PLANNING COMPREHENSIVE MENTAL HEALTH SERVICES IN COLORADO

COMPREHENSIVE PLANNING FOR MENTAL HEALTH SERVICES IN COLORADO

Volume I:

REGIONAL RESPONSIBILITIES AND THE ROLE OF THE STATE

A Basic Plan For Developing Services,

Funds, and Leadership

Formulated By The State Mental Health Planning Committee

Assisted By Fifteen Regional Committees

And Nine Special Task Forces

November, 1965

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TO THE HONORABLE JOHN A LOVE, MEMBERS OF THE LEGISLATURE,

AND THE PEOPLE OF COLORADO

Dear Governor Love:

On October 4, 1963, you opened the comprehensive mental health planning effort in Colorado by addressing a workshop of over 150 citizens at Fort Logan Mental Health Center. You remarked:

> "We have had a number of past studies in Colorado, largely addressed to the needs of state-level institutions. In coping with these needs we have made real progress.
>
> But final solutions, it seems more and more apparent, must occur on the community level, the arena of everyday life where 'mental disorders' first originate and must eventually be resolved. Unless truly comprehensive services are really developed in such a way as to be easily and locally accessible to every citizen, this state and other states will continue to load up state institutions with patients of whom many, cut off from home communities and family ties, will end their lives as chronic bits of institutionalized wreckage.
>
> In our time, we need to bring the care of the 'emotionally disturbed' back to the community. Working out a practical way to do this is the task which this workshop is helping to initiate."

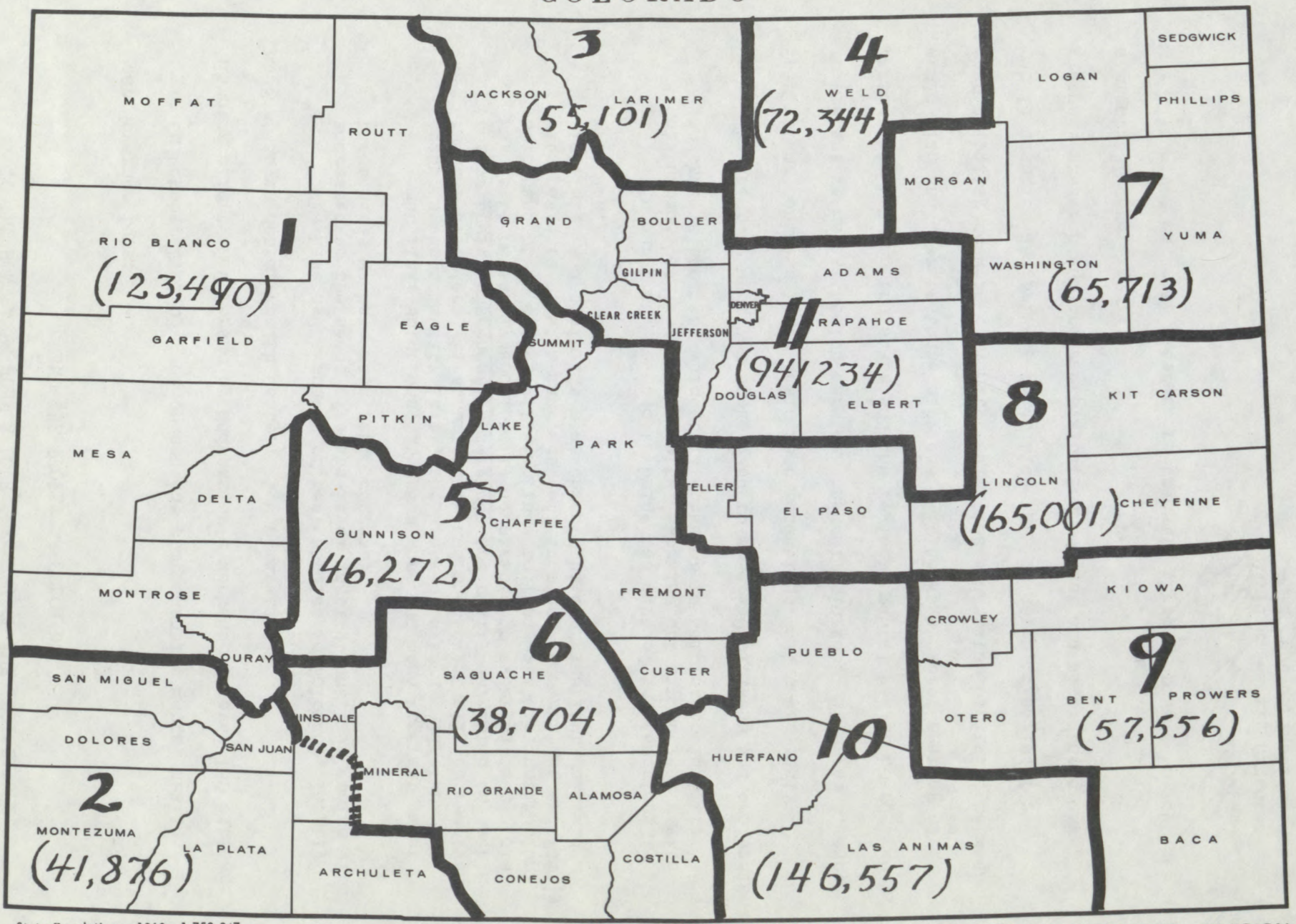
The group to whom you spoke grew to some 450 citizens and professionals. This volume contains their basic recommendations. It urges really comprehensive mental health services thruout Colorado. It urges a major partnership between the state and the regional mental health boards who would plan and operate these services. It seeks a closer sharing of responsibility between community facilities and state hospitals, between public agencies and private practitioners. It hopes, finally, for vigorous research and program evaluation to test and alter these new elements of care.

It gives me great pleasure to transmit these proposals to you.

David A. Hamil

David A. Hamil, Director
Department of Institutions

COLORADO



State Population – 1960: 1,753,947
Regional Base Minimum: 40,000

ELEVEN REGIONS FOR MENTAL HEALTH PLANNING

STATE PLANNING DIVISION

TABLE OF CONTENTS

MAPS, GRAPHS, CHARTS, AND DRAWINGS

Note: All graphs present data on a regional basis

INTRODUCTION: How These Volumes Are Arranged

This is the first of three reports summarizing the findings of the comprehensive mental health planning project in Colorado.

Volume I contains the basic proposals of the State Mental Health Planning Committee and its regional planning committees.

Volume II includes the detailed reports of nine special task forces.

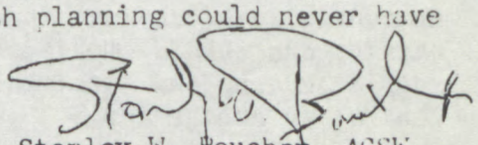
Volume III is a book of data. It contains the basic tables, graphs, and inventory analyses on a region-by-region basis which help support these recommendations and form the basis for future evaluation of the mental health programs of this state.

It is apparent that the heart of this planning effort appears in this first volume. Here is a summary of the recommendations of the State Mental Health Planning Committee. Starting as a 17 member group in 1963, this inter-agency work force grew in two years to 33 persons, 10 of them mental health professionals, 16 from allied professions, and 6 representing citizen organizations. Assisting this group were some nine special task forces which came to include 108 professionals, and fifteen regional planning committees totaling 310 local citizens.

Thus, these volumes represent the work of some 450 persons. They include contributions from the major professional and citizen organizations in Colorado with a stake in mental health planning.

Staff support for this planning effort involving so many agencies and private citizens came from the Department of Institutions. The Project was directed by Dr. Hans M. Schapire, M. D., Chief of Psychiatric Services. The final plan as incorporated in these three volumes was edited and in part written by Stanley Boucher, ACSW, Assistant Director for Mental Health Planning. Much of the data was worked out by Dr. Nancy Wertheimer, Ph.D., Dr. Eugene McGee, Ph.D., Larry Brittain, M.A., and Steven Weiss. Final printing was done at the Colorado State Penitentiary under the technical supervision of Mr. A. L. Blaine.

Our grateful thanks go out to the hundreds of people who gave thousands of hours of time -- much of it necessarily spent in the tedious process of making order from a chaos of data and ideas. Not all can be mentioned here by name, yet without their help this effort to initiate comprehensive mental health planning could never have gained momentum.



Stanley W. Boucher, ACSW
Assistant Director
Mental Health Planning Project

I. THE BASIC PROPOSALS

Three themes dominate this plan to meet the future mental health needs of Colorado: comprehensive services, community action, coordination of effort.

The State Mental Health Planning Committee believes these are issues central to a modern mental health program. They undercut almost every other planning issue -- funds, manpower, insurance, program research, pinpointing responsibilities at the state and local levels, clarifying public and private practice roles, etc. And unless they are solved, future services in Colorado will grow at unequal rates and with dizzying inefficiency.

Accordingly, the state committee, assisted by some 450 persons on its regional committees and task forces, has formulated six basic proposals:

I. *Comprehensive Mental Health Centers, located in communities, serving citizens close to home (including the most seriously mentally ill), are the wave of the future and a logical outgrowth of Colorado's past.*

Such centers should be developed thruout the state.

II. *Regional Mental Health Boards should be appointed in each area of Colorado to study available resources, allocate funds for community services, and eventually assume full responsibility for seeing that the mental health needs of their citizens are being met.*

III. *The State Mental Health Planning Committee, revised to include regional representatives, should become the basic advisory group to the Department of Institutions in setting standards, allocating state aid, evaluating results, and developing appropriate changes in policy.*

IV. *The State Mental Health Authority (Department of Institutions) should take ultimate responsibility for stimulating the development of adequate community mental health programs thru standard setting, fiscal aid, consultation, and program evaluation.*

V. *State Hospitals should give backup support as needed to regional mental health boards and community centers; should participate in the planning and decisions made by regional mental health boards; should develop -- in consultation with regional boards -- community services with their own staff where feasible and appropriate; and should emphasize specialized programs such as training, research, and treatment innovations difficult for community centers to engage in.*

VI. Special priority should be given to the construction of two comprehensive mental health centers, on the Western Slope and northeastern Colorado, in order to provide those citizens most distant from present state hospitals with: comprehensive mental health services for immediately adjacent communities; inpatient and consultation support to neighboring regions as they in turn develop comprehensive services.

II. DETAILS: And A Point-By-Point Commentary

Each of the basic proposals is presented here with the detailed recommendations of the State Planning Committee. Each proposal and set of recommendations is then followed by a commentary which seeks to review the logic behind the proposals -- the "intent", so to speak.

I. *Comprehensive Community Mental Health Centers:*

1. *The committee believes the concept of the "comprehensive mental health center"--when flexibly defined--is appropriate for Colorado's needs, both rural and urban.*

2. *Accordingly, the committee urges that Colorado make a major effort to develop--in the next decade--comprehensive mental health centers throut the state, as accessible as feasible to every citizen.*

3. *Such centers should become the basic tool for solving public mental health problems on the community and regional level.*

4. *State funds should be used to match federal construction funds to build these centers so as to enable poorer regions to construct centers on an equitable basis with wealthier areas. Centers so constructed could be leased by the state to the regional mental health board or other appropriate operating agency.*

5. *The state should enlarge its present pattern of state aid for outpatient clinics so as to help support all elements of comprehensive services--including in-patient care, partial hospitalization, and emergency services.*

6. *State aid for operating community mental health centers should assist poorer regions on a greater proportional scale than wealthier regions--by use of a variable matching formula.*

Commentary: Every present trend supports the location of mental health services as close as possible to the communities in which people live and in which they develop those disorders of living known as mental illnesses. The major focus of the state planning committee has been the orderly development of such services with proper levels of state support, local responsibility, and a due regard for federal legislation which might be adapted to Colorado's needs and traditions.

A major question has been: is the "model" of the comprehensive community mental health center as proposed by President Kennedy a viable one for Colorado?

This model, as outlined in the Community Mental Health Centers Act*, consists of a complex of services designed for an immediately adjacent geographic "community" of from 75,000 -- 200,000 persons. These services need not all be in one building. They could even be offered by a number of separate agencies so long as there were clear administrative agreements guaranteeing easy transfer of patients and records from one agency to another. They should be available to all age groups in the population and must be available to the indigent. At a minimum they would have to include:

1. Outpatient services;
2. Inpatient services;
3. Partial hospitalization (e.g., day hospital, etc.);
4. Emergency services;
5. Consultation and Education.

The big questions raised by the state committee were three:

First, does the catchment area or "community" to be served by this model fit Colorado's needs? For years, we have been developing multi-county mental health clinics based on the premise that 40,000 people is close to the minimum a full-scale clinic could efficiently serve. Some "regions" in Colorado barely approach that figure, yet in terms of driving distances, economic patterns, and the views of their inhabitants they constitute true regions (e.g., the San Luis Valley). It now seems clear that federal legislation and administrative regulations will be reasonably flexible -- where a clear and logical case can be made for developing a regional center serving less than 75,000 persons, the Surgeon-General can permit construction grants and staffing funds to be utilized. Thus the six mental health planning regions in Colorado with populations under 75,000 could still hope to achieve centers.

Second: Is "partial hospitalization" (day hospital, etc.) a feasible requirement for a center serving vast and sparsely populated rural areas? Examination revealed that each of the eleven regions in Colorado had at least one city or town which contained a high proportion of the area's population. A circle encompassing an hour's drive (the probable maximum distance for practical use of a day hospital) would greatly add to the proportion who could be served. Those who lived too far would have to be served by 24-hour inpatient care, although some might soon be able to find housing close to the Center so as to continue treatment during the day and live away from the Center in a more normal community setting at night. Hence, it would not be uneconomical to include partial hospitalization services in Centers, even in rural Colorado. And with ingenuity, many patients could use such services (although probably not as high a proportion as those living in Denver and able to use day hospital care at Fort Logan).

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* See discussion in Chapter III - "What is a 'Comprehensive Community Mental Health Center'?"

Third: Are "comprehensive centers" to serve all the mentally ill in their catchment areas or will they treat only those requiring brief therapy, sending their "rejects" on to a distant state hospital? Or can the comprehensive community center concept be combined in some cases with that of the state hospital?

This question is the most fundamental of all. It would be simple to go ahead and establish machinery by which a few fortunate communities in Colorado could apply for federal aid in setting up comprehensive centers. But if we really wish to rely upon the comprehensive community mental health center as a basic service available to all citizens thruout the state, a number of issues must be resolved. For Colorado already has two model-types of mental health services developing. It has a system of state-operated hospitals and a system of state-aided community outpatient clinics. Would the new comprehensive centers constitute a third system or could they be viewed as a more advanced stage of development for outpatient clinics, state hospitals, or both?

To answer these questions, we should review past trends in Colorado:

Since 1879, the state has assumed major responsibility for financing public mental health services. The original model was the custodial state hospital offering inpatient services exclusively (and often for life). In 1925, this model was altered slightly with the addition of a training hospital at the medical school emphasizing intensive care for acute illnesses thought likely to respond quickly to treatment.

In 1927, a major innovation appeared when staff from the medical school initiated "traveling community clinics" in various Colorado communities. The clinic model, emphasizing early treatment for children and adults not yet so disturbed as to require hospitalization, was revived after the depression and World War II. By 1957, a Governor's Commission on Mental Health had persuaded the legislature to utilize state funds on a 50/50 matching basis to help support community outpatient clinics. In eight years, the number of clinics grew from five to twenty. As services expanded, tentative ties with local general hospitals for brief inpatient care of acute cases were often attempted. But lack of funds made this difficult. Increasingly, suggestions were made that state aid should be broadened -- as in New York or California -- and matching funds for inpatient care added to outpatient allotments.

But in 1961, the state injected "community" into its state hospital model also. Fort Logan Mental Health Center became the second state hospital -- located, deliberately, as close as possible

to the Denver area it was to serve. Although originally designed to be "second echelon" -- i.e., serving long-term patients and those who failed to respond to first echelon community resources -- it emphasized its ties with the community from the beginning. Patients were admitted thru community agencies and practitioners. They were to be returned to community living as rapidly as possible. So dramatic was Fort Logan's impact that by 1963 it had a national reputation as a partial prototype for the comprehensive mental health center concept urged by President Kennedy.

Simultaneously, the older state hospital at Pueblo was decentralizing its internal operations into a number of semi-independent "Divisions," each serving a distinct geographic area of the state. Each division's staff made strenuous efforts to develop working ties with community agencies in its area -- though distance often made this difficult. As for the Pueblo Division of the hospital, it began to offer day hospital services to the adjacent community and to develop program links with the community clinic in Pueblo.

Thus, outpatient clinics -- operated by communities but with major state fiscal support -- have evolved toward ever broader ranges of service. In many parts of Colorado, they represent logical stepping stones toward comprehensive centers able to qualify for federal aid in construction and staffing.

Meanwhile, state hospitals have moved out toward the community even as they have demonstrated that such new techniques as day hospital services are effective and practical with highly disturbed patients.

It is now clear that the major thrust of federal legislation and the activities of the National Institute of Mental Health in the next decade will be to stimulate the development of comprehensive community mental health centers. Quite apart from such inducements as taking advantage of federal aid to supplement state and local funds, the state planning committee believes the comprehensive center concept does, indeed, fit in with Colorado's own developments. And by participating in its implementation, Colorado will have an opportunity to help alter this model, to remedy some of its shortcomings as they become apparent. For this state has already done as much as many and more than most to develop the concept in the first place.

II. Regional Mental Health Boards:

1. The planning committee recommends that each region or community should have a single clearly-designated "authority" or "mental health board" to take leadership in assessing regional mental health needs and working toward better meeting those needs.

2. Such a leadership group should have prime responsibility for determining how to allocate state aid to public mental health services within its region, based on standards set by the State Mental Health Authority.

3. Formation of boards: In a manner to be legislatively prescribed, all counties shall participate in forming mental health boards to serve their respective areas. Such boards shall be formed by action of the County Commissioners within each area, the Commissioners to appoint as board members representatives from their respective counties who also represent in appropriate proportions the major agencies, professions, and consumer groups most concerned and knowledgeable about mental health problems.

4. Each portion of a state hospital which serves a specific region should have representation on that region's mental health board. Thus, the Director of a state hospital would participate from the beginning in community-level decisions which could affect both the range of services within the region and his own facility's manner of contributing to such services.

5. Boundaries for areas to be served by mental health boards shall be set by the State Mental Health Authority, using criteria developed with the advice of the State Mental Health Planning Committee. Such boundaries shall be revised when appropriate. They shall include counties as whole units, never placing portions of a county in different regions.

6. Duties of Mental Health Boards:

   a. Each mental health board shall annually review--and revise when appropriate--the mental health plan for its respective region. Each board shall select one representative to serve on the State Mental Health Planning Committee.

   b. Utilizing standards set by the state mental health authority (with the advice of the State Mental Health Planning Committee), the regional board shall determine whether to apply for state matching funds for mental health services within its area; shall act as sole recipient for such funds; shall prepare an annual budget (if it elects to seek funds) for submission to the state mental health authority, and shall receive appropriate local funds to match state funds and/or federal funds.

c. *Each board may utilize the funds it receives (state, local, and federal) either to purchase mental health services from individuals and agencies (both private and non-profit) meeting state standards or to operate portions of such services directly.*

d. *Each board shall submit its expenditures to an annual state audit.*

e. *Each board should name a Director of Regional Mental Health Services to serve at the board's pleasure and to plan and administer the board's mental health program.*

7. *Wherever appropriate, Regional Boards should be constituted so as to help coordinate development of mental retardation services with mental health services. Combined mental health-mental retardation centers are a logical goal for many areas.*

Commentary: The need for some type of regional mental health authority for each area in Colorado was approved in a questionnaire by a substantial majority of agencies and individual practitioners thruout the state. The concept has been voiced in Colorado at least since 1960 when -- at a meeting of clinic board members and staff -- it was suggested that the state was in danger of developing a variety of mental health tools without any unifying program goals. Every community, it was felt, needed some one group to take a systematic overview of community needs. Clinic boards could do this in some areas, but they were not specifically charged with any responsibilities other than operating their own clinic services. Furthermore, what happens when a community develops more than one clinic? At present, it is up to the Department of Institutions to divide funds available to an area - such as Denver -- among the several clinics. Thus programming and determining priorities for an area are at present done by state consultants. But the principle of stimulating community action to meet community responsibilities would surely be better served by making the regional mental health boards responsible for setting priorities and allocating funds, not merely advising on them.

At the heart of this proposal are three major issues: equity, the principle of equal access to modern mental health services no matter where one lives; professional leadership in partnership with other sources of community leadership and knowhow; state aid and support for community-level services.

As for equity, it is apparent that the state cannot place an ever-increasing reliance on community mental health centers in some regions while others must still send patients hundreds of miles to a distant state hospital. If community services are what are needed,

the state -- which has always played the major role in combatting public mental illness -- has a moral obligation to help foster a system of community services. Hence all counties as local arms of state government, should be required to help set up a mental health board for their region even if, for a time, such a board finds it difficult to initiate local services.

The role of professional leadership was a source of concern to many who answered the questionnaire item on "citizen mental health boards." A few seemed to feel that ordinary citizens would be called upon to make professional decisions beyond their competence -- especially if patronage problems entered the picture as matching funds increased. The State Planning Committee believes such fears will be unwarranted if proper safeguards are set up. "Citizen boards," after all, operate a number of voluntary agencies and general hospitals. They usually have no trouble delegating decisions which can only be made by professionals. And a competent professional can usually explain his major concerns to the lay citizens on his board. As mental health programs take increasing cognizance of social disorders which can only be relieved by community action, it may be more and more important for mental health professionals to develop knowledgeable allies among other community leaders. Finally, any community has a right to have some say in the manner in which mental health services fit into the pattern of its basic health, welfare, and educational services.

The state committee believes local professionals should be tapped by requiring board membership to include such persons as local physicians, hospital administrators, district judges, welfare and health administrators, and existing mental health agencies. Room should be reserved for "lay citizens" from such groups as mental health associations, chambers of commerce, labor organizations, etc. Terms should be overlapping, probably for three-year intervals.

As for state leadership in aiding and supporting these services, the state planning committee believes this must grow -- not decrease -- as community level services develop. State standards are a must if equity is to be preserved. State fiscal aid is crucial -- local funds are quite limited and federal monies must be matched at substantial rates. And Federal staffing money, in particular, will be "seed money" gradually phased out over a four-year period.

One final note: present clinic boards in a number of areas could undoubtedly convert themselves into regional mental health boards if they so chose, with relative ease. A few boards are already named by county commissioners, and board makeup is probably identical with that which would be selected for the regional board. In other areas, clinic boards might wish to remain independent of the regional board but available to it for the purchase of services. In no case, of course, could a local clinic negotiate with the state directly for funds while bypassing the regional board covering its area.

The major reasons for setting up regional mental health boards as instruments of county government rather than simply expanding the functions of present clinic boards (most of which are voluntary non-profit corporations) is to make legal the use of state funds to assist in capital construction, and to make easier the participation of regional citizen boards in advising on state policy and utilizing large sums of state money to further what is, in the final analysis, a traditional state responsibility: meeting public mental health needs.

III. *The State Mental Health Planning Committee:*

1. *The State Mental Health Planning Committee, with appropriate representation from Regional Mental Health Boards, should become the basic advisory group to the State Mental Health Authority in setting standards for community mental health services, allocating matching funds to Regional Boards for such services, and reviewing, accepting, or rejecting annual revisions of regional mental health plans.*

2. *The State Mental Health Planning Committee would advise the State Mental Health Authority on implementation of comprehensive planning for mental health services in Colorado, on annual revisions of the State Construction Plan for Community Mental Health Centers (such revisions are required by federal statute), and in developing cooperative services with allied state agencies and professional organizations which clearly relate to the mental health of Colorado's citizens.*

Commentary: The State Mental Health Planning Committee would become the basic formal mechanism for attempting to work out common policy among the principal state departments and organizations whose activities have a bearing on mental health. It would include the State Mental Health Authority (Department of Institutions) and the state departments of public health, welfare, education, and rehabilitation. It would include also the medical school and state universities, as well as the principal professional mental health disciplines and citizen organizations with a stake in mental health policy. In addition, it would include representatives from regional mental health boards.

Thus, although advisory only, its task would be to orchestrate policy among state organizations and regional boards. Unlike many state advisory committees, this group would be made up not of private citizens serving in an individual capacity but rather of persons representing organizations which have direct operational or moral responsibility for mental health programs and standards. It would be a formal device for promoting negotiation, useful compromise, and -- where possible -- decisions made in common.

IV. *The State Mental Health Authority (Department of Institutions) should take ultimate responsibility for developing and evaluating community mental health programs thru standard setting, fiscal aid, consultation and program evaluation.*

Commentary: Although the thrust of these recommendations has been toward services operated on a local and regional basis, ultimate responsibility toward ensuring that all citizens have services of equally high quality rests with the state. It is quite evident that without strong state leadership in the past (in the form of consultation, public education, and fiscal aid buttressed with standards as to what constitutes a bonafide clinic), most of the present community clinics would not be in existence. It is also evident that without state leadership in creating Fort Logan and the changed programs at Colorado State Hospital, few communities would have any real yardstick with which to measure the practicality of such new innovations as day hospital treatment, vocational rehabilitation of the ex-psychotic, electronic data systems, psychiatric technicians as active treatment agents, etc.

In the future, large sums of federal money will doubtless be available to buttress community mental health services. But without backup support from state institutions, community centers will be swamped in their early fledgeling stages. Without state aid to supplement local funds, few but the wealthier regions will be able to match federal funds. Without state assistance in facilitating multiple-county regions of sufficient size to make substantial mental health complexes feasible, rural areas and small communities will never get on a par with the metropolitan areas. Without state consultants on a routine and ongoing basis over a period of years, regions without mental health experts will never get the experts they should eventually attract as permanent residents. Without state facilities for training personnel -- including technician training such as Fort Logan and Colorado State Hospital supply -- manpower needs will be far more difficult to meet. Without state projects in the use of electronic data systems, regional mental health services will find it difficult or impossible to evaluate their own efforts or make valid comparisons with other regions. Without state support for innovations, pilot projects, and information exchange, creative breakthroughs in new modes of treatment will be far more difficult for struggling community centers. And without the buffer of state standards and legislative intent, new centers in areas with scant experience in community mental health techniques will find it difficult to develop informed leadership to initiate programs.

V. State Hospitals:

1. The eventual goal is for regional mental health boards to assume full responsibility for seeing that the mental health needs of their citizens are met. It is unrealistic to assume that they can do this without a direct partnership with, and major support from the state hospitals.

2. Three functions seem crucial for state-operated facilities: rendering technical and moral backup support to regional mental health boards; developing specialized programs for patient populations found not amenable to treatment at the community level; developing treatment and research innovations which become eventual yardsticks for other facilities to use in improving their own services.

3. For regions beyond reasonable commuting distance, backup support from state hospitals should include:

   a. Assistance in developing realistic planning for regional services through participation in regional mental health boards;

   b. Consultation and--where necessary--participation in pre-admission screening and aftercare services for patients who require state hospitalization;

   c. Consultation and training in the operation of emergency, inpatient, and partial hospitalization services within the region;

   d. Specialized training for professionals and sub-professionals;

   e. Consultation and technical assistance in program evaluation;

   f. Stimulation of pilot projects and demonstrations within such regions.

4. For regions immediately adjacent or within commuting distance, state hospital support should include the items above plus development--in consultation with regional boards--of whatever community-level services appear most feasible and appropriate.

5. Where specific categories of patients can be identified which are not amenable to community-level care, such patient populations should become the special responsibility of state hospitals.

6. State hospitals should emphasize training (including post-graduate training in new techniques), research, and treatment innovations. By pioneering and refining in these areas which are difficult for community centers to devote major attention to, state hospitals should develop constantly improving yardsticks by which regional boards and community centers may gauge their efforts.

Commentary: The exact relationship between comprehensive community mental health centers and existing state hospitals has never been clarified by federal legislation or the regulations proposed thus far by the National Institute of Mental Health. In 1961, the congressionally-sponsored Joint Commission on Mental Health and Illness urged an updating and strengthening of state hospitals. Guarded assertions are now sometimes made that the "Community Center" concept of 1963 is a new direction entirely, that Community Centers will someday "replace" state hospitals. For Colorado, at least, this seems a false dichotomy.

For in this state, the Joint Commission's suggestion was taken literally -- and Colorado's two state hospitals are not only oriented toward advanced forms of treatment but already function in part as community mental health centers. Faced with the apparent dilemna of distinguishing between the functions of state hospitals and community mental health centers, the planning committee spent many months attempting to define "second echelon" versus "first echelon," etc. It became gradually clear that no rigid demarcation is at present feasible or even necessarily desirable. Our choice is not old-fashioned custodial hospitals versus community services. It is rather how to best use our present community-oriented state facilities to help create and support a broader system of community services.

The State Planning Committee believes that in creating broader patterns of service, we must draw heavily upon the criteria and experience developed in our own state facilities. We have, in effect, created our own yardsticks in Colorado for such new therapies as day hospital care, etc. It seems apparent that innumerable future innovations will have to be worked out first in state facilities. It is difficult to see how struggling new community centers could initiate experiments in electronic data processing, for instance, or try out industrial work therapy on a sufficient scale to evaluate its results. Yet the state hospitals already have resources to push such major undertakings.

As for the support role of the state hospital in backing up the efforts of the community center, both dangers and opportunities are forseen. The chief danger -- a matter of grave concern to the planning committee -- is that the support function would gradually mean sending the least desirable type of patient to the state hospital while community centers treat only those most highly responsive, attractive, or interesting. This could result in the state facility again becoming a repository for community rejects, with consequent poor staff morale, etc. It could also mean that community centers would prematurely cease to attempt treatment for types of patients potentially able to benefit from them. The committee is not convinced that any present evidence proves the inevitability of certain patients becoming "chronic", for instance -- yet pressures to concentrate upon responsive patients and ship off the rest to the state hospital could easily re-create the legions of "chronics" who clogged state hospital wards in the past.

On the other hand, it is a possibility -- also not disproved by any present evidence -- that a small percentage of patients in any community program will still fail to respond, will still need longer-term care of a specialized kind best rendered by a state facility. This possibility can only be settled by program research. Meanwhile, it is evident that development of community centers in most parts of the state will take much time, and that for at least the next decade most regions will not be able to handle all the patients within their boundaries. A cooperative relationship -- constantly evaluated upon the basis of accrued research data -- will be essential between such centers and their supporting state hospitals. Otherwise, the centers will be swamped.

Finally, by using state hospitals to back up distant regions and to participate meanwhile in community mental health services in adjacent regions, we preserve our capacity to experiment, to develop more definitive criteria for distinguishing between short-term, long-term, or specialized treatment loads, etc. And by including the state facility in the decision-making of the regional board, we help remove the objection that state hospitals are not responsive to community needs.

VI. *Special Priority for Two Comprehensive Mental Health Centers:*

1. *Two major comprehensive mental health centers should be established as rapidly as possible to serve the two areas whose citizens are now most distant from present state hospitals: on the Western Slope and in northeastern Colorado.*

2. *Although it may prove necessary to initially operate these two centers as state facilities, they should be turned over to their respective regional mental health boards as rapidly as feasible.*

3. *These centers should be tied in by contract or other administrative device with present outpatient clinics and future regional mental health boards in western and northeastern Colorado so as to provide:*

   a. *Comprehensive community mental health services for immediately adjacent communities (which would include the greatest population centers in their areas);*

   b. *Inpatient and consultation support for as long as necessary to neighboring regions as they in turn develop comprehensive services.*

Commentary: The probable location of these two comprehensive centers would be in Grand Junction and Greeley. Each would serve a large area whose inhabitants must presently travel from 150 to 300 miles for service at the state hospital in Pueblo. Each would offer comprehensive community mental health services to the major population clusters within commuting distance. In addition, each would offer inpatient facilities and consultation to nearby regions whose mental health boards would purchase service until able to develop their own comprehensive centers.

Thus a center in Grand Junction would offer a full range of services to the people in its vicinity, plus support and inpatient care for more distant portions of Region 1 such as Glenwood Springs, Aspen, and Craig. It would similarly offer inpatient support as long as necessary to Region 2, and possibly to adjoining portions of Utah.

A Center in Greeley would offer comprehensive services to Region 4, and inpatient support to Regions 3 and 7. It could conceivably offer inpatient support also to Boulder County, presently part of Region 11, although it may well prove feasible for this area to develop its own comprehensive center quite early.

It should be noted that these areas are among the very highest priority areas in the present Construction Plan for community mental health centers as submitted to the Surgeon-General in 1965. At one time, minature state hospitals modeled after Fort Logan were proposed in these areas, but the community mental health centers act offers an approach which meets needs and allows for cooperative state and federal financing.

III. BACKGROUND:

A. Planning -- How It Developed In Colorado

To plan is to seek out desirable change, suggest steps for attaining such change, and -- if possible -- evaluate the results so as to facilitate new and more effective change.

This process requires the participation of key groups in a position to identify, sanction, or carry out the needed changes. It requires data. Finally, if directed at a continuing problem (such as the mental health needs of a large and growing population), a problem subject to a constant drumfire of new concepts and new techniques, planning itself should be a continuing process capable of readjusting or redefining future goals and priorities in the light of constantly accruing feedback on past operations.

Hence, when Colorado received a grant in June, 1963 to initiate comprehensive mental health planning, it faced three major challenges:

1) There is an enormous diversity of disciplines, agencies, and key groups with a major stake in mental health planning. Some 353 agencies were identified thruout Colorado with at least some interest or participation in mental health programming. Hundreds and hundreds of private practitioners take part in at least quasi-mental health activities. Every level of government is involved, with every expectation that future trends will increase such multi-layered partnership. A need existed to somehow select certain groups and key individuals to play the more active roles in planning, knowing that potential participants far exceeded the possibilities for efficiently utilizing their contributions. This process was in turn complicated by the fact that in some areas little was known about available professionals or key citizens. A need to recruit participants existed simultaneously with a necessity to pare down committees and task forces to manageable size.

2) This diversity of agencies and concerned persons is paralleled by an abundance of topics whose fruitful resolution might be considered part of comprehensive planning. With a two-year grant, staff could be hired to gather data and support committee work on only a portion of these topics. As it was, 26 committees were organized and given staff support during this effort. An enormous amount of data was culled and analyzed. But much of the data must be considered exploratory only. And a number of key problems remain to be investigated by further planning in the future.

3) Past mental health planning in Colorado, as in most states, had proceeded in fits and starts. A Governor's Commission on Mental Health in 1956 left as its principal legacy the development of state aid to community clinics. A U. S. Public Health Service survey of the state hospital in 1959 was followed by several Ad Hoc committees focusing attention upon the needs of the state hospital system and urging an overhaul of the Department of Institutions. The White House Conference on Children and Youth of 1960 urged a general upgrading of services for children in local communities. The Fort Logan survey of 1961 helped that new institution plan for expected patient loads from the Denver area. And dozens of local groups helped plan local clinics, local drives to aid state hospital patients, local aftercare services, etc.

But none of these endeavors were designed as continuous operations. None were set up to evaluate the results of their own recommendations. And none of the communities of Colorado had a specific body of local citizens charged with taking an overall look at local needs. Even consolidation of state mental health services within the Department of Institutions did not in itself solve the problem of continuous planning because mental health involves more agencies than can be consolidated within one department, involves the private sector as well as the public sector, includes within its scope training institutions and universities as well as treatment facilities, and increasingly requires community services in addition to those operated directly by the state.

So an attempt was made to use two years of federal funding to initiate planning among key groups, directed at key problems, with data which might form a baseline for future comparisons. The hope was to make a finite number of basic decisions now while simultaneously generating methods for improving those decisions as time and experience dictate.

These basic challenges were attacked as follows:

1. Organization of State Mental Health Planning Committee:

The original proposal placed primary emphasis upon regional citizen planning committees addressing themselves to the needs of geographic sub-divisions of the state. Their activities were to be supplemented by task forces of professionals on the state level exploring such topics as manpower, research, legislation, etc. Staff support and data processing was the responsibility of the Department of Institutions, the mental health authority for the state and administrator of the planning grant.

Coordination was sought thru the State Mental Health Planning Committee, often called the "SMHPC." This group began as a "Psychiatric Advisory Committee" set up in 1962 to advise the Department of Institutions on general psychiatric policy. Its original 17 members helped develop the grant application in March and April of 1963. On June 28, 1963, it adopted its present name and geared itself to focus upon the planning operation.

As can be seen in the list of membership at the end of this volume, the SMHPC included representatives from the principal state departments and state-wide organizations with a major interest in mental health action. It gradually grew from 17 to a final total of 33 persons. All of these individuals represent state-level organizations from which the Director of Institutions solicited representatives for this planning project. As noted in the basic proposals, it is now recommended that this group be reorganized so as to include regional representatives as well, and that it become the basic advisory group to the state mental health authority on future mental health policy.

The first eight meetings were held monthly, from March thru November of 1963. The decision was then made to meet for a longer time (an entire morning) once every two months and to invite regional representatives to participate as desired.

Some members headed or served on special task forces. Some formed a steering committee of nine to work on special problems as they arose. During the first year, much of the SMHPC's energy went into developing and sanctioning regional citizen committees thruout the state, meanwhile studying national legislation and trends. During the second year, focus was directed at the implications of data and questionnaires, the recommendations of task forces and the regional citizen committees, the development of the state's "construction plan" for comprehensive mental health centers (such a plan had to be formulated ahead of the overall comprehensive plan if local communities were to be able to take advantage of federal matching funds), and final adoption of the basic proposals reviewed in Chapters I and II.

2. Regional Mental Health Planning Committees:

The most urgent concern of the SMHPC was to involve an effective range of citizens on the community level to work out plans for community action to handle a range of disorders whose origins and final outcome seem increasingly dependent upon community processes.

But "community" in Colorado is a difficult concept. Certain parts of the state -- heavily urbanized -- are rapidly exploding beyond traditional boundary lines. Other areas rely on county structure for many basic services but are composed of counties too sparsely populated to stand alone in developing mental health services. Hence regional communities were envisioned from the beginning, regions embracing a sufficient number of counties to constitute a reasonable population base for future comprehensive mental health services. The arbitrary minimum was set at 40,000 persons, a figure slightly below the oft-cited 50,000 minimum but realistic in terms of a number of natural geographic areas in Colorado.

A special committee set up boundaries for eleven regions in July, 1963. These regions were mapped out on the basis of natural geography, the 40,000 population minimum, and present boundaries of existing local health departments and mental health clinics. Each region had at least one clinic (though in some cases the clinic did not yet serve all the counties within the region), 8 had organized local health departments, and -- by happy chance -- all 11 had at least one university, college, or junior college. The three regions with major urbanization made up 71.2% of the state's population. The 8 others averaged 54,000 people each. Population projections suggested that while numerous rural counties in Colorado are losing population, each of these 11 regions are slowly growing or rapidly expanding, their urban centers off-setting rural decline.

With tentative proposals for regions, the SMHPC then invited known leaders of many varieties from each region to an initial workshop held at Fort Logan Mental Health Center in October, 1963. Some 150 persons gathered, discussed and altered some of the proposed boundaries, and returned home to create planning committees in their respective regions.

The formation of regional planning committees went on from October, 1963 thru February, 1964 in most instances. One region did not get really organized until August, 1964. And one of the original eleven areas never did get a full-scale committee going although two representatives from that area attended numerous SMHPC meetings.

Region 11 involved the five major counties of the Denver metropolitan area, totaling approximately half the state's population. It included also five immediately adjacent rural counties. In order to straddle the question of whether the Denver metropolitan area is really a single economic-health complex or a series of adjacent areas whose autonomy has operational utility, a single planning committee for Region 11 was set up with five sub-committees serving five sub-regions. Since each of these lesser entities had more population than many of the full-scale regions in other parts of the state, data were collected for each of them as well as for Region 11 as a whole. Hence, it will be noted that almost all graphs and tables include figures for fifteen regions, regions 1 thru 10 plus region 11 divided five ways.

A coordinator or staff person is almost a necessity if a loosely drawn committee of busy professionals and leading lay citizens is to achieve focus and impetus. As was noted in the Joint Commission's report on mental health services thruout the United States*, few rural areas or small cities have persons skilled in "community organization" or consultation of the kind needed to give staff support

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* See Community Resources in Mental Health (Basic Books, N.Y., 1961), Volume 5 of the Report of the Joint Commission on Mental Health and Illness.

to a citizen action-committee. In Colorado part-time paid staff support was found possible for three of the basic eleven regional committees.

For Region 11, a skilled community organization specialist was secured thru the Metropolitan Council For Community Services. Mrs. Virginia Ferguson served the overall Region 11 committee and each of the five sub-regional groups. This freed state staff to concentrate on the rest of the state.

In Region 8 (Colorado Springs, etc.), the executive-director of the El Paso Mental Health Association (herself a mental health professional) was hired by contract. Similarly, in Region 1 the director of the Mesa County Mental Health Association was secured for part-time coordination work.

In all other regions, the duties of coordination fell upon whatever volunteer could be secured. In some cases, a local professional was able to give some time to this effort (e.g., Region 10 where the director of the Pueblo Family Service Agency coordinated much of the planning effort). Otherwise, this essential function was performed by a citizen volunteer with whatever support could be offered by state staff.

Once organized, the regional committees spent the months of February thru June of 1964 working up a basic inventory of agencies and professionals in their areas who were involved in mental health activities. Formal mental health resources were usually easy to identify. But allied agencies, ranging from welfare and public health departments thru family physicians, churches, AA groups, down thru city recreational departments and youth organizations were much more difficult. Thruout this time, from January 1964 on, the chairmen or other representatives of these regional committees met together in Denver once every two months. In July, 1964, a large gathering of regional committee members was hosted by the Region 2 committee in Durango. Federal legislation was reviewed and plans were made to query all possible local professionals regarding basic issues, both state and federal, which could now be identified.

Accordingly, in the Fall of 1964 questionnaires designed for IBM card analysis went out to 353 agencies and over 1,000 individual practitioners. This pool of data was analyzed by project staff in Denver. Its results were released to the regional committees in a series of final strategy meetings around the state from January thru April of 1965.

Each regional committee was then asked to prepare a final report listing key problems within its area, possible solutions with presently available local resources, potential solutions with additional state or federal aid, and local reaction to key state-wide issues as formulated by the SMHPC.

These reports were largely available by June 15, 1965. Region 11 itself took the longest -- which is hardly surprising. Eventually, full-scale reports were in from thirteen of the fifteen regions and sub-regions as well as for Region 11 as a whole. These reports are briefly summarized in Chapter V of this volume -- the data on which they were based is detailed in Volume III of this plan.

3. Creation of Special Task Forces:

Task forces were set up as committees of experts (in contrast to the citizen committees studying regional needs). They focused either upon the treatment needs of special groups of patients or upon non-treatment issues of state-wide import. Nine such task forces ultimately functioned:

I. Special Treatment Needs -

1. Emotionally Disturbed Children
2. Delinquency
3. Alcoholism and Addiction

II. Non-Treatment Issues -

4. The Economic Costs of Mental Illness
5. Architecture and Mental Health Centers
6. Research
7. Case Registers
8. Manpower
9. Legislation

In addition, the steering committee of the SMHPC became in effect a 10th task force, not only formulating basic proposals for overall consideration by the parent SMHPC but launching an attempt to formulate the basic goals of a mental health program, the elements of planning, etc.

The major viewpoints of these 10 special groups are summarized in Chapter IV of this volume. The complete reports of the nine special task forces make up Volume II of this plan.

4. Staffing:

In all, twelve persons made up the basic staff for this effort, of whom eleven were paid for thru grant funds.

Central Office Staff:

1) From the beginning, Dr. Hans M. Schapire, M. D., served as Director of the Project. Devoting one-fourth of his time to the project, Dr. Schapire drew his entire salary from state funds in his capacity as Chief of Psychiatric Services, Department of Institutions.

2) The Assistant-Director of the project was Stanley W. Boucher, ACSW. He began part-time in June, 1963, became full-time from July 1, 1963 to the present.

3) Mrs. Beverly Tirva, A.B., served as full-time secretary for the project from August, 1963 to the present.

4) Dr. Nancy Wertheimer, Ph.D., a psychologist specializing in the epidemiology of mental disorders was hired as a Research Associate February 10, 1964. She was in charge of gathering basic profile data on population trends, etc., for each county and region in the state as well as collecting whatever indices of social disorder could be developed from available data. Formerly a visiting lecturer at the University of Colorado, Dr. Wertheimer worked for the project on a half-time basis from February, 1964 thru January, 1965. She then joined the research department at Fort Logan Mental Health Center and has continued to be available on request to planning staff.

5) From August 11, 1964 thru June 30, 1965, Dr. Eugene McGee, Ph.D., served as part-time Research Associate, specializing in the developing of age-adjusted admission rates to state facilities, the analysis of outpatient clinic data, and the factor analysis of combined social disorder indices, admission rate data, and manpower data on a regional basis. Much of this work appears in Volume III.

6) Larry Brittain, M.A., a clinical psychologist, was hired in October, 1964 to conduct the analysis of the two questionnaires sent out to agencies and individual practitioners thruout the state. This involved directing the electronic data processing for IBM items and a content analysis of written expressions of opinion by nearly 1200 persons. In addition, Brittain helped analyze data from NIMH forms for the construction plan. He worked part-time from October 15, 1964 thru June 30, 1965.

7) Rosemary Wherry, A.B., now a graduate student in social work, joined the staff full-time from January 11, 1965 to March 19, 1965. As a research clerk, she developed a table of Rho correlations for some 30 items of treatment data on the 15 planning regions, and assisted in analysis of state hospital data.

Task Force Staff:

8) Steven Weiss, A.B., a graduate student in economics at the University of Colorado, was hired by contract in January of 1964 to conduct a study of the economic factors affecting mental illness in Colorado. Mr. Weiss worked at this task full-time from January 1, 1964 thru June 30 of 1965. He was supervised by Dr. R. A. Zubrow of the University of Colorado.

9) Robert Hughes, M.A., a graduate student in sociology at the University of Colorado was hired by contract from June 1, 1964 thru May 30, 1965 on a part-time basis to serve as a staff assistant to the task force on delinquency, chaired by Mr. Mylton Kennedy of the Youth Services Division. He was supervised in his data analysis, etc., by Drs. Gordan Barker, Ph.D. and Jules Wanderer, Ph.D., of the University of Colorado.

Coordination and Staff Support, Regional Planning Committees:

10) Services of Mrs. Virginia Ferguson, ACSW, were secured for the six Region 11 committees thru a contract with the Metropolitan Council For Community Service, the health and welfare planning council for the Denver area. This service extended from January 1, 1964 thru June 30, 1965, although the MCCS continued to offer some staff time after the contract had formally ended.

11) Mrs. Lorna Hinds, a psychiatric nurse who had served for some years as executive-secretary of the El Paso County Mental Health Association, was hired via contract with that organization to offer staff support and coordination for the Region 8 planning committee. This service was secured from January 1, 1964 thru June 30 of 1965.

12) Mrs. Mary Humphreys, executive-secretary of the Mesa County Mental Health Association, was the final person located who was in a position to offer part-time staff assistance to a planning committee (Region 1). Mrs. Humphreys rendered this assistance thru contract from October 1, 1964 thru June 30, 1965.

It should be added that much staff time went into consultations with planning counterparts in other states, especially in the planning meetings sponsored by the Western Interstate Commission for Higher Education and the US Public Health Service. Extensive time was devoted also to liaison contact with the mental health committee of the Colorado State Medical Society (chaired by Dr. Edward Billings, M.D.) prior to the all-day mental health planning institute sponsored by that organization on May 23, 1964. Two national meetings sponsored by AMA devoted to mental health planning were attended by project staff as well as a special meeting in February, 1965 sponsored by the American Psychiatric Association.

CHART: ELEMENTS OF A COMPREHENSIVE MENTAL HEALTH CENTER

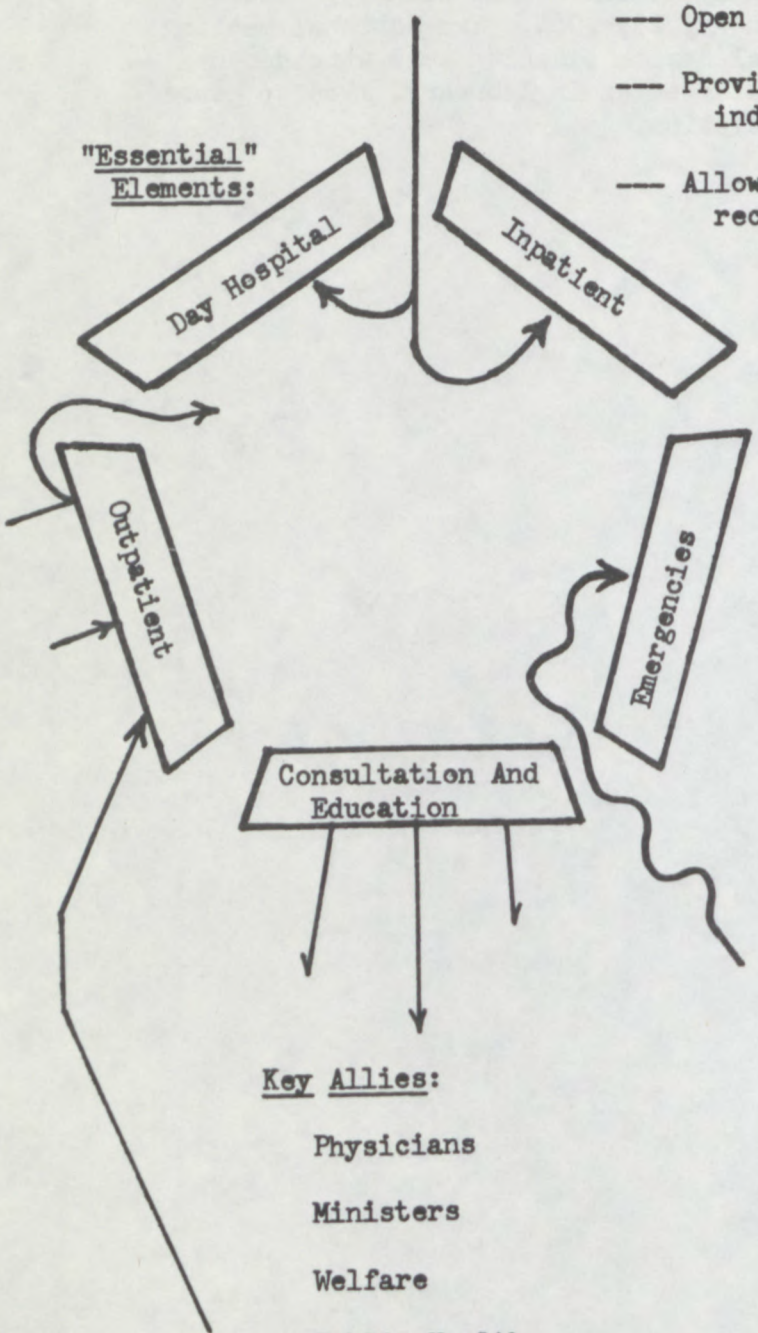
Requirements:

--- Geographically accessible

--- Open to all age groups

--- Provide reasonable service to the indigent

--- Allow for easy transfer of patient and record between elements of care



Possible Additional Elements:

(If Center is fully "adequate")

Diagnostic Services

Aftercare, Pre-care

Rehabilitation

Research

Training

Key Allies:

Physicians

Ministers

Welfare

Public Health

Schools

Courts

Etc.

III. BACKGROUND:

B. What is a "Comprehensive Community Mental Health Center"?

The chart on page 30 depicts the basic elements of a comprehensive center as outlined by congressional legislation in 1963. It should be clearly noted that this represents a range of services rather than a "structure" which must necessarily exist in one physical plant. The comprehensive center concept focuses upon the idea that a number of services should co-exist within a community, that a variety of basic mental health needs would be met by one or another of these services, and that patients should be able to move easily from one element to another as their illness changes.

Five of these elements of care are considered "essential". That is, no center would be comprehensive in the minimum sense of the term if it did not include these five basic elements. Public Law 88-164 spells out that construction funds and federal assistance in the initial staffing of centers will be granted only if the proposed "center" is able to show that it would start off operations by offering the five essential elements of care. These elements are:

1. Outpatient services.

2. Consultation and Education Services, directed toward allied agencies and professionals whose work has mental health implications. Prevention, and the early handling of emotional disturbance before it requires formal mental health care would largely depend on this element.

3. Emergency services, available 24 hours a day.

4. Inpatient services, for those requiring at least some degree of 24-hour hospitalization.

5. Partial Hospitalization, or treatment during substantial portions of the day or evening but without 24 hour hospitalization. Much more intense than outpatient therapy, partial hospitalization includes day hospital, night hospital, weekend treatment, etc.

As can be seen along the right side of the chart, five more elements are desirable if a center is to be fully "adequate". Both construction and staffing funds are available to help set up these five elements also--but a new center would not have to have them as part of its program in order to qualify for funds.

These additional elements are:

6. Diagnostic services: any center would of course diagnose its own treatment cases, but this element of service would imply major capacity to serve as a diagnostic resource for other community agencies such as courts, schools, welfare, etc.

7. Aftercare and precare services in the community such as foster home placements, home visiting, half-way houses, etc.

8. Rehabilitative services such as vocational and educational programs.

9. Research and evaluation.

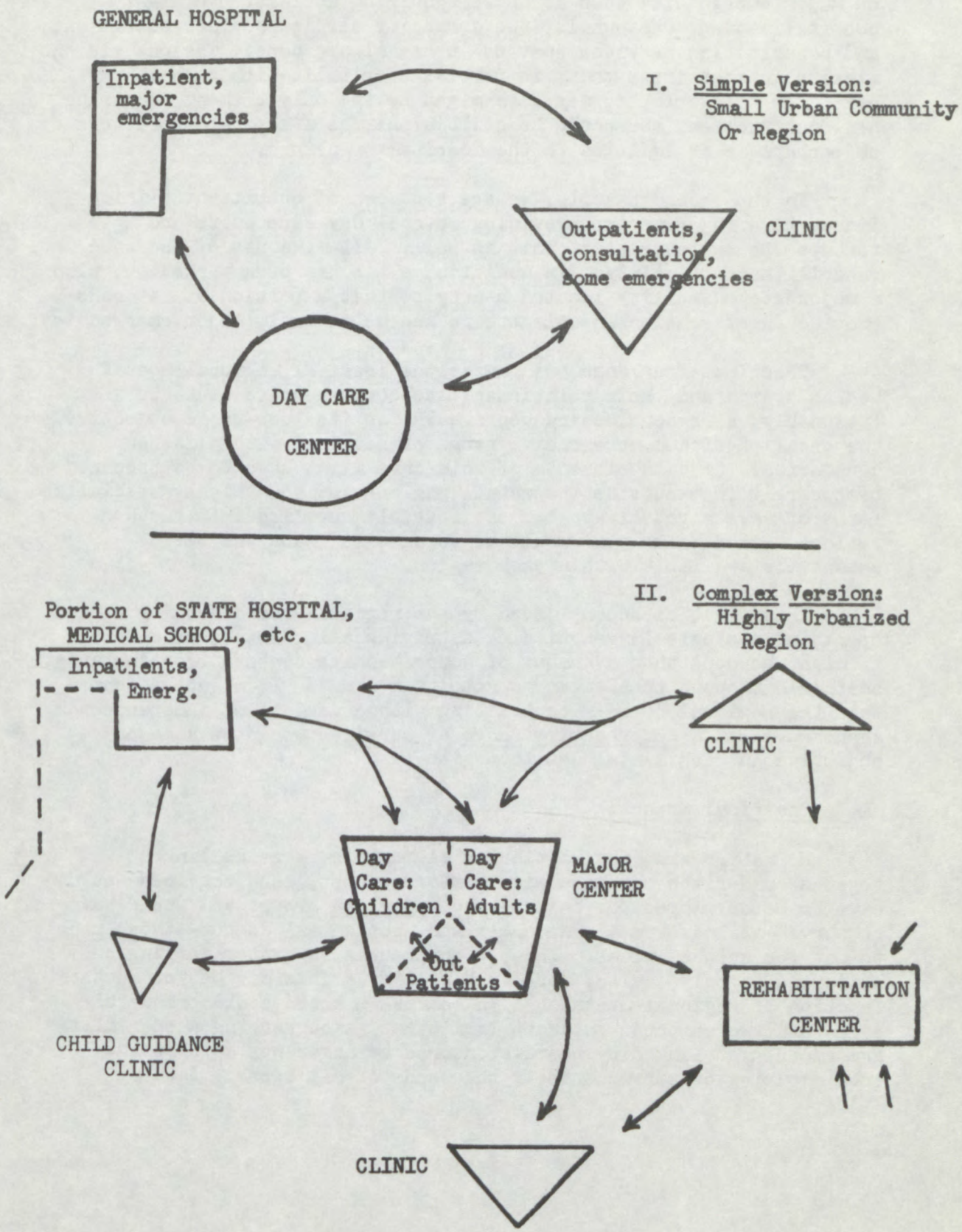
10. Training, such as field placements for the major mental health profe. sions, technician programs, etc.

These ten elements of essential and adequate services appear formidable. But note that of the five "essentials", two are already offered by community clinics thruout Colorado--outpatient therapy and consultation services to allied agencies. Emergency coverage is beginning to be offered by a few clinics and is also rendered by some general hospitals. Inpatient services are given in a growing number of general hospitals as well as some private facilities. Partial hospitalization is the least common service except in state-operated facilities. But day care, evening hospital, weekend care, etc., are beginning to be discussed by many clinic boards as well as by administrators of general hospitals.

Simply by linking already existing facilities via contractual agreements or similar administrative arrangements, a number of communities in Colorado would find themselves close to qualifying for federal aid as comprehensive centers. For a "center" does not have to be run in its entirety by a single agency. So long as the flow of patients and records is made as easy as possible from one agency to another offering a different element of care, it would be possible theoretically for five separate facilities to participate together as a "center."

CHART: TWO SAMPLE VARIATIONS--"COMPREHENSIVE CENTERS"

BASED ON A LINK-UP OF SEPARATE FACILITIES



The next chart, for example, depicts two possible arrangements in which separate facilities are linked by administrative agreements so as to provide comprehensive care thru a variety of settings. In the first example, a general hospital supplies inpatient beds, takes on major emergencies such as those requiring at least overnight hospitalization. Meanwhile, the community clinic provides outpatient and consultation services just as it has always done. The one element missing in most areas today is partial hospitalization such as day care. In this example, day care might be the only element requiring new construction, and could be built either as a separate structure or perhaps as an addition to the hospital or clinic.

In the second example, we see a number of outpatient clinics linked to a major center providing several day care units and perhaps its own outpatient unit as well. All make use of the same rehabilitation facility. In addition, a tie has been worked out with a major state facility located nearby so that a portion of its beds provide first echelon inpatient care and help handle major emergencies.

This latter arrangement raises the issue of regional mental health boards and their relationship to comprehensive centers. Presumably, a regional board would have, as its long-range objective, the creation of a comprehensive range of services within its own boundaries. Certain elements of this care might have to be procured temporarily from outside the actual region--and some highly specialized forms of care might always be most feasibly supplied from another region. But a prime goal would be to have at least the basic essentials available within each region.

This might be accomplished by the regional board setting up and operating a single large building supplying all elements of care. It might be done thru a number of comprehensive centers (for instance, scattered thruout the Denver metropolitan area). It might be done thru the regional board's contracting with a variety of independent agencies. But a comprhensive range of services would be a major objective in each mental health region.

One final aspect:

No matter what the particular elements of service linked together under the comprehensive center concept, such services would have to be developed for each of the major age groups and would have to serve--at least to a reasonable and substantial degree--those unable to pay for such services. Thus, a comprehensive center serving only children, or only adults, would not qualify. This may be yet another function of regional mental health boards--a board could presumably help fund two or three separate facilities, each serving a specialized age group, yet linked by board-sponsored arrangements so that the total complex of services meets the needs of all ages.

As for service to the poor, this is desirable for several reasons. First, the poverty-stricken are in more risk of mental illness than other economic groups. A community center engaged in raising the general level of mental health would naturally want to reach the group whose mental health is most in jeopardy. Secondly, the indigent provide the largest burden upon present public hospitals. While a community center might well serve all economic groups and derive a substantial portion of its income from fees and insurance payments, its service to the indigent places it squarely in the classic tradition of all public mental health programs as they have developed since Dorthea Dix's reforms in state after state over 100 years ago.

CHART: TENTATIVE COST PROJECTIONS

FOR A COMPREHENSIVE MENTAL HEALTH CENTER

(Serving 100,000 people)

1st Approach:

1.) Assume Mimimun Need = 20 inpatient beds
40 day hospital spaces
60 "spaces"

2.) 60 spaces = 21,900 space days per year

3.) 20 beds at $30 per day each = $ 219,000 per year
40 spaces at $15 per day 219,000 " "
$ 438,000

Outpatient cost = 100,000

TOTAL COST = $ 538,000 = $5.38 per capita

2nd Approach:

1.)

6 psychiatrists	=	$ 120,000	)
4 psychologists	=	48,000	)
6 social workers	=	54,000	) Professional
14 nurses	=	84,000	) Staff*
24 technicians	=	120,000	)
		$ 426,000	

2.) Outpatient and consultation share = $ 100,000

3.) Inpatient and partial hosp. share for professionals only = $ 326,000

Add 40% for administration, maintenance, equipment, supplies** 130,400

4.) TOTAL COST = $556,400 = $5.56 per capita.

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* Note: Staffing pattern as suggested by Secretary Celebrezze in testimony to Congress in 1965. Certain other staff such as dieticians, EEG-technicians, etc., are ignored in this chart.

**Note: This figure is based on expenses at Fort Logan Mental Health Center as reflected in current budget requests.

III. BACKGROUND:

C. Funds -- The Question of Feasibility

Feasibility is a product of the technical practicality of an idea plus public support, manpower for implementation, and funds. Manpower--covered elsewhere in this report--is itself in part a function of funds and public support for the new concept. Past experience suggests that those states whose communities first set up major comprehensive mental health centers will be able to recruit the staff to man them.* Eventually, the impact of successful centers around the country will draw additional professionals into the field; but areas which wait for this process to germinate a new and more plentiful crop of therapists may find themselves behind by a decade or so.

What funds are now available to enable a state and its various regions to get a headstart by tapping the present manpower pool? And what new sources should be developed?

Basically, mental health funds may come from local, state, or federal sources. It is convenient to review these in reverse order:

1. Federal Funds:

From 1947 on, federal funds under the National Mental Health Act were used primarily to support training, research, and demonstration projects of limited duration. A trickle of funds was also available as a yearly grant to help stimulate state programs in community mental health (Colorado's share has remained fixed at $65,000 per year for some time).

In 1961, The Joint Commission on Mental Health and Illness recommended to Congress that federal funds be used on a much larger scale to help states and communities set up modern mental health programs. The general ratio of 7: 4: 1 was suggested--that is, 7 parts federal aid to 4 parts state aid and 1 part local funding.

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* Note: For example, when Fort Logan was first proposed, predictions were often made that it could never be staffed. But its attractive program created an excitement which drew staff from all over the United States.

In 1963, President Kennedy urged legislation to help construct community mental health centers. Public Law 88-164 provides for such funds. For Colorado, these funds are as follows:

Fiscal Year	Community Mental Health Centers	Mental Retardation Facilities
1964-65	$ 340,148	$ 100,000
1965-66	476,000	111,000
1966-67	619,000	134,000
1967-68	-----	281,000
TOTALS:	$ 1,435,148	$ 626,000

A construction plan for using this money has now been worked out for Colorado. This plan must be formulated each year by the Department of Institutions and is administered by the State Health Department in conjunction with similar funds under the Hill-Burton program supporting general hospital construction, etc. Like Hill-Burton funds, there is every expectation that Congress will renew this program in suceeding years well beyond the present three year limit.

Note that funds for each year may be carried over for one additional year. Thus, the $340,148 for fiscal 1964-65 may still be used as late as June 30, 1966. Note too that funds for mental health or mental retardation facilities may be switched back and forth if need in one category is demonstrably greater than the other in any particular year.

These funds must be matched. Colorado's construction plan provides for a variable matching rate allowing regions with less wealth to obtain a higher percentage of federal funds than those more affluent. But the average matching ratio is 48.93% federal funds to 51.07% local funds.

Furthermore, at present these federal funds must be matched entirely by local funds. A major recommendation of the State Mental Health Planning Committee is that state funds should be secured to help local areas match these federal monies. (See recommendation 4 on p. 8).

The funds explored above are for capital construction. A center applying for such funds would have to show that it could operate the proposed services for at least two years.

In 1965, Public Law 89-105 made federal funds available to help staff comprehensive centers. These staffing funds would pay for 75% of the costs of new services in a comprehensive center complex during the first 15 months. Thereafter federal participation would decline to 60% the next year, 45% the year following, and 30% in the final year. These funds are obviously seed money to help get centers started. They would have to be replaced in increasing ratios each year by any combination of local or state funds.

2. State Funds:

Since 1957, the state has helped support community outpatient clinics thru matching funds. At present, this amounts to a maximum of 40¢ per capita in state aid to be matched on a 60:40 ratio by the local clinic board. This state aid has resulted in the present pattern of 20 clinics theoretically available to some 96% of the state's population. But services are quite limited in most areas, and state funds for this purpose amount to only 2.8% of the total mental health expenditures by the state.

A major recommendation of the State Mental Health Planning Committee is that this state aid for local mental health services be heavily increased. An eventual goal for outpatient service would be $1.00 per capita on a 60:40 basis. But, even if the present ratio of 60% state aid to 40% local funds be maintained for outpatient and consultation services, a much heavier ratio is suggested for assisting in the costs of inpatient service, partial hospitalization, and coverage for major emergencies. The SMHPC believes an overall ratio of 90:10 in state aid should be implemented.

3. Local Funds:

These usually include patient fees, insurance, funds from voluntary drives (United Fund, etc.), and local tax funds.

Patient fees alone seldom account for more than 5 to 10% of the budgets of current clinics or public hospitals. In poorer areas, they are even less significant. As the general levels of affluence thruout the population increase, this factor may be more important than now. Furthermore, comprehensive centers in many communities may be designed to serve "private-sector" patients as well as the poor and indigent. Data from some communities already suggests that private patients in any given year equal or exceed those going to public facilities. However, even if private patient fees accounted for as much as 50% of a center's total budget, this would not solve the financing for the "public-sector" patients.

Insurance can be expected to play an ever-increasing role. Blue Cross coverage in Colorado already includes the first 30 days of hospitalization in a private facility. Medicare will cover larger and larger groups, beginning with those over 65 and eventually including the medically indigent of all ages. Devices such as blue cross and medicare will probably play an enormous--if not dominant--role in the eventual financing of future mental health programs. But their impact cannot at present be accurately predicted. Hence, the cost data in the accompanying charts does not try to pinpoint insurance contributions.

Voluntary fund drives and local tax funds are probably an essential core for total local contributions. Not quite so fluctuating as fees and insurance, they enable a program director to make solid plans for each year's operations. In the early days of community clinics, it was felt essential to keep local contributions equal to state aid. Only the 50:50 ratio would result in true local autonomy being preserved. The SMHPC believes adequate safeguards can be constructed so that local operational autonomy is preserved and the state's obligation to care for its mentally ill is simultaneously preserved. A 90:10 ratio should overcome the fear that adequate local funds simply cannot be raised via the present sources of tax income available to counties and cities. The state would bear the major financial burden--assisted by whatever federal funds, private fees, and insurance can be brought to bear.

What are total costs likely to run?

It is easy, and quite tempting, to say that no one really knows. It is possible, however, to make some tentative guesses. The first cost chart (page 36) depicts two sample methods for estimating costs of a center serving 100,000 persons. In the first approach, it is assumed that 100,000 people will need the equivalent of 8 full-time professionals in their outpatient and consultation services. These would cost about $100,000 a year. The center would also require 20 inpatient beds and 40 partial hospitalization "spaces".* Costs per bed are then estimated at $30 a day, while partial hospitalization spaces are set at $15. Both these figures are believed to be high estimates, running much closer to general hospital cost experience than to experience at Fort Logan and the Colorado State Hospital.

The result is an annual budget of $538,000 or $5.38 per capita.

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* Note: Miminim recommendations by the SMHPC as embodied in the state construction plan for comprehensive centers.

CHART: STATE-LOCAL FINANCING FOR A COMPREHENSIVE MENTAL HEALTH CENTER

Note: Costs of $5.60 per capita are assumed.

A. Basic Costs Per Capita

Elements Of Care	Percentages: State Aid	Local Funds	Cost Per Capita State	Local	Total Cost Per Capita
1. Outpatient 2. Consultation 3a Minimum Emerg. Service	60%	40%	.60	.40	1.00
3b Major Emerg. Service 4. Inpatient 5. Partial (Day Care, etc.)	96.5	3.5	4.44	.16	4.60
TOTAL BUDGET, ALL FIVE "ESSENTIAL" ELEMENTS	90%	10%	5.04	.56	5.60

B. Costs Per 100,000 People

Elements Of Care	State	Local	Total
1. 2. 3a	$60,000	$40,000	$100,000
3b 4. 5.	444,000	16,000	460,000
TOTAL BUDGET, ALL FIVE "ESSENTIAL" ELEMENTS	$504,000	$56,000	$560,000

The second approach is based on testimony by Secretary Celebrezze. Here, a total budget for professional staff for the inpatient and partial hospitalization elements is estimated at $326,000. Experience at Fort Logan suggests that an additional 40% must be added to cover administrative costs, maintenance, equipment, supplies, etc. Final costs for the total complex come out at $556,400, or $5.56 per capita.

The second chart (p. 41) sets the basic estimate at $5.60 per capita, to allow a little more margin. Cost estimates are then divided between state and local sources. Note that these estimates are kept high rather than low so as to avoid too optimistic a cost estimate. Federal funds, which would be temporary, and insurance including medicare--which may be progressively more important but difficult to estimate--have been ignored.

This estimate of $5.60 per person may well seem high. It should be borne in mind that this state's total mental health program--in state funds alone--now costs $10.37 per capita. By developing comprehensive centers, we would presumably stave off the need to build additional state facilities as our population grows. And other savings--such as the indirect savings thru cutting down wages lost, etc., would probably justify creation of centers on economic as well as humanitarian grounds.

Finally, these estimates are based on SMHPC recommendations of 20 beds and 40 partial spaces per 100,000 people, or 21,900 space-days per year. Would this be adequate? The following is a very tentative table, suggesting that it would.

Suppose admissions are estimated at 300 per 100,000 population.*

If 75%	stay 30 days,	this	=	6,750 space days.
" 10%	" 90 " ,	"	=	2,700 " " .
" 10%	" 180 " ,	"	=	5,400 " " .
" 5%	" 365 " ,	"	=	5,475 " " .
		GRAND TOTAL		20,275 space days per year.

* Note: Age-adjusted admissions to both state hospitals are currently about 160 per 100,000. But experience suggests that a center close to the population it serves will develop at least 250 admissions per 100,000. Here, 50 additional admissions per 100,000 are allowed to cover children (about whom almost no quantitative data are available).

Experience in private general hospitals suggests a total rate as high as 500 per 100,000--but much of this load would presumably be privately financed.

IV. THE FUTURE:

The Major Goals of a Mental Health Program

(Task Force Recommendations)

The ultimate goal of "mental health program" is to improve the mental health of the population it serves. But over 350 agencies and several thousand individual practitioners consciously engage in activities designed to affect the mental health of this state's citizens. No planning effort could or should attempt to set up goals and define boundaries which would wholly embrace this astounding range of activity.

But certain points were repeatedly made by the various task forces. Certain objectives can be set. Certain definitions and sectors of reponsibility can be formulated--especially for public mental health agencies and future mental health boards.

The detailed reports of the nine task forces appear in Volume II. Some highlights, together with some initial formulations by the Steering Committee of the SMHPC, appear below. Focus is upon the two key themes of evaluation and coordination, the basic responsibilities of a mental health program, steps for evaluating such programs, and some key definitions.

A. Two Key Themes: Program Evaluation and Coordination:

The two most pervasive points made by the task forces are for a major state effort to achieve "really adequate feedback" or program evaluation, and for some tangible steps toward closer coordination among allied agencies and professions.

Program evaluation: no fewer than six of the nine task forces made specific pleas for more effective data systems among state agencies treating human disorders. An independent Research Advisory Council to stimulate realistic program analysis by treatment agencies was urged. Its members would be appointed by the Governor. The task force on research went on to ask that 2½% of the budget of the state mental health authority be assigned to program research. The task force on children felt that "an improved capacity for extracting new knowledge from our various treatment efforts and ploughing it back into the system is both feasible and crucial."

Most task forces felt the need for better data systems is quite unrecognized by the general public or most legislators. The age of computers has scarcely even begun to be felt in the field of treatment services for socially and psychologically damaged persons.

Coordination, a term as familiar and almost as abused as the classic plea for "better communication", is far more difficult than previously believed. But despite the hazards and inherent snares, the need for better devices to induce genuinely effective inter-agency collaboration is both obvious and growing. "Mental health" is too broad a field to be shut up within a single department or treatment center. At the state level, four major work groups are proposed, two of them already in existence:

1. State Mental Health Planning Committee:

Already in existence, this inter-agency group should be revised to include both state-level and regional representatives. It would become the basic advisory group to the state mental health authority (Department of Institutions) and a parent to various ad hoc committees and the following ongoing task forces:

a. Mental Health Legislation

b. Children's Mental Health Advisory Council

c. Mental Health Manpower

d. Architecture For Mental Health Centers

2. Research Advisory Council:

To be appointed by the Governor, this would be a 21-member council of behavioral scientists, departmental representatives, and representatives from the general public. Its task would be to stimulate program research among state and local agencies treating human disorders, including routine program evaluation and special research projects.

3. State Health Facilities Advisory Council:

Already existent, this 18 member council is appointed by the Governor to advise the Department of Health on administering federal construction funds for Hill-Burton programs (general hospitals, nursing homes, rehabilitation centers, etc.), comprehensive community mental health centers, and community facilities for the mentally retarded. (The basic construction plan for mental health centers is formulated by the Department of Institutions but administered by the Health Department).

4. Inter-Agency Committee on Alcoholism:

A recommendation of the task force on alcoholism, this would be an inter-agency group sponsored by the State Health Department to stimulate closer program planning and research efforts by the various state departments concerned with the control and treatment of alcoholism.

B. Basic Responsibilities of a Mental Health Program:

The Steering Committee, while recognizing the almost endless possibilities for therapeutic intervention by mental health techniques in a modern society, felt that at a minimum any mental health program attempting to be "comprehensive" should address itself to the following:

I. Major Emotional Disturbance and Mental Illness

a. In children
b. In adults
c. In families as a whole
d. In other special groups at risk

II. The Mental Health Aspects of Socially-Defined Disorders

a. Among delinquents
b. Among victims of chronic "dependency" (Welfare, etc.)
c. Among alcoholics and addicts
d. Among adult criminal offenders

III. The Mental Health Aspects of Biologically-Related Disorder

a. Mental retardation
b. Aging syndromes
c. Physical illness

These categories are obviously somewhat tentative and subject to revision. One could question whether alcoholism should be considered a biologic disorder (or even a mental disorder) rather than a socially-defined malady, for instance. But this scheme attempts to distinguish between areas of primary responsibility as opposed to secondary.

The first category--major emotional disturbance--is obviously the primary responsibility of a mental health program. The mental health professions exist primarily to treat or prevent or otherwise control disorders clearly identifiable as mental illness. While non-mental health agencies and professions can and do help a community cope with such disorders, they clearly do not have prime responsibility here.

In contrast, the second and third categories are usually the basic responsibility of other agencies. The victims of chronic poverty are served by a variety of social agencies with mental health resources usually playing a secondary role. Delinquency control is vested in the courts and state schools for delinquent youth, etc. The problems of housing and serving the aged are rarely vested in mental health agencies.

Mental health authorities are indeed often assigned a major role in coping with alcoholism and addiction, and sometimes mental retardation. But this varies greatly from state to state and is by no means a settled issue among either professionals or the major citizen groups concerned with these problems.

What is crystal clear--and emphasized repeatedly in the task force reports--is that mental health programs should make a conscious and persistent effort to assist whatever agencies do have prime responsibilities in these allied fields. If, as appears to be the case in a number of communities, no agency or group exists to take leadership in handling certain of these disorders, mental health professionals should play an active role in resolving community ambivalence and achieving agencies with community backing to meet these problems.

In summary, a mental health program--whether it serves the state or a regional community--should attempt to systematically reduce the prevalence of disorder in all three categories outlined above. It should take major responsibility for the first group of disorders, those involving overt emotional disturbance and mental illness. It should seek to make firm committments and play an active secondary role in assisting allied agencies to cope with socially-defined disorders and those involving biological factors which have identifiable psychological components.

Delinquency, alcoholism, and the impact of poverty appear to be the three areas with the most immediate plea for greater action by mental health resources.

C. Steps For Evaluating A Mental Health Program:

It seems clear enough that a board planning a new mental health program should build in opportunities for program evaluation from the very beginning. A continuous cycle should be sought in which needed change is identified, enacted, evaluated--and new change suggested.

This requires data, meaning both quantitative numbers and judgmental opinions. Despite the advent of computers, judgments as to where a program is going and how successfully it is achieving its aims may be the most usable tools for some aspects of program planning for years to come. But whether data be in the form of opinions or sophisticated statistics, it loses most of its force unless it can be related to some clearly defined goals and methods.

The Steering Committee arrived at four elements for a board to consider in planning an action program in mental health:

1. THE MISSION--the basic objectives, purposes, long-range goals of an organization. In a sense, the mission represents the basic reason for an organization's existence as well as the limits of its "sector of responsibility".

2. METHODS-- Techniques, tools, procedures for accomplishing the mission. For example, psychotherapy, group therapy, drugs, nursing techniques, milieu design, etc.
   Methods usually change more often than the basic mission.

3. RESOURCES-- Personnel to employ the techniques decided upon, plus funds for supporting the proposed operations, building, capital equipment, etc.
   Resources, especially personnel, often change much more frequently than the mission or methods.

4. POLICY-- Specific applications of specific methods by specific resource personnel to achieve portions of the mission.
   Policy probably changes the most frequently of all.

These four elements may appear either too esoteric or too trite and self-evident. It seems clear to those who have studied previous attempts at program evaluation, however, that many and perhaps most agencies fail to clarify or distinguish between elements. Most often, missions are confused with methods. An agency will assert that its purpose is to offer psychotherapy or public health nursing or financial assistance. Such "purposes" are really techniques or methods believed useful in treating mental disorders or lowering the incidence of communicable disease or the impact of poverty.

If the mission is clearly conceptualized, programs using various methods and different kinds of personnel may be evaluated and compared. But if the mission is thought of as merely offering a particular kind of treatment, a board might stop short with the belief that because treatment was indeed being offered to more and more patients, the mission was being successfully implemented.

As an example, if the purpose of mental health planning were merely to produce a printed document, publication of the printed plan would mean successful achievement of the mission. In contrast, here is the mental health planning project as analyzed by the Steering Committee using the suggested format:

The Mental Health Planning Project, as Defined For Future Evaluation

MISSION: Primary Mission: To stimulate relevant sectors of the mental health field in Colorado (public and private mental health professionals, concerned lay citizens, key decision-makers) to clarify the purposes and means of this field and to reach a consensus on needed changes which can be implemented and evaluated.

Secondary Mission: To examine whatever relevant data can be located which is usable for analyzing the mental health problems of Colorado, and to stimulate creation of better data systems for future planning and evaluation.

Third-Level Mission: To help communities thruout the state to qualify for Federal funds for the construction and/or operation of comprehensive mental health centers.

METHODS: Inter-group planning thruout the state on a regional level supplemented by state-level planning and negotiation among key agencies and organization, this process to be stimulated by providing staff support to planning groups backed up by data collection and analysis.

RESOURCES: Psychiatric Director on one-quarter time; full-time research social worker as assistant director; part-time support staff for central data-analysis and staff support for regional committees and task forces; secretary;
33 member State Mental Health Planning Committee;
15 regional planning committees;
9 special task forces;
Consultants from thruout Department of Institutions and other state agencies and educational institutions.

POLICY: June, 1963-April, 1965:
Initiate planning committees and task forces, collect initial data, examine relevant state and federal legislation;

May, 1965-November, 1965:
Prepare construction plan to enable communities thruout state to apply on a priority basis for community mental health center construction funds. Reach consensus on basic proposals for comprehensive mental health plan. Prepare final reports of task forces for publication. Prepare final plan for publication.

December, 1965--

Assist groups involved in implementing mental health plan recommendations; Assist in revising plan and identifying needed changes and gaps; Bring data up-to-date, etc.

D. Some Key Definitions:

A number of concepts appear in the various task force reports which should be clarified. Some surprising differences in the use of certain terms were encountered by the Steering Committee. The following definitions represent an approximate consensus among the committee members. Painfully arrived at, they are offered as initial guideposts with an awkward sense that they must be subject to much future revision and supplementation.

1. Mental Health:

Mental Health has been variously defined (for example, Freud's "the ability to love and to work"; or the World Health Organization's "complete mental and social well-being"). A more useful definition for a mental health program, however, is the capacity to function adequately under social and psychological stress.

2. Mental Disorders:

Mental disorders are those conditions--associated with social and psychological stress--which arise as a result of failure or inability to deal adequately with internal conflict or external stress. Whenever such a disorder in living cannot be reasonably resolved, a mental health need exists.

3. The Mental Health Field:

It is convenient to distinguish between activities which accidentally or occasionally resolve mental health needs and those specifically intended to meet the mental health needs of a populace. The latter make up the mental health field.

4. Mission of the Mental Health Field:

The mission of the mental health field is to help conserve and strengthen the mental health of the entire population. Its basic method is to develop and use professional and scientific knowledge for reducing the prevalence of mental disorders. Its resources include public and private professionals, a variety of treatment settings and educational institutions, heavy financial committments in public and private funds, and a number of concerned citizen organizations. Its policies are subject to frequent evolutionary change, most recently characterized by attempts to reduce the de-humanization of the mentally ill and speed their recovery by making treatment readily available in dignified surroundings close to the patient's home and community.

5. The Public and Private Sectors of the Mental Health Field:

It is convenient to divide the mental health field into two sectors, the public and the private. Such a division is based upon economic factors rather than methods, disciplines, or the general types of problems dealt with.

In general, the private sector includes activities suppored primarily by fees or insurance paid for by the recipient.

The public sector includes two heavily overlapping divisions: activities supported by tax funds and those supported by charitable contributions administered not for profit and for the benefit of the public at large. Agencies relying upon United Fund contributions, for example--though often called "private agencies"--fall into the public sector by this definition. For while it is still possible theoretically to distinguish between a "voluntary agency sector" and a "tax-supported sector", in the field of mental health this demarcation is becoming increasingly blurred--numerous clinics utilize both United Fund donations and heavy tax support and for all practical purposes may be considered "public sector agencies."

It is likely that present trends will encourage far more interchange between the public and private sectors in mental health. Comprehensive centers stand to gain by such interchange. Insurance plans and medicare will probably increase this process, so that neither sector can be wholly efficient without systematic knowledge of the other's scope and objectives.

6. Levels of Prevention:

Citizens and legislators often urge a greater focus upon "preventive efforts". Classic public health concepts--originally designed to reduce communicable disease and control epidemics--distinguish three levels of action for controlling the prevalence of disease:

Primary prevention refers to measures designed to prevent disease from arising in the first place. Purifying a town's water supply or vaccinating its children are examples. In mental health, primary prevention includes activities designed to help individuals or families handle emotional crises on their own, without formal aid from mental health professionals. It could also include actions designed to prevent stress from arising in the first place.

Realistically, far less is known about primary prevention in mental health than the two levels discussed below. And most of the activities by which a society tries to strengthen its web of family life, its working conditions, its recreation, religion, and education, are not the direct responsibility of mental health agencies.

Secondary prevention refers to early detection of actual disease and rapid commencement of treatment so as to shorten duration of the illness as much as possible. Much of the present work of clinics, hospitals, and state facilities is designed as secondary prevention--to get troubled people into treatment before their emotional disorder reaches major proportions or threatens them with lifetime disability.

Tertiary prevention refers to efforts to ameliorate the effects of severe illness, to rehabilitate the individual following the acute phase of his disorder. An artificial leg for an amputee, for example, will not "cure" his affliction but will alleviate its effects as far as possible. In mental health, tertiary prevention includes aftercare for patients discharged from lengthy hospitalization, vocational rehabilitation, etc.

Comprehensive mental health centers would focus upon secondary and tertiary levels of care. Primary prevention is a far greater unknown at present, partly for technical reasons noted below.

7. Prevalence:

Another way to discuss the mission of a mental health program and levels of prevention is the concept of prevalence. Prevalence represents the sum total of mental disorders at any given time.

It can be argued that the most important single mission of a mental health program is to reduce the prevalence of mental disorder. Unfortunately, accurate data on the total prevalence of mental disorder is not available. The few valid studies (e.g., Mid-Town Manhattan and Sterling County in rural Canada) suggest that at least a quarter of the sampled populations suffer from mental disorders severe enough to impair major life activities. Only a fraction of this group comes to treatment in any given year--hence, most data really tells only the prevalence of treated disorder. Next to developing scientifically valid forms of primary prevention, the most important single challenge for future mental health planning is to develop reliable guidelines on the ratio which treated prevalence should bear to total prevalence. No mental health program as presently conceived can hope to treat everyone who is mentally ill--what proportion should it try to reach?

8. Incidence and Duration:

Prevalence is a function of incidence and duration.

Incidence refers to the number of new cases of disorder which arise within a given time interval (e.g., new cases per year).

Duration refers to the length of time each case suffers from the given disorder.

Obviously, prevalence may be reduced either by lowering the incidence (new cases appearing) or reducing duration (time per case). It is important to note that truly effective primary prevention would reduce incidence. But almost all we have so far learned in the field of mental health is really effective only in reducing the average duration of an attack of mental illness--which is another way of saying that only in secondary and tertiary prevention have we made major headway thus far.

9. "Risk Populations":

Theoretically, a mental health program should attempt to see that every individual with a "mental health need" secures the help necessary to meet that need. Practically speaking, the mental health needs of numerous individuals tend to cluster into groups. By identifying these clusters of need and assigning them priorities, a mental health program could use its scarce resources more economically.

A risk population, then, is a select portion of the total population of an area, a portion with attributes believed to make its members especially vulnerable to mental disorder. Each risk population tends to have somewhat special problems requiring specially tailored solutions if its incidence of disorder is to be reduced. Each is a potential target of opportunity, a group offering special advantages for a community wishing to systematically focus its resources on areas of greatest need.

Some obvious risk populations include:

a. Ex-patients who have suffered previous mental disorder.

b. Children, especially those from disorganized or shattered families, from minority groups, from groups subjected to institutional care of various kinds, etc.

c. The poor of all ages, especially when clustered into ghettos or areas of declining opportunities.

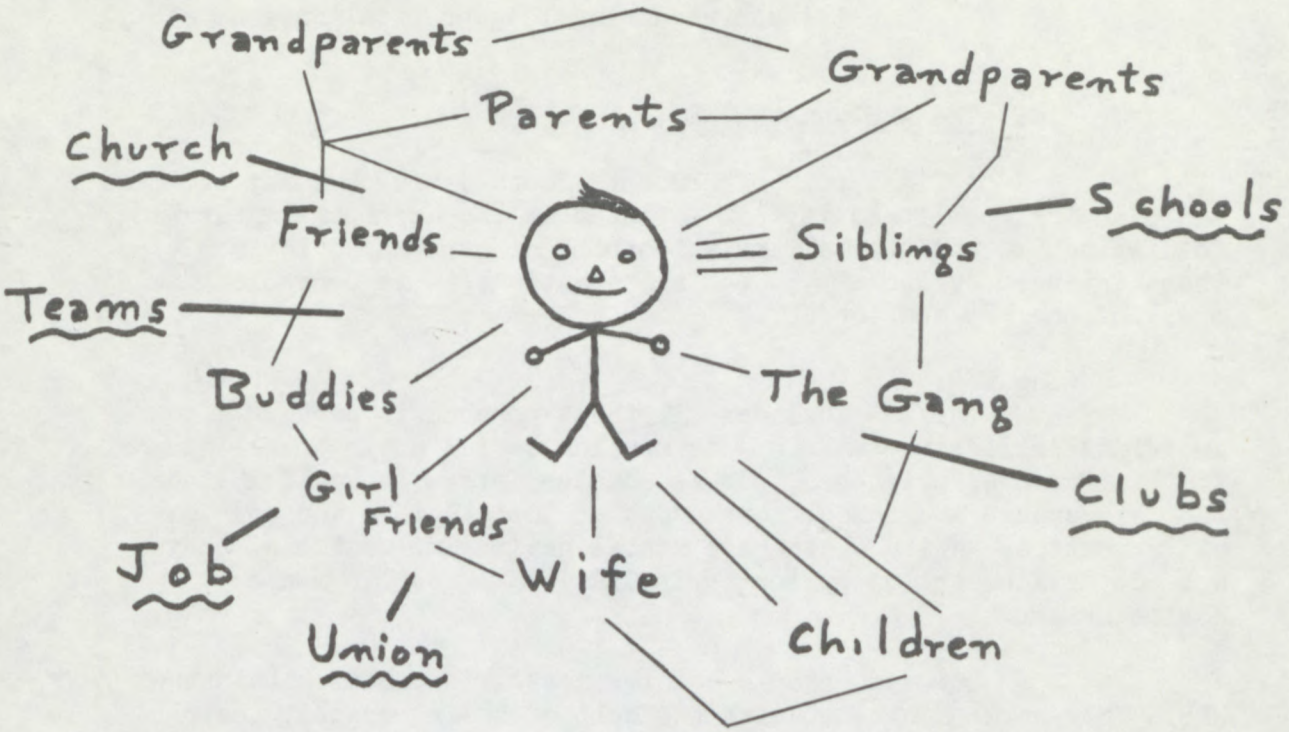
d. The aged, a group with special problems seemingly exacerbated by certain trends in an industrial society.

e. Those who have tried suicide one or more times.

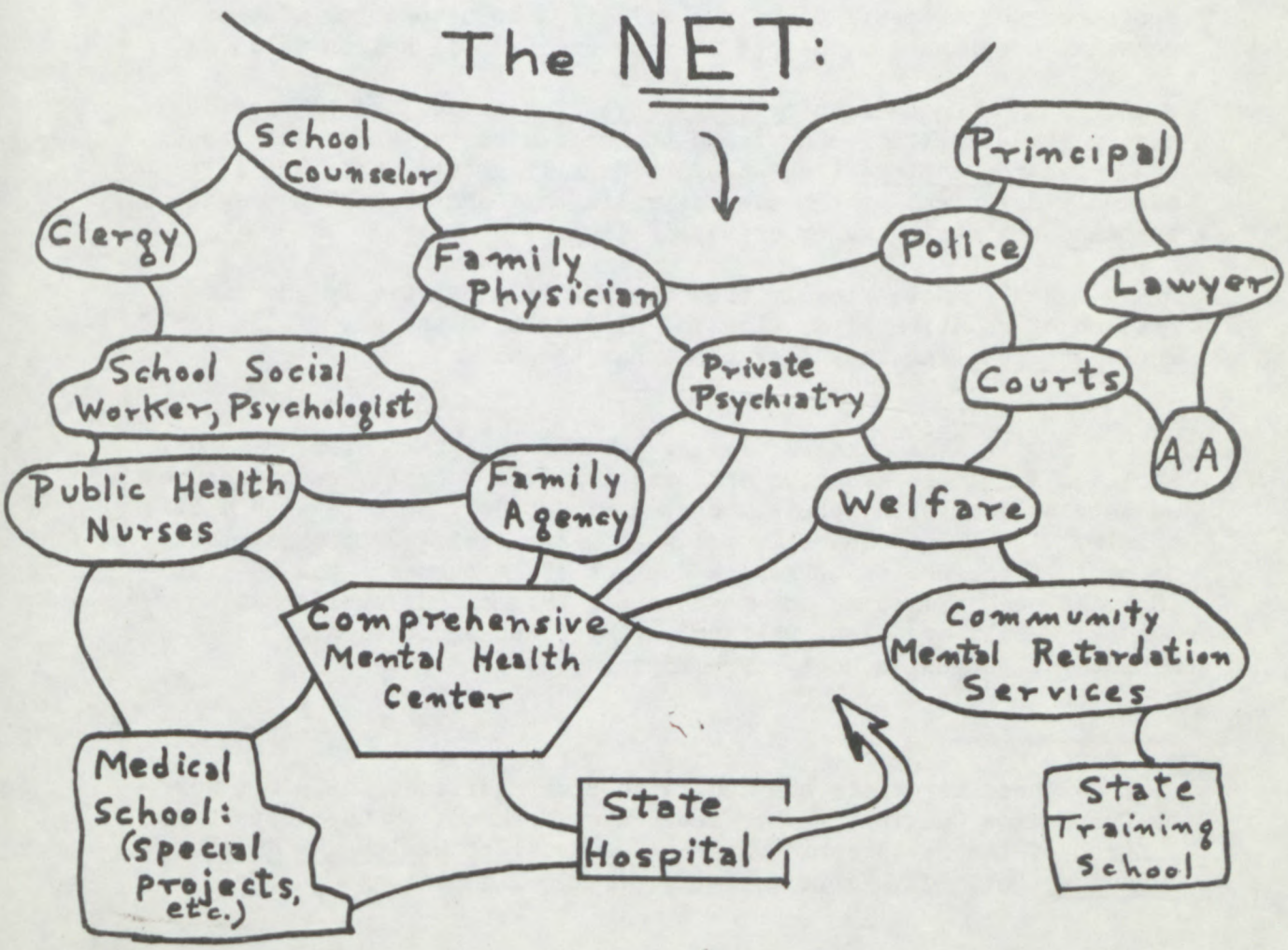
f. Late adolescents, just breaking parental ties and soon to embark upon careers and parenthood themselves.

g. Families whose household head is absent, thru death, divorce, desertion, or thru protracted overseas duty, or hospitalization or criminal sentence, etc.

The WEB:



The NET:



h. Victims of mental retardation, congenital anomalies, crippling physical injury, protracted physical illness requiring long hospitalization, etc., etc.

10. The WEB and the NET:

A final pair of concepts found useful by many of the planning committees is that depicted in the accompanying drawing. To distinguish the "normal" relationships of everyday life from those intended by society to be "therapeutic", it is convenient to speak of the WEB and the NET.*

The WEB:

The WEB includes all those persons in each individual's life who make up his routine social environment--his family, friends, neighbors, job associates, etc. It would include, too, his church and school, his economic institutions and sources of recreation. While these have mental health implications, they are not devices set up by society primarily to resolve mental health crises.

But most people resolve most life crises within the WEB. They work things out with the help of their parents, their spouses, their children. If a person's WEB is adequate and his own ego strengths are sufficient, he will find solutions for most of his personal problems long before they become "mental health needs."

Note that primary prevention as defined on page 50 really means activities designed to build a better WEB. Note too that risk populations (page 52) are usually groups whose WEB is markedly deficient--their everyday life environment is too fragile to sustain them during major crises in living.

Note finally that the WEB is a relatively enduring pattern of relationships, slow and difficult to change. It is far more cohesive, far less flexible, than the NET.

The NET:

When the WEB fails, the NET must take over. The NET includes all those agencies and practitioners formally sanctioned by society to deal with people who need expert help to cope with a life crisis. The NET includes mental health agencies and psychiatrists, psychologists, social workers and psychiatric nurses. But it also includes such allies as non-psychiatric physicians, public health nurses, family agencies, welfare workers, rehabilitation counselors, ministers, judges, school psychologists, etc.

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* These terms are adapted, with some modifications, from work by Dr. Elaine Cumming, Ph.D. See "Phase Movement in the Support and Control of the Psychiatric Patient," Journal of Health and Human Behavior, Vol. III, Issue 4, 1962, pp. 235-241.

In many communities, the NET has two major defects: some troubled persons fall completely thru the NET because their particular problem does not "fit" the criteria set up by any local agency. Others become snarled in too much of the net, becoming involved with five or six agencies simultaneously. Multi-problem families are an example.

It is apparent--and was most forcibly emphasized in the task force report on children--that much of the energy of a mental health program should go into working with and helping to improve the NET. The mentally ill are too numerous for mental health agencies to hope to treat them all directly. Many are already handled in the early phases of their emotional problems (with varying success) by non-mental health portions of the NET. Finally, mental illness is often only part of the total life crisis affecting a patient, and a final resolution cannot be made without help from allied resources.

Thus prevention, in the sense of lowering the incidence of persons coming for mental health treatment, can also involve systematic study of the paths they traverse thru the NET in getting to mental health agencies. It is extremely probable that these paths are too short in many instances--persons become mental patients who might well have been treated by allied agencies earlier and more appropriately. For example, aged persons are sometimes sent to the state hospital only to be placed soon thereafter in nursing homes. With a better NET, they would have gone to the more appropriate nursing home in the first place.

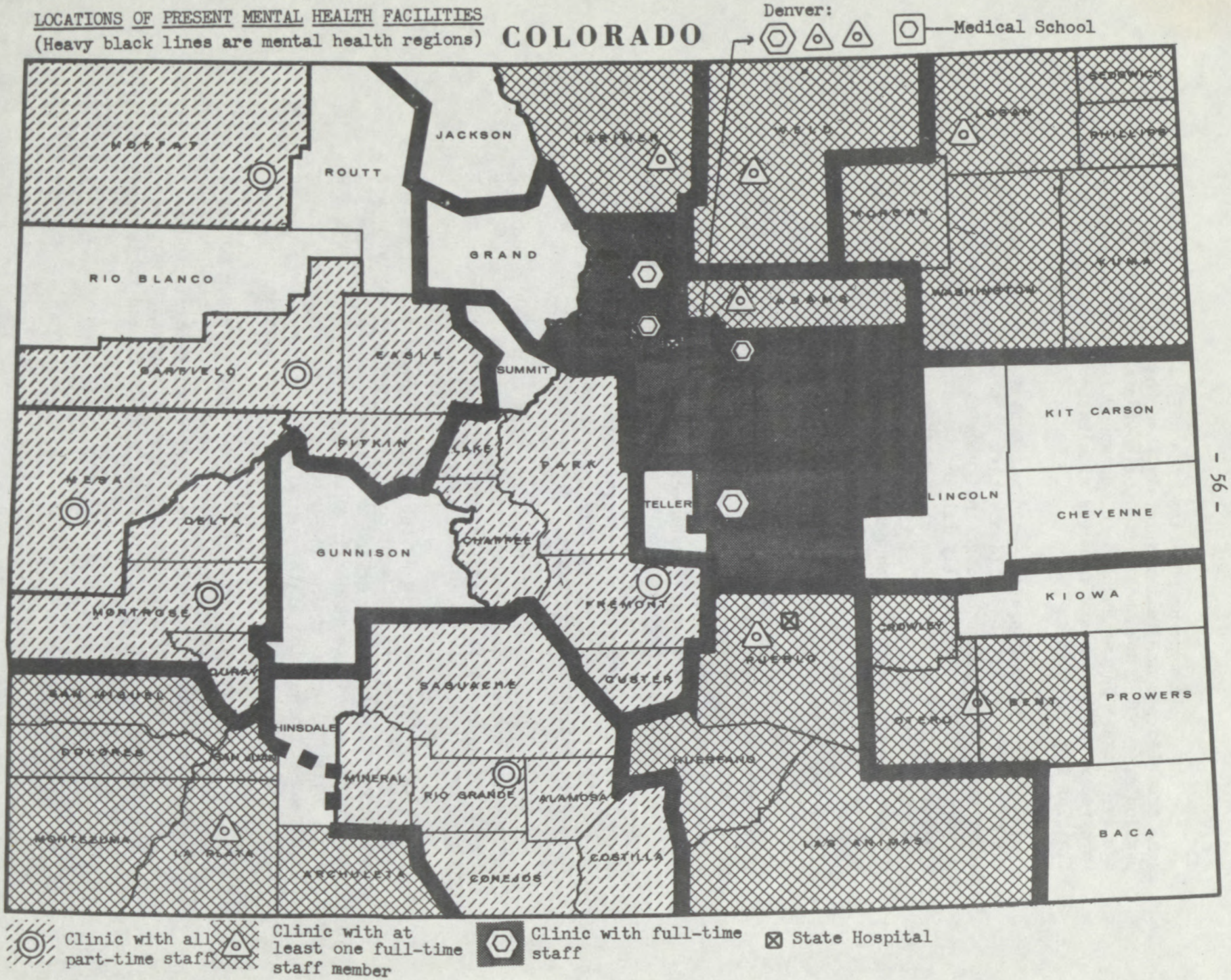
In other instances, the path is probably too long. Persons are shunted from agency to agency, or "shop around", and get the skilled psychiatric help they really need far later in their illness than would have been desirable.

In the world of the future, it would be hoped that each mental health program--and comprehensive center--would have a detailed and continually revised knowledge of the NET within its catchment area, of the manner in which patients traverse the paths within this NET while coming and leaving formal mental health treatment agencies, and of the key allied agencies within the NET with whom tangible working aggrements are most necessary.

Similarly, such a program would endeavor to learn where the risk populations are concentrated, where the WEBs are most deficient, and what steps might be urged upon agencies such as schools, urban renewal authorities, poverty programs, etc., to repair such deficiencies and so take measurable steps toward achieving true primary prevention.

LOCATIONS OF PRESENT MENTAL HEALTH FACILITIES
(Heavy black lines are mental health regions)

COLORADO



Clinic with all part-time staff

Clinic with at least one full-time staff member

Clinic with full-time staff

State Hospital

V. THE FUTURE:

Regional Priorities As Outlined By Fifteen Regional Planning Committees

Each of the regions depicted on the map (p. 56) set up a regional planning committee to look into local needs and forward basic recommendations to the State Mental Health Planning Committee. In addition, each regional committee sent out questionnaires to the principal treatment agencies and private practitioners in its area. These were analyzed by electronic data processing equipment and project staff. Summarized below are the highlights of regional committee reports supplemented by data and recommendations drawn from the SMHPC as well as the "construction plan" for comprehensive mental health centers drawn up during this project.*

It is convenient to group these fifteen regions into five major clusters or areas:

(A) The western slope--regions 1 and 2.
(B) Northeast Colorado--regions 3, 4, and 7.
(C) Central Colorado--regions 5 and 8.
(D) Southeastern Colorado--regions 6, 9, and 10.
(E) Metropolitan Denver--Region 11, including Adams, Arapahoe, Boulder, Denver, and Jefferson sub-divisions.

(A) The Western Slope: Regions 1 and 2

This mountainous area is the farthest of all from state facilities. Its population is the most stable of the major areas, the increase from 1960-70 being estimated at only 9.3% for a total of 180,900. Economically, about 5% of the land is still classified as "mineral" but farming, ranching, forestry, and the tourist industry are more important than mining today. A bewildering prospect for future planning, however, is the possibility that oil shale--which exists in the world's largest known concentration in northwest Colorado--will become a feasible source of fuel. Should this happen, the population would increase enormously, possible to rival the Denver metropolitan area. Resulting social and mental health problems would undoubtedly mushroom accordingly.

The SMHPC believes this area should receive high priority for one of the first comprehensive centers (see Recommendation VI, p. 7).

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* The Construction Plan for Comprehensive Mental Health Centers is formulated by the Department of Institutions and administered by the State Health Department. Copies may be obtained from either department.

Region 1: This ten-county region has 6.6% of the state's population on about 20% of the land. However, 43% of its population lives within commuting distance of Grand Junction. Hence, a comprehensive center located here could serve nearly half the area with outpatient, emergency, and day hospital services. It could probably furnish inpatient and traveling consultation services for the entire region.

In Colorado as a whole, there is one physician per 654 people. In Region 1, only one physician per 1,036 people is available. The average citizen is 239 miles distant from the nearest state hospital. The region experienced a 20% increase in children and a 33% increase in the aged during the past decade. Yet it has now only a single psychiatrist, a single qualified clinical psychologist available for clinic work, and a state training school for the retarded (most of whose staff are not available for substantial amounts of community clinic work).

Four outpatient clinics now exist in Region 1. Only the clinic in Mesa county employs locally resident staff. The clinics in Craig, Glenwood Springs, and Montrose are very new and utilize traveling staff from Denver. Hence, although a brave beginning has been made, the region meets only about 4.9% of minimum outpatient need--the lowest of any region.*

The Region 1 committee felt the prime need at present is for mental health professionals. Clinic staff should be greatly increased with special emphasis upon consultation and education for schools, health and welfare departments, courts and physicians, etc.

The second obvious need is for hospital facilities. Short-term private care is available at St. Mary's Hospital in Grand Junction; but facilities designed for the inpatient and partial hospitalization of large numbers of patients from the area are greatly needed. Alcoholism services should be included.

The Region 1 committee went on to urge major state support for new facilities in its area. Already low in average income, third highest in average property taxes, the region will need major state financial assistance if a comprehensive center is to be developed. Leadership from the state mental health authority will be required to help coordinate regional developments. But the Region 1 committee saw no immediate need to split its large area into two smaller regions.

It should be noted that a comprehensive center at Grand Junction would also be in a position to serve large portions of Eastern Utah. Federal construction funds may be used on a multi-state basis where good reasons can be advanced for a center serving citizens across state lines.

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* "Minimum need" for outpatient service is defined as four full-time professionals per 50,000 people.

Region 2 -- The San Juan Basin: This six-county area with 43,000 people is so isolated by major mountain barriers as to make difficult the joint development of services with adjoining regions in Colorado. However, the Farmington-Aztec area due south in New Mexico would seem a natural area for the development of joint services designed to serve a total of about 96,000 persons.

Region 2 is relatively cohesive and has gone well beyond most regions in developing a sound outpatient clinic. Nevertheless, its people are farthest of all from a state hospital and have no local facilities for psychiatric hospitalization. There is only one physician for every 1,131 people.* The region had a 34% increase in children during the past decade (and a 20% increase in the aged). It has the only Indian reservation in Colorado and 11% of its population is Spanish-surnamed. Resulting problems in acculturation are reflected in high rates of alcoholism and state hospital admissions. In 1960, its unemployment was highest in the state, its average income the second lowest. Some 27% of its families had incomes below $3,000 a year. Thus major elements of the population are at "high risk" of becoming emotionally disturbed.

With two full-time professionals and a traveling part-time psychiatrist flying in from Denver, the present clinic meets 62% of minimum need. Its most pressing need is for a firmer financial base (to promote long-range programming) and a locally resident psychiatrist. Such a psychiatrist could probably combine private practice with clinic leadership. His presence would greatly facilitate establishment of at least minimum inpatient and day hospitalization services in a local general hospital. It is possible that emergency services can be established now with local physicians providing coverage.

A general need for improved community understanding of mental health issues and possibilities was voiced. But firmer sources of funds and a few more local professionals--especially a psychiatrist--could easily lead to a true "comprehensive center" albeit on a small scale.

(B) Northeast Colorado-- Regions 3, 4, and 7:

With a single mountain county, this area is otherwise characterized by rolling plains, a "drylands" agriculture with extensive wheat and livestock grazing and some heavily concentrated irrigation along the South Platte river. Population is fairly stable, expected to rise to 214,600 by 1970 (an 11% increase since 1960). Income is below the state average, but the area is little troubled by massive in-migration or unemployment (with exceptions around Greeley). With two major state institutions of higher learning and three well-established clinics, this area should be ripe for solution of its major mental health dilemma: its people are the third, fourth, and fifth most distant from the state hospital! Heavy use is made of

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* State average: one physician per 654 people.

the medical school's Psychopathic Hospital in Denver. But this cannot compensate for really adequate emergency, inpatient, and partial hospitalization services within the area. Hence, the SMHPC has recommended that this area get high priority for a comprehensive center (see Recommendation VI, p. 7). It would be hoped that adjoining counties from Wyoming and Nebraska might also be served, thus making feasible the use of portions of federal construction funds allotted to those two states.

Region 3-- Fort Collins and Vicinity: This two-county region is the site of Colorado State University and an outpatient clinic which not only meets 57.6% of "minimum need" but also manages to serve a greater proportion of the children and adults from its catchment area than any other clinic. It is next to the bottom in the number of patients it sends to the state hospital. This is partially explained, however, by its very heavy use of Colorado Psychopathic Hospital (the region has the 5th highest rate of psychosis hospitalization). The region has seen some interesting experimentation, both in the hospitalization of a few private psychiatric patients in the general hospital in Fort Collins and the establishment of a school for emotionally disturbed children under the supervision of the mental health clinic. It has more physicians than many rural areas (one per 810 inhabitants) although fewer than the state average. Its clinic staff all reside locally.

With the growth of the University and Fort Collins' inclusion in the general belt of rapidly urbanizing cities along the front range, it is probable that Region 3 will experience at least some of the problems of mushrooming population and over-taxed public facilities which have beset similar communities elsewhere. Its present start in mental health services is sufficiently impressive, however, that it would appear feasible with very little extra effort to establish comprehensive services. If necessary, the region could rely for some years on backup support and inpatient facilities at a major comprehensive center in nearby Greeley--but eventually Region 3 could in all likelihood meet most of its needs locally.

One question is Jackson County, small in population, difficult to reach from any area in Colorado without crossing major passes. Were Wyoming's adjacent Albany County (with 21,290 people) to be tied in with comprehensive services in Fort Collins, efforts to serve Jackson County would be greatly eased.

Region 4-- Greeley and Weld County: Remarkably stable in population, this single-county region is expected to have 80,000 inhabitants by 1970. With the fifth lowest per capita income of any region, about 27% of its families have incomes below $3,000. Twelve percent of the population are Spanish-surnamed. Data from the delinquency task force suggests the poor and minority groups in Region 4 contribute far out of their proportions to state institutions. And the rate of expenditures on public welfare are 3rd highest among all the regions.

But Region 4 is rich in potential resources. The Colorado State College at Greeley has pioneered in training teachers to work with the retarded and now the emotionally disturbed. The mental health clinic is one of the oldest in the state, going back to 1927. All but its psychiatric director are locally resident staff with an active board and growing local support. And Weld County Hospital not only serves some psychiatric patients but has an occupational therapist to work with them. Emergencies are handled occasionally, but a non-psychiatric physician must be used in the absence of a resident psychiatrist.

Recommended solutions begin, therefore with the recruitment of a local psychiatrist to the community, perhaps to combine private practice with service at the present clinic and a future comprehensive center. While the medical profession, clergy, law enforcement officers, and teachers are aware of needs for expanded services, there is a need for improved public understanding and information about available resources and future potentialities. A juvenile detention center which is treatment-oriented is needed, as well as diagnostic and day care services for emotionally disturbed children (the region's social agency heads ranked deviant child behavior first among nine forms of social disorder listed in the planning questionnaire). Foster homes for discharged mental hospital patients are definitely needed also.

The Region 4 committee passed a recommendation that a major "Regional Center" be developed in Greeley to offer backup support to the entire area of Northeastern Colorado (inpatient services could be on a "purchase of service" basis from Regions 3 and 7). This, of course, is reflected also in a major recommendation by the SMHPC. An additional possibility would be to tie in some or all elements of comprehensive services with neighboring Laramie County (Cheyenne), Wyoming. This 60,000 person county already has an outpatient clinic and some general hospital inpatient facilities--being only 51 miles from Greeley, joint services might be of marked mutual benefit.

Region 7--Sterling-Fort Morgan-South Platte Valley: This six-county region has the most stable population of any region, the decade of 1950-60 seeing only a 3% increase. 66,600 people are predicted for 1970. Income is largely based upon agriculture and some petroleum. Although 25% of its families have incomes under $3,000, unemployment is the lowest of any region, average per capita income is sixth highest, and average assessed valuation is the highest of all. School expenditures per child in average daily attendance are also highest of all the regions.

But with only one physician per 1,150 people, the region is the fourth most poorly supplied with this basic professional resource. A few psychiatric cases are briefly handled in local hospitals, but without any local psychiatrists, the area largely depends upon Denver--121 miles away for the average Region 7 citizen--and the State Hospital at Pueblo. This problem of sheer distance makes

psychiatric hospitalization a last resort rather than an expedient to be determined on the basis of the patient's early need for intensive treatment. Thus, distance rather than need probably accounts for the region's low rate of admissions to the State Hospital. Similarly, aftercare follow-up for patients returning to the area is difficult to supervise adequately.

One obvious bright spot is the Northeast Colorado Mental Health Clinic. Serving all six counties since 1957, this facility is often cited as a major example of a multi-county resource serving a relatively vast rural area with high quality treatment services and heavy consultation with schools, physicians, ministers, welfare workers, public health nurses, etc. Two full-time staff reside locally, and students are now placed for fieldwork at this clinic from the Denver University School of Social Work. The board, whose appointment is confirmed by the six counties' commissioners, played the major role in mental health planning and would be able to help coordinate additional types of service in the future.

Major recommendations: Region 7 needs some locally resident psychiatrists. With at least one such psychiatrist, both emergencies and inpatient hospitalization for acute cases of psychiatric disorder could be handled in local general hospitals. Day care and other forms of partial hospitalization would also be feasible. A day-care setting for emotionally disturbed children is vitally needed, possibly to include services for perceptual disorders as well. Consultation services to allied professionals--while currently taking a major proportion of clinic staff time--remain an acute need.

The experience of the region is that resident mental health personnel, willing to become part of the community in which they serve, are vastly more effective than traveling personnel. Attracting such personnel--as is also borne out by this region's experience--requires facilities and salaries attractive enough to more than compete with the big cities. Hence, comprehensive services will require major increases in operating funds. Close ties with an initial major center at Greeley in Region 4 should be feasible--but Region 7 certainly has the potential for developing most such services within its own boundaries.

The region believes leadership and coordination can come from a board enjoying considerable autonomy (such as has already been in existence these past eight years). Considerable consultation and standards set by the state mental health authority should be developed in order to assist regional boards in visualizing goals and general guideposts. The state authority should also conduct research and evaluation and might aid matters in rural areas especially thru fostering training and residency programs in such areas. "Rural psychiatry" may prove to be a recognizable sub-specialty in itself.

Finally, it should be noted that no less than eight Nebraska counties and one in Kansas adjoin Region 7. Services tying in with Sidney and other towns barely across the border could result in a pool of some 54,000 additional people qualifying for service and hence securing additional Federal funds (as well as state and local funds) for Region 7's comprehensive services of the future.

(C) Central Colorado: Regions 5 and 8

Perhaps the least homogeneous of the five "areas" depicted in this chapter, this one possesses three distinct contrasts: the mountain counties of Region 5 with the highest peaks in the state, the most passes, and an economy heavily dependent upon mining and agriculture; the major metropolitan city of Colorado Springs with its dependence upon tourists, military pay rolls, retirement incomes, and light industry and commerce; the eastern plains counties of Lincoln, Kit Carson, and Cheyenne--sparsely populated, largely drylands agriculture and cattle.

Region 5--The Central Mountains And Upper Arkansas Valley: This seven-county region of some 49,400 people is surrounded on all sides and bisected internally by major mountain ranges. Its highways utilize nine major passes. Nevertheless, experience by the West Central Guidance Center suggests that it is a feasible entity for mental health services. Based at Canon City, this clinic's staff travels at scheduled intervals up the Arkansas Valley to Salida and Leadville. Hospitals exist in all three towns--and the hospital at Leadville has been used occasionally for psychiatric emergencies for years. Four major highways, greatly improved in recent years, afford fairly good internal communication.

Although population as a whole increased 10% in the past decade, children under 18 increased by 22% and persons over 65 by 23%. Some 45% of citizens over 65 are on Old Age Pension, the 4th highest rate in the state. With one doctor per 1,446 inhabitants, it has less than half the state's average (one per 654). It has a high admission rate of organically damaged and aged persons to the state hospital. Its suicide rate is second highest in the state, its homicide rate 4th highest. The present clinic, while a courageous undertaking which has made remarkable progress, meets only 35% of minimum needs.

Basic solutions as envisaged by the planning committee for this area are to first build up the outpatient clinic so as to treat more patients and render consultation and inservice training to a larger number of schools, physicians, public health nurses, welfare workers, etc. Hospital care would be a later stage. The need for the

clinic staff to put in some time traveling (up to Salida and Leadville) is probably going to be a continuing requirement. A full-time psychiatric social worker would greatly assist in resolving the administrative and scheduling problems for such a service. Traveling service at Breckinridge and Fairplay might be added, at least for consultation and in-service training. Both Salida and Leadville might offer temporary 24-hour inpatient care in their hospitals. But the core for an eventual "comprehensive center" would probably have to be at Canon City.

Gunnison County, the most westerly in this region, represents a question mark. Although sparsely populated, its possession of Western State College makes it a potential important asset for future training and services. But a substantial case can be made for Gunnison County to join Region 1 to the west--perhaps to get service from the new clinic at Montrose instead of tying in to the West Central Guidance Center. This is a major decision for the future.

Region 8--Colorado Springs and Counties To The East: This five-county region--second largest in population with 217,800 people expected by 1970--has most of its people and most of its services concentrated in the city of Colorado Springs. Here is a private psychiatric hospital, a number of general hospitals (at least one of which treats a sizable number of short-term psychiatric cases), and the Pikes Peak Mental Health Center--the oldest fully-staffed outpatient clinic in the state. One physician per 725 people ranks the region second only to Denver.

But population growth in Region 8 is explosive. A 69% increase in the 1950-60 decade included a 108% increase in children. The percentage of divorced and separated adults is 3rd highest in the state. Children committed to state hospitals rank 4th. Suicide and homicide rates both rank 6th. School dropouts are somewhat higher than would be expected, and committments to the state school for male delinquents are the 6th highest in Colorado. The clinic--although with an able staff and strong board--is still short-handed and meets less than half the "minimum need" for such a population (a population of 200,000 ought to have 16 professionals in its outpatient clinics). Finally, while Colorado Springs is rich in both citizen and professional leadership, knowledge of mental health trends appears quite scanty in the counties to the east (except among a few school people and welfare workers).

Recommendations: The Region 8 committee, some 32 persons strong, felt that the greatest need was for expanding services of the Pikes Peak Mental Health Center--both in terms of serving more patients with limited incomes and geographically (i.e., to make residents of Lincoln, Kit Carson, and Cheyenne Counties eligible, and

perhaps to have a part-time traveling service to Limon). Inpatient psychiatric services for children are not available (the rate of children sent to the State Hospital is 4th highest in the state) and should be. Inpatient services should be established at Memorial Hospital. Partial hospitalization services should be set up, perhaps as a part of the clinic's building program or in existing structures at Cragmor. Mental health consultation and in-service education should be heavily expanded. Psychiatric services for teenagers as a special risk population should be developed. Research, program evaluation, better means of inter-agency communication were also given a high priority.

The committee felt, finally, that the Pikes Peak Mental Health Center's board should not only extend its duties to the other counties of Region 8 but also become the basis of a Region 8 Mental Health Board.

One extra note: Two Kansas counties, Wallace and Sherman, adjoin the easternmost counties of Region 8. The town of Goodland is a trade center of some importance. These counties total 8,751 persons--services could conceivably be extended to them--or a Kansas-based service be utilized for Colorado's Cheyenne and Kit Carson counties. (A study of medical care patterns in Kit Carson County in the 1950's, however, suggested that its people go toward Denver or Colorado Springs for specialized medical care rather than toward Kansas).

(D) Southeastern Colorado: Regions 6, 9, and 10

Clustered around Colorado's second largest city of Pueblo, this area includes some of the state's most conspicuous pockets of poverty and economic decline. But its industrial center continues to grow, and the huge Frying Pan-Arkansas water diversion project may eventually stimulate much of the agricultural economy. The San Luis Valley (Region 6) is a "natural" geographic area, a high flat valley surrounded by chains of peaks, its economy largely agricultural. To the east is the major industrial-trade center of Pueblo, with areas once rich in coal mining to the immediate south (Region 10). Farther east, the great plains economy predominates, with intensive irrigated farming along the lower Arkansas River, drylands farming and cattle grazing in the flat plains slightly above the irrigable levels (Region 9). As will be noted, this area contributes far more patients to state facilities than its population would seem to warrant--a fact partially explained by its geographic closeness to Pueblo, but in all likelihood also due to the widespread economic deprivation among certain elements of its population.

Region 6-- The San Luis Valley: This seven-county region is the least densely populated in Colorado (4.7 people per square mile). It is also the oldest settled portion of the state. Seventy-five percent rural, its people contain the highest percentage of Colorado-born citizens (72%) and the largest proportion of Spanish-surnamed (38%). It seems to be an aging population--that is, although 37.4% of its population is under age 15 (which is second-highest of all regions), the total proportion of children and youth dropped by 15% in the 1950-60 decade. Meanwhile, the proportion of aged over 65 increased by nearly a third (29%). The overall population declined during the same decade but seems now to have stabilized with a 2% increase from 1960-65.

The region should have 41,100 people in 1970--if services were extended to Taos County in New Mexico, 15,934 would be added to create a region for services to about 57,000 persons.

Economically, the region has an average per capita income of $795, less than half the state average. Forty-one percent of its families have incomes below $3,000 a year. Welfare per capita is the highest in the state. Families with incomes over $10,000 per year are the lowest--only 7%. The median mill levy is 70% higher than the state median, yet the revenues realized are the lowest in the state on a per capita basis. Partially counteracting this, revenue from the state constitutes 40% of the funds used to operate local government--by far the highest proportion of all regions.

Mental health resources are slender indeed. With one physician per 1,488 persons, the region is second from the bottom in this essential resource. It has no local psychiatrists or other mental health professionals. The San Luis Valley Mental Health Clinic is off to a good start, but offers only 17 hours of service per 1,000 people per year. The staff travel in once a month for a three-day session.

Region 6 sends patients to state hospital facilities at a rate 40% higher than the state average. Indeed, only Denver and the Pueblo area surpass it. Alcoholism and persons with aging syndromes account for well over two/thirds of these patients--the alcoholism rate of hospital admissions is 2nd highest in the state, as is death from cirrhosis of the liver. Region 6's suicide rate is only slightly above average, but it leads all regions in rate of homicides.

Recommendations: The Region 6 mental health planning committee turned in one of the most carefully detailed reports of any region. Some 27 agencies submitted questionnaire replies and recommendations. The inadequacy of locally-available services was stressed, as well as much concern over delinquency and alcoholism in the area. The first immediate need is for more mental health consultation and diagnostic services to assist local practitioners

and social agencies. The region now utilizes all such consultation it can get, including medical school lectures for its physicians, state hospital consultation and clinic staff. But testing and consultation services to schools are in short supply. And in-service training should be extended to law officers, ministers, teachers, public health nurses, welfare, etc.

The Alamosa Community Hospital, already in a building program, might well be able to supply space for day hospital activities, as well as several rooms for brief in-patient care. Such an arrangement would have to include means for reimbursement for indigent patients.

Foster homes for disturbed children should be increased. With increased state-federal aid, the committee felt the present clinic could be expanded to a full-time operation with a basic team of psychiatrist, psychologist, and social worker. The psychiatrist would probably be allowed to conduct some private practice also. As a partial solution to the recruitment problem, a file is to be gathered of persons trained in a mental health discipline but presently inactive due to marriage, retirement, etc. Such persons, when their training is up-dated (perhaps thru workshops at Adams State College), might prove a major resource. A family counseling service, either as part of this clinic or as a separate "family agency" should be established. Fees should be charged to the non-indigent. A special alcoholism program should be set up (under clinic supervision) with at least three psychiatric social workers, one to be stationed at the clinic in Monte Vista, one in Alamosa at the welfare department, and one to serve Conejos and Costilla counties, again based at a local welfare office. Meanwhile, emergency, inpatient, and day hospitalization should be possible, probably thru remodeling at Alamosa Community Hospital. Finally, the committee would like to see more adequate mental health services in the schools, to include mental hygiene classes, qualified school psychologists, in-service for teachers from the clinic and/or Adams State College, etc.

A locally-selected Mental Health Board for Region 6 was overwhelmingly supported by agencies queried, and highly recommended by the committee.

Region 9-- The Lower Arkansas Valley: Decreasing thruout the 1950's, this six-county region has apparently picked up in population since 1960 and should have about 59,000 people by 1970. Nearly 12% of its people are over 65 (3rd highest proportion in the state), and the aged increased by 29% in the 1950-60 decade. Children under 18 decreased in the same period by 7%. Nevertheless, Region 9 should have nearly 21,000 children in 1970.

In terms of physicians, Region 9 has the lowest ratio in the state--one physician per 1,644 people (state average: 1: 654). It has no psychiatrists. It has some excellent hospitals, some of which occasionally treat psychiatric and alcoholism patients during acute crises under local physician supervision. But no inpatient care is available on a routine basis, especially for the indigent. Psychiatric admissions to the state hospital are somewhat below average, except for those with organic conditions and aging syndromes--here, Region 9 is 4th highest in the state. Children under 18, however, are sent to the State Hospital at the 2nd highest rate in Colorado.

The region is not wealthy. It has the 3rd lowest per capita income ($1,152 compared to the state average of $1,681), the second highest percentage of families with incomes below $3,000--30%. It has the 3rd highest proportion of Spanish-surnamed, and acculteration problems are a noticeable source of stress.

But some bright spots are evident. The mental health planning committee in Region 9 devoted most of its efforts to a re-structuring of outpatient services. Two separate clinics were combined into a single entity, based at Las Animas in Bent County and La Junta in Otero County. This strengthened clinic now has its first full-time mental health professional (the most important single growth step for new clinics). This man, a trained psychiatric social worker, is supplemented by traveling staff from outside the region and part-time staff from the V.A. Hospital at Fort Lyon. In 1964, outpatient services were about 18% of minimum need--they should now be substantially higher. A full clinic service offering diagnosis and treatment for patients plus consultation and in-service for allied professionals is now available for three of the region's counties (Otero, Bent, and Crowley). Treatment services only (but no in-service or consultation) can be purchased from this clinic by neighboring counties such as Kiowa, Prowers, and Baca. It is hoped that these counties can participate fully in clinic services in the future.

Two excellent junior colleges exist in the area (with future potential for training technicians, etc.). And a residential placement setting for disturbed boys is maintained at Boy's Ranch near La Junta.

It is evident that the State Hospital is too far away to meet Region 9's need for acute care facilities. If day hospital care plus some formally organized inpatient and emergency services are to be developed in the region, its local general hospitals must be involved and its mental health clinic greatly strengthened. The region's planning committee was not able to get into such an advanced stage of decision-making. It is notable that of 21 agencies

queried in Region 9 by the committee, 62% dealt with problems involving emotional disturbance at one time or another. Not surprisingly, more mental health consultation services and more treatment services were overwhelmingly desired by these agencies. Some 82% of those queried supported the concept of a regional mental health board to coordinate development of mental health services in Region 9.

One final note: Four Kansas counties and two in Oklahoma border Region 9. Were services to be extended to these counties, an additional 30,000 people would be added, making an ultimate catchment area of nearly 90,000 persons.

Region 10-- Pueblo and the Walsenberg-Trinidad areas: This three-county region will have 178,000 people in 1970, a 21% increase from 1960. Thus, by including the major industrial and trading complex of Pueblo, the region is one of the three areas of rapid urban expansion in Colorado. It has the highest percentage of its working force engaged in manufacturing (31.7%) of any region including Denver.

Though average income is not low, some parts of Region 10 are hard-hit by unemployment, notably the Walsenberg-Trinidad areas, once major coal producers. Average per capita welfare expenditures are second only to the San Luis Valley. As for admissions to state hospital facilities, these are by far the highest of any region including Denver (even if Fort Logan admissions are counted). Moreover, the proportion of organic and aged admissions is highest in the state, and alcoholism admissions are third highest (death by cirrhosis of the liver ranks even higher--2nd!). Region 10 also ranks second highest in the percentage of adults who are divorced, and in percentage of children on Aid to Dependent Children. And it is third in the rate at which it sends teenagers to correctional institutions.

In resources, Region 10 has one physician per 893 people--below the state average but well above most regions. In Pueblo, it has a variety of medical specialists in private practice. With eight psychiatrists, it ranks next to Denver and the Colorado Springs area. Most of these, however, work at the State Hospital (which, in addition, has a number of part-time psychiatrists from Denver). The clinic, now known as the "Spanish Peaks Mental Health Center", has several full-time staff but must still secure psychiatric leadership from outside the region. It meets about 24% of minimum need. Its services have been dramatically extended to Huerfano and Las Animas Counties to the south, and it has established effective working ties with the State Hospital and St. Mary-Corwin Hospital. The latter has long had an inpatient psychiatric facility heavily used by local patients insured or otherwise able to pay private fees.

Colorado State Hospital, located in Pueblo, has for decades been the area's chief mental health resource. It now has a Pueblo Division specifically to serve the largest county in Region 10. This Division already operates Day Hospital services and some outpatient follow-up.

Recommendations: The Region 10 committee assigned first priority to the establishment of a true comprehensive mental health center. It proposed that such a center be a fluid adaptation of present resources including--via contractual agreements--the Spanish Peaks Mental Health Center (for outpatient and consultation services plus some forms of emergency coverage); St. Mary-Corwin Hospital (for acute treatment of patients requiring inpatient care); and the Pueblo Division of the State Hospital (for day hospital care plus inpatient treatment and some consultation). In addition to these five "essentials" for a comprehensive center, the committee recommended rehabilitative services, pre-care and aftercare, training, and research programs.

The nuclei of these activities already exist in large part in agencies relatively independent of each other. The next steps are to develop effective means of inter-relating these elements of care so as to assure transfer of records, continuity of care where indicated, etc. Physical location of possible new construction--especially new quarters for the outpatient clinic--would be set in cooperation with the Pueblo Planning Commission.

One rather unique recommendation is that a "clinic-school" be set up for emotionally disturbed children in conjunction with the outpatient facility. There is a real need for a service for children not so disturbed as to require hospitalization yet unable to participate in the public schools.

Finally, it should be noted that two counties in New Mexico adjoin Region 10--Colfax and Union. Were services to be extended to these, the region's population base would increase by 19,874 to a total of around 198,000 people.

(E) Metropolitan Denver: Region 11, including Adams, Arapahoe, Boulder, Denver, and Jefferson Sub-divisions

The major economic growth in Colorado is concentrated in an elongated belt of cities along the front range. Of these, metropolitan Denver is the most conspicuous example of the problems now commonly identified with rapid urban growth in the United States. It is either a super-city, or cluster of sub-cities closely interrelated. All of its constituent parts are beset by heavy inroads of incoming populations; a chronic undersupply of basic services including health and education; disruption of city-county relationships; and the growth of ghettos with unskilled migrants and the chronically poor pocketed into a central core while the better educated and more affluent tend to locate in the suburban belts.

Region 11, then, consists of ten counties, five of them heavily urbanized, with a mutual inter-dependence only now beginning to be recognized. Political solutions to afford more effective allocation of certain key services are still largely in abeyance. Hence, community mental health services, like most others, tend to be based upon county lines. Somehow, both Mile High United Fund and the major state facility (Fort Logan Mental Health Center) must relate to each of these sub-regions in an equitable and efficient manner. Meanwhile, private sector services quickly and easily ignore county lines.

More than half the state's population is concentrated within Region 11. It is predicted that this mass of people will increase 32% by 1970 at which point it will make up 1,254,000 people (57% of the state's total population). Although the central pockets of poverty are enormous by any standards, the average incomes of the area are far higher--including each sub-division--than all other regions in the state. Proportions of children and the aged in Denver and Boulder are roughly similar to the state as a whole. But the "tri-counties" of Adams, Arapahoe and Jefferson have an extraordinarily high proportion of children and a tiny percentage of aged.

The pool of treatment resources is relatively vast. Physicians exist in a ratio of 1 per 508 persons (as contrasted to the state average of 1:654, which no other regions in the state equal or surpass). Psychiatrists exist in a ratio of 1 per 6,250 persons, three times the rate of the next highest ranking region (the Colorado Springs area). Seven community mental health clinics, two private psychiatric hospitals, several general hospitals with psychiatric units, and two state hospitals (one close, one at Pueblo) serve the area. And the medical school's outpatient clinics and psychopathic hospital draw a major proportion of their patients from within the region. A total of 140 agencies were identified with at least some degree of mental health responsibilities and interest!

As for need, the region as a whole has the highest rate of admissions to public hospitals for psychosis in the state. It sends youth to correctional institutions at the highest rate. Its suicide rate ties for first place with one other region. It is third in homicide rate, second in deaths from cirrhosis of the liver, first in women divorced, fourth in school dropouts. Were more treatment services available, the 140 agencies queried estimate that their mental health referrals would immediately increase by 42%. Some 15,000 of the total annual caseload of these 140 agencies are believed to be emotionally disturbed but getting no present treatment by mental health resources.

Basic recommendations: On the basis of questionnaire results, the need for additional outpatient services ranked first among the five "essentials" for comprehensive centers. Inpatient service came second, with emergency services, partial hospitalization facilities, and consultation next in order. Highest priority should be given to disturbed families. The needs of children and adolescents (especially inpatient care) were seen as crucial. Alcoholism services were heavily emphasized, especially better care for acute episodes, such as could be offered in general hospitals. Law enforcement officers and jails still play a role in handling deviant behavior resulting from mental disturbance--better liaison between these men and mental health agencies should clearly be worked out. Finally, public agencies should be able to utilize private hospital beds when necessary, even for the indigent, The committee felt it was absurd not to be able to place patients in available beds in private hospitals when public facilities are jammed. (The Medicare Act may facilitate such an interchange between the public and private sectors).

Among common concerns for Region 11 as a whole, the committee noted the need for training programs for professionals (which could hardly be set up efficiently on the basis of county lines), case registers and research, salary standards and recruitment, legislative activity, service to Grand County, and specialized services serving a number of counties (e.g., alcoholism treatment, drug addiction, etc.).

A major recommendation of the SMHPC is the establishment of a clearcut mental health board for each "region". In Region 11, the issue of working toward a single "Region 11 Board"--or five smaller regional boards loosely coordinated--has not been finally resolved. It was, however, the consensus of the Region 11 planning committee that it should continue to meet as a regional coordinating group, free to assist in promoting inter-county cooperation and free to reconsider the question of an eventual overall board. Meanwhile, the State Mental Health Planning Committee felt that the sub-regions should be free to contract for elements of comprehensive services across county lines. If necessary, of course, the state mental health authority itself could play the major role in promoting a coordinated use of resources.

Adams County: The phrase "explosive growth" fits Adams County more precisely than any other single county in the state. The 1950-60 decade saw it increase by 199%. In children under 18, it achieved an almost unbelievable 285% increase. By 1970, it is expected to have 196,000 people. The least wealthy of the suburban counties in terms of average income, it has about 10% of its families living on incomes below the $3,000 mark. And many of its communities are so new as to make recruitment of informed leadership, board members, etc., difficult.

Adams County has always had a low rate of admissions to the state hospital. Its use of Fort Logan continues lower than would be expected, and there is some reason to think that patients who are poor or physically handicapped find the transportation problem for utilization of Fort Logan's day hospital and outpatient services difficult. When admissions to the medical school's Psychopathic Hospital are added, however, Adams County is seen to have the second highest rate of psychosis admissions to public facilities in the state.

Its mental health clinic is somewhat famous for its emphasis upon "short-term crisis-oriented" therapy. Although meeting only about 30% of "need" in terms of staff hours, it serves a higher proportion of patients than most other clinics. But if two additional staff members can be hired, the clinic plans to offer at least some long-term treatment as well.

Major recommendations by the Adams County Planning Committee include:

1. A 24-hour emergency service.
2. Special education classes in school districts where none exist, with heavy clinic support for diagnosis and consultation.
3. Increased diagnostic services to the courts.
4. Group homes for delinquent and predelinquent youth.
5. Re-socialization programs for patients returning from lengthy hospitalization.
6. Support for allied agencies which are understaffed or budgeted.
7. Possibly day care services sponsored by the clinic.

Arapahoe-Elbert-Douglas Counties: This region is also one of the fastest growing parts of the state, increasing by 11% in the past decade and due to have 183,600 people by 1970. It has the highest per capita income in the state ($2,426), but still some local poverty with 10% of its families having incomes below $3,000 a year. Like the other suburban counties around Denver it tends to depend upon Colorado Psychopathic Hospital for emergency services, with Fort Logan a major resource for longer-term care (its total admission rate to state facilities is 4th highest in Colorado).

Recommendations: The present outpatient clinic (one of the strongest in Colorado) should become the nucleus of a comprehensive center. A full-time outpatient branch would be set up in Aurora. Consultation services would be greatly increased, especially to schools to assist in developing classes for the emotionally disturbed, to the welfare department, the courts, and public health nurses. Inpatient emergency services should be secured from currently under-used private hospital beds. Separate day care programs for children and adults would be set up within the center and would involve new construction. Small group placements for disturbed adolescents should be set up. And a therapeutic nursery school should be added to the clinic's range of services.

Boulder County: Although only 27 miles from downtown Denver, this rapidly developing center of higher education, scientific research, and specialized manufacturing constitutes a separate social and medical-care entity to perhaps a greater degree than other parts of Region 11. For this reason, Boulder may well remain a separate region for much of its future planning.

Growing 54% in the 1950-60 decade, Boulder County will have at least 100,000 people by 1970 (127,000 by some estimates). Although much of the county consists of mountains (and agriculture in the lowlands is still substantial), 91% of the population is "urban". About one-eighth consists of university students (due to total nearly 20,000 by 1970). This group has a specialized student health psychiatric service as well as psychological counseling available.

In average income, Boulder is 4th highest in the state. Some 17% of its families have incomes below the poverty line ($3,000), and 16% have incomes over $10,000. Its school expenditures per pupil are 3rd highest in Colorado.

In addition to the Region 11 average of 1 physician per 508 people, Boulder's four local psychiatrists in private practice (plus several others in residence but not full-time practice) give it the second highest ratio. Boulder Memorial Hospital has a small inpatient psychiatric ward. The mental health association is active and has strong lay as well as professional representation. Numerous

psychologists and social workers live within the county. The Boulder City-County Health Department is not only strong in basic health services but utilizes mental health consultation on a far stronger scale than many other areas--the aftercare services offered by its public health nurses are a striking case in point.

Boulder Mental Health Center has functioned since 1955, originally as a child guidance clinic only but now offering a wide spectrum of services to adults, children, and allied agencies. It is the first clinic in the state to include 24-hour emergency services as well. In terms of the somewhat arbitrary "minimum need" criteria set up by the SMHPC, Boulder's clinic meets the highest percentage of any region--65%.

Thus, Boulder is in many ways a model for other areas to emulate. Its basic health and mental health services are relatively strong. Its leadership pool is sophisticated and draws from many disciplines. It is not very surprising that in terms of presently available crude indices, Boulder is better off than most areas. Its rate of 1st admissions to public hospitals for psychosis is 4th lowest in the state. Its overall admissions to state facilities are 3rd lowest. It ties for second lowest in suicide rate, and is lowest of all in homicides, death from cirrhosis of the liver, and youth adjudicated to correctional institutions. Only in percentage of divorced does it incline toward state averages. The most obvious immediate problem is the necessity of patients requiring longer-term hospitalization to go all the way to Colorado State Hospital at Pueblo--137 miles away.

Recommendations: A full-time comprehensive mental health center should be established. Utilizing expanded outpatient, emergency, and consultation services from the present mental health clinic, inpatient services would be secured by contractual ties with Boulder Memorial Hospital for those requiring short-term intensive care (including the indigent). A day care center would be constructed to serve both the emotionally disturbed and mentally retarded, with programs focused for adults and children. Alcoholism services would continue to be sought from Fort Logan Mental Health Center, but the hope would be that other major forms of psychiatric care could be developed within the comprehensive center, eventually on a scale such as to handle the bulk of Boulder's mental health needs within the region itself.

Meanwhile, the region's unique services for delinquent youth (involving close ties between the District Court staff, the Mental Health Center, the schools, students from the University, etc.) should be further strengthened by establishment of a "Boys' Ranch" under county auspices.

Two final recommendations were that Boulder County become an independent mental health region (possibly with addition of Grand County--especially if roads are built over the Indian Range due west from Boulder), and that mental health and mental retardation agencies establish a joint planning committee to help implement the goals developed in this plan.

Denver County: Most heavily populated county in the state, Denver is growing less rapidly than its suburban rings. Nevertheless, it grew 19% in the 1950-60 decade, has already grown 7% more, and should have at least 568,000 people by 1970. Its proportion of non-white and Spanish-surnamed persons is far higher than the suburbs. In average income, it is the third wealthiest region--but within its poorer areas are major examples of poverty, social deprivation, and social disorder. Fourth highest in welfare payments on a per capita basis, it ranks first in admissions to public hospitals for psychosis, in suicide, in death from cirrhosis, in percentage of divorced and separated, in youth adjudicated to correctional institutions. It ranks second in homicide rate and total admissions to state hospitals, third in percentage of children on ADC.

Like most major cities, its social and health resources at first seem enormous. Some 79 agencies were identified during planning which have some direct interest in mental health services. It has the greatest number of physicians (1 per 508 people) and the bulk of Colorado's psychiatrists with 62 in full-time and 32 in part-time practice). It is the primary catchment area for which Fort Logan Mental Health Center was designed. It has major mental health resources in the inpatient and outpatient services of its own Denver General Hospital, the Denver Mental Health Center, and the Children's Psychiatric Clinic at Children's Hospital. It has access to several outpatient clinics at the medical school. Its veterans can use the Denver VA hospital for both inpatient and outpatient care. It has two private psychiatric hospitals, three general hospitals with psychiatric services operated on a private non-profit basis, and three privately-operated counseling services. It has several family agencies and a major health and welfare planning council to assist in coordination. Its schools have the greatest proportions of school psychologists and social workers in the state.

But 17% of the caseloads of its non-psychiatric agencies are emotionally disturbed but are getting no psychiatric treatment. This amounts to around 14,000 cases. And agencies queried were in overwhelming agreement as to the need--in this order of priority--for more outpatient services, inpatient beds, emergency services, partial hospitalization, and consultation.

Recommendations: Because of the multiplicity of services and a need for better coordination which is even more acute than in other regions of Colorado, the Denver planning committee urges establishment of the Office of Program Director for Psychiatric Services. This Director would be a psychiatrist responsible to a Denver Mental Health Board. His duties would include planning and developing mental health services (seeking state and federal funds as well as local sources), administering services under direct Denver governmental auspices, and serving in an advisory relationship to

private clinics and allied agencies. Research, case registers, devices to improve multi-agency treatment planning, etc., would also fall under his office.

Other recommendations include a greatly strengthened range of services at Denver General Hospital including better emergency service, care for acute and chronic alcoholism, screening and coordination of treatment for prisoners admitted to the jail, etc. Some of these recommendations are already being implemented, and planning for new construction is now underway.

The first true "comprehensive mental health center" should be based at Denver General Hospital. Additional clinic facilities should be developed by the Office of Program Director, either as new clinics or via contract with presently existing clinics. Additional comprehensive centers will probably be needed, perhaps to be formed around such nuclei as the Denver Mental Health Center. Similar services--especially those designed to meet acute crisis situations--should also be developed at Colorado Psychopathic Hospital. The manner in which medical school facilities, Fort Logan Mental Health Center, and Colorado State Hospital are to relate to these community complexes will require intensive further study.

Grand County: The sole rural county in Region 11 without any present affiliation for community mental health services, Grand County has some 3,625 people for whom service via Berthoud Pass is more practical than going toward Region 1 and Grand Junction, etc. Since even Jefferson County Mental Health Clinic involves a hundred mile round trip, however, Grand County committee members felt emphasis should be upon a consultation service of outside mental health experts to assist local physicians, ministers, public health nurses, and the welfare department in coping with mental health problems. The Region 11 committee agreed this was a realistic goal and such a service should be supplied by some one of the mental health agencies in Region 11.

Jefferson-Clear Creek-Gilpin Counties: This is a region of some 185,800 people, a growth during the 1950-60 decade of 129%--second fastest in the state. Nearly 400,000 people are expected by 1980. The overwhelming bulk of this population lives in Jefferson County in areas adjoining Denver. Clear Creek and Gilpin Counties lie 25-40 miles west of the Jefferson County Mental Health Clinic, in mountainous areas fairly well-served by major highways. Both these sparsely-populated counties rely on Jefferson County and Fort Logan Mental Health Center for formal psychiatric services.

The region ranks next to Arapahoe in average income, being 28% higher than the state's overall average. It has pockets of poverty, but only 10% of its families are below the $3,000 annual income level. Expenditures on schools and other services are heavy. The region is strong on most health, welfare, and educational services although its rapid growth creates frequent needs to push ahead with new services and new construction.

Strong in physicians and private psychiatrists, the region nevertheless ranks 3rd in rate of admission to public hospitals for psychosis. It ties for 3rd in suicide rate and is 4th in percentage of adults divorced. It is 6th in rates of psychiatric admissions to state hospitals and admissions for alcoholism, yet is 13th in deaths from cirrhosis (perhaps a reflection of its relatively young population).

Its basic public mental health resources are three: The Jefferson County Mental Health Center is a well-established outpatient and consultation center meeting about 33% of "minimum need" as defined by the SMHPC. Colorado Psychopathic Hospital at the medical school apparently meets much of the emergency and inpatient needs of the area. And Fort Logan Mental Health Center is so readily accessible as to constitute what amounts at times to a "first echelon" resource. No private or general hospital psychiatric resources exist within the region, but access to those in Denver is simple for patients covered by insurance or private means.

Recommendations: The Jefferson County Mental Health Center plans to expand services markedly in the next few years, continuing its growth experience which has been almost uninterrupted since 1959. The board would now like to work toward developing a comprehensive center. The present outpatient clinic would be supplemented by one or more satellite clinics, perhaps at Arvada, possibly even one in the mountain areas. An inpatient facility for around 45 adult patients will be sought. Such a unit might be developed as part of the Lutheran Hospital complex. A special inpatient facility for children and adolescents is needed, either as part of an existing hospital or as an addition to Fort Logan. A juvenile holding center is needed for court and welfare problems as well as some kinds of mental health crises. An emergency facility would be sought as part of one of the above services. Meanwhile, partial hospitalization services should be developed--possibly by arranging first echelon care at Fort Logan, possibly as an adjunct to the clinic or at Lutheran Hospital. A Childrens Day Care Center with space sufficient for 90 children should be developed. It would require educational facilities, gymnasium, etc., and should definitely be adjacent to the outpatient clinic. Consultation and referral services would continue to be a prime responsibility of the outpatient facility.

MEMBERS: STATE MENTAL HEALTH PLANNING COMMITTEE

The original State Mental Health Planning Committee included representatives from the following organizations:

1. Mrs. Bernice di Sessa
   Colorado State Department of Public Health,
   Public Health Nursing Section

2. Dr. Donald G. Langsley, M. D.
   University of Colorado Medical School

3. Mr. Tom Dillingham
   State Department of Rehabilitation

4. Mrs. Ruth Pierce
   Colorado State Department of Public Welfare

5. *Dr. E. Ellis Graham, Ph.D.
   Colorado State Department of Education
   (Resigned, replaced as education representative by Dr. John Ogden)

   Dr. John Ogden, Ed.D.
   Colorado State Department of Education

6. Dr. E. James Brady, M. D.
   Colorado Medical Society

7. *Dr. Robert Moses, M. D.
   Colorado District Branch, American Psychiatric Association
   (Resigned, Nov. 1963, replaced by Dr. Robert Perry)

   Dr. Robert Perry, M. D.
   Colorado District Branch, American Psychiatric Association

8. *Miss Evie Brunger (Mrs. Robert W. Moses)
   Colorado Nurses Association
   (Resigned, January, 1964, replaced by Miss Nancy Sanford)

   Miss Nancy Sanford
   Colorado Nurses Association

9. Dr. Harl Young, Ph.D.
   Colorado Psychological Association

10. Mrs. Amy Barnard
    Northern Colorado Chapter, National Association of Social Workers

11. *Mr. James D. Voorhees
Colorado Bar Association
(Resigned, April 1964, replaced by Mr. William McGehee)

Mr. William McGehee
Colorado Bar Association

12. Mr. Richard Leavitt
Colorado Hospital Association

13. Mrs. E. Ray Campbell
Colorado Mental Health Association

14. Mr. Henry Wilson
Colorado Chamber of Commerce

15. Miss Florence Harper
Colorado Labor Council, AFL-CIO

16. Hans M. Schapire, M. D.
Chief of Psychiatric Services, Department of Institutions

17. Harold Nitzberg, Coordinator
Community Mental Health Clinics, Department of Institutions

* Original members of the SMHPC, who resigned during the project.

On June 28, 1963, six additional members were proposed, increasing the SMHPC as follows:

18. Mr. Tom Adams
Western Interstate Commission on Higher Education

19. Dr. Henry H. Welch
Metropolitan Council for Community Services

20. Mrs. Clara Brown
Southern Colorado Chapter, National Association of Social Workers
(Also representing the Southern Colorado Chapter, NASW and attending at various times: Miss Marguerite Cowger and Miss Agnes Donaldson)

21. Dr. Elywn N. Akers
State Health Department, Maternal and Child Health Section

22. Mr. Graydon Dorsch
State Health Department, Alcoholism Division

23. Mr. Marvin Meyers
Division of Mental Retardation, Department of Institutions

In January, 1964, three more were added:

24. Mr. George H. Moore
Colorado Association of County Commissioners

25. Mr. Fred P. Lightner
State Department of Employment

26. Mrs. James D. Voorhees
Councils on Alcoholism

Four more members were added during the summer of 1964:

27. Franklin P. Wherry, M. D.
Academy of General Practitioners

28. Dr. Claude Guldner
Iliff School of Theology

29. Mr. Bill Shaw
Rehabilitation Services, Colorado State Hospital

30. Dr. Merle Adams
Department of Sociology
University of Colorado

The fourth addition took place in November, 1964:

31. Dr. Harlan McClure
Colorado Medical Society

32. Dr. Frederick A. Lewis, Jr.
Colorado Medical Society

33. Dr. Edward Billings
Colorado Medical Society

DENVER, COLORADO

Chairmen: Nine Task Forces

1.	LEGISLATION	Judge Marvin Foote
2.	MANPOWER	Dr. Herbert S. Gaskill, M.D.
3.	RESEARCH	Dr. Harl Young, Ph.D.
4.	EMOTIONALLY DISTURBED CHILDREN	Dr. Dane G. Prugh, M.D.
5.	DELINQUENCY	Mylton L. Kennedy
6.	ALCOHOLISM AND ADDICTION	Graydon Dorsch
7.	ARCHITECTURE AND MENTAL HEALTH CENTERS	Daniel Havekost
8.	CASE REGISTERS	Dr. Brenda Dickey, Ph.D.
9.	ECONOMIC ASPECTS OF MENTAL ILLNESS	Steven Weiss, supervised by Dr. Reuben Zubrow, Ph.D.

Chairmen: Fifteen Regional Mental Health Planning Committees

Region 1	Dr. Richard Troy, M. D.
2	Mrs. Arthur Ballantine, Jr.
3	James Dooney, succeeded by Harvey Snuttjer
4	Mrs. Harold Winograd
5	Mr. Laurence A. King
6	Dr. LaVonne Bergstrom, M.D.
7	Mrs. Verda Stolte
8	Dr. Gordon S. Riegel, M.D. and Mrs. Stewart Hinds (Co-chairmen)
9	Dr. L. S. Sampson, M. D., succeeded by Judge George McLachlan
10	Robert Blachly, succeeded by Dr. Raymond E. Anderson, Ph.D., & Dr. Charles E. Meredith, M.D. (Co-chairmen)
11	Frank Wright, successor to Wendell H. Martin
Adams	Mrs. Henry Dickinson
Arapahoe	Mrs. Laurence Currier
Boulder	Dr. Ray Lewis, M.D.
Denver	Dr. William M. Covode, M.D.
Grand	Reverend Michael Jarvis
Jefferson	Karl Williams

EXPENDITURES: Two Years of Mental Health Planning

Note: Figures under State and Local columns are funds for community mental health services--they are included to prove matching capabilities for the federal planning grant. As of July 1, 1965, mental health planning is funded by the state.

First Year: June 1, 1963--June 30, 1964

	State	Local	Private	Federal	Total
Salaries (Including retirement & additional benefits)	35,076.93	-	-	14,531.01	49,607.94
Travel					
Staff, Consultants & Committees	-	-	-	6,229.99	*6,229.99
Consultants & Contracts for Special Studies	-	-	-	6,465.00	6,465.00
**Supplies & Equipment	-	-	-	2,751.21	2,751.21
Other	398,594.33	400,215.43	-	46.63	798,856.39
SUB-TOTAL	433,671.26	400,215.43	-	30,023.84	863,910.53

* $277.75 Refunded

** Specifically for mental health planning, the State supplied office space, use of a State car, IBM data processing equipment and multilith equipment at Fort Logan Mental Health Center, and facilities and supervisory staff at the State Penitentiary for printing final reports.

It should also be noted that one-quarter of the time of the Director of the Psychiatric Division was budgeted for this project--and many hours of other department staff were devoted to planning project efforts.

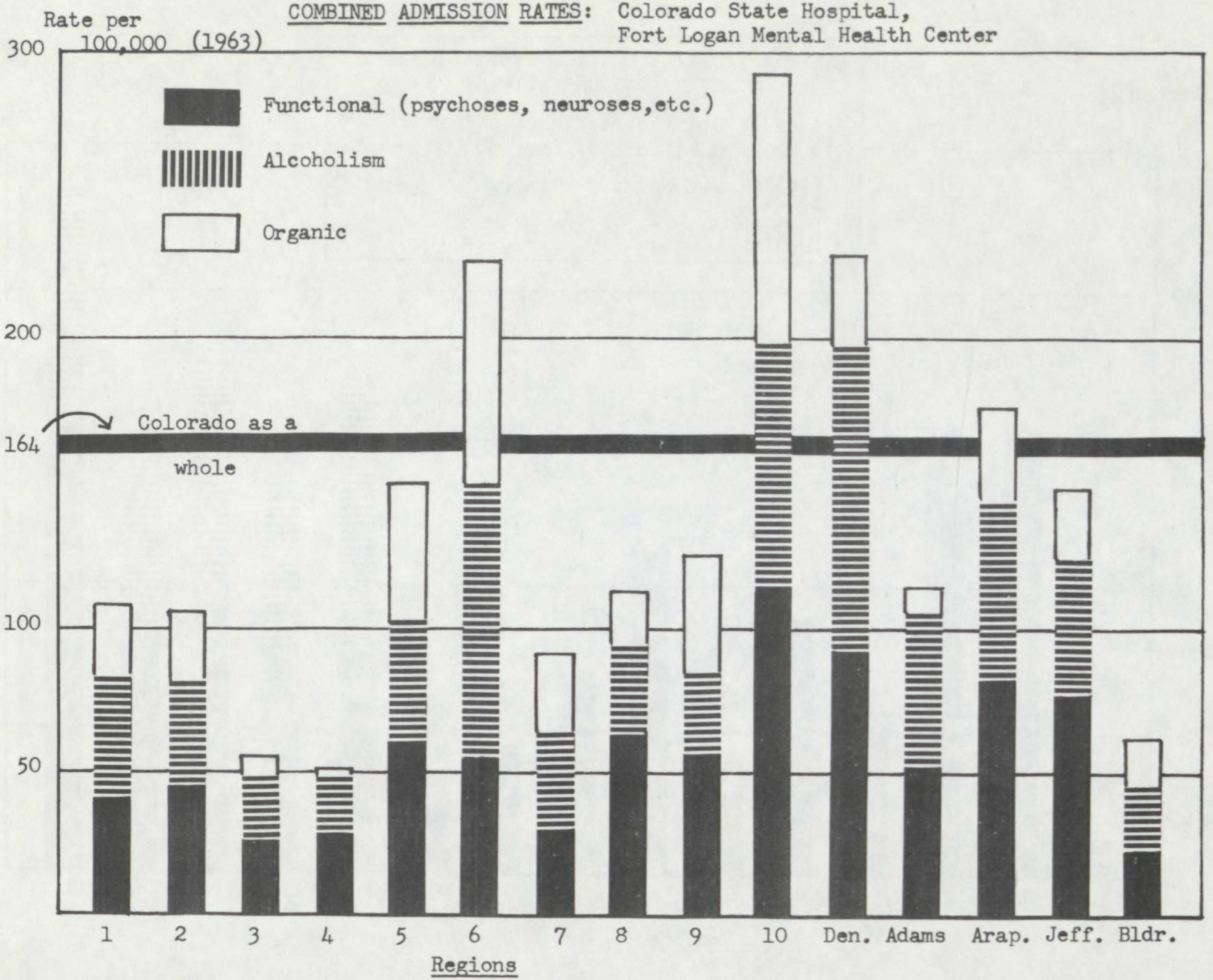
*** In addition, $7,820 from this first year's grant was encumbered via contracts for two special studies which were completed in the second year.

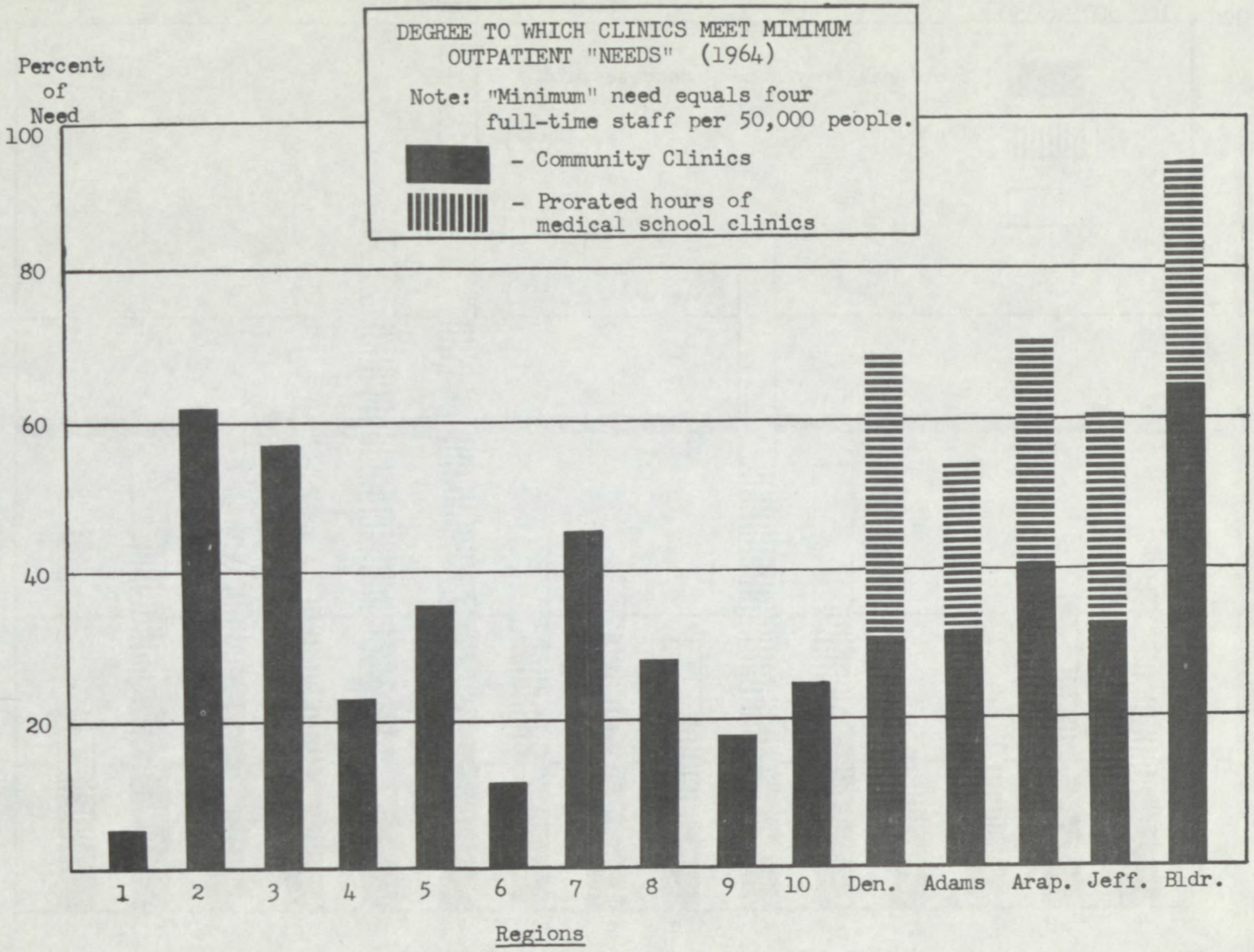
EXPENDITURES: Two Years of Mental Health Planning (Continued)

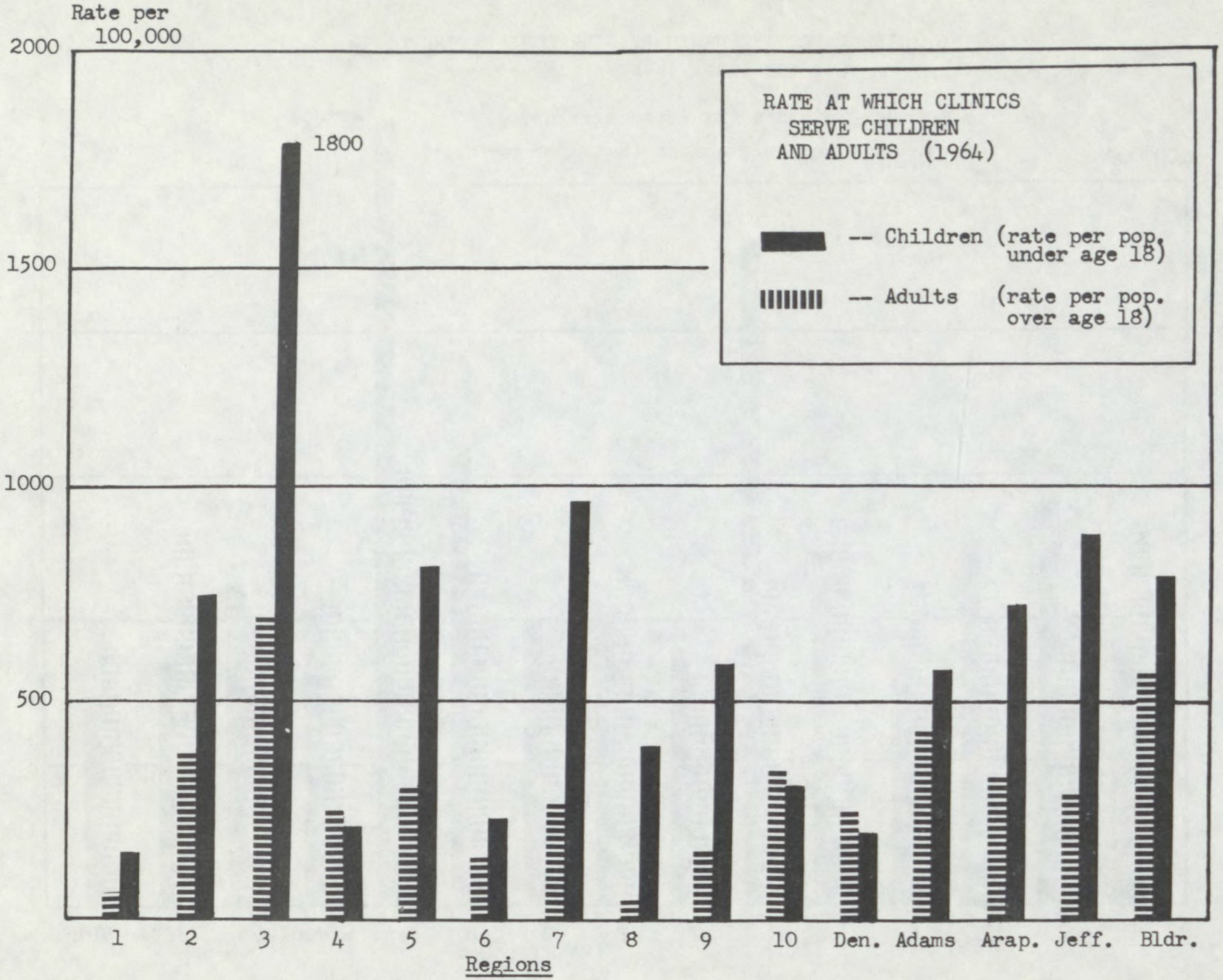
Second Year to 6/30/65

	State	Local	Private	Federal	Total
Salaries (Including retirement & additional benefits)	39,145.47	-	-	17,087.15	56,232.62
Travel					
Staff, Consultants & Committees	-	-	-	8,339.24	*8,339.24
Consultants and Special Studies	-	-	-	31,273.97	31,273.97
Supplies & Equipment	-	-	-	6,128.17	6,128.17
Other	459,760.17	144,478.64	384,009.87	1,502.81	989,751.49
SUB-TOTAL	498,905.64	144,478.64	384,009.87	64,331.34	1091,725.49
GRAND TOTAL	932,576.90	544,694.07	38,4009.87	94,355.18	1955,636.02

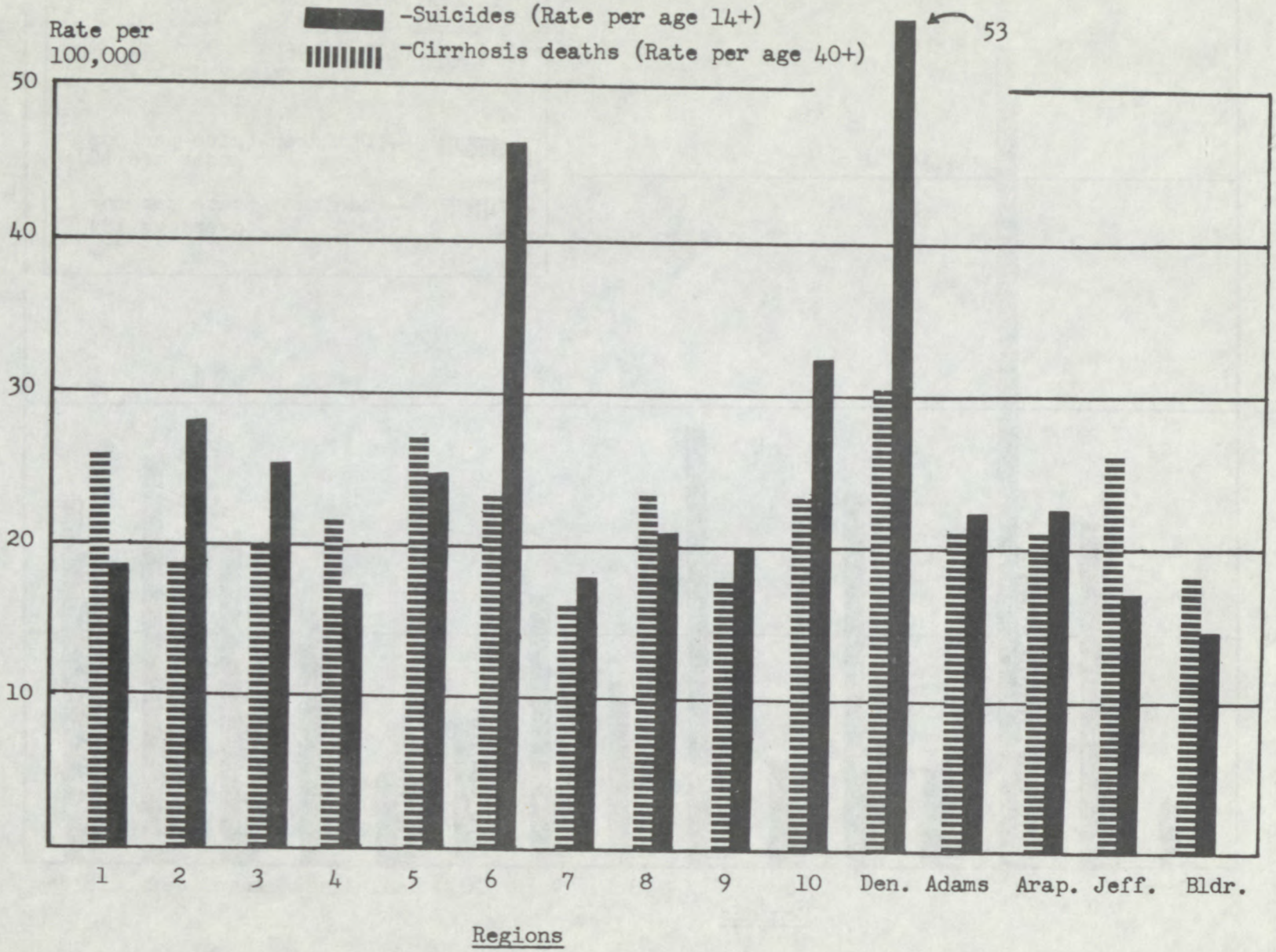
* $212.65 Refunded


COMBINED ADMISSION RATES: Colorado State Hospital, Fort Logan Mental Health Center
Rate per 100,000 (1963)
300
200
164
100
50
Functional (psychoses, neuroses,etc.)
Alcoholism
Organic
Colorado as a whole
1
2
3
4
5
6
7
8
9
10
Den.
Adams
Arap.
Jeff.
Bldr.
Regions


DEGREE TO WHICH CLINICS MEET MIMIMUM OUTPATIENT "NEEDS" (1964)
Note: "Minimum" need equals four full-time staff per 50,000 people.
- Community Clinics
- Prorated hours of medical school clinics
Percent of Need
100
80
60
40
20
1
2
3
4
5
6
7
8
9
10
Den.
Adams
Arap.
Jeff.
Bldr.
Regions


Rate per
100,000
2000
1500
1000
500
1800
RATE AT WHICH CLINICS
SERVE CHILDREN
AND ADULTS (1964)
-- Children (rate per pop. under age 18)
-- Adults (rate per pop. over age 18)
1
2
3
4
5
6
7
8
9
10
Den.
Adams
Arap.
Jeff.
Bldr.
Regions

SUICIDE RATES AND DEATH BY CIRRHOSIS OF THE LIVER:
Average Yearly Rates: 1957-63



INDEX OF MAJOR TOPICS

(In order of first appearance)

TOPIC INDEX (Cont.)

TOPIC INDEX (Cont.)