction, new problems and programs, and so forth.

(5) To be able to simulate costs and workload for proposed new or alternate programs, so that estimates concerning the viability of such programs can be made before committing funds.

(6) To provide feedback to agencies which is oriented toward their own need for information by which to make program and management decisions." (page 3)

Previous 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).

Current Progress

A. Accomplished - A Chief of Program Evaluation was hired.

B. Accomplished - The Division of Mental Health has compiled and distributed to all components the abstracts of all reported evaluation type studies and projects being conducted by agencies affiliated with the Division of Mental Health. In addition, a library of written (some published) reports regarding these projects is being maintained by DMH for the benefit of all central and agency personnel.

C. Accomplished - The Advisory Committee was called together in March 1974, with representatives from 18 member agencies present. The committee immediately formed task forces to work on the statewide program evaluation and management information system.

D. Accomplished - A task force from the Program Evaluation Advisory Committee has completed a proposal for the need assessment project which will be presented for funding with the 1975-76 budget. The work on the outcome survey has been incorporated in the basic management information system in the form of pre-post disruption profiles. This data should be coming in by January 1975 (see new Objective D).

E. Accomplished - As indicated in "D" above, the proposal will be presented with the 1975-76 budget in the fall of 1974. See new objective.

F. In progress - This objective has been delayed somewhat to allow for sufficient experience with the statewide management information system before recommending minimal procedures for all components. It is likely that some minimal standards will be necessary for intra-agency evaluation. See new objective.

G. Accomplished - Negotiations are proceeding on a Department of Institutions, rather than a Division of Mental Health level with input from the Chief of Program Evaluation to the Department personnel responsible.

H. Delayed - This objective must be delayed in line with "F" above. See new objective.

Goal 7 in 1973 Master Plan - In progress and updated - This has been incorporated in the statewide management information system with the pre-post disruption scale as mentioned in "6D" above. Therefore, this goal and its objective is deleted and a new objective written for Goal 6.

Revised Objectives

Objective A. By July 1975, a statewide need assessment system will be operational.

Comments and Recommendations: Programs can be planned and monies allocated on the basis of assumed need, but with the existing competition for the tax dollar, assumptions are no longer adequate justification for funding. The Division plans to use two approaches in order to fully and systematically assess the need

for mental health services within each catchment area: social indicator studies and the identification of "target groups" along with an analysis of their particular needs. Work on the first approach is underway and will continue for the next two years. Work on the second method will begin if the current proposal is funded.

Objective B. By July 1975, a set of guidelines will be developed for minimal evaluation and accountability procedures for all mental health components.

Comments and Recommendations: It is unlikely, given the staffing pattern at central office, that all of the needed evaluation can be conducted at that level. Nor is it particularly desirable since many of the specialized programs, which are pilot or experimental in nature, deal with a local, rather than state-wide, problem. It is important that each system component have its own evaluation capability. To insure that the evaluation conducted in the various agencies is meaningful, certain state standards and guidelines are required, i.e., protection of patients' rights and welfare, confidentiality of data. In addition, the Divisional program evaluation staff should make available technical assistance and consultation.

Objective C. By July 1976, current evaluation programs in centers, clinics and hospitals will be reviewed and evaluated in light of the guidelines referred to in "B".

Comments and Recommendations: Periodic review and evaluation should not only increase the quality of the evaluation efforts of the various agencies, but aid the Division in coordinating similar efforts, avoid unnecessary duplication of effort, and suggest areas of exchange of data and experience.

Objective D. By January 1975, the first pre-post treatment data will be collected regarding clients' disruption profiles

in the areas of personal functioning, close interpersonal relationships, anti-social behavior, and productivity.

Comments and Recommendations: This will represent the first statewide effort to assess the relative success of treatment across all the service components. This information will be compared with other data in the management information system in order to obtain rudimentary cost benefit figures. It should also allow some preliminary indications regarding the relative effectiveness of various programs with various types of clients so that those best suited to a particular treatment modality can be steered in that direction.

Goal 7

Participate in Attempts to Ameliorate those Factors in the Social and Physical Environment that Contribute to Mental Disorder

Issues and Concerns

Because mental health professionals are continuously in contact with people who are mentally disturbed, they become quite aware of environmental factors which are associated with the disturbance and at times are prime causal factors. It is no longer possible to maintain the reserved, distant, non-judgmental stance of the traditional psychotherapist. In order to facilitate needed social change, there should be a conjoint effort among all concerned people including those who work with the mental health casualties of destructive environments.

Previous 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 authority.

Current Progress

Even though guidelines were not completed as required by Objective A, several mental health agencies formally and informally have been taking actions in furtherance of Objective B, especially in the areas of child abuse and migrant worker housing.

Revised Objectives

Objective A. By January 1976, 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, and other variables which contribute to high risk conditions.

Objective B. By January 1976, using the established guidelines, all centers, clinics, and hospitals will report the above conditions to the proper authority.

Comments and Recommendations: These objectives continue to be important ones, and efforts toward their fulfillment must continue. It should be added that not only should mental health personnel report destructive situations to the proper authorities, but they should offer their services to those responsible for correcting the existing condition.

Objective B is unclear in that it does not precisely specify the end point conditions so that accomplishment or non-accomplishment can be easily determined. However, it is left unchanged until the guidelines are available.

Goal 8

Increase Society's Understanding, Acceptance and Tolerance of Persons with Emotional Disorders

Issues and Concerns

Educating people in the community about emotional disorders is a goal of all mental health professionals, but one which usually assumes low priority in the face of overwhelming needs for direct services. Many critical areas are ignored until the public has been educated concerning certain problems, as has been shockingly obvious, for example, in the area of child abuse. Although it is now termed an "epidemic," it is probably that child abuse per se has not increased, but that the frequency of reporting it by the public has risen to epidemic proportions. Similar situations are seen in the areas of drug abuse and learning disabilities. In addition to being informed about the problem, the general public must be aware of the treatment available before they can be expected to show tolerance and understanding.

Also, with the emphasis on community placement and treatment in human services, community residents are increasingly expected to deal with individuals having widely varying problems. In most cases, residents are given minimal information about the problems and little help in handling them. The serious problems in the Capitol Hill area of Denver exemplify a community not being provided with the education, skills, and services necessary to deal with the many chronic patients in boarding homes in the area. As a result, the Capitol Hill area is often referred to as the human services system's "dumping ground," and the neighborhood is left to cope with the problems as best they can. This is a vivid example of what happens when human service providers do not fulfill their responsibility to the community.

Previous 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 aspects of mental health and emotional illness.

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

Current Progress

A. Objective A is reported accomplished in the majority of centers, clinics, and hospitals.

B. The function in Objective B is performed in most centers and clinics; however, few programs have formally assigned the responsibility to a specific staff person. Fort Logan Mental Health Center temporarily cut back their public information offices in 1974 for budgetary reasons. Colorado State Hospital has a full time public information officer.

Revised Objectives

Objective A. By July 1975, each center, clinic, and hospital must schedule a minimum of two public education information programs each six months on some aspects of mental health and emotional illness.

Objective B. By July 1975, all centers, clinics, and hospitals will be required to designate a public education and information representative to inform the public of significant accomplishments in mental health in general, and the center, clinic, or hospital in particular.

Comments and Recommendations: Objective A has been very effective and therefore is increased to two public information programs each six months. Objective B needs to be continued as it has not been accomplished in all centers and clinics.

Objective C. By June 1975, the community needs assessment survey which is being conducted by the division should include a community opinion poll in each catchment area. This poll should provide input on areas of education the public needs, problems they are experiencing with emotionally disturbed individuals, and opinions of the local center, clinic, or hospital.

Objective D. By July 1975, each community mental health center, clinic, and hospital will schedule a thorough education and orientation seminar for their board members. The seminar should include bases of referral to the agency, and treatment available within the agency, along with some measure of the efficiency of treatment.

Comments and Recommendations : Objectives C and D are intended to continue efforts toward informing and receiving feedback from the residents of all communities in Colorado. Objective D is particularly directed towards community board members, who, in many cases, need more factual information for appropriate decision making. The board members also must be encouraged to ask for data as they feel the need.

Finally, joint public information programs with the Mental Health Association and other voluntary civic groups known to have mental health interests, are strongly encouraged.

Goal 9

Develop a Comprehensive System for Insuring Delivery of Continuing Education Programs to Mental Health Personnel and Allied Systems in Both Urban and Rural Areas in the State of Colorado

Issues and Concerns

Since the field of continuing education is an evolving one, the definitions and terminology are apparently changing with usage. "Continuing education includes all those educational activities beyond the basic discipline training program," is one definition.

Another important theme is that continuing education programs are increasingly becoming problem focused.

Thus, continuing education may be defined as two sets of complementary activities:

1) modifying the behavior of individuals in their capacities as practitioners, policy makers, and agency staff members, and
2) modifying the services, resources, administrative structures, programs and policies of agencies, institutions and more complex service systems.

Occasionally referred to as inservice education, usually seen as a planned instructional or training program provided by an employing agency in the employment setting, inservice education is thus one aspect of continuing education, but the terms are not interchangeable. In common usage, it is becoming more popular to use the term "staff development" instead of inservice education.

Simply put, continuing education can take the form of either:

1) a form of "catch-up education," or
2) a process of producing planned change.

Objectives

A. By January 1978, develop networks of mental health resources for training and education, capable of delivering services to all agencies, boards, and community groups throughout the state.

Comments and Recommendations: Efforts to develop the staff of mental health centers, clinics, and affiliated systems to become continuing educators capable of engaging in assessment, design, implementation and evaluation of training activities has already begun. At the present time there are at least three hospitals and ten centers and clinics who have staff accountable for coordinating continuing education and inservice activities. In the majority of instances these coordinators are at urban based facilities. In many instances those assigned to this task have added it to their clinical and administrative responsibilities. In addition, community based groups have been developed to expand resources available for continuing education efforts.

B. By January 1978, to have established a Council on Rural Mental Health Continuing Education which will assess, represent, and monitor the needs of continuing education in rural areas. The Council is expected to coordinate such functions with the Division of Mental Health.

Comments and Recommendations: Recent programs in rural areas have highlighted differences between the character of rural and urban needs for continuing education. Developing a Council on Rural Mental Health will assure comprehensive representation for delivery of mental health and continuing education services.

C. By January 1978, develop a capability of Continuing Education Services for the development and coordination of the following activities: board and administrative orientation and education,

continuing education programs for maintaining or improving staff skills, public education and public information programs on mental health, and staff development activities to help implement changes in policies or procedures for programs of mental health in rural and urban areas.

Comments and Recommendations: Inputs from agencies which are involved in continuing education in mental health should be solicited in order to determine where, by whom, and how continuing education in mental health can be most effectively financed and administered, especially in rural areas.

Goal 10

Coordinate Training Programs for Mental Health Professionals and Paraprofessionals

Issues and Concerns

The relationship of the Division of Mental Health to the trainers of mental health manpower is primarily one of consumer to supplier. The principal activity of the Division of Mental Health is service to the citizen in need. To accomplish this, the Division must have qualified manpower available. The training and mental health fields must be relevant to the services needed by the state. There is also a need for continued professional growth and development of employees of the Division of Mental Health to be accomplished through inservice training and continuing education.

A major concern is the projection of future needs for mental health personnel (e.g., psychiatric nurses, social workers, psychologists, psychiatrists, pastoral counselors, psychiatric technicians). To avoid training too many or too few professionals, the needs of the Division of Mental Health and its related agencies should be estimated and the results transmitted to the respective training facilities for use in their program planning.

The education of psychiatrists needs particular attention. There is need for cooperative integration of the three psychiatric residency programs operating in Colorado. Coordination of these programs could result in better, comprehensively trained psychiatrists able to function in a variety of health care delivery settings. The coordination of these programs should be accomplished in a way that respects the unique features of each training program.

The Division of Mental Health should encourage the use of its facilities for training and education for the entire range of mental health personnel. Placement of trainees should be arranged primarily to contribute to the education of the trainee and not just as a provider of service to the agency. The

responsibility for training at a facility must be shared with the trainee's college or university. The Division of Mental Health should not accept primary responsibility for the training programs; however, it should assume a strong, coordinating role in defining educational and training needs.

Educational institutions should be encouraged to utilize state and community mental health agencies for placement in order to orient and teach the future professional about the techniques and challenges of public practice. The training should also emphasize experience in rural mental health programs. The recruitment problems associated with staffing rural facilities may be aggravated by the fact that professionals in the course of their training have not been exposed to the opportunities, challenges, special satisfactions which can be associated with a rural practice. Experience in rural communities and programs may help alleviate this problem.

Previous Objectives

A. By July 1974, there will be a cooperatively devised plan for coordinating psychiatric residency programs involving the University of Colorado Medical School, 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.

Current Progress

A. The major progress of the last year has been the formation of a joint training planning committee which included the Department of Psychiatry of the University of Colorado Medical School, Veterans Administration Hospital, and Division of Mental Health (including Fort Logan, Colorado State Hospital, and Denver General Hospital). The 1973 Master Plan required that there be developed a plan to coordinate psychiatric residency programs by July 1974. The committee has been active and a plan is now being developed. The earliest date that the plan will be available is July 1975. Therefore, the Master Plan Committee agrees that a change in date to July 1975 be made in light of the progress made by the training planning committee.

B & C. It was also recommended that by July 1975 there will be a plan for determining the extent of need in the state for nurses, social workers, pastoral counselors, psychiatrists, psychologists, mental health workers, and other mental health related disciplines. This plan has not yet been formulated, but the need for it remains critical. With the development of a need assessment program associated with the data processing system being developed within the Division of Mental Health, it should be possible to develop a schedule for planning.

D. A coordinated psychiatric residency program is being considered by the planning committee for psychiatric training referred to above.

Revised Objectives

Objective A. By July 1975, there will be a cooperatively designed plan for coordinating psychiatric training involving the University of Colorado Medical School, Denver Veterans Administration Hospital, Division of Mental Health, Fort Logan Mental Health Center, Colorado State Hospital, and Denver General Hospital.

Comments and Recommendations: This year's recommendation consists of a revision of the previous objective to allow another year for planning. The need for coordination is complicated by authority issues among institutions that fall under state, city, and federal jurisdiction. Undoubtedly the plan will speak to this issue. The fact that these facilities are working together to examine coordination of training demonstrates their commitment to meet future needs of the State of Colorado for trained professionals.

Objective B. By July 1976, there will be a plan for determining the extent of the present need in the state for nurses, social workers, pastoral counselors, psychiatrists, psychologists, mental health workers, and other mental health related disciplines and for making projections for subsequent years.

Comments and Recommendations: The plan is needed to estimate the future demand for mental health services and training to fit with that need. These data are vital to training programs in order to permit consideration of future roles and employment possibilities for graduates. The 1973 Master Plan also recommended that by January 1976, there would be a plan for determining the extent of need and training for professionals and paraprofessionals. It is the

recommendation of 1974 Master Plan that a completion date not be mandated, but that one be set once a plan is developed for estimating needs.

Objective C. By July 1975, there will be appointed a full-time Director of Staff Development and Training at the level of the Division of Mental Health.

Comments and Recommendations: The coordination of the staff development training program should be correlated with the other training facilities and their efforts in continuing education programs, including the Western Interstate Commission on Higher Education. The Director of Staff Development and Training shall recommend the amount of time and training required of each individual working within the state system for their continuing education needs. This recommendation should be coordinated with those to be obtained from the several mental health professional organizations. See also Goal 9.

Objective D. By July 1975, there should be an individual designated as coordinator of staff development in each state mental health institution and each community mental health center. At the Colorado State Hospital and Fort Logan Mental Health Center this function should be carried by a full-time position.

Comments and Recommendations: The position of coordinator of staff development should be a qualified professional person. In the two hospitals the directors of staff development and training should have responsibility for the coordination of staff development and training within their entire catchment area. This would encourage the utilization of Colorado State Hospital and Fort Logan personnel within the regions for staff development and training, and allow the sharing within and between regions of personnel for training purposes.

Goal 11

Improve the Cooperative Effort between the Division of Mental Health and the Division of Corrections in Providing Treatment for Mentally Disturbed Offenders

Issues and Concerns

Crime represents an enormous, constantly escalating social cost in Colorado. Recent nationwide statistics show that metropolitan Denver has the highest rate of certain violent crimes. Although many highly competent groups have made numerous attempts to make progress in slowing the crime rate, there has been a lack of definitive progress. Concerted joint efforts of the Division of Mental Health and the Division of Corrections can assist in alleviating the problem.

The Division of Corrections and the Division of Mental Health have several major goals and responsibilities in common. In both systems, a major focus is on rehabilitating deviant individuals so that they can cope with societal, familial, and self expectations. Both systems have the additional responsibility of attempting to protect society from harm by deviant individuals while they are being treated. Also, efforts must be made to prevent these individuals from harming each other or themselves. In addition, the importance of prevention efforts, community treatment, and institutional care are very similar in both systems.

Not only are the goals similar, but the population treated often overlaps. Severely emotionally disturbed people have a very high probability of getting into trouble with the law. Often it is mere chance whether a disturbed individual ends up in the correctional or the mental health system.

It seems obvious, therefore, that the experience gained by professionals in each field would be of mutual value. Both systems have areas of expertise to share with each other. Joint efforts between the divisions should increase

the effectiveness of both. A committee should be created consisting of Director of the Division of Mental Health and the Director of the Division of Corrections, plus other administrative and professional staff selected by them in order to facilitate the attainment of the following objectives.

Objective A. By September 1975, a plan will be developed to provide joint learning experiences between corrections and mental health professionals so that there is greater mutual understanding of roles and responsibilities.

Comments and Recommendations: The first step in establishing an effective relationship is for the systems to become acquainted with each other. With the large number of staff involved, this will be a difficult task. One approach would be to trade middle management staff for varying durations of time to promote communication through first-hand experiences to both supervisors and subordinates.

Objective B. By September 1975, a plan will be available for budgetary consideration in areas of critical need.

Comments and Recommendations: Some needs require immediate budgetary consideration and cannot be delayed until the plan is complete. Critical issues include: a) in the Division of Mental Health - patients with character disorders and/or very difficult to manage behavior, provision of specialized services, secure settings, and longer term treatment; b) in the Division of Corrections - obvious understaffing of mental health professionals to assist in planning and implementation of treatment programs; c) Division of Adult Parole - mental health services to adult parolees, including follow-up care, family therapy, and help in re-entry in the community. An excellent example of a cooperative relationship between the Division of Corrections and the Division of Mental Health is the Adult Forensic Program of the Pikes Peak Mental Health Center.

This program provides intensive follow-up treatment of adult parolees in a half-way house setting in Colorado Springs.

Objective C. By September 1975, a plan will be developed to more effectively coordinate the process of client transfers between systems.

Comments and Recommendations: The process of transfer between institutions of the Division of Mental Health and the Division of Corrections not only has legal problems, but due to bureaucratic difficulties, is confused and disorganized. The optimum goal should be for each system to develop its own program to handle all of the problems in the population for which it was designed, without providing needless duplication of services. For example, if an inmate at State Penitentiary becomes psychotic, ideally the institution would have the staff and program to handle the problem. If the inmate needs marital counseling upon release, ideally this could be provided by the local mental health center rather than the parole department. Mental health facilities should have the program and staff available so that a client whose behavior is unmanageable would not have to be transferred to a correctional setting. However, if a client continually violates the law, treatment should be available in the correctional program. At this time the ideal does not exist, and transfers due to program deficiencies rather than for the benefit of clients are frequent.

Objective D. By June 1976, a complete, comprehensive plan for the overall coordination of the Division of Mental Health and the Division of Corrections services will be presented along with a design for implementation.

Comments and Recommendations: There are numerous problems inherent in working out a truly cooperative arrangement at all levels, and an organized plan, with goals, objectives, and timetable will be necessary. Some of the areas of cooperation are as follows: 1) prevention of delinquency - it is suggested that

crisis teams at the level of apprehension in urban police departments and at detention centers be explored. These teams should be comprised of personnel from local mental health centers and clinics, the Department of Social Services and Juvenile Probation. Their function would be to evaluate the crisis situation and prescribe community treatment when indicated. Crisis teams such as the one operating at the Arapahoe Youth Center have drastically reduced the unnecessary commitments, as have police intervention programs such as in the Aurora Police Department; 2) probation - many youth and adults on probation are in serious need of mental health assistance. Often the treatment is made a condition of probation by the court, and mental health center personnel should receive training in such areas as working with recalcitrant patients initially unwilling to be involved in treatment; 3) reintegration of offenders into the community - often both adult and juvenile parole services need assistance from state hospitals, community mental health centers, or clinics to provide the mental health treatment necessary for adjustment to society.

Goal 12

To Provide the Full Range of Mental Health Services to the Children and Youth of Colorado

Issues and Concerns

The Joint Commission on Mental Health of Children stated in 1970:

> "As of today, the treatment of the mentally ill child in America remains uncertain, variable and inadequate, this is true on all levels, rich and poor, rural and urban.... Only a fraction of our young people get the help they need at the time they need it."

Colorado is no exception to this statement. Although services vary from region to region, there is no region of the state which provides adequate services to children and youth. In the Denver metropolitan region, which has the greatest availability of services, approximately one percent of the population under 18 years of age is currently receiving treatment. The report by the Subcommittee on the Mental Health Needs of Children and Adolescents of the Metropolitan Denver Mental Health Planning Council, September 15, 1974, suggests that only ten percent of the population needing service are currently receiving it.

In light of the current rash of "Right to Treatment" suits filed on the behalf of minors throughout the nation, it seems obvious that states which do not provide adequate services to young people will eventually be forced to do so by the courts. It would seem far better for mental health systems rather than for legal systems to define what is "adequate."

Along with the above noted considerations of need for treatment and legal difficulties, it is a psychological fact that children and youth are in an optimum position for growth and change. Early detection and intervention, as

well as concentrated efforts on prevention, should prove less costly to society than the current approach. The majority of important life issues and styles are determined and developed in childhood and adolescence. Since children are more flexible, to wait until they become mental health casualties as adults is a reversal of common sense.

Objectives

Objective A. By July 1976, there will be created a new office within the Division of Mental Health, responsible to the Division Director, entitled the Office of Children and Youth.

Comments and Recommendations: Due to the major deficiencies in the area of mental health services to children and youth, many new programs need to be designed, rather than just maintaining or extending current programs. An office at the administrative level of the Division of Mental Health, headed by a Director of Children and Youth, is necessary in order to provide the authority, impetus, and coordinating ability required to design adequate programs for children and youth. The general functions of this office would be as follows: 1) needs assessment and comprehensive planning, 2) system coordination, 3) monitoring of programs for children and youth, 4) evaluation of program effectiveness, 5) community education, and 6) coordination and technical assistance to grants designed to fund.

First, needs assessment and comprehensive planning are vital because the current method of creating programs for children and youth is often a reactive one, e.g., a response to an immediate crisis such as drug abuse and runaways. Also, new programs are designed in response to treatment approaches currently in vogue, whether or not their efficacy has been evaluated. As a beginning step to evaluate problems in the various areas of the state, the Governor's

Commission on Children and Youth conducted 13 regional workshops in the summer of 1974. The results are presented in an extensive report prepared by Interstate Research Associates. One interesting result was that many communities were not aware of the kinds of services available and, therefore, could not evaluate their needs in more than a very general fashion. The Governor's Commission on Children and Youth, Advocacy for Children and Youth (Colorado Coalition), and the Subcommittee on the Mental Health Needs of Children and Adolescents of the Metropolitan Denver Mental Health Planning Council are three very active organizations which should be of assistance to the proposed Office of Children's Treatment.

Second, the immense problem of treating children and youth must be a joint effort of all agencies involved. If one service providing agency is not doing its job well, other youth-serving agencies suffer, as do the clients in their care. The incidence of children, youth, and their families being "dumped" from one social agency to another with no consistency in treatment is well known to workers in the field. All too often children and youth in Colorado need to act out their problems with great intensity before they can get someone's attention. The attention received is often uncoordinated, overly brief, and ineffective. Inadequate budgeting, limited staffing, and ineffective interagency coordination are partly responsible for gaps in service. The tendency to provide a general treatment approach to all children and youth within each agencies' care, rather than an individualized approach, contributes to inadequate treatment. For example, it has been apparent for many years that Youth Services institutions were being inappropriately used as treatment facilities for chronic runaways, because the philosophy of many in the mental health system was that no child needed to be locked up. If the child repeatedly demonstrated the need to be contained, he was referred to the courts and transferred to the Youth Services system.

It is, therefore, a vital function of the proposed Office of Children and Youth in the Division of Mental Health to coordinate services with all agencies involved with youth. Examples of these agencies are: The Division of Developmental Disabilities, Youth Services, the Department of Education, the Department of Social Services, law enforcement agencies, courts, and the private and voluntary sector.

The third role of the Office of Children and Youth concerns administration. The director of the children's program through the Office of Children and Youth would have the responsibility for monitoring the operation of facilities caring for adolescents and children operated by the Division of Mental Health.

Fourth, the evaluation of program effectiveness has been long overdue in the area of mental health because of measurement difficulties. The Office of Children and Youth should coordinate training, education, and evaluation efforts with all other divisions and agencies involved and as an extension of the Office of Planning and Program Development.

A fifth function of the Office of Children and Youth is to provide and coordinate educational programs to communities. A striking example of what happens when communities finally become aware of a problem is the area of child abuse. Child abuse per se is probably not increasing, but community awareness and reporting is increasing to "epidemic" proportions. In Adams County, as an example, the referral rate has doubled each year since 1965.

Finally, the Office of Children and Youth should provide expert assistance in writing grants, acquiring matching funds, and obtaining funding for those projects which are proven to be valuable. Seed money provided by grants is an excellent way to provide the experimentation necessary to continually improve the quality of services.

Objective B. By July 1975, all mental health centers and clinics in the state will submit a plan and budget to the Director of Mental

Health to provide immediate, 24-hour, seven day a week care to any child, youth and his/her family during an emergency.

Comments and Recommendations: Emergency service is a beginning step in providing mental health intervention in an early phase before the problems become so serious that institutionalization is the only answer. Delay in providing treatment is even more critical for children and youth than it is for adults. Generally, they have less ability to delay a need for help until normal working hours.

These services should include telephone hot lines and crisis centers as close to the community as possible. There also must be secure shelter care and short-term facilities available to back up a situation in which immediate return to the family is not indicated. This service could include needs as diverse as child abuse and adolescents temporarily out of parental control.

Emergency services should be able to provide or arrange for appropriate follow-up and have a built-in evaluation program to provide assurance that follow-up has been done.

The community mental health center could use the local general hospital for short-term crisis intervention in many cases if proper services have been planned and contracts developed with the hospital. It is recommended that such contracts include children and adolescents.

It should be noted that the youth detention facilities are already overwhelmed with youth who have committed CHINS or delinquency offenses and should not be used for mental health crises not associated with law violations.

Objective C. By May 1975, complete program plans for long-term intensive treatment centers for adolescents, including a capacity for containment as needed, should be provided by both state hospitals to the Division of Mental Health.

Objective D. By August 1975, programs will be operational and will include evaluation to provide quality control.

Comments and Recommendations: The Closed Adolescent Treatment Center, a grant program which was a combined program between the Division of Mental Health and the Division of Youth Services, has shown the validity of the need for long-term, secure, structured programs for extremely disturbed adolescents. The program is continuously overwhelmed with referrals. The need for similar services to non-adjudicated youth is extremely high and it is felt that the state hospitals are presently the best place for this service.

Also, the plans should assure that admission requirements are not overly selective, that youths are not discharged from the program for similar behavior for which they were admitted, and that they are not used as short-term crisis centers. Rehabilitative school programs must be a strong component of each program.

Objective E. By July 1976, a pilot program for a combination day care and educational program shall be developed with the cooperation of the Division of Mental Health and a community mental health center for a selected neighborhood in metro Denver.

Comments and Recommendations: Treatment oriented day care service is a priority item, but should begin with a pilot program to demonstrate that the function can be carried out on a neighborhood basis. Such a program would provide a structured school, activity and therapy program for six to eight hours a day for youth who can continue to live at home but who need more intensive treatment than outpatient services. This service involves cooperative use of personnel from the local school district. If this pilot program proves successful, future objectives for implementation in other catchment areas must be included in future Master Plan revisions.

Objective F. By July 1977, there will be a pilot program designed by the Division of Mental Health for intensive inpatient treatment of youth with a primary diagnosis of organicity plus behavioral problems.

Comments and Recommendations: One of the most neglected areas of treatment of youth is for those with severe behavioral problems associated with organicity. These youth are not retarded, but often function in a socially retarded manner. Ideally, the combined expertise of the Divisions of Mental Health and Developmental Disabilities should be used in designing this experimental approach. Youth with this diagnosis often are placed in the correctional system or are permanently institutionalized because of inadequate treatment. If this pilot program proves successful, future objectives for implementation in other catchment areas must be included in future Master Plan revisions.

Objective G. By July 1975, there should be designated in each community mental health center a staff member responsible for the coordination and development of children's programs.

Comments and Recommendations: The necessity of having someone in each center responsible should not imply that only one person is needed to handle the treatment load associated with children and adolescents, since approximately one-third of the direct services in many community mental health centers are within this age group. The individual designated should have training and experience in the care of children and youth, and will be responsible for adequate treatment and care.

Objective H. By April 1975, each of the children and adolescent facilities operated by the Division of Mental Health will have applied for Joint Commission on Accreditation of Hospitals (JCAH)

accreditation under the standards for children and adolescent facilities.

Comments and Recommendations: The standards for accreditation of inpatient, partial hospitalization, and outpatient facilities for children and adolescents are now available through the JCAH. Facilities should apply for accreditation under these standards, since compliance with these standards becomes essential for many third party payments.

Objective I. By July 1977, each community mental health center and clinic, by itself or in conjunction with a similar program in an adjoining catchment area, shall have a facility to provide 24-hour care for the children and adolescents in need of mental health care.

Comments and Recommendations: These facilities may be a halfway house, group home, or similar facility appropriate for the communities being served. This facility may be within a psychiatric hospital setting if available within the catchment area.

Objective J. By July 1977, the proportion of direct service time provided by each community mental health center to individuals between the ages of five and eighteen is at least equal to the population statistics for the catchment area.

Comments and Recommendations: It is clear that future National Institute of Mental Health guidelines will require comprehensive services for children and youth as a requirement of continued funding. Children and adolescents have been underserved in most centers throughout the country. This group also represents the most important potential elements for preventive services and proper attention to this age group can help fulfill the basic promise of the community mental health center in the preventive area.

Goal 13

To Improve the Overall Quantity and Quality of Mental Health Services Throughout the State for the Geriatric Patient

Issues and Concerns

Since the White House Conferences on Aging of 1971, a gradual awakening of society to the complex problems of aging has emerged. The increased awareness reveals that approximately 93 percent of people sixty-five years of age and older live in a community setting with the other 7 percent in health care institutions. ("Toward a National Policy on Aging" - Colorado White House Conference on Aging, June 1971.) For those living in the community, health care problems (including psychiatric) have been identified as second only to inadequate income. For the residents of institutions, the problems most typically identified throughout the nation have been lack of adequate rehabilitation techniques, no alternatives to institutionalization, and inadequate manpower trained in gerontology - all resulting in little hope of ever returning to a community way of life.

The quantity and quality of mental health services for the aged vary from state to state, and within Colorado the same is true when comparing one locale with another. However, it is generally accepted that in Colorado services to the geriatric patient have not received a high enough priority. The Division of Mental Health and various elements which comprise it must, in the future, commit more of their resources to this area of need. It might be worthwhile for the Division to consider creating an Office of Geriatrics at some future time.

Current Objectives

Objective A. By January 1976, a comprehensive statewide survey of the mental health needs of the elderly will have been completed.

Comments and Recommendations: The Division of Mental Health recognizes this need and should assume the leadership in conducting such a survey. There exists a variety of community-based agencies and groups, public, private, and voluntary which could be very well utilized in the accomplishment of this objective (see Goal 6, Objective A).

Objective B. By July 1975, a comprehensive statewide directory of existing services and resources for the elderly, including public, private, and voluntary agencies, will be completed and distributed to all elements of the state mental health system.

Comments and Recommendations: Because of the lack of awareness of existing alternatives for the elderly, people working with these clients have often been limited to nursing homes as the primary resource. Much information about existing resources is available and should be adapted to the Division's needs.

Objective C. By July 1975, Colorado State Hospital will implement a comprehensive mental health service for the elderly citizen within its catchment area.

Comments and Recommendations: The service would include intensified inpatient treatment, day and aftercare, alternatives to hospitalization, consultation and education services. The ability to accomplish the above objective is dependent on adequate state funding. Such a request for funding has been made for fiscal year 1975-76.

Objective D. By July 1975, the Fort Logan Mental Health Center will expand a community-based day treatment program for the elderly.

Comments and Recommendations: The ability to accomplish the objective is dependent on adequate state funding. A request for funding has been made for fiscal year 1975-76.

Objective E. By July 1976, the Division of Mental Health will have developed alternatives to 24-hour care as provided by hospitals and nursing homes for the elderly person.

Comments and Recommendations: Twenty-four hour care of the elderly who are unable, for a variety of reasons, to live independently, frequently becomes the responsibility of the state hospitals and/or a variety of nursing homes. Alternatives to this situation for some geriatric patients are both desirable and possible, provided innovative programs are planned and established. Leadership and direction by the Division of Mental Health is essential if this objective is to be accomplished. Certain pilot projects within the Division of Mental Health system (e.g., Intentional Family Unit Program at Fort Logan) have been implemented in this area and results of these projects should be utilized in any future planning and development efforts.

Objective F. By January 1977, the Division of Mental Health, in cooperation and collaboration with the Department of Health and the Department of Social Services, will have completed a thorough evaluation of the standards for nursing homes and other residential care facilities with the purpose of improving these standards.

Comments and Recommendations: If standards for nursing homes and residential care facilities are improved, the legal base for more adequate services to the residents will have been established. Some efforts in this area have been initiated. A Hospital Improvement Project at the Fort Logan Mental Health Center is aimed at upgrading the quality of care in boarding homes. In addition, during 1974 a Governor's task force was appointed to establish standards of mental health care for nursing homes and other types of residential care facilities.

Goal 14

To Improve the Quality of Mental Health Services in Alternative Care Facilities (Nursing Homes, Boarding Homes, Extended Care Facilities, etc.)

Issues and Concerns

An early development in community mental health care was to move the patient from the traditional state hospital to the community family, and social network. Unfortunately, all too often the community mental health agencies have not vigorously followed and cared for the discharged state hospital patient. A decade ago the Colorado State Hospital had a followup program for their former patients residing in the Denver area. This program was phased out approximately five years ago. Currently, as well as in the past, services to former hospital patients are and were inconsistent both in terms of quality and quantity. This condition exists equally in other areas of the state. The need to upgrade the services to this group of citizens cannot be delayed.

Previous 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.

Current Progress

A. The Division of Mental Health stated that by the date noted (July 1974) the directory of facilities was made available to the centers and clinics.

B. The funding for this project is in doubt, although several community mental health centers are exploring the possibility of grants.

C and F. In progress.

D and E. May require some time change in the future.

Revised Objectives

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

Comments and Recommendations: These standards are designed to complement the existing health and environmental standards. They will specifically address the mental health needs of nursing home residents.

Objective B. By July 1976, there will be state standards for mental health services in non-hospital 24-hour care facilities, other than nursing homes.

Comments and Recommendations: These facilities house the majority of citizens who otherwise may have been chronic state hospital patients. These facilities deserve special attention and help at all levels of the state mental health system. State standards should help the home operator to better manage the facilities given the current fiscal restraints.

Objective C. By July 1975, there will be a procedure for regular on-site evaluation of mental health services in alternative care facilities.

Comments and Recommendations: The importance on on-site evaluation is not just for enforcement but also should serve to provide needed consultation regarding proper mental health care. Such site visits should be seen as helpful rather than punitive or an infringement upon the home.

Objective D. By July 1975, each community mental health center will have surveyed all nursing homes, boarding homes, family care homes and mini-homes for all former mental health and state hospital patients within their catchment area.

Comments and Recommendations: As a follow-up on Objective A, this objective will require that each community mental health center will know the existence of, and to some degree, the condition of all former state mental health patients in homes within their catchment area. The state hospitals and the community mental health centers should identify "lost" patients, attempt to locate them, and make certain that all former patients are being served according to their needs and desires.

Objective E. By July 1975, each community mental health center will have developed a community advisory committee regarding nursing homes, boarding homes and related facilities.

Comments and Recommendations: This committee will consist of individuals within the community who work with homes such as representatives of welfare, public health, voluntary agencies and other groups, plus consumers and representatives of the nursing and boarding home industry. This committee should be formed as early as possible to facilitate the provision of full service by the community mental health center to such homes.

Objective F. By April 1976, the Division of Mental Health will develop the materials and curriculum to aid the community mental health centers in attaining Objective G, below.

Comments and Recommendations: The need for centralized leadership in training and curriculum is clear. Center staffs often need direction in helping home managers cope with behavior of former mental patients. An example of the kind of material which can be developed is seen in the packet of material.

Objective G. By December 1976, each community mental health center will have available a consultation and training program for staff of the homes within their catchment area.

Comments and Recommendations: This objective and Objective F above replace the previous Objective E. Each center will be expected to use the materials made available by the Division of Mental Health, modifying it as is appropriate for their catchment area. Some homes may already have ongoing training in their facilities. Some homes may be making use of private consultative services from the community. Under those circumstances, the home should have its choice of how much of the center's services to utilize. An example of the programs which can be offered to the homes is that being currently developed at the Fort Logan Mental Health Center under the H.I.P. (Hospital Improvement) III Grant.

Objective H. By July 1976, each of the patients identified by the mental health team in the survey under Objective D will be evaluated and where appropriate, there will be developed an individual care plan for each patient which will be supervised by a physician.

Comments and Recommendations: Under Titles 18 and 19 of the Social Security Act this goal can be funded and is appropriate in terms of the utilization of mental health manpower. This objective requires careful coordination with the private sector already involved with some homes. The community mental health center should supplement, but not replace, the private agency or practitioner in the providing of service.

Goal 15

To More Fully Integrate Privately-Supported, Voluntary Providers of Mental Health Care into the Planning and Delivery of Mental Health Services in the State of Colorado

Issues and Concerns

Privately-supported, voluntary organizations have a history of experience in the provision of mental health services. Prior to the Comprehensive Community Mental Health Centers Act in 1963, much of the mental health care delivered outside of the state institutions was provided by care givers in the privately-supported voluntary sector.

The voluntary sector continues to be a significant provider of mental health services and must be more fully integrated with the total mental health system. These organizations provide large numbers of people with a variety of quality services (e.g., family and individual counseling). A substantial amount of non-governmental dollars are expended by these agencies in providing services.

The voluntary sector has unique contributions to offer the mental health delivery system. Privately-supported voluntary agencies offer a range of services which complement and/or provide alternatives to those which are publicly supported. Voluntary agencies and organizations possess experience and expertise in the utilization of citizen involvement. Further, voluntary organizations are valuable to the mental health delivery system as a possible source of matching funds.

Voluntary providers of service relevant to mental health problems presently comprise a sub-system currently removed from mental health clinics, centers, and hospitals. Respective roles and relationships of public and voluntary providers of mental health services must be clarified to permit an optimum

level of input and participation in the delivery system by voluntary agencies.

It should be clear that the intent of this goal is neither to encroach upon the prerogatives of independent agencies nor to force an unnatural relationship. The over-riding concern is to work toward a comprehensive network of services within a collaborative relationship which minimizes undesirable duplication.

Moreover, it should be noted that present policies of the Division of Mental Health encourage local catchment area facilities to contract for needed services with other agencies in the community as needed. The emphasis in the activities mentioned below should be on system-building and cost-containment within a cooperative effort.

Objectives

Objective A. By March 1975, a program will be initiated to secure ongoing, statewide planning input by voluntary organizations.

Comments and Recommendations: The Division of Mental Health should proceed immediately to identify voluntary providers of services related to mental health throughout the state. These agencies and organizations should be provided with copies of the 1974-75 Master Plan and those groups wishing to have planning input should be convened by regional coordinators or another designee of the division in each region. These groups should function in the first year as task forces to review the 1974-75 plan and participate in future revisions. However, the development of an ongoing mechanism for input should be considered at an appropriate stage of the process. The feasibility of the Mental Health Association of Colorado in assisting with implementation of this objective should be considered.

Objective B. By March 1975, the eligibility of voluntary organizations for contracts with the state and/or community mental health centers and clinics will be clarified, together with procedures for application.

Comments and Recommendations: Action should be initiated by the Division of Mental Health to actualize cooperative endeavors between public agencies and privately-supported, voluntary organizations in the provision of mental health services. Steps should include assisting in the clarification of roles of these providers relative to one another and clarifying procedures for purchase of service contracts, as well as insurance and third-party payments.

Objective C. By October 1975, there will be a plan with short and long-range objectives to actualize joint efforts between public and voluntary sectors in the delivery of mental health services.

Comments and Recommendations: This objective is predicated on the attainment of Objectives A and B above. The input process referred to in Comments and Recommendations, Objective B, could be instrumental in the development of plans to actualize a collaborative relationship.

Goal 16

To Respond Effectively to Increased Demand for Mental Health Services in Region 11, Resulting from the Impacts of Oil Shale Development

Issues and Concerns

The potential emergence of Garfield, Mesa, and Rio Blanco counties as a national center for the extraction and production of fossil fuels implies extensive human and environmental consequences for the western slope. Current population of the three-county oil shale region approximates 82,300. If intensive oil shale development occurs, 160,000 people could be added to the area by 1987, in addition to the 147,600 additional persons already estimated to result from normal growth.

"Boom" growth is a disruptive factor in any community. Residents must adjust to increased competion for available goods and services. New settlers must adjust to an unfamiliar environment which, by virtue of growth, has inadequate support systems. Rapid growth interrupts and/or reduces the capability of the human service system to respond effectively to needs. Probable consequences may include increased instances of crime and physical and mental illness, attributable not only to the increased number of potentially ill people, but also to intensified life stresses.

In the area of mental health, rapid growth may be expected to aggravate chronic and eposodic depression, suicide attempts, family disruption, child abuse, behavioral problems in children, and alcoholism.

Negative impacts of growth are serious in an urban, already industrialized population center. However, the consequences of boom expansion for a rural area, previously inexperienced with the liabilities associated with the urban setting are particularly serious. Not only are existing problems intensified, but new problems are created.

Previous Objectives: None.

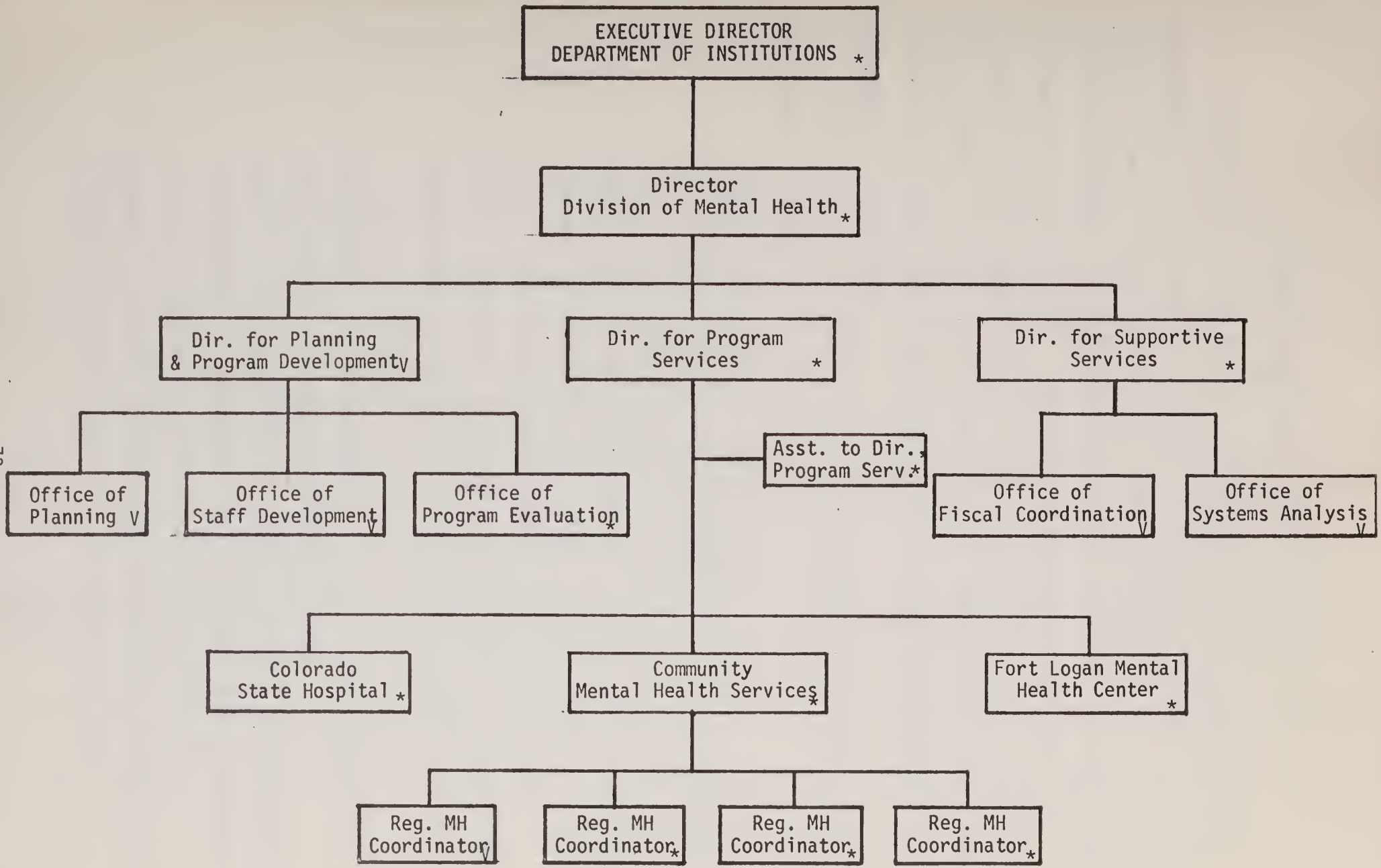
New Objectives

Objective A. By June 1975, the probable immediate, short and long term effects of population growth and industrialization on Region 11 should be evaluated in order to project the need for existing mental health services and requirements for service components.

Comments and Recommendations: Such an assessment should result in a financial plan appropriate to increasing service demands in impacted areas. The initial request should be included in the fiscal 1976 budget.

Objective B. By fiscal 1977, a long-range assessment of state-wide land use and growth projections should be completed.

Comments and Recommendations: The development of information and plans to prepare providers of service for increasing utilization of mental health services is critical to the future quality of life in Western Colorado. Such a process should include recommendations for funding mechanisms for lead-time resources which will permit mental health services to respond pro-actively to future growth and development.



KEY:

* = Positions Presently Authorized

V = Positions Requested

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 Direction: 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 Acccountability: 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.

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 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.

ROLE OF 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 23 communities across the state, which include over 80 percent of the population tion 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.

ROLE OF COLORADO STATE HOSPITAL

The Colorado State Hospital, established in 1879, served as the State's only public mental health facility for a number of years. During the 1950's, the inpatient population reached 6000, and the hospital was classified as a large, well-run, custodial institution.

Early in 1962, a major reorganization was undertaken. This modification involved a radical change in the placement of staff and patients at the hospital. Previously, patients were grouped into ward units according to presumed degree of treatability and ease of administrative control. Under the new "decentralization" program, patients were placed into units according to their residential region. Consequently, the reorganization allowed for stability and continuity of staff-patient relationships within the hospital and after release, to the patient's home community. Over the next decade and continuing to the present, reorganization has occurred as the inpatient population has decreased and additional needs have been identified. Day care, partial hospitalization, outpatient, and aftercare programs were added to the hospital's treatment modalities.

Two other significant developments have occurred which resulted in major changes in the overall role of Colorado State Hospital. The first of these was the establishment of the Fort Logan Mental Health Center in 1961, which in effect, resulted in another state supported mental health facility. This institution was designed to serve the Denver metropolitan area and later the northeast quarter of the state.

The second important development has been the formation of various comprehensive mental health centers throughout the state. Colorado State Hospital assumed an active role in assisting various communities to establish local mental health facilities. This assistance was given without charge and was designed to initiate or supplement local programs.

The most recent reorganization of Colorado State Hospital, in the Spring of 1974, eliminated geographic decentralization as a fundamental aspect. Presently, the hospital is organized according to special treatment services. These clinical specialties include: Children's Treatment Center, General Adult Psychiatric Services, Division of Forensic Psychiatry, Alcoholic Treatment Center, Drug Treatment Center, Psychogeriatric Division and General Medical-Surgical Services. Each unit operates as a separate budgetary entity and carries responsibility for the individual patient's treatment program, whether on inpatient, partial, or outpatient status.

Unlike the past, Colorado State Hospital, for the most part, is no longer required to offer mental health services to the entire state and responsibility for certain types of care has been shifted to other agencies. However, it will remain uniquely qualified to provide a variety of treatment programs that for clinical and economic reasons can best be offered by a regional state hospital. Its catchment area still includes approximately three-quarters of the state, most of it rural in nature, and this includes most planning regions and overlaps the service area of several comprehensive mental health centers and clinics.

Special services and activities at Colorado State Hospital now and in the future should be:

a. Residential treatment, both acute and long-term, for disturbed children, adolescents, adults, elderly, and forensic patients when intervention cannot be accomplished in local settings for clinical reasons or due to a lack of expertise and/or funds.

b. Highly specialized alcohol and drug abuse treatment including inpatient, outpatient and day care programs.

c. The Colorado State Hospital shall continue to serve as the only facility in the state responsible for the treatment of those individuals who have been adjudicated not guilty be reason of insanity to the commission of a crime. The hospital shall continue to serve as the

treatment facility for those individuals from the correctional system who have become psychotic or mentally disturbed during the period of their incarceration.

d. Colorado State Hospital will continue to provide some basic mental health services to various communities within the hospital's catchment area until community-based agencies are prepared and approved to assume responsibility for these services.

e. Initial non-residential treatment services will be provided to new clients when Colorado State Hospital has special expertise and operates special programs within the assignments of the Master Plan or as the result of agreements with other regional agencies.

f. A variety of non-residential treatment services will be provided to former inpatients when continuity of care of this nature is in the best interest of the patients' recovery or the maintenance in the community.

g. 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.

h. General Hospital services for (1) the southern part of the state through a family practice residency program and (2) for clients of the correctional system.

i. Psychiatric career resident program in conjunction with the Department of Psychiatry, University of Colorado School of Medicine.

j. Program evaluation, to improve program operations.

k. Continuing education, to renew and upgrade staff skills as required.

l. Training of health care professionals, para-professionals, and other mental health related disciplines.

ROLE OF FORT LOGAN MENTAL HEALTH CENTER

The history of Fort Logan Mental Health Center is short by state institution standards but packed with significant events. Opened in 1961 as the regional mental health facility for metropolitan Denver, it incorporated all of the newest concepts for the care and treatment of the mentally distressed. Initially the hard to control patients were sent to locked facilities at the state hospital in Pueblo, but as the staff gained experience and confidence, most people needing help were served with the exception of the "criminally insane" who required maximum security.

As the center grew, more and more services were provided within the community with staff rotating between day care, outpatient programs and the inpatient units. Continuity of care was thus insured with the same staff caring for the patient regardless of the type of service. Direct assistance was provided, without charge, to local clinics to help them become comprehensive community mental health centers.

With the increasing maturation of the community mental health centers, the responsibility for providing some services has shifted to these new agencies. Regionalized services provided by Fort Logan Mental Health Center includes those for the socially and psychologically dependent, chronically ill people who need a sheltered long-term treatment setting; vocational rehabilitation, special residential programs for children, adolescents, and senior citizens which are not economically feasible in each local area; alcoholism and drug abuse programs; and treatment settings for the difficult to control adult, i.e., those dangerous to themselves or others. For economic and social reasons, most community mental health centers will not be able to provide these services in the immediate future. Thus, the programs at Fort Logan will become increasingly specialized providing intensive care for people who have traditionally been high resource utilizers.

In order to adequately provide treatment for these special groups the per patient cost will increase from that of previous years when a substantial propostion of the patient population were less severely impaired. Staff training, especially in the adolescent and adult divisions, will be essential. Current staff shortages, especially in the medical area, must be eliminated through active recruitment. The opportunity and challenge of planning new and innovative programs should help with the hiring of sufficiently experienced staff. Some remodeling will be needed as more secure facilities become necessary. Certainly, innovative approaches to the treatment of these most difficult people need to be found if we are to avoid a return to purely custodial care.

In summary, the future role of Fort Logan should be:

1. Intensive treatment for those socially and psychologically dependent, chronically ill adults who can be treated in the community, given they are provided with easy access to the hospital and other resources familiar to these clients, thereby providing continuity of care.
2. Special residential treatment for children, adolescents and older citizens.
3. Specialized alcoholism and drug abuse programs.
4. Research and evaluation of new approaches in the treatment of the above populations.
5. Continuing education and training of professionals and para-professionala.
6. Regional resource for program evaluation, training and continuing education.
7. Provision of sheltered, secure setting with treatment for patients dangerous to themselves and/or others (but not criminally insane).

REGIONAL COMMUNITY SURVEY

In reviewing the regional plans in the 1973 Master Plan, it appeared that they were based exclusively on input from the mental health extablishment. Most of the priorities were service oriented, e.g., 24 hour alternatives, day care, etc., rather than oriented toward problems or target populations. Given the differences among regions across the state, it seemed strange that the priorities did not reflect these differences.

The 1974-75 Master Plan Committee originally wanted input from the regional coordinators regarding regional planning priorities based on meeting with local groups. Given the time constraints, however, it was felt that little information would be available in time for the revision of the Master Plan. Thus, a questionnaire was devised and lists compiled of interested, representative local people and organizations in each region. The questionnaires, lists, and guidelines for selecting participants in the study were sent to the Division of Mental Health in April 1974. The questionnaires were not sent out until September because of fiscal constraints. Most of the returns were in by the middle of October.

Focus of the Survey

The committee was interested in community opinion in several areas:

1. Where does mental health fit in overall community concern when compared with other problems and services?
2. What are the major mental health problems in each community and what are their relative incidence and/or severity?
3. How accessible and adequate are the mental health services in each community and what is the quality of existing services?
4. What services are now available, what is needed, and what are the priorities in each region?

5. What, if anything, is needed in the sense of greater community support?

6. What should be the role of the Division of Mental Health in meeting local mental health needs?

In addition, the committee was interested in the extent of community knowledge about the 1973 Master Plan and the names of people interested in serving on local mental health planning groups.

Procedure and Data Analysis

Approximately 550 questionnaires were sent out in September and 142 were returned by the middle of October. An additional 15 were received after data analysis had begun and could not be used. The overall return rate, therefore, was 28 percent which is respectable for a mail out survey.

While all regions of the state had some representation, the returns from some were skimpy, especially in the less populated areas. In addition, because of an unfortunate error, no questionnaires were sent to citizens in the Jefferson Community Mental Health Center catchment area. No claim is made that the sample reported here was representative of the constituency in each region due to the small return and the population surveyed, which, unfortunately, still included an over abundance of mental health oriented people.

Responses were keypunched and then analyzed using a simple average rank or percentage approach. Open-ended questions included in the survey were content analyzed to determine categories of response.

Findings

A. Major community problems

Mental health was ranked as the primary problem in six of the seventeen areas surveyed with four of these being in the Denver metropolitan area. This is not an unexpected finding given the composition of the sample. In general,

concrete problems and needs were ranked highest, e.g., housing, employment, crime, and medical care. Several urban-rural differences were seen and these, plus other exceptions to general trends, are noted below.

1. Transportation was generally seen as a moderate problem with the exception of Southwest Colorado, Arapahoe/Douglas County, and Colorado West - Region II.

2. East Central and Southwest Colorado ranked the need for legal aid much higher than other regions either because of a lack of lawyers or a larger proportion of people needing assistance of a legal aid nature.

3. The concern about medical care was basically a rural one, where doctors are frequently few and far between. Exceptions to this high ranking in rural areas were Southwest Colorado and Colorado West - Region II where it was given a very low ranking.

4. Crime and housing also reflect differing views of the urban and rural areas. Crime is highly correlated with population density while housing seems to have an inverse relationship. Pikes Peak and Southwest Colorado regions are an exception to the generally high ranking for housing.

5. Education received a split ranking with about half of the areas putting it fourth and the other half ranking it around eighth. This does not seem to be a rural-urban issue although there does appear to be some tendency for rural areas with no large town nearby to rank educational needs high.

6. The problems of minority relations, environmental issues, and nutrition appear to be localized. Minority relations are basically an expressed concern in the southern regions plus Weld County and may reflect the Chicano/Anglo population ratios in those areas. While substantial minority populations reside in the Denver area, minority relations rank eleventh in concern there - a rather unusual and disturbing finding. Nutrition was also a basically southern regional concern although not ranking above eighth.

B. Major mental health problems

Alcohol abuse, marital difficulties, and youth were seen as the leading mental health problems. Drug abuse, children, and school learning problems are generally next in order of concern with sexual problems and bizarre behavior usually ranking last. Some notable exceptions are listed below.

1. Larimer County and East Central Colorado ranked problems of aging much higher than did the rest of the regions.

2. Adams County ranked antisocial behavior and school learning higher, alcohol abuse lower, and youth problems much lower than the other parts of the state.

3. Sexual problems were ranked much higher in the Boulder catchment area than in other regions.

4. Social isolation appears to be a problem of considerable severity in Southeastern Colorado and Colorado West - Middle Park.

5. Suicide is ranked much higher in Southern Colorado and in the San Luis Valley catchment areas than in other areas.

C. Characteristics of service

While it is expected that centers and clinics serving large multicounty areas would not get a high rating on accessibility, this was not always the case. Colorado West, for example, covering ten counties, received higher ratings than did the Denver centers.

East Central Colorado has an extremely small staff so its low rating in adequacy is to be expected. The same is not true again for Denver and Arapahoe catchment areas. It is apparent that in several areas of the state either there are insufficient mental health resources and/or these resources are not addressing the perceived needs within the catchment area.

In general, quality of service was rated as good with some rated between good and excellent.

D. Services now provided

The data suggest that either the respondents were unaware and/or confused about the service in some cases or variation exists from one part of a region to another. In general, however, all areas agreed that outpatient services and consultation/education were now being provided. Those areas with centers rather than clinics also stated that emergency (crisis) services were available. The labels of the rest of the services seemed to puzzle some respondents. The implications for each agency seem clear - if the service exists and the respondents said it did not (and vice versa) then community education is certainly in order.

E. Services needed

In most regions without short or long term 24 hour care facilities, these ranked first and second in terms of needed additional service. Some regions, on the other hand, indicated a desire to continue the expansion of existing services before beginning new ones. This was particularly true in small centers and clinics.

F. Additional support for local mental health services

An overwhelming majority of the respondents felt that more community support was needed for mental health services. A content analysis of the comments revealed that public information and education would be of the greatest help and it should be provided by those delivering the mental health services.

Public information and education was mentioned most frequently as a service need. This category generally referred to publicity from service providers about services available, more frequent communication regarding effectiveness of services and unmet needs. Education to improve community attitudes about mental illness was also included within this category.

Financial support was the second most frequently perceived need for additional community assistance. The majority of respondents did not specify how additional funds should be allocated, but of those who did suggest uses, additional staff and general expansion of direct services were mentioned. Transportation to

make services more accessible, group and individual therapy, short term hospitalization, outpatient rehabilitation and needs assessment research were among the specific capabilities mentioned which needed expansion.

Citizen input was viewed as the need for active involvement in mental health programming by members of the community at large (particularly consumers, minorities, and low income persons). Awareness/sanction of local government generally referred to overall heightened sensitivity in public officials concerning mental health problems which would result in additional financial and policy support for programming.

State legislative advocacy included comments about the desirability of informed legislators, mental health legislation and appropriations at the state level. Additional volunteers were viewed as needed to participate in direct service when appropriate. The facilities category included comments about the need for more accessible and new, more attractive mental health facilities.

It is interesting to note that, while responses generally suggested the need for expanded community support in mental health area, the responsibility for its initiation and maintenance was viewed as resting with local mental health centers, clinics, and hospitals.

G. Role of the Division of Mental Health

In general, respondents viewed the role of the Division of Mental Health as being responsive to a variety of local agency needs. Financial administration included the state's responsibility to secure, allocate, and monitor the usage of monetary resources. It was also viewed as appropriate by some respondents that the Division of Mental Health actively seek matching for federal dollars from the legislative and other sources plus assist in the process of acquiring governmental grants and contracts.

Public information and education was viewed as the responsibility to inform the public at regular and frequent intervals about available services, to educate the public about specific problem areas such as alcoholism and child abuse, and

to generate greater community tolerance, acceptance and understanding of mental illness. The Division's role in consultation can be summarized as the translation of its expertise to local centers, clinics, and hospitals. Areas mentioned as appropriate were program development, planning and evaluation, and fiscal management.

Comments about the role of the Division of Mental Health in monitoring/evaluation most often suggested that local agencies be assisted in the process of self-evaluation. The need for the development of standards was also mentioned.

Many respondents referred to coordination as an appropriate function of the Division of Mental Health. Coordination was often viewed as the need to foster cooperation and establish channels of communication among existing programs with state-sponsored agencies and between the public and non-governmental providers of service such as private practitioners and voluntary agencies.

Planning as a role of the central office most often referred to: 1) research, (specifically, the development of a data base) with which to identify and monitor needs to permit more effective planning and 2) comprehensive planning for the future delivery of service. Advocacy/leadership as a function, viewed the state as a clearinghouse for information, a resource for ideas and technical expertise, and as leverage with local governments to be drawn upon as required by local agencies. Training referred to the role of the Division in developing and conducting a comprehensive program of staff development for agency professionals.

Community organization implied that the state actively and routinely seek the input of citizens on issues pertinent to the development of the mental health delivery system and organize mechanisms and/or opportunities for expanded community involvement. Program development concerned the ability of the central office, by virtue of its statewide perspective, to contribute innovations to local programs. Organizational management generally referred to the need for an effective, efficient and responsive central office.

The issue of the appropriate extent of state control was mentioned by a number of respondents, but not frequently enough to suggest clearly a consensus of opinion. Among those who did address the authority issue, comments more often than not favored an expanded role for the central office -- implying that the Division of Mental Health become more visible, proactive, and comprehensive in its approach to encouraging growth in the delivery system.

In summary, a collective impression from responses to open-ended questions on the central office in the survey could be interpreted as follows:

1. The nature of responses suggest that many are presently unaware of the function and responsibilities of the Division of Mental Health, other than to recognize that it is a possible source of funds.

2. It is viewed as appropriate that the central office assume considerable leadership in facilitating the development of a comprehensive delivery system.

3. The central office should have the capacity to provide a wide range and considerable volume of technical assistance to local agencies upon request and on a statewide basis.

H. 1973 Master Plan Reviewed

Very few of the respondents had reviewed the 1973 Master Plan and it is doubtful that more than a handful knew of its existance. The Master Plan Committee hopes to publish a summary version of the 1974-75 revision and this should have the widest distribution possible, including a mailing to all those who responded to the survey.

I. Local Planning Groups

Most of those responding to the survey indicated a willingness to serve on a local planning group should such a group be formed. Those declining usually cited other time committments as the reason. In addition, over three hundred names were obtained of people known to the respondents who could also serve as valuable resource people on local planning groups.

Conclusions

While realizing that the paucity of data requires the utmost caution in interpreting any of the results, the committee feels that some benefit was derived from the questionnaire. Basic regional differences do appear to exist and rural-urban concerns were further delineated. The list of names for membership on local planning groups will be extremely helpful in pursuing one of the committee's major goals for next year - increased community input.

Note: Copies of this manuscript including the survey instrument and all tables and other data are available on request from the Division of Mental Health. Direct inquiries to Mrs. Doris Davis, Division of Mental Health, 4150 South Lowell Boulevard, Denver, Colorado 80236.

POLICY COMMENTS AND RECOMMENDATIONS:

1974-75 Master Plan Committee

Now two years old, the six member Master Plan Committee of the Division of Mental Health has produced two annual documents for the purpose of guiding comprehensive future planning for the delivery of mental health services. The committee has functioned to date on a volunteer, ad hoc basis. Experiences of the committee in the first two years of its operation have underscored the magnitude and complexity of the effort required to develop thorough, well-conceived future plans. In the interest of maximizing the effectiveness and efficiency of the master planning process, the 1974 Master Plan Committee makes the following recommendations:

1. Purpose. The Master Plan Committee should continue to be instrumental in the development of long range plans for the delivery of quality, comprehensive mental health services in the State of Colorado.
2. Functions. The primary responsibility of the Master Plan Committee should be the generation and development of new ideas to promote the growth of an effective delivery system, reasoned from the collective input of a wide variety and large number of community resources throughout the state. Parameters of Master Plan activity should be the development of program and organizational goals and objectives in service delivery; the design of work plans, operational procedures and implementation strategies should not be the committee's responsibility.

   Among the activities appropriate to the committee's performance of this function are: preplanning (identification of the tasks to be accomplished in a given master planning year); solicitation and review of broad-based community input; revision and update of previous goals and objectives; chapter additions, where appropriate; and rough draft

preparation of the document. Given time constraints imposed by the voluntary composition of the committee, considerable professional and clerical staff assistance from the Division of Mental Health is imperative.

3. Relationship to the Division of Mental Health. The Master Plan Committee is advisory to the Director of the Division. Communication as to progress of the committee should be formalized through meetings of the Director and the committee chairperson at regularly scheduled intervals. Minutes of every Master Plan Committee meeting should be taken, transcribed and distributed to members of the committee and to Division staff. Instructions for implementation of various activities pertinent to the planning process and additional requests for assistance from the Division should be communicated in writing.

4. Staffing requirements. It is recommended by the 1974-75 Master Plan Committee that a member of the Division of Mental Health, preferably the Chief of Planning, should be appointed to be responsible for coordination of assistance required from the Division. Clerical assistance is also required to take and prepare minutes, type draft materials, handle mailings and other organizational details. The assistance of an editor is also required in preparation and formating of the final document.

5. Budget. Staff requirements mentioned above will necessitate budgeting for a part-time secretary. Given the priority of citizen input throughout the state in the master planning process, future committees will need resources to permit travel to outlying regions and for meeting expenses (e.g., duplication of materials and mailing).

6. Membership. Serious consideration should be given to appointing new new members of the committee in advance of the calendar year to permit

smooth transition. Old members and new appointees should participate jointly in initial committee meetings to orient the new committee, critique the completed plan, identify deficiencies and project tentative activities for the following year.

7. Scope of the annual plan. Given time, resource and manpower constraints, the Master Plan should be rewritten only every five years. Intervening years should focus on updates, revisions and additions of new material.

8. Preliminary Objectives - 1975-76 Master Plan.

   a. The 1975-76 Master Plan Committee, with the assistance of the Division of Mental Health, should provide numerous opportunities for statewide citizen involvement in the planning process, resulting in a significantly expanded volume, diversity and representiveness of input. This process may include, though not be limited to:

      1) Further identification of local agencies and interested citizens to be contacted for input.

      2) Broad distribution of the Summary Report of the 1974-75 plan; increased availability through centers, clinics and hospitals of the full 1974-75 report for reference by interested persons.

      3) Review and comment hearings in each region.

      4) Formation of regional task groups to compile and communicate draft materials concerning local needs and problems, including representation from local Councils of Governments and other existing groups involved in mental health issues.

      5) An opportunity for each regional group to meet with the Master Plan Committee after mid-year.

   b. The 1975-76 Master Plan Committee should address the following issues not included in the 1974 plan:

1) Construction plan

2) New funding needs and non-federal funding mechanisms

3) Service goals and objectives concerning:

   a. Alcohol and drug abuse

   b. Forensics

4) The effects of regionalization of the structure and organization of the central office.

c. The target date for the completion of the draft of the 1975-76 edition of this document should permit adequate time for review and comment by interested parties.